Original Publication

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Teaching Medical Students How to Ask Patients Questions About Identity, Intersectionality, and Resilience

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Abstract

Introduction: Medical education addressing people with sexual and gender minority (SGM) identities often focuses on sexual risk, is delivered in silos, and overlooks intersecting identities. SGM individuals—particularly those with coexisting stigmatized identities—experience a disproportionate burden of discrimination, which increases vulnerability to adverse health outcomes, especially when maladaptive coping behaviors are used to manage stress. Adaptive coping and resilience can develop in the context of identity affirmation and social support, for which sensitive clinician-patient interactions provide a crucial foundation. Guided by the AAMC publication *Implementing Curricular and Institutional Climate Changes to Improve Health Care for Individuals Who Are LGBT, Gender Nonconforming, or Born With DSD: A Resource for Medical Educators*, this session introduced first-year medical and dental students to the concepts of identity and intersectionality, providing an opportunity to practice apropos interviewing techniques. **Methods:** This 2-hour session includes prework, a didactic presentation, role-play scenarios, and a small-group session. Prior to the session, faculty facilitators had small-group leadership experience, and students had already mastered social history taking. Electronic student and faculty surveys provided qualitative assessment. **Results:** Faculty and students reported that the session increased awareness of the health impact of identity and intersectionality and the clinician's role in establishing rapport. Suggestions included adding a prework video defining diversity terminology and a patient panel describing diverse identities and experiences. **Discussion:** Addressing health issues related to SGM and other sociocultural identities is challenging yet crucial. This innovative session gave students an opportunity to explore their unconscious biases and practice novel interviewing techniques in a supportive environment.

Keywords

Discrimination, LGBT, Gender Identity, Sociocultural, Social Identity, Intersectionality, Psychological Resilience, Coping Skills, Social Stigma

Educational Objectives

After completing this 2-hour session, students will be able to:

1. Define identity, stigmatized identity, intersectionality, and resilience.
2. Describe the impact of various identifications (i.e., age, gender, race, ethnicity, sexual orientation, ability/disability, national origin, language, education, occupation, income, religion) on patients' lived experiences, the development of adaptive and maladaptive coping behaviors, and eventual health outcomes.
3. Explain the importance of creating a trusting relationship in which patients can safely disclose their identities and lived experiences.
4. More confidently query patients about sexual and gender minority and other sociocultural identities, associated life experiences, and strategies used to cope with adversity.

Appendices

- A. AAMC Competencies Addressed.docx
- B. Session Guide for Small-Group Facilitators.docx
- C. Session Description for Students.docx
- D. To Treat Me You Have to Know Who I Am.mp4
- E. IIR Didactic Presentation .pptx
- F. Case Role-Play Scenarios .docx

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

Introduction

As noted in the AAMC publication *Implementing Curricular and Institutional Climate Changes to Improve Health Care for Individuals Who Are LGBT, Gender Nonconforming, or Born With DSD: A Resource for Medical Educators*,¹ medical education addressing health care for people with sexual and gender minority (SGM) identities frequently conflates identity with behavior and focuses on sexual risk, is delivered in silos apart from the mainstream curriculum (thereby diminishing its importance to students), and overlooks the importance of intersecting identities. SGM individuals—particularly those with coexisting stigmatized identities—experience a disproportionate burden of societal discrimination. Stigma and discrimination increase vulnerability to adverse health outcomes, especially when maladaptive coping behaviors are used to manage stress. Fortunately, SGM individuals can develop adaptive coping and resilience in the context of identity affirmation and social support, for which clinician-patient relationships form a crucial foundation.

The development and implementation of this session took place against a backdrop of renewed interest in integrating SGM topics into undergraduate medical education generated in response to the 2014 AAMC publication.¹ Within this publication, the AAMC Advisory Committee on Sexual Orientation, Gender Identity, and Sex Development presents 30 LGBT/gender nonconforming (GNC)/differences of sex development (DSD) competency specifiers² correlating to 20 competencies across the eight domains of Englander et al.'s Physician Competency Reference Set.³ Furthermore, a national emphasis on addressing social inequities and the rollout of an entirely new curriculum at Harvard Medical School in 2015-2016 created a unique opportunity to integrate novel educational content.

This session was developed to (1) introduce the concepts of identity, intersectionality, and resilience to first-year medical and dental students enrolled in a clinical skills curriculum and (2) provide an opportunity for them to become more aware of their unconscious biases while practicing novel cross-cultural interviewing techniques. By considering SGM identities within a broad sociocultural context, this session provides a model for how to integrate SGM content where it rightfully belongs—alongside consideration of other identities—and to examine the impact of intersecting identities on health outcomes. Several other MedEdPORTAL publications have addressed cross-cultural interviewing and/or how to talk with patients about sensitive topics.^{4,5,6} This innovative session employs educational methods appropriate for adult learners in order to consider SGM identities alongside a wide variety of other sociocultural identities and provides a complementary and practical curricular technique to help students practice asking challenging questions in a supportive environment.

Methods

Curriculum development began with selecting 11 (out of 30) of the AAMC competency specifiers² that were relevant to our topic and goals and continuously referring to them to ensure we included all necessary content. Appendix A includes a table of the competency specifiers we selected for this session. Additional background on the process of creating the LGBT/GNC/DSD competency specifiers has been published in *Academic Medicine*.⁷

Our session was designed for first-year medical and dental students who had already learned how to take a basic social history during a longitudinal clinical skills curriculum. Session content would also be appropriate for medical and dental students in other years of training provided that they have also mastered basic interviewing skills.

One week prior to the session, we distributed the Session Guide for Small-Group Facilitators (Appendix B) to faculty by e-mail. This file contains a description of the learning session, including instructions for prework and how to run the small-group role-play exercise and wrap-up discussion. Faculty small-group facilitators were recruited by sending an e-mail invitation to all faculty involved in teaching portions of the longitudinal clinical skills course in which the students were enrolled. While these faculty members had previous experience leading small groups and providing constructive feedback to students, few had significant experience teaching diversity and inclusion topics specifically. Therefore, 1 week prior to the

session, all participating faculty were invited to attend a faculty development workshop entitled From Minefields to Learning Opportunities: Managing Sensitive Issues About Culture, Race, Ethnicity, Sexual Orientation, and Gender Identity. This submission does not include materials from that workshop since its scope was broad and covered far more than is relevant for our session on identity and intersectionality. However, given the sensitivity of the topics addressed in our session and the wide range of typical faculty experience with these issues, we recommend that institutions electing to use the curriculum convene faculty participants in advance to address any questions or concerns. All faculty members who chose to participate volunteered their time, which included 1-2 hours of preparatory time reviewing the Session Guide for Small-Group Facilitators, 2 hours of in-person teaching, and an additional 2 hours for those who attended the faculty development session.

To stimulate student interest in the topic, the session employed a flipped classroom technique. Following this model, students were expected to complete prework, as described in the Session Description for Students (Appendix C), and arrive at the session prepared to engage actively in classroom discussion and other educational activities. Prework included watching a short video and completing three readings. The video, entitled To Treat Me You Have to Know Who I Am (Appendix D), was created by NYC Health and Hospitals to address the impact of SGM identities on health care. It is included here with permission from Liz Margolies; a non-peer-reviewed version may also be accessed via <https://www.youtube.com/watch?v=NUhvJgxgAac>. The three readings are short essays addressing the impact of racial identification,⁸ transgender status,⁹ and disability¹⁰ on the formation of trusting relationships in the health care setting. These essays are award-winning entries submitted by medical students to the Arnold P. Gold Foundation Humanism in Medicine Essay Contest and represent autobiographical accounts of actual medical student interactions. All instructions, videos, and readings were distributed to students via an academic portal.

A short didactic session supplied a general overview of relevant terminology, theory, and interviewing tips. Following the didactic session, students met in small groups to practice interviewing skills using two of six carefully constructed role-play scenarios (discussed in more detail below) featuring patients with a wide variety of identities, life experiences, and coping mechanisms. Designed to arouse students' unconscious biases, these case scenarios were then discussed and processed during the wrap-up discussion that concluded each small-group meeting.

The 2-hour session began with each faculty facilitator establishing guidelines for safety, including respectfully listening to what others have to say and maintaining confidentiality. Students were then invited to share their responses to the prework for a brief discussion. Next, the facilitator gave a 45-minute presentation (Appendix E) providing an overview of diversity terminology, the impact of identities and lived experiences on health, and suggested questions for students to utilize when interviewing patients. This was delivered in a 200-seat amphitheater using a standard computer-projector setup. The didactic presentation was created by faculty members with expertise teaching topics related to diversity and inclusion. As the session addresses identity and intersectionality, we strongly recommend that the didactic presentation be taught collaboratively by at least two faculty members who personally represent diverse sociocultural identities. For example, two of us served as session leaders and delivered the didactic presentation while representing a diversity of identities that included gender identity (cisgender female), sexual orientation (heterosexual and lesbian), race (black and white), and religion (Christian/Baptist and Quaker), just to name a few.

Following the didactic portion of the learning session, approximately five student pairs (some groups were slightly larger) and one faculty facilitator met in small groups to practice incorporating questions about identity and intersectionality into the social history. This part of the learning session required the availability of multiple small-group breakout rooms. It is important for facilitators to start the small-group activity by repeating the ground rules for safety that have been initially discussed during the didactic presentation.

Using the six case scenarios (Appendix F), each student had the opportunity to serve once in the role of a patient and once in the role of an interviewer during the 15-minute role-plays. The scenarios contain rich

sociocultural information inclusive of a broad array of patient identities and lived experiences and were constructed purposefully to arouse unconscious bias or certain assumptions on the part of the student interviewer (e.g., on learning that a patient has hepatitis C, a student might assume the patient has a history of IV drug use).

For each scenario, the student in the interviewer role received a card showing a line drawing of the patient's appearance, legal name as recorded in the medical record, a brief description of the reason for the visit, and instructions to spend the next 15 minutes learning as much as possible about the patient's social context. The student in the patient role received a card listing the patient's insurance name and preferred name, identities (e.g., age, gender identity and pronouns, race/ethnicity, national origin/language, sexual orientation, partnership status, housing, education and occupation, ability/disability, health condition—related identities, and religion/spiritual practice), sources of stress (e.g., stigma and discrimination, personal safety, and financial situation), and lifestyle behaviors/coping strategies (e.g., support and connection, interaction with the health care system, substance use, sexual behavior, and body image/nutrition/exercise).

Once the small groups completed all scenarios, faculty members led a wrap-up discussion. Guiding questions for this debriefing included:

- What were the major take-home points you learned in this session?
- Did you notice yourself making any assumptions about the patient you interviewed based on the demographic/medical information and line drawing provided at the outset?
- How did you decide how to portray the identities and intersectionality of the patient when you were in the patient role? In what ways did your portrayal manifest unconscious bias/stereotyping?
- Which elements of the role-play exercise went well and which were most challenging?
- On which areas will you focus your attention during subsequent interviewing practice?

Currently, learner assessment for the entire, multisession clinical skills course is collected in aggregate; thus, no quantitative data specific to this session are available. Qualitative assessment was conducted post hoc via online surveys distributed to designated student representatives ($n = 10$), who are involved in reviewing the first-year curriculum and making recommendations for improvement, as well as all of the faculty members ($n = 19$) who facilitated a small-group session.

Results

One hundred seventy-five first-year Harvard Medical and Dental School students who were enrolled in a longitudinal clinical skills course completed this 2-hour session during the 2015-2016 academic year. These students had previously mastered introductory interviewing skills, including performance of a basic social history. Nineteen faculty members with experience leading small-group discussions and providing constructive feedback volunteered to serve as small-group facilitators; only a few of these faculty members had prior expertise teaching topics related to diversity, inclusion, and/or cross-cultural care.

Five out of 10 (50%) of the student representatives who were surveyed responded. These students unanimously reported that the topic of identity and intersectionality was an important addition to the curriculum, as noted in this quote: "Intersectionality is a core concept for understanding how people perceive themselves, how others perceive them, and the many axes of privilege and oppression."

Respondents listed the following as major take-home points resulting from their participation in the session:

- "Identity is multifaceted and contributes to people's health and engagement with the health care system."
- "Our own conscious and unconscious biases are important to identify and address."
- "Err on the side of asking about a person's identity and how it affects them instead of making assumptions."

- “People’s experience of others’ perceptions (and, e.g., associated feelings of shame) will likely follow them into the exam room, so it’s crucial for providers to proactively be welcoming and open to patients.”

When asked if they intended to do anything differently as a result of attending the session, respondents stressed the importance of refraining from making assumptions and of attending to choice of language, as illustrated by the following quotes:

- “I’ll make sure to conduct a thorough sexual history, even when a patient presents with sexual experiences that are unfamiliar to me personally. And, when I don’t understand some term, I’ll make sure to ask.”
- “I’ve been exposed to these ideas in many other settings, so many of the suggestions were things I try to do already. However, I think the focus on the importance of language will influence the terms I use in the future.”

When asked for suggestions on how to improve instruction in the future, respondents had the following recommendations:

- “I found the lecture to be chock full of really important information and suggestions, but I think I would have benefitted from an outline at the beginning of the lecture (perhaps split the lecture into a few sections?).”
- “It might be a good idea to add more structure to the small-group session. One suggestion would be to pick a few topics (e.g., gender identity, sexuality, race) and role-play about these specific topics individually.”
- “More explicit discussion of poverty as a part of people’s lived experiences, as well as consideration of how often physicians feel powerless in the face of intractable structural barriers to health.”

Fourteen out of 19 (74%) of the faculty participants responded to the post hoc electronic query. Several faculty members reported a need to recap information about the importance of identity disclosure during the beginning of the small-group session as some students questioned the importance of addressing identity with patients at all, believing behavior to be more clinically relevant. These students appeared to be satisfied after reviewing examples already presented during the didactic session and readily moved on to perform the role-play exercises. During the small-group debrief following completion of the role-plays, faculty reported particularly rich discussions resulting from students’ awareness of the assumptions and unconscious biases that arose during the exercise. Overall, the majority of faculty survey respondents reported that the learning session was successful in raising students’ awareness about the health impacts of identity and intersectionality and the clinician’s role in establishing rapport. The majority also expressed how much they valued the unique opportunity this session provided for students to practice challenging yet crucial interviewing skills in a supportive environment.

Several students and faculty members made suggestions for curricular refinement. These suggestions included adding a prework video defining diversity terminology and/or a patient panel describing diverse identities and experiences, as well as lengthening the overall session to permit more time for discussion.

Discussion

For the reasons outlined in the Introduction, addressing health issues related to SGM and other sociocultural identities is challenging yet crucial. This innovative session gave students an opportunity to explore their unconscious biases and practice novel interviewing techniques in a supportive environment.

Four evidence-based curricular interventions have been recommended to mitigate harms related to unconscious bias during provision of health care.¹¹ Two of these interventions (i.e., increase self-awareness, develop empathetic skills) focus on the individual student level, while the other two (i.e., create an inclusive learning environment, create learning opportunities for positive interaction) focus on the institutional level. Our identity and intersectionality session addressed each of these four elements. In addition, by incorporating a significant proportion (11 out of 30) of the AAMC Advisory Committee on

Sexual Orientation, Gender Identity, and Sex Development competency specifiers, our session serves as a model for how key content pertinent to specific minority populations can be integrated seamlessly and efficiently into the mainstream medical school curriculum. Furthermore, our session employed a refreshing perspective in examining SGM health through the lenses of identity and resilience, rather than sexuality and maladjustment, and considering SGM identities alongside other intersecting identities. Lastly, our session's use of a flipped classroom technique and experiential role-play exercises engaged students actively in the learning process and afforded an invaluable opportunity not simply to hear about new skills but also to practice them.

Several limitations are also noteworthy. First, although a qualitative assessment of the effectiveness of the session was conducted via post hoc online student and faculty participant surveys, we have not yet collected quantitative data that address the session's impact on the acquisition of specific learner knowledge, attitudes, or skills; these measures will be important to study in the future.

Second, only 50% of the designated student educational representatives responded to the online survey. Since this session is part of a new medical school curriculum, these select students are aggressively surveyed, and we postulate that the low response rate was most likely due to survey fatigue. However, it is possible that nonresponders may have had less favorable evaluations of our learning session compared to those who did respond.

Third, although the role-play scenarios provided exquisite sociocultural detail and our students were talented actors, interviewing an actor posing as a person with multiple intersecting identities can never replace the experience of interviewing an actual patient with the same identities. Indeed, despite establishing ground rules for safety at the beginning of the session, having an actor portray identities different from the actor's own could possibly be triggering or offensive to other students. On the other hand, having students interview actual patients with these same identities could be similarly triggering or offensive for those patients, particularly when we consider that individuals with stigmatized identities often find themselves tasked with being the spokesperson or poster child for the views and experiences of their communities. Ultimately, use of the role-play scenarios gave students a chance to meet and interact with personalities representing complicated, intersecting identities; as such personalities may be uncommonly and sometimes never otherwise encountered during training, this opportunity for interviewing practice was extraordinarily valuable.

Fourth, as previously alluded to, this session addresses emotionally charged topical material, and it is to be expected that some students and faculty members might feel anxious about participating. We therefore dedicated time during both the didactic and small-group portions of the session to discuss explicit ground rules to establish safety. While we did not directly measure participants' level of distress before or after the session, we did not observe any overt manifestations of distress. Although limited by small numbers and a low student response rate, our positive qualitative data suggest that our approach was successful in mitigating the harm that could occur if a student and/or faculty participant were to unknowingly cause a microaggression in the course of practicing or teaching novel communication techniques.

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Disclosures

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Ethical Approval

Reported as not applicable.

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