Introduction

Do primary care physicians have the proper knowledge and comfortability to take care of the lesbian, gay, bisexual, transgender, and queer (LGBTQ) individual? A recent systematic review conducted by Gallup in 2016 indicated that 4.1% of 6 million Americans identified as LGBT, and the National Institute of Health recently released a statement identifying sexual health disparities among LGBTQ individuals. These populations are at an increased risk of discrimination and stigma from different perspectives. LGBT individuals have a higher incidence of suicide, mental health concerns, and substance abuse secondary to social stigma and stressors in comparison to their heterosexual, cisgender counterparts. Transgender individuals were less likely to receive cervical cancer screening. A portion of this discrimination stems from the education that physicians receive on LGBTQ health concerns. Medical school curricula was also surveyed, reporting a mean of 5 hours of LGBTQ education, with 6.8% of schools reporting no LGBTQ education and 33.3% reporting no education in clinical years. A panel of emergency medicine residents were assessed on their comfortability of taking care of LGBTQ patients; it was concluded that residents were overestimating comfortability taking care of LGBTQ individuals. Several studies on intersex individuals concluded that lack of comfortability on providing care to transgender individuals, and another showed lack of knowledge on preventative care affecting sexual gender minority patients. Primary care clinicians were surveyed on their willingness to care for transgender patients; results indicated that willingness declined with increasing age of the physician, and that willingness to provide care was higher among those who met a transgender individual and those with lower transphobia.

So how can physicians improve their knowledge and comfortability taking care of LGBTQ patients? One study reported an increase in LGBTQ health concerns after a lecture on sexual orientation when pre- and post-test scores were analyzed. Further, some schools have implemented LGBTQ panels to meet with students, showing improved levels of comfortability and knowledge. As research is lacking in regards to improving medical education, our study aimed to assess current knowledge and comfortability with LGBTQ health concerns.

Methods and Materials

Specific Aim:
Do primary care residents and attendings have sufficient medical knowledge and comfortability for LGBTQ health issues?

Primary Objective:
To assess Milwaukee family medicine resident and attending physician knowledge and comfortability in regards to LGBTQ healthcare (terminology, screening guidelines, medical management) in pre-primary care and after online presentations given at resident-faculty meetings.

Study Population/Sample Size:
Aurora Family Medicine Residency faculty and residents (either MD or DO) at FPC and FCC locations. NPs, Pas, medical students, RNs, Mas, and clinic staff were not included in the study. There was a total of approximately 36 residents and 15 attending physicians surveyed for a total of 45 participants.

Study Design:
An online pre-survey designed as a pre-test to better understand current knowledge and comfortability was emailed to residents and faculty two weeks prior to the first online educational presentation. Residents were asked to respond to the survey prior to the first presentation, at which time it was then closed. The survey included Likert-scale questions asking the participants to subjectively acknowledge knowledge levels and comfortability taking care of an LGBTQ patient, followed by multiple choice questions on terminology, and case vignettes with multiple correct and incorrect answers.

Upon completion of the survey, two presentations were held over the span of two months discussing LGBTQ health topics (first presentation on gay, lesbian, and bisexual health, and second presentation on transgender and genderqueer health). These were presented at resident-faculty meetings for approximately 10–15 minutes per presentation with time for questions after the presentations. After finishing the second presentation, the participants were emailed a post-survey identical to the pre-survey to complete within three weeks. All residents, faculty, and NPs were emailed the presentations after the resident-faculty meetings as well.

Data Collection/Statistical Plan:
Pre-surveys were collected for two weeks in November 2020. Presentations were held in December 2020 and January 2021, with the post-survey-collected and analyzed in February 2021. Categorical variables were analyzed using Chi-Square tests, and continuous variables were analyzed using T-tests.

Results

Pre-test (n=34) and post-test (n=20) responses were compared using Chi-Square tests, and continuous variables were analyzed using T-tests. While respondents reported improvement in knowledge (pre-test 43.4%, post-test 53.1%) and comfort (pre-test 52.0%, post-test 62.0%) after the lecture series, results were not statistically significant. While self-reported knowledge and comfort scores improved after receiving lectures on LGBTQ health, results were not statistically significant. Interpretation of the data was limited due to fewer respondents on the post-test (n=34 for pre-test and n=20 for post-test). There was no statistical significant difference between pre-test and post-test scores on LGBTQ health questions.

Discussion and Recommendations

While self-reported knowledge and comfort scores improved after receiving lectures on LGBTQ health, results were not statistically significant. Interpretation of the data was limited due to fewer respondents on the post-test. It is unclear what percentage of residents and attendings were able to attend these pre-tests. Results suggest that whether more or less educational sessions would have increased medical knowledge and comfort further. Finally, there is also the possibility that residents and attendings may have overestimated their knowledge and comfort in the pre-test surveys. Addressing barriers to physician attendance and completion of surveys could improve the study.

Conclusions

Investigating the comparison of programs with incorporation of LGBTQ health didactics versus those with little or none would also provide further identification on differences in knowledge and comfortability. While self-reported knowledge and comfort scores improved after receiving lectures on LGBTQ health, results were not statistically significant. Interpretation of the data was limited due to fewer respondents on the post-test.

References