

The Case for a Transgender Curriculum in Medical Education
By Aaron Marshall, Ph.D. · January 1, 2019

The LGBT community has been vocal—rightfully so—about demanding access to patient-centered health care without subtle acts of disenfranchisement, instances of judgement, or overt discrimination from medical personnel. As with many sociocultural problems, a multi-pronged approach to rectifying these issues is needed. One duty in my role as an educator of first- and second-year medical students is the creation and continual maintenance of the medical science curriculum that students are expected to learn as a foundation for clinical practice. This includes everything from how the cells, tissues and organs of the body function and sometimes malfunction, to recognizing and treating disease, to applying the principles of treatment to specific patient populations. This duty eventually led faculty at the University of Cincinnati College of Medicine to create a new transgender medicine curriculum in 2016, which is now part of the basic science course covering the reproductive system.¹

To lay a foundation for trainees to be confident and professional when encountering a transgender patient, the simple yet effective approach discussed here should be considered, the overarching premise of which is to present gender (cis- or trans-) as a *potentially* relevant part of the patient's history. Early on, medical students are attempting to absorb volumes of medical science information and decipher what aspects of a patient's history are relevant to the diagnosis and treatment plan. Like all parts of a patient history, some are more relevant than others, especially when considered in the context of the patient's chief complaint. For example, one's gender may be irrelevant for a patient presenting with sinusitis but of the utmost importance when conducting an annual physical and discussing preventative health care.

Many aspects of transgender medicine are important to teach in a preclinical curriculum. They include simple definitions of sex and gender, historical issues regarding access to health care, recognizing and understanding gender dysphoria, the physiologic effects and considerations of gender-affirming hormone therapy, and more. It's also important to highlight the transgender community as an example of a medically underserved population while at the same time framing the care of transgender patients as simply personalized medicine. Personalized medicine is a paradigm that is here to stay. Its origins stem from sequencing of the human genome and the idea that something as granular as a gene sequence can inform clinical treatment decisions. The concept has expanded to encompass many personalized measures from the broad to the specific. I offer that presenting transgender identity to medical students as an aspect of a patient's history—which if properly understood, will foster better personalized medicine—is a very powerful teaching moment. In essence, the patient's gender and potential use of gender-affirming hormones is just one of the many puzzle pieces a clinician must understand to make an informed health care decision.

The birth of a transgender medical curriculum

The genesis of our school's transgender medicine curriculum, and its placement within the basic science medical school coursework, was sparked by a memorable conversation with a former medical student. This inquisitive student had attended a panel presentation where members of the LGBT community told anecdotes about their experiences interacting with health care professionals. At our institution, the panel discussion had been the most widespread pedagogical approach to “training” medical students to handle clinical encounters with members of the LGBT community. While this personal touch was undoubtedly memorable for many students, it lacked

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the medical science foundation that would force students to reconcile and apply their science knowledge to a transgender patient population.

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Perhaps recognizing this omission, after the panel discussion ended, a student asked me whether a transgender man, opting for gender-affirming hormone therapy, was at an increased risk for cardiovascular disease. The student recalled androgen's action on the body and the cardioprotective effects of estradiol, and attempted to reconcile those facts with the sex steroid status of a transgender male. Although I had personally taught the physiology of sex steroids, I did not know the answer to the question. On the spot, the best answer I could come up with was to hypothesize that there may be a different response by the cardiovascular system of a cisgender male prescribed androgen for clinically low testosterone and a transgender male taking androgen for gender-affirming hormone therapy.

Thus began a domino effect of discussions and meetings, beginning with a search for an answer to this initial question, and ending with a search for a physician collaborator to create a more robust transgender medicine curriculum at the medical school. The result was to create a curriculum that centers on treating gender as another variable to consider when practicing personalized medicine. Naturally, another curricular centerpiece was a deep-dive into transgender medicine to fill in the gaps in students' medical science knowledge. This approach was powerful because it fulfilled preclinical students' desire to learn medical science, and thus met them "where they are," in addition to establishing an understanding about the sociocultural issues surrounding access to health care and communicating with transgender patients in a respectful way.

Widespread adoption of a similar curriculum nationwide may result in an entire generation of physicians with the compassion and aptitude to care for transgender patients. Ideally, success in this arena could be measured by the lack of a need for separate health care clinics for LGBT patients. Stated another way, success would allow all patients to seek care from any provider with the confidence that their physician was trained to understand their personalized needs.