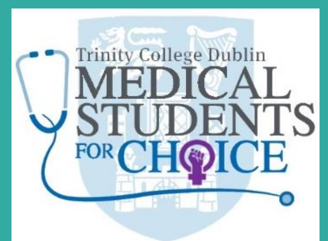
Reproductive Healthcare and LGBTQ+ Health

AUGUST 23

Medical Students for Choice
Authored by: Sara Sotirakos



Proposal to Update the Reproductive Healthcare Curriculum and Create a More Inclusive Curriculum for LGBTQ+ Health.

Introduction

Reproductive healthcare is a major aspect of medical training. This spans from maintenance health and screening of the female reproductive tract, contraception, fertility care, prenatal care, labour and delivery, postnatal care, abortion, and more. Another crucial aspect of healthcare, which has yet to have an adequately established standard of care in Ireland, is LGBTQ+ health. This includes reproductive healthcare for LGBTQ+ patients and gender-affirming care. A key barrier in access to this care is discrimination within the healthcare system and by health policies. Discrimination within the healthcare system may take the form of microaggressions by staff towards patients, lack of available services for patients (ex. Gender-affirming care, psychiatric support for transgender youth), or policies limiting access to care (ex. The National Gender Service). The current curriculum does not adequately address these gaps as the reproductive curriculum is out of date, and there is currently no inclusion of LGBTQ+ specific healthcare.

A brief statement on language used in this proposal. Throughout this proposal, the terminology used will be inclusive to all patients capable of carrying a pregnancy. Furthermore, an important distinction between the terms gender and sex should be acknowledged, as such they will be used based on their correct definition. Gender is a societal construct which exists on a wide spectrum. Sex refers to one's biological/chromosomal makeup. Gender-affirming care refers to medical, surgical, and psychological branches of healthcare, which provide support for patients to feel affirmed in their gender. A list of the terminology used in this proposal can be found in Table 1.

Abortion Care

Since 1861, persons who underwent an abortion in Ireland were subject to criminal penalties (1). In 1983, the Eighth Amendment of the Irish constitution allowed abortion to take place only if the life of the pregnant person was at risk (1). In 2018, the referendum known as Thirty-sixth Amendment, repealed the Eighth Amendment, with a sweeping majority of 67% of people voting in favor of the repeal (1). An analysis of the global rates of unintended pregnancy and abortion found that unintended pregnancy rates are on the decline, whereas the proportion of unintended pregnancies ending in abortion has increased (2). The findings of this analysis indicated that individuals do seek out abortions, even in areas where they are restricted. This stresses the importance of ensuring access to safe abortion care, within the current legal time frame (2).

Access to abortion care in Ireland is still restricted by the current legislation which limits abortion to the first twelve weeks of pregnancy and requires a mandatory three-day wait period between the initial certification by a physician and the procedure (3). Considering urine pregnancy tests do not provide a positive result until at least one week following conception, these added time constraints greatly restrict access. In addition, access may also be limited by a lack of competence in newly trained physicians. The Year 4 curriculum states the following: "The aim of the assessment of the Module in O&G is to establish whether you have achieved the core competencies in women's health required for safe practice as a general practitioner or a non-specialist hospital doctor (and the standard for the 'minimally competent' student is set at this level)." In 2019, 6542 early terminations of pregnancy, performed by general practitioners, were reported in Ireland (4). This procedure is not uncommon, therefore for students to one day practice safely as a general practitioner or non-specialist hospital doctor, the recommended additions to the curriculum enclosed in this proposal, are imperative.

Three years have since passed since the repeal of the Eighth Amendment, but current medical students do not feel their medical training adequately prepares them to provide abortion care. The current training primarily takes place in the 4th year Obstetrics and Gynecology module and includes the legal and ethical aspects of

abortion, as well as contraceptive methods. However, it lacks teaching on the process of medical and surgical abortions. In 2021, the Trinity chapter of Medical Students for Choice (MSFC) conducted a survey of 161 Trinity medical students and graduates (Appendix 1). Of the 161 respondents, 31 were in Year 4, 35 were in Year 5, and 1 was a graduate. In our quantitative analysis, there was an overwhelming majority in favour of enhancing the curriculum surrounding the topics of pregnancy options, the medical and surgical process of abortion, the issues and disparities around access to abortion, and LGBTQ+ health. In our qualitative analysis, the consensus was that contraception and emergency contraception are taught well, but medical abortions, surgical abortions, and LGBTQ+ aware care were not.

LGBTQ+ Health

One of the first clinical skills student doctors are taught is the acronym “WIPER” for first encounters with patients. Wash your hands, Introduce yourself, ask Permission, Expose the patient, and Recline/Reposition the patient. This, along with all else we are taught, is done through a heteronormative lens. A key part of the first encounter with a patient should also include confirming the correct name and pronouns to address them with, as this is incredibly important for building rapport in the patient-doctor relationship and affirming one’s gender identity, regardless of whether their gender identity matches that assigned at birth. A simple way to incorporate this would be to add another P to WIP(P)ER, for Preferred name and Pronouns. With respect to sexuality, a review from the University of Limerick of the attitudes, knowledge and beliefs of nurses and midwives of the healthcare needs of the LGBTQ+ population, noted that 83.2% of lesbian and bisexual women and 65.8% of gay and bisexual men were presumed to be heterosexual by healthcare staff (5). These authors concluded that heteronormativity and neutral or negative attitudes towards the LGBTQ+ population appear to be the greatest barrier of access to healthcare (5). They also recommended that LGBTQ+ issues should be incorporated into undergraduate education and continued professional development, as this would promote positive attitudes, knowledge and beliefs of healthcare providers (5). Small changes at the level of medical education could begin a ripple effect in changing the heteronormative culture that currently operates in the Irish healthcare system.

Another review examines how diversity training is insufficient in addressing heteronormative microaggressions, because the training typically fails to help individuals identify their implicit biases (6). The authors identify that the conception of these heteronormative microaggressions are reinforced at the social level and cannot be addressed only at the individual level (6). The authors recommend that a multi-level approach be adopted to undermine the heteronormative schemas in the clinical setting (6). One level of this would be at the level of curriculum. Another level would be to normalize practicing WIPPER in the clinical setting and slowly shift the culture in the healthcare system to a more mindful and inclusive one.

Furthermore, education on providing healthcare to transgender patients is a necessary addition to the curriculum. Transgender healthcare in Ireland is currently operating on a psychiatric model, which is outdated and not evidence-based, instead of an informed consent model, which is what is advised by the World Professional Association for Transgender Health (WPATH). The only way to access gender-affirming care is through GP referral to the National Gender Service (NGS) at St. Columcille's Hospital, where the wait time is approximately 3 years, and growing. Two psychiatric assessments and a diagnosis of gender dysphoria must be made by the NGS team, and all three components are required before being referred to an endocrinologist. This system gatekeeps and delays gender-affirming care for transgender patients. Transgender patients have significantly increased rates of suicidal ideation, suicide attempts, and death by suicide compared to the general population (7). Data summarized in the WPATH Standards of Care have shown that earlier access to gender-affirming care improves psychosocial outcomes for trans patients (8). Adding teaching on gender-affirming care to the curriculum will not only help reduce microaggressions trans patients face in the healthcare setting, but it will also help expand the services available to better serve the needs in Ireland.

Table 1. Terms and definitions.

Gender	Gender is the spectrum of characteristics pertaining to, and differentiating between, femininity and masculinity.
Heteronormative	Denoting or relating to a world view that promotes heterosexuality as the normal or preferred sexual orientation.

LGBTQ+	Lesbian, Gay, Bisexual, Transgender, Queer, and all other non heterosexual or cis-gender identities.
Microaggression	Brief intentional or unintentional verbal, behavioural, and environmental abasements that communicate hostile, derogatory, or negative racial, gender, sexual-orientation, and religious spurns and insults to the target person or group.
Non-binary	Non-binary or genderqueer is an umbrella term for gender identities that are neither male nor female, i.e. identities that are outside the gender binary.
Sex	Sex is a trait that determines an individual's reproductive function, typically male or female, in organisms that propagate their species through sexual reproduction.
Trans/Transgender	Denoting or relating to a person whose sense of personal identity and gender does not correspond with their birth sex.

Recommendations

These recommendations were developed using the “spiral” curriculum model (9). This model enhances learning by linking new information learned to previously taught material (9). The goal of these recommendations is to introduce these concepts early, and revisit them from year to year. We recommend making the following additions to the modules outlined below.

1st Year

MDU11002 Human Development, Behavioural Sciences and Ethics

1. Provide training on the scope of doctor’s role with respect to LGBTQ+ aware practice (i.e. not assuming the gender of patient’s partners, asking for pronouns, not discussing LGBTQ+ patients outside of the hospital setting)
2. Addition of a lecture or Problem Based Learning (PBL) session on informed consent in the context of abortion.
3. PBL session on the pressures around abortion from family, and doctors’ implicit biases.
4. Ethics session on abortion.
5. Scenario-based sessions: encountering LGBTQ+ patients, patients seeking an abortion, consoling patients, responding to the news of pregnancy, responding to patients who have experienced sexual assault, delivering bad news, how to address opposing beliefs.

MDU11004 Human Form and Function

1. Additional lecture, or incorporation into existing lectures on the endocrinology and physiology of contraception and termination of pregnancy.

2nd Year

MDU22001 Principles of Pharmacology & Practical Scientific Research

1. Additional lecture, or incorporation into existing lectures on contraception and family planning techniques.

MDU22003 Fundamentals of Clinical and Professional Practice

1. Inclusion of pronouns/preferred names to WIPPER and OSCEs.

2. Training session to identify implicit biases and reduce visual judgements of patients.
3. Disparities policy, value clarification workshop.
4. Scenario-based sessions: affirming LGBTQ+ people through communication, patients seeking an abortion, consoling patients, responding to the news of pregnancy, responding to patients who have experienced sexual assault, delivering bad news, how to address opposing beliefs.

3rd Year

MDU33001 Pharmacology and Therapeutics

1. Pharmacology of gender-affirming care (i.e. Hormone replacement therapy).
2. Pharmacology of medical abortion.
3. Epidemiology of family planning (i.e. statistics on the utilization of various methods of contraception, fertility treatments, and abortion services).

MDU33002 Laboratory and Investigative Medicine

1. Spontaneous abortion diagnosis and management.
2. How to manage IVF and other family planning options.

4th Year

MDU44003 Obstetrics and Gynecology

1. Early Pregnancy
    a. Knowledge
        i. Process of medical abortion, how to provide service as GP
        ii. Surgical abortion techniques, how to refer on as GP
2. Skills - Add to logbook, observe:
    a. Medical abortion, how to provide service as GP
    b. Surgical abortion, how to refer on as GP
3. Reproductive and Sexual Health
    a. LGBTQ+ health
        i. LGBTQ+ sexual health
        ii. Pregnancy options
        iii. Gender affirming care

References

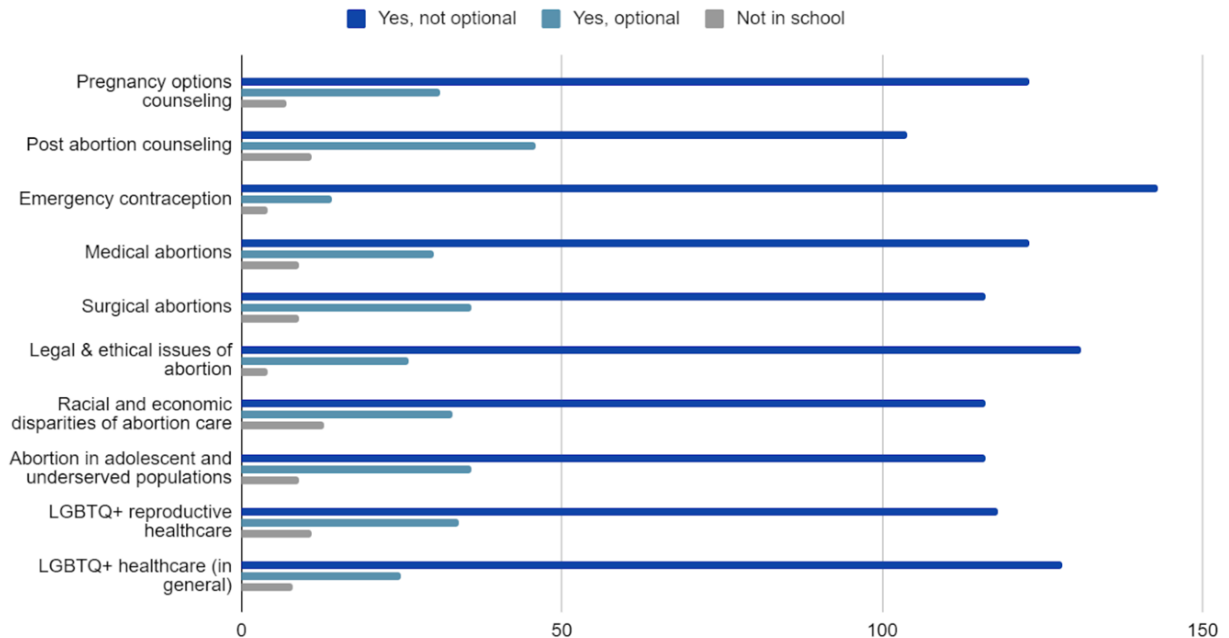
1. History of Abortion in Ireland [Internet]. Irish Family Planning Association. Available from: https://www.ifpa.ie/advocacy/abortion-in-ireland-legal-timeline/
2. Bearak J, Popinchalk A, Ganatra B, Moller A-B, Tunçalp Ö, Beavin C, et al. Unintended pregnancy and abortion by income, region, and the legal status of abortion: estimates from a comprehensive model for 1990–2019. The Lancet Global Health. 2020 Sep;8(9):e1152–61.
3. Hogan C. Why Ireland's battle over abortion is far from over [Internet]. The Guardian. Available from: https://www.theguardian.com/lifeandstyle/2019/oct/03/why-irelands-battle-over-abortion-is-far-from-over-anti-abortionists
4. NOTIFICATIONS IN ACCORDANCE WITH SECTION 20 OF THE HEALTH (REGULATION OF TERMINATION OF PREGNANCY) ACT 2018 - ANNUAL REPORT 2019 [Internet]. HSE Department of Health; Available from: https://www.gov.ie/en/publication/b410b-health-regulation-of-termination-of-pregnancy-act-2018-annual-report-on-notifications-2019/
5. Stewart K, O'Reilly P. Exploring the attitudes, knowledge and beliefs of nurses and midwives of the healthcare needs of the LGBTQ population: An integrative review. Nurse Education Today. 2017 Jun;53:67–77.
6. Dean MA, Victor E, Guidry-Grimes L. Inhospitable Healthcare Spaces: Why Diversity Training on LGBTQIA Issues Is Not Enough. Bioethical Inquiry. 2016 Dec;13(4):557–70.
7. Herman JL, Brown TNT, Haas AP. SUICIDE THOUGHTS AND ATTEMPTS AMONG TRANSGENDER ADULTS Findings from the 2015 U.S. Transgender Survey. :36.
8. Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People [Internet]. The World Professional Association for Transgender Health; Report No.: Version 7. Available from: https://www.wpath.org/publications/soc
9. Harden RM, Davis MH, Crosby JR. The new Dundee medical curriculum: a whole that is greater than the sum of the parts. Medical Education. 1997 Jul;31(4):264–71.

Appendix 1: Survey data

Demographics:

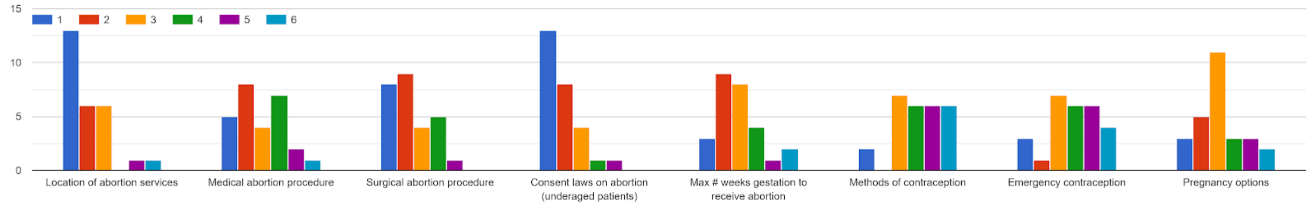
- 161 people completed this survey.
    - 26.1% (n=42) year 1
    - 11.2% (n=18) year 2
    - 19.9% (n=32) year 3
    - 1.2% (n=2) intercalated masters
    - 19.3% (n=31) year 4, of which, 17 people have completed their OBGYN rotation
    - 21.7% (n=35) year 5
    - 0.6% (n=1) graduated

We asked whether the following topics should be included in the medical school curriculum, and if they should, whether they should be mandatory.

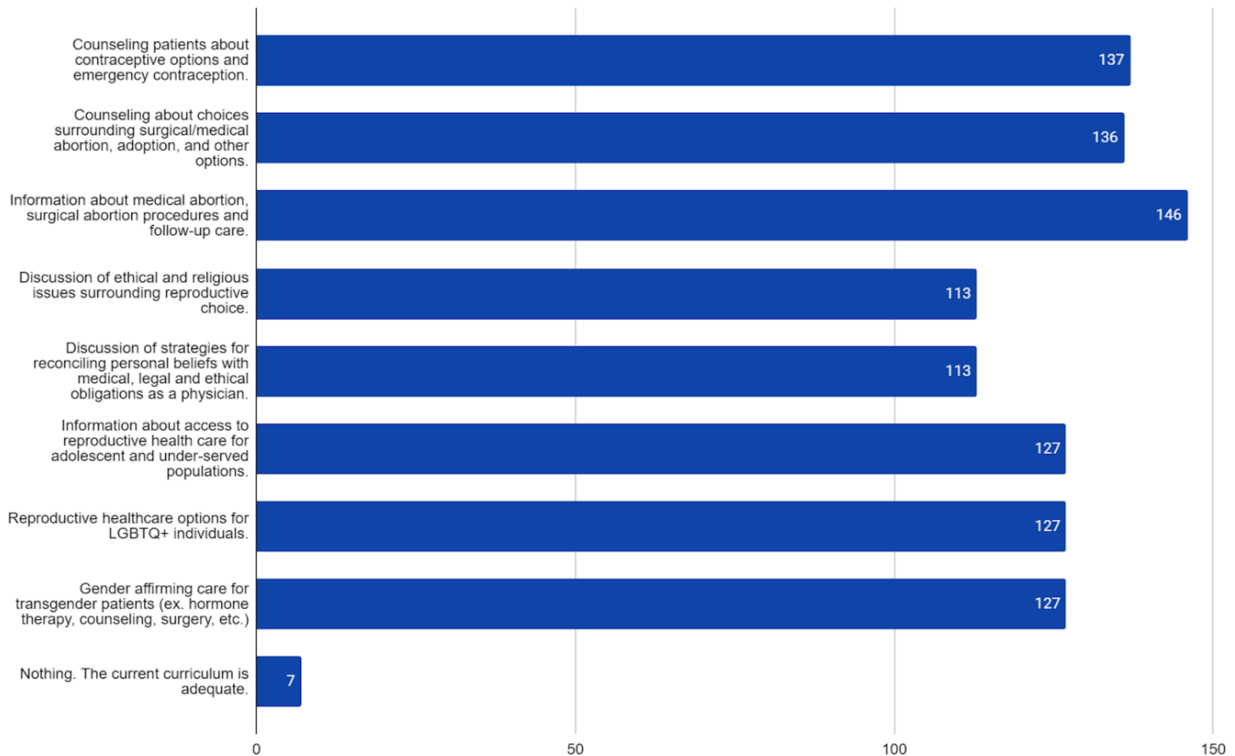


There was an overwhelming majority in favour of enhancing the curriculum surrounding the topics of pregnancy options, the medical and surgical process of abortion, the issues and disparities around access to abortion, and LGBTQ+ health.

We also asked students to rate on a scale of 1-6, how well do you feel you can provide accurate medical information regarding the following topics.



We also asked students which of the following topics they would like to see better addressed in the current curriculum.

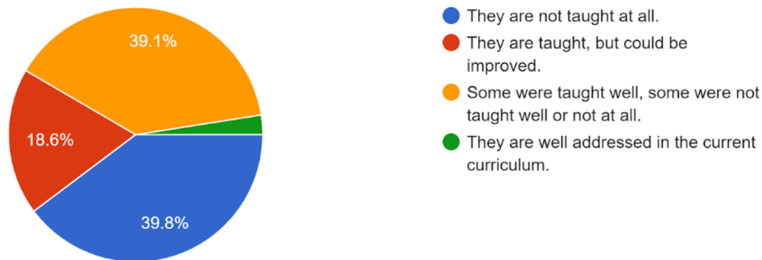


Options:

1. *Counseling patients about contraceptive options and emergency contraception.*
2. *Counseling about choices surrounding surgical/medical abortion, adoption, and other options.*
3. *Information about medical abortion, surgical abortion procedures and follow-up care.*

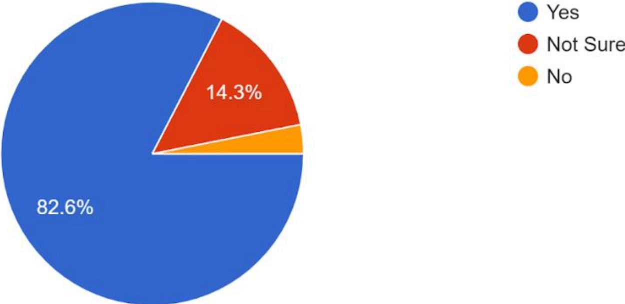
4. *Discussion of ethical and religious issues surrounding reproductive choice.*
5. *Discussion of strategies for reconciling personal beliefs with medical, legal and ethical obligations as a physician.*
6. *Information about access to reproductive health care for adolescent and under-served populations.*
7. *Reproductive healthcare options for LGBTQ+ individuals.*
8. *Gender affirming care for transgender patients (ex. hormone therapy, counseling, surgery, etc.)*
9. *Nothing. The current curriculum is adequate.*

We then asked how well the students feel these issues are currently being addressed in the curriculum.

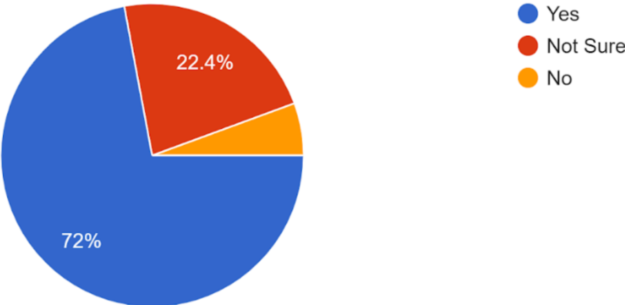


Finally, we also asked if there was interest in the following lecture topics, to which there was overwhelming interest.

If there were a lecture series on “Reproductive Choice and Health” would you be interested in attending lectures on some of the above topics?
161 responses



If there were a lecture series on “LGBTQ+ Health” would you be interested in attending lectures on this topic?
161 responses



If there were a lecture on Gender Affirming Care, would you be interested in attending?
161 responses