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Ne nous faites pas de mal : ce sont les écoles de médecine, et non les étudiants, qui devraient enseigner comment fournir des soins de santé inclusifs aux personnes 2SLGBTQIA+

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Introduction

As society moves towards more inclusive healthcare, recognizing the impact of social determinants of health is crucial for minimizing health inequities. However, 2SLGBTQIA+ individuals still encounter significant health inequities due to bias in healthcare practices, in part stemming from insufficient training among healthcare providers about sex and gender.[1] This shortfall in education results in physicians and medical students, despite good intentions, causing harm through incorrect assumptions, incomplete history-taking, and inappropriate treatment suggestions.[1] Additionally, intersecting systems of oppression, such as colonialism, further exacerbate these health inequities.[1-2,6]

There is a gap in teaching about sex and gender in curricula across Canadian medical schools.[1,3-4] Many curricula do not adequately address these topics, relying instead on standalone lectures that fail to produce lasting changes in practice.[2] Discussions about the role of physicians in perpetuating discrimination—intentional or not—are often missing.[2,5] Cissexism sustains health inequities, which contribute to disease burdens and limit access to appropriate services.[5] We believe educators must improve practices to ensure the health and safety of 2SLGBTQIA+ patients.[1, 6]

Marginalized students bridging gaps in medical education

Student leaders have engaged with peers and curriculum decision-makers to advocate for changes to address these gaps. However, curriculum developers often argue that they cannot add to their already-packed curriculum.[5] As a result, the responsibility of developing and teaching this content frequently falls on the students, with schools encouraging student-led initiatives as optional, and not compensated or recognized, learning opportunities.

For example, in my prior nursing education, I (C.L.) advocated for faculty to address the 2SLGBTQIA+ community's healthcare needs. We collaborated to update resources like case studies. To bridge the remaining gap, I volunteered to develop a peer-led workshop covering terminology, small-group case study discussions, and practical strategies to deliver more comprehensive care to the 2SLGBTQIA+ community. We expanded it to an interprofessional elective hosted by the Center for Advancing Collaborative Healthcare and Education (CACHE). Since 2021, Kelsey Vickers and I have co-led this workshop for students from all healthcare disciplines at the University of Toronto and Michener Institute. We advocated for and secured funding from CACHE and grants from the university and the Ontario Medical Student

Association; we enabled the workshop's sustainability by covering training costs for our student teaching team and honoraria for guest speakers but had to forgo paying ourselves. Most student team members are 2SLGBTQIA+ community members. This work continues because such content is not yet integrated into the curriculum of all these academic programs.

Student-led organizations like QMed at the University of Montreal have also made significant contributions. QMed has hosted a conference series for four years, including a recent webinar led by Dr. Coralie Beauchamp on assisted reproduction for 2SLGBTQIA+ individuals. Similarly, the Canadian Queer Medical Students Association has developed resources for medical learners and professionals since 2020. They created a series of guides to gender-affirming care service delivery for most provinces and territories, and self-paced learning modules and infographics to assist in understanding 2SLGBTQIA+ healthcare topics. They recently published a white paper recommending a comprehensive 2SLGBTQIA+ curriculum for Canadian medical schools.[7] Currently, most education about this topic during MD training is student-led.[8]

Inequitable inclusion practices

Excluding essential 2SLGBTQIA+ education from formal curricula and relegating it to extra- or co-curricular activity perpetuate inequity. Curriculum developers harm students by deeming 2SLGBTQIA+ healthcare non-essential and only worth teaching to physicians who elect to "specialize" in this care. This omission teaches the harmful assumption that only cisgender, heterosexual individuals matter among healthcare users.

Relying on student-led initiatives is unsustainable and unjust because it forces students to explain how to prevent harm to their community, and potentially relive trauma. The schools' practices burden students who already face challenges.[7] Students should not have to teach for the institutions they pay to learn from.[7] The expectation for teaching without compensation sustains the "minority tax"—a term describing the additional responsibilities placed on underrepresented groups without fair reciprocity.[9] Although some students received accolades for their leadership, it is disingenuous for academia to applaud students for teaching this subject but not deem it worthy of teaching it themselves. I (C.L.) have presented this issue at three healthcare education conferences thus far. Despite advocacy at local, provincial, and national levels, through personal interactions, presentations, white papers, and journal publications, students' calls for universities to teach this content have not yet been acted on.

Anti-oppressive medical education requires socially accountable curriculum

Medical schools, that pride themselves in equity, diversity, and inclusion, need updated community engagement and social accountability policies and practices.

We call for comprehensive, longitudinal 2SLGBTQIA+ education to become mandatory in Canadian medical curricula, ensuring all future physicians possess foundational knowledge and skills to provide equitable care regardless of which school they attend.[1-2,4-7] This should be an accreditation standard.[10] Practical application of anti-oppressive principles should be taught in case-based sessions with facilitated discussions and community-based experiences throughout curricula.[2-3,5] Socially accountable medical schools take primary responsibility for integrating inclusive content.[5-6,7,10] Curricula should be sustainable rather than dependent on the voluntary efforts of transient students.

While students with lived experience are well-positioned to create content, this teaching should not fall on oppressed individuals. Schools must sustainably engage marginalized students and community members outside the university to support and help with curriculum development.[2,7] Contributors should be fairly compensated for their efforts.[5] Universities must demonstrate a genuine commitment to equity by ensuring all students have access to high-quality education, unburdened by the minority tax.

A shift towards more equitable healthcare education will promote high-quality care for all patients and greater respect for the well-being of 2SLGBTQIA+ students.[1,6]

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