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Facilitating LGBT Medical, Health and Social Care Content in Higher Education Teaching

Zowie Davy¹, Sarah Amsler² & Karen Duncombe³

1) School of Health and Social Care, University of Lincoln, United Kingdom.

2) School of Education, University of Lincoln, United Kingdom.

3) Greater East Midlands Commissioning Support Unit, United Kingdom.

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Facilitating LGBT Medical, Health and Social Care Content in Higher Education Teaching

Zowie Davy
University of Lincoln

Sarah Amsler
University of Lincoln

Karen Duncombe
Greater East Midlands Commissioning Support Unit

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Abstract

Increasingly, Lesbian, Gay, Bisexual, and Transgender (LGBT) health care is becoming an important quality assurance feature of primary, secondary and tertiary healthcare in Britain. While acknowledging these very positive developments, teaching LGBT curricula content is contingent upon having educators understand the complexity of LGBT lives. The study adopted a qualitative mixed method approach. The study investigated how and in what ways barriers and facilitators of providing LGBT medical, health and social care curricula content figure in the accreditation policies and within undergraduate and postgraduate medical and healthcare teaching. This paper illustrates opposing views about curricula inclusion. The evidence presented suggests that LGBT content teaching is often challenged at various points in its delivery. In this respect, we will focus on a number of resistances that sometimes prevents teachers from engaging with and providing the complexities of LGBT curricula content. These include the lack of collegiate, colleague and student cooperation. By investing some time on these often neglected areas of resistance, the difficulties and good practice met by educators will be explored. This focus will make visible how to support medical, health and social care students become aware and confident in tackling contemporaneous health issues for LGBT patients.

Keywords: lesbian, gay, bisexual, transgender, curricula content, accreditation policies

Facilitando Atención Sanitaria, de Salud y Social del Colectivo LGTB en Enseñanza Universitaria

Zowie Davy
University of Lincoln

Sarah Amsler
University of Lincoln

Karen Duncombe
Greater East Midlands Commissioning Support Unit

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Resumen

Cada vez más, la atención sanitaria a Lesbianas, Gays, Bisexuales y Transexuales (LGBT) se está convirtiendo en una característica importante de garantía de calidad de la asistencia sanitaria primaria, secundaria y terciaria en Gran Bretaña. Si bien reconocemos estos avances muy positivos, la enseñanza de contenidos curriculares de LGBT está supeditada a tener educadores que comprendan la complejidad de la vida de LGBT. El estudio adoptó un enfoque de método mixto cualitativo. Investigó en los planes de estudio cómo y de qué manera las barreras y facilitadores de la prestación médica, atención sanitaria y social de LGBT figuran como contenido en las políticas de acreditación y dentro de la enseñanza médica y la atención sanitaria de pregrado y postgrado. Este documento ilustra puntos de vista opuestos sobre la inclusión curricular. La evidencia presentada sugiere que la enseñanza del contenido de LGBT es a menudo cuestionada en varios puntos de su entrega. En este sentido, nos centraremos en una serie de resistencias que a veces impiden que los profesores participen y proporcionan las complejidades de los contenidos curriculares de LGBT. Estos incluyen la falta de colegiado, compañerismo y la cooperación de los estudiantes. Al invertir algo de tiempo en estas áreas con frecuencia descuidadas de la resistencia, se explorarán las dificultades y las buenas prácticas a cumplir por los educadores. Este enfoque hará visible la forma de apoyar a los estudiantes de medicina, atención sanitaria y social para que tomen conciencia y confianza en la lucha contra los problemas de salud contemporáneos para los pacientes LGBT.

Palabras clave: lesbiana, gay, bisexual, transgénero, contenidos curriculares, políticas de acreditación

It is widely accepted that lack of knowledge by healthcare providers can lead to suboptimal or no provision of healthcare for Lesbian, Gay, Bisexual and Transgender patients (Lee, 2000). This point takes on significance in contemporary societies such as Britain, which has an aging LGBT population whose specific needs and experiences remain largely unknown (Orel, 2014). LGBT healthcare is thus increasingly becoming an important quality assurance matter within primary, secondary and tertiary healthcare in Britain. There has been considerable progress in recent years. For example, Pride in Practice (The Lesbian & Gay Foundation, 2011) promotes and provides a system for primary care surgeries which rates things such as welcoming environment, access, the general practitioner (GP), patient consultation, staff awareness and training, and health promotion for LGB people. Pride in Practice is supported by the Royal College of General Practice. Other initiatives such as Transgender Awareness and Trans Health Matters are *fora* attempting to address complex healthcare concerns for a diverse group of transgender patients.

On the World Wide Web there are LGBT patient groups emerging, while at the same time, ‘out’ LGBT individuals are increasingly visible in the ranks of practitioners and professionals in the health sector as doctors, scientists, practitioners and policymakers. Anecdotally, there is a rise in requests for National Health Service (NHS) stakeholders to contribute to commentaries on LGBT policies and efforts to update them in line with both general and health-specific national and European Union duties, such as the Equality Act 2010 (Office of Public Sector Information, 2007, 2010), Trans Inequalities Reviewed (Equality and Human Rights Commission, n.d.) and the Charter of Fundamental Rights of the European Union (European Parliament/European Council/European Commission, 2010).

Despite these cultural shifts and while acknowledging these very positive developments, a systematic review of developed English speaking countries’ guidelines and policies for LGBT primary care recently revealed a dearth of what McNair and Hegarty (2010) judged as evidence-based, rigorously developed and disseminated guidance for primary, secondary and tertiary care practitioners. Moreover, there is relatively scarce LGBT health literature that addresses and accounts for the different areas of LGBT healthcare in higher education for healthcare professionals and providers, and little practical guidance for the design and development of LGBT curriculum content in university courses. To understand why there is a

dearth of LGBT curricula provision and what education is required to support improving health and social care for these communities, we embarked on a pilot study to uncover the facilitators and barriers to including LGBT issues in curricula for medical, health and social care students. While research from the United States has observed that obstacles to reforming curricula to include LGBT content include lack of time and resources (Obedin-Maliver et al., 2011) and an unwillingness or inability of faculty to teach about LGBT-related concerns (Frenk et al., 2010), there is very little British-based research that considers LGBT medical education in terms of health promotion, prevention, and care at a strategic or operational level. Furthermore, 'questions concerning the role that schools and curriculum play in reproducing the values and attitudes necessary for the maintenance of the dominant society have been raised by educators since the turn of the century' (Giroux, 1979, p. 248). However, these questions have not been well integrated into discussions of LGBT curricular content or practices of curriculum design in higher education.

In this article, we focus particularly on the barriers and aspirations of higher education teachers who include and exclude LGBT curricula content in their courses. We illustrate both interpersonal and structural factors that affect how and in what ways LGBT curricula content is delivered, including a lack of curricular focus and absent assessment and external validation criteria. We also discuss how these areas are facilitated by a deficit of attention to LGBT issues in the accreditation policies underpinning professional healthcare education in Britain. We demonstrate that the majority of participants in this study think that a diffusion of LGBT curricula content is of paramount importance for students while they are at university, when they enter the workplace and as they become competent practitioners. We also highlight the views of those who think that it is less useful, focusing on things that sometimes prevent teachers from engaging with and providing the complexities of LGBT curricula content, including a lack of collegiate, colleague and student cooperation at institutional and interpersonal levels. The article stresses the need to intersperse multiple inquiries of LGBT medical, health and social care issues throughout the curriculum as important aspects of medical, health and social care education, in an attempt to overcome possible resistances to including LGBT issues and perspectives. Exploring both the difficulties and good practices of educators highlights ways that higher educators can support

medical, health and social care students to become aware and confident in tackling contemporaneous LGBT health issues at the intersection of multiple characteristics such as gender, sexuality, disability, ethnicity, age and socioeconomic grouping as a matter of course, rather than understanding LGBT people as separate “special cases”. In the conclusion, we provide initial recommendations on how educational aspirations to include LGBT curriculum content can be achieved.

The Historical Pathologization of LGBT People in Medical, Health and Social Care Education

Lesbians, bisexual women, gay men, bisexual men and transpeople, alongside other groups including disabled people and ethnic minorities, have historically embodied the meaning of stigma in our society (Goffman, 1963). Prevailing approaches to LGBT people in medical, health and social care education have tended to position heterosexuality and gender normativity – people conforming to dominant social standards of ‘appropriate’ feminine and masculine behavior – as the primary context in which health and illness is viewed. A small amount of research has shown that patterns of healthcare which endorse some forms of sexuality and gender identity over others can create pedagogical environments in which gender stereotypes and heteronormativity – the cultural bias favoring opposite-sex over same-sex sexual relationships – result in LGBT people becoming ‘add ins,’ (Hicks & Watson, 2003) or special cases, if and when they are considered at all. For example, one area that is unrelenting in health-focused literature is sexual health and sexual health promotion for gay and bisexual men, especially in the area of HIV. This persistent focus not only highlights a narrow area of healthcare, but reinforces notions that the health problems of men who have sex with men are predominantly related to their sexualities. This can maintain damaging stereotypes while reducing other healthcare areas of concern (Leiblum, 2001). Even less is written about lesbians and bisexual people and their healthcare concerns, and transpeople tend to be pathologized as mentally ill individuals because their gender identity does not conform to their biological sex (Cohen-Kettenis & Pfäfflin, 2010).

Historically, medical, health and social care professional training programs have contributed to the stigmatization of some sexual and gender

identities and ‘their’ sexual and gender practices. By characterizing LGBT people as pathological, diseased, immoral or “exotic” in teaching, or by erasing them from the curriculum altogether, higher education in these fields does not challenge stigmatizing stereotypes and leaves student practitioners lacking the necessary knowledge and skills to offer inclusive healthcare services (Eliason, Dibble, & Robertson, 2011). For example, Davy and Siriwardena (2012) have suggested that the idiom ‘LGBT’ may cause practitioners to link diverse healthcare issues together. For instance, if teachers incorporate ‘transgender’ issues in sessions as an extension on lesbian, gay and bisexual themes, under the idiom of ‘LGBT healthcare’, students may assume that the transpeople have co-extensive healthcare issues with lesbian, gay, and bisexual people in spite of some identifying as LGB. Such convergences of LGBT healthcare may overlook many divergences and particularities of each group and within each group, resulting in intrinsically flawed assumptions which students may carry into their professional lives.

LGBT curricula content is recognized as being important for the education of culturally competent practitioners and for the creation of accessible and non-discriminatory places of work (Wilson et al., 2014). Some research (Vaid, 1995) has powerfully argued that in responding to the requirements of LGBT populations accessing health and social care, demands the use of different models which are underpinned by an extensive reformulation of LGBT healthcare curricula. This would mean changing educational and medical institutions in lasting ways (Vaid, 1995).

Education Facilitating Good HealthCare

Anti-discriminatory policy is vital for improving healthcare provision for LGBT people (Hinchliff et al., 2005). A number of accreditation documents have been developed to ensure non-discrimination, such as that produced by the Council of Social Work Education (CSWE Commission on Accreditation, 2008), which explicitly requires that continuous efforts to provide a learning context in which respect for all persons and understanding of diversity are practiced. It also suggests that this principle should be known to students and aligned with the accreditation standard of *Nondiscrimination and Human Diversity*. The guidance suggests that teaching a commitment to incorporating respect for diversity must be

present in the implicit curriculum for social work students (referring to the educational environment in which the explicit curriculum content is presented). While accreditation policies apply some candor to the requirements of exposing students to how health is impacted within diverse communities, they nonetheless leave decisions about the inclusion and interpretation of LGBT curricula content open to negation by teachers who may be either unable or unwilling to include LGBT curricula in complex ways in their courses.

In the analysis that follows, we show that policy does not automatically translate into practice, and that a lack of knowledge and understanding, and sometimes prejudice surrounding LGBT patients from both educators and students, continue to be major obstacles to inclusive medical, health care and social work practice . We therefore argue that obstacles to LGBT curricula content cannot be overcome through changes to accreditation policies alone and a greater attention to curriculum reform is required (Hinchliff et al., 2005; Whittle, Turner, Combs, & Rhodes, 2008).

Methods and Design

This study was a small-scale qualitative study funded through the College of Social Science at the University of Lincoln. We held one-to-one semi-structured interviews, lasting between 50 and 110 minutes, with university lecturers with practice backgrounds to understand a range of experiences, actions, intentions and meanings associated with the inclusion of LGBT curricula content. We also conducted a thematic ‘discourse analysis’ of multiple medical, health and social care College and Council academic accreditation policies from the UK. The study investigated how and in what ways barriers and facilitators of providing Lesbian, Gay, Bisexual and Transgender medical, health and social care curricula content figure in the accreditation policies and within undergraduate and postgraduate teaching.

Accreditation Policies

The contemporary accreditation policies for medical, health care and social work practitioners were retrieved from the relevant Colleges and Councils. We included documents from General Medical Council, Royal College of Nursing, Royal College of Obstetricians and Gynaecologists, Nursing and

Midwifery Council, Joint Royal Colleges of Physicians Training Board and Health and Care Professions Council. We also retrieved accompanying documents related to equality and diversity and competency frameworks. In total, 18 British medical, health and social care policies, used to set standards covering the development of the knowledge, skills and behavior students must demonstrate by the time they graduate.

Participants

Participants were recruited from one large region in Britain. Following searches of each of the region's university staff lists, we sent 320 emails to members of teaching staff in Schools of Medicine, Health and Social Care, Nursing, Social Work and Psychology in 6 universities in the region. Ten educators responded from 5 different universities. The response rate of just over 3 percent was disappointing and is a limitation in this study. Reasons for this limited response rate may be numerous, such as lecturers' time constraints, beliefs that the research is not needed, or them thinking that they have little to say on the topic. One of the participants said: "My guess is, most likely, is that unless someone is committed to LGBT issues, it will not necessarily get taught in any systematic way" (Sandra, Social Work lecturer) suggesting that educators lack of focus on LGBT curricula may have influenced the response rate. The table below provides more details about the participants.

Table 1.

Participant Characteristics

Participant (Pseudonym)	Gender	Course	Specialism	Modules	Level
Carole	Female	Health and Social Care	Social Science	Equality Diversity and Citizenship, Introduction to the Sociology of Health	Undergraduate
Sandra	Female	Social Work	Law, Rights and Policy	Psychology, Child Observation, Law, Rights and Policy, Research Methods	Undergraduate Postgraduate
Harriet	Female	Psychology	Social psychology	Psychology, Social Psychology, Anthropology	Undergraduate Postgraduate
Jeremy	Male	Psychology	Health Psychology	Health Psychology, Wellbeing Psychology, Research methods	Undergraduate Postgraduate
Susan	Female	Health Psychology	Social Science	Health Psychology, Human Diversity	Undergraduate Postgraduate
Julie	Female	Mental Health Nursing	Health Psychology	Health Psychology, Social and Cultural Issues	Undergraduate Postgraduate Post-registration
Fiona	Female	Nursing	Perioperative Practice	Clinical Skills and Accountability, Perioperative Practice	Undergraduate Postgraduate
Cristina	Female	Medical	Genetics	Human Biology, Genetics	Undergraduate
Alex	Male	Medical	Obstetrics Gynecology	Clinical Practice	Undergraduate
Peter	Male	Medical	Hypertension	General Medicine	Undergraduate

Interview Schedule

The first author conducted all the interviews. Five interviews were face-to-face and five were telephone interviews. A semi-structured topic guide elicited participants' experiences and beliefs about current facilitators and barriers to including LGBT curricula content for medical, health and social care students. Participants were asked about the modules that they taught, whether their lectures and seminars were informed by accreditation policies and course reviews, how important LGBT curricula was for the modules that they taught, if LGBT content features in theirs and other educators' modules, and whether inclusion or exclusion of LGBT curricula content was a personal pedagogical choice. Participants were also asked questions about institutional support and student reactions to LGBT curriculum content. We finished the interviews with questions about their impressions of the facilitators and barriers to including LGBT curricula content.

Analytical Approach

As a caveat, we are not intending to generalize the findings in the traditional sense. We want to illustrate how educators are thinking about teaching LGBT curricula content and examine some of their reasons why it is and is not included in teaching. The interview transcripts were read as whole narratives by two researchers and then thematically coded by each one, prioritizing the empirical issues under discussion. Data was explored for emergent themes derived from the interviews (case analysis) and mapped onto accreditation documents' emergent themes (thematic analysis). The accreditation policies from each discipline were analyzed into themes attempting to capture important aspects of the guidance in relation to the research questions. The themes outlined below represent levels of patterned responses and meanings across the two data sets. In this article, we draw on the interviews and accreditation policies to particularly illustrate the divergences and convergences in attitudes, practices and future aspirations for including LGBT curriculum content for medical, health and social care students. This mapping was guided again by prioritizing the empirical issues under discussion. The data then was collaboratively developed the into final themes that all the researchers agreed upon, and through which we believe conceptual generalizability was reached (Mays &

Pope, 2000). This form of framework analysis enabled the accreditation documentary analysis to be evaluated from the perspectives of the people that they affect, in this case the educators.

Results

In analyzing the data we developed three themes and respective subthemes from both the accreditation policies and interviews:

- Values and competencies
 - Impact of teaching LGBT issues
 - Professional competencies
 - Equality, diversity and ethics
 - Patient centeredness
- Curriculum time and space
 - Time
 - Clinical practice
 - Pedagogical commitment
 - School level commitment
- (Non) Resistances by students and colleagues
 - Knowledgeability
 - Student choices
 - Homophobia and transphobia
 - Balancing curriculum with cultural differences

While these themes emerged inductively from the interview data and accreditation policies, they are theoretically connected through the politics of educational curriculum itself. Decisions about how much time and space can or should be dedicated to certain social and professional issues, ideas, ethical perspectives, practices and groups of people in any field – even ‘serendipitous’ ones – are shaped by judgments about what knowledge is, whose knowledge and experiences are valuable or necessary, and what role particular knowledge plays in maintaining or changing a status quo. In discussing these themes below, we therefore draw both on examples from the discourse analysis derived from the accreditation policies, which frame this politics of knowledge, and from higher educators’ perceptions and

experiences of the contemporaneous state of medical, health and social care teaching in Britain.

Professional Competencies

While many of the medical, social work and psychological courses in Britain are bound by accreditation policies which highlight diverse communities and identities, the policies rarely stipulate the types and range of areas of LGBT curricula content that should be included. For instance, the Standards of Proficiency for psychology students requires: “threshold standards necessary for safe and effective practice. These standards play a key role in ensuring that registrants practice safely and effectively” (Health and Care Professions Council, 2012). The policy continues by suggesting that educators should offer students curriculum that enables them to: “understand the impact of differences such as gender, sexuality, ethnicity, culture, religion and age on psychological wellbeing or behavior” (Health and Care Professions Council, 2012, p. 25). Yet in an interview for this study, social work lecturer Sandra said:

We have the professional capabilities framework and social work as a profession is very committed to social justice, rights, human rights and so on. I kind of think it is interesting when they were circulating the feedback about what those competencies should be; I was quite keen that it specifically mentioned LGBT and they didn't go down that route. So it talks about, so there are two domains and specifically one about values and ethics, and the other one is around rights and diversity and in both of those I thought there was a potential to specifically mention LGBT.

Similarly, the widely consulted *Tomorrow's Doctors* (General Medical Council, 2009) does not specify that teaching should address LGBT issues. Practitioners are more generally made aware that they ought to “[u]nderstand and accept the legal, moral and ethical responsibilities involved in protecting and promoting the health of individual patients, their dependents and the public – including vulnerable groups such as children, older people, people with learning disabilities and people with mental illnesses” (General Medical Council, 2009, p. 25). Such documents could

be read on one level as erasing the important issues that LGBT people face in health promotion, provision and monitoring, and on another level as illustrating that to particularize LGBT communities' healthcare under the axiom of "vulnerable groups" no longer seems important or necessary because these communities have become 'normalized' through socio-legal and duty processes in the UK, so much so that LGBT people are seen as no different to anybody else (Richardson & Monro, 2012). Yet while LG and to a lesser extent B and T people have become more socially visible, challenges remain in relation to encouraging teachers, through the accreditation policies, to highlight that LGBT people continue to be marginalized in health provision and care in spite of these socio-legal gains.

Accreditation policies, duties and practitioner competency documents from a range of Councils all stress that the inclusion of diversity and equality issues is fundamental for students' and practitioners' ability to carry out their practice competently (Eliason, Dibble, & Robertson, 2011). Recent competency frameworks have been critiqued as creating production line tick-box exercises, reducing the complex psychosocial roles required of health practitioners, while losing the humane and empathic nature of healthcare practices (Fish & de Cossart, 2007). Policies that have depicted broad deposit-making gestures, without posing particular health (care) problems of LGBT people and their relations within healthcare environments and society, will inevitably fail to make much difference to the already marginalized positions they inhabit. One participant who talked about the accreditation policies said:

I'm sure it's important. It just, I just don't think it [LGBT] makes it into the curriculum, you know in a formal way, it doesn't really make it into the undergraduate curriculum as far as I know [...] I mean I think plenty of individual teachers might raise it and we do have a session with the undergraduates where we talk about ethics, but we nearly always spend most of that on abortion and surrogate parents and things like that. I don't, I mean we certainly have touched on LGBT issues in the ethics debate, but not for some time and I don't think it, you know it isn't in the curriculum if you see what I mean, it would just come up as it came up rather than being in the curriculum (Alex, Medical School lecturer).

Another participant said:

But we will talk about different things to do with gay men, lesbian women and actually I suppose bisexual is not something which I go into that much, yeah, that's an interesting question. It's just gay and lesbians [...] with regards to transgender, there was, I remember now that, there was a case study that we looked at, but that was again about equality, it was actually connected to refugees and sort of examining the ethics and the actual discriminatory practice within that particular case study (Harriet, Psychological Therapy lecturer).

As Alex and Harriet show in their accounts, attempts to offer inclusive classrooms, respect diversity and illustrate inequalities require that educators negotiate and sometimes approach LGBT curricula content as and when it comes up. Despite the multiple accreditation policies in place and gestures towards LGBT content it tends not to be 'naturally' integrated throughout the courses that we considered.

Although accreditation policies are supported with institutional checks through validation procedures, the interviews suggest that those who monitor university provision are rarely concerned with learning outcomes, approaches or assessments relating to LGBT curricula at the micro level. Institutional checks specifically about LGBT curricula content and assessment, according to this research, seems to be lacking. As Julie suggested:

Our students have to achieve so many theory hours and so many practice hours by the end of the program to be able to get on the register as a qualified nurse, but again how those are broken down is very much up to the individual institution. So the NMC [Nursing and Midwifery Council] validate the curriculum so they want to see the content and what we say we are going to teach and we are validated every five years. Every year the NMC will come and do a visit, they don't always focus on the same areas but they will still come and visit every year to make sure that we are doing what we said we were going to do (Julie, Mental Health Nurse Lecturer).

Curriculum Time and Space

Another reason for the deficiency of LGBT curriculum content was lack of time and space in the curriculum. As Alex stated:

When you move in fields like Gynecology there's a lot of technical, factual stuff which every GP needs to know. That's not to say they don't need to know these [LGBT] issues but perhaps I'm very old fashioned. I don't feel a tremendous lack of discussion about these issues in our particular four year course (Alex, Medical School lecturer).

Most of the interviewees said that they did not know if other faculty taught LGBT sessions, or if content was dispersed throughout their courses, if they themselves did not. Besides Alex refusing to grant LGBT curricula much importance in bringing about change or sustaining any future benefits for LGBT patients and staff working in his particular medical area, he opined that “technical and factual” content should prevail. Yet Alex nonetheless wanted to ‘evidence’ that the course he had contributed to for a number of years was in line with the accreditation policies and the wider cultural competency frameworks.

For Susan, the emphasis was placed on the how different courses and modules have been reorganized in her institution. She stated:

So it's an accelerated four year course and that one the students do a year and a half of lecture based teaching and then two and a half years of clinical. [...] I lead a module called health psychology and human diversity and that runs one semester and it's a little ragbag really, that's come about over the years. So in the past we've had a little bit more sort of social sciences and diversity teaching in the curriculum. But it's been squeezed quite a lot over the years. The situation with three modules which included sort of lifespan issues, health psychology and human diversity have now been squished into one module so the time we've got to deal with issues it's really very general (Susan, Health Studies lecturer).

The decline in diversity training for medical students in particular seemed to be related to the extension, reduction and application of different

social and biomedical models in medical teaching. A number of participants, for example, suggested that there was a lot of pressure to include more technical aspects of disease and cures. As such, resistances to including LGBT content were linked to the contemporary emphasis on the medical model of health and illness. We were offered a number of reasons why this was the case, which we will now turn to.

Impact of Teaching LGBT Issues

It was clear from all of the interviews that inclusion of LGBT issues was a complex matter and dependent on the ever changing micropolitics of departments or schools in higher education institutions and their student cohorts. When LGBT sessions were taught, they tended to be included in areas of anti-discrimination healthcare practices, patient/practitioner interactions, equality and ethics. At the school level, LGBT curriculum content was expected to have most impact in the health sciences that have sociological, psychological or anthropological aspects to the modules, as the integration of LGBT curricula content in these areas was thought to have more bearing on students' understanding of human and ultimately patient diversity. Teachers who were providing the more sociological aspects of healthcare were competing with a number of other resistances while attempting to teach LGBT curricula. For example, there was some evidence to suggest that there was some opposition from other colleagues as to the importance of including LGBT curricula content.

I don't know what the resistance is. I think it is seen as peripheral, not of core importance, of secondary value to other bits of the curriculum. I do not know why this is because it is a hugely important topic. Even for people who identify as heterosexual and are normative still all those discourses are at play anyway. Discourses around how we self-identify are relevant to everyone, but it is treated as some kind of special thing (Harriet, Psychological Therapy Lecturer).

When Harriet was asked why she thought this was the case, she said:

It is more of a collective unconscious and I am sure that if you interviewed my colleagues they would all come across as sensitive and thoughtful people who think that these issues are really important you know, but somehow that doesn't translate into more course content, so it is really weird (Harriet, Psychological Therapy Lecturer).

Teachers in schools of health and social care, nursing, social work and psychology included LGBT curricula more often than those teaching in the medical school examples. However, whether LGBT curricula is included or excluded even within these contexts is often based on personal pedagogical choices and whether members of staff were willing or felt knowledgeable enough to teach LGBT content.

Student Choices

Sometimes teachers were anxious about including LGBT curricula content because of student responses. As a result, student resistance shaped what was offered. Sandra illustrated that it was not only heterosexual and cisgender¹ students who thought that LGBT content was not needed, saying:

Not this current academic year, but the previous academic year, was the first time I had a group of students saying why do we need to talk about these issues, there is not an issue, there's legislation, everything is fine there is no issue anymore, everybody is out. A group of five younger students, and, they were really quite insistent on this, were really not interested in developing their knowledge and understanding and last year I found that more difficult than the homophobia and transphobia. It is funny isn't it, so I have had students read the bible in these sessions before, I had a lesbian student get really angry with me, I didn't know at the time but found out subsequently and having complaints about talking about LGBT issues, and homophobia in the classroom, you know all sorts of things you know it's not plain sailing by any means (Sandra, Social Work lecturer).

Here we can see that teaching about LGBT communities' health, illness and healthcare as a homogenized whole is fraught with the tension that LGBT curricula is needed, but what form it should take is complex. This is coupled with students having questions and information to share, which act as challenges to the teachers' autonomy within the class. According to these participants, there are a number of impositions through student challenges to contend with.

We've had problems in the past where people are not coming for multiple sessions because of their beliefs, you know (laughs). I don't want to come along to this session because it's not consistent with my beliefs [...] You know and we try and get around that by talking all the time about how in the module we're are not going to change your beliefs, but are just trying to make you recognize that it's ok to hold beliefs, but as a doctor you can't let those beliefs affect your [provision of] care. If you've got issues with gay people then now is the time to find ways of dealing with that (Susan, Health Studies lecturer).

Susan attempted to treat the topic as one that was part-known, close at hand and normative to teach. Susan related LGBT curricula (if possible) to students' future working lives through challenging oppressive practices—although one that students might have different opinions on, and certainly one that, at times, would require some additional negotiations in the classroom. This form of student resistance was evident in all the disciplines we researched.

One particular issue to contend with, according to two of the participants, was challenging how students confused civil rights gains with gaining wider social equity. Students, according to these participants, misinterpreted the practical effects that the relatively new medicolegal duties have had on the lives of LGBT people. Moreover, explanations were needed in class about how the maintenance of the heterosexist and cisgender status quo continues through more subtle means of prejudice, discrimination and erasure.

In contrast, a few lecturers suggested that younger students attending university are generally more aware of LGBT issues and that the explicit focus in the curriculum need not be so thorough. In these instances,

awareness was equated with ‘tolerance’ and non-prejudicial treatment, which this study does not support. Yet despite the resistances outlined in this research, Harriet and several other lecturers who teach Masters-level courses said that their students often requested more LGBT curricula content.

I tend to be shipped in to the Masters courses or I tend to be scheduled in to do a session on gender, sexuality and gender identity and then that’s it and at the end of the year in the students’ feedback session and almost every year students say that they would have liked more input on that subject (Harriet, Psychological Therapy Lecturer).

Students’ engagement with and reflective responses to such lessons, according to Harriet, indicated that her students felt that LGBT content was important for their future healthcare practice. Moreover, by introducing LGBT content to students and requesting feedback on the course, Harriet was able to contend with any resistances that may manifest in the future. On one hand, teaching LGBT content by being “shipped in” for “a session” on gender identity and sexuality may not change negative attitudes greatly (Case & Stewart, 2010). On the other hand, teachers in this study who taught even the smallest amount of LGBT curriculum suggested that students who were present in these lectures and seminars left the classroom cognizant about being unable to discriminate against LGBT patients if and when they go into their respective health and social care practices. These two contrasting areas of student resistance and students’ requests were understood by participants as students’ attempts at asserting their power and status (whether the student identified as heterosexual, LGBT or religious) as consumers of education. Generally, however, the data suggests that LGBT curriculum provision is negotiated, left to the will of teachers and the will of some students, or as we will turn to now, serendipity.

Serendipity in Clinical Practice

A number of lecturers mentioned that LGBT issues were often presented to students in medical or clinical practice, while they were applying their learning and attending to patients. Pedagogical studies have suggested that

this type of experiential learning is a “here and now concrete experience” (Kolb, 1984, p. 21) that allows learners to reflect on a situation and modify their practice accordingly. For example, Alex said:

We teach Gynecology and so it would come up in the clinical, you know it might come up in clinical practice, when patients are in clinical practice, but I don’t believe there is any formal section in the module, if that makes sense (Alex, Medical School Lecturer).

The invocation of experiential learning as always having positive outcomes for learners (and in our case LGBT patients) in teaching contexts may be more detrimental than is supposed. Rennstam and Ashcraft (2014) have asserted the importance of facilitating relationships in sensitive communicative spaces such as healthcare. Sensitive communication dilemmas in the clinical encounter have to be met with wide-ranging communicative knowledge of the population being addressed. Teaching students about how to facilitate good relations with their LGBT patients’, such as not using heteronormative language, eliminating stereotypes about lesbians, gay men, bisexuals and transpeople and being able to reflect on whether sexuality or gender expression is pertinent to a patient’s presentation prior to entering the clinic, may go some way towards alleviating the tensions between LGBT patients and practitioners; this was a high priority for a number of teachers in this study. Peter problematized the benefits of all serendipitous experiential learning in clinical practice. While Peter suggested that ad hoc student experiences often happened and can occasionally be useful, he understood that students needed to be aware of the potential diversity of patients that they may meet in clinical practice prior to entering the clinic in order to avoid potentially damaging encounters. He contextualized where some forms of learning may be more appropriate for excellent future clinical care. Such approaches have also been reported by Leiblum (2001, p.60) who illustrates that medical practitioners who are apprehensive or unknowing about handling patient’s questions in areas of human sexuality will be susceptible to “offering inadequate, insensitive, and/or ineffectual treatment to their patients.” Accordingly, Peter attempted to prepare his students to be proactive rather than reactive when encountering LGBT patients prior to entering an experiential leaning space.

I suppose in general medicine and in hypertension whatever you prescribe for the condition that your patient presents to you with, it is in context of their other medical problems and any other medications that they take, and if you want people to buy into your diagnosis and comply with your treatments and investigation then, it does have a social context, if you don't take account of what else is happening then it isn't always successful (Peter, Medical School Lecturer).

Peter contextualized how students should be taught prior to entering clinical practice in relation to LGBT patients. He suggested encouraging them to move beyond a heteronormative position and to use inclusive language. The challenge is that whatever a patient is experiencing may not have anything to do with their gender or sexuality, and the assumption by a professional that it is, may cause more harm than good. This is not to say that the patient and clinician should rule out permanently the possibility that gender or sexuality may be axes amongst others such as class, ethnicity and disability that may contribute to the problems being addressed in consultations. Peter further suggested that students should be constantly aware that combining both the medical and social aspects of health may provide the best diagnostic and care plan for their patients. Healthcare practitioners, according to Peter, should be proactive in finding out how their patients want to be cared for and how they would like any ethical issues resolved, for example not assuming who their next of kin may be. In any scenario involving care, assumptions should not be made about a patient's (hetero) sexuality and relationship status, or what these mean for their sex lives or related health problems. Indeed, basing diagnostic judgments on a sexual identity without due investigation is both unprofessional and precarious. This argument was made explicit when Peter reflected on an experience he had in a meeting with colleagues about sexual health provision:

You know, as I was saying referring to people's husbands or wives when you have absolutely no idea if they have husbands or wives. Yeah, the most recent and sort of disappointing examples of prejudice I came across was in sexual health here at this hospital. [...] I thought there was quite a few assumptions made, that were not, that I am sure are valid for some people [...] but I sort of felt

that there were quite a few assumptions about LGBT people that was fairly sort of stereotypical and I thought was a bit outdated really [...] HIV is a viral infection that infects people regardless of their sexual orientation, so some people with HIV are gay other people are not. So no, it isn't specific. I wouldn't regard HIV itself as much an issue to LGBT people as for heterosexual people (Peter, Medical School lecturer).

Similarly, Susan said:

We pick up sexual diversity, as an aspect of human diversity it's important to study different, different areas that people can have stereotypes about. Especially they need to know about if they're going to be a good doctor. So a part of the course, they have a short lecture on sexual diversity, which really just sort of picks up issues around the fact that, you know, human sexual behavior is diverse and it's difficult to know what people actually do. People who you might classify as gay or straight might have sexual behaviors that don't necessarily conform to the[ir] idea[s]. [...] Later in the module they have a lecture from a diversity trainer from the local LGBT organization (Susan, Health Studies lecturer).

A few participants in this study felt that it was essential to buttress the theoretical knowledge for attaining optimum healthcare for LGBT people with community knowledge. The general benefits of incorporating community-based learning into the classroom have been widely discussed and well documented (Bach & Weinzimmer, 2011; Mooney & Bob, 2001). While not widespread, in our sample there were a few lecturers who spoke of introducing their students to speakers who work professionally with sexuality and gender identity groups and often identify as LGBT, to provide some insight into LGBT lives and healthcare issues. This enabled students to examine and propose solutions to healthcare problems addressed by community organizations and members. This strategy also enabled teachers to deflect any resistances to them including the provision of LGBT curricula content. Such collaborations were conducted with both external and internal groups, such as equality and diversity representatives from the university, local NHS organizations and non-governmental organizations (NGOs).

Inter-professional training efforts have been successful in other areas relevant to patient care, such as HIV/AIDS (D'Eon, Proctor, Cassidy, McKee, & Trinder, 2010). However, there are many challenges to setting up these learning spaces, including lack of funding. The potential of this form of collaborative teaching has not been explored enough to ascertain any benefits to positive health outcomes, equitable provision of care or adherence to the accreditation policies' requirements. Suffice it to say, however, that the successes demonstrated by sociological approaches to community-based learning techniques (Bach & Weinzimmer, 2011; Jakubowski & Burman, 2004) that facilitate the closing of educational gaps in the curriculum (Becker, 2013) warrant further investigation in relation to LGBT healthcare provision, health outcomes and the equitable provision of care.

Discussion and Conclusions

In this article, we have mapped an analysis of British accreditation policies, for medical, health care and social work education, onto interviews to illustrate divergences and convergences in attitudes, practices and future aspirations for including LGBT issues in curriculum. This contextualization of accreditation policies helped us to situate the contemporaneous state of healthcare teaching in Britain, while the interviews illustrated key facilitators and barriers to including LGBT curriculum content in higher education courses. Additionally, we have shown that contemporary accreditation policies for educational programs in Britain (CSWE Commission on Accreditation, 2008; General Medical Council, 2009; Royal College of Nursing, 2010) have attempted to rectify the historical exoticizations, pathologization and erasures of LGBT people by taking steps to mainstream LGBT curricula content under the banner of “diverse communities” or “human diversity.” Accreditation policies and other formalized legislative duties endorse addressing the causes and consequences of stigma, discrimination, social and health inequalities and exclusionary practices (Office of Public Sector Information, 2007, 2010). LGBT curricula content is, in other words, structurally recognized as being important for the education of culturally competent practitioners and for the creation of accessible and non-discriminatory places of work (Wilson et al., 2014). However, we found that resistances to including LGBT curricula

content at the institutional level are facilitated by a lack of focus about particular LGBT issues in the policies underpinning professional healthcare practices, ranging from a lack of directed curricula focus to a dearth of local-level curricula and assessment and a lack of external monitoring or validation. These findings resonate with the results of studies conducted in other national contexts, which call for a more systematic and integrated approach to the planning of incorporating LGBT content into curricula for medical, health care and social work students (Müller, 2013).

According to this research, non-hostile and open healthcare environments for LGBT patients are required and need to be created, in part, by knowledgeable teachers equipped to engage with the richness and complexity of (LGBT) patients' lives. Problematically, reductionist approaches surrounding sexual health in the medical, health and social care literature also impact upon the inclusion and treatment of LGBT content in curricula for medical, health and social care education, and prevent the more complex and variegated plotting of LGBT health and social care issues with student practitioners. A varied research focus on wider LGBT health issues may help challenge the commonplace representations which persist in university classrooms today, with a view to promoting medical, health and social care students' sensitivity to the diversity of health issues and requirements presented by LGBT communities.

We found that training for medical, health and social care students at undergraduate and postgraduate levels about taking a proactive role during training consultations, not making assumptions about patients' sexual orientation and understanding what that may mean for their healthcare practice were all regarded as crucial factors for transforming healthcare for LGBT communities and is consistent with other recent research (Hinchliff, Gott, & Galena, 2005; Sequiera, Chakraborti, & Panunti, 2012). Particularly important was patient-centered communication in consultations, which has been associated with better health outcomes, owing to more recollection of information by the patient, treatment adherence and satisfaction with care (Hall, Roter, & Katz, 1988). These components of effective communication are therefore essential bases for curriculum development in medical education (Stewart, 1995). According to our research, students are taught about the potential sexual and gender diversity that they may encounter in clinical practice and the importance of communicating in non-heteronormative ways to avoid potentially damaging

encounters, such as mis-gendering partners while illustrating a patient centered approach to their patient's care.

The ability to recognize, respect, and value diversity; including age, race, culture, disability, gender, spirituality and sexuality and the ability to communicate well with patients and colleagues with different characteristics will go some way in combatting health inequalities (Stewart, 1995). These abilities inevitably reduce patients' and LGBT providers' fear of feeling marginalized in healthcare environments by providing space to be able to communicate their health and social care concerns as equals. We found, however, that resistances from, faculty, students and the perceived constraints on time and space in the curriculum created more challenges for the educators who were providing some LGBT curricula content. Moreover, our findings illustrated that micro (student and educator) resistances are ephemeral and situationally limiting, requiring that LGBT curricula content be dispersed throughout the curricula as a matter of course and potentially with inter-professional training session. Such dispersal would allow the 'topic' to become mainstreamed, embedded and more resistant to resistances.

Any future study should evaluate how the provision of LGBT content in such curricula is assured through internal and external validation, as is commonly assured for other important protected characteristics such as gender, disability, ethnicity and so on (Office of Public Sector Information, 2010).

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Notes

¹ Sociologists Kristen Schilt and Laurel Westbrook (2009, p. 461) define cisgender as a label for "individuals who have a match between the gender they were assigned at birth, their bodies, and their personal identity."

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Zowie Davy is Senior LecturerAssociate Professor in the School of Health and Social Care College of Social Science Care at University of Lincoln, United Kingdom. ORCID id: [0000-0001-5833-188X](https://orcid.org/0000-0001-5833-188X)

Sarah Amsler is Reader in Education in the School of Education, College of Social Science at University of Lincoln, United Kingdom. ORCID id: [0000-0003-0752-8804](https://orcid.org/0000-0003-0752-8804)

Karen Duncombe is Equality and Diversity Manager at Greater East Midlands Commissioning Support Unit, United Kingdom.

Contact Address: Zowie Davy, School of Health andSocial Care, University of Lincoln, Lincoln, LN56TS, United Kingdom. Email: zdavy@lincoln.ac.uk