How Do OSCE Cases Activate Learners About Transgender Health?

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Abstract

Purpose
To describe the effect of transgender health–related objective structured clinical examination (THOSCE) case exposure on learner activation regarding gender-affirming care.

Method
A modified grounded theory approach was applied to identify the educational value of THOSCE cases. Focus groups with current and former primary care internal medicine residents who participated in THOSCE cases were conducted in 2018–2019. Transcripts were analyzed and coded until saturation to identify themes.

Results
Eighteen (72%) eligible learners participated in the focus groups. Themes were identified relating to gender-affirming care, and modified grounded theory analysis was used as a framework to organize the themes into 4 stages of learner activation: (1) believing the learner role is important, (2) having the confidence and knowledge necessary to take action, (3) taking action to maintain and improve one’s skills, and (4) staying the course even under stress.

Conclusions
Residents were grateful for the opportunity to practice the skills involved in transgender health in a simulation. Many felt unprepared and were concerned about how they were perceived by the standardized patient and faculty. Residents identified feeling more comfortable with gender-affirming care in the inpatient setting, which may provide an opportunity for learning in the future. Residents identified the psychosocial skills of gender-affirming care as more directly relevant while biomedical aspects of gender-affirming care seemed less accessible to residents, given the lack of outpatient experience. The authors propose a staged approach to teaching the skills of gender-affirming care using simulation to address learners of all levels.

Patients who hold transgender, nonbinary, and other gender expansive (TGNB) identities and experiences face great challenges when seeking gender-affirming care. One in 5 has been refused care, half must teach their providers about their medical needs, and 1 in 4 TGNB people have postponed medical care due to fear of discrimination. To prepare learners to address the health care needs of TGNB patients and provide gender-affirming care, educators must consider the elements involved in providing it, identify the barriers to providing those services, and develop educational interventions that support clinicians in providing this care.

To address the needs of vulnerable patient populations, health professions educators often focus learners on the practice of asking questions about the patients’ cultural beliefs to inform shared decision making. The underlying assumptions are that the clinician has expertise in the biomedical aspects of care and will adapt their recommendations to the patient’s cultural beliefs. In the case of TGNB care, patients have distinct cultural values and often have more information than health care providers about the biomedical aspects of their care (hormone doses, screening tests, etc.). Providers maintain the power to choose whether to prescribe hormones, offer health screenings, and clear patients for surgery, as well as to continue providing other primary care services. Due to a lack of biomedical knowledge and discomfort surrounding the cultural aspects of providing gender-affirming care, many providers experience uncertainty in the provision of care for TGNB patients.

This shift in power dynamics involved in clinical encounters with TGNB patients can create discomfort for health care providers, which can lead to health disparities. Poteat and colleagues found that provider uncertainty coupled with stigma lead to reinforcing provider desire for authority and power.

For primary care providers, the biomedical aspects of gender-affirming care include the provision of hormones, health screenings, and preparation for surgical gender-affirmation procedures. Regarding the psychosocial aspects of caring for patients who are transgender, patients may use names and pronouns that are different from those on their legal identification, and use words to discuss their body parts that do not align with traditional medical education. Providers must shift their thinking from gender-based care to anatomy-based care consistent with a patient’s anatomy and hormone exposure. Several evidence-based guidelines exist to guide practitioners in the best practices of gender-affirming care.

Historically, medical education lacks discussion of gender-affirming care. On average, medical school curricula include only 5 hours of LGBT (lesbian, gay, bisexual, transgender) health overall, with much focus on HIV and sexually transmitted infections. A recent review of the literature notes graduate medical education (GME) programs have little, if any, transgender health in their curricula. To date, the majority of these emerging GME educational interventions have been lecture or computer based.
(and, therefore, not interactive), without the ability to assess clinical performance of gender-affirming care. Braun et al’s intervention, which involved both computer modules and time spent interacting with patients, demonstrated short-term knowledge gains and decreased transphobia in participants.

Simulation experiences such as objective structured clinical examinations (OSCEs) present an opportunity in education as they allow learners to have a clinical experience in a low-stakes environment. OSCEs allow the learner to make mistakes and ask questions without the risk of offending or harming a patient in a genuine clinical setting, and to receive immediate feedback on their performance. Additionally, OSCEs have been used to assess cultural competence for many years. A clinician must rely on cultural competence, psychosocial skills, and specific biomedical knowledge to provide excellent gender-affirming care. In a prior study, we demonstrated that primary care residents were able to provide a TGNB patient care that was psychosocially comparable to other OSCE cases tested, while underperforming on communicating about content specific to gender affirmation.

In this study, we sought to examine the characteristics of TGNB health–related OSCE (THOSCE) cases, how learners respond to them, and whether this educational modality activates learners to provide gender-affirming care for transgender patients.

**Method**

This research presents a qualitative study using a modified version of grounded theory (GT) to analyze the elements of simulated patient experiences with transgender-identified standardized patients and whether these experiences activate learners to provide future gender-affirming care to TGNB patients. While pure GT is meant to be atheoretical, allowing the data to inductively drive the analysis, the authors aimed to generate conceptual theory based on the research. Specifically, they explored the degree to which the theoretical framework of learner activation might be supported by the data while striving to be open to emerging, unanticipated, and conflicting themes. Given the lack of literature on this topic, the fundamental elements of GT fit the goals of the research.

Local institutional review board (IRB) approval was obtained before beginning the research. Primary care internal medicine residents in a New York City–based residency program who participated in at least one THOSCE case and were residents or faculty at the time of the study were invited to participate. The THOSCE cases have been run for 3 of the 4 years before this research (March of 2018, March of 2017, April of 2015). One of two cases (Supplemental Digital Appendix 1 at http://links.lww.com/ACADMED/B15) featuring a transgender-identified patient, portrayed by a transgender-identified standardized patient, is run in a 10-12 station “World Wide OSCE” run annually for all residents in the primary care residency program.

**Data collection**

There were 40 current and former residents who completed the OSCE case and were therefore eligible to participate in the focus groups. Of these, 25 remained in the primary care residency as residents or involved as junior faculty members and agreed to participate in the focus groups. Recruitment for the study was performed by email and in-person announcements. Participation was voluntary. Immediately preceding the focus groups, signed consent was obtained for participation and for audiotaping of the focus groups, which were facilitated by a TGNB subject matter expert who has no formal professional relationship with any of the participants.

First-year medical students (n = 240) were surveyed about their experiences following a TGNB lecture and OSCE. Their experiences informed the 10-question focus group discussion guide. The questions were focused on 3 domains: (1) experiences of OSCEs in general and OSCEs as an educational tool specifically for issues of clinical knowledge and cultural humility, (2) experience with transgender people or patients before participating in the OSCE case both socially and in clinical training, and (3) experience with THOSCE cases and desire to take care of transgender patients. There was flexibility in the questions and order to allow for the focus group leader to follow additional lines of thought and new information. After the first focus group requested and received pictures of the standardized patients to aid memory, these pictures were provided to the subsequent focus groups.

**Analysis**

Recordings of each focus group were sent to a professional transcription service for transcription. Speakers were identified by number so that their quotations could be linked across the focus group. Any clearly identifying information about participants, including demographic data and prior medical school, was then removed or redacted by TEC before review by REG. Initial codes based on one focus group were generated individually by REG and TEC, organized by question from the focus group question guide. These codes were reviewed and discussed among REG, TEC, and CG for agreement, and several codes were added during this initial session. Coding was performed in Atlas.ti version 8.3.1 for Mac (Berlin, Germany).

Data analysis was supported through triangulation across multiple focus groups and demonstrated agreement within each focus group and across individual focus group members during axial coding. Preliminary codes were presented at multiple research-in-progress meetings to obtain insight from medical education researchers who have no particular interest in TGNB care, in an effort to challenge the research team to present the findings in the most objective way possible before finalizing conclusions. Data were coded until saturation, the point at which no new themes emerged regarding the specific research question and about themes related to education on TGNB care. It is believed that at the point of data saturation, conceptual insights would remain consistent even were the study to be repeated or more data collected/analyzed. Once all of the data were coded, member checks were performed by bringing the final themes back to a sample of the residents to assess their level of agreement, resulting in no further edits.

Throughout the process, attention to reflexivity and potential bias in the coding was maintained. This was imperative to ensure that focus group questions were responsive to the participants and not overly directive or leading if meaningful results were found. The value of negative feedback was reinforced within team meetings and before focus groups, as
negative impressions were equally if not more useful to the analysis of the OSCE cases as learning tools.

The trustworthiness of the data analysis was supported through triangulation of themes across multiple different focus groups. As codes and themes were developed, they were discussed and debated among the researchers, with different balances of medical education and research expertise, and differences were resolved to achieve consensus. Codes were assigned, and themes were identified, first, within each focus group. Then, during axial coding (deeper exploration of meaning, parameters, relationships within codes), we reviewed codes/themes across all focus groups and established that our coding schema was relevant in all groups. We also used the comparative approach of exploring codes/themes at the individual respondent level, examining the body of responses from each specific resident to generate insights about individual-level themes (rather than viewing each “quote” as a separate data point, which formed the core of our analytic approach). Once all of the data were coded, member checks were performed by presenting the final themes back to a sample of the residents who may have participated in the focus groups to assess how well they felt the results reflected their experiences and the degree to which the interpretations were valid. These residents confirmed that the results were representative of their experiences and thoughts/feelings and that interpretations were accurate.

There were 18 total participants in the focus groups. Following the guidance of Patton, focus groups were divided into 3 groups of residents (n = 12) and 2 groups of faculty (n = 6) who had graduated recently. For the sake of anonymity, demographics about year of training, race/ethnicity, and gender were not collected about focus group participants. Focus group discussions were transcribed and 130 pages were generated. During coding, 22 individual codes were developed. These were then grouped by similar theme into 13 “supercodes.” Supercodes were then analyzed into major themes, which were then organized according to the learner activation framework.

**Learner activation as a framework**

An educational event that motivates learners to engage in gender-affirming care must also motivate them to engage in some aspect of self-learning, given their limited engagement with TGNB patients outside of clinical spaces dedicated to gender-affirming care. There is little in the medical education literature that explicates learner activation. Hibbard and colleagues have developed the concept of patient activation, which defines patient engagement with their chronic medical issues using a robust and well-validated tool. Patient activation is the active engagement of patients with chronic diseases in their own treatment. It specifically focuses on their willingness and ability to act independently to manage their chronic health concerns and has been associated with better outcomes for chronic conditions like diabetes along multiple domains.

The Hibbard model of activation transfers easily to learners, particularly those who may feel fearful of providing necessary care about which they feel they have little information. We have made the transfer (Figure 1) and present our data first according to the stages of learner activation. Supporting quotations are collected in Table 1.

**Results**

**Level 1. Believing the learner role is important**

Lack of outpatient experience with TGNB patients. A minority of focus group participants reported experience of care for TGNB people in the outpatient setting during residency. Those who had outpatient experience were in supplementary HIV clinics that they worked in during residency or after residency when they had actively invited TGNB patients to their clinics. All but one participant who reported outpatient interactions with transgender or nonbinary patients reported a significant lack of confidence in their skills to provide care in that setting.

**Identifying gender-affirming care as specialty vs primary care**

Participants expressed ambivalence about the role of the primary care physician (PCP) in providing hormones for transgender patients. A few participants expressed that this type of care might best be provided by specialists, such as endocrinologists. This may have been the result of discomfort or lack of confidence in the biomedical aspects of gender-affirming care. However, when examined across individual speakers, participants who did not consider the biomedical aspects of care to be part of a PCP’s responsibility were not necessarily those who were the most uncomfortable.

**Residency as defenders of trans patients on inpatient services.** In contrast, many of the participants reported exposure to TGNB people that required a degree of psychosocial knowledge (terminology,
### Table 1

**Learner Activation Framework: Summary of Supporting and Conflicting Data**

<table>
<thead>
<tr>
<th>Theme</th>
<th>Supporting data with quotations</th>
<th>Conflicting data with quotations</th>
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<tr>
<td>1. Believing the learner role is important</td>
<td><strong>Residents as defenders of trans patients on inpatient services</strong>&lt;br&gt;- When they’re in the hospital, we feel like it’s our job to protect them, like, if they don’t have a reason to be outposted, you know, it’s tough, and they’ll make them share rooms, and there’s no doors to the bathroom. —Speaker 2&lt;br&gt;- We were trying to find a single occupancy room, and there wasn’t one, and we were trying to figure out where to put this trans lady, and she said you have to figure out what kind of genitalia this person has. —Speaker 4</td>
<td><strong>Lack of outpatient experience with transgender and nonbinary patients</strong>&lt;br&gt;- I think, though, like, even being in a program where it’s part of our curriculum to learn about trans health, because we don’t see enough trans patients in clinics, I think by the end of our training it will be hard for us to feel as comfortable taking care of trans patients as I would like to. But I think we at least learn the tools that we need, and know where to look stuff up, and know who to ask for help, which is one step. —Speaker 4&lt;br&gt;- I never really found that many patients or maybe they didn’t feel comfortable telling me, that kind of thing. I have a decent number of LGB folks, but I don’t have that many transgender patients I’m aware of. —Speaker 5</td>
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<td>2. Having the confidence and knowledge necessary to take action</td>
<td><strong>OSCE case as an opportunity to practice rare clinical skills</strong>&lt;br&gt;- I do think it's interesting to, if you were a patient, to walk in, you know, as much as your doctor wants to partner with you and is enthusiastic about it, if they don’t know, do you feel a little bit like you’re being experimented on? —Speaker 3&lt;br&gt;- I haven’t ever encountered that case in real life, but I did think that some of the skills required to have a successful interaction around that—I appreciated it. I have not had a lot of transgender patients. I’ve had none in clinic and a couple inpatient, but I did—after that OSCE—feel a lot more equipped. —Speaker 10</td>
<td><strong>Concern about the trans patient’s perception of resident abilities in clinical contexts</strong>&lt;br&gt;- I think it’s interesting to—if you were a patient, to walk in, you know, as much as your doctor wants to partner with you and is enthusiastic about it, if they don’t know, do you feel a little bit like you’re being experimented on? —Speaker 3&lt;br&gt;- I wonder if, for trans patients, you know, obviously like you said there’s some who, it’s their mission to educate, but I’m sure there’s some who do resent that. —Speaker 4</td>
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<td>3. Taking action to maintain and improve one’s skills</td>
<td><strong>Metacognition and reflection on learning from the OSCE cases</strong>&lt;br&gt;- I feel like I had that 1 case, 1 year, and then I […] don’t think I had any other cases in residency, so having some way to have a more continuous way to practice […] I think that just will help you realize, OK, how are you going to respond the next time when you didn’t know the answer and now you’re back with the person? What are you going to do? You can’t just keep not knowing what to do. —Speaker 12&lt;br&gt;- The one thing I think really missing from an OSCE environment that would make an appropriate comparison to clinic setting is you don’t have a computer […] and you don’t have any competing needs on your attention. —Speaker 11</td>
<td><strong>Lack of other meaningful experiences makes this an isolated event</strong>&lt;br&gt;- I think the OSCE highlighted how unprepared I felt, which is useful to identify a deficit, but I haven’t really had another chance to really work on that. —Speaker 12&lt;br&gt;- You forget stuff if you only get that one exposure, and that’s always a little frustrating because then it’s not until, like, the next time we do it like a year later that I get quite the same ability to practice. —Speaker 11</td>
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<td><strong>Impact of one case vs multiple cases</strong>&lt;br&gt;- I remember thinking “oh, this is complex.” There’s a lot of steps, and they expected us […] to really integrate this and really understand it, and I didn’t feel overwhelmed, but I thought there seems like a lot of steps. The feedback, I don’t remember specifics, but I think I felt encouraged. The second one […] I felt more comfortable as the clinician. The feedback felt a little bit more like a pat on the back vs work on this, this, and this. But still I felt encouraged and bolstered to now go out and do this and teach other people. —Speaker 17</td>
<td><strong>Influence of context (simulation vs clinical)</strong>&lt;br&gt;- The one thing I think really missing from an OSCE environment that would make an appropriate comparison to clinic setting is you don’t have a computer […] and you don’t have any competing needs on your attention. —Speaker 11</td>
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<td>4. Staying the course even under stress</td>
<td><strong>Motivation to learn more following the OSCE</strong>&lt;br&gt;- I think it made me realize that I actually was comfortable. It was just sort of a morale boost. I don’t think my skills really changed that much pre and post, but I think the sort of pat on the back—that “oh, yeah, you can totally do this”—I think that really did help a lot. And I think maybe instead of waiting 5 years of practice to really start establishing that kind of clinic within my practice—instead of feeling “oh, I need more experience, I need to do this and this”—it made me feel more confident in just starting. —Speaker 17</td>
<td><strong>Resident fragility</strong>&lt;br&gt;- I remember both because they were both sort of traumatic, like how I remember them. I think certain OSCEs are memorable when you do a really bad job. These 2 fall in that category, and I know the OSCEs aren’t meant to make you feel like you’re on a scale or anything like that, but they, to me, were really eye-opening in how awkward I could be in these encounters and lose all my natural, normal human interaction skills. —Speaker 8</td>
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Abbreviations: LGB, lesbian, gay, bisexual; OSCE, objective structured clinical examination.
etc.) in inpatient settings, frequently when patients were being mistreated. This care was not related to gender-affirming hormones or surgeries; however, participants reported a strong desire to defend and advocate for their patients in this context. Overwhelmingly, the residents who identified inpatient exposure to TGNB patients reported feeling compelled to act against systemic or individual discrimination, including not only their own use of appropriately affirming language but also the education of others on the care team. This seems to have the effect of galvanizing the residents to both believe their role in caring for TGNB patients is essential, and to want to improve their knowledge about affirming language and care. In this context, there was expressed clear ownership of the psychosocial skills involved in caring for TGNB patients.

Level 2. Having the confidence and knowledge necessary to take action
OSCE case as an opportunity to practice or build confidence with rare clinical skill. Participants described the OSCE case to be an opportunity to practice skills they have not otherwise been able to practice; however, they described anxiety about being observed for assessment.

Resident discomfort and embarrassment. A few expressed a fear of being embarrassed in front of faculty who were more expert at these skills. They commented that the social implications of making mistakes (i.e., with language) might cause faculty to label them as insensitive.

Concern about TGNB patient perceptions of resident clinical abilities. Concern was also expressed that TGNB patients would perceive them as being inadequate. In some cases, this seemed to overwhelm the participant’s desire to engage with the skills of TGNB care.

Resident ability to manage both the psychosocial and biomedical aspects of the cases. The majority of participants identified a lack of confidence around the psychosocial aspects of gender-affirming care, including use of affirming language and rapport building with TGNB patients. Regarding biomedical aspects of care, they expressed significant discomfort with this content, despite receiving curriculum on this topic and a perceived acceptance of the role of residents in caring for TGNB people. They expressed a desire for clarity about whether the goals of the case were psychosocial (rapport building, demonstrating use of affirming language) or biomedical (managing hormones or screening tests). They referred to the inclusion of both biomedical and psychosocial aspects of the case to be “inauthentic” to clinical experiences (in spite of the clear need to perform both in the clinical setting).

In case 1, for example, residents were expected to both build rapport with a transgender patient and manage a complication from her Spironolactone, used to block testosterone. Participants commented that, given the paucity of contact with TGNB patients in the outpatient setting, the case seemed to challenge them to perform skills they were unable to practice otherwise.

Level 3. Taking action to maintain and improve one’s skills
Metacognition and reflection on learning from the OSCE cases. Respondents reported they found the cases challenging and engaging. Several of the participants noted that the case had given them the opportunity to think deeply about the skills of gender-affirming care and had inspired them to want to know more. Residents noted that the opportunity to ask questions about the TGNB standardized patient’s pronouns and preferred name and aspects of transition provided an opportunity to recognize areas for improvement of previously learned psychosocial skills. Many participants expressed desire to have more regular contact or other types of skills practice in a nonassessment venue, such as a workshop with TGNB people. Notably, this desire to have other learning experiences outside of the OSCE case indicates some participant activation to obtain greater confidence and knowledge.

Influence of context (simulation vs clinical). Participants discussed feeling that the biomedical aspects of the case were inconsistent with their actual clinical experience, noting that, in clinical situations, they would have access to computers and reference tools.

Lack of other meaningful experiences makes this an isolated event. Participants identified that, given their noted lack of outpatient exposure to TGNB patients, the learning from the OSCE case may have been limited.

Impact of one case vs multiple cases. Participants who experienced only one OSCE case described feeling that the OSCE case was too isolated an event to be meaningful. Interestingly, those who participated in more than one case were more likely to reflect on the subsequent experience and described feeling more confident and able to provide care due to the repeated exposure.

Level 4. Staying the course even under stress
Resident fragility. Many residents perceived these cases as higher stakes than other cases. This increased their fear of using inappropriate language or providing incorrect treatment options. In some cases, this seemed to trigger the participants to reject the notion that gender-affirming care is within their purview. David Mathew described this phenomenon as “fragile learning,” in which learners may give up on learning about a particular topic if a perceived external threat (i.e., embarrassment) is present.23

Motivation to learn more following the OSCE. It is difficult to assess the long-term impact of the OSCE cases on the motivation to learn about and care for TGNB patients given the time frame since beginning the cases. At least one former resident identified this case as a reason they felt confident enough to begin caring for TGNB patients specifically in their practice, and identified wanting to engage in more education on the subject.

Limitations
The investigators and the focus group facilitator may have introduced bias into this work, given their close ties to the TGNB community. To defend against this, the team had frequent check-ins and discussions of reflexivity, continually and transparently reflecting on the biases held by the research team that may inform or impact data analysis and interpretation, and reinforcing the value of negative as well as positive findings to try to limit this bias. Additionally, this OSCE case was run at only one institution, within one program. The residents of this program all work with underserved communities and, therefore, may be predisposed toward working with TGNB patients. Given the small number
of possible participants, to protect anonymity, demographic data about race, ethnicity, gender, and sexuality were not collected. Finally, the participants may have perceived the subject matter to be emotionally charged and may not have offered their true opinions.

**Discussion**

Overall, the OSCE cases with transgender standardized patients served their intended purpose of providing residents with opportunities to practice rarely used but important skills. Focus groups identified that many residents were activated to practice the psychosocial aspects of care, particularly given inpatient exposure to TGNB patients, and were grateful for the opportunity to practice with a person of TGNB experience. The cases were originally conceived as a low-stakes opportunity for residents to practice skills with which they did not feel comfortable and had less exposure. However, the participants’ perception of the OSCE as a high-stakes assessment may in some cases have worked against activating them to learn more about gender-affirming care. For some, the stress and embarrassment may have lowered their activation, lowering their confidence in Stage 2 and making it less likely they will stay the course under stress as noted in Stage 4. How then to develop a learning tool or tools to address these concerns and activate learners around gender-affirming care?

It may be helpful to consider the elements of gender-affirming care in stages. There may be staged competencies that need to be addressed in sequence, rather than in parallel. These stages would move from the most basic psychosocial skills of affirmation to more complex skills of maintaining someone on hormones as part of primary care, to being able to initiate someone on hormones and having a thorough risk–benefit conversation with them, and to the most advanced care, which would include managing complex issues around surgeries and complications of care (Figure 2).

Such a sequence would allow for a variety of educational interventions to be developed to address learner activation at each stage. The fundamental level of this pyramid would include the most generalizable skills—affirming psychosocial skills and effectively asking about and using a patient’s name and pronouns—that apply to all health professionals. It may be possible to capture the urgency residents feel when caring for TGNB patients on the inpatient service with OSCE cases designed to demonstrate interprofessional communication, such as a case in which a team member misgenders a patient. In addition to simulation, opportunities for low-stakes patient panels, role playing, and workshops with TGNB people can provide psychosocial skills practice.

Recently published data have shown that intentionally placed didactics may be sufficient to increase knowledge and, therefore, activation. Participants identified that their lack of biomedical knowledge might have been mitigated through access to online clinical resources. As clinicians typically do have Internet access, there is an opportunity to practice searching for evidence-based guidelines online, in real time, and applying them within simulation. The biomedical skills of gender-affirming care, including hormone therapy and health screenings, will likely be more engaging for learners as they become more commonly used skills and are included in standard assessments and competencies.

Finally, and of paramount importance, increasing resident outpatient experiences with TGNB people will increase...
Curricular Interventions

the perceived importance of both psychosocial and biomedical content to the residents. Increased exposure is likely to reduce the presence of transphobia, according to the work of Stroumsa et al, and to decrease fear of making mistakes and “othering” TGNB patients. It is no surprise, however, given the prior experiences of TGNB patients in the health care system, that TGNB patients avoid resident clinics and seek out already identified competent providers or avoid care altogether. The burden is on the health care system to create welcoming spaces for TGNB patients. Indeed, an intention of these cases was to begin to create competence in gender-affirming care to help create this more welcoming environment. The OSCE cases and the individual exposure they provide to members of the TGNB community afford learners an opportunity to bridge the gaps in their comfort and knowledge and to provide better, more affirming care to TGNB patients.

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