Beyond Men, Women, or Both: A Comprehensive, LGBTQ-Inclusive, Implicit-Bias-Aware, Standardized-Patient-Based Sexual History Taking Curriculum

Jacob J. Mayfield, MD*, Emily M. Ball, MD, Kory A. Tillery, MBA, Cameron Crandall, MD, PhD, Julia Dexter, J. Michael Winer, BA, Zachary M. Bosshardt, Jason H. Welch, Elia Dolan, Edward R. Fancovic, MD, Andrea I. Nañez, MD, Henning De May, Esmé Finlay, MD, Staci M. Lee, MD, Carl G. Streed Jr., MD, Khizer Ashraf

*Corresponding author: Jacob.Mayfield@ucsf.edu

Introduction: This standard-patient-based module prepares medical students to take inclusive, comprehensive sexual histories from patients of all sexual orientations and gender identities. Health disparities faced by lesbian, gay, bisexual, transgender, and queer (LGBTQ) people are at least partially the result of inadequate access to health care and insufficient provider training. This module incorporates implicit bias activities to emphasize the important role providers can play in mitigating these disparities through compassionate, competent care. Furthermore, two of the three included cases highlight the negative impact sexual dysfunction can have on emotional well-being. Methods: Over 3 hours, students participate in a 30-minute large-group lecture and three 40-minute small-group standardized patient encounters with debrief. Prework consists of a short video on sexual history taking, assigned readings, and an implicit bias activity. These materials are included in this resource, along with lecture slides, facilitator guide, and standardized patient cases. Though the cases are adaptable to all levels of medical education, this module is designed for second-year and early third-year medical students. Results: Qualitative student evaluations were positive, and postparticipation surveys revealed statistically significant improvement in comfort with their ability to take a sexual history in general, and take one from patients with a differing sexual orientation. Deployed in the second year of our Doctoring curriculum, this module continues to receive positive evaluations. Discussion: Introducing these skills begins to address the curricular deficiencies seen across medical education and lays the foundation for a more competent health care workforce to address the needs of LGBTQ patients.

Keywords
Communication, Sexual History, Standardized Patient, Sexual History Taking, LGBT, Standardized Patient Cases, LGBTQ, Lecture, Health Equity, Implicit Bias, Sexual Function

Educational Objectives
By the end of this session, learners will be able to:
1. Take an accurate and sensitive sexual history using open-ended, gender-neutral language as measured by self-reported comfort with sexual history taking.
2. Assess high-risk sexual behavior, including identifying and introducing appropriate basic risk-mitigation strategies.
3. Explore how patients’ sex lives affect their quality of life, including interpersonal relationships.
4. Reflect on how their own biases related to sexuality and gender may impact patient care.

Introduction
The sexual history is an integral part of a complete patient examination.13 Often conceptualized as a means to prevent, diagnose, and treat sexually transmitted infections (STIs), taking a sexual history has well-recognized public health benefits.4,5 Despite this, sexual history taking is often cursory or not
routinely performed across a wide variety of practice settings and patient demographic groups. Beyond its importance in infection control, the sexual history is vital to many other aspects of individual and population health. Unplanned pregnancy, for example, continues to be a major population health concern, especially among lesbian and bisexual women. Additionally, sexual dysfunction is routinely left unaddressed by physicians, even though it is known to negatively impact psychological health and portend chronic illness.

Importantly, disparities exist in sexual history taking across various demographic subpopulations. For example, in a single-center survey, trainees felt significantly less comfortable taking a sexual history from lesbian, gay, bisexual, transgender, or queer (LGBTQ) patients. Similar trends have been identified within the geriatric population, especially when patients and interviewers have differing gender expression.

The Centers for Disease Control and Prevention and others have delineated the essential components of the sexual history. A number of authors have contributed to this field in MedEdPORTAL. Two recent publications specifically address sexual and gender minority patients, allowing students to practice asking challenging questions using standardized patients (SPs). These resources informed our efforts and have significantly increased the availability of LGBTQ-inclusive sexual history taking curricula. We build on these works by incorporating implicit bias, reflective exercises, and a novel approach to incorporate sexual orientation in sexual history taking. Specifically, we detail here the use of one SP to deliver the same case twice, varying only sexual orientation, as a substrate for facilitated discussion of implicit bias.

In 2014, a group of students, residents, and faculty members at the University of New Mexico School of Medicine began a review of coverage of LGBTQ topics in the undergraduate medical curriculum in the context of recently released guidance from the Association of American Medical Colleges (AAMC). A multipart needs assessment targeting one cohort of medical students informed our process. Baseline knowledge and opinions of LGBTQ issues were assessed in the first year and reassessed between the second and third years. Our findings suggested that medical students at our institution were not adequately prepared to address the specific health and social issues faced by LGBTQ people at baseline. As part of our ongoing efforts to improve our curriculum, we set out to develop this module with the goal of preparing medical students in the preclinical years to take a complete and culturally competent sexual history, with attention to the important aspects of sexual orientation and gender identity.

Implicit bias describes the influence that unconscious thought patterns have on behavior. Clinically, it manifests as avoiding topics of conversation that are uncomfortable, spending less time interacting with a patient, neglecting to ask certain questions, and other subtle patterns of behavior that affect the patient-provider bond. Implicit bias is thought to negatively impact outcomes, and experiences during medical school have been shown to contribute to these behaviors.

This intervention is meant to introduce sexual history taking. It is not meant to provide the infectious disease, endocrinologic, psychiatric, and other background knowledge that is critical to properly diagnosing and treating sexual health–related complaints. Though the cases are adaptable to all levels of medical education, this module is designed for second-year and early third-year medical students. The curriculum detailed here integrates several previously described methods and offers an innovative update to the existing library of MedEdPORTAL SP cases.

**Methods**

Presession assignments include a short video and readings on sexual history taking (Appendices B-E). We recommend that students also be assigned the sexuality Harvard Implicit Association Test (IAT). Students are expected to complete the presession assignments individually. Our aim is to prime students...
to examine their own biases regarding sexuality. While we do not require students to disclose IAT results, they are asked to keep their results in mind when preparing to interview SPs.

Three documents are required as prereading and are included in this resource. The first two documents (Appendices C & D) are a simplified sexual history taking guide\textsuperscript{31} and a more advanced summary of the 5 Ps framework,\textsuperscript{32} respectively. Both are published by the National Association of Community Health Centers and the National LGBT Health Education Center. The 5 Ps refer to partners, practices, past history of STIs, protection from STIs, and pregnancy plans. A short video summarizing the 5 Ps system is also included in the prework (Appendix E)\textsuperscript{33}. The third and final document (Appendix B) is a flowsheet tying these concepts together, adapted with permission from a recently published LGBTQ health care text.\textsuperscript{34}

On the day of the session, learners were presented with a 30-minute overview lecture on sexual history taking (Appendix F). This included information regarding gender identity, sexual orientation, and sexual practices/behaviors. Emphasis was placed on correct pronoun usage, use of sensitive language regarding sex assigned at birth versus gender identity, nonbinary gender identities, possible discordance between sexual orientation/attraction and sexual behaviors, and pointed questions eliciting sexual practice information. Additional slides raised important considerations as to documentation, language usage, and appropriate settings for obtaining sexual histories.

Students were subsequently divided into small 6-person groups. Facilitators were given 20 minutes to orient students to the SP activity and discuss the prework. Over the following 2 hours, students then interviewed three SPs. Each encounter was limited to 25 minutes. Because there are two students for each SP, we suggest that facilitators either group students into teams or have two students complete each case sequentially. Following each SP encounter, faculty members facilitated a 15-minute discussion based on notes provided in the Facilitator Guide (Appendix A).

The Facilitator Guide (Appendix A) includes session objectives, a description of the students’ preclass assignments, and a detailed schedule. The Patient Encounter Checklist (Appendix J) is provided to faculty members to ensure students receive standardized feedback. Orientation should include a reminder to facilitators regarding the wide range of comfort and experience students may bring to the discussion, and a list of ground rules to be read aloud at the beginning of the session.

Three cases were developed specifically for this project (Appendices G-I). These scripts were inspired by recommendations developed by the AAMC\textsuperscript{24} as well as real-life scenarios. Each case has been designed with sufficient depth to necessitate a thorough sexual history. When combined, the cases touch on a wide variety of sexual identities and practices, risk factors for STIs, and psychosocial issues pertinent to health. Of note, the Alan Gomez case (Appendix G) was adapted from a resource published with the 2014 AAMC guidelines.\textsuperscript{35,36}

The Jen Gallison case (Appendix H) represents an approach to sexual minority history taking that is, to our knowledge, novel. During the small-group sessions, the Gallison case is performed twice. The SP, who presents with sexual dysfunction and resultant emotional distress, is heterosexual and married to a man during the first encounter. In the second encounter, she identifies as lesbian and is married to a woman. The order of these interactions can be reversed based on facilitator preference. This dichotomy creates an important opportunity for learners and facilitators to reflect on how LGBTQ patients and other members of minority groups might receive inferior care due to implicit or explicit bias.

**Results**

This curriculum was administered to the medical class of 2018 (n = 84) at our institution in November of the clerkship year. In the postparticipation survey, 40 (47.6%) identified as male, 37 (44.1%) identified as female, and seven (8.3%) declined to identify. All students identified as cisgender. Five students (6.0%) reported lesbian, gay, or bisexual sexual orientation. One student selected other for sexual orientation,
and seven (8.3%) declined to identify. The remainder of the class (84.5%) identified as heterosexual/straight.

As part of the standard end-of-semester evaluation questionnaire, students were asked a series of questions about this curriculum. Responses were elicited using a Likert scale ranging from 1 (not at all comfortable/not true at all) to 7 (very comfortable/totaly true). We used the Wilcoxon signed rank test to compare each paired question given the nonparametric nature of these data. Statistically significant improvement was observed in general comfort with taking a sexual history ($p < .0001$, Figure 1) and comfort with taking a sexual history from patients with differing sexual orientation/identity ($p < .0001$, Figure 2). We further compared self-assessment of knowledge of the sexual health and practices of men who have sex with men (MSM) and women who have sex with women with matched data from the same cohort obtained just prior to the clerkship year, finding significant improvement ($p < .0001$, Figure 3).

**Figure 1.** Students were asked two scaled questions post hoc. First, “Before this session, how comfortable were you discussing sex with patients overall?” Then, “After this session, how comfortable do you think you will be discussing sex with patients overall?” Responses ranged from 1, being not at all comfortable, to 7, being very comfortable.

**Figure 2.** Students were asked two scaled questions post hoc. First, “Before this session, how comfortable were you discussing sex with patients of a different sexual orientation/identity than your own?” Then, “After this session, how comfortable do you think you will be discussing sex with patients of a different sexual orientation/identity than your own?” Responses ranged from 1, being not at all comfortable, to 7, being very comfortable.

Students’ postparticipation comments were generally positive. When asked what went well, responses included the following:

- “Just practicing the full history and receiving feedback. It’s a history worth practicing many times and was quite nice to be able to receive feedback as that rarely happens in real life.”
- “Discussing the language/vocabulary that would be least offensive to use with the LGBTQ population.

I also liked that we were able to role play the scenario and see how we respond in the situation of eliciting a sexual history from a patient (even if they were fake patients).”
“I really enjoyed being able to talk through some of the more sensitive topics that aren’t really addressed normally in the curriculum (gay/lesbian sexual practices).”

“Working with standardized patients provided valuable experience when taking a full sexual history. The pre-work provided useful information on techniques to elicit important information from patients.”

![Knowledge MSM/WSW is sufficient – before and after](image)

*Figure 3.* Students were asked 6 months earlier to rate the statement, “My knowledge of the sexual health and practices of WSW and MSM is sufficient to attend to LGBTQ patients,” on a scale from 1 to 7, with 1 being not true at all and 7 being totally true. They were then posed the same question following the intervention. Abbreviations: MSM, men who have sex with men; WSW, women who have sex with women.

When asked what could be done to improve the session, many students provided constructive feedback:

- “I think it would be useful to have more patients where we have to assess risk factors and delve into detail regarding practices etc., like the military man with MSM experience. This was better than the cases where there are medical aspects that we need to elicit, where we have a lot of experience already.”
- “Having more standardized patients so that each student can go through a case would be valuable.”
- “[Place the session] earlier in the [medical] school curriculum (like [preclinical] Repro block).”
- “A little more ‘complicated’ cases.”
- “This is our chance to be really challenged. The cases should be off [sic] the strangest things that can be encountered.”
- “The session focused specifically on pronouns which while useful did not specifically help us learn to gather sensitive information from patients with various sexual orientation and gender. I [think] more direct lesson[s] about specific questions and challenges in gathering sensitive information from all orientation[s] and genders would be more useful.”

**Discussion**

Like many medical schools, our institution has faced challenges implementing curricular changes reflecting the health care needs of the LGBTQ community. This resource is designed to address the specific foundational skill of sexual history taking while also prompting students to examine their own biases. Based on our results, we are confident that this curriculum prepares students to take a complete and culturally sensitive sexual history.

Due to the foundational yet comprehensive nature of this curriculum, we believe it to be developmentally appropriate for preclinical medical students and those early in the clerkship year. The included SP cases, however, are applicable to every level of medical training, especially when coupled with the IAT and structured or unstructured reflection.

Many faculty members may not feel adequately prepared to facilitate this session. Sexual history, especially as it pertains to the LGBTQ community, may be outside the scope of practice of many physicians. At our institution, we provide facilitators with the syllabus and all curricular materials during a
faculty-only orientation session 2-3 weeks prior to the start of the Doctoring course. Experienced providers are available to answer questions during this time. Facilitators also meet with the course director immediately before the start of the workshop to address any lingering concerns.

Many comprehensive resources exist for individual learning and for reference in preparing faculty development curricula. Two textbooks stand out as comprehensive, yet digestible. The *Fenway Guide to Lesbian, Gay, Bisexual, and Transgender Health* is the first of its kind, and serves as a clinically oriented guide for any provider, generalist or specialist, focusing on the crosscutting health care, social, and legal issues unique to the LGBTQ community. *Lesbian, Gay, Bisexual, and Transgender Healthcare: A Clinical Guide to Preventive, Primary, and Specialist Care* is also innovative, and particularly useful for medical educators, as it is organized around the standards outlined in the AAMC guidelines for LGBTQ medical education.

When implementing this curriculum, educators should be cognizant of the fact that people are much more than their sexual behaviors. Inclusive sexual history training is only one part of vital cultural competency curricula—medical education programs must also emphasize the unique and formative experiences and cultures of LGBTQ people and their intersection with other dimensions of identity.

Limitations
This session was initially piloted during the clerkship year, which was later than we had anticipated. Ideally, this topic would be introduced earlier, prior to significant clinical experience. Narrative student feedback supports this conclusion. However, if the session is placed too early, students will not have learned the communication skills and/or medical knowledge necessary for sexual history taking.

Many facilitators have not had significant interaction with the LGBTQ community and may need additional training in order to lead meaningful discussion within small groups. Unfortunately, we were unable to assess the baseline knowledge of our faculty facilitators. Future iterations of this curriculum should include dedicated facilitator-training modules outside of the content included in the Facilitator Guide.

Experiences in medical school have been reported to impact providers’ subsequently assessed implicit biases. Interventions, including just taking an IAT have been found to reduce implicit bias in medical trainees, which we believe supports the efficacy of our curriculum. Regrettably, we acknowledge that we were unable to completely assess the effect of our intervention on implicit bias. These data could have been obtained by administering pre- and postparticipation IATs. We plan to incorporate this paradigm in future educational interventions.

Furthermore, due to the heterogeneity of human sexuality, gender identity, gender expression, and sexual behaviors, it is impossible to create a case representative of all possible variables. As such, we were unable to include more advanced cases delving into sexual history taking with transgender, gender nonbinary, and intersex patients. Students noticed the omission of several important groups (e.g., transgender individuals) and asked for more complex cases. While we believe that the communication skills included in this curriculum are a strong foundation for taking a complete sexual history from any patient, we agree that specific training in the needs and acceptable terminology of these communities is necessary.

Jacob J. Mayfield, MD: Intern, Internal Medicine Residency Program, University of California, San Francisco, School of Medicine; Recent Graduate, University of New Mexico School of Medicine

Emily M. Ball, MD: Intern, Emergency Medicine Residency Program, Jackson Memorial Hospital; Recent Graduate, University of New Mexico School of Medicine
Kory A. Tillery, MBA: Medical Student, University of New Mexico School of Medicine

Cameron Crandall, MD, PhD: Professor, Department of Emergency Medicine, University of New Mexico School of Medicine; Vice Chair for Research, Department of Emergency Medicine, University of New Mexico School of Medicine; Director of LGBTQ Diversity and Inclusion, University of New Mexico Health Science Center

Julia Dexter: Medical Student, University of New Mexico School of Medicine

J. Michael Winer, BA: Medical Student, University of New Mexico School of Medicine

Zachary M. Bosshardt: Medical Student, University of New Mexico School of Medicine

Jason H. Welch: Medical Student, University of New Mexico School of Medicine

Ella Dolan: Medical Student, University of New Mexico School of Medicine

Edward R. Fancovic, MD: Professor, Division of General Internal Medicine in the Department of Internal Medicine, University of New Mexico School of Medicine; Executive Director of Assessment and Learning, University of New Mexico School of Medicine

Andrea I. Nañez, MD: Intern, Obstetrics & Gynecology Residency Program, Kaiser Permanente Medical Group (Northern California)/San Francisco; Recent Graduate, University of New Mexico School of Medicine

Henning De May: Student, MD/PhD Program, University of New Mexico School of Medicine

Esmé Finlay, MD: Assistant Professor, Division of Palliative Medicine in the Department of Internal Medicine, University of New Mexico School of Medicine

Staci M. Lee, MD: Assistant Professor, Division of Infectious Diseases in the Department of Internal Medicine, University of New Mexico School of Medicine; Adjunct Instructor, School of Education, Johns Hopkins University

Carl G. Streed, MD: Fellow, Division of General Internal Medicine & Primary Care, Brigham and Women's Hospital

Khizer Ashraf: Occupational Therapy Student, University of New Mexico School of Medicine

Disclosures
None to report.

Funding/Support
None to report.

Informed Consent
All identifiable persons in this resource have granted their permission.

Prior Presentations
Mayfield J, De May H, Nañez A, et al. Lesbian, gay, bisexual, transgender, and queer (LGBTQ) healthcare in undergraduate medical education: assessment and focused intervention for medical students transitioning to the wards. Presented at: Society of General Internal Medicine Mountain West Regional Conference; October 2016; Phoenix, AZ.

Ethical Approval
This publication contains data obtained from human subjects and received ethical approval.

References
1. Pakpreo P. Why do we take a sexual history? *AMA J Ethics*. 2005;7(10).
2. Kripke CC, Vaias L. The importance of taking a sensitive sexual history. *JAMA*. 1994;271(9):713.
3. Wimberly Y, Moore S. Sexual history taking should be taught in medical school. *Am Fam Physician*. 2003;68(2):223.
4. Sefton AM. The Great Pox that was . . . syphilis. *J Appl Microbiol*. 2001;91(4):592-596. [https://doi.org/10.1046/j.1365-2672.2001.01494.x](https://doi.org/10.1046/j.1365-2672.2001.01494.x)
5. Grant RM, Lama JR, Anderson PL, et al; for iPrEx Study Team. Preexposure chemoprophylaxis for HIV prevention in men who have sex with men. *N Engl J Med*. 2010;363(27):2587-2599. [https://doi.org/10.1056/NEJMoa1011205](https://doi.org/10.1056/NEJMoa1011205)
6. Loeb DF, Lee RS, Binswanger IA, Ellison MC, Aagaard EM. Patient, resident physician, and visit factors associated with documentation of sexual history in the outpatient setting. *J Gen Intern Med*. 2011;26(8):887-893. [https://doi.org/10.1007/s11606-011-1711-z](https://doi.org/10.1007/s11606-011-1711-z)
7. Ports KA, Barnack-Tavlaris JL, Syme ML, Perera RA, Lafata JE. Sexual health discussions with older adult patients during periodic health exams. *J Sex Med*. 2014;11(4):901-908. https://doi.org/10.1111/jsm.12448

8. Goyal M, McCutcheon M, Hayes K, Mollen C. Sexual history documentation in adolescent emergency department patients. *Pediatrics*. 2011;128(2):86-91. https://doi.org/10.1542/peds.2010-1775

9. Mosher WD, Jones J, Abma JC. Intended and unintended births in the United States: 1982-2010. *Natl Health Stat Rep*. 2012; (55):1-28.

10. Lindley LL, Walsemann KM. Sexual orientation and risk of pregnancy among New York City high-school students. *Am J Public Health*. 2015;105(7):1379-1386. https://doi.org/10.2105/AJPH.2015.302553

11. Park ER, Bober SL, Campbell EG, Recklitis CJ, Kubers JS, Diller L. General internist communication about sexual function with cancer survivors. *J Gen Intern Med*. 2009;24(suppl 2):S407-S411. https://doi.org/10.1007/s11606-009-1026-5

12. Sobiecki JN, Curlin FA, Rasinski KA, Lindau ST. What we don’t talk about when we don’t talk about sex: results of a national survey of U.S. obstetrician/gynecologists. *J Sex Med*. 2012;9(5):1285-1294. https://doi.org/10.1111/j.1743-6109.2012.02702.x

13. Krane RJ, Goldstein I, de Tejada IS. Impotence. *N Engl J Med*. 1989;321(24):1648-1659. https://doi.org/10.1056/NEJM198912143212406

14. Sefel AD, Sun P, Swindle R. The prevalence of hypertension, hyperlipidemia, diabetes mellitus and depression in men with erectile dysfunction. *J Urol*. 2004;171(6, pt 1):2341-2345. https://doi.org/10.1097/01.ju.0000125198.32936.38

15. Hayes V, Blondeau W, Bing-You RG. Assessment of medical student and resident/fellow knowledge, comfort, and training with sexual history taking in LGBTQ patients. *Fam Med*. 2015;47(5):383-387.

16. Burd ID, Nevadunsky N, Bachmann G. ORIGINAL RESEARCH—EDUCATION: Impact of physician gender on sexual history taking in a multispecialty practice. *J Sex Med*. 2006;3(2):194-200. https://doi.org/10.1111/j.1743-6109.2005.00168.x

17. Workowski KA, Bolan GA. Sexually transmitted diseases treatment guidelines, 2015. *MMWR Recomm Rep*. 2015;64(RR-3):1-137.

18. California Department of Public Health (CDPH), Sexually Transmitted Diseases (STD) Control Branch, California STD/HIV Prevention Training Center. A clinician’s guide to sexual history taking. CDPH website. https://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/CA-STD-Clinician-Guide-Sexual-History-Taking.pdf. Published May 2011.

19. Freeman MG. The sexual history. In: Walker HK, Hall WD, Hurst JW, eds. *Clinical Methods: The History, Physical, and Laboratory Examinations*. 3rd ed. Boston, MA: Butterworths; 1990: chap 216.

20. Curren C, Thompson L, Altnue E, Tartaglia K, Davis J. Nathan/Natalie Marquez: a standardized patient case to introduce unique needs of an LGBT patient. *MedEdPORTAL Publications*. 2015;11:10300. https://doi.org/10.15766/mep_2374-8265.10300

21. Gelman A, Amin P, Pletcher J, Fulmer V, Kukic A, Spagnoletti C. A standardized patient case: a teen questioning his/her sexuality is bullied at school. *MedEdPORTAL Publications*. 2014;10:9876. https://doi.org/10.15766/mep_2374-8265.9876

22. Bakhai N, Ramos J, Gorfinke N, et al. Introductory learning of inclusive sexual history taking: an e-lecture, standardized patient case, and facilitated debrief. *MedEdPORTAL Publications*. 2016;12:10520. https://doi.org/10.15766/mep_2374-8265.10520

23. Lee R, Loeb D, Butterfield A. Sexual history taking curriculum: lecture and standardized patient cases. *MedEdPORTAL Publications*. 2014;10:9856. https://doi.org/10.15766/mep_2374-8265.9856

24. Hollembach AD, Eckstrand KL, Dreger AD, eds. *Implementing Curricular and Institutional Climate Changes to Improve Health Care for Individuals Who Are LGBT, Gender Nonconforming, or Born With DSD: A Resource for Medical Educators*. Washington, DC: Association of American Medical Colleges; 2014.

25. Mayfield J, De May H, Tillery K, et al. Lesbian, gay, bisexual, transgender, and queer (LGBTQ) healthcare in undergraduate medical education: assessment and focused intervention for medical students transitioning to the wards. UNM Digital Repository website. http://digitalrepository.unm.edu/ume-research-papers/. Published 2016.

26. Phelan SM, Puhl RM, Burke SE, et al. The mixed impact of medical school on medical students’ implicit and explicit weight bias. *Med Educ*. 2015;49(10):983-992. https://doi.org/10.1111/medu.12770

27. Green AR, Carney DR, Pallin DJ, et al. Implicit bias among physicians and its prediction of thrombolysis decisions for black and white patients. *J Gen Intern Med*. 2007;22(9):1231-1238. https://doi.org/10.1111/j.1525-1504.2007.tb05285.x

28. Hall WJ, Chapman MV, Lee KM, et al. Implicit racial/ethnic bias among health care professionals and its influence on health care outcomes: a systematic review. *Am J Public Health*. 2015;105(12):e60-e76. https://doi.org/10.2105/AJPH.2015.302903

29. van Ryn M, Hardeman R, Phelan SM, et al. Medical school experiences associated with change in implicit racial bias among 3547 students: a Medical Student CHANGES study report. *J Gen Intern Med*. 2015;30(12):1748-1756. https://doi.org/10.1007/s11606-015-3447-7

30. Sexuality (“gay – straight” IAT). Project Implicit website. https://implicit.harvard.edu/implicit/takeatest.html. Published 2011.

31. Asking sexual history questions: how to begin. In: *Taking Routine Histories of Sexual Health: A System-Wide Approach for Health Centers*. Boston, MA: National LGBT Health Education Center; 2015:5-7.

32. Sexual risk assessment. In: *Taking Routine Histories of Sexual Health: A System-Wide Approach for Health Centers*. Boston, MA: National LGBT Health Education Center; 2015:8-11.

33. California Prevention Training Center. STD current management strategies taking a sexual history. YouTube website. https://www.youtube.com/watch?v=QlG3kJLdw. Published September 13, 2012.

34. Streed CG. Medical history. In: Eckstrand KL, Ehrenfeld JM, eds. *Lesbian, Gay, Bisexual, and Transgender Healthcare: A Clinical Guide to Preventive, Primary, and Specialist Care*. Cham, Switzerland: Springer International; 2016:65-80.
35. Sciolla AF. Scenario 7: a straight man who has sex with men and women. In: Hollenbach AD, Eckstrand KL, Dreger AD, eds. Implementing Curricular and Institutional Climate Changes to Improve Health Care for Individuals Who Are LGBT, Gender Nonconforming, or Born With DSD: A Resource for Medical Educators. Washington, DC: Association of American Medical Colleges; 2014:147-150.

36. Lee R, Imborek K, Tetzlaff K, Crandall C, Bayer CR. A straight man who has sex with men and women (unpublished manuscript, 2016).

37. Obedin-Maliver J, Goldsmith ES, Stewart L, et al. Lesbian, gay, bisexual, and transgender–related content in undergraduate medical education. JAMA. 2011;306(9):971-977. https://doi.org/10.1001/jama.2011.1255

38. Makadon HJ, Mayer KH, Potter J, Goldhammer H, eds. The Fenway Guide to Lesbian, Gay, Bisexual, and Transgender Health 2nd ed. Philadelphia, PA: American College of Physicians; 2015.

39. Eckstrand KL, Ehrenfeld JM, eds. Lesbian, Gay, Bisexual, and Transgender Healthcare: A Clinical Guide to Preventive, Primary, and Specialist Care. Cham, Switzerland: Springer International; 2016.

40. Mayfield J, Fancovic E, reviewers. J Homosex. 2017;64(10):1461-1464. https://doi.org/10.1080/00918369.2017.1321392. Review of: Eckstrand KL, Ehrenfeld JM, eds. Lesbian, Gay, Bisexual, and Transgender Healthcare: A Clinical Guide to Preventive, Primary, and Specialist Care.

Received: May 3, 2017 | Accepted: August 31, 2017 | Published: September 28, 2017