There is a dearth of academic literature regarding sexual and gender minority (SGM) patient care in the perioperative setting. Roughly 4% of the American population identifies as SGM. Fewer than 80% of medical schools teach about gender identity and sexual orientation, and median time dedicated to teaching about SGM issues falls to 5 hours. There are 18 subjective sections which included questions such as knowledge, demographics, and comfort level working with SGM patients, underscoring a need for residency training focusing on drugs, anesthetics, and hormone therapy as shown on the word cloud. There were two subjective questions that had a statistically significant difference (not shown). Non- SGM residents felt more discomfort with their knowledge gap (Fishers Exact Test = 0.0331) whereas SGM residents felt more comfortable caring for SGM patients in the operating room (p=0.0415). Given no difference in test score, this suggests that SGM resident comfort level may be tied to other aspects of care such as interpersonal interactions rather than medical knowledge. Alternatively, social desirability bias may possibly skew subjective reports of comfort, particularly among SGM residents who feel they should be more knowledgeable. Overall, with a mean score of 55.71% (SD 11.78), the residents broadly scored low across the demographics we analyzed suggesting a need for a curriculum intervention.

Limitations include low number of residents early in their training and low number of total residents that completed the survey (3579) which may skew results. The high ascribed pass threshold may artificially increase the fail rate; however, it is unlikely since the distribution was centered around 55% mean score. The higher number SGM anesthesiologists at UCSF (28.5%) compared to the general population (2-4%) may also skew results, particularly since they may be more likely to respond to the survey. Our survey did not specifically ask about competence, which can limit conclusions drawn in future post-test analysis. Given low for gender identities that were non-cisgender, we did not have enough power to analyze this relationship with test score.

We hope to use this needs assessment to create a curriculum that covers the knowledge needed to care for these patients. Given Figure 2, there is no single modality that prevailed as most popular. With regards to topics, focusing on drugs, anesthetics, and hormone therapy as shown on the word map (Figure 1) will be prioritized as these are most pertinent to anesthesiologists. We will create a subsequent post-test in order to assess improvement. Hopefully, we can build from these results in order to ideally have stronger and better powered studies to assess learning across other anesthesia programs, and hopefully eventually leading to improved competence working with these patients in the long term.

References

4. Boriani KA. LGBT health disparities: What progress have we made? Published online 2017. https://doi.org/10.1097/ANE.0000000000003371