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WOMEN'S HEALTH in the CURRICULUM

RESOURCE GUIDE FOR FACULTY:

Undergraduate
Residency&
Continuing Education

Compiled and Edited by
Glenda D. Donoghue, M.D.
with the participants of NAWHME 1996

First Edition

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In 1995, the editorial board, listed on page 9, reviewed this group effort and crafted its content and appearance into its current form. Additionally, considerable feedback and numerous suggestions were provided by Lila Wallis, M.D., Sandra Levison, M.D., Janet Bickel, M.A. and Deborah Diserens, M.A., M.Phil.

Throughout this process, the editor was assisted by Darci Wolffe, whose tireless attention to detail, incredible desktop publishing skills and endless patience were the cornerstones leading to the final work product.

Finally, a number of NAWHME participants and other educators generously contributed items which are reproduced throughout the Resource Guide. These contributors are listed below:

- Alpert EJ, "Curricular Outline: Sociomedical Sciences Seminar--Family Violence", pp. 33-34.
- Baker N and Reif C, "Learning Objectives" and "Implementing and Evaluation Plan for Family Violence Curriculum", pp. 35-36.
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PREFACE

In some ways the women's health movement has promoted the use of health care strategies outside the traditional mainstream, centered on the physician-patient relationship. The provider-patient partnership, patient responsibility for self-care, and attention to the biopsychosocial continuum are principles that have found widespread acceptance outside of physician training, but are now being promoted as essential components of medical education. Women's groups in specialty organizations (eg. American Academy of Family Physicians, American Psychiatric Association, American Society of Nephrology) and multispecialty associations (American Medical Women's Association and American Medical Association, Women in Medicine Committee) and the Society for the Advancement of Women's Health Research have been prominent in promoting these new paradigms.

In 1990 Congress established the Office for Women's Health Research, and the efforts to study the effects of sex and gender on disease processes and their management became focused and goal-oriented. This landmark action followed many years of activism on the part of women and scientists, feminist scholars, women physicians and other health care providers calling for improvements in women's health care and research. In 1991, the Public Health Service's Office on Women's Health was established to oversee and coordinate research service delivery and educational activities in women's health. In 1993, two other events culminated from years of preparatory work. The American Medical Women's Association (AMWA) presented its first course of a multipart "Advanced Curriculum in Women's Health" for practicing physicians, and the Medical College of Pennsylvania (MCP*) received the first Fund for the Improvement of Post Secondary Education (FIPSE) grant to integrate women's health into the undergraduate curriculum. Recognizing that many other individuals were working, often in isolation, to design women's health medical education programs, AMWA and MCPHU formed a partnership to create the National Academy on Women's Health Medical Education (NAWHME) with a vision of bringing together representatives of all the energetic forces working to improve women's health care. It was hoped that together their synergism would accelerate the fragmented process.

The urgency of the issue grows daily, as the continued emphasis on women's health research produces an enormous body of new knowledge about women's biology, pathology, pharmacokinetics, disease history and prognosis. We are also increasingly aware that the affects of social, economic and cultural issues on women's health, health behavior and health care utilization must be taught. Unless we educate health care professionals about these matters, they will not be translated into improved health care for women.

NAWHME held its first meeting in March, 1994 and described the Academy's mission and goals, agreed upon a working definition of women's health, and formulated a plan to develop this Resource Guide.

*Now MCP-Hahnemann University, since Medical College of Pennsylvania merged with Hahnemann University in 1993.

HOW TO USE THIS RESOURCE GUIDE

At a series of meetings in 1994 and 1995, the participants of the National Academy on Women's Health Medical Education, working in small groups, compiled a list of strategies for teaching women's health, opportunities for teaching, strategies for overcoming barriers and a comprehensive list of women's health competencies. Drawing on their wide variety of experiences and successes in teaching women's health and gender-based information, they developed a series of descriptions of how women's health could be incorporated into any curriculum--undergraduate, residency and continuing education--and of strategies for overcoming inertia and resistance. These descriptions, along with selected others collected from various sources, are described and graphically depicted as the central themes of this Resource Guide.

Appendix I contains numerous examples illustrating the central themes in the text, each cross-referenced to keywords and superscripts in NAWHME's tables and grids.

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INTRODUCTION

The NIH Office of Women's Health Research was formed in 1990. In 1994 Congress charged it with determining the extent to which women's health is currently being taught in the nation's medical schools and with describing a core curriculum in women's health. However, should Congress expect to promote this as a curricular mandate it is likely to be ineffective; it is the teaching faculty of medical schools who determine curriculum content.

Faced with the information explosion of the last 25 years, faculty are hard pressed to decide which pieces to add to their courses and how best to teach students to access the information outside of the traditional classroom. Since the medical school curriculum suffers from overcrowding, an explosion in women's health knowledge creates impossible choices if faculty regard it as an add-on to that curriculum; they recognize that new women's health knowledge must be included in the curriculum, but they must be motivated to find ways to meet the challenge. Persuasive factors include: more than half of the patients of most physicians are women; women are greater users of health care services than men; women disproportionately influence health care utilization through their roles in making health care decisions with and for their families and significant others. Education about women's health, however, ought not be included in the curriculum at the expense of men or children, and the goal should be to integrate the information throughout the curriculum, rather than displacing existing material.

This Guide offers effective techniques and models for integrating sex- and gender-based information into existing courses, for optimizing limited opportunities and for overcoming resistance to change. As a representation of NAWHME participants' experiences, it is intended to give faculty ideas upon which they can build their own strategies, tailored to their own particular teaching opportunities and responsibilities. It is not a comprehensive collection of all existing women's health curricula: NAWHME recognizes that many institutions are currently creating opportunities and strategies to teach women's health issues. But for those who have not yet completed, or even started the process, the entries in this guide may be invaluable.

National Academy on Women's Health Medical Education (NAWHME)

The Mission

....

The mission of the Academy is to infuse women's health education into all phases of the medical education curriculum, undergraduate, graduate and post-graduate.

The Sponsors

....

Medical College of Pennsylvania and Hahnemann University

The Medical College of Pennsylvania was established in 1850 as the first medical school in the nation for women, and has a long tradition of promoting women's health care and supporting women physicians. The School merged with Hahnemann University in 1993. It is the recipient of the first Fund for the Improvement of Post-Secondary Education grant to integrate women's health into its undergraduate medical curriculum and develop a model women's health curriculum for dissemination, and is integrating training in women's health into its Internal Medicine Residency. Faculty Development and Continuing Medical Education also focus on women's health issues.

American Medical Women's Association (AMWA)

Founded in 1915 as a professional organization of women physicians, AMWA has traditionally acted as an advocate for women's health. In 1993 the organization developed and presented its landmark Advanced Curriculum in Women's Health, Part I, Midlife and Mature Years. Part II, Early, Young Adult and Advanced Years, was presented in 1994. The course will be updated and presented every 3 years.

The Participants

....

The sponsors invited a broad range of participants to the Academy's founding meeting:

- Directors of existing women's health medical education programs
- Educators with experience with gender related education
- Representatives of advocacy groups in women's health
- Representatives of medical professional organizations concerned with women's health
- Representatives of regulatory bodies with responsibility for medical education

The Process

The focus of the Academy's semi-annual meetings is to define strategies for bringing about the massive change needed to accomplish its mission. The collected expertise of the participants will provide synergism to the process. The Academy will support the ongoing efforts of other groups dealing with women's health advocacy and women's health research, and will build upon the experiences of those groups to define its own activities. In addition, the Academy will be a catalyst for change in medical education, a resource to students and educators alike, and a powerful advocate for improving women's health care through revisions in medical education. Participants will produce recommendations concerning the content of a women's health curriculum, suggest ways to capitalize on teaching opportunities and develop a blueprint for assessing competence in women's health care.

At NAWHME's second meeting, September 26, 1994, the following definition of women's health was adopted. It was refined from previous definitions developed by the U.S. Department of Health and Human Services, Public Health Service Report (1985) and the Women's Health Newsletter, McMaster University Women's Health Office, and represents a consensus of the various approaches to women's health represented on NAWHME.

It <u>does not</u> describe a field of specialization, but is intended for use in evaluating the adequacy of any approach to the care of women and the education of health care providers.

NAWHME’s Definition of Women’s Health

Women's Health is devoted to facilitating the
- preservation of wellness and
- prevention of illness in women,

and includes

- screening, diagnosis and management of conditions which
-are unique to women
-are more common in women
-are more serious in women
-have manifestations, risk factors or interventions which
 are different in women

It also

- recognizes the importance of the study of gender differences
- recognizes multidisciplinary team approaches
- includes the values and knowledge of women and their own experience of health and illness
- recognizes the diversity of women's health needs over the life cycle, and how these needs reflect differences in race, class, ethnicity, culture, sexual preference and levels of education and access to medical care
- includes the empowerment of women, as for all patients, to be informed participants in their own health care

Adopted by NAWHME
September 26, 1994

Themes for Organizing Women's Health

The 5th Report to Congress of the Council on Graduate Medical Education (COGME) is a thorough examination of the status of "Women and Medicine". In contract reports prepared by Janet Henrich, M.D. and Leah Dickstein, M.D. the current movement to improve women's health medical education is described against the backdrop of the continuing challenges women professionals face in the health care fields. Beyond a definition of women's health, Drs. Henrich's and Dickstein's reports describe the milieu which is needed for the appropriate health care of and medical education about women to flourish.

> "A new paradigm in women's health is needed to improve the health care of women in this country. Accordingly, the following overarching themes should serve as a rationale and a guide to action in curricular reform and in the development of academic and clinical programs in women's health:

- Biopsychosocial factors are fundamental to an integrated approach to women's health.
- Expansion of the scientific knowledge base is essential in advancing research, education and clinical care in women's health.
- Gender issues must be considered in all aspects of health.
- Health concerns unique to individuals and their personal experiences should guide appropriate provision of health care.
- The relationship between women and their health care providers should be an interactive process defined by mutual respect and collaboration.
- A multidisciplinary approach should be implemented that integrates content from various disciplines.

- Innovative clinical models for the provision of comprehensive care to women, including prevention, community approaches, and education, are needed.
- The ability to respond to the needs of economically, socially, and culturally excluded populations is fundamental to the development of a women's health curriculum, which must recognize the diversity of the population.
- Medical education is as much a socialization process as it is an acquisition of knowledge and skills. Medical students and residents must be exposed to appropriate role models; women's health cannot be taught exclusively by didactic methods.
- Women's health would benefit from having women in leadership and policy-making positions in all aspects of health care. Efforts must be made to recruit and promote the advancement of women into these positions.

This new paradigm is not unique to women's health; applied broadly, these principles could benefit men as well as women. The rationale for focusing on women's health is that women have been the ones most poorly served by the current system."

Quoted, with permission from Fifth Report: Women and Medicine Council on Graduate Medical Education (COGME) pp. 21-23, Washington, DC, 1995.
Contract Reporter, Janet B. Henrich, M.D. Part I: Physician Education in Women's Health.

Delineation of Competencies in Women's Health

"Competencies should be based on an understanding of the health status of women and certain fundamental aspects of women's health. It is essential that all physicians understand basic female physiology and reproductive biology. In addition, they need to appreciate the complex interaction among environmental (i.e., housing, employment status), biological, and psychosocial factors. Among the conditions that are not unique to women, physicians need to be aware of those aspects of health and disease that are different in women or have important gender implications. The ability to apply this information requires that physicians adopt attitudes and behavior that will help create a conducive relationship between themselves and their patients, who may be different from their own culture, gender, or sexual orientation. Women's relationships with the medical system are also changing, requiring physicians to understand women's patterns of obtaining health care and their methods of communication and interaction, as well as to appreciate gender differences in clinical decision-making. In this context, all physicians should be expected to demonstrate competence in the following areas:

- Knowledge of effects of physiology on women's biological and cognitive function, behavioral changes, and the psychosocial development of women.
- Knowledge of the major gender differences in health and disease across women's life spans, including recent innovations in women's health research, particularly in terms of the following areas:
  - Epidemiologic data
  - Pharmacokinetics of drugs in women and the impact of hormonal status on drug metabolism
  - Behavioral and societal factors that influence health outcomes among women from different ethnic, racial, and cultural backgrounds
  - Community health issues related to disease prevention and health promotion
  - Socioeconomic factors that influence health
- Attitudes and behaviors that are culturally and gender sensitive, including an appreciation of the following factors:
  - The impact of social roles and life cycle events on women's health
  - Women's patterns of obtaining health care
  - Women's forms of communication and interaction
  - Gender differences in medical decision-making
- Ability to apply knowledge of biological and psychosocial factors in the provision of comprehensive care to women, which requires the following skills:
  - The ability to integrate knowledge from the biomedical and biobehavioral sciences and apply it to issues that are fundamental to women's health across their life span
  - The ability to view women within the societal context in which they lead their lives
  - The ability to work collaboratively with women and other members of the health care team

These competencies are intended to be applied broadly across the educational spectrum of all disciplines and to be used as the intellectual framework for further work in this area. Their specificity will vary depending on the educational level of the physician and the discipline to which the competencies are applied. However, special attention should be focused on the disciplines that provide the majority of primary care to women. It is important for the concept of competencies and their content to reflect new information about the health of women as it is accumulated."

Quoted, with permission from Fifth Report: Women and Medicine Council on Graduate Medical Education (COGME) pp. 23-24, Washington, DC, 1995.
Contract Reporter, Janet B. Henrich, M.D. Part I: Physician Education in Women's Health.

Goals & Objectives for including the Social Context of Women's Health in Medical Education

The Women's Health Interschool Curriculum Committee (WHISCC) of Canada has published goals and objectives for medical education; they seek to define what "all physicians should know about the social context of women's health".

"Since physician beliefs, attitudes and awareness affect medical practice, patient care and teaching, the WHISCC has developed the following goals and objectives for medical education at all stages: undergraduate, postgraduate and continuing medical education. These goals are not only for those enrolled in special programs on women's health, nor are they curriculum objectives, since we allude to, but do not articulate extensively, the growing body of knowledge and specific skills required to provide optimal health care for women. Instead, the goals and objectives define an awareness essential for any physician engaged in patient care, medical education or research.

We intentionally did not divide the objectives into the traditional categories of knowledge, skills and attitudes. This reflects our view of the interconnectedness of these three components. The goals were developed collectively by WHISCC participants. A review of some of the many surveys of women's perceptions of their health needs and how those needs could be better served by physicians was central to the development of the goals.

Goals of medical education should include the following:

1. Fostering respect for the equality, individuality and value of all people.
2. Creating a commitment to equality, which means, at some times, treating people the same despite difference or disadvantage and, at other times, ensuring equal outcomes by directing resources preferentially toward a disadvantaged group.
3. Demonstrating an awareness of the existence, nature and negative implications for health of sexism, racism and stereotyping.
4. Fostering an understanding that the system that disadvantages some, such as poor people, women and people of colour, also reinforces physicians' privilege and power.
5. Increasing awareness that the physician's own beliefs, sex-role socialization, ethnic background and class may create barriers to well-being for some patients, particularly the disadvantaged.

6. Creating an understanding of how medicine has historically perpetuated sex-role stereotypes in definitions of health, illness and normality, through research and clinical practice."

Susan Phillips, M.D., CCFP "The Social Context of Women's Health: Goals and Objectives for Medical Education" Can. Med. Assoc. J., February 15, 1995, 507-511.

MAKING THE MOST OF THE OPPORTUNITIES AT HAND: SUGGESTIONS FOR INTRODUCING WOMEN'S HEALTH INTO YOUR CURRICULUM

During the first 12 months of NAWHME's existence, participants accumulated record on their work in developing teaching strategies for women's health. As a group they also analyzed the typical medical education continuum, and found that they could provide examples of ways to include women's health in most of the teaching situations which arise.

Having developed this exhaustive list of examples, they then proceeded to organize the material into a comprehensive description of how to integrate women's health into the medical education curriculum, and how to make use of each and every opportunity that arises. Recognizing that not every medical school or residency program will be willing to revamp its curriculum, and that not every faculty member will have the opportunity or influence to bring about sweeping change, NAWHME participants believe that anything that is done is better than doing nothing.

NAWHME also recognizes that students and faculty alike have many different learning styles. For some, a detailed curriculum on a particular topic will provide the impetus; for others, learning objectives work better. In some instances a faculty member will build upon a series of narrative examples; for others a comprehensive summation in tabular form will be more appropriate.

NAWHME recognizes, in addition, that at every school there is a different way to organize the curriculum and a different process for updating it and changing it. Thus the following charts and tables represent a wide variety of examples of successful ways for including women's health information into the curriculum--undergraduate, residency, and continuing education. Faculty members may pick and choose from these examples, and use them as starting points to create their own approaches to the inclusion of women's health in their teaching.

Finally, it should be noted that many of the examples which follow assume a traditional type of curriculum. Recent changes in health care delivery, particularly the emphasis on ambulatory and managed care, have contributed to a recognition that medical school curricula and residency and practitioner education must change in order to prepare physicians to care for patients in this environment.

Prolonged early ambulatory teaching exposure and the use of inter and multidisciplinary teams are examples of the revisions being made.

Women's health education must be incorporated into these new strategies; indeed, the very act of examining the curriculum for opportunities to include

women's health may be a catalyst for identifying strategies to make medical education more relevant to today's health care environment.

NAWHME's Tables Describing Teaching Opportunities to Integrate Women's Health

In this section several tables are used to describe how women's health could be integrated into the available opportunities without needing to allot specific blocks of time or displacing other material.

Table 1 is a depiction of a "typical" undergraduate curriculum. A similar approach is then applied to d describing ways to capitalize on existing opportunities in residency training (Table 2) and continuing education (Table 3).

In using these tables, the reader should understand that

- The tables are **not** a complete description of how to teach all the competencies in women's health a practicing physician needs. NAWHME's competency lists in Appendix IA provide a more comprehensive picture of what needs to be learned, and the faculty reader is urged to expand upon the examples in these tables when determining where each topic might be taught.
- Lists of required competencies are, like textbooks, outdated at the time of printing. They should be regarded as comprehensive starting points, to be continually updated.
- There may be many opportunities at the reader's own school or training program which have not been described here: NAWHME hopes that its description will spur faculty readers to creative problem-solving for their own curriculum.
- In this abbreviated format key terms have been highlighted with boldface type, with superscripts. These keywords are cross-referenced to Appendix I, where more detailed information can be found.

TABLE 1

TOOLS FOR MAKING THE MOST OF YOUR OPPORTUNITIES TO TEACH WOMEN'S HEALTH IN THE **UNDERGRADUATE CURRICULUM**

COURSES AND CURRICULUM COMPONENTS
Orientation •Introduce Gender and Diversity issues in introductory talks •Discuss historical inequities and why we need to include the emerging information about WH •Teach students **how to detect bias**[9] in literature/textbooks/presentations •Train students how to pose the challenge: **"What if this patient were a woman?"**[8] and to use **teacher evaluations tools**[5]
Basic Sciences Courses •Address sex and gender differences in anatomy, development, function, pharmacology, etc. •Refer to a **database on gender differences**[10] emerging from research •Students as "lookouts" through asking **"What if?"**[8] and using **teacher evaluation tools**[5]
Clinical Lectures •Use a list of required **WH knowledge**[2] in planning of series •Provide speakers with **WH bibliography**[3] in their field •Ask students to act as "lookouts" through asking **"What if?"**[8] and using **teacher evaluation tools**[5] •Use **database on gender differences**[10] to plan presentations
Introduction to Clinical Medicine Course •Teach professionalism and **communication skills**[12] in lectures/workshops •Use standardized patients for teaching sensitive, painless, genito-urinary and breast exam and other **required WH skills**[1] •Develop lectures/discussions/workshops/teaching days on fundamentals (reproductive options, violence, life cycles) •Maintain continuous emphasis on gender differences (students as "lookouts" as above)
Clerkships •Use patient/attending/resident/co-worker to evaluate patient respect and **communication skills**[12] •Use lists of required **WH Skills**[1] and **WH knowledge**[2] to help plan learning •Analyze written exam and skills tests for absence of **gender bias**[9] and presence of WH material based on **WH knowledge**[2] •Analyze H&P for **women's health "prompts"**[11]
Electives in Women's Health •Ensure that faculty model appropriate care of women patients •Use patient/co-worker/faculty feedback to students on appropriate **communication**[12] •Use, eg. 10 **leading causes of visiting a physician**[4] as learning guide •Evaluate performance of required **WH Skills**[1] •Use the characteristics of the patient population to teach specific topics (eg.

Reproductive options, cosmetic surgery)
•Use **WH bibliography**[3] to supplement clinical experiences
•Address racial and ethnic differences in health issues of women
•Develop **multidisciplinary symposia**[7] on WH using a **Leading causes of...List**[4] for planning
•Use research elective, community service rotations, etc. to explore **"hot" topics in WH**[6]

Reading, Journal Clubs and Preparing to Teach
•Use list of required **WH competencies**[2] in planning selection of materials and developing a **WH bibliography**[3]
•Ensure WH journals, textbooks and newsletters are available in library
•Emphasize **how to detect bias**[9] in current textbooks
•Hold journal clubs discussing **"hot" topics in WH research**[6]

Simulations with Standardized Patients, Role Play
•Use **required skills in WH**[1] lists to plan the teaching encounters
•Use **WH "prompts"**[11] to guide evaluation of complete H&P for women
•Evaluate **communication skills**[12]

Student Research Projects
•Use selected topic review (eg. use latest **"hot" topics in WH research**[6]) in making selection
•Set the task of developing a bibliography (eg. use **leading causes of .....**[4] in making selection)
•Accumulate information from the literature contributing to **the database on gender differences**[10]
•Systematically ask **"What if?"**[8] questions as any research project proceeds

Problem-based Cases
•Review cases for **absence of bias**[9] and balance of male/female scenarios
•Use eg. **leading causes of death**[4] in women as specific topics for inclusion
•Rewrite and create cases to provide opportunities to discuss gender differences
•Utilize the technique of asking **"What if?"**[8] questions to address WH issues
•Construct facilitator prompts to direct student attention to WH issues

EVALUATION AND FEEDBACK AS A TOOL

Clinical Skills Exams
•Ensure that required **WH skills**[1] and **WH knowledge**[2] is included in cases
•Ensure that the tests are reviewed for gender balance and **absence of bias**[9] prior to administration of test instruments
•Assess **communication skills**[12] and use of bias-free language as routine part of examination

Written exams
•Ensure that **WH knowledge**[2] is included
•Train faculty to write exam items addressing WH
•Review for gender balance and **absence of bias**[9] prior to administration

Standardized Patient, Patient and Instructor •Evaluate satisfaction with the **communication skills**[12] with questionnaires •Ensure completeness of H&P from **WH "prompts"**[11] •Ensure appropriate performance of **required WH skills**[1] with questionnaires to patients
Licensing Exams (USMLE) •Review for gender balance and **absence of bias**[9] prior to administration •Ensure **WH knowledge**[2] is included •Participate as "lookout" member of planning committees and member of question-writing task groups

TABLE 2
TOOLS FOR MAKING THE MOST OF YOUR
OPPORTUNITIES TO TEACH WOMEN'S HEALTH
DURING RESIDENCY TRAINING

COURSES AND CURRICULAR COMPONENTS
Inpatient Care •Provide faculty and resident development on WH through lecture series, including **Leading Causes of.....lists**[4] to select topics •Use required **WH knowledge**[2] and **WH bibliography**[3] list for the discipline to ensure completeness of experiences •Address gender differences wherever patient discussions occur **(What if?[8])**—morning report, work rounds, case conferences, M&M reviews •Review H&Ps for completeness of **WH "prompts"**[11] (violence, pap smears and other screens, safe sex, breast/pelvic exam, etc.) •Build skills for working with interdisciplinary teams including, eg. social work, nursing, diversity experts
Ambulatory Clinic Experiences •Use interdisciplinary format as a model •Ask **"What if?"**[8] questions when patient care conferences occur •Review H&Ps for completeness of **WH "Prompts"**[11] •Provide feedback on **communication skills**[12] and absence of gender bias from attending, co-workers and students •Use **required skills**[1] and **knowledge**[2] to guide learning
Lecture Courses for Faculty Development and Resident Training •Include lectures on **WH knowledge**[2] for the discipline •Request speakers to address WH in ALL presentations (provide **WH bibliography**[3] for their field) •Evaluate speakers' attention to WH by using **teacher evaluation tools**[5] •Ask **"What if?"**[8] questions to expand presentations to include WH •Use **teacher evaluation tools**[5] to document attention to WH
Workshops and Standardized Patients •Teach painless breast and pelvic exams and other **Required skills in WH**[1] •Teach reproductive options and other fundamental topics such as: domestic violence recognition and management, how to counsel for safe sex, smoking prevention/cessation, etc., using "Put Prevention in Practice" from ODPHP •Teach **communication skills**[12]
Women's Health Electives •Arrange rotations through clinics which cover specific WH issues (osteoporosis, breast, adolescent, reproductive endocrinology, psychiatry, family practice, gynecology, HIV, women's health, Planned Parenthood) •Refer to Undergraduate Education for further specifics

Reading and Journal Clubs •Ensure WH journals, textbooks and newsletters are available in library •Provide **WH bibliography**[3] in the discipline to guide selections •Use **leading causes of...**[4] or **"hot" topics in research**[5] lists to select topics for review •Conduct specific discussions on articles demonstrating gender-bias or omission of WH to emphasize **how to detect bias**[9] Table 2 cont
Grand rounds Series •Model appreciation of importance of WH concerns by stressing WH in planning grand rounds topics •Refer to Continuing Education for further specifics
EVALUATION AND FEEDBACK
Intraining Exams •Ensure that **WH knowledge**[2] for discipline is included •Train faculty examiners to evaluate **communication skills**[12]
Patient and Instructor •Refer to Undergraduate Education for details
Licensing Exams and Specialty Boards •Refer to Undergraduate Education for details

TABLE 3
OPPORTUNITIES TO TEACH WOMEN'S HEALTH IN CONTINUING EDUCATION FOR **THE PRACTICING PHYSICIAN AND FACULTY MEMBER**

Grand Rounds Series •Include interdisciplinary focus, patient education and empowerment •Model gender-appropriate behaviors •Include ethno-cultural and socioeconomic framework •Allot "slots" for WH: use, for example, the **Leading causes of.lists**[4] (causing death, or presenting at the office, or causing morbidity); **"hot" topics in WH research**[6] •Presenters on other topics coached by course director and evaluated by audience for inclusion of current WH information using **teacher evaluation tools**[5] •Ask **"What if?"**[8] questions to address WH concerns •Provide speakers with **bibliography on WH in their field**[3]
Symposia on Women's Health •Organize material of **required knowledge**[2] and **skills**[1] in WH, for example by: -life stage (eg. young adult, perimenopausal) -discipline (eg. ob/gyn, IM, surgery) -audience (eg. practicing physicians in primary care, nurse practitioners) -**"hot" topics in research**[6] or popular culture -emerging knowledge about **gender differences**[10]
Symposia on other Topics •Design to address the emerging body of information about how diseases/management differ in women and men (**database on gender differences**[10]) •Provide speakers with **bibliography on WH**[3] issues in their field and ask them to address them •Use **"What if?"**[8] questions to focus attention on WH issues •Evaluate speaker compliance through **teacher evaluation tools**[5]
Journal Reading and the Media •Encourage journal editors to include WH manuscripts, **evaluate submissions for gender bias**[9] and address WH validity in abstracts by: -writing and phoning editors -corresponding with authors in letters-to-the-editor -sending **WH bibliography**[3] to editors and authors -requesting appointment of WH experts as reviewers

Self Instruction Courses •Organize material on **required knowledge**[2] on women's health by e.g. life cycle, recent developments, etc. •Address WH in courses on general topics by posing **"What if?"**[8] questions •Provide planners with **WH bibliography**[3] •Evaluate materials for **gender bias**[9]
Writing •Correct misperceptions in lay press with letters-to-the-editor; broadcast WH information on radio and TV •Publish editorials/position papers on women's health, especially on **leading causes of...**[4] topics •Address **"hot" topics in research**[6] and **known gender differences**[10] •Publish papers on how to evaluate errors and omissions •Protest errors and omissions and **gender bias**[9] in pharmaceutical literature and new textbooks and publish reviews

Graphic Presentation of Teaching Opportunities

NAWHME's participants also developed the following graphic depictions for the undergraduate curriculum (Grid 1), residency training (Grid 2) and continuing education (Grid 3). They offer the same information as the preceding tables but in a rapidly digestible format.

The reader will note that the categories on the "y" axis consist of a list of courses and teaching opportunities, similar to those previously referred to in Tables 1, 2 and 3. Categories on the "x" axis as column headings correspond to the keywords in boldface type in the tables, superscripts 1-12. As with Tables 1, 2 & 3, detailed information about each column heading is available in Appendix I.

The following examples demonstrate how these grids can be used:

- A curriculum planner of undergraduate clinical courses might refer to the lists of required skills or knowledge in Appendix IA to define what topics need to be covered; a teacher evaluation tool patterned after that in Appendix IB might be designed to ensure topics are covered. Other useful tactics are described in Appendix IC: students can be encouraged to ask "what if this patient were a woman?" when discussing cases; standard H&Ps could be modified to include WH "prompts"; and students could be taught about and evaluated on the use of communication skills which are bias-free.
- Electives in women's health, on the other hand, are usually brief experiences where only the commonest health problems would be encountered: in addition to learning required skills and knowledge, teachers and their students can use a variety of "Leading causes" lists to structure these experiences (Appendix IA). Multidisciplinary symposia might be developed based on, for example, life phases; journal clubs might be developed to discuss "hot" topics in research; a WH bibliography is useful for both learners and teachers. All these tools are described in Appendix IB. Other useful tactics for guiding education during electives are described in Appendix IC: a "prompted" H&P form, attention to bias-free communication and a database on gender differences.

Note also:

- In this format we have left blank spaces on both axes (labeled "other"), recognizing that faculty may want to add material which more accurately describes their own school and its curricula.
- NAWHME's consensus view of where women's health information might be taught <u>may not be valid for the reader's institution.</u> A final BLANK grid has been included in Appendix ID, so that faculty can develop an individualized grid describing their own curricular opportunities.

Grid 1

Tools for Introducing Women's Health at the Undergraduate Level

	Required skills in WH 1	Required knowledge in WH 2	WH bibliography 3	Leading causes of... 4	Teacher evaluation tools 5	"Hot" topics in WH research 6	Multi-disciplinary symposia 7	What if ? 8	How to detect bias 9	Database on gender differences 10	WH "prompts" in H&P 11	Communication skills 12	Other
COURSES AND CURRICULUM COMPONENTS													
Orientation					x			x	x				
Basic science courses					x			x		x			
Clinical lectures and courses	x	x	x		x			x		x		x	
Clerkships	x	x							x		x	x	
Other													
TEACHING SITUATIONS													
Electives in women's health	x		x	x		x	x					x	
Role modeling						x			x			x	
Reading, journal clubs & preparing to teach		x	x			x			x				
Simulations with standardized patients, role play	x										x	x	
Student research projects				x		x		x		x			
Problem-based cases				x				x	x				
Other													
EVALUATION AND FEEDBACK AS A TOOL													
Clinical skills exams	x	x							x			x	
Written tests		x							x				
Standardized patient, patient & instructor	x										x	x	
Licensing exams		x							x				
Other													

Grid 2

Tools for Introducing Women's Health at the Residency Level

	Required skills in WH 1	Required knowledge in WH 2	WH bibliography 3	Leading causes of... 4	Teacher evaluation tools 5	"Hot" topics in WH research 6	Multi-disciplinary symposia 7	What if ? 8	How to detect bias 9	Database on gender differences 10	WH "prompts" in H&P 11	Communication skills 12
COURSES AND CURRICULUM COMPONENTS												
Inpatient care		x	x	x				x			x	
Ambulatory clinic experiences	x	x						x			x	x
Lecture courses		x	x		x			x				
Workshops & standardized patients	x											x
Women's health electives	x		x	x		x	x					x
Reading & journal clubs			x	x		x			x			
Evaluation & feedback	x	x							x		x	x

Grid 3

Tools for Introducing Women's Health into Continuing Education

	Required skills in WH 1	Required knowledge in WH 2	WH bibliography 3	Leading causes of... 4	Teacher evaluation tools 5	"Hot" topics in WH research 6	Multi-disciplinary symposia 7	What if ? 8	How to detect bias 9	Database on gender differences 10	WH "prompts" in H&P 11	Communication skills 12
COURSES AND CURRICULUM COMPONENTS												
Grand Rounds			x	x	x	x		x				
Symposia on women's health	x	x				x				x		
Symposia on other topics			x		x			x		x		
Journal reading & the media			x						x			
Self-instruction courses		x	x					x	x			
Writing				x		x			x	x		

Examples Describing the Teaching of Domestic Violence

This section contains a series of descriptions of ways to approach the teaching of domestic violence. Example 1 follows the NAWHME format for integrating the material into existing opportunities. Example 2 discusses an approach to addressing the need for students to learn sequentially.

Example 3 is a curricular outline for a traditional block course, where hours in the curriculum are set aside to formally teach the particular topic. This can be used at any level of medical training or faculty education.

Finally, example 4, which was developed for residency training, illustrates the use of learning objectives to guide the achievement of competence in the field. The methods used to achieve the objectives are also described in the implementation and evaluation plan.

Example 1: Integration

This approach has the following advantages:

- the topic becomes a part of the curricular fabric--a part of the "norm"
- no block of curricular time need be requested
- experts in the various fields incorporate the information into their own "database" of expertise, and take ownership

Disadvantages include:

- the extensive work needed to have all the experts learn what is needed so that they can teach the material
- the difficulty of monitoring whether each expert fulfills the expectations

OPPORTUNITIES TO INTEGRATE DOMESTIC VIOLENCE INTO THE CURRICULUM

Basic Sciences	Physiology Pathology	"normal" vs. abnormal bruising patterns "normal" patterns of fracture vs. patterns in violence
Clinical Courses	Clinical Skills and Interviewing Psychiatry	causes of post traumatic stress disorder patterns to be recognized dealing with your own feelings
Clerkships	ER Clinics	appropriate history taking and physical exam to uncover abuse use of interdisciplinary team interventions continuity care as the relationship evolves
	Radiology	recognition of radiologic findings
	Ob/Gyn	demographics recognition of "markers"
	Ophthalmology Orthopedics Oral Surgery	recognition of "markers"
	Pediatrics	relationship of child abuse to maternal abuse
Community Projects	Women's Shelters	interview techniques for targets and advocates
Standardized patients & problem-based cases		Realistic combination of apparently unrelated symptoms and signs as "markers" of domestic violence
Reading		Growing literature on incidence and pervasiveness throughout society
Research projects for students		Review charts for "markers"/rate of diagnosis Effects of violence on the lives of women
Lecture courses		Highlight demographics and management techniques
Symposia	-on women's health -on other topics	Presentation of "in house" research Highlight sex and gender differences for topic being presented

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Example 2: Sequential Learning

Medical students fresh out of college cannot be taught advanced concepts before they have received fundamental information. Novack et al[1] found that most schools regard this as a core guiding principle of designing and implementing educational courses in medical interviewing and interpersonal skills, and it can be implied that it is a useful strategy for all educational planning.

The following vignettes illustrate how critical this principle can be in teaching women's health:

- Students need to become comfortable and professional in the presence of a disrobed patient before they can be taught to perform a respectful, painless pelvic examination.
- Students must also be taught techniques for asking probing questions and listening sympathetically to the replies before they can be expected to learn the more difficult task of asking a patient about his/her sexual history.
- Students may need help in dealing with personal feelings about or experiences with abuse before they are ready to acquire the knowledge and skills to elicit information about physical or sexual abuse from a patient. Small group sessions are most effective for this purpose.
- Students must be given enough knowledge of the psychosocial context of violence to permit them to overcome their existing cultural/social/gender biases and dismiss societal stereotyping of violence and abuse.
- A fundamental framework of learning must set the stage. A student must be aware of their patients' social, cultural and economic realities in order to understand their health or illness and the particular encounter with the medical care system.

Much of this material can be presented formally in introductory clinical skills courses; communication skills, interviewing and physical exam training; and special courses addressing, for example, cultural diversity skills. But it is critical that this learning be continually reinforced and validated by subsequent teachers so that physicians' knowledge, skills and attitudes will fundamentally include understanding of the social realities of their patients' lives.

1 Novack et al: Medical Interviewing and Interpersonal Skills Teaching in US Medical Schools. JAMA 269, 16:2101-2105.

Example 3: Curricular Outline

This outline is suitable for a traditional course--a block of time set aside in the curriculum to address a particular topic. It could also, clearly, be used to design training for faculty and practicing physicians.

SOCIOMEDICAL SCIENCES SEMINAR -
FAMILY VIOLENCE

This seminar will explore the medical, social and legal aspects involved in caring for patients whose lives have been touched by intentional violence. The sessions will cover the following topics:

1. Introduction. Scope of the problem (epidemiology, demographics, statistics). Clinical presentation of patients in different specialties. Patient assessment (history and physical exam, documentation on the medical record).
2. Abuse of women. Battered women's shelters.
3. Child abuse, elder abuse.
4. Treatment issues for perpetrators.
5. Acquaintance violence (including gang violence), techniques of conflict resolution that can be taught to patients.
6. Education of health professionals, community outreach, final discussion, Q & A.

The seminar will be interactive, with student participation in discussions being essential. This seminar will feature guest seminar leaders. Limited directed readings will be required. A three page essay on a relevant topic of the student's choice will be required. There will be no formal examination. Class size will be limited to 15.

1992 SEMINAR OUTLINE

Session I	4/9/92	Elaine Alpert, M.D., M.P.H.	Introduction, scope of the problem, statistics, demographics, historical perspectives, international perspectives, presentation of patients to different specialties, debunking myths, ASIDES, history, physical, documentation on the medical record
Session II	4/16/92	Karen Freund, M.D., M.P.H.	The battered woman, battered women's shelters
Session III	4/23/92	Betsy Groves, LICSW	Child abuse and family dynamics. Mandated reporting. Special issues in the history, physical and medical record.
Session IV	4/30/92	Molly Owen, Supervisor of Protective Services, Central Boston Elder Services; Michelle Lang, Harvard Law School Battered Women's Advocacy Program.	Abuse of the elderly. Legal issues, restraining orders, legislation.
Session V	5/14/92	David Adams, Ph.D.	Perpetrator issues
Session VI	5/21/92	Linda Hudson et al	Violence Prevention Project, DHH. Sexual assault, date rape, conflict resolution. Discussion of essay or project topics. Review and wrap up.

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Example 4A: Learning Objectives

For residency training, where so many things occur simultaneously, the learning of a particular topic can be guided by learning objectives.
This is the natural outgrowth of identifying a desired competence, and ideally should be developed for each of the competencies a resident is expected to achieve during his/her residency training.

LEARNING OBJECTIVES FOR
FAMILY VIOLENCE CURRICULUM

Introduction:
Violence can be identified as one of the major health risks impacting families. The physician's office is a confidential and safe environment to discuss these issues. Physicians need to be able to identify families experiencing violence, to choose appropriate collaboration, and to provide ongoing support to those families.

Attitudes:
The Family Medicine resident is expected to exhibit the following, concerning family violence, by the time of graduation.

1. Understand that family violence is an often unrecognized dynamic in the primary care setting for which there can be a successful intervention.
2. Should be able to recognize or discuss these clinical situations.

Knowledge

1. Recognizes the common manifestations of family violence as they present to a family physician both in the abused patient and in the patient's family.
2. Understands the medical and psychological symptoms seen in an abused patient.
3. Understands and appreciates the family dynamics of family violence.
4. Understands the "team" approach to caring for abused patients.
5. Understands the role of community agencies and support groups in the healing process.
6. Understands that physician and patient time line for change may not coincide, but that physician will remain supportive throughout the process.
7. Understands the physician's potential role as an agent of social and system change.

Skills

1. Identify bruising, broken bones or contusions that are common to victims of assault.
2. Be able to explain the power and control wheel, brochures and posters, as they pertain to the patient.
3. Identify family violence as possible cause for unexplained psychosomatic symptoms.
4. To use family violence algorithms as assessment tool for abused adults or children.
5. Refer patient to appropriate agency for intervention and possible emergency shelter.
6. To be able to present information on personal safety.
7. When issues of abuse are raised between clients and clinic staff to address these concerns in a respectful, nonjudgmental, confidential and supportive manner.
8. To be able to reinforce in every patient their right not to be abused and "No one has the right to hurt you".

Example 4B: Plan for Implementation and Evaluation

The next step in designing the learning experience is to plot out an implementation plan and decide how you will measure the outcomes of the teaching strategies--an evaluation plan. This outline is the completion of the curricular plan which began with learning objectives in the previous example.

IMPLEMENTING AND EVALUATION PLAN FOR
FAMILY VIOLENCE CURRICULUM

<u>Methodology</u>

The education of the resident in the area of family violence is imperative to the proper care of any family. Because a topic as emotionally ridden as family violence is difficult to absorb in one or two educational presentations, we propose a longitudinal curricular experience.

G-1 Year

Two hour presentation by violence specialist during the community medicine month, and pre-test will be given at this time.

G-2 Year

Two hour individual experience with St. Paul Intervention Project to gain an understanding of the operation and location of this community agency.

G-3 Year

Two-90 minute workshops with entire G-3 group on Tuesday afternoon 3:30-5:00 p.m.; the first will be a debriefing session focused on violence education issues and will include completion of a post-test followed with discussion, and the second will be on a topic they select.

<u>Ongoing Activities for all Years</u>

- Grand Rounds one per year times three years
  - Year one: Definition of Family Violence
  - Year two: Cultural diversity issues of violence
  - Year three: Referral resources: How to use them
- Family Assessment of violence for all prenatal patients
- Wednesday conference once per month on a topic pertaining to violence
- In clinic interventions using family violence clinic protocol
- Regular review of the following days charts to flag for pertinent issues that may be addressed during the visit
- Resource Book of algorithms to include family violence
- Incorporation of family violence in health maintenance visits
- Attend annual CME conference on family violence
- Optional participation in monthly discussion meetings on CME conference related to violence

<u>Evaluation</u>

Develop pre-test and post-test on family violence awareness in a medical setting. Pre-test to be given during G-1 Family Medicine month and the post-test will be given during G-3 90 minute workshop. Evaluation of the longitudinal goals of Family Violence will be included in the written evaluations of residents during their Family Medicine rotations as well as on faculty feedback during the residency on a case-by-case basis as patients with abuse problems are given health care.

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Other examples of teaching women's health by integration into the existing curriculum

This brief outline highlights a number of other opportunities for teaching women's health topics without needing to request blocks of time in the already overcrowded curriculum. While less detailed and specific than Example 1, on Domestic Violence, it is intended to "seed" the faculty reader's mind with ideas upon which s/he can build.

Discipline	Example
Anatomy and histology:	sex differences in size of heart and coronary vessels
Neuroanatomy	sex differences in hypothalamus
Microbiology:	sex variations in normal immune responses and in HIV infection
Physiology:	milk synthesis and production
Biochemistry:	sex differences in metabolism of alcohol effect of hormones on lipid profiles
Pharmacology:	sex differences in pharmacokinetics of drugs, eg. aspirin, tricyclic antidepressants, etc.
Pathology:	"normal" bruising and fracture patterns compared to those inflicted in violence
Epidemiology:	sex differences in cardiac disease; stroke risk factors; renal disease
Genetics:	localization of breast cancer genes;counselling on relative risks
Introduction to Clinical Medicine:	the holistic approach to the patient in her own social setting
Clinical skills:	gender differences in communication; interviewing techniques; dignified physical exam
Psychiatry:	sex differences in depression, alcoholism, substance abuse
WH ambulatory office:	office gynecology; reproductive options; preconception counseling; respect for patients
Neurology:	sex differences in degenerative diseases, pain, epilepsy, rehabilitation
Surgery:	sex differences in cardiovascular disease management
Urology:	sex differences in incontinence
Pediatrics & Adolescent Medicine:	menarche; interdependence of health/family; adolescent sexuality
Ob/Gyn; Family Medicine:	breast feeding; common office gynecology procedures; contraception; abortion
Orthopedics/Ophthalmology:	detecting violence
Dental Medicine:	erosion of teeth--bulimia
Infectious Diseases:	presentation and progression of AIDS in women
Hematology:	effects of hormones on coagulation factors
Internal Medicine, Family Medicine:	cardiovascular diseases in women; preconception counselling
Emergency Department:	detection of violence; detection and treatment of rape

Source: S. Levison, M.D., L. Wallis, M.D. & NAWHME participants 1994-95

STRATEGIES TO OVERCOME RESISTANCE TO INCLUDING WOMEN'S HEALTH IN THE CURRICULUM

In addition to the over-riding challenge of managing an ever-expanding body of knowledge in a fixed number of hours, those attempting to revise the curriculum may find other kinds of individual and institutional resistance as well as ingrained bias against women. Many of the participants of NAWHME have successfully instituted women's health curricula in medical education; others have successfully overcome resistance to introducing gender-based curricula into other institutions of higher learning. Beyond the education fields, NAWHME includes activists in women's health, experts on gender bias, leaders in policy arenas and members of regulatory agencies, all of whom have experience in developing strategies for overcoming institutionalized inertia and bias.

The following tables document some of the strategies NAWHME's participants have used to succeed in their endeavors. Several levels of strategy are included, from those that can be addressed by an individual faculty member to those which can be used to overcome gender bias and institutional resistance. The reader should not interpret this section to mean that all of the barriers must be overcome before women's health can be successfully introduced into the curriculum....the strategies listed simply describe opportunities to create change. Readers are encouraged to address those issues they have the access and power to change. However, support from the top is very empowering. The reader may wish to use the section on overcoming institutional resistance to help him/her implement the micro-strategies encouraging faculty to include WH in their teaching. And the strength of networks outside the institution and among specialty groups should be utilized where appropriate and needed.

It may also be helpful for faculty attempting to include women's health in their curriculum to consider some of the human reasons for maintaining the status quo. James O'Toole's thoughtful publication *Leading Change*[1] contains many insights into this phenomenon, and he comments that "the shared worldview which unites an organization and gives its members common directions is also a source of resistance to change". He also observes that "The source of resistance to frivolous change is the same as the resistance to the necessary and positive. The leader must be able to show that proposed change is a necessary step towards progress as defined by those who are invested in the status quo."

Lest we ever delude ourselves into thinking that convincing those invested in the status quo that a change meets <u>their</u> definition of progress, O'Toole quotes the following sobering thoughts of T.J. Kuhn[2]: "Outmoded scientific explanations live on long after facts that belie them have been brought to

light....(this) is rooted in the collective investment that members of an established discipline have in the discredited paradigm."

1. J. O'Toole, *Leading Change*, Jossey-Bass, San Francisco, 1995.
2. T.J. Kuhn, *The Structure of Scientific Revolution*, New American Library, 1962.

Encouraging faculty to include women's health in their teaching

LECTURES

Basic Science, Clinical and Others

Possible Obstacles	Strategies
•Lack of information -faculty member does not know about recent research findings in WH in his/her field -s/he is not interested in WH -s/he unconsciously feels gender bias -information on sex/gender differences does not exist	-Enlist librarian's support in developing bibliography and instructional aids library -Develop faculty training programs on new WH information and techniques for using it in teaching -Present introductory lecture on gender bias in medicine -Provide case vignettes on WH topics -Enlist students' support in asking WH questions -Develop a "gender equity in teaching" award (cf AMWA's award) -Get gender equity included in promotion criteria -Include attention to WH on students' evaluation of faculty -Use curriculum content database to ascertain presence of WH information -Start interest group to develop research protocols to answer the questions

CLERKSHIP EXPERIENCES

Major/Minor; Inpatient/Ambulatory

Possible obstacles	Strategies
•Bias in instructors •Bias in patients •Gender differences in communication •Lack of instructor knowledge about WH	-Include specific gender related queries in student evaluations -Develop interactive workshops on dealing with diversity -Develop workshops with standardized patients -Develop faculty training programs on new WH information and how to incorporate it into their teaching -Develop WH care center or clinic with faculty knowledgeable about WH

(continued)

CASE-BASED INSTRUCTION

Problem Based Learning Tracks, or Traditional Track

Possible Obstacles	Strategies
•Case information skewed to male norms	-Revise to include balanced gender distribution
•Cases contain stereotypical biases	-Revise
•Gender differences in diseases not addressed	-Revise
•Diseases unique to women not addressed	-Develop cases
•Biopsychosocial issues not addressed	-Revise

READING AND INSTRUCTIONAL AIDS

Textbooks, journals, instructor handouts

Possible Obstacles	Strategies
•Gender bias in texts and other printed support materials	-Provide instructors with evaluation of texts and recommendations on "best available"
•Absence of WH information in journal articles	-Discuss as journal club topic (as with statistical validity, etc.)
•Lack of WH information in instructor handouts	-Provide instructor with bibliography in his/her field
•Lack of video, computer assisted instruction (CAI) etc. in library collection	-Ask librarian to target WH in future purchases

EVALUATION AND FEEDBACK

Clinical Skills and Written Exams; Instructor/Patient Evaluation

Possible obstacles	Strategies
•Scenarios in clinical exams ignore or downplay women's health	-Develop appropriate clinical scenarios
•Written exams are not appropriately weighted for WH	-Develop test item data bank
•Questions contain stereotypes or gender bias	-Revise questions
•Attention to WH is absent from student evaluation/feedback forms	-Revise standard forms to include student skills in diversity, biopsychosocial issues -Obtain patient feedback on student performance
•WH competencies are not defined	-Work with professional societies to define those WH competencies which are appropriate to various specialties

Source: NAWHME participants 1994-95

Overcoming Gender Bias

Location of bias	Strategies
•In Educational Materials	-Examine and point out bias -Teach students and faculty how to recognize bias -Enlist the expertise of Women's Studies experts
•In Communication	-Teach skills that recognize gender, ethnic and economic differences in communication -Distribute guide to communication free of gender bias
•In a Learning Environment, which may be hostile for women	-Gain support of the leadership -Create a Women in Medicine office or committee -Create a student support group -Draw support from medical school or university women students or faculty -Emphasize prevention of and education about sexual harassment and all forms of gender bias -Offer assistance to department chairs in developing Grand Rounds and other educational programs about sexism as a moral issue and about eliminating gender discrimination in medicine and medical education
•In the Learning Environment, where physicians and students may have personal bias about certain learning issues, such as violence	-Teach faculty and students how personal bias can interfere with patient care -Emphasize professional conduct
•In the political arena, which may be highly charged about certain learning issues,such as reproductive options, abortion	-Try to eliminate politics from education by aiming for the good of the patient -Include all legitimate issues in the curriculum, point out deficiencies and request correction -If necessary go outside the institution to provide the learning experience

Source: Lucia Beck Weiss
Sandra Levison, M.D.
Women's Health Education
Program, MCPHU, 1995

Overcoming Institutional Resistance to Inclusion of Women's Health

Possible Obstacles	Strategies
•Curriculum is overcrowded	-Integrate WH into existing courses -Provide electives which serve several purposes--eg. WH in ambulatory setting
•Faculty/Residents are too busy	-Appoint them to WH education committees -Appeal to desire to provide high quality, up-to-date education -Encourage ownership -Emphasize that inclusion of WH does not mean exclusion of men's health -Enlist support of leadership/powerful faculty -Involve them in WH research/publications
•There is no "reward" for faculty who make the effort	-Present Gender Equity awards, selected by students, to faculty who systematically demonstrate fair and unbiased treatment of women (cf AMWA's awards) -Revise Promotion guidelines to recognize leadership in curricular change -Create "WH speakers bureau" for use in-house and for recommending faculty to national opportunities
•There are few protagonists and role models on the faculty and in leadership	-Develop interest groups on WH -Train, recruit, retain and promote women and men who have excellent skills in WH education and clinical care
•Administrative focus is on different educational strategies (eg. generalism)	-Promote concept that WH is fundamental aspect of all forms of medical care: inpatient/outpatient; specialist/generalist; basic science/clinical
•There is little money to support the introduction of WH education	-Identify interested faculty to teach WH at no additional cost -Drug companies producing medications of value to women may offer support
•Traditional departments see "turf" issues in the changes	-Engage them in interdisciplinary approaches; promote ownership
•WH advocates risk "marginalization", "fringe group" status	-Involve leadership/powerful and supportive men and women in the change process

Source: NAWHME participants 1994-95

APPENDIX I

SUPPORTING MATERIAL FOR NAWHME'S

TABLES & GRIDS

APPENDIX IA: Competencies

Women's Health Competencies

Numerous organizations are working to define "competencies" for their specialty. As a cross-disciplinary field, women's health faces particular difficulties in this process--including the political issues surrounding which specialty is responsible for the care of women. NAWHME is concerned that, whoever takes responsibility for caring for women patients, they are appropriately trained to deliver the best care possible.

NAWHME developed a list of women's health competencies for training internal medicine residents for the Federated Council on Internal Medicine (FCIM) and submitted it to them on October 3, 1994. The American Academy of Family Physicians (AAFP) has published lists defining desired training for its residents in Women's Health (April, 1994) and Obstetrics and Gynecology (Revised July, 1988), and in 1995 the Program Requirements for Residency Training in Obstetrics and Gynecology were revised to embrace a broader focus on women's primary health care. The American Board of Internal Medicine (ABIM), working with the FCIM competencies described above, developed a Position Paper on Women's Health (1995). AMWA's Advanced Curriculum on Women's Health, was developed in the early 1990s, and presented to practicing physicians in two parts, in October, 1993 and October, 1994. Recent and planned textbooks in women's health have also described a comprehensive approach to acquiring competence in caring for women patients.

These works, by and large, describe a similar list of competencies, organized differently for their particular purpose. Each is included so that educators can select the approach which most closely matches the way they customarily work when planning a program for students, residents or practitioners and are amplifications on the references made in NAWHME's Tables (superscripts 1 and 2) and Grids (columns 1 and 2).

NAWHME's List of
Skills and Knowledge Required
to Care for Women Patients

A list of Competencies for Women's Health was developed by the National Academy on Women's Health Medical Education (NAWHME) for the Federated Council on Internal Medicine (FCIM), which is undertaking a project to define the competencies of an internist. FCIM intends to submit their final lists to the Internal Medicine Residency Review Committee as a guideline for residency training in Internal Medicine. The list describes the competencies required for an internist to screen, diagnose and manage conditions which

-are unique to women
-are more common in women
-are more serious in women
-have manifestations, risk factors or interventions which are different in women

Health and illness is affected by social context, ethnicity and race, culture, health beliefs and socioeconomic status as well as biology and pathophysiology. Because these diverse factors often affect the diagnosis, natural history and management of individual conditions, a multi-disciplinary approach to the care of the woman patient is especially important.

The Subcommittee preparing the FCIM Competencies List used the outline of the Chapters for the forthcoming "Textbook of Women's Health", Editor L.A. Wallis, M.D., to be published by Little, Brown and Co., Boston in 1997 as a starting point, and submitted a list of skills and knowledge in women's health required for the training of internal medicine residents to FCIM in October 1994.

The format of the FCIM Competency List has now been modified to produce the document which follows: <u>NAWHME's List of Skills and Knowledge Required to Care for Women Patients</u>. The content has also been enhanced following NAWHME-participant feedback and a cross-review with AAMC's Survey of Medical Schools (1994-95).

The user of this list should note that in addition to this list of conditions which are unique to, more common or more serious in, or require different management for women, there are a host of common diseases which appear to require similar management in women and men (eg. upper respiratory infections, hypertension, congestive heart failure, gastric ulcer, varicose veins, etc.) Future research <u>may</u> demonstrate sex-based differences in these diseases, and this list of competencies in women's health will require constant updating as new research emerges.

Participants of Subcommittee to describe
Competencies in Women's Health
for FCIM
1994

Glenda Donoghue, MD	Vice Provost MCPHU	Convener, NAWHME
Lila Wallis, MD	Professor of Medicine Cornell University	AMWA Chair, NAWHME
Sandra Levison, MD	Professor of Medicine MCPHU	MCPHU Chair, NAWHME
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NAWHME's Required Skills in Women's Health

Skills training usually requires a different pedagogic approach to knowledge acquisition. In medicine, teaching techniques include the use of workshops with models, clinical simulations with standardized patients, and carefully supervised experiences with actual patients. The NAWHME List of Skills Competencies in Women's Health which follows is appropriate for all practitioners who care for women patients,and can be used for designing courses for students, residents in anyfield, and practitioners. These "women's health skills", of course, should be taught **in addition to** those traditionally taught, such as cardiopulmonary resuscitation (CPR), proficiency in venepuncture, etc.

NAWHME'S LIST OF SKILLS
REQUIRED TO CARE FOR WOMEN PATIENTS*

Procedure Skills:

- communication, sensitive to gender, ethnic and socioeconomic class, sexual orientation and gender differences in decision making
- comprehensive history, including questions designed to elicit sex- and gender-related risk factors, history of sexual abuse
- comprehensive physical exam, including
  - painless, sensitive, educational pelvic exam, life-cycle appropriate
  - painless, sensitive, educational breast exam
  - Pap smear
  - specimens for appropriate studies of vaginal discharge, STD screening, HIV
  - instruction in breast self exam
- counseling on health maintenance/disease prevention (including smoking cessation/prevention, diet, stress reduction, substance abuse, immunizations, calcium, exercise, safer sex, seat belt use, sun exposure)
- counseling on psychosocial issues (including sexual harassment, self-esteem, caretaker syndrome, effects of poverty, social isolation of elderly, suicide risk)
- usage of community resources
- usage of referral services in managed care settings
- rape protocol
- institution and monitoring of certain contraceptive modalities (diaphragm, oral, transdermal and intramuscular contraceptive, condom)
- institution and monitoring appropriate hormone replacement therapies and management of normal menopause and its variants

The primary interpretation of the following tests:

- resting EKG in women, including changes during pregnancy
- urinalysis
- vaginal secretion for trichomonas, yeast, etc.
- vaginal secretion for estrogen effect
- pregnancy test

* NAWHME credits FCIM for developing this approach to describing women's health training for internal medicine residents

Ordering the following tests and understanding the significance of the results:

- stress and thallium EKG
- lipid profile
- urine culture and sensitivities
- serum electrolytes
  - acid/base metabolism
  - calcium/phosphate metabolism
- HIV testing and counselling
- colposcopy as follow-up of abnormal Pap
- endometrial biopsy and D&C
- chlamydia testing
- laparoscopy, hysteroscopy
- bladder function tests
- mammogram
- breast biopsy
- fertility workup
- genetic testing
- sleep evaluation
- pelvic ultrasound
- bone densitometry

Understanding indications, contra-indications, expected results, complications when referring for therapeutic procedures

- pelvic floor/bladder repair/perineal surgery
- lumpectomy
- mastectomy
- breast mass aspiration/biopsy
- tubal ligation
- intrauterine contraceptive
- implantation of long-acting contraceptive
- abortion
- Cesarean section
- cervical cryo- and laser surgery
- hysterectomy
- oophorectomy

NAWHME's Required Knowledge in Women's Health

The section on knowledge competencies in women's health is the second part of NAWHME's List of Skills and Knowledge Required to Care for Women Patients. It includes those conditions which are unique to women, are more common in women, are more serious in women, and have manifestations, risk factors or interventions which are different in women.

A competent practitioner should be able to manage these conditions in the role of primary caretaker (P), or by recognizing the condition and referring the patient to a specialist (R). The setting where care may be rendered is defined (office, O; inpatient, H). The priority ranking is estimated based on the likelihood that a disease will become a major focus in the physician's practice. This prioritization, used by FCIM for all its competency lists, is helpful in guiding the design of courses for students and residents: a "1" priority indicates a need for considerable exposure and training, "2" for a lesser degree of training; a "3" priority suggests that, even if no actual patients are seen during the course of training, the learner should at least know how to recognize the condition and to manage it, or refer the patient to another specialist should the need arise.

NAWHME'S LIST OF KNOWLEDGE
REQUIRED TO CARE FOR WOMEN PATIENTS*

Recognition and Diagnostic Evaluation of Findings:

cardiovascular
- atypical chest pain
- palpitations
- syncope
- heart murmur
- lipid profile abnormalities

symptoms of violence and assault
- repeated bruising/fractures
- chronic fatigue and/or depression
- rape
- incest
- PTSD

dermatology
- aging skin
- request for cosmetic surgery

substance abuse and high risk behaviors
- alcohol
- tobacco
- illicit substances
- prescription substances
- high risk behavior for HIV, STDs

occupational
- effects of gender-related occupational trauma

endocrine
- hypermetabolism
- hypometabolism, muscle pains and constipation
- diabetes
- hirsutism/virilization

vaginal/cervical/pelvic
- pelvic mass
- vaginal discharge
- abnormal pap smear

bladder/bowel
- urinary incontinence
- urinary frequency
- dysuria
- bladder pain
- hypermotility
- gall bladder diseases

neurologic
- chronic/intermittent weakness, bilateral, unilateral
- insomnia
- recurrent headache

eating disorders
- obesity
- malnutrition
- weight loss
- eating abnormalities with or without body image disorder

oral
- gum/dental diseases

medications
- polypharmacy
- HRT affecting other medications

menstrual abnormalities
- unexplained vaginal bleeding
- pelvic pain/abdominal pain
- pre-menstrual syndrome

NAWHME'S LIST OF KNOWLEDGE
REQUIRED TO CARE FOR WOMEN PATIENTS*

Recognition and Diagnostic Evaluation of Findings:

infectious diseases
opportunistic infections in the immunologically compromised woman

reproduction
unwanted pregnancy
infertility
request for preconception and genetic counseling
pregnancy and common associated symptoms (heartburn, backache, hemorrhoids, etc.)
presenting with high risk pregnancy
threatened abortion
spontaneous abortion
post-partum depression
contraceptive needs
breast feeding questions
newborns exposed to drugs/alcohol/ toxins in utero

menopause
hot flashes/sleep disorders
vaginal dryness/ dyspareunia

sexuality
life phase sexuality issues and dysfunctions
lesbian sexuality

breast
lump(s)
nipple discharge
galactorrhea
breast exam after reduction/ augmentation surgery

psychological
personality disorders
dementias (estrogen effect)
mood disorders
anxiety and phobic disorders,
post-traumatic stress syndrome
amnesia and dissociation
psychotic disorders
effects of isolation in the elderly
grief reactions
obsessive thoughts/ compulsive behaviors

musculoskeletal
joint pains/swelling
back pain
foot pain
muscle pain
traumatic or spontaneous fracture with generalized bone loss

autoimmune
painful thyromegaly
collagen vascular disorders

* NAWHME credits FCIM for developing this approach to describing women's health training for internal medicine residents

NAWHME'S LIST OF KNOWLEDGE
REQUIRED TO CARE FOR WOMEN PATIENTS*

Diagnosis and Management of conditions:

	Role	Setting	Priority
Cardiac diseases			
Coronary artery disease: typical and atypical angina	P/R	O/H	1
Dyslipidemia	P/R	O	1
Mitral valve prolapse	P/R	O/H	2
Violence and assault			
Physical/emotional abuse	P/R	O/H	1
Sexual Assault	P/R	O/H	1
Sexual harassment	P/R	O	1
Elder abuse	P/R	O/H	1
Child abuse and incest	P/R	O	2
PTSD and somatization disorder as "markers"	P/R	O/H	2
Dermatology			
Aging skin	P	O	1
Cosmetic surgery	P/R	O/H	2
Prevention/Health Maintenance/substance abuse Counselling	P	O	1
Occupational disorders			
Carpal tunnel syndrome	P/R	O	2
Computer/visual disorders	P/R	O	
Impact of disability & chronic illness	P/R	O	2
Psychosomatic illnesses, stress reactions and psychiatric illnesses associated with sexual harassment and gender discrimination	P	O	2
Endocrine disorders			
Hyper/hypo thyroidism	P/R	O/H	1
Diabetes	P/R	O/H	1
Hirsutism/virilization	P/R	O	2
Infectious Diseases			
HIV/AIDS	P/R	O/H	1
Urinary tract diseases			
Incontinence	P/R	O/H	1
Recurrent UTI	P/R	O	1
Interstitial cystitis	P/R	O	2

* NAWHME credits FCIM for developing this approach to describing women's health training for internal medicine residents

NAWHME'S LIST OF KNOWLEDGE
REQUIRED TO CARE FOR WOMEN PATIENTS*

Diagnosis and Management of conditions cont'd:

	Role	**Setting**	**Priority**
GI diseases			
Fecal incontinence/pelvic floor abnormalities	P/R	O	1
Inflammatory bowel syndrome	P/R	O/H	1
Cholelithiasis	P/R	O/H	1
Neurologic disorders			
Migraine and headache syndromes	P/R	O	1
Sleep Disorder	P/R	O	2
Chronic fatigue syndrome	P/R	O/H	2
Eating abnormalities			
Obesity	P	O	1
Anorexia	P/R	O/H	2
Bulemia	P/R	O/H	2
Body Image	P/R	O	1
Malnutrition	P/R	O/H	1
Oral health			
Gum/Dental diseases	P	O	2
Medications			
Polypharmacy	P	O/H	1
Effects of HRT on other medications	P	O/H	1
Menstrual abnormalities			
Irregular menses	P	O	1
Dysmenorrhea	P	O	1
Endometriosis	P/R	O	1
Amenorrhea	P/R	O	1
PMS	P	O	1
Effects of cyclicity on drugs/disease	P/R	O/H	2
Toxic shock	P/R	O/H	3
Vaginal/cervical disorders			
Vaginitis	P	O/H	1
Cervical cancer or dysplasia	P/R	O	1
Genital herpes	P	O	1
STD	P	O	1

* NAWHME credits FCIM for developing this approach to describing women's health training for internal medicine residents

NAWHME'S LIST OF KNOWLEDGE
REQUIRED TO CARE FOR WOMEN PATIENTS*

Diagnosis and Management of conditions cont'd:

	Role	**Setting**	**Priority**
Pelvic abnormalities			
Uterine fibroids	P/R	O	1
Pelvic inflammatory disease	P/R	O/H	1
Ovarian cancer	P/R	O	2
Ovarian cyst(s)	P/R	O	2
Uterine cancer	P/R	O	2
Cystocele, rectocele, enterocele	P/R	O/H	2
Reproduction			
Contraceptive counselling	P	O	1
Reproductive options	P	O	1
Breast feeding counselling	P	O	1
Unwanted pregnancy	P	O	1
Adoption	P/R	O	1
Preconception counselling	P	O	2
Infertility	P/R	O	2
Normal pregnancy (including drugs contraindicated and common associated symptoms)	P	O/H	2
Post-partum depression	P/R	O/H	2
Threatened/spontaneous abortion	P/R	O/H	2
Emotional impact of abortion/stillbirth	P/R	O/H	2
DES Counselling	P/R	O	2
Effects of maternal health practices on fetus	P/R	O	2
High risk pregnancy	R	O/H	3
Menopause			
Hot flashes/sleep disturbances	P	O	1
Vaginal dryness/dyspareunia	P	O	1
Hormone replacement therapy	P/R	O	1
Unexplained vaginal bleeding	P/R	O	1
Sexuality			
Childhood sexuality through older years	P/R	O	2
Reproductive years	P/R	O	2
Perimenopausal years	P/R	O	2
Disabled patients	P/R	O	2
Sexual preference and identity	P/R	O	2

* NAWHME credits FCIM for developing this approach to describing women's health training for internal medicine residents

NAWHME'S LIST OF KNOWLEDGE
REQUIRED TO CARE FOR WOMEN PATIENTS*

Diagnosis and Management of conditions cont'd:

	Role	**Setting**	**Priority**
Breast disorders			
Malignancy	P/R	O/H	1
Benign breast disease	P/R	O/H	1
Galactorrhea (Pituitary adenoma)	P/R	O/H	2
Breast reduction/augmentation	P/R	O/H	2
Psychological/Psychiatric disorders			
Personality disorder	P/R	O	1
Depression	P	O	1
Chronic anxiety/phobia	P	O	1
Post-traumatic stress syndrome	P/R	O	1
Psychological impacts of sexual abuse	P/R	O	1
Psychosomatic disorders	P/R	O	1
Obsessive/compulsive disorders	P/R	O	2
Dissociative disorders	P/R	O	3
Musculoskeletal disorders			
Osteoporosis	P	O	1
Osteoarthritis	P	O	1
Hip fracture	P/R	O/H	1
Fibromyalgia	P/R	O	2
Temporal-mandibular joint dysfunction	P/R	O	2
Foot deformities	P/R	O	2
Nail deformities	P	O	2
Autoimmune diseases			
Rheumatoid arthritis	P/R	O/H	1
Thyroiditis	P/R	O	2
Collagen vascular syndromes	P/R	O/H	2

* NAWHME credits FCIM for developing this approach to describing women's health training for internal medicine residents