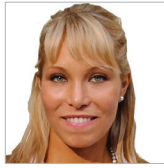


An Approach to Vulnerable Populations in Medical Education

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It was in my second year of medical school and I was sitting in a room with nine of my classmates and a physician during our case-based learning class. The case presented

that day was of a young man with a sore throat and fever. He recently returned from a business trip to South America and was in a committed, exclusive relationship with his boyfriend.

After reading the opening statement about the patient, we began the usual task of developing differential diagnosis. Infections, of course, were a significant subsection of our differential list. These question stems of theoretical patients are designed to lead us in a certain direction unlike

However, I do not need to use my imagination to discover whether HIV would take such a prominent place on our differential list if we did not know about this patient's sexuality. HIV is only mentioned as a differential for patients who are men who have sex with men, regardless of their relationship status, and in sex workers and IV drug users. If the patient presented above was in a committed relationship with a woman, everything else being equal, likely no one in our group would have even mentioned HIV.

Let us break down the assumptions we are taught to make in medicine. First, men who have sex with men have sex with many men, even if this



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means cheating on their partner. Second, men who have sex with men regularly have unprotected sex regardless of what they claim. Finally, any sex between two men has a high chance of spreading HIV.

The first two assumptions are blatantly homophobic, though they are defended in the

real patients who present with both relevant and irrelevant details. To the average medical student studying their "high-yield medical pearls," the most obvious primary differential in a young man who has sex with men is Human Immunodeficiency Virus (HIV). Even if the patient is not sick at all, we are taught to suspect HIV because we are supposed to assume that men who have sex with men have sex with multiple partners (regardless of their relationship status) and do not practice safe sex.

Now some may protest at this point. They may point out that the prevalence of HIV in this population is high, so it is reasonable for HIV to be at the top of our differential diagnosis. They might stress that we are taught to have a healthy level of suspicion with all patients, especially when it comes to stigmatized behaviors like sexual intercourse, drug use, and so on. They might insist that providing the best care for our patients includes not ignoring the possibility of a disease just because it might offend the patient.

And I agree, these are all valid points.

medical community by saying that we never actually believe any patients are telling the truth about their sexual activity. The pros and cons of this undercurrent of distrust in medicine are debatable and not the topic of this piece. The ways in which this distrust is applied to different populations, especially vulnerable populations, is the bigger issue here.

The final assumption is largely inaccurate. According to the Centers for Disease Control and Prevention (CDC), the riskiest thing one can do to contract HIV is to receive a blood transfusion contaminated by the virus, with a greater than 90% chance of transmission.¹ Comparably, everything else the CDC has listed as "risky behavior" for contracting HIV is unlikely to happen. Receptive anal intercourse has the highest likelihood of the remaining behaviors at 138 per 10,000 exposures, or about a 1.4% chance per sexual encounter without protection with an HIV positive partner.¹ This is likely the statistic people will point to as proof that men who have sex with men are more likely to contract HIV. This argument ignores the simple and unavoidable fact that men who have sex with men do not



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exclusively engage in and are not the only people who engage in anal sex. Furthermore, a 1% chance that something will happen is less of a guarantee and more of a minor risk that can and should be mitigated, but not condemned.

Generalizations like these about our patients are taught in our classes, tested on in our exams, and often modeled in our clinical experiences. To the credit of my medical school, who wrote this particular case, the patient ended up having mononucleosis, not HIV. The written case made a point of explaining that we should never assume HIV in a man who has sex with men. On the other hand, this case came after two prior example cases of men who cheated on their wives with men while on overseas business trips and now needed HIV testing. In a way, then, our biases and assumptions were reinforced rather than countered.

Our medical education is littered with contradictions such as this. The ethicists tell us one thing while our mentors and future colleagues show us something different. Which of these discrepancies we encounter and how we navigate them shape what kinds of doctors we will become. Will our practice be driven by norms, which are based on generalizations of statistics most people hardly understand? Or will we rise above these norms, maintaining strict ethical integrity, but creating friction in our workplace and possibly endangering our careers? It is a difficult line to walk

and the way we traverse it has significant, and possibly severe, implications for ourselves, our colleagues, and our patients.

It is an ambitious task to address this discordance in medicine as it is embedded in the very heart of our medical culture. One way to begin shifting cultural norms is to start with the newest members of the group, students. The case presented to us on that day attempted to defy one of the concerning assumptions the medical community tends to make regarding an underprivileged population. However, its well-intentioned point was overshadowed by the rest of the curriculum which drove home the very assumptions it was trying to contradict. A more targeted overhaul of medical education is required, and it must include our textbooks, our standardized tests, and our teachers. Though complex and daunting, this effort is worth the price for more open-minded medical professionals who practice better, safer medicine. ●

References:

1. Centers for Disease Control and Prevention. HIV Risk Behaviors. <https://www.cdc.gov/hiv/risk/estimates/riskbehaviors.html>. Accessed March 28, 2019.

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