One Size Does Not Fit All: creating a LGBTQ inclusive curriculum and clinical environment

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Disclosures

• Almari Ginory, DO- None*
• Marnie Stefan, MD- None*
• Hector Ojeda-Martinez, MD- None

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Objectives

1. Knowledge of the medical and mental health care disparities found in LGBTQ populations and implement recommended assessment and treatment modalities.

2. Understand how to approach the health care of LGBTQ patients in an inclusive rather than exclusive manner.

3. Provide quality care to the LGBTQ population by using strategies for collection of sexual orientation and gender identity data in clinical settings, creating a welcoming environment of care.

4. Understand the importance of incorporating LGBTQ health into residency curriculum.
Overview of Presentation

• Medical Knowledge
  • Terminology and definitions
  • Review of psychiatric and medical conditions more prevalent in the LGBTQ population

• Professionalism
  • Creating an inclusive clinical encounter and environment
ACGME Common Program Requirements

• Residents are expected to demonstrate:
  • Sensitivity and responsiveness to a diverse patient population, including but
    not limited to diversity in gender, age, culture, race, religion, disabilities, and
    sexual orientation (IV.A.5.E.(5))

AMA Principles of Medical Ethics

• Physicians must also uphold ethical responsibilities not to discriminate
  against a prospective patient on the basis of race, gender, sexual
  orientation or gender identity, or other personal or social characteristics
  that are not clinically relevant to the individual’s care. (1.1.2)
• But what does this mean, and how is this implemented?
• How can we, as physicians, create an inclusive, welcoming environment of care for all patients?
• It’s the 21st Century, this isn’t a problem
Not Everywhere

• Over 70 countries where homosexuality is illegal
• Penalties ranging from arrest to death penalty
• Residents come from all over the world
  • 2018- 3,962 non-US citizen IMG matched in PGY-1 positions
United States

- 1990’s

- Today
History of Marriage Equality

• 1970’s- State start passing bans on same sex marriage
• 1996- DOMA signed by Clinton which denies federal benefits to same sex couples
• 1999- California allows for domestic partnerships
• 2000- Civil unions legal in Vermont
• 2003- Massachusetts legalizes same sex marriage
• 2006- States start having constitutional amendments banning same-sex marriage
• 2008- California- May- couples can marry. Nov- Prop 8 passed
• 2010- August- Prop 8 declared unconstitutional- Appeal
• 2010- Parts of DOMA declared unconstitutional
• 2011- Obama administration will not defend DOMA
• 2012- Obama becomes the first president to announce support for same sex marriage
• 2013- DOMA Unconstitutional- US v Windsor
• 2013- Prop 8 unconstitutional USSC
• 2014- Same sex marriage bans begin to be struck down in courts
• June 26, 2016- Obergefell v Hodges- Marriage Equality
Population Estimates - USA

• 4.5% of population identify as LGBT
Trump’s U.S. Census proposes, immediately cuts LGBT survey questions

We’ve been ERASED!

Original

<table>
<thead>
<tr>
<th>Relationship</th>
<th>1860</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rent</td>
<td>1940</td>
</tr>
<tr>
<td>Rooms</td>
<td>1940</td>
</tr>
<tr>
<td>School Enrollment</td>
<td>1800</td>
</tr>
<tr>
<td>Sexual Orientation and Gender Identity</td>
<td>Proposed</td>
</tr>
</tbody>
</table>

Modified March 28

<table>
<thead>
<tr>
<th>Relationship</th>
<th>1860</th>
</tr>
</thead>
<tbody>
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<td>1940</td>
</tr>
<tr>
<td>School Enrollment</td>
<td>1800</td>
</tr>
</tbody>
</table>

A/2. Subjects Planned for the 2020 Census and American Community Survey
FIGURE 1
Sexual orientation and gender identity data collection on the 2015 BRFSS

- No SOGI data collection
- Used the SOGI module to collect SOGI data
- Did not use the module to collect SOGI data
- Used the SOGI module in 2014 but discontinued it in 2015

Note: Micronesia and Samoa do not currently field BRFSS. Palau did not respond to inquiries and is excluded from this analysis.

www.cdc.gov/brfss
Students Perspective

• Hospitals and medical schools “focus so much on the quantitative proof of diversity that they’re missing their failures to safeguard inclusion.”

• 30% of LGBTQ students who matriculate into medical school conceal their identity
  • More than 40% of those do secondary to fear of discrimination
• In the last two decades, the time allotted for teaching LGBT-related topics has increased from a mean of 2 to 5 h in the USA.

• Medical school may be an ideal place for interventions to reduce bias because students are exposed to diverse patients as well as the opinions, attitudes, and behaviors of faculty who impart on students professional norms and expectations, reflecting their biases.

• Medical schools are committed to educating students about the potential impact of bias meanwhile there is little focus on sexual minorities at risk for disparities and no consistent approach.

Phelan et al. 2017
• There is a dearth of information in medical school curricula about LGBT health and very little cultural competency education that considers the experiences of these stigmatized minority groups.

• The amount of contact with sexual minorities has predicted reduced implicit bias, and favorability was associated with reduced explicit bias against gay and lesbian people, reaffirming prior research showing that contact reduces negative attitudes about sexual minorities.

• Interventions should also include fostering an environment where sexual minority faculty and students feel they can disclose their sexual orientation.

Obedin-Maliver J et al. 2011
Phelan et al 2017
• While it is important to train students, it is equally important that attention be paid to training faculty, residents, and other clinical staff.

• If role modeling is lacking and more senior clinicians are not in support of what students have learned, it will be difficult for students to implement these skills into patient care during clerkships and residencies.
Terminology and Definitions

Almari Ginory, DO
Sex vs Gender

• **Gender** - A cultural concept including the combination of social, cultural, psychological, and emotional traits associated with masculinity or femininity. Multifaceted and can be fluid. It is independent of anatomy.

• **Sex** - The biological and anatomical attributes of male and female.
  - Differences of Sex Development or Intersex - chromosomal, hormonal, or anatomical variation in sex

Eckstrand et al, 2016
Gender Concepts

• **Gender Identity** - internally defined concept of self, separate from external appearance or anatomy. Internal sense of male/female

• **Gender Expression** - communication of gender to others via behaviors, personality, and appearance. A particular gender may be expressed without necessarily changing their gender identity

• **Cisgender** - anatomical birth sex and gender identity are congruent

• **Transgender** - anatomical birth sex and gender identity are incongruent

• **Non-binary** - neither male/female or both male/female

Eckstrand et al, 2016
Transgender

• Trans man (female-to-male [FTM])- Someone born anatomically as a woman but identifying as a man.

• Transsexual- someone who chooses to make a physical transition by using hormonal and/or surgical sex interventions.

• Trans woman (male-tofemale [MTF]) Someone born anatomically as a man but identifying as a woman.

• Transition- affirming the identified gender
  • Social Transition
  • Medical Transition
  • Surgical Transition- Gender Affirming Surgery

Eckstrand et al, 2016
Sexual Orientation

• Attraction
• Lesbian - women attracted primarily to women
• Gay - men or women with same sex attraction
• Bisexual - attraction to both men and women
• Pansexual - diverse attraction to variety of gender expressions/identities, and anatomies

Eckstrand et al, 2016
Queer

- Used to be used in a derogatory manner to discriminate
- Re-appropriated by younger generation
- Umbrella term to express whole community
- Can express fluid identities and orientations

Eckstrand et al, 2016
The Genderbread Person

Identity ≠ Expression ≠ Sex
Gender ≠ Sexual Orientation

Sexually Attracted to...
- Women a/o Feminine a/o Female People
- Men a/o Masculine a/o Male People

Romantically Attracted to...
- Women a/o Feminine a/o Female People
- Men a/o Masculine a/o Male People

Gender Identity
- Woman-ness
- Man-ness

Gender Expression
- Femininity
- Masculinity

Anatomical Sex
- Female-ness
- Male-ness
Bias

• **Explicit Bias**: consciously controlled
  • Susceptible to social desirability concerns

• **Implicit Bias**: unconscious, automatic responses/thoughts
  • Study of medical 2000 medical students: ~50% reported an explicit bias towards LGBT. However 80% demonstrated implicit bias

• **Microaggressions**: Behaviors and statements that communicate a derogatory message to members of a targeted social group
  • Can be unconscious or unintentional
  • Verbal, nonverbal, behavioral
  • Micro- subtle manner in which occur
  • Snubs, dismissive looks, gestures, tones

Nadal et al. 2016
Microaggressions forms

- **Microassault**: more conscious and deliberate. Overt verbal or nonverbal insults or behaviors
- **Microinsults**: statements or actions that are demeaning to the person’s identity. Communicate rudeness and insensitivity
- **Microinvalidations**: negate the thoughts, feelings, or reality of an individual.

Nadal et al. 2016
Microaggression Themes in Therapy

• Assuming that sexual orientation is the underlying cause of all issues
• Avoidance and minimizing of sexual orientation
• Attempting to overidentify
• Making stereotypical assumptions
• Expressions of heteronormative bias
• Assumption that LGBTQ individuals need therapy
• Warnings about dangers of identifying as LGBTQ

Shelton et al. 2011
Examples of Microaggressions

• “That’s so gay”
  • Microassault

• “Your too pretty to be a lesbian” “I would have never thought you were gay”
  • Microinsult or Stereotypical assumptions

• “Maybe if you dressed up a bit you could find a husband”
  • Microinvalidation

• “What’s your husband do?”
  • Heteronormative bias

• “My cousin, Tim, is gay too.” “Do you know him?”
  • Overidentify
Other Terms

• Homophobia- disgust/fear of nonheterosexual individuals
• Biphobia- disgust/fear towards those who do not conform to exclusive hetero or homosexuality
• Transphobia- disgust/fear towards those who do not conform to society’s gender expectations
• Heterosexism- negative attitudes, biases, and beliefs held by heterosexuals about nonheterosexuals. Assumption that all people are or should be heterosexual
• Homonegativity- negative attitude towards nonheterosexual identities

Nadal et al. 2016
Mental Health Concerns

Almari Ginory, DO, FAPA
Psychiatric Diagnosis History

**Homosexuality**
- DSM I- Homosexuality was a diagnosis associated with “sociopathic personality disturbance”
- DSM II 1973- Sexual Orientation Disturbance
- DSM III- Ego Dystonic Homosexuality
- DSM III-R- 1987 Removed

**Transgender**
- DSM IV- Gender Identity Disorder
- DSM 5- Gender Dysphoria
DSM 5 Criteria Gender Dysphoria

• Marked incongruence between one’s expressed and assigned gender.
• At least 2 of the following, lasting over 6 months:
  • Incongruence between one’s expressed gender and primary/secondary sexual characteristics
  • Strong desire to be rid of primary/secondary sexual characteristics because of incongruence
  • Strong desire for primary/secondary sexual characteristics of other gender
  • Strong desire to be other gender
  • Strong desire to be treated like other gender
  • Strong conviction that one has typical feelings and reactions of other gender
• Causes significant distress or impairment in social, occupational, or other important areas
Mood Disorders

• Depression:
  • Two or three times more when compared to heterosexuals
  • Higher in bisexuals
  • 44.1% risk of developing depression in transgender

• Bipolar Disorder:
  • Significant increase of experiencing a manic episode or receiving the diagnosis.

Kidd et al. 2016
Substance Use Disorders

• Tobacco: ~2x times higher
• Alcohol: ~2x times higher
• Illicit substances:
  • 2.41 times more for gay or bisexual men
  • 3.50 times more for lesbian or bisexual women
• Past experiences of discrimination raises the risk
Anxiety Disorders

- Two or three times the rate of same gendered heterosexuals
- PTSD:
  - More traumatic events when compared to heterosexuals
    - Twice the risk of getting PTSD
  - Those who have been physically assaulted are at higher risk for mental health diagnosis, feelings of loneliness, and suicide attempts.

Fredriksen-Goldsen et al. 2015
Suicide Attempts - Lifetime rate

• Transgender adults: 41%
• Lesbian, Gay, Bisexual adults: 10-20%
• Overall US population: ~5%
Risk Factors for Suicide - Transgender

- Family Rejection
- Discrimination, victimization, or violence at school/work/healthcare
  - 60% had a doctor or healthcare provider refuse to treat them
- Discrimination, victimization, or violence by LEO
- Homeless
- Younger age
- Lower socioeconomic status
- HIV +
Family - LGBTQ Youth

**Rejection**
- 8x as likely to attempt suicide
- 6x as likely to report significant depressive symptoms
- 3x as likely to use illicit substances
- 3x as likely to be high risk for HIV and STDs

**Acceptance**
- Protective against suicide, depression, and substance use
- Improved self esteem, social support, general health

![Comparative chart showing increased risk in rejection and decreased risk in acceptance]

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*Family Acceptance Project*
Conversion Therapy

- AKA reparative therapy
- Practice of changing an individual's sexual orientation to heterosexual
- Can include psychotherapy (1:1 and group), ECT, and other aversion therapies
- Research has disproven efficacy and shown to cause significant harm
- Increased risk of mental illness, substance use, and suicide
Conversion Therapy

www.hrc.org
Response to Conversion Therapy

- Denounced by numerous organizations
  - Am Acad of Child & Adol Psych
  - American Psychiatric Assn
  - American Academy of Pediatrics
  - American College of Physicians
  - American Medical Association
  - American Psychoanalytic Assn
  - American Psychological Assn
  - American Counseling Assn
  - World Psychiatric Assn

- “Same sex attraction...implies no impairment per se in judgment, stability, reliability, or general social or vocational capabilities.”
- Same sex orientation does not need to be changed and efforts to do so represent a high risk of harm
- No evidence to show that intervention can safely change sexual orientation
- From a mental health perspective, does not need to be changed
- Not a disorder, so doesn’t need to be treated

www.psychiatry.org
Medical Concerns and Disparities

Hector Ojeda-Martinez, MD
Overview of LGBTQ-specific Health Issues Across Time and Age

<table>
<thead>
<tr>
<th>Lesbian &amp; Bisexual Women</th>
<th>Gay &amp; Bisexual Men</th>
<th>Transgender Persons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevention/screening</td>
<td>HIV/AIDS</td>
<td>HIV/AIDS</td>
</tr>
<tr>
<td>STIs/sexual health</td>
<td>STIs/sexual health</td>
<td>STIs/sexual health</td>
</tr>
<tr>
<td>Breast cancer/gynecological care</td>
<td>Anal papilloma/anal cancer</td>
<td>Preventive care (screening for biological sex) &amp; access to healthcare</td>
</tr>
<tr>
<td>Substance abuse</td>
<td>Substance abuse</td>
<td>Substance abuse</td>
</tr>
<tr>
<td>Cardiovascular disease</td>
<td>Prostate cancer</td>
<td>Hormone therapy</td>
</tr>
<tr>
<td>Mental health</td>
<td>Mental health</td>
<td>Mental health</td>
</tr>
<tr>
<td>Psychosocial issues</td>
<td>Psychosocial issues</td>
<td>Psychosocial issues</td>
</tr>
</tbody>
</table>

Courtesy of Noelle Javier, MD
Specific Healthcare Needs of MSM

- MSM, especially from communities of color, may avoid healthcare fearing judgement, lack of privacy/confidentiality, insensitive healthcare environments and lack of services appropriate to their healthcare needs
- Stigma/Disclosure of sexuality how it relates to engagement in care and ARV or PrEP adherence
- High rates of homelessness
- Clinical expertise in recognizing syphilis, anal STIs
Young Black MSM and risk for HIV and STIs

Impact of the Larger Societal & Cultural Influences
- Marginalization of Black identity by larger society
- Societal homophobia
- Devalued personhood

Impact of Black Cultural Influences
- Marginalization of sexual identity by Black community
- Rejection by family and other support systems
- “Abomination” messages from faith community

HIV stigma
- Lack of HIV testing
- Lack of effective engagement in HIV care
- Increased morbidity and mortality
iPREX: PrEP in MSM and TG women

Preexposure Chemoprophylaxis for HIV Prevention in Men Who Have Sex with Men

After exposure to HIV, infection may become established.

Postexposure prophylaxis (initiated soon after exposure) reduces the chance of infection.

Pre-exposure prophylaxis begins treatment earlier (before exposure), which might increase the prophylactic effect.
## Who Should Be Offered PrEP?

Adults and adolescents who:

- Engage in unprotected anal or vaginal intercourse with partners whose HIV status is unknown, have untreated HIV, or who do not have undetectable viral load while on treatment for HIV
- Engage in unprotected anal or vaginal intercourse with partners who have HIV and undetectable viral load but wish to be on PrEP for additional protection
- Are receiving nPEP and demonstrate continued high-risk behavior or have used multiple courses of nPEP.
- Self-identify as being at risk, without disclosing specific risk behaviors.
- Acknowledge the possibility of or anticipate engaging in risk behaviors in the near future.
- Have, or whose partners may have, multiple or anonymous sex partners. Engage, or whose partners may engage, in sexual activity at sex parties or other high-risk venues.
- Are involved, or whose partners may be involved, in transactional sex, such as sex for money, drugs, or housing, including commercial sex workers and their clients.
- Have been diagnosed with at least one sexually transmitted infection in the previous 12 months.
- Report recreational use of mood-altering substances during sex, such as alcohol, methamphetamine, cocaine, and ecstasy.
- Report injecting substances, or have partners who inject substances, including illicit drugs and hormones.
**Table 1: Summary of Guidance for PrEP Use**

<table>
<thead>
<tr>
<th>Detecting substantial risk of acquiring HIV infection</th>
<th>Men Who Have Sex with Men</th>
<th>Heterosexual Women and Men</th>
<th>Persons Who Inject Drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV-positive sexual partner</td>
<td>HIV-positive sexual partner</td>
<td>HIV-positive sexual partner</td>
<td>HIV-positive injecting partner</td>
</tr>
<tr>
<td>Recent bacterial STI†</td>
<td>Recent bacterial STI†</td>
<td>Recent bacterial STI†</td>
<td>Sharing injection equipment</td>
</tr>
<tr>
<td>High number of sex partners</td>
<td>High number of sex partners</td>
<td>High number of sex partners</td>
<td></td>
</tr>
<tr>
<td>History of inconsistent or no condom use</td>
<td>History of inconsistent or no condom use</td>
<td>History of inconsistent or no condom use</td>
<td></td>
</tr>
<tr>
<td>Commercial sex work</td>
<td>Commercial sex work</td>
<td>Commercial sex work</td>
<td></td>
</tr>
<tr>
<td>In high HIV prevalence area or network</td>
<td>In high HIV prevalence area or network</td>
<td>In high HIV prevalence area or network</td>
<td></td>
</tr>
</tbody>
</table>
Effectiveness of TDF/FTC PrEP Improves With Adherence

*Reduction in HIV incidence vs control. †Based on pill counts or the detection of study drug in plasma.

**Effects:**
- **VOICE/FEM PrEP**
  - Efficacy: 0% / 6%
  - Adherence: 29% / ≤ 37%
- **iPrEx**
  - Efficacy: 44%
  - Adherence: 51%
- **Partners PrEP**
  - Efficacy: 75%
  - Adherence: 81%
- **TDF2**
  - Efficacy: 62%
  - Adherence: 80%
- **PROUD**
  - Efficacy: 86%
  - Adherence: ~ 100%

**Adherence (%)**

**Effectiveness (%)**
Safe Sex Counseling

• Harm reduction approaches include:
  • Monogamy with an uninfected partner
  • Reduction in the number of sexual partners
  • Engaging in lower-risk sexual practices
  • Consistent and correct use of barrier methods
  • Avoiding excessive substance use
  • Referrals to community programs
Lesbian and bisexual women

• Higher prevalence rates of obesity, tobacco use, and alcohol use by lesbians
• May explain higher rates of heart attacks observed in lesbian populations
• Nulligravidity, low parity, obesity, tobacco use, and less use of oral contraceptives are more common in lesbians than among heterosexual women

ACOG Committee Opinion Number 525, May 2012
Preventive medicine for lesbians and bisexual women

• General recommendations for mammography, colorectal cancer screening, hormone therapy, and osteoporosis screening also should be followed for all lesbian and bisexual patients

• Receive Pap tests less frequently
  • Due to perception that not at risk both on the part of the patient and provider; but 70% have had sex with men; and HPV transmitted women to women

• Lower rates of mammograms
Trans shapes, Trans sizes

• There is no “typical” way for a transgender to present for care
  • People will be in different stages of transition
  • People may come in for transgender-sensitive care, but not want to undergo medical transition
  • People you may have been taking care of for many years may request transgender-related care without having discussed their gender identity with you earlier
Recognize that the need to affirm one’s gender identity can supersede other critical health concerns.

Meet the patient where they are at.

**Priorities**

*Patient perspective*
- Surgery and HRT
- Name change
- Housing
- Medical Attention
- Benefits

*Provider perspective*
- Legal Issues
- Substance Use
- HRT
- Mental Health
- Medical Attention Including HIV/AIDS
- Housing

Dr. Luis Freddy Molano, Renato Barucco. Trans-experience in the South Brox
http://www.nyhiv.org/pdfs/FreddyMolanoTransgenderPresentationUSCA.pdf
Providing Care to patients of Trans experience

- Familiarize yourself with commonly used terms and the diversity of identities
- If you are not sure what terms to use, ask your patient what they prefer
- **Listen** to how people describe their own identities, partners, and bodies; use the same terms
  - Refer to patients by their preferred name and pronouns
  - Refer to body parts by their preferred name
- Avoid asking questions out of curiosity; ask what you NEED to know
- **Listen** to people’s experiences
  - Recognize that many have had negative experiences in the past and may perceive “slights,” even when not intended
Transgender patients: YOU MAY HAVE TO ADDRESS...

• Difficulty obtaining IDs
• Discrepancies between various IDs and insurance cards
  • This can lead to negative experiences when interacting with healthcare system
• Discrimination in the work place
• Sex work to survive...
• Which can lead to incarceration...
  • Prison rape
  • HIV transmission
  • Other STIs
• Domestic violence
Transgender patients: Performing the physical exam

• The provider needs to be sensitive and defer (if appropriate) examinations of sensitive areas until rapport established

• If you don’t have to exam it, don’t do it!
  • Includes genital, breast, and rectal exams
  • Taping down of male genitals (MTF)
  • Cervical pap screening should be done as the general population (FTM)
  • Breast exams as indicated in both MTF and FTM
  • Site directed STI testing
    • Some patients prefer self-collection
Gender reassignment surgery complications

• Top surgery (breast / chest surgery): Breast augmentation
  • Complications: implant leak or rupture

• Bottom surgery (genital surgery):
  • Penectomy, orchiectomy, Clitoroplasty, labiaplasty, Vaginoplasty, Penile inversion (preferred), colovaginoplasty
  • Major complications: Urethral and rectal fistulas, tissue death, closed loop abscesses, nerve injury
  • Minor complications (and most common): minor bleeding, swelling, foley catheter displacement, superficial wound dehiscence, minor adhesions

• Other surgeries
  • Facial feminization surgery, liposuction, lipofilling, voice surgery, thyroid cartilage reduction, gluteal augmentation (implants/lipofilling), hair reconstruction, and various aesthetic procedures
Health Maintenance in Transmasculine Individuals

**Pap smears**

- As per natal females
- Testosterone can cause atrophy of the cervical epithelium mimicking dysplasia
- Increase in “unsatisfactory” samples seen: 10.8% (10 times higher than in non-trans women) [1]
  - Transmen found to have reduced screening rates and longer latency to follow-up testing [1,2]

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Transmen Pap Test

Customize the pap test

Provide Options:
- bring support person
- ask for a chaperone
- partially undress
- pediatric spectrum
- topical anesthetic
- water-based lube
- consider low dose anxiety med

Gender Affirming Communication

Avoid:
- gendered language (women's/GYN exam, vaginal exam, reproductive health)
- female anatomical terms

Focus on:
- gender neutral language
- masculine identity
- professional language
- body position on table; frog legs vs stirrups

Provider confidence in trans competence

Emphasize:
- provider has experience in trans care
- Patient strategies for exercising control of exam
Risks associated with Hormone replacement therapy

<table>
<thead>
<tr>
<th>TABLE 12. Hormone regimens in the transsexual persons</th>
<th>Dosage</th>
</tr>
</thead>
<tbody>
<tr>
<td>MTF TRANSSEXUAL PERSONS*</td>
<td></td>
</tr>
<tr>
<td>Estrone</td>
<td></td>
</tr>
<tr>
<td>Oral: estradiol</td>
<td>2.0–6.0 mg/d</td>
</tr>
<tr>
<td>Transdermal: estradiol patch</td>
<td>0.1–0.4 mg twice weekly</td>
</tr>
<tr>
<td>Parenteral: estradiol</td>
<td>5–20 mg im every 2 wk</td>
</tr>
<tr>
<td>Valerol or cyponol</td>
<td>2–10 mg im every week</td>
</tr>
<tr>
<td>Antiandrogens</td>
<td></td>
</tr>
<tr>
<td>Spironolactone</td>
<td>100–200 mg/d</td>
</tr>
<tr>
<td>Cyproterone acetate b</td>
<td>50–100 mg/d</td>
</tr>
<tr>
<td>GnRHa agonist</td>
<td>3.75 mg sc monthly</td>
</tr>
<tr>
<td>FTM TRANSSEXUAL PERSONS</td>
<td></td>
</tr>
<tr>
<td>Testosterone</td>
<td></td>
</tr>
<tr>
<td>Oral: testosterone</td>
<td>160–240 mg/d</td>
</tr>
<tr>
<td>Unconcanolate</td>
<td></td>
</tr>
<tr>
<td>Parenteral</td>
<td></td>
</tr>
<tr>
<td>Testosterone enanthate</td>
<td>100–200 mg im every 2 wk</td>
</tr>
<tr>
<td>or cyponolante</td>
<td>2 wk or 50% weekly</td>
</tr>
<tr>
<td>Testosterone</td>
<td>1000 mg every 12 wk</td>
</tr>
<tr>
<td>Unconcanolate</td>
<td></td>
</tr>
<tr>
<td>Transdermal</td>
<td></td>
</tr>
<tr>
<td>Testosterone gel 1%</td>
<td>2.5–10 mg/d</td>
</tr>
<tr>
<td>testosterone patch</td>
<td>2.5–7.5 mg/d</td>
</tr>
</tbody>
</table>

| TABLE 2: RISKS ASSOCIATED WITH HORMONE THERAPY. BOLDED ITEMS ARE CLINICALLY SIGNIFICANT |
|---------------------------------------------------------------|---------------------------------------------|
| Risk Level                                                    | Feminizing hormones                        | Masculinizing hormones                        |
| Likely increased risk                                         | Venous thromboembolic disease*             | Polycythemia                                  |
|                                                               | Gallstones                                  | Weight gain                                   |
|                                                               | Elevated liver enzymes                     | Acne                                          |
|                                                               | Weight gain                                 | Androgenic alopecia (balding)                |
|                                                               | Hypertriglyceridemia                        | Sleep apnea                                   |
| Likely increased risk with presence of additional risk factors* | Cardiovascular disease                     |                                              |
| Possible increased risk                                       | Hypertension                                | Elevated liver enzymes                       |
|                                                               | Hyperprolactinemia or prolactinoma         | Hyperlipidemia                                |
| Possible increased risk with presence of additional risk factors* | Type 2 diabetes*                           | Destabilization of certain psychiatric disorders* |
|                                                               |                                              | Cardiovascular disease                        |
|                                                               |                                              | Hypertension                                  |
|                                                               |                                              | Type 2 diabetes                               |
| No increased risk or inconclusive                             | Breast cancer                               | Loss of bone density                          |
|                                                               |                                              | Breast cancer                                 |
|                                                               |                                              | Cervical cancer                               |
|                                                               |                                              | Ovarian cancer                                |
|                                                               |                                              | Uterine cancer                                |
### TABLE 1A: EFFECTS AND EXPECTED TIME COURSE OF MASCLINIZING HORMONES

<table>
<thead>
<tr>
<th>Effect</th>
<th>Expected onset</th>
<th>Expected maximum effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skin oiliness/acne</td>
<td>1–6 months</td>
<td>1–2 years</td>
</tr>
<tr>
<td>Facial/body hair growth</td>
<td>3–6 months</td>
<td>3–5 years</td>
</tr>
<tr>
<td>Scalp hair loss</td>
<td>&gt;12 months</td>
<td>Variable</td>
</tr>
<tr>
<td>Increased muscle mass/strength</td>
<td>6–12 months</td>
<td>2–5 years</td>
</tr>
<tr>
<td>Body fat redistribution</td>
<td>3–6 months</td>
<td>2–5 years</td>
</tr>
<tr>
<td>Cessation of menses</td>
<td>2–6 months</td>
<td>n/a</td>
</tr>
<tr>
<td>Clitoral enlargement</td>
<td>3–6 months</td>
<td>1–2 years</td>
</tr>
<tr>
<td>Vaginal atrophy</td>
<td>3–6 months</td>
<td>1–2 years</td>
</tr>
<tr>
<td>Deepened voice</td>
<td>3–12 months</td>
<td>1–2 years</td>
</tr>
</tbody>
</table>

A: Adapted with permission from Hembree et al. (2009). Copyright 2009, The Endocrine Society.
C: Highly dependent on age and inheritance, may be minimal.

### TABLE 1B: EFFECTS AND EXPECTED TIME COURSE OF FEMINIZING HORMONES

<table>
<thead>
<tr>
<th>Effect</th>
<th>Expected onset</th>
<th>Expected maximum effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Body fat redistribution</td>
<td>3–6 months</td>
<td>2–5 years</td>
</tr>
<tr>
<td>Decreased muscle mass/strength</td>
<td>3–6 months</td>
<td>1–2 years</td>
</tr>
<tr>
<td>Softening of skin/decreased oiliness</td>
<td>3–6 months</td>
<td>Unknown</td>
</tr>
<tr>
<td>Decreased libido</td>
<td>1–3 months</td>
<td>1–2 years</td>
</tr>
<tr>
<td>Decreased spontaneous erections</td>
<td>1–3 months</td>
<td>3–6 months</td>
</tr>
<tr>
<td>Male sexual dysfunction</td>
<td>Variable</td>
<td>Variable</td>
</tr>
<tr>
<td>Breast growth</td>
<td>3–6 months</td>
<td>2–3 years</td>
</tr>
<tr>
<td>Decreased testicular volume</td>
<td>3–6 months</td>
<td>2–3 years</td>
</tr>
<tr>
<td>Decreased sperm production</td>
<td>Variable</td>
<td>Variable</td>
</tr>
<tr>
<td>Thinning and slowed growth of body and facial hair</td>
<td>6–12 months</td>
<td>&gt; 3 years</td>
</tr>
<tr>
<td>Male pattern baldness</td>
<td>No regrowth, loss stops 1–3 months</td>
<td>1–2 years</td>
</tr>
</tbody>
</table>

A: Adapted with permission from Hembree et al. (2009). Copyright 2009, The Endocrine Society.
C: Estimates represent published and unpublished clinical observations.
Framework for a Transgender Treatment Program: WPATH Guidelines, Endocrine Society Guidelines

www.wpath.org

www.endo-society.org
Creating an Inclusive Environment: Education
Medical Education

• In the last two decades, the time allotted for teaching LGBT-related topics has increased from a mean of 2 to 5 h in the USA.

• Medical school may be an ideal place for interventions to reduce bias because students are exposed to diverse patients as well as the opinions, attitudes, and behaviors of faculty who impart on students professional norms and expectations, reflecting their biases.

• Medical schools are committed to educating students about the potential impact of bias meanwhile there is little focus on sexual minorities at risk for disparities and no consistent approach.
Medical Education

• There is a dearth of information in medical school curricula about LGBT health and very little cultural competency education that considers the experiences of these stigmatized minority groups.

• The amount of contact with sexual minorities has predicted reduced implicit bias, and favorability was associated with reduced explicit bias against gay and lesbian people, reaffirming prior research showing that contact reduces negative attitudes about sexual minorities.

• Interventions should also include fostering an environment where sexual minority faculty and students feel they can disclose their sexual orientation.

Obedin-Maliver J et al. 2011
Phelan et at 2017
Medical Education

• While it is important to train students, it is equally important that attention be paid to training faculty, residents, and other clinical staff.

• If role modeling is lacking and more senior clinicians are not in support of what students have learned, it will be difficult for students to implement these skills into patient care during clerkships and residencies.
Medical Education

• 2011 study of 132 medical schools
  • Average of 5 hours of LGBTQ related teaching
  • Most covered half or less of the topics described as essential

• 2014 study of ER Residencies
  • 45 min per year on LGBT health instruction

Sawning S, et al. 2017
Implementing Curricular and Institutional Climate Changes to Improve Health Care for Individuals Who are LGBT, Gender Nonconforming, or Born with DSD

A Resource for Medical Educators

AAMC 2014

• Education on the health needs of the LGBTQ population and the role medicine has in supporting them

• Providing medical schools suggestions on how to integrate this content including sample clinical scenarios and talking points

• Provide way to assess learners, curricula, and institutions including professional learning competencies:
  • Patient Care, Knowledge for Practice, Practice-Based Learning and Improvement, Interpersonal and Communication Skills, Professionalism, Systems-Based Practice, Interprofessional Collaboration, Personal and Professional Development
Ways to create an inclusive environment

• Institutional Engagement
• Inclusive nondiscriminatory policies and practices
• Celebrating Diversity
• Community outreach
• Advocating for changes in curriculum
• Welcoming patient care environment
Barriers to implementing

• Time- curricular overcrowding and lack of instructional time
• Faculty- lack of faculty expertise, discomfort with topic, additional training requirements
• Resources and institutional commitment

Sawing S, et al. 2017
Online Programs

• University of Louisville

• Online Certificate Program of 11 sessions:
  • LGBT Community Member Panel
  • Leader’s role in Addressing LGBT Health
  • Working with LGBT Pt
  • Making your practice LGBT Affirming
  • Culturally Competent Care
  • Health Disparities
  • Taking an Inclusive History
  • Transgender Health
  • Mental Health
  • Meeting the needs to Bisexual Pt

Sawning S, et al. 2017
Results

• Baseline knowledge gaps
• Improved attitude and awareness
• Limitation: lack of clinical skill practice, extra added work
• Strength: help to overcome challenge of finding a local expert, or time to integrate into curriculum
Sexual History Taking Barriers

• Inadequate training
• Time constraints
• Lack of understanding about the importance of sexual health issues
• Lack of awareness of prevalence
• Lack of comfort
• Personal bias
• Patient age
• Lack of treatment options

Hayes et al, 2015
Suggested Ways for Improvement

**Methods**
- Welcoming culture at institutions
- Specific curriculum on LGBTQ related health and disparities
- Increased clinical exposure

**Format**
- Standardized Pt Interviews
- Lectures
- Video examples
- Patient panel discussions
- On-line modules
- Role Modeling

Hayes et al, 2015
Methods of Improving Biases

• Formal Curriculum
  • Lectures combined with standardized patients

• Community based service

• Diversity within the school/program

• Faculty Role Modeling
  • Both positive and negative
  • Witnessing faculty make negative comments and discriminate sexual minorities reduced bias

Phelan et al. 2017
Pre-Clinical Cultural Sensitivity Panel

Panelist

- Dr. Clinton Brown - the Afro-Caribbean community
- Dr. Monica Sweeney – Older adults
- Dr. Hector Ojeda-Martinez – HIV+ and LGBTQI+ patients
- Dr. Teresa Smith – the ED & patients with sickle cell disease
- Dr. Ramon Gist – pediatrics and young folks
- Rabbi Holzman – the Orthodox Jewish community
- Imam Rashid and Omar Mousse – the Muslim Community
- Shante Austin - the Transgender community
- Mabei Martinez – People with disabilities

Courtesy of: Tonya Taylor, PhD
Creating an Inclusive Environment: Clinical Experience
From Entrance to Exit

• Signage, Posters
• Magazines
• Gender neutral bathrooms
• Nondiscrimination policy
• Intake Forms
• Patient Interview
Modifying Intake Forms

• Inclusive choices
• Blank spaces instead of “other”
• Gender identity
• Sexual orientation
• Relationship status (Marital status)
• Living environment
• Parent/Guardian
• Gender neutral language
• Preferred pronoun
Intake Forms - Online Options

Non-inclusive

- New Adult Packet - FEMALE
- New Adult Packet - MALE
- New Child/Adolescent Packet - FEMALE
- New Child/Adolescent Packet - MALE

More Inclusive

- CLIENT INTAKE FORM
- FINANCIAL AGREEMENT
- OFFICE POLICIES AND PROCEDURES
- ADOLESCENT INITIAL EVALUATION FORM
- MINORS IN MENTAL HEALTH THERAPY
- ADULT INITIAL EVALUATION FORM
**New Patient Intake Form**

Answer all questions as they apply to you. This form will be added to your medical record.

---

**For women only:** Date of last menstrual period ________ Are you currently pregnant or do you think you might be pregnant? ( ) Yes ( ) No. Are you planning to get pregnant in the near future? ( ) Yes ( ) No

Birth control method __________________________

How many times have you been pregnant? ________ How many live births? ________

Do you have any concerns about your physical health that you would like to discuss with us? ( ) Yes ( ) No

Date and place of last physical exam: __________________________

---

<table>
<thead>
<tr>
<th>Urologic/Gynecologic</th>
<th>Painful urination or urinary frequency</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Do you have penile or vaginal discharge?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Any breast pain, lump or discharge?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Have you had recent changes with your menstrual period?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>What was the date of your last menstrual period?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- [ ] Yes  - [ ] No
- [ ] Yes  - [ ] No
- [ ] Yes  - [ ] No  - [ ] N/A
- [ ] Yes  - [ ] No  - [ ] N/A
# BACKGROUND AND CONTACT INFORMATION

**Patient’s Name:**

<table>
<thead>
<tr>
<th>First</th>
<th>Middle</th>
<th>Last</th>
</tr>
</thead>
</table>

**Date of Birth:**

Month / Day / Year

**Gender:**

- [ ] Male
- [ ] Female

---

**Legal Name***

<table>
<thead>
<tr>
<th>Last</th>
<th>First</th>
<th>Middle Initial</th>
<th>Name used:</th>
</tr>
</thead>
</table>

**Legal Sex (please check one):**

- [ ] Female
- [ ] Male

*While Fenway recognizes a number of genders/sexes, many insurance companies and legal entities unfortunately do not. Please be aware that the name and sex you have listed on your insurance must be used on documents pertaining to insurance, billing and correspondence. If your preferred name and pronouns are different from these, please let us know.

**Pronouns:**

---

<table>
<thead>
<tr>
<th>11.) What is your gender?</th>
<th>12.) What was your sex assigned at birth?</th>
<th>13.) Do you identify as transgender or transsexual?</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] Female</td>
<td>[ ] Female</td>
<td>[ ] Yes</td>
</tr>
<tr>
<td>[ ] Male</td>
<td>[ ] Male</td>
<td>[ ] No</td>
</tr>
<tr>
<td>[ ] Genderqueer or not exclusively male or female</td>
<td></td>
<td>[ ] Don’t know</td>
</tr>
</tbody>
</table>
Sex (m/f):    Grade of School: 
Mother’s Name and Occupation: 
Father’s Name and Occupation: 
Parents are (circle):    Married    Separated    Divorced    Living Together    Other: 

Date of birth: _____ / _____ / _____    Age: _____    Number of siblings: _____    Sibling ages: ________________________________

Parent’s name: ____________________________________________    Parent’s name: ____________________________________________

Home phone: (____)__________________________    Other phone: (____)__________________________

Legal Guardian: ____________________________    Legal Guardian: ____________________________

DOB: ____________________________    DOB: ____________________________
Patient Interview

- Ask open ended question
- Avoid Assumptions
- Open-minded
- Empathy
Assessing Identity

• Do not assume gender identity:
  • Male or female? **NO**
  • How do you define your gender? **YES**

• Do not assume pronoun preference:
  • She / He: **NO**
  • What pronouns do you prefer? **YES**

• Do not assume sexual orientation or sexual attraction:
  • How many current female and/or male partners do you have? **NO**
  • How do you define your sexual orientation? **YES**
  • Do you feel attracted to men, women, both or neither? **YES**
Social History

• Do not assume the role of the companion:
  • Is this your wife/husband/ mother/ father? NO
  • Who have you brought with you to the visit? YES

• Do not assume relationship status:
  • Do you have a wife/ husband? NO
  • Are you currently in a relationship? YES
  • Do you have a significant other? YES
    • What do you call your significant other? YES

• Tell me about who makes up the people you consider your family? YES
• Who are the people you turn for support? YES
• Are there people in your life who are not supportive? YES
Sexual History

• Can you describe the sexual aspect of your life with your partner or partners?
• Do you have any concerns or questions about your sexuality, sexual orientation or sexual desire?
• Have you had any sexual contact in your lifetime?
• When was the last time you were sexually active?
• Can you tell whom you are attracted to?
Summary

• There has been improvement in addressing LGBTQ need and health disparities in recent years but there is still significant ways to go

• The LGBTQ is at higher risk for several medical and psychiatric conditions which are in part due to the fear of being discriminated against during their appointment

• Education should start in medical and continue through residency

• The use of several methods of education is important. These include: lectures, patient interactions, and modeling behavior

• In addition, clinical spaces and forms should be LGBTQ inclusive to create a welcoming and open environment
References

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