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RESEARCHERS' CORNER

ADVOCATING FOR LGBTQ+ HEALTH AND WELL-BEING: FROM THE CLINIC TO THE STREETS

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Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ+) persons and communities encompass all races and ethnicities, religions, and social classes. They exist in every corner of the world and deserve the same rights and privileges as any of our other patients. However, laws and regulations continue to undermine their personhood and threaten their daily and long-term well-being. Preceding the 2022 SGIM Annual Meeting in Orlando, Florida, Governor Ron DeSantis signed House Bill 1557, the Parental Rights in Education Act commonly known as the "Don't Say Gay" bill. This and similar laws target LGBTQ+ youth by prohibiting classroom discussion about sexual orientation or gender identity and eliminating any opportunity for youth to seek support in schools related to sexual orientation or gender identity. Further, these laws put LGBTQ+ youth at risk by requiring school officials to inform parents of when youth come out at school. These laws not only restrict freedom of speech but also remove the autonomy of youth and can have long-standing detrimental effects on their mental and physical health. Our concern is that the reach of sweeping policies, such as HB 1557, extends beyond the borders of an individual state. For example, when gay marriage was legalized at the federal level, there was a reduction in high school student suicide attempts. This reduction was most profound among sexual minority students, but the trend was notable in all students.[1] Adolescence is a critical period of identity building. Allowing youth to explore their identity in an inclusive and accepting environment can only benefit them. The message should be, "you are loved, no matter who you turn out to be." Further, limiting discussion of sexual orientation and gender identity worsens stigma against LGBTQ+ people, which can result in physical and mental health consequences. Being told that one's identity can

> Through new research, education, and advocacy at local, state, and national levels, and by advancing the future of health care for #LGBTQ+ communities, we can maintain the energy from #SGIM2022 and create sustainable change in health care.

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FROM THE EDITOR

DIVERSIFYING OUR COMMUNITIES OF PRACTICE

Tiffany I. Leung, MD, MPH, FACP, FAMIA,
Editor in Chief, SGIM *Forum*

Although I didn't visit any amusement parks during the SGIM Annual Meeting in Orlando a few months ago, I distinctly recall a greeting that launched the end-of-night music, light, and fireworks show during an earlier visit in December: "*Ladies and gentleman, boys and girls…*" I was pleasantly surprised to hear, only one week before the annual meetings, that the greeting would be changed to be more inclusive and welcoming of "*dreamers of all ages*" and "*friends*." The change, albeit small, is one tangible and immediate way to ensure our words reflect our values.

In alignment with SGIM's anti-racism, diversity, equity, and inclusion commitments,[1,2] this month's theme issue of "LGBTQIA+, Sex, and Gender Minority Health" focuses on the health of gender diverse populations and sex and gender minority (SGM) populations. Particularly in light of several passed recent state laws that further marginalize—or even outright criminalize the facilitation of care for—some of these patient populations, SGIM members once again responded publicly to amplify the voices and needs of those in our care as physicians.

Unsurprisingly, this issue of SGIM *Forum* will not stand alone on this theme of LGBTQIA+ and SGM Health: sufficient submissions were received so that the July 2022 issue will serve as an ad hoc second issue on the theme. In this issue, readers can appreciate a diversity of articles, including reflections and learnings from the SGIM Annual Meeting #WeSayGay #WeSayTrans rally, activities of the SGIM LGBTQ Health Interest Group, lived experiences shared by a resident who identifies as lesbian and a chaplain who identifies as queer, a conversation with an SGIM leader who identifies as lesbian, and access a quick guide on gender-affirming hormone therapy in primary care.

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SGIM

THE RIGHT TO DO THE RIGHT THING

LeRoi S. Hicks, MD, MPH, FACP, President, SGIM

"I am proud of SGIM; we are a professional society full of doctors who must have the autonomy to provide equitable care for patients and improve the health and wellness of all we serve, regardless of how they identify or whom they love. I also support the many SGIM members who advocate for equity in career advancement opportunities for LGBTQ physicians. As SGIM President, I believe it is imperative that we do all we can as a society to support our community of clinicians, educators, researchers, public health advocates, and health system administrators promoting work to address the treatment and outcomes of the LGBTQ community."

As I practiced what I would say under my breath, I walked slowly toward the unit's nursing station, clenching my fists and taking deep breaths to calm myself. It was spring 1996, and I was an Internal Medicine intern in Massachusetts, struggling with how to navigate the conversation I was about to have. I had been caring for a man who was obtunded and clinically deteriorating from sepsis. The only person who had been regularly calling and visiting my patient now stood at the nursing station anxiously waiting to hear an update. This man wanted desperately to understand why the man he loved and lived with for more than 20 years was dying. At that point in my career, I had a few occasions where I was able to discuss a patient's disease course and prognosis with their spouse in the absence of having a documented health care proxy (HCP). But this time was different. Our hospital ethicist, who was seemingly as troubled as me by the disconnect between our procedures and our values, had just explained to me that I can only share news about my patient's condition with his legal spouse, children, or parents in the absence of an HCP. Faced with the fact that my patient clearly made a life with the man standing before me, I struggled with being advised to limit communication about my patient's care to the one person with whom he clearly chose to live his life. I felt as if I were contributing to stigmatizing their love, contributing further to the heartbreak of a man struggling with the loss of his partner, and that I was being unfair. I was devastated because that feeling was true; I had become part of a system that was reinforcing stigma and causing pain.

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Q & A WITH SGIM'S CEO AND LEADERS OF SGIM'S LGBTQ HEALTH INTEREST GROUP

Eric B. Bass, MD, MPH; Carl G. Streed, Jr, MD, MPH; Rita S. Lee, MD; Helene F. Hedian, MD; Christopher Terndrup, MD; Jenny Siegel, MD; Megan McNamara, MD

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EBB: What are the goals of the LGBTQ Health Interest Group?

IG: We believe that it is within the scope of general internal medicine providers to meet the specific health needs of the LGBTQ population. The LGBTQ Health Interest Group has four main goals: 1) prepare educational content on LGBTQ health issues for SGIM's national and regional meetings; 2) facilitate communication among members about clinical, research, and educational issues related to LGBTQ health; 3) respond collectively to events and policies affecting LGBTQ health and well-being; and 4) provide mentorship and networking opportunities for clinicians and trainees from all regions of the country.

EBB: What did the Interest Group do to bring more attention to LGBTQ health issues at SGIM's 2022 Annual Meeting?

IG: At the Annual Meeting, we partnered with the Health Equity Commission (coordinated by Marshall Fleurant) and the Health Policy Committee (chaired by Elizabeth Jacobs) to collectively respond to laws causing direct harm to LGBTQ youth and communities, notably Florida's HB1557 "Don't Say Gay" bill.[1] This law targets LGBTQ youth by restricting classroom discussion about sexual orientation or gender identity and eliminating the opportunity for youth to seek support in schools related to sexual orientation or gender identity. We shared how this and similar laws, such as legislation opposing critical race theory, are designed to further marginalize people. We also emphasized that physicians have a responsibility to advocate against any law that infringes on anyone's ability to thrive in their own identity. We identified information about local LGBTQ health resources to post on SGIM's web site and used social media to stimulate conversations about LGBTQ health issues and policies affecting the well-being of LGBTQ persons and communities. Our collective action garnered the attention of local news stations in Orlando, bringing attention to the fact that physicians do not support policies that harm the well-being of their patients. We greatly appreciated the support of SGIM leadership in promoting the event and were pleased to see more than 200 SGIM members join the photo rally. Together, we raised our voices in support of LGBTQ rights, chanting: "We say Gay! We say Trans!"

EBB: What do you advise SGIM members to do in response to legislation like Florida's bill that prohibits classroom instruction on sexual orientation or gender identity in elementary school?

IG: We advise physicians to respond to such laws that affect their patients' well-being. Although the bill recently enacted by Florida does not specifically target physicians, we believe it violates SGIM's core values and vision of a just system of care in which all people can achieve optimal health. We encourage members to voice their concerns about similar local, state, or federal policies that impose restrictions on free speech and evidence-based education about LGBTQ health. As physicians, we should be vigilant in objecting to policies that interfere with the patient-physician relationship, especially when it further marginalizes minoritized communities. We support SGIM's recent endorsement of statements by the American College of Physicians and Council of Medical Subspecialties objecting to policies that interfere with the patient-physician relationship.[2-3] We also believe that it is important to find ways to support our colleagues and their patients who live in places directly impacted by laws that violate our vision for a just system of care. To support such advocacy, we are preparing a template for writing a personalized Op-Ed article for a local audience. SGIM members can learn about further actions and opportunities to stay involved in LGBTQ health research, clinical care, education, and advocacy by going to GIM Connect and joining the LGBTQ Interest Group.

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SEVEN REFLECTIONS ON ORGANIZING A PHOTO RALLY AT AN ANNUAL SGIM MEETING

Christopher Terndrup, MD; Jennifer Siegel, MD; Carl Streed, MD, MPH, FACP; Marshall Fleurant, MD

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On March 8, 2022, a month before SGIM's annual meeting in Orlando, Florida, House Bill 1557 "The Parental Rights Educational Bill," also known as the "Don't Say Gay" bill, passed. The bill prevents classroom discussion about sexual orientation and gender identity, penalizes school districts, and is potentially costly to local school systems. The SGIM Planning Committee and SGIM leadership reached out to the LGBTQ Health Interest Group to help coordinate a response condemning this harmful legislation. After a flurry of e-mail communications, we quickly saw a small but powerful group interested in advocacy take the center stage at SGIM. We aim to share lessons learned from this experience to support other SGIM groups in their own advocacy work. In this current political environment, where state laws intend to impact the provider-patient relationship, these seven reflections may prove valuable in the future.

Relationships Matter

Prior relationships with advocacy groups, specifically "The Committee to Protect Healthcare," proved critical. Their experience in advocacy during the 2020 presidential election and George Floyd protests were fruitful and allowed for logistical support, media connections, and expertise. They provided amazing ideas and helped to increase the footprint of the social media blast. The use of white coats, buttons, hashtags, and pride flags all resulted from their prior experience.

Lean on Expertise and Collaborate across SGIM

The members of the LGBTQ Health Interest Group, Health Equity Commission and Health Policy Commission communicated frequently via email and conference calls. New ideas quickly surfaced and together we leveraged our collective experience in advocacy and relationships across SGIM. Allowing fluid communication with leadership, SGIM administrative staff, and members was critical to share ideas, anticipate logistical challenges and ensure amplification of information through SGIM. This truly illuminated the tremendous powers across the ranks of SGIM.

Get SGIM Leadership Support Early

While the Planning Committee had already expressed support, we found it meaningful to include SGIM Council and executive leadership in our planning. Monica Lypson, then SGIM President, and Eric Bass, SGIM CEO, communicated directly with our team and made sure to call out our efforts. They and their teammates were tremendously thoughtful, provided us a location to set up a rally, supported communication to other members about our photo rally, and confirmed a spot within the SGIM Plenary to promote our efforts.

Use GIMConnect and Twitter to Spread the Word

Leading up to the meeting, multiple e-mail reminders went to SGIM members via GIMConnect. As conference attendees will know, this changed the feel of the meeting as people from across the country brought LGBTQ "swag" to Orlando. Twitter and its hashtags helped to drum up additional energy for the photo rally, both before and after the event.

Be Prepared, but Be Flexible

Having people aware of the event and having their LGBTQ buttons on was the first step. The plan for a photograph opportunity, and having SGIM photographer present, went off well. However, as the size of the group grew, it became clear that announcements and a chant would be helpful to the success and meaning of the event. We rapidly shifted approach and added aspects as the event unfolded.

Assign Roles, even for a Part that May Not Happen

While the core planning group was in regular communication, we did not have a clear understanding of who

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Q & A WITH RITA LEE: SGIM LEADER IN LGBTQIA+ HEALTH

Christopher Terndrup, MD; Carley Little, MD

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Tell us something about you that most SGIM readers wouldn't know.

RL: I never actually set out to have a career in advocacy—it was actually something I stumbled into as somebody who identifies as a lesbian. I saw a clear gap in LGBTQ healthcare and education, and that's how I started doing this work. I am an avid gardener and enjoy rock climbing. My wife and I have 2 boys.

What career accomplishment would you say is most important to you?

RL: I will actually reference two things.
First is being a founding member of the UCHealth Integrated Transgender Program. Because of the known health disparities among gender diverse patients, it is critically important that we act to address these. We were not only able to create the clinic to provide direct care to patients and also have had downstream impact on the UCHealth System—implementation of SOGI (sexual orientation and gender identity) data collection in our electronic health record and training staff on being culturally responsive.

The other accomplishment, still in progress, is building the new Health Systems Science curriculum, with a dedicated health equity lens to it. Traditionally, LGBTQ content has been siloed into specific sessions. We are also intentionally integrating LGBTQ content into other domains—we have multiple cases integrating a diverse spectrum of LGBTQ identities across content areas. We don't just exist in an LGBTQ box, and this new curriculum will help trainees see that.

How did you get involved with LGBTQ Health? What were the steps that lead there?

RL: I came out when I was in medical school. I had a negative interaction at a healthcare visit, which made me feel shame. I wondered what it might be like for patients who were not in healthcare. I looked at our curriculum and noticed that there was no content on LGBTQ health so I decided to do something. I recommended that we include content and offered to help build it. They said yes—and that is where this ball started rolling!

Has medicine ever made you feel like you needed to hide yourself and your identity? How did you overcome that?

RL: Unfortunately, yes. When I was a medical student in the late 1990s, I remember overhearing residents making homophobic jokes about a patient with pneumocystis pneumonia. The way they implied that all patients with HIV must be gay or deserved their illness did not feel safe or nurturing to the patient or to myself.

I was not out during the residency application process—I feared I would not get a residency spot. When I arrived there, I knew it was important to come out to my colleagues. When I applied for a job after my chief year, I was intentional in my applications about what I wanted to do and who I was as a lesbian. I wanted to work at a place that would accept me for who I am. If they didn't want to interview me because of who I was, I didn't want to work there.

How do you think LGBTQ and allied providers can best increase representation in Medicine?

RL: Some of it relates to a new focus on holistic admissions into medical schools and residency programs, but also pipeline programs. LGBTQ individuals are still relatively invisible as a demographic. We don't yet have

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a place to identify SOGI data in the application process, so it becomes difficult to be intentional about recruitment and representation. It's hard to feel like you count if they don't count you.

Being able to count and be counted is a critical first step. From there, we can actually be intentional about including it as a dimension of diversity that adds value to Medicine and to health care in general.

How has SGIM helped you get to where you are today?

RL: Early in my career, someone handed off the LGBTQ Health Interest Group to me, one of my earlier leadership roles. It was a great way to get early leadership experience and network with individuals with similar interests. From there, we developed LGBTQ content for SGIM—I have learned a great deal from these folks. Many of us in the interest group have grown up together in our careers. It's especially helpful for those of us who may live in less LGBTQ-dense regions where our home networks are smaller. It is nice to have a space where you feel welcome.

How does it feel to have medical schools all over the country using your LGBTQIA+ curriculum?

RL: It is awesome that our MedEdPORTAL curriculum[1] was in the top 10 for 2021! It really feels good to know that this work is getting disseminated, and we are allowing schools lacking faculty expertise to teach this. To take what we built and to use it across the country feels amazing. The downstream impact will be huge—the number of students at each program, times the number of schools who use it, times the number of patients they will see—I'm in awe of the potential wide-ranging impact.

What keeps you going with so much to do—what keeps you from running out of steam?

RL: I do run out of steam every once in a while, but not very often. For me, it's intentional integration and overlap in the work (with clinical work, Health Systems Science, and HEAL) and doing work that is incredibly meaningful. I connect it to the impact that it can have in so many people's lives—it inspires me to continue moving forward. I also try to pace myself—I will continue to move forward, but don't have to solve it all at once. Racism has been around for hundreds of years, it's not going away overnight. It's the same for LGBTQ oppression. I enjoy teaming with people who have aligned interests and different skill set—it also allows the work to move forward and multiplies the impact. I also set boundaries so I can be present at work, present with my family at home. I practice gratitude every day.

What advice do you have for young physicians interested in medical education and mentoring, particularly in the LGBTQ+ spectrum?

RL: For students who identify as a SOGI minority, bring your authentic self to the work that you do if you can do so safely. It can be intimidating, it may be safer in some places than others, and it's liberating.

In being one of the first out faculty on my campus, people got to know me as an individual and that alone can change people's hearts and minds. It's also easier, emotionally, and cognitively, to focus on being a good student, physician, educator—rather than always worrying about what other people are thinking or saying.

For those interested in medical education or mentorship, don't be afraid to ask for what you need and take advantage of the opportunities that are out there. If there isn't a mentor who "does what you want to do," don't let it stop you. You can be the content expert and simultaneously leverage the skillset of someone else with a medical education background. I used "collateral mentors" to help with survey design, curricular design, and evaluation since no one was doing LGBTQ education at my institution at the time. Believe in yourself. I believe in you.

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SGIM

GENDER-AFFIRMING HORMONE THERAPY: LOWERING THE ACTIVATION ENERGY FOR HORMONES IN PRIMARY CARE

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Health care for transgender and gender diverse (TGD) people, referred to as *gender-affirming care*, includes hormone prescribing in the primary care setting per national and international standards of care. Benefits to integrating hormone prescribing with primary care include easier access to hormones for patients, as specialists in this area often serve large geographic areas and may have long wait times for appointments. Yet many primary care clinicians feel unprepared to initiate hormones or to continue an existing prescription for their TGD patients. As a result, patients may seek care at overloaded specialty clinics, take hormones without medical supervision, or be unable to access hormones altogether. Given the known benefits of gender-affirming hormone therapy,[1] delaying access can cause significant harm to patients.

Our hope is to make it easier for a motivated primary care clinician to grow their medical knowledge and clinical competency by providing a practical pocket guide. While the content in the *Quick Guide* is not unique, the way it is presented is novel and targeted for fast, at-the-bedside consultation. In this article, we describe our approach to creating a quick reference, including our process of consensus building, the challenge of synthesizing disparate guidelines, and how to measure the success of a reference tool. Each of the contributors to this guide is either an internal medicine physician with experience caring for the TGD community, a TGD-identified person, or both.

To start, physicians in our workgroup pooled their existing educational resources. Each of us had independently created presentations which we used for educational purposes institutionally, regionally, or nationally. Although there was a great deal of overlap in how we explained concepts to our learners, we benefited from seeing how our peers described fundamental concepts. Several contributors had also created their own cheat sheets for hormone prescribing based on existing guidelines and practice standards. Given our group mission of creating a quick reference, these were taken as the starting point for our hormone guide. We selected a checklist format to convey the material. Although individual patient factors dictate some variability in approach, hormone prescribing in general is an algorithmic process which we felt could be well-described via a checklist.

All contributors use an informed consent approach to hormone prescribing, which we describe and recommend in our *Quick Guide*. In an informed consent model, a patient who has the capacity to understand and make informed decisions for their health care can decide whether to take hormones based on a demonstration of their understanding of the risks and benefits. This approach is similar to how clinicians prescribe other medications. For example, when we prescribe statins to patients to reduce the risk of heart disease or stroke, we counsel that these medications may cause side effects, such as muscle

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problems or an increase in the risk of prediabetes or diabetes. Patients can decide for themselves whether the benefits of taking these medications outweigh the risks. We discovered some institutional variation in how informed consent is handled. Some institutions have a standard consent form for hormones while others used a verbal consent process—more similar to other medication prescriptions. In the *Quick Guide*, we advise each clinician to select the consent process that works best for their practice setting and potential regulatory environment.

We discussed in detail how much clinicians should ask patients about their experience of gender. In particular, we were concerned about the risks of medical voyeurism (e.g., having clinicians ask questions just because they are curious, not because it is important for a patient's care). We also wanted to prevent clinicians from burdening patients unnecessarily by asking to be educated about gender identity in general. TGD patients value when clinicians are motivated to learn about gender on their own and seek knowledge outside of the clinical encounter. Yet clinicians need some information to be able to document at least six months of gender incongruence and help achieve each patient's individual gender goals. As a result, we advised clinicians to ask specifically about patients' goals and expectations as they pertain to the impact of hormone therapy.

Another challenge we addressed was selecting hormone target ranges, as they differed among the five guidelines we consulted:

- *Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People*; 2nd edition
- *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline*
- *Comprehensive Guidelines for Hormone Management and Titration. Protocols for the Provision of Hormone Therapy*
- *TransLine Gender Affirming Hormone Therapy Prescriber Guidelines*
- *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People*, 7th edition

Links to each of the above resources are available in the *Quick Guide*. We note that the assays for hormone measurement vary by lab technique, timing of assessment, and test characteristics. A majority of group members used target ranges from the Endocrine Society[3] which was included in the *Quick Guide*. Some guidelines list higher targets, and lower targets might be appropriate based on individual patient goals. All contributors regularly check hormone levels to determine optimal dosing, although we weigh patient experience very heavily in guiding adjustments. This approach ensures patient safety while balancing patient experience.

Finally, we sought feedback on the *Quick Guide* from several TGD community members. Historically TGD people have been excluded from research about their own community, and so we felt soliciting input was particularly important. Those who contributed were named as work group members in acknowledgement of their efforts.

To introduce the *Quick Guide* to a larger number of interested clinicians, we printed pocket-size cards and distributed them at SGIM 2022. The guide includes a QR code and URL that directs users to a pdf version. To measure the effectiveness of our distribution, we are monitoring pdf downloads. We are also incorporating the guide in a medical education project. We will ask internal medicine residents if they would be more likely to prescribe gender affirming hormone therapy if they had access to a tool such as this. We look forward to sharing this data once it is available.

We acknowledge that hormones are only one aspect of gender-affirming primary care, and that not every TGD person will use hormones as part of their process of gender affirmation.[2] Additionally, the physiologic knowledge required to prescribe hormones, while important, is only a piece of gender-affirming primary care. The importance of humility and a compassionate, respectful approach towards patients cannot be overlooked. We hope the *Quick Guide* makes it easier for interested primary care clinicians to offer guideline-based care to TGD patients. And we strongly encourage clinicians to seek opportunities to connect, form relationships with, and learn from the larger TGD community.

The *Quick Guide: Gender Affirming Hormone Therapy by the Primary Care Provider* is available for download and printing from: https://bit.ly/GAHT-QUICK-GUIDE. The guide was created by Hedian H, Norwood A, Siegel J, Loeb D. Work Group: Streed C, Ufomata E, Tilstra S, Greene R, Tran P, Kwolek D, and Lee R.

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BEING KNOWN: SPIRITUAL HEALTH AND BLESSING FOR TRANSGENDER PATIENTS

Meredith Cox, MDiv, MA

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The first time I had my primary care appointment at the transgender clinic, I left feeling more at ease than I ever had before in health care. When the nurse called my name from the waiting room, it was without gendered honorifics. When she brought me to be weighed, the first question asked was, "What name do you prefer? What pronouns can I use for you?" When I met the doctor, she had no hesitation in welcoming my gender and sexuality, understanding without my instruction how to care for a nonbinary, queer person like me. At the time, I did not have the clarity I have now as to how I would utilize gender affirming care, but I knew that I was transgender and was hoping to find a doctor who understood me in the fullness of who I am. I wanted to be understood, and I was. Since that day, my doctor, the nurses, and the front desk staff of the transgender clinic continue to provide me with so much healing and possibility that for the first time in my life I feel in control of my health and at home in my body.

Years after that initial experience, it is now my privilege to serve as the chaplain for this clinic and for all LGBTQIA+ services of Vanderbilt University Medical Center. Because I have lived it too, I easily join the expressed gratitude of the patients I serve in this clinic. Many of them sought gender affirming care longer ago than I did, and they share of the difficulty of living without access to care. I have heard stories of how patients used to get their hormones from a veterinarian or from the internet. They share this memory in awe of what it is to receive safe care at a clinic where your whole self is honored and understood.

As the chaplain in this space, I get to bear witness and celebrate the joy when someone signs a consent form to begin hormone replacement therapy. I get to come alongside the everyday life experiences of loss, grief, depression, and family conflict that may be complicated by our transgender identities. More than once I have had a conversion with a transgender person full of regret. Their regret stems not from regret of transitioning but rather regret that it took them so many years of their life to accept themselves. My work with this person is sharing the knowledge that has been passed along to me that there are no missteps on this path. I cannot undo the past for this person, but I can claim with them that this present moment holds so much potential and possibility. Together we welcome the new. For another patient, they may be struggling with the religious teachings they held deeply for much of their life. Their faith tells them that being transgender is wrong, but every feeling in their body when they dress as themself and when they are taking hormone replacement therapy tells them that being transgender is deeply right for them. Here, my job as the supportive person is to affirm the knowledge within, in one's very own body, and to claim with them the goodness of self-acceptance.

Every part of the transgender journey is sacred to me because it is sacred to listen within and to discover what part of yourself needs to be made known. As a chaplain, I feel that it is my greatest honor to journey with someone to that inner space and to affirm with someone that truest form of self.

I deeply love my job, and I hope that more medical centers, hospitals, and clinics will hire chaplains like me trained in LGBTQIA+ spiritual and emotional support. But I am even more grateful that such an affirmation does not require a chaplain. Each of you, by committing to the work of understanding and affirming LGBTQIA+ people are planting seeds or watering what is already there for the transgender person to spiritually thrive.

When you advocate for us to receive fair and safe health care, you are tending to a spiritual need. When you correct yourselves and others when misidentifying a patient in name or in pronoun, you are enacting a justice, a right to a wrong. When you tend to the seasons of life transgender people face just like anyone else—grief, loss, new life, new opportunity—you are embodying spiritual healing. You and I both may not be able to heal in one

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A CALL TO ACTION: PROMOTING VISIBILITY, INCLUSION, AND EMPOWERMENT OF LGBTQIA+ MEDICAL TRAINEES

Subhashree Nayak, MD

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A Growing SGM Physician Workforce

Inclusion and empowerment of sexual and gender minority (SGM) medical trainees is integral to reducing health disparities of the LGBTQIA+ community. SGM medical professionals are more involved in academia and conduct more LGBTQIA+ health education, research, and community service than non-SGM counterparts.[1] Academic health centers have a social responsibility to inclusively recruit and foster positive climates for SGM health professionals and empower these professionals to pursue LGBTQIA+ scholarship. However, trainees and faculty found lack of mentorship, poor recognition of LGBTQIA+ scholarship, and hostile institutional climates to be significant barriers in their own academic careers.[1]

LGBTQIA+ identification is increasing amongst Millennial and Gen Z populations and concomitantly within our patient population and community of medical trainees.[2] In service of our ever-diversifying patients, it is now a professional expectation amongst physicians to provide sexual and gender diverse care in culturally competent ways. Institutions have responded with increased LGBTQIA+ health and health equity training. However, not much attention has been given to recruitment, retention, and empowerment of LGBTQIA+ medical trainees. Studies on underrepresented minorities in medicine (URM) and female medical professional participation have established that their inclusion and visibility results in more equity-based scholarship and improved population health outcomes in marginalized communities served by these physicians.

This perspective piece discusses processes for recruitment and retention of SGM medical students and trainee physicians and explores select strategies that medical institutions can adopt to better address the needs of this growing trainee population.

Improve Self-Identification and Support for SGM Medical Students

Medical schools have a responsibility to collect sexual orientation/gender identity (SO/GI) data that ensures privacy while explicitly stating institutional commitment to an inclusive learning environment. To recruit a representative physician workforce, medical schools must codify inclusive recruitment strategies. Allopathic medical schools employ the American Medical College Application Service® (AMCAS®) for medical school applications. As of 2022, there is currently no demographic data input to declare sexual orientation or gender identity (SO/GI) within AMCAS. Secondary applications sent after medical-school specific screening algorithms may or may not allow for applicants to provide SO/GI information.

During my own application cycle, I described my work in SGM equity as a motivation to pursue medicine as a lesbian, South Asian woman. Without a demographic input to identify SO/GI, I felt my lived experience as a SGM would not have been accounted if it had not related to my professional work. This is still the current system in place and SGM trainees are potentially constrained in a scholarly capacity if their principal mechanism to be "professionally out" is to conduct scholarship or activities for LGBTQIA+ communities. This also reinforces false stereotypes regarding the SO/GI of professionals who conduct LGBTQIA+ scholarship. Relying primarily on subjective, narrative mechanisms (e.g., application essays) to recruit SGM trainees is inadequate and opt-in SO/GI self-identification within AMCAS would present a more equitable mechanism. However, AMCAS demographic data without institutional privacy commitments are insufficient as SGM applicants often possess legitimate fear that SO/GI identification may not remain private or potentially harm to their application, even if it is optional. Therefore, medical schools also need to adopt policies that ensure opted-in applicant privacy and eliminate negative impact of SO/GI to a student's application. The anonymous AAMC Graduation Questionnaire, tendered in a medical student's fourth year after matching into residency currently provides some of the most robust SO/GI medical student data available. This survey illustrates how privacy curtails the threat of institutional bias and

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SIGN OF THE TIMES *(continued from page 5)*

would do what. Reflecting, the event would have benefited from a clear division of labor, including someone to own the chant #Wesaygay and #Wesaytrans, and another person to formally talk with news media. While we did not expect these to happen, assigning roles "just in case" would have made us feel even more prepared. Nevertheless, one of our strengths was having multiple SGIM leaders involved.

Make Everyone Welcome, Particularly Trainees

The biggest success was its size, allowing everyone to feel welcome and truly magnifying the support with SGIM for this important event. The power of numbers was important to getting media attention and spots on the local channel 9 and nearby West Palm Beach.[1] Most important, knowing that someone just being present as an ally was meaningful. As all SGIM members know, there is power in our trainees and making sure they were welcomed, included, and knew that the right hashtags increased the impact of the event.

In the end, we managed to get more than 200 members (close to 10 percent of the conference's total registration) to join us outside for the photo opportunity. Though anxious about being interviewed by news media, we came together for a successful advocacy event. We reflect on one of the meeting's amazing plenaries on the intersection of Public Health and Medicine, seeing a clear avenue for us as physicians into a usually murky policy realm. And, as Dr. Prothrow-Stith shared from the teachings of Rosa Parks, "You must never be fearful about what you are doing when it is right." As state laws continue to impact marginalized populations and interfere with healthcare for our patients, we hope these reflections can help other SGIM members in their pursuit of what is right.

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PERSPECTIVE: PART I *(continued from page 10)*

interaction the religious or spiritual trauma someone may have already experienced, but together we can write a new story of possibility for spiritual and emotional health. Together, we can promote wholeness.

My heart's intention for this article is to offer my deepest gratitude and thank you to every provider striving to make healthcare more accessible and welcoming to LGBTQIA+ people. It may feel small sometimes, it may feel impossible other times, but what you do in caring for our whole selves saves lives and enriches what it is to be alive and transgender. It is sacred work that you do—healing not just the body but the soul—making it possible for us to welcome ourselves home.

Every one of us has this opportunity to change a life. Transgender people deserve just as much care, devotion, and thoughtfulness as every other patient who walks through our doors. Will we meet them with joy? Because when we do, what we offer is the truest form of blessing: to be known.

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PERSPECTIVE: PART II *(continued from page 11)*

results in more representative data collection. Medical schools must accordingly provide secure mechanisms for SGM trainees to self-identify.

Medical schools should establish and support LGBTQIA+ Medical Student Groups as vehicles of equity in scholarship, education, and community for SGM medical students. Once medical students have enrolled, institutions can display their commitment to an equitable learning environment by strengthening LGBTQIA+ Medical Student Groups. During my medical school, there were specific conference funds available for Women in Medicine and SNMA student conference attendees. However, there was no funding allocated specifically for LGBTQIA+ conferences which reflected institutional divestment from LGBTQIA+ scholarly activities. LGBTQIA+ medical student groups often lack the institutional backing that is standard amongst other diversity-oriented groups. For example, Student National Medical Association (SNMA) has a mission of increasing URM representation in medicine and is strengthened through its national structure, including involvement of students in regional and national meetings. Many medical schools have specific financial commitments to their SNMA chapters. Similarly, national professional conferences exist for SGM trainees and physicians (e.g., GLMA) and medical schools must empower medical student groups and SGM students to participate in LGBTQIA+ scholarship.

Medical schools should strengthen zero-tolerance policies on harassment and maltreatment of SGM students, with equitable resources available for individuals who have been affected by SO/GI-based bias

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harm others, to the point that it cannot be spoken out loud, represents a clear attack on these already vulnerable communities.

The 2022 Annual SGIM Meeting was scheduled to take place in Orlando, Florida, just one month after Governor DeSantis signed HB 1557. Thus, many SGIM members immediately began grassroots organizing to show their support for LGBTQ+ youth, families, and communities in Florida and beyond. Under the leadership of Drs. Marshal Fleurant, Jenny Siegel, and Chris Terndrup, a coalition of the LGBTQ+ Interest Group, the Health Equity Commission, and the Health Policy Commission was formed to rapidly prepare more public responses during the 2022 SGIM Annual Meeting. The efforts of hundreds of SGIM members culminated in a massive public demonstration following the Friday plenary session in which hundreds of SGIM members showed up and demanded LGBTQ+ youth and their peers be afforded the protections and right to a safe learning environment. These efforts, while covered by local news media, are only one of many steps in taking action to ensure LGBTQ+ youth, families, and communities are allowed to not only survive, but thrive.

As general internists, our advocacy for patients cannot end at the exam room door or hospital entrance. We must leverage our privilege and power to inform policies that affect individual and population health. While more than a dozen other states consider similar harmful laws, we are called to the streets and legislative chambers to stand with and fight for our colleagues, patients, and communities.[2] The following are recommendations on ways each of us can work to protect LGBTQ+ people.

Individual

- Understand the current and historical health disparities experienced by LGBTQ+ people
- Leverage your privilege and resources to advocate for laws which protect LGBTQ+ people
- Examine your own implicit biases and assumptions
- Support organizations supporting LGBTQ+ rights such as the Human Rights Campaign

Interpersonal

- Include your pronouns when you introduce yourself to new patients, and ask each patient for theirs; share them in e-mail signatures
- Ask open-ended questions and use gender-inclusive language (e.g., partner or spouse)

Community

- Partner with local and national organizations to advance protections for LGBTQ+ people
- Engage with local community organizations, outreach to local schools/communities for health education

Organizational

- Build a coalition within your organization to enact policies which protect LGBTQ+ people and their partners and families
- Form a patient and family advisory council comprised of LGBTQ+ community members to solicit feedback on making your clinic a more welcoming space
- Routinely asking patients regarding sexual orientation and gender identity (SOGI) on intake forms, and ensure forms use inclusive or gender-neutral language
- Openly display non-discrimination statements
- Ensure posters, flyers, and brochures are inclusive of LGBTQ+ people
- Advocate for documentation in Electronic Health Record which acknowledges sexual orientation and gender identity and prioritizes usage of correct name
- Advance quality improvement with an equity lens through inclusion of sexual orientation and gender identity
- Work with medical educators to integrate LGBTQ+ topics throughout medical training using the Association of American Medical Colleges (AAMC) Advisory Committee on Sexual Orientation, Gender Identity and Sex Development's guide: *Implementing Curricular and Institutional Climate Changes to Improve Heath Care for Individuals Who are LGBT, Gender Nonconforming, or Born with DSD*[3]

Structural

- Advocate for the elimination of regressive laws that cause harm and propagate stigma
- Enact protections for marginalized populations such as gender-neutral restrooms in public spaces, anti-bullying laws, anti-discrimination in housing and employment laws
- Advocate for enhanced training for law enforcement
- Support laws requiring inclusion of gender affirming care as standard part of insurance coverage including gender affirming surgery
- Ensure access to necessary care across the lifespan, including gender-affirming care
- Inclusion of SOGI in registries/other large databases (e.g., SEERS, CAHPS, etc.)
- Advocate for the inclusion of LGBTQ+ Health topics in LCME/ACGME requirements

We recognize that some of these steps are small and some of them are large. Some can be done in an afternoon while others will take months of coalition-building and advocacy to reach fruition. Many will require the support of institutional leadership to make a reality, and engaging stakeholders at multiple levels will be a crucial step to make progress. But these harmful policies affect

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> **"The future of our healthcare system will have more LGBTQIA+ patients and providers, and institutional changes are necessary to accommodate this shift."**

and stigma. Institutions have a responsibility to establish safe learning environments for all learners. The AAMC Graduation Questionnaire in 2016-17 showed that SGM students experienced 50% or more mistreatment—including humiliation and mistreatment specific to gender, race/ethnicity, and sexual orientation—compared to non-SGM peers.[3] Thus, SGM medical students are set up to begin their careers as physicians with substantially more burnout than non-SGM peers. Institutions should address factors that exacerbate the stigma and minority stress experienced by SGM medical students including lack of mental health infrastructure and presence of SGM faculty in the evaluation of discriminatory conduct against SGM students.

Strengthen Inclusive Climate, Education, and Mentorship for SGM Residents and Fellows

As a standard, residency and fellowship programs should outline SGM-relevant institutional policies that provide benefits and protections for SGM physicians, and/or highlight institutional-level advocacy on behalf of SGM physician employees. Amongst SGM physician trainees, choosing residency and fellowship includes special social and economic considerations such as institutional protections of employment for SGM employees or medical benefits such as hormone therapy or fertility treatment.[4] SGM trainees are aware of historical inequities and conduct exhaustive online research seeking inclusive workplaces that have defined policies of protection and empowerment. Currently, competitive residencies delineate these within their recruitment.

Academic health centers should develop LGBTQIA+ clinical experience and incorporate the experiences and expertise of SGM physicians in the design of these rotations. Although not available at the start of my residency, an LGBTQIA+ elective is currently in the final stages of implementation at my institution. My involvement in curricular development was invaluable as a trainee, and ingrained that both established LGBTQIA+ curriculum and the process curriculum development have positive impacts on SGM residents. Overall, graduate medical education has a vested interest of including SGM physician voices when developing LGBTQIA+ clinical experiences this process exhibits institutional commitment to equity-based work and holistic education.[4,5]

Academic institutions should develop SGM mentorship infrastructure to improve institutional inclusion and encourage interprofessional collaboration in LGBTQIA+ health equity-based work. Strengthening institutional commitments to LGBTQIA+ mentorship and scholarship is integral to the professional development of SGM trainees. SGM physicians cite strong mentorship programs as an important factor enabling collaborative scholarly activities and equity work and generating more inclusive institutional cultures.[5] One barrier can be low numbers of openly identified SGM faculty, particularly within concordant specialties to the SGM residents. However, interprofessional collaboration can often be advantageous in equity-based scholarship. I experienced SGM mentorship through involvement in my house staff union, where cross-specialty engagement with SGM faculty was encouraged. In many institutions, SGM-specific mentorship is informal and lacks the structure and resources for success. There is institutional incentive to foster these collaborations, as they often lead to equity-based scholarly activities and community service.

A Vision for SGM Medical Trainee Inclusion

These recommendations demonstrate a vision of equity for SGM physicians. The recruitment, retention, and empowerment of SGM trainees and physicians is a necessary step to establishing a more equitable workplace environment in medicine and addressing looming systemic health disparities facing the SGM community. The future of our healthcare system will have more LGBTQIA+ patients and physicians, and structural changes are necessary to accommodate this shift.

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PRESIDENT'S COLUMN *(continued from page 3)*

In 2003, seven years after caring for my dying patient, the Massachusetts Supreme Judicial Court allowed same-sex couples the right to civil marriage, helping to clear the path toward guaranteeing same-sex couples the fundamental right to marry.[1] As I thought about the theme for this issue of the *Forum*, I reflected on the time prior to marriage equality and my personal experiences caring for patients in a system that asked physicians to provide inequitable care that dehumanized and marginalized patients. To be clear, SGIM has a commitment to assuring that all our members feel supported in their ability to practice medicine in an equitable fashion for all populations they serve.

Recognizing that LGBTQ populations are: (1) at increased risk of victimization through interpersonal violence, (2) more likely to report suicidality and a higher prevalence of poor mental health, (3) at a higher risk of cardiovascular disease and obesity, (4) disproportionately impacted from several forms of cancer and (5) more likely to report experiencing health care-related discrimination and delays in care, I am concerned about consistent, increasing political efforts that may further exacerbate these disparities.[2-5] As physicians, we *cannot* be complicit in perpetuating injustice. SGIM must also support our providers to do what is right for their patients.

I am proud of the SGIM membership and believe we are a professional society full of doctors who must have the autonomy to provide equitable care for their patients and improve the health and wellness of all we serve, regardless of how they identify or whom they love. I also support the many SGIM members who advocate for equity in career advancement opportunities for LGBTQ physicians. As SGIM President, I believe it is imperative that we do all we can as a society to support our community of clinicians, educators, researchers, public health advocates, and health system administrators promoting work to address the differential treatment and outcomes for members of the LGBTQ community. This issue of *Forum* represents and example of why our members make me proud.

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us personally and professionally—namely, our families and friends and the health and safety of our patients. Stand up, walk out, speak up. Take a stand with us.

As SGIM members step away from our meeting on Discovery, Equity and Impact, we encourage all to consider these steps as crucial to all dimensions of your careers in General Internal Medicine. Through new research and education approaches, through advocacy at local, state, and national levels, and by advancing the future of health care for LGBTQ+ communities, we can maintain the energy from our meeting in Orlando and create sustainable change in health care.

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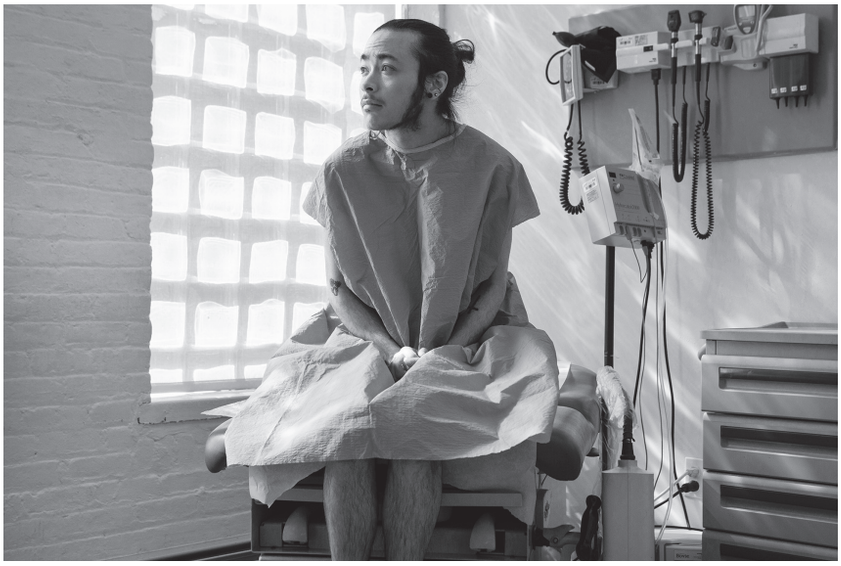

Helene Hedian, MD, selected and shares a visual aid from a freely available photo collection of gender-diverse individuals, available at https://genderphotos.vice.com/.

Marshall Fleurant, MD, Christopher Terndrup, MD, Jennifer Siegel, MD, and Carl Streed, MD, MPH, FACP, are interviewed by a Florida news station during the SGIM Annual Meeting #WeSayGay #WeSayTrans rally.

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