

## FROM THE EDITOR

### Welcome to the LGBT Theme Issue

**With this issue of *Forum*, SGIM members reaffirm their commitment to just, equitable, patient-centered health care for all regardless of race, ethnicity, or gender identity. We would like to give special thanks to LGBT Health Interest Group leaders Rita Lee, MD, and Doug Olson, MD, for their contributions and guidance in planning this important issue. Be sure to visit <http://www.sgim.org/publications/sgim-forum/current-issue> for supplemental content. As always, we look forward to hearing your feedback.**

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## To Frankie

Karen R. Horowitz, MD

"Hello, doctor."

The softly voiced greeting was a startling contrast to the prominent Adam's apple from which it emanated as I entered the exam room. The pink floral bandana could not conceal her balding temples. Tattoos embellished rippling forearms, bearing witness to a distant time, place, and person. But it was her eyes—angry, defiant, and oh so sad—that revealed her pain. It was her dark questioning eyes that pierced my thoughts and exposed my 27 years of inexperience for what they were.

So began our first meeting "to establish care" in the Women's Primary Care Clinic, each assuming her role in the stylized dance of the clinical encounter. Although the words were the same as always, the unspoken meanings were uniquely clear to both of us. Like a hawk she scrutinized my words, ready to pounce on a misplaced pronoun, a faux pas with which I eventually obliged her, triggering an outpouring of pent up fury. Apology. Recant. Start again. HPI... PMH... ROS... SH... give and take, trust and mistrust, fear and hope, need and dread. Perhaps dread was the one thing we agreed upon that day.

She challenged me in every way she could—pronouns, pain meds, estrogen renewals, a benign penile lesion requiring immediate examination and reassurance. Then came the anger and the sadness as she described her broken marriage and children estranged from their father. Slowly the anger melted. Somewhere in the stories emerged an understanding, a shared purpose, and the glimmer of trust that made it bearable for each of us. We found our way to shared goals for the encounter and a short-term plan for her health care.

I was not unflappable at that first visit, but I knew what to do. As I dutifully renewed prescriptions one by one—estrogen... spironolactone... finasteride... tamsulosin—I felt the presence of my teachers and mentors guiding me through this uncharted territory. I thought of Gloria Roblin,<sup>1</sup> whose candid and purposefully challenging (sometimes shocking) lectures on sexuality were more about identity and meaning than about reproduction. I thought of Aaron Lazare,<sup>2</sup> whose insights on the significance of words to hurt or heal and the power of apology have informed a generation of clinicians and patients alike. I thought of Ray Mayewski,<sup>3</sup> who taught me that sometimes the best we can offer is the support to help patients live the fullest lives they can with the health problems that they have. I thought of Bill Branch<sup>4</sup> and his lessons on personal narrative as a tool for finding meaning in the work we do. And I thought of Sam Putnam<sup>5</sup> who, by example, taught the power of kindness to heal invisible wounds.

To Gloria, Aaron, Ray, Bill, and Sam and to clinician-educators everywhere: Thank you for what you do. Your lessons endure. They shape my practice and inform my clinical teaching. You are remembered, and your lessons will continue to guide future generations of physicians.

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# Creating an Affirmative Environment to Provide Access to Quality Care for LGBT People

Harvey J. Makadon, MD; Douglas Olson, MD; and Adrianna Sicari, MPH

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While the rights of lesbian, gay, bisexual, and transgender (LGBT) people have come into greater focus in recent decades, attention to the need for equitable health care has been more recent. This increased recognition was fueled in part by evidenced-based documentation of health disparities among LGBT people (discussed elsewhere in this issue of *Forum*). These disparities were highlighted in Healthy People 2020, which documented unique health issues in the LGBT community, and the Institute of Medicine's report *The Health of Lesbian, Gay, Bisexual and Transgender People: Building a Foundation for Better Understanding*, which was commissioned by the National Institute of Health and published in 2011. This report not only detailed what we know about LGBT health disparities but also discussed their etiology based in stigma and discrimination, including bias in health care and lack of data and education about LGBT health needs throughout our health

care system. To improve care, we must create welcoming environments for affirmative and inclusive care that recognize the great diversity of LGBT people. Three areas, listed below, are worth considering.

*Ending LGBT invisibility.* Ending LGBT invisibility is critical. Greater awareness of LGBT people through the media has helped us move toward erasing traditional stereotypes and has demonstrated the importance of approaching all people without assumptions or judgments. This is particularly true in health care. If we are going to provide quality care for LGBT people, it is critical that providers and patients openly discuss sexual orientation and its dimensions of identity, behavior, and desire as well as gender identity. There are many ways to accomplish this. For many, a routine visit starts with a statement such as "tell me about yourself," which may open an opportunity for self-disclosure assuming the environment embraces an openness to diversity that includes LGBT people. In addition, we have to spend more time ensuring that we ask our patients about their history of sexual health in ways that go beyond risk behaviors and allow safe discussion of sexual orientation and gender identity. It may help to offer structured opportunities for patients to provide this information electronically either through a patient portal or at the time of registration using structured questions in the electronic health record. These approaches are being tested at a number of organizations and have been endorsed by the Institute of Medicine and The Joint Commission. Having these data not

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## Meeting Bill Again

William P. Moran, MD, MS

Bill's life experience now drives his passion to undo the impact of disparities, irrespective of age, race, ethnicity, or sexual preference.



I was going into a noon conference presentation for a new potential recruit when I heard a voice with a heavy Boston accent say, "You don't remembah me, do yah? We were at Saint Mahgahret's togethah." We shook hands—I remembered his name, but of course we both had changed in the intervening forty-something years. I struggled to picture Bill as he had been in the second grade when our teacher Sister Elizabeth asked, "Who is your best friend?" I chose Bill, and Bill chose me. All told, we spent six years together at a Catholic elementary school in an inner-city neighborhood. I lost touch with Bill when I transferred from St. Margaret School to begin the seventh grade at another school. My subsequent life path was similar to many readers of *SGIM Forum*—high school, college, medical school, residency, fellowship, marriage, children, and a career in academic medicine.

Bill's path was different. Bill grew up in the same world of "traditional" Catholic values and rigid Irish beliefs, but Bill was gay. Bill was taunted by classmates, called names, and treated brutally by other adolescents. He was rejected by his father and ran away from home. He dropped out of high school. For a while he lived on the streets of Boston in a world of alcohol and drugs where he suffered vicious and repeated assaults because he was gay. He lived in an incredibly cruel world that beat him physically and nearly destroyed him emotionally.

Bill fought back. He moved in with his aunt in the suburbs and began to rebuild his life. He got a GED, trained to become a certified nursing assistant, and extracted himself from the brutal world in which he had been forced to live. Bill told me about the intervening years when we met 40 years later. At the time he was a coordinator for clinical trials. He is now our medical home team outreach coordinator. He finds people who are lost to follow-up. Bill now uses his life experience to build relationships with people, some of whom still live in that cruel world from which he emerged. "It's why I love these people—I was one of them. It still happens more than you think!"

In those intervening years, our life paths could not have been more divergent. We began life in the same place in Boston and now work in the same place in Charleston. Bill should have had the same opportunities, the same support, and the same path, but he did not because he is gay. Bill's life experience now drives his passion to undo the impact of disparities, irrespective of age, race, ethnicity, or sexual preference. Bill has made our team dramatically more effective—and made us a better primary care team.

This edition of *Forum* is dedicated to the LGBT community, of which Bill is a member. SGIM is dedicated to diversity, inclusion, and social justice. So is Bill. Thanks, Bill!

SGIM

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### Attention SGIM Members With VA Appointments

If you plan to utilize VA funding to attend the 2015 SGIM National Meeting in Toronto, you will need to obtain approvals through the ACES process, your local VA facility and local VA travel office, as well as obtain a government passport. This will likely take some extra planning and effort on your part so plan ahead. Check out what will be required of you locally, and give yourself the extra time it will entail. We will work to keep information about the process and deadlines up to date on the VA Task Force website (<http://www.sgim.org/communities/task-forces/veteran-affairs>).

If you have not already done so, request ACES approval through the VHA conference web page (Intranet only): <http://vawww.ees.lrn.va.gov/Conferences/Guidance/ACES/>.

*Kristina Cordasco, MD, MPH, MSHS, and  
Gerry McGlynn, MEd  
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## LGBT Health in Medical Education

Rita Lee, MD, and Jennifer Potter, MD

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**M**edical education initiatives seeking to enhance the quality of health care for lesbian, gay, bisexual, and transgender (LGBT) individuals began in the late 1970s to early 1980s with establishment of the Boston Women's Health Book Collective, patient advocacy groups such as the Harry Benjamin International Gender Dysphoria Association (HBIGDA), and formation of the Gay and Lesbian Medical Association (GLMA). Three decades of progress notwithstanding, a 2009-2010 survey of 176 allopathic and osteopathic medical schools across the United States and Canada indicated that the median time dedicated to teaching LGBT-related content was still only five hours.<sup>1</sup> Of the 132 programs responding, nine programs reported 0 hours taught during the preclinical years, and 44 reported 0 hours during the clinical years. Five schools reported zero hours throughout the curriculum.

Curricular content should be integrated across the spectrum of medical training and include a wide variety of issues relevant for LGBT populations, such as:<sup>1</sup>

- Sexual orientation and gender identity, including defining sexual orientation and gender identity and recognizing the difference between sexual orientation, sexual behavior, and gender identity;
- Disparities in the frequency of emotional, verbal, physical and sexual abuse, and other types of bias and discrimination among LGBT populations;
- Barriers to care, including the historical context of LGBT health in medicine, discrimination in health care, and lack of medical training on LGBT health issues;
- Roles providers can play in facilitating access to care and promoting adaptive coping behaviors and resilience;
- Coming out, including the process of disclosing sexual orientation and gender identity to oneself and/or others;
- Specific concerns of LGBT youth, including parental disclosure and school bullying;
- Specific concerns of individuals who are gender nonconforming or identify on the transgender spectrum;
- Benefits and potential harmful effects of medical (e.g. hormones) and non-medical (e.g. chest binding, genital tucking, silicone injections) methods used to modify physical characteristics to affirm gender identity;
- Benefits and potential complications of surgical gender affirmation procedures;
- Screening and preventive medicine practices appropriate to age, gender, family history, behavioral risk factors, and the presence of natal anatomical structures requiring vaccines and screening tests for cancer;
- Appropriate screening for and culturally relevant methods for preventing sexually transmitted infections (STIs) including HIV;
- Relevant safer sex counseling, taking into consideration a broad spectrum of sexual behavior and expression;
- Disparities in frequency of depression, anxiety and PTSD, body image and eating disorders, and alcohol/substance use and abuse among LGBT populations;
- Importance of LGBT-competent and/or LGBT-specific mental health and substance abuse treatment programs and where to find resources;
- Prevalence and presentation of inter-partner violence occurring in the context of LGBT relationships and where to find culturally-competent resources; and
- Differences in sex development (formerly known as intersex conditions), how they develop, and the similarities and differences in lived experience and medical/surgical needs compared to those of LGBT individuals.

Spurred by this lack of education and increasing awareness of LGBT health disparities, the Association of American Medical Colleges (AAMC) convened an LGBT and/or Differences of Sex Development (DSD)-affected Patient Care Advisory Committee to help develop educational resources to guide curricular integration and assessment. Curriculum integration objectives (competencies) were published in 2012 (<https://www.aamc.org/download/373186/data/lgbtanddsdaaffectedcurriculumobjectives.pdf>) along with a call for submissions of LGBT and DSD-specific curricular tools to MedEdPORTAL (<https://www.aamc.org/initiatives/diversity/portfolios/330894/lgbt-patientcare-project.html>). The advisory committee invites SGIM members to create and submit their own educational materials for peer review and potential inclusion in this growing online curricular repository. A revised list of competencies and a comprehensive monograph, titled *Improving Care and Climate for Individuals Who May Be LGBT and/or Born with DSD: A Resource for Medical Educators*, will be released at the AAMC Annual Meeting in Chicago in November 2014. An accompanying series of faculty development videos will be available in

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## Pre-Exposure Prophylaxis (PrEP): A New Tool for Primary Care Providers to Help Prevent HIV Infection

Ryan Nall, MD, and Viraj Patel, MD, MPH

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Primary care providers are critical to the reduction of new HIV infections in all populations, including men who have sex with men (MSM) and transgender individuals. Despite advances in HIV prevention and treatment, the number of new HIV infections has remained around 50,000 annually for the past decade. While most groups have experienced declines in new infections, MSM and transgender communities disproportionately account for new HIV infections, particularly in those under age 30.<sup>1</sup> To reduce rates of HIV transmission, primary care must play a central role and is the ideal setting for HIV risk assessment, risk reduction counseling, HIV screening, treatment of sexually transmitted infections (STIs), post-exposure prophylaxis (anti-retrovirals *after* potential exposure), and now pre-exposure prophylaxis (PrEP) with anti-retrovirals (given *prior* to potential exposure).

PrEP is an important tool primary care physicians have at their disposal to reduce the risk of HIV infection. Two large prospective randomized controlled trials of PrEP have shown it to be effective in reducing rates of HIV transmission when paired with risk reduction counseling. First, the iPrEX study group evaluated the use of PrEP among HIV-seronegative men and transgender women who have sex with men;<sup>2</sup> 2,499 participants were randomized to daily tenofovir-emtricitabine (TDF-FTC) or placebo. All subjects received HIV testing, risk reduction counseling, condoms, and management of STIs. Participants were followed for 1.2 to 2.8 years, and 100 new cases of HIV infection (36 in the FTC–TDF group and 64 in the placebo group) were identified, indicating a 44% reduction in the incidence of HIV transmission

(95% confidence interval [CI], 15% to 63%;  $P=0.005$ ). Second, the Partners PrEP study group evaluated the use of PrEP in HIV serodiscordant heterosexual couples in Kenya and Uganda.<sup>3</sup> The HIV-seronegative partner in this study was randomized to daily tenofovir (TDF), TDF-FTC, or placebo. The HIV-seropositive partners in this study were not eligible for antiretroviral therapy according to national guidelines. Couples received standard HIV treatment and prevention counseling. Among the 4,747 couples who were followed, 82 new HIV infections occurred in the 36-month study period—17 in the TDF group, 13 in the TDF-FTC group, and 52 in the placebo group—indicating a relative reduction in the incidence of new HIV infection of 67% with TDF (95% CI, 44% to 81%;  $P<0.001$ ) and 75% with TDF-FTC (95% CI, 55% to 87%;  $P<0.001$ ). Most recently, PrEP was also proven efficacious in IV drug users in Thailand. In all of these studies, efficacy was directly related to adherence, with those individuals who were more than 90% adherent showing no linked transmissions.

PrEP has been found to be safe, well tolerated, and cost effective if given to high-risk individuals. Based on these and other studies of PrEP, in 2012 the FDA approved daily oral TDF-FTC for use as PrEP as part of a comprehensive prevention plan in at-risk individuals. The CDC has also released formal guidelines on the provision of PrEP,<sup>4</sup> and the governor of New York most recently included PrEP as one of the three main components to end the AIDS epidemic in New York State. Further, commercial insurers and other payers, including state Medicaid programs, are increasingly providing coverage for PrEP. For the uninsured and those

whose insurances do not currently cover PrEP, a patient assistance program exists to provide coverage.

### Key Points About Prescribing PrEP

PrEP is not meant to be offered as a sole intervention for HIV prevention but prescribed as part of a comprehensive prevention plan. PrEP is indicated for individuals who have a documented negative HIV test result and are at ongoing high risk for acquiring HIV. A negative HIV test result needs to be confirmed as close to initiation of PrEP as possible. Because efficacy of PrEP is dependent on adherence, PrEP should be prescribed to those who are able to adhere to the regimen. While consistent condom use is a critical part of prevention, lack of use of condoms is *not a contraindication* to PrEP. PrEP is contraindicated in individuals with HIV infection, creatinine clearance less than 60 mL/min, and those who are not ready to adhere to daily PrEP. The first prescription of PrEP (TDF-FTC, 1 tablet PO daily) should only be provided for 30 days to allow for a follow-up visit to assess adherence, tolerance, and commitment. Patients receiving PrEP need regular visits—at least every three months—to monitor HIV status, adherence, and side effects. Follow-up of patients on PrEP should include risk-reduction counseling, ensuring access to condoms, STI screening, and mental health and substance use screening, when indicated. PrEP should be immediately discontinued when patients receive a positive HIV test result and link to HIV care.

Primary care providers are most likely to encounter HIV-negative individuals and are most appropriately

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## Cancer Risk and Prevention in Transgender Patients

Ida M. Bernstein, BA, and Jennifer Potter, MD

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**T**ransgender is an umbrella term for people whose gender identity and/or expression differs from that typically associated with the sex assigned at birth.<sup>1</sup> Transgender individuals may pursue hormone therapy (i.e. androgens or estrogens and anti-androgens) to induce physical characteristics consistent with their gender identity.<sup>2</sup> Some transgender individuals undergo one or more existing gender-affirming surgeries, including reconstructive chest surgeries, hysterectomy, and vaginoplasty, among others. Though not all transgender individuals desire hormone therapy and/or surgery, medical interventions are effective in alleviating gender dysphoria and considered medically necessary for many people.<sup>1</sup>

### Hormone Therapy and Cancer Risk

Studies to date investigating the incidence of hormone-sensitive cancers in transgender individuals receiving hormone therapy have been predominantly retrospective and limited by small cohorts, short-term follow-up, and lack of inclusion of older participants who are most likely to develop cancer. The World Professional Association for Transgender Health (WPATH) has concluded there is inconclusive or no increased risk of breast, cervical, ovarian, and endometrial cancer associated with masculinizing hormones and inconclusive or no increased risk of breast cancer associated with feminizing hormones.<sup>1</sup> Details are provided below and drawn from comprehensive evidence-based literature reviews of hormone therapy evaluated by WPATH.<sup>3</sup>

### Prostate Cancer

The prostate is not removed during genital gender-affirming surgeries. The longstanding belief that low androgen environments are protective against prostate cancer development has been challenged by studies suggest-

ing a link between depressed levels of serum testosterone and prostate cancer incidence, particularly more aggressive forms of prostate cancer.<sup>4</sup> Case reports demonstrate that both benign and malignant prostate tissue can grow readily in individuals on the male-to-female (MTF) spectrum in androgen-deficient states.<sup>5</sup>

A large study of 2,306 MTF individuals (51,173 person-years of exposure) receiving feminizing hormone therapy and bilateral orchiectomy observed an overall incidence of 0.13% of prostate cancer in individuals over age 40, compared to a 3.18% 10-year incidence for natal males age 40 to 60 in the general population.<sup>6</sup> Mean age of hormone initiation in this cohort was 29.3 ± 12.7 years, and mean follow-up time was 21.4 ± 8.7 years. Study limitations include probable under-diagnosis due to lack of routine prostate monitoring and the inclusion of few participants age 65 and older. Although rates of prostate cancer in MTF individuals appear to be low, there may be susceptibility to aggressive prostate cancer tumors when they do arise.<sup>6</sup>

### Breast Cancer

MTF individuals receiving feminizing hormones experience breast cancer, yet the degree of risk relative to natal females is uncertain.<sup>3</sup> Factors that influence individual risk likely include duration of hormone therapy, age at hormone initiation, family history of breast cancer, obesity, and progestin use.<sup>3</sup> Masculinizing hormones do not appear to increase risk of breast cancer in the relative short term (30 years or less) in individuals on the FTM transgender spectrum.<sup>3</sup> Among a cohort of 2,307 MTF (52,370 person-years of exposure) and 795 FTM (15,974 person-years of exposure) individuals undergoing hormone therapy, incidence of breast cancer in both groups was comparable to breast cancer rates in natal males.<sup>7</sup>

### Endometrial (Uterine) Cancer

Testosterone use may increase the risk of endometrial cancer, but evidence is limited.<sup>3</sup> Post-hysterectomy uteruses of FTM individuals receiving hormone therapy appear to be small with endometrial atrophy.<sup>5</sup> There are no long-term studies on endometrial cancer incidence among FTM individuals. Retrospective studies have not detected endometrial cancer in FTM individuals taking testosterone, though one case report has been documented.<sup>3</sup>

### Ovarian Cancer

Testosterone use may increase the risk of ovarian cancer among FTM individuals, but evidence is limited.<sup>3</sup> An increase in ovarian androgen receptors has been reported after long-term testosterone administration.<sup>5</sup> No long-term studies have investigated ovarian cancer incidence among FTM individuals. There are three case reports of ovarian cancer in FTM patients on hormone therapy.<sup>5</sup>

### Cervical Cancer

There is no evidence linking testosterone and cervical cancer in either FTM individuals or natal females. Testosterone use can cause atrophy of the cervical epithelium, which may mimic dysplasia on Pap tests and increase risk of both unsatisfactory and minimally abnormal cytology results.<sup>3</sup>

### Other Hormone-sensitive Tumors

There are several case reports of pituitary tumors after long-term estrogen use in MTF individuals, though prolactinomas have not been identified in large cohort studies.<sup>5</sup> Using estrogen for more than 10 years or at higher-than-recommended doses may increase risk of prolactinoma.<sup>3</sup> The Endocrine Society recommends prolactin monitoring in MTF individuals and radiologic examination of the pituitary if prolactin levels persistently

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# Transgender Care 101: A “Primer” for the Primary Care Physician

Mindy Nguyen, MD; Megan McNamara, MD, MSc; and Rita Lee, MD

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**G**ino is a 26-year-old female-to-male (FTM) transsexual patient who is seeking a new primary care provider. He has been on injectable testosterone therapy for the last six months and would like to continue on this treatment prior to planned sex reassignment surgery (SRS) next year.

Ruth is a 65-year-old male-to-female (MTF) transsexual patient with obesity, pre-diabetes, and hyperlipidemia who needs primary care for her multiple medical issues. She has been on estrogen and anti-androgen therapy for two years.

## What do you need to know about Gino and Ruth’s hormone therapy?

Hormone therapy for transgender patients improves quality of life and mental well-being. The goal of transgender hormone therapy is to reduce endogenous hormone levels and their associated sex characteristics while replacing them with hormones of the preferred sex using doses and therapies typical for hypogonadal treatment.<sup>1</sup>

For Gino, testosterone therapy can be given parenterally or transdermally to achieve testosterone levels in the normal male range (i.e. 300 to 1000 ng/dL).<sup>2</sup> Hematocrit, lipid profile, and liver function tests should be measured every three months during the first year of treatment.

For Ruth, therapy will include both an anti-androgen and estrogen. Anti-androgen therapy reduces Ruth’s endogenous testosterone levels so that estrogen can have its maximal effect and lower doses can be used.<sup>1</sup> Anti-androgen therapy can be pharmacologic (typically spironolactone) or surgical (orchiectomy). Estrogen may be given orally (conjugated estrogens, 17  $\beta$  estradiol) or transdermally; serum estradiol levels should approximate the mean daily level for a reproductive-age woman (i.e. less than 200pg/mL).<sup>2</sup> Ruth should have her

estradiol, prolactin, and testosterone levels checked yearly; serum potassium should be monitored related to spironolactone. Estrogen may have a favorable effect on Ruth’s lipid profile, but her blood pressure, weight, and glucose levels should be followed carefully. Supra-physiologic doses of estrogen should be avoided as they can increase Ruth’s risk for thromboembolism, coronary artery or cerebrovascular disease, and liver dysfunction.<sup>1</sup>

## What other health maintenance should Gino and Ruth be aware of?

Health maintenance screening depends on the patient’s hormonal and surgical history. The basic idea is “screen what you have”—patients should be screened based on their anatomy. For example, since Gino has not undergone any surgical intervention, he should undergo cervical and breast cancer screening with the same frequency as non-transgender females.

Current guidelines suggest that Ruth undergo breast cancer screening as recommended for biological women.<sup>1</sup> SRS for MTF patients does not remove the prostate. Thus, the risks and benefits of prostate cancer screening should be discussed with Ruth.

In general, for patients who are on consistent cross-hormone therapy, the risk of osteoporosis is felt to be low. However, for patients who are not on cross-hormone therapy consistently, the risk of bone loss may be greater. Should there be risk factors for osteoporosis, the Endocrine Society recommends obtaining bone mineral density studies.

## What types of issues should you consider for Gino’s upcoming surgery?

Gino should complete at least 12 months of hormone therapy and con-

sult with his primary care physician and mental health provider prior to SRS.<sup>2</sup> Full discussion of SRS is beyond the scope of this article. Current guidelines recommend that Gino consider total hysterectomy and oophorectomy as part of his surgery in order to eliminate the risks of gynecologic disease and cancer.

## Are Gino and Ruth at risk for other medical or mental health conditions?

The stress associated with fear, discrimination, and violence leaves the transgender community vulnerable to mental health issues and drug and alcohol abuse. Rates of depression, trauma, eating disorders, anxiety, smoking, and domestic violence are higher in the transgender community, and suicide risk is increased by 30%.<sup>3</sup>

Transgender individuals are also at a higher risk for HIV and sexually transmitted infections (STIs)—MTFs more so than FTMs. The prevalence of HIV among MTF persons is approximately 27.7%. Additionally, MTF individuals are also more likely to engage in risky sexual behaviors, including unprotected receptive anal intercourse, multiple casual partners, and sex work.<sup>4</sup> The sharing of needles to inject drugs or hormones is another risk factor for HIV and STIs.

## What are other issues that could face Gino or Ruth?

Under the Affordable Care Act, sex discrimination and discrimination based on HIV/AIDS status is prohibited. However, insurance plans may still exclude coverage for transition-related care, including hormones and/or surgeries.

While the social landscape is constantly changing—with 16 states and DC passing laws to prohibit discrimination in the workforce and businesses—transgender individuals still

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## Health Challenges Faced by LGBT Older Adults

Alexia M. Torke, MD, MS

*Dr. Torke is associate professor of medicine in the department of general medicine and geriatrics at Indiana University School of Medicine and associate director of the Indiana University Center for Aging Research, Regenstrief Institute, Inc.*

Lesbian, gay, bisexual, and transgender (LGBT) persons who are reaching older adulthood have seen tremendous changes over their lifetimes in every aspect of the LGBT experience. From the beginning of the gay rights movement—often recognized as the Stonewall riots in New York in 1969—to the recent progress on gay marriage, civil rights are changing fast. However, there are still substantial barriers to achieve equality in health care.

The lifetime experience of older LGBT individuals varies widely, depending on race, culture, geography, and other factors. Some may have “come out” as LGBT during the gay rights movement while others may have kept their identity a secret. Some may have felt a lifetime of acceptance by family and community while others may have been rejected by their families or friends. Same-sex relationships were regarded as a psychiatric disorder by the *Diagnostic and Statistical Manual* until 1973. Stigma continues to be a barrier for many LGBT older adults. Like many aspects of cultural awareness, an understanding of some of the key issues in health care for older adults can lead to fruitful conversations with individual patients about their needs. Three issues are particularly salient for older LGBT adults: access to medical, legal, and social services; long-term care; and surrogate decision making. These are described in more detail below.

### Access to Medical, Legal, and Social Services

In one 2010 survey, a majority of LGBT respondents reported that they had experienced discrimination from health care providers.<sup>1</sup> In addition to outright denials based on sexual orientation or gender status, LGBT individuals may face denial of

social security, veterans benefits, health insurance, and inheritance tied to marriage. In the United States, there is currently a patchwork of state laws that determines whether same-sex couples are allowed to marry. Recent US Supreme Court cases have now led to federal recognition of same-sex marriages, but in many cases the receipt of federal benefits such as social security is tied to marriage recognition in the state in which the individual lives. For example, a married same-sex spouse would not be entitled to spousal benefits if he/she lived in a state such as Indiana where the marriage was not recognized.

Couples whose marriage is not recognized by the state do not qualify for Medicaid exemptions that allow a spouse to retain assets, such as a house, when a patient needs long-term care. Transgender care, which may include hormones and surgery, is not covered by many insurance plans, leading to very high out-of-pocket costs and decisions to forgo beneficial treatments. In addition to disparities in accessing formal services, LGBT older adults are less likely to have strong informal support networks due to the lower likelihood of marriage and higher rates of estrangement from biological families. Given that the majority of long-term care in the United States is provided informally by family members, LGBT older adults are at risk for having an inadequate care network. However, “families of choice,” made up of friends and partners, are often important sources of support, and health care providers should inquire broadly about potential sources of caregiving support for LGBT older adults.

### Challenges in Long-term Care

Although seeking health care often involves disclosing private information,

living in a nursing home or other long-term care facility requires a major loss of personal privacy in every aspect of daily life. A report by the organization Services and Advocacy for LGBT Elders (SAGE) includes anecdotes of long-term care residents facing hostile fellow patients and staff, as well as denial of visitation by significant others, resulting in social isolation.<sup>2</sup> Some LGBT elders may hide their identity out of fear of discrimination. Such experiences come at the time when the individual may be especially vulnerable due to illness, impaired cognition, and declining functional status and may not have a choice about where to live.

### Challenges in Surrogate Decision Making

When individuals are unable to make their own medical decisions, state law provides guidance about who to turn to for decisions. Most states prioritize legally married spouses and other first-degree relatives. Some states, such as New York, do have surrogate decision-making statutes that recognize unmarried same-sex partners; others do not. Because LGBT individuals may not be legally married or have their marriage recognized by the state in which they reside, they are less likely to have their spouse or partner recognized as a legally valid decision maker. Additionally, many LGBT persons report that they are closest to a “chosen family” that may include a partner and friends due to fractured relationships with the biological family. Such individuals do not automatically have decision-making authority in most states. All states allow individuals to designate a legally authorized decision maker by executing a durable power of attorney for health care. Although inquiring about preferred sur-

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## LGBT Mental Health

Yavar Moghimi, MD, and Douglas Olson, MD

*Dr. Moghimi is a psychiatrist at Whitman-Walker Health Center in Washington, DC, and Dr. Olson (@DoctorOlson) is chief medical officer at Norwalk Community Health Center in Norwalk, CT.*

**S**tigma. This one word underlies much of the increased mental and physical health needs that the LGBT community faces. Stigma has profound effects on the psyche of those in the LGBT community, whether this is an internalized shame of being different or an externalized negative reaction to the hetero-normative world. The good news? This stigma has decreased over the past two decades. The bad news? There is still much room for improvement.

Here are some facts: LGBT individuals as a group have less access to medical care, even with the passage of the Affordable Care Act. They are less likely to have health insurance, seek medical care, report having good health, and receive preventive medical care.

The roots of mental health issues can begin early in life for LGBT patients. LGBT youth are more likely to be hurt in physical fights, experience psychological distress, need medication for emotional health issues, and complete suicide. These issues continue into adulthood. Compared to heterosexuals, there are higher rates of recurrent major depression, generalized anxiety disorder, and substance use among gay men and lesbians. Transgender adults are five times more likely to be a victim of violence compared to non-transgender adults, and 41% have reported attempting suicide. LGBT adults are more likely to smoke and to use and abuse drugs and alcohol, all of which have synergistic effects on exposure to HIV and other sexually transmitted diseases.

So how do you address all this in a 15- or 20-minute office visit? Like any good clinician who practices true biopsychosocial cultural competency,

the first thing most physicians will need to do is acknowledge that LGBT patients have multi-faceted and complex mental and physical health needs. The fact that they have sought care means they have already overcome many barriers to discussing their health. By taking an open, non-judgmental stance, one can quickly identify many issues important to an LGBT patient. Here are some unique issues to keep in mind.

*The degree of "outness."* An authentic self-identity is an important part of development, and hiding a secret from co-workers, family members, friends, or others can contribute to compartmentalized feelings and a false self. Patients who are struggling with "coming out" may rely on illicit substances and secretive, high-risk sex practices as a means of coping. By learning to what degree the patient is out, the clinician can gain insights about the level of social support the patient has.

*Sexual health.* Rather than making assumptions about sexual orientation or gender identity based on appearance or sexual behavior, clinicians should ask open-ended questions, mirroring the terms and pronouns patients use to describe themselves. Skillful and deliberate sexual histories cannot be under-rated! Non-judgmental questions regarding intimate partner violence are important in the medical history as rates of intimate partner violence are higher among some groups, especially if transactional sex or sex work is involved.

*Substance abuse.* It is important to screen for substance abuse with LGBT patients, as it can also be connected to high-risk sexual behavior. Methamphetamine, in particular, is a common drug used among

some men who have sex with men and is connected to increased risk of HIV transmission through sexual activity. Screening for alcohol and other drugs is also important. Motivational interviewing can be an important strategy to help these patients become more aware of the harmful effects of substance abuse on their lives.

LGBT physical and mental health needs are often first identified in a primary care setting. Humility and open mindedness on the part of the clinician are vital to establishing trust and a healthy therapeutic relationship, which is the first step to evaluating, diagnosing, and treating any LGBT physical and mental health need. If and when in doubt, like anything else in medicine, ask for help. Colleagues, friends, and the SGIM LGBT Health Interest Group members can be tremendous sources of expertise.

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## The LGBT Health Interest Group

Rita Lee, MD, and Douglas Olson, MD

*Dr. Lee is associate professor in the department of medicine at the University of Colorado, and Dr. Olson is chief medical officer of Norwalk Community Health Center in Norwalk, CT.*

The Lesbian, Gay, Bisexual, and Transgender (LGBT) Health Interest Group was formed to support LGBT members of SGIM and those interested in LGBT health and health disparities. Our mission is to provide a safe and supportive forum for social engagement, to facilitate collaboration on LGBT health education and research, and to improve LGBT health disparities.

First and foremost, the LGBT Health Interest Group serves SGIM members by creating a welcoming environment for LGBT, queer, or questioning members and allies. Members have cross-pollinated ideas for improving LGBT health education on their campuses, for advocating for LGBT supportive policies at their home institutions, and for potential research projects. The LGBT Health Interest Group includes the following members:

**Rita Lee, MD**, is chair of the LGBT Health Interest Group. Dr. Lee is an associate professor at the University of Colorado and faculty in the LEADS (Leadership Education Advocacy Development Scholarship) Track, which prepares students to engage in addressing health disparities at the community level. She serves on the Health Advisory Committee for the LGBT Center of Colorado and has partnered with One Colorado (a statewide advocacy organization) on its Health Steering Committee. Together, they have developed a comprehensive report on the state of LGBT health in Colorado, surveyed provider willingness and capacity to treat LGBT patients, developed an online CME module ([somed.ucdenver.edu/cme/LGBT\\_CME.html](http://somed.ucdenver.edu/cme/LGBT_CME.html)), and are currently undertaking a state-wide survey on transgender health.

**Douglas Olson, MD** (@DoctorOlson), is chief medical officer of Nor-

walk Community Health Center in Norwalk, CT. In addition to clinical care and administration, Dr. Olson is responsible for all quality improvement and health disparity reduction activities at all health center access points. He and his SGIM colleagues have presented at national SGIM meetings on LGBT-centric topics.

**Ida Bernstein** is a second-year student at Harvard Medical School (HMS). She was an Academic Year Scholar with the HMS Center for Primary Care. This program supported a year of full-time work on the TransPrev study at Fenway Health, focusing on cervical cancer prevention in individuals on the FTM spectrum. She currently serves on the HMS LGBT Advisory Committee.

**Harvey Makadon, MD**, is director of the National LGBT Health Education Center, clinical professor of medicine at the Harvard Medical School (HMS), and a member of the division of general medicine at Beth Israel Deaconess Medical Center in Boston. Dr. Makadon was the lead editor of *The Fenway Guide to Lesbian, Gay, Bisexual, and Transgender Health*, published by the American College of Physicians in 2008, and has written numerous peer-reviewed articles and chapters related to LGBT health as well as articles for popular media. He served on the Committee on LGBT Health Issues and Research Gaps and Opportunities for the Institute of Medicine's 2011 report, *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding*.

**Megan McNamara, MD, MSc**, is a primary care provider at the Louis Stokes Cleveland VAMC and associate professor of medicine at Case

Western Reserve University School of Medicine. She specializes in women's health care with an emphasis on contraception and hormone therapy. She provides primary care for transgender veterans at the Louis Stokes Cleveland VAMC and is interested in medical education about transgender care.

**Ryan Nall, MD**, is a graduate of the University of Florida College of Medicine. He completed his internal medicine residency at Beth Israel Deaconess Medical Center where he also served as the chief resident for primary care. During residency, Dr. Nall learned about LGBT health disparities through his continuity clinic experience at Fenway Community Health. He is currently an assistant professor of medicine in the division of general internal medicine at the University of Florida, where he serves as assistant clerkship director for the third-year ambulatory clerkship.

**Viraj Patel, MD, MPH**, is an assistant professor at Montefiore Medical Center/Albert Einstein College of Medicine, at the Bronx, NY, where he has active research programs focusing on using social media and other technologies for HIV prevention and linkage-to-care interventions for men who have sex with men (MSM) and transgender populations in New York City and in India. He also teaches on LGBT health disparities and clinical care to medical students and residents.

**Jennifer Potter, MD**, is associate professor of medicine at Harvard Medical School, director of women's health programs at Beth Israel Deaconess Medical Center and Fenway Health (BIDMC/FH), and a member of the Association of American Med-

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# No Longer Invisible: Transgender Care at the VA Health Care System

Megan McNamara, MD, MSc

*Dr. McNamara is associate professor of medicine at Case Western Reserve University School of Medicine and the Louis Stokes Cleveland Veterans Affairs Medical Center in Cleveland, OH.*

In May 2014, Secretary of Defense Chuck Hagel stated that the current ban on transgender military service “should be reviewed.” In support of this, an independent commission led by a former US surgeon general indicated that there is no “compelling medical reason” preventing a transgender individual from serving in the military.<sup>1</sup>

Lifting this ban will mark a significant step forward in the provision of health care to transgender veterans who may still feel unwelcome and “invisible” in the Veterans Health Administration (VHA) system.<sup>2,3</sup> According to a recent study, the prevalence of gender identity disorder (GID)—a medical term used to describe distress caused by discordance between biological sex and identified gender—is five times higher in the VHA than in the general US population, and it is estimated that 246 new cases of GID are diagnosed among veterans each year.<sup>4</sup> Although the specific health care needs of transgender veterans are uncertain, it is likely that they experience the same high rates of depression, anxiety, substance abuse, and smoking that prevail in the general transgender community. Suicide rates, in contrast, are 20 times higher among transgender as compared to non-transgender veterans.<sup>4</sup> Despite the increasing awareness of “transvets” and their important health care issues, many may feel inhibited about disclosing their gender identity to their health care provider.<sup>3</sup> In a small focus group study of LGBT veterans receiving care at two VA hospitals, only 24% had discussed their sexual orientation with a VA provider; fear about negative consequences related to their disclosure was cited as an important concern.<sup>3</sup> Although

the “Don’t Ask, Don’t Tell” policy, which barred openly gay, lesbian, or bisexual persons from serving in the military, was repealed in 2010, many LGBT veterans distrust, expect rejection, or feel the need to conceal information from the VHA.<sup>2</sup> Moreover, only 28% of LGBT veterans perceive the VHA to be welcoming.<sup>3</sup>

Currently, the VHA is working hard to change these perceptions, as well as to improve the quality of health care for transgender veterans. In 2011, the VHA published the first-ever directive regarding the care of transgender and intersex veterans. This guide outlines the specific health care services that the VHA provides for all transgender veterans, regardless of their stage in transition. Transgender veterans are entitled to hormonal therapy, mental health care, pre-operative evaluation, and post-operative management of any complications associated with sex-reassignment surgery. An accompanying document provides recommendations (which are very similar to published guidelines) on the benefits, risks, formulations, and monitoring parameters for hormonal therapy. Written informed consent is not necessary for the prescription of hormone therapy, but the VHA recommends that providers who are experienced in hormonal therapy adequately counsel patients. More recently, the VHA updated its policy statements to disavow discrimination based on gender identity or expression and provide a more inclusive definition of family.<sup>2</sup>

The VHA has acknowledged that there is a shortage of health care providers who are knowledgeable about LGBT care and has launched a variety of clinician-oriented educational initiatives. The Office of

Health Equity and LGBT workgroups have produced several online training modules that review the VHA pharmacy guidelines for transgender hormonal therapy and the role of the mental health provider in assessment and diagnosis of GID. Several helpful tools can be found on the transgender sharepoint, including a guide for changing gender in the electronic health record and templated physician attestation letters to assist veterans with obtaining a new driver’s license or other official documents.

While transgender veterans are still banned from serving in the military, the VHA is taking significant steps to eliminate bias and improve care for transgender veterans. The end result will be a medical system that makes both providers and veterans proud by acknowledging and celebrating differences and attending to each individual’s personal and emotional needs.

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## FROM THE SOCIETY

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ical Colleges LGBT and Disorders of Sexual Development-affected Patient Care Committee. Dr. Potter was recently named associate editor for the MedEdPORTAL LGBTQI collection. She participates in other national collaborations, including the Association of Professors of Gynecology and Obstetrics Women's Health Care Competencies for Medical Students Task Force, the Com-

mittee to Advance the Health of Minority Women of the Harvard Center of Excellence in Women's Health, and the Women with Disabilities Education Project.

**Alexia M. Torke, MD, MS**, is associate professor of medicine in the department of general medicine and geriatrics at Indiana University School of Medicine and associate

director of the Indiana University Center for Aging Research, Regenstein Institute, Inc. She also directs the ethics fellowship at the Fairbanks Center for Medical Ethics at Indiana University Health. Dr. Torke's research focuses on decision making for seriously ill older adults, including ethical, communication, and religious and spiritual aspects of decision making.

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## GLOSSARY OF TERMS: TRANSGENDER HEALTH

This glossary has been adapted from publications by Fenway Health, the World Professional Association for Transgender Health, and *Trans Bodies, Trans Selves: A Resource for the Transgender Community*.<sup>13</sup> It is important to note that terminology associated with the care of transgender individuals is rapidly evolving and growing, and existing definitions are dynamic. It is always best to individually assess which terms patients use or prefer to describe themselves and their experiences.

**Assigned sex:** The designation of a person at birth as either "male" or "female" on the basis of physical characteristics including genetics, hormone prevalence, and external and internal genitalia.

**Gender:** A set of socially constructed roles, behaviors, and attributes used to classify an individual as feminine or masculine. Sometimes "sex" and "gender" are used interchangeably; however, sex, gender identity, and gender expression should be distinguished from one another for clarity and accuracy.

**Gender identity:** A person's internal sense of being male, female, both, or neither, which may or may not correspond to the person's assigned sex at birth.

**Cisgender:** A term used to describe people whose gender identity and gender expression align with their assigned sex at birth.

**Transgender:** An umbrella term used to describe a diverse group of individuals whose gender identity and/or

gender expression differ from their assigned sex at birth. While "transgender" is used widely, some people find this term to be an unsuitable descriptor of themselves. The word "transgender" is an adjective and should not be used in noun form (i.e. "a transgender") or otherwise modified (i.e. "transgendered").

**Female-to-male (FTM) spectrum:** A general term used to describe transgender individuals assigned female at birth. People use many terms to describe their individual gender identities and may not identify with "FTM spectrum."

**Male-to-female (MTF) spectrum:** A general term used to describe transgender individuals assigned male at birth. People use many terms to describe their individual gender identities and may not identify with "MTF spectrum."

**Transition:** A process through which individuals alter their gender expression to align with their gender identity. Transition may or may not include feminization or masculinization of the body through medical interventions, including hormone therapy or surgery. The nature and duration of transition is variable and individualized. Some people prefer the term "gender affirmation" to describe this process.

**Gender dysphoria:** A disconnect between an individual's biological sex and gender identity, causing clinically significant distress or impairment in social, occupational, or other important areas of functioning. Not all transgender individuals experience

gender dysphoria and/or need medical intervention.

### Gender affirmation surgery (GAS):

Surgical interventions used to alter primary and/or secondary sex characteristics to affirm a person's gender identity. For some people, GAS is medically necessary to alleviate gender dysphoria. Individuals may undergo one or more GAS procedures, including chest reconstruction surgery, breast augmentation, orchiectomy, vaginoplasty, phalloplasty, hysterectomy, bilateral salpingo-oophorectomy, and facial feminization surgery, among others. Many terms other than GAS are used to describe surgical transition. "Sex reassignment surgery" is increasingly disused as some people find it pejorative.

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## FROM THE EDITOR

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To Frankie: I hear you. You are not alone. Your concerns matter. I will seek, learn, and attain the skills necessary to guide you. This issue of *Forum* is dedicated to you. It is the next step forward for me in the journey we now share.

*Editor's Note:* Names of individuals have been changed in this article to protect their privacy.

### Endnotes

1. Gloria Roblin, PhD (b1925-d2001), psychologist, clinical professor of medicine, University of Buffalo School of Medicine and Biomedical Sciences
2. Aaron Lazare, MD, former chancellor and dean, professor of psychiatry, University of Massachusetts Medical Center
3. Raymond J. Mayeweski, MD, professor of medicine, chief medical officer, University of Rochester Medical Center
4. William Branch, MD, professor of medicine, Emory University
5. Samuel Putnam, MD (b1938-d2005), professor of medicine, Boston University School of Medicine, co-founder, American Academy on Physician and Patient

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## EDITORIAL

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only allows clinicians to address patients' unique health needs but also allows organizations to assess quality of care provided to LGBT people compared to the general population.

*Improving awareness of the clinical needs of LGBT people.* Clinicians, staff, and trainees can all benefit from educational programs that focus on the health needs specific to LGBT people. This includes topics like smoking cessation, which is a preventive health concern in the LGBT community, and care choices. For example, many transgender men may still retain female reproductive organs, including a cervix, that require ongoing cancer screening. Addressing this issue with sensitivity and understanding is critical to providing appropriate care.

Support staff may not need to know specifics of each patient's care, but they will need to know why people change their name or preferred pronouns. This is information that all patients should be asked when first registering for care, and these ques-

tions should be repeated periodically throughout one's life given that our patients may affirm their gender at different life stages and may not offer this information at their initial visit.

*Demonstrating inclusiveness.* Health care organizations should recognize that many LGBT people have had negative experiences seeking health care and may have avoided needed care as a result. Approaches to righting past experiences and ensuring satisfaction begin with demonstrating inclusiveness in many ways. This can begin with revision of forms to replace terms such as "husband and wife" with "partner or spouse." Imagery on brochures promoting services and patient education should include images of same sex-couples, especially for geriatrics and maternity care. Finally, simple ways to learn about the experience of LGBT patients who receive care at your practice can include the addition of one or two questions in routine patient satisfaction surveys asking if patients

identify as LGBT. Such questions can be voluntary but are another indication to LGBT people that a practice is sincerely interested in ensuring access to high-quality care.

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## NEW PERSPECTIVES: PART II

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rogates is an important aspect of advance care planning for all patients, it is especially important to address this topic with older LGBT adults due to the higher chances that their chosen representative will not be recognized by surrogate decision-making laws. A recent survey found that only

34% of LGBT older adults had completed a health care proxy.<sup>3</sup>

Clinicians treating LGBT elders can serve as advocates for patients as they navigate medical and social services. Optimizing access to benefits, helping older adults to find long-term care that is supportive, and

conducting appropriate advance care planning are three ways clinicians can meaningfully improve their patients' experience.

### References

1. Lambda Legal. When health care continued on page 15

## NEW PERSPECTIVES: PART I

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early 2015. These materials are intended to serve as an instructional guide to help medical schools implement needed curricular changes.

In addition to the growing collection of LGBT and DSD-specific curricular tools housed at MedEdPORTAL and the upcoming AAMC monograph, other resources exist for clinicians and medical educators who want to increase their own cultural competence and to integrate LGBT and DSD-related curricular content into their own training programs. The National LGBT Health Education Center, a part of The Fenway Institute, provides live trainings and online modules, courses, and webinars on a wide variety of topics pertinent to high-quality and cost-effective health care for LGBT people (<http://www.lgbthealtheducation.org/>). In addition, a number of medical schools at locations across the country have developed innovative, integrated LGBT education programs that can serve as demonstration projects and provide resources to others who want to enhance LGBT health training. These schools include: Case Western Reserve University, Florida State University College of Medicine, Michigan State University College of Human Medicine, Morehouse School of Medicine, Oakland University William Beaumont School of Medicine, Stanford School of Medicine, University of California San Francisco, University of Pennsylvania Medical School, University of Texas Health Sciences Center at Houston, University of Vermont School of Medicine, and Vanderbilt University School of Medicine.

University School of Medicine.

This is an exciting time for medical educators who are interested in LGBT health, which has become a highly respected and competitive area of scholarly focus. We strongly encourage SGIM members to become involved in the leadership of pertinent educational innovation and curricular reform efforts.

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## CLINICAL UPDATE

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situated to help patients stay HIV negative. This now includes consideration of PrEP in at-risk individuals. Primary care physicians must maintain a non-judgmental approach, take careful ongoing sexual histories, and assess risk of new HIV/STI infections in all patients.

PrEP is an effective new tool to augment behavior change in at-risk populations, help patients stay HIV negative, and reduce HIV transmission and related health disparities ex-

perienced by MSM and transgender communities. For comprehensive guidelines on assessing risk, counseling, and prescribing PrEP, visit [www.hivclinicalguidelines.org](http://www.hivclinicalguidelines.org) or consult the CDC's clinical guidelines.<sup>4</sup>

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## OUTPATIENT MORNING REPORT

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face severe social stigmatization. These concerns should be included in the social history, and consultation with social work may be necessary to ensure safe work and home environments.

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rise despite stable or reduced estrogen levels.<sup>5</sup> There are no reports of other common estrogen-related growth factor tumors, such as focal nodular hyperplasia, hemangioma, or angiomylipoma.

### Cancer-related Mortality

Asscheman et al. determined causes of mortality in a cohort of 966 MTF (8,678 person-years of exposure) and 365 FTM (6,866 person-years of exposure) individuals on hormone therapy with a mean age of 31.4 and 26.1 years at hormone initiation, respectively. The observed number of deaths in the study cohort was compared to the expected number derived from mortality data of the general population, stratified by age and natal sex. The total cancer mortality rate was not increased in either the MTF or FTM group.<sup>8</sup> However, no firm conclusions can be drawn for FTM individuals age 65 to 79 in particular due to cohort size limitations.<sup>8</sup>

Additional studies that examine cancer outcomes specifically are needed to ascertain whether disparities in stage at diagnosis and receipt of oncologic care exist. Valuable data regarding comparative cancer incidence and stage at diagnosis could be obtained if cancer registries mandated collection of gender identity data.

### Importance of Cancer Prevention

Transgender individuals are at risk for cancer and thus require preventive screening appropriate to their anatomy as well as prompt evaluation of associated symptoms. Patient education regarding screening needs is critical, particularly in contexts that are not self-evident (e.g. post-supracervical hysterectomy). To guide

screening for anatomical structures that may be affected by hormone therapy, clinicians should consult national evidence-based guidelines as well as available transgender primary care protocols when considering the effects of hormone therapy and surgery on baseline risk, as summarized in Table 1. (See online supplement at <http://www.sgim.org/publications/sgim-forum/current-issue>.) Cited recommendations have been developed by clinical experts and professional organizations based on published literature and clinical experience where data are scarce or nonexistent.<sup>2</sup>

### Conclusion

Provision of life-saving cancer screenings to gender minorities necessitates awareness of transgender-specific health needs and sensitivity to the barriers that manifest from historical stigmatization of the transgender community. Dissemination of information is an important step in enabling competent care provision. However, evidence for current screening guidelines is incomplete. Further study is critical to better understand the long-term impact of hormone therapy on cancer risk and improve health outcomes among transgender individuals.

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## NEW PERSPECTIVES: PART II

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## UC Health General Internal Medicine Opportunities Hybrid Position as Academic Hospitalist / Bone Marrow Transplant Specialist

The Section of Hospital Medicine at the University of Cincinnati College of Medicine, Cincinnati, Ohio, is seeking Board Eligible Internists to join our faculty as academic hospitalists with a specialty focus on the care of patients with cancer including those undergoing bone marrow transplantation. This position is particularly suited to individuals who are contemplating a career as Hematology-Oncology faculty member and are looking for a pathway to fellowship. As part of the Division of General Internal Medicine, **which performs the bulk of resident and student teaching for the Department of Medicine**, you will provide patient care in several settings, including attending on traditional resident-led ward teams, attending on the resident-led medical consultation service, leading a hospitalist team including an intern and/or physician assistant, and as a nocturnist functioning as the senior Medicine faculty member at night while cross-covering our Bone Marrow Transplant and Malignant Heme service.

Academic opportunities include:

- Teaching in our Internal Medicine Residency program which has been granted status as an ACGME Educational Innovations Program;
- Training in the care and management of patients following bone marrow transplantation;
- Research mentorship in Hematology/Oncology;
- Direct teaching of medical students in all four years of our new clinical curriculum; and
- Collaborating with researchers in our Center for Clinical Effectiveness and Center for Health Informatics.

Opportunities also exist for training in Improvement Sciences and traineeships with mentored research experiences in Outcomes and Clinical Effectiveness leading to a Master's degree in Clinical and Translational Research.

Our hospitalists are leaders in improving both patient care and clinical processes at our primary location, University of Cincinnati Medical Center.

**Candidates should have a passion for teaching and improving patient care.** Salaries are competitive, with opportunities for increases based on productivity.

If you are interested in joining UC Health in Hospitalist Medicine, applicants should contact either Mark Eckman, Director, Division of General Internal Medicine, via email at [Mark.Eckman@uc.edu](mailto:Mark.Eckman@uc.edu) or Kevin Dell, Director, Hospitalist Medicine, via email at [Kevin.Dell@uc.edu](mailto:Kevin.Dell@uc.edu). We are recruiting for July 2015.  
*The University of Cincinnati is an affirmative action/equal opportunity employer.*

