VOL. 45 ▪ NUMBER 7 ▪ JUL 22

SGIM Forum

Society of General Internal Medicine

MEDICAL EDUCATION: PART I

THE IMPERATIVE FOR LGBTQ+ INCLUSIVE MEDICAL EDUCATION

Simone Chriss, Esq.; Ryan W. Nall, MD; Chelsea Dunn, Esq.; Laura K. Guyer, PhD, MEd, RDN

Ms. Chriss (simone.chriss@southernlegal.org) is director of the Transgender Rights Initiative at Southern Legal Counsel in Gainesville, Florida. Dr. Nall (Ryan.Nall@medicine.ufl.edu) is an associate professor and clerkship director of medicine at the University of Florida College of Medicine. Ms. Dunn (chelsea.dunn@southernlegal.org) is the director of the Healthy Kids Medical Legal Partnership at the Southern Legal Counsel in Gainesville, Florida. Dr. Guyer (lkguyer@ufl.edu) is the associate director of Global Health Education Programs and adjunct associate professor at the University of Florida College of Medicine.

Introduction

In the United States, there are significant disparities in health outcomes and access to health care among individuals who identify as lesbian, gay, bisexual, transgender, or queer (LGBTQ+), as compared to their heterosexual and cisgender peers. LGBTQ+ individuals experience disproportionately higher rates of cardiovascular disease, cancer, mental health disorders, and substance abuse.[1] Some of the most marked health disparities exist for transgender individuals, who are nine times more likely to attempt suicide, four more times more likely to be diagnosed with HIV, and twice as likely to have no health insurance, when compared to the general population. Further, transgender individuals report disproportionately negative experiences when seeking health care, including verbal harassment, refusal of treatment, and needing to teach the healthcare provider about transgender people to receive appropriate care. Because they fear mistreatment, nearly 28% of transgender people avoid seeing a physician when they need medical care.[1, 2] Health disparities among LGBTQ+ people worsen when you add the compounding effects of other intersectional identities, such as belonging to a racial minority.

One factor contributing to LGBTQ+ health disparities is a medical community that lacks a foundational understanding of the unique needs of this community due to insufficient education and training in medical school and residency programs. The median time that medical students spend learning about LGBTQ+ health is five hours, and one-third of medical schools provide no instruction at all.[3] This lack of inclusive LGBTQ+ medical education leaves providers unprepared to provide affirming and inclusive care and propagates further the implicit and explicit biases towards LGBTQ+ identifying patients.[4] To address gaps in knowledge and training among providers, the Association of American Medical Colleges (AAMC) Advisory Committee on Sexual Orientation, Gender Identity and Sex Development released the guide, *Implementing Curricular and Institutional Climate Changes to Improve Heath Care for Individuals Who Are LGBT, Gender Nonconforming*, or *Born with DSD*, to influence curriculum development. Although some curricular reforms have been adopted, progress has been slow and LGBTQ+ health concerns have not been systematically integrated throughout undergraduate, graduate and continuing medical education.

While it is true that some topics covered in medical school will be encountered only by students pursuing subspecialties, *all* physicians will care for LGBTQ+ identifying patients throughout their careers. In a 2017 Gallup Poll, 4.5% of the U.S. population or 14.5 million people identified as LGBTQ+ and these estimates increase annually.[5] Though most health conditions, dis-

continued on page 12

CONTENTS

FROM THE EDITOR

IMPACT BEYOND ONE PATIENT-PHYSICIAN ENCOUNTER

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

> *"The only thing I do know is that we have to be kind. Please, be kind. Especially when we don't know what's going on."*
>
> —Waymond Wang (portrayed by Ke Huy Quan), in *Everything, Everywhere, All At Once*

Recently invited to review essays on humanism in health care, I found numerous small, great moments of care and connection in petite packages. They reminded me of a starting student or intern, drinking from the proverbial fire hose of medical knowledge and skill, learning not only *how* to doctor but to *be* a doctor. That is, they grow into this professional identity, originating from a deeply rooted motivation to acquire the most modern and precision skills a doctor needs to care for patients—and then honing that expertise into the craft of clinical practice. Without doubt, this is not the sole ingredient to a great physician. Similarly, the potential for any one physician's—or future physician's—impact is not bound by the microenvironments of individual patient-physician encounters.

Due to an abundance of submissions for last month's theme issue on "LGBTQIA+, Sex and Gender Health," July's SGIM *Forum* includes additional articles on the same topic. As the *ad hoc* second volume on the theme, the content here offers perspectives and information that demonstrate several examples of how much and what kinds of impacts our skills and connections as physicians—with patients, each other, society, and so many more stakeholders in our populations' health—can have, impacting *both* the patient who sits before us *and* people who we will never meet.

Monica Lypson, SGIM Past President, remarked this time last year that the Society would "begin to follow through on our Diversity, Equity, and Inclusion (DEI) Statement issued in May [2021] to ensure a diverse, inclusive society for all." LeRoi Hicks, SGIM President, comments in his column this month on how we as a Society are living by our values. As students, we learn quickly that we care for and connect with patients we see. But in developing a clear alignment of values and actions for ourselves as individual physicians, then pairing that with a similar alignment within a society

continued on page 14

PRESIDENT'S COLUMN

LIVING BY OUR VALUES

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

> *"I strongly support guiding our organizational decisions based on our clearly articulated vision and values. In January 2022, SGIM council approved our most recent value statement after a lengthy strategic planning initiative. To be clear, I believe that all our actions should be aligned with accomplishing our vision of 'a just system of care in which all people can achieve optimal health.' In our statement, we define ourselves as a 'diverse community of talented people in academic general internal medicine who are passionately committed to improving health through research, education, and advocacy.' Understanding how we define ourselves helps in determining how to advocate in a way that best supports our membership."*

It's been a rough couple of years, hasn't it? Since early 2020, we have seen an unprecedented amalgamation of stressors on the healthcare system, and, more specifically, unmatched burdens on the physicians who operate within it. In addition, the polarizing political environment within our country and its resultant "culture wars" have consequences that exhaust many doctors due to the constant barriers that inhibit our ability to provide evidence-based care to all our patients, regardless of socio-economic status, race, ethnicity, sex or gender. While geographic clustering has long been known to contribute to differences in health and well-being here in the United States,[1] we now find that radical differences in physicians' rights to practice safe and effective care with their patients may be significantly restricted solely based on the state in which they practice. It has become clear that regional differences in political leadership may further compromise our ability to accomplish our goal of achieving equity in promoting better health-related quality of life and longer life expectancy for the communities we serve.

As of the writing of this column, two weeks have passed since the release of the *Politico* article that contained leaked documentation of the Supreme Court majority opinion that Roe v. Wade should be overturned.[2] I immediately received messages from our members seeking support for the protection of women's reproductive rights and to issue a strong statement in support of physician autonomy. The *Politico* report came on the heels of returning from our annual meeting which occurred in Florida, a state that just recently passed legislation

continued on page 14

The SGIM *Forum*, the official newsletter of the Society of General Internal Medicine, is a monthly publication that offers articles, essays, thought-pieces, and editorials that reflect on healthcare trends, report on Society activities, and air important issues in general internal medicine and the healthcare system at large. The mission of the *Forum* is to inspire, inform, and connect—both SGIM members and those interested in general internal medicine (clinical care, medical education, research, and health policy). Unless specifically noted, the views expressed in the *Forum* do not represent the official position of SGIM. Articles are selected or solicited based on topical interest, clarity of writing, and potential to engage the readership. The Editorial staff welcomes suggestions from the readership. Readers may contact the Editor, Managing Editor, or Associate Editors with comments, ideas, controversies, or potential articles. This news magazine is published by Springer. The SGIM *Forum* template was created by Howard Petlack.

Q & A WITH SGIM'S CEO AND THE EDITORS OF JGIM

Eric B. Bass, MD, MPH; Steven M. Asch, MD, MPH; Carol Bates, MD; Jeffrey Jackson, MD, MPH

Dr. Bass (basse@sgim.org) is SGIM's CEO. Drs. Asch (sasch@stanford.edu), Bates (cbates@bidmc.harvard.edu), and Jackson (jjackson@mcw.edu) are co-editors of JGIM.

EBB: What is the biggest challenge JGIM has faced in the last two years?

Editors: After the onset of the Coronavirus Disease 2019 (COVID-19) pandemic, we saw a tsunami of submissions, rising from about 2,200 in 2019, to 3,716 in 2020, and 3,277 in 2021. The monthly number of submissions peaked at 450 in April 2020 with an average of about 300 per month since then, compared with an average of about 180 per month in the year before the pandemic. Thanks to the hard work of the entire team, including the associate editors and managing editors, we were able to weather the storm and increase the acceptance rate from 19% in 2019 to 25% in 2020 and 24% in 2021.

EBB: What are the top achievements of JGIM in the last two years?

Editors: In addition to managing the tsunami of submissions, *Journal of General Internal Medicine* (JGIM) achieved its highest Impact Factor ever. According to the last report on Journal Impact Factors published in summer 2021,[1] JGIM's Impact Factor was 5.128 in 2020 (up from 4.597 in 2019), ranking 27th among the 167 journals in the general and internal medicine category, 11th among the 107 journals in the health care sciences and services category, and third among primary care journals.

In the last two years, we published supplements sponsored by the Veterans Affairs (VA) Office of Research and Health Services Research and Development service on opiate safety, patient engagement in healthcare research, and women's health care, as well as a supplement sponsored by the Agency for Healthcare Research and Quality and Kaiser Permanente on implementation science. We launched a History of Medicine series and made plans for the imminent launch of a Medical Decision Making series. We also launched an editorial fellowship program in 2021 with an initial cadre of three editorial fellows for a two-year fellowship.

EBB: What are your top priorities for the next year?

Editors: Our priorities for the next year include increasing the number of issues from 12 to 16 per year, selecting a second class of editorial fellows, increasing the diversity of the deputy editors, and enhancing the Journal's web site. We remain committed to JGIM being a leader in publishing articles about health disparities, implementation science, and medical education.

EBB: What have you enjoyed most about being the editors of JGIM?

JJ: I've enjoyed the camaraderie of the editorial team and the co-editors in chief and admired the collective wisdom of our associate editors; they invariably have great suggestions on how to deal with complicated issues and to improve our journal.

SA: Being an editor of JGIM is like being a kid in an intellectual candy shop. You learn so much even from the articles we can't publish. And just when you think you have seen it all, you learn something new again. It is great to see the enormous variety of issues that SGIM members (and others) tackle and have a chance to influence the way people think about the care they work so hard at.

CB: I love Steve's comment about being a kid in an intellectual candy shop. JGIM has never been more important than we are today given the state of the world, and I feel incredibly honored and grateful to have this role.

References

1. Clarivate. Journal citation reports. https://jcr.clarivate.com/jcr-jp/journal-profile?journal=J%20GEN%20INTERN%20MED&year=2020&fromPage=%2Fjcr%2Fsearch-results. Accessed June 15, 2022.

SGIM

FINDING THE RIGHT "FIT"—STRATEGIES TO HELP LGBTQ+ APPLICANTS IDENTIFY SUPPORTIVE TRAINING ENVIRONMENTS

Megan McNamara, MD, MS; Christopher Terndrup, MD; Jennifer Siegel, MD; Carl G. Streed, Jr, MD, MPH

Dr. McNamara (megan.mcnamara@va.gov) is a professor of medicine at Case Western Reserve University. Dr. Terndrup (terndrup@ohsu.edu) is an assistant professor of medicine at Oregon Health & Science University. Dr. Siegel (jsiegel1@partners.org) is medical director of the Transgender Health Program at Massachusetts General Hospital and member of the faculty, Harvard Medical School. Dr. Streed (carl.streed@bmc.org) is an assistant professor of medicine in the Section of General Internal Medicine at the Boston University School of Medicine and research lead in the Center for Transgender Medicine and Surgery.

Trainees who are applying for residency or fellowship often consider numerous factors when looking for a program that provides the perfect "fit." Geography, location (e.g., urban v. rural), and program size can significantly influence decision-making. Learners who identify as lesbian, gay, bisexual, transgender, or queer (LGBTQ+) may have additional questions about the program: will they feel welcomed and included? Will they be able to identify role models and mentors with shared lived experience? Should they "out" themselves in their application? While the answers to these questions are personal and often nuanced, this article provides tips to help learners identify a training program that provides an affirming environment, mentorship relevant to their identity, and an inclusive curriculum.

For #LGBTQ+ trainees in medicine, finding a residency/fellowship program with the right "fit" means finding a supportive environment that allows them to thrive. Check out these recommendations. What else would you recommend for #LGBTQ+ trainees? @cjstreed @siegenator1 @doctorterndrup

Applying

Identifying Potential Programs

In addition to finding a program that matches your professional goals, it is important to consider which program(s) will provide you personalized support throughout your training and are welcoming of LGBTQ+ trainees. Consider the following questions as you peruse program websites:

- Does the program explicitly state its commitment to diversity and inclusion?
- Are there any mentorship programs or OUTLists that provide opportunities for LGBTQ+ trainees to learn from LGBTQ+ faculty?
- What are the institutional policies, including insurance coverage and familial leave, for explicit inclusion of diverse sexual orientations and gender identities as well as expansive definitions of "family" to include partners regardless of marital status?
- Are there specific curricula or training opportunities dedicated to LGBTQ+ health?

Writing Your Personal Statement

Ultimately, the choice to be "out" in your application materials is a personal one. As in every application process, reasons for not receiving an invitation to interview will remain unknown to the applicant. As such, many may choose not to be out in their application but will be out during the interview to assess a program in real-time. Alternatively, by being out in your application, less welcoming programs may not offer you an interview and more welcoming programs may offer you an interview; you may essentially avoid less supportive programs and find more supportive programs. Unfortunately, there has not been much research on the application process as it relates to LGBTQ+ applicants.

Interviewing

After receiving an interview offer, the interview is largely about fit. If you are out in your application, receiving an interview likely bodes well for a welcoming training environment. During the interview, you may have additional opportunities to explore how and to what extent a program is welcoming of LGBTQ+ applications.

The questions that programs may ask applicants are tightly regulated. As such, they are allowed to ask you any questions related to your application materials, and you are allowed to bring up additional topics which are open then to further questioning. Programs *cannot* ask you your relationship status or family planning unless in-

continued on page 13

ENSURING EQUITABLE RESEARCH PARTICIPATION—EXPLICIT INCLUSION OF SEXUAL AND GENDER MINORITY POPULATIONS

Carl G. Streed, Jr, MD, MPH; Amy Ben-Arieh, JD, MPH;
Shilpen Patel, MD; Eli Glen Godwin, EdM; Lindsay McNair, MD, MPH, MSB

Dr. Streed (carl.streed@bmc.org) is an assistant professor of medicine in the Section of General Internal Medicine at the Boston University School of Medicine and research lead in the Center for Transgender Medicine and Surgery. Ms. Ben-Arieh (aben-arieh@fenwayhealth.org) is the director of research compliance at The Fenway Institute housed within Fenway Community Health. Dr. Patel (shilpenp@gmail.com) is an affiliate associate clinical professor in the Department of Global Health at the University of Washington and is Principal Health Equity & Inclusive Research Medical Director at Genentech. Mr. Godwin (eggodwin@hsph.harvard.edu) is a research specialist in the Department of Pediatrics, Division of Adolescent and Young Adult Medicine at Boston Children's Hospital and a member of the Institutional Review Board for the Fenway Institute. Dr. McNair (lmcnair@wcgclinical.com) is the chief medical officer at WCG and WCG IRB and an adjunct faculty in the Department of Epidemiology at the Boston University School of Public Health.

Despite increasing awareness of health disparities affecting sexual and gender minority (SGM) populations, lesbian, gay, bisexual, transgender, queer, and Two Spirit (LGBTQ/2S) persons, explicit inclusion of these populations in clinical research remains absent.[1] The goal of clinical research is to effectively assess, prevent, diagnose, or treat conditions that affect health and well-being. Successful and well-designed research studies must identify, recruit, and retain participants representative of the communities to which the results will apply in order to ensure research yields generalizable knowledge. The dearth of appropriate sexual orientation and gender identity (SOGI) data collection and absence of SGM persons in clinical research foreclose opportunities to understand their unique needs in clinical care. This absence renders SGM persons and their needs invisible in the medical literature and fails to adequately capture the impact of sex, sexual orientation, and gender on health.

There are many SGM-specific issues that warrant investigation, but SGM inclusion in *all* randomized controlled trials must be expanded to allow for robust subpopulation analysis. While clinical research has advanced preventive, diagnostic, and treatment modalities for HIV, particularly for cisgender men who have sex with men, it has often excluded transgender men and/or erroneously grouped transgender women with cisgender men.[2] A cadre of cardiovascular clinical research trials has led to significant advances in predicting and preventing cardiovascular disease. However, the tools generated from such research remain limited in application to only binary categories of sex and do not take into account the various factors that affect cisgender men and women (e.g., early menopause, hypogonadism) as well as transgender persons receiving gender-affirming hormone therapy.[3] These and other deficiencies in research design and conduct have resulted in troubling limitations in clinical care.

Regulatory directives and public calls for greater diversity in research participation led to improvements in the inclusion of cisgender women and marginalized racial and ethnic populations in clinical trials. According to the Food and Drug Administration's Center for Drug Evaluation and Research Drug Trials Snapshots Summary, the proportion of Black or African-American persons participating in novel drug trials increased between 2015 (4%) and 2020 (8%). This increase offers critical lessons in improving the participation of populations often excluded from clinical research. Yet, calls to assess and address the health and well-being of SGM persons[1] and for improved collection of SOGI data[4] have remained unanswered.

Within the resulting regulatory vacuum, Institutional Review Boards (IRBs) are well positioned to actively address existing gaps in inclusion of SGM persons. Included within the IRB mandate to protect the rights and welfare of study participants is the responsibility to consider the equitable selection of subjects. This concept of equity is embedded within the principle of justice, emphasized within the Belmont Report as one of the pillars of research bioethics, a touchstone of IRBs. By explicitly considering the inclusion of SGM participants as part of their research ethics oversight function, IRBs appropriately exercise their responsibility to ensure research benefits are maximized (i.e., what's learned is maximally generalizable and nuanced for the benefit of society) and that risks are shared. While the Belmont Report seems to narrow the lens of review to the four corners of a sin-

continued on page 7

gle trial within a specific locale, it provides space within the principle of justice to evaluate the larger social context: "injustice arises from social, racial, sexual and cultural biases institutionalized in society. Thus, even if individual researchers are treating their research subjects fairly, and even if IRBs are taking care to assure that subjects are selected fairly within a particular institution, unjust social patterns may nevertheless appear in the overall distribution of the burdens and benefits of research."

Consequently, IRBs can evaluate community involvement in research design, identify potential harms based on sex, gender, and/or sexual orientation, and propose mitigation strategies. Failure to consider how a research question may pathologize SGM persons can lead to study delay, harm participants, cause the suspension of approval or study closure, and lead to further loss of trust from SGM communities.

In evaluating a research protocol, IRBs routinely interrogate the appropriateness of inclusion and exclusion criteria—but often without awareness of how any particular criterion may discriminate against SGM populations. Bringing an SGM-inclusive lens to this review will ensure that the most appropriate and largest number of potential study participants is considered to answer the proposed research questions. IRBs must also evaluate data collection and ensure appropriate collection of sex, gender, behavior, and additional demographics germane to the research question.[4] Insufficient collection of participant demographic information can lead not only to less robust conclusions being drawn by any particular study being evaluated but also to weakened conclusions of future studies (e.g., meta-analyses) that may inform development of clinical tools,[5] risking propagating bias downstream to healthcare delivery.

Further, IRBs can review and advise revision of recruitment materials and consent documents to foster inclusion of SGM participants. This may include ensuring participant-facing materials accurately delineate inclusion and exclusion criteria (e.g., sex, gender, and other participant demographics), utilize community-informed language, and avoid assumptions of who may be interested in participating in research. IRBs can also correct gender-specific language in protocols and informed consent documents where necessary or appropriate to convey accurate information. For example, it is common practice to use "female" as an inclusion criterion when the population of interest is any individual with a cervix. IRBs can flag this for investigators, who are then able to assess their descriptors more critically. IRBs may find that providing general education and direction to researchers and research sponsors and working with them as they develop research proposals and recruitment plans is more effective than responding to individual submissions during the protocol review process.

Finally, in fulfilling their responsibility to protect the welfare of study participants, IRBs must evaluate the potential harms associated with participating in clinical research. Research studies that recruit from marginalized populations in settings that criminalize behavior (e.g., anti-sodomy laws) must have adequate protections in place to ensure not only confidentiality of study participants but also their safety. Even routine or minimal risk study activities may carry higher risks for SGM participants than cisgender heterosexual ones. Could they be "outed" by a focus group held in a community center? Will gender-affirming care be billed to a parent or guardian's insurance policy? Do data collection instruments contain cis- or hetero-normative language or assumptions? IRBs are situated to inquire deeply about local context, understand the significance of local laws and policies, and ensure investigators consider the situational vulnerabilities of SGM participants (e.g., those living with family who are not aware or supportive of their SGM identity).

Further upstream from the purview of IRBs is the clinical trial sponsor, who can also advance research standards to ensure inclusion of SGM persons. However, progress is slow and disjointed across study sponsors, researchers, and IRBs. Ultimately, regulatory bodies that oversee clinical research conduct must explicitly call for and incentivize improvements to ensure equity in clinical research participation and inclusion of SGM persons.

References

1. National Academies of Sciences Engineering and Medicine (NASEM). *Understanding the Well-Being of LGBTQI+ Populations*. Washington, DC: The National Academies Press; 2020.
2. Poteat T, German D, Flynn C. The conflation of gender and sex: Gaps and opportunities in HIV data among transgender women and MSM. *Global Public Health*. Aug-Sep 2016;11(7-8):835-848. doi:10.1080/17441692.2015.1134615.
3. Streed CG, Jr., Beach LB, Caceres BA, et al. Assessing and addressing cardiovascular health in people who are transgender and gender diverse: A scientific statement from the American Heart Association. *Circulation*. Jul 8 2021:CIR0000000000001003. doi:10.1161/CIR.0000000000001003.
4. Baker KE, Streed CG, Durso LE. Ensuring that LGBTQI+ people count—Collecting data on sexual orientation, gender identity, and intersex status. *N Engl J Med*. 2021;384(13):1184-1186. doi:10.1056/NEJMp2032447.
5. Caughey AB, Krist AH, Wolff TA, et al. USPSTF approach to addressing sex and gender when making recommendations for clinical preventive services. *JAMA*. 2021;326(19):1953-1961. doi:10.1001/jama.2021.15731.

SGIM

A TRIBUTE TO *MI FAMILIA*: HE/SHE/THEM, WHOEVER THEY WANT TO BE AND LOVE, I STAND WITH YOU

Lucille M. Torres-Deas, MD

Dr. Torres-Deas (lmt2183@cumc.columbia.edu) is an assistant clinical professor in the department of medicine, director of the Community and Population Health, and co-chair of the Diversity, Equity, and Inclusion Committee in division of Internal Medicine at the Allen Hospital at Columbia University Vagelos College of Physicians and Surgeons.

As early as I can remember, there was tension, which I did not understand, between my eldest sister and parents: a silence of the unspoken. My sister rarely visited, and I usually saw her only at holiday gatherings. I remember visiting her at college once and having a wonderful time. I could not understand why I did not see her more often. As I got older, I learned the secret: she was lesbian. My parents—Catholic Puerto Ricans with traditional beliefs—found it challenging to accept her fully.

We navigated these trepidatious waters for four decades until, finally, my sister's daughter was born. Her daughter, Hope (name changed for her protection, but reflection of what she brought to our family), brought my family together. The tension diminished as my parents only saw love and hope. We had more gatherings, more laughter, more of everything.

Reflecting on this, I wished it happened sooner. There were so much unnecessary emotional, mental, and physical (of being slapped/hit) traumas due to conflicts of complex belief systems that encompass from generational trauma and expectations from family due to their cultural beliefs and expectations. Not only for my sister, my parents, but also *mi familia*. She tried to be the exemplary daughter—attaining her educational degrees, becoming professional, and trying to be "perfect," even though my parents' religion and culture were not in line with who she was as a person. My sister persevered. She has accomplished many goals and helped my family navigate the loss of both of my parents. She opened the door for me to live with my Black boyfriend for years until we finally decided to tie the knot because we wanted to not because society said we had to and for our nieces and nephews to be who they wanted to be and love who they wanted to love. Before my parents passed, they accepted her, me, their daughter, my nieces, and nephews for who they were and who they loved. There was no longer a secret or tension but love and hope.

These experiences helped me on many occasions in the clinical setting. One day, my LatinX patient came in for a follow up. She was in tears because her daughter had told her she was lesbian. Although she loved her daughter, who was so accomplished, this conflicted with her beliefs. She felt so distressed that she couldn't speak to anyone about this in her family or community. She couldn't sleep. I thought my family situation, given our similar backgrounds, would provide healing and reduce stigma for her. Since it was personal and not medical, I asked permission to discuss what happened with my family.

"Is it ok if I share with you something personal, something that happened to my family?" She accepted. We discussed what happened, the aspect of rigid culture and religious beliefs that were similar and how they caused separation and pain. In the end, the beautiful outcome of acceptance and love, when one could find what was most significant about that relationship. That she didn't have to wait for four decades to re-connect. In the end, she came to her own conclusion that her faith asked her to love all. So, she should love her daughter for who she was. She felt the weight lifted. In sharing the experience and allowing for the moment of compassionate presence, my patient was able to have a new understanding and appreciation of her daughter and who she was. She was no longer in conflict or distressed with her cultural and spiritual beliefs.

When there's so much discord in the world, from media to state legislation, it's important we recognize the human experience as unique, meet individuals where they are at, educate, and advocate for those who are considered "different." There is a high prevalence of distress, violence, and suicidality among individuals who identify as LGTBQIA+. I'm thankful for *Mi Familia* and our experience. To my nieces, nephews, children and LGTBQIA+ community, I stand with you, next to you, behind you, in front of you, whatever is needed on your journey to be who you want to be and love who you want to love. Thank you for making this world brighter by being entirely you!

I call on governmental bodies, professional organizations, and healthcare systems to do the same. As there are threats to LGTBQIA+ rights from local to national levels, specialties, healthcare organizations, professional societies, and governmental bodies must join forces to advocate for protection of LGTBQIA+ rights and ally with LGTBQIA+ organizations when those rights are in jeopardy. **SGIM**

DON'T MAKE ME READ MY CHILD'S OBITUARY

Aliza Norwood, MD

Dr. Norwood (Aliza.Norwood@viventhealth.org) is assistant professor of internal medicine at the University of Texas Dell Medical School and the medical director at Vivent Health in Austin, Texas, where she provides HIV primary care, HIV prevention, and gender-affirming care. Her opinions are her own.

In Texas, my home state and where I practice as a primary care physician, the rights of transgender people have been continuously targeted in a battle for political power. In May 2022, the Texas Supreme Court ruled that the Texas Department of Family and Protective Services (DFPS) could continue their investigations of families of transgender children after a lower court that had temporarily halted the inquiries statewide. The inquiries started in February, when Governor Greg Abbott directed the DFPS to investigate parents who with transgender children, based on an opinion by Attorney General Ken Paxton that asserted that certain medically accepted treatments for transgender youth constitute child abuse.

On March 11, instead of seeing patients in clinic, I sat in the back of a large auditorium at the Texas Department of Family and Protective Services (DFPS) and listened to stories of trauma for hours. Each story started with the same phrase: "My name is—, and I'm here to read a statement from the family of a transgender child who is too terrified to be here." One by one, community members stepped up to read statements to DFPS council members from transgender kids and their families submitted from across the state. Brave family members and transgender youth also stood up to speak themselves, despite the extremely personal nature of their testimony and the great personal risk.

One mother spoke of how she did not initially support her transgender son's transition after he came out. She choked back tears as she described coming home one day to find her son unconscious on the floor of his room. I watched a council member blot away tears as this mother poured out her soul, explaining that his suicide attempt convinced her to listen to him and how, with treatment, he is now thriving and happy. Another family pleaded with the council, "Don't make me read my child's obituary." These parents described making difficult decisions driven by an unconditional love for their children, and an intense fear that the unthinkable could happen—that a state agency could take their children from them for loving and supporting them.

I, too, was there on behalf of others. As an internist, I have provided gender-affirming care to adults in my practice for the past eight years, but I went to represent my colleagues in pediatrics who can't risk putting their patients and themselves in danger by speaking up. Due to political and financial pressure, clinics that care for transgender youth have been shutting down to avoid persecution.

As of May 24, 32 states have passed or proposed anti-transgender legislation, including restricting access to gender-affirming care. Some bills carry severe penalties for healthcare providers and sometimes families, who provide or seek out gender-affirming care for minors. The UCLA Williams Institute predicts that more than 58,000 transgender youth are at risk of losing care because of these state bans. Even without making gender-affirming care illegal, clinics are under threat of having funding pulled and families are at risk of investigation, as is the case in Texas. Primary care doctors face a moral challenge in the face of unethical political overreach into the lives of patients and disruption of the patient-physician relationship. As the fight over transgender healthcare continues to get national attention, the public will be looking to physicians to understand what transgender healthcare is and is not. To ensure consistent and clear messaging, we must invest in education of our trainees and colleagues, most of whom are unfamiliar with gender-affirming care.

Ignorance does not always mean malintent, but it's our responsibility to make sure physicians are knowledgeable and respectful when caring for transgender and gender-diverse patients. According to the 2015 National Transgender Discrimination Survey, one-third of those who saw a health care provider had at least one negative experience related to being transgender, such as being verbally harassed or refused treatment because of their gender identity. Additionally, nearly one-quarter (23%) of respondents reported that they did not seek the health care they needed in the year prior to completing the survey due to fear of being mistreated as a transgender person, and 33% did not go to a health care provider when needed because they could not afford it.

Clearly, our work is cut out for us. There is currently no AAMC requirement to teach medical students about

continued on page 15

TELEHEALTH FOR MENTAL HEALTH CONDITIONS IN THE PRIMARY CARE CLINIC: OPPORTUNITIES AND A WAY FORWARD

Erica Heiman, MD, MS; Leslie Suen, MD, MAS; Jennifer Wootten, MD; John Goodson, MD

Dr. Heiman (erica.heiman@emory.edu) is an assistant professor at the Emory School of Medicine and a physician site lead for the Grady Primary Care Center. Dr. Suen (leslie.suen@ucsf.edu) is a research and clinical fellow within the UCSF National Clinician Scholars Program. Dr. Wootten (jwootte@emory.edu) is an assistant professor in the Department of Psychiatry and Behavioral Health at Emory University School of Medicine and the medical director of Grady Outpatient Behavioral Health Services. Dr. Goodson (jgoodson1@mgh.harvard.edu) is a physician at Massachusetts General Hospital and an associate professor at Harvard Medical School.

On January 1, 2022, the Centers for Medicare & Medicaid Services (CMS) implemented permanent changes in the Medicare Physician Fee Schedule that offer new possibilities to expand the scope of telehealth for mental health (MH) and substance use disorders (SUD) for Medicare patients. These changes are a direct response to recent increases in MH and SUDs over the last two years, which have been especially deadly in combination with the tsunami of synthetic opioids (namely fentanyl) that has cascaded across the United States.[1]

> “These Medicare telehealth changes represent a call to action for the primary care community to bring its expertise in MH and SUD treatment to the telehealth arena and lay claim to a revenue support model that pays for the work done.”

Amid the shelter-in-place regulations of the COVID-19 pandemic, telehealth emerged as a powerful tool. Telehealth can improve access to care, particularly among vulnerable populations who may lack funds for travel and care of dependents. For patients with SUDs, stigma may present further barriers to in-person care, which telehealth may help to alleviate.[2] Not only do primary care clinics present an entryway into care for MH disorders, they increasingly receive a greater proportion and volume of visits for MH disorders than psychiatry offices.[3]

Those of us in general medicine have long been hampered in our efforts to expand access for our patients SUD and MH conditions by insufficient resources. With the new service code options provided by CMS, we can explore innovative ways of care delivery that leverage the expertise of a multi-disciplinary team. In the table, we lay out relevant Medicare telehealth service codes with the respective payments in relative value units (RVUs). RVUs translate to dollars by multiplying times the Medicare conversion factor, roughly $35.

Here Are the CMS Changes You Need to Know About

The patient can be located anywhere—whereas telehealth services were previously confined to dedicated spaces, telehealth services for MH and substance use care can be provided to patients who are home, or at another location including a shelter, car, or their place of work. State licensing restrictions still apply. Encounters should be clearly focused on MH/SUD but other conditions can and should be addressed.

In-person visits are sometimes required—CMS has required an in-person visit no more than six months before the telehealth visit, and at no greater than every 12 months after. However, the 12-month periodic in-person visit can be waived if a provider documents that the burdens of an in-person visit outweigh the benefits; and how vital signs, patient monitoring data, and lab testing are available as needed. Finally, *all* in-person requirements can be waived for SUD telehealth visits.

Audio-visual technology preferred but audio-only allowed—CMS’ preference remains for audio-visual telehealth visits, but audio-only may be delivered if the patient does not have the capabilities or does not consent to participate in a video telehealth visit, and this is appropriately documented.

Examples of How the New Medicare Codes May Be Used

Scenario 1: Depression Follow-up

Mr. J, a 54-year-old man with depression and emphysema, is an established patient in the clinic. He is scheduled

continued on page 11

Mental Health and Substance Use Disorder Telehealth after the Public Health Emergency (PHE)

Type of Care	CPT Code(s)	RVU (non-fac/fac)	Time Criteria	Documentation Needed	Modifier Needed
Mental Health (MH) and Substance Use Disorder (SUD) Outpatient E/M Care					
E/M: New Patients	99202	2.14/1.43	> 15 minutes	Complexity of OR time spent	95 for A/V, 93 for audio only
	99203	3.29/2.44	> 30 minutes		
	99204	4.90/3.95	> 45 minutes		
	99205	6.48/5.36	> 60 minutes		
E/M: Established Patients	99212	1.66/1.06	> 10 minutes		95 for A/V, 93 for audio only
	99213	2.661.95	> 20 minutes		
	99214	3.75/2.86	> 30 minutes		
	99215	5.29/4.25	> 40 minutes		
Other Behavioral Health Services					
Alcohol Use Screening	G0442	0.55/0.27	> 8 minutes	Statement of tool used and time spent	95 for A/V, 93 for audio only; 25 if billed along with E/M code
Alcohol Use Counseling	G0443	0.77/0.69	> 8 minutes	Statement of time spent	95 for A/V, 93 for audio only; 25 if billed along with E/M code
Depression Screening	G0444	0.54/0.27	> 8 minutes	Statement of time spent	95 for A/V, 93 for audio only; 25 if billed along with E/M code
Substance Use Disorder Treatment—Bundled Care	G2086 (initial)	11.50/9.26	> 70 minutes/ 30 days	Statement of time spent	95 for A/V, 93 for audio only
	G2087 (subsequent)	10.01/8.28	> 60 minutes/ 30 days		
	G2088 (add on)	1.79/1.13	Additional 30 minutes beyond 120 minutes		

CPT=Current Procedural Terminology; RVU=Relative Value Units; PE=Practice Expense;
E/M=Evaluation and Management; A/V=Audio-visual

for an audio-video visit, during which his PCP addresses his depression, including medication titration and re-referral to counseling. His inhalers are refilled; an outpatient established patient service code, such as 99214, code is used for billing purposes.

Scenario 2: Bundled Opioid Use Disorder Treatment
Ms. Y, a 43-year-old woman without past medical history, is referred to the clinic from her rural ER, where she presented for treatment of an abscess related to injection opioid use. The ER diagnoses her with opioid use disorder and provides her with a telehealth appointment with a primary care doctor. A doctor spends 30 minutes on the phone with her discussing her initial treatment plan and induction with buprenorphine. A follow-up telehealth check-in is scheduled for later in the week with a Physician Assistant. An appointment is made for later that month with the clinic's therapist via telehealth. The month of multidisciplinary care is coded with the Medicare service code, G2086, for billing purposes.

Pitfalls and Cautions

CMS has been hesitant to permanently add telehealth billing codes for medical conditions, as there is a concern that fraud may be rampant, despite little evidence of this. Additional concerns, none clearly demonstrated in previous research, include the potential for difficulty in rapport-building, and possibility of decreased understanding of medical recommendations, particularly in audio-only encounters.[3, 4] We caution providers to use standardized documentation tools when available to prevent fraud and bias and involve a multi-disciplinary team to ensure high-quality, coordinated care. We encourage providers to always verify the patient's name, date of birth,

continued on page 13

eases, and treatments are the same in both LGBTQ+ and cisgender, heterosexual patients, physicians must be prepared to address barriers to care in the institutional climate and create an inclusive environment that is able to address the unique needs of LGBTQ+ persons. The inclusion of LGBTQ+ content into the curriculum increases knowledge and develops positive attitudes in medical students about healthcare delivery to LGBTQ+ persons. Comprehensive medical education and training about LGBTQ+ health creates a profession that is better prepared to serve this community with empathy, comfort, and cultural competence. Medical schools and training programs should adopt the AAMC's recommendations so that students and residents are well- prepared to provide high quality, patient-centered LGBTQ+ health care.

The Legal Landscape for LGBTQ+ Healthcare Discrimination

In 2020, the U.S. Supreme Court's historic ruling in *Bostock v. Clayton County* established that discrimination against a person because they are gay or transgender constitutes unlawful sex discrimination. 140 S. Ct. 1731 (2020). In this landmark ruling, the Court made clear that its decision was a "straightforward application of legal terms with plain and settled meanings" and plainly stated that one "must scramble to justify" the rationale for carving LGBTQ+ individuals out of the protections based on sex. The far-reaching implications of that decision were anticipated: "What the Court has done today––interpreting discrimination because of 'sex' to encompass discrimination because of sexual orientation or gender identity––is virtually certain to have far-reaching consequences." *Id.* at 1778 (Alito, J., dissenting). More than 100 federal statutes prohibit discrimination based on sex, including the prohibitions against discrimination in health care. It did not take long for federal courts across the country to begin applying the *Bostock* framework to protect the rights of LGBTQ+ Americans seeking equal access to health care.

Congress enacted the Affordable Care Act ("ACA") in 2010. The ACA contains a non-discrimination provision, known as § 1557, which states in relevant part: "[A]n individual shall not…[on the basis of sex]…be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity...". The U.S. Department of Health and Human Services' (HHS) Office for Civil Rights is responsible for enforcing Section 1557 and protecting the civil rights of individuals in accessing health care. After the Supreme Court ruling in *Bostock*, the DHHS issued a Notification of Interpretation and Enforcement stating that the agency would be interpreting and enforcing Section 1557's prohibition on discrimination on the basis of sex to include: (1) discrimination on the basis of sexual orientation; and (2) discrimination on the basis of gender identity. Thus, Section 1557 of the ACA imposes an *affirmative obligation not to discriminate against LGBTQ+ individuals in the provision of health care*. Meeting this legal obligation requires medical providers to be trained to competently identify and address the needs of the LGBTQ+ patient population.

In conclusion, because of the recent changes to the legal landscape through binding case law and notices of interpretation and enforcement by the responsible government agencies, medical schools should ensure their students are equipped to uphold their legal obligations to provide non-discriminatory healthcare services to LGBTQ+ patients.

Moving Forward: From Silence to Action

Medical education and patient care that are not inclusive are, by default, *exclusive, narrow, circumscribed, limited, and incomplete*. Every medical school can take steps to create a LGBTQ+ inclusive curriculum by following these suggestions:

1. **Assess** the institutional climate and current curriculum.
    - Evaluate mission statements and non-discrimination statements to ensure they are inclusive of LGBTQ+ populations.
    - Conduct focus groups that include students, faculty, administrators, community stakeholders, and patients to determine how LGBTQ+ health education can be improved.
    - Evaluate the diversity fostered throughout the admissions process
2. **Create** a LGBTQ+ Health Education Advisory Committee.
    - Include faculty, students, community members, patients, and stakeholders.
    - Build relationships with LGBTQ+ organizations on campus and the community. Open a dialogue to learn about suggestions that promote inclusive care and medical education.
3. **Integrate** LGBTQ+ health and care into the core competencies.
    - List core LGBTQ+ learning objectives and recommendations for their integration into the curriculum. Use the AAMC's *Implementing Curricular and Institutional Climate Changes to Improve Heath Care for Individuals Who are LGBT, Gender Nonconforming*, or *Born with DSD* as a guide.
    - Include LGBTQ+ patients in case presentations, simulations, and as standardized patients
    - Learn about reliable LGBTQ+ resources
4. **Evaluate** progress.
    - Measure changes in student and faculty knowledge, at-

continued on page 15

MEDICAL EDUCATION: PART II *(continued from page 5)*

cluded in your application. If family planning, child care, or being openly LGBTQ+ are important to you, you are not only welcome but also encouraged to bring these up during the interview; this can lead to a helpful and informative conversation.

As the interview is focused on “fit” and ensuring you find the program that is going to best prepare you for your career, be sure to ask questions that relate to your personal and professional goals in areas such as research, advocacy, and/or community engagement:

- Who could be a mentor as an Out LGBTQ+ leader in your program/institution/organization?
- Can you tell me about the culture for LGBTQ+ individuals at this program?
- What opportunities exist to address LGBTQ+ health?
- What family/partner benefits exist for same-sex couples with or without children?
- How does the health insurance policy address LGBTQ+ health? Is there explicit inclusion of gender-affirming medical and surgical care?
- Does the health care system provide explicit guidance for persons who undergo gender-affirming care during training? Does Human Resources provide training on respectful conduct?
- How do you recruit and retain LGBTQ+ applicants and future physicians?

Conclusion

Ultimately, finding a program that prepares you for your chosen specialty is about ensuring you are supported and encouraged to thrive. By finding a supportive environment with welcoming leadership and peers, you can more easily become the best clinician you aspire to be.

SGIM

HEALTH POLICY CORNER *(continued from page 11)*

as and location (as providing care across state lines may have legal implications); and to query any unexpected pauses in the conversation or changes in tone, as to maintain two-way understanding despite being physically distant.

Next Steps: A Call to Action within Your Practice or Enterprise

Many colleagues are pivoting to telehealth due to necessity during the pandemic, and finding not only that it is effective but also that it enhances equity and retention particularly with the treatment of SUDs.[5] The current Medicare telehealth flexibilities, which have expanded telehealth’s reach greatly and increased revenue for audio-only visits via the 99441-99443 codes, are set to expire, unless Congress takes action. The CY 2022 Medicare Physician Fee Schedule final rule lays out a framework for an expanded role for telehealth in the care of MH conditions and SUDs. We believe these changes represent a call to action for the primary care community to bring its expertise in MH and SUD treatment to the telehealth arena and lay claim to a revenue support model that pays for the work done.

Primary care, as a cognitive specialty, has long been subject to under-reimbursement, a phenomenon that has recently begun to be addressed, though thus far inadequately. If primary care physicians do not work to claim the reimbursement they deserve based on their knowledge, patient care skills, and collaborative capabilities, we risk not seizing an opportunity to enhance the care we aspire to deliver.

These regulations and codes listed above are only applicable to Medicare, but in many cases, other public and private insurers will reimburse similarly to Medicare. And if health systems and clinicians continue to use these codes to provide important services to their patients, further legislation and regulations will follow to continue to support this expansion to include virtual care, and even audio-only care, for those with one or more chronic medical conditions.

References

1. Aronowitz SV, Engel-Rebitzer E, Dolan A, et al. Telehealth for opioid use disorder treatment in low-barrier clinic settings: An exploration of clinician and staff perspectives. *Harm Reduct J.* 2021 Nov 25;18:119.
2. Olfson M. The rise of primary care physicians in the provision of US mental health care. *J Health Polit Policy Law.* 2016 Aug;41(4):559-83. doi: 10.1215/03616878-3620821. Epub 2016 Apr 28.
3. Connolly SL, Gifford AL, Miller CJ, et al. Provider perceptions of virtual care during the Coronavirus Disease 2019 Pandemic: A multispecialty survey study. *Med Care.* 2021 Jul;59(7):646–52.
4. Voils CI, Venne VL, Weidenbacher H, et al. Comparison of telephone and televideo modes for delivery of genetic counseling: A randomized trial. *J Genet Couns.* 2018 Apr;27(2):339–48.
5. Samuels EA, Khatri UG, Snyder H, et al. Buprenorphine telehealth treatment initiation and follow-up during COVID-19. *J Gen Intern Med.* 022 Apr; 37(5): 1331–1333. Published online 2022 Jan 3. doi:10.1007/s11606-021-07249-8.

SGIM

PRESIDENT'S COLUMN

(continued from page 3)

limiting the discussion of gender and sexuality in schools. All these events raise significant concerns that political intentions are threatening physician ability to provide care that best meets the needs of their patients. In addition, we continue to see political division over the role gun legislation plays in relationship to public health and welfare; particularly concerning the numerous mass casualty shootings that have occurred in the United States over the past two years.[3]

In each of these areas, we find SGIM members expressing a desire for the society to act. As an organization that represents such a diverse group of physicians, we must create a safe space for all members, regardless of their political leanings. As I prepared to write the column for this issue of the *Forum*, it occurred to me that we must be clear about our values and how they shape our advocacy in health policy.

I strongly support guiding our organizational decisions based on our clearly articulated vision and values. In January 2022, SGIM council approved our most recent value statement after a lengthy strategic planning initiative.[4] To be clear, I believe that all our actions should be aligned with accomplishing our vision of "a just system of care in which all people can achieve optimal health." In our statement, we define ourselves as a "diverse community of talented people in academic general internal medicine who are passionately committed to improving health through research, education, and advocacy." Understanding how we define ourselves helps in determining how to advocate in a way that best supports our membership.

In our organizational credo, we articulate seven core values:

1. Excellence, innovation, and leadership in education, research, and clinical practice
2. High value, evidence-based, person-centered, and community-oriented health care
3. Action and policy that dismantle structural racism and oppression
4. Diversity, equity, and inclusion
5. Attention to population health outcomes and their social determinants
6. Interdisciplinary collaboration and team-based care, and
7. Collegiality, mentorship, and career development.

It is obvious that current political actions across many of our states counter many of our stated values. More importantly, these efforts present significant risks to our members ability to practice medicine in a way that is aligned with our organizational core values and in achieving our vision. Given our commitment to achieve high value, evidence-based health care and to support policies that dismantle oppression and support work that promotes better population health outcomes, I believe we are obligated to stand with other organizations in opposing legislation aimed at reversing the progress that has been made in this country. I support our members and partnering organizations in standing against threats to women's health and access to safe, evidence-based, reproductive care. I previously made clear my support for organizational advocacy to protect the health and well-being of our LGBTQ+ community. Further, I believe that gun violence is a public health concern worthy of attention and stand with our members who continue to advocate for public health measures to address its threats. From my viewpoint, our recently published statements and support of these and other issues are aligned with our stated goals and are an example of SGIM living by our values.

References

1. Sampson RJ. The neighborhood context of well-being. *Perspectives in Biology and Med.* 2003;46(3):S53-S64.
2. Gerstein J, Ward A. Supreme Court has voted to overturn abortion rights, draft opinion shows. *Politico*. https://www.politico.com/news/2022/05/02/supreme-court-abortion-draft-opinion-00029473. Published May 3, 2022. Updated May 4, 2022. Accessed June 15, 2022.
3. Crandall M, Bonne S, Bronson J, et al. *Why We Are Losing the War on Gun Violence in the United States*. Switzerland: Springer Nature; 2021.
4. Society of General Internal Medicine. Vision and Values. https://www.sgim.org/about-us/vision—values. Published January 2022. Accessed June 15, 2022.

SGIM

EDITOR'S CORNER

(continued from page 2)

like SGIM, our impact feeds into a virtuous cycle that can continue reaching beyond greater bounds than we might have previously imagined possible.

References

1. Lypson ML. The July effect and SGIM's lifecycle of renewal. SGIM *Forum*. https://connect.sgim.org/sgimforum/viewdocument/the-july-effect-and-sgims-lifecycl. Published July 2021. Accessed June 15, 2022.

SGIM

PERSPECTIVE: PART II *(continued from page 9)*

health related to the entire umbrella of LGBTQI+ communities, much less transgender people specifically. In 2020, a staggering 52% of transgender youth reported considering suicide. More than a dozen studies have shown that gender-affirming care for youth improves anxiety, depression and thoughts of suicide, and is endorsed by every major medical organization, including the Texas Medical Association, the American Academy of Pediatrics, and the American Psychiatric Association. If we are to lean into health equity teaching, we must include dedicated training on inequities that affect transgender patients.

Despite fearmongering, gender-affirming care for youth follows well-established, age-appropriate standards of care. For young children, that care includes just supporting them socially, by using the name and pronouns they prefer. Adolescents with gender dysphoria are much more likely to identify as transgender when they are in adulthood; for them, temporary puberty blockers can be considered while they undergo counseling with trained mental health professionals and physicians before moving to less reversible treatments such as hormones. Genital surgeries, often referenced by legislators, are in fact not recommended for minors by current guidelines.

The real danger here is denying high-risk youth medically indicated, life-saving care while ripping them from supportive families. Family rejection is extremely common when transgender people come out to their family, something I hear about from most of my adult transgender patients. Transgender adults rejected by their parents are twice as likely to attempt suicide with higher odds of alcohol or drug abuse.

In keeping with the Hippocratic Oath, we cannot allow our hospitals and clinics to deny this care and leave patients to fend for themselves. What we can do is advocate for evidence-based medicine and support organizations defending transgender youth on the ground, such as OutYouth, the Transgender Education Network of Texas, Organización Latina de Trans en Texas, the National Black Trans Advocacy Coalition and Equality Texas, and others across the country facing similar threats. We can train the next generation of clinicians to be knowledgeable about transgender and involve transgender stakeholders in our curricular development. We can and should share resources to teach each other as we teach our colleagues and students. A group of SGIM members lead by Dr. Hedian published an easy-to-use *Guide for Gender Affirming Hormone Therapy* for primary care clinicians and trainees, accessible at https://bit.ly/GAHT-QUICK-GUIDE and featured in the June 2022 SGIM *Forum*.[6] An example of involving transgender patients in curricular development and teaching was presented by myself and colleagues at the 2022 SGIM annual meeting. Together, and with the transgender community, we take a stand and defend the rights of patients to access gender-affirming care—care that could literally save their lives.

Note: An earlier version of this article appeared in *Salon* and may be accessed at https://www.salon.com/2022/03/29/dont-make-me-read-my-childs-obituary-texas-risks-lives-by-banning-gender-affirming-care/.

References

1. Dey S. Houston hospital pauses hormone therapy for transgender children as threats of child abuse investigations loom. *Texas Tribune*. https://www.texastribune.org/2022/03/04/texas-transgender-children-hormone-therapy/. Published March 4, 2022. Accessed June 15, 2022.
2. Conron KJ, O'Neill KK, Vasquez LA, et al. Prohibiting gender-affirming medical care for youth. https://williamsinstitute.law.ucla.edu/publications/bans-trans-youth-health-care/. Published March 2022. Accessed June 15, 2022.
3. Turban J. The evidence for trans youth gender-affirming medical care. *Psychology Today*. https://www.psychologytoday.com/us/blog/political-minds/202201/the-evidence-trans-youth-gen-

continued on page 16

MEDICAL EDUCATION: PART I *(continued from page 12)*

titudes, and skills as discussions about LGBTQ+ patients become more frequent, deliberate, and explicit.
- Measure changes in medical students' satisfaction with the curriculum and their perceived ability to provide inclusive care.

5. **Disseminate** work outcomes and innovations so other institutions can learn from your failures and successes.

As the United States continues the struggle to create a more fair and just society, we as clinicians and medical educators must examine our roles in cultivating future physicians who can help all patients access high quality healthcare in an affirming and inclusive environment. This is not only our ethical obligation but also a legal one. The stakes for our students and their patients are high and the time to act is now!

continued on page 16

SGIM Forum
Society of General Internal Medicine

Society of General Internal Medicine
1500 King Street, Suite 303, Alexandria, VA 22314
202-887-5150 (tel) / 202-887-5405 (fax)
www.sgim.org

MEDICAL EDUCATION: PART I *(continued from page 15)*

References

1. Lunn MR, Cui W, Zack MM, et al. Sociodemographic characteristics and health outcomes among lesbian, gay, and bisexual U.S. adults using Healthy People 2020 leading health indicators. *LGBT Health*. 2017 Aug;4(4):283-294. doi: 10.1089/lgbt.2016.0087. Epub 2017 Jul 20.
2. James SE, Herman JL, Rankin S, et al.: The report of the 2015 U.S. Transgender Survey. Washington, DC; National Center for Transgender Equality: 2016.
3. Obedin-Maliver J, Goldsmith ES, Stewart L, et al. Lesbian, gay, bisexual, and transgender-related content in undergraduate medical education. *JAMA*. 2011 Sep 7;306(9):971-7. doi: 10.1001/jama.2011.1255.
4. Fallin-Bennett K. Implicit bias against sexual minorities in medicine: Cycles of professional influence and the role of the hidden curriculum. *Acad Med*. 2015; 90:549-52.
5. Newport F. In U.S., estimate of LGBT population rises to 4.5%. *Gallup: Politics*. https://news.gallup.com/poll/234863/estimate-lgbt-population-rises.aspx. Published May 22, 2018. Accessed June 15, 2022.

SGIM

PERSPECTIVE: PART II *(continued from page 15)*

der-affirming-medical-care. Posted January 24, 2022. Accessed June 15, 2022.

4. The Trevor Project. National survey on LGBTQ youth mental health 2020. https://www.thetrevorproject.org/survey-2020/?section=Introduction. Accessed June 15, 2022.
5. Klein A, Golub SA. Family rejection as a predictor of suicide attempts and substance misuse among transgender and gender nonconforming adults. *LGBT Health*. 2016;3(3). https://doi.org/10.1089/lgbt.2015.0111.
6. Hedian H, Streed C, Siegel J, et al. Gender-affirming hormone therapy: Lowering the activation energy for hormones in primary care. SGIM *Forum*. https://connect.sgim.org/sgimforum/viewdocument/gender-affirming-hormone-therapy-l. Published June 2022. Accessed June 15, 2022.

SGIM

The ISSN for SGIM *Forum* is: Print-ISSN 1940-2899 and eISSN 1940-2902.