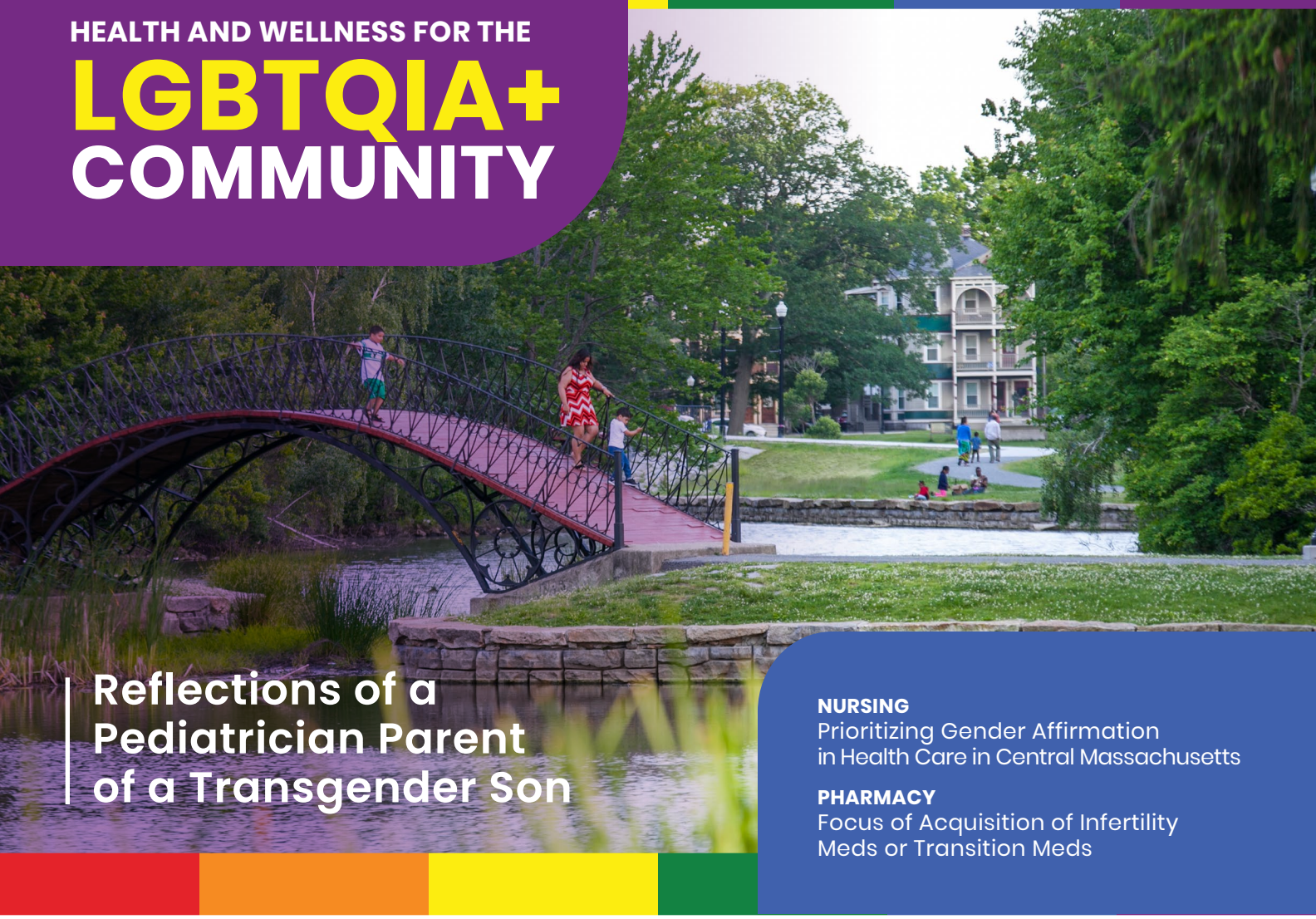
WORCESTER
medicine

Volume 91 • Number 2 Published by Worcester District Medical Society March / April 2022

HEALTH AND WELLNESS FOR THE LGBTQIA+ COMMUNITY



Reflections of a Pediatrician Parent of a Transgender Son

NURSING
Prioritizing Gender Affirmation in Health Care in Central Massachusetts

PHARMACY
Focus of Acquisition of Infertility Meds or Transition Meds

WDMS.ORG

Through

INNOVATION AND COLLABORATION

we are building
tomorrow's healthcare, today.

ARE YOU?

Learn more at practiceatreliant.org

RELIANT
MEDICAL GROUP
Part of OptumCare®

WORCESTER medicine

Contents

MARCH / APRIL 2022

on the cover
Elm Park,
Worcester, MA

Health and Wellness for the LGBTQIA+ Community

As I See It

Society Snippets

PUBLISHED BY
Worcester District Medical Society
321 Main Street, Worcester, MA 01608
wdms.org | mwright@wdms.org | 508-753-1579

PRODUCED BY
Studio DiBella

THANK YOU TO
The Reliant Medical Group
UMass Memorial Health Care
Music Worcester
Physicians Insurance
Carr Financial

ADVERTISING
Inquiries to Martha Wright
mwright@wdms.org
508-753-1579

Editorial

Julianne Lauring, MD

LGBTQIA+ stands for lesbian, gay, bisexual, transgender, queer, intersex, asexual, and additional genders and orientations. There is no single "correct" list of letters, with organizations and individuals choosing different acronyms for many reasons. (Also, yes, this is technically not an acronym since we pronounce each letter, but for ease of discussion, this is frequently referred to as an acronym.) In this issue, I am purposefully using the longer acronym to promote awareness of the spectrum of individuals we are discussing in this issue. We also opted to be consistent throughout the issue. The LGBTQIA+ community is diverse and heterogeneous. Each individual has a different lived experience, and it is impossible to completely cover such a broad topic in a single issue. But when the editorial board suggested this topic, I felt it critical to highlight the continued disparity faced by this population, and the ongoing work in Massachusetts to help reduce that disparity. We are fortunate to have authors willing to share some powerful personal stories, and leaders in this field advising on how to improve our practice.

The article "Healthcare for LGBTQIA+ Patients: Bridging the Disparity Chasm" by Frances Grimstad, MD, MS, and Aditya Chandrasekhar, MD, MPH, provides an excellent place to start for anyone looking for additional information on the definition of each identity. After these definitions, they detail the disparities experienced by LGBTQIA+ individuals both in regard to their health, but also their experiences in society.

Several articles in this issue focus on transgender individuals. This population experiences high rates of violence and discrimination, and can bring a different set of challenges to healthcare providers. Carole Allen, MD, MBA, FAAP, current President of the Massachusetts Medical Society, provides a personal reflection on her experiences and advice, in her article "A Pediatrician Parent of a Transgender Son." We have also included information from the Youth Gender Services Program at UMass Memorial Health, a program for transgender and gender non-conforming children and teens here in Central Massachusetts.

Gender-affirming care can be lifesaving for transgender patients, and Rebecca Thal, NP-C, AAHIVS, and Ben Aldred NP-C, AAHIVS, provide guidance on how to provide gender-affirming care within any medical practice in their article "Prioritizing Gender Affirmation in Health Care in Central Massachusetts." Their principles of inclusion can also be applied to so many of our patients. In the article "Adult Transgender Hormone Therapy" by Anna K. Morin, Pharm. D, the pharmacology of gender-affirming medical treatment is described, including the monitoring and adverse effects to look out for in adult patients. The medical and surgical treatment of transgender patients must be complemented by gender affirmation in the healthcare environment.

University of Massachusetts TH Chan Medical School student, Andrea Chin, and her mentor, Tara Kumaraswami, MD, provide us with examples of microaggressions and their impact on LGBTQIA+ individuals. They also provide insights into ways to make your space and practice more inclusive, as well as reduce the microaggressions an LGBTQIA+ patient must face in the healthcare setting.

We are lucky to provide two "As I See It" pieces in this issue. Alec Allein, a medical student at University of Massachusetts TH Chan Medical School, describes medical student burnout as it particularly affects LGBTQIA+ students. Pawina Subedi, MD, an Internal Medicine resident a St. Vincent Hospital, describes the difficulties faced by trainees with a uterus when compared to those without.

And as always, I encourage you to check out our Society Snippets.

Culturally competent care is not something that can be perfected by reading a single magazine issue. It takes education and practice. We have provided a list of resources, both those referenced by our authors, and some others that may be helpful. And I acknowledge this is an area in which I continue to work to grow my practice. Recently, I was caring for a non-binary pregnant person. We spent a lot of time talking, and then I slipped and referred to them as "mom." Phrases like "birthing-person" instead of mother, and "support person" instead of father, have become the more inclusive terms. Changing old habits is never easy, but for the health and wellbeing of our patients it is important we do so, as well as educate the next generation of providers to be better.

One final note on letters. The A in LGBTQIA+ has also been used to denote an ally. An ally is a heterosexual or cisgender individual who recognizes their own privilege and works to promote equity and support members of the LGBTQIA+ community. I hope this issue gives voice to the LGBTQIA+ community and helps make stronger allies within the healthcare community. ✚

Julianne R. Lauring, MD
Assistant Professor in Obstetrics and Gynecology at University of Massachusetts Chan Medical School, Maternity Center Medical Director for Umass Memorial Health Memorial Campus

Reflections of a Pediatrician Parent of a Transgender Son

Carole E. Allen, MD, MBA, FAAP

Many years ago, I attended a pediatric seminar at Boston Children's Hospital led by adolescent medicine and endocrine specialist, Dr. Norman Spack. He brought a legally married heterosexual couple, both of whom were transgender, to meet with community pediatricians and answer questions. Several things struck me. The husband, apart from medium stature, presented as any other man. The wife, in contrast, was tall and large boned, with a deep voice and prominent Adam's apple: she presented more as a cross-dressing man. When asked about their regrets, the woman said she regretted having gone through puberty before transitioning as an adult because of the deep voice and other immutable male characteristics. Neither of them referred to genital organs as a concern. At the time, an irony didn't escape me: as society was debating whether same-sex marriage should be legalized, here was a couple within the LGBTQ community who faced no legal impediment to their marriage because they happened to be of the opposite sex.

Near the end of the seminar, Dr. Spack presented a dilemma he was facing. He was caring for a preteen patient with gender dysphoria, who was committed to transitioning, with a supportive family. Puberty-delaying hormones were available but not in wide use for this purpose, and he didn't know whether he should prescribe them for this patient. As a result of these experiences, and because he truly listened to his patients and sought solutions for them, Norm went on to cofound the Gender Management Service, or GeMs, at Children's Hospital in 2007. It is America's first clinic to treat transgender children. I encourage you to watch his TED talk from 2013 in which he describes the evolution of his program and, even more importantly, why there is a desperate need to provide the highest level of individualized, safe and affirmative care to gender-diverse and transgender individuals and their families.

I wish I had learned to open my eyes within my own family after attending this seminar. In the late '90s, our elder son came out as gay, and his younger sister was exploring her sexuality as well. Focused on my two gay kids and learning to advocate for their equal rights to marry and establish families, I failed to examine how our younger child never embraced femininity. In fact, both of our kids married when same-sex marriage became legal and started families of their own. Around six years ago, this younger sibling addressed his own gender dysphoria and transitioned to his male identity at the age of 35. Our family is fortunate – his wife, his network of friends, and his employer, the federal government, – have supported and embraced his changed status.

My son had to go through many hoops – legal, emotional, logistical, and medical – to secure his place in the world as a man. My husband and I are proud of him and grateful he has afforded us the opportunity to become advocates for, not only the gay community but the trans community as well. Our granddaughter is lucky to have a dad who paves the way for others to live as their authentic selves.

My experience with transgender patients within my own pediatric practice was limited. What I have learned from reading, observing and listening is natal sex does not necessarily equate to gender identity – the feeling of who you are – and gender fluidity is not uncommon. When a 10-year-old natal female or 13-year-old natal male presents to the pediatrician as feeling they are in the wrong body, that child is at high risk for depression, self-harm, or suicide. A first step for your practice is to welcome all patients. Ask what name, pronouns and markers they prefer and assure the medical record and all staff adhere to using them. Referring that child and family to a gender management clinic, or prescribing hormone blockers to delay puberty, may be lifesaving. As Dr. Spack points out in his TED talk, these hormone blockers are reversible; and they buy valuable time until the patient is mature enough to be certain of their gender identity. Social transition is the main work of childhood and adolescence. More permanent physical transition can take place in later adolescence or adulthood, as the patient desires. Some surgical treatments may in themselves be lifesaving – for example, performing a hystero-salpingo-oophorectomy in a transgender male to prevent the possibility of ovarian or uterine cancer later on.

As a pediatrician and the president of the MMS, I am proud the medical community has listened to our patients and followed the science regarding gender, even as we continue to learn. I leave it to the specialists to map out within this publication specific strategies for helping transgender children and their families. I hope you will consult the references for more information. I applaud the Worcester District Medical Society for choosing to explore this issue. Acceptance and support of LGBTQ individuals is the most important intervention there is.

I find it sad and discouraging that some players around the country have latched onto transgender equity to foster discrimination and appeal to a political base. Particularly concerning is proposed legislation in some states to prohibit gender-affirming care such as the use of puberty blockers in pre-adolescents. The medical community must continue to oppose such draconian measures. As you care for the health and safety of your patient populations, I encourage you to become advocates for the transgender community.✚

Carole E. Allen, MD, MBA, FAAP is a pediatrician and the current president of the Massachusetts Medical Society. Email: president@mms.org

SEE PAGE 16 FOR BILBLIOGRAPHY

Health and Wellness for the LGBTQIA+ Community

Healthcare for LGBTQIA+ Patients: Bridging the Disparity Chasm

Frances Grimstad MD, MS
Aditya Chandrasekhar MD, MPH

Individuals who are LGBTQIA+ are part of a heterogenous community and face significant disparities in health care. This mistreatment is a byproduct of stigma, discrimination and violence this group faces in everyday life. Often, these experiences are due to patients being targeted for their sexual and gender minority status, including targeting by health care providers.

Before exploring these challenges in further detail, it would be helpful to familiarize oneself with various terminologies used to describe the diversity within the community. Sexual orientation refers to how a person characterizes their sexual and emotional attraction to others. While some terminologies including homosexual, heterosexual and bisexual are widely understood within the medical community, there are related terms that are less familiar to many. An asexual individual experiences little or no sexual attraction to others, but this does not necessarily mean they are not sexually active. A pansexual individual experiences sexual attraction to all gender identities.

Gender refers to the characteristics and roles of men and women according to social norm. The term "sex assigned at birth" refers to the sex assigned as an infant, typically based on external anatomy. An intersex individual is someone whose sex characteristics (e.g., chromosomes, gonads and genitals) may not fall into the typical "male" or "female" sex binary. Gender identity refers to an individual's inner sense of gender. When an individual's sex assigned at birth is congruent with their gender identity, they are referred to as being cis gender. When they are not congruent, they are referred to as being transgender. It is important to realize that the term transgender is an umbrella term often used to describe various identities. A nonbinary individual is a person whose gender identity falls outside of the binary classification prevalent by social norm. Someone who is gender fluid describes a gender identity that is not fixed. An agender individual identifies as not having any gender. Finally, as sex is separate from gender, intersex people can identify along a spectrum of genders including cis, transgender and nonbinary identities.

Several terminologies that were formerly used are now redundant or even considered offensive by members of the community. A broader description of all the terminologies used is beyond the scope of this article but can be easily accessed through reliable online publications. It is best practice to ask patients how they describe their own sexual orientation and gender identity, and use terminology congruent with that preference in subsequent health care interactions. It must be noted that these identities can evolve, and it is therefore important to revisit them periodically with the patient. It is also important to practice use of inclusive questions when gathering sexual histories to have patients feel respected and not judged.

Given the lack of LGBTQIA+ competent medical training, it is not surprising that LGBTQIA+ patients face stigma and discrimination when seeking health care. For example, a 2015 study found more than two thirds of U.S. and Canadian medical students rated their schools' LGBTQ-related curriculum as fair or worse (1). Further, LGBTQIA+ people continue to be poorly identified in medical records and systems, leading to additional disparities from lack of appropriate identification and inclusion in care (2). Finally, many patients do not report discrimination or abuse due to fear of revictimization.

As caregivers, it is primarily our responsibility to ensure LGBTQIA+ patients feel safe and welcome in our physical and virtual spaces. Capturing sexual orientation and gender identity information, adopting gender inclusive restroom policies, designing intake forms that reflect LGBTQIA+ relationships, and building clinical systems that are anatomy based (i.e., anatomic inventory) rather than identity based are just some examples of ways in which we can make spaces more inclusive. Training of staff, both clinical and administrative about providing affirming care is critical in ensuring that LGBTQIA+ patients remain engaged in care. Images in clinic educational materials, social media and websites can be visibly exclusionary for members of the community.

Consequently, LGBTQIA+ persons have lower rates of health care utilization, as high as up to one in four transgender persons,. They have increased risk for depression, suicidal ideation, substance use and high rates of poor self-reported physical health, including acute and chronic illnesses (1, 2). For example, lesbians and bisexual women are noted to have a greater risk of obesity and higher rates of breast cancer (2). Eating disorders, HIV and certain mental health issues disproportionately affect gay and bisexual men. Transgender and gender diverse individuals report higher rates of fair or poor physical health compared to their LGB peers (1).

It is critical for health care providers to screen LGBTQIA+ patients for depression, substance use, prior trauma and social determinants of health to connect them with appropriate resources. More than a quarter of homeless youth are LGBTQIA+. One in 10 transgender persons who have been out to immediate family have experienced violence and 8% were

Is your financial plan due for a checkup?

Our firm has served the unique needs of health care providers for over 30 years.

As fiduciaries, we strive to provide the highest standard of care possible for our clients. We are local, independent, Certified Financial Planners *guiding you toward a life of success, as you define it.*

Call us today for a no-obligation discussion about what we can do for you.

Securities offered through LPL Financial, member FINRA/SIPC. Investment advice offered through Private Advisor Group, a registered investment advisor. Private Advisor Group & Carr Financial Group are separate entities from LPL Financial.

CARR FINANCIAL GROUP

TAX STRATEGY INVESTMENT RETIREMENT

www.CarrFinancial.net

Call 508.795.0264

Or visit us at
20 Park Avenue Worcester, MA 01605

Health and Wellness for the LGBTQIA+ Community

Healthcare for LGBTQIA+ Patients: Bridging the Disparity Chasm *Continued*

> *"As caregivers, it is primarily our responsibility to ensure that LGBTQIA+ patients feel safe and welcome in our physical and virtual spaces"*

kicked out of the house. One third of transgender persons have experienced provider hostility, a far higher rate than their LGB peers. These negative experiences often result in verbal harassment, refusal of treatment or having to teach the health care provider about transgender persons in order to receive appropriate care. People with intersex traits also face unique discrimination in health care including stigma and significant experiences of dissatisfaction with treatment and surgery, including undergoing procedures which alter genital and reproductive function without their consent. People with intersex traits also suffer significant medical barriers and medical erasure even within LGBTQIA+ spaces.

Individuals who are at the intersection of multiple marginalized identities such as LGBTQIA+ persons of color experience far greater disparities than their white counterparts. This can include greater difficulty accessing care and higher rates of HIV (1, 3). Similarly, transgender people of color experience more discrimination and disparities than their white respondents. This includes higher rates of HIV in Black transgender women and higher rates of physical violence, intimate partner violence and homelessness in undocumented transgender persons. Transgender individuals with disabilities also face higher rates of disparities including serious psychological distress and mistreatment by health care providers. The rural-urban divide of the U.S. provides interesting stratification. LGBTQ persons in rural areas have higher rates of poor access to care and worse self-reported health while LGBTQ persons in urban areas have higher rates of emotional and physical violence and HIV.

Finally, and despite these barriers, the overall health of LGBTQ persons in recent years has shown signs of improvement. It is also important to acknowledge the significant resilience in the community (1). Many publications identify how LGBTQIA+ patients have created strong communities and organizations, building safety nets where formal health care institutions are failing to provide care. They have created numerous workarounds to get the care they need. ✚

Frances Grimstad MD, MS is a Pediatric and Adolescent Gynecologist at Boston Children's Hospital and the director of the Transgender Reproductive Health Program

Aditya Chandrasekhar MD, MPH is a Primary Care Internist at Fenway Health

REFERENCES

1. Harless, C., M. Nanney, A.H. Johnson, A. Polaski, and J. Beach-Ferrara. 2019. "The Report of the 2019 Southern LGBTQ Health Survey." Campaign for Southern Equality: Asheville, NC.
2. 2011 Institute of Medicine report on The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding
3. James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). The Report of the 2015 U.S. Transgender Survey. Washington, DC: National Center for Transgender Equality.
4. Zeeman L, Aranda K. A Systematic Review of the Health and Healthcare Inequalities for People with Intersex Variance. Int J Environ Res Public Health. 2020;17(18):6533. Published 2020 Sep 8. doi:10.3390/ijerph17186533

BIBLIOGRAPHY

https://www.lgbtqiahealtheducation.org/wp-content/uploads/2020/10/Glossary-2020.08.30.pdf

https://www.lgbtqiahealtheducation.org/wp-content/uploads/2021/05/Ten-Strategies-for-Creating-Inclusive-Health-Care-Environments-for-LGBTQIA-People-Brief.pdf

Health and Wellness for the LGBTQIA+ Community

Youth Gender Services Program

UMASS MEMORIAL HEALTH AND THE PHYSICIANS of Umass Memorial Medical Group are committed to providing world- class health care for transgender and gender traverse patients. Referring physicians can call 1-800-Umass-MD for referrals ranging from medical concerns to surgical consults. The Division of Adolescent Medicine runs a clinic specifically for pediatric patients with gender identity concerns. The Division of Plastic Surgery is performing gender affirming chest surgery and gender affirming facial surgery in high volume and welcomes referrals directly to Joyce McIntyre MD. Be on the look out this year for invitations for Worcester District Medical Society members to conferences related to transgender health sponsored by Umass Memorial Medical Group and Umass Chan Medical School. ✚

Joyce K. McIntyre, MD Craniofacial and Pediatric Plastic Surgery, Associate Program Director, University of Massachusetts Medical School and UMass Memorial

Youth Gender Services

Caring for children and teenagers up to 19 years of age, UMass Memorial Children's Medical Center Youth Gender Services offers resources and support to transgender and gender non-conforming youth. Our team of caregivers assists patients with gender transition, if desired, or exploration of their gender identity. We also provide families with assistance in understanding their child's unique needs, including the effects of gender dysphoria on youth. Our goal is to help our patients comfortably integrate their gender identity into their everyday lives.

Our program's pediatric endocrinologist, Penny Feldman, MD, and adolescent medicine specialist, Diane Blake, MD, take a collaborative approach in assessing each person's individual situation and creating a medical care plan, customized to the individual's particular needs. Treatment options include hormone therapy and puberty blocking treatments, along with coordinating access to critical resources, such as support groups and referral to a gender therapist.

Patients we care for include:

- Parents of young children whose gender identity differs from their birth gender
- Pre-teens just approaching puberty and considering delaying puberty with medication, known as a pubertal blocker
- Adolescents nearing the end of puberty or having completed puberty with an interest in gender-affirming hormone treatment

To make an appointment, call 855-UMASS-MD.

UMass Memorial
Children's Medical Center

Youth Gender Services
55 Lake Avenue North, Worcester, MA 01655

Commonly Used Terms

Gender Dysphoria – The emotional distress that results from one's gender identity differing from the sex assigned at birth.

Gender Expression – The way a person expresses gender through behavior, dress, mannerisms and other characteristics.

Gender Identity – An individual's inner sense of being male, female, or another gender (e.g., nonbinary or gender fluid). Gender identity is not necessarily the same as sex assigned at birth. Every person has a gender identity.

Gender Incongruence – Sex assigned at birth differs from one's internal sense of being male, female, or another gender.

Gender Nonconforming – A term used to refer to people who do not follow other people's ideas or stereotypes about how they should look or act based on the sex assigned at birth.

Transgender – A term used to describe a person who identifies with or expresses a gender identity different from the sex assigned at birth.

Resources

Local programs are available free of charge and offer additional support to lesbian, gay, bisexual, transgender and questioning youth, and their friends and families. These programs provide a safe, welcoming environment in which visitors can socialize and access resources. Visit their web pages to learn more about the services they offer.

GLSEN – Dedicated to creating a safe, inclusive school environment.
http://www.glsen.org/educate/resources

Parents, Families, Friends, and Allies United with LGBTQ People (PFLAG)
www.worcesterpflag.org

Safe Homes
www.safehomesma.org

Supporters of Worcester Area GLBTQ Youth (SWAGLY)
www.aidsprojectworcester.org/swagly-supporters-of-worcester-area-gay-lesbian-youth

Prioritizing Gender Affirmation in Health Care in Central Massachusetts

Rebecca Thal, NP-C, AAHIVS
Ben Alfred, NP-C, AAHIVS

Working as primary care nurse practitioners at a large, federally qualified community health center, we became aware of a striking need for transgender-inclusive and -affirming health care in Central Massachusetts. Very often, transgender people in our community travel as far as Boston to obtain care. When we as health care providers fail to serve this population in our practices, we also contribute to stark health disparities. Nationally, it is estimated that 1.4 million people (0.6% of the U.S. population) identify as transgender. However, transgender people face numerous barriers to health care and are less likely to access care than their cisgender counterparts (1). A recent study found nearly two-thirds of transgender people worried about being judged negatively by health care providers (2). Previous data show 50% of transgender people had to educate their health care providers about their own care (3). Transgender people face markedly worse physical and mental health outcomes than their cisgender counterparts, perhaps most alarmingly a 42% lifetime likelihood of attempting suicide (4). These disparities are due in large part to discrimination, violence, and adverse social and economic determinants of health (5). Transgender-affirming health care can save lives. We can and must welcome transgender community members into our clinics.

How can we as health care providers affirm the fullness of transgender lives and the importance of transgender health? We urge you to start small. There are many ways to affirm a patient's gender and all health care providers should be conversant in these basics to welcome the transgender population into our practices. As health care providers, we need to examine our own social position, experiences and knowledge gaps. We must challenge our own biases, including assumptions about which patients may or may not identify as transgender or nonbinary. We recommend you ask all patients the name and pronouns they use and provide your own pronouns during patient encounters. It is important to ask all patients not just about their sexuality but also their gender identity, and not assume aspects of a patient's identity - such as gender identity, heterosexuality or monogomy. You will only know your patient is transgender, nonbinary or gender variant if you ask.

Transgender people deserve the same excellent, competent health care you provide all patients. It is important to learn about standards of care in transgender health from trusted sources. Two good starting points are the UCSF Transgender Care and Treatment Guidelines and the World Professional Association for Transgender Health, or WPATH, Standards of Care. These guidelines can serve as a starting point for understanding the primary and preventive care needs of transgender people. As health care providers, we must ensure patients receive needed preventive and primary care interventions based on anatomy, not identity. For example, all persons capable of becoming pregnant should be asked about their pregnancy intentions, rather than restricting this practice to patients who identify as female. All persons with a prostate, not only those who identify as male, need to receive information about prostate cancer screening.

In addition to a health care professional's self-education about the transgender community, it is critical to outfit practices with the tools needed to promote fully gender-affirming care. In our practice, the starting point was to develop a cohort of health care professionals interested in participating in continuing education and developing clinic-wide protocols for welcoming transgender patients. These health care professionals have tended to come from areas of clinical interest that overlap significantly with the transgender population. For both of us, HIV care forms a cornerstone of our practice and we know transgender people are disproportionately affected by HIV. Our health care professional group; which includes nurse practitioners physicians, and behavioral health providers engaged with this undertaking through the lens of advocacy; asking the question: how could we advocate for inclusion of transgender patients within our clinic?

It is important to have a dedicated person or group to arrange staff training; ensure gender-neutral bathrooms and other welcoming health promotion signage; update hiring practices to ensure candidates of all gender identities are welcomed; and revise surveys, questionnaires and other clinic materials to include gender-diverse identities. All staff, whether patient-facing or not, must be trained in appropriate and respectful interaction with transgender people. This includes front desk staff, pharmacy, radiology, dental and billing/referrals. It can also be significantly challenging to ensure your electronic health record environment is set up to reflect gender-diverse identities; in particular, displaying a patient's affirmed name and pronouns and flexible enough to avoid hard stops such as only allowing cervical cancer screenings to be ordered for patients whose charts reflect a female gender. In taking on this work, our group has relied on The National LGBT Health

Prioritizing Gender Affirmation in Health Care in Central Massachusetts *Continued*

Education Center's Creating a Transgender Health Program at Your Health Center guideline. (https://www.lgbtqiahealtheducation.org/wp-content/uploads/2018/10/Creating-a-Transgender-Health-Program.pdf).

Once you have established your practice as welcoming to transgender members of your community, we urge you to continue your journey to provide gender-affirming interventions such as hormone therapy. We know expanding access not just to general primary care but also to dedicated gender-affirming care can save lives. In fact, the WPATH strongly recommends gender-affirming hormone therapy be considered part of primary care and be performed by primary care providers (6). Providing this care is one of the highest-impact, most meaningful things we do in our day-to-day practice. But whether you are already providing this care, working toward it, or considering doing so, you can affirm patients in all aspects of your practice.

Affirming care for the transgender community of Central Massachusetts can take the form of asking name and pronouns, making physical changes to your clinic site, attending transgender-specific continuing education, providing additional gender-affirming services and more. Even those practices not providing gender-affirming hormonal therapy or referrals for surgery can provide critical, lifesaving primary and preventive interventions to these patients and, in doing so, we can and must ensure a dignified, welcoming and safe environment.✚

Rebecca Thal, NP-C, AAHIVS, is a primary care provider at Family Health Center of Worcester

Ben Alfred, NP-C, AAHIVS, is a primary care provider at Family Health Center of Worcester

Acknowledgment: We would like to acknowledge Teri Aronowitz, PhD, APRN, FNP-BC, FAAN, professor at UMass Tan Chingfen Graduate School of Nursing; and Kenneth Peterson, PhD, MS, FNP-BC, assistant professor at UMass Tan Chingfen Graduate School of Nursing, for their editorial assistance.

SEE PAGE 17 FOR REFERENCES

Health and Wellness for the LGBTQIA+ Community

Adult Transgender Hormone Therapy

Anna K. Morin, PharmD

Gender-affirming hormone treatment involves the use of medications in transgender individuals to achieve hormone concentrations equivalent to the physiological concentrations of the gender identity (1). Individuals assigned as males at birth who transition to female are transgender females (transwomen; male to female [MTF]) and individuals assigned as females at birth who transition to male are transgender males (transmen; female to male [FTM]) (1, 2). The goal of gender-affirming hormone treatment is the development of secondary sex characteristics associated with the gender with which the individual identifies and the suppression of secondary sex characteristics associated with the gender assigned at birth. Gender-affirming treatments are not FDA-approved and prescribing is considered off-label.

FEMINIZING (MTF) HORMONE THERAPY

MTF hormone treatment for adult transwomen, also known as feminizing hormone therapy, includes the use of estrogen plus anti-estrogen medications to decrease total testosterone levels to the normal female range (30-100 ng/dl) and maintaining estrogen levels in the physiologic range for menstruating non-transgender premenopausal women (<200 pg/ml) (1, 2, 3). The lowest dose necessary to achieve desired physical effects should be prescribed. Feminizing hormone therapy begins with taking an anti-estrogen, such as spironolactone or gonadotropin releasing hormone agonists, to block androgen receptors and suppress testosterone production. Spironolactone, a potassium-sparing diuretic that directly inhibits testosterone production and blocks androgen receptors at higher doses, is the most commonly used anti-androgen in the United States. Adverse effects of high dose spironolactone include polyuria, polydipsia, postural hypotension, and hyperkalemia (particularly in patients with impaired kidney function or taking concomitant potassium-sparing drugs such as ACE inhibitors) (1, 3). 5-alpha reductase inhibitors (i.e., finasteride, dutasteride) do not block the production of testosterone, but instead inhibit conversion of testosterone to the more potent androgen dihydrotestosterone (3). 5-alpha reductase inhibitors can be used in those unable to tolerate or with contraindications to the use of spironolactone, those seeking partial feminization, or in those who continue to exhibit masculine features or hair loss after complete androgen blockade or orchiectomy. Anecdotal reports suggested that the addition of progesterone (i.e., oral medroxyprogesterone acetate) to feminizing hormone regimens may improve breast development in transwomen (1, 3). Side effects of progesterone include depressed mood, weight gain and elevated lipids.

Estrogen therapy is started four to eight weeks after spironolactone(1, 2, 3). Estradiol (17-beta estradiol) is preferred as it is most similar to the estrogen produced by the ovaries. Estradiol can be administered via oral (e.g., estradiol valerate tablets), intramuscular (e.g., estradiol valerate injection) or transdermal (e.g., estradiol patch) routes. Other routes of estradiol delivery, such as topical creams, gels or sprays may not be able to produce desired blood levels in the physiologic female range (3). The use of ethinyl estradiol and oral conjugated estrogens should be avoided due to an increased risk of blood clots, particularly in individuals with a personal or family history of venous thrombosis (1, 3). Side effects of estrogens may include migraines, mood swings, hot flashes, and weight gain (1, 3).

Within one to three months, MTF treatment results in changes including, testicular atrophy and cessation of spermatogenesis, decreased libido and spontaneous erections, breast growth, body fat redistribution, reduced muscle mass, slowing of scalp hair loss, decreased facial and body hair growth, and softening of the skin (1, 3).

MASCULINIZING (FTM) HORMONE THERAPY

Testosterone is used in FTM hormone treatment, also known as masculinizing hormone therapy, in adult transmen (1, 2, 4). Testosterone is available in a number of different formulations in the United States, all "bioidentical" or chemically equivalent to testosterone secreted from human testicles (4). Higher doses of injectable (intramuscular or subcutaneous) and topical (gel, patch or cream) preparations of testosterone, marketed for use in non-transgender men with low androgen levels, may been needed to achieve normal male physiological testosterone levels (range: 300-1000 mg/dl) in transgender men (2, 4). Oral testosterone is unlikely to achieve physiologic concentrations of testosterone and is not appropriate for gender-affirming treatment (4).

FTM testosterone treatment results in the development of facial hair, deepening of the voice, a redistribution of facial and body subcutaneous fat, increased muscle mass, increased body hair, change in sweat and odor patterns, frontal and temporal hairline recession (1, 4). Sexual and gonadal effects include an increase in libido, clitoral growth, vaginal dryness, and cessation of menses and ovarian estrogen production (1, 4). Adverse effects associated with testosterone include weight gain, increased oily skin and acne, development

> *The goal of gender-affirming hormone treatment is the development of secondary sex characteristics associated with the gender with which the individual identifies and the suppression of secondary sex characteristics associated with the gender assigned at birth*

of male-pattern baldness, sleep apnea, dyslipidemia, hypertension, type-2 diabetes, venous thromboembolism, vaginal atrophy, pelvic pain, and clitoral discomfort (1, 4).

ADVERSE EFFECTS AND MONITORING

Gender-affirming hormone therapy is not recommended in individuals with a history of hormone-sensitive cancer (i.e., prostate cancer in MTF and breast cancer in FTM), thromboembolic disease (i.e., deep vein thrombosis, pulmonary embolism), uncontrolled behavioral health conditions, limited ability to provide informed consent or uncontrolled significant medical conditions (1, 4). Masculinizing hormone therapy should not be initiated in transmen who are pregnant or breastfeeding (4). The risk of permanent infertility increases with long-term use of gender affirming hormone treatment. Testicular, ovarian and uterine function may not recover even after stopping hormone therapy (1, 3, 4). It is also important to keep in mind that while testosterone may limit fertility, transmen who have a uterus and ovaries are still at risk of pregnancy and contraception (i.e., an intrauterine device, a barrier form of contraception, or oral continuous progestin birth control) should be used (4).

Adverse outcome preventions and long-term care in both genders includes hormone concentration (testosterone and estradiol in transwomen and testosterone in transmen) monitoring every 3 months during the first year and then once or twice yearly as well as routine lipid, fasting blood sugar, liver enzyme, blood pressure, cardiovascular risk factor and behavioral health monitoring (1, 3, 4). Testosterone can cause polycythemia and full blood counts should be monitored in transmen using the male, rather than the female, hemoglobin reference range (1). Transmen should undergo cervical and breast cancer screening and transwomen prostate cancer screening, as long as they physiologically retain these tissues (1). A risk of hyperprolactinemia exists with estrogen treatment and some clinicians monitor prolactin concentrations in transwomen (1, 3). Calcium and vitamin D supplementation, along with bone mineral density screening based on age and gender-appropriate criteria, are recommended for both genders (2).

Gender–affirming hormone therapy is considered safe and effective but is associated with adverse effects, including decreased fertility, sexual dysfunction and other medical conditions. A complete medical and behavioral health evaluation to rule out or address any medical conditions that may affect or contraindicate treatment should be done before feminizing or masculinizing hormone therapy is started, with all risks and benefits carefully weighed. Some transgender individuals may need to undergo surgery, in addition to gender-affirming hormone treatment, to address the clinically significant distress or impairment associated with gender dysphoria.✚

Anna K. Morin, PharmD
Associate provost – Worcester/Manchester
Massachusetts College of Pharmacy and Health Sciences

REFERENCES

1. Tomlins L. Prescribing for transgender patients. Australian Prescriber 2019;42(1):10-13.
2. Gardner I, Safer J. Progress on the road to better medical care for transgender patients. Current Opinion in Endocrinology, Diabetes and Obesity 2013;20(6):553-558.
3. Deutsch MB. Overview of feminizing hormone therapy. UCSF Transgender Care. Published June 17, 2016; available at: https://transcare.ucsf.edu/guidelines/feminizing-hormone-therapy.
4. Deutsch MB. Overview of masculinizing hormone therapy. UCSF Transgender Care. Published June 17, 2016; available at: https://transcare.ucsf.edu/guidelines/masculinizing-therapy.

Health and Wellness for the LGBTQIA+ Community

LGBTQ Microaggressions in Health Care

Andrea Chin, MS
Tara Kumaraswami, MD, MPH

In 1981, queer health scholar virginia brooks described health inequalities experienced by the LGBTQ community in Minority Stress and Lesbian Women showed psychological and biophysical stressors were truly detrimental to health. Despite 40 years of activism, health disparities are still distressingly pervasive throughout the LGBTQ population. Their etiology relates to include everything from overt discrimination to microaggressions, perpetuated by society, in health care settings and from providers themselves.

LGBTQ health disparities include everything from inadequate cancer and sexually transmitted infection screening to a risk of greater dependency on tobacco, alcohol and other substances. Young LGBTQ individuals are two to three times more likely than their peers to attempt suicide or commit acts of self-harm (1). Older LGBTQ individuals born prior to gay liberation movements are understandably distrustful of the medical system and struggle to find culturally competent providers (2). Many fear disclosing aspects of their identity after lived experiences of care refusal, providers using excessive precautions, inappropriate language, and physically rough or abusive touch (3).

One reason LGBTQ health disparities persist is because of the microaggressions patients face. Microaggressions, actions that disempower minorities through subtle verbal or non-verbal messages, reflect implicit biases and are frequently done unconsciously (4). They include microassaults, explicit acts that communicate a target is of lesser worth, microinsults, disparaging actions against an individual's identity, and microinvalidations, neutralizing or denying experiences, i.e. "I don't see color" negates the lived experiences of People of Color)(4). Studies show, when compounded over time, these experiences affect mental health, lead to depression and anxiety, contribute to negative affect or views of the world, poor behavioral control, cultural mistrust, and lower levels of well-being (4). Microaggressions reflect systemic discrimination built into society through institutions, policies and practices designed by and for straight, cisgender, wealthy, able-bodied, neurotypical people.

Health care microaggressions represent institutional and organizational practices that fail to respond to discrimination appropriately. Healthcare spaces that convey heteronormative microaggressions suggest the identities, experiences, and relationships of LGBTQ individuals are abnormal, pathological, unwelcome, or shameful (5, 6). Common microaggressions include the use of improper pronouns; heterosexist words for partners; heteronormative brochures, posters, or reading materials; and forms without appropriate identity options (7). Endorsement of heteronormative culture and behaviors, stereotypical maintenance of effeminate gay men or masculine lesbian women; assumption of universal experience, requirement of gender affirming treatment to transition "properly;" disapproval of lifestyle choices; and assumption of sexual deviance are all too commonly experienced (5). Microinsults and microinvalidations undermine trust in providers and clinics, make them complicit in the erasure of identity, and pathologize gender, sexual orientation, or body presentation.

Certain identities experience further marginalization from providers who are not adequately informed of representative differences within the LGBTQ population. Transgender people are misgendered; asked for "preferred" pronouns, implying individual choice in identity rather than simply asking for pronouns; called their "dead" name, names they formerly used but no longer align with; and provided forms with only male/female options, enduring constant cis normativity through microinsults and invalidations (7). If providers are not completely ignorant of pansexuality, they often erase pansexual and bisexual identity with misperceptions they are enroute to something else, are fulfilling sexual fantasies or are assumed to be sexually deviant (8). Intersex persons, or their parents, are pressured to normalize genitalia from medical professionals working within heteronormative frameworks; microaggressions that suggest they fix a biological mistake in order to realign with normal social constructs (5). Asexual individuals confront assumptions they have a physical or psychological disorder, often hypoactive sexual desire disorder (5). Having one's identity understood and respected without having it pathologized is a continual struggle. These microaggressions reinforce messages that the LGBTQ population is constantly outside of normal.

Culturally competent health care systems understand the intersections of race, ethnicity, and sexual health. It's important for providers to realize that hetero- and cis-normative attitudes, and anti-LGBTQ beliefs, influence communication, trust and confidence in health care, widening medical inequality. Providers with less exposure to the LGBTQ community can read literature written by those who identify as LGBTQ, watch films of their experiences, participate in LGBTQ community events,

Lesbian Gay Bisexual Transgender and Queer Microaggressions in Healthcare *Continued*

and follow socially conscious LGBTQ providers who promote awareness and inspire advocacy, as for example, @inclusivecareproject and @themshealth on Instagram. Increasing exposure can teach providers to ask more comprehensive histories, hold more supportive attitudes, be better prepared to defend disenfranchised communities and actively reduce health disparities.

Continuing education opportunities can open the door to learning about health disparities and providing appropriate care. However, online training modules are ill-equipped to undo a lifetime of reinforced societal habits outside of health care spaces. In tandem with trainings, the creation of welcoming environments can improve LGBTQ comfort in healthcare spaces: changes to physical space, diversifying imagery, reading materials; gender neutral bathrooms, documentation, inclusive language, increasing form options; displaying and enforcing policies, confidentiality, inclusive nondiscrimination; addressing health histories, social and mental stressors; discussing behavior without judgment; forming families; ensuring safe home/work places; and offering resources, referrals to LGBTQ-friendly specialists (3, 9). Development of inclusive health care and removal of institutionalized discrimination must include input from sex- and gender-oppressed populations, intersexual people, people of color, incarcerated individuals, and people experiencing homelessness, alongside providers, policy makers, and grassroots organizers to best mobilize knowledge and effective strategies.

Providers should develop basic insight to the layers of sexual and gender identities, recognize these identities as valid, and care for patients as they exist. Not all patient experiences are the same, this article is not intended to generalize or speak for all patients, but rather to improve how health care providers interact with the LGBTQ community. Acknowledgement of the existence of microaggressions and challenging them within medical spheres can foster enhanced conversations regarding power, privilege, and health care. It is important to realize each identity within the LGBTQ spectrum has unique health issues and there is intersectionality to the identities a person carries. Care providers must keep in mind the homophobia, biphobia, transphobia and cissexism experienced by LGBTQ individuals along with racism, xenophobia, ableism, classism and other forms of oppression each patient experiences. By becoming better allies to LGBTQ patients and addressing microaggressions that health care perpetuates, providers can use the privilege and position they hold to fight against injustices within health care systems and outside of it. ✚

Andrea Chin, MS is a fourth-year medical student at the University of Massachusetts Chan Medical School in Worcester, Massachusetts. Email: andrea.chin@umassmed.edu.

Tara Kumaraswami, MD, MPH is an Assistant Professor in the Department of Obstetrics & Gynecology at the University of Massachusetts Chan Medical School in Worcester, Massachusetts. Email: tara.kumaraswami@umassmemorial.org.

REFERENCES

1. Liu RT, Mustanski B. Suicidal ideation and self-harm in lesbian, gay, bisexual, and transgender youth. American Journal of Preventive Medicine. 2012; 42(3). doi. org/10.1016/j.amepre.2011.10.023
2. Healthy People 2020 [Internet]. Washington, DC: U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion [cited [December 16, 2020]. Available from: [https://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health].
3. Kane-Lee E, Bayer C. Meeting the needs of LGBT patients and families. Nursing Management. 2012; 14(2):42-46.
4. Cruz D, Mastropaolo C, Rodriguez Y. Perceived microaggressions in health care: A measurement study. PLoS ONE. 2019; 14(2). doi: 10.1371/journal.pone.0211620
5. Dean MA, Victor E, Guidry-Grimes L. Inhospitable Healthcare Spaces: Why Diversity Training on LGBTQIA Issues Is Not Enough. J Bioeth Inq. 2016 Dec;13(4):557-570. doi: 10.1007/s11673-016-9738-9.
6. Liebel AM. LGBTQ health disparities and microaggressions. Health Communication Partners. June 21 2019. https://healthcommunicationpartners.com/lgbtq-health-disparities-microaggressions/
7. "7 Microaggressions Trans People Face in Health and Mental Healthcare Settings". Lighthouse LGBTQ+ Affirming Care. 2020. https://blog.lighthouse.lgbt/transgender-healthcare-microaggressions/
8. Ulrich L. Bisexual Invisibility: Impacts and Recommendations. San Francisco Human Rights Commission, LGBT Advisory Committee. Published, 2011. 41 pages.
9. Coren JS, Coren CM, Pagliaro SN, Weiss LB. Assessing your office for care of lesbian, gay, bisexual, and transgender patients. Health Care Manag (Frederick). 2011 Jan-Mar;30(1):66-70. doi: 10.1097/HCM.0b013e3182078bcd.

As I See It

LGBTQIA+ Medical Student Burnout

Alec Allain, MS4

UNCERTAIN HOW ACCEPTING THIS NEW ROTATION WILL BE, I RUMMAGE through my closet looking for a shirt without a pastel color or floral design. I modify my body language throughout the day. I don't walk too flamboyantly, I stop using my hands while I talk and I do not sit with my legs crossed. I try not to talk too much and, when I do, I lower my voice and change my vernacular. I avoid talking about my partner and I dodge questions asking about my personal life. I have mastered all these skills over a lifetime of disguise. I come across as cold, but I am safe.

Medical school is hard. It requires sacrifice and demanding hours. A study in the Annals of Internal Medicine showed almost half of medical students experience burnout that is associated with increased likelihood of suicidal ideation (1). Burnout in medical students needs to be taken seriously and certain groups of individuals are more at risk than others.

A recent study in JAMA found LGB students have a significantly higher statistical rate of burnout compared to their heterosexual peers. There was a statistically significant increase in LGB medical students reporting public humiliation and mistreatment as well. This study also found a dose-response relationship between the level of mistreatment and risk of burnout (2).

As I see it, medical students' burnout is a major problem with serious consequences, and the LGBTQIA+ student population is at a higher risk due to mistreatment and minority stress. To combat this, we need to create a welcoming environment for LGBTQIA+ students. We can start by ensuring our colleagues in medicine are aware of the unique challenges LGBTQIA+ medical students face as well as fostering LGBTQIA+ visibility and mentorship for these students. ✚

Alec Allain is a fourth year medical student at UMass Chan Medical School, class of 2022.

REFERENCES:

1. Dyrbye LN, Thomas MR, Massie FS, et al. Burnout and Suicidal Ideation among U.S. Medical Students. Ann Intern Med 2008;149(5):334.
2. Samuels EA, Boatright DH, Wong AH, et al. Association Between Sexual Orientation, Mistreatment, and Burnout Among US Medical Students. JAMA Netw Open 2021;4(2):e2036136.

Reflections of a Pediatrician Parent of a Transgender Son *Continued from page 5*

BIBLIOGRAPHY:

Deutsch MB, Green J, Keatley JA, et al. J Am Med Inform Assoc 2013;20:700–703.

Kimberly LL, Folkers KM, Friesen P, et al. Ethical Issues in Gender-Affirming Care for Youth. Pediatrics. 2018;142(6):e20181537

Herman, Jody L., Mallory, Christy, and Wilson, Bianca D.M. Estimates of transgender populations in states with legislation impacting transgender people. The Williams Institute. 2016.

Murchison, M.P.H., Gabe., et. al. Supporting and Caring for Transgender Children. 2016.

Rafferty J, AAP Committee on Psychosocial Aspects of Child and Family Health, AAP Committee on Adolescence, AAP Section on Lesbian, Gay, Bisexual, and Transgender Health and Wellness. Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents. Pediatrics. 2018;142(4):e20182162

Rider GN, McMorris BJ, Gower AL, et al. Health and Care Utilization of Transgender and Gender Nonconforming Youth: A Population-Based Study. Pediatrics. 2018;141(3):e20171683.

Substance Abuse Mental Health Services and Administration, Ending Conversion Therapy: Supporting and Affirming LGBTQ Youth. HHS Number No. (SMA)15-4928. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015.

Turban, Jack L., et. al. Understanding Pediatric Patients Who Discontinue Gender-Affirming Hormonal Interventions. American Medical Association. Published 2018.

Hidden in Plain Sight

Pawina Subedi, MD

Residency is an exciting phase of a young physician's life. While medical school gives us the opportunity to peek into the realm of medicine, it is residency that begins to enhance our sense of what lies ahead. Internship is undoubtedly a learning curve, steep for some, precipitous for others. So, we embark on this new journey with the passion to give our all and provide the best possible care to our patients. Some days are almost smooth, but there are also days of total exhaustion, when the thought of making a difference in someone's life is all that keeps us going.

The experiences of healthcare providers with and without a uterus vary in some major regards. With no firsthand experience, it can be difficult for our counterparts without a uterus to comprehend what menstrual pain feels like, how it affects our emotions, and what it's like rushing to take care of one sick patient after another as your endometrium is tearing away from you. You could be one of those lucky people with a uterus (whom I honestly could not envy more) whose uterus sheds in peace. Or, you could be one of us whose endometrium—at any poorly timed moment—announces itself with cramping, pain, nausea, vomiting, and other exasperating misery. No matter what part of this spectrum we fall on, we are expected to deal with it in silence. It is, after all, a private matter. It is a health concern we don't feel comfortable discussing with others, having been conditioned early on not to discuss it in public. What probably goes unnoticed is how this plays a silent yet powerful role in our work environment. Everyone is busy, especially in the middle of a pandemic, and unless you make a point to communicate what you're dealing with, there is no way your colleagues know why you might be irritated and why every small thing is getting to you.

Lately, physicians' reproductive health has been garnering some well-deserved attention. Why are we experiencing more pregnancy-related complications than the general population? Why are we planning pregnancy late? Maybe it has something to do with us delaying pregnancy, as we are so focused on medical school and residency. Maybe it is poor sleep hygiene, or the financial burdens of student loan debt that is taking a silent toll on our health. We are determined to conquer the vast ocean of medical knowledge no matter what and make it a personal mission to remain unfazed by terrifying extensive exams. We become accustomed to this daily stress, and it starts slipping into the background noise. These are unceasing challenges, regardless of gender, but this extra inevitable layer faced by those with a uterus points to a need for enhancing this sometimes-overlooked aspect of physicians' lives..✚

Pawina Subedi, MD
PGY3, Internal Medicine
Saint Vincent Hospital

Prioritizing Gender Affirmation in Health Care in Central Massachusetts

Continued from page 11

REFERENCES

1. Medina C, Santos T, Mahowald L, Gruberg S. *Protecting and Advancing Health Care for Transgender Adult Communities*. Center for American Progress. Published August 18, 2021. Accessed January 19, 2022. https://www.americanprogress.org/article/protecting-advancing-health-care-transgender-adult-communities/.
2. Meyer IH, Wilson, BDM, O'Neill KK. *LGBTQ People in the US: Select Findings from the Generations and TransPop Studies*. Williams Institute, UCLA. Published June 2021. Accessed January 19, 2022. https://williamsinstitute.law.ucla.edu/publications/generations-transpop-toplines/.
3. James SE, Herman JL, Rankin S, Keisling M, Mottet L, Anafi M. *The Report of the 2015 US Transgender Survey*. National Center for Transgender Equality. Published December 2016. Accessed January 19, 2022.
4. Medina et al, 2021.
5. Medina et al, 2021.
6. Coleman E et al. *Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People*. World Professional Association for Transgender Health. Published 2012. Accessed January 19, 2022. https://www.wpath.org/publications/soc.

Health and Wellness for the LGBTQIA+ Community

Resources

Local

Gender Management Service (GeMs) at Children's Hospital

Youth Gender Services at UMass Memorial Health

Parents, Families, Friends, and Allies United with LGBTQ People (PFLAG) of Greater Worcester
https://www.worcesterpflag.org

Safe Homes
https://www.safehomesma.org

Supporters of Worcester Area GLBTQ Youth (SWAGLY)
https://www.aidsprojectworcester.org/swagly/

National

It Gets Better Project
https://itgetsbetter.org/

The Trevor Project
https://www.thetrevorproject.org/

National Center for Transgender Equality
https://transequality.org/

Out and Equal Workplace Advocates
https://outandequal.org/

Parents, Families, Friends, and Allies United with LGBTQ People (PFLAG)
https://pflag.org/

Straight for Equality
https://straightforequality.org/

National Resource Center on LGBTQ+ Aging
https://www.lgbtagingcenter.org/

Resources *Continued*

For Physicians:

UCSF Transgender Care and Treatment Guidelines

The World Professional Association for Transgender Health (WPATH) Standards of Care

The National LGBT Health Education Center's Guide to Creating a Transgender Health Program at Your Health Center guideline https://www.lgbtqiahealtheducation.org/wp-content/uploads/2018/10/Creating-a-Transgender-Health-Program.pdf

World Professional Association for Transgender Health (WPATH)

For Students:

GLSEN – Ddedicated to creating a safe, inclusive school environment: https://www.glsen.org/educate/resources

24/7 Crisis Resources:

The Trevor Project Crisis Counselor for Young People 1-866-488-7386 (also has text and chat options available on their website)

SAGE LGBT Elder Hotline for Elders and Caretakers 1-877-360-LGBT (5428)

Trans Lifeline staffed by transgender people for transgender people. 1-877-565-8860

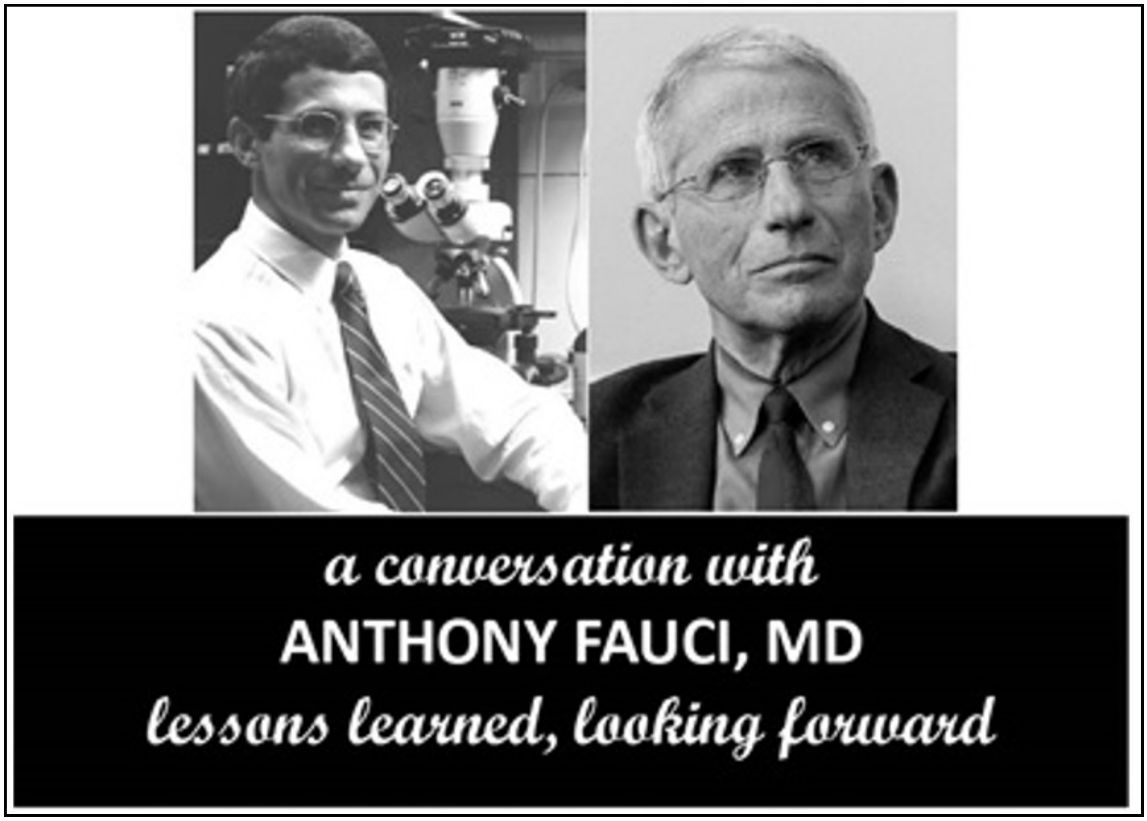
Society Snippets

Worcester District Medical Society

BOSTON MEDICAL library

15th WDMS Annual Louis A. Cottle Event
And
46th Annual BML Garland Event

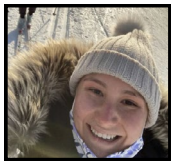
Held on Thursday, October 21, 2021



Click here to view the event
OR visit our Website: **www.wdms.org**
Under Past Events

Worcester District Medical Society
"Med Moth"
Tuesday, December 14, 2021

This event was held In lieu of our annual tradition of "Movie Night", moderated by WDMS Student Members

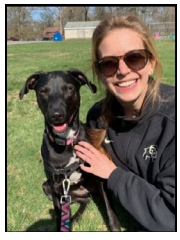



Margaret Ruddy and Timothy Winn

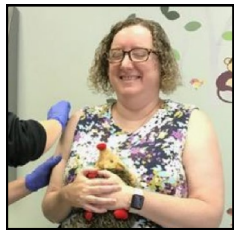
The Speakers

The speaker's shared their journeys into medicine, meaningful patient encounters, or other experiences that have shaped their personal or professional identity.

Dr. David Hatem
"Found Hope In An Unexpected Way"



Rosemary "Rosie" Kelly, Medical Student
"Silence"



Dr. Heather Finlay-Morreale
"Lifting Of The Veil"

Dr. Karen Rothman
"Will It Hurt?"

Dr. Samantha Rosenblum
"Shadowing During Holiday Break"

Dr. Michael Hirsh
"Spirit Of Christmas"

CLICK HERE TO VIEW THE EVENT

Society Snippets

WDMS Annual Business Meeting and Awards Ceremony
Wednesday, April 13, 2022
Beechwood Hotel, Worcester, MA ~ 5:30 PM

Please Note: Each attendee needs to register individually

CLICK HERE TO REGISTER

KEYNOTE SPEAKER

Senator Harriette Chandler

AWARD PRESENTATIONS

Anniversary Members

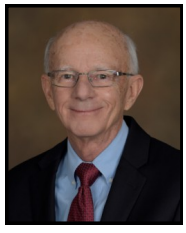
50 Year Member
Peter S. Chen, MD

25 Year Members
Michael W. Potter, MD
Richard A. Rosiello, MD
Karen F. Rothman, MD

MMS / WDMS Community Clinician of the Year Award

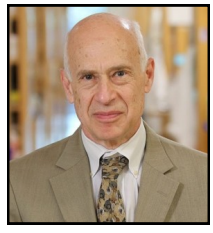
Recipient:
June R. O'Connor, MD

WDMS Editor's Award



Recipient:
Robert W. Sorrenti, MD

WDMS President's Award



Recipient:
Robert W. Finberg, MD
(Posthumously)

INTRODUCING OUR NEW IVF CENTER.

Complete infertility care now offered locally.

The path to pregnancy can be overwhelming. Your patients need an expert team with the right experience and capabilities. That's why we're pleased to announce the addition of our on-site IVF Center to round out our robust fertility services — ensuring convenient, state-of-the-art care, close to home. Call 508-334-1345 to speak to one of our infertility specialists.

For referrals, call Physician Concierge Services at 800-431-5151.

UMass Memorial Health
UMASS MEMORIAL MEDICAL CENTER