

Presentation 3:

Two Sides of the Same Coin: Looking at Inclusion from a Patient Facing Direction

Presenter:

Victoria Ainsworth, Student , *Medical Physics Program, UMASS Lowell, Lowell, MA*
(*She/Her; They/Them*)

Slide 3.1: Title

Hi, my name is Victoria Ainsworth, I am a joint Masters and PhD student at Umass Lowell and I use both She/Her and They/Them pronouns. Today I'll be presenting the first half of "Two sides of the same coin: Looking at Inclusion from a Patient Facing Direction"

Slide 3.2: Leading Principle

To focus the presentation, I would first like to go over our leading principle—that all healthcare interactions with LGBTQIA+ patients need to be both affirming and supportive and not just with their PCP. This principle is imperative for ensuring the comfort and safety of LGBTQIA+ patients, colleagues and trainees. This will lead to higher quality of care to all patients

Slide 3.3: Where are we now

With Jessica, we dove into the history that built the foundations of mistrust between the LGBTQIA+ community and the healthcare system, highlighting the resulting human cost that persists today. We also learned that there's very little teaching of LGBTQIA+ issues within medical school and that most experience ends up coming from clinical exposure which furthers the healthcare disparities

With Toni, we learned about the impact of having multiple minority identities and the disparities created from how they overlap and highlighting how crucial it is to have intersectional advocacy to serve all communities to the best of our ability; with intersectionality being a metaphor for understanding the ways that multiple forms of inequality or disadvantage sometimes compound themselves, and create obstacles that are not understood within conventional ways of thinking about our social justice advocacy structures that we have. Kimberlé Crenshaw, a Black lawyer, professor and feminist, who coined this term in 1989.

Slide 3.4: Some Definitions

Here's a quick reminder of the definitions we learned with Jessica's presentation—And it's important to highlight here that the use of Trans- and Cis- are the adjectives to one's gender identity, not their identity itself, and that when dealing with a patient with a name different than their legal one, its important to remember that using their legal or dead name is very disrespectful, but if you make a mistake, correct yourself, apologize and continue, making sure to always center your patient in your apology, and not yourself.

Slide 3.5: A look into the community

When asked what would increase their comfort within the clinic, SGM and ally twitter users responded with the following: asking about all patient's pronouns and having theirs visible on their badge or lapel. The avoidance of gendered terminology when possible, having more expansive intake forms that allow for diverse pronoun selections, having different options for gender and sex assigned at birth, and similarly different areas for correct or true name versus legal name and always using that correct name if different from legal. Having LGBTQIA+ inclusive signage and literature visible in common areas and pursuing additional learning opportunities for gender affirming care.

Slide 3.6: Leading by Example

Many practices throughout the nation have already implemented steps to ensure their LGBTQIA+ patients' safety and comfort and have found great success. These steps include the expansion of intake forms to include pronoun and naming options while also including sensitive and affirming health history options. Having all employees display their pronouns, indicating that their clinic and providers are safe spaces either by signage or wearing an explicit pin that says so. Some places have also hired SGM community leaders to vet the language in their signage or pamphlets provided in communal spaces as well as partnering with trans-lead and LGBTQIA+-lead organizations for community health initiatives.

Slide 3.7: Examples from the clinic

Here are some further examples of some of the approaches discussed in the previous slide. In the upper left, we have a picture of a nurse's board with all patient's pronouns listed, which not only helps providers remember their patient's pronouns while also normalizing this practice. In the upper right, we have an example of a restroom sign using clear, concise and affirming language.

Finally, the center two images are cropped from the same example image, found on the human right's campaign's website and provided by Fresno Medical Center, of a sample EMR intake form with expanded options. This specific example is from HealthConnect, but according to a rule made in 2015 by the HHS all EHR and EMR software is required to have the ability to collect SOGI data, it's just a matter of learning how to turn it on in your specific system. And while this example is a great attempt, it's still not perfect—for instance having different options for “female and male” vs transwoman and transman implies to your trans patients that they are not truly the gender they say they are—remember the comment earlier about cis- and trans- being adjectives not definers. A potential way of fixing this is having an option for gender identity that includes female, male, non-binary, decline to answer and other, then including a separate question of “do you identify as transgender or cisgender?” Another thing to think of in this vein is how will your record and verify systems display this collected information?

This example also shows the option to allow patients to list what organs they may or may not still have, which can be helpful in our setting to know how it might change our approaches to care without having to ask intimate and invasive questions directly to the patient, however its also important to note the phrasing on this one, it says “which birth organs are still present?” is not great; a better option would be to leave it as a more open-ended question—“Which organs do you *currently* have?” while also allowing for a declination to answer. These examples of striving for better inclusion but still making mistakes is a highlight of the need to bring everyone to the table when decision making is happening.

Slide 3.8: First Hand Patient Impact

As proof these changes make a difference, here is a testimony by a friend of mine, Amie. She told me that she’s always hated the doctors, mainly because of weight-related anxiety, and that going to a doctor about trans related care terrified her. However, because her doctor’s office created a welcoming environment in part by all staff having pronouns on their nametags, respecting her by not using her deadname, and taking the time to really understand both her gender identity and sexuality, she now has a doctor that she actually trusts and wants to see.

Slide 3.9: Sounds Great how do we start?

So, this all sounds great, you think—but how do we start? First off, you can start by being an advocate for your SGM patients. Begin having these conversations with your colleagues and seek out additional trainings. Think about your word usage and practice using gender neutral terminology when you can, and similarly, try to recognize when you start making assumptions and avoid acting on them—for instance, you may ask about a male patient’s wife as a means to either build rapport or enquire about who will be helping him at home during his treatment, but he might have a husband, and didn’t feel comfortable telling you—think about using gender-neutral language, for instance, using the term partner instead of wife, or if we wanted to focus on the care giving aspect of this hypothetical, ask “who will be

helping you at home?” leave your questions open ended so your patient can answer comfortably.

Most importantly, put yourself in your patient’s shoes. Is it obvious from their perspective that your clinic is a safe space? Is it obvious that *you* are a safe space? You might think ‘well of course I am’, but try to take a look at your clinic from their eyes, how do you indicate that you are a safe space? Are there either more or better ways to visibly signal to all patients that you are a safe space?

Slide 3.10: Laying the Foundations-Short Term

So, you’ve put yourself in your patients shoes and you’ve decided that your clinic is lacking in visible affirmations for your SGM patient community. What can you do without overwhelming yourself? The best way to approach this is to think about what you can do in the short term, versus what will take longer to accomplish. These shorter-term goals may include printing out and posting a non-discrimination statement, ordering pronoun pins or ribbons for you and/or your staff, advertising for any LGBTQIA+ cancer support groups in your area, and starting to practice interactions with SGM patients on your own

Slide 3.11: Laying the Foundations-Long Term

Longer term goals could include helping to establish a LGBTQIA+ cancer support group if none already exists, ordering information and pamphlets for LGBTQIA+ centered cancer care—although depending on your clinic’s policies this could be short term, you can also advocate for pronouns to be printed on future ID badges by finding out who you’d need to ask this from and what would be required for this request to be considered.

Slide 3.12: Going Beyond Foundations

There are also some things that might not fall into either category, expanding your intake forms for instance, could depend on your systems and policies, it could

be an easy thing to implement within the EMR, or a fairly simple template change to in-house forms, but if you have to go through an administrative body, it could take longer to implement—so in the meantime, you could suggest to providers that they include supplemental notes within their own files. You can also start standardize offerings and questions posed to all patients.

Slide 3.13: Seek out Further Education and Furthering Education

And finally, the two biggest steps you can take is to seek out further education and to seek to further currently available knowledge. This can be a short term initially, but in keeping with the mission of life-long learning, all staff, including medical physicists, and support staff like translators and secretaries should be expected to provide SGM-friendly and affirming care, but can only accomplish this via further training and education, keeping up with it just like any other training required to maintain licensure. This, along with posting a nondiscrimination statement is very important to LGBTQIA+ patients when seeking healthcare. Take the time to learn the LGBTQIA+ terminology and about gender-affirming accessories that your patients might be wearing that could contain metal that would potentially impact treatment and practice discussing these interactions in effective yet affirming ways.

For those of you in imaging, seek to learn more about how gender affirming surgeries might impact what you see in the images, so that you're aware and can respond appropriately. Similarly, for treatment planning, if a patient has undergone gender affirming surgery, there may be additional considerations that need to be taken into account for instance, with respect to potential difference in dose limits affecting skin grafts.

And finally, for those of you more on the research sides of things, think about explicit SGM inclusion in clinical trials, as we heard from Jessica, there's a lack of SGM specific data in many clinical trials, especially within trans specific patients, and it would be beneficial to all to build on that limited data.

Slide 3.14: Check it Out! Resources and Recommendations

Here are a few resources and recommendations for you, these and many more are included in the provided electronic hand out you all have access to!

Slide 3.15: Thank You!

I'd like to give special thanks to Anthony Velasco, Dendron Chamberlain, Amie, and especially to Jessica, Toni and Sunshine. I would also like to give a huge thank you to you for attending today and showing your interest and commitment to serving your patients!

Slide 3.16: References

These are my references, and they will also be included in the electronic handout sheet that you all have access to.

Listed References:

Presentation 3:

- American Medical Association. Creating an LGBTQ-friendly Practice. *Population Care*.
- Gay & Lesbian Medical Association. (2006). Guidelines for Care of Lesbian, Gay, Bisexual, and Transgender Patients. In.
- Human Rights Campaign. *Patient Self-Identification*. Retrieved from Human Rights Campaign Website:
- Cazza, T. (2015). STATEMENT: New HHS Rules Require Sexual Orientation and Gender Identity Data Collection in Electronic Health Records Program [Press release]

- National LGBT Health Education Center. (2016). Understanding the Health Needs of LGBT People. In F. Institute (Ed.).
- National LGBT Health Education Center. (2018). Learning to Address Implicit Bias Towards LGBTQ Patients: Case Scenarios. In F. Institute (Ed.): The Fenway Institute.
- National LGBT Health Education Center. (2020). Affirmative Services for Transgender and Gender-Diverse People: Best Practices for Frontline Healthcare Staff. In F. Institute (Ed.), *Fenway Institute*.
- National LGBT Health Education Center. (2021). 10 Strategies for Creating Inclusive Health Care Environments for LGBTQIA+ People. In N. L. H. E. Center (Ed.).
- The Joint Commission. (2011). Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care for the Lesbian, Gay, Bisexual, and Transgender (LGBT) Community: A Field Guide.
- National Center for Transgender Equality. (2016). Frequently Asked Questions about Transgender People.
- Handley, N. (2019). Guide for GPs Treating Transgender Patients. In TransLeads (Ed.). www.transleads.lgbt.
- Hudaisa Hafeez, M. Z., Muhammad A. Tahir, Nusrat Jahan, Sadiq Naveed. (2017). Health Care Disparities Among Lesbian, Gay, Bisexual, and Transgender Youth: A Literature Review. *Cureus*. doi:10.7759/cureus.1184
- Institute of Medicine (US) Committee on Lesbian, G., Bisexual, and Transgender Health Issues and Research Gaps and Opportunities. (2011). *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding*: National Academies Press (US).
- Kevin L Ard, H. J. M. (2016). Improving the Health Care of Lesbian, Gay, Bisexual and Transgender (LGBT) People: Understanding and Eliminating Health Disparities. *The Fenway Institute*.

- Pflag. (2021). PFLAG National Glossary of Terms.
- Desert Aids Project. (Ongoing). About DAP.
- Quinn, G. P., Alpert, A. B., Sutter, M., & Schabath, M. B. (2020). What Oncologists Should Know About Treating Sexual and Gender Minority Patients With Cancer. *JCO Oncology Practice*, 16(6), 309-316. doi:10.1200/OP.20.00036
- Reisner, S. L., Radix, A., & Deutsch, M. B. (2016). Integrated and Gender-Affirming Transgender Clinical Care and Research. *JAIDS Journal of Acquired Immune Deficiency Syndromes*, 72. Retrieved from https://journals.lww.com/jaids/Fulltext/2016/08151/Integrated_and_Gender_Affirming_Transgender.6.aspx
- Sarah Gibson, J. F. (2018). *Gender Diversity and Non-Binary Inclusion in the Workplace: the Essential Guide for Employers*. London: Jessica Kingsley Publishers.
- Schabath, M. B., Blackburn, C. A., Sutter, M. E., Kanetsky, P. A., Vadaparampil, S. T., Simmons, V. N., . . . Quinn, G. P. (2019). National Survey of Oncologists at National Cancer Institute–Designated Comprehensive Cancer Centers: Attitudes, Knowledge, and Practice Behaviors About LGBTQ Patients With Cancer. *Journal of Clinical Oncology*, 37(7), 547-558. doi:10.1200/jco.18.00551
- Seay, J., Hicks, A., Markham, M. J., Schlumbrecht, M., Bowman, M., Woodard, J., . . . Schabath, M. B. (2019). Developing a web-based LGBT cultural competency training for oncologists: The COLORS training. *Patient Education and Counseling*, 102(5), 984-989. doi:<https://doi.org/10.1016/j.pec.2019.01.006>
- Sharita Gruberg, L. M., John Halpin. (2020). *The State of the LGBTQ Community in 2020*. Retrieved from Center for American Progress:
- HealthLink, LGBT. *#Lgbtwellness News: Our New Lgbt Cancer and Wellness Brochures Are Here!* Edited by LGBT HealthLink. LGBT HealthLink Blog, 2018.

Presentation 4:

LGBTQIA+ Inclusion: Supporting Trainees and Colleagues

(Two Sides of the Same Coin)

Presenter:

Sunshine Osterman, Ph.D., DABR Medical *Physics Residency Director*, NYU
Langone Health, NY, NY
(She/Her/Hers)

Slide 4.1: Title Screen

It is an honor for me to be giving this talk today on LGBTQIA+ Inclusion in Medical Physics: Supporting our trainees and colleagues.

My name is Sunshine Osterman, I identify as a lesbian and the Medical Physics Residency Director at NYU. I use She/Her/Hers pronouns.

Slide 4.2: AAPM Statement on Racism, Injustice and Humanity

It's helpful to start with the AAPM statement on Racism, Injustice and Humanity:

AAPM as an organization values the importance of diversity and inclusion, which at its heart, acknowledges the value and worth of every person and all that they bring to our organization, to health care, and to our communities

And why is this important to us as a professional society? It's because we believe Inclusion results in:

- Higher levels of satisfaction and better outcomes for our patients
- More innovation in our research

- Better retention and reduced burnout of our trainees and professionals
- Higher levels of productivity (both short and long term)

Slide 4.3: Justice = Equity and Inclusion

When talking about inclusion, it is helpful to start by defining Equality and Equity. I think this image does a nice job of that.

On the left we have Equality. Each child is given an equal sized box to stand on and watch this baseball game. It doesn't really help them. Only one of them can really see the game well. In the image on the right, we've given them an unequal number of boxes to stand on. This allows them all to see the game, all to participate fully, to cheer and have a good time.

One of the things that is different about this image from other images that I've used in the past is that it emphasizes that it's not the individuals' personal attributes or decisions that are responsible for their lack of access. In fact, all of these children are about the same size, it is the uneven ground underneath - and the unequal barriers in front that have been established by history and policy that determine their access.

Now imagine, one step further, that you are in the position of hiring someone to lead your cheer team and you want to make the hire based on merit and consider recommendations from the baseball team. Which scenario is likely to increase your chances of getting the best child for the job?

Slide 4.4: Inclusion in Medical Physics

Inclusion in Medical Physics to me is about bringing individuals whose voices are not always heard to the table and being responsive to their input and suggestions, their priorities and their insight, supporting research that may add to our knowledge and improve our effectiveness of providing care to those patients whose needs are not currently being met.

And this applies to therapy, diagnostic physics, nuclear medicine, product development and marketing, even.

It's an opportunity to voice our concerns, and hear those of others in an environment that is safe and responsive, and here I mean

Safe: without fear of retribution and

Responsive: careful listening with a reaction that is thoughtful, quick, and positive

So, it's really about how to be an Ally, it's about how to be an educator, and it's about how to be a strong and effective leader.

Slide 4.5: Roadmap

The roadmap for the rest of this talk is as follows:

We know that 5% or more of our patients are LGBTQIA+ and that health inequities persist for this community. I am going to present some data on why representation is so essential in the healthcare provider system, including Medical Physics.

I will outline some of the active work that we can engage in as a profession to improve recruitment, retention and mentoring.

Slide 4.6: Targeting Healthcare Disparity: Adequate Representation

The first study that I'd like to bring to your attention is one that was published in 2020. It looked at over two decades of data and almost 2 million births in the state of Florida, and it showed that controlling for all factors, if you had a Black physician delivering a Black baby, the discrepancy in infant mortality between Black and white babies dropped by 50%.

I think that this is evidence that our colleagues of color and by extension, our LGBTQIA+ and other minority colleagues may be an essential resource if we are to hope to eliminate health disparities.

Slide 4.7: Improving Recruitment

Working off the premise that diversity is important to Medical Physics, we need to look at improving recruitment and some of the specific challenges in that. This study by Hebl et al. in 2002 looked at bias towards homosexual applicants when applying for jobs.

The applicants applied for 6 jobs in a mall wearing one of two printed baseball caps, which manipulated their sexual preference to be either obviously gay or assumed heterosexual based on statements printed on the caps. The interactions with the potential employer was limited to under 5 minutes. Without knowledge of which cap they were wearing; the applicants rated the interactions as less favorable when they were wearing the gay pride hat and their chances of being offered the job lower. These interviews were recorded and scored by a third party who was also unaware of which hat was being displayed.

This tells us is that interpersonal bias and discomfort will show when we are interviewing even in the absence of explicit bias and discrimination. The good news is that it can be eliminated with education and training, so ask for it!

In a 2018 study from Memorial Sloan Kettering in New York City surveyed over 1200 Oncology HCPs and ~1/2 of the respondents got 4 out of the 7 LGBT knowledge questions incorrect, which is not surprising given that typically in medical school, the training on LGBTQIA+ related issues is less than five hours.

Slide 4.8: Recruitment

The take home message from that is that in terms of recruitment, Implicit Bias training for those interviewing and hiring is essential, but it's not enough just to be able

to talk-the-talk. Your applicants are going to be looking for concrete examples of policy and opportunity at your institution.

Whether that's healthcare benefits (do you include health care for domestic partners, are there second-parent adoption benefits or time-off? For example). Is there an employee resource or action groups (Are they visible and active?) Are pronouns displayed on formal communications? Is there a printed non-discrimination policy that includes Sexual and Gender Minorities? And they may even inquire if your facility has a "Leader in LGBTQ Healthcare Equity" designation (HEI).

Slide 4.9: Barriers to Retention (Hostile/Unwelcome Environment)

Assuming we've been successful at hiring, the next question becomes can we keep these hires. Here I will draw from a study of 4th year medical student responses to the AAMC graduation questionnaire. Over 26,000 responses were analyzed and what it found was that ...

Being LGB was associated with increased burnout with an odds ratio of 1.62. Mistreatment accounted for only 31% of the total association between LGB sexual orientation and burnout.

What we're seeing again here is that while explicit mistreatment is very damaging, 2/3 of the association between LGB sexual orientation and burnout, is not stemming from explicit discrimination, Interpersonal discrimination and the associated stresses are significant factors pushing LGB individuals out of the trainee pipeline. And when there is explicit mistreatment and discrimination, lesbian, gay or bisexual students were reporting this mistreatment specific to their sexual orientation had an 8-fold higher predicted probability of burnout compared with heterosexual students.

But what does this look like for early career STEM academicians? Here also, perceived interpersonal discrimination and stress relates to a decline in performance outcomes (some of these long term), specifically this study, by O'Brien et al, measured faculty engagement and participation in institutional service activities.

Slide 4.10: Improving Retention

Luckily that paper also provided us with some guidance on what may help us improve retention.

Perceived support from a supervisor is able to mitigate the effects of interpersonal discrimination on stress in STEM academicians

So here are some things that we can do: Organizing and advertising student, staff and faculty support organizations for LGB; Implementing a mentorship network of out and visible Sexual and Gender Minority faculty; Providing opportunities for further LGBTQIA+ education for both trainees and faculty; and meaningful inclusion of sex, gender, sexual orientation and related patient care topics in discussions and curriculum.

Slide 4.11: Realizing a Training and Practice Environment for Medical Physicists that is Free of Racism, Homophobia, Transphobia and Gender Discrimination

Realizing a training and practice environment for Medical Physicists that is free of racism, homophobia, transphobia, and gender discrimination requires self-education and transformation, implicit bias training related to interactions with Sexual and Gender Minorities. It involves a lot of allyship- including an Equity Diversity Initiative or LGBTQIA+-specific bullet point in recurring meetings, add pronouns to your electronic signature, if someone else's ideas are not heard, repeat and give credit, help establish a safe and responsive workspace where incomplete ideas can be hashed out and materialized into practical solutions. Really try and leverage our humility, be kind, check understanding, apologize when we make mistakes, and all of us will, and avoid defensive responses.

Slide 4.12: Montage

This is a montage of some of the steps we're taking and the activities that are happening at my center. We set up an advisory council for LGBTQ+ identifying patients and their families. It was driven initially by medical oncology. Offering a seat at the table and involving leadership so that we could respond to valuable discussion and inputs that happen at these meetings. A more local one in radiation oncology department, was the LGBTQ+ Action Squad! It's organized by one of our very enthusiastic and knowledgeable medical residents, and we report at the High Reliability Organization Meeting that happens after chart rounds weekly, these activities may include changes in signage in the bathrooms or the collection of SOGI, which is Sexual Orientation and Gender Identity data, into our medical records. (And HRO includes all departmental staff). We're also involved in changing the screening for our GYN brachytherapy patients to ask more identity questions and about symptoms related to both physical and sexual health, changing some of the language to address and acknowledge that not everyone has the same anatomy and not everyone is comfortable referring to that anatomy in the same way.

Slide 4.13: Thank You Team!

I would like to thank my fiercely brave and passionate collaborators and instigators on this AAPM symposium: Victoria Ainsworth, Toni Roth and Jessica Vadas.

I am also appreciative of the strong group that's paved the way and supports me at NYU.

Slide 4.14: References

Finally, I present the full references for the papers I spoke about in this talk. I am looking forward to the Q&A!

Listed References:

Presentation 4:

- Banerjee SC, Walters CB, Staley JM, Alexander K, Parker PA. Knowledge, Beliefs, and Communication Behavior of Oncology Health-care Providers (HCPs) regarding Lesbian, Gay, Bisexual, and Transgender (LGBT) Patient Health care. *J Health Commun.* 2018;23(4):329-339. doi: 10.1080/10810730.2018.1443527. Epub 2018 Mar 9. PMID: 29521575; PMCID: PMC5961501.
- Dimant OE, Cook TE, Greene RE, Radix AE. Experiences of Transgender and Gender Nonbinary Medical Students and Physicians. *Transgend Health.* 2019 Sep 23;4(1):209-216. doi: 10.1089/trgh.2019.0021. PMID: 31552292; PMCID: PMC6757240.
- Greenwood BN, Hardeman RR, Huang L, Sojourner A. Physician-patient racial concordance and disparities in birthing mortality for newborns. *Proc Natl Acad Sci U S A.* 2020 Sep 1;117(35):21194-21200. doi: 10.1073/pnas.1913405117. Epub 2020 Aug 17. PMID: 32817561; PMCID: PMC7474610.
- Griggs J, Maingi S, Blinder V, et al. (2017). American Society of Clinical Oncology Position Statement: Strategies for Reducing Cancer Health Disparities Among Sexual and Gender Minority Populations. *Obstetrical & Gynecological Survey.* 72. 598-599. 10.1097/01.ogx.0000524472.14033.3f
- Hebl MR, Foster JB, Mannix LM, Dovidio JF. Formal and Interpersonal Discrimination: A Field Study of Bias Toward Homosexual Applicants. *Personality and Social Psychology Bulletin.* 2002;28(6):815-825. doi:10.1177/0146167202289010.
- O'Brien KR, McAbee ST, Hebl MR, Rodgers JR. The Impact of Interpersonal Discrimination and Stress on Health and Performance for Early Career STEM Academicians. *Front Psychol.* 2016 Apr 28;7:615. doi: 10.3389/fpsyg.2016.00615. PMID: 27199848; PMCID: PMC4849428.
- Samuels EA, Boatright DH, Wong AH, Cramer LD, Desai MM, Solotke MT, Latimore D, Gross CP. Association Between Sexual Orientation, Mistreatment, and Burnout Among US Medical Students. *JAMA Netw Open.* 2021 Feb 1;4(2):e2036136. doi: 10.1001/jamanetworkopen.2020.36136. PMID: 33528552; PMCID: PMC7856540.
- Quinn, Gwendolyn & Alpert, Ash & Sutter, Megan & Schabath, Matthew. (2020). What Oncologists Should Know About Treating Sexual and Gender Minority Patients With Cancer. *JCO Oncology Practice.* 16. 309-316. 10.1200/OP.20.00036.