

An Introduction to LGBTQIA+ Issues in Radiation Oncology from the Medical Physicist's Perspective

Electronic Handout*

*This is not a complete list of all available resources, just ones that we thought would be beneficial to include. We urge you to use these suggestions as a springboard to launch yourself into furthering your education, and maybe even inspire you to help create more resources.

Websites:

❖ American Medical Association: Creating an LGBTQ-friendly practice

- Advice and further resources for providing a welcoming and visually affirming environment
- <https://www.ama-assn.org/delivering-care/population-care/creating-lgbtq-friendly-practice>



Taken from Google Images

❖ CDC's Lesbian, Gay, Bisexual and Transgender Health Home Page

- Information hub for information specific to the different identities within the LGBTQIA+ umbrella including youth specific, broad data and statistics and resources
- <https://www.cdc.gov/lgbthealth/index.htm>

❖ Center for Applied Transgender Studies

- The leading academic organization dedicated to scholarship on social, cultural and political conditions of transgender life including programs, publications, and events
- <https://www.appliedtransstudies.org/>

**Center for
Applied
Transgender
Studies** ●●●

Taken from Twitter

❖ GLMA: Health Professionals Advancing LGBTQ Equality



- A national organization committed to ensuring health equity for LGBTQ and SGM people, including a Provider Directory (*Your clinic could join!*), as well as resources for patients, providers, and care givers
- www.glma.org

❖ Johns Hopkins' Office of Diversity, Inclusion and Health Equity

- LGBTQ resources for patients, families, students, staff and faculty available through Johns Hopkins
- <https://www.hopkinsmedicine.org/diversity/resources/lgbtq-resources.html>

❖ National LGBT Cancer Network

- A national network working to improve the lives of LGBT cancer survivors and those at risk via risk education for the community, training for health care providers, and advocacy for survivors
- <https://cancer-network.org/>

❖ National LGBTQIA+ Health Education Center: A Program of the Fenway Institute

- Education center that aims to advance health equity, address and eliminate health disparities, increase access to cost-effective health care options, and improve quality of care for the LGBTQIA+ community via training and technical assistance to health care providers and staff
- <https://www.lgbtqihealtheducation.org/>

❖ The Pride Study

- The first large-scale, long-term national health study of LGBTQ+ populations to provide vital insights on health and wellbeing of the community
- www.pridestudy.org



❖ Project Implicit

- Test your Implicit Bias on Social Attitudes and Health Related Topics
- <https://implicit.harvard.edu/implicit/>



Taken from Google Images



Project Implicit®

Taken from Google Images

❖ Transhealth Northampton

- A trans-lead organization serving trans and gender-diverse kids, adults and families—hosts a comprehensive resource databank for clinicians, patients, and caregivers
- www.transhealth.org

Podcasts:

❖ ***Code Switch***

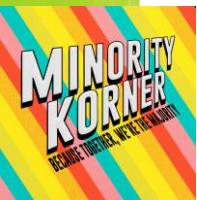
- Hosted by Gene Demby, Sheeren Marisol Meraji
- Fearless conversations about race as it impacts politics, pop-culture, history and more from the lens of journalists of color



Taken from NPR

❖ ***Minority Korner***

- Hosted by James Arthur M.
- An introspective look at pop-culture, politics, news, media and history from a Black, Queer perspective



Taken from MaxFun.com

❖ ***Queer Health Pod***

- Hosted by Dr. Gabrielle Mayer, Dr. Richard Greene, Dr. Sam Dubin
- Covering Queer Health topics by Queer Docs for Queer (& Ally) listeners



**Queer Health
Podcast**

Taken from Google Images



Taken from Google Images

❖ **Queer MEDucation**

- Hosted by Kerin “KB” Berger
- A series of interviews with medical experts, mental health professionals, students, advocates and community members with the goal of improving the health and well-being of queer people

❖ **Rule 63**

- Hosted by Anna Marie and Danny
- An exploration of science, politics, media and more from a Trans perspective



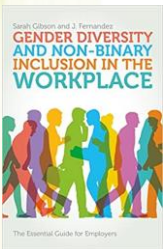
Taken from Google Images

Books*:

***As language changes and evolves, some older published works may use outdated language. Be sure to check your reading material for publication date, and double check the language you read against currently defined and used vernacular.**

❖ ***Affirmative Services for Transgender and Gender-Diverse People: Best Practices for Frontline Healthcare Staff.***

- National LGBT Health Education Center: A Program of the Fenway Institute. Updated *Winter 2020*.
- *“Provides best practices and guidance for frontline healthcare staff on how to best serve transgender and gender diverse patients.”*



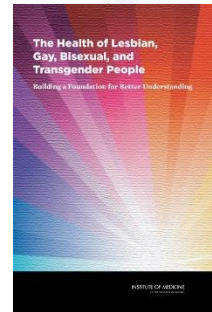
Taken from Google Images

❖ ***Gender Diversity and Non-Binary Inclusion in the Workplace: The Essential Guide for Employers.***

- Sarah Gibson and J. Fernandez. Pub *Jan 18, 2018*.
- Builds the knowledge of and for non-binary identities as well as providing practical solutions to many basic workplace problems

❖ ***The Health of Lesbian, Gay, Bisexual and Transgender People: Building a Foundation for Better Understanding.***

- Committee on LGBT Health Issues and Research Gaps and Opportunities. Pub 2011
- A report to address the questions related to the unique health disparities of the LGBT community



Taken from Google Images

❖ ***How to be an Antiracist.***

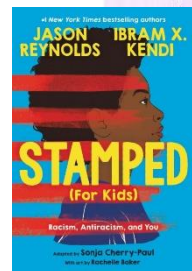
- Ibram X. Kendi. Pub Aug 13, 2019
- A memoir combining ethics, history, law and science to help the reader rethink their most deeply held and potentially implicit, beliefs and reexamines policies

❖ ***Stamped from the Beginning: The Definitive History of Racist Ideas in America.***

- Ibram X. Kendi. Pub Apr 12, 2016
- "A narrative chronicling the entire story of anti-Black racist ideas and their staggering power over the course of American History."

❖ ***Stamped (For Kids).***

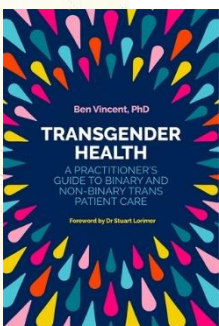
- Ibram X. Kendi, Jason Reynolds. Pub May 18, 2021
- Illustrated and adapted-for-kids version of *Stamped from the Beginning* to relay where racist ideas came from, identifying their impact on America today and meeting those who have fought racism with anti-racism



Taken from Google Images

❖ ***Transgender Health: A Practitioner's Guide to Binary and Non-Binary Trans Patient Care.***

- Ben Vincent, PhD. Pub 2018
- Provides accessible and practical advice to tailor social and ethical aspects of practice to suit the needs of each individual



Taken from Google Images

❖ ***Understanding Trans Health: Discourse, Power and Possibility.***

- Ruth Pearce. Pub 2018
- Addresses urgent challenges and debates within trans health, drawing on patient voices, social theory and autobiography to look at shifting language, patient mistrust, and professional power to shape clinical encounters

Trainings:

❖ **Cultural Competency Training via National LGBT Cancer Network**

- A tailored-to-your-needs training curriculum that focuses on reexamining LGBT Healthcare (currently paused; will resume TBA)
- <https://cancer-network.org/cultural-competency-training/>

❖ **The Inclusive Care Project**

- Training for healthcare providers in LGBTQ+ and BIPOC care to reduce health disparities for queer communities and people of color
- <https://inclusivecareproject.podia.com/>
- Follow them on Instagram @inclusivecareproject



Taken from Instagram

❖ **Learning Resources Database at the National LGBTQIA+ Health Education**

Center: Program of the Fenway Institute

- Learning Modules, publications, videos, and webinars spanning a wealth of LGBTQIA+ health topics (includes CME credits)
- <https://www.lgbtqihealtheducation.org/resources/>



NATIONAL LGBTQIA+ HEALTH
EDUCATION CENTER

A PROGRAM OF
THE FENWAY INSTITUTE

Taken from Google Images

❖ ***“Patient First Care for Transgender Patients” Workshop***

- Taught by Dendron Chamberlain, a workshop focusing on patient first communication and care for Transgender Patients
- Contact Dendron.C@Gmail.com for more information on booking training

❖ **Practice your Pronoun Usage!**

- Get a handle on pronouns you’re unfamiliar with via an easy online application
- www.practicewithpronouns.com

SWAG:

When looking to purchase affirmations for your clinic, seek out LGBTQIA+ or QTBIPOC sellers or sellers that donate a portion of proceeds to pro-LGBTQIA+/QTBIPOC organizations

❖ **Pronoun Ribbons**

- A hub for information run by two volunteers on how/what/why/who for pronoun ribbons and where to buy them
- <http://www.pronounribbons.org/>



Taken from pronounribbons

❖ **Pronoun Buttons/Stickers**

- <https://nngenderfluid.squarespace.com/>
- <http://www.etsy.com/> Search terms: *Pronoun Pins, Pronoun Pins Bulk, Pronoun Stickers*

❖ **Advice on Pronoun-related Purchasing**

- *Getting pronoun badges right: Five recommendations for event organizers* Lal Zimmin
- <https://medium.com/trans-talk/getting-pronoun-badges-right-five-recommendations-for-event-organizers-5458116b2ffc>

❖ **Positive Signage**

- The Welcoming Project <https://thewelcomingproject.org/>
- The AMA’s Non-Discrimination Statement found in previous AMA link



*Taken from etsy:
MoxieDesigns*



Thank you so much for your interest and dedication to your patients and for your time!

****A non-image/printer friendlier version can be made available by contacting
Victoria_Ainsworth@student.UML.edu****

Presentation 1:

Current State of LGBTQIA+ Healthcare

Presenter:

Jessica Vadas, Ph.D. *Medical Physics Resident, Beaumont Health, Royal Oak, MI*
(She/Her)

Slide 1.1: Title Screen

Hello everyone, and welcome to our session on LGBTQIA+ healthcare within Radiation Oncology. My name is Jessica Vadas, I'm a resident at Beaumont Health, and I'll be starting off with a brief introduction to the current state of LGBT healthcare.

Slide 1.2: Definitions

To orient everyone, I'll start off with some relevant definitions, the first of which is the acronym **LGBTQIA+**, which stands for lesbian, gay, bisexual, transgender, queer or questioning, intersex, asexual, and others that identify as something other than heterosexual or cisgender. This is often shortened to **LGBT** or **LGBTQ** for brevity.

Many people in the community will use the term "**queer**" as an umbrella term for "not heterosexual," which has historically been used as a slur but has since been reclaimed by some and is generally used by people within the community.

Oftentimes in healthcare you might see the acronyms **SGM** and **SOGI** used for patients, which stand for sexual or gender minority and sexual orientation and gender identity, often used in the context of demographic data.

Transgender is used to describe someone whose gender identity is different than the one they were assigned at birth, and **cisgender** is used for someone whose gender identity does align with the one they were assigned at birth.

SAAB stands for sex assigned at birth, which is often based on apparent sex characteristics and/or genetics.

Slide 1.3: The LGBTQ+ Community

I first want to start off by saying that the LGBT community is colorful and diverse. It's made up of many different people with different identities and experiences that each have different needs.

The concept of intersectionality describes how multiple identities can overlap in often complex ways, and the next presenter in this session will talk specifically about how LGBTQ identities intersect with race.

Identities within the LGBT community are mainly defined by a person's sexual orientation, which describes who they're attracted to, and their gender identity, which is their internal sense of gender.

A person's gender expression is the way in which a person communicates their gender within a culture or societal standard, and this may or may not be the same as their gender identity, for a number of reasons.

It's important to note that everyone has a sexual orientation and gender identity, even heterosexual and cisgender individuals.

Slide 1.4: LGBTQ+ Demographics

According to recent estimates, approximately 4.5% of adults in the US identify as LGBT, and of these, about 1.4 million identify as transgender or gender non-conforming, where the younger generations represent a growing fraction of the LGBT population.

The actual number of LGBT-identifying people is likely much higher than reported, due to the fact that it's difficult to obtain sexual orientation and gender identity demographic information, as well as the stigma and fear people experience when self-reporting whether or not they're LGBT.

The statistics surrounding the climate of healthcare for LGBT individuals is quite frankly alarming. Over half of LGBT patients have experienced discrimination at some point while receiving healthcare.

Worse even, as recently as 2017, 8% of sexual minority people and 29% of transgender people reported being outright refused healthcare due to their sexual orientation and gender identity.

Slide 1.5: Human Cost of Refusing Care

The refusal to provide someone with necessary medical care comes with a heavy cost. This was borne out on a massive scale during the AIDS crisis in the 1980s, where healthcare providers refused to treat patients with HIV or AIDS, even long after it was established that there was a low risk of transmission to the provider. Many objected on moral grounds, since HIV had primarily spread between men who had sex with men, sex workers, and intravenous drug users.

Even as of 2016, over 10% of people living with HIV still report being denied healthcare due to their status.

If they are able to obtain healthcare, providers will often use harsh language, refuse to touch them, or even blame them for their own health status.

The transgender community also faces disproportionately fatal discrimination that persists today. Some more well-known examples of this include the story of Robert Eads, who was a transgender man from Georgia who developed ovarian cancer in 1996. Over a dozen different doctors refused to treat him because they thought doing so

would “harm their practice,” but by the time he found a provider willing to treat him, his cancer metastasized, and he died in 1999.

In a separate incident, Tyra Hunter was a black transgender woman who was the victim of a car crash in 1995. When EMTs arrived on the scene, they refused to treat her and instead shouted racial and transphobic epithets. The posthumous medical report states that she would have had an 86% chance of survival if she had received proper care.

Slide 1.6: 2015 US Transgender Survey (n=27,715)

In an effort to address some of the disparities facing transgender Americans, a survey was conducted in 2015 of nearly 28000 transgender individuals, which represents the largest sample size for a survey of this kind.

In this survey, one out of every four respondents reported being denied insurance coverage for routine care due to being transgender, and over half of respondents were denied coverage for transition-related surgeries, even if they were able to find in-network providers.

One in three transgender Americans has reported at least one negative experience when receiving healthcare due to being transgender, where they were refused treatment, harassed, or assaulted, or had to teach the provider about transgender people in order to receive care in the first place.

These rates are higher for transgender people of color and people with disabilities.

Because of how widespread this discrimination is, 23% of respondents just simply didn't seek necessary medical care because of the fear of being mistreated as a transgender person. More still did not seek care because they could not afford it.

Most shockingly, these statistics are drawn from the experiences of transgender individuals during just the 12 months prior to the survey. Lifetime statistics are much higher.

Slide 1.7: Effect of Discrimination on Seeking Medical Care

Experiencing discrimination has a huge effect on whether LGBT people will seek necessary or preventative care. Having experienced at least one instance of discrimination is enough to increase healthcare hesitancy by a factor of 2 to 3, for fear of experiencing further discrimination

Slide 1.8: LGBT Experience with Health Care Providers

Over 10% of LGBT individuals often experience this discrimination directly from their providers, where the doctor is uncomfortable with their patient's sexual orientation or gender identity, and just doesn't know how to treat LGBT individuals.

Transgender patients face even higher rates of provider mistreatment, especially transgender people of color, where the doctor is uncomfortable, abusive, or just simply refuses to see or treat the patient.

Slide 1.9: LGBTQ+ Healthcare Legislation

Unfortunately, there is often little recourse for patients experiencing this kind of mistreatment, because the healthcare of the LGBT community is even still being legislated. These headlines are just from the past 12 months of legislation that revokes protections, legalizes medical discrimination, and even makes it illegal for doctors to provide necessary care to the LGBT community.

Slide 1.9(b): LGBTQ+ Healthcare Legislation (con't)

Only as of May of 2021 have federal healthcare protections for the LGBT community been restored, but this is not guaranteed nor secured since it can and has change depending on whichever administration is in power.

Slide 1.10: Barriers to Health Care for LGBTQ+ Patients

Discrimination represents a major barrier in receiving healthcare as I've described previously in this talk, which can take the form of treatment by providers, insurance practices that are set up to deny claims, or unnecessary requirements and gatekeeping before being able to receive treatment.

There's even an expression used for a common experience among transgender individuals, called "transgender broken arm syndrome," which is a tongue-in-cheek expression describing a hypothetical scenario where a transgender patient present to the ER with a broken arm, and the doctor says, "I think your problem is your hormones!" Oftentimes providers look to use a patient's sexual orientation or gender identity as a reason or cause for their ailment.

This represents another unique barrier for LGBT patients, namely the provider's lack of knowledge. LGBT patients often have to teach their providers about LGBT people in order to receive care. This is largely due to how little teaching of LGBT issues there is in medical school, averaging about 5 hours of didactic information over a 4-year curriculum.

This means that most of a trainee's experience with LGBT patients comes from clinical exposure, so if their attending physician is discriminatory or biased towards LGBT patients, that will be perpetuated by the trainee.

Our last presenter of this session will go into more detail about medical training.

Another common barrier to LGBT healthcare is socioeconomic since LGBT people are more likely to be uninsured or unable to afford care.

Slide 1.11: Cancer in the LGBTQIA+ Community

For us as medical physicists, it's important to recognize that younger generations are increasingly more likely to identify as LGBT, and as they age, we will encounter more of them in our clinics.

This is especially relevant, since LGBT people are at higher risk for developing certain kinds of cancer than the heterosexual or cisgender population.

Nearly one in three LGBT adults smoke, which is 68% higher than other adults, increasing the risk of lung and head and neck cancers.

Gay and bisexual men experience an incidence rate of anal cancer 3-4 times higher than heterosexual men, and this rate increases to 30 times higher for individuals living with HIV.

Lesbian and bisexual women have higher risk factors for breast cancer, due to higher rates of nulliparity, substance use, and obesity.

Unfortunately, not enough data exists on transgender-specific cancer risks and incidence rates

Slide 1.12: Cancer-Related Health Disparities

Despite these higher risks, LGBT patients are less likely to access care and seek out preventative cancer screening, largely due to fears of discrimination, and also the

general lack of awareness of their health, which is perpetuated by provider lack of knowledge.

Lesbian women are 3 times less likely to initiate the HPV vaccine than heterosexual women, and gay men are no more likely to either despite being at higher risk of transmission.

Lesbian women are less likely to have pap tests, and a majority of gay men aren't even aware that an anal pap test exists

Bisexual women and transgender individuals are also about half as likely to meet mammography guidelines.

Slide 1.13: Cancer Survivorship for LGBTQ+ Patients

Cancer survivorship is another important factor in the LGBT patient population. LGBT patients often create families that aren't always recognized by law or by healthcare systems, and we all know how important it is for patients to have support systems.

Many LGBT cancer survivors report that their partners weren't permitted in the emergency room with them, or otherwise involved in care and treatment decisions.

This is especially important for palliative care, where a patient has to question whether their provider will treat them with the same amount of compassion as a heterosexual or cisgender person, and whether their chosen family can be involved in their care and end-of-life decisions.

Patient support is extremely important for better clinical outcomes and quality of life. If an LGBT patient's support network is prevented from being involved in their care, they will suffer.

I'll leave you with this: it is important to recognize the health care disparities facing the LGBT community so that we can work to eliminate the inequity and remove

the barriers that prevent this community from accessing the quality health care they rightfully deserve.

Listed References:

Presentation 1:

Presentation 2:

Intersection of Race and LGBTQIA+

Presenter:

Toni M. Roth, MS, DABR, *Clinical Physicist, WashU in St Louis, St. Louis, MO*
(She/Her/Hers)

Slide 2.1: Title

Hi, my name is Toni Marie Roth, my pronouns are she/her/hers, I'm a Clinical Physicist at Washington University in St. Louis, and this talk will be over the Intersection of Race and LGBTQIA+ Individuals

Slide 2.2: Perspective

I want to acknowledge that although I identify as QTBIPOC, I am not under the assumption that my personal experience can speak for all racial identities or LGBTQIA+ people. What I will do, is encourage all people to embrace the notion that the LGBTQIA+ community will not achieve full equality as long as LGBTQIA+ people of color continue to face oppression and marginalization on the basis of race.

Slide 2.3: Terminologies and Definitions

Here are some terminologies and definitions.

Slide 2.4: Contents

Intersectionality is the overarching theme of the presentation. Kimberlé Crenshaw, Law Professor at Columbia and UCLA, coined the term intersectionality more than 30 years ago. It describes the way people's social identities can overlap. As she stated, "what's often missing is how some people are subjected to all of these

inequalities and levels of discrimination, and the experience is not just the sum of its parts.”

Slide 2.5: Contents (Con’t)

We want to use the lens of intersectionality so we may see how some people are subject to all of these inequalities and the experience is not just additive but nuanced. How can we understand these unique and layered experiences through the lens of intersectionality? This is the question we are aiming to answer.

Slide 2.6: Contents (Con’t)

We will explore BIPOC and Healthcare, which will include the ethical shortcomings of policies, practices, and research studies that existed in the U.S. Poverty in QTBIPOC vs Non-QTBIPOC populations. Mental and emotional health in QTBIPOC vs Non-QTBIPOC individuals, including a youth perspective.

Slide 2.7: BIPOC and Healthcare

We’ve heard the history, and the current state, of the relationship between LGBTQIA+ individuals and the healthcare system. To understand the intersection of LGBTQIA+ and race, we have to first understand the relationship between BIPOC and healthcare. Forced sterilization powered by the U.S. Eugenics movement, which peaked in the 1920’s and 1930’s, primarily targeted the poor, BIPOC, mental illness, immigrants, and “criminality” (which was subjective). This ultimately prevented individuals, who were deemed unfit based on pseudoscience, from having children via sterilization. The U.S. Eugenics Movement was an inspiration to Nazi Germany where they took off and ran with the concept of Eugenics.

Slide 2.8(a): U.S. Public Health Service Syphilis Study at Tuskegee

The U.S. Public Health Service Syphilis Study at Tuskegee had a cohort of 600 Black men, 399 with Syphilis and 201 without. In 1932 was when the study started, and researchers told the men they were being treated for “bad blood.” In 1943, Penicillin

became the treatment option of choice, but the men were not treated on the study.

“The experiment was designed to determine through autopsies what damage untreated syphilis does to the human body.” – AP The Associated Press (AP) broke an article on the subject and the study ended three months later. In 1974, the National Research Act Passed.

Slide 2.8(b): U.S. Public Health Service Syphilis Study at Tuskegee (Con’t)

The study was considered to be unethical due to the lack of informed consent and the lack of treatment for Syphilis. Changes to research practices in the form of the National Research Act mandated that Voluntary Informed Consent and Institutional Review Boards (IRB) need to be in place. The ramifications of the study still exist today with Black people’s trust in medical research and providers, still bruised.

Slide 2.9(a): Racial Segregation of Hospitals and Professional Medical Organizations

Let me be clear, it was Black individuals who were most impacted by racial segregation of hospitals and professional medical organizations. The American Medical Association was founded in 1847 and is the largest association for MDs and DOs in the U.S. It was consistently at odds with the Civil Rights movement an example being that, although they allowed Black physicians to join the AMA, they refused to force, via policy changes, the integration of all Local and State Medical Associations.

Slide 2.9(b): Racial Segregation of Hospitals and Professional Medical Organizations (Con’t)

The AMA did not change course until the Civil Rights Act where federal funding could be withheld from any hospital that practices racial discrimination.

Slide 2.10: AMA Update

In response to the George Floyd killing and subsequent protests across the country and around the world, many organizations began similar initiatives to the ones presented by the AMA.

Slide 2.11: Contents Revisited

Alright, everyone take a nice deep breath. [Inhale;Exhale] Hope you're all doing okay; I know that's heavy. In the words of Kris Jenner, "You're Doing Amazing, Sweetie" Getting back to our Goals – we're here to understand these unique and layered experiences through the lens of intersectionality.

Slide 2.12: Poverty in QTBIPOC vs Non-QTBIPOC

As stated previously, poverty and homelessness are risk factors for health outcomes due to the lack of access to healthcare. The Williams Institute within the School of Law at UCLA conducted a study titled LGBT Poverty in the United States. What they found is that poverty rates differ by sexual orientation and gender identity. The LGBT Poverty Rate is 21.6% versus 15.7% for cis-gender straight people. It's important to note that Transgender people have especially high rates of poverty at 29.4%.

Slide 2.13: LGBT Poverty

Lesbian [17.9%] and straight [17.8%] cisgender women have higher poverty rates than gay [12.1%] and straight [13.4%] cisgender men. Cisgender lesbian women do not have significant poverty rates than cisgender straight women. Bisexual cisgender women [29.4%] and men [19.5%] have higher poverty rates than cisgender straight women [17.8%] and men [13.4%].

Slide 2.14: LGBT Poverty (Con't)

"Poverty was also particularly high at the intersection of racial and SOGI minority statuses." Table 4 represents the stratification of LGBT and cisgender straight people by race and ethnicity. The bold percentages indicate respondents differed significantly by row.

Slide 2.15: LGBT Poverty (Con't)

Poverty rates follow similar patterns for both cisgender straight people and LGBT people. LGBTQ+ people of all races and ethnicities show higher rates of poverty than their cisgender straight counterparts.

Slide 2.16: LGBT Poverty (Con't)

Table 5 demonstrates poverty rates of various SOGI folks stratified by race as compared to their White counterparts. This collection of data highlights how race plays a significant role in the poverty level among SOGI and Cisgender populations. QTBIPOC individuals are more likely to experience poverty relative to their Cisgender, straight counterparts as well as to their White, LGBTQIA+ counterparts. QTBIPOC folks have a unique experience when it comes to navigating both the racial and queer landscape in the U.S., from a socioeconomic standpoint. We know that one's socioeconomic status impacts the quality and access of healthcare. As such, their access to affordable healthcare and engaging with the healthcare system, is limited.

Slide 2.17: Contents Revisited

For those of you who don't know, the woman in the pink dress, Marsha P. Johnson, is credited with starting the Stonewall Riot in New York City on June 28th, 1969. A year later, the U.S. would have its first Gay Pride Parade to celebrate Gay Liberation Day on June 28th, 1970.

Slide 2.18: Mental and Emotional Health in QTBIPOC vs Non-QTBIPOC

Aside from the socioeconomic conditions of this marginalized community, the mental and emotional health and wellbeing of these populations is compromised.

Further contributing to the dehumanization of these minority populations. 28% of LGBTQ+ adults of color currently have no health insurance coverage. 26% of QTBIPOC adults needed to see a physician but could not because of cost.

Slide 2.19: HRC Partnered Study

The HRC partnered with the University of Connecticut to release a study regarding LGBTQ+ youth. Only 11% of LGBTQ youth of color believe their racial/ethnic group is regarded positively in the U.S. *Only 4% of Black youth and 5% of Latinx youth. To help accelerate the next generation, we need to build awareness and take action in providing a safe and comfortable environment. Children and adolescents that experience mental and/or physical trauma are at higher risk of engaging in high risk behavior as in smoking, alcohol abuse, drug abuse. We know these high risk behaviors increase the risk of cancer and other co-morbidities as adults.

Slide 2.20: Hate Crime Statistics

Mental and Emotional Health is further eroded by racially motivated hate crimes which remain the most common hate crime in the U.S., with nearly half of race-based hate crimes targeting Black people. The 3rd most common is bias against sexual orientation.

Slide 2.21: AAPI Hate

Since the COVID-19 pandemic, hate crimes against Asian American and Pacific Islanders rose by 150% in 2020. We all must have cultural humility so we may assist in the eradication of hate towards any of our marginalized brothers, sisters, and siblings.

Slide 2.22: Venn Diagram

Due to the many facets that comes with a persons identity we need to aim for intersectionality when talking about or attempting to better understand the

healthcare disparities that plague the LGBTQIA+ community. Doing so can vastly improve access to care and potentially bridge the gap of healthcare disparities among the LGBTQIA+ community as a whole.

Slide 2.23: Thank you

Thank you to my SAM session team Toria, Sunshine and Jessica, my colleagues at WashU Matt Riblett and Vivian Rodriguez, my incredible fiancé Danielle Key who is always my number one, my grandmother Emilia Rius for being there since the beginning and demonstrating what it means to be an ally to all people. Thank you all for coming and attending this session.

Slide 2.24

And here are my references.

Listed References:

Presentation 2:

- Campaign, H.R., *The State of Mental Health in LGBTQ Communities of Color*. 2021.
- Cerdeña, J.P., M.V. Plaisime, and J. Tsai, *From race-based to race-conscious medicine: how anti-racist uprisings call us to act*. The Lancet, 2020. **396**(10257): p. 1125-1128.
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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.

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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!

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