WEBINAR VIDEO TRANSCRIPT

Partnership for Care HIV TAC

Effective Communication with LGBT People: Interactive Case Scenarios

29 October 2015

ADRIANNA SICARI: Good morning everyone. This is Adrianna Sicari from the National LGBT Health Education Center, a program of the Fenway Institute in Boston, Massachusetts. We are pleased to have you with us today for our webinar-- Effective Communication with LGBT people- Interactive Case Scenarios. Today's webinar will last 90 minutes, and we really encourage participants to interact with our presenter, Dr. Makadon, throughout the presentation using chat and hand raising.

And additionally, we'll have some designated time at the end for Q&A, but we really want people to interact throughout the presentation. And so in order to do that, what we're going to do is we're going to promote all the attendees to panelists. And you guys will be able to use the Raise Hand feature in the Panelist list where you see your name. This also means that you'll be able to mute or unmute yourself from the Panelist list.

And that will give you the ability to interact with Harvey during the presentation as well. And so with that, I'm going to turn the mic over to Chelsea White and just, again, remind all of our attendees that you're now in the Panelist list. You should see your name there on the right hand side. And you'll be able to raise your hand to get our attention for us to call on you and interact throughout the presentation. So with that, I'll turn the mic over to Chelsea to begin.

CHELSEA WHITE: Hi everyone. Welcome to the Effective Communication with LGBT People-Interactive Case Study Scenario webinar co-hosted by LGBT Health Education Center and the Partnership for Care HIV training, technical assistance, and collaboration center, otherwise known as HIV TAC. The Partnership for Care project is a three year multi-agency project funded by the Secretary's Minority AIDS Initiative Fund and the Affordable Care Act.

The goals of the project are to expand provisions of HIV testing, prevention, care, and treatment in health centers serving communities highly impacted by HIV, build sustainable partnerships between health centers and their state health department, and improve health outcomes among people living with HIV, especially among racial and ethnic minorities. The project is supported by the HIV training, technical assistance, and collaboration center.

This webinar will be facilitated by Dr. Harvey Makadon, Director of Education and Training at the Fenway Institute, a division of Fenway Health, Boston, and a Professor of Medicine at Harvard Medical School. Dr. Makadon teaches about how to improve access to quality care for lesbian, gay, bisexual, and transgender people in health care settings around the country. He directs the National LGBT Help Education Center, a HRSA funded cooperative agreement to improve cultural competence in LGBT health in community health centers, and the National Center for Innovation in AIDS Care, also funded by HRSA.

HARVEY J. MAKADON: Good morning, everybody. Today is really an opportunity for us to review some basic concepts on communications with LGBT people, and also to go over some cases, some of which you've submitted for us to discuss. And we also welcome you to raise questions about other cases as part of the discussion. This is a bit of an experiment, but we've been trying to work more and more towards having interactive sessions.

So today, we've limited the amount of didactic presentation to a review of material that some of you may have heard in the past if you've been on these calls. And then to really get into some discussion of some situations that occur in the context of providing care. A lot of the issues that we raise are issues that might occur anywhere in the health center, but in particular, I think it's important that we discuss these issues at some point with frontline staff as well as clinicians.

Because they really are things that make a difference for patients throughout the time they spend in any kind of health care facility and any health center. I do want to highlight, though, that while the focus of this talk is effective communication with LGBT people, LGBT people are not necessarily synonymous with HIV. I mean, sometimes people think the two issues are extremely closely related.

In fact, we actually try in many of our webinars to emphasize non-HIV related issues. Because LGBT people experience a lot of unique issues. But in this session, we're really going to focus on basic communication. And I do think that it's also important to recognize that if we look at people who are infected with HIV, it includes large numbers of men who have sex with men, and more recently, particularly an increase in the number of young black men who have sex with men, particularly in the South, but also in other parts of the country, as well as transgender women.

And I think that these are populations where we're hearing from health centers that people are being seen far more frequently. And we get any questions about this. So we thought it would be useful to have this session on communication. So here goes. First, just a little bit about us. The Fenway Institute is housed at Fenway Health, a Federally Qualified Health center in Boston, Massachusetts that's within sight of Fenway Park.

Sometimes when I tell people I work at the Fenway, they say, oh, it must be great to take care of baseball players in between the innings. But that's not what we do. We're a health center that's across the street from Fenway Park. But we do is really get caught in the traffic during

baseball games. But Fenway is a 501c3 Federally Qualified Health center that was founded in 1971 with a mission to enhance the well being of the LGBT community as well as others in our neighborhood.

The Fenway neighborhood is traditionally a very poor neighborhood with a high number of elderly people, a high number of students. And it should be no surprise that originally when the health center was founded, it was founded actually as a collaborative or free clinic for elderly people, for women, and for gay men. And during the early years of the HIV epidemic, we clearly began to see a lot of people with sexually transmitted infections and HIV, which really began us in terms of really developing our HIV programs which we've always tried to keep in balance with other programs.

And we now have an integrated primary care model much as you're trying to develop in your health centers in which we see people with HIV as well as transgender people integrated into our primary care practice. Fenway currently cares for about 2,200 people with HIV and about 1,800 people who are transgender. The Fenway Institute focuses on research, education, and policy.

And the Division of Education and Training offers programs such as the one we're doing now. But we also do individual training and technical assistance with health centers. We do grand rounds at hospitals and health centers. And we have a lot of online learning materials, including webinars and learning modules for which we offer continuing education credits as well as credit for the Health Equality Index, for those of you who participate in that.

But these are available for free, and for many of you, I think it really extends the kind of learning that we offer on these webinars. We also have lots of resources and publications which you might find helpful for your staff. So in terms of why we have programs for LGBT people, it's as I suggested already. A number of studies have suggested that LGBT people do experience unique health issues.

This was highlighted in Healthy People 2020, the Department of Health and Human Services report that comes out every 10 years. But for the first time in 2010, highlighted LGBT people as a population that did experience disparities. And the Institute of Medicine report on the health of lesbian, gay, bisexual, and transgender people that came out in 2011, again, was a very extensive review of health disparities that were known as well as really a focus on a research agenda on what we needed to do to learn more about the health needs of LGBT people.

Both of these publications are very relevant for the work that you do. And obviously we're working hard to try and work on these issues and also learn more about these populations. I think the bottom line of what both of these works really state is that the source of health disparities or health inequities really is rooted in stigma and discrimination experienced by LGBT people, and the impact it has on their health.

And when we think about stigma and discrimination, we have to think about both interpersonal stigma and structural stigma-- and I'll get to these points in a second-- which result in an impact on individuals that creates stress, anxiety, depression, and ultimately a variety of health inequities. And this is a very important construct to keep in mind as we go about trying to change the way we do things in our health center, and I think highlights both interpersonal aspects and structural aspects of the way we set up systems of care.

Just a couple of studies which have noted the effect of stigma on health. One is by Mark Hatzenbuehler and his colleagues. He's at the Columbia School of Public Health. But he demonstrated that internalized homophobia, experiencing discrimination, and expectations of rejection were associated with the increase in HIV risk behavior. And then another study of a database of over 2,500 female to male transmasculine people by Sari Reisner, who's a member of Fenway staff as well as works at the Children's Hospital in Boston, demonstrated that enacted and anticipated stigma that occurs in the context of health care resulted in a 40% increase in delaying needed urgent and preventive care in this sample of people.

So we can see that clearly there's an impact of stigma on health and access to health care, both of which are important issues for us to be thinking about. In terms of a summary of the kind of disparities that people experience, we've seen that these occur throughout the life course, beginning with childhood and adolescence, and going on through later adulthood. From Healthy People 2020, a short summary shows that LGBT youth are more likely to attempt suicide, more likely to be homeless, have a higher risk of HIV and STDs.

And as I pointed out earlier, the risk of HIV and STDs is really highest among young black MSM, but all communities of color are at higher risk of HIV and STDs. LGBT populations have the highest rates of tobacco, alcohol, and other drug use. And lesbians, but also bisexual women and transgender men, are also less likely to get preventive services for cancer.

And that's detailed more in some of our other programs. Transgender individuals experience a high prevalence of HIV and STDs. Transgender women have the highest prevalence of HIV of any adult population group. They also experience STDs, victimization, mental health issues, and have a high rate of suicide. And then we have to think about the elderly. Elderly LGBT individuals face additional barriers to health because of isolation, fewer family supports, and a lack of social support services.

And we'll talk-- we have a case to discuss about this later on in the program. So getting back to the concepts that I introduced in the beginning, interpersonal stigma really deals with interactions with other individuals. And as I already highlighted, as shown on the left, that too often these interactions occur in the context of seeking health care. And that is something that I think we all need to work hard to try and avoid is that the experience while getting health care should not lead to stigma.

Clearly there's bullying at schools, and there's a lot of attempts to try and work on these issues. And trans people are often victims, but also often commit harm to themselves by committing

suicide. But just this year in 2015, through the beginning of the year and sometime in late June, over 15 transgendered people were killed in the United States. And that's a conservative number. That's just based on the number that are known.

And I think we have to keep this in mind. Because living your life in a situation like that can clearly cause a great deal of stigma as well as personal stress, as I've tried to highlight. Turning from interpersonal stigma to structural stigma, the difference is that rather than focusing on the individual, structural stigma really broadens our understanding and focuses on structural or institutional barriers to care.

So structural or institutional discrimination can include the policies of private and governmental institutions that intentionally restrict the opportunities of certain people. Examples might be laws like the Defense of Marriage Act or laws like Don't Ask, Don't Tell, which kept people from really revealing who they were when there were in the armed forces. And fortunately, both of those laws don't exist any longer.

But it also could be that major institutional policies are not intended to discriminate, but their consequences nevertheless hinder the options of people causing stigma. And I think it's important to think about whether that may be true in organizations where we work, where policies might just not out of any malice, but just have developed over time and never considered the changing nature of the workforce or the patients who are coming for care and met all of their needs as opposed to the needs of people who are traditionally being seen.

So as I already alluded, structural stigma and health includes things like laws, which I've already mentioned, housing-- it's hard to have good health if you don't have a place to live, nutrition-- I'd say the same thing. The health coverage and insurance allows people to get access to care. Employment is often important, both for economic reasons, but also that's also the source of health coverage for many people. And clearly, education leads to new opportunities for people. That's something that we need to be thinking about.

LGBT people may be invisible unless they really talk about who they are, but still can experience stigma by virtue of what they hear other people say, what they overhear that people are not intending them to hear. And we'll get to some issues like this in the cases that we're about to discuss. But intrapersonal stigma really relates to the way an individual feels and is impacted.

And this was first described by Erving Goffman in the 1950s in a book called The Presentation of Self in Everyday Life. And he said, "And to the degree that the individual maintains a show before others that he himself does not believe, he can come to experience a special kind of alienation from self and a special kind of wariness of others." So I think that talks about the notion of how people experience internalized homophobia or transphobia, and how it may impact them and affect the way they deal with people in everyday life.

And this is very important for us to keep in mind. So now we're going to turn to some case scenarios for us to discuss. And just another as a way of explanation, a case scenario the way

we're envisioning this, we see as an educational tool-- just like many other kinds of tools-- but something that promotes learning through facilitated discussion with peers. And the implication of that is we want you to be engaged and listen to what some of your colleagues might say.

Because we're all not going to have the same opinion about these cases. And this is also something that you can engage in wherever you work by talking about a case of somebody who's been cared for and what happened and asking people's opinions on how to make things better. But we've developed these case scenarios for us to discuss and talk about what would be appropriate responses to different situations, to try different approaches to solve problems, and to consider how problems that evolve could be prevented.

Several of the scenarios will require you to put yourself in someone else's role. For example, think of yourself as a nurse, a case manager, or front desk clerk. Or if you are that person, think of this as something that you may have already experienced. But you don't have to actually have this role in order to participate in the discussion. All the scenarios that we're about to go through are designed to help us increase our understanding and build empathy for patients as well as colleagues and students, no matter what role you're playing in this scenario.

So the first case we're going to talk about is entitled Janice and Tonya, and it's about a same-sex couple. Janice and Tonya are new patients. Janice is a new patient and she and her baby present to the health center for immunizations, for routine immunizations. Janice's wife Tonya is with them. Pointing to Tonya, the medical assistant says, "Oh, did you bring your sister? How nice!"

Later, the medical assistant overhears Tonya saying, "Maybe we should go someplace else for care." So clearly something happened. Does anyone want to talk about what they think may have happened and what they might want to do about it? So in this case, I guess just to restate the question I already asked, is how might Janice and Tonya feel about the medical assistant's comment that led to their feeling like they might want to leave the health center?

Does anyone have any comments? Does anyone want to talk about this?

CHELSEA WHITE: I'll read it aloud. So this person says there's a huge assumption that took place from the start of the introduction. As providers, it's important that we not assume.

HARVEY J. MAKADON: That's right. I mean, I'd say probably that's one of the basic comments. That's one of the basic issues that probably underlines most of what we're going to be talking about today is that we can't make any assumptions about anyone. And really in this case, after overhearing what they said, I think the medical assistant probably should realize that she made a mistake and apologize.

But probably we should also think about what to do to avoid such a situation. And I think going back to the issue that was highlighted by the comment, I'd say make no assumptions. And if

someone is with someone else, say, oh, I see you brought someone with you. Would you like them to come in the exam room? And introduce yourself to them. And then they can make the decision to introduce you and say, oh, this is my wife, Tonya.

Or this is my close friend. But it's really up to the patient to divulge that information to you. But you can make every effort to be welcoming and say, would you like to bring Tonya into the exam room with you? Because again, you can't even make an assumption that that's someone who should be part of the visit. And yet, we don't want to exclude people unnecessarily or inappropriately. Is there any more questions about this case?

These cases are short and simple, but they can actually-- I think if you think about these situations, they come up frequently. So it leads us to think about what's in a word. So when we think about gender identity and sexual orientation, there's lots of terms that go along with it. People might refer to themselves in many different ways. And I think that as this case highlights, increasingly, same sex couples can marry throughout the United States.

And we'll refer to someone who's with them as their husband or their wife. And so that's something that's been a big change in many states recently, but has been happening across the United States since 2004 when Massachusetts was the first state to legalize same-sex marriage. And I think even LGBT people are getting used to using that terminology, but nevertheless it's something we're going to hear more and more.

And we have to be thinking about that. So that's something for us to be thinking about. I think we also have to think about how we get to know about someone's sexual orientation and gender identity. And we have to make asking questions about sexual health, sexual orientation, and gender identity routine. So just think to yourselves about how often you've ever been asked by a clinician about your sexual health, and specifically your sexual orientation or your gender identity.

And if you are provider, how often you actually ask your patients about this. Because I'd say that most times when I talk with groups of people in a live setting, about half of people raise their hand and say they've been asked this question, the question about their sexual health. But very few have ever been asked specifically about their sexual orientation or gender identity. And so again, we need to-- the underlying issue for this case is to avoid assumptions, to listen to how people describe their own identities and partners, and use the terms they use if you're comfortable.

And if you're not, I think it's important to examine what might make you uncomfortable and try and deal with that. Because our patients are really why we're doing our work. And we have to make sure that we accommodate them and make them feel as comfortable as possible if we're really going to provide patient centered care, but also recognize that there's differences among LGBT people.

And if you know one, you may only know one LGBT person. And different people have different ways of characterizing both how they describe themselves as well as their relationships. And we need to learn about that. So now we're going to go to our second case, unless someone has anything they'd like to comment on. So please feel free to do so. But we'll go on to our second case, Marcus, which is about HIV and STD screening.

So here's Marcus. In talking about history, Marcus told Amy, his nurse, that he had had two male sexual partners this year as well as female partners in prior years. As a result, Amy encourages Marcus to have an HIV test. Amy says many of my gay male patients get tested at least once a year. And after this, Marcus appears to be upset. So now why would Marcus be upset? Does anyone want to comment on that? Come on, you guys know this.

CHELSEA WHITE: Marcus might be upset because he's not gay, but may consider himself bisexual.

HARVEY J. MAKADON: OK. So that was a really good comment. Because I think that many people have sex with men, but don't consider themselves gay. They may consider themselves bisexual. They may not even consider themselves bisexual. I do a lot of work in the South where we often use the term men who have sex with men, because people don't think of themselves as either gay or bisexual, but like to think of themselves sometimes as heterosexual and may just have sex with men.

There's also other terms that are used in different cultures, such a same gender loving, and I think we need to get used to the fact that, as I said, there are many words to describe sexual orientation and gender identity, and how people describe their sex partners or themselves. But we need to be aware of that. Because we can upset somebody about it. And again, I think that the realizing that someone's upset would probably lead me, if I was the nurse, to say I'm really sorry, It seems like I upset you. Do you want to talk to me a little bit about that?

And hopefully Marcus would have felt comfortable saying something about the fact that he didn't identify as gay. And she might talk to him about how he considers himself and what terminology she should use in describing his identity. On the other hand, it may not be that important since his behavior he's already talked about, and that's really what's relevant in terms of the specifics of this case.

On the other hand, in the bigger context, sometimes it is important to understand someone's identity so you can understand a wider range of issues, ranging from behavioral issues to issues related to whether or not someone may be considering having a family, and other things that are tied to people's identity. And so again, the situation could've been avoided by not making any assumptions and asking people simple questions about how they identify themselves.

But again, this is the reason we're doing this is so we can learn more about avoiding these issues in the future. And again, just to highlight, sexual orientation is really defined as how a person identifies their physical and emotional attraction to others, but has three components.

One is desire. So there are people who think of themselves as wanting to have sex with a man, may even consider themselves gay or lesbian, but never have acted on that.

So it may be a desire that by talking to somebody about, do you have any sexual desires that you've never acted upon, you can open the discussion with somebody and help them fulfill what for them may be a very important piece of their identity. Behavior, which has to do with who people do engage with sexually-- men who have sex with men or men who have sex with men and women, and the same thing's true for women.

And then we really need to get into what kind of sex people have, how often they have it, in order to determine risk for HIV and sexually transmitted infections. And finally, identity, which we've mentioned, which people generally would say is either straight, gay, lesbian, or bisexual, but could be other things. And sometimes people use words like queer. Or as I said, same gender loving, which are terms that we need to become familiar with.

Because our patients may use those. In order to help learn more about taking a history of sexual health, the education center has worked together with the National Association of Community Health Centers, or NAC, to develop this tool kit on taking a history of sexual health in which we go through a lot of the questions that need to be asked not just to define risk, but more holistically on issues relating to plans for pregnancy and challenges to having children, to issues such as intimate partner violence.

And so I think that it's important for people to think about these as they see all of their patients, not just LGBT people. Because patients have different priorities and experiences and define themselves in different ways. And I think we have to be thinking about this in the different pieces of our history and the different parts of what people may say to us or want to say to us, and give them a chance to talk about a variety of different issues that all are part of the overall holistic history of sexual health.

Again, I think that one of the things that a lot of people ask is how do I begin this discussion. And I think the most important thing is to begin it by assuring people that you're not asking them this because a way they look or a way they behave, but the questions regarding sexual health are something you ask all of your patients. And so you might say something like, I'm going to ask a few questions about your sexual health and sexual practices.

I understand these are very personal, but very important for your health. And I ask these questions of all my adult patients. Like the rest of our visit, everything we discuss is confidential. And ask them if they have any questions before you begin asking them these questions. The situation is slightly different for adolescents, but it's still important that we ask these questions. And the American Pediatric Association does recommend that the provider spent time in private with younger patients so that they can give them an opportunity to talk about these things.

And that's something that is a very important issue for us to consider. And it's very important to know what your health center's rules are about that and how to maintain confidentiality of the conversations which then take place, so information doesn't get inappropriately back to family members who may be receiving bills for the visit. OK. So we'll go to the next case, Chris. This is a case that takes place during registration.

A new patient, Chris, completes his registration paperwork and hands it to Mike at the front desk. We know that many health centers do registration in different ways. Some do it on paper, some do it electronically, some do it verbally. And so you might have to think about how this might be modified depending on the circumstance that you're working in. But when Mike looks over the forms, he notices that Chris has skipped the question about gender, which asks whether he's male or female. Mike asks Chris to complete the skipped question, but Chris says, I don't identify with either of the options, male or female, and I left it blank on purpose.

So what would we do in this circumstance? How can Mike work with this patient to be respectful? So again, I think that there's a number of questions which can be related on the chart. First is one related to legal gender, which has to do with information that comes from insurance. And really, there are only a couple of options, although people can decline to answer. But they're male or female.

And in order to submit a bill, you need to give this information to an insurance company. It's usually information that appears on someone's insurance or their driver's license. And in order to make the situation clearer for people, we're going to talk a little bit about other ways of asking for additional information from patients that might make them feel more comfortable.

Because that's really what we need to do, I think. In this case, for Chris, there's probably not much he could have done. But he could have, again, apologized and just suggested that this is generally information that's needed for billing, but not pressed the patient too much at the point of registration. I think it's important that all people have to know that everybody has a sexual orientation and a gender identity.

And how people identify this can change over time, which is really where the situation of Chris arose. Gender identity, though, is not the same as sexual orientation. Gender identity is a person's internal sense of their gender. And so while some people may consider themselves male or female, others, as was the case here, may consider themselves as both or neither.

And all people have a gender identity. So someone just raised a question and said, Mike may have to ask the patient what was his birth sex or gender. The scenario could've been avoided if more options were listed such as other. We're going to get to that in just a second. Because I think that there are different ways to do that, and we'll talk through that. But that's a really good point.

So gender identity, again, as I just said, may be neither male nor female. Gender expression is different and has to do with how one presents themselves through behavior, mannerisms,

speech patterns, dress, and hairstyles. And these don't always correlate with gender identity. So sometimes someone may dress in a way that looks feminine, but still have a male identity.

And so we can't necessarily conflate or assume anything from the way someone looks. And we really need to ask these questions. And I think that the point that was just made about asking more questions is really important. So again, the bottom line for what I just said was we can't assume the gender that someone is from either what they look like or just by giving them two options.

Because gender actually is a very complex issue and is probably more represented by the ball of yarn on the right than the two symbols that we commonly see on the left. I think that in terms of the kinds of questions that we can ask, I'll just explain that in addition to asking about legal gender, it's important that we ask about both sex assigned at birth, which would be male or female-- and that's always male or female-- as opposed to legal gender, which people could change.

So for example, if somebody grows up and affirms themselves-- was assigned the sex of male at birth, but affirms the fact that they're female as they grow up. They may change their legal gender on their insurance or their driver's license. But you really can't change the assigned sex at birth. And then we want to know when someone's current gender identity is. And that's where we would give them a variety of options, including male, female, transgender male, transgender female, gender queer or gender non-binary.

And there can be a lot of other options to answer that. So in response to the question from Britney, these are the kinds of things that we want to ask about. And we have more information on our website. Turning to the next slide, family relationships, we have the case of John. Stella, a case manager, is meeting a new patient, an older gentleman named John. And I alluded to this case earlier in the beginning of the presentation.

Stella asks John who will be his emergency contact. He remains silent for a bit, appearing to be unsure of who we would want to list. And he eventually gives a name. And then Stella then asks what's John's relationship to this contact. John said, well, I guess you could say he is my close friends. Stella is surprised he would choose a friend and asks John if he has any family he could include instead.

And then John becomes visibly uncomfortable as he sits through the rest of the registration process. So again, what kind of questions come up here? I think in some ways, probably what's most important is that when you're asked to give an emergency contact, the nature of the relationship could be asked. It could be asked on the form, but it shouldn't be assumed or asked by someone just as a way of learning more about somebody or saying something like, well, I wondered if you had any family members.

Because really, the person's contact is the person's contact and whoever he identifies is important. So I think John may have named a friend because probably he is older, and he grew

up in a time when people may not have identified their same-sex partners. Or maybe now even this person could have been his husband, but may not feel comfortable identifying that as such and may just feel more comfortable referring to him as his friend.

And Stella could have responded in a more respectful matter by not probing and ask that he define this person in a different way. On the other hand, I do have to say that I think that we see a lot of older patients who often are accompanied by "friends" when they are coming to be seen. And we need to think about how to include those friends in the patient visit if the patient wants them there by asking them if they'd like to have the person who is accompanying them be able to be part of the visit.

And asking them, as I said in the earlier case, you can introduce yourself to the person and let them define on their own what the relationship is. Because again, people may feel more or less comfortable being open about their relationship. And I think this is where we get into issues such as creating a welcoming environment in a health center that has images of same-sex people or brochures for same-sex people to read about what kinds of questions they may want to talk to their doctors about or nurses about can make a big difference in terms of people feeling comfortable sharing this kind of intimate information with individuals where they've never really talked about it before.

So again, as we said before, LGBT elders experience stigma discrimination across the life course and they may have less social support and experience and more isolation than elders in the general population. And we have to recognize that. Now we're turning to a case of preventive screening with transgender people, and the case is Miles. Miles is a young man. A provider asks Gladys, the medical assistant, to help her get ready for a pap smear on her next patient who is in the examination room. Gladys glances at the chart and notices that the name of the chart is Mary Smith, so therefore she felt she would need to do a pap smear.

But when Gladys enters the room, she sees a man sitting on the examination table. And he says, hi, I'm Miles. So obviously this was a bit of a surprise for Gladys, the provider, and something that she needed to feel comfortable dealing with. So let's see what happens. So how can Gladys politely determine if she's in the correct room and if the patient here is actually here for a pap smear?

Does anyone have any thoughts on what they would do when there was a discrepancy between the name on the chart and what the patient says or what the patient looks like when the person goes in the exam room? Well, I think, again, our underlying principle, which we kept reiterating, is that we shouldn't make any assumptions. But here we have a discrepancy between what it says on the chart and what the patient says his name is.

And so you might want to say, well, it says on your chart-- it has a different name on your chart. Did you ever go by a different name or did you ever have a different name? Someone just suggested the patient could confirm with double identifiers their name and date of birth to

know that it's the same person. and that's a really good point, because sometimes there's actually multiple people with the same name.

And date of birth can be helpful at making sure that we are actually dealing with the same person. But in this case, I think it's also very likely that you can say, is there's some error here? The chart has a different name. Have you changed your name? And I think it sounds to me like the way Miles responded that he would probably feel comfortable explaining that he has affirmed his sex as a male.

And then, of course, you'd still want to understand-- and we should always understand-- when somebody has affirmed their gender as something different from their assigned sex at birth, what anatomy they have, whether they still have a cervix, whether they're going to need a pap smear. And if so, while it may be more sensitive to do a pap smear on a transgender men, most transgender men still have a cervix and still need pap smears.

And so this is a very important part of the history that has to take place after you found out that someone has transitioned. And we would probably say now that once you've ask questions regarding assigned sex at birth and current gender identity, if there's an incongruity or difference between the two on the chart, that you should ask people about their anatomy-- and some people refer to this as doing an anatomical inventory-- to understand what kind of preventive screening they may need.

An example that's different from this but would be if someone transitioned or affirmed the fact that they were a female having been assigned the sex of male at birth, that person will have a prostate gland and will need a prostate screening and be screened for prostate cancer, and the prostate could be the source of fever in the case of prostatitis. So knowing that person has a prostate is very important and something for us to be thinking about.

So we need to feel comfortable going beyond just asking about assigned sex at birth and current gender identity, but really understanding what anatomy someone has so that you can take appropriate care of them. Both preventative care and acute care in the case of, let's say, acute prostatitis. So someone just highlighted something that I think is really important. At our health center, the preferred name for our transgender patients are listed in the electronic health record as an alert.

I'd say that that's really important to have the preferred name highlighted as an alert. I think some of our colleagues who we've talked to recently have suggested that the preferred name for all patients should be highlighted in the EHR as an alert so that you're not just singling out a field that, if filled, means that someone is transgender. And a lot of people have pointed out that while their first name may legally be one thing, their middle name may be the name they go by and want to be called by the people who they see a health center.

And so we should be thinking about how we do this for all patients, not just for transgender people. But again, just to highlight what I just went through, the majority of transgender men

do not undergo complete gender affirmation surgery and may still retain a cervix. They should have the same kind of screening as natal females. But sensitivity to unique issues is important, while still emphasizing the importance of regular screening.

And so again, I think this applies to transgender men with respect to cervical cancer screening, it would also apply to transgender men with respect to screening for breast cancer, even though they may have had breast reduction surgery. They may still have residual breast tissue. And as I've highlighted, transgender women would have a prostate gland. I think we have here at Fenway some resources on cervical cancer screening for transgender men, which can be found on our website under the Publication section.

And so if you're interested in this topic, you can look for more information such as this. We're now going to go to another case, Maxine, a transgender person at the registration desk. Maxine walks up to the registration desk to check in for her appointment and introduces herself. The medical assistant sees that the name under the appointment is Paul, not Maxine. Despite her introduction, the medical assistant refers to Maxine as he when letting the provider know that Maxine has arrived on time.

So clearly here we have someone who has affirmed their gender identity, but clearly there's a discrepancy in the system within the hospital or health center where this person is being seen. And so I think the answer to the first question, how might Maxine react to this conversation, is obvious. She'd probably be a bit upset at hearing herself referred to as he. And this is where we need to think about issues such as the one just raised in the previous comment from Britney [INAUDIBLE] that we have forms and systems that give people the opportunity to identify both their current gender identity, their preferred name and pronouns, as well as their sex assigned at birth.

And this way, if this information is appropriately displayed-- and I have to say that I've heard from some people that their electronic health records have made these changes, but that they're not clearly visible so that they're hard for people to find. And so we have to make sure that when we make these changes in our EHR, they're easy for people to see. But making these changes will help ensure that these kinds of problems don't have happen again.

But again, when problems do occur or when uncomfortable situations arise, I think the second principle after making no assumptions, the second principle that we should get out of today's discussion is that we should always apologize and make sure that the patient knows that we feel concerned about the error that was made and will work to change the system to make sure that that error does not happen again.

And so again, I think most people are pretty responsive when they know that people are genuinely concerned with their care and understand that they've gone through a complicated transition, and that not everybody has necessarily kept up with that. But I think we in health care have to do more stay ahead of the curve and make sure that we make these kinds of changes so these uncomfortable situations don't arise more often than they need to.

So again, just to highlight what that Bethany's already told us, it's important to use the patient's preferred name and pronouns when talking about a patient. For example, most transgender women want you just say she or her when talking about them. Trans men prefer he or his. But some people may use pronouns that are unfamiliar. Pronouns such zie or they are sometimes used by people who do not want to identify with gender binary of he or she, just like the patient in the earlier case who didn't want to identify as male or female.

And so again, we have to become more familiar with some of this terminology. And we have a list of preferred pronouns here on the next slide. So we have the traditional she, her, her, hers, herself, and then he, him, his, his, and himself. But then some people might prefer they, them, their, theirs, and themself, or others such as ze, zim, zir, zirs, and zirself.

And they can really change. But again, we have to be aware that people may be using these when we give them an opportunity to fill out preferred names and pronouns. Putting what you've learned into practice-- again, just to highlight what we've been trying to say, if you're unsure about a person's preferred name or pronoun, you can always say I'd like to be respectful, what name and pronoun would like me to use.

This would have been applicable in a couple of the cases. If you accidentally use the wrong term or pronoun, just as I highlighted, you'd say I'm sorry, I don't mean to be disrespectful. And if the patient's name doesn't match their insurance or medical records, you might say, could your chart or insurance be under a different name, or what is the name on your insurance.

The electronic health record, as we've already discussed, adds an element of possibility to us. We can have patients entering both a lot of this information both at home, through patient portals, at registration on site, or during the visit with clinicians. And the information they provide could be, as we have here-- this is the demographic field, a screenshot of Fenway's demographic field where we ask about sexual orientation, whether it's gay, lesbian, or homosexual, straight or heterosexual, bisexual, something else, or don't know.

And then also with respect to gender identity. As people have already suggested, we want to ask about current gender identity and give a variety of options, what sex you were assigned at birth, and then what is your preferred name and what pronouns do you prefer. And these all would be in addition to the standard question regarding legal gender that is required on-- I think in most states, that's required by insurance companies-- that has to be filled out that can be changed.

The only item that wouldn't be changed from someone's sex assigned at birth would be the question that specifically says what sex were you assigned at birth. Now, people can decline to answer that. But that, then, would raise a question with respect to asking them more about their current gender identity and whether there's been any change over their lifetime. Because people may be more comfortable talking about that than talking about their assigned sex at birth.

So I think that we've highlighted a number of issues that come up frequently. I think another one is that one of the ways that I think health centers can deal with a lot of these issues is by bringing the community into the health center. And a lot of times, we talk about community engagement and having community advisory boards. But we also have to have community involvement and really ask the community how they want these questions to be asked.

And in the best of all worlds, have people from the community working in the health center to really help make sure that their represented and these things are done in a way that really meets their needs and really provides them with patient focused care. So I think our challenge in providing quality care for all is that we do good data collection in a sensitive way, that we educate our clinicians about-- and not just our clinicians, that we educate all staff on how to communicate with people and what kinds of clinical issues may be unique for LGBT people, but we also educate consumers about what kinds of questions to ask and what they might expect.

And this way, we can provide patient centered care. So with this, I'd like to thank you and ask, once again, if anyone has any particular cases they want to talk about or any questions that they want to ask or highlight. Well, on behalf of MayaTech and also the National LGBT Health Education Center, I'd like to thank all of you for participating. I think that you've all been working very hard to develop programs to care for people with HIV.

And clearly, understanding the needs of men who have sex with men as well as transgender people, particularly transgender women, is an extremely important part of HIV care if we're going to do effective screening, prevention, and treatment. And so thanks again for joining us today, and we look forward to having opportunities do more sessions like this in the future.

We'd be particularly interested in hearing your comments about today's session. This is one of the first times we've tried to focus more on discussion than on didactics, and it would be good to get your input in terms of how to make these sessions meet your needs. So thank you very much for participating today.

ADRIANNA SICARI: Thank you, Dr. Makadon for giving a fantastic presentation. And thank you everyone for joining the presentation and entering your questions or comments. We appreciate your participation. And as Dr. Makadon mentioned, please give feedback about today's presentation so we can figure out the best ways that we can better serve your needs in the future with more webinars such as this. Thank you again.

CHELSEA WHITE: Thanks so much, everybody.