Episode 8: Promoting Inclusive Healthcare Environments for LGBT Patients

Co-Hosts: Dr. Pooja Jaeel, Dr. DJ Gaines
Guests: Dr. Lisa Moreno-Walton, Matías Castro

TRANSCRIPT

Intro

[0:12] DJ: Welcome to The DEI Shift, a podcast focusing on shifting the way we think and talk about diversity, equity, and inclusion in the medical field. I'm Dr. DJ Gaines. My pronouns are he, him, and his, and I am a third year internal medicine resident.

[0:27] Pooja: And I'm Dr. Pooja Jaeel, and my pronouns are she, her, and hers, and I am a third year med-peds resident, and we will be your hosts for today's episode.

[0:36] DJ: In honor of Pride Month today, we are excited to bring you an episode dedicated to creating a more inclusive healthcare environment for our LGBTQ communities. Before we start the show, we wanted to take a moment to give a brief background and define some of the terms that we and our guests will use throughout the show. During the introduction, you'll notice that one of our guests politely corrects us when we use one of these concepts incorrectly. Instead of editing the section out, we thought it would be not only educational, but also keeping in line with the open dialogue and say space we want to create on this show. Here are the terms we want to go over, courtesy of PediatricEducation.org.

[1:15] Pooja: The first term ‘gender’ denotes the public, and usually legally recognized, lived role as boy or girl, man, or woman; biological factors combined with social and psychological factors contribute to gender development. Gender is not dichotomous, and other terms such as third gender agender, or gender queer, reflect this

[1:37] DJ: The second term ‘assigned gender’ refers to a person's initial assessment as male or female at birth, sometimes called birth gender or natal gender, as a natal female or natal male. It is based on the child's genitalia and other visible sex characteristics.

[1:53] Pooja: Third, we have ‘gender identity.’ This is a category of social identity and refers to an individual's identification as male, female, or some other category other than male or female. It is one's deeply held core sense of being male, female, some of both or neither, and does not always correspond to biological sex.

[2:16] DJ: The next term ‘gender atypical,’ or ‘gender nonconforming,’ or ‘gender variant,’ refers to physical features or behaviors that are not typical of individuals of the same assigned gender in a given society.

[2:28] Pooja: Fifth, we have ‘cis-gender,’ which describes individuals’ whose gender identity or expression aligns with the sex assigned to them at birth.

[2:37] DJ: Sixth, ‘transgender’ refers to the broad spectrum of individuals who transiently or persistently identify with a gender different from their gender at birth.

[2:47] Pooja: Next, we have ‘gender dysphoria,’ which is when an individual's gender identity is incongruent with their assigned gender or sexual body characteristics. And this incongruence causes extreme distress. If this incongruence does not cause distress, it's not diagnosed as dysphoria. And if this distress is caused by social stigma, bullying, or family nonacceptance, it also is not diagnosed as gender dysphoria.

[3:13] DJ: The eighth term ‘sexual orientation’ is the personal quality inclining persons to be romantically or physically attracted to persons of the same sex, opposite sex, both sexes, or neither sex.

[3:26] Pooja: ‘Gender expression’ is the manner in which a person communicates about gender to others through external means such as clothing, appearance, or mannerisms.

[3:37] DJ: The next term is ‘transitioning.’ This is the process where individuals change their social and/or physical characteristics for the purpose of living in their desired gender role. It includes social and/or general affirming treatment.

[03:51] Pooja: Similarly, ‘social transitioning’ is when a person starts to live in the experienced gender role and encompasses clothing, gender role behavior, and the use of a name or pronoun of that gender. This is a reversible process.

[4:05] DJ: The final term is ‘gender affirming treatment,’ which is the clinical approach that supports the expression of one’s experienced gender of which puberty blockers, hormone treatment, and surgeries may be a part. This can be a reversible or non-reversible process, though.

[4:20] Pooja: This is not an exhaustive list. We hope that these terms help our listeners throughout the show. Now back to it!

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[4:34] DJ:

We have two incredible guests to help us with this discussion. Today, first, we have Dr. Lisa Moreno-Walton, a professor of emergency medicine at Louisiana State University (LSU) and president elect of the American Academy of Emergency Medicine. At LSU, one of her many roles is the director of diversity. In addition to her research papers, she's also the editor of two books on diversity and inclusion and quality patient care, which contain chapters on LGBTQ health. So welcome, Dr. Moreno-Walton, to The DEI Shift! What are your preferred pronouns?

[5:07] Dr. Moreno: My preferred pronouns are she/her/hers.

[5:12] Pooja: Thank you so much, and welcome! Our second guest today is Matías Castro. Matías works as the health educator and testing coordinator at the Sacramento LGBTQ Community Center. In addition to helping you through health education and testing at the center, they work with local, state, and national governments to advocate for better education and community engagement. They have a particular interest in improving the health of our marginalized communities that are affected by other social determinants of health. Welcome, Matías! And before we start, what are your preferred pronouns?

[5:45] Matías: Hi everyone, thank you for having me; my pronouns are they/them. And if I could just use this opportunity...when speaking about pronouns, they're not 'preferred'. They are pronouns, simple as that. So I think that the way we engage with language is important, and especially the way that we refer to pronouns; and so I think being intentional about just using 'pronouns' and not using 'preferred pronouns' is important when engaging with our community.

[6:14] Pooja: Thank you so much for that feedback.

[6:17] DJ: So we're really looking forward to this discussion with you. Before we jump in, though, we would like to get to know both of you a little more through your respective backgrounds.

[6:27] Pooja: That's right. We want to transition over to one of our favorite segments of this show called 'A Step in Your Shoes.'

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[6:44] Pooja: In this segment, we ask our guests to share one part of their background or identity. So for example, previous guests have shared a poem, a hobby, food, or music...anything that helps us get to know you a little bit better and helps us flex our cultural competency muscle. So with that, we'll turn it over Matías to share with us a piece of their background.

[7:06] Matías: Yeah, hi. So there are many things that I can talk about from my background and in terms of culture, but just one thing: As a millennial, art is super important to me. So I just want to keep it short and say, Everyone, stream *how i'm feeling now* by Charlie XCX, #teamJaidaforthecrown, support black, brown, and indigenous efforts, projects, and arts. Period.

[7:31] Pooja: Wow, thank you! And Dr. Moreno, can you share for 'A Step in Your Shoes'?

[7:40] Dr. Moreno: Yeah, sure. So very critical to my identity is the fact that I'm a native New Yorker. I'm a partner, a mother, and a physician. I love music. I love working out and cooking and indulging my children, and my hobbies are gardening and kayaking.

[7:59] Pooja: Wow, that sounds great. Have you been gardening a lot?

[8:04] Dr. Moreno: Well, now that I'm on lockdown, I'm definitely doing more gardening because I actually sometimes even sit out in my garden during phone calls and, then I'll end up starting to kind of pull some weeds, or do some mulching, or whatever, while I'm on the phone. So I'm having a little bit of a healthier lifestyle with the COVID lockdown.

[8:27] Pooja: That sounds wonderful.

[8:30] DJ: Thank you both very much for sharing.

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[8:39] DJ: So we are so grateful to have you both on as guests today because you both are present [at] two very different entry points to healthcare for the LGBTQ community.

[8:49] Pooja: That's right, and through our research for this episode, we found some pretty upsetting statistics about the trust some of our LGBTQ patients have and their use of health care as a consequence of that. So a survey that was done in 2008 showed that 19% of our transgender gender nonconforming patients were denied care because of their gender identity, and 28% of those individuals felt verbally or physically harassed in a medical setting. Other surveys and research studies show that our LGBTQ+ community members are more likely to delay or avoid medical care because of fear of discrimination.

[9:29] DJ: Clearly, we as a medical system are not doing a great job. So with that, we can jump into our questions. So, Matias, question for you: Organizations like the Sacramento LGBTQ Community Center are often where these individuals come to for care, so can you give us a little bit of background about the Center and others like it throughout the country?

[9:56] Matías: Yes, of course. I do want to give a little bit more context, too. As we all know, this country was founded on the enslavement and killing of indigenous and black folks, right, and anyone else considered as an outsider or considered as an 'other' has always been pushed to the margins. And this is true for our LGBT community. We've been forced to live precarious lives, right. And it's important that organizations like ours, the Sacramento LGBT Community Center, and other LGBT serving organizations can provide these necessary services and interactions to our very own community. Because as we see, we cannot rely on the government or really anyone else to be there for us. So here in Sacramento, other organizations at the general health center, we really focus on our most marginalized communities because we know that we can not rely on anyone else to do so for us.

[10:55] Pooja: And can you give us a little bit of a background on what kind of services the Community Center provides for our LGBTQ community? It sounds like this has become a safe space for a lot of the community members...so can you tell us a little bit more about that?

[11:15] Matías: Yeah, definitely. So in the capacity of my work—our health department is HIV testing, STD testing, and HIV prevention work and STD prevention—so really what we see is that our most affected communities in Sacramento are queer communities, LGBT

communities, and people of color communities, right, and so here at the Center, we offer a unique place where gay people, where people of color can come and receive services from those very people, from their very own community members.

[11:49] DJ: Oh, that's us. Excellent. And I'm glad that, you know, that these particular centers are key to helping the marginalized—like you mentioned throughout history—and I think that's excellent work that you guys do in Sacramento and in other communities as well. Follow up question for you, what is your role as a health educator?

[12:12] Matías: Yeah, so there's kind of a few things as a health educator. So first and foremost is sharing health education/risk reduction techniques as it relates to HIV and STD for community members in counseling sessions. So we offer rapid HIV testing here that takes 20 minutes, and while that process is going, we offer a counseling session to help community members work on how to better navigate these risks involved in their life and how to mitigate those, right. And one of the biggest things that I also do is I support the work that our outreach director does in terms of cultural humility training. And I think that that is very important because a lot of us might think we're well intentioned or we know what's best for people, but without actually hearing it from direct community members what's best and how to best engage with those community members, I think that background and knowledge is necessary. And so a lot of what we also do here at the Center as a health educator is provide those cultural humility trainings so that our medical staff here in Sacramento is prepared on how to engage with the queer person, on how to engage with the trans person, and even more so how to engage with the black trans person, how to engage with the brown trans person, right.

[13:39] Pooja: Yeah, that's absolutely true. I mean, there's not just one identity that somebody has. And so, knowing that each person comes with a whole cultural context behind them is so important. And I'm glad that you brought up this cultural humility education just because we mentioned through the research that we'd done so far and even the stuff that we've seen in our own practices, we do have a long way to go in the traditional medical system and kind of understanding what our community members need. So I'm wondering if you can kind of share with us a little bit about the experiences that the community members that you see have had in the traditional medical system, what kind of feelings are present, and what have you kind of noticed in terms of feedback?

[14:28] Matías: Definitely. So I see a large range of patients, right. A majority of our community members are patients who come and see us are part of the queer or LGBT community. And so really what I see from people who come and use our services instead of

using the traditional medical systems or their own primary care physicians, it's because they don't feel comfortable accessing these places, or they've had bad experiences or bad interactions, right, and so, they come to us. One specific group though, I am fortunate to be able to speak Spanish and hear in California, there is a huge Spanish speaking population that is also undocumented. And so, here at the center, actually, I engage with quite a few people who have never had any medical access in the United States, who have no idea how to navigate these spaces, and receiving our testing services is actually the first time that they're receiving any type of medical services here. And from there, at least I'm able to help them navigate these medical systems to the extent that we can to get them some services, right.

[15:42] Pooja: Right, absolutely, and Dr. Moreno, I wanted to get your experience as a physician working in emergency medicine, where the emergency room can be the only sense of primary care that a lot of people have. What are you seeing in some of the LGBTQ patients that are coming into the emergency room? Are you kind of seeing these same hesitations and this kind of history of hesitancy with the medical system?

[16:10] Dr. Moreno: Absolutely. That is absolutely true. Exactly the things that Matías said: Patients are uncomfortable, and they don't trust the medical system. To a large degree, the reason that these problems exist are because of the bad experiences that they've had in the past. So, as an emergency department, by EMTALA [Emergency Medical Treatment and Labor Act] Law, we cannot turn anybody away, but we've been told stories of private physicians who turn patients away simply because of their sexual orientation. We do know that there are a lot of social determinants of health, so one of the good things that we're moving towards as a profession is the realization that it isn't just genetics and environment that are determinants of health, but social determinants of health have as much of an impact. And we know that race is a social stressor, and being different in any way, shape or form, as Matías said, is a social stressor. So individuals who are perceived as different are marginalized by the majority community, and they know that, and they've had very uncomfortable experiences with primary care physicians, or they've been unable to establish care with a primary care physician because the LGBT community is less likely to be insured than the heterosexual community. And when you combine that with the prejudice of a lot of primary care physicians, these individuals are not being able to establish primary care, and then they're waiting a time to come into the emergency department because of their discomfort and the bad experiences they've had. So they come in sicker. And the irony of the whole situation is that this community needs medical care probably more than the sexual majority community. We know that gay women have higher rates of obesity and subsequently have diabetes, hypertension, and high cholesterol. Gay

males have higher rates of HIV and STDs. Trans people have higher rates of depression, suicide, and are more likely to be victims of domestic violence. There are some studies that show that 50% of trans people have been victims of domestic violence. We also know that LGBTQ people are more likely to have an unstable housing environment. Adolescents get thrown out of their homes by parents who disagree with their lifestyle. They lose jobs because of prejudice against them. So the very individuals who we should be very compassionate towards and who we should be reaching out to, to provide adequate medical care, are the individuals who we, and when I say we, I mean, the, medical status quo, the medical system, we're actually marginalizing them.

[19:10] Pooja: Wow. Yeah, that's, that's definitely so powerful. And, Matías, it sounds like groups like yours end up becoming the catch net and trying to fill in a lot of these gaps. A lot of these services are very much needed, but can you let us know how equipped you are to do that?

[19:30] Matías: Yes. So, as a nonprofit, and as a nonprofit that serves LGBT people, a lot of funds aren't directed towards us. And so, as the only person who is in the health department currently here at our center, I'm the one who's doing all the testing, all the counseling, all the outreach. And so, while we do have these opportunities of intervention, it's also very intensive on us, right, because we're usually resourced much less, funded much less, and it becomes difficult, but a passion for community is really what drives us.

[20:09] Pooja: Definitely. And so, Dr. Moreno, how do you try to fill these gaps of resources, especially in such limited encounters in the emergency room?

[20:18] Dr. Moreno: Well, one of the things that I've tried to do during the time that I've been an emergency physician has been to try to address some of the issues in the emergency department. Although often we get pushed back and get told, well, we're not, you know, primary care providers, but we do, for example, do HIV and HCV testing in our emergency department. We do domestic violence screening in our emergency department. And I teach my residents, my medical students, to ask patients about whether they have a primary care physician. What is the barrier to them getting a primary care physician? We know physicians in the community who, for example, speak Spanish. We know physicians in the community who are LGBTQ friendly. And so, we can make referrals to these physicians so that the patients are able to get better care. The other thing that I teach my residents and medical students is you never send a patient home until you ask them: Do you have a safe place to go? Are you going to be able to fill this prescription? Are you going to be able to get to your follow-up appointment? And if the answer to those things is 'no,'

then we need to work out a way to make it possible for the patient to be able to follow up and get the care that they need. And we can do that. It's in our power to do that. And we should.

[21:42] Pooja: And I'm just curious, from the perspective of your trainees, your medical students and residents, do you find that a lot of the trainees feel equipped to do this additional counseling, or help kind of bridge some of these gaps?

[21:57] Dr. Moreno: No, they don't know how to do it. So what we do, and one of the things I'm really proud of about working at LSU New Orleans is that they take full advantage of people like me, who offer this kind of education. So, our residents do get didactic training. We create an open environment where our residents can admit that they have knowledge gaps, admit that they don't know...we are running to the end of the academic year right now, but in the very beginning of the academic year, I had an intern who came over to me and said: 'Dr. Marino, I don't know what to do. There's a patient in this room that I'm going to go to talk to, and his medical record says his name is John. But when I stuck my head in the door, the patient is wearing a wig and makeup, and has long acrylic fingernails, and I just don't know what to do.' And so, I said to the resident, 'Thank you so much. I am so proud of you that you asked me what to do and told me that you don't know what to do because this is the art of medicine, and it is no less important than the science of medicine. And I need you to tell me that you don't know how to handle this situation, the same way that I need you to tell me that you don't know how to put a central line in, because both of these things are really important, and becoming a doctor involves developing those social skills and that cultural competency, as well as developing the knowledge base and the skillset.' So we create that environment in our residency, we create that environment at our medical school where our students and trainees know that they are to come and ask for help. Faculty know; some of our faculty are older and they weren't trained at a time when this was spoken of as an issue in medicine and a desired competency, and they will come and ask for help. And I do workshops all the time at our residency, and thank goodness, at many other residencies also, because people are ill-equipped. You spoke to me about the paper that I recently published with some of my colleagues. And one of those issues that came out was: Why are residency leadership not incorporating LGBTQ health concepts into their didactic training of the residents? And they said, 'We're uncomfortable, and we don't have content experts.' And so, because of that, we have gone about, through AAEM, the American Academy of emergency medicine, and ADIAM, the Academy for Diversity and Inclusion in Emergency Medicine, of SAEM, we have gone about creating resources that people can use and making available content experts so that we can help to train because faculty and residents are absolutely not comfortable and

absolutely not culturally competent and absolutely not comfortable in dealing with LGBQT patients.

[25:17] DJ: That is excellent. And I really love the fact that you talked about humility, because I bring that up so much with interns, and you said it, you hit the nail on the head, just like medicine is an art and just like medicine as a science, like if you want, the humility is like the base of both of those aspects. And like, with humility, we can create a more open environment, and you actually, I was going to ask you about resources available and that's amazing. And I'm really glad that you guys started that resource for other residency programs. I'm looking to create a more inclusive environment.

[25:54] Pooja: Definitely, and from what I'm hearing from both Mathius and Dr. Moreno is [that] there's just so much discomfort on both sides, there's discomfort and fear on the side of the patients, there's discomfort on the side of the staff and faculty. And I mean, our job is to really bridge that. And so, Matías, I'm wondering if you could kind of describe to us from the perspective of your patients and clients that you see at the center, if you could describe the most ideal perfect inclusive in a welcoming clinical environment, what would that look like?

[26:33] Matías: Yeah, definitely. Since we only offer HIV and STD testing at our center, my answer might not fully apply to clinic or ER visit, but people come to me or to the center specifically for a relaxed, nonjudgmental nonclinical experience. And so people are really looking to receive services in a comfortable place in which they can trust their providers. And they really just want that human connection, right, and us as providers, it's up to us as individuals to push against those models of profit over people and truly intervene for our most marginalized and treat them just like everyone else, if not better.

[27:14] DJ: Absolutely. I think that is so important to make sure that we are creating that open environment. So Dr. Moreno-Walton, given what Matías has told us, how can we—in the reality of the clinic and medical system—build this inclusive environment, especially with our limited clinical encounters?

[27:35] Dr. Moreno: Well, I think that the key is building trust. And Matías talked about that and has mentioned that a few times, because it is so critical. The whole concept of building trust is very difficult in an environment where healthcare is run as a business, so RVUs [relative value units] and throughput time is emphasized; there's little emphasis on patient education, trust building, communication, actually sitting down, touching a patient, making eye contact with them and letting them know that you absolutely care about them,

and you're there to be the best doctor that you can be for them. This is not remunerated in our system, and it's not rewarded, and corporate medical groups are not interested in caring for the uninsured, and as we said earlier, a great number of the LGBT community is uninsured. And while Medicare pays well, Medicaid pays very poorly. And if they have government insurance, this group is more likely to have Medicaid than Medicare. So we come down to the fact, essentially, that we're the only nation in the world that does not view healthcare as a human right. We have huge disparities because we view healthcare as a for-profit business, and this is one of the reasons, too, that I am proud to be the incoming president of the American Academy of Emergency Medicine because we consistently stress that every patient deserves to have the highest level of care, regardless of any factors, their race, their religion, their creed, their sexual orientation, where they were born, what kind of insurance they have...it doesn't matter. And I think for physicians, we have a little bit of an edge, because physicians take an oath to put the patient's needs above our own needs and to offer comfort and healing and to do no harm. And when you point out to trainees, or even faculty positions, that psychological harm is harm and that they are violating their oath if they provide an environment that is psychologically unfriendly and harmful to the patient. Prejudice is harm. Willful ignorance is harm. And when you point out to a resident, or a student, or even another faculty physician, that this is what you're doing: You are violating your oath to the patient. When I tap into a physician's commitment to their vocation, that's actually, when I see results.

[30:17] Pooja: That is incredibly empowering to hear, especially as a trainee, when a lot of the times, it feels like we are just cogs in a large wheel, in a large machine. While we might have the inclination to do something, the system is running away that kind of goes against those instincts. On a personal note, a couple of years ago at one of the hospitals that I work at, we had a patient who was a trans patient, and the whole hospitalization used the wrong pronouns and the wrong names for this individual. And a few weeks after discharge, this patient unfortunately committed suicide. And in the suicide note, this individual outlined the many times that their identity was completely ignored. And I think the stuff that you say about the psychological harm that it causes, it's so real, and I think for me as a trainee, I know that the people who worked at the hospital, that everyone on the team was well intentioned, but I think those additional steps, it didn't matter what we had done medically, we ultimately, as a system, caused so much harm to this individual. So thank you so much for empowering your residents, and I'm hoping that this continues to empower additional trainees and students to speak up and kind of go with those instincts.

[31:53] Dr. Moreno: One of the things you said is really important when you talked about this individual committing suicide. As I mentioned earlier, suicide rates are much, much higher among LGBT, and especially, the trans community. And part of that is the fact that

what is suicide? Suicide is obliterating my existence. And what do we do to people when we refuse to acknowledge their personhood, their identity? We are obliterating them. So if we refuse to acknowledge a person for who they are and how they present themselves to the world, if we refuse to call a person by the name that they want to be called by, if we refuse to use the pronouns that they choose to be identified by, then we are obliterating that person's existence and obliterating their humanity and making them feel like a non-entity. And then we act all surprised when they make a suicidal gesture or a successful suicide when all along, everyone in their world has been obliterating them.

[33:04] Pooja: Yes, definitely. And I think it's something definitely to keep in mind for every patient that we see, and I think for our listeners and for us as a team as well, I wanted to ask both of you: What are some of the, I guess, concrete steps that you take to build that trust, to ask those questions, to build that rapport, when you do meet a patient? So I think Dr. Moreno, in your research paper, you said you found: 63% of resident physicians didn't ask about gender identity when interviewing patients who had abdominal or genital urinary concerns. And so, for both Matías and Dr. Moreno, can you tell us what are some of the phrases that you use? What are some of the actual verbiage, so that we and our listeners can use that as a launching point for these discussions?

[34:00] Matías: Yeah, definitely. I want to thank you both, first off, in acknowledging that mis-gendering someone and deadnaming someone is an act of violence. And so one of the ways that I think is best to engage in these conversations—I'm going to keep it really simple—for me, the easiest way to introduce myself in conversations around gender identity is by introducing my name and my pronouns to anyone and everyone I meet and allowing people the opportunity to reply. It's really that simple. Oftentimes, I think people outside of the trans, or outside of the LGBT, community are worried about stepping on toes. But as doctors and as providers, y'all have the unique position of influencing people's lives. And I think that normalizing the usage of pronouns in the medical field is a perfect moment of intervention to begin these larger conversations with gender identity and other spaces.

[35:01] Dr. Moreno: So I think that's very true. And part of the way that I normalize that entire process is that I tell my trainees: When you walk into the room, you tell the patient who you are. My name is ‘so and so,’ whatever you want to be called. So some of my residents or students will say, some of my students will say, ‘I want to be called John Smith.’ And some of them will say, ‘I want to be called Student Dr. John Smith.’ So tell the patient who you are, what you want to be called, what your role is on the healthcare team, and then ask the patient, what would you like me to call you? And this is just an issue of respect. It has nothing to do with anything but respect. This is not strictly because you ‘think the patient may be LGBT’ or because you ‘think that you're uncertain about how to address the

patient'. You do this with every patient. Like Matías said, this is normalizing respect and it's normalizing decency. The other thing that I think is really helpful, and again, this is not just strictly with sexual minorities, but with any kind of cultural competency, you have to make clear to the patient: I am here to take care of you, and I want to be the best doctor that I can be for you, and I want to give you the best possible care. So if you don't know about something, for example, you may have a patient who comes into your office, or the emergency department, who has a disease that you haven't heard of since medical school, and maybe you've never taken care of a patient with that disease. So what do you do? You tell the patient: 'I want to take the best care of you possible. I haven't had a lot of experience with that particular disease. I'm going to have to look a few things up, and can you educate me a little bit about what you know?' So the same thing with LGBT patients; sometimes you have to say to them: 'I want to be the best doctor that I can be for you. I don't know a whole lot about trans health, but I want to do a really good job of taking care of you, and I want you to feel welcome here, so I may have to look a couple things up, and I may have to ask you some questions, is that okay?' And patients usually respond very well to that. They're put at ease when you admit that you don't know everything there is to know about their particular personal situation, but that you want them to feel welcome.

[37:49] Pooja: I like that point. And I actually had a followup question, and this is based on an interaction I had with one of my patients who described to me that sometimes they felt a kind of burden of having to educate when they were in a kind of a vulnerable position themselves as a patient. Is that something that either of you have encountered, and, I guess, how do you kind of balance wanting to learn and being as open as you can, but still respecting that this person is in a relatively vulnerable time in their life?

[38:25] Dr. Moreno: I think that does happen. And certainly we see it happen with, you know, there's the entity of racial fatigue where you're sort of, you always become the go-to person, and you're the go-to person for people wanna understand the latinx community or whatever, and it is fatiguing, and sometimes, it is hard for the patient. So I think acknowledging that and saying to the patient, 'I completely understand that. You can come to the emergency department, you're coming to a doctor's office and you need to be taken care of; do you mind, then, if I look a few things up, or do you mind if I call an expert?' And so, you know, in the same way that any physician who is in general practice, or an emergency physician, has a cadre of specialists that they can call for consultations, your specialists should include people who are experts in LGBT care. That should be on your list. So for example, we have an endocrinologist on our list who has the biggest practice for transgender patients who are, and I may not be using the correct terminology and I'll acknowledge that, is it correct, Matías, to say that they are transitioning?

[39:46] Matías: If they are transitioning under what circumstances?

[39:51] Dr. Moreno: So they are undergoing preliminary treatment hormone therapy in preparation for gender correction surgery.

[40:01] Matías: Yes. That would be correct.

[40:03] Dr. Moreno: Okay, so this particular endocrinologist has the largest patient panel of transitioning of any in the United States. We call her if we have a question. Because if I don't know if somebody's hormone doses are contributing to their elevated blood pressure, or contributing to their headaches, or contributing to some other problem they are having, I am going to call a consultant the same way that if I have a patient who is having rapid atrial fibrillation, I'm going to control that, but then I'm going to consult a cardiologist to find out if the patient needs ablation; this should be no different. LGBT patients should be no different than any other patient that you see. If you don't know how to treat a certain aspect of their health issues, their presenting problems, their chief complaints, you need to be able to reach out to a specialist. And so every doctor should have a list of specialists in LGBT care that they can consult if they need additional help.

[41:12] Pooja: I like that. And thank you for modeling how to, how to ask when you're not sure yourself. That was great.

[41:22] DJ: I had a question, actually, and you know, we touched on the things to do correctly in terms of names, pronouns, and also admitting if we don't know a certain aspect of their health or their identity, but what are some things that you see commonly aside from what we mentioned that people do incorrectly, or that they could improve on.

[41:45] Dr. Moreno: One of the biggest issues is not admitting things you don't know. Another big issue is not asking the patient: 'What would you like to be called? What are your pronouns?' And the other thing is that for a lot of people who do not spend a good portion of their life in the LGBT community, sometimes you may quote 'slip.' I can tell you that I still do. I don't have a lot of people in my personal world who use the pronoun 'they' and I sometimes will slip when I am talking to a patient. I will then revert in the middle of a conversation, I may revert to 'he' or 'she.' And so I tell patients early on and people in my social circle, I tell them early on in the conversation: 'I may forget to address you by your pronoun. If I do that, please just stop me and correct me.' Because the more times that

people stop me and correct me, the more I will remember to be cognizant and keep that in the front of my mind, that I need to respect people's right to be called what they want to be called. So I think that that is an important thing to do, to invite the other people in your environment to correct you if you do something that is negating or that is neglectful, or that is unthoughtful.

[43:24] DJ: Thank you, so that's excellent. Once again, creating that open and humble environment that we were discussing before. Matías, did you have any additional comments or additional thoughts?

[43:36] Matías: Yeah. Definitely that human connection is key there, right, and so one of the things that I often do see is when people misgender someone, is that they make a big deal out of it. And I just want to give this note that not every trans person navigates being misgendered the same, but what I do often find is that not making a big deal out of it—and like being extra remorseful doesn't do any good or doesn't do any more good than bad, right—so oftentimes, what I see is people who misgender someone else will automatically be like, 'Oh, I'm so sorry; I didn't mean to say that,' and kind of make it into a bigger deal, right. And I will say that as a trans person who gets mis-gendered when people do that, it's rather more uncomfortable for me. And so on a personal experience, I really just appreciate what Dr. Moreno is saying in terms of just initially owning up to the fact that if you aren't comfortable, for example, using they/them/their pronouns in your everyday language, just being honest about that upfront so that if you do later mess up, there's that established human connection, right, so, yeah, I think that on a personal experience, if you do mis-gender someone, don't make it into a big deal because oftentimes, that's not a pleasant experience for trans people.

[45:02] Dr. Moreno: And, you know, I've seen that. I've seen situations where people do become very flustered and get very upset, and then the misgendered person is made to feel uncomfortable as if they did something wrong. And I think that's what informed my decision to tell people early: 'Please correct me if I make a mistake, because if I do make a mistake and you correct me, I will become more cognizant, and I will become better at treating people the way that they deserve to be treated.' And so I've seen that happen, and I think it's very easy, then. And in my experience, patients have been very comfortable where if I'm in the middle of a long dialogue with the patient, and I say 'she,' the patient just looks at me and goes 'they,' and I say, 'oh yeah, they,' and we just keep moving. You know, we just keep it moving.

[46:00] DJ: Thank you so much for your response, that's extremely helpful. And on this topic of the lack of staff training and the way that our medical system is set up is not very inclusive, and only recently, like some EMRs are just capable of even updating the gender pronouns and preferred names in a patient's medical chart. And most people don't even know where to click to find that. And so it's still under-utilized. So I wanted to ask you, Dr. Moreno, you've done a lot of work in quality improvement and as a researcher in terms of addressing this lack of structural inclusivity. And so I wanted to ask if you could tell us about some of your work you've done and some of the challenges you've had in making the workflow a little more friendly for the LGBTQ community.

[46:52] Dr. Moreno: Well, I think one of the things is definitely being able to get people to call patients what they want to be called. So part of that is the training that I do. And part of that is also the medical record. Now, unfortunately, in the state of Louisiana, unless it's changed really recently, like within the past couple of weeks, the law still is that unless they have a legal name change, the name that we put on their record, or the name that the registration clerks put on their record, is their government name that they were given at birth unless they go to court and have their government name changed. One of the things we've been able to do is to add a second name and they do it as 'aka,' which isn't the most ideal, but you will see that the patient's government name is listed, and then it says 'aka' and another name is listed. We know that the other name is the name that the patient wants to be called by. So that, in conjunction with the fact that I've trained people to go into the room and say, what would you like me to call you?, has been very, very helpful in making the environment a little bit more conducive to patients. That, and the fact that we encourage people to admit when they don't know something, we encourage people to reach out and ask for resources. We do have a resource list of physicians who are specialists in LGBT health. And we do have a referral list of patients, I'm sorry, of physicians that patients can be referred to. So all of that I think helps to create a friendlier environment. And I will tell you that peer pressure works. So if we do have the outlier, the nurse, or physician, or a nurse's aid, who is acting in a very intolerant way, peer pressure will pretty quickly bring them into line because there will be five or six other people—healthcare professionals—who will go up to that person and pull them aside and say, 'You are not acting in a professional fashion, and you need to keep your personal opinions outside of the workplace.'

[49:05] Pooja: That's pretty incredible. I mean, it sounds like you guys have really been able to create a whole culture of acceptance within the staff and the trainees. That is pretty incredible!

[49:20] Dr. Moreno: Well, and I think, too, part of it is that we sort of recruit our residents and our medical students, so if any of our residents self identify as lesbian, or gay, or trans, or any of our students self-identify as lesbian, gay, or trans, we will immediately, you know, I will immediately tell them: 'Okay, would you like to be part of the diversity committee? This is the kind of work that we do. Would you like to join ADIEM, which is the Academy for Diversity and Inclusion in Emergency Medicine, that I co-founded at SAEM [Society for Academic Emergency Medicine]?' And I asked them again, of course, to join the diversity, equity, and inclusion committee in AAEM [American Academy of Emergency Medicine], so that we create that environment. We use every resource we can, we get people who are allies, who are conscious, to become part of the organized change that we're trying to make in emergency medicine and in our hospital.

[50:20] Pooja: That's wonderful. And I think, um, that kind of leads nicely to, to our next topic of experiences in advocacy that you need to be change makers, not to start local bubbles of hospitals and individual communities, but on a larger level of larger professional organizations, local, and state governments. And both of you are very involved in these advocacy efforts. So I'm just wondering if you can give us a little bit of background on the key health related initiatives that you and your peers are working on, and what level you're working on for those—so for example, if you're working with local government. Matías, maybe you can tell us a little bit more about some of the local initiatives that the Community Center's working on.

[51:11] Matías: Yeah, definitely. So there are a lot of health related initiatives that we're working on here at the center, especially since I joined. And so currently, one of the things that we are starting up, and will soon be launching is a sexual health clinic in South Sacramento, which would complement the services that we offer here in downtown Sacramento. And specifically, this would be in South Sac, which is in the hood, right, and as we all know, black and latinx folks are impacted in many ways. But they are the most impacted by HIV and STDs. And this is very true here in Sacramento. And so this summer, we will be launching this project to amplify the health in our southside communities. And personally as someone who was born and raised in South Sacramento and who did not get tested for HIV or STDs until I was 19, this is very personal and important to me because accessibility locally, especially for our rural communities, is really, really important. And I'm involved in a lot of other projects, too, with UCSF working on a research study to connect black and latinx youth to prep through different ways of intervention. This would launch sometime next year, which is a different intervention that hasn't really been seen before, so keep an eye out for that. But yeah, especially now during the pandemic, we're trying to change all of our services because we aren't equipped like other medical facilities.

And so currently we're working on creating social distancing guidelines to offer HIV and STD testing still and offer at home testing because not everyone feels comfortable leaving their house right now. So really a lot of my work is local, right, but at all points, in any space, I advocate for our most marginalized, which is our queer and trans black and latinx community.

[53:14] Pooja: That's fantastic. And can you give us some, some tips or some pointers on how to be an advocate on the community level, or in the levels that you're working at?

[53:26] Matías: Of course. My biggest thing is being engaged with community; you cannot speak for the community if you are not engaged with the community. And so, that's really my biggest advice is for people out here who really want to help any given community is to engage with that community, because I think it's easy for us to speak for people, but really what we should be doing is amplifying voices, right, and so one of the biggest pieces of my work is always getting community input. Am I doing this right? Am I doing this wrong? Should I be doing something better? One of the biggest groups impacted is the black community. And as someone who isn't black, I really rely on my black friends and peers to help me with those gaps. It's important to amplify voices and not speak for these voices. And so as someone who is a part of the latinx community, I still heavily engage with the latinix community to better understand how to serve them. It's important to understand that these groups aren't monolithic, right. Someone who was born in the U.S. who identifies as latinx, who has citizenship, would have very different experiences than someone who is undocumented and wasn't born in the US, who doesn't speak English, right? And so it's really about engaging with communities, amplifying their voices, and understanding the nuances in communities.

[54:55] DJ: That's excellent. I really loved the point that you made about really getting to know the community and hearing their voice and understanding their voice. And I think it can be difficult because when we try to advocate for our communities, or for other marginalized people, the people that we're advocating to often are not involved in those communities, often have not heard their voices, and it can be very frustrating. And this question can go to either you, Matías, or Dr. Moreno, like how do you go about talking to the people that you're advocating to? How do you kind of get them to understand why these things are needed, why these changes need to be made?

[55:40] Dr. Moreno: So I think that involvement of the community is absolutely key. One of the ways that I like to engage the community is any time that I'm doing a project, I always have focus groups. I live in the community that I serve. I do not live in the suburbs. I

do not live in the part of my community where most physicians live. And so, I have relationships with my neighbors. I talk to them, I ask them what their feeling is; give me feedback. You create an environment where people can approach you. You have to be approachable. And then I have formal focus groups, and I get funding for my grants, so I can pay these people who give me information, because I also place a value right on my community is giving me services. They are giving me skills. They are giving me knowledge that is going to help me to be a better doctor and to train other people to be better doctors. And so, they are paid and they participate in focus groups. I've done multiple education videos. I just completed one on difficult conversations with LGBT patients. And we're going to be distributing that through the AAMC [Association of American Medical Colleges] for free. But when I got the grant to do that project, I also hired people from the community to be the actors who played the patients. And why? Because how can I possibly write the script for what would a patient say in this situation? Or how would a patient feel in this situation? I don't know.I am not a member of the LGBT community. I am not a patient in this situation. And so, we had them be the actors, and we had them inform us. I empowered them. I told them: Stop me if this doesn't seem right, stop me if this is not going well for you, and tell us how this really needs to go. And they were involved in the script writing. It's really important, I think, I cannot stress what Matías said. They made a really, really powerful point in saying that you have to be in touch with the community. The other thing that I think a lot of us forget who are members of underrepresented minorities in medicine is you have, we have, I have, a tremendous amount of power. And just by modeling appropriate behavior, just by having zero tolerance for hatred of any kind, zero tolerance for racism, sexism, prejudice of any kind, you are giving a powerful message that this behavior is not going to be tolerated. And I think that that's one of the things that I sort of had to grow into as an underrepresented minority, realizing the power that I have and being a full professor, the power that I have in being an educator, the power that I have in being president of AAEM, that people are going to listen to certain things that I say. And so if I say that this organization, this department, this hospital has zero tolerance for hatred and prejudice in any shape or form, then that statement has power. And I think we need to use those statements and use the positions that we have to change the environment for our most vulnerable patients to make the environment supportive, friendly, welcoming, and to make certain that we, as a healthcare professional, that we, as the healthcare, and I don't want to say healthcare industry, but we, as the healthcare service, are providing what we should be providing to the community. And the other thing that I remind my residents of all the time is: If the patients don't come, you don't have a job. And so you have to treat the patients with respect, or when you go out into private practice, nobody's going to be coming to your practice, and you won't have a job. It just comes down to respect. It comes down to wanting to be the best you can be for every patient, admitting your knowledge

deficits, reaching out for resources when you need them, and that's really what the bottom line is—it's just common decency.

[1:00:14] Pooja: Wow, I think that was a great lesson to kind of wrap up this discussion. Thank you both so much for sharing your experiences, for sharing these lessons. It was really humbling to hear the kind of amount of power, or the amount of authority, that we do have to affect change. The very important reminder that in order to be a good ally, we have to engage with those folks that we're trying to be good allies for, and to, you've both said, kind of amplify their voices, involve them in these changes, and continue to be a good role model out there. So with that, as we start to wrap up, we just wanted to ask you both just share just a couple of take-home points for our listeners. So, if there's nothing else that they remember from this discussion—which I imagine is hard because it's been a very powerful discussion—what are those couple take-home points that you would like to leave our listeners with? We can start with you, Matías.

[1:01:27] Matías: Yeah, I'll keep it short. So, I just want to say, be intentional about your work, amplify community voices, give that human connection to patients, and continue to do work, to educate yourself, to create a world in which we can create the normalization of all of these people who are considered 'others', right, and really just putting that effort into helping our trans and queer siblings survive because I think that doctors have a really good moment of intervention of sustaining our communities, so just continue to do that work.

[1:01:59] Dr. Moreno: So, I think my take home points would be: Essentially, it comes down to wanting to be the very best doctor or health care professional that you can be for every single patient. And to do that, you have to acquire knowledge and skills, but admit your knowledge deficits and reach for the appropriate resources. And I think it is really important. That whole sense of humility that we've discussed multiple times is really important. Remember that every human life matters, and that you, or your child, or your parents, could be in your patients' shoes at any given time. And to treat everyone the way we want to be treated, or the way we want our children and our parents and our siblings and our loved ones to be treated. And if you just kind of follow that simple human decency, everything else is going to fall into place. I just want to say that I honor you both and your entire production team for doing this. I mean, you are giving us a voice. You are giving us a platform to speak for our patients and I want to honor you for doing that.

[1:03:20] DJ: Yes, I think it's so important, honestly. And what you said there, just about human decency, I, you know, my parents were very much, they spread that message to me throughout my life. And any indecency for any person is in decency for everybody in my

opinion. These names and pronouns are so important to a lot of people. And if we just take the time just to understand that and just get to know them, it just makes such a huge difference not only in our community, but just as humanity as a whole.

[1:03:53] Pooja: If you want to continue learning about these topics, please visit our website at The DEI Shift. That's thedeishift.com. We have a full transcript of this conversation, as well as links to the resources and research cited by our guests.

[1:04:08] DJ: And continue the conversation through our social media pages on Twitter and Instagram @thedeishift—that is D-E-I—for more information!

[1:04:17] Pooja: Thank you so much for spending your time with us; have a great day!

Outro

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