Take To introduce away our speakers
for today’s Smilow Cancer Hospital
and Yale Cancer Center grand Rounds.
Hosted by the Office of Diversity,
Equity and Inclusion at Yale Cancer Center.
And I’d like to start by introducing Dr.
Obannon Malaver,
who uses the pronouns she, her, hers.
She is an assistant professor in the
Department of Obstetrics and Gynecology
at Stanford University School of Medicine.
She specializes in gynecology and
reproductive health care of needs of
sexual and gender minority people, which include, but are not limited to, lesbian, gay, bisexual, transgender, queer and questioning people. This interesting experience. Grabs her research interests towards promoting the health and well being and equity of LGBTQI people. She is the director or Co director of the PRIDE study, a multi site online, prospective longitudinal cohort of sexual and gender minority individuals based at Stanford. She is also an incredible advocate in this space and has been very active in health policy.
Doctor Ash Alpert, who uses the pronouns they them, is a current T 32 fellow in HealthEquity at the Center for Gerontology and Healthcare Research at Brown University at the School of Public Health. Doctor Albert’s research investigates community solutions to improving the experiences and outcomes of transgender people with cancer. They work with an Advisory Board of transgender people who’ve been diagnosed with cancer and whom they have conducted research. Published manuscripts and applied for.
grant funding over the last two years.
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This includes a young investigator award from conquered cancer to ask
a foundation to develop patient centered and non stigmatising gender identity data collection methods.
Doctor Alpert is also very involved with advocacy efforts.
That includes the ASCO sexual and gender Minority Task Force and the NCCN.
So it is our great pleasure to hear from both of them.
Today I will pass the baton they will be presenting on advancing transgender and gender diverse visibility and inclusion and data accuracy and oncology.
Thank you.

And thank you so much for this kind welcome and introduction. We’re both very honored to be here. Thank you, Doctor Collins as well as all of the attendees. Also to Renee and other folks who have helped with the logistics. It often takes an army to make these things happen. So thank you so much. And. Overall, we’ll be focusing today on specific mechanisms for improving visibility and inclusion of transgender people in oncology.
and thereby ensuring that our data in clinical decision making are accurate and efficacious.

You should say, I'm Juno, open in Malibu, and everyone just calls me Juno and I'll let Doctor Albert introduce themselves.

Hi I'm doctor cash. So we're going to talk for a moment about what brings us to this work. Will then review some of the epidemiology of transgender and gender diverse populations. Some linguistics and terminology as well, and then move into how this all relates to cancer is specifically describing
the experiences of transgender and gender diverse people with and without cancer and healthcare context all towards proposing a new model of how we think about bodies and how we. Think about the care that we're providing and moving away from oversimplified notions of sex or sex. Assigned at birth and being more broad and expansive to really take care of whole person health, and this will turn you know, finish with a discussion of how the Cancer Center could improve visibility, accuracy, inclusion some steps that you can take today.
And then of course, the longer range, goals and activities our slides will be available to you, so there's a lot of references and action steps as well. We are also so very grateful to the following folks who have worked with us in various capacities and whose insights and wisdom are shared here specifically. The transgender Cancer Patient Advisory Board that Doctor Albert works very closely with. So we have no relevant financial
disclosures to this presentation, but have been supported by some of the following grants and activities. They don’t present any conflict here, and our job here really is to give you some of the foundational understanding of how invisibility in accuracy and exclusion among transgender and gender diverse people plays out in oncology and thereby foster future action and learning towards visibility, accuracy and inclusion, and ultimately towards HealthEquity. And so to do that, we really see these three objectives...
00:05:18.504 --> 00:05:19.820 describing the exclusion of
NOTE Confidence: 0.893097683333334
00:05:19.875 --> 00:05:21.830 transgender and gender diverse people,
NOTE Confidence: 0.893097683333334
00:05:21.830 --> 00:05:24.700 and sensitize you to some of the
NOTE Confidence: 0.893097683333334
00:05:24.700 --> 00:05:26.550 health sequelae that follow.
NOTE Confidence: 0.893097683333334
00:05:26.550 --> 00:05:28.602 On from that exclusion,
NOTE Confidence: 0.893097683333334
00:05:28.602 --> 00:05:30.654 describe some conceptual frameworks
NOTE Confidence: 0.893097683333334
00:05:30.654 --> 00:05:33.506 that hopefully will be useful to you in
NOTE Confidence: 0.893097683333334
00:05:33.506 --> 00:05:36.654 your work and sensitization to these topics,
NOTE Confidence: 0.893097683333334
00:05:36.654 --> 00:05:38.918 including linguistic and systemic,
NOTE Confidence: 0.893097683333334
00:05:38.920 --> 00:05:41.458 come and support you in addressing
NOTE Confidence: 0.893097683333334
00:05:41.458 --> 00:05:43.150 health disparities by enhancing
NOTE Confidence: 0.893097683333334
00:05:43.217 --> 00:05:44.819 visibility and inclusion.
NOTE Confidence: 0.893097683333334
00:05:44.820 --> 00:05:46.825 And then to identifying some
NOTE Confidence: 0.893097683333334
00:05:46.825 --> 00:05:49.400 key steps that can be taken.
NOTE Confidence: 0.893097683333334
00:05:49.400 --> 00:05:52.800 So we wanted to start here by talking
NOTE Confidence: 0.893097683333334
00:05:52.800 --> 00:05:54.750 about some of the ways transgender
people are often invisible in the medical landscape in our language, in our documents, and the effects that that has on transgender and gender diverse people. So two staggering statistics.

Or are these two that nearly one half of transgender people will attempt suicide in? Their lifetimes. It’s a really staggering number. It’s actually probably much higher given the poor data collection that we’ll talk about here in a moment.
And that’s in comparison to 1.6% of the general population of adults.

Actually, one transgender person is murdered every three days, so if these don’t grab your heart, we wanted to share a little bit more about our stories, and we hope that this really starts to bring to visibility the interlocking systems of oppression that don’t recognize transgender people’s existence.

You know I’m a cisgender queer woman, uhm.
I live and move in LGBTQ spaces and had been for a long time and working and living in San Francisco, working on LGBT health and it was in my internship year when I really started to recognize how transgender people weren’t considered even as part of that bigger umbrella of LGBTQ plus.

It was an intern I was working in the in, in the ICU, and a transgender woman who was very well known to our hospital system came in with complications of her longstanding lung disease. Shortly after she arrived,
code processes began as she went into respiratory failure and as part of this process, she was undressed and when she was undressed it was noted that she had a penis. At that point, all code activities stopped. People lost their composure and critical activities were halted. People actually stepped away from the bed and there was this long, terrible pause where people lost their professional activities and all the steps that they should have been taking to help save her life.
Concurrently, her wife was being called urgently and asked if she wanted extreme measures taken for her wife. Our patient was misgendered, saying, you know whether we should sustain life or you know ** *** it and it was terrible. So at the point of her death this woman was disrespected and invisible in that you know her death wasn’t seen as the death of a woman. In this setting, and that her wife takes that forward into thoughts and memories of what.
happened in the end of her wife's care.

So this blatant disrespect and lack of human decency really propelled me to start to think about how I could do better and how we could all do better in medicine.

With that I'm going to turn it over to Doctor Albert.

Thanks for that very beautiful and moving story.

So I'm ash I'm nonbinary, and I wanted to share a very different story from back before I actually even knew that I wanted to be a doctor.

I was in college and about 20
I fell in love with somebody who is transgender. And I remember sitting at a dining table and listening to her tell the stories about her life. It was a very strange and scary feeling. But it was also incredibly freeing and that person that I had was breaking open was changing taken as a given was in fact not a given. It was a very strange and scary feeling. But it was also incredibly freeing and that person that I had
fallen in love with was also very interested in issues of social justice. And it really felt like in that moment that I was seeing the possibility of a revolution and transformation. Later, when I was in medical school, I started doing qualitative research with LGBTQ plus people. And I noticed a similar feeling that the stories of transgender people in particular had in them the possibility of reviewing the assumptions of our medical systems and creating the possibility for change. So I’m hoping that what you’ll hear today is both the urgency of making
changes to our systems to save the lives of transgender people, and also the beautiful possibility that if we change our systems in these ways, we might also provide more nuanced and efficacious care for all of our patients.

Thank you so much Doctor Albert for sharing your perspective and wisdom as always. So from the stories that you’ve just heard, what will and what will present today? We want you to take away from some central concepts and themes. One is that systemic oppression...
which is experienced daily levels, leads to cancer disparities as it’s an undercurrent of catalyzing other things that we know worse than the incidence, prevalence and severity of cancer. Invisibility, which is ubiquitous in our world. Just look, you know, at any magazine, any media. There’s certainly more visibility of transgender and gender diverse people, but it’s pales in comparison to binary assumptions about gender and who people are and how people move in the world. And this actually leads to data in accuracies for all people,
not just trans people, and limits our understanding of how the world works, frankly. And we hope to demonstrate some of that and more specifically leads to substandard care for transgender and gender diverse people and then stigma, which can be implicit or explicit, leads to poor experiences and outcomes. And we see that in many different characteristics and domains, but specifically we'll be talking about limited notions of gender here, and we'll see that these 3 threads run through the rest of our presentation.
Next slide, but first.

First thing is first we have to level set on a little bit of terminology. Likely many of much of this is familiar to many people in here, but without assumptions, these are some of the terms that we use LGBT sometimes LGBTQ plus LGBTQIA. Those are all meaningful different abbreviations, but without assumptions, these are some of the terms that we use LGBT sometimes LGBTQ plus LGBTQIA. Those are all meaningful different abbreviations, but broadly speaking, same for lesbian, gay, bisexual, transgender, queer questioning. The plus is really speaking to the fact that the diversity of communities that are not cisgender and not straight are not cisgender and not straight up is broad and
00:13:25.135 --> 00:13:27.360 actually represented them more than
00:13:27.360 --> 00:13:29.901 just these few letters and subpopulations
00:13:29.901 --> 00:13:32.547 and so in recognition of that,
00:13:32.550 --> 00:13:35.147 actually academia has said we needed a
00:13:35.147 --> 00:13:38.299 bigger term to kind of get our arms around.
00:13:38.300 --> 00:13:40.826 The folks who are not cisgender
00:13:40.826 --> 00:13:43.200 and so this umbrella term,
00:13:43.200 --> 00:13:46.410 sexual and gender, minorities, or SGM.
00:13:46.410 --> 00:13:48.828 Is what’s used in academic spaces,
00:13:48.830 --> 00:13:51.826 so not much really yet or at
00:13:51.826 --> 00:13:53.110 all by communities.
00:13:53.110 --> 00:13:56.267 It is used by the NIH and SGM people
00:13:56.267 --> 00:13:58.889 are recognized as a health disparities
00:13:58.889 --> 00:14:00.968 population for research by the NIH.
00:14:00.970 --> 00:14:02.881 Transgender term that we’ve used a number
00:14:02.881 --> 00:14:04.968

23
00:14:02.881 --> 00:14:04.648 of times already in this population.
NOTE Confidence: 0.91289004

00:14:04.650 --> 00:14:07.134 Someone whose gender differs from that
NOTE Confidence: 0.91289004

00:14:07.134 --> 00:14:09.090 commonly associated with their sex.
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00:14:09.090 --> 00:14:10.830 Assigned at birth,
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00:14:10.830 --> 00:14:13.350 so that’s in some ways the opposite
NOTE Confidence: 0.91289004

00:14:13.350 --> 00:14:15.609 of this other term cisgender,
NOTE Confidence: 0.91289004

00:14:15.610 --> 00:14:16.645 which again, really.
NOTE Confidence: 0.91289004

00:14:16.645 --> 00:14:17.680 Came from academia,
NOTE Confidence: 0.91289004

00:14:17.680 --> 00:14:19.192 which is someone whose gender is
NOTE Confidence: 0.91289004

00:14:19.192 --> 00:14:21.011 the same as is commonly associated
NOTE Confidence: 0.91289004

00:14:21.011 --> 00:14:22.139 with their sex.
NOTE Confidence: 0.91289004

00:14:22.140 --> 00:14:25.099 so I use that term in reference to myself.
NOTE Confidence: 0.91289004

00:14:25.100 --> 00:14:27.578 I said I’m a cisgender queer woman.
NOTE Confidence: 0.91289004

00:14:27.580 --> 00:14:29.464 That means I was assigned female
NOTE Confidence: 0.91289004

00:14:29.464 --> 00:14:31.512 sex offenders have what’s commonly
00:14:31.512 --> 00:14:33.716 associated with typical female reproductive organs.

00:14:33.716 --> 00:14:34.818 I challenged that terminology, uterus, ovaries, dudes, etc.

00:14:34.820 --> 00:14:36.760 And then transgender man and woman.

00:14:36.760 --> 00:14:39.292 It’s really important that we always use terminology that affirms peoples gender,

00:14:39.292 --> 00:14:43.468 and a transgender gender.

00:14:43.470 --> 00:14:45.768 a transgender presumably assigned female sex at birth and non binary person who

00:14:45.770 --> 00:14:48.024 is not simply a man or woman may have multiple genders or outside of the non binary outside of a binary man,
So these are some important terminology. One thing that will point out is that not everybody who is transgender uses that terminology for themselves, so really important to use the language that people use for themselves and reflect that back to people and similarly cisgender. A lot of people who we would classify as just gender don’t know that terminology, so there’s a difference between when you’re working with individual people versus doing research policy, etc.
understanding of sex or sex assigned at birth as distinct from gender.
So sex assigned at birth is identification usually made by looking at external genitalia.
In my field, often in at the time of birth, sometimes before birth, right?
We’re getting more and more information from ultrasound, genetics, etc.
Often by healthcare providers, sometimes by parents.
And that’s a different from gender.
Someone internal sense of themselves as a woman, a man, another gender.
There are many more than one gender,
and this also breaks down into gender identity. Clothes you wear. Sorry gender identity, which is something only you can know by inside your own head, right? You would have to ask someone and they would have to feel comfortable disclosing that to you for you to know their gender identity. Can’t know it by looking at them versus gender expression, which is known. Or is something that is red and how we move in the world here makeup clothes? How we cross our legs,
vocal intonations. Those are all markers of gender expression, and those don’t necessarily quote UN line up in ways that we’ve tried that they traditionally do, and that’s really different than sexual orientation, which is comprised of individuals, sexual attraction, identity behavior. So there’s actually many components of sexual orientation as well, which may or may not quote a line so. Some lesbian women do have sex with men and that is a distinction between behavior and identity.
There are many sexual orientations, and people have both a sexual orientation and a gender identity, and we need to think about those as different domains. OK, let’s make sure that as clinicians and administrators, we are really teaching and distinguishing between sex assigned at birth and gender, which are so commonly completed. In medicine and research, they are so commonly completed. So some of you at this point might be wondering, Gosh, great lots of concepts here,
but how important is this? How common is this? Why am I listening maybe? And wanted to present a little bit of that began genealogy, so I’ve talked about this bigger umbrella LGBTQ plus and current research would say that you know, actually, the most accurate question answer to the question of how many LGBT people are there, or how many transgender people are there? Is that we don’t know because most research Census, American community surveys,
all these others.

Don’t ask people systematically.

Their sexual orientation,

sex assigned at birth.

And gender identity for us to really

understand who’s in our population.

However, we have some data and we

think of these as floor statistics,

not as a ceiling because not everybody

feels comfortable answering questions

like from a random digit dial are.

So these data which come from Gallup

show that 7% actually over 7% of adults

in the US today identify as LGBTQ plus.

It’s more than all the children of

five and under in the United States,
Including 20% of Generation Z adults, and among that 1% are transgender. So next slide.

And if we look a little bit more closely into the transgender population and epidemiology, we see that overall about 1%, or which translates to at least 1.8 million people. And we do know that there's a difference by age and generation, and the numbers here. But there's really good evidence to suggest it's not necessarily that population prevalence.
Statistics are changing, but rather there are real differences in terms of comfort with disclosure, changes in understanding and representation of various gender norms and concepts of gender. We do see that in the youngest generation, one in 50, or identifying as transgender, and we know that that's a lot less than probably who is and and thinks of themselves and or has the experience of being trans one really important thing is that trans and gender diverse status is not unique to a particular age, race, ethnicity,
00:20:04.140 --> 00:20:04.565 income,
00:20:04.565 --> 00:20:06.265 bracket or education level,
00:20:06.270 --> 00:20:09.210 and many people have multiple identities,
00:20:09.210 --> 00:20:11.114 so the take home is you are
00:20:11.114 --> 00:20:12.742 taking care of transgender people
00:20:12.742 --> 00:20:14.974 whether you know it or not.
00:20:14.980 --> 00:20:16.912 And it really is critical that
00:20:16.912 --> 00:20:19.502 we all work to make sure that
00:20:19.502 --> 00:20:21.138 our spaces are welcoming.
00:20:21.140 --> 00:20:22.190 And with that I’m going to
00:20:22.190 --> 00:20:23.210 pass it to Doctor Albert.
00:20:27.230 --> 00:20:29.024 So while we have limited data
00:20:29.024 --> 00:20:30.220 regarding cancer incidence and
00:20:30.273 --> 00:20:31.869 outcomes for transgender people,
00:20:31.870 --> 00:20:34.712 many aspects of the lives of transgender
people may predispose us to increase cancer morbidity and mortality. For example, the majority of trans people who were out or perceived as transgender in schools experienced some sort of mistreatment, and one in five dropped out as a result. One in five transgender women will be incarcerated in their lifetimes. One out of three transgender people were fired in the last year or experience some sort of mistreatment at work. One out of three transgender people will experience homelessness one out of two experienced
sexual assault in our lifetimes.

One out of four or unable to access hormone therapy because of lack of insurance coverage.

One out of five transgender people will participate in the underground economy, including in sex work.

One out of two black and Latino trans women are living with HIV. And so you can imagine that the indirect and direct effects of some of these things lead to increased cancer morbidity.
Mortality, for example, increased rates of HIV related malignancies and HPV related malignancies. Transgender people also have negative experiences with physicians. And that likely also leads to barriers to care. So you can imagine that if one in three trans people had negative experiences with physicians in the last year, that it makes sense that a number of transgender people would not present to healthcare for regular preventative care and cancer screening, and also that people may not...
have symptoms evaluated.
So if people aren’t presenting to care,
this likely leads to presentations with
later stage cancers and worse outcomes.
And in fact,
Sarah Jackson recently published some data.
Suggesting that that’s in fact the
case that transgender people with
specific types of cancers present late
and have worse outcomes as a result.
We frame our research and
scholarship within a conceptual
model that acknowledges the ways
interactions between oncology,
clinicians and transgender people with
cancer are affected by the structure, culture and policies of the institutions in which we find ourselves, as well as the systems policies and social context around us. So because of that understanding and changing the experiences and outcomes of individual patients will require not just us learning more and changing the ways we interact with people, but also changing the systems and policies around us. For example, guidelines of organizations like ASCO and NCCN impact research, clinical practice, and institutional policies,
and ultimately the experiences and outcomes in patients. For this reason, Doctor Overton, Malaver and I have been working closely with NCCN and ASCO to change guidelines to be inclusive of transgender people. In other words, to acknowledge transgender people in our language and the ways that we’re thinking about guidelines. Similarly, transgender people are also impacted by state and national policies. So for example, this is a map representing Medicaid policies.
that cover gender related care, such as hormones or surgeries.
And so, although this hasn’t been investigated as far as we know, these policies likely also change people’s access to cancer screening and other types of care. So you can imagine that the experiences of transgender people living in state Connecticut, where Medicaid policies coverage under related care might be very different than the experiences of transgender people and their primary care doctors and their oncologists living in Texas.
With that, I'll turn it back to doctor over and over to explore this further.

Thank you and so one of the things that we need to ask ourselves as providers is how can we signal to transgender and gender diverse people that the space is the clinical spaces that we are offering are places that are safe for them to disclose their identity and to have a welcoming experience.

And so I want to propose this model of the four doors that has been very helpful. I think to easily start to think about and do a landscape analysis of your own setting.
So the first question is what happens when someone comes in your door? What is the signage that they're seeing the graphics on? If it’s a place where you are primarily taking care of uterine, ovarian, tubal cancer, is that the Women’s Cancer Center or are the signage all pink? These types of things same with breast cancer and we’ll see more of this later then and are the people who are taking insurance cards. People who are parking folks, people who are rooming individuals.
00:25:37.570 --> 00:25:39.810 comfortable with working with people of all genders.

00:25:41.640 --> 00:25:44.268 Next, what happens behind closed doors? And I think Doctor Albert, if you can click once, I think those four that that great. Thank you so much.

00:25:44.270 --> 00:25:46.580 And I think Doctor Albert, if you can click once, I think those four that that great. Thank you so much.

00:25:46.580 --> 00:25:47.780 if you can click once, I think those four that that great. Thank you so much.

00:25:47.780 --> 00:25:50.125 Histories and physicals, and the information that you’re asking, are you asking about gender affirming processes and procedures? Thinking about who someone is in their totality?

00:25:50.130 --> 00:25:51.502 Thank you so much. Thinking about who someone is in their totality?

00:25:51.502 --> 00:25:54.209 So then what happens behind closed doors in? Histories and physicals, and the information that you’re asking, are you asking about gender affirming processes and procedures? Thinking about who someone is in their totality?

00:25:54.210 --> 00:25:55.125 Histories and physicals, and the information that you’re asking, are you asking about gender affirming processes and procedures? Thinking about who someone is in their totality?

00:25:55.125 --> 00:25:56.955 and the information that you’re asking, are you asking about gender affirming processes and procedures? Thinking about who someone is in their totality?

00:25:56.960 --> 00:25:58.585 are you asking about gender affirming processes and procedures? Thinking about who someone is in their totality?

00:25:58.585 --> 00:25:59.885 are you asking about gender affirming processes and procedures? Thinking about who someone is in their totality?
Even if you’ve done all of that work in your own specific clinical space and behind closed doors, what happens when you were first and went out to another department or another institution? How’s that information carried forward? And then finally, what happens to welcome people into the door so? Not just that, we are taking care of transgender and gender diverse people by happenstance, but really making ourselves
a destination of choice.

Next, so one of a group of colleagues and I wanted to address the fact that many organizations have really recognized non discrimination policies as a good marker and signal to communities and reflection of the culture of an institution, of how they’re taking care of different communities, including the LGBTQ plus community. And so we performed a web based analysis to evaluate the landscape of patient nondiscrimination policies at NCI.
Designated cancer centers and we found that while 82% of cancer centers had a patient, non discrimination policy that was accessible in their website in 90% mentioned, protection by sex and 70% by sexual orientation a little less 67% by gender identity, none of the policies included sex assigned at birth or LGBTQ plus or SGM identity, and so a big. is that there are actions that we can take that are feasible and within our control to help signal and make spaces more welcoming. We'll talk about a little bit
more of what happens when spaces aren’t welcoming through the qualitative research that we’ve both conducted, and there’s some illustrative quotes and experiences that Doctor Albert will go through next.

Go ahead, OK. Thank you so much. So now we’ll get into some of the details of what happens to patients when they present to clinic, and we’ll be presenting from both of our qualitative research, and there’ll be a few themes that will describe throughout this.
section and the first one is that

our institutions themselves may not

be welcoming of transgender people,

and may actually inadvertently exclude them.

So I’m going to read a quote from a

project I did exploring the experiences

of transgender people with cancer.

So one of the participants who was a

white non binary person said I needed

to have a lot of follow up mammograms

every time this wasn’t aggressively

gendered experience to the point of no,

I’m not putting on that pink floral gown.

You can’t make me.

You can do it in nothing.
I'll put on this rap I have or you can get me. Something else, but I'm literally not doing this. And having to push back really hard against. I don't want to change in the special woman to changing room. I don't want to hang out in the special goal mammogram. Word. Thanks Shirley. This is a whole hospital. No doubt you have other places I could sit and you can imagine that you know already experiencing a cancer diagnosis and dealing with treatment and the follow up. It may be very difficult to
00:29:25.012 --> 00:29:27.350 be in spaces and be given.
NOTE Confidence: 0.87542729368421
00:29:27.350 --> 00:29:29.678 Clothing to wear that.
NOTE Confidence: 0.87542729368421
00:29:29.678 --> 00:29:31.424 Explicitly are in,
NOTE Confidence: 0.87542729368421
00:29:31.430 --> 00:29:35.056 in contrast to how you see yourself.
NOTE Confidence: 0.87542729368421
00:29:35.060 --> 00:29:36.668 So not only do we need to change
NOTE Confidence: 0.87542729368421
00:29:36.668 --> 00:29:37.979 how we’re talking to people,
NOTE Confidence: 0.87542729368421
00:29:37.980 --> 00:29:42.844 but the the institutions in which we work.
NOTE Confidence: 0.87542729368421
00:29:42.850 --> 00:29:44.914 Another way that cancer centers may
NOTE Confidence: 0.87542729368421
00:29:44.914 --> 00:29:46.641 signal inclusion or exclusion to
NOTE Confidence: 0.87542729368421
00:29:46.641 --> 00:29:48.417 patients is through our intake forms
NOTE Confidence: 0.87542729368421
00:29:48.417 --> 00:29:50.209 and what happens at registration.
NOTE Confidence: 0.87542729368421
00:29:50.210 --> 00:29:50.824 For example,
NOTE Confidence: 0.87542729368421
00:29:50.824 --> 00:29:52.666 in another study of Latina Trans,
NOTE Confidence: 0.87542729368421
00:29:52.670 --> 00:29:55.148 Woman said, starting with how to identify,
NOTE Confidence: 0.87542729368421
00:29:55.150 --> 00:29:58.108 you don’t have options during registration.
NOTE Confidence: 0.87542729368421
00:29:58.110 --> 00:30:00.090 It’s easy for me to sign in as a woman,
but then the provider ends up asking me inappropriate questions. For example, when was my last period, or if I might be pregnant? And if somebody is asking about your last period, or if you might be pregnant, you’re put in a situation. If you’re a trans woman to have to either lie or come out to someone who it may not feel safe to come out to, and then after somebody asked you that question, it may be even more difficult to.
you’re transgender because they’ve already signaled that they don’t know that or think that you’re. Existence is a real thing. So the language used by oncology clinicians may also not reflect the bodies or experiences of transgender people. For example, a weight nonbinary participant. Said, I remember somebody saying it’s OK, you’re still a woman. You can probably still have children. Thank you. No thank you. And so I’m sure that clinician was really trying to, you know, create, build, report and be close to the patient by by making this statement.
But in fact, really made an assumption that was in fact not the case, and they have eroded reform made it even more difficult for that person to be there.

Similarly, in a study about sexual and reproductive health care, transgender participants said if you start out the conversation talking about female or woman that are only male and female, just a simple statement of female reproductive system or whatever.

It’s just so triggering for gender, expansive folks and trans people that it’s like, regardless of what comes after that,
there’s already a disconnect.

It’s like this person is basic and they don’t understand who I am.

So clinicians are taught to think about gender and sex as synonymous, and because of that they may tend to get the names, genders, or pronouns of patients wrong. This is called misgendering and this may be even further exacerbated when clinicians know that patients are transgender.

So in one of our qualitative studies, transgender people talked about their experiences after physicians found out that they were transgender. And for example,
one black transgender woman said it wasn’t until after I told the Doctor that I was on hormones for transition that I started being keyed. In other words, the physician started referring to her with he pronouns and his accidental or whatever. As it was, it was after. Before that it was she. So in other words, transgender people may face a very difficult dilemma of choosing between the dangers of being open about their identities and the dangers of not.
00:32:45.661 --> 00:32:47.346 giving clinicians all the information
NOTE Confidence: 0.913664499166667
00:32:47.346 --> 00:32:49.670 they may need for clinical decision making.
NOTE Confidence: 0.913664499166667
00:32:49.670 --> 00:32:50.316 For example,
NOTE Confidence: 0.913664499166667
00:32:50.316 --> 00:32:51.608 that they’re on hormones,
NOTE Confidence: 0.913664499166667
00:32:51.610 --> 00:32:53.656 or that they’ve had particular surgeries.
NOTE Confidence: 0.84585182
00:32:56.370 --> 00:32:57.870 In the same qualitative study,
NOTE Confidence: 0.84585182
00:32:57.870 --> 00:32:59.306 we investigated the experiences
NOTE Confidence: 0.84585182
00:33:01.101 --> 00:33:03.009 of transgender people who reviewed
NOTE Confidence: 0.84585182
00:33:03.010 --> 00:33:05.090 their own electronic health records,
NOTE Confidence: 0.84585182
00:33:05.090 --> 00:33:06.870 and we felt that this was very important
NOTE Confidence: 0.84585182
00:33:06.870 --> 00:33:08.259 given the 21st Century Cures Act,
NOTE Confidence: 0.84585182
00:33:08.259 --> 00:33:10.574 which mandates patients
NOTE Confidence: 0.84585182
00:33:10.580 --> 00:33:12.278 to their own records.
NOTE Confidence: 0.84585182
00:33:12.278 --> 00:33:14.392 To nearly all the patients in
NOTE Confidence: 0.84585182
00:33:14.392 --> 00:33:16.236 our study who had accessed their
NOTE Confidence: 0.84585182
00:33:14.392 --> 00:33:16.236 electronic health record noted,
the use of the wrong name pronounced gender marker. Often referred to as misgendering, which I think I mentioned. So even in the context of otherwise positive relationships with clinicians, and even when clinicians displayed other signs of being welcoming. They described the seeing misgendering or stigmatising language in the electronic health record really eroded their trust, not just in that particular clinician, but the medical field as a whole. So for example,
one participant said there’s like stickers that are like LGBTQ affirming blah blah.

Yet they both misgendered me in their notes.

And many people in the study did talk about their performative, but sometimes performative nature of inclusiveness.

So it brings up the question of how we can really like, be authentic and all the places we’re communicating with patients.

Participants also describe the intersectional nature of transphobia and racism through use of the word such as hostile or aggressive in the health records of transgender people of color.
For example, one chicken X nonbinary person described the ways that those words were carried forward and used against patients they said.

In the electronic health record, those details that people added in the notes can definitely get used against the patients, especially if you’re a person of color and you’re trying to be enforcing pronouns. You’ll usually get labeled as hostile, and then that establishes a pattern near medical record that then is used to treat you poorly or should not be listening to what you’re seeing.
And in fact, there’s other literature that supports some of these concepts because we know that. From that research, we know that negative language in the electronic health record influences the attitudes of other clinicians and causes them to treat patients differently. For example, to treat pain less aggressively. So these these things are very concerning. Oncologists are also trained to follow guidelines. As you all know, but these may not always be in line with patients priorities, for example NCCN.
Prioritizes fertility sparing interventions that may not be in line with the needs of patients and particularly transgender patients. And we don’t always have a lot of guidance about what to do when guidelines are different from patient priorities. So for example, a white non-binary person with ovarian cancer said because I had a really large tumor. They talked about doing the full hysterectomy or just taking out the one ovary. I wanted the full hysterectomy and they were like you don’t know.
In a few years you might change your mind so they did fertility sparing surgery.

It’s very distressing, especially in that focus group that this person had gotten this surgery that was not the one that they wanted and really brings up the question of how we can really share decision making of patients and center their priorities and making decisions about their care.

Oncology clinicians may be providing incomplete or inaccurate information because of the simplistic ways, incomplete or inaccurate information.
NOTE Confidence: 0.889450598076923
00:36:33.830 --> 00:36:35.942 in manage information regarding
NOTE Confidence: 0.889450598076923
00:36:35.942 --> 00:36:38.310 gender anatomy and Physiology.
NOTE Confidence: 0.889450598076923
00:36:38.310 --> 00:36:40.406 So one concern is that we have very
NOTE Confidence: 0.889450598076923
00:36:40.406 --> 00:36:42.134 limited data regarding the health
NOTE Confidence: 0.889450598076923
00:36:42.134 --> 00:36:44.044 outcomes of transgender people with
NOTE Confidence: 0.889450598076923
00:36:44.044 --> 00:36:46.692 cancer and any role that hormones may
NOTE Confidence: 0.889450598076923
00:36:46.692 --> 00:36:49.679 play in improving or worsening outcomes.
NOTE Confidence: 0.889450598076923
00:36:49.680 --> 00:36:51.608 And I think this is a concern for
NOTE Confidence: 0.889450598076923
00:36:51.608 --> 00:36:53.140 patients and clinicians as well.
NOTE Confidence: 0.889450598076923
00:36:53.140 --> 00:36:55.983 So for example,
NOTE Confidence: 0.889450598076923
00:36:55.983 --> 00:36:57.950 one transgender woman in one of our
NOTE Confidence: 0.889450598076923
00:36:56.008 --> 00:36:57.944 studies said it was good in one way
NOTE Confidence: 0.889450598076923
00:36:57.944 --> 00:37:00.086 that the doctors had no issues with
NOTE Confidence: 0.889450598076923
00:37:00.086 --> 00:37:03.730 thought about it in relation to cancer.
NOTE Confidence: 0.889450598076923
And they were like no, no problem.

Go ahead, it’s fine.

But there is no really good critical thought about, oh, you’re going through this major hormonal shift at the same time as you’re going through chemotherapy, and there wasn’t any discussion about that.

It’s like, OK, you let me do what I needed to do, and you didn’t interrupt that.

Portion of my transition, but you didn’t give me any information you didn’t even try to think critically using your doctorate knowledge.

One problem clinicians may have and
having these types of conversations with patients is that the data regarding connections between hormone therapy and cancer are of very poor quality and it may be difficult to know how best to counsel patients. So for example, in the last few years there were two studies out of the Netherlands that both had retrospective data regarding cancer risk for transgender people. Transgender women specifically. And this one got a huge amount of media attention, partly because of this sentence.
that was in the popular press.

That trench and the woman had a 47 foot higher risk of developing breast cancer.

But as I mentioned, these studies were both retrospective, so correlative and there was no like ability to establish a causal relationship.

And also what was less well publicized is that transgender women in these studies have lower rates of breast cancer than cisgender women.

So it brings to mind how the media may be influencing our conversations with patients and what we do in the absence of quality data.
out that was looking at prostate cancer and transgender women and found lower rates of prostate cancer and transgender women compared to standard men. And interestingly, this study got almost no press attention. Which brings up, you know what’s in our mind because of the popular press and what does that do to our conversations with locations? So we know that hormone therapy and surgeries decrease suicidality for transgender people who want them and improve quality of life. So when having these conversations with patients,
00:39:11.820 --> 00:39:13.576 it’s really important too.
NOTE Confidence: 0.9019870836
00:39:13.576 --> 00:39:15.771 Understand patients priorities and to
NOTE Confidence: 0.9019870836
00:39:15.771 --> 00:39:18.155 weigh the known benefits of hormone
NOTE Confidence: 0.9019870836
00:39:18.155 --> 00:39:20.484 therapy and surgeries with the unknown
NOTE Confidence: 0.9019870836
00:39:20.484 --> 00:39:22.394 but potential risks of hormone
NOTE Confidence: 0.9019870836
00:39:22.394 --> 00:39:24.560 therapy in the setting of cancer.
NOTE Confidence: 0.877617323333333
00:39:27.550 --> 00:39:29.438 The systems that we work in also have
NOTE Confidence: 0.877617323333333
00:39:29.438 --> 00:39:31.386 been set up to deal with gender and
NOTE Confidence: 0.877617323333333
00:39:31.386 --> 00:39:33.331 and sex assigned at birth data in
NOTE Confidence: 0.877617323333333
00:39:33.331 --> 00:39:35.215 various simplistic ways that do not
NOTE Confidence: 0.877617323333333
00:39:35.215 --> 00:39:37.430 extrapolate well to the bodies of
NOTE Confidence: 0.877617323333333
00:39:37.430 --> 00:39:41.442 So for example, the laboratory data
NOTE Confidence: 0.877617323333333
00:39:41.442 --> 00:39:43.576 normal ranges are based on research
NOTE Confidence: 0.877617323333333
00:39:43.576 --> 00:39:45.550 done on cisgender women and men,
NOTE Confidence: 0.877617323333333
00:39:45.550 --> 00:39:47.440 and research suggests that transgender
people have a normal lab values
that fall outside of these ranges.
So this ends up meaning that the lab
values in the charts of transgender people
are often flagged even though it may
not be of any clinical or other significance.
So consider a transgender man who’s
registered as a man and flagged as anemic,
but is actually not because he
meant straights and so has a
half a non pathologically lower
hematocrit than cisgender women.
And this did come up in one of our
qualitative studies have changed under
man said when I get labs done they
00:40:23.479 --> 00:40:25.788 have me as female for my lab levels,
NOTE Confidence: 0.877617323333333
00:40:25.790 --> 00:40:27.561 and so they’re always a little bit
NOTE Confidence: 0.877617323333333
00:40:27.561 --> 00:40:29.661 off and it freaks me out and I’m
NOTE Confidence: 0.877617323333333
00:40:29.661 --> 00:40:31.682 like is this normal and it is very
NOTE Confidence: 0.877617323333333
00:40:31.682 --> 00:40:33.170 difficult that patients who now have
NOTE Confidence: 0.877617323333333
00:40:33.228 --> 00:40:34.788 access to their medical records,
NOTE Confidence: 0.877617323333333
00:40:34.790 --> 00:40:36.547 as well as clinicians or left to
NOTE Confidence: 0.877617323333333
00:40:36.547 --> 00:40:37.880 interpret these for themselves.
NOTE Confidence: 0.833211717619047
00:40:40.120 --> 00:40:42.012 Possibly even greater concern,
NOTE Confidence: 0.833211717619047
00:40:42.012 --> 00:40:43.904 chemotherapeutic dosing is sometimes
NOTE Confidence: 0.833211717619047
00:40:43.904 --> 00:40:46.308 based on creatinine clearance which is
NOTE Confidence: 0.833211717619047
00:40:46.308 --> 00:40:49.231 based on the sex or gender marker and
NOTE Confidence: 0.833211717619047
00:40:49.231 --> 00:40:51.577 we don’t have robust data regarding
NOTE Confidence: 0.833211717619047
00:40:51.577 --> 00:40:54.225 how these algorithms apply or do not
NOTE Confidence: 0.833211717619047
00:40:54.225 --> 00:40:55.985 apply to transgender people who’ve
NOTE Confidence: 0.833211717619047
00:40:55.985 --> 00:40:58.489 had surgeries or on hormone therapy.
So in the future, we could consider revising our laboratory ranges to be based on more objective measures that would be relevant, such as volume of distribution, body composition, hormone levels, renal or hepatic function, or a host of other factors that influence drug metabolism clearance. And so, with all of those really important voices and stories in mind, building on this idea of where oncology practice may be missing, a mark is that our systems may be holding us back.
So this is a screenshot from my EMR use epic, in which one of my patients that I was taking care of, a nonbinary patient of mine who had assigned female at birth, had a cervix. Needed contraception and I was taking care of them for cervical dysplasia and I got you know this diagnosis of dysplasia of the cervix uteri is not valid for the patients X which of course was not true. I was performing the exam person was in front of me.
It’s very valid for their experience but I was not allowed to charge and that’s obviously a problem just for that individual patient. But then if we extrapolate out it hinders care more broadly and also hinders research. As medical charting, diagnosis codes, etc are the foundation of much research endeavors, Qi Work etc. So it’s really important that we cease the traditional conflation of sex and gender and we need to disaggregate these important concepts.
of the organs that somebody has at birth and currently which of course may differ both for transgender and gender diverse people as well as cisgender piece people.

And disaggregate that from somebody’s gender identity which we do need to know. It’s not just about origins but we need to know and take care of somebody’s gender identity as well as their sexual orientation.

And actually we have a rubric you know in medicine to do these things. We systematically go through medical history, meds, family etc.
But we need to be sensitized to how we bring gender into that and how we bring gender affirming care and processes and experiences of transgender people into all of those components 'cause they influence. Every single one of those, and I bring up this picture partially 'cause I'm in OB GYN, but also because I think it's a really good visual model to consider which is the picture on the left are two gay men. One is a transgender Kaden in the front who's carried two children and given birth to two children.
that he and his partner Elijah, a cisgender gay man. Have and they’re partnering together and we can only imagine that their experiences are quite different as two black gay men raising kids, then this presumably white cisgender couple that we see who I actually don’t know. But we’re just, you know, in terms of all of these different multiplicity of experiences, and we need to ask and think about how those differences will play out. And unfortunately there’s a lot of missing data,
and in accuracies here that we need to start to debunk.

And address so next slide

if we think

Just a presentation of some inclusion criteria from a clinical trial about prostate cancer,

But what about women who may also have prostate cancer rate?

Transgender women and also, you know participants must agree to using

79
00:44:45.896 --> 00:44:48.472 condom if they having sex with a woman.
NOTE Confidence: 0.865578255833333
00:44:48.480 --> 00:44:51.288 So what do they mean by sex and
NOTE Confidence: 0.865578255833333
00:44:51.288 --> 00:44:54.240 what do they mean by women here?
NOTE Confidence: 0.865578255833333
00:44:54.240 --> 00:44:56.500 There are obviously assumptions of
NOTE Confidence: 0.865578255833333
00:44:56.500 --> 00:44:58.280 that are threaded throughout this,
NOTE Confidence: 0.865578255833333
00:44:58.280 --> 00:44:59.790 and in addition in terms
NOTE Confidence: 0.865578255833333
00:44:59.790 --> 00:45:00.998 of the exclusion criteria,
NOTE Confidence: 0.865578255833333
00:45:01.000 --> 00:45:02.206 they mentioned hormone
NOTE Confidence: 0.865578255833333
00:45:02.206 --> 00:45:03.814 therapy for prostate cancer.
NOTE Confidence: 0.865578255833333
00:45:03.820 --> 00:45:05.500 But as Doctor Alpert mentioned,
NOTE Confidence: 0.865578255833333
00:45:05.500 --> 00:45:07.600 we know actually the transgender woman
NOTE Confidence: 0.865578255833333
00:45:07.600 --> 00:45:10.600 likely have lower prostate cancer,
NOTE Confidence: 0.865578255833333
00:45:09.440 --> 00:45:10.600 at least in one study.
NOTE Confidence: 0.865578255833333
00:45:10.600 --> 00:45:12.240 We need more studies right?
NOTE Confidence: 0.865578255833333
00:45:12.240 --> 00:45:15.656 And So what about estrogens for transition?
NOTE Confidence: 0.865578255833333
00:45:15.660 --> 00:45:16.011 Finally,
when we think about excluding people, current infections such as HIV. Unfortunately, currently transgender women have very high. Prevalence of HIV, and so we may be excluding whole swaths of population who still get prostate cancer despite also having HIV. So who’s being included, who’s being excluded and we need to think very strategically about this so that we’re providing accurate and inclusive care.
So we reviewed with some colleagues ovarian cancer guidelines and we noticed the word woman appears 100 times. It’s just one example, but you can imagine. These guidelines will not promote use of gender consistent language with people’s identities for men or nonbinary people with ovaries, and you can imagine that providers then aren’t sensitized. How to take care of people? And this was the case of Robert EADS, a man pictured here on the bottom, who was turned away from 12 oncologist office for treatment of this.
ovarian cancer because they said that they didn’t know how to care for a man with cancer essentially.

Next up, similarly, we looked at prostate cancer guidelines and sort of the same story. The word men appears 472 times, rather than being specific to the organs, and in that way it wouldn’t have really provided helpful guidance to taking care of someone like Sally, a woman of trans experience who died of prostate cancer, and so we have to really think about
what we're putting out and how this just isn't meeting our population, so.

One example of potential practical alternatives is represented here, where you know the concern for risk reducing self inject me alone is that people with at least one ovary or people who menstruate versus pre menopausal women. So we need to get much more specific.
Next slide, so as you go back to your day as we start to close up here, we want you to just start to critically assess your own materials, your own space and think about you know is what exclusive thinking, certainly about gender but also race, ethnicity, skin color, age, gender, ability and size, and so this can take you into thought, experiments and really looking at what elements of the
visuals in your clinical settings

promote inclusion and in what domains.

And what images, decoration, signage etc.

Promote exclusion and in what domains?

And the real promise here is

that we can get it right, right?

This is also from one of our

research studies where Doctor

Albert study actually said,

you know, as soon as a trans man

I know talked about his gender

experience with his gynecologist.

They were very careful to not use

gender language during exam and

it was all very matter of fact.
They actively took steps to minimize any chest exposure,
referring to chest tissues, breasts and things of that nature,
and this is a promising quote, but it also would encourage us to not.
Wait for us to know you know that this is a trans person that we’re supporting,
but rather just to make all of our practices welcoming and inclusive.
With that, I’ll turn it back to Doctor Albert to finish us out here.
So some good news is that ASCO actually is making changes to their guidelines,
and recently we changed the guideline template to ensure that all the guidelines that are created are done so with gender inclusive language. So if you want to, you can scan these QR codes to see both the new methodology manual and the first guideline that came out using gender inclusive language and with comments about why that’s being done. So there are a number of next steps that Yale cancer can take, and these are just some of our ideas. But really, we want you all to be thinking about what you think would work best for your center.
And then you know, we talked earlier about EMR best practices and we would recommend fees that patients needs genders, pronouns, or correctly and consistently documented throughout the EMR. That words like preferred or identifies as and describing patients, genders, pronouns, or names are eliminated. And that words that may suggest stigma or blame like disturbed or hostile or removed from the record. We would also suggest based on the recommendations of patients avoiding unnecessary mention of
sex assignment or so called.

Biological sex,
because often those things can be communicated by describing anatomy or other factors.

We also listed some individual steps for individuals,
and these slides will be available after, and these slides will be available after.

We won’t go through these in depth,
but we wanted you to have you know something you could do right now today.

And then here are some training and resources that are available for any Cancer Center in case you want to.
00:50:40.895 --> 00:50:42.890 do more work around these topics.

00:50:45.220 --> 00:50:46.956 And we want to remind oh sorry,

00:50:46.960 --> 00:50:48.058 Doctor Overton Oliver.

00:50:48.200 --> 00:50:50.096 Yeah, well we we all live in society

00:50:50.096 --> 00:50:52.310 today and I think it would be hard if

00:50:52.310 --> 00:50:54.934 if you hadn’t noticed the news that

00:50:54.934 --> 00:50:57.579 there are some very active fights going

00:50:57.579 --> 00:51:00.479 on for trans transgender and LGBTQ.

00:51:00.479 --> 00:51:02.258 Plus people broadly.

00:51:02.260 --> 00:51:05.000 Just to mention that there are 147 anti

00:51:05.000 --> 00:51:09.698 in 2021 that are being either addressed

00:51:09.698 --> 00:51:12.651 or seen now and just two weeks ago,

00:51:12.651 --> 00:51:13.919 Idaho House approved legislation

00:51:13.919 --> 00:51:15.390 that makes it a felony.

NOTE Confidence: 0.930339188866667
NOTE Confidence: 0.84280753
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NOTE Confidence: 0.876625424375
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For doctor to provide gender affirming care and so we as citizens need to also be taking a care and thinking about these things and advocating because it influences our patients and it influences our society. And then the last plug I'll put in here just my own little plug is if you have LGBTQI plus patients, we really encourage you to ask them and to be involved in research and so one way it just one study is the PRIDE study which you can. Learn about here pridestudy.org, which is the next slide. And with that,
I think we’ll move to questions and then know that there’s actually dozens of slides after this that gives some more information and resources, etc. So we encourage you to check out those slides as well, and our contact information is here on the next slide, as well as an evaluation we you know good for each of our portfolios into in to, you know, enhancing our future talks. So thank you so much for your kind attention. Thank you so much. So I just want to really thank you for
00:52:26.892 --> 00:52:28.656 your vulnerability first of all and
NOTE Confidence: 0.750939336
00:52:28.656 --> 00:52:32.740 sharing your own stories, and I’m really.
NOTE Confidence: 0.750939336
00:52:32.740 --> 00:52:36.100 Giving us the language to start
NOTE Confidence: 0.750939336
00:52:36.100 --> 00:52:38.980 enacting change and and I really
NOTE Confidence: 0.750939336
00:52:38.980 --> 00:52:42.339 I think my own take away is,
NOTE Confidence: 0.750939336
00:52:42.340 --> 00:52:44.512 you know we want our patients
NOTE Confidence: 0.750939336
00:52:44.512 --> 00:52:47.910 to feel seen and I think we want
NOTE Confidence: 0.750939336
00:52:47.910 --> 00:52:50.220 you know in language matters.
NOTE Confidence: 0.750939336
00:52:50.220 --> 00:52:52.726 And so I think so I thank
NOTE Confidence: 0.750939336
00:52:52.726 --> 00:52:55.319 you for that fantastic talk.
NOTE Confidence: 0.750939336
00:52:55.320 --> 00:52:58.057 So I’d love to turn to chat
NOTE Confidence: 0.750939336
00:52:58.057 --> 00:53:00.569 with a couple of questions.
NOTE Confidence: 0.750939336
00:53:00.570 --> 00:53:02.676 Some were we had a couple
NOTE Confidence: 0.750939336
00:53:02.676 --> 00:53:04.890 on EHR so one was on.
NOTE Confidence: 0.750939336
00:53:04.890 --> 00:53:06.606 Thank you for this informative session.
NOTE Confidence: 0.750939336
00:53:06.610 --> 00:53:08.787 Do you know if any hospitals or
cancer centers have a process to flag inappropriate EHR notes and to address the behavior and fix them?

No review can address that. The short answer, at least from my end, is no. I don’t know of any such. Policies or procedures in place to manage this sort of data.

Yeah, I don’t either, but I think that our patients are telling us already and so it’s kind of starting from the education place that we don’t fix it. And then we do. All can be champions now, so I often notice it and colleagues notes.
and I gently pointed out to them and say, "hey, maybe this is a template, but you gotta fix the template so or you know."

Patient, you know, came back to me or other patients have come to me to not, you know and say hey can you fix this? I notice this is inconsistent throughout the record. Yeah, exactly and Doctor Albert if you don’t mind sharing and then maybe we can see bigger perfect that’s great. can see bigger perfect that’s great.

Thank you for the last. We’ll have five more minutes and for questions has I? I also there’s a question about.
clinical trial eligibility,
and I think as a Cancer Center, that’s a primary mission
that’s a primary mission of ours and I think I,
I loved that you brought that up and
I loved that you brought that up and
we have eligibility around doing pregnancy tests and eligible.
So really, I think.
It’s great to raise that,
so one of the questions is has
there been a review of clinical
trial eligibility criteria
for appropriate inclusion?
I don’t know of any such research,
although I think it would be wonderful to do that.

We really, you know, did these looks at the guidelines in clinical trial data in preparation for some conversations with NCCN and FDA.

But I think a more rigorous look at maybe even a qualitative analysis or natural language processing tool to look at inclusion and exclusion criteria for cancer clinical trials would be really super would really potentially give us more.

More data to drive change and bring these issues to the floor.

Yeah, and I would say in all research
You know we really need to think about what we’re measuring and why. So it’s actually not appropriate to just say women, right? Because if you’re doing a study on uterine cancer, only people with uteruses can be affected, but that could be transgender men. It could be nonbinary people. It can’t be somebody who was born with a congenital absence of the uterus. Actually inaccurate, so we really wanna say...
you know anybody who has or had a you
You know a uterine cancer or depending on the criteria and just to be very specific and it may be that it’s really only relevant for you.
Know cisgender women, but we need to so state and say why right?
And we also need to think retrospectively about research and point this out as a limitation where we are extrapolating. You know I’m extrapolating from studies on cisgender women to view this.
Transgender man in front of me and this is the areas that I don’t understand right now and so we need to partner around that.
This is mechanistically how I think XYZ would work. I don’t know you know, and we’re working to fill that in. And so, that’s what the NIH is calling for, and I would challenge every researcher here is familiar with the NIH, you know? A requirement on describing sex as a biological variable, and so. In that statement we need to actually carry that forward and really be critical and what that’s really asking for.
And I routinely, my NIH grants say I can report on sex assigned at birth. I cannot report on gender. I will not report people by men and women 'cause that’s actually irrelevant or. You know some other permutation depending on the specific research. Great, thank you. There’s an interesting question on a chaperoning. By Doctor Kim, one of our Gu medical oncologists. So what are your thoughts on the use of chaperones for examining transgender patients?
00:57:33.130 --> 00:57:35.426 Well, I think we should think about,

00:57:35.430 --> 00:57:38.804 you know. Where it’s a great question,

00:57:38.804 --> 00:57:41.255 but I think I always like to think what

00:57:41.255 --> 00:57:43.534 am I gonna do routinely to make situations

00:57:43.534 --> 00:57:46.094 better for everybody and so likely there

00:57:46.094 --> 00:57:48.396 is a place where a patient advocate

00:57:48.396 --> 00:57:51.021 may be good for every person, right?

00:57:51.021 --> 00:57:54.389 So I’m often as an OB GYN who

00:57:54.389 --> 00:57:57.055 identifies and reads as as a woman.

00:57:57.060 --> 00:57:58.580 Often women patients don’t

00:57:58.580 --> 00:58:00.100 think anything of it,

00:58:00.100 --> 00:58:02.656 but then as soon as a male or male

00:58:02.656 --> 00:58:04.716 presenting colleague of mine comes in,

00:58:04.720 --> 00:58:06.450 they think about that, but.

00:58:06.450 --> 00:58:07.926 You know there’s actually nothing to

00:58:07.926 --> 00:58:08.100
say that I may be, and I hope I never am,
but inappropriate or do something sexually inappropriate with a woman.
And so if we should think probably about chaperoning for everyone.
Understanding that more people in the room may or may not be better.
And so I think we need to think
about that and or I often have partners in the room chaperones.
I often have a nurse in the room for everybody, actually.
I think that’s a wonderful comment,
I’d love for both of you, maybe in kind of 1 sentence to say what you are hoping the field will do. Leave us with kind of a dream for the future.

Doctor Albert will start with you.

Yeah, I mean, I think that in my mind the most important thing right now is to rethink the ways that we have conflated gender and sex assigned at birth, and if we can disaggregate those ideas and concepts both in the ways that we’re talking to patients and thinking about bodies, but also the ways that we’re writing guidelines,
thinking about lab values,
NOTE Confidence: 0.905681834666667
thinking about chemo,
NOTE Confidence: 0.905681834666667
therapeutic dosing,
NOTE Confidence: 0.905681834666667
I think will really change the landscape,
NOTE Confidence: 0.905681834666667
not just for transgender people,
NOTE Confidence: 0.905681834666667
but to provide better care
NOTE Confidence: 0.905681834666667
for all our patients.
NOTE Confidence: 0.619737475
Thank you Doctor Obit in malver.
NOTE Confidence: 0.777569478571429
Absolutely so many things.
NOTE Confidence: 0.777569478571429
First of all, just thank everybody.
NOTE Confidence: 0.777569478571429
Uhm, I would say that. It really.
NOTE Confidence: 0.777569478571429
There’s often this sort of doom and
NOTE Confidence: 0.777569478571429
gloom kind of idea about working with and
NOTE Confidence: 0.777569478571429
supporting transgender and gender diverse
NOTE Confidence: 0.777569478571429
people who do face so many challenges.
NOTE Confidence: 0.777569478571429
But I also think incredibly strong and
resilient communities who actually have so much to show us about all of our medicine and healthcare and and and the assumptions that we make that really are a detriment to all of our patients, right? So we could learn so much about you know, hormone management about mechanisms of. Presence or absence of certain experiences, hormones, organs, etc. That and really what transgender and gender diverse people offer us is this incredible gift to examine our assumptions and to become much, much more accurate and actually precise in our health.
So this is truly precision,

health and meeting people and the diversity people where we're at.

And if we can decode the genome,

we can actually meet individuals where they're at all these axes of their identities and experiences.

To provide really excellent care.

Thank you, well thank you both of you for really a fantastic presentation and one that I hope our listeners will become advocates in this space.

So I thank you for that.

Doctors open in Malvern.

Albert have agreed to stay on for
the next hour for our trainees, so I encourage the trainees to stay on. But I think if there are other people who would enjoy staying on we would welcome that. You will be promoted to host so that everyone can see each other. Doctor Barbara Burtness is here as our associate director of DI for the Cancer Center and will be leading the next session. So thank you everybody so much.
to the kinds of grand rounds

So it's particularly wonderful that you're willing to stay on and field questions and have some discussion.

With the fellows, so let's just give them a minute to join.

Do you know when I'm going to sign off, but that was just amazing and I it's so great to see you both and I hope we can continue some collaborations and so I know our fellows will get a lot out of this. 

So thank you for agreeing to both of these sessions. I appreciate it. Absolutely thank you. Again, thank you so welcome. Bye bye bye.

01:02:33.950 --> 01:02:35.099 Dr. within Melbourne.

01:02:37.830 --> 01:02:40.390 So yeah, I was.

01:02:40.390 --> 01:02:41.350 I was going to introduce you.

01:02:41.350 --> 01:02:42.160 Ben is one of the chief.

01:02:45.910 --> 01:02:47.830 And his has actually been amazing

01:02:47.830 --> 01:02:50.216 in the role we’ve introduced ADEI

01:02:50.216 --> 01:02:55.750 sort of under his leadership. Purple

01:02:55.870 --> 01:02:57.118 great, very exciting.

01:02:59.000 --> 01:03:00.000 I have to apologize.

01:03:00.000 --> 01:03:01.835 The timing did not workout so great

01:03:01.835 --> 01:03:03.509 or the scheduling did not workout

01:03:03.520 --> 01:03:06.580 so well because. Are actually

01:03:06.610 --> 01:03:08.120 in service. Exam is also
today, so portion of our fellows are unfortunately unavailable by I think we do have trainees from some of the other training programs as well. And in addition to hematology oncology. Both. So I wonder if we should go around and do introductions. Or if there’s another way we should start. It would also be great to the extent that some of you can come. Turn your videos on. Uhm? I was, you know, thinking that we would do this in a very informal way, if that’s OK with the two of you and.
You know, I, I know when you're putting together a talk, even as a single speaker, there's all kinds of stuff you have to leave out. And then when there are two of you, there may be things that you want to go into in more depth as well. I'm Barbara Burtness. I'm a medical oncologist. And I'm the interim associate director for DI and. Trying to build an educational environment that.
Fosters culture change here.

Ben, we already introduced, I guess, Nick.

I am a fifth year PhD candidate in the Townsend lab.

I was a trainee of the cancer biology training program.

Julia.

I am Julia. I'm a fourth year medical oncology fellow.

I am Julia. I'm a fourth year medical oncology fellow.

Doing breast cancer, clinical care and research and will be a breast medical oncologist.
I just wonder why external advisors?

But it’s great to have you here. Well,

I had this on my calendar

’cause I got the permission.

I'm not sure how, but I was thrilled.

This is a wonderful presentation.

My name is Shawn Chang.

I'm a cancer epidemiologist on

faculty at MD Anderson Cancer Center.

I also am a training program director for our

cancer prevention research training program,

and I'm also an multiple pie of a

new course for skills development.

We don’t have.

Not officially got an hour.
01:05:58.610 --> 01:05:59.975 No gay yet,
NOTE Confidence: 0.907547359
01:05:59.975 --> 01:06:03.390 but our project is to provide early
NOTE Confidence: 0.907547359
01:06:03.390 --> 01:06:06.790 career researchers with cancer education.
NOTE Confidence: 0.907547359
01:06:06.790 --> 01:06:08.065 Cancer Research orientation
NOTE Confidence: 0.907547359
01:06:08.065 --> 01:06:10.190 for those who are interested
NOTE Confidence: 0.907547359
01:06:10.190 --> 01:06:12.660 in SGM Cancer Research, so.
NOTE Confidence: 0.907547359
01:06:16.930 --> 01:06:17.770 Great, thank you.
NOTE Confidence: 0.946248529090909
01:06:18.210 --> 01:06:19.701 I'm just calling on people as you
NOTE Confidence: 0.946248529090909
NOTE Confidence: 0.815476095
01:06:28.360 --> 01:06:30.607 And Renee, I don't know if you
NOTE Confidence: 0.815476095
01:06:30.607 --> 01:06:33.906 want to come. Turn your video on.
NOTE Confidence: 0.815476095
01:06:33.906 --> 01:06:35.438 Renee is our communications
NOTE Confidence: 0.815476095
01:06:41.710 --> 01:06:43.525 Sure, hi everyone we met
NOTE Confidence: 0.79945593
01:06:43.525 --> 01:06:45.065 earlier before Grandma started.
NOTE Confidence: 0.79945593
01:06:45.065 --> 01:06:47.928 So thank you again for doing this.
01:06:47.930 --> 01:06:50.380 By helping support. Saidul
01:06:53.690 --> 01:06:55.160 hi, my name is stagel.
01:06:57.874 --> 01:07:00.295 I am one of the first year hematology oncology fellows here and I am interested in providing care for the young adult early onset cancer population.
01:07:08.900 --> 01:07:19.048 OK, some people maybe. 
01:07:19.050 --> 01:07:23.605 Oh Eileen says her desktop does not have a micro camera.
01:07:27.710 --> 01:07:30.392 OK, thank you for joining us and I'm Liz.
01:07:36.540 --> 01:07:38.268 Stop. Can't hear you this.
01:07:50.280 --> 01:07:55.020 One last person is David Schoenfeld.
01:07:53.070 --> 01:07:55.030 One of the fellows.
David, if you want to just briefly introduce yourself, sure.

Hi, my name is David. I’m one of the third year fellows on the research track, so I have a couple more years left.

I’m working with Harriet Cougar during kidney Cancer Research and interested in immunotherapy.

And I just want to thank you for the very wonderful and interesting talk today.

Thank you, so I’m sorry closing now.

Oh yeah, yeah we can.

Much like Shine, I got forwarded to me somehow.

I’m actually at the Ohio State
University I'm James Cancer Hospital.

I am an advanced practice nurse and nurse scientist doing research in this area and so when I saw that I do now and ask for presenting, so I'm just eavesdropping to hear what else is going on. So thanks so much. Great, OK, well maybe the first thing I'll do is just ask if people have questions that they want to throw out and and if not I have a few so.
into the chat or should we just kind of throw into the form of us?
I think people can just.
I mean, for those of you who have no Mike, Eileen, postdoctoral fellow in translational oncology in the room lab, part of the CBTP training program, her mic is off, so she will ask her to use the chat, but for those of you who who can, I think I’d like this to be conversational and and interactive. I think it’s OK with everybody.
Yeah.
Quick question, I guess I’ll give you 2 two lines of thinking and
NOTE Confidence: 0.889108900714286
01:09:42.278 --> 01:09:45.550 let y'all go down whatever Rd you feel
NOTE Confidence: 0.889108900714286
01:09:45.639 --> 01:09:48.270 like one is about like the there are.
NOTE Confidence: 0.90047126125
01:09:50.530 --> 01:09:51.856 Traditionally, different approaches
NOTE Confidence: 0.90047126125
01:09:51.856 --> 01:09:54.066 to care for different diseases,
NOTE Confidence: 0.90047126125
01:09:54.070 --> 01:09:56.620 often based on these sort of
NOTE Confidence: 0.90047126125
01:09:56.620 --> 01:09:57.895 section formed approaches.
NOTE Confidence: 0.90047126125
01:09:57.900 --> 01:10:01.085 And trans people, you know cancer
NOTE Confidence: 0.90047126125
01:10:01.085 --> 01:10:03.200 is a disease that that thrives on,
NOTE Confidence: 0.90047126125
01:10:03.200 --> 01:10:06.610 like just disruptions and signaling.
NOTE Confidence: 0.90047126125
01:10:06.610 --> 01:10:08.416 And it seems like there’s a lot
NOTE Confidence: 0.90047126125
01:10:08.416 --> 01:10:10.762 of for people who elect to have
NOTE Confidence: 0.90047126125
01:10:10.762 --> 01:10:13.020 like a medical and hormonal sort
NOTE Confidence: 0.90047126125
01:10:13.020 --> 01:10:15.510 of aspect to their transition.
NOTE Confidence: 0.954171211666667
01:10:17.950 --> 01:10:21.688 There might be some places where,
NOTE Confidence: 0.954171211666667
01:10:21.690 --> 01:10:23.318 without you know, necessarily
NOTE Confidence: 0.954171211666667
undergoing entire clinical trials,

you can adjust the the sort of
dosage and care of people based off
of what we know about signaling.

So I wanted to know if if there was any thoughts about.
That or the the other thing that comes to mind is the need for like because.
Medical record and even a medical ontology or like.
Require this labeling and hierarchical structure in order for them to just sort of technically function.

How is that like?
What?
What are some tips for addressing
trans folk who don’t necessarily like applying labels to themselves, especially in ways that don’t that aren’t founded in medical jargon, I should say. I mean, I can speak to the second question first. I think the first question it might be helpful, at least for me, to get a little more detail about the sort of scenarios you’re thinking about. But in terms of the second question, I mean what I can say kind of like broadly is that we know from our qualitative research that oftentimes
part of what is helpful and what trans people want is to share the decision making around what is in the electronic health record, and to know, you know, the the Pros and cons of various decisions. So there may be, you know, various implications to the gender marker in the chart or the other demographics that are there, including issues related to insurance coverage and billing issues in terms of being out and who’s accessing the medical record. So what a lot of people have said in our studies is, you know,
I really appreciated when my physician said I need a diagnosis to prescribe hormones, what would you like that diagnosis to be? Or brought up other issues like that. And then yeah, I think in terms of your first question about signaling, I think I would. I would appreciate any specific scenarios that you’re thinking of to try to answer your question better. Yeah, I mean there are. It’s it’s hard ’cause there. It’s like there’s a thousand different...
treatments for 1000 different things,

but even just thinking like there's speculative roles and pathways for things like.

Ben, Jeff isoforms and how they're different among physiological signaling.

And thinking about like the Jeff inhibitors as a key aspect for him for preventing.

Vascularisation and metastases and and cancer, like if there is some some sense in medically transitioning trans folk.

Have physiological states that are neither like are in between or somewhat liminal and signaling states.

If there are ways to adjust dosages to represent that sort of liminal state.
Well, I would say that’s really why we need more inclusion in research, because the challenge right now is that there are definitely trans folks in clinical cancer trials, but we can’t see who they are. We don’t know when they’re dosing on various hormones. We don’t know when they’re going on and off and kind of cumulative dose, and so we don’t know how that’s informing things. And so we need to, you know, at the very fundamental level and ask.
01:13:51.883 --> 01:13:54.480 relevant ways so that we can get
NOTE Confidence: 0.940027407692308
01:13:54.556 --> 01:13:56.866 much more specific and understand
NOTE Confidence: 0.940027407692308
NOTE Confidence: 0.940027407692308
01:13:58.450 --> 01:13:59.314 I mean we,
NOTE Confidence: 0.940027407692308
01:13:59.314 --> 01:14:02.126 we all know you know cisgender men have a
NOTE Confidence: 0.940027407692308
01:14:02.126 --> 01:14:04.667 broad range of you know testosterone levels.
NOTE Confidence: 0.940027407692308
01:14:04.670 --> 01:14:06.890 Cisgender women have a broad range
NOTE Confidence: 0.940027407692308
01:14:06.890 --> 01:14:08.958 of estrogen progestin levels, and we
NOTE Confidence: 0.940027407692308
01:14:08.958 --> 01:14:11.310 there’s a lot we don’t know about that.
NOTE Confidence: 0.940027407692308
01:14:11.310 --> 01:14:12.366 But if we’re really going to
NOTE Confidence: 0.940027407692308
01:14:12.366 --> 01:14:13.070 get into precision health,
NOTE Confidence: 0.940027407692308
01:14:13.070 --> 01:14:14.525 we really need to think
NOTE Confidence: 0.940027407692308
01:14:14.525 --> 01:14:15.689 for everybody like we,
NOTE Confidence: 0.940027407692308
01:14:15.690 --> 01:14:17.382 we gotta be doing this better, right?
NOTE Confidence: 0.940027407692308
01:14:17.382 --> 01:14:19.006 Like why is there a preponderance of
NOTE Confidence: 0.940027407692308
01:14:19.006 --> 01:14:20.539 certain cancers that are certain hormonal?
Dates or whatnot, and so actually this is the opportunity that I was trying to speak to. Is that trans people actually really? Present us this incredible opportunity to understand more about these various components specifically as it pertains to cancer care. I think you know where we are. Some hormones, estrogen, progesterone, testosterone, positive, right. But what does that mean for somebody who’s going on and off or was actively using blockers or other things? And how does that then?
What does that teach us about the mechanisms of how these neoplastic processes?

Advanced, but we just don’t have that.

We don’t have those models sorted out yet for anybody,

so if we could really deliver on this promise of more accurate inclusion of variables,

and I’m really rethinking and not just saying men and women,

right?

But really rethinking from an ontological perspective.

What is what are the questions that we’re asking?

So that we can get our arms around,
everyone will learn a lot more
for everybody’s cancer care,
I think.
Maybe just just building off that.
You’ve referred
to ASCO and NCCN and and FDA.
A lot of the most impactful
clinical trials and cancer recently
have been industry studies.
And you know, they obviously
right things that FDA will be.
Will accept.
But unless there’s a mandate
from FDA to change things,
my experience is that they are very
comfortable continuing to do things
exactly the way they did them in 1975, and.
I'm just wondering have there been formal conversations with?
Big Pharma and or have you been involved in writing studies
Where?
You've attempted to address.
Inclusion in eligibility criteria.
No, I mean I can say that you know about a year ago,
the FDA did convene like a sexual and gender minority like one day workshop
where we did start to talk about some of these issues and in fact are writing
01:16:44.909 --> 01:16:47.107 a manuscript to talk about how we
01:16:47.107 --> 01:16:48.846 would suggest changing clinical trial,
01:16:48.846 --> 01:16:50.438 inclusion and exclusion criteria,
01:16:50.440 --> 01:16:52.636 and a myriad of other factors
01:16:52.636 --> 01:16:53.734 to really better.
01:16:53.740 --> 01:16:56.456 Get data that can be extrapolated to
01:16:56.456 --> 01:16:59.496 all people, but I don’t know of folks.
01:16:59.500 --> 01:17:02.020 I don’t know of folks who are working
01:17:02.020 --> 01:17:04.066 with industry to figure out how to
01:17:04.066 --> 01:17:06.140 make that more widely disseminated,
01:17:06.140 --> 01:17:09.290 and I don’t really know.
01:17:09.290 --> 01:17:10.893 What all the steps would be in
01:17:10.893 --> 01:17:12.369 trying to create an FDA mandate?
01:17:12.370 --> 01:17:15.610 I know that the FDA has issued some
01:17:15.610 --> 01:17:17.282 guidance around exclusion criteria
01:17:17.282 --> 01:17:19.278
as it relates to HIV diagnosis, and I think like similar. Strategies could be employed to talk about some of these other issues, but I am not 100% sure what the way forward will look like, but I am very interested to figure that out and to work with all of you too. Build something better than what we currently have. And there are efforts from the FDA, so building on what Doctor Albert just mentioned, I think that you know it’s a slow process and there’s
a lot of areas of unknowns. But the FDA actually born out of the Office of Women’s Health has been looking at this and what I put in was a presentation. Actually that was done and hosted by the FDA from the Office of Women’s Health two years, three years ago now. In their slides where they say sex is not gender and they start to break that apart. So I think that there is increasing awareness and I think you know it’s kind of like a bidirectional challenge, right? Like we needed to come, you know,
01:18:22.900 --> 01:18:24.500 from the FDA we needed to come from
NOTE Confidence: 0.874594828571429
01:18:24.549 --> 01:18:26.014 researchers who were saying like
NOTE Confidence: 0.874594828571429
01:18:26.014 --> 01:18:27.479 this doesn’t work and challenging
NOTE Confidence: 0.874594828571429
01:18:27.533 --> 01:18:28.778 that and and there’s office.
NOTE Confidence: 0.874594828571429
01:18:28.780 --> 01:18:29.984 This handshake,
NOTE Confidence: 0.874594828571429
01:18:29.984 --> 01:18:33.596 especially in academic medical centers where
NOTE Confidence: 0.874594828571429
01:18:33.600 --> 01:18:37.440 industry initiated studies still work with,
NOTE Confidence: 0.874594828571429
01:18:37.440 --> 01:18:38.364 you know,
NOTE Confidence: 0.874594828571429
01:18:38.364 --> 01:18:39.750 academic colleagues to.
NOTE Confidence: 0.874594828571429
01:18:39.750 --> 01:18:41.598 To run them and and vice versa so
NOTE Confidence: 0.874594828571429
01:18:41.598 --> 01:18:43.337 you know if there’s challenges
NOTE Confidence: 0.874594828571429
01:18:43.337 --> 01:18:45.367 coming from all different directions,
NOTE Confidence: 0.874594828571429
01:18:45.370 --> 01:18:46.651 I think that’s how we can start
NOTE Confidence: 0.874594828571429
01:18:46.651 --> 01:18:47.200 to move forward.
NOTE Confidence: 0.867087066666667
01:18:50.380 --> 01:18:51.349 Great, thank you.
NOTE Confidence: 0.46296514
01:18:53.820 --> 01:18:54.368 I have a quick
01:18:54.380 --> 01:18:56.840 question specifically about the types of cancers that are hormonally driven in their pathophysiology, and also that depend on hormones for our treatment.

01:19:01.480 --> 01:19:03.570 So thinking about breast cancer, my field.

01:19:08.210 --> 01:19:12.949 Uhm? Would you have any suggestions in terms of how to deal with that potentially conflicting?

01:19:12.950 --> 01:19:16.998 For example, are treatments for breast cancer that might be directly conflicting with a medication that someone is taking for transition.

01:19:21.360 --> 01:19:25.100 Mechanisms of. For example, are treatments for breast cancer that might be directly conflicting with a medication that someone is taking for transition.

01:19:25.100 --> 01:19:26.775 are treatments for breast cancer that might be directly conflicting with a medication that someone is taking for transition.

01:19:26.775 --> 01:19:28.619 that might be directly conflicting with a medication that someone is taking for transition.

01:19:28.619 --> 01:19:30.564 How do you handle those situations?
So I mean, I think that you know all people have hormones in their body. You know exogenous or endogenous hormones, and there are various ways that we feel like we need to to change hormone levels in patients based on the type of cancer that they have. So I think just like all people with hormones talking about, you know the risks and benefits of continuing to have the same levels of hormones in your body. So I think in the case of like an estrogen receptor positive breast cancer for a trans woman on estrogen therapy, I think probably the conversation is...
very similar to a cisgender woman who needs to go in a room at ACE inhibitor. But I think that. What I think can be really important is just making sure that we’re understanding patients priorities understanding their concerns. Talking about the real data that we have, even data that we need to extrapolate and then like making a joint decision. I’ve definitely heard transgender people say, you know, I’d rather. This is like services, different scenario, but like I’d rather die having had the surgery that I wanted than than
not having had it so I think the best that we can do for our patients is talk about risks and benefits of any intervention in therapy and then like work with them to make the decision that feels best for them.

Thank you.

There’s just this added piece of like if it is, say. A breast cancer in a transgender man who’s already had top surgery, right? Like understanding that there’s like this whole other potential layer may or may not be relevant for anyone individual, but of like you know,
01:21:25.480 --> 01:21:28.320 or you trinkets or for a transgender man,

01:21:28.320 --> 01:21:30.084 you know that there may be

01:21:30.084 --> 01:21:31.899 this other layer of like God.

01:21:31.900 --> 01:21:35.148 This piece of my body and experience

01:21:35.148 --> 01:21:38.376 that may not be like in line

01:21:38.376 --> 01:21:40.499 with my identity is now this.

01:21:43.330 --> 01:21:45.258 You know is now gonna kill me or

01:21:45.258 --> 01:21:46.609 potentially you know these kinds


01:21:49.650 --> 01:21:51.690 And I that’s actually something I

01:21:51.690 --> 01:21:53.992 was very surprised about in in my

01:21:53.992 --> 01:21:55.457 work on pregnancy and fertility

01:21:55.460 --> 01:21:57.392 in transgender expensive people,

01:21:57.392 --> 01:21:58.817 I expected you know,
along before I did my first study on pregnancy experiences and trans masculine folks, that everybody would have a bad experience with being pregnant. And, you know, that was just my assumption going in. And then a lot of people, didn’t, you know, they’re like, yeah, I’m a pregnant guy. What’s the deal like I have this organ? It works, it’s. How I became a father, so you know. But then certainly people did have this for it and some people were like yeah,
I just you know stomached through this very, you know woman. Gendered experience of like dealing with this organ that everybody associates with motherhood and womanhood and whatever. So for some people you know I really am working with them and saying, like, yeah, A gendered experience that doesn’t work for you? How can I support you in that? For some people it’s like, well, cancer just sucks. But knowing that you know there’s
there's a potential there that it

has this additional element and

it's really just about meeting

that person who's in front of you?

Knowing that you know discrimination,

and pervasive gender norming is

at play in most scenarios and and

being willing to talk about that.

So like when I send somebody for a

transvaginal ultrasound, I say hey,

how do you feel about that like is is that?

You know, have you ever had one?

Are you concerned about it?

Some people like Nope, not a problem.

Some people like.
Yes, I don’t wanna be, you know, there’s no way and I do that with my cisgender patients too, So I just like that’s something that actually I’ve learned from a lot of trans people to really stop and slow down. Like what are we doing to your body? What are my assumptions here? How am I talking about these procedures? Is this gonna meet you? Is this gonna affirm you? How can I make it better? Ash and you know, I don’t know if you could.
See what was in the chat,

but Eileen had a question.

About bystander intervention and any advice
correct,

more senior colleagues and then actually.

Really resonated with me as well,
because we’ve had a lot of conversations
here about just people really
don’t know what to say and they.

Yeah, so maybe you could address Eileen’s
question as globally as possible.

Funny that that question just
showed up in the chat because
I was actually just thinking of
asking the trainees if they’d like to
share any experiences they’ve had,
like this one where they’re seeing maybe patients being treated in a stigmatising way, or they themselves have experienced stigma from patients or colleagues because I think that these conversations are so important to have, maybe not even as a question and answer. But how can we all talk collectively about? These experiences and and what we’re doing about them because I think that I know that this is something that I’ve struggled with throughout medical training, so I would love to hear any experiences you all want to share. Both about like situations that have
been difficult or how you manage them.

Maybe maybe I can start so actually one this is. This was one question, question of like my standard.

Scenario isn’t training and I I guess I don’t have one specific example specifically about sexual minorities that comes to mind, but what I can say is that in all of our previous discussions during this the DI series that Doctor Bernice had mentioned this is the number one question that always comes up and one of the most important topics of discussions is.
You know what, what?

What are actionable items and how can we go out on an individual level. Making changes in the environment.

So I don’t know that I have like a specific example, but it is something that hopefully we can discuss further. Hopefully we can discuss further.

Maybe other folks have some examples to provide as well.

I know it comes up all the time. I think we see it on a daily basis in terms of gender discrimination.

More broadly in terms of underrepresented minorities.
in both clinical and also professional academics and situations. Yeah, I was actually shined. Gonna just call you out because you put in this comment. You know that you’re sort of grateful that you don’t have to face this in the clinical space, but I wonder if. Speaking up as a bystander isn’t pretty similar in many different arenas. And you know, I think that there are components. There’s there’s sort of role playing. There’s practicing. There’s learning how to speak up. There’s being part of a community
where everybody speaks up,
so that gets modeled for you.
There’s affirming people who speak up,
and, you know,
giving them some credit for it.
But just from your training perspective.
You know, I’d love to hear
what you owe and Junos just
put in a thing about Stanford,
stand up or upstander training, but
that’s very cool.
I’ve just clicked on it and
will be sharing that with our
trainees to thank you for that.
So my training program we are starting
to work more on impostor phenomenon
ability mindset and perceived
discrimination and the intersection
of these experiences with our with
regard to training research trainees,
but the conversation here is about if
I understand more correctly that it’s
really more about like in a clinical
setting and you know how to sort of
manage that power dynamic if you’re.
Seeing something happen and how to intervene.
So this is sort of the, you know,
just as Juno sent us about upstander
or bystander intervention so.
I’m not very good at this.
I’m still learning how to you know
what many tools there might be,

but one of the things I always think about is asking questions. You know, oh, I didn’t understand that. Could you explain more about that? Things like that. One of the things I was about I was typing Barbara when you were calling me out, there it was. Something I used when I was a postdoc, which is to request in service. So I wonder if maybe you know junior colleagues trainees can ask for in service for everyone.
01:29:20.300 --> 01:29:21.780 How can we do better?
NOTE Confidence: 0.79668540952381
01:29:21.780 --> 01:29:25.656 How does this affect our patients?
NOTE Confidence: 0.79668540952381
01:29:25.660 --> 01:29:27.436 How can we support each other?
NOTE Confidence: 0.79668540952381
01:29:27.440 --> 01:29:30.113 And so once the request is made and once
NOTE Confidence: 0.79668540952381
01:29:30.113 --> 01:29:33.057 it is delivered then people have a more
NOTE Confidence: 0.79668540952381
01:29:33.057 --> 01:29:36.098 common basis for having these conversations?
NOTE Confidence: 0.79668540952381
01:29:36.100 --> 01:29:37.696 Because then you can remind each other.
NOTE Confidence: 0.79668540952381
01:29:37.700 --> 01:29:39.450 Oh, remember at that you
NOTE Confidence: 0.79668540952381
01:29:39.450 --> 01:29:40.800 know workshop that we have.
NOTE Confidence: 0.79668540952381
01:29:40.800 --> 01:29:42.144 We talked about this.
NOTE Confidence: 0.79668540952381
01:29:42.144 --> 01:29:44.658 Oh,
NOTE Confidence: 0.79668540952381
01:29:44.658 --> 01:29:46.58 let’s you know blah blah blah.
NOTE Confidence: 0.79668540952381
01:29:44.660 --> 01:29:48.690 So I have a lot to offer but I think that
NOTE Confidence: 0.79668540952381
01:29:48.690 --> 01:29:51.238 perhaps there might be others who have.
NOTE Confidence: 0.79668540952381
01:29:51.240 --> 01:29:51.760 You know,
NOTE Confidence: 0.79668540952381
01:29:51.760 --> 01:29:53.672 some training or better training
and we can request their help.

Out.

Juno, can you tell us about the Upstander life?

Yeah, so this is an initiative out of Stanford and really recognizing this, you know that this is, I think, just like you were mentioning.

This was like the most common thing that was coming up and so the response was to really like how do I help people?

And recognizing that like by standards called up standards or hopefully to champion people like actually
01:30:28.650 --> 01:30:32.220 acting and being engaged and being.
NOTE Confidence: 0.854528603846154
01:30:32.220 --> 01:30:34.630 Champions through being upstanders UM
NOTE Confidence: 0.854528603846154
01:30:34.630 --> 01:30:38.139 is moving away from just by standards,
NOTE Confidence: 0.854528603846154
01:30:38.140 --> 01:30:39.890 and that those are the often the
NOTE Confidence: 0.854528603846154
01:30:39.890 --> 01:30:41.433 largest percentage of people in the
NOTE Confidence: 0.854528603846154
01:30:41.433 --> 01:30:42.915 room or who are witnessing things,
NOTE Confidence: 0.854528603846154
01:30:42.920 --> 01:30:45.170 and that that’s actually those are
NOTE Confidence: 0.854528603846154
01:30:45.170 --> 01:30:47.994 the folks that need to be mobilized
NOTE Confidence: 0.854528603846154
01:30:47.994 --> 01:30:50.079 to really create culture change.
NOTE Confidence: 0.854528603846154
01:30:50.080 --> 01:30:54.937 But how do we do that?
NOTE Confidence: 0.854528603846154
01:30:54.940 --> 01:30:57.614 You know people ask him for tools
NOTE Confidence: 0.854528603846154
01:30:57.614 --> 01:30:59.870 and and department by department.
NOTE Confidence: 0.854528603846154
01:30:59.870 --> 01:31:02.458 These trainings are happening
NOTE Confidence: 0.854528603846154
01:31:02.458 --> 01:31:04.399 and it’s really.
NOTE Confidence: 0.854528603846154
01:31:04.400 --> 01:31:08.144 Did initiate in terms of sort of thinking
about discrimination and sexism in and thinking about equity for women, and then has broadened out to really recognize diversity across the gender spectrum and other axes of identity and difference. So actually across the traditional, like quote, UN quote, traditional, like sexism and racism were like. Kind of the two pillars that people were like. How do I say something now that I'm sort of? Sensitized and now people have understood that this that's actually broader than that,
so this is, you know, sort of 1 approach. I think the big thing is, you know recognition and talking about it. And I think also I really empathize with trainees. I think trainees are in a really Complicated situation and that there are really intense power dynamics in the hierarchies of medicine where we could say Oh no. No talk about it. But there are sometimes reprisals, there really is backlash.
And so we really understanding like what are safe spaces for people to do that, and also noting that up standards there’s a vulnerability there and people may be sensitized being up standards because it’s. Part of their own identity or experience and then that may put people in a very vulnerable position, and so some of the strategies around. You know, partnering with. Essentially, this is the place where allies. Come in, you know. So like if you are a white cisgender. You know able body person like
really taking that step as a.

You know when you see it,

it's like it's it's on me to act.

If I'm seeing racism happening,

If I'm seeing ableism happening.

If I'm seeing really disparaging remarks around transphobia.

Other things because I'm not as personally vulnerable and it's.

Effectively, therefore easier for me and takes that burden off my colleague who is.

In even more vulnerable situation, having been said,
01:33:20.876 --> 01:33:22.640 you know thinking about how that’s done,
01:33:22.640 --> 01:33:28.140 so it doesn’t. Take away or you know.
01:33:28.140 --> 01:33:33.460 Do it in such a way that that disempowers or.
01:33:33.460 --> 01:33:35.284 Takes voice away from individuals and
01:33:35.284 --> 01:33:37.426 or comes in as a savior, you know?
01:33:37.426 --> 01:33:38.266 So it’s. It’s not easy.
01:33:38.270 --> 01:33:39.014 If it was easy,
01:33:39.014 --> 01:33:40.130 it would have already been solved,
01:33:40.130 --> 01:33:43.106 but I think just this like active training,
01:33:43.110 --> 01:33:44.724 we get trained on so many things, right?
01:33:44.724 --> 01:33:46.488 Like so this is active training.
01:33:46.490 --> 01:33:48.135 We all need to do and challenge
01:33:51.210 --> 01:33:53.541 If I could just make a personal comment to
01:33:53.541 --> 01:33:55.898 the junior people and I I’m by no means,
01:33:55.900 --> 01:33:58.102 am I suggesting that you go
NOTE Confidence: 0.883767498333333
01:33:58.102 --> 01:34:00.744 out and you know become target.
NOTE Confidence: 0.883767498333333
01:34:00.744 --> 01:34:04.080 Practice for people in power but.
NOTE Confidence: 0.883767498333333
01:34:04.080 --> 01:34:06.120 If you don’t say anything,
NOTE Confidence: 0.883767498333333
01:34:06.120 --> 01:34:07.824 then 30 years later you’re working
NOTE Confidence: 0.883767498333333
01:34:07.824 --> 01:34:09.687 in the same crappy environment that
NOTE Confidence: 0.883767498333333
01:34:09.687 --> 01:34:11.697 you hated when you were training.
NOTE Confidence: 0.883767498333333
01:34:11.700 --> 01:34:14.190 Plus it’s on you that you
NOTE Confidence: 0.883767498333333
01:34:14.190 --> 01:34:16.356 never said anything you know,
NOTE Confidence: 0.883767498333333
01:34:16.356 --> 01:34:19.562 and I think I was a generation
NOTE Confidence: 0.883767498333333
01:34:19.562 --> 01:34:21.150 that felt like.
NOTE Confidence: 0.883767498333333
01:34:21.150 --> 01:34:23.134 Well and and I really I came right
NOTE Confidence: 0.883767498333333
01:34:23.134 --> 01:34:25.242 after the class action suit first class
NOTE Confidence: 0.883767498333333
01:34:25.242 --> 01:34:27.508 in my medical school that was 50% women.
NOTE Confidence: 0.883767498333333
01:34:27.508 --> 01:34:29.314 First class of interns at Yale that
NOTE Confidence: 0.883767498333333
01:34:29.314 --> 01:34:31.035 was 50% women like I was right
at that time and I think we had this naive idea that as long as we could show that we could do all the work the same as everybody else, it would work out. And you know, 30 years later, that’s clearly not what happened, right? And so you know, absolutely you have to, you know, be careful. But I also think there is a burden on you keeping quiet as well. Be pile onto that comment, Barbara. I think that often we think as individuals that we have very little
01:35:05.550 --> 01:35:07.950 power and and sometimes that’s true.
NOTE Confidence: 0.91241731
01:35:07.950 --> 01:35:09.530 But what I have learned,
NOTE Confidence: 0.91241731
01:35:09.530 --> 01:35:11.450 especially being an empty neologist,
NOTE Confidence: 0.91241731
01:35:11.450 --> 01:35:12.790 is that when we band
NOTE Confidence: 0.91241731
01:35:12.790 --> 01:35:14.130 together and we collect data,
NOTE Confidence: 0.91241731
01:35:14.130 --> 01:35:16.684 we have a huge amount of power.
NOTE Confidence: 0.91241731
01:35:16.684 --> 01:35:20.040 And I love that slide that Ash and
NOTE Confidence: 0.91241731
01:35:20.040 --> 01:35:22.595 Juno that you shared at the beginning
NOTE Confidence: 0.91241731
01:35:22.595 --> 01:35:25.210 about I wrote it down actually
NOTE Confidence: 0.91241731
01:35:25.210 --> 01:35:27.602 about how systemic oppression.
NOTE Confidence: 0.91241731
01:35:27.602 --> 01:35:30.592 Leads to disparities and invisibility
NOTE Confidence: 0.91241731
01:35:30.592 --> 01:35:33.072 leads to in accuracies and
NOTE Confidence: 0.91241731
01:35:33.072 --> 01:35:35.317 substandard like yes yes yes.
NOTE Confidence: 0.91241731
01:35:35.320 --> 01:35:38.274 And we can dispel that with data.
NOTE Confidence: 0.91241731
01:35:38.280 --> 01:35:40.308 So when junior people band together
NOTE Confidence: 0.91241731
01:35:40.308 --> 01:35:42.544 and they and they say, oh we,
we took a survey of all the residents and fellows and we found a very high level of dissatisfaction with. Turns out the people in leadership kind of quake in their boots. They really don’t like that kind of thing. Sometimes it’s about recognizing that you do have power, but you have to harness it. You have to collect the data and then you have to have a unified voice to make a request. That’s what I was saying about you know,
being able to.

You know, ask for things you ask for the in service.

You know I’m coming from a junior level.

It’s appropriate for you to ask

for for in service stuff that then

benefits everybody so you can have

your hidden agenda that will,

you know, help fix the world.

But you know,

be sure to tap into the power

that you actually have.

So I you know I,

I tried to tell this to students

as well because students often

feel like they have no power.
And I say actually you have so much power. Because the faculty hate when you are unhappy because it causes trouble for them. So same for you. Know people in training. It's really important. And yeah, there are dinosaurs at the top and in leadership, but they're also advocates and champions as well. So you just have to find them and get them to help work from all different directions. Just like Ashland, you know we're
saying it has to be everybody together, not just the leaders or the seniors or whatever. That's what I used to think when I was a junior person. I'll leave it to the adults, let them fix everything, and then when I'm a senior person I'll help. Well, no, no no. That's not how it works. That's not how we advance. Change, at least not my lifetime. So it has to come from everywhere. Which is, you know, the message that ash in June
we're sharing with us and and

Barbara to thank you,

yeah?

I would also say I think it it's

dangerous though to like only

recognizing that there is just

incredible vulnerabilities, you know.

So I get emails all the time from Elk

Med students, undergrads,

residents fellows saying you know,

can I be out like this is a

significant portion of my work?

don’t know. I was asked.

Totally illegal, egregious things on
the residency and fellowship trail.

Still, I get asked.

Terrible and egregious things as an assistant professor like you know.

So all that’s the say,

I totally so much agree and it has to be multidirectional, but I think it’s also really important that we protect our trainees and recognize that like. There are certain things that we could do today, you know, stroke of the pen. So how are you asking about gender unlike, you know, intake forms, interview forms. Are we asking people prone?
NOTE Confidence: 0.879297495238095
01:38:36.876 -- 01:38:39.372 is settled science like we should all
NOTE Confidence: 0.879297495238095
01:38:39.372 -- 01:38:41.708 be asking that actually like no more
NOTE Confidence: 0.879297495238095
01:38:41.708 -- 01:38:43.780 is needed from our trainees to say.
NOTE Confidence: 0.879297495238095
01:38:43.780 -- 01:38:45.985 And sadly I think that the challenges
NOTE Confidence: 0.879297495238095
01:38:45.985 -- 01:38:48.472 that I see trainees spending so much
NOTE Confidence: 0.879297495238095
01:38:48.472 -- 01:38:51.501 time and energy just trying to make these
NOTE Confidence: 0.879297495238095
01:38:51.501 -- 01:38:53.763 spaces safe for themselves and for.
NOTE Confidence: 0.879297495238095
01:38:53.770 -- 01:38:55.770 Patients and her colleagues that
NOTE Confidence: 0.879297495238095
01:38:55.770 -- 01:38:58.161 they actually are at a disadvantage.
NOTE Confidence: 0.879297495238095
01:38:58.161 -- 01:39:00.507 Actually in terms of grants in
NOTE Confidence: 0.879297495238095
01:39:00.507 -- 01:39:03.252 terms of papers in terms of just
NOTE Confidence: 0.879297495238095
01:39:03.252 -- 01:39:05.132 studying for whatever tests because
NOTE Confidence: 0.879297495238095
01:39:05.140 -- 01:39:07.040 they are working so hard.
NOTE Confidence: 0.879297495238095
01:39:07.040 -- 01:39:09.686 So I would never say don’t work on it.
NOTE Confidence: 0.879297495238095
01:39:09.690 -- 01:39:12.434 But also I’m like we don’t need anymore
NOTE Confidence: 0.879297495238095

171
Actually research on racial disparities to know that we need to change things. We also actually don’t need much more on gender differences to realize like we’ve just missed the boat. In terms of having a binary notion of gender, and we have a lot of solutions out there that we all just need to enact and. Yeah. And I didn’t mean to suggest totally. No, I just wanted like say that because I am there as a mentor like to people who are. You know, and and myself too. I mean, I was told many times not to do this as my career list.
Last night I'd be shunned in the world of medicine, and I couldn't not. But it's been hard, very hard, you know. Frankly, it would have been a lot easier to study like preterm labor or something, you know but well, but that's not what we do, right? We go for this stuff that's important to us, and in that passion we can do better. So thank you for doing that. Thank you for taking on that challenge. Now as a senior person, I will say that I have an obligation. I have a responsibility to help the field.
and so that means pulling people up.

OK, so when it comes time for promotion and need for support and things like that, I want people to come to me and say would you? Would you be able to write a good letter for me and I say yes absolutely, because we need better people. More better people. More thoughtful, different perspectives. All that kind of stuff to populate the field at all levels so you know the idea of, knowing who the Champions and advocates are is really critical because you know what the junior people,
what the trainees cannot, and maybe should not take on themselves that can be shared with other people who have positional power and tenure. You know to take the hit right totally. You know, so you got it. So you know when to lean in and when to hold back and let others lean in. So you know the mentorship is important. So oh, and Ashley, that’s a great time for me to do a shameless plug for our program.
I'm going to put it in the chat.

We have not updated it because we only got our score a couple weeks ago, so we haven't gotten the money yet.

We're in the process of about to get organized to get the courses moving, so just you know, keep an eye on, you know, put a tab on it and you know look for our promotional emails when it's time to sign up for the workshop. So and if anybody is, thank you.

If anybody is going to the LGBT health
workforce conference in New York.
At the end of April we’ll be there and we’ll be celebrating. So come by for a little champagne.
One of the things I wanted to do was ask both Ashland and Juno, just what was it that you had to not include in the talk, but that you wanted to, but there wasn’t enough time.
I think that such a rich topic I’m sure you both had. Other things that.
You had to to kind of make room. With.
Oh, ask. You go first, please.
I wanted to say one other quick thing about this bystander conversation.
we were having, which I don’t know

But in my experience, every situation in which I’m witnessing mistreatment of another person is very different, and in each of those situations my own personal safety. You know, either physical safety or safety in terms of my career is very different, and so the tactics that I use in these different situations vary.

Greatly like for example, I remember being at a tumor board where. There was, just like very clear, misogyny between attendings that were much more senior than I was,
and it was from people who were very aggressive in their approach and were in leadership. So I felt in the moment that the best I could do was just like, clear my throat, very loudly, over and over again, like just to kind of say, hey, something’s going on here. And then to talk about it with the other Chinese and then talk about it with my attendings, but I feel like. I try to be very forgiving of myself.
and to just do the best that I can in any given situation and to try to do whatever seems possible and safe.

And then I think that the other issue about training is that we’re so busy that there’s very little time to process these things that happen. But I think one thing that I find very helpful is having close colleagues that I can call up and just say like hey, this is what happened today and kind of like talk through, you know, a strategy, a different strategy that I could have used in the moment or a strategy that we could use together now in terms
01:44:39.966 --> 01:44:41.800 of like what are we going to do about this?
01:44:41.800 --> 01:44:44.218 Faculty member who continues to make
01:44:44.218 --> 01:44:46.523 fat phobic comments about his patient
01:44:46.523 --> 01:44:48.700 in clinic or or whatever it is?
01:44:48.700 --> 01:44:50.530 Uhm?
01:44:50.530 --> 01:44:52.990 And so I just I guess I want to also
01:44:53.067 --> 01:44:55.680 express like a lot of empathy and
01:44:55.680 --> 01:44:58.405 admiration for all of you for really
01:44:58.405 --> 01:45:01.373 trying to do this very difficult work.
01:45:01.380 --> 01:45:02.271 OK, so then,
01:45:02.271 --> 01:45:04.728 in terms of the top I I don’t want.
01:45:06.860 --> 01:45:07.688 I guess there’s two
01:45:07.700 --> 01:45:08.780 things that come to mind.
01:45:08.780 --> 01:45:10.364 One is that I work with a Community
01:45:10.364 --> 01:45:11.632 Advisory Board of transgender people

NOTE Confidence: 0.6126488
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who've been diagnosed with cancer,
and we've been working together probably for over three years.
Some of us and. Last night we were talking about actually Juno and I are working on a chapter for the ASCO book together. And so I brought it to them and we had a conversation about it and dumb. It was a very difficult conversation about how we're talking about data collection, in particular whether we're asking about sex assigned at birth or not. And inadvertently, I like I kind of like pushed, pushed through instead of like really
I think that one of the Community Advisory Board members felt very they kind of bulldozed over and not listened to. And so I guess I’m bringing this up because I think that our work with community members is so important and necessary for doing research and so so difficult in so many ways. Also so so difficult in so many ways. And I think, especially with the time constraints of like. Deadlines Grant deadlines, publication deadlines that it can be really hard to like. Slow down and try to be a good
listener and collaborator,

but I think that the work with that Community Advisory Board has been like probably some of the most influential of like my career as an oncologist,

I wish that I had had more time to talk about those relationships in that work.

Thanks. And then I mean,

I think I always like to give people sort of very practical things so you know,

usually it’s obviously like many talks, kind of in some ways condensed

But there’s for the folks who
are really research minded.

I really, you know.

And or doing research like to

think about things like you know,

example table,

ones of like if you’re studying

uterine cancer like these are

the various groups you should.

Think about it and I have to

like mock table ones and those

to be, you know,
cisgender women, transgender men,
NOTE Confidence: 0.83719397
nonbinary people,
NOTE Confidence: 0.83719397
and looking across those different
NOTE Confidence: 0.83719397
groups to really make visible
NOTE Confidence: 0.83719397
differences and experience,
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and then for the clinician colleagues,
NOTE Confidence: 0.83719397
really, you know,
NOTE Confidence: 0.83719397
how do you ask about pronouns?
NOTE Confidence: 0.83719397
I mean,
NOTE Confidence: 0.83719397
how do you document them in your chart?
NOTE Confidence: 0.83719397
How?
NOTE Confidence: 0.83719397
Are you asking about sexual activity
NOTE Confidence: 0.83719397
and or who’s who’s supporting you?
NOTE Confidence: 0.83719397
Or you know, going through cancer, right?
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Like these kinds of things so that
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it’s just very real and granular,
and so there’s that’s kind of the whole. Next, you know, there’s a lot of like these kinds of talks but but.

You know the hope is at least you know planting seeds like I didn’t we didn’t. None of us learned how to do a history on our patients. You know, in one talk or you know, learn about. Cisgender women all-in-one talk right so like same same type of thing so, but there’s obviously a lot more in terms of really taking care of transition gender, diverse people,
and actually all people in a in
NOTE Confidence: 0.83719397
a more accurate way.
NOTE Confidence: 0.856128265
Thank you. So I just
NOTE Confidence: 0.856128265
can’t help noticing that.
NOTE Confidence: 0.58328223
You know, I, I could see the four trainees,
NOTE Confidence: 0.74549484
bannik Julia and David and.
NOTE Confidence: 0.849111691666667
Are you guys OK ’cause you’re
NOTE Confidence: 0.784983131666667
not smiling and I just worry because this.
NOTE Confidence: 0.784983131666667
You know I am new to this area of work.
NOTE Confidence: 0.784983131666667
I’ve only been doing this work for maybe
NOTE Confidence: 0.784983131666667
about 5 something years and it’s tough.
NOTE Confidence: 0.784983131666667
And I just wanted to check in
NOTE Confidence: 0.952696822
with you or you OK.
NOTE Confidence: 0.59083183
You look pensive.
NOTE Confidence: 0.889411163333333
There’s a lot to think about, right?
NOTE Confidence: 0.889411163333333
Like part I guess.
Part of it is thinking about like the multitudes of scales right? Because a lot of this even assumes that trans folk are getting into the hospital doors at the first instance. And like what sort of skews and even from a research sort of stats perspective, like had you account for it can be like a smaller subset, it be like a a smaller subset, it can be like a smaller subset, it can be like a a smaller subset. When they’re just kind of diserved, very broadly. And how?
When you have like that intersections of identity that even further fragment your ability to resolve. Thanks for a very data driven standpoint, which I think. You know institutions of power rely on as like admissions of evidence, whereas like things like ethnographies are a little less admitted as evidence in these spaces. Yeah. Very very tough. As a cancer epidemiologist, I think about the numbers all the time. I think about the data all the time. Some of the work that I’m doing is about, How do we get more?
You know, sexual orientation, gender identity, data into our electronic health records?

How do I get I? I’m at MD Anderson. How do I make it happen here?

And fortunately, you know when I have messaged upstairs to leadership they have been positive and responsive but it’s still slow. Slower than is desirable, so fortunately you know the time is now and we are moving towards gathering people and beginning to think about how we’re going to exert some
pressure to really move things forward.

And you know, Barbara and I.

We were just on a meeting last week together.

'cause I sit on the external

Advisory Board for the Yale Cancer

Center and these issues come up.

It's actually in the announcement for

Cancer Center support grants now,

and you know, we have to.

We have to address these issues and we

are we have been slow but it has to happen.

And you're right,

the multitude of.

Issues and complexities.

And you know,

just doing it is not just doing,
it’s doing it. Doing it appropriately and with consideration and respect and inclusion. And you know multiple perspectives and involvement, so it’s hard. But I think you know the time is really good because there are a lot of really good people who are in it now and want to make it work well. And the other thing I would say is that the Generation that is, so much more committed to like a good world, right? I mean you see it in you see it in climate.
You see it in their response to Black Lives Matter. But also I think. When it comes to gender and sexual minorities, much more accepting of each other, much more accepting of themselves than certainly, you know, my generation was. So I I actually. Although it is painful work and these conversations. Uhm? You know, you remember a lot of things that weren’t great. I’m actually more full of hope than I have ever been because I see a new generation coming that’s. Not accepting, you know,
not putting up with as much, I would say. I think Ben was gonna say something if I missed. Touch. Well, actually, maybe I’ll just doctor Albert if you don’t mind me, doctor Alper and doctor within Melbourne. Doctor Alper and doctor within Melbourne. If you could expand upon a little bit more about. What’s known about sexual and gender minority providers?
The experiences of the providers and what?

What are other interventions that we can do to make sure that we create an open kind of workplace environments, because I think a lot of the things that we've been talking about so far has been very patient centric and also how?

In open kind of workplace environments, because I think a lot of the things that we’ve been talking about so far has been very patient centric and also how?

How we can go about delivering better care? But how about I?

I think that among colleagues in the interactions that we have.

Is kind of like a unique experience as well, slightly different.

The Ben and I were talking a little bit in the chat about a paper that a friend of mine published basically doing it.
He did a survey of trans and gender.

Diverse clinicians and just found that people face significant barriers during training, including having to hide their identities and witnessing statement discrimination. And I was also saying that you know, I think that I’ve been talking with various colleagues about building better networks of SGM clinicians across the US that we can better support each other. Probably not as much as Doctor Obannon Malaver, but I have talked to many people who are facing like a lot of really
challenging decisions about whether to be out in their personal statements or on the interview trail and how to manage those things so I don’t have like more data to quote you, but I do think But trying to figure out how to better support each other with these things would be really helpful. Yeah, I, I think you know it’s it’s easy to say like do it be out in whatever and that’s actually not the real sadly people are facing it’s it’s a hard situation. People do face discrimination, people are fired, people are,
you know, lots of.

The term microaggressions get used.

I think there’s nothing micro about my God.

Persistent microaggressions, right?

But you know, even minor things like you

know department picnics where like you know,

do you know if someone has kid

like do they bring their partner?

Do they not?

Do they bring their you know

kids or you know queer or trans?

Or you know like all of these things and

yet face face that parental leave you

know all of all these things that are not,

you know, assumptions.
I get asked about my husband all the time. You know, like those kinds of things, even in San Francisco, even you know. So all that’s to say, I think there’s a lot of work to do, and then we all of us need to be, you know, thinking about our language and our policies. We also the usual things when we’re thinking about diversity of colleagues, right? So, recruitment, retention, satisfaction, quality of life, equity in terms of pay retention packages, startup packages? Space you know does the does the the...
corner office with no window and
whatever like versus you know the and?
And if that if we’re thinking about
colleagues you know, I will say that.
You know,
we know that there’s a minority tax in,
e specially in academic institutions,
that faculty and providers of color,
women, LGBTQ, plus folks,
transgender diverse folks spent
a lot of time.
Everybody wants folks on their committees.
you know.
everybody wants folks to mentor folks,
you know.
So and then, that limits productivity.

It limits, certainly quality of life.

Sleep.

All these other, you know, Wellness things.

So we had to really be thinking.

I think carefully about this and and thinking about things like you know how much support people are getting.

So you know an academic Medical Center, for example, with it’s, you know, pillars of education, training, research, and there’s the service component.

I think all of those should be visible in terms of percent time allocations.
And part of promotions and whatnot, and should be effectively monetized and considered as part of people’s time and percent packages, right? So the fact that I’m on every search committee for new faculty because people want an LGBT perspective, which is beautiful. But it’s also. Therefore I don’t get to write the papers and grants as much as my White cisgender male colleagues who are not being asked to be on every single ’cause. There’s so many more of them and you know, so these are the kinds
of things that we really need to be asking ourselves, those institutions and how our systems are inculcating difference and disparities within them.

This has just been a fabulous session on top of your wonderful talk and I think really a very meaningful thing for us here at Yale, where I think we don’t talk enough about these topics and I hope we have a chance to engage again in the future and wish you both well with your really important work and thank you again for making time for us.
Yes, thank you so much and. And just to say, please any of you, individually you know, feel free to reach out. Our emails are on our slides. We’ll make sure that. That Renee has our slides and they are accessible to you. Please feel free to tweet just speaking to Doctor Lu’s comment a question about tweeting. Thank you very much, of course, and happy of course to come back or talk further in other settings.
I will just say we are setting up a mentorship network for SGM researchers ASH. I don’t even think you know about that. Yeah, it’s gonna be so. We’re working on that through PRIDE study and Pride net. We’re also gonna be setting up a researcher boot camp for folks who are interested in SGM research to really train on. Sort of these things, like how do you handle multiple gender identities in your metrics in these kinds of things for community based researchers as well as academic researchers as
well as internship programs and postdoctoral programs so we have summer undergraduate internship programs. We have postdocs. We now are gonna have three with the bright city, so there’s some various developments to actually train. Built the next generation of STM researchers so please stay in touch. So much care. Bye bye.