

Prioritizing Equity video series: LGBTQ Voices

This June 18, 2020, installment of our YouTube health equity series focused on how COVID-19 may uniquely impact LGBTQ individuals and communities. Hear from LGBTQ physician leaders on topics such as the pandemic's impact on testing, trends and equity concerns in health care and beyond.

Moderator

- **Aletha Maybank, MD, MPH**—Chief health equity officer, group vice president, Center for Health Equity, American Medical Association

Panel

- **Oni Blackstock, MD**—Assistant commissioner for the New York City Department of Health and Mental Hygiene, Bureau of HIV
- **Jesse Ehrenfeld, MD, MPH, FASA, FAMIA**—Senior associate dean and director, Advancing a Healthier Wisconsin Endowment
- **David J. Malebranche, MD, MPH**—Associate professor of medicine, director, Student Employee Health Services at Morehouse School of Medicine
- **Shilpen Patel, MD, FACRO, FASTRO**—Radiation oncologist, associate professor in the UW Department of Global Health and affiliate appointment in the Division of Public Health at the Fred Hutchinson Cancer Research Center.
- **Asa Radix, MD, PhD, MPH, FACP**—Senior director of research and education at Callen-Lorde Community Health Center.

Transcript

June 18, 2020

Dr. Maybank: Good afternoon, everyone. Welcome back to our series, Prioritizing Equity, launched by the American Medical Association's Center for Health Equity. My name is Dr. Aletha Maybank, and I

am the chief health equity officer at the American Medical Association.

Our role as the Center for Health Equity is really to facilitate a process for centering and embedding equity across all of our work throughout the enterprise, and amplify that work, as well. So, it's an honor again, as always, to be here with you. I thank all of those who are joining and all of those who are going to watch this in the future.

I just want to remind folks, we have, and to visit, our Health Equity Resource Center for COVID that is on our AMA website. We had a great conversation last week about what health professionals can do in terms of centering anti-racism work within their health care settings, and next week, we're also going to talk to a group of physicians who are really working to move upstream, addressing the political and structural determinants of health in their work, and going to help us provide some opportunity.

But today, we have an awesome panel to really elevate and speak with physicians who are at the intersection of LGBTQ and transgender/non-conforming experiences for themselves and also of their patients. And really, to highlight what has been going on especially at this particular time. Last Friday, excuse me, the Trump administration reversed an Obama-era policy that banned health care providers from discriminating against populations, including LGBTQ, women who are seeking abortion and those who need language services.

This week, the Supreme Court provided big news in the advancement of human rights. On Monday, it was a really big day. The Supreme Court upheld civil rights for LGBTQ and transgender workers, and today, it was announced and upheld that the 650,000 immigrant young people who are identified as DACA, the Deferred Action for Childhood Arrivals, also known as the DREAMers, will continue to be able to live and to learn and to work in this country.

And so, with this push towards justice, there's this backdrop, though, of COVID-19 and police brutality. And as Audre Lorde says, "There is no thing as a single-issue struggle because we do not live single-issue lives." And there are continued needs for solidarity, as Audre Lorde also expressed, "I am not free while any woman is un-free, even when her shackles are different than my own."

And so, today, we have a panel of experts, folks who I've known for a while and very much admire, to speak with you all. We have first Dr. Oni Blackstock, if you could just raise your hand very quickly, who's assistant commissioner for the New York City Department of Health and Mental Hygiene over the Bureau of HIV.

We have Dr. Jesse Ehrenfeld, who is senior associate dean and director for Advancing a Healthier Wisconsin Endowment. He was also the former chair of AMA board, and one of the reasons why I'm able to be here to speak with you today. So, very thankful for Jesse and his work and leadership.

Dr. David Malebranche, who is associate professor of Medicine, director of Student Employee Health Services at Morehouse School of Medicine. Dr. Shilpen Patel, who is immediate past chair of the AMA LGBTQ Advisory Committee as well as at the Division of Public Health at the Fred Hutchinson Cancer Center. And then, Asa Radix, Dr. Asa Radix, who is senior director of Research and Education at Callen-Lorde Community Health Center, which I'm very familiar with from being here in Brooklyn.

So, thank you all for joining us today. I'm going to open up as I always open up, and it really is about telling about yourselves. Where you are, literally in this world, where you are, and how are you doing? I will start with, let's go with Dr. Blackstock.

Dr. Blackstock: Hello. Okay, great. Can you hear me okay?

Dr. Maybank: Yes.

Dr. Blackstock: Okay, great. I just want to say, my pronouns are she/her/hers. I'm in New York City in Harlem, New York, and I sort of split my time working at the health department and also seeing patients at Harlem Hospital. For the duration of the pandemic, thus far, I've been basically working from home, which poses challenges. I think we're all aware of this. But also being able to do televisits with many of my patients, and there's a certain—even though we're not face-to-face, there is a certain level of intimacy, talking to your patients while you're sitting on your couch. I don't know. It's something about it that sort of makes you feel, in some ways, closer. So, my patients, most of them have my cell phone numbers and call me, and I guess what I'm seeing is that, you know,

I take care of mainly Black and Latino young men. Many are men who have sex with men, many of them have lost their jobs or are frontline workers so at increased risk for exposure to COVID-19. And so, it's been probably even more challenging. I think we talk probably a lot more than usual, because I'm trying to be as supportive as I can in addition to really engaging in this care remotely, which has its challenges.

Dr. Maybank: Absolutely. Thank you. Dr. Ehrenfeld?

Dr. Ehrenfeld: Well, thank you so much. I am in beautiful Milwaukee, Wisconsin, where I practice at the Medical College of Wisconsin. This is a strange time—oh, by the way, I use he/him/his pronouns—given the stress and the isolation that we're all feeling. And so, the question "How are you doing?" is a complex one.

It's exhausting. Sort of I think what we're all collectively up against, the stress and the isolation. I learned earlier today that someone who I'm very good friends with, his brother took his life this past week. And yet, I remain optimistic. I have tremendous hope in the resilience of our nation, and of the LGBTQ community that's been through so much over so many decades, and the Supreme Court ruling that you referenced is obviously a bright spot, I think, in a lot of our weeks. And so, that's kind of

where I am. It's a mixed bag.

Dr. Maybank: Yeah. Thank you. Dr. Radix?

Dr. Radix: Hi. Well, first of all, my pronouns are he or they, and I also want to say, I'm so grateful to be part of this panel, and really in awe of everyone else who's here with me.

Actually, right now I'm sitting home in Brooklyn, trying to get some work done, and as you probably know, New York City was one of the hardest hit very early on. 200,000 people with COVID, and just shy of 20,000 people who died. So, I think, like many of us, I'm exhausted; I've not been sleeping well. I think, as most of us, have been holding a lot, and I think part of that is just seeing our communities completely devastated by this pandemic.

And really seeing, I can say, the glaring result of centuries of structural racism that systematically impacts Black and Brown communities, communities that I'm part of. So, it is a tough place to me. I know there's light at the end of the tunnel, but the isolation is, as you said, I think all of this is getting to be a little much.

Dr. Maybank: Absolutely. Thank you. Dr. Patel?

Dr. Patel: My pronouns are he/him and his. Physically, I'm actually now in San Francisco, staying here, and I split my time between seeing patients in the East and South Bay, and then doing breast cancer research between the two.

I feel very honored to be on this panel with, really, just some amazing people who I consider both peers and some of my heroes, as well. So, really exciting to kind of discuss this. I think for me, where I am in terms of all of this COVID, it's definitely been this fine line in terms of taking care of our patients, taking care of our co-workers, and at the same time, how do you also take care of yourself, you know?

Because it's really hard to deliver good quality care or do good quality research when you can't take care of yourself. And so, I think for me, it goes a little bit back and forth between those two, to kind of take care of yourself, take care of your family, and then at the same time, obviously, be there to take care of our community.

So, it's a very—it's definitely been a challenge, and it's one that I feel like I have to navigate every day and kind of ask that question, too.

Dr. Maybank: Thank you. Dr. Malebranche?

Dr. Malebranche: Yeah, hey, and my pronouns are he/him/his, and also, just very thankful, Aletha and to the AMA, for having me on this panel. There are some heavy hitters on this panel, so I'm honored to be among the group here.

I'm in a kind of strange, precarious position in that I've been away from my job at Morehouse School of Medicine since about October when my father fell sick. Used up all my vacation time, my FMLA, my sick time and then my father passed in early January. And so, I'm currently on unpaid leave physically in upstate New York, helping my mother.

So, Shilpen's comments about, you know, how do you take care of yourself and then also taking care of your family and your loved ones, and those of us that have children or elders or other family members that depend on us physically, emotionally, financially, a combination of all those things, can be a little bit daunting especially in the context of a pandemic that is decimating Black and Brown communities, and the acute and chronic exacerbation of the racism pandemic that has been centuries old.

So, it is one of those things where it's kind of like oscillating up and down, but I think one of the bright spots that I've learned is discovering and rediscovering new talents, or old talents, that I probably pushed to the side. So, getting back to a lot of my writing, doing telehealth more frequently; I can't tell you how many Zoom calls and webinars and things like that, I know all of you can agree with this, that I've been invited to over the past three months.

And just all the skills that we have as clinicians, as educators, as activists is phenomenal. And I think sometimes we forget that being a part of this medical community means being an activist, as well. And so, I'm just excited to be on this panel and part of this series doing this, because I think part of being a good clinician and being in the medical community is about the activism. So, thank you.

Dr. Maybank: Absolutely. Thanks to you all for your introductions. And kind of to build on what you were just talking about, and Dr. Blackstock mentioned, in terms of seeing patients in telehealth, and it doesn't have to be about telehealth specifically, but what is the experience right now? What are you hearing from your patients that do identify as LGBTQ or transgender/non-conforming?

There's such an invisibility to the experience overall in the media, and it's not shared and it's not expressed much or well, and I think it would be really useful and helpful for the audience to hear, what are you hearing that's just different, it's nuanced, that folks just don't hear about? And then, the things that are the same that everybody is experiencing, as well. And any of you can kind of take it on and jump in.

Dr. Patel: I think from what I'm hearing, and I hear it more from the community, is we know that the LGBTQ population faces considerable disparities when it regards to health, risk behaviors, access to competent health care. We know that the rates of smoking, heavy alcohol consumption, drug abuse, poor mental health are significantly higher in our community than in the general population.

And I think what I've seen from friends, as well as even in my patient population, is this is just exacerbating it, right, in this kind of shelter-in-place. San Francisco, we are still essentially sheltering

in place, and people are not really going out much, and I think, so, I have heard from friends, they're having a hard time finding culturally competent care, and in addition to that, I think it's like there's still a lot of fear that's associated with it.

So, it's been interesting to kind of track that, I guess, from my own both personal as well as professional.

Dr. Ehrenfeld: Yeah, we have a lot of folks that drive to see us, and that's obviously been hard when folks are traveling distances to get specialized care. The only thing I'll just say is, you know, I've never come out on a Zoom meeting before. It's awkward, it's hard and having authentic conversations with patients through these platforms is just, it's possible, but I think it adds another level of complexity that makes it challenging for folks to get the care that they frankly need.

Dr. Radix: I think there's also the reality that not everyone can access telehealth services. I mean, we're seeing LGBTQ health center that mainly serves people who just don't have the ability to have a cell phone, smartphone that they can do this, or have access to the internet, wifi, computer.

The people who can access it, that's great, but we need to be thinking about, you know, could be anywhere, 30, 40, maybe even 50% of the folks we serve who are just not able to get in contact with us.

Dr. Blackstock: I think, as I was mentioning before, just talking with my patients on the phone, sort of two major buckets are those that are still having to work, and obviously concerned about their exposure, and others who have lost their jobs and are concerned about housing, and where they're going to find their next meal. And just thinking about how there's the pandemic and then, obviously, being Black and Latinx, and then being queer and trans and all of that, sort of compounds the situation.

So, I think what was probably already a precarious situation for many has just been made even more so. I think this is also just to say, just to talk about data collection, we're really limited in terms of the data that we have and are aware of in terms of how LGBTQ/TGNC people are being impacted. There's a push here in New York State by one of the state senators who is out, and really pushing the state Department of Health to begin collecting this data around COVID-19, but we're already three months into the pandemic.

The contact tracing initiative that's started here in New York City, they will hopefully be collecting sexual orientation and gender identity data, but in terms of being able to really characterize, it's almost like, the invisibility that you were talking about is even like hyper-invisibility, because we don't have the numbers that so many people in this culture really need in order to understand some of the gravity of the situation. But I think we also have the qualitative experiences of our loved ones, of ourselves and of our patients, as well.

Dr. Malebranche: I think the thing that I've seen a lot with patients, that I've seen also just being in the community, is kind of looking at this sense of intimacy that has been lost in this COVID-19 pandemic, and particularly around the stay-at-home orders and being disconnected. And if you're looking at the spectrum of where we live along sexual orientation and gender identity lines, especially for a lot of our trans brothers and sisters and gender non-conforming folk that are already feeling a certain level of being ostracized or isolated not only from heterosexual spaces but also from LGBTQ, supposedly, spaces as well.

And it's just been hard for everybody. And so, I think when we're talking about mental health and accessing care, that's been a challenging thing, as well, and to Asa's point, if people can't get on telehealth, how are they coping with the mental health strategies? How are they dealing with the finances?

There was a wonderful trans sister, I was on a Zoom call yesterday, Toni Michelle Williams, who's an advocate in Atlanta, trans sister in Atlanta, and she was just talking about some of her sex worker friends in the community who are really having trouble financially and having trouble with being homeless and dealing with a lot of these issues right now that are even compounding what was happening before COVID-19.

So, I think for ourselves as providers, we have to be cognizant of all those things, that it's not just a simple matter of people getting tested or not being able to get tested, or being sick or not being sick, we're seeing this kind of decimate the foundations that didn't really have a foundation for a lot of our communities to begin with. So, we have a lot of work to do both on a medical level as well as every other level in society.

Dr. Ehrenfeld: I'm so glad you said that, because social engagement is a buffer against the stress that so many folks feel and deal with throughout their daily lives, and that's been just taken away in so many places. I think it's been really compounding the challenges, the anxiety that folks are experiencing.

Dr. Blackstock: Yeah, and I just wanted to also add. So, I take care of many people who are living with HIV, and I think particularly for people who have survived the early days of the AIDS pandemic, people are experiencing a lot of anxiety. I think people are seeing parallels with sort of government inaction, or delayed responses on part of the federal government, the inequities that we're seeing in certain communities being impacted.

And also social isolation. I think particularly for some of my patients who are older, that social isolation already, I think speaking to the issues around intimacy, you know, it's already an issue for many people who are older, particularly those who are living with HIV, many of whom have lost chosen family and friends. And so, this is further compounding a lot of that, as well.

Dr. Maybank: Absolutely. And then, compounding the experience of COVID is also, recent, I guess, media tension around police brutality. This has existed for generations, right? This is not new, and I think it really highlights, and especially for those who are Black and transgender, the critical need to understand what is meant by intersectionality, and how that plays out.

Kimberlé Crenshaw, who really coined the term of intersectionality and explaining it as a lens through which we see where power comes and collides, where it interlocks and intersects, and it's not simply that there's just a race problem, or there's a gender problem, or that it's simply just a class or a LGBTQ problem. If we look at it that way, we are totally missing, really, the experience.

And I had this opportunity to meet her a couple years back, and just asked her about kind of the overuse of "intersectionality", and she's like, "The way to think about it is just a more critical and in-depth way to explain racism, and to understand it, and to understand especially the experience and oppression of Black women, which is inclusive of trans Black women."

And so, I think definitely missing from the national dialogue is that, but I would like to hear you all kind of speak more also about the intersection of COVID-19 and the experience of police brutality, and what that impact has on health, and really what we need to do about it at this point in time.

Dr. Malebranche: I could start. I just think it's trauma on top of trauma.

When you're looking at COVID-19 and what's been happening, and I remember at the beginning, there were a lot, in some Black communities, that were saying, "Well, Black people aren't getting it," and there was this myth that somehow we weren't going to get it. And I was like, "Okay, that's wrong. They're not collecting the data yet. Once we get the data, we're going to find out." And then once the data started to show itself, then we realized, and then we have to deal with this bevy of media hype around, "Well, why are these disparities happen? They must not be wearing their mask," and you have the Surgeon General getting out there and saying, "It's all about personal responsibility, and you all need to do better, and you all need to do it for Big Mama and all those other people."

And it was just kind of an interesting thing. So, we're dealing with that trauma, and then we're seeing people in our individual lives—I had a friend who was only 40 years old, lived outside of DC, and he died of COVID-19. I've had other friends who have called me and been on the phone with me, talking about their symptoms, and me navigating them through the hospital systems to figure out what's going on.

And so, you're seeing this, COVID-19, you're seeing how it's decimating Black and Brown communities, you're dealing with it in your own personal life, you're worried about it for yourself and your families, and then comes along all the racist stuff that has always been there, but now there's just more video cameras, and it's like trauma after trauma after trauma. And then, people always want to come to you to get your advice, to get your thoughts on it, and you have to rehash it. It's like ripping off

a scab time and time again.

And so, when you look at these intersecting things, and these intersecting levels of oppression, I think you coined it correctly. I think a lot of things that people get wrong about Kimberlé Crenshaw and the whole concept of intersectionality, it's not that we all have different social identities; we do. She was talking about specific intersection of identities that oppress Black women, and that concept can be used as oppression of other groups, as well.

But I think we have to focus on that part. It's not just, "Hey, I'm Black, and I'm queer, and I'm this, and I'm that at the same time." It's almost that these identities allow yourself to be oppressed by society, or object you to discrimination and oppression by society. And I think it's been really hard. I can speak for myself personally, and a lot of other friends, that it's really challenging to have to do these things on top of navigating your work life, your personal life, your family, your romantic life, your need for intimacy yourself as physicians and as clinicians, which we sometimes put to the side.

And so, it can be really challenging, and I think the intersection of all these things has really done a number, and it'll be interesting to see how we all are able to move forward. There's not going to be a cookie-cutter approach to what works, but I think we're all going to have to struggle to find our way.

Dr. Maybank: Anybody else want to comment?

Dr. Blackstock: I think you had mentioned also, specifically thinking about Black trans women in particular, and I was just thinking about this past weekend here in New York City, how 15,000 people got together to say Black Trans Lives Matter, and I think it was a really robust sort of visual rebuttal of Friday's decision, which is wonderful.

But I think about this quote that I saw, Raquel Willis post on Twitter, which it was that, like, we have a duty to elevate Black trans power, and I think part of that is amplifying the voices of Black trans women. So, a panel like this, hearing the voices of Black trans women, I don't feel like I'm, as a Black cis woman, able to speak on behalf of my trans sisters, but I think it's also about, you know, some increasing that awareness, but also codifying the non-discrimination, obviously, into law. Which I think the Supreme Court decision on Monday helped to do.

But Raquel Willis also said White trans people are focused on legislation, and Black trans women, "We're focused on our lives." So, then thinking about a culture change that we need in terms of really working on dismantling patriarchy, and obviously homophobia, transphobia, which are all linked, obviously, to White supremacy culture.

So, having those conversations, and also just something that we do at the New York City health department is supporting trans-led grassroots organizations to build their organizational capacity and expand services. And what this also does is it provides employment opportunities for trans people.

And as also provide psychosocial support funding to a number of agencies in the city who are specifically focused on trans women, but we really need, really, equitable access to the critical services with a focus on Black trans women and really elevating and supporting Black trans women, as well.

Dr. Maybank: Then from the provider perspective, in mentioning last week in Trump's reversal of the policy, what do we think are going to be the short-term, and some of them are already mentioned, but the long-term impacts of a change such as what he announced in the policy in guidance? And especially at the health care, institutional level. Dr. Radix, can you speak to that, since you're at Callen-Lorde and you all do lots of work and lots of advocacy, and really just fantastic work over the years?

Dr. Radix: Right. Sorry, I actually completely lost the—you froze for a moment when you started.

Dr. Maybank: The question?

Dr. Radix: Yes.

Dr. Maybank: Okay. No problem. Kind of continuing on what Dr. Blackstock was saying, and last week, Trump's announcement about reversing the Obama-era policy about health care for those who identify as LGBTQ, wanted to get a sense of what we all thought were the kind of short-term and long-term impacts of that kind of reversal, and especially at the health care, institutional level.

Dr. Radix: Right. Thank you. It was strange, because I think we all felt like we had a little bit of whiplash, because that announcement came out and then, you know, basically in 24 hours, we had the Supreme Court's decision.

I mean, I certainly, and where I work, we were incredibly concerned about what it meant specifically for trans and gender-diverse people. Just the fact that access to health care, which is already problematic, but thinking that people might even have those few avenues closed to them, people who have been waiting years, perhaps, for gender-affirming surgery, and to see maybe those doors close. The fact that people could be discriminated against even more so when trying to access care, and the fact that they wouldn't have any protections around being roomed in incorrect spaces when they're in hospitals.

But I should just say, we're already in a situation where trans and gender-diverse people have often, in many places, limited opportunities to access care, and face incredible amounts of discrimination. I mean, this has been going on for a very long time. And we're always trying to fight that. We've heard the stories: physical abuse, verbal harassment in health settings.

So, the fact that this would now be almost condoned, in a way, was incredibly problematic. For the people I work with who are LGBTQ, who are specifically trans and gender-diverse, that was a day that most people couldn't get out of bed. Right? Because it has impacted us so personally.

I know that there's a lot that other people want to say about that, but I think mainly around access issues.

Dr. Ehrenfeld: You know, when I think about what the administration did in making that unfortunate reversal, I don't think the functional impact at a facility or a practice level is probably significant. I mean, my hospital's not going to throw out our non-discrimination policy because suddenly, it's okay.

But what Dr. Radix was talking about, I think is critical. We know that if you lived in a state where the state had a ban on marriage equality prior to the Supreme Court decision in 2015 that your health was worse, because of the stress associated with knowing that the government isn't on your side. And suddenly, we have this national proclamation that it's okay.

And I think it unfortunately gives those who feel like it's okay to discriminate more of a sense that they have a license and the wherewithal to do so. I think that's the bigger impact than sort of a functional decision-making at a practice level.

Dr. Patel: To add to what Asa and Jesse just kind of said, as well, I mean, we know transgender people in particular report that there's a shortage of health care providers that are knowledgeable about transgender medicine, right? That's it. And that lack of knowledge is such a huge barrier, I feel like, and there's this huge lack of access that exists.

And physicians, even when surveyed, say they don't have, there's a lack of training, there's a lack of knowledge. And I think what really concerns me is, again, the administration saying, "Well, that's fine." We need somebody that's actually pushing to get more access and more information out there, and for the administration to give a pass, I think, is so unfortunate.

Dr. Blackstock: And just to add that we already know that LGBQ and TGNC people already defer care out of concern that they're going to be discriminated against, and because of experiences that they had in health care, being discriminated against, so it's just going to further scare people from coming in. So, I think you'll probably see more people deferring care or forgoing care, which obviously has potential for substantial harm and potential loss of life, even. So, this is, I think, incredibly concerning.

I do think that the decision on Monday, the Supreme Court decision, because of that, though, I think there'll probably be a number of legal challenges potentially to Friday's announcement, so hopefully we may see something happen in a positive direction.

Dr. Maybank: Yeah, and that brings, so, I get the questions, just so you all know, as they're coming through, and I try to pull them in. A question is kind of tied to that. Knowing what is happening, the political rhetoric and action, you know, one of the questions is, "So, then what do we do during this time, when people do fear speaking with their providers, what can we do and what should be done at this point in time?"

Because as you mentioned, Dr. Blackstock, that that is real, and that is a fear moving forward. What are actions that folks can make?

Dr. Malebranche: Well, I think there's a lot of actions you can take either as an individual or within your institutions, or even if you're not affiliated with an institution, you can start something yourself. I think it starts with modeling your behavior, and then also kind of being a voice. Whether it be on social media or with a YouTube channel, or with other media outlets to put yourself out there, to be that voice. Because you never know who's accessing the content, you never know who's listening.

I think there are also formal CME activities. I've partnered with several groups and organizations over the years, including the AMA, where we provide training for providers with regard to these things so people will be able to do that. I also think, on the flip-side of that, it's also important that we work in communities, and I was part of a initiative with NASTAD, and I'm not going to try to, since I know this is a live program, go over the entire acronym, but they're based in Washington, DC.

National Alliance of State and Territorial AIDS Directors. Yes, I got it, and without a stutter. So, we worked on a website, two websites, actually, that was called His Health. And then, there was also one called Well Versed, and we were focused on training providers, specifically for Black gay man, about some of the cultural intersections and some of the things you should be doing both as a medical professional with the current guidelines, but then also bringing in some of the social contextual factors that are going on.

And what was wonderful about that is that the His Health website provided CME credit and training modules that they could use, and that ranged from transgender health to whole health, to linkage to care, to PrEP; all these kind of different modules, but then for the Well Versed website, we actually did videos with members of the communities. And so, it was more about the empowerment.

So, I think part of it was training the provider side to be more open, or giving them information, but then also training the community and educating the community to say, "Hey, you have the power to demand more, and you need to know these things when you walk in your provider's door. And if they say no at the beginning, this is how you should push these things, and here are the resources that can help you with that."

So, I think when we think about practical things we can do, there are a lot of levels that we can focus on those, as far as solutions are concerned.

Dr. Maybank: Absolutely. Dr. Ehrenfeld, now coming off of being chair of AMA and very much helping to push forward lots of policy at the AMA level, and Shilpen, you as well. We're going to come to you, too. Can you speak to some of the work AMA has been putting forward as it relates to LGBTQ health, and really encouraging physicians to take the lead in?

Dr. Ehrenfeld: Sure. Yeah, well, the AMA has been deeply engaged in education, advocacy and policy work to improve care delivery and health outcomes for the LGBTQ and transgender/non-conforming community. A lot of that work guided by an advisory committee, which Dr. Patel chaired until a few weeks ago.

There's a whole bunch of free online education resources, as a part of Pride Month, and LGBT health, diversity and inclusion online CME bundle was rolled out on the AMA education hub. Great, check it out if you haven't already seen it already; those sessions provide vital information that has been hard to get at across the provider community.

I've got a paper in Academic Medicine coming out that looks at training requirements across all of GME. Guess how many training programs have requirements around LGTBQ health? Not many. Check out the paper.

AMA's done a lot, obviously, on the policy front in terms of trying to stand up for what is right, in terms of trying to drive action at the federal level within HHS and other parts of the federal government. Coming back to that Supreme Court decision, the impact is likely not to be immediate because, again, you're talking about a decision around federal employment law. Health care law's a different space. But as was mentioned, there are likely to be profound implications that's going to make any legal challenge to the administration's rule much more likely to succeed when courts start looking at laws that talk about sex discrimination in this way that includes sexual orientation, gender identity.

The AMA, through our advocacy resource center and litigation center, has been very active in many cases, trying to use all levers at our disposal to advance those interests, and it was a pleasure to serve as chair of the board and, frankly, to be the first openly gay person on the board of trustees. And I have to say, you asked earlier, "What can we do?", the question came in, as individuals, as members of communities and as providers, and look, we're all physicians on this panel. We have to demand accountability of the places that we work, the places that we engage with.

You just have to look at the Human Rights Campaign's health equity index they push out every year. Hospitals and facilities can voluntarily participate in this ranking system where they look at policies and say, you know, "Do you have everything in place that you should or not? Are you adhering to best practices or not?" And lots of places have gaps. Those gaps shouldn't be acceptable, and we need to demand that they get addressed.

Dr. Patel: To add to, there's a lot that—the AMA's had some kind of longstanding policy in terms of LGBTQ health, and there is, while it has grown, it's continuing to grow. And so, I think that we are constantly looking for more input from the community and whatnot. They really have, as Jesse said, done a lot in terms of advocacy, amicus briefs, trying to work both at the federal and state level, and partner with state medical organizations, as well. And I think to add to that, the other thing that I've been really impressed with other the last couple years is they've started doing SOGI data collection did a collection for the members of the health care community, and hopefully creating some model questioning, and we've worked with the community on that.

They're trying to get other hospitals around the country, at least, to start modeling and including, because I think it is so critical that we, each of us in our community, get counted. And so, I think that's important as well as, you know, Jesse alluded to the fact that we do have some educational material that's on the website. That is, over the next year, probably two years, will be expanded, and we'll be working with a number of community groups to make sure there is up-to-date education.

So, what is there is going to eventually be just a small portion of what will eventually be available. I think there's a lot that each of us as individuals need to do, as most people on this panel have said already. There's a lot of learning that each of us as health care providers need to do, we need to encourage our peers to do some learning, and to help carry that banner forward.

Dr. Maybank: Got it. Thank you. So, Dr. Blackstock, I wanted to go to you because New York City Department of Health, and I'm very biased, I will admit, from being there for the time I have been, and just know kind of, just the leading kind of campaigns that have been put out over the last couple of years. And more recently during COVID, as we talk about what folks can do, some of the very sex-positive messages related to the realities of COVID and realities of folks still wanting to have and engage in sexual relations, you all, kind of,

you met that mark, and so, can you just speak to that work? And why do you all go in that direction, and why is it so important, and how is it received? I actually was curious how that was received. It was shared widely, but I was just interested how it was received from folks.

Dr. Blackstock: We developed a Sex and COVID-19 guidance that came out about a month or two ago, and then had a recent update. And both garnered lots of attention, and I think because we know, sexual health obviously is a part of overall health and well-being, so, it's a priority for us.

And we also know that people are still having sex, so we actually just launched a few weeks ago a program called Door to Door, where New Yorkers can order condoms and have them delivered directly to their homes, and we literally busted our budget, we're looking for more funds, in 24 hours. So, people are having lots of sex, and they want to be as safe as possible when they're having sex.

We also have a program that allows folks to get a code that they can enter online to have the HIV home test sent to them, and that program is also doing incredibly well. And what it just tells us is that people, we're human beings, sex is an important part of intimacy, and we want to be able to support New Yorkers in being as safe as possible and also helping them to reduce part of COVID-19.

Dr. Maybank: Okay. So, I have a question here, if I can just get my phone to work. I have two questions. The first starts, "Would the panelists discuss their changing experience of being LGBTQ in medicine? A friend of a friend who was at a T5 institution was told to go back in the closet. I'm applying to med school, and I'm concerned my interests in supporting people with non-traditional sexual reproductive health experiences won't be taken seriously." Any comments?

Dr. Ehrenfeld: I'll just say, I think that the profession continues to evolve. I was told a few years back that if I stood up and advocated for a set of LGBT-inclusive policies that it would be the end of my career in organized medicine.

A decade later, I was the chair of the AMA as an out gay person. So, there you go. I think we each have to make individual decisions about the work that we do, and how we bring ourselves, our full selves, to the table. But I think that visibility is really important, and I do my best to be out every day in every way that I can be, because I think it's important to educate our colleagues about what it means to be an LGBT person, and whether you're an LGBT person or an ally in the profession, we all have work to do to make sure that people like that who want to come into the profession don't have to leave themselves at the door.

Dr. Malebranche: Yeah, I would echo that, what Jesse just said. I think you have to come with your full self to the table. I remember mentoring a medical student once who, on his personal statement, gave a story about how a good friend of his had been, and he's a Black, a gay man, a good friend of his had been diagnosed with HIV, and that got him interested in internal medicine. And he used that on his personal statement when he was applying to not medical school, but to residency at the time, and his mentor told him not to, because that would call into question his sexuality.

So, when he gave it to me to look at, I shredded it up because I said, "Dude, this doesn't even sound like you," because he had changed it into a narrative that he was concerned about HIV because of its impact on Black women. And I said, "That is true," I said, "But your work has been focused on Black, gay men." So, he changed it to what, I said, "Change it back to what you originally thought it would be." He changed it, and then put that in his personal statement and applied to residency, and he said wherever he went for his residency interviews, all the directors said that the statement stood out for them. Whoever the chairman was, whoever the residency director was, and he ended up getting into an amazing residency program in internal medicine, and continues to do phenomenal work now.

I would just say to the medical students, to the residents who are out there, when you're applying, this is an evolving process. It doesn't end when you become an assistant professor, an associate

professor, a full professor. It's a constant thing. But I wouldn't term it as coming out. If any of you are familiar with the work of Darnell Moore and some of his writings, he actually re-conceptualizes coming out and says, "Look at it as more inviting in."

And so, you are inviting, you have the power where you're inviting someone else into your space, and you're saying, "You know what? You guys are worthy. You all are worthy of knowing my truth." And so, I think sometimes I flip that on its end because the coming-out paradigm sometimes can be very pejorative, and ring very negative, although it is true for a lot of people that they feel trapped within something. But sometimes, if you can think about it that you have the empowerment here, you have the control over this, and you get to invite who you want into your space, and just look at it that way.

And like Jesse said, just show up to the table fully who you are, and don't be afraid to be who you are. And if they reject you for being who you are, then that's not the place you were supposed to be in the first place.

Dr. Maybank: Another question we have here: "I have a question concerning over the susceptibility to COVID infection of a person that is HIV-undetectable. Is there data regarding this?"

Dr. Blackstock: I'll just speak for some of the data that we've been looking at at the New York City health department. Just to say that this is evolving, and we're learning with everyone else.

Some of the preliminary data that we have suggests that people living with HIV are not over-represented among lab-confirmed COVID-19 patients. So, people living with HIV account for about 1.4% of the New York City population, and about 1.2% of lab-confirmed COVID cases.

We also do know that many people had COVID-like illness and may not have had access to testing for whatever reason. We know that people who are Black and Brown had less access; could it be possible that this is an under-count in terms of cases among people with HIV? Because at least in New York City, Black and Brown people are disproportionately represented.

However, when we look at once people are hospitalized, once people die, it does appear that people living with HIV were more likely to be hospitalized, need a ventilator and to die from COVID-19. However, these are preliminary analyses. We don't know whether what's driving that is older age, because people living with HIV who had COVID tended to be older. Whether it's related to higher prevalence of other underlying medical conditions, HIV itself or all of those things.

So, we're trying to disentangle that right now, and hopefully in the next few months, we'll have more information. Just to say, it doesn't appear that people living with HIV are at higher risk of acquiring COVID-19, but it's possible that people living with HIV do have worse outcomes, but what's driving that, we need to figure out. There's no data to suggest that people who are virally suppressed are at increased risk of acquiring HIV or having worse outcomes.

Dr. Maybank: Dr. Radix, did you have something that you were going to add?

Dr. Radix: I mean, I think that we've been talking a lot about education and opportunities, and I just wanted to say one thing. I think that for a very long time, for LGBTQ folk, we've relied on the existence of excellence to LGBTQ care, or providers who, like, we know. We can identify the folks like David in the community. That's who I want to go to for my sexual health care, because he gets it.

But the gaps have emerged, right? What's ended up happening is a lot of the community health centers and folks aren't as available anymore, because their offices are closed, the clinics have closed, and people are sitting at home and really concerned about where to access their care, and terrified. I've had patients absolutely terrified about going to go to the emergency room, short of breath, and saying, "I don't know where to go. I don't want to leave my house. I'm worried about, you know, I'm worried about the police presence. I'm worried about going to the emergency room."

And a lot of that really is around the lack, so far, of mandated training. So, in addition to saying, yes, people should avail themselves of all of this great information that's out there, we shouldn't really leave it up to people to decide whether or not they're going to develop these competencies. You know, folks need to address, you know, be conscious of the implicit bias. I mean, they have to do the work, and unfortunately, as I said, this pandemic has really exposed the major gaps in the system that are really detrimental to LGBTQ, especially trans and gender diverse.

Dr. Maybank: Thank you, thank you. We have a little bit of time, but not really much time. I just wanted to speak with you each, and this is another question that actually came up, is, "How have you experienced your own pride this month amidst all that is happening?" Dr. Patel, do you want to start?

Dr. Patel: Sure. It's definitely been a challenge in terms of not being able to congregate publicly, in terms of your chosen family, I guess, for lack of better words, and kind of celebrate together. And obviously, there's not going to be any large gatherings in the Bay Area by any stretch any time soon.

So, I think a lot of it has been Zoom calls, and kind of connecting in smaller groups. We recently did a drag bingo just by Zoom calls, and just to talk about what's happening, and there's been a series of discussion groups that have happened around Pride and what's happening around the community, as well.

So, it's been an interesting new way to connect, and at the same time, it's also very exhausting to connect that way with all of these Zoom calls and try and keep it together. It's a cause for celebration in some senses, and at the same time, a chance for us to connect as best as we can, given the circumstances.

Dr. Maybank: Thank you. Dr. Malebranche?

Dr. Malebranche: Well, I would say, I think the source of Pride for me, and it hasn't just been this month. It's been kind of in the course of this horrible year so far that we've called 2020.

The thing that's really encouraged me is seeing a lot of people, and particularly it reminds me, there are some parallels with the HIV epidemic, and people have been drawing that a lot since COVID-19 hit. One of the things that I've seen, that's been absolutely glorious to see, is that while the medical and public health communities sometimes have been stagnant, the governmental response has a lot of times been stagnant, what I've seen is how our communities have mobilized, and held Zoom calls, had informational sessions, webinars, podcasts to disseminate information out to people.

And one of the things that I think we learned from the HIV epidemic is that we can't wait for others to save ourselves. We're the answers we've been looking for, and I think since we learned that in such a harsh way during the HIV epidemic, with COVID-19, a lot of people just stepped on the gas pedal and said, "We don't have time to wait for you. We need to get this PPE out to the hospitals. We need to make sure testing is available. We need to make sure people are getting the most up-to-date information. We need to make sure that we're connecting. Since we can't connect physically, we need to make sure that our community is together and that we're seeing each other, we're talking with each other, we're exalting each other, and we're celebrating each other in the ways that we would be doing in person."

But, like Shilpen said, it's frustrating, but I think that's one of the silver linings that I see out of this, is seeing how creative and brilliant and beautiful we are as a diverse community and how we've really rose to the challenge.

Dr. Maybank: Absolutely. Dr. Radix?

Dr. Radix: I think it's been really wonderful to see how innovative have been, and doing online Pride events, and so forth. I have to say, for myself personally, I haven't had the time or the energy to really participate in anything. This is probably the closest that I've done. I'm waiting for a better time, when we've maybe passed some of these immediate challenges.

Dr. Maybank: Thank you. Dr. Ehrenfeld?

Dr. Ehrenfeld: It's funny, when I think about what Pride is and what it's become, go back 50 years to 1969, to the Stonewall riots where a group of very brave LGBTQ people stood up against police brutality and violence. And a year later, there was a celebration, and now 50 years later, here we are, thinking back, and, you know, in most years, I'd put on a rainbow t-shirt and go to a parade and hang out with friends. This year, I'm really finding instead, thinking, "What does Pride really reflect and what does it mean?" And I think back to standing up for those who can't, and I think about walking in my neighborhood last night with my Black and Brown brothers, taking a knee in front of my hospital for nine minutes to recognize the atrocities that police brutality have caused in our country.

And for me this year, I think that I've been celebrating Pride differently, but perhaps in a more powerful way.

Dr. Maybank: Thank you for that. And Dr. Blackstock, I'm going to go back to New York City, but you, you'll be able to answer however you choose, but I feel like we would have been on a float.

Dr. Blackstock: Thank you.

Dr. Maybank: Down the street, right? Dancing.

Dr. Blackstock: Totally. Totally. I have to say, I am really disappointed and in mourning. I don't know if many of you know; I'm actually going to be transitioning out of the health department next month, and was really looking forward to—we'll talk, David—was really looking forward to, yeah, being on our health department float. But I think just sort of echoing what everyone else is saying, I think being part of some of these collective actions is, again, I think I'm really into the intimacy even though we can't really physically be close, has really sort of helped inspire me and motivate me. And so, I'm just sort of using that. Tomorrow, I'll be out at tons of Juneteenth things, probably by myself, in and around Harlem.

But in some ways, that is sort of replacing some of the disappointment and mourning I have about just being at every Pride event this June.

Dr. Maybank: Yes, thank you. Well, we've reached the end of the show, they always go pretty quickly, and I really just want to offer everyone, happy Pride month. It's tomorrow. Happy Juneteenth. The AMA is actually having their first half-day in recognition and off for Juneteenth, so, very excited about that leadership that is happening.

So, again, thanks to all the panelists. Thank you for your time, your leadership, your voices, your work. I know you are all exhausted; it comes through. We all are. And just hope that we're able to find those ways to make sure that we are able to care for ourselves, and be in, I think I like the words of intimacy, Oni, the importance of that, and finding those moments to help us get through and carry us through these times.

So, thanks again, and thanks for everyone for tuning in, and see you next time.

Dr. Blackstock: Thank you.

Dr. Radix: Thank you.

Dr. Blackstock: There is literally a march going down my block right now. This is amazing.

Dr. Malebranche: It's New York.

Dr. Blackstock: I know it's the celebratory, dystopian landscape.

Dr. Maybank: New York is like that. They're having the same thing here.

Dr. Blackstock: Yeah. Thank you.

Dr. Maybank: Thank you.

Dr. Ehrenfeld: Thank you.

Dr. Malebranche: Thank you.

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