Journal of the Student National Medical Association

Diversifying the Face of Medicine Since 1964
ABOUT THE STUDENT NATIONAL MEDICAL ASSOCIATION

The Student National Medical Association is the nation’s oldest and largest independent, student-run organization focused on the needs and concerns of medical students of color. Membership includes more than 6,000 medical students, pre-medical students, residents, and physicians. Established in 1964, SNMA is dedicated to both ensuring culturally sensitive medical education and services, as well as increasing the number of African-American, Latino, and other students of color entering and completing medical school.

REPRINTING

To reprint articles appearing in this issue, reference the article using the following text: "This article was re-printed from the Winter 2014-2015 issue of the Journal of the Student National Medical Association, first published [DATE DD/MM/YYYY] by [AUTHOR]."

COPYRIGHT

This issue of the Journal of the Student National Medical Association is copyright © 2014 by the Student National Medical Association. All rights reserved.
<table>
<thead>
<tr>
<th>Page</th>
<th>Title</th>
<th>By</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td><strong>Your Story Matters: Interview with Tolulope Rosanwo</strong></td>
<td>Comfort Elumogo</td>
</tr>
<tr>
<td>8</td>
<td><strong>Transgender Medicine: Depathologization, Organizing, and Practice</strong></td>
<td>Eli Erlick</td>
</tr>
<tr>
<td>12</td>
<td><strong>#whitecoats4blacklives: Who Are We Missing?</strong></td>
<td>Vanessa Ferrel</td>
</tr>
<tr>
<td>15</td>
<td><strong>The Diachronic Approach</strong></td>
<td>Mary E. Fleming, MD, MPH and Candice S. Byrd</td>
</tr>
<tr>
<td>17</td>
<td><strong>Science on Saturdays at CMSRU wins National Award from AAMC</strong></td>
<td>Denise Garcia and Imoh Ikpot</td>
</tr>
<tr>
<td>18</td>
<td><strong>The Stigma of Truth</strong></td>
<td>Anthony Kulukulualani</td>
</tr>
<tr>
<td>19</td>
<td><strong>What the Single GME Accreditation System Means to Me, as a Current Medical Student</strong></td>
<td>Gavin Kuns</td>
</tr>
<tr>
<td>20</td>
<td><strong>Abstinence Rates among College Cigarette Smokers Enrolled in A Quit and Win Contest: The Impact of Concurrent Hookah Use</strong></td>
<td>Erick Marigi</td>
</tr>
<tr>
<td>23</td>
<td><strong>The Single GME Accreditation System</strong></td>
<td>Lucie E Noriscat Mitchell</td>
</tr>
<tr>
<td>27</td>
<td><strong>Educating Ourselves: How We Can Improve the Health of LGBT Patients and Families</strong></td>
<td>Henry Ng, MD, MPH, FAAP, FACP</td>
</tr>
<tr>
<td>30</td>
<td><strong>Addressing Health Disparities: The LGBT Community and HIV</strong></td>
<td>Juan C. Oves Jr., MPH</td>
</tr>
<tr>
<td>32</td>
<td><strong>Minority Stress Model: Health and Mental Health Effects of Stigma</strong></td>
<td>Daena Petersen, MD, MPH, MA</td>
</tr>
<tr>
<td>38</td>
<td><strong>The Battle to Stop Electric Shock Cures for Homosexuality in the UK</strong></td>
<td>Peter Tatchell</td>
</tr>
<tr>
<td>44</td>
<td><strong>Homophobia and HIV: A Response To, and Lessons From, The Jamaican Linked Epidemics</strong></td>
<td>Maurice Tomlinson</td>
</tr>
</tbody>
</table>
As articulated by the CDC, “People who are lesbian, gay, bisexual, or transgender (LGBT) are members of every community. They are diverse, come from all walks of life, and include people of all races and ethnicities, all ages, all socioeconomic statuses, and from all parts of the United States.” Nevertheless, there is a great need for culturally competent healthcare for the LGBT community specifically; for, as with other communities that remain victims to social inequalities, the LGBT community suffers from poorer health outcomes and health disparities unlike those faced by other social groups.

The SNMA recognizes the poor health outcomes and injustices faced by the LGBT community and the dire need for action. President Topaz Sampson has included addressing LGBT health in her executive agenda for the 2014-2015 academic year. This issue of the JSNMA sheds light on the LGBT community highlighting hardships and failures, progress and triumphs faced by this community.

Enjoy the work of your talented colleagues in this winter issue of the JSNMA. May you learn more about LGBT health and be inspired to take action. As always, if journalism peaks your interest, consider becoming a member of the 2014-2015 Publications committee and/or becoming a future JSNMA contributor!

All the Best,

Jasmin Scott-Hawkins, MPH
Wright State University Boonshoft School of Medicine
Doctorate of Medicine Candidate, 2016
SNMA Publications Committee Co-Chair, 2014-2015
Editor-in-Chief, Journal of the Student National Medical Association
JSNMA@snma.org

Your Story Matters
Interview with Tolulope Rosanwo
Case Western Reserve School of Medicine

By Comfort Elumogo,
Publications Committee Co-chair

Tell me about yourself.
I am a British/Nigerian/American female medical student who likes Star Wars, Jane Austen, Rocky, blogging, and eating carrot cake. I play the cello and like to cook.

Why did you decide to do medicine?
Medicine for me seems like a perfect way to explore my natural desire to constantly learn, touch the lives of others, and be a part of fighting health disparities in the United States. Many of my loved ones have Sickle Cell Disease, the most common genetic disease in the US. It impacts 1 in 500 individuals of African descent as well as other people with ancestors originating from malarial regions. There is no cure, and there is only 1 FDA approved drug for treatment besides opioids for pain management, and I find that completely unacceptable. I wanted from an early age to play a role in not only being an expert on that disease, but also a part of taking care of people holistically who have chronic illnesses like it.

What challenges did you face as an undergraduate student? Was there ever a time when you felt discouraged or someone discouraged you from being a doctor? How did you handle that?
BIOCHEMISTRY and GENETICS. Those were tough. Also the quantum mechanics portion of my general chemistry course was quite difficult. Before college, I had often gotten by with just paying attention in class, but with these difficult courses I had to work with others and read the textbooks closely – especially when I had no idea what the professor was saying (i.e., throwing Schrodinger’s equation and wave functions on the board was not helping me in class!). What was discouraging was the feeling of always being afraid of where I was on the curve for these large lecture courses. At times it was discouraging. But, what got me through it was to reach out to my professors and refuse to be “weeded out.” I also tried to remember that just because I did not like quantum mechanics or do that great at it, does not mean I cannot be a great doctor one day. Those tough classes are just something
you have to go through and you can’t give up! My faith also got me through it.

How did you find out about SNMA and what made you join?
I learned about SNMA my first year through the SNMA-MAPS chapter at my undergrad institution. They had a “Summer Opportunities Panel.” I wanted to join because I thought the mission of SNMA – to advance and support premedical students was something I wanted to be a part of. I later on became the publicity chair on the executive board and then by my senior year, was the co-president of SNMA-MAPS. Naturally when I came to Cleveland, I wanted to be a part of SNMA as well. I appreciated the mentorship I received from SNMA members when I was an undergrad and wanted to be a great mentor to someone else as well as work closely with other minority medical students.

What has been your favorite experience in SNMA so far?
Helping to plan the “White Coat Die-In,” which was a part of the nationwide #WhiteCoats4BlackLives movement here at Case Western. The aim of the demonstration at Case was not to protest the judicial verdicts regarding Ferguson and Staten Island (although I and many of my peers found it so distressing), but to protest the structural violence and racism towards Black and Hispanic patients in hospitals--places where they should be feel safe and treated with respect.
That memory will always stay with me because I was so taken with all the support we students had from each other as well as faculty. Seeing my society dean in the crowd was a moment when I truly was proud to call Case Western home. Additionally, the demonstration sparked a lot of dialogue regarding race, medicine, and politics and the role medical students should play (or “not play” to some) in the thick of it. #BlackLivesMatter

Do you have any causes or issues about which you are passionate? How have you been further exploring this issue?
The disparity in SCD research and the role of the family in prognosis of SCD are definitely issues of interest to me. I am a part of the Urban Health Pathway at Case and am currently trying to develop a research project concerning familial support. Also, I am trying to reach out to the Sickle Cell Association of America, which is based in Cleveland, so that I can come in contact with more families touched by SCD.

#WhiteCoats4BlackLives, as mentioned previously, is an interest of mine and we are starting a student group at Case.

Medical school education surrounding social justice and race issues is something I am very passionate about and hope to see improvements in this area as time goes on. I am excited to partner with other students who already have ideas about revamping our curriculum.

Cultural competency has been a hot issue these past few years. How would you go about addressing this issue within the medical education system?
Cultural competency seems to be a bad phrase recently, and is often replaced with “cultural sensitivity.” The difference here is that instead of the idea that you can “master” a person’s cultural identity (supposedly an idea propagated by “cultural competency”) you instead should grow in sensitivity to it by asking questions and learning from your
patients and peers in a humble way. Cultural sensitivity demands dialogue, but medical schools are usually not diverse enough for students to come across students from different cultural backgrounds. Additionally, minority students may feel uncomfortable taking the role of an educator and informer in such settings—especially to their own peers.

The issue I see with the cultural sensitivity movement is that some medical education systems may grow less rigorous in coaching/informing students on what is culturally appropriate to think about people and treat them. Thus, I am all for culture competence (not arrogance) AND sensitivity. Some people really need to just “read a book.” But, unfortunately many medical students are not aware that saying incompetent phrases like, “that’s ghetto” is not okay because no one is telling them.

A diverse group of medical professionals need to educate students about cultural competency and sensitivity from the beginning of medical school and discuss why this is important. A physician sharing a story of when they erred or a colleague made a mistake in this area could send a message about how cultural competency and sensitivity helps build patient trust. I can go on and on about this but I’ll just pause here.

What advice would you give undergraduates interested in medical school?
There are many paths to medical school, and if you are determined you will make it there. Surround yourself with studious, motivated people who support and believe you can do it. Get a mentor who is honest and can advocate for you. Remember that whom you know is also important in addition to what you know.

East coast, West coast, Midwest or the South?
Midwest! Chicago is my town!
Transgender Medicine: Depathologization, Organizing, and Practice

By Eli Erluck
Director of Trans Student Educational Resources

Is being transgender a medical condition? While some researchers attempt to attribute transgender (trans) identities to neurobiological mechanisms, there has never been conclusive, significant research illustrating how these identities are biological. Even then, there is always the issue of neuroplasticity, the concept of neurons changing due to environment or behavior, some hypothesize that simply identifying as transgender could lead to the observed differences in the nervous tissue from a cisgender (people who identify as their sex assigned at birth) control group. The essentializing of what some may consider being medical “causes” of transgender identities can also be harmful if a certain aspect of biology become the standard to test for to make sure a trans person is “actually” trans. Any form of pathologization (which is encoded with stigmatizing and societally negative attitudes of “mistake” and “abnormality”) of transgender people has had an oppressive history in the community along with holding the potential to leave out many trans people who do not fit the diagnostic criteria.

Bearing all this in mind, though trans people are not “born this way” as a pathological condition would suggest, being trans should continue to not be treated as a choice or lifestyle. In my own organizing experiences, I have worked with some trans activists who have internalized the rhetoric of pathology and cling onto the notion of an inherent male or female identity that correlates with a trans person’s gender identity as “proven” through the medicine. These conceptualizations of transness do not just leave out people who identify outside the gender binary, but can be dangerous to the community as a whole.

Both psychological and medical models for being transgender have limited the ability for trans people, particularly trans people of color, trans youth, and queer (non-heterosexual) trans people to access medical care. One classic example of this is Ray Blanchard’s “typology of transsexualism”, which limited queer trans women’s access to medical transitioning by describing non-heterosexual trans women as “autogynephilic men.” His theory of autogynephilia claimed that any trans woman who was attracted to cisgender women was also sexually attracted to the notion of having a vagina. Additionally,
to be considered a “woman trapped in a man’s [sic] body” (as Blanchard would designate), a trans woman would have to almost exclusively be hyperfeminine and have consistently presented as feminine since a young age, contrary to the experiences of many trans women. iii Consequentially, psychological and medical professionals began refusing medical treatment to trans women who did not fulfill these narrow criteria (it should be noted that a psychologist’s letter is generally necessary to receive medical treatment as a trans person). iv Even though this blatantly discriminatory model originated over 30 years ago, it remains prevalent in practices today.v

My childhood experiences did not fit the limited narrative of the inherent transgender identity: I exclusively identified as a boy until I was eight and never questioned my gender during that period. I also did not exhibit an “innate” affinity for feminine things, I enjoyed a mix of toys marketed to both girls and boys and only opted to play with “girl” toys due to my peers’ interrogation of my gender identity. I am not and have never been heterosexual, but was only coerced into identifying as straight during a short period of my life because the people in my rural community could not comprehend a trans woman who was queer, incorrectly conflating the concepts of gender, sex assigned at birth, and sexual orientation (in reality, each is a district, separate spectrum).vi According to the 1980’s pathological model of being transgender, I would be a heterosexual man from this description.

Unfortunately, when I came out as female in 2003, the predominant research available relied on a limited cognitive-behavioral training model of gender identities. My mother is a doctor and, like many others, was only willing to respect peer-reviewed medical and psychological publications despite a faulty understanding of the etiology of transgender identity. At the time, Kenneth Zucker and Susan Bradley were the leading researchers on gender in youth. Their publication, Gender Identity Disorder and Psychosexual Problems in Children and Adolescents, concluded that if a gender nonconforming child’s gender identity and expression were not affirmed, they would continue to identify as their sex assigned at birth.vii This, while incorrect and dangerous, was what my parents believed and they continued to not affirm my gender identity for five years. I was lucky that they realized how unhappy I was and allowed me to transition when I was 13. However, though my social transition had begun, my medical transition was riddled with pathologizing institutional barriers that prevented me (along with many other trans youth) from accessing the care I needed.

At the time, WPATH – The World Professional Association for Transgender Health – was still using its sixth version of the Standards of Care, which provided guidelines, often used as regulations, for transgender medicine. Because I was required to be 16 years old to obtain hormones by this model and was only 15, I had to drive for dozens of hours and visit two therapists, two doctors, and an endocrinologist to get the medical treatment I needed. viii These institutional barriers still exist in a lesser form: one must be 13 to have hormone treatment (long after many children begin puberty), 16 to receive some surgical treatments, and 18 to receive genital surgery (which can cause intense psychological distress due to the unnecessary waiting
These numbers are still somewhat strictly enforced despite extremely low rates of regret from trans people of any age: one thorough study of several hundred trans people found that 97% were satisfied with hormone therapy and 90% with surgery. Another found significant increases in psychological functioning for a group of trans youth after puberty suppression, hormone treatment, and gender affirming surgeries.

You may be wondering why WPATH has such strict Standard of Care guidelines if it is so clear trans youth are satisfied with their medical transitions. The answer is as easy as looking at the writers and influencers of the criteria, among which are Kenneth Zucker and Ray Blanchard. Cisgender professionals, who have a limited understanding of transgender psychological and medical needs, and not transgender activists, wrote most of the Standards of Care.

I urge medical professionals and institutions to be aware of WPATH’s publication, but not use their Standards of Care as a concrete model, particularly regarding the requirements for treatment. After years of organizing in the transgender community along with knowledge gained from personal experiences, I now understand that the most effective, affirming, and safe times to allow informed trans youth access to hormones or puberty suppressants is directly before puberty begins and access to surgery at age 16.

Additionally, practice on a larger scale needs to be critically interrogated. While some practices retain the very restrictive Standards of Care as a stringent protocol, more and more institutions such as the Howard Brown Health Center in Chicago and The Center of Excellence for Transgender Health at University of California – San Francisco are using an informed consent model, which educates the patients of the benefits and consequences of their medical choices and trusts them to make their own decisions.

Reforming the ways transness is medicalized to become more inclusive is not enough: depathologization is necessary for transgender medical justice. It is not possible for all transgender people to be represented under any medical model and medicalization within itself confines the definition of being transgender to a limited essentialist framework. Depathologization would be a move from seeing our lives as a “mistake” of biology to understanding and celebrating trans identities as a central part of our concepts of gender. Along with this, informing medical and psychological institutions about the importance of the depathologization of transgender people is critical for our care. With a new standard of informed consent, institutions can profoundly expand access to the medical care transgender people need. No longer regarding transgender people as having a medical or psychiatric disorder is central to our wellbeing as a community and has the potential to expand knowledge and support for our lives.

---


1 The World Professional Association for Transgender Health (WPATH). Standards of Care for the Health of Transsexual, Transgender, and Gender-nonconforming People. Vol. 7, 2011
1 De Vries, Annelou LC, Jenifer K. McGuire, Thomas D. Steensma, Eva CF Wagenaar, Theo AH Doreleijers, and Peggy T.

#whitecoats4blacklives: Who Are We Missing?

By Vanessa Ferrel

Vanessa Ferrel is a medical student at the University of California, San Diego with a strong passion for public health, cultural humility, community outreach, and improving the health of Black, Latinx, and LGBTQIA communities.

The white coat symbolizes our collective end goal of becoming healers, advocates for basic human rights, and leaders who empower humankind. Perhaps most importantly, the white coat represents the Hippocratic Oath - a pledge we have all taken to First, Do No Harm.

On December 10th 2014, medical schools across the country coordinated a White Coat Die-In demonstration against police brutality. The campaign, #whitecoats4blacklives, was created to call attention to the institutionalized racism impacting communities of color which has broken
through mainstream media in recent days. The die-in was a visual representation of the historic and systematic dehumanization affecting black and non-black bodies of color on a day-to-day basis. From micro-aggressions to racial profiling, from workplace and employment discrimination to housing discrimination, from hate crimes to prison pipelines.

The call to put an end to the systematic "every 28 hours" killing of black bodies by police officers, security guards, and vigilante citizens is incredibly important. From a mainstream standpoint, the most recent events surround the injustice of targeting unarmed black men. As leaders of this stream of healthcare provider consciousness, we must ask ourselves - who are we missing? When we say that black lives matter, we must consciously remind ourselves, our peers, our colleagues, and all others around us that we mean all black lives matter, and take into account the compound magnification of marginalization of black individuals with multi-tiered oppressed identities in the United States, including black women, black queer womyn, black transgender women, black Muslims, and black people with disabilities, who face misogyny, homophobia, trans-misogyny, transphobia, religious oppression, and ableism, in addition to anti-blackness.

Transgender women of color are often profiled as sex workers, drug addicts, or criminals. Black transgender women in particular are subjected to an enormous amount of daily hardship due to a combination of anti-blackness, transphobia, and misogyny. The hierarchy was once explained to me as such: compared to black men - who are so pointedly and systematically devalued in this country, black cisgender women are devalued many times more, and black transgender women exponentially more.

According to Stotzer's report, approximately 50% of transgender people experience sexual violence at some point in their lifetime. According to the National Coalition of Anti-Violence Programs, at least 12 transgender women of color were brutally killed in the United States in 2014 (as of December 17th, 2014). With an approximated homicide rate of one trans* person every three days globally, it is very likely the actual number is much higher.

Grant's report states 21% of transgender women and 47% of black transgender individuals report having been incarcerated at some point in their lives. In 2011, CeCe McDonald and her four friends were attacked by a group yelling racist and homophobic slurs. She stabbed one of the attackers with a pair of scissors in self-defense, and was sentenced to 41 months in prison on charges of second-degree intentional murder. Monica Jones in 2013 accepted a ride to a neighborhood bar, was arrested by undercover police for "manifesting prostitution", and sentenced to 30 days in prison. To compound the indecency of disproportionate rates of incarceration, transgender women are most often sentenced to all-male rather than all-female prisons. Black transgender women are incarcerated at astounding rates for the "crimes" of being black, being trans*, and being women. Black transgender women are our responsibility not only from a social standpoint, but also from a practice of medicine standpoint. The Centers for Disease Control and Prevention reports that black
transgender women have the highest percentage of new HIV-positive test results. According to Grant, one in ten transgender individuals have been sexually assaulted in a healthcare setting. Of the 6,540 transgender individuals in the study, 28% of participants had experienced verbal harassment in a doctor's office, 19% reported being refused medical care altogether because of their transgender status, and 2% of respondents reported being physically attacked in a doctor's office.

Like racism, trans-misogyny, transphobia, homophobia, ableism, classism, sexism and the many other "-isms" in our society are public health crises. Because grief has an enormous impact on the human body, our patients' grief is our grief also. Because stress - especially stress associated with the minority stress model - has an enormous impact on the human body, our patients' stress is our stress also. That's the thing about patients; you have to connect with them, not them with you.

It's time to be cognizant of broadening our consciousness and advocating for intersectionality as we mobilize – we must ask ourselves; who are we missing?

We must be mindful of our commitment to serve and Do No Harm in the face of the multitude of injustices our patients of all identities and backgrounds encounter on a daily basis. We are where we are today so that we may hold ourselves accountable until the end of time, with equity and justice for all.

Reference:

I saw this issue of the JSNMA as a great opportunity for my sister and I to collaborate on an article surrounding LGBT health. As a community, Black Americans tend to struggle with having outlets to share and express their opinions that address the many facets of LGBT health. And more importantly, have a dialogue that delves deeper than the superficial discussion of sexual orientation. As with any family, we continue to learn about each other and how we better understand each other. I asked my sister (the creative one) to think about how we can share something important with the SNMA family. She taught me this: the diachronic approach. This poem expresses the female consciousness of a queer woman of color in today’s society. Born into the time of third wave feminism & witness to politics surrounding the LGBTQ spectrum community & intersectionality.

All these critics around me
People doing all this work, seems almost for nothing
Some still yelling, "Land of the Free"
Unable to see the norms that they have constructed socially
Now learning about consciousness and intersectionality
Social construction is a part of this mirage
Something that goes unnoticed until you enroll in college
See I spent a lot of time assuming it was me
But apparently that change is meant to be made by society

With a heart full of pride
And a mind made up of gold
the key to knowledge I hold,
A gentle soul bares, hoping to unfold the untold

With walls of individualism & confidence
Corners sealed with intellectual thoughts, that no one can bear
With no boundaries & binaries to cage in this desired notion with little despair
An unconditional precious existence speaks louder hoping for legislation to care
It is with this hope, that the war between her & her oppressors will be mended
Yet sometimes I forget that the emotion called love existed

Certain bans and policies promote the stigma
That my way of life is different, not fully allowed or even accepted
That’s when the radical in me is ignited
Making choices are a part of growth & makes us more united
I hope that with such passion & knowledge spoken can inspire others
After all, when we make mistakes, we can't go & hide underneath the covers
Identity is safe territory & should be uplifted
The part where I should be ashamed,
sorry I must've missed it.

**Diachronic**: of, relating to, or dealing with phenomena (as of language or culture) as they occur or change over a period of time.
Science on Saturdays at CMSRU wins National Award from AAMC

By Denise Garcia, MSIII and Imoh Ikpot, MSIII
Cooper Medical School of Rowan University

Science on Saturdays is a part of Rowan’s Upward Bound program for ESL students in the Camden area. The science program, coordinated by CMSRU medical students, is focused on teaching advanced science labs for high school students to further enrich their education and critical thinking skills.

The goal of Upward Bound and Science on Saturdays is to encourage academic curiosity and motivate students to pursue higher education after high school. Science is a very experiential and hands-on subject that allows students to learn the English language via experimentation with peers of differing English language levels. We encourage them to collaborate on projects and challenge them to build their communication skills with classmates while developing scientific knowledge.

We decided to enter the Project Med competition because we were reaching a limit as to the labs we could create on a shoestring budget with materials from the grocery store.

We were realizing that many of our lessons had only mini experiments and much more discussion of theory. We knew our students’ education would greatly benefit from better resources to allow for more complex and technological science. With the funding we will be able to create an advanced laboratory experience that will give our Upward Bound students an edge over their peers when applying to college regardless of their career path. Our motto for the video was, "DO Science!" and now we'll be able to do just that!
The Stigma of Truth

By Anthony Kulukulualani
National President-Elect

Tick tock, tick tock ...
the long and short hands
raced about feverishly
seas of white arrived
as unconsciousness pervaded
your lifeless form.

Splash, splash ...
splotches of crimson
stained the surrounding whiteness
a diagnosis was determined, but
erroneously because you were afraid
to speak the truth.

Shhh! Shhh! ...
those unspoken words
irrelevant
as time escaped us
life continued on
headed towards deterioration.

Tick tock, tick tock
tick ...

time is out.
What the Single GME Accreditation System Means to Me, as a Current Medical Student

By Gavin Kuns, OMS- II
SGA Vice President
University of New England College of Osteopathic Medicine

If you haven’t been keeping up with the Osteopathic Politics, we had a historic day on July 19, 2014 as Resolution H-800 was passed through the American Osteopathic Association (AOA) House of Delegates. Thus agreeing to the terms of the Single Accreditation system for Graduate Medical Education (GME).

What does this mean for you?

It is important to know that there will be a five-year transition period from 2015 until 2020, as current AOA residency programs will have to apply for accreditation through the Accreditation Council for Graduate Medical Education (ACGME). However, as long as a program is pre-accredited or applies for accreditation while you are a resident you will be eligible to apply for any fellowships that you choose. This will greatly expand your opportunities as an osteopathic medical student seeking residency or fellowship.

As newly inducted AOA president Dr. Juhasz put it:
“You can train in the best program of your choice. This agreement preserves that opportunity for our residents. Any graduate entering a residency program that is pre-accredited for ACGME accreditation will then be able to apply to any residency program, whether it is AOA or ACGME.”

The agreement also opens up the opportunity for all residency programs to have a better understanding of Osteopathic Principles and Practice, as well as our testing and our progress examinations.

If you have further questions or want to know more about the benefits of the Single GME Accreditation please visit www.osteopathic.org. This is a phenomenal resource not only for your questions about GME but also planning the next steps at this dynamic stage of our career.
Abstinence Rates among College Cigarette Smokers Enrolled in A Quit and Win Contest:
The Impact of Concurrent Hookah Use

Janet Thomas, PhD, 1Jill Bengtson, MPA, 2Qi Wang, MS, 3,4Xianghua Luo, PhD, 5,6Erick Marigi, B.S.; MS1, and 1Jasjit S. Ahluwalia, MD, MPH, MS

1University of Minnesota, Department of Medicine, Division of General Internal Medicine; 2University of Minnesota, Center for Translational Sciences Institute; 3University of Minnesota, School of Public Health, Division of Biostatistics; 4University of Minnesota Masonic Cancer Center; 5UMN Center for Health Equity; 6St. Olaf College; 6University of Minnesota, Medical School

Abstract

Background: College represents a critical transition period for the use of tobacco. Cigarette smoking prevalence among college students in America is 21.3% and the use of other tobacco products is increasing, including the use of water pipe or hookah. Concurrent use of both hookah and cigarettes is on the rise yet little is known about these high-risk smokers. We examined the baseline characteristics and self-reported 30-day, 4- and 6-month, and continuous abstinence rates between hookah users and non-users of hookah and multivariable logistic regression (MLR) analyses examined the association of 30-day abstinence at 1, 4, and 6-month follow-up after adjusting for baseline covariates.

Methods: Two and four-year college students (N = 1217) enrolled in a Quit and Win tobacco cessation research study, completed questionnaires and provided urine samples at both enrollment and at the completion of either one 30-day contest or three successive, 30-day contests. Chi-square tests examined baseline demographic, tobacco-related and psychosocial differences between hookah users and non-users of hookah and multivariable logistic regression (MLR) analyses examined the association of 30-day abstinence at 1, 4, and 6-month follow-up after adjusting for baseline covariates.

Results: All participants smoked cigarettes at least one cigarette per day on at least 10 occasions in the prior month and 22% used hookah in that same time period. Hookah smokers (n=270) vs. cigarettes only (n=947) were significantly more likely to be male (p<0.0001), younger (p<0.0001), report more binge drinking (p<0.0001) and overall impulsivity (p<0.001) and report smoking more in response to cues (p<0.01). After adjusting for covariates, MLR analyses identified a trend in abstinence outcome rates in that hookah smokers were 36% less likely
to report 30-day abstinence at the end of treatment (4-month) than cigarette only smokers (OR = .064, 95% CI=.45-0.93). In addition, both the self-report and biochemically verified continuous abstinence at 6-months was significantly lower among the hookah users than non-users (OR = 0.45 [p<0.01] and 0.37 [p=0.05], respectively).

Conclusion: Results suggest that college cigarette smokers who concurrently use hookah display multiple smoking-related risk factors including binge drinking, impulsivity and cue-respondent smoking. Compared with smokers who do not use hookah, hookah-using smokers may be less likely to achieve tobacco abstinence following a tobacco cessation program. Novel tobacco cessation methods may be needed to successfully help hookah users to obtain tobacco abstinence.

Reference:

22. Substance Abuse and Mental Health Services Administration, Rockville, MD.
The Single GME Accreditation System

Lucie E Noriscat Mitchell, OMS-IV
Osteopathic Schools Committee Co-Chair

According to the American Osteopathic Association, when fully implemented in July 2020, the new system will allow graduates of osteopathic and allopathic medical schools to complete their residency and/or fellowship education in ACGME-accredited programs and demonstrate achievement of common milestones and competencies.

The AOA strongly believes the public will benefit from a single standardized system to evaluate the effectiveness of GME programs for producing competent physicians. Through osteopathic-focused residency programs, the new GME accreditation system will recognize the unique principles and practices of the osteopathic medical profession and its contributions to health care in the U.S.

Some common questions and answers about the new accreditation process are provided below.

What is the timeline for the development of and transition to a single graduate medical accreditation system?
Between July 1, 2015 and June 30, 2020, AOA-accredited training programs can register for
ACGME pre-accreditation status and begin application for ACGME accreditation. This means training programs have a five-year period to comply with ACGME requirements. Prior to July 1, 2015, the AOA and AACOM will be providing education to OPTIs, hospital administrators, DMEs and specialty colleges to prepare them for the transition.

**Will the AOA continue accrediting new residencies and/or fellowships until July 1, 2020?**
The AOA has the ability to accredit new and existing postdoctoral training programs until July 1, 2020. There are a number of programs currently in the pipeline to AOA accreditation, and those programs will likely start operations under the AOA standards. However, new AOA training programs established after July 1, 2015, will not be eligible for pre-accreditation status, and their graduates would not be considered graduates of an ACGME-accredited program for ACGME advanced training and fellowships. As we get closer to the transition date, it seems likely that the number of new programs seeking AOA accreditation will decrease as more make the choice to apply directly to the ACGME. A number of our osteopathic medical schools have indicated that they expect the single GME system will facilitate their ability to start new GME programs because the hospitals will be able to accept both DOs and MDs into newly established programs.

**Will all AOA programs transition to ACGME at one time in 2020 or may some programs transition earlier?**
Programs can begin the transition process as early as July 1, 2015. They will be granted ACGME pre-accreditation status upon application and then full accreditation after they demonstrate compliance with ACGME standards and requirements. There will not be a “batch” transition of all AOA programs to ACGME accreditation on June 30, 2020. We hope that all programs have successfully achieved ACGME accreditation by that time.

**When will the AOA stop accrediting GME programs?**
AOA programs are expected to complete the transition to ACGME accreditation before July 1, 2020. The AOA will cease to provide GME accreditation on June 30, 2020.

**When is the earliest that osteopathic training programs could accept applications from qualified MD candidates?**
Once the transition to a single GME accreditation system is complete, all DOs and MDs will have access to ACGME-accredited training programs, including those with an osteopathic principles dimension. However, there is no specific date when osteopathic-focused programs must begin accepting MD candidates. Prerequisite competencies and a recommended program of training likely will be required for MDs to enter osteopathic-focused programs. These prerequisites and prior training requirements will be developed by the newly formed Osteopathic Principles Committee.

However, current eligibility rules will still be in effect until we begin the transition in July 2015 and likely for a while after that date. MDs will not be able to enter osteopathic-focused training programs until standards for these programs have been developed, and that individual program has become ACGME-accredited. Accreditation will occur on a program-by-program basis. Since 2015 is the beginning of the five-year transition period, it may take a year or longer after that date for
the first osteopathic-focused ACGME programs to be able to admit MDs.

**How will this affect my board certification? Will DOs be required to take the osteopathic certification examinations?**
The single accreditation process will not affect board certification. Osteopathic certification exams will be recognized by the ACGME as valid and appropriate credentials for service as faculty members and as co-program directors in ACGME training. No MD or DO will be required to take either certification exam; both certifications will be available to DOs. All DO residents will be encouraged to take osteopathic certification exams to demonstrate their competency in osteopathic principles and practices within the specialty. MDs that complete osteopathic-focused training programs may be allowed to take AOA certifying board examinations.

**As we move toward a single graduate medical education accreditation system, will we move toward a single board certification system in the future?**
The single accreditation system is strictly limited to GME and does not include board certification or medical school accreditation. The AOA believes it is important to the public for osteopathic physicians to demonstrate their competency in osteopathic principles as part of the osteopathic board certification process.

**If residents in programs with pre-accreditation status graduate prior to July 1, 2020, are those individuals allowed to be boarded by both the AOA and ABMS boards (assuming their programs are osteopathic-focused)?**
Under the current ABMS rules, a physician must have completed an ACGME-accredited residency to be eligible for ABMS board certification. Our understanding is that a program's pre-accreditation status—which does qualify DO residents in that program for advanced ACGME residencies and fellowships—will not change a physician's eligibility for ABMS board certification.

**Will there be a single Match?**
The MD Match is administered by the National Residency Match Program (NRMP), not the ACGME, and the osteopathic Match by the National Matching Services (NMS). Consequently, this is an issue that can be resolved only when the NRMP and NMS join our discussions. However, if all programs are considered ACGME-accredited after the transition to a single GME system is complete, it is likely there ultimately will be one Match. During the transition, as AOA programs get approved by the ACGME, we expect to begin conversations with the NRMP and the NMS to see the best way to administer the match during the transition process.

**What does this mean for DO students applying to currently AOA-accredited programs? Applying to currently ACGME-accredited programs?**
An overarching goal in agreeing to a single GME accreditation system is to maximize access to GME opportunities and options for all osteopathic medical students and graduates. DO graduates applying to currently AOA-accredited programs will enter the system during a time of transition. They should know that they will be eligible to move from their AOA program into ACGME fellowships and advanced residencies as long as their AOA program has applied for ACGME accreditation, which gives it "pre-accreditation" status, and there are no specialty-specific restrictions. DOs planning
to enter ACGME programs during the transition process should see no change from the current process.

Overall, all DO students should know that this new system aims to benefit them. It will allow osteopathic medical students to apply for programs in specialties of their choice. It’s not necessarily going to be an easy transition across the board, but we believe it will increase recognition of osteopathic medicine and bring our unique health care to a wider audience.

If you have any questions concerning this matter, please contact the AOA at singlegme@osteopathic.org
Educating Ourselves: How We Can Improve the Health of LGBT Patients and Families

By Henry Ng, MD, MPH, FAAP, FACP

Henry Ng, MD, MPH is the Clinical Director of the PRIDE Clinic, a hospital-based LGBT health service line in Cleveland, OH, and the President of GLMA: Health Professionals Advancing LGBT Health Equality.

When I started medical school nearly 20 years ago, I was introduced to lesbian, gay, bisexual and transgender (LGBT) health during one of our “gay day” lectures. This is what the other students in the class had nicknamed the only session our medical school had on LGBT health. It was a one-hour panel discussion facilitated by a faculty member and a few self-identified lesbian, gay, bisexual or transgender people. In those 60 minutes, they talked about their experiences in health care. . .and many of those were negative. I was an out gay medical student, but was in my first year of medical school and still contemplating what it meant being gay and Asian and how it would impact my career as a physician.

It was in my 2nd year of medical school that I had my first contact with a patient who was gay, lesbian, bisexual or transgender. She was a bisexual woman in her 40’s living with fibromyalgia, hepatitis C infection, anxiety and post-traumatic stress. That year I had a crash course in pharmacology, mental health, infectious diseases and pain management. But at that time there were few resources available to me to learn how to effectively care for and about LGBT patients. I was left to reflect on my own personal experiences as a patient and the hour-long session I had the year before as I tried to assist the patient before me.

In the decade which followed that patient care experience, little progress was made in LGBT health education for myself and most medical students. The 2011 Institute of Medicine Report: The Health of Lesbian, Gay, Bisexual, and Transgender (LGBT) People: Building a Foundation for Better Understanding identified a number of gaps and opportunities in closing health disparities for sexual minority populations (1). One important opportunity lies in improving education on LGBT health for health professionals-in-training. Historically, little time is spent on LGBT health content in undergraduate and graduate medical education. In 1992, Wallick et al found that an average of 3 hours and 26 minutes were provided for exposure to LGBT health in 4 years curriculum (2). In a follow-up study by Tesar in 1998, this time had decreased to 2
hours and 30 minutes (3). A 2011 study on undergraduate LGBT education time and content noted an increase in to 5 hours median time among the medical school participants (4). However, when these health topics are taught, those presentations tend to address foundational “101” issues and do not include topics such as transgender medical and surgical care, mental health, intimate partner violence, hate-motivated violence and intersectionality with other social determinants of health. When sexual history taking is taught, the skill set is often superficial and inadequate. To date, much work needs to be done in improving LGBT health education.

Fortunately, there are tools and recommendations from health organizations focused on LGBT health. GLMA: Health Professionals Advancing LGBT Equality (previously known as the Gay & Lesbian Medical Association) is the world’s largest and oldest association of LGBT healthcare professionals. GLMA was founded in 1981, as the American Association of Physicians for Human Rights, with the mission of ensuring equality in healthcare for LGBT individuals and healthcare professionals. Originally open only to physicians, residents and medical students, in 2002, GLMA expanded its mission and now represents the interests of tens of thousands of LGBT health professionals of all kinds, as well as millions of LGBT patients and families (5).

Among the resources developed to assist medical students and other health professionals-in-training to develop cultural competency and clinical competence in the care of LGBT people include GLMA’s patient-focused, “Top 10 Health Issue Fact Sheets.” The health issues listed in these factsheets are identified as most commonly of concern for LGBT people and include topics such as access to health care, mental health, tobacco use and HIV. And while not all of these items apply to all patients in the LGBT community, it is wise for health professionals and students to be aware of these issues:

- 10 things Lesbians Should Discuss with Their Healthcare Provider
- 10 Things Gay Men Should Discuss with their Healthcare Provider
- 10 Things Bisexuals Should Discuss with their Healthcare Provider
- 10 Things Transgender Persons Should Discuss with their Healthcare Provider

Another tool developed by GLMA and authored by Shane Snowdon is a White Paper entitled “Recommendations for Enhancing the Climate for LGBT Students & Employees in Health Professional Schools, a comprehensive set of recommendations (6).”

These recommendations offer a multitude of resources for making any health professional school more equitable, inclusive and welcoming from an LGBT standpoint. Students, staff, faculty and others involved in health professions education will find the information they need to improve their climate to better support LGBT community members, promote general awareness of LGBT needs and provide LGBT equity. Moreover, this year the American Association of Medical Colleges (AAMC) published the first guidelines for training physicians to care for LGBT people and those who are gender nonconforming, or born with differences of sex development (DSD). Entitled “Implementing Curricular and Institutional Climate Changes to Improve Health Care for
Individuals Who Are LGBT, Gender Nonconforming, or Born with DSD,” this comprehensive set of stands guides medical schools and health care organizations train students and health professionals in these patients’ health care needs (7).

Students and health professionals seeking additional practical patient-centered education resources can review GLMA’s webinar modules on Quality Healthcare for Lesbian, Gay, Bisexual & Transgender People: A Four-Part Webinar Series (8), learning modules LGBT health from the National LGBT Health Education Center (9), and evidence-based transgender health care guidelines and recommendations (10). Finally, educational meetings and conferences such as GLMA’s annual academic conference are another opportunity to learn and improve one’s knowledge on LGBT health and develop clinical skills needed to meet the health needs of LGBT people.

In developing both LGBT health cultural competency and clinical competency, we all contribute to the creation of a more welcoming environment where patients are not afraid to be who they are and are free to place their trust in the health professionals caring for them. This work extends to all the staff in the clinical setting, not only the health professionals. However, physicians and health professional leaders are often the role models and champions for change and inclusion in health care.

Reference:


Addressing Health Disparities: The LGBT Community and HIV

By Juan C. Oves Jr., MPH
Health Promotion & Disease Prevention
Florida International University

The Lesbian, Gay, Bisexual, and Transgender (LGBT) community is composed of sexual and gender minorities that have unique health care needs. This became clear during the 1980s historical epidemic that took the lives of many gay and bisexual men. Gay men in New York, California, and other parts of the world were developing rare opportunistic infections and cancers that were highly resistant to treatment. These were known to be the first cases of Acquired Immune Deficiency Syndrome or AIDS. After researchers determined the cause was the Human Immunodeficiency Virus or HIV, a sexually transmitted disease, a platform for prevention and treatment began to evolve. During the epidemic, community members struggled to come together and advocate for action and change among health policy makers, practitioners, government agencies, and researchers. Unfortunately, the HIV/AIDS epidemic evolved in an environment of stigma and discrimination for LGBT and other minority communities, which continue to struggle with particular health disparities. The HIV/AIDS epidemic in the U.S. became a new movement for health equity and social justice. Today HIV/AIDS continues to affect over 33.4 million globally and over 1.1 million people in the United States (Moss, 2014). Although gay, bisexual, and other men who have sex with men (MSM) make up 2% of the U.S. population, they continue to be disproportionately affected, particularly minority groups such as African Americans and Hispanics (Moss, 2014). In Miami-Dade County, 80% of reported HIV cases in men are among the MSM population and 59% of those living with HIV/AIDS are Hispanics (Florida Department of Health, 2012). African Americans represent 16% of the U.S. population, but account for 46% of individuals living with HIV/AIDS (Moss, 2014). Behavioral studies have suggested that factors such as education, income, partner selection, disclosure of sexual orientation, and unprotected sex increases the risk of acquiring HIV and other sexually transmitted infections. Other factors such as healthcare provider services, poverty, and stigma are common barriers to prevention and treatment for minority groups. In order to address LGBT health disparities, multilevel perspective and action is required in developing effective health promotion and disease prevention interventions.

Theory-based interventions such as Mpowerment have been able to address cultural, social, and behavioral determinants of HIV/AIDS within the MSM community and proven to be effective. Mpowerment was...
developed, evaluated, and improved by faculty from the University of California, San Francisco’s Center for AIDS Prevention Studies (Kegeles, 1999). During an initial pilot test unprotected anal intercourse among young gay men was reduced from 20.2% to 11.1% with non-primary partners during intervention (Kegeles, 1999). This community-based program is based on various health behavior theories such as the social cognitive theory, empowerment model, and the theory of diffusion of innovations (Kegeles, 2012). In the social cognitive theory, individuals are more likely to adopt a behavior if allowed the opportunity to learn about the behavior such as through a focus group discussion. This increases self-efficacy and self-awareness in sexual health issues, communication, and sexual risk-reduction skills (Kegeles, 2012). Mpowerment consists of program components such as a core group and volunteers, a project space, formal/informal outreach, facilitated discussion groups, publicity campaigns tailored to the community, and a community advisory board (Kegeles, 2012). These core elements maintain the fidelity of the intervention and provide assistance in tailoring the program to community’s specific needs and culture.

Founded in 2008, Latinos Salud, a non-profit community-based organization provides services and resources to the Latino/Hispanic gay, bisexual, and transgender community in the South Florida area. The Mpowerment-based program provides a variety of services including peer leadership, life coaching, HIV rapid testing, STD testing, linkage services for HIV treatment and care, and free resources such as condoms and lube. The program is specifically tailored for the Hispanic/Latino community and takes into consideration cultural factors such as family and social networks. Effective behavioral interventions such as Mpowerment are at the frontline of the HIV/AIDS epidemic. Through effective behavioral interventions such as Mpowerment we are able to address multi-levels factors in our community to help reduce health disparities such as HIV/AIDS.

Reference:


Minority Stress Model: Health and Mental Health Effects of Stigma

Daena Petersen, MD, MPH, MA

Daena Petersen, MD, MPH, MA, has been an advocate for LGBT health and mental health for over two decades and for HIV+ youth and adults since the late 1980’s. She’s currently an American Psychiatric Association Public Psychiatry Fellow and Chairperson, and Psychiatry Resident at Medical University of South Carolina.

Acknowledgment: Kat Morgan, MSOD, MSW, has been an advocate for LGBT rights and inclusion since 1983. She edited this article and identified important resources.

Introduction: Marriage Not Civil Rights

By early January 2015, marriage equality (same sex marriage) was legally established in 36 of 50 states. (2014) Polls indicate the majority of US Americans in almost every region support marriage equality. (McCarthy 2014) In contrast, full civil rights for lesbian, gay, bisexual, and transgender (LGBT) people, including the right to equal health and mental health care, remains beyond reach. (Institute of Medicine Committee on Lesbian, Transgender Health et al. 2011) Despite marriage equality, in a healthcare or mental healthcare office, LGBT patients are regularly stigmatized and treated unprofessionally by providers. While seeking medical or mental health care, LGBT patients have reported being confronted by medical providers who accuse them of “living in sin.” In another report, a lesbian woman collapsed and required hospitalization prior to leaving on a family vacation. Upon arrival at the hospital, the woman’s lesbian partner and three children were refused visitation. The collapsed woman died and all but her sister were denied visitation. (Legal 2010) A colleague recounted an incident during which she, a pre-op transgender individual, went to her primary care physician’s office for an evaluation of a cold. During the patient’s appointment the provider wanted this patient to pull up her skirt so he could look at her groin rather than evaluate her upper respiratory infection. And more recently, on


2 Gay means individuals who identify as fantasizing about, being sexually attracted to, and having sexual relations with individuals of the same sex, and primarily, but not exclusively, refers to men. Ibid.

3 Bisexual is defined here as individuals who identify as having sex with, or being sexually attracted to, individuals of both the same and opposite sex. Ibid.

4 Transgender is defined as individuals who experience their gender identity as different from their sex assigned at birth, and individuals who experience emotional pain or dysphoria about their assigned sex versus their gender identity. Ibid.
December 28, 2014, Leelah Alcorn, a trans high school student, committed suicide. Her story gained international attention after her Tumblr post appeared after her death, describing her gender dysphoria, her sense of alienation, and her own parents’ lack of support.(Pasulka 2015)

**Barriers to Health and Mental Health Access**
Per a Lambda Legal nonrandomized survey (n=4,916), 56% lesbian, gay, and bisexual (LGB) respondents reported experiencing discrimination when seeking medical care. Discrimination in this study was defined as refusal to treat or touch patients, use of unprofessional language including abusive language, or physically “rough or abusive” treatment of patients. In this same study, seventy percent of transgender or gender non-conforming individuals reported mistreatment or treatment refusal by providers.(Eliason and Schope 2001, Legal 2010) Additionally, LGBT people are less likely to have health insurance coverage than their heterosexual counterparts. Due to multiple barriers to healthcare access, LGBT individuals are more likely to seek health care through the emergency room.(Legal 2010, Institute of Medicine Committee on Lesbian, Transgender Health et al. 2011)

**Parity Not Civil Rights**
The Affordable Care Act is creating parity for psychiatric and mental health treatment.(Mechanic 2012) Despite parity, LGBT individuals seeking treatment may be confronted by homophobic, bi-phobic, or trans-phobic mental health providers, or providers with minimal training regarding the mental health concerns of LGBT individuals.(Lee 2000, Kelley, Chou et al. 2008, Shukla, Asp et al. 2014) Further complicating LGBT health and mental health care, the at-times piecemeal nature of the United States legislative process creates baffling dualities. For example, in some states with strong anti-LGBT sentiment, same sex couples may now get married, making them eligible for spousal health insurance coverage. However, marriage equality alone does not prevent employers from firing LGBT employees due to their sexual orientation or gender identity when they attempt to claim these benefits. Without inclusive anti-discrimination laws LGBT individuals, couples, and families remain vulnerable.(McBride, Durso et al. 2014)

**Medical Profession and Mistreatment of LGBT Physician Trainees and Physicians**
Within the recent past, uninformed medical school officials assumed that LGBT equality had progressed within the medical system, making it a safer place for LGBT medical students and physicians. A 2007 Association of American Medical Colleges report, however, revealed that one in five medical student respondents “knew of mistreatment toward lesbian, gay, bisexual, and transgender (LGBT) medical students.”(Prescott 2011) While these numbers have improved in some regions of the country, medical students, residents, and physicians, as well as other medical providers, continue to experience discrimination.(Risdon, Cook et al. 2000, Legal 2010)

**Minority Groups and Additive Social Stressors**
As members of minority groups, LGBT individuals are one of many groups experiencing the health and mental health disparities described above. LGBT people as a group represent a broadly diverse
population, including a range of socioeconomic statuses, races, ethnicities, sexes, sexual orientations, gender identities, psychiatric illnesses, physical illnesses, and disabilities. (Meyer 2003) The history of each minority group is unique and there are representatives from each who belong to more than one group. (Landrine and Klonoff 1996, Harper and Schneider 2003, Balsam, Beadnell et al. 2013) Belonging to any of these groups carries its own set of stressors and membership in multiple groups accordingly increases social stressors experienced by individuals (Balsam, Beadnell, Molina, 2013; Harper & Schneider, 2003; Landrine, & Klonoff, 1996). Per Meyer (2003), the impact of stress on minority groups is important because increased levels of stress contribute to significant physical and mental health illnesses. These medical and psychiatric illnesses in minority individuals occur at increased rates and in an additive manner for individuals belonging to multiple groups. LGBT African American HIV positive individuals in the Southeastern United States are an example of minority individuals impacted by stressors due to race, physical illness, sexual orientation, and, for many, socioeconomic status, particularly for transgender individuals within this group. In addition, HIV positive individuals experience a disproportionate level of depression specific to their HIV positive serostatus. Levels of depression in HIV positive men and women of color are likely to be higher per the additive effect of minority stress. For African American transgender individuals, depression is likely to be the highest. (Harper and Schneider 2003, Meyer 2003)

**Minority Stress Model**

Over the last 25 years, Meyer has developed an evidence-based model that explores and explains the impact of bias and stigmatization on minority individuals and groups within social contexts. (Meyer 2003) Meyer’s minority stress framework stems from research-based social stress theory, which focuses on those individuals experiencing disproportionate levels of social stress stemming from experiences of bias and stigmatization, which may lead to significant adverse effects on their health and wellbeing. (Meyer 2003, Link and Phelan 2006, Balsam, Beadnell et al. 2013) Meyer also developed the LGBT minority stress model, which demonstrates how stressful life events are linked to emotional distress, multiple problem behaviors, and poorer health outcomes in LGBT persons and communities than in non-LGBT populations. (Balsam, Beadnell et al. 2013)

**Minority Stress Model: Advocating for Change at the System Level**

The importance of the LGBT minority stress model as a way to understand the unique life stressors faced by members of this population cannot be overstated. (Balsam, Beadnell et al. 2013) The long history of blaming minority populations for their poorer health outcomes is both biased and simplistic, as it places responsibility for change on the shoulders of individual patients, rather than pointing out the need for large-scale system level change. This narrow view abdicates professionals of our responsibility to intervene. Numerous studies in the scientific literature demonstrate that individuals and communities with fewer resources have higher rates of substance abuse, homelessness, suicide, violence, poor education, and poor health outcomes. (Dean, Meyer et al. 2000, Meyer 2003, Bravman and Egerter 2008) These same individuals and communities are blamed for these problems.
and have lower self-esteem and higher rates of depression, anxiety, and alcohol and drug abuse. (Dean, Meyer et al. 2000, Link and Phelan 2006)

Minority Stress Model: Reframing Poor Health and Mental Health Outcomes
It is critical as health care providers that we understand the impact of minority stress. Reframing these problems through the conceptual lens of the minority stress model, we understand that individuals, communities, and minority or under-resourced populations experience higher rates of these problems and poorer overall health outcomes because they belong to groups exposed to significantly higher levels of stress and have fewer resources, including decreased access to medical and mental health services. (Meyer 1995, Meyer 2003, Balsam, Beadnell et al. 2013) As medical and mental health providers in our privileged positions it is our responsibility to reimagine a system of care that will benefit all of our patients effectively. (Bravman and Egerter 2008, Ard and Makadon 2012)

Call to Action: Recommendations for Creating Change
In order to increase access to health and mental health care for LGBT individuals specifically, experts have developed recommendations for increasing cultural competence and access to care. This includes creating a supportive and equitable work environment for LGBT employees. (Commission 2011) Specific recommendations include: “demonstrat[ing] ongoing leadership commitment” to LGBT inclusion and support, which includes: visible, high level engagement; assessing the climate; addressing areas of concern; disciplining intimidation and harassment of both LGBT staff and patients; forbidding discrimination “including sexual orientation, gender identity, or gender expression.”

One Joint Commission (2011) recommendation is particularly relevant to medical students and associations: establish “support forums for employees to freely and openly discuss any LGBT-related questions or concerns in a group setting to encourage learning.” Articles and special issues of publications like this one are important and commendable. Individual providers can and should familiarize ourselves with practical tools designed to equip us to be well-informed and effective providers, and resources that can help us support family members of LGBT individuals. Organizations like the Family Acceptance Project, the Center of Excellence for Transgender Health, Parents and Friends of Lesbians and Gays (PFLAG), and The Fenway Institute and Fenway Health have produced such resources. 6

Finally, in the words of National LGBTQ Task Force’s Deputy Director Darlene Nipper, who

keynoted at the 2014 APA Institute on Psychiatric Services, “We have lived through a lot of discrimination, hatred, bigotry, and stigma. So it takes us working together to address...the...systems in place that still hold us back.” (Watts 2014) As medical providers, we hold positions of influence in these systems. Let us use our privilege and power to advocate for change, change that will improve the health and wellbeing of our patients, families, communities, and ourselves.

Reference:


The Battle to Stop Electric Shock Cures for Homosexuality in the UK

By Peter Tatchell

Peter Tatchell has been campaigning for LGBTI and other human rights since 1967. He is Director of the human rights organization, the Peter Tatchell Foundation. For more information, to receive email bulletins or to make a donation: www.PeterTatchellFoundation.org

In London in November 1972, I disrupted a lecture by Prof Hans Eysenck, who was at time one of the world’s most famous psychologists. He was justifying the use of electric shock and vomit-inducing nausea “aversion therapy” to supposedly “cure” same-sex attraction, which echoed attempts by the Third Reich to eradicate homosexuality.

These “psycho Nazi” methods continued to be practiced in the UK until around 1973; often by public health service doctors paid for by the taxpayer.

At least one man died while under-going this so-called “treatment” - Captain Billy Clegg-Hill, in 1962. It took me and others over 30 years to expose his cruel, barbaric death. http://bit.ly/jEAqvq

Although aversion therapy officially ceased in the UK four decades ago, even today there are fringe counselors (mostly religiously motivated) who practice so-called “gay conversion therapies”; often using prayer and close supervision techniques rather than electric-shock and nausea-inducing treatments.
Moreover, right up to the mid-1990s some strands of psychoanalysis in the UK took a prejudiced, non-scientific view towards lesbian, gay, bisexual, transgender and intersex (LGBTI) people; refusing to allow them to become therapists and often designating homosexuality as the root cause of a person’s mental health problems - even when there was no evidence to suggest that this was the case.

The World Health Organization only finally declassified homosexuality as an illness in 1990.

This is my story about the 1972 protest against Prof Hans Eysenck:

The London Medical Group (LMG) - a forum for doctors and medical students - held a symposium on 2 November 1972. The subject was aversion therapy, a two-part course on Punishment and Treatment. As an activist in the London Gay Liberation Front, I went along to challenge so-called cure therapies and the psychiatric abuse of LGBTI people.

Professor Hans Eysenck and Dr. Isaac Marks were the speakers at the symposium. Their theme was: Aversion Therapy and Patients' Freedom. It was held at St. Thomas's Hospital, one of London's most prestigious medical establishments, located opposite the House of Parliament. The packed audience were doctors and medical students from across the capital.

Professor Eysenck was in those days one of the world’s leading psychologists - specializing in personality theories and tests and, very controversially and unhappily, in claimed links between race, genetics and intelligence. In the Gay Liberation Front we branded him a "psycho Nazi", because he also advocated reactionary theories on the nature and treatment of homosexuality that sometimes seemed to come close to echoing the homophobic ideas of Nazi leaders, such as Heinrich Himmler and the notorious SS Doctor, Carl Vaernet.

Much favored in establishment and psychiatric circles, Eysenck was the best-known public exponent of aversion therapy - even though it was not a major focus of his work. In various pronouncements he suggested that homosexuality is associated with perverse, abnormal, unnatural, neurotic and criminal behavior. He endorsed the use of aversion therapy to cure what he saw as a misdirected sexual impulse.

Dr. Marks, Eysenck's co-speaker, was a Senior Lecturer and Consultant Psychiatrist at the world-renowned Maudsley Hospital in London and was known for his research into, and application of, aversion therapy.

Interestingly, because of the symposium's controversial theme, and perhaps because the organizers feared disruptions, the LMG took the unprecedented step of closing this particular lecture to members of the public. Undeterred, I succeeded in smuggling myself past security. The door check assumed that I was entitled to enter for apparently no other reason that I was dressed in smart business attire, carried a clipboard and was wearing a doctor's pass that I lifted from reception, while the attendant was distracted.

During the symposium there were no speakers against aversion therapy. It was all rather one-sided, with those who spoke in

fear being famous psychologists of high repute in the medical profession.

The chair of the meeting repeatedly commended Eysenck and Marks, praising "these great men" and their "outstanding contributions to psychology." Even I felt a bit intimidated by their awesome reputations. I guess most of the audience would have also found it difficult to question such esteemed men.

Professor Eysenck began by emphasizing that there was "no relationship between aversion therapy and punishment.....it does not involve sadistic motivations.....Neither does aversion therapy seek to act as a deterrent. The fact is that aversion therapy is used for the patients' own good."

I allowed this and similar statements to pass unchallenged for a while. But having given Eysenck a fair hearing, when similar statements were later repeated I interjected. How could it be for the patient's good if people, having undergone aversion therapy, later become chronic depressives and impotent?

Somewhat taken aback by this unscripted dialogue - as opposed to the intended monologue (no Q and A was scheduled) - Prof. Eysenck continued: "Aversion therapy is only undertaken where it is of the patient's own choice."

Interjecting again, I mentioned the cases of gay men who were virtually blackmailed into undergoing aversion therapy when it was allegedly offered by the courts as an alternative to prison (this was the era when many aspects of gay life remained criminalized). Vulnerable men were also sometimes pressured into it by their families or church. Those who "voluntarily" underwent treatment often felt obliged to do so because of internalized shame about their sexuality and because of the intolerable oppression of homosexuals by society. Remove the stigma and oppression, I argued, and no gay or bisexual men would ever volunteer.

I also raised the question of LGBTI people being induced to volunteer by an exaggeration of the success rate and by the playing down of the pain and discomfort involved.

None of my queries got an answer. But having made my point, I allowed the lecture to continue without further interruptions - for a while.

Nervously continuing, Prof. Eysenck outlined the principles of aversion therapy, which, he explained, were based on Pavlov's experiments on conditioned reflexes. He said it was "used to change the emotions, where the person cannot change them of his own free will.... By associating emotion with pain or fear, the emotional response can be re-conditioned."

Then he went on to explain how, in the case of homosexuals, nausea was induced by drugs, whilst the patient viewed photos of naked men or gay sex. Thus the patient is supposed to learn to associate homosexuality with pain and fear. He mentioned that whilst photographs are used normally, the actual performance or witnessing of a same-sex act would be preferable and produce better results.
Eysenck stated: "There is a success rate of 50 percent, which justifies its use as much as any method."

At this point my patience waned. I challenged him to substantiate his claim of 50 percent success, describing how most gay men who had undergone such treatment remained "uncured" and frequently became deeply unhappy asexual "vegetables". I offered these failures as an explanation for the reported decrease in the use of aversion therapy over the previous two years.

Prof. Eysenck responded, suggesting that "50 percent success was better than no success at all."

I questioned his ends justify the means mentality, and his use of the success rate to justify the continuation of aversion therapy. On both counts it was, I suggested, ethically dubious to say the least.

Eysenck then argued that the therapy hardly merited concern as it was used so little. So why was he making an issue of it by hosting a special lecture on the subject and going out of his way to publicly defend it?

To quieten any fears, he reassured the audience that the pain and discomfort of aversion therapy was greatly exaggerated: "It is just like a visit to the dentist....It is no different from any other form of therapy." Just like a visit to dentist? No different from popping an aspirin for a headache? A bizarre suggestion, I thought.

He went on to describe psychoanalysis as far more traumatic than aversion therapy and entailing greater distress to the patient. Aside from the fact that this assertion is disputable, does the fact that treatment A has bad side effects mean that we should not fuss about the less bad side effects of treatment B? May be they are both bad and morally indefensible.

Prof. Eysenck finished by enthusiastically declaring that "there is no ethical principle involved in aversion therapy that is not involved in any psychological treatment." Although a controversial and contestable claim, the audience responded with loud and prolonged applause.

The second speaker, Dr. Isaac Marks tried to dispel any doubts which my interjections may have raised by citing the film "A Clockwork Orange". He asked how many people had seen the movie. Most of the audience indicated that they had. He then asked how many had actually seen aversion therapy. Three people out of the audience of over 100 indicated that they’d seen it. Perhaps satisfied that few people were in a position to question his authority and claims, he said A Clockwork Orange was a totally inaccurate, exaggerated portrayal of aversion therapy.

Outlining the circumstances under which the medical profession was entitled to use the treatment, Dr. Marks proposed that this should be when the "patient asks for help" or when "society asks to be relieved of the burden of an individual". His second criteria had particularly frightening implications. With that rationale, it could potentially be used against any minority that incurred social disapproval - not just LGBTI people, but also people deemed to be dissenters, outsiders and troublemakers.

To justify this criterion, Dr. Marks drew a very questionable analogy. He said: "For instance no-one objects when people with
smallpox are quarantined...or that sadists and murderers are removed from society." On the basis of this analogy he justified the use of aversion therapy on the individual where it was "in society's interest."

Unable to allow such a statement to pass unquestioned, I demanded to know how LGBTI people could in any way be compared to smallpox carriers, sadists or murderers. This intervention plunged the symposium into chaos.

Amid the uproar, I attempted to point out that the use of aversion therapy "in society's interests" could so easily be abused. Wasn't this the logic used by the Nazis to persecute Jewish, disabled and gay people, Jehovah Witnesses, left-wingers, trade unionists and others?

I was on the receiving end of broadsides from the podium and the audience alike. It was pandemonium.

Dr. Marks asked me to leave. I refused to do so. Stepping back and returning to his seat, he said he would not continue while I was in the room. Ten heavies then surrounded and grabbed me. I was punched and licked as they dragged me from the symposium.

The parting comment from the chairman was that I had spoiled the whole lecture. What a shame. Needless to say, he had apparently never thought of the many LGBTI people whose lives had been spoiled by aversion therapy.

Perhaps it was pure coincidence but the following year all reports of the use of aversion therapy in the UK ceased. It could have continued undercover for a while longer but I was never aware of that.

The 1972 protest was a huge embarrassment and PR disaster for the medical and psychiatric professions. It may have helped finally seal the fate of an already declining and discredited therapeutic practice. I hope so.
Homophobia and HIV: A Response To, and Lessons From, The Jamaican Linked Epidemics

By Maurice Tomlinson

Maurice Tomlinson is a Jamaican lawyer and university lecturer who has been working with a variety of local and international LGBTI groups to combat homophobia and HIV across the Caribbean. He won the inaugural David Kato Vision and Voice Award in 2012, which celebrates the life, legacy, and leadership of the murdered Ugandan LGBTI and HIV activist.

On the night of July 22, 2013, Jamaican Tran* youth, Dwayne Jones, decided to attend a public street dance in the popular resort city of Montego Bay dressed as she identified. From age 14, Dwayne, who also went by the name “Gully Queen”, had been living in an abandoned building with some other gay and Trans* youth, and they had all been evicted from their homes because of their sexual orientation or gender expression.

On this fateful night, Dwayne was dancing with one of her gay colleagues when a female member of Dwayne’s church recognized and outed her to the crowd. They turned on Dwayne, stabbed, shot, ran over her body with a car, and then threw her lifeless remains in nearby bushes before returning to dance. The police found Dwayne’s corpse at 5 a.m. the next morning.

Dwayne was only 16 years old, and although many persons saw this very public murder, there have been no arrests.
Just two years earlier another teen, Oshane Gordon, had met a similar grizzly fate. In the early hours of the morning, armed men burst upon Oshane and his mother while they slept. The men used a machete to chop Oshane on his foot as he tried to escape through an open window. This was done in order to slow him down. When they caught up with Oshane, they finished him off with several more blows with their machetes. The men then returned for Oshane’s mother and chopped her as well. Thankfully she survived. Oshane was murdered because of his “questionable relations” with another man. His mother was attacked for harbouring him.

As the country with the third highest per capita murder rate in the world, many Jamaicans have become desensitized to these acts of savagery. Indeed, when I mentioned to one Jamaican government official that the murders of lesbian, gay, bisexual and trans* (LGBT) Jamaicans was a serious crisis, she blankly stared and said: “We kill straight people too.”

For most of my professional life, I was unfazed/uncathed by this violence. While I certainly identified as gay, I qualified as a “rich queen” because of my relatively privileged position as a lawyer and university lecturer. I therefore had a private car to drive, and I lived in safe gated communities. In addition, I self-selected into exclusive parties where I was certain not to be harassed for my same-gender attraction. At the same time, I knew that I was expected to suppress any visible manifestations of my homosexuality. I could not have a male partner for a sustained period, as that would raise too many questions. Therefore, like many Jamaican gay men, I practiced “serial monogamy” where relationships had a very short shelf life because of the intense and withering public scrutiny.

In addition, I submitted to the religious dictates of this very religious society by getting married to a female as a way to cure my homosexuality. Of course, this did not work, and I ended up hurting her psychologically when the marriage disintegrated.

Mine is not a unique story. What is tragic is that ignorance of these realities, coupled with state ambivalence towards assaults against LGBT Jamaicans, are major contributors to why Jamaica has the highest HIV prevalence rate among men who have sex with men (MSM) in the western hemisphere, if not the world (33%). Attacks against and vilification of gays has simply driven MSM underground, away from effective HIV prevention, treatment, care and support interventions. Further, research by Professor Peter Figueroa, former head of Jamaica’s STI/HIV programme, and now head of Public Health at the region’s premier university, UWI, has identified that nearly 60% of Jamaican MSM also have sex with women, many to mask or cure their homosexuality. This allows for a bridging of HIV between the heterosexual and homosexual populations. A visible manifestation of this phenomenon is seen with regard to other homeless LGBT teens like Dwayne. The hysteria around homosexuality has led some parents to kick their LGBT kids out on the streets as young as 10 years old. Many of these kids used to live in abandoned buildings, however police evicted the youngsters and the structures were then torn down in order to prevent the teens from re-infesting them. A group of these youth are now living in the sewers of the capital city, Kingston. Many of them sell
sex to survive and their mostly married male clients pay them extra for condomless sex. This increases their vulnerability to HIV.

WHY IS JAMAICA SO HOMOPHOBIC?

In a September 2014 poll, 91% of Jamaicans supported the retention of the island’s 1864 British colonially-imposed anti-sodomy law. Many reasons have been proffered for the level and drivers of homophobia on the island. However, research conducted by the University of the West Indies in 2011, and repeated in 2012 confirmed that religion and popular music, or “dancehall”, are the two major culprits. The vast majority of Jamaicans belong to fundamentalist evangelical churches with strong links to North American counterparts. These religious groups regularly preached a virulent and popular brand of homophobia in the late 1980’s at the height of the AIDS epidemic. Gays were identified as biblical abominations who were simply reaping the rewards of their “sinful lusts.” Many Jamaican musicians grew up in church, as attendance was rarely optional. During their formative years, these singers imbibed the anti-gay animus preached from the pulpits, and when they became of age, they simply performed what they knew. As a result, Jamaica now has the record for the most “murder music” per capita, (over 200), which call for the murder of gays, the rape of lesbians, etc.

Jamaica is hardly a quiet society and from Mondays to Fridays these songs were played in buses, taxis, cars, on the radio, at dances, etc. On weekends, persons went to church and were fed another steady diet of anti-gay religiosity. The result was a perfect storm of homophobia. Recently, this anti-gay animus has been supplemented by new flotsam and jetsam of bigoted academics, pastors, lawyers, and politicians from the Global North who are washing up on our shores. These individuals are mostly losers in the marriage-equality culture wars and have sought to peddle their hate on the relatively easier terrain of the Caribbean. These modern-day religious crusaders are now focused on demonizing gays as threats to the family, and most importantly, to children. Regrettably, they have failed to grasp that it is their hate-filled vitriol, which is threatening the lives of young LGBT persons, as seen from the examples of Dwayne and Oshane described above. Blind ideology is often deadly.

The fear-mongering by these imported fundamentalists has been buttressed by resurgence in the HIV epidemic among MSM in some societies that have begun to provide greater protections for the human rights of LGBT people. As reported in the 2012 edition of the Lancet, HIV is raging among French MSM, despite the fact that there are now increased protections for the rights of LGBT people in that country. The simple logic that the homophobic zealots have used in the Caribbean is that anti-gay laws, which are a holdover from British colonization, must remain on the books in order to prevent an explosion in the level of HIV among MSM. Of course, their logic fails because Jamaica HAS such a law, which imposes a term of imprisonment for even private acts of male same-gender intimacy, including two men kissing in a bedroom. And yet, as described above, the country still has the highest HIV prevalence rate among MSM in the western hemisphere. Clearly, therefore, the law does not work to prevent HIV. In fact, the same Lancet article indicated that such laws actually inhibit HIV outreach by, among other
things, limiting the ability of governments to directly advertise anti-HIV services to MSM.

Such anti-gay laws also give licence for homophobic violence, of the sort suffered by Oshane and Dwayne. Gay Jamaicans are effectively "unapprehend criminals" with few, if any rights. Therefore, citizens who attack gays feel that they are doing both the Lord's, and the Law's, work. Although there is an official police policy not to discriminate against victims of crime, it is clear that violations against LGBT people are not rigorously investigated. When I received multiple e-mail death threats for my own activism on behalf of gay Jamaicans, I reported them to the police. However, despite an official request by the Inter-American Commission on Human Rights that the police assist me in finding the persons who sent the threats, they have failed to comply.

In response to these challenging situations, I have been working with local, regional, and international groups to change the laws and policies that sustain Jamaican homophobia and the related HIV epidemic. I am also actively seeking to educate the populace about the serious public health and societal implications of our rabid homophobia.

Starting in 2009, I helped to organize various public events to highlight the presence of local LGBT people; with the deliberate aim to dispel the myth being spread that homosexuality is imported. Along with allies, we also started an aggressive letter-writing campaign to directly rebuff the relentless stream of anti-gay pieces, which were being published in the popular press. An unprecedented number of radio and TV appearances by gay Jamaicans soon followed, including the first paid advertisement that called for tolerance for sexual diversity in the fight against HIV and AIDS. Shortly thereafter we saw a very strong editorial in a major daily calling for recognition of the human rights of gay Jamaicans.

Working with the international NGO, AIDS-Free World, we filed the first ever case challenging the Jamaican anti-sodomy law before the Inter-American Commission on Human Rights. Other cases ensued, including a suit before the Supreme Court challenging three TV stations that refused to air an ad calling for respect for the rights of homosexuals; a case before the Caribbean Court of Justice challenging the ban on the entry of homosexuals into Belize and Trinidad; and another matter before the Jamaican Supreme Court challenging the Jamaican anti-sodomy law. We also conducted extensive capacity building, as well as human rights documentation and advocacy trainings for groups working with LGBT people on the island.

Further, my husband, Tom, and I travelled around the Caribbean delivering LGBT sensitization training for police officers and other stakeholders involved in the AIDS response. We did this first as representatives of AIDS-Free World and then on behalf of the Canadian HIV/AIDS Legal Network. Tom had developed a similar programme while he served as LGBT liaison officer for the Toronto police service and this has been used to train police in North America, Europe, Australia, and New Zealand. The programme was adapted for and brought to the Caribbean because we realized that the security services play an important role in fighting the stigma and discrimination that sustains the HIV epidemic among MSM in the region. Simply
put, people need to get to know homosexuals in order for the fear of sexual diversity to subside. However, gays will not feel safe to be visible until they are reasonably secure that the police will protect them in case of attack. Police have to be exposed to the humanity of homosexuals in order to counteract their social conditioning against gays. That is why I deliver the courses with my husband, so that officers can ask their sometime intrusive, but rarely malicious, questions in a safe space. To eradicate hate we must educate. This includes being visible and vulnerable.

The response of the religious fundamentalists has been predictable, and they have ramped up their anti-gay campaigns in light of the challenges to their religious hegemony. For example, there have been massive island-wide homophobic demonstrations; voter registration campaigns threatening Parliamentarians with political defeat if they repeal the anti-gay laws; well-funded and orchestrated conferences attended by senior government officials denying the human rights claims made on behalf of LGBT people; and deceptive media campaigns which allege that the anti-gay laws are needed to prevent a burgeoning HIV epidemic. Most extraordinary was a coalition of 13 religious groups that joined as interested parties to oppose the constitutional challenge to the anti-sodomy law.

Despite these seemingly overwhelming odds, we have recorded some successes. For example, both the island’s Ministers of Justice and Health have publicly condemned violence against LGBT people along with the anti-gay stigma that is driving the HIV epidemic. The current Prime Minister also indicated her willingness to review the anti-sodomy law when she was campaigning for office, but sadly has yet to deliver on that promise. Many civil society partners have also publicly taken up the cause of human rights for LGBT people, including one brave Anglican priest, Father Sean Major-Campbell, who washed the feet of two lesbians during his World Human Rights Day service on December 7, 2014. This event was reported on extensively for two weeks and helped to disrupt the national narrative of total religious incompatibility with recognizing the human rights of LGBT people. Many parents of LGBT youth are also speaking out in the media in support of their children, and there are plans to establish a shelter for homeless LGBT youth.

There are many challenges ahead, but it is clear that the human rights approach has to precede the biomedical response to fighting HIV in the Caribbean. A simple example will suffice. In our small close-knit societies it is highly likely that if a person sought HIV prevention, treatment, care and support interventions then they would encounter some family member or friend as the healthcare provider. If the health-seeker happens to be gay and has not come out because of hostility towards same-gender relations, then they will not be truthful about their sexual practices. Simply providing Pre-Exposure Prophylaxis (PrEP) or other interventions will not work if people have limited options, or are too afraid, to access them. Therefore, health care workers in the Caribbean HIV response must be alive to the need to combat stigma and discrimination against marginalized groups, even while they fight HIV. I dare say that a similar reality exists in many marginalized and racialized communities in the United States.