

UC Davis

Dermatology Online Journal

Title

Clinical recommendations to address dermatologic healthcare disparities in sexual and gender minority patients: a review

Permalink

<https://escholarship.org/uc/item/4v04q67g>

Journal

Dermatology Online Journal, 27(8)

Authors

Scholl, Matthew
Jimenez, Antonio
Culbertson, Claire
et al.

Publication Date

2021

DOI

10.5070/D327854683

Copyright Information

Copyright 2021 by the author(s). This work is made available under the terms of a Creative Commons Attribution-NonCommercial-NoDerivatives License, available at <https://creativecommons.org/licenses/by-nc-nd/4.0/>

Peer reviewed

Clinical recommendations to address dermatologic healthcare disparities in sexual and gender minority patients: a review

Matthew Scholl¹ BS, Antonio Jimenez¹ BS, Claire Culbertson¹ BSA, Paige Hoyer² MD, Lindy Ross² MD

Affiliations: ¹School of Medicine, The University of Texas Medical Branch, Galveston, Texas, USA, ²Department of Dermatology, The University of Texas Medical Branch, Galveston, Texas, USA

Corresponding Author: Lindy Ross MD, 301 University Boulevard, 4.112 McCullough Building, Galveston, TX 77555, Tel: 409-747-9218, Email: lsross@utmb.edu

Abstract

Background: In the United States, an estimated 4.5% of the population identifies as a sexual or gender minority (SGM). Efforts are underway to address this population's healthcare disparities.

Objective: This review aims to highlight dermatologist's role in treating SGM patients, raise awareness about SGM-related stigma, and identify clinical interventions to improve SGM care.

Methods: Articles were selected by review of literature from PubMed's database from 2000-2020.

Results: The first intervention outlines methods to educate the healthcare team on the terminology used by the SGM community and how HIV epidemiology is a distinct topic through separate trainings. The second intervention emphasizes better communication with SGM patients in routine discussions, including the proper elicitation of a sexual history by avoiding heteronormative questioning. The last intervention discusses enhancing this population's clinical experience by updating clinical intake forms to include a fill-in-the-blank for patients' pronouns, refraining from gender-specific bathrooms, and advertising commitment to SGM care online.

Conclusion: Our review article highlights a dermatologist's integral role in SGM care. The review emphasizes three distinct intervention areas that aim to destigmatize sexual/gender identity in the workplace, promote cultural humility, and improve the therapeutic alliance between SGM patients with dermatologists.

Keywords: general dermatology, HIV health, LGBT health, medical dermatology, sexual gender minority health

Introduction

In 2018, an estimated 4.5% of the United States population identified as sexual and gender minorities [1]. Research has shown that social stigmatization about sexual orientation or gender identity worsens pre-existent healthcare disparities and affects access to care [2-5]. Dermatologists may be the first healthcare provider to interact with sexual and gender minority (SGM) patients for benign or malignant dermatoses, sexually transmitted infections (STIs), or gender-affirmation procedures. Therefore, they are in a unique position to promote an inclusive and safe environment for their SGM patients. This paper utilizes the terminology SGM, rather than LGBT, to use the most inclusive and current language to represent this community. The purpose of this review is to highlight a dermatologist's role in the management of SGM-specific conditions, raise awareness about SGM-related stigma in healthcare and its consequences on dermatological practice, and identify clinical interventions that promote cultural competence, office-based inclusivity, and therapeutic alliance between dermatologists and SGM patients. Furthermore, discussion is needed on the distinctions between SGM and HIV+ patient populations, rather than the often-discussed overlap.

Methods

A review of literature was performed using the PubMed database from 2000-2020. When reviewing the literature, the older term LGBT was utilized to perform a more inclusive and relevant review. The articles selected focused on dermatologic conditions in LGBT patients or HIV+ patients, HIV and LGBT-related stigma in healthcare, quality of care in HIV+ or LGBT patients, clinical management recommendations that destigmatize HIV status and sexual/gender identity, and healthcare disparities among these patient groups in dermatologic practice. The included articles were either review, commentary, randomized control trial, or case series. The excluded articles did not discuss stigma, healthcare disparities, or recommendations to improve the health of HIV+ or LGBT patients.

History of dermatology and STIs, HIV, and SGM health

In the annals of dermatological history, the specialty was first recognized as "Dermatology and Syphilology" or "Dermatology and Venereology" because of a dermatologist's role and focus on the treatment of syphilis and other STIs [6]. Dermatologists were among the first physicians to recognize the cutaneous manifestations of syphilis and document the natural progression of the disease [7]. As the field of dermatology evolved, the treatment of syphilis and STIs was de-emphasized and the term "Dermatology" was used to encompass the treatment of all skin, hair, and nail conditions [7]. Although venereology is no longer markedly emphasized in conventional practice, dermatologists continue to recognize and treat the cutaneous manifestations of STIs, including syphilis, herpes simplex virus (HSV), human papillomavirus (HPV), and HIV [8].

When HIV first emerged, and before widespread knowledge on the disease was available, dermatologists were at the forefront of the diagnosis and management of Kaposi sarcoma (KS), the most recognized cutaneous manifestation of HIV at the time [9]. In addition, dermatologists tackled the cutaneous side-effects of highly active antiretroviral therapy (HAART) such as facial lipoatrophy, morbilliform drug reactions, and Stevens-Johnson syndrome/toxic epidermal necrolysis [9-13]. In 2016, an estimated 707,000 gay and bisexual men were

living with HIV [14]; moreover, in 2019, a systematic review and meta-analysis estimated that 14% of transgender women in the US were living with HIV [15]. Left untreated, the virus can lead to adverse inflammatory, infectious, and neoplastic cutaneous manifestations [16-20]. These manifestations and complications remain a reason why SGM patients present to the dermatologist, but are not the sole reason these patients often seek dermatologic care. An estimated 70% of the 38,000 new human immunodeficiency virus (HIV) cases in the United States occurred in SGM, specifically gay and bisexual men and transgender women [14]. This data (2019) shows that although a majority of cases are in SGM, a significant proportion of new cases are from heterosexual contact and injection drug use. The Centers for Disease Control and Prevention (CDC) indicates around 30% of new HIV cases are not in SGMs [14]. Although historically HIV treatment has been an SGM issue, this finding highlights that HIV positivity and SGM status are less intimately intertwined and deserve independent examination.

Parts of the SGM community, specifically sexual minority males, are at an increased risk for cutaneous skin malignancies [21]. This may relate to the increased usage of indoor tanning by sexual minority males [22, 23]. In addition to the treatment of benign and malignant skin pathologies, dermatologists often have a role in the management of hormone therapy-induced skin conditions and non-invasive cosmetic procedures associated with gender transition [24-27]. To address the healthcare disparities of SGM patients, as well as enact meaningful clinical changes, a discussion regarding the stigma associated with a person's sexual orientation or gender identity is paramount. There is a considerable lack of research done to help dermatologists become culturally competent and sensitive to the needs of the SGM population. Furthermore, discussion is needed regarding the distinctions between SGM and HIV+ patient populations, rather than the often-discussed overlap.

Sexual/gender identify stigma in healthcare and its effect on dermatologic practices

It is well documented that SGM-related stigma can stem from discriminatory social contexts, including peer victimization and rejection [28-30]. Societal

perceptions regarding SGM patients can therefore lead to the development of internalized stigma, which can cause shame, fear of disclosure, and depression [28,29]. In addition, institutional and governmental healthcare policies can also promote discrimination in SGM patients. In June 2020, new legislation eliminated a regulation in section 1557 of the Affordable Care Act, also known as the Health Care Rights Law. This law prohibited discrimination in healthcare against transgender patients. The new provision updated the interpretation of "sex discrimination" to only include male or female patients as determined by their biology [31]. This limits the law's protection of the transgender community, further impeding their access to care and likely increasing societal delegitimization of transgender people. The recent legislative changes highlight the pervasive nature of societal stigma and discrimination against sexual and gender minority patients, but healthcare for both groups is both a human rights issue and public health issue.

There often is a close tie between SGM-related stigma and unfavorable health outcomes. For example, in respect to dermatological procedures, transgender women often resort to illicit use of cosmetic neurotoxin and filler injections. Wallace et al. noted that 16.7% of illicit filler use was associated with transgender women [32]. She also noted that stigma-related barriers put transgender women at a higher risk of seeking out these procedures instead of seeking professional cosmetic augmentation. This alarming rise in unlicensed medical procedures can lead to unpredictable and irreversible consequences for this already at-risk patient population [32]. Additionally, the SGM community is also vulnerable to physician discrimination. It is critical that dermatologists provide procedural access and safe, non-judgmental consultation to their SGM patients.

Clinical stigma-reduction recommendations for dermatologic practices

Intervention 1: education of the healthcare team

Much of the stigma surrounding SGM patients stems from inadequate education on the epidemiology of HIV and the terminology used by the SGM community. Nyblade et al. stated that healthcare workers' lack of understanding of the modes of

transmission of HIV, as well as possibly associating blame with SGM and HIV status, has led to unnecessary fear of contracting the disease from their patients [33]. Providers with these fears may use inordinate precautions when working with HIV+ patients, which can result in alienation [33].

Guidelines from Nyblade et al. suggest implementing an institution-wide HIV training program, which includes all members of the healthcare team [33]. Despite the overlap between the HIV and SGM populations, a training program that combines the healthcare of both groups could perpetuate misunderstanding regarding HIV epidemiology and continue to combine the two patient groups in the trainee's minds. The recommended HIV training should be separate from SGM trainings, incorporate the epidemiology of HIV, demonstrate the proper prophylactic methods used by the clinic to prevent occupational exposures, and delineate each member's role in the reduction of HIV stigma in their practice [33,34]. With regard to HIV epidemiology, the CDCs statistics could be used to educate trainees on the significant proportion of cases that occur outside sexual and gender minorities [14].

Based on the findings of Yeung et al., many healthcare institutions have no SGM education for their employees, leaving their teams poorly equipped to help SGM patients feel comfortable in their clinics [22]. Additionally, providers may not be informed how their interactions with SGM patients can be unintentionally stigmatizing. This stigma can have negative effects on the overall health and wellbeing of their patients. Patients having an initial negative experience with a provider are much less likely to return for follow up treatment even if the provider had good intentions [35]. Knowledge of inclusive language and cultural sensitivity are crucial for developing trust in the physician-patient relationship. Training about SGM health should include defining common terms used by the SGM community and identifying steps the clinic can take to reduce assumptions that may harm members of this population. For example, all staff members interacting with the patient could include their pronouns in their introductions to patients or make

them visible on identification badges, to help patients feel more comfortable sharing their pronouns [36]. Another suggestion from Jia et al. is to increase communication between the staff that will be interacting with the patient. They also recommend enhancing the visibility of the patient's identification information in their chart. These interventions will help to reduce the number of introductions the patient is required to make while in the clinic [36]. The institution should also consider including a survey given before and after the training, as well as periodically throughout the year, to gauge the teams' existing attitudes toward SGM patients [33].

Residency programs should consider implementing separate and specific training programs outlining HIV+ care. Additionally, depending on the program, dermatology residents may receive minimal-to-no training specifically dedicated to the care of SGM patients [37,38]. Trainings about SGM dermatologic care, such as the strategies outlined above, could be implemented to reduce the stigmas residents may carry into their practices after licensing. Residents and faculty may consider attending conferences dedicated to the SGM community to help improve their understanding and patient interactions.

Intervention 2: the clinical role of the dermatologist in providing culturally sensitive care

Dermatologists have a unique role in the clinical diagnosis and care of SGM patients. Sexually transmitted infections often present with a variety of cutaneous manifestations. As such, dermatologists may be the first providers to suspect an STI infection in a patient. The CDC suggests annual testing for HIV in asymptomatic sexually active men who have sex with men, as their sexual behavior puts them at greater risk of transmission and is a clinical indication for screening [39]. It should be noted that research has found that women who have sex with women and men have higher rates of self-reported STIs than women who have sex with only men [40]. For example, HSV-2 seropositivity [41] and oral HPV infection [42] are higher in women who have sex with women than in women who have sex with men. It is imperative that dermatologists are aware of and up to date with the STI testing guidelines for

screenings and offer to test their patients when they are symptomatic or asymptomatic based on these indications [43,44]. A patient's sexual history is crucial in determining their individual risk of contracting STIs and it may provide diagnostic information regarding dermatologic conditions.

Dermatologists should always promote cultural sensitivity and open dialogue when eliciting a sexual history from a patient, but sensitivity is especially important when interviewing members of the SGM community who may feel stigmatized by the sexual history portion of the clinical encounter. An example for sexual history questioning includes, "Are you romantically and/or sexually involved with someone?" "How many sexual partners have you had?" "Are your partners female, male or both?" As with any examination, the clinical necessity of taking a sexual history should be thoroughly explained based on their symptoms to reduce any feelings of discrimination they may experience based on their gender or sexual identity [39]. Providers should maintain use of their patients' pronouns and refrain from using heteronormative questioning [45, 46]. For example, when taking a sexual history from a cis-male patient, providers should refrain from asking "how many women have you been sexually active with?" Dermatologists should consider training courses or conferences that teach them culturally sensitive strategies to empower them with the tools to properly counsel their SGM patients on safer sex practices in a non-judgmental fashion.

Sexual or gender minority patients may feel stigmatized during the clinical encounter by the assumptions made by the provider. Dermatologists should never assume a patient's sexual behavior based on their SGM identity alone; STI testing should only be offered to patients with clinical indication for screening—which includes clinical symptoms, a physical exam, or history of high-risk sexual behaviors [24,39]. If the patient has concerning history or symptoms, it is appropriate to offer STI testing in the same way dermatologists offer STI testing to non-SGM patients. Similarly, providers should refrain from making assumptions about the treatments SGM patients seek, as these assumptions may be incorrect and thus stigmatizing for the

patient [24]. Dermatologists should seek to understand the ever-evolving language of these communities in an effort to provide culturally competent care to their patients, improving patient comfort and outcomes.

National dermatology conferences like the American Academy of Dermatology or the American Society of Dermatologic Surgery can consider the addition of lectures dedicated to further educating attendees on the cultural sensitivity related to SGM patient care at their annual conferences. From a surgical and cosmetic standpoint, workshops and lectures specifically tailored to how to properly cosmetically assess SGM patients and address their concerns would be very useful. Providers should be mindful of what insurance may or may not cover and be ready to offer alternative treatments when possible. Finally, workshops dedicated to education about how to perform gender-affirming procedures would also be of use to dermatologic surgeons to improve their patient interactions and procedural skills.

Intervention 3: enhancing the clinical experience of sgm patients

Combating stigma associated with SGM populations goes beyond the interactions between members of the healthcare team and their patients. SGM patients may face discrimination within the clinic by the exclusive availability of pamphlets lacking SGM representation or the presence of non-inclusive statements on intake forms [24]. These sources of nonverbal exclusion could make patients less willing to disclose their sexual/gender identities to providers they are going to see because the clinic environment is perceived as unaccepting or judgmental.

Several strategies for improving the clinical experiences of SGM patients have been proposed. Jia et al. states the patient's experience begins when they walk into the waiting room and providers should aim to make their patients' entire clinical experiences as inclusive as possible [36]. Providing pamphlets that are relevant to the dermatological needs of the SGM populations, such as gender affirming procedures, can help patients feel more welcome in the clinic. Additionally, prioritizing diversity in the hiring of healthcare team members

may reduce stigma within the office and make patients feel more comfortable and understood. Creating gender-neutral bathrooms and asking patients how they would like to be addressed before calling their name out in the waiting room may also help reduce some of the stress gender minority patients experience when attending their appointments [24]. This can be accomplished by having the patient inform the front desk what name they use or ask this question on the sign-in form.

Sexual or gender minority patients often experience stigma and discrimination when filling out healthcare forms. Many clinical intake forms are outdated and fail to include options that correctly align with patients' sexual/gender identities or their pronouns [47,48]. For questions about gender, sexual orientation, and pronouns, clinics should consider including choices that are more inclusive of the SGM population. Some solutions include giving the option to fill in the blank instead of choosing between strict binary-rigid options or the choice not to disclose that information at all. Leaving self-identification to the patient provides them with more freedom to express themselves without any perceived stigma and allows patients to share what they feel comfortable with disclosing. Including similar options in the patient's chart or in the electronic medical record can ensure that the patient's self-identification information is available to everyone on the healthcare team who works with the patient, thus reducing unnecessary stigmatization or discrimination.

Efforts to reduce the stigma surrounding SGM patients can also be approached online using social media before patients even step into dermatology clinics [49-51]. The patient's experience can begin before they ever walk through the clinic door. Inclusive language on institutional websites and social media platforms can be an effective way of indicating to SGM patients the clinic cares about their health and wellbeing. Simply adding an SGM community symbol, like a rainbow flag, to the website or adding a line about being a welcoming environment to all sexual and gender minorities can help broadcast that the institution is supportive of the SGM population. Jia et al. recounts several hospitals that have created Facebook groups for

specific populations of patients or employees to discuss healthcare issues they face [36]. Dermatology clinics could consider facilitating discussions on online forums, such as Facebook, about topics relevant to SGM communities to digitally provide support to patients who may feel uncomfortable seeking care in person. All these strategies should be considered as potential methods of reducing SGM stigmatization of patients within dermatology clinics.

Conclusion

Sexual or gender minority patients are at risk of stigmatization and discrimination for both their sexual and gender identity. This can lead to significant healthcare barriers and psychological stress on patients. Fear of judgment from healthcare providers can lead to postponement or rejection of care. Although efforts to reduce SGM-related stigma are underway, the removal of policies that protect transgender patients from discrimination further hinders the effort to reach this marginalized population. These discriminative policies can add to a patient's unwillingness to disclose their STI history, sexual orientation or gender identity, and sexual behaviors. Furthermore, discriminatory policies can

contribute to poor communication, a decreased patient-physician therapeutic alliance, and a lack of appropriate illness-related education, screening, and intervention. Sexual or gender minority patients often have cutaneous disease similar to non-SGM populations and dermatologists should strive to promote culturally competent care for their patients and aim to be inclusive regardless of institutional or government policies that deliberately discriminate against SGM patients. Leaders in the field of SGM dermatology may also be sought out to provide lectures and workshops at national conferences like those sponsored by the American Academy of Dermatology and American Society for Dermatologic Surgery. Clinical management recommendations that promote cultural competence and office-based inclusivity to improve the therapeutic alliance can be implemented to improve patient's experience at the dermatology clinic. Dermatologists are in a unique position to positively impact an SGM patient's quality of life and implementing these measures may help them achieve better patient care.

Potential conflicts of interest

The authors declare no conflicts of interest.

References

- Newport F. In U.S., Estimate of LGBT Population Rises to 4.5% (Gallup). 2018. <https://news.gallup.com/poll/234863/estimate-lgbt-population-rises.aspx>. Accessed on January 12, 2021.
- Bockting W, Coleman E, Deutsch MB, et al. Adult development and quality of life of transgender and gender nonconforming people. *Curr Opin Endocrinol Diabetes Obes*. 2016;23:188-97. [PMID: 26835800].
- Hatzenbuehler ML, Phelan JC, Link BG. Stigma as a fundamental cause of population health inequalities. *Am J Public Health*. 2013;103:813-21. [PMID: 23488505].
- Gagnon M. Re-thinking HIV-Related Stigma in Health Care Settings: A Qualitative Study. *J Assoc Nurses AIDS Care*. 2015;26:703-19. [PMID: 26300466].
- Foster PH. Use of stigma, fear, and denial in development of a framework for prevention of HIV/AIDS in rural African American communities. *Fam Community Health*. 2007;30:318-27. [PMID: 17873638].
- Heymann WR. The history of syphilis. *J Am Acad Dermatol*. 2006;54:322-3. [PMID: 16443063].
- Rosen T. Syphilis and the dermatologist. *Cutis*. 2017;100:279-80. [PMID: 29232424].
- Rosen T. Sexually transmitted diseases 2006: a dermatologist's view. *Cleve Clin J Med*. 2006;73:537-8, 42, 44-5 [PMID: 16784153].
- Coates SJ, Leslie KS. What's new in HIV dermatology? *F1000Res*. 2019;8. [PMID: 31297183].
- Kong HH, Myers SA. Cutaneous effects of highly active antiretroviral therapy in HIV-infected patients. *Dermatol Ther*. 2005;18:58-66. [PMID: 15842613].
- Hoosen K, Mosam A, Dlova NC, Grayson W. An Update on Adverse Cutaneous Drug Reactions in HIV/AIDS. *Dermatopathology (Basel)*. 2019;6:111-25. [PMID: 31700852].
- Sharma A, Vora R, Modi M, Marfatia Y. Adverse effects of antiretroviral treatment. *Indian J Dermatol Venereol Leprol*. 2008;74:234-7. [PMID: 18583790].
- Introcaso CE, Hines JM, Kovarik CL. Cutaneous toxicities of antiretroviral therapy for HIV: part I. Lipodystrophy syndrome, nucleoside reverse transcriptase inhibitors, and protease inhibitors. *J Am Acad Dermatol*. 2010;63:549-61; quiz 61-2. [PMID: 20846563].
- Centers for Disease Control and Prevention. HIV Surveillance Report, 2018 Updated (vol.31). 2020. <http://www.cdc.gov/hiv/library/reports/hiv-surveillance.html>. Accessed January 3, 2021.
- Becasen JS, Denard CL, Mullins MM, et al. Estimating the

- Prevalence of HIV and Sexual Behaviors Among the US Transgender Population: A Systematic Review and Meta-Analysis, 2006-2017. *Am J Public Health*. 2019;109:e1-e8. [PMID: 30496000].
16. Trent JT, Kirsner RS. Cutaneous manifestations of HIV: a primer. *Adv Skin Wound Care*. 2004;17:116-27; quiz 28-9. [PMID: 15194973].
 17. Ameen M. Cutaneous markers of HIV infection and progression. *Curr HIV Res*. 2010;8:450-5. [PMID: 20636278].
 18. Garman ME, Tyring SK. The cutaneous manifestations of HIV infection. *Dermatol Clin*. 2002;20:193-208. [PMID: 12120434].
 19. Nnoruka EN, Chukwuka JC, Anisuiba B. Correlation of mucocutaneous manifestations of HIV/AIDS infection with CD4 counts and disease progression. *Int J Dermatol*. 2007;46 Suppl 2:14-8. [PMID: 17958624].
 20. Karadag AS, Elmas Ö, Altunay İ. Cutaneous manifestations associated with HIV infections: A great imitator. *Clin Dermatol*. 2020;38:160-75. [PMID: 32513397].
 21. Blashill AJ. Indoor Tanning and Skin Cancer Risk Among Diverse US Youth: Results From a National Sample. *JAMA Dermatol*. 2017;153:344-5. [PMID: 28030714].
 22. Yeung H, Luk KM, Chen SC, et al. Dermatologic care for lesbian, gay, bisexual, and transgender persons: Epidemiology, screening, and disease prevention. *J Am Acad Dermatol*. 2019;80:591-602. [PMID: 30744875].
 23. Singer S, Tkachenko E, Hartman RI, Mostaghimi A. Association Between Sexual Orientation and Lifetime Prevalence of Skin Cancer in the United States. *JAMA Dermatol*. 2020;156:441-5. [PMID: 32049301].
 24. Sullivan P, Trinidad J, Hamann D. Issues in transgender dermatology: A systematic review of the literature. *J Am Acad Dermatol*. 2019;81:438-47. [PMID: 30885756].
 25. Dhingra N, Bonati LM, Wang EB, et al. Medical and aesthetic procedural dermatology recommendations for transgender patients undergoing transition. *J Am Acad Dermatol*. 2019;80:1712-21. [PMID: 30678999].
 26. Yeung H, Kahn B, Ly BC, Tangpricha V. Dermatologic Conditions in Transgender Populations. *Endocrinol Metab Clin North Am*. 2019;48:429-40. [PMID: 31027550].
 27. Marks DH, Awosika O, Rengifo-Pardo M, Ehrlich A. Dermatologic Surgical Care for Transgender Individuals. *Dermatol Surg*. 2019;45:446-57. [PMID: 30789503].
 28. Hafeez H, Zeshan M, Tahir MA, et al. Health Care Disparities Among Lesbian, Gay, Bisexual, and Transgender Youth: A Literature Review. *Cureus*. 2017;9:e1184. [PMID: 28638747].
 29. Moran TE, Chen CY, Tryon GS. Bully victimization, depression, and the role of protective factors among college LGBTQ students. *J Community Psychol*. 2018;46:871-84. [PMID: 30565737].
 30. Johnson KC, LeBlanc AJ, Sterzing PR, et al. Trans adolescents' perceptions and experiences of their parents' supportive and rejecting behaviors. *J Couns Psychol*. 2020;67:156-70. [PMID: 32105126].
 31. Sanger-Katz M, Weiland N. Trump Administration Erases Transgender Civil Rights Protections in Health Care (The New York Times). 2020. <https://www.nytimes.com/2020/06/12/us/politics/trump-transgender-rights.html>. Accessed on January 8, 2021.
 32. Wallace PM. Finding self: A qualitative study of transgender, transitioning, and adulterated silicone. *Health Education Journal*. 2010;69:439-46. [DOI: 10.1177/0017896910384317].
 33. Nyblade L, Stangl A, Weiss E, Ashburn K. Combating HIV stigma in health care settings: what works? *J Int AIDS Soc*. 2009;12:15. [PMID: 19660113].
 34. Alexandra Marshall S, Brewington KM, Kathryn Allison M, et al. Measuring HIV-related stigma among healthcare providers: a systematic review. *AIDS Care*. 2017;29:1337-45. [PMID: 28599599].
 35. Durso LE, Meyer IH. Patterns and Predictors of Disclosure of Sexual Orientation to Healthcare Providers among Lesbians, Gay Men, and Bisexuals. *Sex Res Social Policy*. 2013;10:35-42. [PMID: 23463442].
 36. Jia JL, Polin DJ, Sarin KY. Ways to Improve Care for LGBT Patients in Dermatology Clinics. *Dermatol Clin*. 2020;38:269-76. [PMID: 32115137].
 37. Park AJ, Katz KA. Paucity of Lesbian, Gay, Bisexual, and Transgender Health-Related Content in the Basic Dermatology Curriculum. *JAMA Dermatol*. 2018;154:614-5. [PMID: 29590284].
 38. Fakhoury JW, Daveluy S. Incorporating Lesbian, Gay, Bisexual, and Transgender Training into a Residency Program. *Dermatol Clin*. 2020;38:285-92. [PMID: 32115139].
 39. DiNunno EA, Prejean J, Irwin K, et al. Recommendations for HIV Screening of Gay, Bisexual, and Other Men Who Have Sex with Men - United States, 2017. *MMWR Morb Mortal Wkly Rep*. 2017;66:830-2. [PMID: 28796758].
 40. Everett BG. Sexual orientation disparities in sexually transmitted infections: examining the intersection between sexual identity and sexual behavior. *Arch Sex Behav*. 2013;42:225-36. [PMID: 22350122].
 41. Xu F, Sternberg MR, Markowitz LE. Women who have sex with women in the United States: prevalence, sexual behavior and prevalence of herpes simplex virus type two infection-results from national health and nutrition examination survey 2001-2006. *Sex Transm Dis*. 2010;37:407-13. [PMID: 20531032].
 42. Sonawane K, Suk R, Chiao EY, et al. Oral Human Papillomavirus Infection: Differences in Prevalence Between Sexes and Concordance With Genital Human Papillomavirus Infection, NHANES 2011 to 2014. *Ann Intern Med*. 2017;167:714-24. [PMID: 29049523].
 43. Esson GA, Holme SA. HIV testing in dermatology - a national audit. *Int J STD AIDS*. 2018;29:611-3. [PMID: 28950765].
 44. Nast A, Rosumeck S, Erdmann R, et al. [Current guidelines in dermatology: A selection of clinically relevant recommendations]. *Hautarzt*. 2016;67:391-6. [PMID: 27052528].
 45. McIntyre M, McDonald C. The limitations of partial citizenship: health care institutions underpinned with heteronormative ideals. *ANS Adv Nurs Sci*. 2012;35:127-34. [PMID: 22469811].
 46. Newman-Valentine D, Duma S. Injustice to transsexual women in a hetero-normative healthcare system. *Afr J Prim Health Care Fam Med*. 2014;6:E1-5. [PMID: 26245442].
 47. Brown C, Frohard-Dourlent H, Wood BA, et al. "It makes such a difference": An examination of how LGBTQ youth talk about personal gender pronouns. *J Am Assoc Nurse Pract*. 2020;32:70-80. [PMID: 31232865].
 48. Guss CE, Eiduson R, Khan A, et al. "It'd Be Great to Have the Options There": A Mixed-Methods Study of Gender Identity Questions on Clinic Forms in a Primary Care Setting. *J Adolesc Health*. 2020;67:590-6. [PMID: 32402797].
 49. Hatzenbuehler ML, Pachankis JE. Stigma and Minority Stress as Social Determinants of Health Among Lesbian, Gay, Bisexual, and Transgender Youth: Research Evidence and Clinical Implications. *Pediatr Clin North Am*. 2016;63:985-97. [PMID: 27865340].
 50. Mustanski B, Greene GJ, Ryan D, Whitton SW. Feasibility, acceptability, and initial efficacy of an online sexual health promotion program for LGBT youth: the Queer Sex Ed intervention. *J Sex Res*. 2015;52:220-30. [PMID: 24588408].
 51. Jaganath D, Gill HK, Cohen AC, Young SD. Harnessing Online Peer Education (HOPE): integrating C-POL and social media to train peer leaders in HIV prevention. *AIDS Care*. 2012;24:593-600. [PMID: 22149081].