

WORCESTER medicine

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LGBT access to healthcare in the community

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 321 Main Street, Worcester, MA 01608
 e-mail: wdms@massmed.org
 web: www.wdms.org
 phone: (508) 753-1579

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 88 Winter Street, Worcester, MA 01604
 (508) 756-5006
sales@pagioinc.com

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Editorial

Jane Lochrie, MD



Jane Lochrie, MD

Though the lesbian, gay, bisexual, transgender (LGBT) community is diverse, these patients face a common set of challenges in accessing culturally competent health care services. Numerous health disparities stem from structural and legal factors, social discrimination and lack of knowledge of health care providers. Individuals in same-sex relationships are significantly less likely to have health insurance, report more unmet health needs and are less likely to receive preventative care. Older adults are particularly vulnerable, as they do not have access to spousal benefits though Social Security.

Due to several factors, including lack of research and the reluctance of some individuals to answer survey questions about their sexual practices, it is difficult to define the size and distribution of the LGBT population. Researchers estimate that 3.5 percent of U.S. adults identify themselves as lesbian, gay or bisexual and 0.3 percent are transgender (approximately 9 million people). What is clear is that there is a large population at risk. This issue of *Worcester Medicine* looks at these concerns.

In the first article, Shelley Ware, LCSW, states that health care workers do not receive sufficient training in the unique needs of LGBT elders. Insufficient training leads to inadequate services and staff that lack empathy and knowledge of LGBT issues. This leads to health care avoidance behavior by elders and may result in poor outcomes.

John Trobaugh, MFA, describes a transgender patient panel that he hosted for the medical students as part of a Population Health clerkship. Patients requested to be addressed by their correct names and pronouns by all staff, from the front desk to the physician; to be treated with kindness and respect; and not to have to educate their doctors about their health care needs. Medical records must be inclusive so that every provider working with a patient can know their preferred name, gender and pronoun.

Erika Oleson, DO, MS, opines that the older LGBT adult may opt for silence when it comes to discussing their sexual identity. In recent studies, 40 percent of 60- to 70-year-old LGBT patients stated that their health care provider did not know their sexual orientation and 56 percent of LGB older adults and 70 percent of transgender individuals experienced discrimination in their health care.

Since its founding almost 30 years ago, AIDS Project Worcester has been supporting the LGBT community in the area. Martha Akstin, director of Prevention and Screening, enumerates the group's many outreach programs. Today, AIDS Project Worcester hosts Supports of Worcester Area Gay and Lesbian Youth (SWAGLY) and provides a wide range of support services regardless of HIV status, including overdose education and Naloxone distribution. Sadly, she reports that

many medical providers are uncomfortable discussing sexual practices and prescribing pre-expose prophylaxis (PeEP). She provides some simple suggestions to make patients more comfortable discussing their sexual health.

Sean Cahill enumerates the many health care disparities that LGBT persons encounter and provides us with ways to make our practices welcoming to this community, including asking patients their preferred names and querying persons accompanying a patient about what their relationship is to the patient.

As always, the medical students at the University of Massachusetts Medical School have made a significant contribution to this issue of *Worcester Medicine*, and the Editorial Board is very appreciative of their contributions and, in particular, we are grateful to the efforts of our student representative, Alex Newbury.

A third-year medical student, Brittany Novak, gives a heartfelt description of her experience working with Drs. Blake and Feldman in the Youth Gender Clinic at the UMass Memorial Children's Medical Center. This clinic provides holistic care, addressing the physical and emotional needs of children who are struggling with gender identity, as well as their families.

Joseph Homsy, also a third-year medical student, has a passion for creating an atmosphere that is inclusive of all LGBTQ students, faculty and patients on the UMass campus, which certainly comes through in his comments. He has already done an enormous amount of work in this regard, including starting an elective for medical students on LGBTQ health, initiating the ID badge rainbow sticker campaign and placing educational material in more than 200 outpatient offices. Though he ends by saying a lot more can be done to address the LGBTQ health care inequality, we applaud his enormous contribution.

Alireza Edraki, a Ph.D. candidate, asserts that one would expect health care policies to protect such a vulnerable minority, but the facts say otherwise. LGBTQ individuals are at higher risk of certain sexually transmitted diseases, mental disorders and substance misuse, yet have less access to health care. He calls for institutions to develop and display inclusive policies, sensitivity training for health care workers and for health insurance to provide equally to the LGBTQ community.

The Legal Consult deserves a special recognition. Jennifer Garner, Esq., defines sexual orientation, gender identity and gender expression. Society expects these to align, but there are times when they do not, and this can cause angst in patients and their families. She explains conversion therapy, an attempt to change a child's or adolescent's actual or perceived sexual orientation, gender identity or gender expression, is outdated and injurious, especially to a child or adolescent already in distress. Legislation has been introduced in Massachusetts that would prohibit any licensed medical professional from engaging in conversion therapy.

Please don't forget to read the President's Message, Society Snippets and As I See It before closing this issue.

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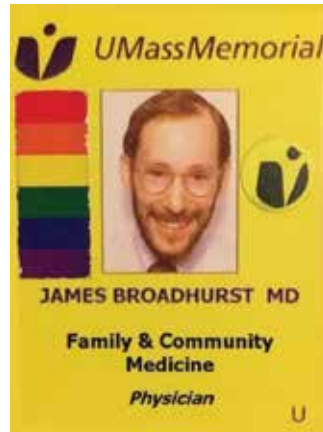
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Face disparities and embrace diversity

James Broadhurst, MD



James Broadhurst, MD

I am very proud to be a member of the Worcester District Medical Society – the privilege of being president is both icing on the cake and affords me the opportunity to contribute to our focus as a society for my tenure. This year, our holiday reception included a screening of *Something the Lord Made*, an HBO dramatization of the life of Vivien Thomas and the contributions he made to groundbreaking medical advances and to the birth of cardiac surgery in his partnership with Dr. Alfred Blalock. Sharing the experience of viewing this film together provided an opportunity for those present to confront striking depictions of institutional racism, which characterized life in the United States in the 1930s to the 1950s, both on the street and in our academic medical centers. Two of my colleagues from the Department of Family Medicine and Community Health at UMass, Drs. Ivonne McLean and Heather Lyn Haley, facilitated a discussion after the film, which probed our understanding of and sensitivity to issues of privilege, poverty and the persistence of unconscious bias in our society. Indeed, these issues exist in Worcester, in our health care institutions and, yes, in our Society. This is an uncomfortable area in which to practice self-reflection. Our colleagues in Minnesota provided their perspective in the Dec. 1, 2016 issue of *The New England Journal of Medicine* with an essay titled, “Structural Racism and Supporting Black Lives – The Role of Health Professionals.”¹ I encourage you to read and reflect. If you have more time, you might review the 2003 Institute of Medicine

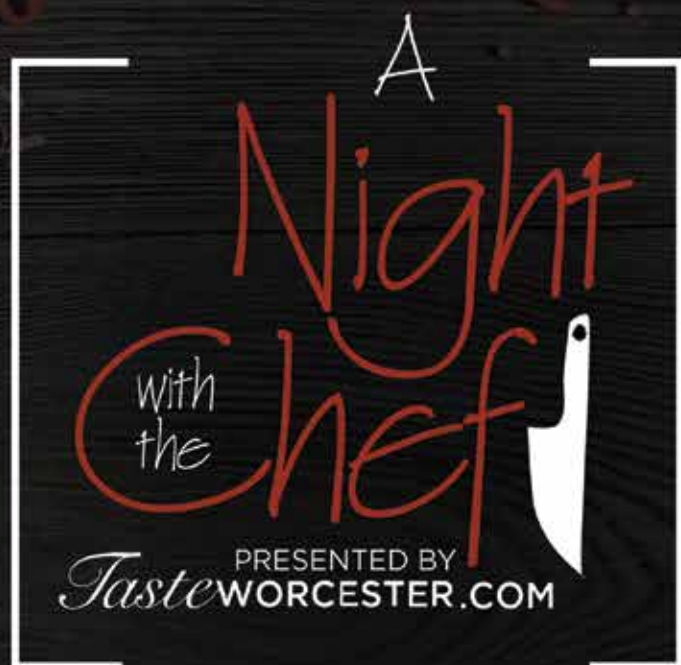
report, “Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care.”²

This issue of *Worcester Medicine* highlights another area in health and patient care which deserves our attention from the perspective of disparities, discrimination and the potential for and the promise of sensitivity and inclusion. Medical students at the University of Massachusetts Medical School have led the way in the area of LGBT compassionate, inclusive care by challenging all health professionals to demonstrate our willingness to learn, to be open and to advertise our commitment to sensitive care. The simple, yet powerful, intervention is to provide stickers to be applied to one’s ID badge – a sticker with the colors of the rainbow (see the picture of my badge). Many readers with institutional administrative responsibilities will recognize that implementing this intervention was a considerable feat. Among the obstacles to identify and to surmount was to have those responsible for what could and could not be displayed on the official identification badge to approve the rainbow sticker! Stickers are available throughout UMMS – ask any medical student for help to obtain one for your ID badge.

Finally, I wish to acknowledge a colleague whose name does not appear in the table of contents of this issue but who has contributed in ways both large and small to improving care for patients regardless of gender identity, gender expression, sexual orientation or preference. Dr. Diane Blake is a specialist in Adolescent Medicine in the Department of Pediatrics at UMMS. “Dede” is a leader in the Learning Communities in the medical school as a mentor and having served as a head of house and the coordinator of the first-year course in Doctoring and Clinical Skills. My thanks to her for her quiet, but sustained and tireless, efforts to help us provide better, more sensitive and comprehensive care for all of our patients.

References

- ¹ “Structural Racism and Supporting Black Lives – The Role of Health Professionals.” *NEJM*, 375;22 December 1, 2016 p2113-2115.
- ² “Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care.” Institute of Medicine, 2013. The PDF is available at <http://nap.edu/10260>.



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Aging without closets

Shelley Ware, LCSW



Shelley Ware, LCSW

In my first year of grad school, I was allowed to go to the annual Hospice and Palliative Care Conference as part of my internship. I had been a geriatric social worker for more than 10 years, so having to choose several seminars to attend throughout the day, I decided to go with a topic that I did not know much about: LGBT and Aging. What occurred during that seminar was that my career and role as advocate was changed forever.

In 2010, Stu Maddox directed a documentary called *Gen Silent*. This documentary was filmed in Boston and tells the story of six

older adults who identify as gay, lesbian, bisexual or transgender – LGBT for short. These six people selflessly opened the window to their private worlds in the hopes of bringing awareness to a social and societal dilemma that many people may not know exists. This dilemma surrounds the health care disparities that currently face our aging LGBT population.¹

Over the past five years, research has revealed an alarming trend, showing that health care workers do not receive sufficient training in the unique care needs of LGBT elders. This lack of education creates an unfortunate domino effect. Insufficient training of medical workers results in inadequate services and staff that lack empathy and knowledge of LGBT issues. Subsequently, this leaves LGBT individuals with a limited number of clinics that provide informed, quality care. The deficiency of care, in turn, leads to health care avoidance behaviors by LGBT elders and can result in health complications, comorbidities and, in many cases, premature death.

I could not believe that this was possible! It is the 21st century, after all, and we live in an age of tolerance, individuality and respecting the rights of all people, right? Not so much.

LGBT baby boomers, also referred to as “Stonewall Seniors,” fought for gay rights and equality in the 1960s and are now being considered the first “out” generation in LGBT history.² Stonewall Seniors are retiring, becoming frailer and are having to think about their aging needs, including the possibility of having to depend on others for care. However, many of them are not seeking that care out of fear that direct care workers who come into their homes might discriminate against them. Other fears include possible abuse or the force of religious prayer with the purpose of asking forgiveness for their “choice” of engaging in homosexual behaviors.

One key concern is how we gain back the trust of LGBT baby boomers. These boomers came out of the closet and fought for gay equality during a time of intolerance, a time when people were deemed mentally ill because of their sexual orientation.³ Gender dysphoria, defined as “a marked incongruence between

one’s experienced/expressed gender and their assigned gender,”⁴ continues to be a diagnosis in the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* or DSM-5. Although it was kept in the DSM as a means of ensuring access to care and effective treatment options,⁵ it still carries a connotation of psychiatric illness. As a result of past discrimination and insensitivity from service agencies, LGBT elders are reluctant to disclose their sexual orientations or gender identities or to access services from non-LGBT agencies.⁶

Recent population-based surveys indicate that approximately 3.5 percent of adults in the U.S. identify as lesbian, gay or bisexual and 0.3 percent of adults identify as transgender.⁷ This equates to nearly 9 million people,⁸ and at least 1.5 million of them are older than 65.⁹ By 2030, the number of LGBT older adults will likely double.¹⁰ Additional statistics by Gallup polls over the last two years have shown that LGBT older adults are more likely to live and die alone and are less likely to have children than older heterosexuals.¹¹ The polls also revealed that only 1.9 percent of people age 65 and older identified as LGBT as opposed to 2.6 percent of people between the ages of 50-64.¹² This shows that, as they continue to age, fewer LGBT older adults are revealing their true sexual orientation or gender identity, often out of fear. They are also more likely to rely on friends – referred to as their “family of choice” – rather than biological family, to meet their needs.

Advancement is critical in ensuring that all agencies serving the elder population are LGBT-friendly. It begins with raising awareness on this issue with elder care agencies. Trainings need to be provided to all medical and direct care staff in order to develop cultural competence and sensitivity when dealing with the unique needs of the LGBT elder population. These steps are critical so that LGBT elders can stop being afraid and can confidently seek medical and in-home, hands-on care as they age. No elder should be alone and without the compassion and quality care that is needed in the later years of life.

Many LGBT elders that reside in central Massachusetts will choose to travel a longer distance in order to go to a LGBT-educated clinic, such as Fenway Health in Boston, to receive their health care rather than go to a clinic that they do not feel will treat them with dignity and respect. There is a need in the Central Massachusetts area for more training, education and services dedicated to this population. There are some agencies, including the Worcester LGBT Elder Network (WLEN) and Worcester Agency on Aging, but more needs to be done at *all* Central Massachusetts agencies that service elders.

On January 15, 2015, Bill H.526 was filed by Massachusetts State Representative Elizabeth A. Malia. This bill calls for LGBT awareness training for aging services providers.¹³ The bill started with the House Committee on Elder Affairs in January 2015 and was moved forward to the Senate, which concurred with the bill. A hearing was then scheduled with the Joint Committee in October 2015, and in November 2015, it was referred to the Committee on House Ways and Means, where it remained until July of this year. The committee recommended an amendment, and Bill H.4535, with the same title, has substituted Bill H.526 and has been ordered

to a third reading. This bill, which proposes that all agencies that service older adults be mandated to have LGBT awareness and competency trainings, still has to be passed in the Massachusetts House and Senate before it can be signed into law. In the meantime, there are no requirements for agencies to receive this critical education outside of their own desire to better serve this population.

Those in the *Gen Silent* documentary took a risk with their transparency to shed light on the very real dilemma that geriatric physicians, social workers, nurses and other care providers are now facing. Becoming advocates for this underserved population – with the goal of establishing trust, so that they will allow us into their safe spaces – is pivotal in order to provide the care they will need at the end of their lives. This *has* to be done in a judgment-free way, however, and that means that those who want to be advocates need to educate themselves and keep their minds and hearts open.

Lawrence, who cared for his partner, Alexandre, said it best in the *Gen Silent* documentary when describing this societal dilemma: “I think there are a lot of people hidden. Just as Alexandre and me; we were hidden ... and I think there are many gay couples like that, especially a lot of older gay couples who are very comfortable in their little isolated worlds. They’re protected, but when illness happens, this becomes a real threat to their environment; to their *protected* environment...our home is the safest environment. It is the one place where the closet no longer exists.”¹⁴

Shelley M. Ware is a licensed certified social worker (LCSW) and works as a geriatric social worker for a Program of All-inclusive Care for the Elderly (PACE) as well as hospice. She received her MSW at Springfield College School of Social Work

References

- ¹ Maddux, S. (Director). (2010). *Gen Silent* [Motion Picture].
- ² Fitzgerald, E. M. (2013). *No Golden Years at the End of the Rainbow: How a Lifetime of Discrimination Compounds Economic and Health Disparities for LGBT Older Adults*. The National Gay and Lesbian Task Force, Washington. Retrieved from www.thetaskforce.org
- ³ Lim, F. A., & Bernstein, I. (2012, May/June). PROMOTING AWARENESS of LGBT Issues in Aging in a Baccalaureate Nursing Program. *Nursing Education Perspectives*, 33(3).
- ⁴ American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington D.C.: American Psychiatric Publishing.
- ⁵ American Psychiatric Association. (2013). *Gender Dysphoria fact sheet*. Retrieved from DSM5: <http://www.dsm5.org/Documents/Gender%20Dysphoria%20Fact%20Sheet.pdf>
- ⁶ Rogers, A., Rebbe, R., Gardella, C., Worlein, M., & Chamberlin, M. (2013, August). Older LGBT Adult Training Panels: An Opportunity to Educate About Issues Faced by the Older LGBT Community. *Journal of Gerontological Social Work*, 580-595.
- ⁷ Werner, C. A. (2011). *The Older Population: 2010*. Retrieved October 31, 2015, from United States Census Bureau: <http://www.census.gov/prod/cen2010/briefs/c2010br-09.pdf>
- ⁸ Ard, K. L., & Makadon, H. J. (2012). *Improving The Health Care Of LGBT People: Understanding and Eliminating Health Disparities*. The National LGBT Health Education Center, The Fenway Institute; Brigham and Women’s Hospital; and Harvard Medical School, Boston.
- ⁹ *Sage general facts & discrimination*. (2012-2015). Retrieved October 31, 2015, from Sage-Services and Advocacy for Gay, Lesbian, Bisexual & Transgender Elders: <https://www.sageusa.org/issues/general.cfm>
- ¹⁰ Fitzgerald, E. M. (2013). *No Golden Years at the End of the Rainbow: How a Lifetime of Discrimination Compounds Economic and Health Disparities for LGBT Older Adults*. The National Gay and Lesbian Task Force, Washington. Retrieved from www.thetaskforce.org
- ^{11, 12} Gates, G. J. (2015). *In U.S., LGBT More Likely Than Non-LGBT to Be Uninsured*. Retrieved July 5, 2015, from Gallup Poll Web site: <http://www.gallup.com/poll/175445/lgbt-likely-non-lgbt-uninsured.aspx>
- ¹³ MA Legislature. (2016, April 10). *Bill H.526: An Act relative to LGBT awareness training for aging services providers*. Retrieved from The 189th General Court of The Commonwealth of Massachusetts.
- ¹⁴ Maddux, S. (Director). (2010). *Gen Silent* [Motion Picture].



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Trans-inclusive care

John Trobaugh, MFA



John Trobaugh, MFA

We recently hosted a transgender patient panel for our medical students as part of a Population Health clerkship. The students wanted to get to know some patients who are transgender in the community, so I invited some friends. It started with a good friend, Jesse, who has been an advocate for many years: “The basics of what is needed for a positive health care interaction for transgender patients is known: being addressed by correct name and pronouns by ALL staff (front desk all the way to physician), being treated with respect and kindness, not having to educate

our own doctors about our lives and health care needs. Transgender patients deserve to have these interactions during every single visit. If an institution is only addressing training needs in the wake of patient complaints, then something is already terribly wrong.”

No one wants to be wrong. Everyone is afraid of the unknown. Here is personal story (echoed by many) that point to the right direction. I asked my friends to tell me what would be an ideal interaction, what would be a correctable mistake and what would be a catastrophic mistake. In general, when it is clear the office or institution is making a good faith effort (as above), people understand mistakes happen.

The following story illustrates the need for a systemic response. George, a trans man, told his story:

“Last winter I went to a local hospital ER with chest pains after shoveling heavy snow for two hours. I felt like some stupid statistic of the middle-aged guy overdoing the shoveling and having a heart attack. I was, in the end, not having a heart attack but had pulled a muscle in my chest. But I had to deal with many medical professionals, as I was first in the ER, then checked in for observation and testing all night with a stress test in the morning. This hospital’s medical record system had no way to mark my preferred name and gender. So, I found myself explaining myself to numerous medical professionals, one after the other, while I was also worried I might have had a heart attack! First with the front desk staff, then with the initial intake nurse, who told me, when I asked, that was no way to put my preferred name in the system.

“When I was taken in to a medical room in the ER to wait, I was pleased to see an intern who seemed genderqueer or trans. They came over to me, and we had an excellent discussion and were both so happy to meet each other. They were dealing with their own issues of being trans and non-binary and being misgendered and not understood

in their hospital workplace. We really bonded, and it showed me the importance of having trans medical providers as part of being welcoming to trans patients. Once I was wheeled upstairs to a hospital room for the night, I explained to the overnight nurse manager about being a trans man, and she said she’d tell my nurse. I may or may not have said something to the phlebotomist. In the morning, I explained to the transport staff and the provider doing my stress test. She and I had a very open conversation, and she told me about learning a lot from a trans woman patient in the past. I decided to be very open and answer questions she had about transgender people. That was a positive experience.

“All the staff was respectful, but it was exhausting feeling like I needed to continually explain myself during an ER and overnight hospital visit – all because their medical record system was not designed to be inclusive of transgender people. That is a huge issue. Medical sites need to devise and invest in electronic and paper medical record systems to be inclusive so that every medical provider working with a patient knows the patient’s preferred name, gender and pronoun.”

There are very specific recommendations for the Fenway’s LGBT Health Foundation (<http://www.lgbthealtheducation.org/lgbt-education/learning-modules>) under “Improving Health Care for Transgender People.” However, if you follow Jesse’s guidelines above, create a system where your office can note the patient’s preferred name and be aware that annual exams often cover routine exams for the opposite gender. It is respectful to use a preferred name for any patient whose name differs from their legal/insurance name. It is also a good practice to make your office welcome greeting and general language as gender neutral as possible – and the staff has less to interpret! We have all been mistaken by a bad connection or a cisgender person* who has an uncommon voice or appearance. When you are trans, this can happen at every single interaction. It wears you out, but the staff would never know. The annual exam, as well as hormone replacement therapy, can both be handled by the patient’s general practitioner – at least once the baseline has been set by an endocrinologist.

In the end, patients just want to deal with what ails them, not their normal everyday existence.

Special thanks to Chris, Colleen, Chastity, Debbie, Evan, George, Jesse and Lori, who all took time to respond to the panel in person or in writing to my many questions.

*Cisgender is a term for people who have a gender identity that matches the sex that they were assigned at birth.

John Trobaugh is a leader in the LGBTQIA community and arts educator with experience in using storytelling for patient and provider education through digital media. He also writes for Pulse Magazine’s Out and About monthly LGBTQIA column. John is a diversity specialist in the Diversity and Inclusion Office at UMass Medical School and UMass Memorial Health Care.

Medical care for the LGBT community

Martha Akstin

AIDS Project Worcester (APW) was founded in 1987 to help those with AIDS – primarily gay men back then – die with dignity. Today, we help those with HIV/AIDS live full and rewarding lives, thanks to advances in medical treatment and critical psycho-social supportive services. As you, as a medical provider, know, the face of AIDS has changed over the decades and now can be found in every racial, ethnic and socio-economic stratum in America.

Our history of outreach and care into the gay, lesbian, bisexual and transgender (GLBT) community continues to be part of who APW is today. Although the agency has expanded services into other areas, such as overdose education, Naloxone distribution, the city's syringe services program and counseling and testing for HIV/HCV and other sexually transmitted infections, we honor these roots in the GLBT community.

APW hosts SWAGLY (Supporters of Worcester Area Gay and Lesbian Youth), a weekly GLBT youth drop-in support program, and the agency offers two transgender support groups. APW acts as resource for Worcester County's GLBT residents. Through the agency's Prevention and Screening Department, we provide a range of services to support, counsel and educate members of the GLBTQ community who live and work in Central Massachusetts. Services are offered to individuals regardless of their HIV status (HIV positive or negative).

At least once a month, the agency receives a call or an email asking, "Are there any gay-friendly doctors in Worcester?"

How are we supposed to answer this question? Aren't all doctors gay-friendly? With world-class medical institutions in the city, why are people asking this question?

When folks are asked to explain what has happened to them, they talk about encountering bias or prejudice when they try and speak to their medical providers about health issues or sexual practices. Many say their medical provider appears uncomfortable, which in turn makes them feel uncomfortable. If it's a man who has sex with men, the medical provider is often hesitant or refuses to prescribe pre-exposure prophylaxis (Prep), which is a way for people who

don't have HIV to prevent HIV infection by taking one pill every day. However, many primary care doctors are uncomfortable about prescribing Prep – even when their patients ask for it – and instead refer them to an infectious disease doctor or clinic. Several young men have told APW outreach workers that they wouldn't be on Prep if it were up to their primary care doctors, that they had to advocate for them to get on this CDC-approved regimen. But what about those who don't know how to self-advocate?

Another gap in medical services in the Worcester area that APW hears about is medical care for the transgender community. Fenway Health in Boston is seen as "the Cadillac" for trans health, but why is that? Many trans folks struggle with transportation challenges to get to Fenway. There are many transgender men and women right here in Central and Western Massachusetts who could benefit from a trans medical clinic.

When asked what their medical providers could do to make them more comfortable, many say something as simple as a gay-friendly brochure in the waiting room or exam room would speak volumes. One person mentioned that a doctor at the adult clinic at UMass does have such literature, but she hasn't seen it in other offices at other medical institutions. The American Medical Association agrees and recommends that providers "consult the Guidelines of Care for Lesbian, Gay, Bisexual and Transgender (LGBT) Patients, created by the Gay and Lesbian Medical Association, for advice on communicating with LGBTQ patients, guidelines for forms and patient-provider discussions and more."

Speaking of forms, they are a great opportunity for patients to feel included. Are patients asked their gender identity at birth and their gender identity now? Are they asked if they are male-to-female or female-to-male? Is there a question that asks if they are a man who has sex with men or a woman who has sex with women?

These are all simple ways to overcome stigma: begin a discussion about sexual health and create an atmosphere of inclusion and respect. Perhaps it's just a matter of being aware that there is an issue in the first place.

Martha Akstin is the director of Prevention and Screening at AIDS Project Worcester.

Health considerations for the LGBT older adult

Erika Oleson, DO, MS



Erika Oleson, DO, MS

Lesbian, gay, bisexual and transgender (LGBT) older adults may face several challenges to their health care. It is estimated that there are more than 3 million LGBT individuals in the United States that are older than 55.¹ With the aging baby boomer population, this number is estimated to double over the next 20 years.¹ Older adults have experienced changes in perceptions about LGBT issues throughout their lifetime. Homosexuality was considered a psychiatric disease until the American Psychiatric Association removed it from the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) in 1973.

LGBT older adults may opt for silence in their interactions with health care providers and health care system. In a research study from Services and Advocacy for Gay, Lesbian, Bisexual and Transgender Elders (SAGE), 1,857 LGBT individuals ages 45-75 years old and 519 non-LGBT individuals were studied. Forty percent of 60- to 70-year-old LGBT study participants said their health care providers didn't know their sexual orientation.¹ A study showed that 56 percent of LGBT older adults faced discrimination in their health care and 70 percent of transgender individuals had experienced discrimination in their health care.²

Social support and networks may also have variations for LGBT individuals. Many LGBT older adults have long and lasting partnerships and may have created families comprised of individuals to whom they are not biologically related. Thirty-two percent of older LGBT individuals live alone, compared to 21 percent of non-LGBT individuals.¹ Forty percent of LGBT older people say their support networks have become smaller over time, compared to 27 percent of non-LGBT people.¹ Thirty-two percent of LGBT older persons are concerned about "being lonely and growing old alone," compared to 19 percent of non-LGBT persons.¹ As individuals age and have different medical illnesses, there is an increased risk for needing a health care proxy. LGBT individuals may identify a partner or friend as their preferred health care decision-maker.

There are differences in health conditions for LGBT individuals. The Washington State Behavioral Risk Factor Surveillance System Data 2003-2010 included 96,992 persons, of whom 853 women and 651 men identified as gay or bisexual.³ In this study, lesbian and bisexual women had higher odds for disability (Adjusted Odds Ratio=1.47) and poor mental health (AOR=1.40). Also, gay and bisexual men had higher odds for poor physical health (AOR=1.38), disability (AOR=1.26) and poor mental health (AOR=1.77).

Transgender individuals have their own specific health needs. The National Transgender Discrimination Survey included 6,450 transgender individuals, of which 110 were older than 65. The study found that 70 percent of transgender adults older than 65 have delayed gender transition to avoid discrimination in employment. Sixteen percent of transgender older adults report attempted suicide at least once in their lifetime, and 13 percent of transgender older adults reported abusing alcohol and drugs to cope with mistreatment.⁴

In 2015, the American Geriatrics Society (AGS) published a position statement for the care of LGBT Older Adults.⁵ The statement included

emphasizing the development of a culture of respect for LGBT older adults that reside in facilities that provide care, such as assisted living facilities and long-term care facilities. It is estimated that 120,000 LGBT older adults reside in long-term care facilities.⁶ Some of these facilities may not allow partners to share a room. Older adults may not express their sexual orientation or gender identity when they become ill, vulnerable and dependent on others. The American Medical Directors Association (AMDA) published a white paper regarding care of the LGBT individuals in long-term care settings.⁷ AMDA's recommendations included encouraging facilities to revisit admission and procedure forms to incorporate appropriate language, to have all members of the interdisciplinary team to include pertinent discussion with spouse/life partner/significant other during initial assessment, and to ensure privacy for all individuals.

The AGS policy statement recommended specific skills that health care providers can utilize to impact the care of the older adult patients.⁵ These skills include taking a social history that is inclusive of the LGBT individual and taking a sexual history that is open and encourages disclosure. Also, for a transgender individual, the medical history should include medical surgeries and hormone therapies that the individual has undergone.

Additionally, health care providers can ask the patient about pronoun preference.⁸ Providers may ask about relationship status and sexual attraction/behavior. Providers should offer a supportive environment and encourage individuals to bring in partners/caregivers. Providers should stay relaxed, make eye contact and avoid asking unnecessary questions. Create an environment of accountability for staff and continue to use a patient's preferred name and pronoun, even when they are not present.

LGBT older adults may have unique health concerns and social structure considerations. As health care providers, we need to be aware of these concerns and consider them as we develop treatment plans for our older adult patients in order to provide comprehensive, inclusive care for older adults.

Erika Oleson, DO, MS, is an assistant professor of Family Medicine and Community Health, Division of Geriatric Medicine, University of Massachusetts Medical School.

References

- 1 "Out and Visible: The Experiences and Attitudes of Lesbian, Gay Bisexual, and Transgender Older Adults Ages 45-75." <http://www.sageusa.org/resources/publications.cfm?ID=214>. Accessed Dec.11, 2016.
- 2 "When health care isn't caring: Lambda Legal's survey of discrimination against LGBT people and people living with HIV." www.lambdalegal.org. Accessed Dec.11, 2016.
- 3 Freriksen-Goldsen, et al., "Health Disparities Among Lesbian, Gay, and Bisexual Older Adults: Results From a Population-Based Study," *Am J Public Health*. 2013; 103(10):1802-1809.
- 4 "Improving the Lives of Transgender Older Adults." <http://www.sageusa.org/resources/publications.cfm?ID=13>. Accessed Dec.11, 2016.
- 5 "American Geriatrics Society Ethics Committee, American Geriatrics Society Care of Lesbian, Gay, Bisexual, and Transgender Older Adults Position Statement," *JAGS*. 2015.
- 6 Cohen, HL and Jenkins, D, *Older Lesbians and Gay Men: Long-term Care Issues, Annals of Long-Term Care* 2008; 16 [2].
- 7 "In the Care of Lesbian, Gay, Bisexual, and Trans-Gender Persons in the Long-Term Care Setting," American Medical Directors Association White Paper, March 1, 2012.
- 8 "Affirmative Care for the Transgender and Gender Non-Conforming People: Best Practices for Front-line Health Care Staff." http://www.lgbthealtheducation.org/wp-content/uploads/13-017_TransBestPracticesforFrontlineStaff_v6_02-19-13_FINAL.pdf. Accessed Dec. 11, 2016.

What does quality care for LGBT people look like?

Sean Cahill, Ph.D.



Sean Cahill, Ph.D.

Outside of overt discrimination from providers and other staff in health care facilities, which still happens, the primary problem lesbian, gay, bisexual and transgender (LGBT) patients in Massachusetts face is accessing quality care from providers who understand the unique health needs of the LGBT population. Both “Healthy People 2020,” a national health promotion and disease prevention initiative of the United States Department of Health and Human Services issued in 2010, and “The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding,” a 2011 report by

the Institute of Medicine, found that LGBT people are at increased risk for a number of health disparities when compared to the general population, including:

- LGBT youth are two to three times more likely to attempt suicide.
- LGBT youth are more likely to be homeless.
- Lesbians are less likely to receive preventive cancer screenings.
- Gay men are at higher risk of HIV and other STDs, especially black and Latino gay men.
- Lesbians and bisexual females are more likely to be overweight or obese.
- Transgender individuals have a high prevalence of HIV/STDs, violence, victimization, mental health issues and suicide and are less likely to have health insurance than heterosexual or LGB individuals.
- Elderly LGBT individuals face additional barriers to health because of isolation and a lack of social services and culturally competent providers.
- LGBT populations have disproportionately high rates of tobacco, alcohol and other substance use.

What does quality care for LGBT people look like? It begins with ensuring that your practice welcomes and affirms all people. Discrimination based on sexual orientation and gender identity should be explicitly prohibited in your employee manuals and organizational policies. Signs and literature in waiting and exam rooms should welcome LGBT patients. A rainbow sticker or other image at the front desk sends a message that a practice is LGBT-friendly. Patient education materials on sexual health should explicitly include LGBT people and address same-sex behavior. Add statements about welcoming LGBT patients to your website and patient portal. Proactively identify your practice or health center as LGBT-inclusive in provider directories.

Many of the steps that can be taken to make your practice or health center inclusive of LGBT patients hold the potential to improve the experience of care for all patients. Consider the practice of asking all new patients their preferred name. This is a very important question for transgender patients, who often use a first name that differs from what

is on their health insurance card or medical record. But it also benefits any patient who prefers to be called by a nickname, a middle name instead of a first name, etc.

Train all staff in how to affirm LGBT patients and families. For example, while tending to a new mother with an infant, a doctor who sees two women in the exam room with the baby might assume that the new mom has brought her sister to the exam. The second woman could be a sister. But she could also be a close friend or the baby’s other mother. Employee training should include a reminder to introduce yourself first and then ask those in the exam room for their names and relationships to each other. Again, this benefits all patients.

It’s important for clinicians to seek out training on the provision of comprehensive health care for LGBT patients. Start by educating yourself about common health issues and disparities among LGBT patients. The IOM report referenced above is a good place to start.

Recognize that multiple intersectional identities related to race, ethnicity, language, disability and immigration status may lead to health disparities. For example, black gay men have much higher rates of HIV than white gay men. This is not because they have more sexual partners than white men; in fact, studies have shown that they have fewer. The disparity is directly related to lower rates of health insurance and access to health care among black gay men because of racial discrimination and economic inequality. As a result, black gay and bisexual men have higher rates of undiagnosed and untreated sexually transmitted infections that can facilitate HIV infection, higher rates of undiagnosed HIV infection and lower rates of antiretroviral treatment adherence if diagnosed with HIV. Because of these factors, there is a greater per-capita pool of non-virally suppressed HIV-positive men in black gay male social and sexual networks, which makes it easier for HIV transmission to occur among black gay and bisexual men.

Become familiar with primary care protocols specific to transgender individuals and be aware of continued need for screenings and services for transgender patients based on their current anatomy. Most transgender men should be screened for cervical cancer, as relatively few undergo hysterectomies as part of their transitioning process. Yet many doctors may not even think to ask their transgender male patients about whether or not they still have a cervix, and fewer still have been trained to conduct such an exam in a sensitive and gender-affirming manner.

There are many resources available to health care staff and clinicians. The American College of Physicians recently published the second edition of *The Fenway Guide to Lesbian, Gay, Bisexual, and Transgender Health*, which should be on every clinician’s shelf. The National LGBT Health Education Center of The Fenway Institute also offers free webinars and publications available online. Topics range from best practices for front-line health care staff in providing affirmative care for transgender people to taking a sexual health history with new patients to building patient-centered medical homes for LGBT patients and families.

Sean Cahill, Ph.D., is director of Health Policy Research at The Fenway Institute at Fenway Health in Boston.

Transcending barriers to transgender care

Brittany Novak



Brittany Novak

What would you do if you never quite felt right in your body? If you spent your life trying to conform to society's expectations of the person you should be, but deep down, you knew that the gender that society saw on the outside was not the gender that you felt on the inside?

You might try to lie to yourself. You might self-medicate with recreational drugs or face bullying or isolation from your peers. You might struggle with depression and anxiety, engage in high-risk sexual behaviors or reach suicidal levels of desperation.

These are just some of the struggles that transgender and non-binary youth face all across the country. Here in Worcester, fortunately, adolescents have the Youth Gender Clinic to help them navigate these difficult issues.

Drs. Blake and Feldman have built a Youth Gender Clinic here at UMass Memorial Children's Medical Center to help children and families struggling with gender identity and dysphoria. The services they provide through their clinic are wide-ranging and tailored to their patients' and families' specific needs. Discussions start with gender identity exploration. Some sessions are devoted to dealing with family issues, like parental support or parental disapproval of their child's situation and desires. Care is provided in a holistic way, addressing the physical and emotional issues most pressing to the patient, as well as building their support network at home and in the community.

Patients who are interested in medical transition may face a variety of hurdles, including gaining support from their parents, maintaining acceptance from romantic partners as their bodies change and working with their schools to assure that everyone uses their preferred name and correct pronouns. Drs. Blake and Feldman also meet with parents and children who are pre-pubertal or early in puberty to discuss the possibility of blocking puberty. This provides children additional time to explore their gender identity without developing the secondary sex characteristics of their natal sex.

After initial counseling sessions, the discussion turns to medical intervention. Drs. Feldman and Blake discuss the anticipated effects (reversible and irreversible), benefits and risks and typical side effects of hormone therapy. After ensuring that patients (and parents, if the patient is a minor) have provided informed consent, they provide their patients with hormonal therapy to help youth transition to their affirmed genders. They meet with their patients frequently throughout this process to assess progress, answer questions and see how their patients are doing.

In just a few days in clinic with Dr. Blake, I saw some powerful situations with patients.

One of the patients undergoing hormone therapy was struggling with clitoromegaly from the testosterone he was receiving. Dr. Blake asked if his clitoris had increased in size since the last visit. Turning away, he mumbled, "I don't know. I try not to ever look down there." His mumbled reply was a heartbreaking insight into his world.

Another patient felt like he was spiraling into depression because of several stressors, chief among them his impending menstrual period. Adolescence can be an incredibly turbulent time of self-discovery and self-acceptance. To compound that state with revulsion from the biology of one's own body seems an unbearably cruel burden to bear.

Some patients are fortunate to have the support of their parents. One patient's mother is so proactive about helping her son transition that she has not only navigated insurance coverage for transgender services and changed the gender marker on things like his license, passport and other legal documents, but she has also offered to write a manual about it for Dr. Blake to help all her future patients.

Other patients had much of their meeting with Dr. Blake devoted to family discussion and acceptance. One patient's mother could not quite yet support her son to initiate hormonal therapy to begin the transition. In counseling her, Dr. Blake recommended an excellent book, *Helping Your Transgender Teen: A Guide for Parents*, to help her to have a better understanding of her child's experience. She also offered the mother space to discuss her concerns and feel heard. Chiefly, the mother's concern was the permanent nature of the hormonal effects and what would happen to her child if she changed her mind at a later time. While that meeting did not change anyone's mind, it facilitated the discussion that may ultimately lead to this mother's permission for her son to have hormonal therapy.

In one short week, I was able to watch Dr. Blake help her patients through many stages of their gender experience. With one patient, we discussed body image. With another, we talked about his girlfriend's difficulty contemplating continuing their relationship when his therapy led him to develop male characteristics. Another patient appointment was devoted entirely to diet and exercise counseling – the focus of the appointment was standard health care maintenance because our patient was so well established in his gender transition!

Through the week, I marveled at the amazing services that Dr. Blake provided her patients. Before she and Dr. Feldman opened this clinic, where did these adolescents go for information, support and answers to their questions about medically transitioning to their affirmed gender? Would they have found care, or would the trajectory of their lives be entirely different for lack of access to this care?

The gender clinic that Drs. Blake and Feldman have started fills a tremendous need in our community. It was a privilege to spend a few days seeing one of my mentors shaping her practice to suit the needs of the community she cares for.

Brittany Novak is a third-year medical student at the University of Massachusetts Medical School.

His name isn't Stacy – improving health care for LGBTQ patients

Joseph Homs, B.S.



Joseph Homs, B.S.

The patient was waiting for his electroconvulsive therapy (ECT) when we met. He was a teenager, had a scruffy beard and was wearing a faded hospital johnny. Just like many adolescents, he fidgeted between talking to me – a third-year UMass medical student – and texting on his phone. The patient said his ECT treatments had helped him with his depression. I told him I was glad it was working for him. As I leaned on the overbed table, I began to read the patient's chart: "Patient Name: Stacy." Looking back up, I smiled and was admittedly a bit confused. Typically, a patient's chart reveals to us more about a patient, but at that moment, I was unsure if I even knew this patient's name. I excused myself and walked over to the nurse as she prepared the IV bags for that morning's ECT session. "Is that patient's name actually Stacy?" I said. "Well, whatever the chart says," she responded. I paused, and then asked, "Has anyone asked the patient what name they go by?" I walked back over to the patient. "You can call me Jason," he said.

Fathom this moment: when secretaries, nurses, physicians and medical students all call a patient, who has depression, the wrong name. Moments such as this highlight the health disparities that affect LGBTQ people and the importance of creating an atmosphere that is inclusive of all LGBTQ patients. As a medical student at UMass, I wanted to change the atmosphere on campus to be more inclusive for LGBTQ students, faculty and patients. By doing so, I hoped to create a more welcoming environment that provides acceptance to a population that has been frequently ignored.

The first step I took was to create an elective on campus called LGBTQ Health Education, with the stated goal being to educate medical students on how to provide appropriate and sensitive care to patients who are LGBTQ. Students were taught about LGBTQ terminology, health disparities affecting LGBTQ people and how to have conversations about relationships and sexual behavior without assuming heterosexuality. By learning how to ask questions that mirror the terms and pronouns that patients use to describe themselves, students learned how to affirm their patient's sexual orientation and gender identity. More specifically, we also spoke about the care of transgender patients, including the process of transitioning, hormonal therapy, gender-affirmative surgeries, and even prostate, breast and cervical cancer screening in patients who have transitioned. Through our collaborations with Fenway Health, Boston Children's Hospital, the Stone Wall Center at UMass Amherst and UMass Medical School, we created a curriculum that made the LGBTQ Health Education elective become the most attended elective at UMass Medical School. Students who participated in the elective overwhelmingly said they

felt more comfortable, confident and prepared to provide care for patients who are LGBTQ.

In addition to the elective, I also began the ID Badge Rainbow Sticker initiative, which offered rainbow stickers that UMass students and staff could place on their ID badge (see image). LGBTQ patients often search for subtle cues to determine acceptance in an environment, and the hope was that these simple stickers placed on personnel badges would make LGBTQ patients feel more welcome. For many patients, their clinicians may be the first individuals to whom patients "come out," and such discussions are further encouraged when a patient knows their physician would support them. While this initially started as a small initiative among medical students, it came to involve primary care physicians, hospitalists, emergency medicine physicians, surgeons, nurses, valet employees and even custodians. The hashtags #BeAnAlly and #UMassWelcomesAll became a focal point of the campaign, which spread across the entire UMass Memorial Health Care system. After a few short months, more than 10,000 ID Badge Rainbow stickers had to be ordered to meet demand. My mentor, who works as a family medicine physician, told me his patient of 10 years had come out to him just recently. The patient stated that he was unsure what his doctor would think of him, but then he saw his sticker.

In an effort to further create a welcoming environment for patients, we wanted to place educational pamphlets in outpatient rooms to encourage patients to talk to their health care providers about being LGBTQ. Through collaborations with Fenway Health, we brought their "Do Ask, Do Tell" pamphlets to our UMass University Campus. The pamphlets emphasized to patients that by "coming out" to their providers, their clinician can provide them more comprehensive and personalized care. Other areas the pamphlets highlighted were behavioral, physical, sexual and reproductive health, which are especially relevant in the LGBTQ population. Patients were also encouraged to tell their providers the terms that they prefer to use, as well as how they describe themselves and their partners. Most importantly, they were reminded that their conversation would be confidential and protected by law. The pamphlets were initially placed in a handful of outpatient rooms, but after much popularity among clinicians and patients, the program was expanded. Currently, the pamphlets are in more than 200 outpatient rooms throughout the UMass Memorial Health Care system and the initiative is continually growing.

While we have made tremendous progress at UMass throughout the past few years, there is always more that can be done to address LGBTQ inequality in health care. To begin addressing these inequalities, providers must first become mindful of the sexual orientation and gender identity of their patients. Just as we strive to provide culturally competent care to any community, we must also offer equally competent and sensitive care to the LGBTQ community. This requires us to begin taking nonjudgmental histories using proper terminology, creating inclusive environments for our patients and educating ourselves on the health issues that are important to LGBTQ patients. Lastly, we must spend time reflecting to discover any biases or personal sentiments that may impede our ability to provide the supportive care that our LGBTQ patients need. Enacting these changes will enable clinicians to provide the highest quality health care for all patients, especially those in the LGBTQ population.

All patient names in this article have been changed to protect their privacy.

Joseph Homs, B.S., is a third-year medical student at UMass Medical School in Worcester. He is a local of Norwood, who enjoys playing piano and spending time with friends and family. He is an active advocate for equality in health care. His current clinical interests lie in anesthesiology and internal medicine.

LGBTQueued for health care

Alireza Edraki



Alireza Edraki

Due to the lack of better words, I identify as a “white heterosexual male.” As a result, I initially had a contentious inner debate over writing about the LGBTQ community and their experience with health care. But I realized that was exactly the problem: We do not have to be a member of a community to empathize with their experiences. All it takes is educating one’s self and a sense of compassion.

Word choice plays a significant role in human cognition. The acronym LGBTQ itself implies a sense of alienation, them vs. us. It ignores the continuity of sexual orientation by grouping a very diverse group of

people together. American society is slowly realizing this; we have come a long way from the term “homophile” in the ’50s to LGBTQ in the 2010s. But the acronym by no means encompasses all sexual orientations and everything in between. The scientific consensus is that there are underlying biological and psychological aspects behind the sexuality of every single individual. Perhaps there will come a day in the future when our society has either accepted the continuity of sexual behavior or has run out of letters to describe different orientations.

Regardless of semantics, the well-being of 40 million Americans is not trivial. The health of the LGBTQ community is intertwined with social and financial obstacles. For example, 20 percent of the homeless youth in America are LGBTQ (compared to comprising about 10 percent of total youth population). Such a disproportionately high number of homeless among the LGBTQ results in financial hardship, higher risk of diseases with less access to health care, and social isolation. One would expect health care policies in place to protect such a vulnerable minority group, but the facts say otherwise.

Historically, our health care system has shown an extreme bias against the LGBTQ community. Until 1973, homosexuality was listed as a disorder in the *Diagnosics and Statistics Manual of Mental Disorders*. Fifty years later, we no longer attribute sexual orientation to disease, but the underlying biases have more implicit manifestations. In 2007, 18 percent of Californian doctors reported discomfort in treating gay or lesbian patients. In another survey, about one in three LGBTQ respondents suffering from HIV reported that health care professionals refused to touch them. This inequality seems to be more or less nationwide, and Massachusetts is no exception. For example, MassEquality, a Massachusetts-based LGBTQ advocacy organization, reports similar health experiences for the community in Massachusetts. It is therefore unsurprising that many LGBTQ individuals refrain from disclosing their sexuality to their doctors, which may have unforeseen consequences.

Although no disease is specific to a sexual orientation, information regarding an individual’s sexuality is paramount to effective diagnosis and treatment. LGBTQ individuals are at higher risk of certain sexually transmitted diseases, mental disorders and substance misuse. For example, LGBTQ adolescents are three times more likely to commit suicide than their heterosexual counterparts. In fact, the mental well-

being of the LGBTQ community is perhaps the least appreciated aspect of their health care. A study found that 17 percent of gay men had experienced an eating disorder, compared to about 3.4 percent of heterosexual men. An alarming 95 percent of the LGBTQ community report feeling lonely and isolated, with adolescents particularly at risk of social isolation. Imagine you are a 19-year-old lesbian suffering from depression. Would you disclose your sexuality and risk being discriminated against or hide this information and risk misdiagnosis? No individual in need of health care should be faced with such a lose-lose conundrum.

So far, we have assumed that the LGBTQ community has access to health care and is willing to seek it. Unfortunately, most members of this community face difficulties accessing health care, primarily due to a lack of employer-sponsored health plan, and those with insurance are more likely to report unsatisfactory experiences with their health care than their heterosexual counterparts. But as it turns out, even the availability of health care does not guarantee that the individual will ask for help. The LGBTQ community often receives unequal treatment (or rejection) from medical institutions, which creates a lack of trust and renders seeking health care seemingly obsolete. For example, more than half of transgender individuals report reluctance to seek medical help due to the discrimination they face.

This is a problem we can no longer sweep under the rug. But like most things in life, the solution is more complicated than we would like it to be. A total eradication of health care inequality relies on many factors, but what steps can we take to improve the LGBTQ’s experience with health care?

We should educate health care professionals about LGBTQ health. Medical institutions must develop and display inclusive policies regarding gender and sexuality. We should create awareness in doctors, nurses and the general public by distributing LGBTQ health fliers and brochures in hospitals and clinics. A few hospital systems, like Mount Sinai in New York City, have already launched medical and sensitivity training with promising results.

Health insurance must be provided equally to the LGBTQ community, and violators must face penalties. No individual should fear being discriminated against by disclosing his or her sexuality to their insurance or medical professional.

Above all, we need to foster a welcoming environment for all. Our kids must be raised with the core belief that sexuality is a part of human nature, that our sexual preference is something that makes us unique, something that must be celebrated. We need a culture of acceptance; we need to put care back in health care.

Alireza Edraki is a Ph.D. candidate at the RNA Therapeutics Institute, UMass Medical School. He can be reached at Alirezaedraki.wordpress.com.

References

- “LGBTQ homeless youth report”, National Alliance to End Homelessness. www.endhomelessness.org
- “When Healthcare Isn’t Caring” (2010). Lambda Legal Foundation.
- “Healthcare Inequality Index” (2016). Human Rights Campaign Foundation.
- “Learning to be LGBTQ-friendly” (2015). Johnson, S.R. www.ModernHealthcare.com
- “Health care problems of lesbian, gay, bisexual, and transgender patients” (2000). Lee, R. Western Journal of Medicine. www.Massequality.org

The line between help and harm: the medical consensus and legal state of conversion therapy for LGBTQ minors

Jennifer Garner, Esq.

The public's understanding of sexual orientation and gender identity has come a long way in the past several decades.

Although once considered an abnormal medical condition that was listed in the *Diagnostic and Statistical Manual of Mental Disorders*, alongside bipolar disorder and major depressive disorder, homosexuality has long been removed as a diagnostic category. Now, it is generally understood that sexuality exists on a continuum and variations in sexual orientation are part of the normal range of sexuality.

What is the difference between biological sex, gender identity and gender expression?

Unlike sexual orientation, gender identity refers to a person's deeply felt, inherent sense of being a girl, woman, or female; a boy, a man, or male; a blend of male or female; or an alternative gender. This concept is distinct from a person's sex, which is based on biological attributes. Gender identity is also distinct from gender expression, which pertains to the way that a person presents or communicates their gender to others.

A person's biological sex, gender identity and gender expression are separate aspects of one's complete identity. However, society expects that they will align – and many times, they do. In other words, most individuals who are assigned a female biological sex at birth identify as girls and adopt a traditionally feminine gender expression.

Although gender dysphoria still appears in the *Diagnostic and Statistical Manual of Mental Disorders*, the newest definition marks a shift from its earlier versions. The critical element of the current classification is the distress that a person experiences due to issues surrounding gender identity. Gender nonconformity is not, in and of itself, a mental disorder.

Sexual or gender minority youth are at increased risk for psychological distress, substance use behavior and suicidality, among other risk factors. Those who lack supportive environments are especially vulnerable, as those risks tend to stem from stresses of prejudice, discrimination, rejection, harassment and violence – not from the person's sexual orientation or gender identity itself.

There is a broad sense in the medical community that sexual orientation and gender identity are immutable traits. Notwithstanding that fact, requests for treatment geared to change a child's or adolescent's actual or perceived sexual orientation, gender identity or gender expression persist. These types of treatment are known as conversion therapy, and such practices have been rejected by every mainstream medical and

mental health organization.

The severity of such practices vary; some use talk therapy and/or shame to instill loathing for same-sex attraction and/or transgender identity, while others use aversive conditioning by inducing nausea, vomiting or paralysis while exposing the person to certain images; electroshock therapy; forcing stereotypical gender-role behaviors; and hypnotizing subjects to impose change. Not only are these practices discredited, they pose significant health risks and worsen the psychological distress that young members of the community already face. Requests for these types of therapy most often come from a parent or guardian.

So, where is the line between supportive therapy and conversion therapy, and how do we draw it?

Supportive therapies emphasize acceptance, support assessment and understanding. The goal is to identify sources of distress and work to reduce them. Notably, these types of therapy do not seek predetermined outcomes – the defining feature for supportive therapy is that its goal is to reach a patient's best level of psychological health and should focus on allowing the person the freedom of self-discovery within a context of acceptance and support.

In contrast with conversion therapy, supportive therapy does not endeavor to repair, change or shift a patient's sexual orientation, gender identity or gender expression.

How do we protect LGBTQ youth from conversion therapy?

Many jurisdictions, including California, Oregon, New Jersey, Washington, D.C., Illinois, and Vermont, have banned the use of conversion therapy by licensed medical professionals within their respective states. Although other states have introduced bills to ban those practices, the success of those bills varies.

Legislation has been introduced in Massachusetts that would prohibit any licensed medical professional to engage in conversion therapy, require mandatory reporting of suspected instances of its use and define any advertising which promotes conversion therapy as deceptive practices in violation of the Massachusetts Consumer Protection Act. But that legislation has not yet become law.

These protections are crucial for the health of minors. Too often, children fall victim to conversion therapy because they cannot make their own decisions with respect to medical care.

Jennifer Garner, Esq. is an attorney in Bowditch & Dewey LLP's litigation practice and editor of the firm's blog, LGBTQ Legal Issues.

Worcester's time is now

Edward M. Augustus, Jr., Worcester City Manager



Edward M. Augustus, Jr.

The following edited extracts are from the keynote address of City Manager Edward M. Augustus Jr. at the annual meeting of the Worcester Regional Chamber of Commerce on Friday. He prefaced his remarks with appreciation to a number of people, including Mayor Joseph M. Petty and the City Council for their leadership and support, and his predecessor, Michael V. O'Brien, for setting in motion some of the developments he was describing.

I was invited to speak at this event two years ago, and a lot has changed since then, for the city and for me. I was still a bit naïve, but I was fueled

by optimism for the future.

What we are experiencing right now is a truly unique time in the history of our city.

Going back and looking at my remarks from two years ago, I had one central message: "Worcester is the second largest city in New England. Let's start acting like it."

I would submit to you that's exactly what we're doing. Worcester is no longer content to just get by. Worcester is now the model for other cities of our size.

Drive around the city and you can see it, and you can hear it, and you can feel it. The momentum is real. Those cranes down the street are building the future of a dynamic and exciting downtown. The murals now adorning our urban landscape are symbols of a creative energy bursting out across our community. There are new manufacturing jobs being created at the South Worcester Industrial Park and in Quinsigamond Village. There are new restaurants and places to have fun in the Canal District and Shrewsbury Street and downtown and all across our city.

Worcester's time is now.

Yes, there will be those who will roll their eyes at the very idea that good things are happening. I grew up here, and I've seen that mentality forever.

Which is why it's been so gratifying to see us finally break free of those shackles.

Worcester has seen close to \$3 billion in investment over the past five years. This year, home prices are up 5 to 8 percent. Rental rates are up

8 percent. And how could you miss the new hotels already redefining our skyline? Those hotels are being built for a reason. Our hotels are consistently full.

Across the city, property values in the last year have shot up by a billion dollars.

That sounds like a big city to me.

And big cities have strong and vibrant downtowns. That's what we're building here. Our vision is one where downtown is a neighborhood ... where people work, play, go to school, AND live. A downtown that doesn't pack up and head home at 5 o'clock, but a downtown that people return home to at the end of the work day.

In the next 18 months, 350 luxury apartments will be completed at CitySquare and more than 2,000 people will be living in new housing across downtown. We've already seen new restaurants and hotels. UMass (Memorial) is bringing hundreds of new jobs downtown. This is a vision – and it's already becoming a reality.

And the city of Worcester is supporting those efforts with critical investments in infrastructure, public safety support and programming. Walk around downtown now, and you'll notice new streets and sidewalks.

And next year, we'll embark on the granddaddy of them all: an \$11 million dollar complete overhaul of Main Street ... a re-envisioning of what Main Street is, including new streets, new sidewalks, new ornamental lighting, a dedicated bike lane, new brick-banded crosswalks and public art installations ... a 21st-century Main Street built to encourage parking your car and walking to multiple experiences, all throughout downtown.

It will include a complete redesign of Carroll Plaza in front of the Hanover Theatre.

I recently attended an event at the Hanover Theatre held by the Massachusetts Restaurant Association. The executive director told the gathering that the two hottest markets for restaurateurs in the state are the seaport district in Boston ... and the city of Worcester.

In the past 18 months, 55 new restaurants have opened in Worcester. Fifty-five!

And a huge part of welcoming those new visitors into our city is providing a clean and safe environment. So I'm extremely happy to share with you another data point:

Crime is down. I'll say it again: Crime is down. We already were the envy of similarly sized cities like Hartford and Springfield, and in 2015, the numbers went even lower. Violent crime was down nearly

8 percent. Property crime was down 4 percent, according to the FBI's crime statistics.

I know that any crime is too much and that statistics don't comfort the victim of a crime. But I'm confident that with the leadership of our new police chief, Steve Sargent, we will build on our success, continuing to pursue innovative policing methods and making Worcester even safer.

Engagement at the neighborhood level is key to the success of our police department. Part of that success is our newly formed Neighborhood Response Team, an innovative approach that is already drawing rave reviews and producing real results.

The work of building a city is not just about the infrastructure or the development projects. It's the people. And it starts young. And I'm so proud to work with my new partner, Superintendent Maureen Binienda, as we work with all of you to make sure that Worcester has the best urban school system in Massachusetts.

Early in my tenure, we created a program called Recreation Worcester. Every day in the summer, from 9 a.m. to 5:30 p.m. in 10 parks across the city, we offer free recreation, arts and educational activities to the young people of our city. We hire high school and college-age kids from the neighborhood as counselors; we provide free lunch and dinner; and we give parents across the city peace of mind. Parents who now know their kids are safe, active and continuing to engage their minds and bodies during the summer.

We've now expanded Recreation Worcester to the school year as an after-school program. AND we're doing it with no taxpayer money, through the generosity of private partners, many of whom are here in this room today.

As many of you hopefully read, Fitch Ratings has given Worcester its highest-ever municipal bond rating – a double A. To put that into context, that's four rungs higher than Fitch rates the city of Providence.

The question is no longer how can Worcester be more like Providence or Portland – it is now how can they catch up to Worcester?

When you leave here today, carry this message that Worcester's time is now... to everyone who still might not have heard it and those who still might not believe it

Source

Posted: Sunday, Dec 4, 2016 at 6 a.m.

<http://www.telegram.com/opinion/20161204/as-i-see-it-city-manager-edward-m-augustus-jr---worcesters-time-is-now>

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221ST ANNUAL ORATION

"A GLASS (MORE THAN) HALF FULL: TOP TEN REASONS TO BE OPTIMISTIC ABOUT THE NEXT 220 YEARS OF MEDICINE IN WORCESTER."

Wednesday, February 8, 2017; 5:30pm
Beechwood Hotel, Worcester



**ORATOR:
TERENCE R. FLOTTE, MD**

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SAVE THE DATE

ARTS, HUMANISM, AND CAREGIVING: A SYMPOSIUM

Saturday, April 29, 2017; 7:45am – 3:00pm



This symposium is about caregiving and caregivers – what we can do for those in need and what we can do about caring for ourselves. We will tell you surprising – maybe even dazzling – things we can do for those in need and how that all works. We will also speak of caring for ourselves, since, after all, if we can't care for ourselves, we can't really care for others. Those of us in the caregiving business often forget that vitally important piece of the equation.

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LITERATURE AND MEDICINE

"Finding Hope and Healing Through the Arts" Drs. Frank Domino, Gary Blanchard
"Why We Need to Tell – and Listen to – Stories" Dr. Lucia Knoles

MUSIC AND MEDICINE

"Symphony of the Brain" Dr. Joel Popkin
"Music Therapy: Clinical Applications within the Medical Model"
Ms. Kayla Daly, MT-BC, LMHC

ART AND MEDICINE

"The Art of Observation" Dr. Jim Welu
Docent tours of the Worcester Art Museum
Dr. Paul Steen, et al.

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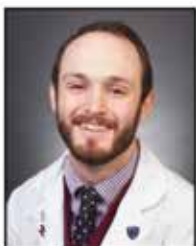
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National Symphony of Ukraine
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Venice Baroque Orchestra
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Pre-Concert Event



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Worcester Chorus
March 24, 2017



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Violin & Piano - April 7, 2017

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