Statement on LGBTQIA+ Health

Student National Medical Association
Health Policy and Legislative Affairs Committee
Statement on LGBTQIA+ Health

First Revision

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INTRODUCTION

The mission of the Student National Medical Association (SNMA) is to increase the number of clinically excellent, culturally competent, and socially conscious physicians, as well to address the needs of underserved communities. The lesbian, gay, bisexual, transgender, queer or questioning, intersex, asexual, and others (LGBTQIA+) community is an underrepresented and under-researched population in the field of medicine in the United States. As a result, health care professionals frequently misunderstand the specific health needs of the LGBTQIA+ community.\(^1\)\(^-\)\(^3\) This policy statement will discuss the barriers to care and current health disparities experienced by LGBTQIA+ patients. It will also provide recommendations of methods through which we can begin to ameliorate the discrepancy in care between LGBTQIA+ and non-LGBTQIA+ populations. The SNMA supports policies and practices that reduce barriers to health for LGBTQIA+ individuals and promote education and training for medical professionals to better serve the sexually minoritized population.

BACKGROUND

The term LGBTQIA+ is often used as an umbrella term to signify a single community, however, it is actually made up of several distinct populations with distinct health needs and barriers to care.\(^4\) Since the US Census currently does not ask about sexual orientation or gender identity,\(^5\) only estimates of the makeup of the LGBTQIA+ population in the US exist. As of 2016, at least 4.1% of the US population is estimated to identify as “LGBT.” This translates to over 10 million individuals.\(^6\) The LGBTQIA+ community experiences certain diseases and chronic conditions at a higher prevalence than their cis-gendered, heterosexual counterparts. LGBTQ individuals have reported worse health outcomes as well as increased discrimination and poverty.\(^7\)

The mistreatment and misunderstanding of the LGBTQIA+ community has been ingrained in both society and the medical community for decades. The concept of gender and gender roles developed in the 1950’s,\(^8\) but it was not until over a decade later that the psychosocial aspect of gender was acknowledged. Homosexuality itself was considered a psychiatric disease in the Diagnostic and Statistical Manual of Mental Disorders (DSM) until 1973.\(^9\) This alone shaped the way medical professionals treated and approached this underrepresented population. The 1978 publication of DSM-III recognized a new “disorder,” Gender Identity Disorder (GID), in which an individual’s sex at birth differs from the gender they identify with.\(^10\) GID remained in the DSM
manual until 2013 (DSM-V), when it was renamed “Gender Dysphoria” in an attempt to de-stigmatize the diagnosis.\textsuperscript{11}

Recent years have been momentous for LGBTQIA+ equality and right.\textsuperscript{12} The Affordable Care Act (ACA) took great measures to move towards health equity for LGBTQIA+ individuals.\textsuperscript{13} The ACA expanded access to health insurance coverage for LGBTQIA+ individuals, and provided specific protections related to sexual orientation and gender identity. This allowed more LGBTQIA+ individuals to select from a wider range of healthcare providers, thus making access to the health system more equitable. In 2011, Centers for Medicare & Medicaid Services ruled that all healthcare organizations participating in Medicare or Medicaid must inform patients of their right to decide for themselves who may visit or make medical decisions on their behalf, regardless of sexual orientation or gender identity.\textsuperscript{14} The 2013 ruling to overturn portions of the Defense of Marriage Act (DOMA) resulted in the recognition of legally married same-sex couples, including health coverage and workplace protections of the federal Family Medical Leave Act.\textsuperscript{15} This paved the way for the 2015 Supreme Court decision in Obergefell v. Hodges, which legalized same-sex marriage nationwide. This decision acknowledged the constitutional right to same-sex marriage and defended the rights of same-sex couples regarding the welfare of their partner and their children.

**SCOPE OF THE PROBLEM**

*Discrimination from Medical Professionals*

In a 2010 Lambda Legal poll, 56% of lesbian, gay, and bisexual respondents reported that physicians have refused to provide them medical attention, have used excessive precautions during care, have blamed them for their “condition,” or have used abusive language towards them in the medical setting. This number jumps to 70% for transgender respondents.\textsuperscript{16} Prior experiences and the fear of mistreatment discourages LGBTQIA+ individuals from disclosing their gender identity or sexual orientation, or from seeking primary care outright.\textsuperscript{17} This delay in seeking care can lead to higher utilization of emergency departments, worse health outcomes, and a heavier burden of disease.

Though healthcare providers’ attitudes toward LGBTQIA+ individuals are increasingly improving with the change in social climate, there is still much work to be done to create an inclusive and respectful environment. For example, a 2015 study found that 46% of heterosexual
first-year medical students expressed explicit bias, attitudes, and beliefs about a person or group on a conscious level, against LGBTQIA+ people. Furthermore, 82% expressed some form of implicit bias, a judgment or behavior that results from subtle cognitive processes also against LGBTQIA+ people.

**Double Discrimination**

LGBTQIA+ people of color oftentimes experience both discriminations based on race and based on sexual/gender identity. This phenomenon is known as “double discrimination.” There is a widespread misconception that just because these individuals identify with multiple oppressed groups, the discrimination that they face is no more than others in individual oppressed groups. In actuality, the discrimination has an additive effect on these individuals, with increased rates of depression, anxiety, and suicidal ideation for those that belong in both communities. Another study showed that rates of illicit drug use are increased in those that face this double discrimination. An additional study showed that 79% of victims from non-terrorism anti-LGBTQIA+ homicides and 61% of victims of hate violence were people of color. Moreover, 61% of the homicide victims were transgender women of color. In order to combat the effects of double discrimination and promote better health outcomes, one study recommends community power-building, especially in the form of advocacy by community leaders.

**Chronic Health Conditions**

LGBTQIA+ patients report worse health outcomes with chronic health conditions. Chronic conditions such as heart disease, obesity, and substance use disorder occur at disproportionately higher rates in the LGBTQIA+ community. These conditions are not specific to the population, however the barriers to equitable care magnify the burden of disease. Nearly 33% of the LGBTQIA+ population report cigarette smoking, which equates to a 68% higher utilization than the rest of the US population. Additionally, bars were among the few safe spaces that LGBTQIA+ people have found to socialize openly. This may contribute to the heavy utilization of both tobacco and alcohol in the community. Lesbian and bisexual women report increased rates of obesity, physical inactivity, and substance abuse. Each of these factors increases the risk of heart disease. The Department of Health and Human Services has addressed these disparities as part of Healthy People 2020 initiative and aims to improve LGBTQIA+ health by expanding social
services, improving patient-provider interactions, and increasing cultural competence in medical education.¹

**HIV**

HIV is a major concern within the LGBTQIA+ community, particularly among men who have sex with men (MSM). In fact, the Substance Abuse and Mental Health Services Administration reported in 2012 that MSM are 44 times more likely to be diagnosed with HIV than other men, given that they represent only 4% of the male population in the United States, but over 78% of the new HIV diagnoses and 63% of all existing infections.⁴ The Centers for Disease Control and Prevention (CDC) estimates that 67% of 40,324 new HIV infections that occurred in 2016 were accounted for by MSM alone. Within that population of MSM that received an HIV diagnosis in 2016, 38% were Black/African American, 29% were Hispanic/Latino, and 28% were White.²⁴ Black/African American MSM are more than twice as likely to be infected than White or Hispanic MSM, while both Black/African American and Hispanic MSM are more likely to be diagnosed at a younger age (13-29 years).⁴ The racial disparities in HIV morbidity and mortality are largely due to factors such as less access to antiretroviral therapy within communities of color, rather than differences in unsafe sexual behavior.¹⁵ Since the HIV epidemic began, more than estimated 370,000 MSM with an HIV/AIDS diagnosis have died, including an estimated 6,531 in 2015.²⁴,²⁵

**Behavioral Health Services**

The climate of discrimination and stigmatization in the United States is steadily changing. Nevertheless, LGBTQIA+ individuals continue to experience higher rates of negative attitudes from family and friends, and more frequent acts of violence against them.³ A 2009 study compared the impact of supportive family attitudes to that of negative family attitudes on the mental health of individuals. This study found that strong, negative attitudes lead to poor mental health outcomes, such as increased rates of suicide attempts, depression, illegal drug use, and risky behavior.²⁶ According to the Substance Abuse and Mental Health Services Administration, up to 68% of transgender men have reported suicidal ideation and up to 32% have attempted suicide.⁴ LGBTQIA+ youth, especially transgender youth, are 3 times more likely to report suicidal ideation and attempt suicide.²⁷,²⁸ LGBTQIA+ people overall are also report higher rates of intimate partner
violence, according to the CDC’s 2010 Findings on Victimization by Sexual Orientation.\textsuperscript{3} The lifetime prevalence of rape, physical violence, and/or stalking by an intimate partner was 43.8\% for lesbians, 61.1\% for bisexual women, and 35\% for heterosexual women, while it was 26\% for gay men, 37.3\% for bisexual men, and 29\% for heterosexual men.\textsuperscript{3} Proper access to mental health services and culturally competent providers is necessary to adequately serve the needs of this community.

**STATEMENT OF POSITION & RECOMMENDATIONS**

It is the position of the Student National Medical Association that attaining equality, health equity, and improved health outcomes is of the utmost importance for the underserved LGBTQIA+ community. The historical discrimination and stigmatization of this population by the medical community has led to the health disparities that are seen in LGBTQIA+ health today. Therefore we, the members of the SNMA, endorse the following recommendations to change the culture in medicine and improve healthcare and outcomes in the LGBTQIA+ community:

1. All health institutions must adopt non-discriminatory and fair visitation policies that prohibit discrimination based on sexual orientation or gender identity.
2. All health institutions must have policies to safely report and act on gender or sexual orientation-based discrimination and/or abuse.
3. Medical students, health professionals, and health institutions must create a safe environment for the sharing of sensitive information, such as gender identity, sexual orientation and/or sexual behaviors as a standard of care. Establishing an opportunity to share sexual orientation will assist medical professionals in providing more appropriate care.
4. Medical students and health professionals should be required to undergo culturally and structurally sensitive training on sexual orientation and gender identity.
5. Medical students, health professionals, and health institutions must create an environment of acceptance, inclusion, and understanding for LGBTQIA+ health and health concerns.
6. Medical students, health professionals, and health institutions must continue to advocate for the equality of LGBTQIA+ individuals, their rights, and their ability to access healthcare.
REFERENCES


