



Presentation to the Institute of Medicine's Committee on Lesbian, Gay, Bisexual, and Transgender (LGBT) Health Issues and Research Gaps and Opportunities

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**from the
Gay & Lesbian Medical Association
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On behalf of the Gay and Lesbian Medical Association (GLMA), I am pleased to have the opportunity to submit comments to the Institute of Medicine's (IOM's) Committee on Lesbian, Gay, Bisexual, and Transgender (LGBT) Health Issues and Research Gaps and Opportunities. GLMA commends the IOM for convening and challenging this committee to assess the state of the science on the health status of LGBT populations and identify recommendations about needed research, training, and other opportunities to improve LGBT health.

GLMA is the world's largest and oldest membership association of LGBT healthcare professionals. GLMA was founded in 1981 as the American Association of Physicians for Human Rights (AAPHR) with the mission of maximizing the quality of health services for LGBT people, promoting full civil rights, and fostering a professional climate in which the organization's diverse members could reach their full potential. In 1994 the organization changed its name to GLMA as part of a broader expansion of visibility, leadership, education and advocacy. GLMA's current mission is to ensure equality in health care for LGBT individuals and health care professionals, and we work to achieve this mission by using medical expertise in professional education, public policy work, patient education and referrals, and the promotion of research.

Health disparities affecting LGBT populations are significant and well documented. In 2001, the Gay and Lesbian Medical Association (GLMA), working in collaboration with other LGBT health groups and funded with support from the Health Resources and Services Administration of the U.S. Department of Health and Human Services, published the *Healthy People 2010 Companion Document for LGBT Health*.¹ This document examined the full range of these health disparities in areas that included access to quality healthcare, cancer, mental health, tobacco and

¹ Gay and Lesbian Medical Association and LGBT health experts (2001). *Healthy People 2010 Companion Document for Lesbian, Gay, Bisexual, and Transgender (LGBT) Health*. San Francisco, CA: Gay and Lesbian Medical Association.

substance use, and violence. While there are many factors that contribute to health disparities among LGBT people, those that deserve special emphasis are negative societal attitudes towards LGBT people and lack of appropriate education among health professionals. I urge you to use the *Companion Document* as a resource in the preparation of the report.

Discrimination and stigma directed against the LGBT community is the principal source of health disparities among LGBT populations. The health effects of stress related to living with a stigmatized identity include higher rates of depression, anxiety disorders, suicide attempts, and substance abuse.^{2,3,4,5,6,7} Despite a steady increase in the acceptance of LGBT people over the past two decades, there still is great stigma in the United States. Homophobia, biphobia, transphobia, and other forms of heterosexism continue to play a role in the inadequate assessment, treatment, and prevention of LGBT health problems. LGBT individuals also continue to suffer from discrimination in housing, employment, and basic civil rights. There is still no federal law that consistently protects LGBT individuals from employment discrimination, and it remains legal in 29 states to discriminate based on sexual orientation and gender identity or expression in 38 states.⁸ Insurance companies, government, hospitals, and health clinics often fail to recognize committed same-sex relationships, and deny gay and lesbian partners the privileges granted to married heterosexual couples.^{9,10}

To reduce disparities based on sexual orientation and gender identity and lessen the negative consequences of minority stress, healthcare systems and healthcare professionals must become more inclusive and responsive to the needs of LGBT populations. One of the key recommendations of the *Healthy People 2010* report was to make cultural competency training specific to LGBT populations a standard component of all health professional training curricula. However, there is evidence that many medical schools and other health professions schools are not adequately preparing future healthcare providers with the skills, knowledge, and attitudes necessary to provide appropriate care to the LGBT community.

² Cochran, S. D., & Mays, V. M. (2007). Physical health complaints among lesbians, gay men, and bisexual and homosexually experienced heterosexual individuals: results from the California Quality of Life Survey. *American Journal of Public Health, 97*(11), 2048-2055.

³ Cochran, S. D., Keenan, C., Schober, C., & Mays, V. M. (2000). Estimates of alcohol use and clinical treatment needs among homosexually active men and women in the U.S. population. *Journal of Consulting and Clinical Psychology, 68*(6), 1062-1071.

⁴ Drabble, L., & Trocki, K. (2005). Alcohol consumption, alcohol-related problems, and other substance use among lesbian and bisexual women. *J Lesbian Stud, 9*(3), 19-30.

⁵ Gilman, S. E., Cochran, S. D., Mays, V. M., Hughes, M., Ostrow, D., & Kessler, R. C. (2001). Risk of psychiatric disorders among individuals reporting same-sex sexual partners in the National Comorbidity Survey. *American Journal of Public Health, 91*(6), 933-939.

⁶ Hughes, T. L., Wilsnack, S. C., Szalacha, L. A., Johnson, T., Bostwick, W. B., Seymour, R., et al. (2006). Age and racial/ethnic differences in drinking and drinking-related problems in a community sample of lesbians. *Journal of Studies on Alcohol, 67*(4), 579-590.

⁷ Kipke, M.D., Weiss, G., Ramirez, M., Dorey, F., Ritt-Olson, A., Iverson, E., & Ford, W. (2007). Club drug use in Los Angeles among young men who have sex with men. *Substance Use and Misuse, 42*(11):1723-43.

⁸ Human Rights Campaign (HRC). Employment Non-Discrimination Act. Retrieved January 28, 2010 from HRC website: http://www.hrc.org/laws_and_elections/enda.asp.

⁹ Gay and Lesbian Medical Association (GLMA). (2008). *Same-Sex Marriage and Health*. San Francisco: GLMA.

¹⁰ Gay and Lesbian Medical Association (GLMA) and Human Rights Campaign (HRC). *Healthcare Equality Index 2009*. Washington, DC: GLMA and HRC.

A number of research studies have documented that many medical schools have little or no formal training in LGBT health content.^{11,12,13} Additionally, many LGBT medical students, faculty, staff, and patients continue to face discrimination within their own institutions.^{14,15} Hostility towards LGBT individuals in many medical schools lead many students to hide their sexual orientation and remain “closeted,” leading to increased levels of stress and anxiety among these future healthcare providers.^{16,17}

A study of third and fourth year medical students from one school in New York City found that students with more clinical exposure to LGBT people were more likely to take sexual histories on all their patients, and had more positive attitudes and more accurate knowledge about LGBT health than did students with limited clinical exposure.¹⁸ Based on this finding, it is logical to posit that exposure to other LGBT students would also result in more positive attitudes and more accurate knowledge of LGBT health issues among non-LGBT identified medical students. Yet if LGBT medical students hide their sexual orientation from their peers, it would be difficult for interactions to result in meaningful attitudinal and educational outcomes.

It is clear to us that discrimination and stigma, both within and outside of the health professions, is directly responsible for health disparities affecting the LGBT community. However, this same discrimination and stigma has resulted in a lack of inclusion of questions about sexual orientation and gender identity in many national health surveys, which frustrates efforts to get a true sense of the magnitude of these health disparities. Historically, health data collection efforts have not included LGBT populations or gathered information regarding the specific healthcare needs of LGBT people. The limited nature of research about LGBT populations makes it difficult to document and prioritize their health needs. Although numerous studies have been conducted with certain health conditions, notably for HIV in gay men and breast cancer in lesbians, in most other areas data are seriously lacking and, as noted previously for transgender individuals, very few studies have been attempted. To illustrate this point, a study published in 2002 that reviewed all English-language articles on human subjects published between 1980 and 1999 in the

¹¹ Sanchez, N.F., Rabatin, J., Sanchez, J.P., Hubbard, S., & Kalet, A. (2006). Medical students’ ability to care for LGBT patients. *Family Medicine*, 38(1), 21-27.

¹² Tesar, C. M., & Rovi, S. L. (1998). Survey of curriculum on homosexuality/bisexuality in departments of family medicine. *Family Medicine*, 30(4), 283-287

¹³ Wallick, M.M., Cambre, K.M., & Townsend, M.H. (1992). How the topic of homosexuality is taught at US medical schools. *Academic Medicine*, 67, 601-603.

¹⁴ Klamen, D.L., Grossman, L.S., & Kopacz, D.R. (1999). Medical student homophobia. *Journal of Homosexuality*, 37(1), 53-63.

¹⁵ Oancia, T., Bohm, C., Carr, T., Cujec, B., & Johnson, D., (2000). The influence of gender and speciality on reporting of abusive and discriminatory behavior by medical students, residents and physician teachers. *Medical Education*, 34, 250-256.

¹⁶ Brogan, D., Frank, E., Elon, L., Silvanesan, S., & O’Hanlan, K. (1999). Harassment of lesbians as medical students and physicians. *JAMA*, 282:1290-1292.

¹⁷ Merchant, R., Jongco, A., & Woodward, L. (2005). Disclosure of sexual orientation by medical students and residency applicants. *Academic Medicine*, 80: 786.

¹⁸ Sanchez, N.F., Rabatin, J., Sanchez, J.P., Hubbard, S., & Kalet, A. (2006). Medical students’ ability to care for LGBT patients. *Family Medicine*, 38(1), 21-27.

Medline database found that LGBT issues were addressed by 3777 articles, or 0.1% of all Medline articles.¹⁹

Knowledge on the science and health status of LGBT populations could be expanded in several ways. The committee could consider encouraging academic institutions to participate in this expansion through NIH-supported grant cycles or research centers of excellence. Broadening the scope of health surveys administered by the National Center for Health Statistics and the Centers for Disease Control & Prevention by including questions on sexual orientation and gender identity is another important step. There are methodological challenges that exist but these could be addressed with additional cognitive testing and research. Results of this work could also be applied to the Census so that the effects of age, race, ethnicity, and geography are better understood.

Fundamentally, many health disparities among LGBT populations can be linked to barriers to accessing competent health care providers and systems. The committee must clearly recommend the need for health care professional schools to include education on LGBT populations as part of standard curricula. The Association of American Medical Colleges, the American Medical Association, and GLMA are all committed to supporting this effort.

Assuming that an LGBT individual reaches a competent provider the health care system may present additional barriers. Will diagnosis and procedure codes exist to appropriately document the care of the LGBT patient? If the individual is privileged to have health insurance coverage, will the company reimburse the organization and provider for rendered services? The committee and the Institute must see the World Health Organization, the American Medical Association, America's Health Insurance Plans, the Center for Medicare & Medicaid Services, and the Veterans Administration as partners and collaborators in overcoming LGBT health care disparities.

I remind the committee that youth, seniors, and transgender populations are often the most disenfranchised members of LGBT communities and deserve special attention. Additionally, LGBT people from racial and ethnic minority communities experience extremely high levels of health disparities. LGBT individuals who are member of racial and ethnic minority communities must often navigate multiple instances of discrimination based on sexual orientation or gender identity, language, ethnicity, and gender. Finally, the committee and the Institute must not shy away from strong recommendations related to politically charged issues. Legal recognition of same-sex relationships and marriages, non-discrimination in employment, and same-sex parenting and families are topics that, while polarizing, directly affect the health and wellness of LGBT people. These issues are deserving of special focus as research gaps and opportunities.

Thank you for the opportunity to share the views of the GLMA with the Committee on LGBT Health Issues and Research Gaps and Opportunities. We look forward to assisting and participating in future activities organized by the committee, and we look forward to seeing the final report of the committee.

¹⁹ Boehmer, U. (2002). Twenty years of public health research: inclusion of lesbian, gay, bisexual, and transgender populations. *American Journal of Public Health*, 92(7), 1125-1130.