Improving Healthcare for LGBTQ Populations

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Background

LGBTQ, traditionally referring to lesbian, gay, bisexual, transgender and queer, is used in this paper to be inclusive more broadly of all forms of non-heteronormative sexual orientation and non-binary gender identity. LGBTQ populations continue to be marginalized in Canadian society, with unique sets of health issues, risks and concerns [1-3]. Given the special needs of these populations, it is appropriate that medical students gain experience and training in how to provide comprehensive health care to this diverse group of people. Medical schools should also exemplify safe and judgment free environments, and provide prejudice-free training on this sensitive topic.

There are numerous barriers that LGBTQ populations face when it comes to accessing healthcare services. Depending on the individual, a combination of past experiences with healthcare services, cultural, religious, and personal beliefs can all affect a patient's comfort in accessing healthcare and disclosing concerns related to their sexual orientation or gender identity [7, 15]. Fear of victimization and stigma are strong deterrents to accessing health care [7, 15, 16]. Feeling negatively judged by a physician or feeling that their physician is not competent in addressing their concerns contribute to patients' barriers to accessing appropriate care [3, 7, 15, 17]. With regards to Indigenous peoples, accessing care often requires leaving one's community, either temporarily or permanently, due to the lack of resources, as well as cultural barriers including conflicts between Indigenous values and both mainstream Western medicine and LGBTQ culture [14].

There is scant data on the health of LGBTQ and two-spirited Indigenous populations in Canada. However, it is known that these individuals experience higher levels of stigma than other LGBTQ communities in Canada [1, 14]. Although specific statistics vary regarding disparities for each of the communities that make up LGBTQ populations, the key message here is that there are unique clinical concerns, which are relevant to medical students and practising physicians.

The Canadian Federation of Medical Students (CFMS) recognizes the negative impact of LGBTQ discrimination even within its own membership, including the risk of chronic stress on LGBTQ-identified medical students and the effect this stress has on their wellness. This stems partially from fear of discrimination or reprisals from self-identifying during medical training. Although studies of Canadian medical students are not currently available on these issues, recent studies in the USA have identified that these are concerns for medical students [7, 25, 26]. LGBTQ-identified students are known to have higher rates of anxiety, depression and loneliness than their peers [27]. Language used during training is an additional concern. Lack of awareness of inclusive language, especially in colloquial phrases, can impact the learning environment and therefore the wellness of trainees [28].

Position Statement:

1. The CFMS affirms that healthcare is a basic human right and that the violation of human rights in all forms is unacceptable.
2. Health systems should not discriminate on the basis of sexual identity or orientation, gender identity, and/or intersex status.
3. Graduates of Canadian medical schools should be competent in providing care to LGBTQ patients, as well as in collaborating with LGBTQ peers/professionals in a respectful, inclusive and culturally sensitive manner.
4. Medical schools in Canada have the responsibility to provide comprehensive and prejudice-free curricula in the care of LGBTQ individuals.
5. The care of LGBTQ individuals often requires a multidisciplinary, team-based approach in order to address the diversity within these communities; this team should include both clinical and non-clinical experts.

Recommendations:

Accordingly, the Canadian Federation of Medical Students calls upon:

1. The Federal and Provincial Governments to:
    a. Conduct nation-wide environmental scans to determine the current state of LGBTQ healthcare in the country;
    b. Develop and implement specific policies and strategies to ensure that LGBTQ patients have access to comprehensive, high-quality healthcare that is free of prejudice;
    c. Support research into the healthcare needs of LGBTQ populations.

2. The Association of Faculties of Medicine of Canada and individual Faculties of Medicine to:
    a. Conduct institutional climate scans to determine the current environment in which learners are trained, in order to ensure all students have access to a high-quality, safe and supportive learning environment

b. Produce specific learning objectives, including knowledge and skills, that would be important for a physician in Canada to adequately support their LGBTQ patients; these include
    i. Addressing LGBTQ status as a social determinant of health
    ii. Inform students about the specific health issues, vulnerabilities and barriers to healthcare access that LGBTQ populations experience
    iii. Highlight and incorporate inclusive and culturally-sensitive language
    iv. Allow for increased exposure to LGBTQ populations through pre-clinical curricula and clinical rotations
    v. Create and integrate teaching materials which reinforce the aforementioned principles in a positive and normalizing manner throughout the curriculum
c. Identify, recruit and support institutional champions to lead curriculum development, monitoring and evaluation, and inclusive-environment changes
d. Maintain zero-tolerance policies related to hate crimes, whether motivated by gender identity, sexual orientation, or other

3. The CFMS and its Board of Directors to:
    a. Promote awareness of LGBTQ healthcare issues nationally, through awareness campaigns, advocacy activities and support of initiatives to better LGBTQ health in the country
    b. Review and revise current policy and position statements, as well as other content authored on behalf of the CFMS, to ensure they are inclusive of LGBTQ communities

4. Medical students in Canada to:
    a. Support and maintain a positive and inclusive learning and working environment that is respectful of LGBTQ diversity
    b. Promote awareness and advocate for LGBTQ healthcare issues
    c. Partner with local LGBTQ advocacy groups in order to better understand the healthcare needs of LGBTQ patients

Appendix 1: Terms and Definitions

The terminology used to describe identity within LGBTQ communities is ever changing and widely debated. Some terms used within LGBTQ communities were once considered to be pejorative, but have now become more commonplace following reclamation. Many terms have multiple definitions, and some LGBTQ individuals may prefer specific terms to others, with preferences changing over time. Some individuals may chose not to identify with any term or label and will prefer to use their own words to describe their experience or state of being. It is important to allow individuals to self-identify, and to respect and affirm their gender and sexual identities.

Some commonly used terms are defined below:

Referring to Gender:

Gender: Psychological, behavioral and cultural characteristics that are believed to be associated with maleness and femaleness. [7]

Gender Identity: an individual's personal and subjective inner sense of self as belonging to a particular gender. [7]

Cisgender: Individuals that according to social patterns possess a gender identity that aligns with the labels that were assigned to them at birth. [7]

Transgender: individuals who have gender identities that do not align with the gender labels they were assigned at birth. [7]

Trans Female-to-male: Usually refers to a transgender individual who was identified as female at birth, but who identifies as male in terms of his gender identity. [7]

Trans Male-to-female: Usually refers to a transgender individual who was identified as male at birth, but who identifies as female in terms of her gender identity. [7]

Gender affirmation procedures: Any medical, pharmacological or surgical treatment, aid or prostheses used to affirm an individual's gender identity. It is important to note that the extent of the procedures undertaken is a highly personal and variable choice, which must be respected. [29]

Transitioning: the process undertaken by a transgender individual of adopting a social gender identity that is different from the gender assigned to that individual

at birth. Transitioning may or may not include changes in physical expression, medical and surgical interventions, and/or changes in legal documents. [7]

Transsexual: historically a term used to refer to a person who has undergone what today are called gender-affirming interventions/procedures.[7]

Gender Nonconforming: a person who does not conform to prevailing gendered behaviorsor roles within a specific society. People who are gender nonconforming may not take part in activities conventionally thought to be associated with their assigned gender. [7]

Referring to Sex and Sexuality:

Sex: the aggregate of an individual's biological traits (genotype and phenotype) as those traits map to male/female differentiation and the male-female anatomical and physiological spectrum. [7]

Sexual Identity: how people think of themselves or others in terms of romantic and sexual attractions. A person's sexual identity may not match that person's sexual orientation and/or sexual behaviors. [7]

Intersex: historically, a term used in biology and, later, in medicine to refer to beings (including people) whose sex development falls between the male-typical and female-typical forms. [7]

Asexual: Usually refers to an individual who feels no sexual desire. [7]

Bisexual: Usually refers to an individual who is attracted to both males and females. [7]

Gay: usually refers to a person who identifies his or her primary romantic feelings, sexual attractions, and/or arousal patterns as being toward someone of the same gender or sex. [7]

Lesbian: usually refers to a female person who identifies her primary romantic feelings, sexual attractions, and/or arousal patterns as being toward a person of the same gender or sex. [7]

Homosexual: literally "same-sex," usually used as an adjective to refer to same-gendered relations. Although "homosexual" was also historically used also as a noun to refer to a gay person, that use has now fallen out of favor. [7]

Heterosexual: literally "other sex" or "different sex," usually used as an adjective to refer to relations between a man and a woman. Although "heterosexual" was also historically used as a noun to refer to a straight person, that use has now fallen out of favor. [7]

Pansexual: used as an adjective to describe a person who can develop physical attraction, love and sexual desire for people regardless of their gender identity or biological sex. [40]

Queer: Queer is a theoretical discourse, deriving from postmodern and post-structural thought. It is often used as an umbrella term to describe all lesbian, gay, bisexual and transgender people; however, it can also refer to individuals who fall outside of those terms, as well as being an identity of sexual orientation in its own right. Queer is a term that has been reclaimed from its previous pejorative use and for this reason it is not embraced universally across the community it attempts to define, and remains controversial. [29]

Straight: usually refers to a person who identifies her or his primary romantic feelings, sexual attractions, and/or arousal patterns as being toward a person of the opposite gender or sex. [7]

Appendix 2: Justifications

A long-standing history of discrimination against LGBTQ individuals exists in healthcare, which continues to affect the healthcare-seeking behaviours of LGBTQ patients. LGBTQ individuals report avoiding healthcare settings due to fear of discrimination by their healthcare providers with respect to their sexual or gender identity [30,31]. Homosexuality was listed as a disorder in the Diagnostic and Statistical Manual of Mental Disorders (DSM) until 1973. Transgender identity was also regarded as a pathology up until the most recent DSM revision in 2013 [37]. LGBTQ individuals were previously subjected to electroshock therapy or castration for "treatment" of their sexual and or/gender identities [37]. While these practices have been formally rejected by major physician organizations, there still remains a high prevalence of reparative, or conversion therapy – counselling and psychotherapy offered with the aim of eliminating homosexuality [38]. Major organizations, including the American Psychiatric Association and the American Academy of Paediatrics have formally adopted resolutions opposing these practices [38]. In June 2015, Ontario became the first Canadian province to formally ban conversion therapy.

The HIV/AIDS epidemic has also played a significant role in contributing to discrimination and homophobia in the health care environment. Although no longer identified as the original name of Gay Related Autoimmunodeficiency Disease (GRID), HIV/AIDS continues to be described as a "gay disease." Several fears and misconceptions relating to HIV/AIDS are still held by health care providers [39].

Physicians have also reported feeling they have inadequate knowledge and training for treating LGBTQ patients. Several physicians have stated they feel uncomfortable with treating LGBTQ patients [30, 31]. The combination of these factors has contributed to several disparities in the physical and mental health of LGBTQ patients, which have been highlighted by numerous studies.

<u>Physical Health Inequalities</u>
A Statistics Canada Health Report from 2008 illustrates numerous physical health disparities within LGBTQ populations. Compared to heterosexual populations, bisexual individuals were more likely to report their health as "fair or poor" as opposed to "excellent" or "good", as well as to report having had an unmet healthcare need in the past 12 months. Gay men and bisexual women were also more likely to report having a chronic condition. Differences were also apparent between heterosexual and LGBTQ populations in the utilization of preventative screening tests. Bisexual women aged 50-59 were less likely than lesbian and heterosexual women to have had a mammogram in the

past 2 years. In addition, less than 2/3 of lesbian women reported having had a pap test done in the past 3 years [32].

A population-based study conducted in the US demonstrated that lesbian and bisexual women had higher rates of heart disease compared to heterosexual women. This was independent of differences in age, race, income, education, health insurance, tobacco use, and obesity (33). A different study reported that bisexual women were more likely than heterosexual women to report several physical health problems, including chronic fatigue syndrome, back problems, and digestive complaints. Compared to exclusively heterosexual men, gay men and heterosexual men with homosexual experiences had higher rates of heart disease, liver disease, asthma, back problems, and chronic fatigue syndrome. Bisexual and homosexual individuals were more likely to report having poor overall physical health than heterosexual individuals. In addition, lesbian women and bisexual women were more likely to be receiving disability income. Rates of sexually transmitted infections, including HIV, were also higher among non-heterosexual individuals [34].

Mental Health Inequalities

LGBTQ individuals are more likely than heterosexual people to report having unmet mental health needs [32]. Meyer's Minority Stress Model posits that discrimination and social stigma creates hostile and stressful social environments for LGBTQ individuals, thus contributing to higher rates of mental health problems [33]. Substance abuse disorders are more prevalent in LGBTQ individuals who report experiencing discrimination based on gender, sexual orientation, and/or race [34]. This is of particular significance when taking into account that approximately two-thirds of the LGBTQ population reported having experienced some form of discrimination in the previous year (34). A population-based survey conducted in 1999 demonstrated that lesbian individuals were more likely than heterosexual individuals to report being depressed in the past 30 days, and were more likely to be taking an antidepressant [35]. Suicide rates in the LGBTQ youth population in the US are almost two and a half times higher than the rates in heterosexual youth; this has been attributed to the increased discrimination these youth face, as posited by the minority stress model. This increased risk for suicidality, as well as increased rates of depression have been demonstrated for youth in multiple countries, including Canada [36].

Medical Education

Significant stigma also exists in medical schools towards both LGBTQ patients and students [7, 18, 19]. A study performed in the USA showed that nearly half of medical students displayed explicit bias against LGBTQ individuals and most showed some implicit bias [20]. This problem has not gone completely unnoticed, with some schools implementing curricular changes to positively alter these views and better prepare their graduates to serve LGBTQ communities [7, 21, 22]. In Canada, medical schools vary significantly in content and time spent on LGBTQ health in their curricula. Of the 11 Canadian medical schools which agreed to participate in a recent study by Obedin-Maliver *et al*., schools varied from 0 to 13 hours of preclinical teaching, averaging 4 hours, with no school including clinical teaching [23]. Increased exposure via curriculum,

specifically in a clinical context, has been shown to improve delivery of LGBTQ health care, with reduced stigma and increased knowledge and willingness to treat [7, 22, 24].

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