

Policy Document

Lesbian, Gay, Bisexual, Transgender, Intersex, and Queer (LGBTIQ) Health Policy

Background

The Australian Medical Students' Association (AMSA) is the peak representative body of Australia's medical students. AMSA believes that all communities have the right to the best attainable health. Accordingly, AMSA advocates on issues that may impact health outcomes.

Compared to the general population, lesbian, gay, bisexual, transgender, intersex and queer (LGBTIQ) people in Australia experience worse health across a range of health indicators. These include higher alcohol and drug use [1], anxiety, self-harm and suicidal ideation [2], higher rates of sexually transmitted infections among gay men [3] and increased rates of obesity among lesbian and bisexual women [4]. Intersex individuals face a number of medical challenges, including sterilisation, normalising surgeries in infancy and inappropriate medical care into adulthood [5].

Barriers to equitable healthcare include discrimination [6], transphobia and homophobia in healthcare settings [7, 8] and lack of cultural competency when engaging with LGBTIQ communities [8, 9]. LGBTIQ people face intrusive and inappropriate language and questions [7], hostility and verbal abuse from health practitioners [8]. This has contributed to their reluctance to seek medical advice and decreased health-seeking behaviour [6, 10]. Research indicates that LGBT (intersex and queer communities not included) individuals hide their sexuality or gender identity for fear of discrimination [1]. Discrimination in healthcare settings is associated with mental health: amongst gender diverse patients, a positive correlation has been reported between experiences in healthcare and mental health outcomes [8]. Lack of cultural knowledge amongst health professionals is also of concern [1, 9, 10] with some patients reporting having to educate medical professionals around their identity [8]. At a broad societal level, institutionalised discrimination increases the risk of adverse mental health outcomes. The Royal Australian and New Zealand College of Psychiatrists have acknowledged the link between improved mental health outcomes and inclusive legislative changes to the Marriage Act [11].

While limited research has been done in Australia, research involving medical student cohorts overseas shows that increased exposure to LGBT patients and teaching specifically on LGBT health improves student knowledge of [12], engagement with [13] and attitudes [14] towards LGBT people. Data collected in a 2013 survey suggests that Australian medical students think LGBTI health is important and would like more teaching on the topic than they are receiving [15]. Similarly, LGBTI communities in Australia also report a desire for increased medical education about respectful practice with LGBTI people and LGBTI health [1, 2, 7, 8]. Studies in Australia and internationally suggest that not enough teaching is done on LGBTIQ health in medical training [10, 16, 17] and it is therefore essential that it is addressed in medical schools.

Position Statement

AMSA believes that

1. Healthcare systems should not negatively discriminate against individuals on the basis of their gender identity, sexuality/sexual orientation and/or intersex status;
2. Medical graduates in Australia should be competent in providing inclusive, respectful, culturally sensitive and appropriate care of LGBTIQ individuals;
3. Medical schools have a responsibility to provide appropriate and effective curricula in LGBTIQ healthcare and cultural competence to medical students;

4. Management of intersex individuals should be carried out by multidisciplinary teams and should occur within a human rights framework that respects individuals' autonomy over their own bodies;
5. Individuals should have access to gender affirmation procedures, should they wish to seek them and do so with full consent; and
6. LGBTIQ health requires a multidisciplinary approach to address the diversity within LGBTIQ communities, including consulting with LGBTIQ organisations and representatives to ensure the needs of their community are being met.
7. Marriage equality would reduce the discrimination and thus minority stress that LGBTIQ persons suffer, leading to improved health.

Policy

Accordingly, AMSA calls upon:

1. Australian governments to:
 - a. Implement goals, policies and strategies to minimise the health inequalities experienced by LGBTIQ communities;
 - b. Support research into the healthcare needs of LGBTIQ communities to better address health inequalities;
 - c. Developing healthcare services and practices which are inclusive to LGBTIQ communities;
 - d. Removing all discriminatory references from the Marriage Act 1961 to allow all people, regardless of intersex status, sexuality and gender identity, the opportunity to marry;
2. The Australian Medical Council to include knowledge, cultural competency and respectful care of LGBTIQ communities into their accreditation standards for medical schools;
3. Australian medical schools to incorporate knowledge, cultural competency and respectful care of LGBTIQ individuals in their curriculum by:
 - a. Addressing sexuality/sexual orientation, gender identity and intersex status as a social determinant of health, including:
 - i. Teaching of health issues specific to LGBTIQ communities;
 - ii. Teaching of the vulnerabilities of LGBTIQ populations and the barriers to healthcare;
 - iii. Teaching cultural competence with LGBTIQ individuals as a core learning objective;
 - b. Addressing the health of minority groups within LGBTIQ communities, including:
 - i. Engagement with Aboriginal and Torres Strait Islander LGBTIQ organisations and communities to develop a culturally sensitive approach to the health of these communities;
 - ii. Encouraging rural clinical schools and medical students in rural placements to promote resources on LGBTIQ health for rural LGBTIQ individuals;
 - c. Developing strategies for competent engagement with LGBTIQ populations:
 - i. Highlighting the use of appropriate, safe and inclusive language (including the appropriate use of names, pronouns, titles and patient's preferred terms for their body parts) as paramount to providing adequate healthcare;
 - ii. Creating teaching materials that explore the needs of LGBTIQ populations in a positive and non-stigmatising way, in particular patient-based learning (PBL) scenarios, clinical cases and lectures;
 - iii. Allow for increased exposure to LGBTIQ communities through clinical rotations and national and international electives;
 - iv. Consulting with LGBTIQ organisations to develop accessible and relevant resources on LGBTIQ health for medical students;
 - v. Teaching LGBTIQ health in an integrated manner throughout the medical curriculum, where appropriate;
 - vi. Inviting participation of LGBTIQ health professionals and community members in teaching and curriculum development;
 - d. Avoiding stigmatising models of sexuality, sexual orientation, intersex status and gender identity;
 - i. Rejecting stigmatising representations and terms of non-binary, intersex and gender diverse individuals;
 - ii. Utilising the most current version of the World Professional Association for Transgender Health (WPATH) guidelines as the basis for developing an inclusive curriculum;
 - e. Developing modules on anti-discrimination legislation and the legal responsibilities of medical professionals to LGBTIQ individuals;
4. The AMSA Executive to promote awareness of LGBTIQ health issues nationally by:

- a. Where applicable, lobbying for anti-discrimination laws, policies and legislation in alignment with statements 1-3 above;
 - b. Fostering and supporting initiatives to better LGBTIQ health;
 - c. Updating and reviewing current AMSA policies to ensure they are inclusive of LGBTIQ communities;
5. Medical students, student clubs and medical students' societies to promote LGBTIQ health issues locally by:
- a. Ensuring the interests and well-being of LGBTIQ medical students are represented within the medical student body;
 - b. Promoting the teaching of LGBTIQ health issues within their medical schools;
 - c. Advocating against prejudice and discrimination of LGBTIQ medical students among the medical community.

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Appendix

Appendix 1: Terms and Definitions

Terms to describe identity and their definitions are often debated within the LGBTIQ community. It is important to keep in mind that some terms have multiple definitions, variations or are fluid, as they apply to personal experience which may not be transferable to others. Additionally, not all people may identify with terms that others might consider apply to them. This appendix aims to clarify terms used throughout the policy, but recognises that other interpretations are possible, and that some terms are controversial.

Intersex: Congenital differences of anatomical sex. This includes primary and secondary sexual characteristics which are neither wholly male nor female, a combination of male and female or neither male nor female [18]. In the clinical context, intersex status has been referred to as hermaphroditism or disorders of sex development; however, these are often considered derogatory or inappropriate terms.

Transgender: An umbrella term used to describe all those whose gender identity is at odds with their assigned sex at birth [19]. In other contexts, similar terms used are trans or gender diverse.

It is important to acknowledge that:

1. Gender identity is not necessarily binary (man/woman). People may identify as having no gender, fluid gender, multiple genders, a gender other than man or woman, or consider their gender in another paradigm from these [19].
2. Terms are culturally specific. Some indigenous communities use the terms *sistergirl* and *brotherboy* to describe individuals whom we consider transgender. Similarly, other cultures recognise genders which are outside the male-female binary. It is important to acknowledge and respect these culturally-specific gender identities [20].

Queer: Queer is a theoretical discourse, deriving from postmodern and post-structural thought. It 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. For the sake of this policy, queer was taken to mean the following:

1. An umbrella term to describe all lesbian, gay, bisexual and transgender people
2. A term that refers to individuals who fall outside of those terms, such as pansexual, polysexual and asexual.
3. An identity in its own right, often used as a term that describes gender or sexual, physical and romantic attraction different to the norms of sexuality and gender identity.
- 4.

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.

Appendix 2: Justification

Mental Health Inequalities

Research over the last decade has shown LGBTIQ individuals experience higher levels of mental health issues, including depression, anxiety and self-harm compared to the general population. Within the gay, lesbian and bisexual population, the rate of suicidal ideation and behaviour is almost three times that of those identifying as straight [21]. Self-harm and suicidal ideation amongst same-sex attracted and gender diverse youth has been shown to be disproportionately high [2]. Similarly, transgender men and women have reported the lowest scores of overall mental health and had the highest levels of nonspecific psychological distress [1]. Similar statistics have been found in intersex people, with 60% having experienced suicidal thoughts and 19% having attempted suicide specifically related to having a congenital sex variation [22]. It is acknowledged that normalising surgical intervention at infancy is damaging to the mental health of intersex individuals [5]. These issues are compounded by the lack of appropriate interventions and prevention strategies, and in some cases, a lack of cultural competence on the part of health practitioners [7]. Some of the inequalities in mental health may be attributed to the phenomenon known as 'minority stress', which LGBTIQ persons experience in their struggle for validation and societal acceptance [23]. Stigma and discrimination against sexual minorities has been extensively documented [24] and assessed as likely to be at least part of the reason for the higher rates of psychological morbidity observed [25, 26].

Physical Health Inequalities

A 2012 study indicated that the self-reported general health of LGBT individuals was much lower than the national average, with transgender individuals reporting the lowest level of general health [1].

There are higher rates of alcohol consumption, tobacco intake and drug use amongst the LGBTIQ community compared to national averages [27]. Obesity is also more prevalent among lesbian and bisexual women in particular [28]. Furthermore, studies also indicate anal cancer is more common in gay and bisexual men [29], while lesbian and bisexual women face discrimination when accessing cancer screening programs [10, 30]. In relation to intersex communities, there is a need for more research evaluating the outcomes of current medical and surgical interventions. Non-consensual normalising genital surgery is sometimes performed on infants born with ambiguous genitalia [5]. Often this surgery is performed for reasons other than medical concerns, such as to relieve parental distress or promote a stable gender identity [31]. Although high quality data on the outcome of non-consensual genital surgery are lacking [32], some of the negative outcomes reported in the literature include sexual dysfunction [33], poor cosmesis, and complications requiring further surgery [34]. However, there is enough evidence to support retiring the current practice of genital surgery on intersex infants in favour of respecting bodily autonomy [5]. Overall, these physical health statistics highlight the need for culturally sensitive programs and services targeting the poor health outcomes experienced by LGBTIQ individuals.

Aboriginal and Torres Strait Islander Communities

Aboriginal and Torres Strait Islander communities and peoples have different cultures, languages and experiences which are often dissimilar to those of non-Indigenous Australia. As such, Aboriginal and Torres Strait Islander people who identify as LGBTIQ may have experiences, challenges and needs which are distinctly different from the other populations within Australia. A 2010 Australian survey of 3,134 LGBTIQ youths found that the Indigenous population were more likely to have contracted or been exposed to an STI compared with the non-Indigenous population (11% vs. 5% respectively) [35]. Research also reveals a high incidence of drug use, imprisonment and sexual violence among gay Indigenous men [36]. These health inequalities may partly be explained by the dual effects of heterosexism and racism. A Queensland survey of 160 gay Indigenous men found significant rates of heterosexism experienced from the Indigenous community and even higher rates of racism experienced within the LGBTIQ community [36]. Aboriginal and Torres Strait Islander people may also face

additional barriers to healthcare as a result of geographic location, culturally inappropriate services and concerns about confidentiality when accessing local Aboriginal Medical Services [37].

Social Inequality

Discriminatory policies relative specifically to marriage equality (where marriage equality is defined as achievement of policy point 1d above) have been shown to have negative health effects, with significant increases in psychiatric disorders amongst lesbian, gay and bisexual persons living in states that banned gay marriage [38]. In Australia, the *Marriage Act 1961* (Cth) currently defines marriage as a legal union solely between a man and a woman, which discriminates institutionally on the basis of sexual orientation. Marriage denial reinforces stigma associated with sexual identity and undermines well-being for all LGBTI persons, with adolescents and young adults again particularly sensitive. Conversely, marriage equality would confer broadened developmental options for lesbian and gay adolescents and young adults, who could then envision marriage as a key element of their adulthood [39].

Policy Details

Name: LGBTIQ Health Policy

Category: F – Medicine in Australia

History: Adopted Council 2 2016

Amalgamation of LGBTIQ Health policy (2014) and the Marriage Equality and Health policy (2013)