Perspective: **A Grand Challenge to Academic Medicine: Speak Out on Gay Rights**

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Abstract

Social responsibility, a dearly held value in the medical community, requires that medicine use its influence to end discrimination and to reduce barriers that affect access to care. Although the gay, lesbian, bisexual, and transgender (GLBT) population has been identified as suffering from health care disparities and oppression, the medical community and its affiliated organizations have done little to lobby in defense of the GLBT population. And with regard to the specific issue of gay marriage, medicine has yet to raise its voice in that debate, even if only to correct unscientific, capricious, and slanderous depictions of GLBT relationships. Closer to home, in medical schools and residencies, GLBT faculty and students are not provided with a safe and equal environment in which to work and learn. No credentialing provisions require residencies and their affiliate hospitals to include GLBT status in their nondiscrimination policies or to offer GLBT faculty and residents equal benefits. There is no assurance that those in power at peer-reviewed journals will use reviewers who are familiar with the research on sexual minorities to review manuscripts on GLBT topics, a situation that likely contributes to the community's status as an understudied population. Medicine cannot fulfill its obligation to GLBT patients, students, and faculty without a considerable and determined commitment to change. Some of the suggested remedies would require amending policy at the level of the Accreditation Council for Graduate Medical Education and the Association of American Medical Colleges.

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There are times when politics and health are so intertwined that to forgo politics is to neglect health. This was certainly the case in the early 1970s, when the American Psychiatric Association made the courageous decision to remove the diagnosis of homosexuality from the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV). It could not have been easy to take such a controversial stand. Nonetheless, guided by evidence-based medicine, psychiatry entered the political fray and freed gay individuals from this demeaning stigma.[*] The removal of sexual orientation from the DSM-IV energized advocates of gay rights. Science had become a new partner in the fight against discrimination.

Today, the term "gay rights" is most often associated with marriage rights, but its meaning is much broader.[†] The definition of gay rights is implicit in the name of the Human Rights Campaign, one of the largest gay, lesbian, bisexual, and transgender (GLBT) advocacy groups in the world. Gay rights are human rights, as delineated by the United Nations Universal Declaration of Human Rights and the U.S. Constitution. They include natural rights, such as the right to pursue happiness and the right to procreate, as well as more ambitious rights, such as the right to freedom of expression, the right to an education, the right to health care, the right to work, and the right to equality under the law. Those who support gay rights believe that the denial of marriage rights, discrimination in hiring, denial of adoption rights, and problems with access to health care that currently are experienced by the GLBT population are violations of human rights.

The constituents of academic medicine—in particular those people, associations, and institutions empowered to influence institutional policy, disseminate scientific knowledge to the public, and advocate at state and federal levels of government—have a necessary and important role to play in the gay rights movement. Some medical organizations have voiced support for gay rights by issuing pro-rights resolutions. The American Academy of Pediatrics has taken a stand in defense of adoption rights, the American Medical Association has recommended that hospitals provide partner benefits, and the American Society for Reproductive Medicine has disputed the denial of fertility services on the basis of marital status or sexual orientation.[‡] Such organizational resolutions and public statements are a good start, but much more work, including policy and curriculum reform within our own academic institutions, is needed.

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[*] Gender identity disorder is still listed as a diagnosis in the DSM-IV. It is worth noting that this diagnosis is applied only when a person is struggling with his or her gender identity—not on the basis of transgender identification. External factors, such as social stigmatization and oppression, are not addressed in the diagnostic criteria.

[†] "Gay rights" is a colloquial term, and it is used here because of its familiarity to the general public. For the remainder of this article, "GLBT," a more inclusive term, is used for references to the gay, lesbian, bisexual, and transgender population.

[‡] A list of all American Medical Association resolutions and policies regarding sexual orientation and gender identity can be found on the American Medical Association's Web site under GLBT Advisory Committee. Readers should go to (http//www/ama-assn.org/ama/pub/about-ama/our-people/member-groups-sections/glbt-advisory-committee/ama-policy-regarding-sexual-orientation.shtml).

Academic Medicine's Potential to Affect GLBT Rights

When I suggest that academic medicine should and could serve as an ally to the GLBT community, I often encounter resistance. Two hesitations arise again and again, and they are best illustrated by sharing feedback I have received when I try to publish on gay rights. First, I have been given the message that GLBT issues are not a priority. Second, I have repeatedly been told that GLBT issues are not within the domain of academic medicine. Before suggesting remedies for discrimination against GLBT patients, students, and faculty, I will respond to these two perceptions.

Are GLBT issues currently a priority?

One reviewer's comment was, "I fail to understand how you can say that this is a critical time for gay rights." Certainly, there are times when I think responses like these stem from homophobia—a fear or dislike of gays and lesbians—but sometimes I attribute them to a lack of information. Poor knowledge of the status of gay rights may be due, in part, to the depth and breadth of legal action during the last eight years. GLBT-rights-related laws have been enacted at every level of government—town or city, county, state, and federal—and through every legal method available—administrative action, the judiciary, the legislature, and the ballot box—all with ongoing appeal and debate. Even for those with a vested interest in gay rights, it is difficult to understand the effect on GLBT persons of such a rapidly shifting legal terrain.

About 10 years ago, the gay rights movement seemed to explode into public consciousness. Many factors were responsible for this zeitgeist, most notably a shift in media exposure. In 1997, Ellen DeGeneres's popular television character "came out" as gay. It was the first time that viewers in the United States encountered a likable gay character on a television show. After Ellen DeGeneres herself came out, she became a powerful national spokesperson for gay rights. She appeared on major interview shows (e.g., "The Oprah Winfrey Show" and ABC's "20/20") and was even invited, with her partner, to the White House. Ellen broke through the wall that kept the GLBT community invisible. Gay and lesbian characters began to spring up all over prime-time television.

Although initially liberating, the new visibility of the GLBT community soon evoked a strident backlash. A number of countries, including our neighbor Canada, legalized gay marriage, but a growing partisan divide in our own country seemed to amplify differences on social policy, especially gay rights. For the 2004 U.S. national elections, 11 states had ballot measures constitutionally banning gay marriage. The lives and moral character of gay men and women were publicly scrutinized and often slandered. The GLBT community was simply unprepared, fiscally and politically, to counter those attacks. In all 11 of those states, the antigay marriage ballots passed.

Since that time, battles have been waged over a vast array of rights, some seemingly obscure—such as recognition of GLBT student groups, inclusion of sexual orientation in health class curricula, and the question of whether the Boy Scouts can reject gay and bisexual participants while benefiting from tax breaks. Although easily dismissed as representing local differences of opinion or low-impact legislation, these types of legal actions have great effects on individual lives and can create legal precedence for larger-scale discriminatory action. To the GLBT community, the constant debate over every right, small and large, has been exhausting and disheartening.

Today, the GLBT community remains excluded from the federal Nondiscrimination Act. It is legal in most states to fire someone solely on the basis of his or her sexual orientation. In many states, housing rights are limited and adoption rights denied. One of the largest employers in the United States, the armed forces, has singled out gays for discrimination. Since the "don't ask, don't tell" policy was instituted in the armed forces, more than 9,000 gay men and women have been fired from their jobs and forced to leave the military, solely because of their sexual orientation. As of this writing, only Connecticut and Massachusetts allow gay marriage, which ensures gay and lesbian couples the full range of rights afforded to married heterosexual couples. A small number of states have passed laws that allow civil unions,[§] but the rights associated with this entitlement vary significantly from state to state and rarely are fully commensurate with the rights conferred by marriage.

In the end, what held the potential to be a time for great advancement for gay rights resulted in more legal defeats than victories. In my state, Michigan, a ballot measure was passed that resulted in changes to the state constitution barring not only gay marriage but also the legal recognition of any union, other than marriage, "for any purpose." Emboldened by the passage of that ballot measure, Michigan Attorney General Michael Cox reinterpreted second-parent adoption law so as to prohibit judges from conveying second-parent adoption to anyone who is not legally married to the primary parent. Because same-sex partners cannot marry, and thus cannot both adopt the child or children they are raising, the nonadoptive parent is deprived of equal partnership in the many legal, financial, and emotional aspects of child rearing, including medical decision making, providing the child's health care insurance, and the security of knowing that the child cannot be taken away from him or her if the biological or adoptive parent dies.

Are GLBT issues within the domain of academic medicine?

Clearly, this is a critical time in the struggle for gay rights, but is that struggle of concern to academic medicine? Is activism of any kind within the scope of the medical education enterprise? I will argue that the answer is most certainly "yes," as long as that advocacy is rooted in the findings of evidence-based medicine.

In academic medicine, we teach that patients are more than tissue and bone. We tell our students that they are feeling, thinking, social beings who are positively and negatively affected by their contexts. The manner in which they are affected has direct and meaningful consequences

[§] Same-sex couples in New Hampshire, New Jersey, and Vermont are able to enter into state-level civil unions. Domestic partnership benefits are offered in Oregon. Same-sex couples in California, Hawaii, Maine, Maryland, Oregon, Washington state, and Washington, DC, are given some level of domestic partnership recognition. For example, GLBT couples in Maryland are allowed 11 protections, including sharing a room in a nursing home, hospital visitation, and the right to make funeral decisions.

for health. It is through this biopsychosocial lens that a physician learns to see and appreciate the social context, but we take it a step further in medicine by teaching physicians to intervene (to be activists) when the social context is oppressive.

Justice, which can be defined as the equitable distribution of benefits, is a long-held and dearly valued guiding principle of medicine and the backbone of social responsibility. In essence, social responsibility places a value on physician behaviors that reduce social oppression or the effects of social oppression. The idea of social responsibility conjures up thoughts of volunteerism, community activism, and personal sacrifice. It reminds one that the domain of the physician extends far beyond the walls of the clinic. The pursuit of social responsibility is the medical community's self-imposed challenge to care about the welfare of patients, even when it requires searching beyond the human body to discover the causes of poor health, and even when it requires developing cures that cannot be found in a laboratory. In summary, a commitment to the just treatment of all patients and a commitment to a holistic conceptualization of the patient have led those at the helm of academic medicine to steer research, curricula, and publications toward identifying and addressing what have been termed "health disparities." That is why academic medicine, if it is to be true to its ideals, will work to end the oppression suffered by the GLBT community.

What do we know so far about the effects of social context on the GLBT population? We know that GLBT adolescents are at risk of harassment, injury secondary to bullying, withdrawing from school because of safety fears, and suicide attempts.[1–3] Antigay discrimination is a common experience for GLBT adults as well, and it is associated with negative mental health outcomes.[4] Although a lack of research on the GLBT population has made it difficult to evaluate disparities, current data suggest that the GLBT community is at elevated risk of anxiety, mood, and substance use disorders; suicidal thoughts and plans; smoking; and unsafe sex.[5–7]

We know that marriage, which provides a substantial range of psychological, social, and health benefits, is an important aspect of social context.[8] In fact, evidence suggests that legal and social recognition of GLBT relationships may reduce discrimination and lead to better physical and mental health for gays and lesbians.[9]

I would argue that marriage is the single most important right denied to GLBT individuals. In fact, the Human Rights Campaign has identified 1,000 legal rights associated with marriage, such as hospital visitation, visa rights, tax-related inheritance advantages, medical decision-making rights, and pension benefits, but it is the less obvious, more social "soft benefits" of marriage that are most easily taken for granted. Some of these benefits are spousal support groups; acknowledgment of spouses at graduations and retirements; offers of prayer for sick spouses; emotional, psychological, and monetary support in times of natural crisis or disaster (e.g., Red Cross and government support for married partners of 9/11 victims); and the presentation of a U.S. flag at the death of a spouse in military service.

Some may think that civil unions are an adequate substitute for marriage, but they are not. Far too many rights and social benefits are tied to marriage for the difference between marriage and civil unions to be inconsequential. When civil unions are conferred in lieu of marriage, every one of those rights and benefits becomes a potential battleground. If we have learned anything from our past, we should already know that civil unions will always be inferior to marriage. Different rights, segregated rights, can never truly be equal rights.

During the past 10 years, the United States and much of the world debated gay marriage,[¶] but medicine remained essentially silent. Not a single article on the health-related aspects of gay marriage, including health care benefits, was published in any of the core medical journals in the United States.[10]

[¶] Marriage equality was first achieved in the Netherlands. Since that breakthrough, same-sex marriage has been legalized in Belgium, Canada, South Africa, Spain, and, in January 2009, Norway. Fourteen countries, including France, Germany, New Zealand, Sweden, Switzerland, and the United Kingdom, confer nationwide rights that approximate marriage rights.

Ten Ways That Academic Medicine Can Support Gay Rights

There are many ways in which academic medicine can play a role in the fight against discrimination. Most of the following suggestions target systemic changes that can make the academic world a safer and more just place for students and faculty. Some of these recommendations would require that the Accreditation Council for Graduate Medical Education (ACGME) and the Liaison Committee on Medical Education (LCME) amend accreditation standards for schools and residency programs.

These suggestions are stated in a bare-bones manner, and they do not address the issues in all their complexity. Each idea can easily be challenged with arguments of political implausibility and legal conundrum. Certainly, implementation of these and other efforts to combat GLBT health disparities will take considerable commitment from those with talent and know-how in law and strategic planning. By presenting these ideas, I hope to raise awareness of disturbing inequalities and to stir up a debate as to whether enough is being done to remedy them.

1. *Create a task force.* Several recent studies found higher levels of stress and anxiety in gay, lesbian, and bisexual residents of states that passed antigay marriage legislation than in those who live in states that did not pass such legislation.[11,12] In addition to the stress associated with greater exposure to negative media and negative conversations, participants reported feeling alienated from their communities and even feeling fearful. Their fears included the fear of losing their children and the fear of becoming a victim of antigay violence. Many reported having thoughts that they may need to move to find a more accepting community.[13] In light of these findings, the ACGME and the LCME could create a joint task force to compile research on the effect of antigay legislation on medical students, residents, faculty, and patients. Findings could be disseminated along with recommendations for further study in areas deemed necessary.
2. *Require that teaching hospitals offer equal benefits to GLBT residents and faculty, when state law permits.* When state law does not allow provision of equal

benefits, efforts should be made to advocate for change. To draw the best applicants to medicine, we have to demonstrate that the medical community values diversity and supports its minority constituent's rights to equal and fair benefits and opportunities. Sadly, business has done more to support its gay workers than has medicine. Companies such as Borders, Google, Microsoft, Disney, and even the San Francisco 49ers have documented policies that offer equal benefits to GLBT employees. Many hospitals do not, and there is no system devised to compel or to track hospital initiatives in offering equal benefits to GLBT nurses, residents, and faculty.

The ACGME, through the various Residency Review Committees, could require that residency programs offer benefits to GLBT residents and faculty that are equal to those offered to other residents and faculty. The first step in achieving this goal would be to explore the ways in which large international companies such as Microsoft have identified entitled couples (typically, by using evidence such as shared accounts and housing) and worked with insurers and pensioners to make equal benefits a reality. The Residency Review Committees have the oversight, the leverage, and the obligation to ensure that all residents receive nothing less than fair and equal treatment during their training.

3. *Require that hospital-based training programs provide protection from employment discrimination for GLBT residents and faculty by including GLBT status in the nondiscrimination clauses when it is legal to do so.* When the law prohibits employment rights for GLBT persons, efforts should be made to advocate for those rights. There can be no academic freedom in the absence of such protection. How can faculty interested in GLBT studies feel safe in electing to focus their research on GLBT health if they fear their careers will suffer as a result? At this time, only faculty lucky enough to work in hospitals, residencies, and medical schools that have endorsed a pro-GLBT policy can risk publishing on GLBT-related topics. It is a fact that the GLBT population is understudied.[14,15] If nothing changes, we in medicine will never meet our full potential as investigators of health-related issues among minorities.
4. *Create a national Web site through which GLBT medical students, residents, and faculty can report incidents of discrimination and programmatic success in their training environments.* Contributors could be identifiable or anonymous, as desired. Links to this Web site could be made available to those applying to medical schools and residencies. The addition to existing Association of American Medical Colleges (AAMC) surveys taken among matriculating and graduating students of questions examining whether the school or residency is a hostile or supportive environment for GLBT students should be considered.

   Evidence suggests that, although prejudice against GLBT patients is decreasing,[16,17] it still persists.[18–21] Subtle forms of bias, such as heteronormativity (the assumption of heterosexuality and lack of inclusion of homosexuality), are common in medical centers and are reflected in our waiting rooms, documents, and provider communications,[22] and GLBT patients continue to struggle with whether to come out to their health care providers.[23] If we do not take a stand on gay rights, we will not root out homophobia where is resides undisturbed. If medicine takes action to fight for and protect the rights of GLBT students, residents, and faculty, it is likely that they will feel more comfortable taking leadership roles that will improve services to GLBT patients.
5. *Invite the president of the Gay and Lesbian Medical Association to give a keynote address at the AAMC national conference.* Now is the perfect time for this step. The Gay and Lesbian Medical Association and the Human Rights Campaign Foundation have just released the first Healthcare Equality Index.[24] This report rates hospitals on health care for and nondiscrimination policies toward GLBT persons.

   The GLBT population should routinely be included in discussions of cultural competence and health disparities at all national conferences. Although Healthy People 2010 identified the GLBT population as suffering from health disparities,[25] GLBT health concerns remain on the fringes and out of sight of those without a personal investment. It is time for GLBT health to be integrated into mainstream medicine.
6. *Publish a special issue of* Academic Medicine *on GLBT health disparities and/or GLBT-related curriculum in medical schools and residencies.* Because of the paucity of research, we may first have to create an academic environment that encourages research on GLBT patients, students, and faculty. Topics for further research might include medical school curriculum, faculty and student perceptions of work and training environment, and patient–physician relationships.
7. *Develop ethical standards for peer review that reflect the need for peer reviewers to have adequate familiarity with a minority population if they are to serve as reviewers for manuscripts concerning that population.* It is not uncommon to find manuscripts on GLBT topics being reviewed by reviewers with no exposure to research on the GLBT population. Such a situation defeats the purpose of peer review, which should offer expert peer evaluation, and it makes light of potential bias, intentional and unintentional, on the part of reviewers who, through lack of exposure, may not have considered their own internalized homophobia.‖
8. *Encourage constituent groups (regional meetings and interest groups) to identify how they will work to implement the goals put forth by the AAMC's Group on Student Affairs and Office of Student Representatives.* These recommendations appeared in a joint publication[26] and were approved by the AAMC Executive Council. Speakers, such as those on the medical experts panel of the Gay and Lesbian Medical Association, should be asked to address organizations at state and local levels to provide educational programming that will enhance goal planning and implementation.
9. *Provide relevant medical and scientific research about health consequences, to allow for more-informed public policy debates on GLBT rights.* The American Psychological Association has been

‖ The articles cited in the current report were published primarily in public health and GLBT specialty journals, even though many report data from large or even national studies. Very few of the articles cited were published in mainstream medical journals. This dilemma is discussed in more detail by Boehmer,[14] who notes a paucity of published material on GLBT health and health promotion in mainstream medical journals, other than material on the very limited, and somewhat stigmatizing, area of HIV-related topics.

active in promulgating research findings and educating the public on relevant public policy debates governing GLBT rights, such as the right of GLBT individuals to adopt children and enter into domestic partnerships and marriage. The research is clear: Gay and lesbian relationships are essentially indistinguishable from and not inferior to heterosexual relationships.[27] Likewise, the children of gay and lesbian parents fare as well on psychosocial scales of adjustment as do the children of heterosexual parents.[28] Organizations should use their influence to disseminate this and other scientific information to challenge prejudicial laws associated with health care benefits, marriage, adoption, hate crimes, and employment and housing discrimination. Medical students and residents need to see that their mentors are willing to work for justice and are interested in their rights and well-being.

10. *Encourage the hiring of GLBT faculty, just as ethnic diversity in hiring is encouraged.* Likewise, efforts to recruit and retain GLBT students should be encouraged and monitored. Diversity helps to ensure that people from all types of lifestyles find a voice for their needs and a slice of power in program development. A diverse staff signals to patients that everyone will be treated with respect. Hiring openly gay faculty is especially important in communities with invisible GLBT populations, where gays may feel unsafe and be unwilling to talk with their medical providers about sexual or relationship concerns.

The Time to Act

I know that many people who read this article will downplay the power of academic accreditation as a vehicle for enforcing equal rights. Others will continue to say that gay rights have nothing to do with medicine, despite the negative health effects of discrimination. Some, caught between long-held religious beliefs and a commitment to science, will say nothing, and some, infected with homophobia, will refuse to think about this issue at all. Perhaps it is this same pessimism and these same prejudices that have stopped academic institutions from doing what it is in their nature to do, for no professional body is better prepared or more suited to work for justice than is academia. Academic medicine has always worked to uncover the truth, even when it was unpopular, and has always reached out to the public to correct misinformation that puts individuals at risk. The GLBT population has suffered from legalized discrimination for far too long. I challenge the innovative leaders of academic medicine to fight for equity, internally and externally, for their students and their patients. Medicine has always held true to the pragmatic notion of "see one, do one, teach one." The only way to prepare physicians to "do" justice is to demonstrate to them the courageous and complex work of fighting for justice.

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