REPORT 9 OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH (A-08)
Optimizing Care for Gay Men and Lesbians
(Reference Committee E)

## EXECUTIVE SUMMARY

Objective: To update the 1994 Council report on the health care needs of gay men and lesbians.

Methods: To supplement the literature search from the 1994 Council report, English-language reports on studies using human subjects were selected from a PubMed search of the literature from 1995 to April 2008 using the MeSh terms "homosexuality, male or female," in combination with "statistics & numerical data," "sexual behavior," "risk-taking," "epidemiology," "sexually-transmitted diseases," "ethnic groups," "medical history taking," "genetics, behavioral," "health services/utilization," "cancer," "substance-related disorders," "mental disorders/diagnosis," "preventive health services," and "prejudice or violence." In addition, Web sites of the Gay and Lesbian Medical Association, American Academy of Pediatrics, National Institutes of Mental Health, Centers for Disease Control and Prevention (CDC), American Academy of Child and Adolescent Psychiatry, American Psychiatric Association, American Academy of Family Physicians, and the American College of Physicians also were searched for relevant documents. Additional articles were identified by manual review of the references cited in these publications.

Results: Gay men and lesbians are confronted with many of the same health issues as their heterosexual counterparts, but in addition have certain unique conditions related either to sexual or other disease risk factors or to use of fewer preventive services. Emotional and mental health concerns related to stigmatization and societal discrimination, substance use, access to care, and partners' involvement in medical decision-making create a backdrop against which other clinical issues are evaluated. Although attitudes among health care professionals have improved over the last two decades, barriers still exist to providing optimal care and eliminating disparities for gay men and lesbians, including reluctance on the part of some patients to disclose their sexual identity.

Additional issues facing gay men include sexually transmitted and other infectious diseases, and cancer risks related to human papillomavirus infection. Lesbians may have higher risks for breast and ovarian cancer, as well as cardiovascular disease, but utilize screening services at a low rate. Adolescents face a range of issues in dealing with their emerging sexual identity, and young gay men are exhibiting an increase in behaviors and practices that raise the risk of sexually transmitted diseases, including infection with the human immunodeficiency virus (HIV).

Conclusion: Improvements are still needed to address disparities in health care for gay men and lesbians. Gay men and lesbians are disproportionately at risk for societal discrimination and violent hate crimes, STDs, a variety of mental health conditions, substance use, and certain cancers. Problems are encountered with access to quality care and counseling pertinent to actual lifestyle behaviors.[59] Physicians can assist by providing a welcoming practice environment, relevant educational materials, and inclusive patient intake and other forms, and by becoming familiar with the issues facing gay men and lesbians. When physicians and practices cannot accomplish these tasks, referral of the patient to another physician who can provide such care is imperative. With appropriate education and training, physicians can play a vital role in ensuring access to quality care for gay men and lesbians, and in helping them lead healthier lives.

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 9-A-08

Subject: Optimizing Care for Gay Men and Lesbians

Presented by: Mary Anne McCaffree, MD, Chair

Referred to: Reference Committee E
(Shannon M. Kilgore, MD, Chair)

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Introduction

This Council has previously addressed the health care needs of the homosexual community; first in 1981 as the human immunodeficiency virus (HIV) epidemic was unfolding, and again in 1994 when effective treatments for HIV were available, but disparities in providing quality care to gay men and lesbians became more widely recognized.[1,2]

Recently, the American Medical Association (AMA) Advisory Committee on Gay, Lesbian, Bisexual and Transgender (GLBT) Issues requested that the Council again consider this topic. The Committee supported its request by identifying topic areas that needed updating, based on new findings and published data. The recognition that many lesbian, gay, bisexual, and transgender health issues were not fully understood led the Institute of Medicine to issue a report in 1999 on the status of lesbians' health.[3] *Healthy People 2010* identifies gay men and lesbians as 1 of the 6 most underserved groups subject to health disparities.[4]

The Council agreed to the request and this report represents a collaborative effort between the Council and the GLBT Advisory Committee. The report focuses on the health care needs of gay men and lesbians in the United States, including specific discussion and/or advice, for physicians on how to optimize the care of these individuals.

The report does not examine the issue of same sex marriage nor specifically examine the physiological and psychological well-being of children raised by same sex couples. However, the Council notes that current AMA policy supports: (1) allowing the adoption of a child by the same sex partner, or opposite sex nonmarried partner, who functions as a second parent or co-parent to that child; and (2) equality in laws affecting health care of members (including dependent children) in same sex partner households (Policies H-60.940 and D-65.995, AMA Policy Database). The American Academy of Pediatrics also has concluded that "there is no relationship between parents' sexual orientation and any measure of a child's emotional, psychosocial, and behavioral adjustment" and that "greater stability and nurturance within a family system [regardless of parents' sexual orientation] predicts greater security and fewer behavioral problems among children."[5] Similarly, the American Academy of Family Physicians supports promoting a safe and nurturing environment, including psychological and legal security, for all children, including those of adoptive or foster parents, regardless of the parent's sexual orientation.[6] Nationally, 33% of female-partnered and 22% of male-partnered households live with their children under the age of 18 years.[7]

This report also does not specifically address gender identity except to differentiate it from sexual orientation (see below). Many gay men and lesbians have gender identities concordant with their biological sex. However, transgender persons have a gender identity discordant from their biological sex with psychological and social attributes that do not correspond to their physical bodies.

Action of the AMA House of Delegates 2008 Annual Meeting: Report 9 of the Council on Science and Public Health Recommendation Adopted, and Remainder of Report Filed.

Transsexuals, a subset of transgender, are people who have a strong and persistent cross-gender identification, discomfort with their biological self (gender dysphoria), and desire to acquire the characteristics of the other sex, which may lead them to seek sexual reassignment surgery. Sexual orientation and gender identity are independent attributes and it is possible for a transgender individual to have either opposite sex or same sex desires.

## Methods

To supplement the literature search from the 1994 Council report, English-language reports on studies using human subjects were selected from a PubMed search of the literature from 1995 to April 2008 using the MeSh terms "homosexuality, male or female," in combination with "statistics & numerical data," "sexual behavior," "risk-taking," "epidemiology," "sexually-transmitted diseases," "ethnic groups," "medical history taking," "genetics, behavioral," "health services/utilization," "cancer," "substance-related disorders," "mental disorders/diagnosis," "preventive health services," and "prejudice or violence." In addition, Web sites of the Gay and Lesbian Medical Association, American Academy of Pediatrics, National Institutes of Mental Health, Centers for Disease Control and Prevention (CDC), American Academy of Child and Adolescent Psychiatry, American Psychiatric Association, American Academy of Family Physicians, and the American College of Physicians also were searched for relevant documents. Additional articles were identified by manual review of the references cited in these publications.

## Definition of Terms

In order for physicians to better understand their gay and lesbian patients, the terminology and demographics of homosexuality are briefly reviewed. Gay refers to a male who is emotionally, romantically, sexually, and relationally attracted to other males. Popular usage also employs gay to refer to men and women with same sex attractions. Lesbian refers to women who are emotionally, romantically, sexually, and relationally attracted to other women.

Sexual Orientation vs Sexual Behavior. The distinction between sexual orientation (identity) and sexual behavior is important when considering the medical care of gay men and lesbians. Sexual orientation consists of 3 attributes: desire or attraction, behavior, and identity. These attributes frequently do not co-exist. Individuals may identify with one sexual orientation, yet their sexual behavior, either in the past or present, may not correspond. One widely quoted study found that for men, 7.7% have same sex desires, 7.1% participated in same sex behaviors, and 2.8% self-identified as being gay.[8] This study found that for women, 7.5% express same sex desires, 3.8% participated in same sex behaviors, and 1.4% self-identified as being lesbian.[8] Thus, more individuals have homosexual feelings than engage in homosexual behavior, and more engage in homosexual behavior than develop lasting homosexual identification.[8] Furthermore, an individual's sexual behaviors may vary over time. For example, some gay men, lesbians, and bisexuals are or were married, and some have children either from their own heterosexual relationships or by adoption.[9] Self-identified lesbians who want to have their own children may choose to be artificially inseminated, after which the birth mother and her lesbian partner may seek to legally adopt the child.[10]

Prevalence of Gay Men and Lesbians. Differences regarding personal perception and accepted definition of sexual orientation versus behavior contribute to the uncertainty about the prevalence of gay men, lesbians and bisexuals. In addition, given the sensitive nature of the subject and the societal stigmatization of homosexuality, underreporting may occur. An analysis of 5 surveys conducted between 1970 and 1990 estimated that at least 5% to 7% of U.S. males report same-gender sexual contact during adulthood.[11] When the largest metropolitan areas are surveyed, more than 9% of men self-identify as gay.[8] Surveys conducted from 1996 to 2000 indicate that the rate of men who have

sex with men (MSM) is in the range of 3.1% to 3.7%.[12] Per the definition of terms provided above, some of these surveys blurred the lines among sexual behavior and sexual identity. The 2002 National Survey of Family Growth (NSFG) report found that among males 15 to 44 years of age, 6% have had oral or anal sex with another male.[13] The proportion of men who had a male sexual partner in the last 12 months was 2.9%, or approximately 1.77 million men. The proportion of men who had only male sexual partners in the last 12 months was 1.6%.

The NSFG also found that among women 15 to 44 years of age, 11% answered yes when asked, "Have you ever had any sexual experience of any kind with another female?" The proportion of women who had a female sexual partner in the last 12 months was 4.4%, or approximately 2.71 million women, and the proportion who had only female sexual partners in the last 12 months was 1.3%. In the Women's Health Study of American Physicians, 2.6% of respondents self-identified as lesbian.[14] Information derived from exit polling and longitudinal health care studies reveals that lesbian self-identification is somewhat higher in younger, compared with older individuals.[15,16]

Thus, self-reports of sexual orientation vary across age groups, and also differ by geographical locations. Gay men and lesbians are found in all communities, and therefore, comprise a portion of the patient pool for health care services throughout the country.

Non-disclosure of sexual identity. Religious background, culture, and race affect and often complicate how people self-identify (or misidentify) themselves. Gay-identified MSM face stigma in various aspects of their lives. Shame and hostility surrounding lesbians and particularly gay men are more prevalent in certain racial/ethnic communities. African-American and Latino MSM face racial discrimination from society at large and homophobia from their own ethnic groups, often feel unaccepted in the mainstream gay community, and are more likely to identify as heterosexual than white MSM.[17] When faced with fear of alienation and lack of community support, such individuals may characterize their actions as sexual behavior as opposed to a sexual orientation,[18] which prevents MSM in both groups from identifying as gay and, thus, limits exposure and response to prevention messages.

Internalized homophobia and nondisclosure are maladaptive methods of trying to reconcile the shame and guilt that occur when the beliefs of an individual's religion, culture, or race differ from his or her desires and behaviors. Internalization of these experiences influences health care utilization, HIV testing, communication, and adherence behaviors among members of this population. This may lead to seclusion and risk-taking behaviors. Thus, how men and women choose to self-identify is important and should be considered by physicians and their staff when shaping communication and prevention strategies in order to foster appropriate disclosure of sexual behaviors and identity; nondisclosure can be harmful to the patient and his or her partners.[6]

General Issues Confronting Gay Men and Lesbians That Affect Well Being and Medical Care

Mental Health. The 1994 Council report highlighted an undercurrent of emotional concerns affecting gay men and lesbians.[2] All patients, regardless of their sexual orientation, have a right to respect and concern for their lives and values. However, as noted above, gay men and lesbians face ostracism and discrimination from many elements of society, including some health care professionals.

Societal reactions force some gay men and lesbians to feel stigmatized and hide their true identity from their co-workers, friends, family, and physicians. Societal and internalized homophobia may affect access to appropriate care and directly impact mental health and well-being. Adolescents who are ambivalent about their sexuality or who are aware of their homosexual orientation but isolated from emotional support are especially vulnerable to societal reactions. As a result, gay men and

lesbians have a greater vulnerability to certain psychiatric disorders; the 12-month prevalence of panic disorder, major depression, and generalized anxiety disorder is higher in gay men and lesbians.[19] Additionally, gay men and lesbians use mental health care services at a significantly higher rate compared with heterosexual men and women.[19]

Psychiatric disorders develop (in part) as a result of leading marginalized lives; enduring the stress of hiding one's sexuality; or facing sexual prejudice that manifests as verbal, emotional, or physical abuse/violence from intolerant family members and communities.[20-22] According to 2004 Federal Bureau of Investigation statistics, hate crimes based on sexual orientation constituted the third highest category reported and made up 15.5% of all reported hate crimes; only race- and religion-based prejudice crimes were more prevalent.[23] The prevalence of domestic violence among gay and lesbian couples is as common as it is in heterosexual relationships.[24] While same sex battering mirrors heterosexual battering both in type and prevalence, gay and lesbian victims may receive fewer protections.[25]

Additionally, many older gay men in particular, who lived through the acquired immunodeficiency syndrome (AIDS) crisis, often continue to feel guilt for many years and sometimes throughout the remainder of their lives. This guilt is due to the fact that they lost many friends and loved ones but are still alive, even though they engaged in the same behaviors as those lost. While this may have negative psychological implications, these individuals often have a greater understanding of HIV/AIDS.

Substance Use. Substance use and substance use disorders are prevalent in all segments of American society (see CSAPH Report 8, A-08). Counseling gay men and lesbians about smoking cessation is important because they have significantly higher smoking rates than the general population.[26] Accurately establishing the epidemiology of substance use in gay men and lesbians is complicated by sampling techniques and definitions used. Nevertheless, the reported rates of substance use and substance use disorders, including alcohol, tobacco, and other drugs (eg, marijuana, cocaine, methamphetamine), appear to be somewhat higher among gay men and lesbians, particularly in urban areas, compared with their heterosexual counterparts.[27-32]

Patterns of substance use are in part influenced by the fact that bars are common meeting venues for gay men and lesbians. So-called "club drugs" (3,4-methylenedioxymethamphetamine [MDMA; Ecstasy]; gammahydroxybutryate [GHB]) along with methamphetamine are popular among young adults and urban MSM. Substance use can camouflage or exacerbate other underlying mental health problems, and increases the probability of engaging in high-risk sexual behavior.[33,34] In particular, increased sexual risk behavior has been associated with the use of methamphetamine and inhaled nitrites ("poppers").[35-39]

Access to Care. Access to health care is another important issue.[3,4] Optimal health care requires access to both knowledgeable physicians and appropriate prevention services. Impaired access to health care and the resultant underservice can be caused by economic, geographic, cultural, linguistic, or attitudinal barriers. Gay men and lesbians encounter barriers to accessing care, clustering around 4 main issues:[40] (1) reluctance of some gay men and lesbians to disclose sexual identity, in part because of fear of negative reactions; (2) insufficient numbers of physicians who feel competent to provide care; (3) barriers emanating from lack of financial resources, lack of insurance, or impediments that limit visiting and medical decision-making rights (see below) for gay men and lesbians and their partners; and (4) lack of culturally appropriate prevention services.

Surrogates and Medical Decision-Making. In regard to medical decision-making, particularly concerning patient preferences for life-sustaining treatment, physicians need to consider the special

needs of gay men and lesbians who have significant partner relationships. Although biological relatives are usually consulted in surrogate decision-making, many gay men and lesbians have not informed their families of their homosexual relationships and many would prefer their partners to be involved in proxy medical decisions. In 2006, our AMA adopted policy that encourages all hospitals to add to their rules and regulations, and to their patient's Bill of Rights, language permitting same sex couples and their dependent children the same hospital visitation privileges offered to married couples. Whenever possible, physicians should explore surrogate decision-making preferences of their homosexual patients before the need arises. To do this effectively, physicians and patients must know their state and local laws on surrogate decision-making.

Response of the Medical Profession

The 1994 Council report chronicled relevant information about the views of physicians toward gay men and lesbians. In 1973 the American Psychiatric Association (APA) officially removed homosexuality from the list of diagnoses of mental disorders. In 1986 the APA deleted a diagnostic category of "ego-dystonic homosexuality" for individuals diagnosed as overly concerned about their homosexuality, but in succeeding years, the attitudes and beliefs of certain physicians have continued to reflect the often negative or at best ambivalent views of the larger society toward homosexuality, and a majority of physicians surveyed expressed discomfort regarding the care of gay men and lesbians.[41] Reparative therapy, or conversion therapy, is aimed at changing a person's sexual orientation from homosexuality to heterosexuality. Many organizations, including both the AMA and the APA warn that such attempts may be harmful to the patient (AMA Policy H-160.991).

More recent surveys suggest a substantial reduction in homophobia among physicians, but reflect lingering uncertainties and discomfort in their abilities to provide optimal care, especially among pediatricians treating adolescent gay males or lesbians.[42,43] These and other barriers may lead to delays in seeking care or an avoidance of preventive and treatment services. The Gay and Lesbian Medical Association (GLMA) with assistance from our AMA is conducting a national survey to study physicians' attitudes, knowledge, and beliefs about LGBT patients' unique health care needs in order to improve knowledge and practices in this area.

Understanding Homosexuality. Better understanding about the origins of homosexuality could improve attitudes and practices. Twins studies demonstrate that familial factors, a portion of which are genetic, have a substantial impact on sexual orientation. Concordance rates of 48% to 60% were found in studies of male and female pairs of monozygotic twins, in which at least one twin was homosexual; one monozygotic triplet set has been identified with all 3 concordant for homosexual orientation.[44-46] In fraternal male twins, if one is gay, there is a 22% chance the second twin will also be gay. Additionally, among those raised in the same household, 11% of the non-twin brothers are gay, 9% if adopted. In fraternal female twins, there is a 16% chance the second twin will be lesbian. Adopted sisters of lesbians have a 6% chance of being lesbian. These studies relied on recruitment of subjects through publications targeting gay men and lesbians, potentially biasing the sample. Studies that relied on self-report questionnaires in national twin samples and sibling pairs, or that were based on volunteer twin registries also have demonstrated significant familial aggregation, but with a lower concordance rate for homosexual orientation of approximately 30%.[47,48] Heritability reflects the degree to which a given trait is associated with genetic factors, but nothing about the specific genetic factors involved or about the mechanisms through which they exert influence (i.e., direct or permissive effects).

A consistent biodemographic correlate of sexual orientation in men is birth order, originally observed in a Canadian sample in the 1990s, and since confirmed by others.[49, 50] Younger brothers are more likely to be gay; older sisters neither enhance this effect nor negate it. Another correlate of sexual

orientation in men is handedness. If no older brothers exist, 12% of heterosexual males and 16% of homosexual males are left-handed, respectively. However, fraternal birth order and handedness may interact in influencing sexual orientation.[51] Both childhood social/rearing and prenatal mechanisms have been advanced to account for the "fraternal birth order" effect in men. A recent analysis of four samples of gay and heterosexual men, including individuals reared in nonbiological and blended families (i.e., raised with step-siblings or as adoptees) supports a prenatal origin to the fraternal birth order effect since only biological older brothers, including those not reared with the participant, increased the probability of homosexuality in men.[52]

Other findings point to discernible differences in neurodevelopment and neurophysiologic function between homosexual and heterosexual individuals, including variations in the size or volume of a putative sexually dimorphic area in the human brain (interstitial nucleus of the anterior hypothalamus), cochlear function and tone discrimination, and central nervous system processing and response to human pheromone-like substances.[53-58]

Optimizing Primary Care of Gay Men and Lesbians

As noted above, creating a welcoming environment and engaging in nonjudgmental discussion are initially important to optimize the patient-physician relationship, and thus the care delivered for gay men and lesbians. A patient's experience in a health care setting is influenced by all of the individuals encountered during the visit. Cogent advice on creating a safe health care environment for gay men and lesbians is available from the GLMA.[59] To educate a new generation of clinicians, the American College of Physicians also has published the first comprehensive text on the care of sexual and gender minority patients.[60] This text provides an extensive list of resources based on topic, as well as sample intake (and sexual history) forms for new patients that are available free online (www.acponline.org/acp_press/fenway/).

Taking a Patient Sexual History. A major reason why physicians may not offer appropriate guidance for gay men and lesbians is a failure to identify such patients. Physicians begin their relationship with patients by taking a medical and pertinent social/family history; a sexual history is an important and often overlooked component of the medical history. Previous surveys indicated that communication between gay men and lesbians and their primary care physician may be limited on several levels, and that a minority of primary care physicians routinely conducted a sexual history of new adult patients.[2] These findings were duplicated in a recent survey, which found that although approximately 60% of primary care physicians asked about sexual activity at a routine visit, only 12% to 34% conducted a sexual history.[61] Another survey found that less than 20% of obstetricians and family practitioners routinely assessed their patient's sexual orientation.[62] The goal of open communication is complicated by the fact that a significant percentage of gay men and lesbians do not routinely reveal their sexual orientation to their primary care physician because of fear of discrimination or ostracism.[63,64] Less than 20% of gay men patients routinely discuss their risk of sexually transmitted diseases (STDs) with their physician, and of these, only 1 in 5 are prompted to do so by their physician.[65]

Thus, many physicians continue to experience awkwardness around issues of sexual health and HIV/AIDS, leading to incomplete discussions of these topics, despite interest from their patients. Patients usually feel comfortable talking with their physician about sexual practices and believe it is appropriate for physicians to question them in this area. When physicians do not ascertain sexual orientation and sexual behavior and assume patients are heterosexual, gay men and lesbians may not acknowledge or share these facts, which can contribute to the physician overlooking risk factors. Sample recommended questions for intake forms are available in the *Guidelines for Care of Lesbian, Gay, Bisexual, and Transgender Patients.*[59] Taking an inclusive and nonjudgmental history and being

aware of the range of health-related behaviors and medicolegal issues pertinent to gay men and lesbians enables physicians to perform relevant screening tests and to make appropriate referrals. Indeed, the very act of taking a sexual history in a nonjudgmental and attentive manner with open-ended questions can help the patient feel comfortable and willing to share information.

For the sexual history, general questions raising the topic of sexual activity without probing into specific behaviors should be asked first (for example, lead-in questions might be, "Are you sexually active or do you abstain from sex?" "When did you first engage in sexual activity?" or "Do you have sex with men, women, both or neither?"). Questions that could confuse behavior with orientation (for example, "Are you gay?") should be avoided, as many patients may have had sexual contact with others of their own sex and yet would not consider themselves gay or lesbian by their understanding of the term. These can be followed by more specific questions (which differ for men and women) relating to actual activity and behavior to assist in risk assessment for STDs, including HIV. Guidance for conducting a sexual risk assessment in MSM is available from the GLMA.[66] For women, the CDC recommends asking about the “five P’s”: partners, practices, prevention of STDs, past history of STDs, and prevention of pregnancy. Previous pregnancy, induced abortion, and hormonal contraceptive use are common among women who report sex with women, regardless of self-identification as lesbian.[67]

Patient history-taking and evaluation is also an appropriate time to screen for sexual abuse, domestic violence, and other life stressors among gay men, lesbians, and bisexuals that have implications for mental health and well being (as noted above).

Diagnostic and Therapeutic Considerations

There is no disease that can be ruled in or out solely on the basis of a patient's sexual orientation or sexual behavior. Generally, men and women who engage in same sex behavior suffer from the same health afflictions as individuals who engage in opposite sex behavior. Physicians should be vigilant for tobacco, alcohol, and other substance use, and allow for discussion of stress and other life events that may affect well being, or increase the occurrence of mood and/or anxiety disorders in their gay and lesbian patients. Some disease entities, however, are of particular concern to men and women who engage in same sex behavior and care must be taken to consider them in the development of a differential diagnosis and treatment plan.

Lesbians: Additional Considerations for Clinicians

Most major health issues confronting lesbians are similar to those of heterosexual women, but issues that may require more attention include: fostering increased routine screening for breast and cervical cancer and certain STDs; evaluating risk for cardiovascular disease; assessing substance use and substance use disorders; assessing mental health and assisting patients in coping with sexual stigma and sexual prejudice; and screening for domestic violence, hate crimes, and other sources of significant ongoing stress.

Sexually Transmitted Diseases. Attempts to use national or local surveillance data to estimate the risk of STD transmission between women are limited because many risk classification schemes have either excluded same-gender sex among women or subsumed it under a hierarchy of other behaviors viewed as higher risk.[68] This issue also is complicated by the fact that often times, women who have sex with women (WSW) have had sex (or continue to have sex) with men.[69] Among such individuals, acquisition of chronic virally transmitted diseases, including human papillomavirus (HPV) genital herpes, and HIV from male partners, presumably occurs at a rate per contact similar to that in heterosexual populations. Additionally, compared with heterosexual women, lesbians have

higher rates of sex with bisexual women and injection drug users.[70] These facts reinforce the need for physicians to be aware of their patient's sexual history, regardless of their reported sexual orientation.

Although women who do not have sexual contact with men are at substantially reduced risk for contracting syphilis, gonorrhea, and chlamydia, these cannot be eliminated from consideration on the basis of sexual history alone. If symptoms or signs are present, these infections should be ruled out with appropriate testing. Sexual transmission of HPV, herpes simplex (particularly HSV-1), *Treponema pallidum, Trichomonas vaginalis, Chlamydia trachomatis,* and even gonorrhea and hepatitis between women has been reported.[71-74] The prevalence of bacterial vaginosis among lesbians is high; vaginitis in lesbians is caused by the same organisms as in heterosexual women and is treated similarly.[75,76]

Human papillomavirus (HPV) DNA has been detected in 13% to 30% of WSW. Self-identified lesbians and women who have never had sex with men are less likely to undergo pelvic examinations and Pap tests.[77-79] However, squamous intraepithelial lesions are common among women who are sexually active with women, and also occur among those who have never had sex with men.[79] Thus, Pap test screening should not differ for WSW regardless of their sexual history, and current recommendations on HPV vaccination should be followed.[80,81] Vaccination is not a substitute for routine cervical cancer screening, and vaccinated females should have cervical cancer screening as recommended.

Women now comprise about 25% of newly diagnosed HIV/AIDS cases, with black women representing the fastest growing segment, but female-to-female transmission of HIV has not been conclusively demonstrated, despite various case reports. The well documented risk of female-to-male transmission of HIV shows that vaginal secretions and menstrual blood contain the virus and that mucous membrane exposure (e.g., oral, vaginal) to these secretions has the potential to cause HIV infection.

Through December 2004, a total of 246,461 women in the United States were reported as HIV-infected. Of these, 7,381 were reported to have had sex with women; however, most had other risk factors, such as injection drug use; sex with men who are infected or who have risk factors for infection; or, more rarely, receipt of blood or blood products.[82] Among women who reported that they have had sex only with women (n=534), 91% also had another risk factor—typically, injection drug use. The CDC gives high priority for follow-up investigation to HIV-infected women whose only initially reported risk factor is sex with women. As of December 2004, none of these investigations had confirmed female-to-female HIV transmission, either because other risk factors were later identified or because some women declined to be interviewed. A study of more than 1 million female blood donors found no HIV-infected women whose only risk factor was sex with women. Despite the absence of confirmed cases of female-to-female transmission of HIV, currents findings do not negate the possibility.

Cancer. Based on survey data, self-identified lesbians as a group have more risk factors for certain cancers compared with their heterosexual counterparts, including higher rates of smoking and alcohol use; higher rates of overweight, central adiposity, and obesity; lower lifetime use of oral contraceptives; fewer pregnancies (lower or nulliparity); and lower consumption of fruits and vegetables.[15,16,83] When addressed by standard risk assessment models, lesbians (as a group) have higher 5-year and lifetime risks for developing breast cancer, and would appear to have higher risks for ovarian cancer as well.[84] Additionally, lesbians are less likely to have had a mammogram in the past 2 years than other women.[85] Because lesbians usually do not need contraceptives, they tend to wait longer between Pap smears and general gynecological examinations. As noted above, lesbians are less likely to undergo pelvic examinations and screening for cervical cancer. By not presenting

for regular Pap tests or screening mammograms, individuals miss the opportunity to receive other preventive care.

Despite these findings and behaviors, there is no prospective population-based study of the comparative incidence of cancers in lesbians, and no outcome data confirming that lesbians have higher cancer rates. This lack of research is problematic because general epidemiological studies of cancer in women have identified specific risk factors that are distributed differently in the lesbian population. The only population-based cohort study that examined the subject found no evidence for an increased rate of cancer in lesbians.[86] Physicians should screen lesbians for breast and cervical cancer according to established guidelines for the general population. Further clinical decisions should be based on evaluation of individual risk factors as determined by social and sexual history and physical examination.

Cardiovascular Disease. As noted above, lesbians have more risk factors for heart disease than the general population. One recent population-based study confirmed that lesbian women are more likely to be overweight and obese.[87] Population-based data also suggest that lesbians are more likely to report a diagnosis of heart disease than heterosexual women.[88] Increased attention to screening and prevention of cardiovascular disease in these individuals is warranted.

Gay Men: Additional Considerations for Clinicians

Most major health issues confronting gay men are similar to those of heterosexual men, but several unique issues exist including routine screening for HIV and other STDs, screening for and immunizing against hepatitis viruses, and screening for HPV-related neoplasia. As noted above, physicians also should be prepared to assess substance use and substance use disorders and mental health status in patients who are coping with sexual stigma and sexual prejudice, or who may be victims of domestic violence or hate crimes, and who are subject to other ongoing sources of significant stress, such as discrimination or harassment in the workplace. Intimate partner violence occurs at the same rate in same sex as in opposite sex relationships.[89]

Sexually Transmitted Diseases. MSM may present with various syndromes typical of STDs.[59] HIV infection remains a predominant health concern of the gay community; HPV and herpes simplex virus infection also are common (see below). In 2006, 73% of HIV/AIDS diagnoses among adolescents and adults were for males. Male-to-male sexual contact remains the primary transmission category for new diagnoses, followed by injection drug use and high risk heterosexual contact.[90] MSM currently account for ~70% of all HIV infections among male adults and adolescents; blacks are substantially overrepresented, accounting for nearly half of new diagnoses.[91]

After declining during the 1980s and 1990s, the number of HIV diagnoses for MSM and the occurrence of unsafe sex practices appear to be increasing.[92] Individual, sociocultural, and biomedical factors affect HIV risk behavior among MSM.[93] Sexual risk factors and apparent increases in unprotected anal intercourse may be responsible, exacerbated in some cases by substance use; additionally, advances in treatment for HIV infection have led to an increase in the number of persons who are living with HIV infection. The availability of highly active antiretroviral therapy may lead to the belief that improved treatment reduces infectiousness or makes HIV a less serious disease (therapeutic optimism), causing some MSM to underestimate the risks associated with HIV infection.[92,94-96] Additionally, 1 in 4 persons in the United States who are infected with HIV are unaware of their infection.[91] Young MSM, particularly blacks, are even more likely to be unaware they are HIV-positive and may lack perspective on the toll AIDS has taken on gay men.[97] HIV prevention efforts can improve behavior and reduce sexual risk factors;[98,99] such efforts include making HIV testing a routine part of medical care, implementing new models for diagnosing HIV

infections outside of medical settings, and preventing new infections by working with HIV-infected persons and their partners to reduce risky behaviors.

The rates of other STDs, including syphilis, gonorrhea, and chlamydia, have increased in some urban areas, also affecting blacks and Hispanic disproportionately.[92,100-102] Urethritis is the most common presentation of chlamydia, but proctitis also may manifest. Other bacterial, protozoa, and viruses also have been implicated in non-gonococcal urethritis in MSM.[103] Therefore, clinicians should routinely assess the risks of STDs for all male patients. MSM should routinely undergo nonjudgmental STD/HIV risk assessment and client-centered prevention counseling to reduce the likelihood of acquiring, or for those who already infected, of transmitting HIV or other STDs. Current CDC guidelines recommend that the following studies be performed at least annually for sexually active MSM: HIV serology, if HIV-negative or not previously tested; syphilis serology; urethral culture or urine nucleic acid amplification test for gonorrhea; urethral or urine test (nucleic acid amplification) for chlamydia; pharyngeal specimen collection to test for gonorrhea in men with oral-genital exposure; and rectal gonorrhea and chlamydia screening in men having receptive anal intercourse.[104]

Hepatitis. All forms of hepatitis can be encountered in gay men. Hepatitis B disproportionately affects MSM, accounting for 15% to 20% of new infections annually in the United States; however, few adolescent and young adult MSM are vaccinated against HBV.[105,106] The Advisory Committee on Immunization Practices (ACIP) recommends universal hepatitis B vaccination for all unvaccinated adults in settings in which a high proportion of adults have risks for HBV infection, such as health care settings targeting services to MSM, STD/HIV testing and treatment facilities, and drug abuse treatment and prevention settings. Hepatitis A also disproportionately affects MSM, accounting for approximately 10% of all new HAV infection in this country; hepatitis A infection is generally based on fecal-oral routes of transmission.[107] Therefore, vaccination against hepatitis A and B is recommended for all MSM in whom previous infection or immunization cannot be documented.

Cancer. Anogential HPV types are divided into low risk types, which are associated predominately with anogenital warts and mild dysplasia, and high risk types (e.g., 16, 18, 31, and 45), which are associated with high grade dysplasia and anogenital cancers. HPV infection is prevalent in gay men.[108] The same strains of HPV that are associated with cervical cancer (usually 16 and 18) can also develop into anal carcinoma. Anal cancer is a rare tumor in the general population (age adjusted incidence of 1.5/100,000), but the incidence has risen over the last 25 years. Anal cancer is much more common in HIV-positive MSM, with an estimated incidence of 35/100,000, a rate that exceeds that of cervical cancer.[109-110] Another study estimated that the incidence of anal cancer is 80 times higher in gay and bisexual men.[111]Anal cancer and its precursor lesion, anal high grade squamous intraepithelial lesions (HSILs), are associated with HPV infection, anoreceptive intercourse, cigarette smoking, and immunosuppression, as well as HIV infection; a high proportion of tumors have detectable HPV.[112,113]Anal HPV infection and anal SILs are most common in HIV-positive MSM (perhaps because of persistent HPV infection), but sexually active HIV-negative MSM in all age groups also have a high prevalence of SILs, as do HIV-positive heterosexual men.[114]

Similar to the cervical Pap smear, anal swabs for cytology are a possible screening method for anal SILs and anal cancer and may be cost effective when administered every 2 to 3 years in HIV-negative men 40 years of age and older; some experts recommend annually screening in HIV-positive MSM.[115-117] More studies are needed to confirm the utility of this screening approach, as well as the potential value of HPV vaccination in men; the latter approach is currently being studied in clinical trials.

Adolescents: Additional Considerations for Clinicians

When dealing with their sexual identity, adolescents face a major milestone in their development. Heterosexual adolescents who conform to the norms of society have their own set of concerns, but adolescents who think they may be homosexual confront an enormous psychosocial challenge. Gay and lesbian youth face unique developmental challenges to managing their emerging identity within the constraints of a heterosexual family, society, and tradition.[118]

Adolescents access to care is influenced by the balance between their minor status, their emerging sexuality, and the need for confidential, culturally competent care.[59] Often alienated from their families, schools, and communities, these youth are hindered by societal stigmatization and prejudice, limited knowledge of human sexuality, a need for secrecy, a lack of opportunities for open socialization, and limited communication with healthy role models. They may seek, but not find, understanding and acceptance by parents and others; such rejection may lead to isolation, runaway behavior, homelessness, depression, suicide, substance abuse, and school or job failure. A substantial number of gay and lesbian youth experience violence related to their sexual orientation and suffer harmful psychological and psychosocial consequences.[59]

The psychosocial difficulties encountered by homosexual adolescents put them at risk for depression and suicide. According to the Secretary's Task Force on Youth Suicide issued nearly 20 years ago, gay male adolescents were 2 to 3 times more likely than their peers to attempt suicide.[119] More recent analysis suggests that suicide attempts in gay and lesbian youth are significantly associated with gender nonconformity, early awareness of homosexuality, stress, violence, lack of support, family problems, school drop-out, and substance use or other psychiatric disorders.[120] The combination of substance use and unprotected sex is particularly problematic for gay and lesbian youth. Alcohol and substance use are significantly related to high risk sexual behavior.[59,121] A significant number of gay youth engage in high risk sexual activity and unprotected anal intercourse, and are unaware of their HIV status.[122,59]

Today, an increased number of resources are available to assist GLBT youth as well as their families and friends. Organizations such as Parents and Friends of Lesbians and Gays (PFLAG) and the Gay and Lesbian Straight Education Network (GLSEN) have become increasingly visible in communities across the country. These organizations work to educate both heterosexual and GLBT populations on the need for acceptance and understanding of individual differences, sexual orientations, and/or gender identities. Over the past 10 years, the GLSEN in particular has been very successful in bringing Gay/Straight Alliance student groups to schools across the country. Information about these organizations may be found at www.pflag.org and www.glsen.org.

Conclusion

Improvements are still needed to address disparities in health care for gay men and lesbians. Gay men and lesbians are disproportionately at risk for societal discrimination and violent hate crimes, STDs, a variety of mental health conditions, substance use, and certain cancers. Problems are encountered with access to quality care and counseling pertinent to actual lifestyle behaviors.[59] Physicians can assist by providing a welcoming practice environment, relevant educational materials, and inclusive patient intake and other forms, and by becoming familiar with the issues facing gay men and lesbians. When physicians and practices cannot accomplish these tasks, referral of the patient to another physician who can provide such care is imperative. With appropriate education and training, physicians can play a vital role in ensuring access to quality care for gay men and lesbians, and in helping them lead healthier lives.

RECOMMENDATION

The Council on Science and Public Health recommends that Policy H-160.991, Health Care Needs of the Homosexual Population, be amended by insertion and deletion to read as follows:

**H-160.991 Health Care Needs of the Homosexual Population**

1. Our AMA: (a) believes that the physician's nonjudgmental recognition of sexual orientation and behavior enhances the ability to render optimal patient care in health as well as in illness. In the case of the homosexual patient this is especially true, since unrecognized homosexuality by the physician or the patient's reluctance to report his or her sexual orientation and behavior can lead to failure to screen, diagnose, or treat important medical problems. With the help of the gay and lesbian community and through a cooperative effort between physician and the homosexual patient effective progress can be made in treating the medical needs of this particular segment of the population; (b) is committed to taking a leadership role in: (i) educating physicians on the current state of research in and knowledge of homosexuality and the need to take an adequate sexual history; these efforts should start in medical school, but must also be a part of continuing medical education; (ii) educating physicians to recognize the physical and psychological needs of their homosexual patients; (iii) encouraging the development of educational programs for homosexuals to acquaint them with the diseases for which they are at risk; (iv) encouraging physicians to seek out local or national experts in the health care needs of gay men and lesbians so that all physicians will achieve a better understanding of the medical needs of this population; and (v) working with the gay and lesbian community to offer physicians the opportunity to better understand the medical needs of homosexual and bisexual patients; and (c) opposes, the use of "reparative" or "conversion" therapy that is based upon the assumption that homosexuality per se is a mental disorder or based upon the a priori assumption that the patient should change his/her homosexual orientation.

2. Our AMA will (a) educate physicians regarding: (i) the need for women who have sex exclusively with women to undergo regular cancer and sexually transmitted infection screenings due to their comparable or elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; and (b) support our partner medical organizations in educating women who have sex exclusively with women on the need for regular cancer screening exams, the risk for sexually transmitted infections, and the appropriate safe sex techniques to avoid that risk.

3. Our AMA will use the results of the survey being conducted in collaboration with the Gay and Lesbian Medical Association to serve as a needs assessment in developing such tools and online continuing medical education (CME) programs with the goal of increasing physician competency on gay, lesbian, bisexual, and transgender health issues.

4. Our AMA will continue to explore opportunities to collaborate with other organizations, focusing on issues of mutual concern in order to provide the most comprehensive and up-to-date education and information to physicians to enable the provision of high quality and culturally competent care to gay men and lesbians. (Modify Current HOD Policy)

Fiscal Note: No significant fiscal impact

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