AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 004
(A-22)

Introduced by: Medical Student Section

Subject: Recognizing LGBTQ+ Individuals as Underrepresented in Medicine

Referred to: Reference Committee Amendments to Constitution and Bylaws

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Whereas, The Association of American Medical Colleges (AAMC) has defined underrepresented minorities (URMs) in medicine as "racial and ethnic populations that are underrepresented in the medical profession relative to their numbers in the general population" since 2003, with an overarching goal to advocate for population parity[1]; and

Whereas, The AAMC 2016 Report on Diversity in Medical Education noted that considering diversity as referring solely to race and ethnicity is too narrow and that broadening the definition of diversity would help to encompass sexual orientation, religion, geography, disability, age, language, and gender identity[2]; and

Whereas, The acronym LGBTQ+ is an umbrella term encompassing people who identify their sexual orientation as lesbian, gay, bisexual and/or who identify their gender identify as transgender; the last two components of the acronym can stand for queer or questioning and are meant to encompass all identities that are not heterosexual or cisgender[3]; and

Whereas, Individuals can belong to the LGBTQ+ community by virtue of their sexual orientation, gender identity, or both of these identity aspects[3-5]; and

Whereas, The National Institutes of Health (NIH) formally designated sexual and gender minorities (SGMs) as a health disparity population for NIH research due to mounting evidence that SGM populations have less access to healthcare and higher burdens of diseases such as depression, cancer, and HIV/AIDS[6]; and

Whereas, In 2015, a study in *The American Journal of Public Health* showed the majority of heterosexual healthcare providers reported moderate to strong implicit preference for heterosexual patients over homosexual patients, while gay and lesbian providers showed more implicit preference in favor of homosexual patients[7]; and

Whereas, In 2015, the American College of Physicians emphasized the need for “programs that would help recruit LGBT[Q+] persons into the practice of medicine and programs that offer support to LGBT medical students, residents, and practicing physicians”[8]; and

Whereas, Two-thirds of LGBT physicians have heard disparaging remarks about LGBTQ+ people at work, one-third have witnessed discriminatory care of a LGBT patient, and one-fifth have experienced social ostracism because of their LGBTQ+ identity[9]; and

Whereas, Data on LGBTQ+ individuals in medicine are limited due to their self-reported nature and fear of disclosure, with the AAMC's 2018 *All Schools Summary Reports* including a caveat in the methodology that demographic data may not be generalizable[10-12]; and

Whereas, The AAMC's *Reports on Diversity and Inclusion* assert that "a nuanced diversity and inclusion data collection and analysis strategy will allow for a more accurate understanding of underrepresented groups in medicine"[13]; therefore be it

RESOLVED, That our American Medical Association advocate for the creation of targeted efforts to recruit sexual and gender minority students in efforts to increase medical student, resident, and provider diversity; and be it further

RESOLVED, That our AMA encourage the inclusion of sexual orientation and gender identity data in all surveys as part of standard demographic variables, including but not limited to governmental, AMA, and the Association of American Medical Colleges surveys, given respondent confidentiality and response security can be ensured (Directive to Take Action); and be it further

RESOLVED, That our AMA work with the Association of American Medical Colleges to disaggregate data of LGBTQ+ individuals in medicine to better understand the representation of the unique experiences within the LGBTQ+ communities and their overlap with other identities. (Directive to Take Action)

Fiscal note: Moderate - between $5,000 - $10,000

Date received: 04/08/22

References:

1. (2017) "Underrepresented in Medicine Definition." Association of American Medical Colleges.
2. Castillo-Page, L. Diversity in Medical Education: Facts & Figures 2016. Association of American Medical Colleges. 2016.
3. The Williams Institute on the Study of Sexual Orientation and Gender Identity. Comment On The Definition Of Sexual Orientation And Gender Identity Submitted To The Drafting Committee, Yogyakarta Principles On The Application Of International Human Rights Law To Sexual Orientation And Gender Identity; 2017. https://williamsinstitute.law.ucla.edu/wp-content/uploads/Yogyakarta-Review-SOGI-Definition.pdf. Accessed September 25, 2019.
4. American Psychological Association. Gender Identity. In: APA Dictionary Of Psychology. 2nd ed. Washington, D.C.: Author; 2015:450,970,974.
5. Young RK. Sex/gender. In: AMA Manual of Style: A Guide for Authors and Editors. New York, NY: Oxford University Press; 2007. https://www.amamanualofstyle.com/view/10.1093/jama/9780195176339.001.0001/med-9780195176339-div2-350. Accessed September 18, 2019.
6. (2017) "Director's Message." National Institutes of Health: National Institute on Minority Health and Health Disparities.
7. Sabin *et al*. Health Care Providers' Implicit and Explicit Attitudes Toward Lesbian Women and Gay Men. *American Journal of Public Health*. 2015 Sep;105(9):1831-1841.
8. Daniel, H. & Butkus, R. Lesbian, Gay, Bisexual, and Transgender Health Disparities: Executive Summary of a Policy Position Paper from the American College of Physicians. Annals of Internal Medicine. 2015 Jul;163(2):135-137
9. Sitkin, N. & Pachankia, J. Specialty Choice Among Sexual and Gender Minorities in Medicine: The Role of Specialty Prestige, Perceived Inclusion, and Medical School Climate. LGBT Health: 2016 Dec;3(6):451-460
10. Medical School Graduation Questionnaire. Association of American Medical Colleges; 2018:44. https://www.aamc.org/download/490454/data/2018gqallschoolssummaryreport.pdf. Accessed September 18, 2019.
11. Medical School Year Two Questionnaire. Association of American Medical Colleges; 2019:20. https://www.aamc.org/download/496618/data/y2q2018report.pdf. Accessed September 18, 2019
12. Matriculating Student Questionnaire. Association of American Medical Colleges; 2018:26. https://www.aamc.org/download/494044/data/msq2018report.pdf. Accessed September 18, 2019
13. Castillo-Page L. Diversity In Medical Education: Facts & Figures 2016. Association of American Medical Colleges; 2016. http://www.aamcdiversityfactsandfigures2016.org/. Accessed September 18, 2019.

RELEVANT AMA POLICY:

Increasing Demographically Diverse Representation in Liaison Committee on Medical Education Accredited Medical Schools D-295.322
Our AMA will continue to study medical school implementation of the Liaison Committee on Medical Education (LCME) Standard IS-16 and share the results with appropriate accreditation organizations and all state medical associations for action on demographic diversity.
Citation: Res. 313, A-09; Modified: CME Rep. 6, A-11; Reaffirmed: CME Rep. 1, A-21

Strategies for Enhancing Diversity in the Physician Workforce H-200.951
Our AMA: (1) supports increased diversity across all specialties in the physician workforce in the categories of race, ethnicity, disability status, sexual orientation, gender identity, socioeconomic origin, and rurality; (2) commends the Institute of Medicine (now known as the National Academies of Sciences, Engineering, and Medicine) for its report, "In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce," and supports the concept that a racially and ethnically diverse educational experience results in better educational outcomes; (3) encourages the development of evidence-informed programs to build role models among academic leadership and faculty for the mentorship of students, residents, and fellows underrepresented in medicine and in specific specialties; (4) encourages physicians to engage in their communities to guide, support, and mentor high school and undergraduate students with a calling to medicine; (5) encourages medical schools, health care institutions, managed care and other appropriate groups to adopt and utilize activities that bolster efforts to include and support individuals who are underrepresented in medicine by developing policies that articulate the value and importance of diversity as a goal that benefits all participants, cultivating and funding programs that nurture a culture of diversity on campus, and recruiting faculty and staff who share this goal; and (6) continue to study and provide recommendations to improve the future of health equity and racial justice in medical education, the diversity of the health workforce, and the outcomes of marginalized patient populations.
Citation: CME Rep. 1, I-06; Reaffirmed: CME Rep. 7, A-08; Reaffirmed: CCB/CLRPD Rep. 4, A-13; Modified: CME Rep. 01, A-16; Reaffirmation A-16; Modified: Res. 009, A-21; Modified: CME Rep. 5, A-21

Medical Staff Development Plans H-225.961
All hospitals/health systems incorporate the following principles for the development of medical staff development plans: (a) The medical staff and hospital/health system leaders have a mutual responsibility to: cooperate and work together to meet the overall health and medical needs of the community and preserve quality patient care; acknowledge the constraints imposed on the two by limited financial resources; recognize the need to preserve the hospital/health system's economic viability; and respect the autonomy, practice prerogatives, and professional responsibilities of physicians. (b) The medical staff and its elected leaders must be involved in the hospital/health system's leadership function, including: the process to develop a mission that is reflected in the long-range, strategic, and operational plans; service design; resource allocation; and organizational policies. (c) Medical staffs must ensure that quality patient care is not harmed by economic motivations. (d) The medical staff should review and approve and make recommendations to the governing body prior to any decision being made to close the medical staff and/or a clinical department. (e) The best interests of patients should be the predominant consideration in granting staff membership and clinical privileges. (f) The medical

staff must be responsible for professional/quality criteria related to appointment/reappointment to the medical staff and granting/renewing clinical privileges. The professional/quality criteria should be based on objective standards and the standards should be disclosed. (g) The medical staff should be consulted in establishing and implementing institutional/community criteria. Institutional/community criteria should not be used .inappropriately to prevent a particular practitioner or group of practitioners from gaining access to staff membership. (h) Staff privileges for physicians should be based on training, experience, demonstrated competence, and adherence to medical staff bylaws. No aspect of medical staff membership or particular clinical privileges shall be denied on the basis of sex, race, age, creed, color, national origin, religion, disability, ethnic origin sexual orientation, gender identity or physical or mental impairment that does not pose a threat to the quality of patient care. (i) Physician profiling must be adjusted to recognize case mix, severity of illness, age of patients and other aspects of the physician's practice that may account for higher or lower than expected costs. Profiles of physicians must be made available to the physicians at regular intervals.
Citation: BOT Rep. 14, A-98; Modified: BOT Rep. 11, A-07; Reaffirmation A-10; Modified: CMS Rep. 01, A-20

Eliminating Health Disparities - Promoting Awareness and Education of Sexual Orientation and Gender Identity Health Issues in Medical Education H-295.878
Our AMA: (1) supports the right of medical students and residents to form groups and meet on-site to further their medical education or enhance patient care without regard to their gender, gender identity, sexual orientation, race, religion, disability, ethnic origin, national origin or age; (2) supports students and residents who wish to conduct on-site educational seminars and workshops on health issues related to sexual orientation and gender identity; and (3) encourages medical education accreditation bodies to both continue to encourage and periodically reassess education on health issues related to sexual orientation and gender identity in the basic science, clinical care, and cultural competency curricula in undergraduate and graduate medical education.
Citation: Res. 323, A-05; Modified in lieu of Res. 906, I-10; Reaffirmation A-11; Reaffirmation A-12; Reaffirmation A-16; Modified: Res. 16, A-18; Modified: Res. 302, I-19