Health Policy Considerations for Our Sexual Minority Patients

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Homosexuality and transsexuality are still widely viewed by lay individuals as morally negative and deserving of legal proscription. Peer-reviewed data confirm that experiences of legal discrimination are associated with stress-related health problems, reduced utilization of health care, and financial and legal challenges for individuals and families, especially those with children. In the last 3 years, the American Psychiatric Association, American Psychological Association, and American Psychoanalytic Association have each reviewed the research on sexual orientation and identity, and each has confirmed that sexual orientation and gender identity do not correlate with mental illness or immorality. They have each endorsed laws that confer equality to sexual minorities, including nondiscrimination in employment, medical insurance coverage, adoption, and access to civil marriage. The American College of Obstetricians and Gynecologists (ACOG), by virtue of its history of advocacy for women's health, is in a position to promote policy and make similar recommendations, recognizing that sexual minority women's health and their family issues are an integral component of taking care of all women. The College should review the policies of America's premier mental health associations and consider including sexual orientation and gender identity in its own nondiscrimination policy, and ACOG should issue a policy statement in support of laws to provide safety from violence and discrimination, equal employment opportunities, equal health insurance coverage, and equal access to civil marriage.

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Historically, homosexuality has been considered by most European cultures to be a mental illness or an immoral proclivity. Antisodomy laws in early America were inherited from the British penal code, and such laws resulted in the jailing of many homosexuals, proscription from military service and civil employment, denial of child custody, and social alienation. Based on abundant research starting in the 1940s, the American Psychiatric Association removed homosexuality from their Diagnostic and Statistical Manual in 1973, and the association has issued many updates and policy statements about their research reviews on this topic since then, confirming the natural occurrence and moral neutrality of diversity in sexual orientation and gender identity.[1] However, more than half of Americans still report a belief that homosexuality is morally wrong,[2] and they have supported discriminatory laws to enforce perceived social morality. Information from population-based survey data obtained under the auspices of the National Institutes of Health reveal that the experience of social or legal discrimination, per se, confers a disparate health risk on homosexuals compared with heterosexuals for stress-related mental disorders, including increased suicidality, decreased levels of self-care, and diminished access to medical care.[3,4] Research also confirms that children parented by same-gender couples developed normally and needed the same family protections that marriage laws provide.[1]

To address these health disparities, the American Psychiatric Association, the American Psychological Association, and the American Psychoanalytic Association reviewed the current literature about sexual orientation and identity, and they confirmed that sexual orientation and gender identity do not correlate with mental illness or immorality. These 3 groups issued policy statements that endorse laws prohibiting discrimination in employment and medical insurance coverage and encouraged laws granting access to adoption and civil marriage.[1,5,6]

Obstetricians and gynecologists

have long understood the health disparities conferred by misinformation and by laws that discriminate against our female patients and their families, such as restrictions of reproductive options or equal rights in employment or health access. Our national association, ACOG, has taken historic political stands for our female patients and weighed in with American courts and state and federal legislatures to advocate respect for women's health and independence. This article describes some of the same health challenges, which are now observed among our patients who are lesbian or transsexual. Armed with the peer-reviewed evidence, ACOG is in a key position to issue a policy statement that would better the lives and health of more female patients and their families.

COMPONENTS OF HUMAN SEXUAL EXPRESSION: SEXUAL ORIENTATION AND GENDER IDENTITY

According to the population-based study of human sexuality conducted by the University of Chicago, sexuality can be divided into 3 general areas: attraction, behavior, and identity. Gender identity covers a broad range of gender nonconforming identities, appearances, and behaviors and includes transsexuals: those who have undergone gender-confirming surgery on their breasts and genitals to be whom they feel they are inside. Transsexual persons are predominantly heterosexual, but they may also be homosexual, bisexual, or asexual.

Multiple population-based studies suggest that 4–11% of women report a same-gender attraction, 4–17% have had same gender sexual activity since puberty, but only 1.4% identify themselves as lesbians, with an estimated 4 million lesbians in the United States population. There are no reliable population-based estimates of the female transsexual population.

Since 1995, the peer-reviewed literature confirms that sexual orientation and gender identity are biologically conferred and unchangeable.[1] The biological bases include evidence from the neuroanatomical, behavioral, and physiological differences that are already known to exist between men and women. Comparisons of these multiple sex-dimorphic nuclei in the brain suggest that homosexuals and transsexuals have anatomic landmarks that are intermediate on the spectrum between the 2 poles of sex-typical male and female. Additionally, standard tests of sex-typical auditory physiology, motor-function, spatial relations and memory, handedness, electroencephalograms, and cognitive and linguistic skills suggest a neurobiologic origin of both orientation and gender identity.[7] The American Psychological Association states that "sexual orientation emerges for most people in early adolescence without any prior sexual experience and is not changeable."[1]

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HEALTH CONSIDERATIONS FOR LESBIANS AND TRANSSEXUALS

Among lesbians responding in the 2001 Kaiser Family Foundation survey, one third reported that they had not told their health care providers about their sexual orientation.[2] Additionally, many lesbians do not avail themselves of routine care for a variety of reasons: because they have jobs without medical insurance benefits, because they do not believe that they need annual visits since they do not require contraceptives, or because they anticipate disdainful care. The demographic profiles of lesbians' health obtained in federally funded surveys reveal significant disparities from heterosexual women's health that should be addressed in the annual examination.

Cardiovascular Disease Risk and Obesity

Evidence from the Women's Health Initiative baseline questionnaire and the Nurses' Health Study II reveal that lesbians weigh more, smoke more, undergo more weight cycling, have greater abdominal/visceral adiposity, and thus have a higher risk of heart disease than heterosexual women.[8,9]

Cancer Risks

Data from both the Women's Health Initiative and the Nurses' Health Study II confirm that lesbians possess more risk factors for many cancers. These include nulliparity, alcohol and tobacco abuse, and obesity.[8,9] Lesbians may get fewer mammograms than women in the general population and have higher rates of breast cancer.[8] Lower parity and less frequent use of oral contraceptives, combined with higher rates of obesity and endometriosis (from nulliparity) may increase the risk for ovarian and uterine carcinomas among lesbians.[8] Also of concern is the fact that approximately 75–90% of lesbians report prior sexual relations with men, underscoring their need for Pap tests, which they may believe they do not need. Moreover, lesbian adolescents may experiment sexually with their gay male peers, putting them at risk for sex-

ually transmitted diseases, human immunodeficiency virus (HIV), and even unwanted pregnancy. Finally, transmission of human papillomavirus and nearly every sexually transmitted infection has been documented with exclusive lesbian sexual contact.[10]

Substance Abuse and Mental Health

Data from the National Household Survey on Drug Abuse, the Nurses' Health Study II and the Women's Health Initiative reveal that lesbians have higher rates of tobacco use and alcohol abuse and are more likely to report depression[8,9] and to be taking antidepressants.[9] Lesbians in the National Survey of Midlife Development in the United States report more stress-related disorders. However, when the data in that study was analyzed controlling for the reported experience of orientation discrimination, the mental health differences between lesbians and heterosexuals disappeared.[3]

Health of Sexual Minority Youth

Among 44,307 grade 7–12 United States students surveyed by the Centers for Disease Control and Prevention, 3.8% of boys and 1.7% of girls identified that they were gay, lesbian, bisexual, transsexual, or "questioning."[4] Among these sexual minority youth, violence, property damage, school absence, substance use, sexual risk-taking, and suicidal ideation and attempts were significantly increased compared with other youth.

Transsexual Health Issues

Transsexuality is now understood as a biologic phenomenon, which, like homosexuality, is not chosen, but realized. Many of the issues that homosexuals face, such as acceptance and understanding by families and a dearth of awareness by society, are experienced even more intensely by those who feel that they were born into a body with the wrong gender. Although many physicians are unfamiliar with hormone management and surgical issues in transsexual care, information has recently become more widely available. Provided that careful diagnosis takes place with a specialized gender team and that the criteria for starting the procedures early are stringent, prospective longitudinal studies show that addressing the patient's need for social, medical, and surgical reassignment improves their psychometric measurements to normal. However, the Americans with Disabilities Act states that none of the medical, psychological, or surgical care related to their transsexual status must be covered by medical insurance. This results in financial difficulties, reduced medical care, and profound psychosocial challenges for transsexuals. Demographic data are lacking, but there have been isolated reports of both prostate and breast cancer in male-to-female transsexuals, who typically use estrogen supplementation for long periods. Fatal ovarian cancer associated with delay of diagnosis has been reported in a female-to-male transsexual, prompting recommendations that oophorectomy be performed during gender confirmation surgeries.[11] Recognizing that transsexuality is a biologic phenomenon and that treatment improves the life of the transsexual, it would be reasonable to require insurance coverage standards similar to that for other diagnoses that are amenable to medical and surgical therapy.

To respond to this growing body of evidence on sexual minorities, the Institute of Medicine (IOM) convened a study group in 1999. The IOM recommended more study in the areas of cancer and cardiac risk, life stressors, and resiliency.[12] To further encourage research, the National Institutes of Health Scientific Workshop on Lesbian Health recommended that health researchers stratify ongoing federal surveys by sexual orientation, especially in the areas of cancer, cardiovascular diseases, infectious diseases, life-span development, and mental health.[13] This, in part, resulted in reports from the Centers for Disease Control, the National Survey of Midlife Development in the United States, the National Household Survey on Drug Abuse, the Nurses' Health Study II, and the Women's Health Initiative referenced herein.[3,4,8,9]

HEALTH CONSIDERATIONS FOR FAMILIES

In most surveys, more than 60% of lesbians are in committed, long-term relationships with shared responsibility for each other and for their children. Three quarters of surveyed lesbians said that they would like to get legally married.[14] In the 2000 United States Census, 601,209 same-gender couples identified themselves, making up 0.4% of the census population, or 1% of all couples. Among these families, more than 85% had been committed to each other for over 5 years, and over 30% were raising children under age 18. The American Psychological Association, the American Academy of Pediatricians, and the North American Council on Adoptable Children have each endorsed foster-parenting, adoption, and parenting by same-gender couples, with the reassurance that their review of all the research on these children show that they develop normally.[1]

Many lesbians in committed relationships seek to create families by insemination.[1] Licensed infertility clinics and sperm banks offer the safest methods of conception,

but 45% of infertility clinics surveyed nationally in 1999 refused to inseminate lesbians.[15,16] This may predispose uninformed lesbians to obtain sperm in ways that leave them susceptible to infections, inherited diseases, or custody battles.

In lesbian families, adoption of one's partner's biological children ensures the child's eligibility for health benefits from the nonbiological parent, provides legal grounds for either parent to make decisions on behalf of the child, confers inheritance and Social Security survivor's benefits if either parent dies, and establishes child support, custody, and visitation rights and responsibilities in the event of the parents' separation.

The state and federal governments deem the family unit to be the basic foundation for a solid society, and therefore these governments confer legal and financial protections that contribute to its stability, health, and longevity. The responsibilities of spouses to each other and for children are legally established in civil marriage law, with disputes adjudicated in a family court system that focuses on the best interests of the children. Without access to civil marriage, same-gender couple's death, disability, and divorce disputes are relegated to civil courts, which apply contract or business law, but not family law, such that children's concerns are ignored. Civil marriage law also confers federal responsibilities and benefits that cannot be otherwise created by a contract:

1) mutual responsibility for debt and joint taxation;

2) right to sue for wrongful death;

3) adoption as stepparent;

4) hospital visitation and sick leave for spousal care;

5) medical, legal, financial, and child conservatorship for an incapacitated or deceased spouse; and

6) disability or unemployment benefits, including Social Security, Medicare, and death benefits, when spouses are disabled or diseased.

Standard civil contract law, state domestic partnership, or civil union laws do not provide any of the aforesaid federal benefits to same-sex couples or their children.

EVIDENCE-BASED SOLUTIONS

Although being a lesbian or a sexual minority person is not inherently (genetically, biologically, or morally) hazardous, mental and physical health risk factors and family destabilization are conferred through social stigma and misinformation. Popular misinformation, unimpeded by the evidence-based information, is reflected in our current laws and results in continued socialization of heterosexuals against homosexuals and concomitant conditioning of gays, lesbians, bisexuals, and transsexuals against themselves. This must be recognized by health care providers as a legitimate and potent health hazard.

The American Psychological Association, the American Academy of Pediatrics, and 8 other professional groups have worked together to produce a booklet for parents and school administrators to reassure them of the unanimity of the mental health professions on the normality of homosexuality and the need for protections for gender-atypical children in schools.[1] The booklet provides parents and teachers information to help them care for and support the healthy development of gay, lesbian, or questioning youth. The American Medical Association has condemned "reparative therapies," which are treatments aimed at changing these children to a heterosexual identity or to be more gender-typical.

Based on its review of current literature, the American Academy of Pediatrics has recommended that pediatricians "become familiar with professional literature regarding gay and lesbian parents and their children, support the right of every child and family to the financial, psychological, and legal security that results from having legally recognized parents who are committed to each other and to the welfare of their children, and advocate for initiatives that establish permanency through co-parent or second-parent adoption for children of same sex partners through the judicial system, legislation and community education."[17]

Many countries recognize the need to support committed same-gender families. The Netherlands, Belgium, Spain, Canada, and South Africa permit civil marriage and adoption for same-gender couples. The European Union requires that all member countries create domestic partnerships for same-gender families to confer benefits, responsibilities, and protections equal to those conferred by civil marriage. Some U.S. states (Hawaii, Alaska, Vermont, Connecticut, California, and New York) offer domestic partnerships that provide state-limited rights and responsibilities for same-sex couples. Civil marriage in Massachusetts became legal in May 2004, and no adverse effects have been reported. The 1994 United States Congressional Defense of Marriage Act denies to same-gender families the benefits of the 1,049 federal civil marriage rights and responsibilities that reinforce the health and welfare of the family unit. A Federal Marriage Amendment prohibiting all same-gender civil marriage and eradicating domestic partnerships is under active consideration by Congress. Many states have already passed their own constitutional amendments prohibiting

same-gender civil marriage. These laws are harmful to the stability, health, and welfare of our female patients who are lesbians and put their children at risk.

After reviewing the literature in 1993, the American Medical Women's Association (AMWA) passed without opposition a policy statement urging: ″National, state, and local legislation to end discrimination based on sexual orientation in housing, employment, marriage and tax laws, child custody and adoption laws; to redefine family to encompass the full diversity of all family structures; and to ratify marriage for lesbian, gay and bisexual people...creation and implementation of educational programs... in the schools, religious institutions, medical community, and the wider community to teach respect for all humans.″[18]

Since then, the American Psychiatric Association, the American Psychoanalytic Association, and the American Psychological Association have all reviewed the research and have issued policy statements recommending access to civil marriage for same-gender couples.[1,5,6]

ACOG TAKES RESPONSIBLE ACTION FOR OUR FEMALE PATIENTS AND THEIR FAMILIES

In its operational mission statement, ACOG states that it seeks "remedies for problems in access to women's health care, developing and implementing solutions that involve the College and obstetrician-gynecologists at the national, state and community levels." ACOG also claims in its mission statement "a responsibility for assisting in programs of family life education in communities and schools. The College should vigorously support extensive programs of instruction, sex education and family responsibility."

Since 1964, ACOG has issued historic policy statements for women's health, starting with the controversial publication of "Sex Education Is a Professional Responsibility."[19] In 1998, ACOG issued a policy statement decrying the inadequacy of federally funded programs for sex education and use of abstinence-only sex education. The College has issued a policy statement supporting equal opportunity for women in employment. In 1999, ACOG wrote its controversial brochure about the benefits of oral contraceptives for adolescents. In 2003, ACOG issued an Amicus Brief defending women's access to D&X, the intact dilation and extraction, the so-called "partial birth abortion." The College's progressive current legislative agenda includes policy statements for improvements in family health insurance coverage, antiviolence programs, women's working conditions, and women's equality. The College has an excellent Web site dedicated to reducing violence against women, with sections devoted to domestic abuse, elder abuse, and even sections specific to the Latina and Jewish community concerns.

In 1996, the ACOG produced a patient education brochure about lesbians and their health issues, encouraging disclosure to their physicians about their sexual orientation. The College included issues about lesbian health in their 2005 booklet "Special Issues in Women's Health."[20] However, it has not yet weighed in with policy statements on any issues of current national significance regarding sexual orientation or identity, such as the debates on hate crimes, employment nondiscrimination, adoption, and access to civil marriage. The current ACOG nondiscrimination statement does not include sexual orientation, per se.

The College should use its respected status as America's expert on women's health care to advocate for lesbian and transsexual patient healthcare. The College should revise its nondiscrimination statement to include the words "sexual orientation and gender expression." The College should recommend that clinicians place a nondiscrimination statement on the wall of our waiting rooms that says, "This office and its staff celebrate all women's health. We do not discriminate by age, ability, race, religion, sexual orientation, or gender expression." Clinicians could provide other cues to their lesbian patients that they are welcome in the practice, such as revising intake forms to include "Domestic Partner" in the section inquiring about marital status.

We expect that ACOG be respected as the pre-eminent expert society in women's health because ACOG uses peer-reviewed evidence to guide its policy statements, even in the political arena. Accordingly, ACOG should embrace the peer-reviews of the American Psychological Association, the American Psychiatric Association, American Psychoanalytic Association, and the American Academy of Pediatrics. These groups have provided evidence-based educational materials and policy statements confirming that transsexual and lesbian health and family issues are part of the normal spectrum of humanity and deserve the same health care protections that other Americans and their families enjoy. The College can similarly protect its lesbian and transsexual patients by issuing a policy statement endorsing equality, freedom from discrimination in employment, equal insurance coverage, documentation of hate crimes, child custody, adoption, and access to civil marriage. Members of ACOG have historically seen that the health of all women is

compromised by societal discrimination and by laws and judicial opinions that are unfounded in science, and ACOG has taken politically charged stands that support our patients' health.

CONCLUSION

The American College of Obstetricians and Gynecologists is urged to take an evidence-based progressive stand to improve the health of our minority patients by 1) amending its nondiscrimination statement to include "sexual orientation and gender expression," and by 2) issuing a policy statement in support of national and state laws that protect lesbians, transsexuals, and their families with equal access to marriage and family law, insurance, and employment. History will reflect well on these enlightened policies.

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