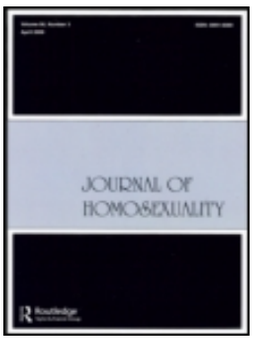

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Lesbian, Gay, Bisexual, and Transgender (LGBT) Physicians' Experiences in the Workplace

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Little is known about the experiences of lesbian, gay, bisexual, and transgender (LGBT) physicians in the workplace. There is little formal education in medical school about LGBT issues, and some heterosexual physicians have negative attitudes about caring for LGBT patients or working with LGBT coworkers, setting the stage for an exclusive and unwelcoming workplace. The current study used an online survey to assess a convenience sample of 427 LGBT physicians from a database of a national LGBT healthcare organization, as well as a snowball sample generated from the members of the database. Although rates of discriminatory behaviors had decreased since earlier reports, 10% reported that they were denied referrals from heterosexual colleagues, 15% had been harassed by a colleague, 22% had been socially ostracized, 65% had heard derogatory comments about LGBT individuals, 34% had witnessed discriminatory care of an LGBT patient, 36% had witnessed disrespect toward an LGBT patient's partner, and 27% had witnessed discriminatory treatment of an LGBT coworker. Few had received any formal education

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on LGBT issues in medical school or residency. It appears that medical schools and health care workplaces continue to ignore LGBT issues and operate in discriminatory fashion far too often.

KEYWORDS health care settings, knowledge and attitudes, LGBT physician

Lesbian, gay, bisexual, and transgender (LGBT) physicians serve an important role as advocates for LGBT health care issues, but little is known about their experiences within health care systems that are still relatively hostile and exclusionary. As patient advocacy groups across the nation are calling for cultural competency training for physicians and other health care providers, these calls often ignore diversity based on sexual and gender identification (e.g., Berger, 2008; Williams, 2007). For health care providers today to be truly competent to address the needs of all of their patients and treat their colleagues with respect, they must learn about sexual and gender diversity as part of their larger education about diverse populations. There is a small but growing body of research on LGBT people's access to and usage of health care (e.g., Bakker, Sandfort, Vanwesenbeeck, van Lindert, & Westert, 2006; Heck, Sell, & Sheinfeld-Gorin, 2006; Tjepkema, 2008; Xavier, Honnold, & Bradford, 2007), perceptions of quality of care by LGBT patients (e.g., O'Neill & Shalit, 1992; White & Dull, 1998), and reports of anxiety about disclosure and avoidance of preventative care for fear of discriminatory treatment (e.g., Barbara, Quandt, & Anderson, 2001; Boehmer & Case, 2004; Eliason & Schope, 2001; Platzer & James, 2000; Trippett & Bain, 1992). Questions about sexual orientation and gender identity are slowly being added to large population-based health surveys, resulting in mounting evidence that living with minority stress is related to higher rates of depression, anxiety disorders, suicide attempts, and substance abuse (Cochran, Keenan, Schober, & Mays, 2000; Cochran & Mays, 2007; Drabble & Trocki, 2005; Gilman et al., 2001; Hughes et al., 2006; Kipke et al., 2007; Mays & Cochran, 2003; Mays Yancey, Cochran, Weber, & Fielding, 2002).

Thus far, however, most of the research has focused on LGBT patients or consumers of health care, but there is a need to study LGBT physicians as well. They must operate daily within health care systems that have discriminatory policies and with colleagues who lack training and awareness of LGBT issues. The literature review is divided into three brief sections. The first addresses heterosexual physicians' knowledge, attitudes and behaviors because they are largely responsible for the climate in which LGBT physicians and consumers must navigate. The second section summarizes the limited research on LGBT inclusion in medical education, and the third section reviews the scant research on experiences of LGBT physicians in the workplace.

HETEROSEXUAL PHYSICIANS' ATTITUDES, KNOWLEDGE, AND SKILLS

Some early studies attempted to measure homophobia (negative attitudes about LGBT people) in physicians finding rates that vary from 58% in 1982; 26–36% in the late 1980s; and 19% in 1999 (Chaimowitz, 1991; Mathews, Booth, Turner, & Kessler, 1986; Smith & Mathews, 2007). A study of second year medical students in Chicago (Klamen, Grossman, & Kopacz, 1999) found that 25% believed that homosexuality is immoral and 9% believed it is a mental illness. Another study found that medical students, residents, and physician teachers had witnessed derogatory remarks and discrimination among their medical colleagues to about the same extent as they witnessed gender and racial discrimination (Oancia, Bohm, Carr, Cajec, & Johnson, 2000). One study of over 1,000 physicians in New Mexico (Ramos, Tellez, Palley, Umland, & Skipper, 1998) found that 11% would not refer a patient to an LGBT physician, and another study reported that 25% of family practice program directors would hesitate to match openly gay residents to their programs (Oriel, Madlon-Kay, Govaker, & Mersy, 1996). Sanchez, Rabatin, Sanchez, Hubbard and Kalet (2006) surveyed nearly 250 third- and fourth-year medical students from one school and found that fewer than half of the students always asked their patients about same-sex behaviors, and the majority said that they rarely or never discovered a patient's sexual orientation. A significant subset (28%) said that they were uncomfortable addressing an LGBT patient's health needs. Finally, Kitts (2010), in a survey of 184 residents and attending physicians at one medical school, found that 23% agreed that same-sex relationships are always or almost always wrong and that only 29% would routinely discuss sexual orientation with adolescent patients. These studies suffered from significant limitations such as highly localized samples, relatively low response rates, different measures of attitudes, and most assessed only attitudes, not knowledge or skills.

MEDICAL EDUCATION AND LGBT ISSUES

The lack of knowledge of LGBT issues and the negative attitudes toward LGBT people is not surprising given what we know about medical education. Without explicit teaching about LGBT issues, physicians and medical students will reflect the same extent of homophobia and heterosexism as exists in the broader society. Health care professional training programs have contributed to stigma through the invisibility of sexual and gender identities in the curriculum except for mention as pathologies, diseases, or "exotic" forms of human sexuality. There is very little research on how much and what type of content on sexuality is contained within medical school training and most of the limited research available is quite old. Tesar and Rovi (1998)

found that over half of medical school curriculi had no information about LGBT people, and Wallick, Cambre, and Townsend (1992) reported that for programs that do have LGBT content, there is less than one hour of content per year over the four-year curriculum. In many programs, mention of LGBT issues occurs only in a human sexuality unit. More recently, Solursh and coauthors (2003) surveyed North American medical schools and found that the majority had three or more hours of generic sexuality content (54% of programs had 3–10 hours; 33% had 11–20 hours). The topics covered in the sexuality unit included causes of sexual dysfunction (94%; the article did not report whether the content differentiated between other-sex and same-sex relationships), treatment of sexual dysfunctions (85%), and sexuality in illness or disability (69%). The only mention of sexual orientation in this article was the authors' report that 79% of programs discussed "altered sexual identification," presumably referring to lesbian, gay, or bisexual sexual identities. Whereas cross-cultural and diversity training has become increasing common, to date there are no reports as to whether LGBT issues are consistently covered within these larger diversity programs in medical schools or continuing education programs.

In one of the few studies to examine the impact of LGBT educational content, Kelley, Chou, Dibble, and Robertson (2008) studied pre- and post-assessments of a two-hour intervention with second-year medical students. The intervention included a syllabus, a panel of LGBT patients with the large group, and a small group facilitated discussion with an LGBT faculty member about three problem-based cases illustrating LGBT health concerns. Students showed a significant increase in awareness of barriers to health care, LGBT people and relationships, the importance of knowing a patient's sexual orientation, and openness to treating patients with gender identity issues.

The result of the lack of education in most medical education is that many physicians feel uncomfortable working with LGBT patients because their formal education has not challenged the negative attitudes in society about LGBT people, and because they have not been taught how to ask their patients questions about sexuality and gender (e.g., Hinchliff, Gott, & Galena, 2005). This body of literature is also somewhat dated, incomplete, and often does not address the quality of the education about LGBT issues, only the presence of LGBT content in the curriculum.

LGBT PHYSICIANS' EXPERIENCES

In one of the first studies of lesbian, gay, and bisexual physicians, Schatz and O'Hanlan (1994) surveyed the members of the American Association of Physicians for Human Rights, an LGBT medical organization (now called the Gay and Lesbian Medical Association). Of 1,311 members, 711 completed

the survey (a 54% response rate), representing 46 states and over 50 medical subspecialties. None of the respondents identified as transgender, 37% were female and 63% male. About 24% responded that more than 90% of their colleagues knew of their sexuality, and 22% reported that less than 10% of their colleagues knew, and the remainder of the sample fell somewhere between these extremes. Some of the key findings included:

- 17% of lesbian, gay, and bisexual physicians reported being refused privileges or denied promotion or employment based on their sexuality;
- 16% reported being denied referrals;
- 34% had experienced verbal harassment from their professional colleagues;
- 37% felt socially ostracized.

Shockingly, 88% had heard their medical colleagues disparage LGBT patients, 52% had directly witnessed substandard care or denial of care to LGBT patients, and 14% had been victims of overt gay bashing.

A more recent study found that 95% of LGBT students applying for medical school did not disclose their sexuality for fear of discrimination, and 46% did not disclose when applying for a residency (Merchant, Jongco, & Woodward, 2005). The following studies suggest that the fears of disclosure are valid. Brogan, Frank, Elon, Silvanesan, & O'Hanlan (1999) reported that 41% of lesbian physicians surveyed had experienced harassment in health care settings and were more likely to have histories of depression than heterosexual female physicians, suggesting that added stress impacted the health of even these highly educated women (Brogan, O'Hanlan, Elon, & Frank, 2003). Patients may discriminate against physicians they know to be LGBT. A study of LGBT internists in Canada revealed that 30% had been subjected to homophobic remarks by patients on three or more occasions (Cook, Griffith, Cohen, Guyatt, & O'Brien, 1995).

In a related set of studies that addressed whether consumers of health care would accept having an LGBT physician, one Canadian study showed that 12% of randomly selected adults would refuse to see an LGBT family physician (50% of those because they perceived the LGBT physician would be incompetent); older respondents were more likely to refuse to see LGBT physicians than younger respondents (Druzin, Shrier, Yacowar, & Rossignol, 1998). A national random sample survey of individuals in the United States found that 30% said they would change their provider if they found out the provider was LGBT, and 35% would switch to a different clinic or practice if they found the practice employed openly LGBT health care providers (Lee et al., 2007). LGBT physicians report that they sometimes choose to "pass" as heterosexual to avoid these potential problems with patients (Riordan, 2004).

In summary, this brief review indicates that while research on LGBT physicians' experiences in the workplace is lacking, the available research suggests that medical school and medical practice settings may be discriminatory or hostile work environments for some LGBT health care professionals and that consumers of health care may also reject LGBT physicians. This current study was developed, in part, to replicate the unpublished Schatz and O'Hanlan study of 1994 and to extend the study design to include heterosexual physicians. In late 2008, the American Medical Association (AMA) partnered with the Gay and Lesbian Medical Association (GLMA) to develop a random sample survey study of physician attitudes and behaviors from the AMA database and an oversampling of LGBT physicians using the GLMA database. This article reports on the findings of the LGBT oversample portion of the study; results of the comparisons of LGBT and heterosexual physicians will be reported elsewhere.

METHOD

Sample

The study began with a convenience sample of all physicians in the database of the GLMA ($n = 502$) and the cover letter asked these physicians to complete the survey and forward the link to any other LGBT physicians they knew. There were 228 respondents to the GLMA database survey, for a response rate of 45%, and 199 respondents in the snowball sample.

Instrument

A project workgroup was convened to develop the questionnaire.[1] The instrument was designed to assess individual attitudes, knowledge, and behaviors; collect information on formal education about LGBT health; and assess workplace policies and procedures regarding LGBT patients and employees. The survey instrument was pilot tested with approximately 20 individuals, about 50% LGBT and 50% heterosexual, and minor revisions to wording were made prior to launching the survey.

Procedures

The project was approved by the institutional review board at the University of Illinois, the body that governs the AMA Office of Research. The questionnaire for the GLMA oversample study was developed in Survey Monkey for administration online. In the summer of 2009, the link to the survey was sent to the GLMA physician database with a request to complete the

questionnaire and a request to forward the link to other LGBT physicians. Reminders were sent by e-mail twice, approximately one month apart, for a total of three emails.

Data Management and Analyses

Survey Monkey data were downloaded from the site into Excel 2003 where the data were cleaned and then uploaded into SPSS (Version 16). The data were then processed, checked, and rechecked. Descriptive statistics (means, standard deviations, and frequency distributions) were generated. Statistical inferences were gathered by generating chi square tests, *t* tests, Mann Whitney U tests, and analyses of variance (ANOVAs), depending on the type of measure.

RESULTS

Convenience versus Snowball Samples

The snowball and GLMA member samples did not differ on age, medical specialty, current gender identification, race, how likely they were to have revealed their sexuality or gender to coworkers, or religious beliefs, but did differ on distribution of sex and gender (there were more women, 36%, in the snowball sample than the member sample, 24%), and political beliefs (17% of the snowball sample were middle-of-the road or conservative compared to 8% of the member sample). The data from the two samples were combined for the remainder of the analyses.

LGBT Physician Characteristics

The respondents had a mean age of 46.8 ($SD = 10.67$, Range 25–92). The sample consisted of 30% individuals who reported being born female and 70% male, with none indicating other or intersex. As for current gender, 29% reported female, 70% male, 1% transgender, and one person identified gender as "queer." By ethnicity, 85% were White, 8% Asian or Pacific Islander, 3% Latino, 3% African American, and 8% indicated mixed race or other. The majority of the respondents were not at all religious (44%) or only slightly religious (30%), whereas 20% reported they were moderately religious and 6% very religious. Most respondents had liberal political views: very liberal, 42%; liberal, 46%; middle of the road, 10%, and 2% conservative or very conservative. The vast majority (94%) were supportive of same-sex marriage, although 6% said they supported civil unions or domestic partnerships, but not legal marriage. By sexual orientation, 69% reported they were

gay, 26% lesbian, 4% bisexual, and less than 1% other. The majority (59%) reported that they were out to 90% or more of their coworkers, although 8% were out to less than 10% of their colleagues. Most respondents reported having five or more LGBT friends and acquaintances (over 80%), 40% had an LGBT immediate family member, and 70% reported having an LGBT extended family member.

The specialty areas of the sample were quite diverse, with 22% in internal medicine, 21% in family practice, and all other specialties were under 10%. Nearly half (47%) indicated that they provided HIV care. They were asked about the number of patients in their patient panel, with a varied response (from 8 to 10,000), with a mean of 1319.1 patients, and a median of 700.

Knowledge and Education About LGBT Issues

Table 1 shows the number of hours of education on LGBT issues in medical school, residency, and continuing medical education. We asked about education concerning each sex or gender identity group separately, because the workgroup's experience was that many medical students and practicing physicians receive fairly extensive education about HIV, which is often discussed only in terms of men having sex with men. Other sexual and gender minority issues are less often discussed, as shown in Table 1, although many LGBT physicians appear to seek out this education in continuing medical education programming. When asked to rate how helpful the educational content was in preparing them to work with LGBT patients, 56% said that medical school was not at all helpful, 50% said that residency training was not at all helpful, and 30% found continuing medical education to be not at all helpful. In contrast, 75% said that their own personal experience working with LGBT patients was very helpful.

Experiences with LGBT Patient Care

Most respondents reported that they worked with some LGBT patients, although it was a small number of their total patient panel. By sexual and

TABLE 1 Average Number of Hours (and Standard Deviation) about LGBT Health at Different Levels of Medical Education and Percentage who had no Content

Education	Lesbian content	Gay male content	Bisexual content	Transgender content
Medical school	1.46 (5.5)	2.31 (6.6)	1.03 (5.6)	0.90 (5.2)
	61% none	49% none	78% none	76% none
Residency	3.18 (25.6)	4.98 (27.8)	1.41 (8.1)	1.28 (6.9)
	68% none	60% none	79% none	79% none
CME	14.73 (35.8)	30.36 (79.5)	10.54 (54.2)	11.40 (54.2)
	42% none	37% none	51% none	46% none

gender identity group, 18% had no lesbian patients (those who served lesbian patients reported a median of 10 lesbians in their patient panels), 21% served no gay male patients (those who served gay patients reported a median of 20 gay men), 44% had no bisexual women in their patient panels (those serving bisexual women had median of 5 bisexual woman), 45% had no bisexual men in their patient panels (those serving bisexual men had median of 5 bisexual men), 53% had no male-to-female transgender patients (those serving MTF patients had a median of 2), and 66% reported no female-to-male transgender patients (those serving FTM patients had a median of 2).

On a scale from 1, *very comfortable*, to 4, *not at all comfortable*, respondents were asked how comfortable they would feel taking care of patients who were lesbians, bisexual women, gay men, bisexual men, transgender women (MTF), transgender men (FTM), men who have sex with men (MSM), and women who have sex with women (WSW). Interestingly, some physicians are not completely comfortable working with transgender patients and MSM and WSW who do not identify as lesbian, gay, or bisexual. Table 2 shows this data divided by respondent gender. As expected there were significant gender differences with women being significantly more comfortable with lesbian and bisexual women's care ($U = 15{,}822$, $p = .003$; $U = 16{,}046$, $p = .014$) and men being more comfortable with gay and bisexual men's care ($U = 15{,}327$, $p = .002$; $U = 15{,}451$, $p = .013$). Men were significantly more comfortable caring for MSM patients ($U = 14917$, $p = .036$). There were no significant differences between men and women in their comfort level caring for MTF, FTM, or WSW patients.

Many respondents were unaware of the policies of the health care agencies where they worked, but only 26% worked in a setting where the written forms asked for patient's sexual orientation (6% did not know) and only 19% worked in organizations that included questions about gender identity on the written forms (14% did not know). More agencies had forms that allowed patients to indicate if they were in a same-sex relationship (43% said yes; 12% did not know). If sexual orientation or gender identity of patients were known, 66% of respondents indicated that this information

TABLE 2 Level of Comfort Working with Sexual and Gender Minority Patients: Percentage Very Comfortable

Working with patients who are:	Male respondents	Female respondents
Gay men	98%	89%
Lesbians	87%	97%
Bisexual men	95%	88%
Bisexual women	87%	95%
Women who have sex with women	74%	73%
Men who have sex with men	75%	63%
FTM transgender	64%	69%
MTF transgender	65%	66%

would be recorded on medical records. Regarding visiting policies, 59% said that same-sex couples would be allowed to visit intensive care or emergency department settings, although 24% did not know their agency's policy about visitation. Two-thirds of respondents (67%) worked in a setting that had a nondiscrimination policy including sexual orientation (12% did not know), and 37% said that gender identity was included in the nondiscrimination policy (28% did not know). In addition, 62% said their agency had domestic partner benefits (7% did not know). Few agencies had staff training about LGBT issues (29%) or had access to posters or brochures about LGBT issues (26%).

The next series of items assessed how often the individual practitioner engaged in LGBT health related activities. Over half (56%) often asked patients about their sexual orientation (but 11% never did), 22% often asked about gender identity (31% never did), and 21% often asked patients' permission to record sexuality or gender information on medical records (40% never did). Only 3% had referred an LGBT patient to another provider because they were uncomfortable treating the patient. Some providers (23%) often asked patients if they had power of attorney for health care (37% never did), 31% had ever prescribed or monitored hormone use of a transgender patient (69% never did), and 20% had ever referred a patient for gender reassignment surgery (80% had never done so). Respondents were also asked about their perceptions of the impact of their sexuality or gender on patients. Some (20%) strongly agreed that coming out to patients enhanced communication between provider and patient; 22% thought that coming out enhanced trust, but about one third thought that their sexual orientation (31%) and gender identity (34%) had no effect on their patients.

Workplace Climate and Policies

Table 3 summarizes the workplace experiences of LGBT physicians and where possible, compares the rate of occurrence to the previous survey (Schatz & O'Hanlan, 1994). Respondents were less likely to have adverse consequences in the workplace in 2009 than in the 1994 study, although some of the problems had decreased only slightly. For example, 16% of respondents in 1994 reported that they were denied patient referrals because of their sexual orientation, and in 2009, 10% reported this as a problem. The rate of being denied entry to medical school was low, but virtually unchanged from 1994 to 2009 (2%). More than 1 in 10 physicians are still stigmatized by colleagues in the patient referral process. Harassment and social ostracizing by professional colleagues was reported by 37% of respondents in 1994, and had decreased in 2009 to 15% and 22%, respectively. About one third of LGBT physicians in 2009 had witnessed discriminatory actions in the workplace. Some respondents reported that there were positive consequences of being openly LGBT employees: many (46%) had received

TABLE 3 Comparison of Negative Workplace Experiences Related to Sexual or Gender Identity 2009 Versus Schatz & O'Hanlan (1994)

Event	% experienced (2009)	% experienced (1994)
Refused staff privileges	0	*
Fired	3%	*
Denied employment	8%	*
Denied educational program	5%	*
Denied promotion	6%	*
Denied medical school entry	2%	2%
Denied patient referrals	10%	16%
Denied a residency	4%	11%
Discouraged from applying	5%	not asked
Denied a loan	2%	4%
Harassed by colleagues	15%	37%
Socially ostracized	22%	37%
Any discrimination because of LGBT pts	2%	5%
Accused of unethical behavior	2%	not asked
Ever heard disparaging remarks	65%	88%
Witnessed discriminatory care of LGBT pt	34%	52%
Witnessed disrespect of LGBT pts' partner	36%	not asked
Witnessed discrimination against LGBT employee	27%	not asked

*In the 1994 survey, these first five items were collapsed into one question about job discrimination, and 16% indicated that they had experienced one of these.

referrals of LGBT patients, over half (52%) had been sought out as experts on LGBT health, and some (34%) had been asked to do grand rounds on LGBT topics.

Demographic Differences Among the Sample

We examined the data for potential age and sex and gender differences, focusing on the categories of male and female current gender, since there were only five transgender respondents. Very few differences emerged on the questionnaire items related to attitudes, knowledge, or behaviors. Significantly more men (8%) than women (2%) gave an incorrect response to the knowledge question about bisexuality as a stable sexual identity ($\chi^2 = 5.26$, $p = .019$), and men reported more education about LGBT issues (a sum of all hours across medical school, residency and continuing medical education) with an average of about 91 hours, compared to 66 hours for women. There were significant differences by gender in political beliefs with men being more conservative than women ($U = 14{,}551$, $p = .001$), and significantly ($p = .004$) more men supported civil unions or domestic partnerships over legalizing same-sex marriage (8% of men, 1% of women).

In exploring age differences, older physician's age was significantly correlated with asking patients about durable power of attorney ($r = .18$, $p = .001$). Older age was significantly ($p < .001$) associated with more hours

of LGBT content in CME courses (lesbian, $r = .28$; gay, $r = .32$; bisexual, $r = .26$; and transgender, $r = .23$), and belief that CME and life experiences were helpful for LGBT patient care ($r = .30$, $p < .001$ and $r = .13$, $p = .007$). Being older was also significantly correlated with coming out to patients ($r = .31$, $p < .001$) and in agreeing that coming out to patients enhances communication and trust with patients ($r = -.15$, $p = .003$, $r = -.13$, $p = .01$). Younger age was significantly ($p \leq .001$) associated with more hours of LGBT content in medical school (lesbian, $r = -.32$; gay, $r = -.28$; bisexual, $r = -.18$; and transgender, $r = -.26$). Younger age was significantly ($p \leq .002$) associated with more hours of LGBT content in residency (lesbian, $r = -.21$; gay, $r = -.15$; bisexual, $r = -.15$; and transgender, $r = -.15$). Belief that the LGBT content in medical school or residency was helpful was significantly associated with younger age ($r = -.29$, $p < .001$ and $r = -.20$, $p < .001$).

The sample was not sufficiently ethnically diverse to explore potential differences by racial or ethnic identification, as the largest group of non-White respondents were in the other category with no explanation of what that meant.

DISCUSSION

Results of this study suggest that LGBT physicians continue to encounter unacceptable levels of discriminatory and sometimes hostile practices at the healthcare institutions where they work, ranging from exclusionary employee and patient policies, lack of referrals from their colleagues, and witnessing derogatory remarks about LGBT individuals. In fact, 65% frequently heard disparaging remarks about LGBT patients at work, and 35% witnessed discriminatory care of an LGBT patient. The good news is that fewer LGBT physicians have these experiences and personal experiences with discrimination than they did in 1994. Many more agencies now have nondiscrimination policies that include sexual orientation (although few include gender identity), and more institutions provide benefits for domestic partners now than in 1994.

It appears that some small progress has been made in incorporating LGBT issues in the medical school or residency educational experiences of physicians. Younger respondents reported significantly more LGBT content in medical school and residency than did older respondents, but the overall amount of education is still inadequate. In medical school, just under half of the respondents reported that they had no education at all about gay male issues; 61% received no content on lesbian health, 78% reported nothing on bisexual health, and 76% had no content on transgender health. These omissions were not remedied in residency or even continuing education programming, where 37–51% of LGBT physicians reported no LGBT content.

This lack of education may help to explain why even some lesbian and gay physicians report being uncomfortable working with transgender, MSM, and WSW patients. Most of the physicians in this study reported that they had to rely on their own personal experiences, rather than formal education, to learn about LGBT patient care. This omission was understandable in 1994, when there were few educational resources related to sexual orientation and gender identity, but today there are several textbooks which would be appropriate for medical education (e.g., Dibble & Robertson, 2010; Eliason, Dibble, DeJoseph, & Chinn, 2009; Makadon, Mayer, Potter, & Goldhammer, 2008; Meyer & Northridge, 2007; Shankle, 2006), and also including a report from the prestigious Institute of Medicine (IOM, 2011).

In addition, curricular modules can easily be introduced into medical school or residency programs (Kelley et al., 2008). It is imperative that curricular administrators including those who design CME programs routinely include comprehensive LGBT education in the curricula (and not just in the sexuality curriculum) to increase the knowledge of future health care providers who will provide care for this vulnerable population. In addition to the curricular innovation described by Kelley et al. (2008), there are now Web resources for health care training such as www.lavenderhealth.org, with case studies, lectures, and group and individual activities to facilitate learning about LGBT health issues.

The questions about inclusion of LGBT-supportive policies and procedures in health care settings revealed that most LGBT physicians continue to work in settings where they are invisible. The high numbers of LGBT physicians who did not know their agency policies was a bit puzzling. For example, 24% did not know if same-sex partners were included in visiting policies, 12% did not know if their employers had nondiscrimination policies based on sexual orientation, and 28% did not know if the policy included gender identity. Nor did LGBT physicians automatically include sexuality and gender when taking histories from their patients. It may be that many did not ask the appropriate questions for fear of offending patients or their employers. It may also be that LGBT physicians are constrained by the heterosexist policies and procedures and the general climate of their institutions.

One major study limitation is the nonrepresentative sampling method. More than half of the respondents came from an LGBT health advocacy organization, and may be more politically savvy and open about their sexuality and gender than LGBT physicians who do not belong to such an organization. Indeed, we did find that the GLMA sample had fewer women and was more politically liberal than the snowball sample. GLMA members were predominantly white gay males, who may not be representative of the diversity of LGBT physicians as a whole. Second, the response rate of the convenience sample was under 50%, and we have no way of calculating the response rate for the snowball sample, as GLMA members were requested to forward the link to other LGBT physicians they knew. This also

impacts our ability to generalize these findings. Finally, a quantitative survey is inadequate to fully understanding and addressing workplace climate issues as many LGBT physicians have subjective responses to events in the workplace and experience subtle forms of discrimination or harassment not easily captured by quantitative methods. In spite of these limitations, the findings are an important step in documenting the experiences of LGBT physicians in the workplace, and represent a broad range of medical practices, geographical regions, and types of healthcare settings.

In conclusion, we found that conditions had improved somewhat for LGBT physicians in the workplace, but far too many still witnessed discrimination and were exposed to negative comments on a frequent basis. More than one out of five LGBT physicians still feels socially ostracized by their coworkers, and over one third had witnessed discriminatory treatment of LGBT patients and their partners. Formal education in medical school and residency programs has not been sufficient to foster a shift in the heterosexist and gender normative practices of the field of medicine, and a concerted effort is needed to include LGBT educational content as part of overall diversity initiatives. A multipronged approach of individual agency level practices, such policy review and revision and staff workforce development programs must be coupled with more attention to LGBT health care issues in medical school and residency training, and with higher level policy statements from national and international medical organizations that mandate LGBT education as part of diversity training in general.

NOTE

1. Members of the project workgroup included Judy Bradford, Mhel Cavanaugh-Lynch, Jennifer Chaffin, Mickey Eliason, Rob Garofalo, Emilia Lombardi, Graham MacMahon, and Randy Sell. Representatives from GLMA included James Beaudreau and Joel Ginsberg; and from the AMA, Matt Wynia.

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