



A path forward: lesbian, gay, bisexual, transgender, and queer in medicine and gastroenterology

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THE CURRENT STATE OF LESBIAN, GAY, BISEXUAL, TRANSGENDER, AND QUEER MINORITY GROUPS IN ACADEMIA

The final article in the American Society for Gastrointestinal Endoscopy's (ASGE's) "A Path Forward" series focuses on the lesbian, gay, bisexual, transgender, and queer (LGBTQ) community in medicine and gastroenterology. The growth of the LGBTQ community, also referred to as Sexual and Gender Minorities (SGMs), has been significant in the 21st century. In the last 10 years, the percentage of people in the United States identifying as LGBTQ has increased, with the last poll from *Gallup* reporting 7.6% in 2023, increased from 7.1% in 2021, 5.6% in 2020, and 4.5% in 2017.¹⁻³ LGBTQ identification is highest in younger generations, with 22.3% of Generation Z (born between 1997 and 2012) identifying as LGBTQ in 2023, nearly doubling the percentage of those identifying as LGBTQ in 2020 for this age group.¹⁻³ The reason for this increase is likely multifactorial and may be partly attributable to America's growing acceptance of same-sex rights and support of nondiscrimination protections for the LGBTQ community.⁴ Because individuals feel more comfortable sharing their sexual orientation and gender identity (SOGI), this trend is likely to continue throughout society, including the medical profession.

Within the last decade, the Association of American Medical Colleges (AAMC) has started collecting data regarding SGMs within the profession. Since 2016, the AAMC has included SOGI questions in its annual Matriculating Student Questionnaire (MSQ) and Medical School Graduation Questionnaire (MSGQ).^{5,6} From 2020 to 2021, the percentage of graduating medical students identifying as LGBTQ was 10%, with 5% as bisexual, 4.3% as gay or lesbian, and 0.7% as transgender.⁷ This is increased from 2017 and 2019, which reported a total of LGBTQ as 8.4% and 9.5%: specifically, 4.2% and 5% as bisexual, 3.6% and 3.8% as gay or lesbian, and 0.6% and 0.7% as transgender, respectively. Although these numbers show a small upward trend in SGMs, the recorded representation is likely underestimated because of underreporting and a lack of complete response rate. In the MSGQ survey for

2020 to 2021, 79% out of a total 29,917 participants responded, and even fewer commented on SOGI.⁷ Of 15,154 respondents on sexual orientation, 3.6% identified as bisexual, 4.2% identified as gay or lesbian, and 92% identified as heterosexual. There were 15,324 respondents on gender identity, of which 99.4% identified as the same gender identity as the sex assigned at birth, and 0.6% identified as a different gender identity from the sex assigned at birth.⁷ A 2015 study, which examined survey results from 2009 to 2010 about the status of LGBTQ in U.S. and Canadian medical schools, found the following: of the small number that responded (920 medical students), 44% feared discrimination in medical school, 61% said their sexual identity was "nobody's business," and 30% of those respondents concealed their sexual identity.⁸ In this study, it should be noted that the response rate was only 5.7%. Therefore, the true numerical representation of LGBTQ students in medical school is not known.

Although its true reflection in medicine is currently unknown, the LGBTQ community within the medical profession is expected to increase. The MSQ reported 14.1% of matriculants identified as LGBTQ in 2025.⁵ This is in contrast to the <10% reported in the 2016 data.⁶ Harvard Medical School reported that 15% of its 2020 medical school matriculation class identified as LGBTQ.⁹ To our knowledge, there is only 1 study by the AAMC that quantifies the prevalence of LGBTQ individuals in U.S. medical school faculty.¹⁰ We are not aware of any published data specifically on the prevalence of LGBTQ individuals in the U.S. gastroenterology faculty. A survey from 2019 to 2022 found that 4% of faculty identify as lesbian, gay, or bisexual, which does not include those who are transgender or queer. This is likely an underestimate because there was only a 57% response rate from 26 institutions, and of those, only 84% responded with details regarding sexual orientation.¹⁰ Because the LGBTQ community within the medical school graduating and matriculating classes continues to increase, the number of LGBTQ individuals in faculty will likely mirror this growth. Further national surveys are needed to study whether faculty and leadership reflect all the diverse groups, including LGBTQ.

WHY IS LGBTQ REPRESENTATION IN MEDICINE IMPORTANT?

Addressing health disparities in LGBTQ populations

There is a greater prevalence of decreased engagement in health care among SGMs.¹¹ The reason for this is unclear; however, patient fear of health care discrimination and refusal of care has been a historical reality and impacts willingness to participate in physical and mental health screening and treatment.¹²⁻¹⁴ This barrier to care is concerning because some groups within the LGBTQ patient population may be at higher risk for certain cancers, obesity, cardiovascular disease, substance abuse, and suicide, according to an Institute of Medicine consensus report.¹⁵

The term LGBTQ has been used to identify a single group, yet each subgroup has its own history and health care needs. Sexual minority women, defined as women who self-identify as LGBTQ, report fewer lifetime cervical cancer screenings because of patient and provider misunderstanding of the lower risk of human papillomavirus.¹⁶⁻¹⁸ Sexual minority men have higher rates of anal cancer, especially if infected with HIV. Unfortunately, anal cancer education and high-resolution anoscopy are not routine medical care and are mostly performed in specialized settings, limiting access to screening and treatment.¹⁹⁻²² According to the U.S. Transgender Survey (USTS), the largest survey documenting the experiences of transgender people in the United States, including 27,715 respondents, 33% of those who saw a health care provider reported having at least 1 negative experience related to being transgender. The most common scenarios included having to educate their provider about transgender people to get appropriate care, being asked unnecessary and unrelated invasive questions about their transgender status, refusal of care, and verbal harassment.²³ Furthermore, 39% of respondents have experienced extreme psychological distress, and 40% of respondents have attempted suicide. One-fourth reported not seeking health care for fear of discrimination.

Advancing LGBTQ focus within academia

LGBTQ health care professionals and trainees have demonstrated a commitment to advancing patient care and academia related to LGBTQ concerns. In a survey of 252 health care professionals and trainees who identified as LGBTQ, 61.5% developed LGBTQ educational activities, 39.3% volunteered for the LGBTQ community, 39.7% instituted best practices in the care of LGBTQ patients, and 32.5% conducted LGBTQ-related research.²⁴ Among the trainees, 81.1% reported an interest in pursuing an academic career. Engagement of the LGBTQ community has specifically succeeded in improving cultural competency through training ses-

sions that address knowledge, skills, and attitudes of providers toward LGBTQ individuals. Although gaps may still exist in best practices for training providers in LGBTQ care and in research methodology for LGBTQ research, these steps forward are encouraging for the field.²⁵

A PATH FORWARD FOR LGBTQ PATIENTS AND PROVIDERS

Provider education

Improving LGBTQ patient care begins with refining provider education for both LGBTQ and non-LGBTQ professionals, with the latter encompassing the majority of those caring for the LGBTQ community. Surveys have demonstrated that LGBTQ patients are more likely to disclose relevant sexual orientation information and have better healthcare experiences when care settings and providers are inclusive, affirming, and culturally competent.²⁶ Unfortunately, surveys of healthcare providers demonstrate that many feel some level of discomfort when caring for LGBTQ patients and believe issues involving LGBTQ health should be reviewed in more detail in medical school curricula.^{14,15} A 2011 study found the median time of teaching LGBT content in U.S. and Canadian medical schools was 5 hours across the 4 years of medical school training.²⁷ A follow-up study published in 2024 found that dedicated time in the medical school curriculum increased to a median of 11 hours in 2022 across the surveyed U.S. and Canadian medical schools. Despite the significant increase in curriculum hours over the years, the study found the instruction varied significantly and still didn't meet the recommended competencies by AAMC.^{28,29} Curriculum change is needed to ensure health care professionals receive culturally appropriate education and are competent to care for this population. Incorporating LGBTQ education into conferences and CME programs will ensure a broad reach into the medical community. For example, in June 2022, the ASGE's Diversity and Inclusion Committee hosted a webinar to discuss clinician interactions with the LGBTQ community. Most recently, in the ASGE-sponsored Heallo video series on diversity, equity, and inclusion, sexual health in the LGBTQ patient population was discussed.³⁰

Improving LGBTQ representation

Surveys of LGBTQ health care professionals and trainees, including national meeting data, have shown high engagement in academic roles but also a higher likelihood to consider leaving.^{24,31} This is consistent with prior studies of LGBTQ students and faculty in higher education because they are more likely to experience isolation, discrimination, and/or gender harassment and, in turn, have reported diminished interest in staying in academia.^{8,32-34} By broadening our diversity mission to include SGMs, we can understand the barriers for LGBTQ representation in medicine so that we

can better cultivate the talent and contributions of the LGBTQ health care community.

The first step to improving LGBTQ representation in medicine is to create a safe environment for SGMs. Implementing this culture at the institutional level would be a critical first step. Phelan et al³⁵ found that medical school-level factors that improve the diversity climate, reduce negative role modeling, and increase preparedness for the care of sexual minority patients were associated with decreases in biases over time. In the past, LGBTQ physicians reported being refused privileges or denied promotion or employment based on their sexuality and experienced verbal harassment and isolation.¹³ Efforts such as creating a written zero-tolerance policy for homophobic suggestions (from both patients and faculty), using LGBTQ-friendly language on intake/job forms, providing resources for LGBTQ families/family planning, and expanding benefits for family leave are commonly cited strategies to support recruitment and retention of SGMs.^{36,37}

Another factor that can improve SGM representation is to recognize and endorse LGBTQ scholarly projects. After excluding projects about HIV/AIDS and sexual health, only 0.1% of all National Institutes of Health-funded studies focus on LGBTQ health between the years 1989 and 2011.³⁸ In the past, participation in LGBTQ scholarship has been a perceived barrier to promotion.³⁹ Data from the Health Care Perspective surveys by Sánchez et al²⁴ found that approximately 20% of trainees and faculty perceived limited support for LGBTQ research, education, and community service.

Lastly, mentorship for SGMs is an important tool to increase LGBTQ representation and visibility in medicine. Mentorship programs for trainees *underrepresented in medicine*, a term that the AAMC has referred to as ethnic and racial minorities, have positively influenced feelings of inclusivity, improved recruitment of underrepresented trainees, and increased retention of underrepresented faculty.⁴⁰ Although those “unrepresented in medicine” have not historically included the LGBTQ community, institutions have followed this precedent by implementing LGBTQ mentorship programs for the aforementioned reasons. In addition, mentorship need not be only LGBTQ-identified personnel, but also LGBTQ allies, like what we see in the #HeforShe movement, where male-identified physicians advocate and support the female-identified colleagues.

CLOSING REMARKS REGARDING LGBTQ REPRESENTATION IN GASTROENTEROLOGY

As the LGBTQ community grows, its representation in medicine is expected to follow suit. However, to date, there are a paucity of data on the status of the LGBTQ faculty in gastroenterology. Community members and allies are now beginning to establish a presence on social media,

such as Rainbows in GI on X (formerly known as Twitter), as well as within the major GI societies and at international conferences. With the diversity, equity, and inclusion (DEI) initiative, the ASGE has committed its support for LGBTQ research (related to providers and patients) and leadership appointments. The first annual update for the 2021 to 2022 academic year has been published as a baseline intake to ensure transparency and accountability for all aspects of DEI, including the LGBTQ population.⁴¹ Quantitative data are important to assess the growth of DEI in gastroenterology, and this initiative is a step in the right direction.

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Abbreviations: AAMC, Association of American Medical Colleges; DEI, diversity, equity, and inclusion; LGBTQ, lesbian, gay, bisexual, transgender, and queer; MSGQ, Medical School Graduation Questionnaire; MSQ, Matriculating Student Questionnaire; SGMs, sexual and gender minorities; SOGI, sexual orientation and gender identity; USTS, U.S. Transgender Survey.

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