Original Article

Are we being trained to discriminate? Need to sensitize doctors in India on issues of gender and sexuality

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Abstract

Even though the struggle for LGBTQIA+ (Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual; with the + indicating myriad others) rights is an ongoing one, we have come a long way in terms of acceptance and inclusion. In spite of the progress, the LGBTQIA+ community in India still faces rampant bias in society as well as in healthcare. This is fueled by misinformation, which leads to prejudice and violence against these individuals. This paper discusses this struggle, touching upon the legal and social aspects. The focus is on the detrimental effects of stigma on health outcomes and health disparities for LGBTQIA+ individuals. The outlook of some in the medical fraternity and the deficiencies in medical training, including redundant and outdated curriculum/ textbooks, are discussed. It is implied that these factors result in biased and ill-informed doctors who are poorly equipped to meet the health needs of the LGBTQIA+ population. Correcting the deficiencies is a priority in the face of the recent ruling by the Honorable Supreme Court of India striking down Section 377 of the Indian Penal Code that previously criminalized consensual carnal intercourse among consenting adults of this community of people.

Keywords: Gender identity; Healthcare disparities; Legislation; LGBTQIA+ people; Medical education, undergraduate; Section 377; Sexual and Gender Minorities; Transgender persons

Introduction

We have come a long way in terms of acceptance and inclusion, however, rampant bias towards the LGBTQIA+ community still exists, in society as well as in healthcare. LGBTQIA+ stands for Lesbian, Gay, Bisexual and Transgender, Queer, Intersex, Asexual; with the + indicating myriad other identities.[1] The terms Lesbian and Gay denote same sex physical/romantic attraction, the former for women, and the latter for people of

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all gender identities, but usually men. The terms in the public health literature are MSM ("Men who have sex with men") and WSW ("Women who have sex with women") - referring to individuals who engage in sexual activity with members of the same sex. [2] The term bisexual denotes physical/romantic attraction toward both men and women, while "queer" is an umbrella term used for non–conforming identities. The fourth term in the abbreviation stands for transgenders – these are individuals whose gender expression does not conform to the sex assigned at birth.[3] They must be differentiated from Intersex individuals, who naturally (without intervention), develop primary and secondary sex characteristics that are ambiguous. Finally, asexual people, in general, are those who feel no sexual attraction at all – this is different from celibacy in that celibacy is a deliberate choice.[1]

These are all independent of each other: biological sex (sex assigned at birth), gender identity (a person's innate identification as a man / woman / transgender / other), gender expression (external manifestation of gender identity which may or may not conform to societal norms), and sexual orientation (one's physical, romantic or other attraction or non-attraction to other people).[2] Failure to grasp the concept that these are separate things leads to discrimination in society, and in the legal and healthcare systems. Individuals belonging to different subclasses of the LGBTQIA+ community face a very different set of challenges, but what ties them together is the stigma and its adverse consequences. The latter are discussed together in this article.

The Global Perspective

The World Health Organization (WHO) accepts homosexuality as a normal variant of human sexuality, a status that was accepted in 1990 [5]. The DSM – III (Diagnostic and Statistical Manual of Mental Disorders) held the last relic of pathologized alternate sexuality in the form of Ego Dystonic Homosexuality, which was removed in its 1987 revision (DSM – III R) [6]. Open acceptance of homosexuality by the medical community paved the way for legal and cultural shifts in the western world. It deprived the opposing authorities of medical or scientific rationalization for discrimination.[7]

Similarly, in the DSM–5 (2013), "gender dysphoria" replaced "gender identity disorder" and explicitly stated that "gender non-conformity is not in itself a mental disorder",[8] shifting the focus entirely to the distress that many transgender people face as a result of their gender non–conformity. It is more this distress, and not their identity so much, which leads them to seek medical, surgical or psychiatric help.

The shaky legislative journey

The battle for equal rights in India has seen both highs and lows in a short span of time. Section 377, an archaic law banning the act of "sodomy", and modeled on the British-Indian Buggery Act rooted in 1533 English law,[9] was reinstated by the Supreme Court of India in December, 2013 after being struck down by the Delhi High Court in 2009.[10]

In August 2017, The Supreme Court found that Right to Privacy and the protection of sexual orientation lies at the core of the fundamental rights guaranteed by the Constitution, and noted that sexual orientation is an essential attribute of privacy.[11] A five judge bench of the Supreme Court then decided to reconsider the 2013 judgment, and gave the verdict on September 6,

2018, stating that Section 377 was in violation of fundamental rights.[12]

Another landmark judgment (NALSA judgment) was passed by the Supreme Court on April 15, 2014, which upheld the legal right of an individual to self-identify gender identity as male/female/transgender without having to first avail medical and surgical treatment.[13] This allowed male and female-identifying transgender people to recognize themselves as 'transgender' and to do so legally.

The Supreme Court directed the Centre and State governments to formulate welfare schemes, employment and education related schemes, rehabilitation and healthcare access schemes, and reservation policies for transgender people. Unfortunately, the recommendations of the judgment were watered down significantly in the Transgender Persons (Protection of Rights) Bill 2016 introduced by the Ministry of Social Justice and Empowerment.[14] It deviated significantly from the aspect of self-identification, by recommending the setup of a screening committee to make determinations on an individual's gender.

Stigma leads to disparities in health for minority groups

Homosexuality is still a taboo in many communities and is deemed as unacceptable by many religious and social sects across the country.[15,16] Both MSM and transgender individuals face systemic discrimination, social victimization and violence (both physical and sexual).[16] Such discrimination and its negative health consequences have been widely studied in Western literature. According to the "Minority Stress Model", members of sexual or gender minority groups may experience distal stressors (like the experience of discrimination and violence) and proximal stressors (like expectation of rejection, concealing true identity, and internalized homophobia).[17] These have been linked to poor mental, sexual and physical health as well as decreased access to health care for minority populations.[18]. LGBT individuals are 2.5 times more likely to experience depression, anxiety, and substance misuse compared with heterosexual individuals.[19] Twenty percent of sexual minority adults have attempted suicide - in comparison, the rate is four percent for the general public.[20]

The minority stress model has been adapted and studied in the Indian context, including an examination of disparities in health of these groups.[21] Data from quantitative and qualitative studies has shown poor mental health outcomes in these populations, with disproportionately high rates of stress, depression, anxiety, suicidality and substance abuse. [22-24] Poor psychosocial health has further been linked to sexual risk-taking and a higher prevalence of HIV in these populations.[25]

Negative attitudes can prevent optimal utilization of healthcare services. Studies have shown physician homophobia to be a barrier to health care, with LGBTQIA+ patients being more likely to delay or avoid care due to fear of harassment or discrimination.[15-17,26] There are limited studies from India, but they detail the discrimination faced by members of the transgender community; for instance, there are reports of trans-women being given male gowns and being placed in male wards.[26,27].

According to the Joint United Nations Program on HIV and AIDS (UNAIDS), transgender women are 49-times more

likely to acquire HIV than the general population.[28] Among transgender individuals in India, condom use remains low and almost two-thirds report no access to treatment for sexually transmitted infections; around half were referred for HIV testing and up to 67·1% had not been given proper counselling on antiretroviral therapy adherence.[29] While the Supreme Court of India, through NALSA, had directed governments to set up HIV screening centers specifically for the trans population, this was left out of the 2016 Transgender Persons (Protection of Rights) Bill.[13,14] Novel interventions to prevent HIV transmission, like PrEP (Pre-Exposure Prophylaxis), have gained popularity in the West but are not widely distributed in India. In a qualitative study in Indian MSM, stigma related concerns were suggested to be a barrier for PrEP uptake in the country.[30]

Opinions and practices of medical practitioners

In the past, there have been statements from senior psychiatrists calling homosexuality "not natural" and a "grey area in Psychiatry".[31] There is a prevalence of conversion therapy for "treatment" of homosexuality, with practitioners asking large sums of money for the same. Such practitioners have also been known to propagate baseless notions about hormonal, genetic and psychological "reasons" for homosexuality, and they offer aversive therapy, electroconvulsive therapy, psychotropic medication and even religious texts to guarantee time bound, complete conversions.[32] The WHO has issued a statement condemning such therapies for lack of any medical justification and stating that they "constitute a violation of the ethical principles of healthcare and violate human rights".[33]

In July 2018, the Indian Psychiatric Society took a similar step forward by issuing an official statement about "same sex sexuality" being a "normal variant of human sexuality much like heterosexuality and bisexuality". They further went on to state that "there is no scientific evidence that sexual orientation can be altered by any treatment" and finally strongly supported the "decriminalization of homosexual behavior".[34]

Among some of the positive steps taken by the state governments, Tamil Nadu and Kerala are the first Indian states to introduce a transgender (hijra/aravani) welfare policy under which transgender people can access free sex reassignment surgery (SRS) in government hospitals (only for male-to-female) and get proper documentation issued. The transgender welfare board in Tamil Nadu has representatives from the transgender community.[35]

Other practices have come under scrutiny for their discriminatory policies. Blood banks of prominent hospitals have been reported to "ban" homosexual people from donating blood, or discourage participation by inquiring about sexual orientation during the screening process.[36]

Knowledge gap in trainees

Data on physician attitudes towards homosexuality in India is very limited. A study of 244 medical students and interns showed an insufficient knowledge of homosexuality. For example, the statement "Greece and Rome fell because of homosexuality" was incorrectly identified as true by 191 (78%) students. In agreement with preceding work, the above study also noted an increase in positive attitudes with better knowledge.[37] A study on 212 dental

students measured regard for patients from often-stigmatized populations, through different stages of their curriculum. According to the study, the least positive regard was noted for patients with LGBT identity, and there was no significant shift in different stages of training.[38]

Deficiencies in education and training

Such results are not surprising in the context of the outdated medical curriculum.[39] Widely followed textbooks have come under criticism for pathologizing and criminalizing homosexuality and transgender identity.[40] Multiple textbooks on Forensic Medicine and Toxicology, which have previously also been criticized for insensitive discussion of sexual violence against women, also often portray distorted views on the LGBTQIA+ identity.[41] Archaic terms such as "pederasty" and "tribadism" are discussed in conjunction with bestiality and pedophilia, reinforcing negative stereotypes. A widely followed textbook of undergraduate psychiatry enlists methods like psychotherapy, aversion therapy and even androgen therapy for changing a person's sexual orientation. Similar methods are suggested for "Reconciliation with the anatomic sex" in transgender individuals.[42]

Such negative characterizations and outdated treatment guidelines have little basis in current medical literature and they misinform medical students. Discussions about patient confidentiality, clinical etiquette and the importance of an aware, non-judgmental worldview could be included in the curriculum by introducing newer subjects like medical ethics and medical humanities. However, there is dearth of these subjects in both undergraduate and post graduate education in spite of arguments in favor of their inclusion in the curriculum.[43,44] In one study, participants (postgraduate medical and dental residents), ranked internet and newspaper sources higher than medical textbooks as sources of their ethics knowledge.[45] Probably the greatest evolution in LGBTQIA+ perspective has been in the discipline of Psychiatry, and so, such discussions could be a part of the Psychiatry curriculum - currently the topic is inadequately addressed during undergraduate medical training.[46]

Recommendations for the future

The Medical Council of India (MCI) announced its plans for a revised and updated medical curriculum, to be implemented by 2018. Among other things, it is to focus on "professionalism and ethics" as well as "sexual health issues".[47] This is a step in the right direction, as it may teach students about sexuality, sexual risk-taking and how to take a sexual history. However, many of the problems (including stigma) faced by LGBTQIA+ individuals aren't necessarily "sexual" in nature.

The American Association of Medical Colleges has recommended wider inclusion of LGBTQIA+ topics, dedicated teaching time, clinical exposure to LGBTQIA+ patients, and faculty training to impart trainees with the required knowledge and clinical skills. They have also stressed on the importance of a safe and healthy learning environment, free from judgment and discrimination.[48] This may be especially relevant in light of institutions composed of individuals from a variety of socio-cultural backgrounds, with their own implicit attitudes and biases. Anti-discriminatory policies and anti-harassment policies are yet to be formulated and implemented by the MCI for Trans and Queer professionals and students in the medical fraternity.

A good way to encourage discussions about these issues could be to include medical humanities in training which would include the study of literature, art and history. As discussed, medical ethics should also be more prominently featured in the curriculum. Hopefully these subjects would impart learning about the constantly changing culture, raise questions about ethical conduct and foster a sense of compassion and awareness of the human struggle.

It may also be beneficial to give more time and weightage to Psychiatry, considering the evolution of LGBTQIA+ diagnosis in Psychiatry and the poor mental health and identity struggles of the community. More medical students and doctors should take up research on LGBTQIA+ topics so as to clarify the stance of the medical fraternity on this population. For practicing clinicians, CMEs and online training could be a good way to sensitize them to LGBTQIA+ issues and bring them up to speed about hormonal and surgical treatments for transgender individuals, prevention and treatment of HIV/other STDs, and other health needs of LGBTQIA+ patients. The basic message is that appropriate, comprehensive and compassionate healthcare should be given to all patients irrespective of sexual or gender identity.

Conclusion

Considering the legal battles, social stigma and the resulting negative physical and mental health outcomes among the members of the LGBTQIA+ community, it becomes all the more important for health care providers to have adequate knowledge and develop positive attitudes towards these individuals. It is warranted that we step-up our efforts in training doctors who can not only save lives but can also be well-rounded and well-informed, progressive thinkers. The scientific community has always served an important role in shaping people's opinions about phenomenon which defy existing societal norms. With the Honorable Supreme Court's favorable verdict on Section 377, it is high time we publicly address issues of gender and sexuality so as to reduce ignorance and, hopefully, pave the way for legal, social and health policy reforms targeted towards betterment of this marginalized community. The hope is to reach a place where doctors focus on specific health problems that LGBTQIA+ individuals face instead of pathologizing and discriminating against their identities.

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