LGBTQIA+ Health – 2021

The AMA Position

The AMA affirms that…

- Many people who are LGBTQIA+ in Australia live happy and healthy lives. However, people who are LGBTQIA+ can experience unacceptable health inequities when compared to those who do not identify as LGBTQIA+;
- Many of these health inequities are associated with high levels of overt and implicit discrimination against these communities and populations, both socially and within institutions;
- Doctors have an ethical and professional duty to provide evidence-based care impartially and without discrimination, including on the basis of gender identity and expression, sexual orientation, and sex characteristics;
- Shared decision making is a key aspect of the doctor-patient relationship, and people who are LGBQTIA+ bring vital expertise in their lived experience to this process;
- The principles of patient-centred care, consent, non-discrimination, bodily autonomy, and respect are central to healthcare for people who are LGBTQIA+;
- People who are LGBTQIA+ thrive in health care environments where they feel safe, affirmed, respected and understood;
- Public acceptance of, support for, and celebration of, people who are LGBTQIA+, is a vital part of reducing discrimination against these communities and boosting health and wellbeing; and
- Being LGBTQIA+ is normal, healthy, and representative of the diversity in human sexuality, gender identity, and sex characteristics. The historical pathologisation of LGBTQIA+ people is associated with poorer health outcomes at the individual and population level.

Calls on the Australian Government to…

- Prioritise support for mainstream health services, including mental health services, to increase cultural safety in their practices, including by funding training, education and accreditation programs;
- Fund high-quality research on the health outcomes and experiences of people who are LGBTQIA+, including to investigate differences within sub-communities and across various intersections of identity and characteristics/demographics; and to investigate the health impacts of differing service approaches, models of care, and treatment pathways;
- Building from research outcomes, support LGBTQIA+-community led health services to provide targeted, informed and appropriate support for people who are LGBTQIA+;
- Enhance access to beneficial gender-affirming treatment that people who are trans and gender diverse have given consent for, including through the Pharmaceutical Benefits Scheme;

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- Through each of the above actions, take specific steps to improve access to LGBTQIA+-inclusive care for people living in rural and remote areas, particularly LGBTQIA+ young people;
- Add sensitive, evidence-based, and community-guided questions on gender, sexual orientation, and intersex variations to the Australian Census, in order to better understand the distribution of people who are LGBTQIA+ and thus provide appropriate services where needed; and
- Improve school-based sexual education curricula to be more inclusive of the sexual and reproductive health needs of people who are LGBTQIA+, and fund targeted sex and relationships education for people who are LGBTQIA+;

Calls on state and territory governments to…

- Ban coercive 'conversion' practices that intend to change, alter or supress a person's sexual orientation or gender identity;
- Facilitate LGBTQIA+-inclusive practice within their health systems, including by ensuring systems and electronic medical records are set up to acknowledge patient-directed names and pronouns.

Calls on medical practitioners to…

- Provide evidence-based, respectful, sensitive, non-discriminatory care to people who are LGBTQIA+, in line with the AMA Code of Ethics (1) and the Medical Board's Code of Conduct 4.8 (2);
- Engage in further learning and education about the health needs of these groups and the benefits of difference models, treatments and approaches to better serve them;
- Actively foster LGBTQIA+-inclusive environments by using patient-directed names and pronouns, avoiding heteronormative language; and supporting patients' rights and perspectives in a culturally safe practice; and
- Affirm Yogyakarta Principle 32 that "no-one should be subjected to invasive or irreversible medical procedures that modify sex characteristics without their free, prior and informed consent, unless necessary to avoid serious, urgent and irreparable harm to the concerned person" (3).

Calls on the Australian Medical Council to…

- Include LGBTQIA+ health knowledge as a graduate outcome for students undertaking medical programs of study in Australia.

Explanatory Notes

1. LGBTQIA+ populations in Australia

1.1 Definitions

'LGBTQIA+' is an umbrella term that brings together a range of diverse identities. It stands for 'Lesbian, Gay, Bisexual, Trans and/or Gender Diverse, Queer, Intersex, Asexual', with the '+'

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representing people who identify as part of a sexuality, gender or sex diverse community but who do not identify with one of these specific identities.

In the context of this Position Statement, the term 'LGBTQIA+' is used to communicate the disproportionate health risks and difficulties accessing care that people identifying in these groups experience. The AMA recognises that people identifying as LGBTQIA+ are not a homogenous group, and that experiences between and within these communities vary significantly. Where alternative acronyms are used, this is to reflect the terms used in external sources.

A person's sexual orientation is defined by the Human Rights Campaign as "an inherent or immutable enduring emotional, romantic, or sexual attraction to other people" (4). Lesbian (women or non-binary people who are attracted to women), Gay (men or non-binary people who are attracted to men), Bisexual (people who are attracted to both women and men, or to more than one gender), Pansexual (people who are attracted to people of all genders) Asexual (people who do not experience sexual attraction) and Heterosexual (people who are attracted to people of the opposite gender) are all examples of sexual orientations.

A person's gender identity is defined by the Human Rights Campaign as "one's innermost concept of self as male, female, a blend of both or neither – how individuals perceive themselves and what they call themselves" (4). Trans and gender diverse people are those whose gender identity is different from that assigned to them at birth. For example, trans women are women who were assigned male gender at birth, trans men are men who were assigned female gender at birth, and non-binary people are people whose gender is not exclusively male or female. Aboriginal and Torres Strait Islander people may use the terms 'Sistergirl' (gender diverse people who have a female spirit and take on female roles within the community) and 'Brotherboy' (gender diverse people who have a male spirit and take on male roles within the community) to identify themselves (5). Cisgender is a term used to describe someone whose gender identity is the same as the gender assigned to them at birth.

'Queer' is a term that describes a range of sexuality, gender and sex diverse identities, and has been reclaimed by many LGBTQIA+ people after historically being used as an insult. The Australian Institute of Family Studies notes that "the term queer now encapsulates political ideas of resistance to heteronormativity and homonormativity and is often used as an umbrella term to describe the full range of LGBTQIA+ identities" (6).

The term 'intersex' is defined by the United Nations Human Rights Commission as "people who are born with sex characteristics (including genitals, gonads and chromosome patterns) that do not fit typical binary notions of male or female bodies" (7). Intersex is an umbrella term which covers over 40 variations in sex characteristics, including relating to genitals, gonads, and chromosome patterns. It is important to note that being intersex is different to and independent from gender identity and sexual orientation. People with intersex variations exist across the spectrum of gender and sexual orientation, just as the endosex (non-intersex) population does.

1.2 Data gaps for LGBTQIA+ populations

There is currently no nationally representative measure of the size of LGBTQIA+ populations in Australia, largely because robust data on sexual orientation, gender identity and intersex status are not collected in the Census or other representative research studies from which this measure could be extrapolated with confidence. 2016 Census results counted 0.9% of couples as "same-gender

relationships" and 1260 individuals that selected "other – please specify" in response to the gender question (8, 9). These measures are widely acknowledged as underestimates due to the restrictive wording and criteria of questions.

Non-census estimates of the LGBTQIA+ population vary considerably, from 3.6% of males and 3.4% being part of a "minority sexual identity" (10), to 5.7% of all adults identifying as LGBTIQ+ (11). Intersex Human Rights Australia estimates that approximately 1.7% of the general population are intersex (12).

The lack of nationally representative data on LGBTQIA+ populations makes it difficult for governments to plan and design appropriate health services for these communities. As a result, health groups and community organisations advocated in 2019 for the inclusion of questions about sexual orientation, gender identity and intersex status in the 2021 Australian Census (13). The Australian Bureau of Statistics has now released a *Standard for Sex, Gender, Variations of Sex Characteristics and Sexual Orientation Variable*, which outlines standard questions and answers for these four variables and is designed for use by government, academic and private sector organisations in various research and epidemiological initiatives (14). Full implementation of this standard across federal and state data collection activities, as well as investment in rigorous academic and clinical research, should enhance understanding of the LGBTQIA+ population in Australia.

2.Health Issues for LGBTQIA+ Australians

2.1 Overall Health outcomes

People who identify as LGBTQIA+ experience a range of different health issues, and these vary between and within identity groups. Many people in LGBTQIA+ communities live healthy, happy lives, and these communities are highly adaptable and resilient. However, LGBTQIA+ people do face disproportionate health risks in a number of areas. These include:

- A higher current smoking rate among both LGBTIQ adults (15) and LGBTQA+ young people (16), compared to the general population;
- A higher likelihood of exceeding alcohol use guidelines among people who are homosexual or bisexual (17), and among LGBTIQ adults (15), compared to the general population;
- Higher levels of substance abuse disorders among LGBTIQ adults, including struggling to manage alcohol and drug use, and higher use of drugs for non-medical purposes, compared to the general population (15);
- Higher rates of mental ill-health, including psychological distress, mental health diagnoses, suicidal ideation, and suicide attempts, among both LGBTIQ adults (15) and LGBTQA+ young people (16), compared to the general population; and
- Higher rates of experiencing family violence among LGBTIQ+ adults, across all categories of violence (11), and higher rates of experiencing intimate partner violence among LGBTIQ adults (15), compared to the general population (18).

2.2 Health issues for specific groups

In addition to these health risks, some sub-populations of the LGBTQIA+ community experience particular health risks specific to their circumstances and experiences.

Gay, bisexual and other men who have sex with men experience a higher risk of sexually transmissible infections, including HIV, when compared to the general population (19). Men who have sex with men also have a higher risk of some cancers, including anal cancer (20).

Lesbian, bisexual and other women who have sex with women experience a higher risk of some cancers than heterosexual women, including breast and gynaecological cancers (21). This higher risk has been attributed to the higher use of alcohol and tobacco among women in these communities, as well as evidence of lower rates of cancer screening (22).

People who are asexual report the lowest level of alcohol, tobacco and other drug use, when compared to people of other sexual orientations, although they are also the least likely to rate their overall health as very good or excellent (15).

In general, people who are trans or gender diverse experience poorer health outcomes than people who are cisgender, including cisgender people within LGBQIA+ communities. Poorer mental health outcomes among trans and gender diverse people are particularly notable. Trans women, trans men, and people who are non-binary all reported significantly higher levels of mental ill-health, including suicidal ideation and attempts, psychological distress, and mental health diagnoses than cisgender respondents to the Private Lives 3 Survey (15). Further, 86% of trans women, 91% of trans men, and 90% of non-binary respondents reported having ever considered suicide, compared to 76% of cisgender women respondents, 64% of cisgender men respondents, and 13% of the general population (15).

People with intersex variations report a range of negative health outcomes, although 79% report that they are extremely, very or moderately healthy (23). Common physical health conditions experienced by people with intersex variations include bone issues (some related to their variation, some related to hormone therapies), overweight and obesity, heart problems, and diabetes (23). 42% of respondents to an Australian survey of intersex people reported considering self-harm on the basis of issues related to their sex variation, and 60% had considered suicide on this basis (23). Of 117 respondents who had undergone a medical intervention for their variation, 83% reported a negative health impact, including scarring, loss of sensation, trauma and anxiety, complications from surgery, decreased bone density, weight gain and suicidal ideation (23).

2.3 Intersectionality

Many people who identify as LGBTQIA+ in Australia also face disadvantage in other areas of their lives, and this intersectionality has significant implications for their health issues and experiences. People who are LGBTQIA+ and have a disability, are Aboriginal and/or Torres Strait Islander, come from a culturally and linguistically diverse background, live in rural or remote areas, or are socio-economically disadvantaged, for example, face exacerbated health risks as a result of multiple levels of disadvantage (15).

For example, LGBTIQ adults from multicultural backgrounds are more likely to experience very high psychological distress than their Anglo-Celtic peers, and reported higher rates of suicidal ideation and attempts (15). LGBTIQ people with mild, moderate or severe disability are also more likely to experience high or very high psychological distress, and this risk increases with the severity of disability (15).

LGBTIQ people living in rural and remote areas are significantly more likely to rate their health as poor or fair, and significantly less likely to rate their health as very good or excellent, when

compared to LGBTIQ people living in urban areas (15). People who are LGBTQIA+ and living in rural and remote can face difficulties finding connection with LGBTQIA+ communities, and may face greater levels of discrimination, prejudice and social isolation (24). Access to LGBTQIA+-inclusive services can be particularly difficult in rural and remote areas, meaning that LGBTQIA+ people may avoid or delay seeking care, or need to travel significant distances to do so (24). For Aboriginal and Torres Strait Islander people who live in rural and remote areas, leaving country to access inclusive care is an added barrier.

While intersectionality is an important consideration in terms of disadvantage, many LGBTQIA+ people draw strength, resilience, and belonging from their experience of intersectionality.

3.Health risk factors for LGBTQIA+ Australians

3.1 Minority Stress Model and Discrimination

Factors contributing to poorer health outcomes among people who are LGBTQIA+ are complex, but there is a general consensus that discrimination and stigma in the community, as well as within formal institutions, play a significant role.

The minority stress model proposes that poorer health outcomes in minority groups can be partially attributed to stressors caused by living in a hostile, heteronormative culture (25). Minority stress arises from external factors, such as discrimination, or internal factors, such as internalised homophobia or identity concealment. Research conducted following the marriage equality postal vote in Australia has built strong evidence for this model – there was a clear association between areas with higher proportions of 'no' voters and poorer life satisfaction, mental health, and overall health among lesbian, gay and bisexual people (26).

A high proportion of LGBTQIA+ Australians report experiencing discrimination, both generally and in health setting specifically. 57% of respondents to the Private Lives 3 survey reported being treated unfairly in the past 12 months based on their sexual orientation, and 77.5% of trans and gender diverse respondents reported being treated unfairly based on their gender identity (15). Just 43.4% of LGBTIQ respondents felt accepted a lot or always when accessing health services (15). In the Victorian Population Health Survey, 34% of LGBTIQ+ adults experiences discrimination in the last 12 months, compared to 16% of the non-LGBTIQ+ population. 25.2% of LGBTIQ+ respondents to this survey reported experiencing discrimination by doctors, nurses or other staff at hospitals or doctors surgeries (11).

Labelling LGBTQIA+ identities as "illnesses" or "diseases" has led to negative health outcomes. 'Homosexuality' was included in the International Classification of Diseases until 1990, and language referring to diverse gender identities as 'disordered' was removed in 2018 (27). Intersex advocates note that pathologising language is commonly used in relation to people with variations in sex characteristics, including terms like "disorders of sex development" (27). United Nations bodies agree that this pathologisation has driven harmful behaviour such as conversion practices, involuntary treatments, criminalisation of and discrimination against LGBTQIA+ communities and individuals (28).

In the education system, lack of visibility of LGBTQIA+ identities can also contribute to poor health outcomes for students who are LGBTQIA+. School-based sexual and reproductive health education curricula often excludes messages and information about LGBTQIA+ relationships, with gender and

sexuality diverse young people reporting that sex education at school is heteronormative, irrelevant, confusing, and stigmatises LGBT behaviours and communities (29). In a survey of Australian school students, students who were bisexual, questioning, genderqueer, and gay felt negatively about their sex education experiences, preferring to seek out information online, and feeling like their identities were excluded from educational material – both in terms of sexual health and healthy relationships (30). Higher risks of sexual and reproductive ill-health and family and domestic violence among people who are LGBTQIA+ would benefit from inclusive, sensitive and targeted education programs.

3.2 Health-seeking behaviours

Previous experience or fear of being treated negatively in healthcare settings may discourage people who are LGBTQIA+ from seeking health services. 66% of LGBTIQ adults report having a regular General Practitioner, compared to 81% of females and 73% of males in the general population (15). 38% of LGBTQA+ young people who had experienced suicidal or self-harm ideation in the last 12 months reported accessing a professional health service to address it; and 71% of LGBTI+ people aged 16 to 27 did not access a crisis support service during their most recent mental health crisis – 33% of whom attributed this to anticipated discrimination (31).

3.3 Social determinants

As outlined in the AMA's existing Position Statement, *Social Determinants of Health – 2020*, a person's health is shaped by the social, economic, cultural and environmental conditions they live in, including their income, education, employment, and level of social support (32). People who are LGBTIQ in Australia are more likely to have a bachelor degree when compared to the general population, but are more than twice as likely to report being unemployed or unable to work (15). 43% of LGBTIQ people report earning less than $400 per week, with trans men and people who are non-binary more likely than cisgender people in LGBQI communities to report this (15).

4.LGBTQIA+ populations and medical care

4.1 Barriers to accessing health care

People who are LGBTQIA+ experience a range of barriers to accessing healthcare. Having experienced stigma or discrimination in healthcare settings before is strongly related with reluctance to seek care in the future (33, 34). Being treated disrespectfully by health staff – including the use of incorrect names and pronouns; assumptions about gender identity, sexual orientation, and sex characteristics; and offensive comments or language, can discourage people who are LGBQTIA+ from accessing health services. For people who are intersex, negative experiences with health services, including receiving inadequate information about treatment and medical history, being excluded from treatment decisions, and experiencing complications from surgery can also result in mistrust and reluctance to seek care from health services (23). Expected experiences of stigma and discrimination can also impede care, including among LGBTQIA+ people who have not personally experienced this (35).

Insufficient knowledge about LGBTQIA+ health and behavioural competencies in order to provide respectful, sensitive, non-discriminatory care among health and medical professionals is also a barrier to seeking care. Trans and gender diverse community members have highlighted education for health professionals as a key priority for improving access to care, with many having educated their own health care providers on trans health issues (36). People with intersex variations also

report a lack of understanding among the medical profession as a clear barrier to care (23). Exposure to education material about LGBTQIA+ health, including via brief sessions, has been shown to increase the knowledge and confidence of health professionals in this area (36, 37).

Financial and structural barriers also make it harder for people who are LGBTQIA+ to access health care. For some people who are trans and gender diverse, access to gender-affirming medications and surgery can be cost-prohibitive (38), especially considering higher rates of unemployment and lower incomes among people who are LGBTQIA+. Lack of access to subsidised gender-affirming care under Medicare can exacerbate this barrier (39). Limited availability of LGBTQIA+-friendly services, especially in rural and remote areas, can make it very difficult for people who are LGBTQIA+ to access care that is appropriate and sensitive (34).

4.2 Gender-affirming care

Gender-affirming care is a model of healthcare that centres on non-judgemental acknowledgement and recognition of a person's gender identity (40). Fundamentally, gender-affirming care involves an understanding that trans and gender diverse people "tell the truth about who they are" (40). Gender-affirming treatments, including puberty blockers, hormone treatments, and gender affirmation surgeries, may form part of this care for trans and gender diverse people, but these are not sought by all patients. 50% of trans women, 50% of trans men, and 26% of non-binary people in Australia report that they were able to access gender-affirming care when they needed it (15).

Gender-affirming care is linked with a range of positive health outcomes for people who are trans and gender diverse. Cross-sectional data of more than 27,000 participants indicates that having a health provider that understands someone's gender identity and treats them with respect is associated with significant reductions in depression and suicidal thoughts (41, 42). Receiving gender-affirming care is also associated with decreased substance use, improved HIV medication adherence and reduced harms from self-prescribed hormones (43). Recent systematic reviews have found evidence of increased quality of life following both gender-affirming hormone treatment (44) and gender-affirming surgery (45), however this evidence remains constrained by risk of bias and confounding. Further high-quality, long-term research is needed to fully understand the both the benefits and the risks of treatment options.

The provision of gender-affirming treatment, like all medical care, should include discussion with patients about the risks and benefits of each potential treatment pathway, including acknowledging areas and treatments for which evidence is still emerging. Where the long-term effects of treatments are unknown, this should be clearly communicated with patients along with information about identified short- and medium-term effects. Treatment and legal guidelines are important resources that doctors should use to guide their provision of gender-affirming treatments (46, 47, 48).

The provision of gender-affirming care is beneficial to trans and gender diverse people in all medical contexts, including if they are seeking care for reasons unrelated to their gender. Using patient-directed names and pronouns, being respectful of gender identity, and facilitating a culturally safe environment reflect genuine respect and sensitivity.

4.3 Care for people with intersex variations

In Australia, people born with inherent variations in sex characteristics have a range of experiences with medical and health services, but a significant number report negative experiences. While some intersex variations do require medical intervention because of significant health risks, many intersex people report undergoing early medical interventions primarily for 'normalising' purposes – to assign them a binary sex as an infant, child or adolescent (49, 15). These experiences are associated with a range of harms, including experiencing anxiety and trauma in medical settings, loss of sensation and sexual function, shame and low self-esteem, higher rates of mental ill-health, and physical health complications from surgeries and hormone treatments (23). 83% of intersex respondents to a 2016 Australian survey who had undergone a medical intervention related to their variation reported experiencing at least one of these negative impacts, and just 9% had experienced only positive impacts (23).

Intersex people in Australia report being excluded from treatment decisions about their own bodies, including by being too young to participate in consent processes, being given insufficient information about treatment risks and benefits, not being offered alternatives or no treatment, and not being given access to their own medical records (23). Therefore, the concepts of bodily autonomy and integrity are of central importance to many intersex people (50).

Intersex people who report positive interactions with medical providers say that this was due to their doctor either having good knowledge about their variation, or making active attempts to educate themselves about it (23). Supporting people with intersex variations to be involved in treatment decisions, providing training for staff on intersex variations, and providing referral to intersex peer support groups are other ways that intersex people felt supported by medical and health services (23).

4.4 'Conversion' practices

Conversion practices are rooted in the false assumption that sexual orientations other than heterosexuality, and gender identities other than cisgender, are mental disorders that can and must be altered (51). Despite a move away from pathologizing LGBTQA+ identities in recent decades, people who are LGBTQA+ are still vulnerable to 'conversion' messaging. In the United States, 67% of surveyed LGBTQ youth reported that someone had tried to convince them to change their sexual orientation or gender identity, and this was associated with mental ill-health, low self-esteem, internalised homophobia and transphobia, and sexual dysfunction (51). Results from a 2020 survey indicate that one in ten LGBTQA+ Australians have experienced religion-based attempts to change their sexuality or gender identity, from formal 'counselling' programs to informal spiritual groups (52).

There is strong agreement among the medical profession in Australia that conversion practices have no medical benefit or scientific basis, and that there is evidence of significant harms resulting from such practices (53, 54). The AMA acknowledges that in some situations, it is the role of doctors to facilitate sensitive exploratory discussions with patients, including when patients are experiencing distress related to their sexual orientation or gender identity (53). Where these conversations are grounded in a genuine therapeutic intent, aim to reduce stigma associated with LGBTQA+ identities,

and have no intent to change or supress a person's sexual orientation or gender identity, they should not be considered conversion practices.

4.5 LGBTQIA+- inclusive care

The provision of appropriate, respectful and culturally safe healthcare is vital for the health and wellbeing of people who are LGBTQIA+.

People who are LGBTQI access mainstream medical clinics more frequently than any other health service, with 84% accessing one in the last year compared to 35% accessing a hospital, 25% accessing a mainstream medical clinic known to be LGBTQI-inclusive, and 6% accessing a medical clinic catering only to people who are LGBTI (15). Those accessing LGBTI-specific and LGBTI-friendly services were significantly more likely to feel that their sexual orientation or gender identity was very respected than those accessing mainstream clinics and hospitals (15). A significant proportion of respondents (47%) report that their preference in the future is to access a mainstream service that is LGBTIQ-inclusive (15).

Research supports a diversity of health service types being available, as some LGBTQIA+ people will benefit from LGBTQIA+-specific health services, while others will prefer and benefit from accessing LGBQTIA+-inclusive care in a mainstream health service (55). A 2012 review of evidence conducted by the National Drug and Alcohol Research Centre found some improved health outcomes associated with LGBT-specific services, compared to mainstream services, particularly for LGBT people with methamphetamine use issues (56).

Health services run by LGBTQIA+ communities are available in metropolitan areas but are generally difficult to access in rural and remote areas. Prominent organisations include ACON, a NSW based community-led organisation that provides free mental health support, HIV prevention and support, a sexual health clinic, and alcohol and other drugs support for people who are LGBTQI and people with HIV; Thorne Harbour Health, a Victorian community-led organisation that runs health services and General Practice clinics for LGBT community members, including a specific Gender Diverse Health Service; and the Queensland Council for LGBTI Health, which provides HIV and sexual health promotion, awareness and prevention services for gay and bisexual men and Aboriginal and Torres Strait Islander peoples.

Many doctors working in mainstream health services are already providing LGBTQIA+-inclusive care to their patients. Health providers indicate this in a range of ways, whether it be made explicit on their websites, in their workplaces through the use of posters, flags and supportive materials, through formal accreditation programs such as the Rainbow Tick (57), and by adding their names to registers of LGBTQIA+-friendly providers (58, 59, 60).

A range of LGBTQIA+ community organisations have developed resources and guidance for mainstream health services on delivering culturally safe care for people who are LGBTQIA+. These include for example:

- QLife's QGuides for Health Professionals on the topics of bisexuality; young people; coming out; gender diversity; families; intersex; suicide prevention and other topics;
- Rainbow Health Victoria's Training Programs, including on LGBTIQ-Inclusive Practice; attaining Rainbow Tick Accreditation; and LGBTI Ageing and Aged Care;

- The Australian Professional Association for Trans Health's (AusPATH) e-learning modules on Trans Primary Care and Trans Mental Health Care;
- Intersex Human Rights Australia's Inclusion Guide to Respecting People with Intersex Variations, and Healthcare pathways resources; and
- ACON's suite of Pride Training online learning courses for medical professionals, on a broad range of topics relevant to LGBTQ Inclusion.

LGBTIQ+ Health Australia maintains a comprehensive list of resources and training available for the healthcare workforce.

5.LGBTQIA+ representation in the medical profession

Australia's medical profession should reflect the same diversity present in the general population, including in relation to LGBTQIA+ identities. Patients who are LGBTQIA+ and who are reluctant to seek medical care based on fear of stigma and discrimination may prefer to see a health provider who identifies as LGBTQIA+. However, doctors and medical students who are LGBTQIA+ can also experience discrimination and stigma from patients, colleagues, and employers based on their sexual orientation, gender identity, or sex characteristics. This can make it difficult for LGBTQIA+ doctors to be open about their identity at work, and affects mental health and wellbeing. Professional associations such as the Australian Lesbian Medical Association, the Australian Medical Students Association Queer Network, and GLADD: LGBTQIA+ Doctors Australia provide supportive networks for doctors and medical students who are LGBTQIA+, and play an important role in enhancing visibility and advocacy.

The AMA is committed to promoting diversity and inclusion within the medical profession in Australia, and within our own organisation. The AMA's *Diversity and Inclusion Plan 2020-2022* outlines a range of actions the AMA is taking to promote this, including advocating for equitable access to leave entitlements for all doctors; taking steps to encourage diversity in representation and opportunity within our organisation; and improving our own data collection methods (61). The AMA encourages all medical employers to actively foster LGBTQIA+-inclusive workplaces, including by developing non-discrimination policies and practices, increasing awareness among all staff through training, encouraging respectful language, and considering gender-neutral bathrooms and dress codes.

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