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Multiple Identities: A Literature Review on the Unique Experiences and Challenges of LGBT Female Physicians of Color

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Abstract

Lesbian, gay, bisexual, and transgender (LGBT) female physicians of color experience an interesting intersectionality of identities. While socially advantaged due to their status as physicians, they are also struck with socially disadvantageous statuses by being female, person of color, and LGBT. These individuals are united by recurring themes of oppression, lack of visibility, perceived inferiority, and of course empowerment. The purpose of this paper is to review the current literature on LGBT female physicians of color and to provide a framework for potential solutions. By increasing the number of LGBT female physicians of color in both the general workforce and positions of leadership, the patient-physician relationship can be strengthened, improving healthcare outcomes for the underserved. Further, improved physician satisfaction will promote physician wellbeing and longevity and protect against physician burnout.

Keywords: Female; Gender; LGBT; Minorities; Race

Introduction

When you meet someone new, what is the first thing that you notice? Most people will automatically notice sex and race. The human brain uses sex and race to form visual representations of faces, allowing us to distinguish thousands of faces [1]. Scientists at Harvard University have even discovered a region of the human brain called the fusiform face area that is responsible for differentiating faces by sex and race [2]. As a result, sex and race not only influence how we perceive others and how others perceived us, but also how we perceive ourselves.

Identity is complex. Intersectionality is a "theoretical framework that posits that multiple social categories (e.g. race, ethnicity, gender, sexual orientation, socioeconomic status) intersect at the micro level of individual experience to reflect multiple interlocking systems of privilege and oppression at the macro, social-structural level (e.g. racism, sexism, heterosexism)" [3]. In addition, physicians possess a strong sense of professional self-identity to "think, act, and feel like a physician" that has been explicitly ingrained into their personal identity [4]. The purpose of this literature review is to address the concept of multiple identities and the unique experiences and challenges for lesbian, gay, bisexual, and transgender (LGBT) female physicians of color.

To date, no studies have examined the prevalence of practicing LGBT female physicians of color in the United States. Therefore, we will have to extrapolate this number from the current available data. According to the Association of American Medical College, in 2015, there were 859,848 active physicians in the United States, of those physicians, 292,003 (34.0%) were female [5]. Data on female physicians of color is unavailable, but in 2015, medical school graduates comprised of 19.8% Asians, 5.7% Black or African American, and 4.6% Hispanic or Latino [6] which would equate to approximately 87,893 female physicians of color. Assuming 3.4% of the population identifies as LGBT, there could potentially be 2,988 LGBT female physicians of color [7]. Those are 2,988 individuals who share unique stories and struggles (Figure 1) [3].

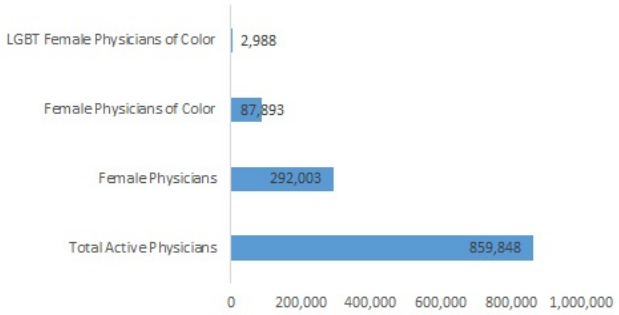

Figure 1: Demographics of United States physician.

A PubMed search was performed using the keywords "LGBT", "lesbian", "gay", "female", "gender", "race", "minority", physician", and "workforce". The purpose of this paper is to review the current literature on LGBT female physicians of color. The paper highlights how societal inequities impact not only the physicians themselves, but also the patients that they serve. This review also includes methods that have proven effective at addressing these disparities and suggests potential solutions for the future

Female Physicians

Despite the women's rights movement, female physicians still experience institutionalized sexism. An obvious example is the

persistent sex differences in physician salaries. In 2015, female physicians at Unites States public medical schools earned on average $51,315 less than their male counterparts [8]. Some people hypothesize that this sex salary gap can be explained by the constraints of family responsibilities leading to decreased hours and productivity [9,10]. That may have been the case in the past, but recent studies found that this gender salary gap cannot be explained by age, experience, specialty, practice type, work hours, research productivity, or clinical revenue [8,11]. A double-blinded study found that American universities viewed men as more competent and deserving of higher salaries than equally qualified women [12]. Possible explanations include overt discrimination, under-recognition for accomplishments [13-15] and lower prioritization of pay [16].

From 1990 to 2015, the presence of female physicians has doubled from 17% to 34% of the physician workforce [5,17] This number will continue to grow as females account for 45% of residents and fellows [5] and 50% of medical students [18]. However, this shift in demographics is less evident at the top. Women represent 15% of department chairs, 16% of deans [19] and 10% of hospital CEOs [20] even though a large 88% of female physicians believe that attaining leadership is important [21] This disparity in leadership is referred to as a "leaky pipeline phenomenon" as competent female physicians fail to be promoted for perceived inferiority [12,22] Increasing the visibility of female role models and mentors appears to be a promising solution to this leaky pipeline.

The presence of successful female leaders increases the rate of female recruitment, retention, and promotion. These female physicians act "like a magnet attracting females of similar caliber and also paving the way for younger female trainees" [23]. For example, female medical students are more likely to choose residency programs with higher proportions of female residents [24] Cheng et al. found that departments with female chairs had a significantly greater percentage of female faculty and residency program directors than departments with male department chairs (50% versus 12%) [25]. Quality mentorships are invaluable and promote both career commitment and development [26].

In today's society, women strive to achieve both professional and personal goals. However, many female physicians feel obligated to delay personal goals like marriage and children due to perceived career threats [27]. Stentz et al. found that women whose first pregnancy occurred during medical school (68.2%) perceived less workplace support than those whose first pregnancy followed training (88.6%) [28]. Therefore, the average physician is 30.4 years old when she has her first child which is 4 years older than the general American population [28,29]. This delay in childbearing is associated with higher rates of infertility and pregnancy complications [28,30]. The pressure to delay childbearing for career affects not only female physicians but also their children, so systems need to be implemented to support female physicians with children. Gender disparities regarding household and parenting responsibilities also need to be addressed. Women still remain predominantly responsible for childcare. Most women take part-time positions due to dependent children, while most men take part-time positions to hold other professional positions [19] Moreover, 85.6% of women's spouses work full-time compared to only 44.9% of men's spouses [31] Systemic gender biases need to be addressed so that female physicians may achieve an ideal work-life balance.

Physicians of Color

Racial health disparities are hypothesized to stem from three root causes: biologically inherited susceptibility, race as a proxy for socioeconomic class, and race as a distinct construct akin to caste [32], Related to the second and third root causes, physician workforce diversity has proven again and again to improve the healthcare of minorities [33-36]. These physicians provide an invaluable sense of affinity and understanding within the patient-physician relationship. This perceived personal similarity enhances communication, trust, patient satisfaction, and adherence. 33-36 Physicians of color are more likely to work with underserved patient populations and to advocate for their patients and patient policies, thus increasing patient access to care and quality of healthcare [33,34] Racial diversity within the workforce also indirectly improves patient care by enhancing the cultural competency of peers [35-37].

The Institute of Medicine has addressed the United States racial healthcare crisis by advocating for diversity in the medical workforce [38]. Physicians of color have always been underrepresented in the United States with the exception of Asians. In 2015, the physician workplace was comprised of 19.8% Asians (compared to 5.6% of the general population), 5.7% Blacks or African Americans (13.3%), and 4.6% Hispanics or Latinos (17.6%) [6,39]. Racial barriers begin early in life and continue to permeate throughout medical training and practice.

Students of color are less likely to attend private primary schools, complete high school, attend college, attend selective colleges, and graduate from college. In 2013, 40% of whites between 25 and 29 years old had a bachelor's degree or more, compared to 20% of blacks, 15% of Hispanics, and 58% of Asians [40]. Students of color are also underrepresented in medical schools, and the United States Supreme Court's decision to uphold state bans on affirmative action in postsecondary institutions has led to a 17% decline in graduating medical students of color [41]. Within the medical school system, black and Asian students may be subject to racial bias as they are 6-times and 2-times, respectively, less likely to receive induction into the Alpha Omega Alpha honor society than white students [42]. Membership to this prestigious honor society has a large influence during residency application process, especially for highly competitive specialties. A national survey of 4,339 general surgery residents found that compared to their white colleagues, physicians of color are less likely to feel compatible with their residency program and have less positive relationships with faculty and peers [43].

Physicians of color in academic medicine enhance the quality of medical education [37] and increase research on underrepresented patient populations [44]. Their visibility and mentorship also affects medical student recruitment and retention [45]. However, these physicians are underrepresented in academic medicine and continue to experience both overt and covert prejudices [46,47,51]. Physicians of color are often less satisfied [48], less likely to receive grants [49], less likely to be promoted [50] and more likely to leave academic medicine [51]. They suffer from isolation, lack of mentoring, and racial battle fatigue [46,47]. Racial battle fatigue is defined as "the physical and psychological toll taken due to constant and unceasing discrimination, microaggressions, stereotype threat" [52]. The most proven method of increasing physicians of color in medicine is the to create faculty development programs that include networking, support of senior faculty, and institutional culture training [46,53,54].

In the clinical setting, physicians are not immune to racist patients. In June 2017, a racist rant was caught on film as a white woman demanded that a white doctor treat her son. This video went viral and was featured by major news stations like CBS News and the Huffington Post [55,56]. This is just one of many incidences of racism. Racist remarks and refusal of care based on physician race can be angering, painful, and traumatizing to people of color. Of note, competent patients have the right to refuse medical care and are protected by the Emergency Medical Treatment and Active Labor Act (EMTALA) to receive appropriate medical care, so care must be taken to balance protection of the physician and medical need of the patient in event of such a moral and legal dilemma [57].

LGBT Physicians

The LGBT civil rights movement has achieved momentous victories in the recent years. In 2015, Obergefell v. Hodges represents a landmark decision by the United States Supreme Court that guaranteed the same civil rights of marriage to same-sex couples [58]. While same-sex marriage is protected under federal law, there are no federal laws protecting LGBT individuals from being fired due to their sexual orientation [59]. Workplace civil rights remain non-existent, and being openly LGBT in the workplace can prove to be dangerous.

Embracement of one's LGBT identity positively affects academic and career development by providing individuals with the confidence to pursue careers of greater intrinsic interest rather than feeling confined to traditional careers [60]. Moreover, a supportive workplace climate can predict job satisfaction, which thereby predicts life satisfaction [61]. While more people are openly embracing their LGBT identities and workplace discrimination is decreasing, these issues remain a significant threat to LGBT wellbeing. The Williams Institute at the University of California Los Angeles School of Law reported that only 25% of LGBT individuals disclose their sexual orientation in the workplace. This low percentage is likely secondary to the fact that 27% of LGBT individuals have experienced workplace harassment and 7% have lost a job. When open about their sexual orientation, the prevalence of workplace harassment increases to 38%. Transgender individuals experience an exceptionally high rate of workplace discrimination. 78% of transgender individuals have experienced workplace harassment and 47% have been discriminated against in hiring, promotion, or job retention [62]. These reports of discrimination are unacceptably high and prove that explicit LGBT workplace rights are necessary and should be mandated by federal government.

Only a few workplace studies have been performed regarding LGBT physicians. A survey of 427 LGBT physicians found that 10% reported that they were denied referrals from heterosexual colleagues, 15% had been harassed by a colleague, 22% had been socially ostracized and 65% had heard derogatory comments about LGBT individuals [63]. While these rates of discrimination have decreased since earlier reports, they are still at an unacceptably high rate. In 2014, Lee et al. made an upsetting discovery among surgical residents. Over half of surgical residents, 57% and 52%, concealed their sexual orientation from fellow residents and attending physicians, respectively. 54% of respondents had witnessed homophobic remarks by nurses and residents, however 0% reported these events. Reasons for not reporting homophobic events include fear of reprisal (17%), not wanting to create more "trouble" (50%), and a belief that nothing would be done about the event (25%) [64]. These legitimate reasons reflect the harsh reality of today's society and must be addressed.

Conclusion

Professional minority…have to justify professional qualifications that should speak for themselves. We have to be "twice as"… good, smart, talented, aggressive, outspoken, witty, etc. than everyone else in our professional or work environments; proving that we are not "imposters"; biting our tongues and tempering our words because we don't want to appear "angry"; being passed up or looked over, underpaid, undervalued, and under-appreciated. –Olayiwola JN [65].

LGBT female physicians of color experience an interesting intersectionality of identities. While socially advantaged due to their status as physicians, they are also struck with socially disadvantageous statuses by being female, person of color, and LGBT. Intersectionality does not presume that all interlocking identities are equally disadvantaged. Each individual will experience each identity differently, e.g. an Asian American versus African American or a masculine- versus feminine-presenting lesbian.

However, these individuals are united by recurring themes of oppression, lack of visibility, perceived inferiority, and of course empowerment (Table 1). By addressing these issues of discrimination and increasing the number of LGBT female physicians of color in both the general workforce and positions of leadership, the patient-physician relationship can be strengthened, improving healthcare outcomes for the underserved. Further, improved physician satisfaction will promote physician wellbeing and longevity and protect against physician burnout.

Recurring Theme	Population	Study	Findings
Oppression	Female physicians	Jean AB et al. 2016	Female Physician earn $51,315 less than their male counterparts. The salary gap is unexplained by age, experience, specialty, practice type, work hours, research productivity or clinical revenue.
		Moss-Racusin CA et al. 2006	Men are viewed as more competent and deserving of higher salaries.
		Tecco H, 2017	There is a large disparity in leadership positions. Women only represent 15% of department chairs, 16% of deans and10% of hospital CEOs.
		Association of America Medical Colleges, 2014	
		Schoon I, 2014	The "leaky pipeline phenomenon" refers to the gender disparity in leadership as competent female physicians failed to be promoted due to perceived inferiority.

		Moss-Racusin CA et al. 2006	
	Physician of color	National Center for Education Statistics, 2016	Students of color are underrepresented in medical schools. State bans on affirmative action in postsecondary institutions has led to a 17% decline in graduating medical students of color.
		Graces L et al. 2015	
		Yu PT et al. 2013	Physician of color are often less satisfied, less likely to receive grants and less likely to be promoted.
		Ginther DK et al. 2001	
		Palepu A et al. 2000	
		AMN Healthcare, 2015	
		Rodrigues J et al. 2014	Physician of color suffer isolation, lack of mentoring and racial battle fatigue.
	LGBT Physicians	Cunningham-Parameter K, 2015	There are no federal law protecting LGBT individuals from being fired due to their sexual orientation.
		Eliason MJ et al. 2011	LGBT physicians report that 10% have been denied referrals, 15% have been harassed by a colleague, 22% have been socially ostracized and 65% have heard derogatory comments about LGBT individuals.
		Lee KP et al. 2014	57% and 52% of surgical residents conceal their sexual orientation from resident and attending physicians, respectively
	Female physicians	Yedida M et al. 2001	The presence of successful female leaders increases the rate of female recruitment, retention and promotion.
		Cheng D et al. 2008	Departments with female chairs have a significantly greater percentage of female faculty and residency program directors than departments with male department chairs (50% versus 12%).
	Physician of color	Street RL et al. 2008	Racial diversity within the physician workforce directly improves the healthcare of minorities.
		Bureau Health Professions, 2006	
		Powe NR et al. 204	
		Cohen JJ et al. 2002	
		Whitla DK et al. 2003	Racial diversity within the workforce indirectly improves patient care by enhancing the cultural competency of peers.
		Collins KS et al. 2002	Physicians of color increase research on underrepresented patient populations.
		Price EG et al. 2005	Physicians of color increase the recruitment and retention of medical students of color through visibility and mentorship.
		Rodrigues J et al. 2014	Creating faculty development programs that include networking, support of senior faculty and institutional culture training will increase the retention of physicians of color.
		Beech BM et al. 2013	
		Dalley SP et al. 2011	
	LGBT Physicians	Schneider MS et al. 2010	Personal embracement of LGBT identity positively affects academic and career development.
Empowerment		Allan BA et al. 2015	A supportive workplace climate can predict job satisfaction, which thereby predicts life satisfaction.

Table 1: Studies that highlight how female physicians, physicians of color, and LGBT physicians are united by recurring themes of oppression and empowerment.

Solutions and Future Directions

It is everyone's responsibility to fight discrimination and improve healthcare outcomes. Educational pipeline programs should be strengthened in order to properly prepare underrepresented individuals for a career in medicine. Medical schools should have adequate social and academic support and retention systems in place for minority students. Residency programs should place an emphasis on training their resident and attending physicians on cultural competency for the sake of their peers and patients. Medical schools and residency programs that encourage and actively support the advancement of minorities to senior faculty level positions should be recognized and rewarded.

More research is needed on LGBT female physicians of color. Currently, no study has been done looking at this group of individuals. Epidemiology is non-existent, and nothing has been documented about how these identities intersect and impact their lives. Future research is needed to explore the impact of a more diverse medical workforce on disparities in health and healthcare.

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