RESOLUTION 23-027

ANTI-DIVERSITY, EQUITY, AND INCLUSION LEGISLATION AFFECTING MEDICAL SCHOOLS AND HEALTH INEQUITIES

Introduced by: Andreia Alexander, MD

Referred to: REFERENCE COMMITTEE 3

Whereas, 23 states have introduced bills prohibiting the establishment and employment of a diversity, equity, and inclusion (DEI) office and/or DEI officers; public funds from being used on DEI programming, goods, and services; and banning implicit bias training; and

Whereas, during the 2023 Indiana legislative session, House Bill 1338 was introduced but did not become law, which sought to prohibit public institutions from requiring enrolled students from engaging "in any form of mandatory gender or sexual diversity training or counseling." The bill would have additionally prohibited schools from requiring students to attend any student orientation, other training, or presentation "that presents information regarding race or sex stereotyping or bias on the basis of race or sex."; and

Whereas, implicit biases have proven dangerous for patients, often resulting in less diagnostic testing, fewer interventions, and greater rates of mortality for given diseases despite similar or lower rates of acquiring the disease (e.g., breast cancer, cardiovascular disease, renal transplantation, prostate cancer, COVID-19). and our underrepresented and marginalized trainees and physicians; and

Whereas, increasing diversity in the physician workforce is an important factor in combating health inequities, as a diverse physician workforce is associated with improved health outcomes for all; and

Whereas, physicians that are underrepresented are more likely to work in underserved areas and disproportionately serve our patients that are experiencing health inequities; and

Whereas, to create a physician workforce that is representative of the demographic profile of the United States, we must recruit racially and gender diverse individuals not only into medical school but also into graduate medical education; and

Whereas, the Liaison Committee on Medical Education (LCME) accreditation standards requires efforts to attract and retain diverse student bodies for medical schools to remain accredited; and

Whereas, DEI efforts primary aim is to create environments where medical students, residents, fellows, and faculty from underrepresented backgrounds feel welcome and

can learn in a climate free of racism, sexism, homophobia, ableism, etc.; and

Whereas, hundreds of medical students, residents and fellows each year report mistreatment, mostly around sexism and racism; and

Whereas, lack of representative diversity and experiences of mistreatment, racism, and sexism are the top reasons we do not retain our underrepresented students and trainees; and

Whereas, Indiana remains one of the unhealthiest states (ranks #35 in overall health, according to America's Health Rankings) with some of the largest health inequities (e.g., cancer, diabetes, and maternal and infant mortality); inequities that are largely seen in our Black and Hispanic populations that will continue if we cannot retain a diverse physician workforce; and

Whereas, having anti-DEI legislation in place sends the message that those that are underrepresented in medicine are not welcome or safe here in Indiana; therefore, be it

RESOLVED, that the ISMA oppose any legislation that will restrict funding and programming around diversity, equity, and inclusion and implicit bias in medical schools and their affiliated institutions of higher education.

RESOLUTION 23-042 **MEDICAL AND SURGICAL GENDER TRANSITION THERAPY FOR MINORS**

Introduced by: Thomas W. Huth, MD

Referred to: REFERENCE COMMITTEE 2

Whereas, in its 2023 session, the Indiana Legislature passed Senate Enrolled Act (SEA) 480, which banned gender transition medical and surgical therapy for minors, which ISMA opposed; and

Whereas, medical and surgical gender transition treatments in children entail the medical suppression of their normal hormonal mechanisms necessary for mental and physical growth and development, the hormonal replacement with drugs not appropriate for their genetically-determined biological need, and the surgical removal of normally functioning healthy reproductive and mammary organs and creation of poorly- or non-functional simulacra of their opposite sex equivalents, using drugs and procedures that have not been Federal Drug Administration-approved for these purposes; and

Whereas, medical and surgical gender transition treatments in children are known to frequently lead to reduced stature, reduced bone mineral density, irreversible changes to the voice, abnormal hair loss patterns, sterility and anorgasmia, and have poorly-studied but potential long-term ill effects such as higher rates of cardiovascular disease and cancer, and burden children with expensive lifelong requirements for hormonal suppression and replacement, as well as future surgical therapies to revise previous surgeries and manage complications, with the attendant medical and surgical risks which are not negligible; and

Whereas, it is often asserted that medical and surgical gender transition treatments for children are "evidence-based," with those asserting this rarely being able to cite the relevant evidence, when, in fact, the scientific evidence is weak, usually involving small-scale, single-center, uncontrolled, voluntary surveys conducted within a few weeks of surgery and which usually have high rates of non-participation, and when, in fact, contradictory evidence is ignored or downplayed, and when, in fact, there are no properly sized and controlled long term studies of the safety, effectiveness, complication rates and outcomes in children subjected to these treatments; and

Whereas, it is often asserted that medical and surgical gender transition treatments are necessary to prevent gender dysphoric children from committing suicide, when, in fact, there is no scientific evidence that dysphoric children who do not receive these treatments attempt or complete suicide at a higher rate than those who are treated; and

Whereas, it is often asserted that providing so-called puberty blockers to prepubescent gender dysphoric children is a safe, temporary, fully-reversible means of giving such a child time to think about what he or she wants to do without worrying about puberty

causing potentially unwanted physical changes, when, in fact, interrupting puberty with gonadotropin release hormone analogues for any significant duration does cause significant irreversible changes at least to the stature and bone density attainment, and there are no reliable studies to exclude other potential long-term effects in these children, and when, in fact, there is no "thinking" about next steps because 95% or more of those who elect to take puberty blockers proceed as soon as possible to cross-sex hormones and surgery, meaning that they and their parents/guardians immediately commit to the full transition pathway, with puberty blockers merely serving as the gateway; and

Whereas, gender dysphoric children have high rates of complicating intellectual and mental health comorbidities, such as autism, adverse childhood experiences, and mood and behavioral disorders that typically precede the development of gender dysphoria, and which are often unaddressed by transition caregivers and nevertheless affect their gender dysphoria, and which have their own attendant rates of suicidal ideation which may at least in part explain the higher rate of suicidal thoughts in gender dysphoric children, and for which there is no evidence that gender transition therapies improve their social functioning or symptomatology in the long term; and

Whereas, gender dysphoric children have very high rates of same-sex attraction, for which they often experience peer group and domestic disapproval, and for whom gender transition is often seen as a way of escaping the stigma of homosexuality; and

Whereas, about 80% of gender dysphoric children who do not receive transition treatments become homosexual adults, which means that gender transition treatments are effectively, if unintentionally, a form of gay conversion therapy, to which, according to Resolution 22-29, ISMA is opposed, and which is why some gay and lesbian individuals and groups oppose transition therapies for minors; and

Whereas, by the completion of puberty, gender dysphoric children not subjected to medical and surgical treatments desist from their dysphoria and embrace their biological sex at high rates, from 60% to 95% of the children depending on the subgroup in question, and there is no evidence-based way to determine *a priori* who will desist and who will not, which means that a very high proportion of children who receive medical and surgical treatment are unnecessarily subjected to permanently disfiguring, expensive and risky interventions with irreversible lifetime implications; and

Whereas, there is no evidence-based standard for ensuring that children can properly understand the lifetime implications of these treatments and provide informed consent for them, especially since so many gender dysphoric children suffer from intellectual development and mental health problems, and partly because of which, in 2020, the UK High Court ordered the temporary shutdown of the London Tavistock Clinic, England's premier children's transition center, in *Bell v. Tavistock*, the first of many liability suits filed against the clinic; and

Whereas, because of the foregoing, many very socially liberal countries in Western Europe, including Finland, Sweden, Denmark, Netherlands and the United Kingdom, which are much more advanced in their transition programs than the United States, have revised their policies to allow the medical or surgical transition of minors only as part of properly overseen research protocols with narrowly limited entry qualifiers and with court-supervised systems to protect the participating children; and

Whereas, the first duty of ISMA members is to do no harm to patients and the duty of ISMA is to advocate for the same in our state; and

Whereas, on balance, the current practice of medical and surgical gender transition treatment is harmful to children; therefore, be it

RESOLVED, that the ISMA oppose medical and surgical gender transition treatment for minors in the state of Indiana and advocate for this position with state lawmakers and regulatory agencies; and

RESOLVED, that the Indiana delegation to the AMA will carry forward a resolution to the AMA to oppose medical and surgical gender transition treatment for minors with federal lawmakers and regulatory agencies.

RESOLUTION 23-010 **RECOGNITION AND PROTECTION OF GENDER-AFFIRMING CARE**

Introduced by: Alison Case MD; Tracey Wilkinson MD; and Gabriel T. Bosslet, MD

Referred to: REFERENCE COMMITTEE 2

Whereas, the rights of gender non-conforming persons are under attack across the country, particularly with regard to access to gender-affirming care; and

Whereas, the Indiana General Assembly has already passed legislation limiting gender-affirming care for transgender and non-binary youth; and

Whereas, all major medical associations, including the American Medical Association, the American College of Physicians, American Academy of Pediatrics, American College of Obstetricians and Gynecologists, and American Academy of Family Physicians affirm the importance of evidence-based gender-affirming care for the health and safety of gender non-conforming patients; and

Whereas, current ISMA policy (RESOLUTION 21-38) states "RESOLVED, that the ISMA oppose legislation criminalizing gender affirming care of minors."

RESOLVED, that the ISMA oppose legislation criminalizing gender affirming care of minors; therefore, be it;

RESOLVED, that the ISMA actively oppose any legislation limiting access to gender affirming care, including criminalization of physicians providing that care, patients seeking that care, and any person, entity, or fund who facilitates the care.