Attitudes of Family Medicine Residents Toward Homosexuality

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Physicians' attitudes toward homosexuality, and any subsequent effects these may have on the quality of patient care, have special significance with respect to the projected increase in the number of patients with acquired immunodeficiency syndrome (AIDS).[1] Mathews et al[2] reported that nearly one quarter of the physicians in their 1982 study expressed strongly negative attitudes toward homosexuality. When stratified by specialty, the data suggested that family physicians were more uncomfortable with homosexuals than other specialists surveyed.

Concern over the findings of that study motivated an effort to determine attitudes of family medicine residents toward homosexuals. The effects of the AIDS epidemic in influencing these young physicians was also studied.

METHODS

Anonymous questionnaires were mailed to family medicine residents and fellows within a group of nine university-affiliated residency programs in Southern California. The survey instrument included three demographic areas, age, sex, and current residency year, followed by a 20-item Likert-type attitudinal scale: Heterosexual Attitudes Toward Homosexuality (HATH).[3,4] The HATH scale was extended to assess attitudes toward the treatment of patients with AIDS (pHATH). A series of questions were also added that assessed whether respondents felt that homosexuals should be excluded from certain professional activities. Reliability analyses were conducted on the HATH and the pHATH scales, and descriptive statistics were obtained on all instrument variables. The HATH scale sum distribution was divided into tertiles, and respondents were categorized as uncomfortable with homosexuals (score = 20 to 49), neutral (50 to 69), or comfortable with homosexuals (79 to 99). Chi-square analyses were used to determine whether there were differences attributable to sex of respondent between HATH categories of pHATH scores.

A *t* test was used to determine whether there were any differences in HATH or pHATH scores based on respondents' prior experience in treating AIDS, whereas a Pearson correlation was used to examine associations between HATH scores and respondents' views concerning whether patients were deserving of their illness. Frequency distributions were calculated for survey items regarding attitudes toward colleagues.

RESULTS

Of the 196 questionnaires mailed, 117 (59.7 percent) were returned. Of the responding residents, 71 identified themselves as male and 40 as female; the remaining six left the question of sex unanswered. The age distribution was similar for both men and women (28.8 ± 2.9 years). The overall reliability for both scales was excellent: HATH, alpha = 0.96; and pHATH, alpha = 0.96. All subsequent analyses reported are sex specific. The distribution of attitude sums is shown in Table 1. There were no statistically significant differences found with regard to residency year. Overall attitude sums were then calculated for the 23-item pHATH scale, and only differences related to sex were found.

The descriptive statistics for the remainder of the survey, those questions with yes or no responses that were not included as part of either the HATH or pHATH scales, are presented in Table 2.

Seventy-nine percent of men and 90 percent of women stated that they had treated at least one patient with AIDS. With respect to HATH or pHATH results, no significant differences were noted when comparing scores of those who had cared for patients with AIDS with those who had

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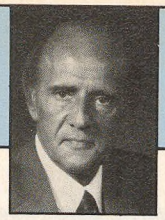

Home IV Antibiotic Therapy: An Introduction

Lowering health care costs while maintaining high quality care is a goal that all physicians strive for. An important step toward this goal is the development of home health care that is both therapeutically and economically effective. One particular aspect of home health care that is gaining acceptance is home intravenous antibiotic therapy.

Evolution of an Industry

Experts anticipate that over the next several years home IV antibiotic therapy will be one of the fastest growing segments of the home health care market. Today, physicians have access to an industry that provides necessary technology, personal services and pharmaceutical supplies — an industry devoted to home health care. With the growth of this industry, most physicians will be able to successfully manage many patients with a minimum of acute hospital care.

The Home IV Therapy Decision

Almost any patient who requires IV antibiotic therapy, and is hospitalized to receive that therapy, could be considered for treatment at home. However, four criteria are often applied before implementing home IV therapy:[1]

1. No suitable oral therapy is available.
2. The patient's condition is stable enough for discharge, and the patient can monitor his/her own therapy.
3. The patient agrees to outpatient therapy after a full disclosure of responsibilities and potential problems.
4. The patient has a suitable home environment, including a phone for emergency communications and a refrigerator for antibiotic storage.

Any infection that responds to IV therapy can potentially be treated at home, including osteomyelitis, endocarditis, wound infections, urinary tract infections, septic arthritis and others.[2]

Many classes of antibiotics appear suitable for home IV infusion; however, antibiotics used in outpatient care should have low toxicity, a broad spectrum of activity and a long half-life, allowing for less frequent dosing. Antibiotics with long half-lives enhance the convenience and cost effectiveness of home therapy and facilitate patient compliance.

Advantages

Home IV antibiotic therapy removes the risk of nosocomial infection. Receiving therapy at home in warm and familiar surroundings also provides psychological benefits. Another benefit is that patients in the home care environment become more active in their recovery. These intangibles appear to contribute to more rapid and predictable recovery.

There are also considerable financial advantages to home IV antibiotic therapy. For those patients who are able to work while receiving therapy, the benefits are obvious. Of course, savings are also accrued because patients are not hospitalized for long periods of time. In one study, the calculated savings ranged from $2,791 to $4,651 per patient.[3]

In addition, reimbursement for home services has greatly improved during the past five years. Many insurers now pay for outpatient therapy that can replace treatment given in the hospital. Congress has also provided for such reimbursement in the Medicare population under the catastrophic health insurance law that was recently enacted.

The success of home IV antibiotic therapy depends on a team effort employing sound case management by the physician and quality service from the home health care industry. Teamwork by these two groups will help ease the medical profession into a new era of health care.

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TABLE 1. DISTRIBUTION OF RESPONDENTS BY HETEROSEXUAL ATTITUDES TOWARD HOMOSEXUALITY (HATH) SCALE SCORES (percentage) AND BY SEX (N = 111)*

Respondents	Uncomfortable with Homosexuals	Neutral	Comfortable with Homosexuals
All (N = 117)	12.8	24.8	62.4
Female (n = 40)	2.5	20.0	77.5
Male (n = 71)	19.7	29.6	50.7

** Six of the 117 respondents provided no sex identification.*
P < .01

TABLE 2. COMPARISON RESULTS (percentage) OF PRESENT STUDY WITH THOSE OF MATHEWS ET AL

Questions	Mathews et al[9]		Present Study	
	Yes	No	Yes	No
Should a highly qualified homosexual applicant be admitted to medical school?	63.7	36.3	89.2	10.8
Would you refer patients to a homosexual colleague in the following specialties?				
Pediatrics	50.0	50.0	70.3	29.7
General surgery	67.5	32.5	78.4	21.6
Psychiatry	52.3	47.7	79.3	20.7
Radiology	70.9	29.1	84.7	15.3
Family practice	NA	NA	74.7	25.3

not. When questioned whether patients with AIDS were deserving of their illness, 5.1 percent of the responses said yes. These respondents had lower total HATH scores ($P < .01$) than those who answered no.

DISCUSSION

There have been four surveys published in the last 18 years examining physicians' attitudes toward homosexuality and toward homosexual patients. Two studies[5,6] antedated the AIDS epidemic, a third was conducted in 1982,[2] and the most recent study was published in 1985.[7] Each investigation differed with respect to methods and target population, and each had varying results.

In the present study, 62.4 percent of the respondents indicated they were comfortable with homosexuals by the HATH scale. In comparing this sample of family medicine residents with the general practitioners and family physicians' attitudes as reported in the study by Mathews et al, significant differences are noted. In the latter study the population was more uncomfortable with homosexuals (31 percent) than was that of the present study (12.8 percent). The population of the Mathews et al study, surveyed in 1982, included a wide range of ages, whereas the population of the study reported here was younger and more homogeneous with respect to age. The observed differences in measured dislike for homosexuals between the samples could be due to changes in attitude occurring across generations and in the course of the 1980s.

In the present study, women residents were significantly more comfortable with homosexuals than were male residents. Physicians were generally willing to refer to homosexual specialists. There appears, however, to be a slight trend toward more discomfort in referring to those homosexual physicians recognized to have more direct physician-patient contact (Table 2).

When the issue of admittance of homosexual students to medical school is examined, differences between the Mathews et al 1982 study and the present are again found. Thirty-six percent of the 1982 respondents queried would not admit a qualified homosexual student to medical school, while only 10 percent of the present sample would oppose admission ($P < .001$).

Some physicians in this study retain the notion that homosexual patients are deserving of AIDS, reflecting the profundity with which negative feelings toward persons with risk factors for AIDS are held.[8] Residents held these beliefs regardless of personal experience with patients suffering from the illness. This finding suggests that merely providing opportunities for young physicians to care for these patients will have little effect on these attitudes. Should one be able to quantitate and define more clearly attitudinal differences and the effect of sex, educational or behavioral interventions might then be assessed with instruments such as the HATH scale or that developed by Hudson and Ricketts.[9]

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