

Discrimination against gay, lesbian and bisexual family physicians by patients



Evidence

Études

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Abstract

Background: Discrimination against gay, lesbian and bisexual (GLB) patients by physicians is well known. Discrimination against GLB physicians by their colleagues and superiors is also well known and includes harassment, denial of positions and refusal to refer patients to them. The purpose of this study was to identify and quantify the attitudes of patients toward GLB physicians.

Methods: Telephone interviews were conducted with 500 randomly selected people living in a large urban Canadian city. Subjects were asked if they would refuse to see a GLB family physician and, if so, to describe the reason why. They were then given a choice of 6 reasons obtained from consultation with 10 GLB people and 10 heterosexual people.

Results: Of the 500 subjects 346 (69.2%) were reached and agreed to participate. Of the 346 respondents 41 (11.8%) stated that they would refuse to see a GLB family physician. The 2 most common reasons for the discrimination (prevalence rate more than 50%) were that GLB physicians would be incompetent and the respondent would feel "uncomfortable" having a GLB physician. Although more male than female respondents discriminated against GLB physicians, the difference was not statistically significant. The proportion of male and female respondents who discriminated increased with age ($p < 0.01$).

Conclusions: The observed prevalence of patient discrimination against GLB family physicians is significant. The results suggest that the discrimination is based on emotional reasons and is not related to such factors as misinformation about STDs and fear of being thought of sexually. Therefore, educational efforts should be directed against general perceptions of homosexuality rather than targeting specific medical concerns.

Résumé

Contexte : La discrimination pratiquée par les médecins à l'endroit des patients gais, lesbiennes et bisexuels (GLB) est bien connue. La discrimination pratiquée à l'endroit des médecins GLB par leurs collègues et leurs supérieurs est aussi bien connue et comprend le harcèlement, le refus d'un poste et le refus de leur référer des patients. Cette étude visait à définir et quantifier les attitudes des patients face aux médecins GLB.

Méthodes : On a interviewé par téléphone 500 personnes choisies au hasard vivant dans une grande agglomération urbaine du Canada. On a demandé aux sondés s'ils refuseraient de consulter un médecin de famille GLB et, le cas échéant, de préciser pourquoi. On leur a alors donné un choix de six raisons découlant de la consultation de dix personnes GLB et de dix personnes hétérosexuelles.

Résultats : Sur les 500 sujets, on a réussi à communiquer avec 346 (69,2 %) qui ont consenti à participer à l'étude. Sur les 346 répondants, 41 (11,8 %) ont déclaré qu'ils refuseraient de consulter un médecin de famille GLB. Les deux raisons les plus fréquentes de la discrimination (taux de prévalence de plus de

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50 %) étaient que les médecins GLB seraient incompetents et le fait que le répondant ne se sentirait «pas à l'aise» d'avoir un médecin GLB. Plus d'hommes que de femmes pratiqueraient de la discrimination à l'endroit des médecins GLB, mais la différence n'était pas significative sur le plan statistique. La proportion des répondants, hommes et femmes, qui ont déclaré qu'ils pratiqueraient de la discrimination augmentait avec l'âge ($p < 0,01$).

Conclusions : La prévalence observée de la discrimination pratiquée par les patients à l'endroit des médecins de famille GLB est importante. Les résultats indiquent que la discrimination est fondée sur des raisons émotives et n'est pas liée à des facteurs comme de l'information erronée sur les MTS et le fait que les répondants craignent qu'on pense à eux de façon sexuelle. Les efforts d'éducation devraient donc viser à lutter contre les perceptions générales de l'homosexualité plutôt que cibler des préoccupations médicales particulières.

Discrimination and prejudice on the basis of sex or race within the medical community occur worldwide.¹⁻⁵ Prejudice is rarely limited to one "category" of individual and should be denounced wherever and whenever it occurs. In recent years discrimination against gay, lesbian and bisexual (GLB) workers in a wide variety of professions, including medicine, has become more discussed.^{6,7} Personal difficulties of GLB physicians or GLB people aspiring to become physicians include being denied positions in medical schools or residency training programs as well as being fired or refused promotions.⁸ These perceptions are supported by Oriel and associates,⁹ who found that 8% of family medicine residency coordinators in the United States had negative attitudes toward homosexuality, and 25% admitted they might rank a homosexual applicant lower because of his or her sexual orientation.

GLB physicians have also reported ostracism and harassment by colleagues.^{8,10,11} In a study conducted among family medicine residents, less than 65% of the respondents were "comfortable with homosexuals," 1 in 10 said that they would not permit a highly qualified homosexual to enter medical school, and about 1 in 4 would not refer a patient to a homosexual colleague.¹⁰

Discrimination has also been practised by insurance companies and medical administrators based on the belief that patients would not want to see a GLB physician.⁸ However, to our knowledge there has been only one attempt to examine patients' attitudes toward GLB physicians. In a survey conducted by the lay press, less than 40% of people said they would see a homosexual physician.¹² Information about the respondents' age, sex and reasons why they might refuse a GLB physician were not included.

As with all nonvisible minorities, GLB physicians can choose to conceal their minority status. However, hiding this aspect of one's personal life may be more difficult than changing one's name to conceal a religion or nationality. For example, the absence of a spouse at social gatherings, such as an office party, or attendance at a public

GLB establishment or event may compromise the GLB physician's ability to remain secretive ("closeted"). Heterosexual family physicians often publicly announce their sexual orientation by wearing a wedding band or having family pictures in the workplace. GLB physicians must guard against such behaviour to keep their sexual orientation hidden, which may be why closeted GLB physicians appear to suffer more stress than GLB physicians who are open about their sexual orientation.¹² The level of stress suffered may be trivialized or not understood by some heterosexual physicians. Therefore, we ask readers to reflect on how it might feel if they were asked to deny their own family or culture, or even simply change their name to prevent discrimination. With this in mind, consider the monumental differences between changing one's name and denying one's sexual orientation. Finally, considering the levels of discrimination against GLB physicians, would the reader worry about being labelled "homosexual" if he or she agreed to attend a gay pride parade or be coauthor of a paper dealing with GLB issues?

Clearly, a GLB physician's decision to "be out" professionally is a difficult one. The potential reaction of both colleagues and patients must be taken into consideration. The objective of the present study was to identify and quantify the attitudes of patients toward GLB family physicians. We decided to limit our study to family physicians because patients choose their family physician but are usually referred to a specialist.

Methods

The study was designed to determine whether, and for what reasons, subjects would discriminate against a family physician based on the physician's sexual orientation. A list of reasons was developed by asking 10 GLB people and 10 heterosexual people to predict why a person might refuse to see a GLB physician. We then used the top 6 reasons selected. Each of these had been suggested by more than 10 of the 20 people questioned.



We interviewed 500 subjects by telephone in the spring of 1995. We obtained the telephone numbers by first compiling a computer-generated random list of 500 numbers between 1 and 1658 (the number of pages in the greater Montreal residential telephone listings). The first name on each of the 500 pages was then called until someone answered, up to a maximum of 10 tries. The telephone calls were made at different times of the day over a 4-week period.

A brief telephone interview was conducted with each subject. The subjects were asked their age and sex; they were excluded if they were less than 18 years of age or were unable to speak English or French. They were then asked whether they would refuse to see a male family physician, and, if so, to give the reason. Following this open-ended question, the subject was asked to choose from the list of 6 reasons we developed in the pilot study (more than one choice allowed). The question on discrimination against male family physicians was followed by one on female family physicians, one on gay or bisexual male family physicians and, finally, one on lesbian or bisexual female family physicians. If a subject indicated that he or she would refuse to see a male physician, and therefore would also refuse to see a gay male physician, the subject was not considered to discriminate against GLB physicians. Responses regarding female physicians were treated similarly.

Analysis

We determined the prevalence of patient discrimination against GLB physicians with 95% confidence intervals. We analysed the distribution of attitudes with regard to respondents' sex using χ^2 analysis, and with regard to respondents' age using χ^2 analysis for linear trend.

We based our sample size of 500 subjects on a prevalence rate of discrimination of 61%,¹² an a priori relevant difference of 15% between the attitudes of men and women and a rate of nonparticipation of up to 35%, owing to refusal to participate and no answer after 10 calls.

Table 1: Prevalence of discrimination against family physicians by male and female respondents, by sex or sexual orientation of the physician

Sex/sexual orientation	Sex; % of respondents (and 95% confidence interval)	
	Male <i>n</i> = 152	Female <i>n</i> = 194
Discrimination against		
Male physicians	0.0	1.0 (0.0–2.4)
Female physicians	0.7 (0.0–2.1)	1.5 (0.0–3.3)
Gay, lesbian or bisexual (GLB) physicians exclusively	15.1 (9.3–20.9)	9.3 (5.1–13.3)

Results

Of the 500 subjects telephoned, 150 (30.0%) refused to participate, and 4 (0.8%) could not be reached. Of the 346 respondents, 249 (72.0%) were aged 50 years or less, and 194 (56.1%) were women. The proportions of women and men within each age category were approximately equal.

Whereas the prevalence of discrimination based on the physician's sex was minimal (Table 1), the overall prevalence rate of discrimination based on sexual orientation was 11.8% (95% confidence interval 8.5% to 15.1%). Given the nature of the question, one might expect that the nonrespondents would have been more likely than the respondents to discriminate against GLB physicians, but we cannot be sure. Therefore, we applied a sensitivity analysis to the results. If none of the nonrespondents was a discriminator, the prevalence rate of discrimination would have been 8.2%. If all the nonrespondents were discriminators, the prevalence rate would have been 39.0%.

Male respondents appeared more likely to discriminate than female respondents, but the difference was not statistically significant. The proportions of male and female respondents who discriminated against GLB physicians increased with increasing age ($p < 0.01$) (Fig. 1).

Table 2 lists the reasons given for discrimination by the 41 respondents who would refuse to see a GLB physician. Over half gave the reason that a homosexual physician would be incompetent. Fewer subjects were afraid of being sexually harassed or contracting a disease. Among "other" reasons, the most common was feeling "uncom-

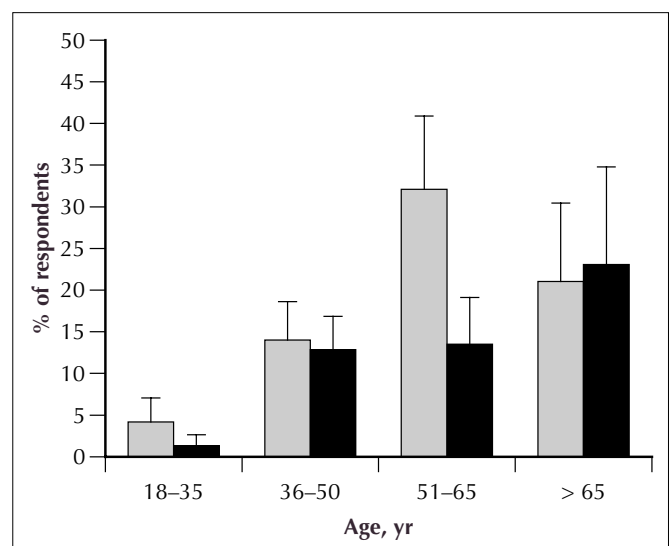


Fig 1: Proportion of male (screened bars) and female (black bars) respondents who would refuse to see a gay, lesbian or bisexual family physician, by age group. Error bars represent standard errors.

fortable” with homosexuals (24 respondents). Other reasons included the belief that a homosexual physician would be “bizarre” or “not normal” (2 respondents), the respondent’s upbringing (2 respondents), the belief that a homosexual physician is somehow a threat to children (1 respondent) and dislike of homosexuals (1 respondent). The reasons for discriminating against gay male physicians did not differ from those for discriminating against lesbian physicians.

Discussion

Although 11.8% of our respondents indicated that they would discriminate against GLB family physicians, our sensitivity analysis suggests that the actual figure for the entire study population may be as low as 8.2% or as high as 39.0%. These results reaffirm the fears and anecdotal experiences of GLB physicians.^{6-8,10} Our results are also in keeping with the finding that 30% of general internists in Canada have experienced homophobic remarks by patients on at least 3 occasions.¹³ The difference between the proportions is to be expected, because one patient is likely to be responsible for several physicians’ experiences. Research is needed to determine whether this type of discrimination is limited to GLB physicians or whether other “categories” of physicians are also discriminated against.

Our results suggest a lower prevalence of discrimination than the rate of 61% previously reported in the lay literature.¹² There are several possible reasons for this difference. First, we limited our survey to an urban population, whereas Henry¹² did not specify the population, and residents from rural areas may have been included (despite repeated attempts, we were unsuccessful in clarifying this issue with the author or the publisher). Second, the wording of the surveys was different. In the study by Henry the subjects were asked whether they “would see a homosexual doctor.” This question may have been interpreted to mean “actively seek” a homosexual physician. If so, some subjects

who preferred heterosexual physicians may have answered “no” and would have been considered to discriminate against homosexual physicians. However, these same subjects might still continue to see a physician whom they know to be homosexual. We chose to ask whether people would “refuse” to see a GLB family physician. Therefore, an affirmative answer would require a much stronger objection, which we feel is more representative of true discrimination rather than preference. Third, Montreal is located in a province that has traditionally supported the development of laws to protect the GLB community against discrimination. This may reflect a more liberal attitude among the study population as well.

We found that fewer younger people than older people discriminated against GLB physicians. This difference may reflect changing attitudes toward homosexuals as they become more visible in society. Alternatively, the different attitudes may reflect the large decrease in the influence of organized religion in Quebec.

A higher proportion of male respondents than female respondents in each age group discriminated against GLB physicians, although the differences were not statistically significant. The difference between the sexes may become statistically significant with larger samples; however, we feel that the small magnitude of the differences does not warrant targeting educational efforts toward a particular subgroup of the population.

The most common reasons given for discriminating against GLB family physicians were nonspecific (e.g., the respondent would feel “uncomfortable” with a GLB physician, or GLB physicians are “generally incompetent”). Even when presented with a list of possible specific reasons, many of those who discriminated against GLB physicians maintained that they simply felt “uncomfortable” and would not elaborate. This pattern suggests that it is a general negative conception of homosexuality that is primarily responsible for discrimination against GLB physicians. Specific reasons, such as fear of contracting AIDS, were less likely to be cited. With an optimistic perspective, one might conclude that this result reflects the success of educational campaigns for AIDS awareness. However, the results also suggest that the discrimination in our study is based on emotional reasons rather than inaccurate information. Countering such arguments to decrease discrimination may be harder than traditional educational campaigns.

Our study has several limitations. Since the data were collected through telephone interviews, the study was limited to people who could afford and who chose to have a telephone. In addition, it is difficult to elicit an accurate response during a telephone interview. We recognize that topics concerning homosexuality are controversial, and, therefore, some respondents may have given “socially ac-

Table 2: Reasons given for discrimination by the 41 respondents who would refuse to see a GLB physician

Reason	No. (and %) of respondents
Fear that the physician would be generally incompetent	23 (56)
Fear that the physician could not relate to or understand one’s lifestyle (e.g., family issues, sexual needs)	7 (17)
Fear of being thought of sexually	2 (5)
Fear of being sexually harassed	4 (10)
Fear of contracting AIDS or other STD	4 (10)
Other*	31 (76)

*See Results.



ceptable" answers rather than honest answers. Therefore, 12% is likely an underestimate of the actual prevalence of prejudice in the community.

We chose to limit our study to the two independent variables age and sex, even though other demographic factors (e.g., level of education, religious affiliation, income level, the subject's own sexual orientation and whether the subject knows any GLB people) almost certainly influence a person's attitude toward GLB physicians. This was done to maximize the response rate by avoiding any personally threatening questions and to keep the survey as short as possible. These variables should be explored in future studies.

Our findings are based on a sample size of 500 subjects, with a response rate of 69.2%. Although a larger sample or a higher response rate would have narrowed our confidence intervals, it would not have changed the overall message. For instance, even if the small difference between male and female respondents became statistically significant, we feel it would have been clinically irrelevant.

Finally, our study population was a large urban population, and the conclusions should not be extrapolated to populations in rural areas, where attitudes toward GLB people may be very different.

Conclusion

Discrimination and prejudice against GLB physicians are prevalent and have considerable negative consequences for the doctors involved and for the medical community as a whole. As a nonvisible minority, GLB physicians are faced with a choice, and the decision to hide their sexual orientation must be made by weighing the relative benefits and risks. Although our results suggest that GLB physicians should be concerned about discrimination by their patients, the age trend suggests this may be less of a problem for physicians with young patient populations. Furthermore, educational efforts aimed at changing the public's general conceptions of homosexuality would be more effective than targeting specific concerns such as STDs and sexual harassment. Future research is needed to explore discrimination against doctors from other nonvisible and visible minorities.

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