Commentary

Do We Really Mean Preventive Medicine for All?

The success of any preventive medicine program depends on numerous factors, the most basic of which is an individual's access to the practitioner. Access depends in part on how the individual interfaces with and perceives the medical system. Access is improved when the patient views the medical institution as a friendly, inclusive, welcoming environment that induces trust.[1] Additional factors influencing access include the perceived relevance of the health care provided, the sense of cultural inclusion, and, of course, the kind of treatment afforded the individual during the health encounter.[2] Issues of discrimination by race, gender, class, educational status, age, and ability potentially limit access to care.[3–6] Actual, perceived, or anticipated discrimination because of sexual orientation can limit access to health care, with potentially significant delay of diagnosis and therapy.[7,8]

Homophobia is the unreasoning fear of or antipathy toward homosexuals and homosexuality.[9] The social expression of and personal experience of antigay and antilesbian prejudice have psychosocial consequences for homosexual individuals. The usual sources of stress from daily life issues such as work, finances, and health are compounded among members of the gay community by the added stress to conceal their identity or to risk disdain and potential loss of employment by not concealing their identity.[10,11] Additional stress on gay men and lesbians derives from anxiety, depression, and guilt from being widely viewed as immoral and deviant, an effect compounded by the stigma of the HIV epidemic.[12,13] Individuals who carry multiple socially marginalized statuses (e.g., race, ethnicity, and sexual orientation) are known to carry a higher risk of depressive distress.[14–16]

Medical practitioners, like all members of our society, have been taught and have innocently learned the systems of oppression based on race, gender, class, educational status, age, and ability.[17] Many physicians have undergone some form of systematic education of "unlearning" these prejudices, called diversity training. However, few of these courses include issues about homophobia. As a result, well-meaning health care providers may not be aware that their practice is not specifically inclusive of members of the homosexual population, comprising some 3%–6% of Americans. In a survey of nearly 1,000 southern California physicians, one third of physicians in primary care specialties were found to have significantly homophobic attitudes.[18]

Peer-reviewed journal articles have documented how lesbians and gay men perceive the disdain for them by some health practitioners and elect not to return, missing annual Pap smears and the myriad of yearly tests and advice given to patients in the routine exam.[15,19–23] The resultant delay in any disease diagnosis can significantly affect both quality of life and survival probability. Comparative data between the homosexual and heterosexual populations on morbidity and mortality from vascular diseases, cancers, and lung disease would be valuable. However, until 1995, outside the context of HIV, data on the health and psychology of homosexuals have not been sought in national probability health surveys.[24] The Nurses Health Study will be publishing the recently obtained information about the demographics of a cohort of 121,000 nurses, stratified by sexual orientation (KA O'Hanlan, personal communication with Walter Willett, MD, and Patricia Case, MPH, Nurses Health Study II, Harvard Medical School and School of Public Health, 1994). In addition, after intense lobbying of the National Institutes of Health, the Women's Health Initiative decided to include a question about sexual orientation. However, this data will not be available for a few years.

More information is available about lesbian health than about gay men's health because lesbian health activists have circulated and compiled seven convenience health surveys of over 13,000 lesbians since 1980.[20,25–30] In the absence of comparative data with heterosexual women, only theoretical implications can be made based on the effects of observed demographic factors, such as parity, screening rates, and sexual behavior. For example, it is known that low parity is associated with higher rates of breast, ovarian, and endometrial cancers.[31] In the lesbian population, with a parity rate of 10%–31%,[20,27,32] versus 85%–90% for all women,[33] risks of cancer of the breast, ovary, or endometrium may be elevated, and heightened screening may be indicated.[34] Lesbians may also suffer higher rates of endometriosis as a result of their lower parity rate.[8]

Use of oral contraceptives reduces the risk for developing endometrial and ovarian carcinoma.[31] Although no data are available documenting lesbian use of oral contraceptives, lesbians appear unlikely to have used any contraceptive extensively.

National studies have shown that unmarried women have higher rates of cigarette abuse and lower rates of breast self-exam, clinical breast exam, and screening mammography when compared to married women.[35] Since lesbians are more likely to be counted as "unmarried women," this data can suggest that lesbians may smoke more and use screening less often. Although it is not acceptable science to assume that lesbians resemble the entire population of unmarried women, such an extrapolation can be used now only to suggest the need for quality data. Infor-

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mal surveys of lesbian communities suggest that screening is underused. One fourth of lesbians over age 40 in a Michigan study had never had a mammogram.[27] The interval between Pap smears for lesbians was reported to be nearly three times that for heterosexual women,[36] even though rates of dysplasia among homosexual and bisexual women were not different.[37] As many as 5%–10% of lesbian respondents in two large surveys had never had a Pap smear or had one over 10 years ago.[20,27]

Perceiving the medical establishment as hostile or exclusive is a deterrent to screening, with subsequent loss of opportunity for prevention or early diagnosis of other common ailments. The multiple early warning signs and symptoms of heart disease and many types of cancer will not be detected without regular exams. Diet, exercise, smoking cessation, and calcium supplementation will not be recommended to patients. Serum cholesterol levels will not be screened. Thus, gay men and lesbians who are not aware of, or who do not receive, the standard screening and regular medical exams risk the loss of maximal health while aging, and even decreased longevity.

Reportedly, senior lesbians are not recognized as such in their nursing homes[38] and often experience social isolation as they age.[39,40] Elderly lesbians risk loss of medical insurance and financial distress not faced by legally married individuals if their life-partner were the only wage-earner and died first, because lesbians cannot have access to their life-partner's social security benefits.[41]

Many other current federal and state laws persist that perpetuate discrimination against homosexuals with both psychological and physical health effects. Peer-reviewed pediatric literature has amply documented that children raised in homosexual households have normal psychological and social development.[42,43] However, in divorce courts, lesbians still frequently lose custody of their children to their ex-husbands (even when the ex-husband killed his previous wife!) because judges presume that lesbians are de novo unfit mothers. Lesbian and gay couples are prohibited in many states from adopting their partner's children, or adopting as a "single" parent. These laws prevent inclusion of the children on the nonbiological parent's health insurance policy and preclude medical conservatorship by the nonbiological parent, even in emergencies. Additionally, accredited sperm banks may legally deny lesbians requesting insemination. These lesbians are relegated to using nonmedical and less safe methods of sperm acquisition, with attendant increased risk of HIV and other sexual transmitted diseases from unscreened donors of sperm or from unprotected sexual intercourse.[20]

Health care providers must learn that being gay or lesbian is not biologically or psychologically hazardous, but that risk factors for health problems are conferred by ubiquitous homophobia. The process of homophobia itself, in which the socialization of heterosexuals against homosexuals and concomitant conditioning of gays and lesbians against themselves takes place, must be recognized as the health hazard.

How has homophobia become so pervasive in our society? This form of discrimination is currently accepted in mainstream society, and is, in many cases, government-enforced.[44,45] Well-meaning, intelligent adults believing, erroneously, that teaching children about homosexuality risks promoting homosexuality fail to discuss it. From this omission, children learn that diversity of orientation must be too evil to discuss. Youths observe the popular and usually negative stereotypical media portrayals of homosexuals and see news of recent challenges to the ban on homosexuals from serving in the military or from marrying their loved one.[46] They then assume that there must be substance to the arguments in favor of such bans, initiating a whole new generation of hatred among heterosexuals, as well as social alienation and low self-esteem among homosexuals.[47] Multiple studies suggest rates of suicide ideation, actual attempts, and completions are higher among homosexual youths than rates reported in other studies for broader groups of predominantly heterosexual youths.[48,49] Even though pediatricians are actively concerned about the effects of media violence on children,[50] little is being done to educate parents and children about facts of homosexuality and homophobia where it is essential: at home,[51–53] in their schools,[54] and in their doctors' offices.[55]

Solutions to homophobia require comprehensive re-education about sexual orientation, which needs to come from psychologists, pediatricians, obstetrician/gynecologists, and internists, the specialties with the greatest interface with issues regarding family health. Educational brochures and patient education pamphlets about homosexuality must be written and provided for patients in each of these specialties. Specialty societies can provide credible resources for their membership by creating such pamphlets and including issues about sexual orientation in their continuing medical education conferences.

Changes in the practice of medicine should include revision of office questionnaires, currently requiring patients to identify themselves in heterosexual terms such as single or divorced to include "living together" or "domestic partner." This will indicate inclusion of the gay or lesbian patient in that practice. Use of generic terms such as "partner" or "spouse" rather than "boyfriend" or "girlfriend" for all patients will tell patients that this physician appreciates the diversity of humankind. Physicians should routinely ask whether each patient is sexual with men, women, both, or neither and not reserve their questions about sexual behavior for the gender-atypical individuals based on dress, mannerisms, speech, or other unreliable "clues" to sexual orientation. While it is impossible to predict which patients are struggling with issues of sexual orientation, all patients will benefit from the nonbiased demonstration of the health care provider's positive attitude toward issues of orientation. Questions in the sexual history should be focused on specific behaviors, without requiring use of labels for orientation, because many men and women engage in same-sex behaviors but will not identify themselves as a gay man or a lesbian. Regardless of the physician's own personal beliefs, the responsible practitioner must consistently convey a nonjudgmental attitude to all patients. Thus, the training of providers in cultural competence has become essential.

Medical, nursing, and allied health professionals need organized curricula to provide factual information on homosexuality, increasing their ability, comfort, and confidence in caring for the gay or lesbian patient.[56] Unfortunately, such systemwide solutions take on the air of political advocacy instead of health improvement, and alienate the populace. Many are fearful of taking a principled stand, fearing they will be labeled or disdained.

For the past four years, the Gay and Lesbian Medical Association, the association of gay, lesbian, bisexual, and transgendered physicians and supporters, has been calling for a National Institutes of Health–sponsored Consensus Conference on Health and Homosexuality. Only through such a recognized and credible source can significant information be presented, analyzed, and disseminated nationally to begin to create the necessary changes.

The requirements for a Consensus Conference—that the health problem be significant, controversial, and have sufficient data available to resolve the controversies—have been met. Medical and psychological effects of prejudice from health care providers, family, educational, religious, and governmental organizations will diminish only when they are provided a reliable resource about homosexuality and homophobia. Resource documents from a Consensus Conference could be used to create rational, evidence-based policy changes in many arenas.

Changes in government will need to reflect an appreciation of all individuals as valued members of society, capable of serving the country, marrying, and contributing to the natural order.[57] Greater understanding and knowledge of who lesbians and gay men are and the amelioration of the psychological effects of societal disdain for them will enable health care providers to maintain the highest standard of medical care for all of their patients, including the gay or lesbian patient.[56]

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