

Health Care Needs of Gay Men and Lesbians in the United States

[Council Report] Council on Scientific Affairs, American Medical Association

In 1981 the House of Delegates of the American Medical Association (AMA) adopted a report from the Council on Scientific Affairs entitled Health Care Needs of the Homosexual Population. A substantial number of studies involving gay men and lesbians have subsequently appeared in the medical literature that provide a better understanding of health issues related to sexual orientation and behavior. For this reason, the original recommendations were reviewed, including that of reversal of sexual orientation in selected cases. [1]

DEFINITION AND DEMOGRAPHICS

In this report, sexual orientation refers to an individual's self-perception as gay, lesbian, bisexual, or heterosexual. Sexual behavior may or may not correlate with sexual orientation. Furthermore, an individual's sexual behavior and orientation may vary over time.

The scientific literature indicates that homosexual feelings are more frequent than homosexual behavior and that same-sex behavior is more frequent than lasting homosexual identification. [2-11] According to researchers from RAND, [10] (p145) "...like virtually all available data on human sexuality, studies [on homosexual behavior] have relied on nonprobability 'convenience' samples, including patients of STD [sexually transmitted disease] clinics, members of accessible organizations, persons who frequent public places for sexual contact, and volunteer respondents to magazine and other publicly-announced surveys."

In addition, given the sensitive nature of the subject and the societal stigmatization of homosexuality, underreporting will likely occur. [12,13]

Thus, it is difficult to determine the prevalence of persons with homosexual and bisexual orientations. The 1948 Kinsey survey used a convenience sample of volunteers and provided several different estimates of male homosexuality. [14] One of these estimates, 10%, is commonly cited today, despite data from larger and more representative studies.

In general, human sexuality surveys have lacked adequate sampling design and representative samples. There are exceptions, however. One recent study combined 6 annual national probability surveys from 1988 through 1994 and a separate 1992 national probability survey to produce a 4% estimate of men who have had sex with men in the last 5 years. [15] The same researchers reported a national probability survey of urban populations that had a 6.5% reported level of same-sex experiences in the past 5 years. [15] Two studies in 1994 were recognized for their excellence in sampling designs and execution. Sexual Attitudes and Lifestyles [16] conducted in Great Britain and The Social Organization of Sexuality [17] conducted in the United States reported the results of probability samples with large populations from which better estimates of the prevalence of same-sex orientation and behavior were available. The US study included 3 characteristics measuring homosexuality and bisexuality: desire, identity, and behavior. The authors stressed that these characteristics overlap, making it impossible to ascertain the exact number of homosexual or bisexual people. The study estimated that 2.4% of the men

and 1.3% of the women "define themselves as homosexual or bisexual, have same-gender partners, and express homosexual desires." [17] (pp300-301) On the other hand, 10.1% of the men and 8.6% of the women demonstrated at least 1 of the 3 components of homosexuality. In the British survey, 3.6% of the men reported genital contact with a man, and 1.4% had had at least 1 same-sex partner in the last 5 years. Of the women, 1.7% reported genital contact with a woman, and 0.6% reported at least 1 same-sex partner in the last 5 years. The percentages of men (6.1%) and women (3.4%) who reported ever having any same-sex experiences were even larger. [16] Both studies indicated that people are more likely to report bisexual than exclusive same-sex behavior, and that same-sex behavior is neither "uniform" nor "stable over time." [16,17] (p283)

DIAGNOSTIC AND THERAPEUTIC CONSIDERATIONS

Generally, men and women who engage in same-sex behavior have the same health afflictions as individuals who engage in opposite-sex behavior. Some diseases, however, are of particular concern to men and women who engage in same-sex behavior and therefore are important in a differential diagnosis and treatment plan.

Women

It is difficult to compare disease morbidity and mortality rates of lesbians with those of heterosexual women because of the sexual heterogeneity of the lesbian population, the lack of representative samples of lesbians, and the inevitable inclusion of all sexual orientations in any sample of women. [18] However, based on known risk factors, the potential threat for certain diseases in lesbians can be considered.

Sexually Transmissible Diseases (STDs).--Women who only have sex with women are at less risk for contracting syphilis, gonorrhea, and chlamydia than women who have intercourse with men. [19] However, if symptoms or signs of an STD are present, these symptoms should be investigated with appropriate testing. The risk of infection with herpes viruses, human papillomavirus (HPV), and human immunodeficiency virus (HIV) is greater for women who have sex with men. Bisexual women may become infected from men and transmit these diseases to other women. [20,21] In a recent study of 101 lesbians who had had no sexual intercourse with a male in the past 12 months, 29% were diagnosed with bacterial vaginosis. Nearly three fourths of the infected women had lesbian partners with bacterial vaginosis, suggesting concordant vaginal secretions and possible transmission of bacterial vaginosis within lesbian couples. [22]

Transmission of HIV between lesbians is believed to be rare. [20,21,23-25] The Centers for Disease Control and Prevention does not even have a risk category for lesbians in its surveillance reports. [26-29] In a 1993 survey of 498 lesbians and bisexual women derived from a random sample of San Francisco and Berkeley, Calif, residents, 1.2% were HIV-infected. Because these women had histories of heterosexual relations or injecting drug use, the rate of female-to-female transmission of HIV could not be determined. [30] In a study conducted between 1990 and 1992 in 8 Los Angeles County, California, STD clinics, bisexual women were more likely than heterosexual women to engage in HIV risk behaviors, including injecting drug use (24.1% vs 4.0%), sex with a bisexual man (35.6% vs 4.3%), sex with a man who injects drugs (37.4% vs 10.3%), and anal intercourse (42.0% vs 14.8%). [31]

The greatest risk of HIV infection for all women is from injecting drug use and sex with bisexual men. [32-34] However, female-to-female transmission of HIV can occur through exposure to cervical and vaginal secretions of an HIV-infected woman. The amount of shedding from these secretions likely increases the risk of HIV exposure. [30]

Cancer.--Because the risk for HIV infection and other STDs is lower for lesbians than for heterosexual women, lesbian patients may assume that they are not at risk for gynecologic diseases, such as breast and ovarian cancer. These conditions may go undetected in lesbians who view health care as

unnecessary, assuming that they are not at risk. [13,35-37] Also, some physicians may omit routine gynecologic tests under the erroneous assumption that lesbians do not need the same gynecologic screening as heterosexual women. [36] In 1 practice setting, an obstetrician/gynecologist stated that "other OB/GYNs here don't do Pap smears on a lot of their openly lesbian patients." [38] (p15) In a 1994 study by the Gay and Lesbian Medical Association, an organization of gay, lesbian, and bisexual physicians from the United States and Canada, of member physicians, 45% of the gynecologists had "observed substandard or denied care" given to homosexual patients. [38] (p28) Also, some lesbians avoid health care because of potential negative responses from physicians regarding their sexual orientation. In a survey of 558 lesbians and bisexual women who disclosed their sexual orientation to their physicians, examples of negative responses from physicians were given; eg, "All [my] doctors have become nervous" and "He got up, left the room and had a nurse finish the questioning." [39] One study found that lesbians undergo Papanicolaou tests at intervals nearly 3 times longer than those of heterosexual women. [19] In several studies, 67% to 72% of the lesbians surveyed concealed their sexual orientation or behavior from their physician when they did seek medical care. [4,36,40,41]

No prospective population-based study of the comparative incidence of cancers in lesbians has been performed. This lack of research is problematic because general epidemiologic studies of cancer in women have identified specific risk factors that are distributed differently in the lesbian population. [4] Breast cancer may be more common in women who have never given birth. [18,42,43] Nulliparity may be a risk factor for ovarian cancer [44,45] and may be implicated in endometrial cancer as well. [46] Use of oral contraception may confer some protection from ovarian cancer [45,47]; however, lesbians are less likely to take such medication.

Several studies indicate that lack of heterosexual intercourse or delayed initiation of heterosexual coitus decreases the risk of cervical cancer. [19,48] However, these studies also show that lesbians with a history of vaginal intercourse with men have an increased rate of cervical cancer, between 2.7% and 2.9%, which is in the high-normal range for all women. [19,48] Because of their sexual practices and their lower incidence of HPV infection, lesbians are at less risk for cervical cancer than women who have sex with both men and women. [46]

Men

HIV.--Infection with HIV is a major health concern of the gay community. Men who have sex with men account for more cases of the acquired immunodeficiency syndrome (AIDS) in the United States than persons in any other transmission category. [49] During 1994, 34 974 new cases of AIDS were reported among men whose only exposure to HIV was having sex with other men. [50] In San Francisco, Los Angeles, New York City, and Chicago, the prevalence rate of HIV infection among sexually active gay men has at times reached between 35% and 50% since 1981. [51] In addition, in a study of 16 small US cities, 9% of 1991 gay men (mean age 31.3 years) acknowledged they were HIV-positive, and 31% of the entire sample reported they had unprotected anal intercourse in the previous 2 months. [51] A 1993 population-based study of gay and bisexual men in San Francisco aged 18 to 29 years revealed that of 420 men tested, 17.6% (74) were positive for HIV. In the older cohort of this sample, 187 men aged 27 to 29 years, 54 (28.9%) were HIV-positive. [52] Other studies found that 33% of gay youth and 52% of bisexual youth had unprotected anal intercourse. [53,54] In a 1989 study of condom use among men aged 20 to 44 years in multiethnic neighborhoods of San Francisco, 53% of the gay and bisexual men with 2 or more sexual partners reported unprotected anal intercourse. [55] In a recent analysis of 76 HIV-positive gay and bisexual men from the Multicenter AIDS Cohort Study and the Coping and Change Study in Chicago, researchers discovered that insertive anal intercourse and receptive oral sex were being used as "safer" alternatives to receptive anal intercourse, while in fact they can pose significant risk of transmitting HIV when condoms are not used. [56] These studies underscore the need for continuing prevention of HIV infection in the gay community.

Hepatitis.--All forms of hepatitis can occur in gay male patients. Because of the risk for hepatitis B virus infection, sexually active gay and bisexual men should receive the hepatitis B vaccine. [57,58] In general, gay men are at greater risk for contracting hepatitis B virus than hepatitis C virus infection, which is frequently transmitted by injecting drugs. [59-63]

Cancer.--In a 1992 retrospective study, researchers determined an 84 to 1 relative risk of anal cancer after AIDS diagnosis among gay men compared with the incidence of anal carcinoma in age- and sex-matched persons in the general population. [64] In a 1982 study of anorectal cancer in Washington State, the incidence among men who reported homosexual behavior was 25 to 50 times that of age-matched heterosexual controls. [65] As with cervical carcinoma in women, these cancers are preceded by detectable premalignant changes and are related to specific types of HPV infection, HIV infection, and smoking. Recent studies indicate that HIV infection in gay men may facilitate the sexual transmission of anal HPV. [66]

Little information is available to guide the physician in the detection and treatment of premalignant anal lesions. However, a combination of anal Papanicolaou tests followed by anoscopy for patients at risk, although not recommended routinely, may help in the early diagnosis of anal cancer. [67]

Sexually Transmissible and Other Diseases.--Gay men who practice oral-anal, oral-genital, and anal receptive/insertive sex are at increased risk for certain gastrointestinal infections and STDs. [46,68,69] The gay male patient's genital, anal, and perineal regions should be examined routinely for the presence of condylomata. [69] Proctitis, enteritis, colitis, and proctocolitis are more often prevalent in men who have receptive anal sex with men. Proctitis in such men can be caused by *Neisseria gonorrhoeae*, herpes simplex virus, *Chlamydia trachomatis*, or *Treponema pallidum*. [68] Although symptoms may be lacking for some of these conditions, the physician should not preclude their existence in patients at risk. Most cases of anal syphilis occur in gay men. [70] Primary syphilis is characterized by anal chancres, inguinal adenopathy, and lesions infected with spirochetes. [70,71] Anoscopic examinations can be helpful in the detection of otherwise occult disease. Allergic proctitis (caused by reaction to lubricants), trauma, fissures, fistulas, prolapsed hemorrhoids, rectal ulcers, and foreign bodies also can be encountered. Enteritis, colitis, and proctocolitis can be caused by *Salmonella*, *Shigella*, and *Campylobacter* organisms, *Entamoeba histolytica*, *Giardia lamblia*, or *Cryptosporidium* organisms. Even if *Blastocystis hominis* and *Endolimax nana*, which do not pose a serious problem for heterosexual men, are the only pathogens present in the gay male patient with enteritis, diagnostic evaluation and treatment are suggested. [69,72]

Urethritis in the gay male is commonly caused by *N gonorrhoeae*, *C trachomatis*, or *Ureaplasma urealyticum*. In addition, sexually active gay men, particularly patients presenting with urethritis, should be routinely screened for proctitis and pharyngitis. Not all oral regimens for genital gonorrhea constitute adequate treatment for rectal or pharyngeal infections. [69]

SEXUAL HISTORY

Several studies indicate that only 11% to 37% of primary care physicians routinely take a sexual history from new adult patients. [73-75] In addition, 44% of the gay men in a 1992 study did not reveal their sexual orientation to their primary care physician. Of the gay men in this sample who were HIV-positive, 44% did not inform their primary care physician of their HIV status. [76]

A physician who does not determine sexual orientation and sexual behavior, tacitly assuming that the patient is heterosexual, may deter the patient from openly confiding in the physician and may overlook risk factors. [13,35] Taking a sexual history in a nonjudgmental and attentive manner with open-ended questions can help the patient feel comfortable and willing to confide in the physician. Patients usually feel at ease talking with their physicians about sexual practices and believe it is appropriate for physicians to question them in this area. [77] When taking a sexual history, the physician must keep in

mind that it is specific behavior rather than sexual orientation that exposes a person to risk of HIV infection or other STDs. During the sexual history interview or physical examination, the physician can discuss the behaviors that put patients at risk for HIV infection and other STDs. [78-81]

In addition, during the sexual history interview of gay men, lesbians, and bisexuals, the physician should ask questions about sexual abuse and domestic violence just as with heterosexual patients. Male childhood sexual abuse, usually perpetrated by an older male, has been underreported, often concealed by fearful abused boys. [82-86] In a study of 1001 gay and bisexual men attending STD clinics in Chicago, Denver, and San Francisco, 348 (35%) of the respondents had been "encouraged or forced to have sexual contact before the age of 19" with an "older or more powerful" male. Fourteen percent of these incidents occurred in boys younger than 6 years, 47% in boys between 6 and 11 years, and 33% in boys between 12 and 15 years. [84] Research indicates there is no causal relationship between homosexuality and child sexual abuse; however, as they mature into adolescence, sexually abused children may run away from home and turn to substance abuse, including injecting drug use, and prostitution, thereby putting themselves at risk for HIV infection. [83,85-88]

In a national survey of lesbians, 21% reported sexual abuse in childhood, 15% in adulthood, and 4% in both. In the same survey, 24% reported physical abuse in childhood, 16% in adulthood, and 6% in both. [89] In general, lesbians do not suffer as severe sequelae from childhood sexual abuse as gay men do, but abuse of lesbians may lead to alcohol abuse and use of cocaine and other drugs. [86,89,90] However, these studies of homosexuals' experiences of childhood sexual abuse may not be representative.

MENTAL HEALTH ISSUES FOR GAY MEN AND LESBIANS

Emotional Concerns

All patients, regardless of their sexual orientation, have a right to respect and concern for their lives and values. Gay men and lesbians face ostracism and discrimination from many sources, including some health professionals. In addition, the HIV epidemic has had a substantial impact on gay men, causing multiple personal losses and stigmatization of their sexual expression. [91,92]

Because of negative societal attitudes that are exacerbated by the perception that HIV infection is a gay man's disease, many gay men (as well as lesbians) hide their sexual orientation from their coworkers, friends, family, and physicians. Adolescents who are ambivalent about their sexuality, or who are aware of their homosexual orientation but are isolated from emotional support, are especially vulnerable to societal reaction. These pressures lead to psychiatric complications, such as depression, in adult and adolescent homosexuals. [91-93] Furthermore, patients with newly diagnosed HIV infection frequently experience depression and are more at risk for suicide than their uninfected counterparts. [92-96]

Emotional disturbance experienced by gay men and lesbians that is related to their sexual identity apparently is due more to a sense of alienation in an unaccepting environment than to any other cause. For this reason, aversion therapy that links homosexual behavior with unpleasant sensations or aversive consequences is not recommended for gay men and lesbians. [97] Gay men and lesbians can become comfortable with their sexual orientation and understand the societal response to it.

Physician Attitudes

In 1973 the American Psychiatric Association officially removed homosexuality from its categories of mental disorders, [98] and in 1986 it deleted "egodystonic homosexuality" as a diagnosis for individuals who are overly concerned about their homosexuality as a result of an unaccepting society. [98] Despite these changes, some psychiatrists may continue to regard homosexuality as a disorder, and some mental health practitioners may present homosexuality as abnormal and dysfunctional. [98]

Physicians in general have often expressed discomfort with gay men and lesbians. In a 1989 survey of general practitioners, only 32.7% felt comfortable with gay men and 40.8% thought gay men should not

work in schools. In the same study, 11.4% of those who responded thought that homosexuality was an illness. [99] In another study published in 1991, 25% of the psychiatric faculty of a medical school admitted they were prejudiced against gay men and lesbians. [100] The Gay and Lesbian Medical Association conducted a study of their membership in 1994 to which more than 700 of the group's 1300 members responded. Although 98% of the respondents felt homosexual patients should disclose their sexual orientation to their physician, 64% also believed that as a result of disclosure, homosexual patients risked receiving substandard care. Fifty-two percent had observed "colleagues providing reduced care or denying care to patients because of their sexual orientation." In addition, 59% of those surveyed felt they had suffered discrimination, harassment, or ostracism from the medical profession because of their sexual orientation. [38]

Examining the physical and psychological needs of gay men and lesbians in undergraduate and postgraduate medical education may help physicians feel more confident and less uncomfortable with homosexual and bisexual patients. [101,102] By expressing a nonjudgmental attitude toward gay men and lesbians, physicians can learn more about their homosexual patients, enhance rapport with these individuals, and provide optimal medical care to those in need. [103]

Substance Use and Abuse

Substance use and abuse can be a symptom camouflaging underlying mental health problems such as low self-esteem due to societal discrimination. [89,104] Investigators and clinicians working with homosexual patients suggest that the prevalence of substance abuse among gay men and lesbians ranges from 28% to 35% compared with 10% to 12% for the heterosexual population. [105] In a recent survey of 2 metropolitan areas, marijuana use in the preceding month was 23.5% for lesbians and 37.5% for gay men compared with reported marijuana use of 9.1% for women and 16.5% for men in a 1990 national survey of the general population. In the same surveys, 38.1% of lesbians and 35.4% of gay men smoked cigarettes compared with 22.0% of women and 27.1% of men in the general population. [106] According to several studies, cigarette smoking contributes to decreased immune function, thereby leading to HIV disease progression in infected individuals. [107,108] However, a few researchers question the representativeness of these studies, especially those concerning lesbians and alcohol use, asserting that some study samples were obtained from gay bars where lesbians tend to congregate for socializing. [109]

Not only does substance use (including recreational and occasional use) put gay men and lesbians at risk for diseases such as lung cancer and alcoholism, but it also increases their danger of engaging in high-risk sexual behavior. [110] When using drugs such as alcohol, marijuana, cocaine, or volatile nitrites ("poppers"), individuals may be less inclined to practice safe sex. [111-114] Despite a ban on selling alkyl nitrates, some gay men still use nitrite-based poppers that are chemically formulated to circumvent federal drug regulations. [115]

Adolescents

When dealing with their sexual identity, adolescents face a major milestone in their development. Adolescents who think they may be homosexual confront an enormous psychosocial challenge. [86] According to the American Academy of Pediatrics, [116] (pp632-633) youth who are alienated by their families, schools, and communities (which includes many gay and lesbian adolescents) "are severely hindered by societal stigmatization and prejudice, limited knowledge of human sexuality, a need for secrecy, a lack of opportunities for open socialization, and limited communication with healthy role models. Subjected to overt rejection and harassment at the hands of family members, peers, school officials, and others in the community, they may seek, but not find, understanding and acceptance by parents and others.... Such rejection may lead to isolation, runaway behavior, homelessness, domestic violence, depression, suicide, substance abuse, and school or job failure. Heterosexual or homosexual promiscuity may occur, including involvement in prostitution (often in runaway youths) as a means to survive."

The psychosocial difficulties encountered by homosexual adolescents put them at far higher risk for depression and suicide than their heterosexual peers. In a study of gay and bisexual male adolescents, 30% attempted suicide at least once. [117] According to the Secretary's Task Force on Youth Suicide, gay male adolescents were 2 to 3 times more likely than their peers to attempt suicide. [118] In a national survey of lesbians, 24% between 17 and 24 years old attempted suicide and 32% had thoughts of suicide. [89] Concern about homosexual orientation is a major cause of adolescent suicides or attempted suicides. [89,119,120]

While drug use may be a symptom of low self-esteem or childhood sexual abuse, the combination of alcohol consumption, other drug use, and unprotected sexual encounters among homosexual adolescents exposes them to risk of HIV infection. In a recent study of gay and bisexual male adolescents, lifetime use of alcohol was 76% among those surveyed, marijuana 42%, and cocaine/crack 25%. Alcohol and other drug use was significantly related to high-risk sexual behavior. Fifty-two percent of the youths never or inconsistently used condoms with male partners. [54] In a 1991 study of 239 gay and bisexual youth recruited through gay publications, direct appeals, and previous survey participants, an alarming number (63%) engaged in unprotected anal intercourse or injecting drug use. [53] In addition, other studies have shown that adolescents who are gay or lesbian may barter sex for money or drugs, further exposing themselves to HIV infection and other STDs. [34,54] In a 1992 study of 793 adolescents aged 13 to 21 years, 71 youths (9%), most of whom (63%) were male, were HIV-infected. Transmission was predominantly through anal intercourse with other men. [121]

MEDICAL DECISION MAKING

Physicians need to consider significant partner relationships of gay men and lesbians when medical decisions are involved, particularly for life-sustaining treatment. Many gay men and lesbians have not informed their families of their homosexual relationships. [122-124] In a study of 118 gay men with AIDS, 47% wanted their partners or friends to act as surrogate decision makers, 32% designated their families, and 14% their physicians. [125] Whenever possible, physicians should explore surrogate decision-making preferences of their homosexual patients before the need arises. [126] To do this effectively, physicians and patients need to know state and local laws regarding surrogate decision making. In addition, physicians and gay male and lesbian patients should be aware of, and plan for, the possibility of conflict between the families and partners of these patients.

COMMENT

Research about the health care needs of gay men and lesbians has provided a better understanding of how health relates to sexual orientation and behavior. After examining this research, the Council on Scientific Affairs updated its policy regarding gay men and lesbians and deleted the 1981 recommendation concerning reversal of sexual orientation. The 1994 recommendations follow.

RECOMMENDATIONS

1. The AMA believes that the physician's nonjudgmental recognition of sexual orientation and behavior enhances his or her ability to render optimal patient care in health as well as in illness. In the case of the homosexual patient this is especially true, since the physician's failure to recognize homosexuality or the patient's reluctance to report his or her sexual orientation and behavior can lead to failure to screen, diagnose, or treat important medical problems. With the help of the gay and lesbian community and through a cooperative effort between the physician and the homosexual patient, effective progress can be made in treating the medical needs of this particular segment of the population.

2. The AMA is committed to taking a leadership role in the following ways:

- (a) educating physicians on the current state of research in, and knowledge of, homosexuality and the need to take an adequate sexual history; these efforts should start in medical school, but must also be a part of continuing medical education;

- (b) educating physicians to recognize the physical and psychological needs of their homosexual patients;
 - (c) encouraging the development of educational programs for homosexuals to acquaint them with the diseases for which they are at risk;
 - (d) encouraging physicians to seek out local or national experts in the health care needs of gay men and lesbians so that all physicians will achieve a better understanding of the medical needs of this population; and
 - (e) working with the gay and lesbian community to offer physicians the opportunity to better understand the medical needs of homosexual and bisexual patients.
3. The AMA continues its support for a national health survey that incorporates a representative sample of the US population of all ages (including adolescents) and includes questions on sexual orientation and sexual behavior.
 4. The AMA encourages research to identify the unique health care issues of gay men and lesbians in order to improve diagnosis and treatment of their health care needs.

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