Wellbeing of gay, lesbian, and bisexual doctors

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Gay, lesbian, and bisexual doctors have long had a largely covert presence within the medical profession; their visibility is a relatively recent phenomenon. The American Psychiatric Association's landmark decision in 1973 to remove homosexuality from the nomenclature of psychiatric disorders was a major catalyst for this, allowing homosexual and bisexual doctors to take tentative steps into the culture at large. A search of the medical literature yields information on medical attitudes towards homosexual and bisexual patients, but little about homosexual and bisexual doctors themselves. Their challenges and triumphs are likely to be similar to those of other minority groups within the profession, except that they can choose whether to make their minority status known to patients and colleagues.[1 2]

Although societal tolerance towards sexual minorities has greatly improved since 1973, "coming out" as a homosexual or bisexual doctor remains a difficult decision, with both personal and professional consequences. Such doctors have to ask themselves several questions in deciding whether to come out:

- If I come out during medical school will it affect my grades or my ability to get into a competitive residency programme?
- Will I have the support of my classmates or will I be ostracised?
- Can I even be a homosexual or bisexual paediatrician, gynaecologist, or urologist?
- If I become a specialist, will my openness negatively affect referrals to me from colleagues?
- Will patients shun me?
- Can I practise in a small town, or am I consigned to a large metropolitan area?

Wellbeing implies personal and professional satisfaction and the ability to effectively integrate the two to form satisfying relationships with patients and colleagues and to attain their respect. In this article we review the literature on those factors most likely to affect the wellbeing of gay, lesbian, and bisexual doctors: homophobia, the difficulties encountered by homosexual and bisexual medical students and staff, and anti-homosexual discrimination. We also suggest directions for future research in this topic and ways to enhance the wellbeing of gay, lesbian, and bisexual doctors.

Summary points

While research has investigated doctors' attitudes towards homosexual and bisexual patients, relatively little attention has been paid to gay, lesbian, and bisexual doctors

The factors most likely to affect the wellbeing of such doctors are homophobia, discrimination, the challenges of medical school and residency, and lack of support systems

There is documented homophobia among doctors and directors of medical school education

Gay, lesbian, and bisexual doctors experience verbal harassment or insults from medical colleagues, and many believe that they risk losing their job if colleagues discover their sexual orientation

Although the situation has improved, more needs to be done to enhance the wellbeing of gay, lesbian, and bisexual doctors

Methods

We conducted a search of the Medline database from 1966 to June 2000 using the search terms "gay," "lesbian," "bisexual," or "homosexual" *and* "physician," "doctor," or "health professional" *and* "professional practice." We limited our search to papers written in English. We reviewed the references of the selected papers to identify studies missed by our initial search.

Homophobia

Several studies have looked at the existence of homophobia within the medical community. In 1982 Mathews et al sent a questionnaire to all members of the San Diego County Medical Society to elicit attitudes towards homosexual patients and colleagues.[3] Using the validated heterosexual attitudes toward homosexuality (HATH) scale, they found that 23% of respondents had homophobic attitudes (37% scored in the homophilic range, the rest were neutral). In four specialties (orthopaedic surgery, obstetrics and gynaecology, general and family practice, and general surgery) over 30% of respondents displayed homophobic attitudes. A 1988 survey of family practice residents at nine university-based programmes in southern California showed overall that 20% of male residents were homophobic (compared with only 3% of women).[4]

The rise of AIDS drew fresh attention to gay men and gave homosexual and bisexual concerns a new visibility. Some homophobic views were probably softened through empathy, while others hardened amid increasing vitriol directed at the gay community. A 1989 survey of 1745 third year residents in internal medicine and family practice looked at attitudes toward caring for patients with AIDS and toward homosexual people in general.[5] Of the respondents, 35% agreed with or were unsure about the statement "Homosexuality is a mental disorder," while 20% admitted that they weren't comfortable in the presence of homosexuals.

Perhaps the most egregious example of homophobia within the medical literature is a 1984 editorial in the *Southern Medical Journal*.[6] The author speculates on the aetiology of AIDS and, citing biblical quotations, concludes that "homosexual men [are] reaping … [the] expected consequences of sexual promiscuity," and that "homosexuality is a pathologic condition." The author suggests that doctors should "seek reversal treatment for

their homosexual patients just as vigorously as they would for alcoholics or heavy cigarette smokers."

Homosexual issues in medical education and training

Given that homophobia is common in practising doctors, how are homosexual issues being addressed in medical school curricula? A 1991 study, with a 65% response rate, polled the directors of medical school education in psychiatry at all US medical schools and found that, on average, about 3.5 hours was devoted to the topic of homosexuality over the four years.[7] The most common teaching technique used by the schools was lectures (80%), and about 40% of the courses used direct contact with homosexual people.

Support services for gay, lesbian, and bisexual medical students and residents, while not ubiquitous, seem to be growing. A 1994 survey of 185 homosexual and bisexual medical students from 92 medical schools in 34 states found that 70% of the students had a gay, lesbian, and bisexual support group at their school. Nine of the medical schools had an official liaison for gay, lesbian, and bisexual students (up from four in 1990).[8]

A study in 1994 of 291 directors of family practice residency programmes and 67 homosexual and bisexual third and fourth year medical students looked at attitudes surrounding specialty choice, interviewing for residency, and the ranking of residents.[9] Seventy one per cent of residents said their homosexuality affected their decision about choice of specialty, 52% felt that an openly homosexual or bisexual student would be ranked lower in a shortlist for a programme, less than half planned to disclose their sexual orientation during interviews, and 30% had edited their curriculum vitae to remove activities or memberships that might reveal their homosexuality. When asked questions from the HATH scale 8% of the programme directors scored in the homophobic range. A few directors included comments that homosexuality was a "genetic defect," a "psychiatric diagnosis," or "an aberration." A quarter said that they would rank an openly homosexual or bisexual candidate lower, and another quarter thought that disclosure of sexual orientation during interview was inappropriate. Not surprisingly, the 32% of directors who had had recent experience with homosexual or bisexual residents in their programmes had more homophilic HATH scores.

Discrimination

Anti-homosexual discrimination represents homophobia in action. That action may be a careless remark or joke that belittles a homosexual or bisexual patient, or it may be denying gay, lesbian, and bisexual students admission to medical school or marking them down during training on the basis of their sexuality. It may also involve denying a residency position to a homosexual or bisexual doctor or refusing to refer patients to such a doctor.

A 1994 survey of its membership by the American Association of Physicians for Human Rights—since renamed the Gay and Lesbian Medical Association—attempted to quantify and document instances of anti-homosexual discrimination in medicine.[10] Of the 1311 members, 711 (54%) returned questionnaires. Among the findings were that 17% of respondents had been denied referrals, 34% had experienced "verbal harassment or insult by their medical colleagues," and 66% felt that many homosexual and bisexual doctors would risk losing their practices if colleagues discovered their sexual orientation, while only 12% felt that they were treated as equals within the profession. Even more compelling than these statistics were the many personal anecdotes detailing callousness, ostracism, insults, rescinded job offers, and invitations to undergo psychotherapy.

These results were corroborated by a 1993 survey of lesbian doctors reporting harassment for their sexual orientation: 41% reported harassment at some time in their life, 18% during graduate medical education, 19% during medical practice, and 33% in any work after medical school.[11]

Fortunately, there is some evidence that these negative attitudes are changing. A study of opinions of New Mexico doctors' toward homosexual and bisexual colleagues, published in 1996,[12] paralleled the questions asked in 1982 by Mathews et al in San Diego.[3] Fewer doctors in the 1996 study would deny admission to medical school to a highly qualified homosexual or bisexual applicant (4% *v* 30% in the 1982 study). In addition, less than 10% (*v* 45% in 1982) would discourage a homosexual or bisexual doctor from becoming a paediatrician. On the subject of referral practices, 91% indicated that they would still refer patients to a psychiatrist colleague if they found out that he or she was homosexual (compared with only 57% in the San Diego study).

Questions and issues still facing gay, lesbian, and bisexual doctors

- Do gay, lesbian, and bisexual doctors feel accepted in their professional life?
- Would they advise a homosexual or bisexual premedical student to choose medicine as a career?
- Would they themselves do it again?
- What changes in medicine would improve their wellbeing?
- Are most gay, lesbian, and bisexual doctors open about their sexual orientation to colleagues, office staff, and patients?
- What are the professional ramifications of a decision to be open?
- Are openly gay, lesbian, and bisexual doctors happier and more successful, and do they suffer more or less stress?
- How many employers of doctors include "sexual orientation" in their non-discrimination statement? How many offer benefits for homosexual partners?

Future research and possible solutions

Although there is evidence that the climate of acceptance has improved over the past quarter century, gay, lesbian, and bisexual doctors still face many questions, issues, and dilemmas (see box).

Anyone conducting research in this subject has to confront a major issue: how to obtain a representative sample. If we conservatively estimate the percentage of gay, lesbian, and bisexual people in the US general population to be 3% and assume they are proportionately represented within medicine, there should be over 20 000 gay, lesbian, and bisexual doctors nationwide. Since the largest US organisation for gay, lesbian, and bisexual doctors has a membership of

Suggestions for enhancing wellbeing among gay, lesbian, and bisexual doctors

- Where possible come out
- Join a gay, lesbian, and bisexual organisation; if none is available near you form one
- If you work for a hospital or doctor group ask that "sexual orientation" be added to its non-discrimination statement—if not for yourself then for your patients
- Sponsor a booth at the local Gay Pride celebration
- Join a gay, lesbian, and bisexual email list, such as glb-medical. To join, send an email message to listserv@listserv.utoronto.ca and, in the body of the message, write: "subscribe glb-medical-l (Your name)"
- If you live near a medical school volunteer to speak as part of the homosexual and bisexual curriculum
- Act as a mentor for a homosexual or bisexual medical student or resident

about 2000, it is clear that sampling only the members of such organisations is inadequate.

Makadon has suggested that gay, lesbian, and bisexual doctors' own openness and honesty in the health services depends on explicit attention to medical education on homosexual and bisexual health issues in all aspects of training.[13] Studies evaluating the effectiveness of medical school curricula on homosexuality have independently shown that students who are acquainted with a gay man or lesbian have improved attitudes toward them.[14 15] It is no surprise to find that, anecdotally, many gay, lesbian, and bisexual doctors participate in doctor education on homosexual health issues by disclosing their own sexual orientation and acting as the "acquaintance" resource for students, residents, and colleagues in their learning process. Katsufrakis has explored the risks and benefits of serving in this role.[2] The long term effects of this strategy on wellbeing have not been researched but deserve further study, as more doctors are coming out in the workplace.

From the limited data available and our own personal experiences, we cannot recommend that all gay, lesbian, and bisexual doctors should come out to students and colleagues en masse, with the goal of improving education, attitudes, and career life. Instead, we suggest that—when and where it feels safe—lesbian, gay, and bisexual doctors join others in the workplace in the casual, honest conversations that pertain to career, family, and personal choices. In our experience these informal conversations are a great aid to doctor wellbeing. We also suggest that the colleagues of such doctors listen respectfully to this shared information, realising the cost at which it has been spoken, and welcome these doctors into conversations. For those who are not ready to come out—because of a real or perceived threat to their livelihood, family, or personal safety—we advise tolerance and patience within the homosexual and bisexual doctor community. Other practical suggestions are listed in the box.

Conclusion

Despite the encouraging indicators, at present it is difficult to assess whether gay, lesbian, and bisexual doctors have crossed a major threshold or will continue to struggle for equal treatment and respect from their peers, two essential components of wellbeing. The optimist in us trusts that the future will be considerably brighter.

Competing interests: None declared

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Commentary: The medical profession should face up to its own homophobia

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Burke and White provide a welcome US perspective on the hostile attitudes and behaviours experienced by lesbian, gay, and bisexual doctors. Such homophobia has also been documented in a qualitative study of Canadian doctors in training.[1] In Britain the Gay and Lesbian Association of Doctors and Dentists (GLADD) regularly receives requests for advice from doctors, dentists, and students who are concerned about discrimination at work because of their sexuality. What can we say about the nature of homophobia in Britain, and how can we work towards its eradication?

The nature of homophobia is more complex than is suggested in Burke and White's article, and the factors affecting wellbeing are more wide ranging. As lesbian, gay, and bisexual health professionals and students, we do not just experience overt homophobia but also more subtle hostility from our colleagues.[2] In addition, some of us have to deal with our own internalised homophobia—we have to reconcile our sexual identities with societal expectations that heterosexuality is the norm.[3] Some of us may choose never to disclose our sexuality for fear of the consequences of

revelation to families, peers, or patients. Further, we are not afforded legal protection from discrimination nor equal partnership rights. Battling with all of these issues is unpleasant and exhausting, particularly in the early years of a career when job changes are frequent.

The Gay and Lesbian Association of Doctors and Dentists held a workshop recently on challenging workplace bullying and homophobia in the NHS.[4] The workshop addressed the need for a national guideline to make it clear that homophobia in the healthcare professions is unethical and unacceptable. Those who discriminate against others on the grounds of their sexuality cannot be effective team members nor can they provide a professional service to all their patients. The workshop identified a lack of empowerment to deal with homophobia within the workplace and a lack of confidence that unambiguous support from authorities would be forthcoming if homophobia were challenged.

The workshop identified two main approaches to addressing this situation. Firstly, support must be provided for lesbian, gay, and bisexual students. There is currently a wide regional variation in such support.[5] Secondly, all members of the profession need effective opportunities to learn about issues relevant to lesbian, gay, and bisexual patients and colleagues. It is not surprising that homophobia exists in medicine since doctors and students share similar attitudes to those of the general population. This is why they need specific opportunities to foster an awareness of, and to deal with, their own homophobic attitudes.[2] Unfortunately, many medical schools do not yet offer such opportunities.

We urge the General Medical Council and deans of medical schools to work with those responsible for curricular development to provide effective learning opportunities to help students face up to their own homophobia and challenge and eradicate it. We urge the royal colleges and postgraduate deans to ensure that appropriate learning opportunities are provided as part of general and specialty training programmes and continuing professional development. We are planning a further workshop to draw up guidelines for best practice for medical schools, NHS trusts, and general practice partnerships.

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A memorable patient

Suffering in silence

In less developed societies where poverty, illiteracy, and deeply ingrained cultural beliefs coexist, human distress can take on an unimaginable garb.

I saw her in the mental health clinic in Orangi, one of the many slum areas of Karachi, Pakistan's largest city. She was barely 5ft tall and, walking with a slight droop of the shoulders, looked shorter still. The doctors could not find any reason for her complaints—headaches, palpitations, weakness, appetite, and weight loss. Various analgesics, vitamins, tranquillisers, and antidepressants had had no effect. X rays, endoscopies, blood and urine tests were all normal.

Married with two grown up sons, she had no other living relatives. I could not understand the cause of her symptoms.

I ask about her relationship with her husband. "It's all right," she says. But a slight hesitation in her answer alerts me. I follow with another question about him and suddenly, unexpectedly, it all comes out. A short tempered man, he is never satisfied and hits her frequently. He has been hitting her from the second day of marriage. The missing front teeth and loss of hearing in one ear bear testimony to the viciousness of his beatings. He threatens her with divorce and makes her cover her face so bruises do not show. Ashamed of talking to others she has somehow borne and tolerated his behaviour.

I feel her voice cracking as she desperately tries to retain her composure. She looks down avoiding my eyes. Having exposed herself to a total stranger she seems uncertain what to do next. She holds back her tears as I hold back mine. I don't know whether to feel sorry or angry for not doing anything about her situation. But as I see the forlorn figure in front of me I want to reach out to comfort and reassure her that I'll speak to her husband and make him understand how wrong it is for men to hit women. But I know from experience he will neither attend nor admit any wrongdoing. She pleads with me not to tell him or he will beat her even more.

It is a recurring story. In this society the man can do anything to assert his authority. That is the way he has been brought up from an early age.

For the woman it can be a life of torment—verbal, physical, psychological—but one she must put up with, for her children's, family's, and her own sake. For no matter how terrible the abuse she must remain married. That is what this society, her family, and she herself demand. To do otherwise would spell the end.

On the long drive back a hundred questions cross my mind. Why are women in this society brought up to be so dependent on men? To be powerless against men who abuse them? Why are boys brought up in such a way that physical abuse of females is accepted behaviour? Do we not understand that if the man is to respect his wife he must see women in his own home—mother and sisters—treated equally to him?

For the tormented woman of Orangi such questions are irrelevant as she and countless other women of this society continue to suffer in silence.

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We welcome articles of up to 600 words on topics such as *A memorable patient, A paper that changed my practice, My most unfortunate mistake*, or any other piece conveying instruction, pathos, or humour. If possible the article should be supplied on a disk. Permission is needed from the patient or a relative if an identifiable patient is referred to. We also welcome contributions for "Endpieces," consisting of quotations of up to 80 words (but most are considerably shorter) from any source, ancient or modern, which have appealed to the reader.