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The AIDS-Related Experiences and Practices of Primary Care Physicians in Los Angeles: 1984-89

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Abstract: Telephone interviews of random samples of Los Angeles primary care physicians in 1984, 1986, and 1989 obtained information about their AIDS-related practice experiences, and sexual history taking. Data from mid-1989 reveal almost 74 percent have worked up at least one patient for AIDS or HIV infection in the past six months and 39.5 percent are caring for at least one patient with AIDS or AIDS-related complex. Self-reported use of appropriate sexual history questions has improved substantially over this five-year period. (*Am J Public Health* 1990; 80:1511-1513.)

Introduction

There has been growing speculation, based primarily upon surveys of physicians' attitudes, that a significant proportion of doctors might fail to provide care to patients found to be infected with the human immunodeficiency virus (HIV) and/or who developed acquired immunodeficiency syndrome (AIDS).^{1,2}

Over the past six years, we have conducted three telephone surveys of random samples of primary care physicians in full-time office-based practice in Los Angeles, California (January 1984,³ summer 1985,⁴ and summer 1989). Data presented here illustrate changes over this period in physicians' experiences with patients at risk or infected with HIV.

Methods

Stratified random samples of internists, family practitioners, and general practitioners were drawn to reflect the

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relative proportion of each of these groups practicing in Los Angeles County. The samples were drawn from data tapes provided by the American Medical Association Physician Masterfile, containing listings of all primary care physicians in full-time office-based practice in Los Angeles—a pool of about 5,000 physicians.⁵

Results

Response Rates and Characteristics of the Sample

The response rates for all three surveys have been above 60 percent; the most recent survey resulted in a 77 percent response rate. These response rates are calculated using as the denominator all physicians actually contacted (see Table 1).

Examination of the demographic characteristics of respondents versus nonrespondents during each survey period has revealed no obvious source of bias. The increase in the proportion of women interviewed over the past five years reflects the growing number of women primary care physicians practicing in Los Angeles County; for Los Angeles as

TABLE 1—Response Rates and Characteristics of Respondent Physicians

| | 1984 (635) ^a | 1986 (279) ^b | 1989 (463) ^a |
|--|----------------------------|----------------------------|----------------------------|
| % Response Rates | 63.1 | 60.0 ^c | 77.0 |
| Specialty | | | |
| % General Internal Medicine | 42.4 | 44.1 | 47.7 |
| % General Practice | 26.3 | 17.2 | 17.3 |
| % Family Practice | 31.3 | 38.7 | 35.0 |
| % Solo Practice | 50.4 | 54.5 | 51.2 |
| % Foreign Medical Graduates ^d | 17.3 | 19.9 | 21.4 |
| % Female | 6.8 | 9.0 | 19.7 |

a) Los Angeles County.

b) Los Angeles SMSA.

c) Response rate represents that for the entire state of California (N=1000).

d) Does not include graduates of Canadian or Western European medical schools.

a whole, the proportions are: 11 percent in 1984, 14 percent in 1986, and 16 percent in 1989.⁵

AIDS-Related Practice Experiences

The proportion of physicians who, within the six months prior to being interviewed, had worked up or referred a patient for work up of possible HIV infection, including AIDS, has almost tripled, growing from 27 percent to over 73 percent in the five years between 1984 and 1989. Also, the proportion of physicians who have at least one patient in their practice with AIDS has grown from less than 1 percent in 1984 to almost 40 percent in 1989. While 29 percent of primary care physicians surveyed in 1989 had between one and five AIDS patients in their practice, a small group of these physicians (3 percent) were caring for 15 or more patients with AIDS (see Table 2).

Sexual History Taking Questions

Physicians were asked if they took sexual histories on all their new patients. Those responding affirmatively were asked, "What do these questions cover?"

As Table 2 indicates, the proportion of physicians who volunteered they ask about the sexual orientation of their patients has doubled during this five-year interval, with close to half the physicians in 1989 saying they asked for such information. The proportion reporting they ask patients about the number of sexual partners has tripled in the five-year period.

Physicians' Attitudes

Physicians were also asked the extent to which they think the average physician is uncomfortable discussing sexual matters with homosexual patients. In an attempt to avoid only socially acceptable responses, the question was phrased in general terms, rather than asking about the doctor's own level of discomfort. Table 2 shows that these figures have changed little over the past five years, with nearly three-fourths estimating that their colleagues have moderate or considerable discomfort. The estimated discomfort

of others is unrelated to physicians' own reported AIDS-related experiences.

Discussion

The data from these three surveys suggest that, as a group, a significant number of primary care physicians in Los Angeles have responded to the growth in the number of AIDS cases by accepting responsibility for the care of patients with AIDS or AIDS-related complex. Unfortunately, these data do not allow us to estimate the extent to which the patients under care of these physicians represent their established patients who have developed AIDS, or whether these are new patients in the practice. Nor can we distinguish among the 60 percent of physicians who have no AIDS patients in their practice how many have refused to care for a patient with AIDS, as contrasted to those who merely have not yet encountered any patients with AIDS.

It may be reassuring to those responsible for funding physicians' education about AIDS that physicians' awareness of the content of a sexual history has improved substantially during the past five years.

While the data on physicians' sexual history taking is self-reported, there is evidence that their awareness of some key questions that should be asked has increased. Knowledge of these is a prerequisite to their use, but we have no data from patients to validate that these were asked. Despite this improvement, a majority of primary care physicians apparently are not asking questions essential in assessing sexual risks.

The persistent belief over time among physicians that their colleagues are uncomfortable in dealing with homosexual patients remains puzzling, given the increases in contact with AIDS patients and reports of more comprehensive sexual histories. Lacking additional data, we were unable to determine whether physicians' perceptions of colleagues' discomfort is unrelated to their own feelings, or that feelings of discomfort simply are not strong predictors of the willing-

TABLE 2—AIDS-Related Experiences and Practices

| | 1984 ^a (95% CI) | 1986 ^b (95% CI) | 1989 ^a (95% CI) |
|---|-------------------------------|-------------------------------|-------------------------------|
| <i>Practice Experience</i> | | | |
| Worked up a patient for AIDS or HIV infection in past 6 months | 27.0 (23.5, 30.4) | 43.0 (37.2, 48.8) | 74.7 (70.7, 78.7) |
| Caring for at least one patient with AIDS or ARC | 0.6 (- .002, 1.2) | 6.1 (3.3, 8.9) | 40.0 (35.5, 44.5) |
| <i>Sexual History Taking^c</i> | | | |
| Ask patients about their sexual orientation (sex of partners) | 23.0 (19.7, 26.3) | 20.1 (15.4, 24.8) | 42.3 (37.8, 46.8) |
| Ask patients about number of sexual partners | 9.9 (7.6, 12.2) | 9.0 (5.6, 12.4) | 29.8 (25.6, 34.0) |
| Ask patients about sexual practices | 12.1 (9.6, 14.6) | 16.5 (12.1, 20.8) | 18.4 (14.9, 21.9) |
| <i>Physicians' Attitudes</i> | | | |
| To what extent do you think the average physician is uncomfortable discussing sexual matters with gay patients? | | | |
| Considerable | 34.9 (31.2, 38.6) | 28.5 (23.0, 34.0) | 33.3 (28.8, 37.8) |
| Moderate | 41.2 (37.4, 45.0) | 43.7 (37.7, 49.7) | 38.6 (33.9, 43.2) |
| Small to None | 23.9 (20.6, 27.2) | 27.7 (22.3, 33.1) | 28.1 (23.8, 32.4) |

a) Los Angeles County: 1984 (N=635); 1989 (N=463).

b) Los Angeles SMSA: 1986 (N=279).

c) Percentages are based on the total number of physicians surveyed.

ness of some physicians to provide care in the face of this extraordinary epidemic.

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Behavioral Change in Longitudinal Studies: Adoption of Condom Use by Homosexual/Bisexual Men

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Abstract: We compared reporting serial cross-sectional prevalence of sexual behavior over time, to reporting individual patterns of behavioral change in a cohort of homosexual men at a six-month interval. Aggregate prevalence rates underestimated the magnitude of change to safer practices, and failed to provide information on relapse to less safe practices. We conclude that it is important to report data based on individual fluctuations in behavior for the evaluation of change over time. (*Am J Public Health* 1990; 80:1513-1514.)

Introduction

During the past few years, the issue of condom use by homosexual/bisexual men in response to the threat of acquired immunodeficiency syndrome (AIDS) has been addressed in several reports from diverse geographic areas. While some reported cross-sectional findings,¹ others have dealt with the more complex task of describing longitudinal behavior patterns.² A recent letter by Kelly and St. Lawrence³ has highlighted the difficulty of documenting relapse to unsafe sex practices through serial cross-sectional studies that mainly monitor relative increases (or decreases) in sexual behavior prevalence.

We have been surveying adoption and maintenance of safer sexual practices, most recently with regard to condom use in receptive anal sex, in a cohort of homosexual/bisexual men in Chicago. This brief report utilizes some findings from that cohort to highlight methodological issues related to reporting behavioral change in longitudinal studies.

Methods

Participants in the Chicago Multicenter AIDS Cohort Study are concurrently enrolled in a longitudinal behavioral

and psychosocial investigation. Detailed methods of recruitment and assessment have been described previously.^{4,5} Self-administered questionnaires are completed semi-annually after each visit to the study center. Men have already participated in nine such visits and data collecting is ongoing. At visit 4 (V4) in February 1986, 729 men completed a new section of the questionnaire dealing with condom use in receptive anal sex. At visit 5 (V5), complete data were available for 642 men. A total of 601 men completed this section at both visits. Dropout effect was negligible, as participants at V4 and/or V5 did not differ significantly with regard to baseline sociodemographic or behavioral variables. Men in the V4-V5 cohort were predominantly White (89 percent), had a mean age in 1984 of 34.5 years, a mean educational attainment of 16.4 years, and a mean annual income in 1984-85 of \$26,300. Forty percent of them were HIV seropositive by V5.

Participants described consistency of condom use during receptive anal sex (always, sometimes, never) with various types of sexual partners, ranging from those with whom they had a steady relationship to anonymous contacts. Two methods for analysis of these data are considered below. The first one defines four levels of condom use in receptive anal sex, from most to least safe.

1. no receptive anal sex;
2. consistent condom use with all partners;
3. inconsistent condom use;
4. no condom use.

This method was applied in serial cross-sectional analyses at V4 and V5. The second method includes these same four components considered in terms of behavioral consistency between V4 and V5. For men in each of the above categories at V4, subsequent behavior at V5 was described in one of three ways:

1. maintenance of the same behavior;
2. change to any less safe practice;
3. change to any safer practice.

Results

Table 1 reports aggregate serial cross-sectional findings from V4 and V5. It shows a slight increase in the prevalence of safer sexual practices (no receptive anal sex or consistent condom use) with some decrease in no condom use. Overall, change reported as aggregate data suggests that prevalence of

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