

The Hispanic, Gay, Lesbian, Bisexual and HIV-Infected Experience in Health Care

MILTON L. WAINBERG, M.D.

Abstract

This presentation, relying both on personal experience and an array of studies, surveys the problems minorities face in trying to obtain adequate health care. From another viewpoint, these are problems that physicians have in trying to provide health care to persons they do not understand and cannot really see or hear. And the problems multiply when the patient is a minority in more than one sense. The gay, Hispanic, HIV+ patient, for example, is removed from the average physician's comprehension to a degree that is itself almost incomprehensible. Treating patients as they ought to be treated requires that physicians overcome many layers of prejudice and unfounded assumptions. Failure to overcome such prejudices distorts medical practice. **Key Words:** Gay, lesbian, homosexuality, homophobia, racism, Hispanic, health care access, psychiatric population.

I HAVE THE TASK OF PRESENTING AN OVERVIEW of some of the difficulties that Hispanics, HIV-positive individuals, and gay, lesbian, and bisexual people experience in accessing health care. I am glad that others are presenting on the Hispanic experience. I shall also make some remarks about the severely mentally ill population, another minority with difficulty accessing health care.

I will report on statistics and research, and also try to bring my personal experience to this meeting. I guess the fact that I am gay and Latino, and that I work with people who have HIV and with the psychiatric population makes me a perfect guest speaker.

I shall discuss each of these groups separately. Yet, as you can imagine, any individual who

belongs to more than one of them may experience difficulties exponentially greater than those which face members of only one of these minorities.

During my training here at Mount Sinai and at the Bronx Veteran Administration, which included rotations in psychiatry, medicine and neurology, I was impressed by some remarks made by a few of the attendings and my colleagues about these minorities and several others. As my Jewish last name does not reflect my Hispanic heritage, and not everybody with whom I trained was aware of my homosexuality, other health care providers did not monitor their comments in my presence. The prejudices I encountered are not unique, of course, to my experience. They are endemic and they reveal an important problem in our society.

Here is an anecdote which illustrates the problem. In my first year of training, during morning rounds, a prominent white male physician was telling us that Hispanic women are not very reliable patients, since one can elicit any symptom from them. He said something to the effect that "They are so histrionic and somatize so much that they will say yes to anything you ask

Assistant Professor of Psychiatry, Columbia University College of Physicians and Surgeons, and Director, Behavioral Health, HIV/AIDS Center, St. Luke's-Roosevelt Hospital Center, New York, NY.

Address correspondence to Milton L. Wainberg, M.D., Department of Psychiatry, College of Physicians and Surgeons of Columbia University, 722 West 168th Street, New York, NY 10032.

them.” To demonstrate, he conducted an interview and physical examination on a delightful 50-year-old Spanish-speaking woman. The woman was confused, yet respectful of this physician, who basically seduced her into agreeing with every manipulative question he asked. She never embarrassed him by letting him know that his Spanish at times did not make sense, that often she did not understand what he meant and only agreed with him out of respect, the way her culture expects her to. He felt he had proven the character of the Hispanic female patient. I am sure you can understand my rage at that moment. With the support of my chief resident, who also was enraged, I challenged his theory and reproduced the same interview and results with a middle-aged white woman just across the room. Needless to say, my evaluation in that rotation was the worst of my training. But what is worse, I feel embarrassed for my behavior for two reasons. As a lesbian colleague of mine pointed out, it might have been a better idea to choose a white man and not a woman for the second interview, so as to challenge his hypothesis about gender. Better yet, I should have repeated the evaluation with the Hispanic woman appropriately and, thus, demonstrated how to perform a thorough yet respectful interview. I should not have exposed another person to the same manipulation and humiliation.

So, what is the point of this story? The first thing, of course, is that this attending was unable to conduct a thorough and accurate evaluation because of his attitude. More important, all health care providers need to be aware of how our labels, preconceptions, fears and beliefs can interfere with our work.

Where do such labels, preconceptions, fears, and beliefs come from? Several factors may be involved. A terrible personal experience in our past may make it hard for us to deal with someone who reminds us of that experience. Also, in many different ways we are taught to fear, hate, or condemn some groups. We learn these attitudes from our parents, friends, schools, the media, movies, etc. And then there are idiosyncratic reactions to particular groups. Homophobia and racism can be an expression of our own internal difficulties. Some of the worst anti-Semites are closeted Jews. The same phenomenon occurs with individuals who fear homosexuality out of their own feelings for the same sex. One study of a group of self-defined heterosexual men who were exposed to gay male pornographic material reported that those subjects who had the worst regard for homosexuals or who

showed a high degree of homophobia actually experienced penile erections in response to the materials (1).

Some people, even though versed in the realities of HIV transmission, fear contagion. The fear of contagion can be an unconscious fear. I have supervised many psychotherapy sessions and interviews of HIV positive individuals by medical residents where there was absolutely no possibility of physical contact with the individual and thus no possibility of contagion. Yet, such fears were evident in the behavior of the health care provider. At times, psychiatric patients also bring out fear in providers.

So, what are the repercussions on minorities of these labeling behaviors? Let me offer some relevant data. In the *Journal of Nursing Scholarship* in 1988, Stevens and Hall (2) reported the following about a sample of lesbians interviewed in the state of Michigan:

- 84% were reluctant to seek health care due to homophobia
- 40% feared they would receive inferior care if they “came out” or disclosed their homosexuality
- 84% found practitioners nonempathic
- 72% had experienced ostracism
- 96% of respondents indicated that they would get poorer care if their lesbianism were known.

In a 1989 survey published in the *Journal of Nursing Education*, Randall (3) found the following among the nursing faculty of a prominent school:

- 17% felt lesbianism is a disease
- 23% believed that it was immoral
- 34% claimed that it was disgusting
- 52% claimed it was unnatural
- 17% thought that lesbians molest children
- 8% felt that lesbians were not fit to be nurses.

In the 1987 *Journal of Medical Education*, Kelly (4) reported a survey of 119 Mississippi medical students. It revealed that gay men with AIDS or leukemia:

- Were seen as more responsible for their illness
- Were seen as being more dangerous to others
- Were thought to be suffering less pain than others
- Were considered and treated as inferior to heterosexual patients
- Were thought to deserve to lose their jobs, be quarantined, and die.

We could say that New York is different from Mississippi or Michigan. But a survey of third-

year New York medical students published in *Psychosomatics* in 1990 by McGrory et al. (5) reported that students felt that:

- Patients with HIV were more responsible for their illness
- More than a quarter of their peers and half of their faculty had negative attitudes toward gay/lesbian patients and patients with HIV.

These attitudes explain the high rate of discrimination against gay, lesbian and bisexual professionals in the field of medicine. The currently utilized term “gay bowel syndrome” as a diagnosis is an insulting expression. Imagine a syndrome being called the “heterosexual vaginal syndrome” or the “straight male penis syndrome.”

HIV/AIDS affects many minorities openly stigmatized or hated:

- Ethnic minorities—African Americans, Asian Americans, and Hispanics, where racism may have a big impact on their care
- Gays, lesbians and bisexuals, who may receive inadequate care because of homophobia and biphobia
- Intravenous drug (IVD) users, who also confront discrimination in their care.

Also, because of stigma surrounding the disease itself, many individuals with HIV/AIDS do not disclose their status to relatives and friends. Thus, relatives and friends may not be included in the provision of care, to enhance comfort and support. The HIV/AIDS epidemic intensely reflects the issues of access and allocation of health care. Unfortunately, HIV mostly affects stigmatized minorities. Many believe this is the reason that little has been done to help those afflicted by HIV, and to prevent the spread of HIV within minority communities. Perhaps those outside these minority communities think that it will stay within these populations. However, HIV does not discriminate.

In the 1970s and early 1980s, the “gay liberation” era, gay men were unknowingly infecting one another with HIV. Given their strong sense of community, their education and affluence, the white gay male community, even though heavily stigmatized, united to transform the economics, access and delivery of health care, as well as the speed of research implementation, approval and application. Community-based organizations like

Gay Men’s Health Crisis (GMHC), and Aids Coalition to Unleash Power (ACT UP) were the vortex of such activity. Unfortunately, it took several years before other minorities were included in this process.

Because of distrust of the medical establishment, many minorities do not seek treatment for their HIV-related conditions. You may have seen reports in the news that African Americans and Hispanics are benefitting less than Caucasians from treatments for HIV-related illnesses. However, with the development of the protease inhibitors, which can offer a new lease on life for some, there has been some influx of individuals from minority groups coming to our clinics asking for help and hope. Nonetheless, it is staggering to find out how many HIV-infected individuals are not getting care. Although HIV-related hospital admissions have decreased in number, homeless minority individuals who are not medically followed anywhere continue to have a high rate of admissions. Also, it has been my experience that, while they are hospitalized, HIV-infected individuals who require consultation from providers other than the HIV clinic’s staff experience discrimination, delayed evaluations and, at times, refusal of indicated procedures and care. Providers in HIV centers spend many hours trying to get some consultants to do their jobs and trying to ensure that proper and nondiscriminatory recommendation are observed. Perhaps the substandard care may be explained by some of the data above about the attitudes toward homosexuals and IV drug users. The reality is that nobody wants or deserves to be infected with HIV.

Only recently have hospitals made some efforts to hire minorities. Just count how many minority physicians you know. You also do not see many openly gay, lesbian and bisexual physicians outside of HIV centers, where (perhaps) the attitude is to let gay physicians treat their own people. In general, the medical community is not inclined toward openness. Many gay providers will get only gay referrals, and not necessarily by choice.

Severely mentally ill individuals are also heavily stigmatized. On a unit for schizophrenic patients, one of my patients presented all the signs and symptoms of appendicitis. Yet the consulting surgeon believed the patient’s delusions were influencing the clinical presentation and decided to wait. The surgical procedure performed the following day was much more complicated and dangerous than it would have been if performed earlier. As a consultant for psychiatric

patients on medical floors, I often encounter health care providers who resist seeing the person behind the psychiatric diagnosis. Organic problems are often misdiagnosed as psychiatric symptomatology, and the risk of HIV infection is not associated with mentally ill individuals. As if psychiatric patients do not have sex or share needles! Researchers were surprised to find out that the rate of infection in the psychiatric population was similar to that in the rest of the population.

Let me give you some examples of the consequences of health care providers' attitudes.

Robertson and Schachter (6) reported in a 1981 survey that the interval between Papanicolaou smears was 21 months for lesbians, but only 8 months for heterosexual women, with the consequence of 2.7% of cervical dysplasia found in the lesbians screened. They also reported that the number of single lesbian women who had never been offered mammography is much higher than that of married or divorced women (6).

Research on teen suicide reveals that the rate of attempted and successful suicide is greater in gay teens. This research has also shown that suicide attempts often occur 24–72 hours after a visit to a health care provider (7–10).

Minorities do not trust the health care system. Thus, they often do not seek help until an emergency occurs. The reports of the Tuskegee study, of African American men with syphilis, substantiate minority distrust of the health care system.

As health care providers, we are in this business because we care about people, that is, all people, not just those who speak our language, share our sexual orientation, or share our heritage or our belief. We need to be aware that all of us carry some hatred in different degrees, so that we can transcend it and treat people appropriately. People must be made to feel comfortable and welcome to encourage their participation in their care. Do not allow fear of mental illness to affect your judgement. Respect the person's heritage, and understand and even enjoy their culture without judging or comparing it. Do not assume you know your patient's sexual orientation. Do not ask about your patient's husband/wife but about

the person in his/her life, and ask their gender. If you learn that the patient's significant other is of the same gender, do not assume any stereotypes. And do not judge people by their illness. If you maintain the usual and appropriate precautions to decrease possibilities of contagion, you do not have much to fear. Listen to what the patient says. Do not fear that you will have to approve their behavior or do anything besides what you know how to do. That is why they have come to see you. If you don't know something, ask. If you do not know how to manage some problem, say that you don't and, as with any other question, consult for an answer.

Most important, remember that phobias and hatred are health hazards, and that we all carry hatred. Your professional goal is to create a comfortable setting in which to prevent, care for, or palliate illness. Do not let your hatred complicate illness.

References

1. Adams HE, Wright LW Jr, Lohr BA. Is homophobia associated with homosexual arousal? *J Abnorm Psychol* 1996; 105(3):440–445.
2. Stevens PE, Hall JM. Stigma, health beliefs and experiences with health care in lesbian women. *Image J Nurs Sch* 1988; 20(2):69–73.
3. Randall CE. Lesbian phobia among BSN educators: A survey. *J Nurs Ed* 1989; 28(7):302–306.
4. Kelly JA, St. Lawrence JS, Smith S Jr, et al. Medical students' attitudes toward AIDS and homosexual patients. *J Med Ed* 1987; 62(7):549–556.
5. McGroary BJ, McDowell DM, Muskin PR. Medical students' attitudes toward AIDS, homosexuals, and intravenous drug-abusing patients: A re-evaluation in New York City. *Psychosomatics* 1990; 31(4):426–433.
6. Robertson P, Schachter J. Failure to identify venereal disease in a lesbian population. *Sex Transm Dis* 1981; 8(2):75–76.
7. Millard J. Suicide and suicide attempts in the lesbian and gay community. *Aust N Z J Ment Health Nurs* 1995; 4(4):181–189.
8. Muehrer P. Suicide and sexual orientation: A critical summary of recent research and directions for future research. *Suicide Life Threat Behav* 1995; 25 Suppl:72–81.
9. Richardson J. The science and politics of gay teen suicide. *Harv Rev Psychiatry* 1995; 3(2):107–110.
10. Shaffer D, Fisher P, Hicks RH, et al. Sexual orientation in adolescents who commit suicide. *Suicide Life Threat Behav* 1995; 25 Suppl:64–71.