

# FOCUS A GUIDE TO AIDS RESEARCH

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## The Impact of AIDS on Medicine

Charles E. Lewis, MD

Advances in medicine within the past three decades have had an enormous impact on society. Individuals with chronic disease are living longer. Those with defective joints often can replace them, and patients with disabilities can live better with them. Our use of non-invasive diagnostic tools has spiraled. We now find that our understanding of the very basic processes of life exceeds our capacities to deal with the consequences.

Physicians tend to talk about the impact of medicine on society rather than society's impact on medicine. But most physicians currently practicing medicine have never faced an epidemic of an uncontrolled disease. For them AIDS is a new phenomenon. The result for most is a new and uncomfortable feeling, one made more intense by the fact that AIDS is primarily spread through sexual contact and is presently an untreatable disorder.

AIDS has already had a significant impact on medicine; it promises to continue doing so in the future. The description that follows of a research project assessing physician competence in caring for persons with AIDS illustrates this point.

### A Study of Competency

In 1983 we mounted a study examining the effect of various teaching and learning methods on physicians' competencies related to AIDS.

The first problem was defining "competency". With the help of subspecialists, the following areas of competency were defined:

- (1) The ability to take an adequate sexual history to define risk;
- (2) The ability to provide sexual counseling about high-risk and low-risk behaviors;
- (3) The level of understanding about the epidemiology of HIV as manifested by recognition of low-risk forms of interpersonal contact;
- (4) The ability to apply knowledge to solve a problem, that is, clinically evaluating a patient with symptoms suggestive of HIV infection; and
- (5) The level of understanding of the appropriate use of HIV antibody testing with particular reference to the problems of sensitivity and specificity of the tests and the subsequent generation of false positives.

To assess the effectiveness of written, aural (audiotape), and audiovisual (videocassette) approaches to presenting information aimed at improving areas of competency, it was first necessary to determine the baseline competency of a random sample of primary care practitioners in Los Angeles County. We conducted telephone interviews to assess AIDS knowledge and

physician practices.

In mid-1984 we interviewed three groups of physicians: internists, family physicians, and general practitioners in Los Angeles County, (N-600). Each reported practicing medicine for more than 20 hours a week. The results were striking. Only a handful of the physicians interviewed took sexual histories, and sexual counseling was nonexistent. Only 20 percent knew of a screening test, and only 15 percent adequately approached a patient who might have symptoms of AIDS. Most of the respondents grossly over-estimated the dangers of low-risk circumstances, such as casual contact associated with restaurant dining.

The interview materials were prepared carefully because we were interested also in testing whether a somewhat light-hearted approach to the presentation of AIDS information would have a salutary effect. We interviewed these same physicians again four months later. There were significant increases in most measures of competence among *all three groups*, though not in sexual history-taking or counseling.

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On closer inspection of the data, however, it became apparent that individuals who said they had not used the material we provided did as well on the post-test examination as those who had used and enjoyed it. It became obvious that physicians, in general, were being bombarded with information about AIDS from a variety of mass media sources. Compared to the rather miniscule education effort provided by our study, most had improved their knowledge more from watching the nightly news than from reading our material.<sup>1</sup>

This study was unique in many ways. It was the first time in more than 20 years of research that the principal investigator found it necessary to meet with research assistants (interviewers) as a group to listen to their concerns. Many were decidedly upset by their contact with the physicians in the study. One assistant said, "I called a doctor and told him what the survey was about. He said, 'I don't have any of those patients, and if I did, I wouldn't treat them, because those bastards deserve to die.'"

This was not an isolated example. The collected data demonstrated that those physicians who were uncomfortable with gay men were less competent in the areas being studied. But the interviews revealed more than incompetence; they also uncovered rampant homophobia in its ugliest form.

The pieces of the puzzle began to fall together. In the development of the interview guide, we met for lunch with a group of internist friends practicing in Los Angeles to explore with them the proposed content of the questions. When we mentioned sexual history-taking, one older physician said —

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### A Publication of the AIDS Health Project University of California San Francisco

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# The Impact of AIDS . . .

*continued from cover*

after reviewing a certain set of questions — "If I asked my patients these questions, they would get up and walk out of the office!" A young woman internist across the table said, "So what's the big deal? I simply ask, 'Are you sexually active?' and if he says 'yes,' I ask 'With men, women, or both?'"

Los Angeles is an atypical area of the world; findings there cannot necessarily be extrapolated elsewhere. To get a more representative sample we undertook a statewide study using the same interview structure. We interviewed a random sample of 1,000 primary care physicians in active practice throughout California. The results completely validated those from Los Angeles.<sup>2</sup>

The statewide sample was selected in such a way that physicians practicing in small communities were oversampled. We interviewed more than 300 physicians practicing in these small communities — approximately half of all practicing in these areas. The responses of these physicians led to one conclusion: AIDS is *not* a disease of major urban centers alone, in California or elsewhere in the country. It is a problem primary care physicians can expect to face wherever they live and practice.

Approximately 80 percent of the smalltown physicians said one or more patients expressed concern about contracting AIDS, the same percentage found among physicians from San Francisco, Los Angeles, and other metropolitan areas of the state. Approximately half had one or more patients in their practice they knew to be at risk for HIV infection. Despite that, fewer than 60 percent had counseled these patients about the means of reducing their risk.

The only major difference between the two studies was that while 12 percent of the primary care physicians in metropolitan areas of California had at least one case of AIDS in their practices, only 5 percent of those in rural areas did. Again, discomfort in dealing with gay men was significantly associated with incompetence in caring for these patients.

The same variables that predicted competence in general were relevant both in the statewide and in the Los Angeles County samples. That is, internists performed better than family physicians, who in turn performed better than general practitioners. Younger physicians, particularly those under 40, performed much better than older physicians. Physicians in group practice did better than those practicing alone; graduates of American medical schools did better than graduates of medical schools from less developed countries. And, of course, those who had cared for one or more AIDS patients were more competent than those who lacked this experience. The participation rate in the statewide survey was 60 percent, not quite as good as in Los Angeles County. There was no evidence of bias in terms of the non-respondents by any of the gross demographic variables available, but it was strongly suspected that the principal reason for non-compliance was physicians' unwillingness even to talk about AIDS, let alone admit that patients at risk might exist within their practices.

Physicians are not alone among health care providers with these homophobic attitudes and behavior.<sup>3</sup> But our studies suggest that physicians generally believe that gay physicians probably do a better job caring for gay AIDS patients than do heterosexual physicians.<sup>2</sup>

These results pose a problem for those who would like to operationalize the positions taken by the American Medical Association and the American College of Physicians; namely, that it is unethical for *any* physician to refuse to care for an AIDS patient. Our evidence suggests that just as some physicians should not attempt to care for patients in cardiogenic shock after a heart attack, some physicians are emotionally incapable of concerned decision-making in caring for persons they fear or

dislike, and as a result they should not treat them.

To return to the question of the impact of AIDS on medicine: at the system level, the burden of caring for persons with AIDS is already obvious, and that burden will only increase. Setting aside the personal and emotional costs, the economic costs are staggering. They will increasingly affect expenditures for national health care. Unless additional funds are made available, AIDS patients will receive less care.

Avoiding people with AIDS can also be seen on an institutional level. Most hospitals do not wish to be known as AIDS hospitals, a term used by some for any institution that has ever knowingly admitted a person with AIDS. University teaching hospitals have expressed concern about being unable to recruit the best and the brightest house staff when there are "too many" AIDS patients on the wards.

## Limited Progress in Attitude Changes

At the individual level, it is difficult to dissociate discomfort with human sexuality from the pain of contact with death and dying and the fear of becoming infected. However, some progress has been made. After decades of talking about the importance of physicians' knowing something about their patients' sexuality, we are finally recognizing the need to have this information. Perhaps we will realize soon that most patients are not embarrassed or resentful when the topic of sex is raised, as long as the physician is not. In fact, many patients are relieved. The physician's questions about sex legitimizes it as an area of medical concern, thus giving the patient permission they may need to seek relevant information.

AIDS has also made it imperative to operationalize some of the definitions of "comprehensive, continuing care". It is essential to manage the care of people with AIDS from the identification of HIV antibodies through the use of experimental drugs, from acute episodes of opportunistic infections to long-term pre-terminal or terminal care. Concern with humanity, if not with costs, requires a long view of patient care.

Our early experience with this study of physicians' competence led us to seek support from the National Institute of Mental Health to develop materials for health providers who deal with AIDS. We developed materials that deal primarily with the affective dimensions of medicine, to enhance competence by increasing comfort. For example, our class on ethics (using professional actors) presents real and difficult problems. Each scenario runs two to two and a half minutes, but a small group with a competent leader can spend the next hour wrestling with their own approaches to the problem. While knowledge is important, the application of knowledge requires individuals to confront their feelings and concerns and to admit their anxiety, if any, in dealing with sexual issues or their anger in dealing with medically unresolvable problems.

The major impact AIDS has had on medicine has been to make physicians more aware of the extent to which their own values and feelings are an integral part of the scientific decision-making process. The impact of AIDS on this long-neglected dimension of medical education may be one of the few positive effects of this otherwise disastrous disease.

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## Diagnosis/Treatment/Prevention

# Countertransference Reactions of Female Health Care Providers to Women With HIV Infections (part one)

Judy Macks, LCSW

Countertransference reactions refer to the providers' conscious or unconscious behavioral, cognitive or emotional reactions to the circumstances, emotions or behavior presented by the client. These responses are among some of the most difficult and, at the same time, some of the most rewarding aspects of providing care to people with HIV-related concerns.

The AIDS epidemic has evoked strong personal and professional reactions among health care providers because it has required that providers face their own feelings and attitudes toward gay people, drug addicts, sexuality and death. As the epidemic has widened, health care providers have experienced working with greater numbers of women who are concerned about their risk for HIV infection or who are already infected with HIV. With the emergence of this new group of clients, AIDS service providers have also been confronted with new countertransference issues.

The reactions of female providers to working with women who have concerns about HIV can be summarized as follows:

- (1) fear of contagion,
- (2) denial and magical thinking,
- (3) discomfort with sexuality and sexual behavior change,
- (4) combating helplessness and despair,
- (5) anger and blaming the victim,
- (6) blurring of ethical and professional boundaries, and
- (7) fear of professional inadequacy.

### **Fear of Contagion**

The presence of greater numbers of women infected with HIV brings the fear of contagion more to mind for female health care providers. Previously, providers could draw a clear demarcation between themselves and their clients on gender differences, but now working with women challenges this basic distinction between self and other. The conscious or unconscious fear is, "If it can happen to her, it could happen to me." One consequence of this acknowledged fear of one's own risk of HIV infection is increased concern about the occupational risks of HIV exposure. This fear of contagion can result in *physical and empathic withdrawal from the women with HIV* and can be devastating for the client who already feels contaminated. Awareness of this situation can lead also to feelings of guilt on the part of the provider as she feels she is letting her fear get in the way of providing compassionate care.

### **Denial and Magical Thinking**

Denial is a common psychological defense mechanism used by individuals to keep unwanted thoughts or feelings from the conscious mind. Denial has functioned to keep the thought of being at risk for AIDS from the minds of female providers as well as from women generally. Working with women who are infected, however, confronts the female provider's denial about her own risk of HIV infection.

Magical thinking is another defense mechanism often employed by the practitioner in her personal and professional life. Practitioners may tell themselves unconsciously, "I will not get sick or become infected with HIV because I am working to stop this epidemic." Working hard becomes synonymous with protection. Similarly, in their personal lives providers may have convinced themselves of their "intuitive" ability to choose "safe" partners and therefore maintain a false sense of security.

### **Discomfort with Sexuality**

The AIDS epidemic requires new tasks of health care professionals. One of the most uncomfortable and disquieting is the need to discuss with clients specific sexual behaviors, such as anal intercourse. In order to perform a thorough risk assessment or accurately instruct a client about AIDS prevention, providers must be familiar and comfortable with talking about the full range of human sexual behavior.

Assessing the female clients' risk for HIV may be a reminder of the female providers' current or past sexual practices. If these behaviors had put them at risk for HIV exposure, talking with clients about AIDS prevention may raise feelings of guilt and anxiety. Further, the task of promoting sexual behavior change

*Feeling overwhelmed with the psychosocial realities of HIV can become commonplace for the provider as she identifies with the client.*

among women at risk may also raise difficult issues for the female health care provider. Many express frustration that stems from several different sources. First, it is difficult to encourage behavior changes when women generally do not perceive themselves to be at risk for HIV. Second, the institutionalized power differences between men and women often make it difficult for women to insist on safe sexual practices with their male partners. To insist may mean risking abandonment, the withdrawal of economic support and physical violence. Third, many women lack the needed self-esteem or communication skills to directly discuss sexual behavior changes with their partners.

Consequently, female practitioners may feel particularly frustrated or angry with female clients who find it difficult to make changes in their sex lives. This reaction may reflect a strong identification with the client because the provider may share the same lack of assertiveness and sense of powerlessness in her sexual relationships. The requirement that the female client successfully change her behavior is needed by the practitioner as a reassurance that the same changes are possible for herself.

### **Combating Helplessness and Despair**

Helplessness and despair are reactions easily triggered by working with people with HIV. These reactions are associated with the physically debilitating course of the illness, the lack of medical treatment and the inability to cure, the severe economic impact of the disease, the difficulties in planning for the future, and the impact on intimate relationships.

Most practitioners will desire instinctively to protect themselves and their clients from these feelings of helplessness and despair. Although the desire to protect may originate in genuine caring, it may seriously interfere with the provider's ability to empathize with the client. Feeling overwhelmed with the psychosocial realities of HIV can become commonplace for the provider as she identifies with the client. In an attempt to master feelings of helplessness, practitioners may respond in characteristic ways: One, the "fix it stance" maintains that there is always something that can be done about whatever it is that is causing the feeling of helplessness. Practitioners will suggest a myriad of "things for the client to try" to resolve the situation and therefore the feelings of helplessness in the provider. Secondly, over-identification may result in problems with setting limits with clients, accepting one's own professional limitations in meeting the client's needs, managing feelings of dislike for certain clients, investing unrealistic amounts of time and energy in the client, and fusing personal needs and professional responsibilities.

*(Part two will appear next month.)*

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# BRIEFS

## Recent Reports

### Fear of AIDS Among Dental Professionals

The fear of contagion that is so commonly associated with AIDS is expressed among increasing numbers of health care providers. One group of providers which has not been surveyed extensively is those who provide dental care. In this report from the Montefiore Medical Center in New York City<sup>1</sup> a large number of dental professionals were studied for occupational exposure to HIV.

Dentists (1132), hygienists (131) and assistants (46) without other behavioral risk factors for HIV infection were studied using self-report questionnaires and blood samples tested for the presence of antibodies to HIV. About half of the sample (51%) were from high incidence AIDS areas (New York City, San Francisco, Houston and Miami). Seventy-two percent of the professionals reported that they had treated patients who had AIDS or were felt to be members of high-risk groups. Few of the subjects, about a third of the dentists, reported that they "always" used gloves during their work, while 7% reported that they "never" used gloves. Accidental needle or other instrument "sticks" were common: 94% of the professionals reported accidentally puncturing the skin with instruments used in treating patients. Nonetheless, only one dentist without a history of other behavioral risk factors for AIDS developed antibodies to HIV.

The authors conclude that despite a low compliance with recommended infection control procedures, a high incidence of accidental skin punctures, and a patient population from high AIDS incidence areas, only one case of occupationally acquired HIV infection was found. Thus, the risk of occupational exposure to HIV for dental professionals is extremely low. Strict adherence to recommended guidelines should help minimize even further this already minimal risk.

### P-24 Antibodies as Disease Predictors

In a recent article<sup>2</sup> about a longitudinal study of 84 gay men with persistent generalized lymphadenopathy (PGL), investigators in London reported on the temporal relationship between the appearance of antibody to the p-24 antigen (found on the surface of the human immunodeficiency virus), the presence of the p-24 antigen itself (indicating the presence of free virus in the blood), and the development of AIDS and ARC in the study subjects over a five-year period. The study demonstrated a progression rate to AIDS of 5% per year — a rate which is consistent with findings in several other studies. More importantly, the investigators also demonstrated that those patients who remained physically well during the study retained higher levels of antibodies to p-24 compared to those who progressed to ARC or AIDS.

In those subjects who developed the full-blown syndrome, a significant and gradual decline in antibody levels to p-24 occurred up to 18 months before the antigen itself was detectable in the patients' blood. Furthermore, the p-24 antigen was found in 40% of AIDS patients two years before diagnosis, thus demonstrating that reduced levels of antibody to p-24 may be an earlier and more consistent way of predicting disease progression than appearance of the antigen itself. Knowledge of

this antibody response may prove useful in determining when anti-HIV therapy should be initiated.

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**AIDS Health Promotion Exchange** is a quarterly newsletter published by the Global Programme on AIDS of the World Health Organization intended for those planning, implementing and evaluating AIDS health promotion programs. *The WHO Exchange* provides an opportunity to learn about innovative approaches and evaluation results from around the world. *The WHO Exchange* is available, initially without charge, in English, French and Spanish. Health educators, communication specialists, social scientists and public health professionals working in AIDS health promotion programs are invited to request their individual or organizational subscription. Volume 1, Number 1 was published in January of this year.

AIDS Health Promotion Exchange, Global Programme on AIDS, World Health Organization, 20 Avenue Appia, 1211 Geneva 27, Switzerland.

**AIDS in the Workplace.** A valuable resource for educators and public policy planners is the report issued by the Citizen's Commission on AIDS for New York City and Northern New Jersey. Titled "Responding to AIDS: Ten Principles for the Workplace," the 32-page document outlines what a basic, rational approach to this issue should be for any workplace. AIDS in the workplace promises to be an escalating concern worldwide. This report helps employers and employees alike develop their policies on a sound foundation. For further information, contact the Citizens Commission on AIDS, 51 Madison Avenue, Room 3008, New York, NY 10010.

## Next Month

Faced with issues of life and death, people affected by AIDS often consider the role of spirituality and religion in their lives. For many individuals, this involvement represents a spiritual renewal, a return to a former source of meaning and support. In the April issue of **FOCUS**, Fr. Richard Dunphy, SJ will consider the impact of AIDS on organized religion and the benefits of spirituality for some people affected by the epidemic. Reverend Dunphy is the AIDS Education Coordinator for the Archdiocese of St. Louis. He is also an adjunct professor of theology at St. Louis University.

In addition, the second in the two-part series "Countertransference Reactions of Female Health Care Providers to Women with HIV Infections" will appear in the April issue. Author Judy Macks, LCSW will emphasize anger and blaming the victim, blurring of professional and ethical boundaries, and fear of personal inadequacy. Macks is the Coordinator of Professional Education for the AIDS Health Project in San Francisco.

## FOCUS A GUIDE TO AIDS RESEARCH

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