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Physician’s Willingness to Treat HIV Positive Patients

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PHYSICIANS' WILLINGNESS TO TREAT HIV POSITIVE PATIENTS

by

Tania Tiara Kazanjian

A Thesis
Submitted to the
Faculty of The Graduate College
in partial fulfillment of the
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I would like to thank God for keeping an eye on me throughout the duration of this study, and Father John Grarthwohl for giving me this prayer:

The Road Ahead

My Lord and My God, I have no idea where I am going.

I do not see the road ahead of me. I can not know for certain where it will end. Nor do I really know myself, and the fact that I think that I am following your will does not mean that I am actually doing so. But I believe that the desire to please you does in fact please you. And I hope I have that desire in all that I am doing.

I hope that I will never do anything apart from that desire. And know that if I do this, you will lead me by the right road though I know nothing about.

Therefore will I trust you always, though I may seem to be lost in the shadow of death. I will not fear, for you are ever with me, and you will never leave me to face my perils alone.

...Thomas Merton

I would also like to thank my parents for supporting me, and Julie and Aram for helping me get through this period of my life. Dr. Smith for being there, and Drs. Walker and Douma for your concern.

Tania Tiara Kazanjian
Two research questions guided the present study: (1) Are there physicians' traits that influence their willingness to treat HIV positive patients? (2) Are there patients' traits that influence physicians' willingness to treat HIV positive patients? A total of 12 independent variables were selected for this study, five of which were related to the following physicians' traits: age, religion, geography, OSHA training, and the method of health insurance compensation. The other seven related to patients' traits such as race, ethnic background, and the manner in which patients contracted the disease. Three modes of transmission selected for study reflected on patient behaviors whereby patients knew of the high risk involved before performing acts of homosexual or criminal (prostitution or intravenous drug use) behaviors. The other two modes were rape or blood transfusions in which patients were victims.

Seventy-nine (79) physicians from southwestern, southeastern and western Michigan were surveyed about their willingness to treat HIV positive patients. Data from these surveys were used to analyze the previously stated research questions. In turn, a Chi-square analysis was used to answer these research questions.
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CHAPTER I

INTRODUCTION

Background

Because the identification of the Human Immunodeficiency Virus (HIV) as the cause of Autoimmune Deficiency Syndrome (AIDS), much work has been done to expand our knowledge base about this dreadful disease. In spite of our expanded knowledge, responses from people to those who have tested HIV positive continue to cover a wide range. Shunning was one of the earliest responses to those who were identified as having AIDS, and regardless of how one contracted the disease, many people did not want to have any contact whatsoever with such patients. On the other hand, there were those who were more compassionate and caring toward those suffering from AIDS, both among the general public and the healing professionals. It should be noted, however, that “for some physicians, the fear of contagion, their ethical responsibilities, and desire to be ‘there’ for the patient produce intense internal conflict,” which is not included in the Hippocratic Oath, especially when dealing with HIV positive patients. (Eptean, Christie, Frankel, Rosseau, Shields, and Suchman 1993, pp. 265-66)

According to Epstein, physicians who treat HIV patients struggle to fulfill two conflicting obligations: to protect themselves from becoming infected and to care
properly for HIV positive patients. Many see themselves as being caught on the horn of a dilemma: a professional responsibility to treat coupled with a personal obligation to protect oneself from being victimized by a most dreaded disease. According to Dworkin, Albrecht, and Cooksey, “Complex emotional reactions to HIV/AIDS by physicians are based not only on perceived health threats by physicians, but also on underlying feelings about professional responsibility to treat the HIV positive patients.” (1991, p.239)

The literature review (Chapter II) reveals that both physicians’ and patients’ traits may influence physicians’ willingness to treat HIV positive patients. Examination of the current available literature in Chapter II eventually led to the formation of two research questions that guided the current study.

The first question explored was the physicians’ traits and how they may or may not influence physicians’ willingness to treat HIV positive patients. Five physicians’ traits were selected after a careful review of literature (age, religion, geographical location of clinics, OSHA training, and method of insurance compensation accepted). It was expected that these traits would influence physicians’ willingness to treat HIV positive patients. The results are presented in Chapter IV.

The literature review raised questions relating to physicians’ traits and how these traits could influence their willingness to treat HIV positive patients. As far as the issue of physicians’ ages is concerned, in a study by Heald conducted in 1988, she indicated that physicians’ ages did not influence their willingness to treat HIV positive patients. The results of her study revealed that the distribution across physicians of all
ages was equal with respect to their willingness to treat HIV positive patients. The age ranges Heald selected were: 31-40, 41-50, 51-60, and greater than 60. Overall, physicians of all ages were willing to treat HIV positive patients. Heald’s findings did not convince the current researcher that the same results would occur in the present study, because she felt that younger physicians may want to take on the responsibility of treating HIV positive patients as a challenge. On the other hand, older physicians may feel as if they have already taken on numerous challenges in their past career histories, and consequently may not feel it necessary to take on new challenges.

The next physicians’ trait examined in the literature review was the issue of religion and how it would either hinder or encourage their willingness to treat HIV positive patients. The literature review was limited, but a “Good Morning America” program (Fall, 1995) revealed that the use of prayer did influence some physicians’ willingness not only to treat patients, but also to encourage their recovery.

The issue of religious affiliations is relevant to the present study, because most of the dominant religions of the world advocate the idea of healing, but not all religions may recognize that certain types of patients--for example, homosexuals--as worthy of receiving medical attention for an ailment brought upon due to do behavior against the teachings of the church. There are differences in philosophy among religions. More detail will be discussed in Chapter II on this issue that will better explain these differences in attitudes, and how these attitudes may influence physicians’ willingness to treat patients, especially HIV positive patients.
The question of the geographical location of physicians’ clinics was prompted by a study by Preston, conducted in 1991. She found that urban physicians have much more exposure to HIV positive patients since more HIV positive patients live in urban areas. The increase in exposure, she felt, also increased those physicians’ willingness to treat HIV positive patients. Based on this information, the current researcher felt that urban physicians would be more willing to treat HIV positive patients than their rural counterparts. It is this researcher’s belief that being exposed to more patients with the disease would also increase the physician’s familiarity with the treatment and necessary care, which would also increase their willingness to treat them.

Another factor thought to influence the willingness of physicians to treat HIV positive patients was their OSHA training or lack of it. Physicians who take advantage of OSHA training may be more knowledgeable about how to protect themselves from contracting the virus from their patients who are HIV positive. According to the U.S. Government Manual 1995-96, the OSHA Act of 1970 prompted the bloodborne pathogens and universal precaution regulations that specify how physicians should handle their patients’ inflected bodily fluids. Consequently, it is reasonable to assume that OSHA trained physicians would be more willing to treat patients with the disease than those physicians who have not been trained.

Finally, it is thought that physicians who operate on a fee-for-services plan would also be more inclined or willing to treat HIV positive patients. This arrangement allows physicians to charge the patient per visit, per test, etc. On the other hand, physicians who operate under managed care insurance companies are not permitted to
charge the patient for each office visit, etc. Salaried physicians have to provide treat-
ment, which may exceed their prepaid monthly premium, and consequently absorb the 
loss. Therefore, physicians in this category may not be as willing to treat HIV positive 
patients as those who operate under the fee-for-service plan.

The literature also suggested that patients’ traits may influence physicians’ will-
ingness to treat HIV positive patients. These traits included both those ascribed, such 
as race and ethnic background, and those acquired, such as the manner in which the 
patient contracted the virus: homosexuality, deviant behaviors (prostitution and intra-
venous drug use), blood transfusion, and rape. It was expected that these patients’ 
traits would influence physicians’ willingness to treat HIV positive patients. The re-
results are presented in Chapter IV.

Purpose of Study

This essentially is an exploratory study to ascertain the extent to which several 
factors play a role in the willingness of physicians to treat patients with AIDS. After a 
review of the pertinent literature, the current researcher sensed a need to find answers 
to two important research questions, namely:

1. Are there physicians’ traits that influence their willingness to treat HIV 
positive patients?

Specifically, the current researcher wanted to know what role, if any, age plays 
in the willingness of physicians to treat their AIDS patients. Four other factors (relig-
ion, geographical location of clinics, OSHA training, and the method of insurance
compensation) were also investigated in an effort to see if they have any influence on the level of treatment of AIDS patients by physicians.

2. Are there patients' traits that influence physicians' willingness to treat HIV positive patients?

In an attempt to answer this question the current researcher wanted to look at the role of race and ethnicity and the extent to which physicians are willing to treat based on these two ascribed variables. The manner in which patients contracted the disease is also thought to be relevant; hence, the following five contract modes were investigated HIV as a result of (1) homosexual behavior, (2) deviant behavior (prostitution or intravenous drug use), and (3) events, such as blood transfusions or rape, for which patients can not be held accountable.

Hence, these two research questions were used as informal hypotheses for the purposes of this study.

Summary: What is Known. What is Unknown.

It is evident that there is a certain degree of perceived risk involved when medical professionals treat HIV positive patients. This perceived risk can pose a concern for physicians while they are treating HIV positive patients, consequently making them less willing to treat these patients. The current available literature suggested that having knowledge about how to protect oneself properly through way of OSHA training may reduce an unwillingness to treat HIV positive patients. This notion is further discussed in Chapter II. Knowing how to protect oneself from contracting HIV from
patients may not be enough of an incentive for physicians. However, being able to earn more money per patient by physicians who operate their business under a fee-for-service system welcome to all patients, especially HIV positive patients, versus those physicians who operate under managed care systems who do not welcome patients may provide enough incentive to provide treatment to HIV positive patients. Again, Chapter II provides more information on this topic. Being OSHA trained and earning more money are two dimensions relating to physicians' traits, but there may be more, as was revealed in a study by Heald in 1988. She found that physicians' ages did not influence their willingness to treat HIV positive patients. However, could a different group of physicians surveyed refute these results regarding age? Chapter II gives more information on this concern.

Another physicians' trait that was found to persuade some physicians to treat all patients was their religion. Only two physicians shared their religious convictions and explained how their belief in religion helped them while treating their patients. What is not known is whether religious affiliation, in general, increases all physicians' willingness to treat HIV positive patients. Also, could there be certain religions whose teachings would hinder or encourage physicians' willingness to treat HIV positive patients. More details are provided in Chapter II.

The current available literature revealed that the majority of medical professionals who have prejudicial feelings for HIV positive patients are nurses. These feelings are not synonymous with perceived risks. For example, according to an article by (Preston, 1991), rural nurses in a clinical setting especially expressed a distinct unwill-
ingness to treat people with HIV/AIDS. What is unknown is whether rural physicians feel this way too. This study investigates whether physicians’ willingness to treat HIV positive patients are influenced based on these physicians’ geographical locations.

The current available literature reveals that physicians’ traits were not the only ones that either increase or decrease physicians’ willingness to treat HIV positive patients. Additionally, the literature revealed that those patients who acquired the disease through homosexual or criminal behaviors would face an unwillingness to treat HIV positive patients by physicians. This study’s purpose is to determine if these findings in this sample of physicians support the past findings of other studies reviewed. Detailed information related to how these seven selected patients’ traits may influence physicians’ willingness to treat them is explored in Chapter II.

Given the two questions guiding this study, it is now necessary for the following steps to be taken in order to provide answers for the empirical validity in Chapter IV. First and foremost, the contents of Chapter II furnish information that led to the formulation of these two questions. Essentially, the literature review provides background information that other authors found about physicians’ traits and patients’ traits and how they may relate to physicians’ willingness to treat HIV positive patients. The purpose of the literature review is to layout the framework from which the current researcher could speculate about factors that may influence physicians’ willingness to treat HIV positive patients.

Once the researcher has developed the exploratory questions, she then proceeds to describe the methods and procedures used to find the answers to the two
exploratory questions. The methods and procedures followed in this study are found in Chapter III, which describes the steps taken by the researcher in order to obtain the data needed to answer the two questions. These major steps include how the researcher selected the sample frame and the manner in which the instrument was distributed. Next, this chapter describes how the data were collected and distributed to the respondents, according to some of their demographic characteristics. The data collected enabled the researcher to measure how each of the independent variables may influence the two dependent variables selected for this study. The operationalization section of both independent and dependent variables describes how each independent and dependent variable is measured.

Finally, Chapter III explores the researcher's predictions of the expected results. Chapter IV presents the actual results which either confirms or refutes the researcher's predictions. The results presented in Chapter IV explain how the data are analyzed according to the two informal hypotheses and the kind of statistical test selected to perform the analysis. The relevance of these results are summarized in Chapter V, which also suggests how future researchers may build on other studies based on how these relevant results may impact our society.
CHAPTER II

LITERATURE REVIEW

The research on HIV is still fresh; therefore, little information is available in the current literature. However, some existing research indicates that nurses feel that their care of the HIV positive patients depend, in part, on the mode of transmission (Preston et al. 1991). “The literature is replete with reports on nurses' attitudes toward AIDS. Generally, the results of these investigations showed that nurses as well as other health care providers hold negative attitudes towards AIDS, along with fear of contracting AIDS, homophobia, need for social distance, and unwillingness to provide care.” (Barrick's study as cited in Cole, 1993, p. 1112) These nurses' attitudes can provide us with a model for our investigation process with respect to physicians' attitudes. From the results of the same article, it was revealed that these attitudes may have been developed “because AIDS is associated with pre-existing stigma, reactions to AIDS are reactions to gay men, drug users, racial minorities, or outsiders in general, and the lethal nature of the disease.” (p.1112)

Negative attitudes by nurses or physicians may in turn result in prejudicial ones held toward HIV positive patients. According to Mary Bedikian (1995), an attorney, “The topic of prejudice against HIV positive patients by physicians is still quite fresh; and the Americans with Disabilities Act is the most important to date that protects
HIV positive patients from being turned away by a physician.” The AIDS and the Americans With Disabilities Act, Public Law 101-336, July 26, 1990, states that,

An insurer, hospital or medical service company, health maintenance organization, or any agent, or entity that administers benefit plans, or administering such risks that are based on or not consistent with State law...shall not be constructed to prohibit or restrict...treatment of HIV positive patients. United States At Large, 101st Congress, 2D Session 1990, Vol. 104 Post 1, p. 1-1016 public laws.

This act serves as an overall law that protects HIV positive patients from being confronted with physicians who may not want to treat patients, due to physicians’ own prejudicial feelings about the patient.

Physicians’ Traits

Physicians’ Ages

Focusing on literature directly pertaining to the five dimensions related to physicians’ traits, attention is first directed to their age. Recent literature seemed to confirm Heald’s conclusion that there was a direct correlation between the age of the physician and the number of HIV positive patients the physician had seen. Heald (1988) found that, “The younger the physician, the more HIV positive patients physicians had seen.” (p. 764) The researcher of the current study felt that physicians who see more HIV positive patients may ultimately be more comfortable with these patients, consequently making them more willing to treat HIV positive patients. Therefore, the researcher felt it necessary to test again whether age increased or decreased physicians’ willingness to treat HIV positive patients.
Physicians' Religions

The second physicians' trait to be analyzed focused on their religious affiliations. According to a segment on ABC's "Good Morning America" (1995), two physicians' religious affiliations had influenced their attitudes toward treating all patients. One physician, Dr. Mathews, even prays with patients; however, he does not replace conventional medicine with prayer. Another physician who appeared on the same segment commented, "It may not even be the prayer that the physician says with the patient, but rather the use of words or phrases that may help the patient relax." This is referred to as the relaxed response. Both physicians agreed that the physician must also be able to pray with the patient according to the patient's religious affiliation, in order to benefit the patient. According to Roberts (1996), medical healing should not be substituted with prayer; however, the use of prayer can be a vital part of the process. Therefore, a physician's religious convictions should only be used to supplement the medical treatment already provided to the patient.

On the other hand, one's religious upbringing could hinder one's willingness to treat HIV positive patients. For example, some physicians who may have been brought up in strict Baptist homes may still cling to the church teachings about homosexuals. Recently the media WWMT Channel 3 in Kalamazoo, Michigan covered a story on a Baptist Minister who spoke out against a gay male, who had been hired to teach music in the high school of the town where this minister resides. Unfortunately, he had prejudicial feelings against homosexuals which may be shared by others, even
physicians who have been taught by their church that homosexuals are not valuable or worthy people. According to Wilhem (1990), some homosexuals may be indispensable to our communities based on their outstanding contributions to human society. It is reasonable to assume that those physicians who have been raised to think that homosexuals are worthy people may, consequently, be willing to treat them as HIV positive patients.

Geographical Location of Physicians' Clinics

The geographical location of physicians' clinics may influence physicians' willingness to treat HIV positive patients. The literature explains that metropolitan regions are more often equipped with the knowledge and experience needed to treat HIV positive patients. Further, it may be that metropolitan areas draw more people with homosexual or deviant lifestyles. Typically, homosexuals are better able to express their sexual orientation in areas where there are others like themselves and gravitate to the special clubs that people like themselves go to for social activity. As far as prostitutes or intravenous drug users are concerned they typically find it easier to carry out their behaviors in larger cities, where again, they find more people who also engage in similar activities. While engaging in these self-imposed behaviors, HIV may be contracted. These people eventually realized that they may require medical attention. Hence, they are examined by local urban physicians.

On the other hand, some HIV positive patients may contract HIV in rural communities, which suggests that these patients would likely be examined by a “rural”
physician. Rural physicians may not be as experienced or comfortable treating HIV positive patients since they do not regularly treat HIV positive patients. It is reasonable to assume that rural physicians, therefore, may prefer to refer HIV positive patients to a specialist in the next largest city.

Preston (1991) found that in 1986, the Center of Disease Control projected that by 1991, 80% of the 145,000 people needing care for AIDS would be in New York City and San Francisco. Cities with large medical centers, schools, and hospitals are better equipped and staffed with numerous infectious disease specialists. It is also known that urban areas have better access to new information regarding HIV and ways to treat HIV positive patients. According to Shelton (1991), more efforts are being made to provide lectures, seminars, workshops, or mini-residencies for urban physicians so that they can learn more about their current or potential HIV positive patients. Because of the distance factor, rural physicians may not receive new facts on the disease on a timely basis. Not having as much experience regarding HIV may indirectly decrease rural physicians’ willingness to treat HIV positive patients. According to Preston (1991), rural communities have fewer educational programs for physicians to clarify myths about AIDS, and to help them handle their feelings and fears about the disease. Because of the preceding factors revealed in the literature review, it is the researcher’s opinion that the more HIV positive patients seen by physicians the more likely physicians would be to treat these types of patients.
OSHA Trained Physicians

OSHA training is relevant to this study because the researcher felt that physicians do face a certain degree of perceived risk when treating HIV positive patients. However, having formal training in ways that would reduce the chances of becoming infected may pose less of a concern about contracting the disease by physicians who treat them. Knowing how to protect oneself may result in a higher level of willingness to treat HIV positive patients.

The role of the Occupational Safety and Health Administration (OSHA) is summarized in the U.S. Government Manual. 1995-96, as follows:

The Assistant Secretary for Occupational Safety has responsibility for occupational safety and health activities. The Occupational Safety and Health Administration, established pursuant the Occupational Safety and Health Act of 1970 (29 U.S.C. 651 et seq.), develops and promulgates occupational safety and health standards; develops and issues regulations; conducts investigations and inspections to determine the status of compliance with safety and health standards and regulations; and issues citations and proposes penalties for noncompliance with safety and health standards and regulations. (p. 394)

Having been formally trained is critical, because not knowing how to handle infected bodily fluids during treatment could result in a physician who may have more fear of contracting the disease, thus decreasing one’s willingness to treat HIV positive patients. The OSHA Act of 1970 has put into effect two regulations that can better describe infectious control. They are bloodborne pathogens and universal precautions.

According to the Code of Federal Regulations (29 CFR 1910 1030),

Bloodborne pathogens means pathogenic micro organisms that are present in human blood and can cause disease in humans. These patho-
gens include, but are not limited to hepatitis B virus (HRV) and human Immunodeficiency virus (HIV). (p.336-7) Physicians who treat HIV positive patients are confronted with occupational exposure which means reasonably anticipated skin, eye, mucus membrane, contact with blood or the potentially infectious materials that may result from the performance of an employee’s duties. Code of Federal Regulations (29 CFR 1910 1030), (p. 337) Code of Federal Regulations (29 CFR 1910. 1030, p. 337)

Basically universal precautions are a set of precautions used by individuals who are in contact with patients who are infected with bloodborne pathogens or sexually transmitted diseases. Again, according to the Code of Federal Regulations (29 CFR 1910.1030),

Universal precautions are an approach to infectious control. It also states, All human blood and human fluids are treated as if known to be infectious for HIV, HBV, and other bloodborne pathogens (p. 338).

These regulations have been promulgated because the government found it necessary to teach those who handle infectious materials how to approach the situation. Physicians especially are susceptible to contracting the disease; therefore, it is the researcher’s opinion that the more training a physician has on how to protect oneself from contracting the disease, the more willing the person will be to treat HIV positive patients.

The Method of Insurance Compensation Accepted by Physicians

The issue of the method of insurance compensation to the physician raised the concern about “rewards” they received for services rendered. For physicians, one of the “rewards” would be money. For example, physicians who are entitled to payment
for each treatment, test, office visit, etc., may be more willing to treat patients, especially HIV positive patients who would require many treatments. Whereas, those physicians who are salaried and not permitted to charge for specific services, for example, managed care physicians, may be less willing to treat such patients who may need detailed and numerous treatments. According to Williams and Guerra (1992 pp. 270-1),

Payment of physicians, and many other professionals, in the United States has traditionally been through a mechanism that is fee-for-service reimbursement. Fee-for-service means the more the provider does to the patient, the more he/she is paid. Obviously, the more that the physician (or any provider paid this way) does, the more total payment will be. Physicians also have the responsibility to refer patients to other providers for more specialized care or to the resources of the hospital for inpatient services. These decision-making duties give the physician further power to create more care options for the patient as well as to run up more bills. (Health Care Services in the 1990s, A Consumer’s Guide, Williams and Guerra 1991, p. 270-71)

Therefore, one may anticipate that physicians who operate under fee-for-services may be more willing to treat HIV positive patients. On the other hand, “Health maintenance organizations (HMOs) provide comprehensive services for a fixed, prepaid amount that is independent of the number of services actually used.” (Harding and Pinsky, 1992, p. 75) If the cost of caring for that member exceeds the monthly prepaid amount--because the member needed expensive testing or consultation with a specialist--the doctor must absorb the loss. (Spragins, 1995) Upon reviewing the literature, it became apparent that the method of health insurance compensation would be tested as a physician trait in Chapter IV.
Patients' Traits

Having explored the available literature on physicians' traits, attention is next focused upon the research concerning the characteristics of patients that could result in a physician's unwillingness to treat or to refer these patients to another physician. This section of the literature review is concerned with certain of those patients' traits and certain of the physicians' reasons for not treating patients.

The literature reveals that some patients' traits do influence a physicians' willingness to treat HIV positive patients. According to Barbour et al, (1995), patients who had HIV and were African-American, or of ethnic backgrounds, would face a physician who would be less willing to treat these patients. This same attitude may be directed to patients who acquired the virus through homosexual or criminal (prostitution or intravenous drug use) behaviors.

The following sections summarize several of the studies where traits either increased or decreased physicians' willingness to treat HIV positive patients. These traits will be one of the major variables for this study.

The seven patients' traits selected include (a) the ascribed traits of race and ethnicity, and (b) the means by which patients contracted the disease--homosexual behavior, criminal behavior (prostitution or intravenous drug use), blood transfusion, or rape.
Race

It was thought by the current researcher that race may turn out to be an important factor in the willingness of physicians to treat minority members with AIDS. There are some stories of the horrible treatment of racial minorities in this country. The Tuskegee story comes to mind where several decades ago scores of African American males, without their knowledge or permission, were deliberately injected with syphilis. Also, Dr. Drew who perfected the blood plasma technique, died as the result of being denied treatment at a white hospital in the South. He had been injured in an automobile accident. Similar documented stories can be found among Asian Americans, Native Americans and other racial minorities.

According to Stevens (1995), Kimberlydawn Wisdom, an emergency room physician at Henry Ford Hospital, Dearborn, Michigan, has witnessed African Americans going undiagnosed or untreated for AIDS. Stevens further states that:

Racism is a factor. Health experts concede blatant racism may account for some of the disparities. But they believe these differences underscore the medical system’s basic failure to meet the needs of minority patients. (Stevens, 1995, p. 9)

In this same connection, Stevens felt it noteworthy to mention that,

A Federal Study released last year found blacks less likely than whites with HIV to receive drug therapies used to prevent pneumonia, a major killer of HIV-infected people (Stevens, 1995, p. 9)

Historically, African Americans have not received prompt or necessary medical attention, which is exemplified by the health statistics regarding African Americans’ life expectancy rates. Macionis (1993) reveals that the life expectancy rate for blacks
is on the average of five years less than whites. This disparity again confirms the notion that African Americans face trials when needing medical nurturing.

**Ethnicity**

Not unlike race, ethnicity may also be an important variable in a physicians' willingness to treat those with AIDS. Hence, Hispanics and other ethnic groups, who are HIV positive may also face some form of differential, though unfavorable, treatment when they go for medical treatment. This researcher, raised in an ethnic group and around other similar ethnic groups, has observed friends and acquaintances who would rather be examined by a physician of his/her own ethnic group, particularly when there may be a language or communication problem. It would not be unusual for an ethnic person to deliberately seek out a physician, based on the spelling of his/her last name. This tendency is commonplace in such places as Dearborn, Michigan, where there is a large middle eastern community and southwestern Detroit where there is a large Hispanic community. Seeking out a doctor among one's own ethnic group is seen as one way of avoiding being discriminated against because of one's ethnic affiliations.

The problem associated with ethnic groups' affiliation and medical care tends to be exacerbated even more when AIDS becomes an element in the situation. For many HIV positive patients, having to go outside of one's immediate ethnic community for medical assistance poses some special problems, such as language difficulties, different cultural values, and more. The scarcity or absence of physicians from one's
own ethnic or racial group means that those with AIDS are forced to seek caregivers from other outsiders. “Outsiders,” according to a rich literature on race and ethnic relations, have always encountered some reluctance from members of the dominant group, and physicians are no exception.

Homosexuals

Does the manner by which HIV positive patients contract the disease relate to physicians’ willingness to treat them? It might be reasonable to suspect that if there are, then maybe the more differences in their willingness to treat HIV positive patients surface. The first of five modes of acquiring HIV investigated was homosexual behavior. The literature reviewed indicated that homosexual HIV positive patients may face an unwillingness to treat them, based on their sexual orientation.

An article written by Heuer, 1995 dealing with lesbian cancer patients indicated that physicians treat the lesbian cancer patients quite insensitively, which led the researcher to believe that the element of homosexuality decreased physicians’ willingness to treat those patients. This particular study’s results prompted the American Medical Association “to urge its members to be more sensitive and non-judgmental when dealing with issues of sexuality.” (Heuer, 1995, p. 5F)

The results of another study revealed that 35% of the 2,004 physicians surveyed said they would feel nervous among a group of homosexuals. (Shelton, 1995) It is possible that the present study will produce similar results, because the issue of homosexuality is a national one which does provoke similar responses by people who
live all over in our society. A physician is capable of having prejudicial feelings and may not be able to prevent these attitudes from influencing his/her professional ethics.

**Deviant Behaviors**

Some physicians are not uncomfortable with treating intravenous drug users, but recognize that it may cost more to treat HIV positive patients who are also drug addicts. (Heald 1988) According to another researcher, 55% of the physicians surveyed expressed discomfort at the prospect of having intravenous drug users in their practice. (Shelton 1995) The results of this study show that physicians produce feelings of discomfort when faced with HIV positive patients who acquired the disease in a manner where they knew the risk involved. Perhaps physicians believe that HIV positive patients who contracted the disease knowing the risk involved deserve being infected and may not feel that these patients are worthy of treatment. The researcher felt that this issue of discomfort when treating intravenous drug users or prostitutes who are HIV positive patients was worth investigating again because she wanted to see if the same results would occur.

Parallel concerns can be drawn from how some physicians feel about intravenous drug users who are HIV positive patients. Unfortunately, HIV positive patients who acquired HIV through a deviant behavior, whether it be prostitution or intravenous drug use, know the high risk involved, and yet they engage in these risky behaviors. Idealistically, physicians should not pass judgment on these patients and behave in ways that would reflect an unwillingness to treat them. Realistically, however,
physicians may hold negative feelings about these patients, which in turn may become apparent when faced with prostitutes or intravenous drug users who are HIV positive patients. This study examines whether patients who acquired the disease through a deviant behavior produces an unwillingness by physicians to treat these patients.

**Blood Transfusions**

Physicians' perceptions about HIV positive patients may be based on one significant factor, whether patients were responsible for contracting the disease. HIV positive patients who contract the disease by a manner known to involve risk may indeed be thought about negatively by physicians who treat them. Negative attitudes may lead to prejudicial attitudes, which may in turn result in an unwillingness to treat certain types of HIV positive patients.

To see if this hypotheses is accurate, social researchers' Leone and Wingate (as cited in Dowell, 1991) created a hypothetical fictional character who was supposed to have acquired HIV through one of three different modes of transmission: homosexuality, intravenous drug use, and a blood transfusion for hemophilia. The members of an undergraduate psychology class were asked to reveal their feelings about each of the three. The members reported the most positive attitude was toward the character who had acquired the disease through a blood replacement.

A similar study exploring the concern related to physicians' willingness to treat HIV positive patients based on whether patients could be accountable for contracting the disease was conducted involving nurses. Siminoff's study (as cited in Cole 1993)
concluded that nurses felt that contracting the HIV disease through a blood replacement was socially acceptable; hence, nurses believed that the individuals who acquired the virus without violating social norms are typically “innocent victims.” These findings suggest that nurses may be more willing to treat HIV positive patients if the disease was contracted by an event for which patients cannot be held accountable. This is relevant because the current researcher felt that perhaps physicians may feel the same way; consequently, contracting HIV through blood transfusion was selected as one of the seven patients’ traits this study would investigate. The results are found in Chapter IV.

Rape

Not all persons who are HIV positive patients contracted the virus as a result of their own behavior. It is known that one can acquire the virus as a result of rape. Again, the literature is limited on available information regarding raped HIV positive patients. However, one may reasonably assume that patients who acquired the disease through a rape experienced an intense physical and emotional event, which may cause some physicians to feel sorry for them. Consequently, physicians may be more willing to treat their condition.

HIV, the virus that causes acquired immunodeficiency syndrome, is primarily transmitted through sexual contact with an infected person. . . In the aftermath of sexual assault, victims and their families often have many concerns about possible risk of HIV infection. In terms of the physical trauma of the assault, the forced sexual penetration itself can result in microscopic tears, thus increasing the risk of viral transmission. (Rape and Sexual Assault III, 1991, pp. 221-2 and 225)
This information reveals that rape victims who subsequently acquire HIV positive symptoms definitely would require medical attention, and due to the intense trauma, may face physicians who may be more willing to treat HIV positive patients. This study will investigate this concern further in Chapter IV.

Summary of the Literature Review

The literature review revealed that both physicians' and patients' traits may influence physicians' willingness to treat HIV positive patients. The literature revealed that five physicians' traits—age, religion, geographical location of the clinics, OSHA training, and the method of health insurance compensation accepted by physicians—may influence physicians willingness to treat HIV positive patients. The literature review also revealed that seven patients' traits—the ascribed traits of race and ethnicity and the manner in which patients contracted the disease (homosexuality, behavior, criminal behavior of prostitution or intravenous drug use, or through blood transfusion or rape—may influence physicians' willingness to treat HIV positive patients.

The five physicians' traits and the seven patients' traits became the foundation for the independent variables selected for this study. Each of these independent variables are paired with two dependent variables selected for this study. The two dependent variables are the physicians' willingness to treat HIV positive patients because they felt it was their duty to treat HIV positive patients and physicians' preference to refer HIV positive patients to another physician because they wish not to treat HIV positive patients.
The results of the two informal hypotheses developed for this study which were previously mentioned at the end of Chapter I are presented in Chapter IV.

Chapter III describes how the data were collected and the rationale selected to process the data.
CHAPTER III

METHODS AND PROCEDURES

Sample Selection

The sample frame which formed the basis for the group of physicians surveyed were listed in the Home Alliance Plan (HMO) for Southeast Michigan; Preferred Physicians Organization (PPO) catalogs from Blue Cross-Blue Shield; Monroe, Michigan Yellow Pages; and advertisements in the Downriver News Herald. These sources were selected because the researcher found that they supplied the need for the appropriate type of physicians needed to generate the frame. The sample frame was one of convenience, chosen from geographic areas that were familiar to the researcher, which was found acceptable for a distribution of 200 surveys.

Given that one of the questions focused on the location of the respondents, survey instruments were distributed to physicians in the following urban areas: The cities of Allen Park, Southgate, Trenton, Dearborn, Dearborn Heights, and Taylor. All are located in the southeastern part of Michigan, near Detroit. The rural areas included Wayland, Plainwell, Otsego, Paw-Paw, Three Rivers, Hastings, Richland, all located in the southwestern part of Michigan, and Ludington, which is in the west central part of Michigan, and Monroe, which is in the southeastern part of Michigan.
The sampling frame was comprised of a total of 200 physicians. Two hundred were selected because it was a sufficient size for the purposes of this study. As stated previously, this group of 200 were systematically subdivided further into two new sampling frames (urban and rural physicians). In the two new sampling frames, 100 questionnaires were distributed to the rural areas and 100 questionnaires to physicians in urban areas. Of the two hundred questionnaires, equal numbers were distributed to small and large clinics, as well as to HMO/PPO's and fee-for-services physicians.

The external validity may be limited due to the response rate. The overall rate of return was 39.5%, albeit good considering one is querying physicians, who traditionally are a difficult group of people to survey. Because the group of people surveyed in this study were busy with other pressing tasks, the researcher was not able to obtain more data that may have altered the results one way or another.

Instrumentation

This exploratory study used both self-administered questionnaires to obtain physicians' willingness to treat HIV positive patients (see Appendix C for a copy of the questionnaire) and personal interviews. The final draft of the survey instrument was based on suggestions and comments from a pre-test which was carried out in October of 1995, with the cooperation of seven physicians at the Sindecuse Health Center at Western Michigan University. The purpose of the pre-test was to determine if the general format and the language used in the survey was acceptable. The comments received from the pre-test physicians were instrumental in rewording some
questions and in consolidating several other questions. The final draft of the instrument included a total of 41 questions. The pre-test took respondents approximately 10-12 minutes to answer the survey questions.

Two or three weeks prior to the distribution of the surveys, pre-survey letters were sent through the mail informing the physicians in the sample frame that a sociology graduate student from Western Michigan University would soon personally distribute a survey at their respective offices (see Appendix A for a copy of the pre-survey letter). The purpose of this pre-survey letter was to improve the response rate.

Data Collection

Two-hundred survey instruments with a cover letter were hand delivered by the researcher to the physicians' offices in the sample. The content of the cover letter was similar to the pre-survey letter. Within one month, a total of 51 surveys were collected by the researcher, who returned to the physicians' offices to pick them up. Another 28 were mailed to the researcher, following telephone contacts. A total of 200 surveys were distributed and 79, or 39.5% were collected.

Following the analysis, these frequencies and percentages are tabulated in Tables 1-6. The purpose of these tables is to display pertinent demographic data about participating physicians. More detailed information regarding the results are presented in Chapter IV. The following tables summarize the distributions of the respondents according to some of their demographic characteristics:
Table 1
Type of Clinics

<table>
<thead>
<tr>
<th></th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>HMO/PPO's</td>
<td>39</td>
<td>49.4%</td>
</tr>
<tr>
<td>Fee-for-Services</td>
<td>26</td>
<td>33.0%</td>
</tr>
<tr>
<td>Missing Cases</td>
<td>14</td>
<td>17.2%</td>
</tr>
<tr>
<td>Total</td>
<td>79</td>
<td>100%</td>
</tr>
</tbody>
</table>

Table 2
Geographic Location of Physicians’ Clinics

<table>
<thead>
<tr>
<th></th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban</td>
<td>55</td>
<td>69.6%</td>
</tr>
<tr>
<td>Rural</td>
<td>24</td>
<td>30.4%</td>
</tr>
<tr>
<td>Total</td>
<td>79</td>
<td>100%</td>
</tr>
</tbody>
</table>

Summary of Respondents’ Demographic Characteristics

As Table 1 shows, the majority of physicians who responded were from HMO/PPO clinics (49.4%); Table 2 shows 69.6% were from an urban area. In Table 3, nearly two-thirds of the physicians making up the respondents in this study are be-
between the ages of 31-50 years of age, and more than half (53.1%) were Protestant or Catholic, which can be seen in Table 4. Most of the responding physicians (64.6%) were employed in small clinics. Most (64.6%) were white, as shown in Table 6.

Table 3

<table>
<thead>
<tr>
<th>Physicians’ Ages</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-30</td>
<td>4</td>
<td>5.1%</td>
</tr>
<tr>
<td>31-50</td>
<td>50</td>
<td>63.3%</td>
</tr>
<tr>
<td>51-69</td>
<td>16</td>
<td>20.3%</td>
</tr>
<tr>
<td>Missing Cases</td>
<td>9</td>
<td>11.4%</td>
</tr>
<tr>
<td>Total</td>
<td>79</td>
<td>100%</td>
</tr>
</tbody>
</table>

In the following sections of this study, the researcher summarizes the tests of the informal hypotheses, to determine if any significant relationships exist between any of the independent and dependent variables. A Chi square test because dependent variables were categorical (nominal). Before Chapter IV begins, Chapter III concludes with a section on how the variables are operationalized.
Operationalization of Variables/Independent Variables and Dependent Variables

Physicians' Traits

The following section is focused on five selected characteristics of physicians that were thought to differentiate between those who would be willing to treat HIV positive patients, and those who would rather refer HIV positive patients to other physicians.

Table 4
Religious Affiliations

<table>
<thead>
<tr>
<th></th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protestant</td>
<td>20</td>
<td>25.3%</td>
</tr>
<tr>
<td>Catholic</td>
<td>22</td>
<td>27.8%</td>
</tr>
<tr>
<td>Jewish</td>
<td>2</td>
<td>2.5%</td>
</tr>
<tr>
<td>Muslim</td>
<td>2</td>
<td>2.5%</td>
</tr>
<tr>
<td>Hindu</td>
<td>6</td>
<td>7.6%</td>
</tr>
<tr>
<td>None</td>
<td>9</td>
<td>11.4%</td>
</tr>
<tr>
<td>Other</td>
<td>8</td>
<td>10.1%</td>
</tr>
<tr>
<td>Missing Cases</td>
<td>10</td>
<td>12.7%</td>
</tr>
<tr>
<td>Total</td>
<td>79</td>
<td>100%</td>
</tr>
</tbody>
</table>
Table 5
Physicians’ Clinic Sizes

<table>
<thead>
<tr>
<th></th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Small</td>
<td>51</td>
<td>64.6%</td>
</tr>
<tr>
<td>Large</td>
<td>24</td>
<td>30.4%</td>
</tr>
<tr>
<td>Missing Cases</td>
<td>4</td>
<td>5.1%</td>
</tr>
<tr>
<td>Total</td>
<td>79</td>
<td>100%</td>
</tr>
</tbody>
</table>

Table 6
Physicians’ Races

<table>
<thead>
<tr>
<th></th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>51</td>
<td>64.6%</td>
</tr>
<tr>
<td>African-American</td>
<td>1</td>
<td>1.3%</td>
</tr>
<tr>
<td>Native-American</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Asian</td>
<td>17</td>
<td>21.5%</td>
</tr>
<tr>
<td>Other</td>
<td>8</td>
<td>10.3%</td>
</tr>
<tr>
<td>Missing Cases</td>
<td>2</td>
<td>2.5%</td>
</tr>
<tr>
<td>Total</td>
<td>79</td>
<td>100%</td>
</tr>
</tbody>
</table>
Physicians' Ages

The first independent variable is physicians' ages. It measures ages by the respondents' answers to question 39 (refer to Appendix C). Survey question 39 asked participating physicians their ages because the literature review revealed that physicians' ages had been measured in past studies. It is expected that young physicians' will be more willing than older physicians to treat all HIV positive patients. (See Table 3)

Physicians' Religions

Another independent variable is the physicians' religious affiliations. To measure this independent variable, participating physicians answered survey question 38 (refer to Appendix C). Survey question 38 asked participating physicians to indicate their religious affiliation because it is the researcher’s belief that certain religion affiliations may increase some physicians' willingness to treat patients, especially HIV positive patients, and certain other religious affiliations may decrease some physicians' willingness to treat HIV positive patients, especially if patients acquired the disease through homosexual or criminal behaviors. (See Table 4)

Geographical Location of Physicians' Clinics

The third independent variable is the geographical location of the physicians' clinics. Geography was measured by a pre-determined color code for urban and rural
areas. Urban physicians received white surveys; rural physicians received cream colored surveys. The researcher felt that urban physicians, having better access to HIV education and having a higher index of HIV positive patients, are more willing to treat HIV positive patients than those practicing in clinics located in rural areas. (See Table 2)

**OSHA Trained Physicians**

The fourth independent variable is whether physicians took advantage of OSHA training. To measure this independent variable, participating physicians answered survey question 15 (refer to Appendix C), indicating whether or not they were OSHA trained. The researcher felt that those physicians who took advantage of official OSHA training would be more knowledgeable about how to protect themselves from acquiring HIV when treating patients who were infected. This increase in knowledge may consequently cause an increase in physicians' willingness to treat HIV positive patients when compared to those physicians who had not received such training.

**The Method of Insurance Compensation Accepted by Physicians**

The fifth independent variable is the method of insurance compensation accepted by practicing physicians. In order to measure this independent variable, participants responded to survey question 37 (refer to Appendix C). This question asked participating physicians what type of insurance compensation they accepted (HMO/PPOs or fee-for-services). Physicians who accept fee-for-services do charge
patients per service rendered and, consequently, may earn more money from treating patients, especially HIV positive patients. These fee-for-services physicians, the researcher hypothesized, are more likely to treat HIV positive patients than those who work in HMO/PPO clinics. (See Table 1)

Patients' Traits

The patient traits selected for analysis as independent variables are race, ethnicity, and means of acquiring HIV—through homosexual behavior, prostitution, intravenous drug use, blood transfusions, or rape. In order to measure patient traits, participants responded to the following questions.

Survey questions 6 and 7 asked participating physicians about the percentage of both African-American and Hispanic HIV positive patients in their caseloads. (See Appendix C) These questions were asked in order to find out if a higher/lower percentage of either of these groups would influence physicians' willingness to treat HIV positive patients. The purpose was to see if perhaps examining more HIV positive patients from these two groups would ultimately make physicians more comfortable while treating African-American and Hispanic HIV positive patients. The researcher felt that having more exposure to these two groups would increase physicians' willingness to treat African-American and Hispanic HIV positive patients.

Survey questions 21-25 (see Appendix C) asked participating physicians if they would treat HIV positive patients in an undesirable, neutral, or desirable way depending upon the means of their contracting the disease. Undesirable treatments were pre-
sented by options 5, 6, 7; neutral ones by option 4; and desirable ones by options 1, 2, 3. These seven options are shown on a matrix that corresponds with survey questions 21-25. The five modes included were homosexual behavior, through prostitution, the result of intravenous drug use, blood transfusions, and rape. It was anticipated by the researcher that physicians would be more willing to treat patients who acquired HIV by way of rape or a blood transfusion.

Dependent Variables

The manner by which the two dependent variables are measured is presented below. In the present study the dependent variables were defined as physicians’ positive or negative willingness to treat HIV positive patients. Survey questions 13 (prefer to refer) and 34 (duty to treat) were used. (refer to Appendix C) These two questions are paired with each of the independent variables associated with both physicians’ traits and patients’ traits. They will informally be used as hypotheses. This shows whether any relationships exist between the independent variables and dependent variables. The individual relationships will be discussed in Chapter IV.

Researcher’s Predictions

The review of the literature leads this researcher to anticipate that all five physicians’ traits would influence the physicians’ willingness to treat HIV positive patients. In the researcher’s opinion, younger physicians would be more willing to treat HIV positive patients due to a desire to take on a challenge, whereas older phy-
sicians may not feel the need to demonstrate their talents. It is also the researcher’s opinion that some degree of religiosity would increase physicians’ willingness to treat HIV positive patients. It also became apparent to the researcher that the geographical location of physicians’ clinics (urban versus rural) may result in differences in willingness to treat HIV positive patients, mainly because urban physicians tend to see more HIV positive patients and, consequently, may be more comfortable when treating these patients. It also became evident that those physicians who may take advantage of OSHA training beyond the mandatory observation of OSHA regulations may learn ways to better protect themselves from contracting the disease while treating HIV positive patients. Finally, the researcher felt that the more rewards (money) physicians earn when treating HIV positive patients may increase their willingness to treat them.

The literature revealed that the two ascribed traits of rare and ethnicity would decrease physicians’ willingness to treat HIV positive patients. The researcher anticipates that the present study will also show that these two ascribed traits would be associated with physicians being less willing to treat HIV positive patients. It was also revealed that the means by which patients contracted the disease also would be related to physicians’ willingness to treat HIV positive patients. For example, it is the researcher’s expectation that in the current study, patients who acquired the virus through a rape or blood transfusions will confront physicians who feel that it is their duty to treat these patients because these patients cannot be held accountable for acquiring the virus. Conversely, physicians may rather refer prostitutes and intravenous
drug users to some other physician due to the deviant criminal means by which the pa-
tients acquired the virus.

The results of these predictions are found in Chapter IV, and the results will be
summarized in Chapter V.
CHAPTER IV

FINDINGS

Introduction to Findings

Upon reviewing the available literature, it became evident that certain physicians' and patients' traits may influence physicians' willingness to treat HIV positive patients. In the present study, the researcher wanted to investigate whether these same physicians' and patients' traits would influence physicians' willingness to treat HIV positive patients. These physicians' and patients' traits became the foundation for the two distinct types of independent variables selected to conduct this study. The physicians' traits were comprised of five variables which included age, religion, geographical location of clinic, OSHA training, and the method of insurance compensation accepted by the physician. The patients' traits were comprised of seven dimensions, which included the two ascribed traits of race and ethnic background, and the five traits identifying the means by which patients acquired the disease, which included homosexual and criminal (intravenous drug use and prostitution) behavior, blood transfusions and rape. The dependent variable of this study was the physicians' willingness to treat HIV positive patients. Willingness was characterized by whether the physician felt it a duty to treat HIV positive patients or whether the physician would prefer to refer HIV positive patients to another physician.
Physicians' Traits

As stated earlier, this study examines whether physicians' traits would influence their willingness to treat HIV positive patients. The traits of age, religion, geographical location of clinic, OSHA training, and the method of insurance compensation were examined here. Attention is turned to the analysis of these characteristics of physicians in order to determine if they are related to their treatment of HIV positive patients. First, is a physician age important?

Physicians' Ages

Survey question number 39 asked the physicians to identify their age. (Respondents were to select from one of five age ranges: 20-30, 31-40, 41-50, 51-60, or 61-69.) Out of the 70 respondees to this question, only 5.1% were between age 20-30. The majority (63.3%) were ages 31-50, and 20.3% were ages 51-69. These age ranges were identified (for the sake of the analysis) as early adulthood (20-30), middle adulthood (31-50), and the elderly (51-69).

These categories were utilized in part due to the limited number of respondents. The new categories selected were a result of consulting the textbook Sociology by Macionis (1993), who suggested that the adulthood years can be subdivided into early adulthood, middle adulthood, and the elderly.

Survey question number 34 asked the respondents whether they felt that treating HIV positive patients was their duty. The respondents were asked to select from
three options: (1) Yes, (2) No, or (3) Undecided. As is shown in Table 7, a Chi-square test obtained a value of 6.61 with a significance of .16. Overall, 52% indicated it is the physicians’ duty to treat HIV positive patients. In the middle adulthood group, 49% indicated it was their duty to treat HIV positive patients. The elderly physicians were divided on the responses, with 43.8% reporting it was their duty and 43.8% reporting it was not their duty to treat this clientele. Because a significance of .16 exceeds the .05 alpha level, one fails to reject the null hypothesis that there are no differences between the physicians’ ages and whether physicians felt that treating HIV positive patients was their duty.

Table 7
Physicians Who Feel It Is Their Duty to Treat HIV Positive Patients by Physicians’ Ages

<table>
<thead>
<tr>
<th>Age</th>
<th>Yes</th>
<th>No</th>
<th>Undecided</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>Early Adulthood</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(20-30)</td>
<td>6</td>
<td>100.0%</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Middle Adulthood</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(31-50)</td>
<td>26</td>
<td>49.1%</td>
<td>18</td>
<td>34.0%</td>
</tr>
<tr>
<td>Elderly</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(51-69)</td>
<td>7</td>
<td>43.8%</td>
<td>7</td>
<td>43.8%</td>
</tr>
<tr>
<td>Total</td>
<td>39</td>
<td>52%</td>
<td>25</td>
<td>33.3%</td>
</tr>
</tbody>
</table>

Note. $p=.16$, $df=4 \chi^2=6.61$ NS.
Survey question number 13 asked the physicians whether or not they would rather have someone else treat those patients who were positive for HIV. Respondents were given three options: (1) Yes, (2) No, or (3) Undecided. When it comes to referring HIV positive patients, the Elderly physicians were most likely to have someone else provide treatment (75%), as Table 8 reveals. None of the few younger physicians were inclined to refer, preferring to provide the treatment themselves. The Middle Adult respondents were less in agreement, with nearly 40% willing to refer, 43% not, and 17% not sure. As shown in Table 8, a Chi-square value of 12.35 with a significance of .01 was obtained. Because a significance of .01 does not exceed the

Table 8
Physicians Preferring Someone Else to Treat HIV Positive Patients by Physicians' Ages

<table>
<thead>
<tr>
<th>Age</th>
<th>Yes N</th>
<th>Yes %</th>
<th>No N</th>
<th>No %</th>
<th>Undecided N</th>
<th>Undecided %</th>
<th>Total N</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early Adulthood (20-30)</td>
<td>0</td>
<td>0.0%</td>
<td>4</td>
<td>66.7%</td>
<td>2</td>
<td>33.3%</td>
<td>6</td>
<td>80%</td>
</tr>
<tr>
<td>Middle Adulthood (31-50)</td>
<td>21</td>
<td>39.6%</td>
<td>23</td>
<td>43.4%</td>
<td>9</td>
<td>17.0%</td>
<td>53</td>
<td>71%</td>
</tr>
<tr>
<td>Elderly (51-69)</td>
<td>12</td>
<td>75.0%</td>
<td>4</td>
<td>25.0%</td>
<td>0</td>
<td>0.0%</td>
<td>16</td>
<td>21%</td>
</tr>
<tr>
<td>Total</td>
<td>33</td>
<td>44.0%</td>
<td>31</td>
<td>41.3%</td>
<td>11</td>
<td>14.7%</td>
<td>75</td>
<td>100%</td>
</tr>
</tbody>
</table>

Note: p=.01, df=4, $x^2=12.35$ S.
.05 alpha level, one fails to disprove the null hypothesis that there are no significant differences between the physicians’ ages and whether physicians would rather have someone else treat HIV positive patients. Most of this difference appears to be among physicians whose ages ranged between 51-69.

In summary, the ages of these physicians influenced their willingness to treat HIV positive patients. There was support for a relationship between ages of physicians and their preference to have someone else treat HIV positive patients. This relationship was especially evident among physicians whose age ranged between 51-69.

**Physicians’ Religions**

To see if religion is associated with attitudes toward treating HIV positive patients, survey question number 38 asked the respondents to identify their religious affiliation. Respondents were to select from one of the following seven categories: Protestant, Catholic, Jewish, Muslim, Hindu, None, or Other. Out of the 69 respondents to this question, 25.3% were Protestants, 27.8% Catholic, 2.5% Jewish, 2.5% Muslim, 7.6% Hindu, 1.4% None, and 10.1% Other. The other category included African Methodist, Agnostic, Armenian Orthodox, Buddhist, Monotheists, Zoroastrian, and Christian. Ten physicians did not respond. See Table 9.

Catholics were most likely to report no, Jewish physicians were most often the ones indicating it was their duty to treat HIV positive patients, with Muslims, Hindus and other physicians the least likely to feel it was their duty. As indicated in Table 9, a Chi-square value 12.43 with a significance of .41 was obtained. Because a significance
of .41 exceeds the .05 alpha level, one fails to reject the null hypothesis that there are no significant differences between the physicians' religions and whether physicians felt that it was their duty treat HIV positive patients.

Table 9
Physicians Who Feel It Is Their Duty to Treat HIV Positive Patients by Physicians' Religions

<table>
<thead>
<tr>
<th>Religious Affiliation</th>
<th>Yes N</th>
<th>%</th>
<th>No N</th>
<th>%</th>
<th>Undecided N</th>
<th>%</th>
<th>Total N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protestant</td>
<td>14</td>
<td>60.9%</td>
<td>7</td>
<td>30.4%</td>
<td>2</td>
<td>8.7%</td>
<td>23</td>
<td>35%</td>
</tr>
<tr>
<td>Catholic</td>
<td>10</td>
<td>47.6%</td>
<td>8</td>
<td>38.1%</td>
<td>3</td>
<td>14.3%</td>
<td>21</td>
<td>28%</td>
</tr>
<tr>
<td>Jewish</td>
<td>2</td>
<td>66.7%</td>
<td>1</td>
<td>33.3%</td>
<td>0</td>
<td>0.0%</td>
<td>3</td>
<td>.04%</td>
</tr>
<tr>
<td>Muslim</td>
<td>1</td>
<td>33.3%</td>
<td>0</td>
<td>0.0%</td>
<td>2</td>
<td>66.7%</td>
<td>3</td>
<td>.04%</td>
</tr>
<tr>
<td>Hindu</td>
<td>3</td>
<td>42.9%</td>
<td>2</td>
<td>28.6%</td>
<td>2</td>
<td>28.6%</td>
<td>7</td>
<td>.09%</td>
</tr>
<tr>
<td>None</td>
<td>5</td>
<td>55.6%</td>
<td>4</td>
<td>44.4%</td>
<td>0</td>
<td>0.0%</td>
<td>9</td>
<td>12%</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>33.3%</td>
<td>4</td>
<td>44.4%</td>
<td>2</td>
<td>22.2%</td>
<td>9</td>
<td>12%</td>
</tr>
<tr>
<td>Total</td>
<td>38</td>
<td>51%</td>
<td>26</td>
<td>35%</td>
<td>11</td>
<td>15%</td>
<td>75</td>
<td>100%</td>
</tr>
</tbody>
</table>

Note. p = .41, df = 12, χ² = 12.43 NS.

Do physicians' religious affiliations influence their willingness to refer HIV positive patients? Overall, 45% of the physicians prefer someone else to provide treat-
ment. Catholics are most likely to respond in this manner 46%; Protestants, 44%; and Hindus, 43%. Two thirds of those physicians identified as Muslims and Jewish do not prefer someone else to treat those patients. As shown in Table 10, a Chi-square value of 11.05 with a significance of .54 was obtained. Because a significance of .54

Table 10

Physicians Preferring Someone Else Treating HIV Positive Patients
by Physicians' Religions

<table>
<thead>
<tr>
<th>Religious Affiliation</th>
<th>Yes N</th>
<th>Yes %</th>
<th>No N</th>
<th>No %</th>
<th>Undecided N</th>
<th>Undecided %</th>
<th>Total N</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protestant</td>
<td>10</td>
<td>43.5%</td>
<td>8</td>
<td>34.8%</td>
<td>5</td>
<td>21.7%</td>
<td>23</td>
<td>32%</td>
</tr>
<tr>
<td>Catholic</td>
<td>10</td>
<td>45.5%</td>
<td>7</td>
<td>31.8%</td>
<td>5</td>
<td>22.7%</td>
<td>22</td>
<td>30%</td>
</tr>
<tr>
<td>Jewish</td>
<td>1</td>
<td>33.3%</td>
<td>2</td>
<td>66.7%</td>
<td>0</td>
<td>0.0%</td>
<td>3</td>
<td>.04%</td>
</tr>
<tr>
<td>Muslim</td>
<td>0</td>
<td>0.0%</td>
<td>2</td>
<td>66.7%</td>
<td>1</td>
<td>33.3%</td>
<td>3</td>
<td>.04%</td>
</tr>
<tr>
<td>Hindu</td>
<td>3</td>
<td>42.9%</td>
<td>3</td>
<td>42.9%</td>
<td>1</td>
<td>14.3%</td>
<td>7</td>
<td>10%</td>
</tr>
<tr>
<td>None</td>
<td>3</td>
<td>33.3%</td>
<td>3</td>
<td>33.3%</td>
<td>0</td>
<td>0.0%</td>
<td>6</td>
<td>.08%</td>
</tr>
<tr>
<td>Other</td>
<td>6</td>
<td>66.7%</td>
<td>3</td>
<td>33.3%</td>
<td>0</td>
<td>0.0%</td>
<td>9</td>
<td>12%</td>
</tr>
<tr>
<td>Total</td>
<td>33</td>
<td>45.2%</td>
<td>28</td>
<td>38.3%</td>
<td>12</td>
<td>16.4%</td>
<td>73</td>
<td>100%</td>
</tr>
</tbody>
</table>

Note. p=.52, df=12, \(x^2=11.05\) NS.
exceeds the .05 alpha level, one fails to reject the null hypothesis that there are no significant differences between the physicians' religions and whether physicians would have someone else treat HIV positive patients.

Although the present study's overall findings revealed no differences, one respondent indicated that his religious background in Judaism has made him more compassionate toward all HIV positive patients. He also responded by saying that this compassion helps him treat all the HIV positive patients equally, irrespective of the way in which patients acquired the virus.

Geographical Location of Physicians' Clinics

Out of the 79 total respondents, 69.6% were from urban, and 30.4% were from rural areas. Their responses were analyzed (see Table 11) according to the geographical location of the physicians' clinics.

The respondents indicated the majority (53.8%) of urban physicians feel it is their duty to treat HIV positive patients, while 28.8% did not, and 17% were not sure. The respondents practicing in rural areas are equally divided between those who feel it is a duty and those who do not. Overall, rural physicians are much more likely to indicate it is not their duty to treat these patients (46%-29%). As shown in Table 11, a Chi-square value of 2.50 with a significance of .29 was obtained. Because a significance of .29 exceeds the .05 alpha level, one fails to reject the null hypothesis that there are no significant differences between the geographical location of physicians' clinics and whether physicians felt that treating HIV positive patients was their duty.
Table 11

Physicians Who Feel It Is Their Duty to Treat HIV Positive Patients by Physicians' Geography

<table>
<thead>
<tr>
<th>Geography</th>
<th>Yes N %</th>
<th>No N %</th>
<th>Undecided N %</th>
<th>Total N %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban</td>
<td>28 53.8%</td>
<td>15 28.8%</td>
<td>9 17.3%</td>
<td>52 68.4%</td>
</tr>
<tr>
<td>Rural</td>
<td>11 45.8%</td>
<td>11 45.8%</td>
<td>2 8.3%</td>
<td>24 31.6%</td>
</tr>
<tr>
<td>Total</td>
<td>39 51.3%</td>
<td>26 34.2%</td>
<td>11 14.5%</td>
<td>76 100%</td>
</tr>
</tbody>
</table>

Note. p=.29, df=2, \( x^2= 2.50 \) NS.

In Table 12 the information concerning the physicians' clinic locations and their attitudes toward referrals, rural physicians are most willing to refer (56.5%). Physicians in the urban areas are less inclined to refer their HIV positive patients, yet just under 40% would, and one-fifth were undecided. As shown in Table 12, a Chi-square value of 4.06 with a significance of .13 was obtained. Because a significance of .13 exceeds the .05 alpha level, one fails to reject the null hypothesis that there are no significant differences between the geographical location of physicians' clinics and whether physicians would rather have someone else treat HIV positive patients.

In summary, the geographical location of the physicians' clinics (rural versus urban) did not influence physicians' willingness to treat HIV positive patients. The
results suggested that no significant differences existed between the physicians’ willingness to treat HIV positive patients and their geographical locations.

Table 12

Physicians Preferring Someone Else to Treat HIV Positive Patients by Physicians’ Geography

<table>
<thead>
<tr>
<th>Geography</th>
<th>Yes</th>
<th>No</th>
<th>Undecided</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>Urban</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>20</td>
<td>37.7%</td>
<td>22</td>
<td>41.5%</td>
</tr>
<tr>
<td>Rural</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>13</td>
<td>56.5%</td>
<td>9</td>
<td>39%</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>33</td>
<td>43.4%</td>
<td>31</td>
<td>40.8%</td>
</tr>
</tbody>
</table>

Note. p=.13, df=2, $\chi^2=4.06$  NS.

OSHA Trained Physicians

Does OSHA training differentiate between physicians who are willing to treat or to refer their HIV positive patients? Survey question number 15 asked the respondents to identify whether they had taken advantage of formal OSHA training.

The OSHA trained physicians are more likely to feel it is their duty to treat HIV positive patients (51.8%), yet nearly 45% of those who had not been so trained also felt it their duty to treat these patients. As shown in Table 13, a Chi-square value of 1.03 with a significance of .60 was obtained. Because a significance of .60 exceeds
the .05 alpha level, one fails to reject the null hypothesis that there are no significant differences between OSHA trained physicians and whether physicians felt that treating HIV positive patients was their duty.

Table 13

Physicians Who Feel It Is Their Duty to Treat HIV Positive Patients by Physicians Who Are OSHA Trained

<table>
<thead>
<tr>
<th>Duty to Treat</th>
<th>OSHA Trained</th>
<th>Yes</th>
<th>No</th>
<th>Undecided</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>29</td>
<td>20</td>
<td>7</td>
<td>56</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>51.8%</td>
<td>35.7%</td>
<td>12.5%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>8</td>
<td>6</td>
<td>4</td>
<td>18</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>44.4%</td>
<td>33.3%</td>
<td>22.2%</td>
<td>35.1%</td>
</tr>
<tr>
<td></td>
<td>Undecided</td>
<td>11</td>
<td>18</td>
<td>11</td>
<td>40</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>14.9%</td>
<td>24.3%</td>
<td>14.9%</td>
<td>14.9%</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>37</td>
<td>26</td>
<td>11</td>
<td>74</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>50.0%</td>
<td>35.1%</td>
<td>14.9%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Note. JL = .60, df=2, $\chi^2=1.03$ NS.

The information reported showed that nearly 45% of the respondents, whether OSHA trained or not, prefers someone else to treat HIV positive patients, with none of these trained more likely to prefer others than those physicians not trained (46% compared to 39%). As shown in Table 14, a Chi-square value of .70 with a significance of .70 was obtained. Because a significance of .70 exceeds the .05 alpha level, one fails to reject the null hypothesis that there are no significant differences between
OSHA trained physicians and whether physicians would rather have someone else treat HIV positive patients.

### Table 14

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Undecided</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>OSHA Trained</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>26</td>
<td>22</td>
<td>8</td>
<td>56</td>
</tr>
<tr>
<td></td>
<td>46.4%</td>
<td>39.3%</td>
<td>14.3%</td>
<td>75.7%</td>
</tr>
<tr>
<td>No</td>
<td>7</td>
<td>7</td>
<td>4</td>
<td>18</td>
</tr>
<tr>
<td></td>
<td>38.9%</td>
<td>38.9%</td>
<td>22.2%</td>
<td>24.3%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>33</td>
<td>29</td>
<td>12</td>
<td>74</td>
</tr>
<tr>
<td></td>
<td>44.6%</td>
<td>39.2%</td>
<td>16.2%</td>
<td>100%</td>
</tr>
</tbody>
</table>

**Note.** $p = .70$, $df = 2$, $x^2 = .70$ NS.

In summary, all findings indicate there are no significant differences between those physicians that took advantage of formal OSHA training and their willingness to treat HIV positive patients.

Although the present study's overall findings revealed no differences, one respondent indicated, "One does not have to receive OSHA training by law, but one must recognize and follow the OSHA guidelines and regulations. OSHA is a very frustrating component within the health care system in that OSHA employees will enforce their regulations even if they are impractical and inefficient. Their auditors will
find the most minuscule discrepancy and charge the doctor a high fine. At first OSHA was a good idea, but it turned into a bureaucracy. I would never deviate away from the OSHA guidelines, but I do believe that some of OSHA's regulations are redundant. For example, two-three drops of urine does not warrant a separate waste container. A dirty diaper that is disposed in a regular waste container is more deserving of going into a bio-hazardous waste container."

**The Method of Insurance Compensation Accepted by Physicians**

Does the method of insurance compensation accepted by physicians have any bearing on their willing to treat HIV positive patients? Survey question number 37 asked the physicians to identify the method of insurance compensation accepted by them. Out of the 65 physicians who responded to this question, 49.4% practiced in an HMO/PPO setting, and 33% practiced in a setting utilizing a fee-for-services policy. Fourteen physicians did not respond.

The physicians' willingness to treat HIV positive patients according to method of compensation is presented in Table 15. The data show that overall the "fee-for-services" physicians are more likely to be willing to treat these patients than are the physicians who practice in the HMO/PPO's (56% compared to 49%). As shown in Table 15, a Chi-square value of 1.41 was obtained, with a significance of .49. Because a significance of .49 exceeds the .05 alpha level, one fails to reject the null hypothesis that there are no differences between the method of insurance compensation accepted by physicians and whether they felt that it was their duty to treat HIV positive patients.
Table 15

Physicians Who Feel It Is Their Duty to Treat HIV Positive Patients by Method of Insurance Compensation Accepted by Physicians

<table>
<thead>
<tr>
<th>Duty to Treat</th>
<th>Insurance</th>
<th>Yes</th>
<th>No</th>
<th>Undecided</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>HMO/PPO</td>
<td>24</td>
<td>16</td>
<td>9</td>
<td>49</td>
</tr>
<tr>
<td></td>
<td></td>
<td>49.0%</td>
<td>32.7%</td>
<td>18.4%</td>
<td>66.2%</td>
</tr>
<tr>
<td></td>
<td>Fee-for-Services</td>
<td>14</td>
<td>9</td>
<td>2</td>
<td>25</td>
</tr>
<tr>
<td></td>
<td></td>
<td>56.0%</td>
<td>36.0%</td>
<td>8.0%</td>
<td>33.8%</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>38</td>
<td>25</td>
<td>11</td>
<td>74</td>
</tr>
<tr>
<td></td>
<td></td>
<td>51.4%</td>
<td>33.8%</td>
<td>14.8%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Note. n = 41, df = 2, $x^2 = .49$ NS.

Are there differences between the physicians in the two compensation settings in their preference that HIV positive patients be treated by others? This information is reported in Table 16. As shown in Table 16, a Chi-square value of 6.28 with a significance of .04 was obtained. Because a significance of .04 does not exceed the .05 alpha level, one fails to disprove the null hypothesis that there are no significant differences between the type of clinic physicians practiced out of and whether physicians would rather have someone else treat the HIV positive patient. Most of this difference appears to be among physicians who accept HMO/PPO insurance policies. These physicians indicated that they were undecided whether they would have someone else treat HIV positive patients. Of those physicians preferring someone else to provide the treatment, more were in the HMO/PPO compensation method (44%) than in the
The findings obtained from the survey responses were quite similar to those obtained by way of personal interviews. According to one physician, "In HMO's the doctors will decide when you are sick. Also, either you have the right insurance or you have the wrong insurance. The health care industry is economically driven."

Another physician said, "After being affiliated with an HMO I became so disillusioned by the attitude of the HMOs that I decided by all conscience I could not be a member of that system. If I wanted to carry on and practice, then I had to be out of the system.
and not within the system." He also reported that "HMO's place enormous obstacles in their attempts to deliver care to patients." Also, according to another respondent who was previously employed at an HMO clinic, "Any patient who needs to be treated by a physician whose illness is anything other than a minor cold will be confronted with the fear of being turned away by the clinic." This person further explained that he had actually witnessed how doctors would find a way to deny patients with acute illnesses, such as HIV, from receiving care from the clinic.

In short, this example seems to suggest support for a relationship between the insurance accepted by the physicians and their preference to have someone else treat HIV positive patients.

The findings of this study indicated that only two of the five categories which made up physicians' traits decreased their willingness to treat HIV positive patients. These two categories were ages of physicians and the method of insurance compensation accepted by physicians. The results indicated that physicians whose ages range between 51-69 preferred to refer HIV positive patients to another physician. The second category regarding health insurance compensation indicated that physicians who accepted managed care insurance compensation versus fee-for-services would also prefer to refer HIV positive patients to another physician. The relevance of these findings will be discussed in Chapter V.
Patients’ Traits

The literature review (Chapter II) revealed that seven patient traits may influence physicians’ willingness to treat HIV positive patients. These seven traits are individually examined below.

Race

Does the patients’ “race” influence physicians’ willingness to treat or to prefer that others treat? To get at this possible influence, survey question 6 asked the respondents, “Approximately what percent of HIV positive patients that you treated were African-American?” The respondents were given seven options from which to select. The seven options were: (1) 0-15%, (2) 16-30%, (3) 31-45%, (4) 46-60%, (5) 61-75%, (6) 75 and above, or (7) Don’t know/uncertain. For the purposes of the statistical analysis, the categories were collapsed due to the limited number of cases collected. The new categories were: (1) 0-45%, (2) 46-100%, (3) Don’t know/uncertain. These new categories were collapsed in this fashion, because the researcher wanted to find the mid-point between 0 and 100%. This same collapsed mechanism is used for the Ethnic section of the analysis.

Using the three categories of percentages of HIV positive patients, Tables 17 and 18 show that the trait of “African-American” race seems to have little bearing on the physicians’ willingness to provide treatment or to prefer that treatment be provided by others. As shown in Table 17, a Chi-square value of 1.90 with a significance of .75
was obtained. Because a significance of .75 exceeds the pre-chosen alpha level of .05, one fails to reject the null hypothesis that there are no significant differences between percentages of African-American HIV positive patients and whether physicians felt that treating HIV positive patients was their duty.

Table 17

Physicians Who Feel It Is Their Duty to Treat HIV Positive Patients by Percentage of African-American Clients

<table>
<thead>
<tr>
<th>Percentage of African-American HIV Positive Patients</th>
<th>Yes</th>
<th>No</th>
<th>Undecided</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>0-45%</td>
<td>13</td>
<td>37.1%</td>
<td>18</td>
<td>51.4%</td>
</tr>
<tr>
<td>46-100%</td>
<td>7</td>
<td>31.8%</td>
<td>11</td>
<td>50.0%</td>
</tr>
<tr>
<td>Don't Know/uncertain 1</td>
<td>25.0%</td>
<td>1</td>
<td>25.0%</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>21</td>
<td>34%</td>
<td>30</td>
<td>49.2%</td>
</tr>
</tbody>
</table>

Note. $n=.40$, $df=4$, $x^2=4.06$ NS.

As shown in Table 18, a Chi-square value of 4.06% with a significance of .40 was obtained. Because a significance of .40 exceeds the pre-chosen alpha level of .05, one fails to reject the null hypothesis that there are no significant differences between
percentages of African-American HIV positive patients and whether physicians would rather have someone else treat those patients who are positive for HIV.

Table 18

Physicians Preferring Someone Else to Treat HIV Positive Patients by Percentage of African American Clients

<table>
<thead>
<tr>
<th>Percentage of African-American HIV Positive Patients</th>
<th>Yes N</th>
<th>Yes %</th>
<th>No N</th>
<th>No %</th>
<th>Undecided N</th>
<th>Undecided %</th>
<th>Total N</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-45%</td>
<td>21</td>
<td>58.3%</td>
<td>10</td>
<td>27.8%</td>
<td>5</td>
<td>13.9%</td>
<td>36</td>
<td>59.0%</td>
</tr>
<tr>
<td>46-100%</td>
<td>11</td>
<td>50.0%</td>
<td>7</td>
<td>31.8%</td>
<td>4</td>
<td>18.2%</td>
<td>22</td>
<td>36.1%</td>
</tr>
<tr>
<td>Don’t Know/uncertain</td>
<td>2</td>
<td>66.7%</td>
<td>0</td>
<td>0.0%</td>
<td>1</td>
<td>33.3%</td>
<td>3</td>
<td>4.9%</td>
</tr>
<tr>
<td>Total</td>
<td>34</td>
<td>55.7%</td>
<td>17</td>
<td>27.9%</td>
<td>10</td>
<td>16.4%</td>
<td>61</td>
<td>100%</td>
</tr>
</tbody>
</table>

Note. p=.75, df=4, $\chi^2=1.90$ NS.

Ethnicity

Because it was found that race was not a factor in a physicians' willingness to treat or to refer HIV positive patients, what may be the role of ethnicity, if any? Survey question 7 asked participating physicians, “Approximately what percent of HIV positive patients that you treated were Hispanic?”

None of the physicians in this study had HIV positive patients who were
Hispanics. Of these, 53% did not feel it was their duty to treat them, compared to 35% who did. As indicated in Table 19, a Chi-square value of 1.62 with a significance of .44 was obtained. Because a significance of .44 exceeds the pre-chosen alpha level of .05, one fails to reject the null hypothesis that there are no significant differences between the percentage of Hispanic HIV positive patients and whether physicians felt that it was their duty to treat HIV positive patients.

Table 19

Physicians Who Feel It Is Their Duty to Treat HIV Positive Patients by Percentage of Hispanic Clients

<table>
<thead>
<tr>
<th>Percentage of Hispanic HIV Positive Patients</th>
<th>Duty to Treat</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>0-45%</td>
<td>19</td>
</tr>
<tr>
<td>46-100%</td>
<td>0</td>
</tr>
<tr>
<td>Don't Know/uncertain</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>21</td>
</tr>
</tbody>
</table>

Note. p = .44, df = 2, χ² = 1.62 NS.

Given their responses to “duty to treat” Hispanic patients, one would probably not be surprised to find that a majority of the physicians indicate a preference for
someone else to provide the needed health care (57% to 35%). (See Table 20) Yet, the differences are not statistically significant. As shown in Table 20, a Chi-square value of 3.29 with a significance of .19 was obtained. Because a significance of .19 exceeds the pre-chosen alpha level .05, one fails to reject the null hypothesis that there are no significant differences between the percent of Hispanic HIV positive patients and whether physicians would rather have someone else treat those patients who are positive for HIV.

Table 20

Physicians Preferring Someone Else to Treat HIV Positive Patients by Percentage of Hispanic Clients

<table>
<thead>
<tr>
<th>Percentage of Hispanic HIV Positive Patients</th>
<th>Yes</th>
<th>No</th>
<th>Undecided</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>0-45%</td>
<td>32</td>
<td>57.1%</td>
<td>14</td>
<td>25.0%</td>
</tr>
<tr>
<td>46-100%</td>
<td>0</td>
<td>0.0%</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Don’t know/uncertain</td>
<td>2</td>
<td>50.0%</td>
<td>2</td>
<td>50.0%</td>
</tr>
<tr>
<td>Total</td>
<td>34</td>
<td>57%</td>
<td>16</td>
<td>27%</td>
</tr>
</tbody>
</table>

Note. p= .19, df=2, $x^2 = 3.29$ NS.
Although the present study’s overall findings revealed no significant differences, one respondent indicated that, "A patient of an ethnic background may suffer from an inferiority complex when being examined by a white Anglo-Saxon doctor. Sadly, some White Anglo-Saxon doctors may perpetuate prejudicial feelings toward patients of ethnic groups, especially in rural areas." This respondent also opined that doctors may differ in their approaches to the ethnic patient, a factor which is probably personality based. This respondent believes that his religious upbringing has helped him become a physician who treats his patients with high quality treatment, irrespective of the patient's background or mode of contracting HIV.

According to another respondent interviewed, prejudice does exist within the medical professionals. "The non-medical professionals appear to treat patients of ethnic origin like strangers as compared to patients that are not of an ethnic background. On one occasion at this clinic we happened to have an ethnic patient who was positive for HIV that was treated differently than the majority of the non-ethnic and non-HIV positive patients. Among these non-medical professionals, conversation seems to evolve around speculations on the possible mode of transmission based on their ethnic appearance."

Homosexuals

Does the manner by which one contacts HIV influence physicians’ willingness to treat or to refer such patients? Survey question 21 asked the respondents to choose from seven different ways to treat homosexual HIV positive patients. The seven dif-
ferent selections included: (1) Meeting less frequently; (2) Limiting social conversation; (3) Running fewer tests; (4) No difference in behavior; (5) Treating her/him more compassionately; (6) Being more willing to hold social conversation or; (7) Running more tests. An initial review of the response distribution to the seven aforementioned items strongly suggested that it would perhaps be better to collapse those items in the following fashion where (a) the behavior implied in items 1, 2, and 3 would be viewed as undesirable behavior; (b) the behavior implied in item 4 would be viewed as neutral behavior; and (c) the behavior implied in items 5, 6, and 7 would be viewed as desirable behavior. To interpret the data in such a fashion makes sense, because on the face of it an argument can be made that meeting a patient less frequently, limiting social conversation with a patient, and running fewer tests are all undesirable behaviors, especially if one is an HIV positive patient. Correspondingly, treating the patient more compassionately, being more willing to hold social conversation, and running more tests on patients may be seen to reflect desirable behaviors. For the remainder of the section dealing with the mode in which patients acquired the virus, the same three physicians' behaviors (undesirable, neutral, and desirable) will be consistently used throughout the analysis.

The findings (see Table 21) indicate that the physicians indicating desirable behaviors also feel it is their duty to treat homosexual HIV positive patients. There were more physicians who indicated through neutral behaviors that they did not feel a duty to treat them (46% to 40%). Possibly important here is the finding that only two physicians treated the homosexual HIV positive patient in an undesirable way. Over-
all, when considering that the patient is also homosexual, the physicians are more likely to report it is not a duty (44%) to provide treatment and/or to be more

Table 21

Physicians Who Feel It Is Their Duty to Treat HIV Positive Patients by Homosexual Clients and Physicians’ Treatment Orientation

<table>
<thead>
<tr>
<th>Physicians’ Treatment Orientation</th>
<th>Yes N</th>
<th>%</th>
<th>No N</th>
<th>%</th>
<th>Undecided N</th>
<th>%</th>
<th>Total N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Undesirable Behaviors</td>
<td>0</td>
<td>0.0%</td>
<td>1</td>
<td>50.0%</td>
<td>1</td>
<td>50.0%</td>
<td>2</td>
<td>3%</td>
</tr>
<tr>
<td>Neutral Behaviors</td>
<td>26</td>
<td>40.0%</td>
<td>30</td>
<td>46.2%</td>
<td>9</td>
<td>13.8%</td>
<td>65</td>
<td>93%</td>
</tr>
<tr>
<td>Desirable Behaviors</td>
<td>2</td>
<td>66.7%</td>
<td>0</td>
<td>0.0%</td>
<td>1</td>
<td>33.3%</td>
<td>3</td>
<td>4%</td>
</tr>
<tr>
<td>Total</td>
<td>28</td>
<td>40.0%</td>
<td>31</td>
<td>44.3%</td>
<td>11</td>
<td>15.7%</td>
<td>70</td>
<td>100%</td>
</tr>
</tbody>
</table>

Note.  $p=.29$, $df=4$, $x^2=4.96$ NS.

undecided (16%). Further, Table 22 shows that the majority of these physicians prefer someone else to provide treatment (52%) or to have doubts as to what is desirable (some 16%). As shown in Table 21, a Chi-square value of 2.80 with a significance of .59 was obtained. Because a significance of .59 exceeds the pre-chosen alpha level of .05, one fails to reject the null hypothesis that there are no significant differences between homosexual HIV positive patients and whether physicians felt that treating HIV positive patients was their duty.
As shown in Table 22, a Chi-square value of 4.96 with a significance of .29 was obtained. Because a significance of .29 exceeds the pre-chosen alpha level of .05, one rejects the null hypothesis that there are no significant differences between homosexual HIV positive patients and whether physicians would rather have someone else treat those patients who are positive for HIV.

**Table 22**

Physicians Preferring Someone Else to Treat HIV Positive Patients by Homosexual Clients and Physicians’ Treatment Orientation

<table>
<thead>
<tr>
<th>Physicians’ Treatment Orientation</th>
<th>Yes N</th>
<th>Yes %</th>
<th>No N</th>
<th>No %</th>
<th>Undecided N</th>
<th>Undecided %</th>
<th>Total N</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Undesirable Behaviors</td>
<td>1</td>
<td>50.0%</td>
<td>0</td>
<td>0.0%</td>
<td>1</td>
<td>50.0%</td>
<td>2</td>
<td>3%</td>
</tr>
<tr>
<td>Neutral Behaviors</td>
<td>34</td>
<td>51.5%</td>
<td>22</td>
<td>33.3%</td>
<td>10</td>
<td>15.2%</td>
<td>66</td>
<td>93%</td>
</tr>
<tr>
<td>Desirable Behaviors</td>
<td>2</td>
<td>66.7%</td>
<td>1</td>
<td>33.3%</td>
<td>0</td>
<td>0.0%</td>
<td>3</td>
<td>4%</td>
</tr>
<tr>
<td>Total</td>
<td>37</td>
<td>52.1%</td>
<td>23</td>
<td>32.4%</td>
<td>11</td>
<td>15.5%</td>
<td>71</td>
<td>100%</td>
</tr>
</tbody>
</table>

*Note.* $p=.59$, $df=4$, $x^2=2.80$ NS.

**Deviant Behaviors**

Survey question 23 asked the respondents to choose from the three physicians’ treatment orientations with respect to HIV positive patients who acquired the disease through prostitution.
The respondents are divided on their sense of duty to treat HIV prostitutes (43% yes--44% no). However, there is an agreement among the physicians studied that they prefer that others provide such treatment. (See Table 24). Half of the physicians would prefer that prostitutes who are HIV be treated by someone else (52%). As shown in Table 23, a Chi-square value of 5.18 with a significance of .27 was obtained. Because a significance of .27 exceeds the pre-chosen alpha level of .05, one fails to reject the null hypothesis that there are no significant differences between HIV positive prostitute patients and whether physicians felt that it was their duty to treat HIV positive patients.

### Table 23

**Physicians Who Feel It Is Their Duty to Treat HIV Positive Patients by Prostitute Clients and Physicians' Treatment Orientation**

<table>
<thead>
<tr>
<th>Physicians' Treatment Orientation</th>
<th>Yes N</th>
<th>%</th>
<th>No N</th>
<th>%</th>
<th>Undecided N</th>
<th>%</th>
<th>Total N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Undesirable Behaviors</td>
<td>4</td>
<td>100.0%</td>
<td>0</td>
<td>0.0%</td>
<td>0</td>
<td>0.0%</td>
<td>4</td>
<td>6%</td>
</tr>
<tr>
<td>Neutral Behaviors</td>
<td>23</td>
<td>38.3%</td>
<td>28</td>
<td>46.7%</td>
<td>9</td>
<td>15.0%</td>
<td>60</td>
<td>88%</td>
</tr>
<tr>
<td>Desirable Behaviors</td>
<td>2</td>
<td>50.0%</td>
<td>2</td>
<td>50.0%</td>
<td>0</td>
<td>0.0%</td>
<td>4</td>
<td>6%</td>
</tr>
<tr>
<td>Total</td>
<td>29</td>
<td>42.6%</td>
<td>30</td>
<td>44.1%</td>
<td>9</td>
<td>13.2%</td>
<td>68</td>
<td>100%</td>
</tr>
</tbody>
</table>

*Note. p = .17, df = 4, \( \chi^2 = 6.48 \) NS.*
As shown in Table 24, a Chi-square value of 6.48 with a significance of .17 was obtained. Because a significance of .17 exceeds the pre-chosen alpha level of .05, one fails to reject the null hypothesis that there are no significant differences between HIV positive prostitute patients and whether physicians would rather have someone else treat HIV positive patients.

Table 24
Physicians Preferring Someone Else to Treat HIV Positive Patients by Prostitute Clients and Physicians' Treatment Orientation

<table>
<thead>
<tr>
<th>Physicians' Treatment Orientation</th>
<th>Someone Else Treating</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Undesirable Behaviors</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>0.0%</td>
</tr>
<tr>
<td>Neutral Behaviors</td>
<td>34</td>
</tr>
<tr>
<td></td>
<td>55.7%</td>
</tr>
<tr>
<td>Desirable Behaviors</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>50.0%</td>
</tr>
<tr>
<td>Total</td>
<td>36</td>
</tr>
<tr>
<td></td>
<td>52.2%</td>
</tr>
</tbody>
</table>

*Note. p = .27, df = 4, $x^2 = 5.18$ NS.*

How do the physicians respond when the patient is a drug user? The findings pertaining to "duty" and "referral" are presented in Tables 25 and 26 below. The number of physicians who feel it is their duty to treat drug users are quite similar to those who do not (42% - 43%). A few were undecided. Regardless of their sense of duty
overall, the patients are treated similarly with neutral behaviors more often indicated by the respondents. As shown in Table 25, a Chi-square value of 2.67 with a significance of .26 was obtained. Because a significance of .26 exceeds pre-chosen alpha level of .05, one fails to reject the null hypothesis that there are no significant differences between the HIV positive intravenous drug user patients and whether physicians felt that it was their duty to treat HIV positive patients.

Table 25

Physicians Who Feel It Is Their Duty to Treat HIV Positive Patients by Intravenous Drug User Clients and Physicians' Treatment Orientation

<table>
<thead>
<tr>
<th>Physicians’ Treatment Orientation</th>
<th>Yes</th>
<th>No</th>
<th>Undecided</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Undesirable Behaviors</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Neutral Behaviors</td>
<td>18</td>
<td>17</td>
<td>7</td>
<td>42</td>
</tr>
<tr>
<td>Desirable Behaviors</td>
<td>10</td>
<td>12</td>
<td>3</td>
<td>25</td>
</tr>
<tr>
<td>Total</td>
<td>28</td>
<td>29</td>
<td>10</td>
<td>67</td>
</tr>
</tbody>
</table>

Note.  \( p = .79, \) \( df = 2, \) \( \chi^2 = .46 \)   NS.

When it comes to the treatment of drug users, 51% of the respondents would prefer someone else handle the task. Further, it is noted that those physicians preferring someone else are also very likely to be neutral in their treatment orientation. Even
those not inclined to refer are more often neutral in their treatment orientation. As shown in Table 26, a Chi-square value of .46 with a significance of .79 was obtained. Because a significance of .79 exceeds the .05 alpha level, one fails to reject the null hypothesis that there are no significant differences between HIV positive intravenous drug user patients and whether physicians would rather have someone else treat HIV positive patients.

Table 26

Physicians Preferring Someone Else to Treat HIV Positive Patients by Intravenous Drug User Clients and Physicians' Treatment Orientation

<table>
<thead>
<tr>
<th>Physicians' Treatment Orientation</th>
<th>Yes</th>
<th>No</th>
<th>Undecided</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Undesirable Behaviors</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Neutral Behaviors</td>
<td>25</td>
<td>13</td>
<td>5</td>
<td>43</td>
</tr>
<tr>
<td>Desirable Behaviors</td>
<td>10</td>
<td>9</td>
<td>6</td>
<td>25</td>
</tr>
<tr>
<td>Total</td>
<td>35</td>
<td>22</td>
<td>11</td>
<td>68</td>
</tr>
</tbody>
</table>

Note. p=.26, df=2, $x^2=2.67$ NS.

Blood Transfusions

Contracting HIV through blood transfusions is most often not the “fault” of
the victim who is generally viewed with more compassion and less blame. It is ex­pected that physicians would relate more positively to these patients. Survey question 25 asked the respondents to indicate the different ways to treat HIV positive patients who acquired the virus through a blood transfusion.

The manner of their treatment and their sense of duty to provide treatment is presented in Table 27. Of the physicians indicating it is their duty to treat patients with blood transfusion acquired HIV, nearly twice as many used the neutral behaviors’ mode as used desirable behaviors orientation. Of those using desirable behaviors, there is little difference between the number who did and those who did not feel it was a duty to provide such treatment (36% - 37%). As shown in Table 27, a Chi-square

<table>
<thead>
<tr>
<th>Duty to Treat</th>
<th>Physicians’ Treatment Orientation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes N %</td>
</tr>
<tr>
<td>Undesirable Behaviors</td>
<td>0 0.0%</td>
</tr>
<tr>
<td>Neutral Behaviors</td>
<td>18 39.1%</td>
</tr>
<tr>
<td>Desirable Behaviors</td>
<td>10 43.5%</td>
</tr>
<tr>
<td>Total</td>
<td>28 40.6%</td>
</tr>
</tbody>
</table>

Note. p=.51, df=2, x²=1.36 NS.
value of 3.81 with a significance of .15 was obtained. Because a significance .15 exceeds the .05 alpha level, one fails to reject the null hypothesis that there are no significant differences between HIV positive patients who acquired the virus through a blood transfusion and whether physicians felt that treating HIV positive patients was their duty.

The findings related to whether or not the physicians prefer someone else to treat patients contacting HIV through blood transfusions are in Table 28. The results are shown in Table 28. A Chi-square value of 1.36 with a significance of .51 was obtained. Because a significance of .51 exceeds the pre-chosen alpha level of .05, one

Table 28

Physicians Preferring Someone Else to Treat HIV Positive Patients by Blood Transfusion Clients and Physicians’ Treatment Orientation

<table>
<thead>
<tr>
<th>Physicians’ Treatment Orientation</th>
<th>Yes</th>
<th>No</th>
<th>Undecided</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N %</td>
</tr>
<tr>
<td>Undesirable Behaviors</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0 0%</td>
</tr>
<tr>
<td>Neutral Behaviors</td>
<td>28</td>
<td>13</td>
<td>6</td>
<td>47 67%</td>
</tr>
<tr>
<td>Desirable Behaviors</td>
<td>8</td>
<td>10</td>
<td>5</td>
<td>23 33%</td>
</tr>
<tr>
<td>Total</td>
<td>36</td>
<td>23</td>
<td>11</td>
<td>70 100%</td>
</tr>
</tbody>
</table>

Note. p=.15, df=2, \( x^2=3.81 \) NS.
fails to reject the null hypothesis that there are no significant differences between HIV positive patients who acquired the virus through a blood transfusion and whether physicians would rather have someone else treat HIV positive patients. Half of the physicians indicated it was their duty to treat these patients, yet over three-fourths of them provide only neutral treatment behaviors.

Rape

Some HIV positive patients have been infected through rape. Survey question 22 asked the respondents to indicate their physicians' treatment orientations of patients who acquire HIV through rape. The findings are presented in Tables 29 and 30.

First, the physicians were nearly evenly divided between those who did and those who did not feel it is their duty to treat such patients (44%-41%). A number of physicians were undecided. However, it is of interest to note that among those who sense a duty to treat those patients, undesirable treatment was evident for one in five. Moreover, three-fourths of the physicians used neutral treatment behaviors for these patients. Why rape victims with HIV are so treated is something that needs further research. As shown in Table 29, a Chi-square value of 5.94 with a significance of .20 was obtained. Because a significance of .2 exceeds the alpha level of .05, one fails to reject the null hypothesis that there are no significant differences between raped HIV positive patients and whether physicians felt that treating HIV positive patients was their duty.
Table 29
Physicians Who Feel It Is Their Duty to Treat HIV Positive Patients by Raped Clients and Physicians’ Treatment Orientation

<table>
<thead>
<tr>
<th>Physicians’ Treatment Orientation</th>
<th>Duty to Treat</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes N %</td>
<td>No N %</td>
<td>Undecided N %</td>
<td>Total N %</td>
<td></td>
</tr>
<tr>
<td>Undesirable Behaviors</td>
<td>6 60.0%</td>
<td>3 30.0%</td>
<td>1 10.0%</td>
<td>10 15%</td>
<td></td>
</tr>
<tr>
<td>Neutral Behaviors</td>
<td>22 41.5%</td>
<td>22 41.5%</td>
<td>9 17.0%</td>
<td>53 80%</td>
<td></td>
</tr>
<tr>
<td>Desirable Behaviors</td>
<td>1 33.3%</td>
<td>2 66.7%</td>
<td>0 0.0%</td>
<td>3 5%</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>29 43.9%</td>
<td>27 40.9%</td>
<td>10 15.2%</td>
<td>66 100%</td>
<td></td>
</tr>
</tbody>
</table>

Note. \( p = .69, df = 4, \chi^2 = 2.27 \) NS.

Over half of the physicians would rather someone else treat those HIV positive rape patients (52.3%). However, the treatment orientation provided by those physicians are very similar to that provided by those who had no such preference—neutral. As shown in Table 30, a Chi-square value of 2.27 with a significance of .69 was obtained. Because a significance of .69 exceeds the pre-chosen alpha level of .05, one fails to reject the null hypothesis that there are no significant differences between raped HIV positive patients and whether physicians would rather have someone else treat HIV positive patients.
Table 30

Physicians Preferring Someone Else to Treat HIV Positive Patients by Raped Clients and Physicians' Treatment Orientation

<table>
<thead>
<tr>
<th>Physicians' Treatment Orientation</th>
<th>Yes</th>
<th>No</th>
<th>Undecided</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N %</td>
<td>N %</td>
<td>N %</td>
<td>N %</td>
</tr>
<tr>
<td>Undesirable Behaviors</td>
<td>3 30.0%</td>
<td>4 40.0%</td>
<td>3 30.0%</td>
<td>10 15%</td>
</tr>
<tr>
<td>Neutral Behaviors</td>
<td>30 55.6%</td>
<td>19 35.2%</td>
<td>5 9.3%</td>
<td>54 81%</td>
</tr>
<tr>
<td>Desirable Behaviors</td>
<td>2 66.7%</td>
<td>0 0.0%</td>
<td>1 33.3%</td>
<td>2 4%</td>
</tr>
<tr>
<td>Total</td>
<td>35 52.3%</td>
<td>23 34.3%</td>
<td>9 13.4%</td>
<td>67 100%</td>
</tr>
</tbody>
</table>

Note. $p_{.20}$, df=4, $\chi^2$=5.94 NS.

The results of this study revealed that none of the seven patients' traits influenced physicians' willingness to treat HIV positive patients and that only two physicians' traits had influenced their willingness to treat HIV positive patients. More information on the relevance of these findings will be presented in the next chapter.
CHAPTER V

SUMMARY

The purpose of this research was to determine if selected traits of patients and physicians influenced physicians' willingness to treat HIV positive patients. After reviewing the available literature, the researcher gave 200 physicians a questionnaire consisting of 41 questions focusing upon selected traits related to the physicians' attitudes toward treating HIV positive patients. A total of 79 physicians from southwestern, southeastern, and western Michigan returned surveys. A pre-test questionnaire was conducted in order to see how the format operated. The information obtained from this survey was organized into two sets of variables which were thought to make a difference in the physicians' willingness to treat HIV positive patients. These two sets of variables included five selected physicians' traits (i.e., age, religion, geographical location of clinic, OSHA training, and the method of insurance compensation accepted by them) and seven selected patients' traits (i.e., race, ethnicity, and means by which patients contracted the disease--homosexuality, intravenous drug use, prostitution, blood transfusions, and rape).

The findings covered in Chapter IV were presented with the intention of answering questions related to whether or not certain physicians' traits and certain patients' traits would influence the physicians' willingness to treat HIV positive patients.
as a duty or whether the physicians would prefer that treatment be provided by someone else. First, concerning physicians, the answer to research question 1: Are there physicians’ traits that influence their willingness to treat HIV positive patients? indicated that the method of insurance compensation accepted by physicians and the physicians’ ages made a difference in their willingness to treat HIV positive patients. The other three physicians’ traits such as their ages, religions, nor OSHA training had not influenced their willingness to treat HIV positive patients.

Second, the answer to research question 2, Are there patients’ traits that influence physicians’ willingness to treat HIV positive patients? focusing on patients’ characteristics showed that none of the patients’ characteristics influenced physicians’ willingness to treat HIV positive patients.

Researcher’s Predictions Versus Results

After careful review of the available current literature, this study’s researcher anticipated that certain physicians’ traits or patients’ traits would either increase or decrease physicians’ willingness to treat HIV positive patients. The researcher found five categories of physicians’ traits that the literature suggested would influence their willingness, and seven categories of patients’ traits that would influence physicians’ willingness to treat HIV positive patients. The five categories related to physicians’ traits included age, religion, geography, OSHA training, and health insurance compensation. It was the researcher’s belief that each of these trait categories would have an impact on physicians’ willingness to treat HIV positive patients. Some of the expecta-
The researcher’s predictions found in Chapter III were that the seven patients’ traits included: race, ethnicity, and the various means in which the disease was contracted. The means selected for this study were homosexual and deviant behaviors; rape and blood transfusions. It was the researcher’s belief that the event of a rape or blood transfusion is one in which patients can not be held accountable, consequently increasing physicians’ willingness to treat them. It was expected that a physician would be less likely to feel it was a duty to treat HIV positive patients who were Hispanic, homosexual, and/or who had contracted the virus as a result of drug use or prostitution. It was expected that for these patients the physicians would prefer that treatment be provided by someone else. However, it was anticipated that if the patient had contracted HIV as a result of rape the physicians would be more likely to feel it was their duty to provide treatment that they would be less likely to refer and probably use a favorable treatment program. The findings for this sample of physicians revealed that various patients’ traits do not influence physicians’ willingness to treat nor their orientation toward treatment of HIV positive patients. Further details about the researcher’s predictions regarding these seven dimensions can also be found in Chapter III.

Drawing upon the results of this study as presented in detail in Chapter IV, only two of the five physicians’ traits decreased their willingness to treat HIV positive patients. These two traits were (1) ages of physicians, and (2) the method of insurance compensation accepted by physicians. The study’s results indicated that physicians whose ages ranged between 51-69 and who accepted managed care compensation are
less willing to treat HIV positive patients than physicians in other age groups and in practices using a fee-for-service compensation method. These physicians would prefer to refer HIV positive patients to another physician. These two results conformed with the researcher's expectations expressed in Chapter III.

Limitations of the Study

Throughout the duration of this study the researcher recognized that her study had some limitations, which if remedied in the future by other researchers would improve the quality of the information presented. The three apparent limitations were lack of returned surveys, lack of patients' point of view, and finally lack of a survey instrument that could get physicians to answer in precision versus estimation. First, the response rate of 39.5% could have been made higher if 300-400 surveys had been distributed. The probability of a higher response rate would increase. Second, HIV positive patients were not surveyed in order to present their interpretation of treatment orientations based on this study selected patients' traits. Perhaps patients would have revealed neglect or prejudice by their physicians. Finally, the survey instrument is too indirect in its approach versus using bolder, more direct questions which would ultimately obtain more precise data. Also, the questions were perhaps too predictable in that the researcher realistically could guess how the physician would want to answer the question in order to present her/himself as a dedicated physician. For example, survey question 21-25 ask the physicians to reveal their treatment orientations toward
the seven selected traits. In the researcher’s opinion, physicians would not care to reveal that they would treat any HIV positive patient undesirably.

Researcher’s Concerns

Three factors might explain why the results were different from what the researcher had anticipated: (1) the time frames in which the previous studies were conducted, (2) the sampling frames used in those previous studies, and (3) the social desirability bias. The time frame of many previous studies preceded the increase in HIV education. Presently, physicians respond differently because of this education, than in the past. The earliest study reviewed for this study was conducted in 1986. A decade of educational literature and research findings might well explain the differences between physicians’ attitudes and knowledge in 1986 and 1996. The differences between the anticipated and the empirical results might also be related to the fact that the sampling frames used in the past studies may have reached a broader audience. The sampling frame that was chosen for this study was limited.

Moreover, the theory of a social desirability bias suggests that the participating physicians may not have answered honestly on the survey. For example, one respondent in the this study, while being interviewed, indirectly indicated his true attitudes toward his willingness to treat HIV positive patients. The attitude was revealed when he received a telephone call during the interview from another colleague who asked him to accept an HIV positive patient; the physician responded by saying, “Why don’t you keep him at your hospital?” This same respondent in the interview stated that he
would never turn away a HIV positive patient, a socially desirable, but not necessarily truthful answer.

Results, Their Relevance, and Suggestions for Future Research

The results of this study will serve as “stepping stones” for future studies. The results showed that physicians’ ages did influence their willingness to treat HIV positive patients, while the published literature revealed that physicians’ ages had not influenced their willingness. The difference between the results of previous and present studies are relevant in that it demonstrated how studies using different samples at different times, in different geographical regions, can end with different results. Further, it is the present researcher’s opinion that differences in the results of different studies using the same variables will frequently occur, because no two sampling frames will ever be identical. This leads the researcher to believe that other physicians’ traits may be responsible for the differences in the end results.

It is also the researcher’s belief that the purpose of doing sociological research is to identify any concerns in our society. This study did indicate that physicians who accept managed care insurance compensation are not as willing to treat HIV positive patients, as physicians who are compensated on a fee-for-service basis. In fact, they are not as willing to treat any patient who is in need of detailed and numerous treatments, consultations, or referrals. Part of the reason, at least, is that salaried physicians who provide services beyond the pre-paid monthly premium must absorb the cost of the extra services. The researcher believes that this circumstance will only become
worse in time, due to existing managed care policies. It is the researchers’ belief that well thought out research may be help remedy this undesirable situation.

The responses from the 79 returned surveys revealed that 61 (77.2%) of these physicians had actually treated HIV positive patients. Out of those 79 participating physicians, 69.6% indicated that 16-30% of their patients were HIV positive. This result is significant because physicians who have never treated HIV positive patients may not have similar views regarding treatment as those physicians who have treated HIV positive patients. The researcher is inclined to believe that the results of this study may have been different had all physicians in the sample treated HIV positive patients. A suggestion for a future study would be to survey only physicians who have treated HIV positive patients. It is the researcher’s prediction that such a sample of physicians would be found to be more willing to treat HIV positive patients than the sample used in this study.
Appendix A

Pre-Survey Letter
November 1, 1995

Dr. ---:
address

Dear Dr. ---:

As part of my graduate education in Sociology, I am conducting a survey of physicians' attitudes and beliefs about contact with HIV positive patients. This is an important health care issue about which very little is known. Your participation in this survey is critical if we are to be able to obtain scientifically valid data from our sample of Michigan physicians.

In about two weeks I will deliver a questionnaire to your office. You may complete it at your convenience. It will only take a few minutes to complete and, of course, your responses will be anonymous.

I thank you in advance for your cooperation. If you have any questions concerning the survey, please feel free to contact my advisor, Dr. James C. Petersen (616-387-3600).

Sincerely,

Tania Tiara Kazanjian
Appendix B

Cover Letter
Hello, my name is Tania Kazanjian. As part of my graduate education in Sociology at Western Michigan University, I am conducting a survey of attitudes and beliefs of physicians with respect to contact with HIV positive patients. Your participation in this survey is essential because the data collected will be used to develop my Master’s thesis, “Physician’s Attitudes Toward HIV Positive Patients.” If you participate you can be guaranteed that all of your responses are anonymous, as well as confidential.

If you have any questions concerning this survey, or would like results of the findings, please contact Dr. James Petersen at (616) 387-3600.

Thank you for your cooperation.

Respectfully,

Tania Kazanjian
Appendix C

Survey
EXPERIENCE WITH HIV POSITIVE PATIENTS

1. Have you ever treated patients who were HIV positive?
   1. Yes
   2. No (Please skip to #8)

2. Approximately what percent of HIV positive patients you treated were female?
   1. 0-15%
   2. 16-30%
   3. 31-45%
   4. 46-60%
   5. 61-75%
   6. 76 and above
   7. Don't know/uncertain

3. Approximately what percent of HIV positive patients you treated were homosexual?
   1. 0-15%
   2. 16-30%
   3. 31-45%
   4. 46-60%
   5. 61-75%
   6. 76 and above
   7. Don't know/uncertain

4. How many of your patients either past or current were HIV positive? ______

5. Approximately what percent of HIV positive patients that you treated were white?
   1. 0-15%
   2. 16-30%
   3. 31-45%
   4. 46-60%
   5. 61-75%
   6. 76 and above
   7. Don't know/uncertain
6. Approximately what percent of HIV positive patients that you treated were African American?
   1. 0-15%
   2. 16-30%
   3. 31-45%
   4. 46-60%
   5. 61-75%
   6. 76 and above
   7. Don't know/uncertain

7. Approximately what percent of HIV positive patients that you treated were Hispanic?
   1. 0-15%
   2. 16%-30%
   3. 31-45%
   4. 46-60%
   5. 61-75%
   6. 76 and above
   7. Don't know/uncertain

**VIEWS ABOUT HIV POSITIVE PATIENTS**

8. I think that the population of persons who are HIV positive is:
   1. Higher in cities than rural areas
   2. Lower in cities than rural areas
   3. Neither

9. The most common age for HIV infection is:
   1. Birth-20
   2. 21-29
   3. 30-39
   4. 40-50
   5. 51 and over
10. Do you think that patients who are positive for HIV tend to fall into a particular socioeconomic category?
   1. Yes
   2. No

   If yes, which category?
   1. Upper class
   2. Middle class
   3. Working class
   4. Lower class
   5. All social classes

11. I think the number of HIV positive patients under 30 years of age exceeds the number of patients that are 30 years of age or older.
   1. Yes
   2. No
   3. Undecided

12. On a scale from one to 10, where one is accept fully and ten is reject fully, how would you rate your acceptance of people who are HIV positive?
   Please circle the number.

   1-----2-----3-----4-----5-----6-----7-----8-----9-----10.
   Accept Fully            Reject Fully

13. Do you feel that you would rather have someone else treat those patients who are positive for HIV?
   1. Yes
   2. No
   3. Undecided

14. Would you prefer not to treat patients who are at high risk of becoming HIV positive?
   1. Yes
   2. No
   3. Undecided

15. Have you received OSHA training?
   1. Yes
   2. No (Please skip to #19)
16. To what extent do you feel you would follow the OSHA regulations pertaining to bio-hazardous waste?
   1. Always
   2. Almost always
   3. Sometimes
   4. Almost never
   5. Never

17. Do you feel that the degree to which you follow OSHA regulations influences your willingness to care for the HIV positive patient?
   1. Yes
   2. No
   3. Undecided

18. Do you feel that your employer has provided you with adequate information regarding the OSHA mandatory regulations pertaining to the handling of bio-hazardous waste?
   1. Yes
   2. No
   3. Undecided

19. Do you ever fail to properly dispose of needles after use on patients?
   1. Always
   2. Almost always
   3. Sometimes
   4. Almost never
   5. Never

20. Do you feel that you are at more risk than the general public for contracting HIV because of your position?
   1. Yes
   2. No
   3. Undecided
For the following questions 21-25, select as many as apply from the following choices:

1. Meeting less frequently
2. Limiting social conversation
3. Running fewer tests
4. No difference in behavior
5. Treating her/him more compassionately
6. Being more willing to hold social conversation
7. Running more tests

21. Generally, I would treat the homosexual HIV positive patient differently from the heterosexual HIV positive patient by: __________

22. Generally, I would treat the IV drug user HIV positive patient differently from the from the non-IV drug user HIV positive patient by: __________

23. Generally, I would treat the prostitute HIV positive patient differently from the non-prostitute by: __________

24. Generally, I would treat the raped HIV positive patient differently from the non-raped HIV positive patient by: __________

25. Generally, I would treat the HIV positive patient who acquired the disease through a blood transfusion differently from the HIV positive who did not acquire the disease through a blood transfusion by: __________

26. Do you think that the fear of litigation/legal consequences influences your willingness to care for the HIV positive patient?
   1. Yes
   2. No
   3. Don't know/uncertain

27. Do you think that your patients who use intravenous drugs should be charged as criminals?
   1. Yes
   2. No
   3. Undecided

28. I think I would treat the pediatric HIV positive patient more compassionately than I would treat the adult HIV positive patient.
   1. Yes
   2. No
   3. Undecided
29. Do you feel comfortable in performing a physical examination on patients from sub groups with high HIV prevalence?
   1. Yes
   2. No
   3. Undecided

30. I feel knowledgeable about HIV transmission?
   1. Strongly agree
   2. Agree
   3. Agree somewhat
   4. Disagree somewhat
   5. Disagree
   6. Strongly Disagree

31. Are there ever conditions under which it is acceptable for the physician to refuse to treat the HIV positive patient?
   1. Yes
   2. No
   3. Undecided

32. Do you feel that your attitude toward treating HIV positive patient has changed in the last seven years?
   1. Yes
   2. No
   3. Undecided

   If yes, how has it changed:
   ___________________________________________________________
   ___________________________________________________________
   ___________________________________________________________

33. Do you think the physician who has fears of contracting the disease from the HIV positive patient would actively refer the patient to another physician?
   1. Yes
   2. No
   3. Undecided

34. Do you feel that treating HIV positive patients is your duty?
   1. Yes
   2. No
   3. Undecided
35. Do you believe that the physician who has used IV drugs in the past might be more compassionate toward the HIV positive patient who acquired the disease through IV drug use?
   1. Yes
   2. No
   3. Don't know/uncertain

**DEMOGRAPHICS ON PHYSICIANS**

36. Do you practice out of a:?
   1. Solo practice
   2. Partnership of two
   3. Small group (3-10)
   4. Large group (11 or more)

37. Do you practice out of a:
   1. HMO
   2. PPO
   3. Both
   4. Neither

38. What is your religious affiliation?
   1. Protestant
   2. Catholic
   3. Jewish
   4. Muslim
   5. Hindu
   6. None
   7. Other, please specify _______

39. What is your age range?
   1. 20-30
   2. 31-40
   3. 41-50
   4. 51-60
   5. 61-69

40. What sex are you?
   1. Male
   2. Female
41. What race are you?
   1. White
   2. African American
   3. Native American
   4. Asian
   5. Other _____
Appendix D

Research Protocol Approval From the Human Subjects Institutional Review Board
Date: October 16, 1995
To: Tania Kazanjian
From: Richard Wright, Chair
Re: HSIRB Project Number 95-10-13

This letter will serve as confirmation that your research project entitled "Physicians' attitudes toward HIV positive patients" has been approved under the exempt category of review by the Human Subjects Institutional Review Board. The conditions and duration of this approval are specified in the Policies of Western Michigan University. You may now begin to implement the research as described in the application.

Please note that you must seek specific approval for any changes in this design. You must also seek reapproval if the project extends beyond the termination date. In addition if there are any unanticipated adverse reactions or unanticipated events associated with the conduct of this research, you should immediately suspend the project and contact the Chair of the HSIRB for consultation.

The Board wishes you success in the pursuit of your research goals.

Approval Termination: October 16, 1996

xc: James Petersen, SOC
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