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# Are Patients Ready for Lesbian, Gay and Bisexual Family Physicians – A Croatian Study

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## ABSTRACT

*Discrimination and harassment of lesbian, gay and bisexual (LGB) physicians from their colleagues and superiors are known. However there is little knowledge about the patients' attitudes and discrimination toward physicians. A cross sectional Internet survey was conducted in urban Croatian regions. The participants were asked to answer questions regarding their socio-demographic status, the Attitudes Towards Lesbians and Gay Men Scale (ATLG), and whether they would refuse to see a LGB physician and, if so, why. Of the 1004 participants, 8.8% said they would refuse a male GB physician while 7.9% would refuse a female LB physician, and 7.3% would refuse both. The two most common reasons for discriminating were: "disaccord with political or religious beliefs" and "fear of being sexually harassed". A logistical regression model showed that male sex, higher ATLG score and higher age were associated with more refusals of male GB physicians. Also higher age, higher ATLG score were associated with more refusals of female LB physicians, while personal contact with LGB people was associated with less refusals of both groups. The observed prevalence of discrimination is significant. The results suggest that discrimination is based on emotional reasons and stereotypical beliefs. Educational efforts should be directed towards changing misconceptions about LGB people.*

**Key words:** attitudes, discrimination, health care worker, patients, physicians, sexuality

## Introduction

Discrimination of lesbian, gay and bisexual (LGB) patients has been identified, but the discrimination of LGB medical personnel by heterosexual patients is still underinvestigated. Discrimination of LGB individuals vary across nations, and within central Europe, Croatia seems to range at the rather homophobic end<sup>1</sup>. A study from 2007 reported that 49% of the participants in Croatia feel that LGB people should not be allowed to work in public services, while in 2010 58% of male and 39.5% of female respondents believe that LGB individuals should not be allowed to work with children<sup>2,3</sup>. In light of such a situation it was of interest to see if the general public would have similar attitudes towards a family physician that is lesbian, gay or bisexual.

It is likely that discrimination also affects LGB health care professionals, but this has been rarely researched. In a survey performed among LGB family medicine residents in the USA, 71% reported that the choice of the medical specialization was influenced by their sexual orientation,

and as many as one quarter of respondents omitted information about their involvement in any sort of activist activity, or membership in LGB organizations from their curriculum vitae. Moreover, 25% of medical specialization directors would rank a LGB candidate lower than an equally capable heterosexual one<sup>4</sup>.

A survey done among the members of the Gay and Lesbian Medical Association showed that out of 711 LGB participants more than a third reported »verbal abuse and insults from work colleagues«, and only 12% feel equal with respect to their heterosexual work colleagues<sup>5</sup>. Also, lesbian and bisexual female physicians reported higher incidence of sexual abuse at work in comparison to their heterosexual counterparts<sup>6</sup>. In a 2011 study in the USA it was reported that 65% of LGB physicians regularly hear derogatory comments about LGB people from their colleagues, 34% have witnessed discriminatory behaviour towards LGB patients and their partners, 15% reported having been abused at the workplace and 22% feel iso-

lated at work<sup>7</sup>. It is also likely that work-related sexual orientation differences known from the general population also apply to medical professionals. For example, in comparison to heterosexual workers, LGB workers earn lesser wages, have difficulties in getting certain rights for their partners or the children of their partners such as social security, health insurance, sick leave benefits all of which puts LGB workers into an unenviable position which in turn promotes further discrimination and declines their psychosocial health<sup>8–10</sup>.

Traditionally, the physician is an authoritative figure in the »physician patient« relationship and therefore discrimination towards the physician from the patient may seem surprising. However, these cases of »reverse« discrimination have been reported in a few studies<sup>7,11</sup>, but the evidence is sparse, especially outside of the USA.

The aim of this study was to investigate whether Croatian patients would be willing to be under the care of a LGB primary care physician (family medicine specialists, general practitioners), and, if not, what would the reasons for this objection be as well as what attitudes do patients harbour towards LGB people in general and how do those influence their choice. Family medicine specialists (general practitioners) were chosen for two reasons: patients can choose their family physicians freely and therefore sexual orientation might be a factor that deters some patients from choosing a family physician. Secondly, family physicians' work in individual practices, usually independent from other colleagues which, together with the fact that they follow patients through many years puts the doctor patient relationship as the principal, if not the only, kind of interpersonal relationship at a workplace setting<sup>12</sup>.

## Methods

### Participants

Participants were citizens of the Republic of Croatia, older than 18 years. In total a number of 1004 participants chose to take part in our study. Relevant socio-demographic data is shown in Table 1.

### Methods

The study was conducted via the Internet using an online survey programme. The link to the survey was uploaded to several web-sites that offer news and or entertainment. The time to complete the questionnaire was around 6 minutes. In order to assure anonymity, no personal information or IP addresses were stored. The link was active from the 1<sup>st</sup> of February until the 1<sup>st</sup> of September 2012.

When choosing this way of gathering information we had the known advantages in mind: speed, flexibility, environmental protection, low financial cost and assurance of data accuracy<sup>13</sup>.

**TABLE 1**  
PARTICIPANTS' SOCIO-DEMOGRAPHIC DATA

Question	Answer N (%)
Age: range, median (interquartile range)	18–77; M= 31 (IQR= 15)
Gender	284 (28.3%) male 720 (71.7%) female
Sexual orientation	910 (90.6%) heterosexual, 42 (4.2%) homosexual 52 (5.2%) bisexual
Residence	482 (48.0%) Zagreb (capitol and lagrest city) 194 (19.3%) lagre city (100 000 to 500 000 residents) 176 (17.5%) city (50 000 to 100 000 residents) 64 (6.4%) small town (10 000 to 50 000 residents) 88 (8.8%) village (up to 10 000 residents)
Education	502 (50.0%) university education or higher 164 (16.3%) college (bachelor's degree) 333 (33.2%) high school 5 (0.5%) elementary level or no education
Would you describe yourself as a religious person?	530 (52.8%) – Yes 354 (35.2%) – No 120 (12%) – Rather not say
What religion do you practice?	485 (48.3%) – Rather not say 470 (46.8%) – Catholic 49 (4.9%) different religious practice
How would you describe your political views?	467 (47.4%) – liberal 183 (18.2%) – centrist 147 (14.6%) – very liberal 73 (7.3%) – conservative 3 (0.3%) – very conservative 122 (12.2%) – Rather not say
Estimated monthly income	297 (29.6%) to 3000 kn 239 (23.8%) 3000 to 5000 kn 320 (31.9%) 5000 to 8000 kn 148 (14.7%) more than 8000 kn
Do you personally know a LGB person?	756 (75.3%) – Yes 248 (24.7%) – No

### Questionnaire

The study questionnaire was comprised of three parts: general socio-demographic data, »Attitudes towards Lesbians and Gay Men Scale« (ATLG), and questions regarding the reasons of objecting to a LGB physician created specifically for this study. We used the ATLG scale in order to determine the connection between the attitudes towards LGB people in general and LGB physicians specifically.

### General Socio-demographic Data

Questions from this part consisted of general information about socio-demographics, financial and individual characteristics of the participants (age, gender, sexual orientation, education level, religious views and political stance). It consisted of both multiple choice answers as well as open-ended questions.

### Attitudes towards lesbians and gay men scale

The Attitudes Towards Lesbians and Gay Men Scale (ATLG) is an established questionnaire with 20 items and two subscales for attitudes towards gay men and lesbian women<sup>14</sup>. A shorter version was later developed, which is recommended as it requires less time. It consists of 10 questions, again divided in two scales with 5 questions regarding attitudes towards lesbian women and 5 about attitudes towards gay men and was used in our study. The items were Likert typed, ranging from 1 to 5, where 1 is »strongly disagree«, 3 is »not agree nor disagree« and 5 is »completely agree«. The summary score ranges from 10 (positive attitude towards gays/lesbians) to 50 (negative attitude)<sup>14,15</sup>. Cronbach alpha in our study was 0.827, which is comparable to other research that used the same scale<sup>14,16–18</sup>. The questionnaire is originally in English and was translated using back translation into Croatian language.

### Reasons to refuse a physician based on sexual orientation

The third part of the questionnaire consisted of 6 items assessing the reasons why a participant as a potential patient, would refuse care from a LGB family physician. The items were created with help of a focus group of 40 people (20 self-identifying LGB people and 20 self-identifying heterosexual people) who answered an open call for the participation in the focus group that was sent through two non-governmental organizations involved in human rights protection (»Zagreb Pride« and »Centre for Peace Studies«). The volunteers were individually asked to make a list of 10 potential reasons why they or someone in general, would refuse to be treated by a LGB physician. The collected answers were grouped according to main reason given and six most frequently stated reasons were chosen for the study questionnaire. Each of the final six reasons were given by more than half of the focus group volunteers, which included: »seeing a LGB physician is against my religious and/or political views«, »fear of contracting HIV or another STD«, »fear of being sexually harassed«, »fear that my child is going to be sexually harassed«, »LGB people are themselves ill and therefore cannot treat me« and »LGB physicians are less competent than heterosexual physicians«.

Separate items were created to see if the participants would refuse to be treated by a male or female heterosexual physician and male or female LGB physician, in

order to assess if the refusal might be based on the gender of the physician and not on the sexual orientation alone. If the participant answered that they would refuse a heterosexual physician and a LGB physician of the same gender the participant was regarded as not to be discriminative towards sexual orientation but only towards a certain gender.

### Statistical Analysis

Due to the non-normal distribution of the attitude-variables, we report the median and ranges for the descriptive statistics. Nonparametric statistical tests were used (group differences with the Mann-Whitney U test for two groups and the Kruskal-Wallis for three or more groups). For group comparisons of categorical variables we used  $\chi^2$  - test.

Multivariate logistic regression models were used to investigate which variables were independently associated with refusal of LGB physicians. The statistical analysis was performed using the SPSS 20.0 statistical software (Chicago, IL, www.spss.com).

### Ethical considerations

The research was approved by the Ethical Committee of the School of Medicine, University of Zagreb on the 26<sup>th</sup> of January 2012.

### Results

#### Refusal of LGB physicians

Out of 1004 participants in our study, 8.8% (88) would refuse treatment from a male LGB physician; 7.9% (79) would refuse a female LGB physician, while 7.3% (73) would refuse treatment from both male and female LGB physicians. Also only one participant would refuse treatment from a male heterosexual physician and a male LGB physician.

In regards to the participants gender, results showed that male participants are more inclined to refuse treatment from LGB physicians in comparison to female participants in all three cases; refusal of male LGB physician (5.88% vs. 2.89%,  $\chi^2=71.42$ ; df=1,  $p<0.001$ ), refusal of a female LGB physician (4.68% vs. 3.19%,  $\chi^2=41.16$ ; df=1,  $p<0.001$ ) and both (4.58% vs. 2.69%,  $\chi^2=46.80$ ; df=1,  $p<0.001$ ).

Participants who consider themselves as religious, compared to non-religious participants, tend to refuse treatment from male LGB physicians (7.97% vs. 0.29%,  $\chi^2=57.47$ ; df=2,  $p<0.001$ ) and female LGB physicians (7.07% vs. 0.19%,  $\chi^2=49.74$ ; df=2,  $p<0.001$ ) in comparison to participants who do not consider themselves as religious. Also, participants who stated their religious beliefs as »catholic« would refuse treatment from a LGB physician more than any other religious group (7.56% vs. 1.19%,  $\chi^2=78.3$ ; df= 8,  $p<0.001$ ).

Participants who reported not to know a LGBT person themselves personally would also refuse treatment from a LGBT physician more often in comparison to those participants who personally know at least one LGBT person (5.38% vs. 1.89%,  $\chi^2=102.75$ ;  $df=1$ ,  $p<0.001$ ). Among the participants who identify as homosexual or bisexual there are no reported cases of refusal of treatment by a LGBT physician, compared to heterosexually identified participants (0.00% vs. 7.27%,  $\chi^2=8.13$ ,  $df=2$ ,  $p=0.017$ ).

### Reasons of refusal

Reasons given of why the participants would refuse to visit a LGBT physician is given in Figure 1. »Receiving care from a LGBT family physician is not in concordance with my political and/or religious beliefs« was chosen by 31.6% of the participants, »I am afraid that I might be sexually harassed or assaulted by a LGBT family physician« was chosen by 23.2% and »All LGBT people are ill and therefore should not be physicians« was chosen by 22.1% of the participants. Further 17.9% of the participants chose »I am afraid that I might get HIV or another STD infection from a LGBT family physician«. »LGBT physicians are less competent than heterosexual ones« and »I am afraid that my child might be sexually harassed by a LGBT family physician« were chosen by 3.2% and 2.1% of the participants respectively.

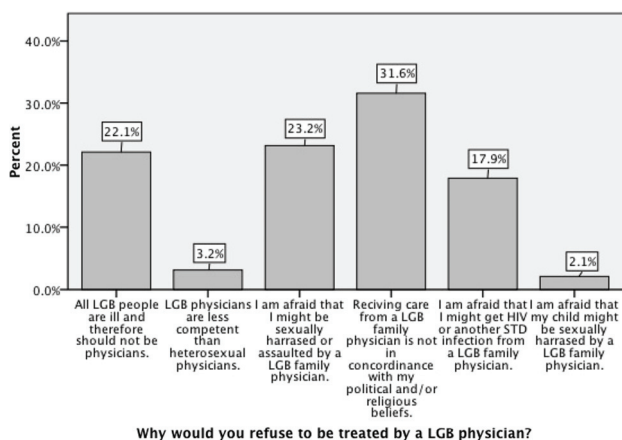


Fig. 1. Reasons given by the participants why they would refuse treatment from a LGBT physician.

### ATLG score

Mann-Whitney U test showed a significant difference in ATLGL score between participants who personally know (MD=18.00; IQR=8) a LGBT person and those who do not (MD=25.00; IQR=16),  $U=50570$ ,  $Z=-10.93$ ;  $p<0.001$ . With respect to gender differences, female participants (MD=18.00; IQR=9) had significantly more positive attitudes towards LGBT people in comparison to male participants (MD=21.00; IQR=16),  $U=85058.5$ ;  $Z=-4.16$ ;  $p<0.001$ .

Figure 2 shows the connection with the median ATLGL score and the self-reported political views of the participants. It is noticeable that the median ATLGL scores rise from reported »liberal« views towards »conservative« political views. This was also observed by the Kruskal-Wallis test which showed statistically significant difference in ATLGL scores between participants grouped by their political views ( $\chi^2=260.93$ ,  $df=5$ ,  $p<0.001$ ).

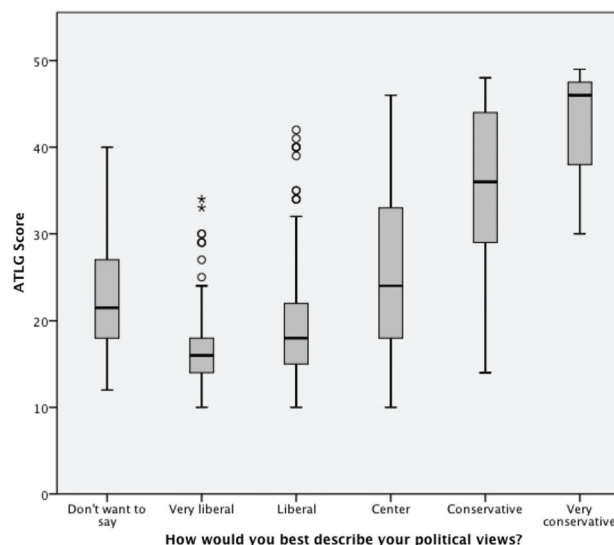


Fig. 2. Median ATLGL scores group according to the participants' political views.

The Kruskal-Wallis test also showed statistically significant difference in median ATLGL scores of participants who declared themselves as »religious« as opposed to those who do not, where people with religious beliefs have high-

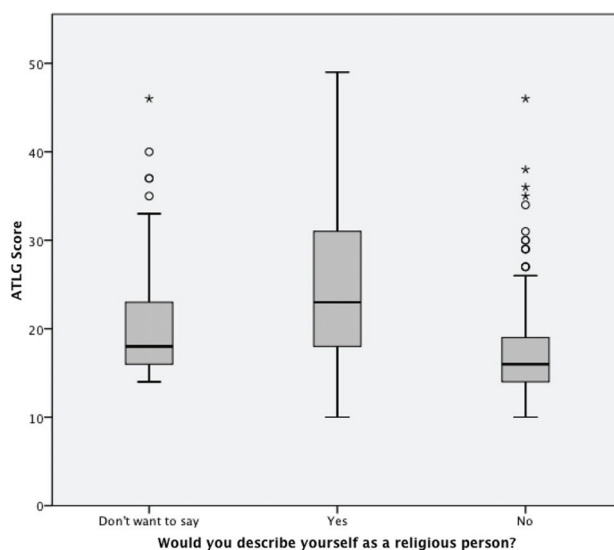


Fig. 3. Median ATLGL scores based on participants self-reported religiousness.



**TABLE 2**  
LOGISTIC REGRESSION MODEL PREDICTS THE LIKELIHOOD OF REFUSING TREATMENT FROM A MALE  
HOMOSEXUAL/BISEXUAL PHYSICIAN

Model Variables	B	S.E.	Wald	DF	p	OR	95% CI
Age	0.04	0.01	6.33	1	0.012	1.04	1.01–1.07
Gender (male)	1.25	0.34	13.53	1	<0.001	3.50	1.79–6.83
ATLG score	0.23	0.02	108.03	1	<0.001	1.26	1.20–1.31
Knows a LGB person	–1.19	0.34	12.34	1	<0.001	0.30	0.15–0.59

**TABLE 3**  
LOGISTIC REGRESSION MODEL PREDICTS THE LIKELIHOOD OF REFUSING TREATMENT FROM A FEMALE  
HOMOSEXUAL/BISEXUAL PHYSICIAN

Model Variables	B	S.E.	Wald	DF	p	OR	95% CI
Age (Year)	0.05	0.01	12.51	1	<0.001	1.05	1.02–1.08
Gender (male)	0.39	0.35	1.27	1	0.259	1.48	0.75–2.95
ATLG Score	0.23	0.02	107.94	1	<0.001	1.26	1.20–1.31
Knows a LGB Person	–0.78	0.35	4.94	1	0.026	0.46	0.23–0.91

er ATLG scores (MD=23.00; IQR=13) in comparison to those who describe themselves as not religious (MD=16.00; IQR=5), and those who would not want to state their religious views (MD=18.00; IQR=7),  $\chi^2=180.82$ ,  $df=2$ ,  $p<0.001$  as shown in Figure 3.

### *Association of refusal and attitudes*

Participants who would refuse a male LGB physician held more negative attitudes towards gays/lesbians (ATLG scores MD=40.50; IQR=12) in comparison to those who would not refuse treatment from a LGB family physician (MD=18.00; IQR=9),  $U=4680$ ;  $Z=-13.75$ ;  $p<0.001$ . Similarly, participant who would refuse a female LGB physician also achieve higher ATLG scores (MD=41.00; IQR=11) and tend to show more negative attitudes in comparison to those who would not refuse a female LGB physician (MD=18.00; IQR=9),  $U=4118.5$ ;  $Z=-13.14$ ;  $p<0.001$ .

### *Multivariate analysis*

Logistic regression analysis was performed to assess the independent association of variables (age, gender, ATLG score, knowing a LGB person) on refusal to be treated by a male or female LGB physician (Table 2).

Refusal of male gay/bisexual physician: All predictions in the logistic regression were statistically significant. The strongest predictor variable was »male gender«: males were more than three times more likely refusing to be seen by a male gay/bisexual physician (OR = 3.5, 95%CI 1.79–6.83). For every single increase in the ATLG score OR is 1.26 with 95%CI 1.20–1.31, as well as for every additional year of life OR 1.04 (95%CI 1.01–1.07); this suggests that older people and people with more negative views towards LGB people in general (higher ATLG score) are

more likely to refuse treatment from a male LGB physician. Knowing a LGB person significantly decreased the odds of refusing a male gay/bisexual physicians (OR=0.30; 95%CI 0.15–0.59)

Refusal of female lesbian/bisexual physicians: (Table 3). All, except gender, proved to be statistically significant. With an OR of 1.26 (95%CI 1.20–1.31), which means that each single increase in the ATLG score increases the likelihood of refusing treatment from a female LGB physician 1.26 times. Similarly, with age, where every year of life increases the likelihood of refusal (OR= 1.05; 95% CI 1.02–1.08). Odds ratio in participants who said that they know a LGBT person personally was 0.46 (95% CI 1.20–1.31) suggesting a decreased likelihood of refusal which was also the strongest predictor (OR of 0.46 corresponds to an OR of 2.14).

### **Discussion**

Research on the discrimination of LGB physicians is usually focused on relationship with the peers, or supervisors and rarely investigates discrimination of physicians by patients<sup>5,6,19</sup>. A research done in Canada on 346 participants in 1998 showed 11.8% refusal to see a LGB physician<sup>11</sup>.

The results showed more refusals of male physicians in comparison to female homosexual/bisexual physicians. This is in line with previous findings that men have more negative attitudes towards LGB individuals than women<sup>2,20</sup>. The reasons for this gender difference are multimodal and largely unexplained, but likely related to gender roles and stereotypes<sup>2,21–23</sup>. We also found that participants that refuse treatment by a male LGB physician are more likely to refuse a female LGB physician as well.

Results of this research confirmed previously reported data that men show more negative attitudes towards LGB people than women. We have showed that male participants refuse LGB physicians in comparison with women in all three cases: male and female LGB physicians, and both. Furthermore, men have higher ATLG scores in comparison to women, which would suggest more negative attitudes towards LGB people in general, and logistic regression model has showed that male gender, independent of other factors, is the strongest predictor of refusal to see a male LGB physician. Even after controlling for potential confounding variables, men were 3.5 times more likely to refuse treatment by a LGB physician than women which can also be linked to norms regarding masculinity and traditional gender roles<sup>2,21,22,24</sup>.

Literature suggests that self-identification with a religious group is not necessarily a predictor for negative attitudes towards LGB people, but it can be one when religious groups promote negative attitudes. However research almost consistently shows that more negative attitudes are more prevalent within people who identify themselves as religious<sup>25–27</sup>, which is not surprising as most religions condemn homosexuality. Our results suggest that people who identify themselves as religious have higher ATLG scores which would imply more negative attitudes in comparison to those who do not identify as religious (Figure 3). People who identify themselves as religious also tend to refuse LGB male physicians and female physicians.

People who harbour conservative political views usually show more negative attitudes towards LGB individuals. Our research showed that as participants move away from more »liberal« views towards more »conservative« ones they have higher ATLG scores (Figure 2), which was also confirmed by other research<sup>28</sup>.

Negative attitudes towards LGB people is transferred and maintained by negative stereotypes and myths surrounding LGB people. Research findings indicate that the role of personal acquaintances with LGB people lowers homo-negative attitudes and prejudice<sup>14,29–31</sup>.

Our data is in line with those findings where participants not knowing any LGB persons held more negative attitudes towards gays and lesbians and more likely refuses a LGB physician in comparison to those who indicate that they know a LGB person themselves. Notably, even after controlling for other variables, knowing a LGB person was associated with three-fold lower refusal of gay/bisexual male physicians and a twofold lower refusal of female lesbian/bisexual physician.

Our study showed that older participants refused LGB physicians more likely than younger participants. This is in line with studies that found similar effects of age with attitudes towards LGB individuals<sup>27</sup>.

Analysis of the reasons why the participant would refuse to be treated by a LGB physician showed that most of the participant chose unspecified reasons to discriminate as shown in Figure 1.

From the rise of the public awareness of the AIDS epidemic the general public turned to gay and bisexual men

as responsible for the spread of HIV. Today, it is known that sexual orientation itself has nothing to do with the risk of contracting HIV but rather with individual behavioural risk factors. However, in Croatia the most common way of HIV transmission is »homosexual intercourse« with 58.7%<sup>32</sup>. Considering that fear of contracting HIV or another STD is ranked fourth with our participants we could positively interpret this as the positive influence of public health campaigns and the removal of the stigma that LGB people are responsible for STD epidemic. However, one fifth of our participant chose this reason, therefore there the need for education about STDs remains a challenge.

Prejudice about sexual promiscuity that characterise LGB people as sexual predators are common in the general public, however they are unsubstantiated by research. From the 1980s onwards research shows that between 40% and 60% of gay men and 60% to 80% of lesbian women have long-lasting monogamous relationships. Also between 2000 and 2005 research has noticed that the number of homosexual couples has increased by 30% which would indicate that legal changes and the possibility of entering into unions that are recognized by law strengthens and increases the visibility of non-heterosexual relationships<sup>33,34</sup>.

However the fear of being sexually harassed was chosen as a reason to refuse a LGB physician in 23.2% of our participants. The best reason to indicate this as a nonsubstantiated prejudice is that homosexual and bisexual participants didn't indicate this reason although they would be the likely victims of such abuse. The fear of sexually harassing a child was stated by 2.1% of the participants. According to statistics, sexual harassment of young girls by heterosexual men is far more common than sexual harassment of young boys by homosexual men. Research has shown that sexual harassment of children by homosexual men is rare, and with lesbian women almost non-existent<sup>35,36</sup>.

Reasons that »LGB people are themselves ill and therefore cannot treat me« and »LGB physicians are less competent than heterosexual physicians« could be put in the category of uncertainty of professional competences of LGB physicians. Together they make up almost one fourth of chosen reasons to refuse a LGB physician. These prejudices are completely unsubstantiated as there is no theoretical basis nor research that would indicate that sexual orientation could decrease the ability of someone to work as a physician or any other profession.

Unspecified reasons such as »seeing a LGB physician is against my religious and/or political views« suggests »inherited« or learned discriminatory behaviour of the participants for which they themselves have difficulties in articulating or finding reasons. However, this reason was the most common in our participants. Difficulties with dispersion of these kinds of prejudices are that they require a different approach than the usual anti-discriminatory campaigns as they are not based in the lack of knowledge but on learned patterns of behaviour that are difficult to change. Considering the high levels of homo-negativity in Croatia, these results are a cause of concern<sup>1,2</sup>.

There are several limitations of our study. One is our sampling strategy. Our study sample mostly consists of young, urban and educated participants, which are characteristics usually in connection with more positive attitudes and less discriminatory views. Thus, our findings are likely an underestimation of the actual discriminatory attitudes towards LGBT physicians in Croatia. Also, the Internet based survey makes it impossible to see what the true response rate was. However, due to the unfavourable attitudes on these topics from the Croatian public<sup>2,20</sup> the internet platform was the only one which would allow people to voice their opinions without the confounding factor of giving socially desirable responses. Furthermore, anonymous web surveys do not put researchers in potentially dangerous situations: we actually experienced threats during our previous related research projects<sup>20</sup>. Unfortunately, these kind of violent outbursts have been reported by other groups outside of Croatia as well<sup>37</sup>. Finally, the cross sectional study design does not allow causal inferences. Furthermore, it would be of interest to repeat the study on a population of older patients or those with chronic conditions as they more frequently use medical services.

## Conclusion

The results of our study indicate the existence of discriminatory attitudes of a substantial fraction of patients

towards LGBT physicians in Croatia and are a cause for concern. Today, LGBT physicians in Croatia are forced to choose not to disclose their sexual orientation at the workplace or to do so and suffer from prejudice and discrimination. Our findings also shed light on the reasons of the discriminatory attitudes and likely resulting related discriminatory behaviour. It is the duty of the societies in general and the medical profession, not only those that work in occupational health, to work on creating better and healthier work environments. Achieving this could be done through educational programmes directed to the general public but also health care professionals who should be trained to notice and eradicate discrimination within the profession in concordance with the highest moral and ethical codes that the medical profession holds most important. Further research should be done with LGBT physicians themselves, and in implementation and evaluation of safe spaces within the workplaces of medical professionals.

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## **JESU LI PACIJENTI SPREMNI PRIHVATITI LGB OBITELJSKE LIJEČNIKE?**

### **SAŽETAK**

Diskriminacija i uznemiravanje lezbijskih, gej i biseksualnih (LGB) liječnika i liječnica od strane kolega i nadređenih je poznata, no malo je poznato o stavovima pacijenata te diskriminaciji prema liječnicima. Presječna internet-studija provedena je u urbanim hrvatskim sredinama. Ispitanici su zamoljeni odgovoriti na pitanja vezana uz socio-demografski status, Attitudes Towards Lesbians and Gay Men Scale (ATLG), te bili odbili biti u skrbi LGB liječnika tj. liječnice i ako da zašto. Od ukupno 1004 ispitanika, 8,8% odbilo bi biti u skrbi muškog GB liječnika dok bi 7,9% odbilo LB liječnicu, te 7,3% odbilo bi neovisno o spolu liječnika. Dva najčešće izabrana razloga su: »protivno političkim ili vjerskim uvjerenjima« te »strah od seksualnog iskorištavanja«. Model logističke regresije pokazao je da muški spol, viši rezultat ATLG upitnika te starija dob su povezani s češćim odbijanjem muških GB liječnika. Starija dob, viši rezultat ATLG upitnika bili su povezani s odbijanjem ženskih LB liječnica, dok je osobni kontakt s LGB osobama bio povezan s manje odbijanja obje grupe liječnika. Razine zabilježene diskriminacije su značajne. Rezultati ukazuju da je diskriminacija utemeljena na emocionalnim razlozima i stereotipnim uvjerenjima. Edukativne mjere trebaju biti usmjerene na mijenjanje stereotipa o LGB osobama.