Some characteristics of homosexual men

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Summary

Although recognition of homosexuals is often important, many doctors lack the necessary skill or experience, so to assist them a group of 5,302 men was surveyed using a computer-based data system and 9.1 per cent. were recorded as homosexual. Analysis showed a relatively high proportion of homosexuals among men with syphilis and gonorrhoea, and a low proportion among men with non-specific genital infection (non-specific urethritis and proctitis) and other infections. All men with secondary syphilis were homosexual. A relatively high proportion of men born in Eire, Spain, and North America were homosexual and a relatively high proportion of men living in the West End of London were homosexual. While these findings will be of most value to those working in STD clinics in London they may also be helpful to those working elsewhere and in other disciplines.

Introduction

Recognition of homosexuality in male patients is important in many fields of medicine, especially in clinics for treating sexually transmitted disease (STD) where special investigation will be omitted and infection may be missed if homosexuality is not recognized. Some homosexuals can be identified by their physical appearance, style of dress, and mannerisms, but others display none of these characteristics. Many doctors lack expertise in recognising homosexuals. In a survey of homosexuals with syphilis and gonorrhoea, the British Co-operative Clinical Group (1973) showed that these men were concentrated in larger cities and especially in the West End of London, but the study did not

consider any other distinguishing features of homosexual men. A review of the medical and social characteristics of homosexual men attending one clinic for the treatment of sexually transmitted disease was carried out to discover features which might help to identify homosexuals.

Methods

Patients were recorded as homosexual if they voluntarily admitted recent sexual contact with another male or if they admitted such contact when questioned by a doctor. Patients were not routinely questioned about this practice as it was felt that this approach was likely to lead to concealment, but when homosexuality was suspected the patient was questioned at each visit. When there was uncertainty men were classified as heterosexual.

Since January, 1972, the production of the quarterly returns to the Department of Health and Social Security (DHSS) in this clinic has been done by a computer-based system. Certain details for each new patient are recorded on coding forms, and at the end of each quarter the completed forms are sent to the Computing Unit for Medical Sciences where the information is transferred to a magnetic tape file. Any patient who had previously attended and had then been discharged was entered as a new case if he presented again with a fresh complaint. A patient with two diagnoses was recorded as two cases. The details recorded include age, country of birth, district of current residence, source of referral (self referral, referral by family or other doctor, or as a contact), diagnoses, and in males homosexuality or heterosexuality.

This has resulted in an easily accessible databank of information concerning patients attending the clinic since January, 1972. The details of all men attending the clinic between January 1, 1972, and March 31, 1974, were extracted and examined.

Results

During the period under review there were 5,302 cases in men and 483 (9.1 per cent.) of them were recorded as homosexual.

The age distribution of homosexual cases compared with that of heterosexual cases is shown in Table I. These two distributions are significantly different from each other ($\chi^2 = 42.871$; $P < 0.001$). It is

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noticeable in Table I that there is a higher than expected proportion of homosexuals amongst the older age groups, and a lower than expected proportion of homosexuals amongst the younger age groups. For example the 40 to 44-age group has 58 homosexuals out of 354 cases, a proportion of 0.16, but there are only 30 homosexuals among 461 males under the age of 20 years, a proportion of 0.06.

TABLE I *Age distribution of homosexual and heterosexual men*

Age group (yrs)	Homosexual	Heterosexual	Total
<16	0	15	15
16 & 17	4	76	80
18 & 19	26	340	366
20-24	92	1,274	1,366
25-29	118	1,208	1,326
30-34	71	646	717
35-39	56	485	541
40-44	58	296	354
45-49	29	191	220
>50	29	288	317
Total	483	4,819	5,302

Table II shows the distribution of diseases in homosexual cases compared with same distribution in heterosexual cases. These two distributions are significantly different from each other ($\chi^2_6 = 351.035$; $P < 0.001$). This Table was investigated further by dividing it in two and additional comparisons were made. First the cases of syphilis were combined and the distribution of syphilis, gonorrhoea, non-specific genital infection (non-specific urethritis and non-specific proctitis), and other infections in homosexuals was compared with the distribution of these conditions in heterosexuals. This comparison was significant ($\chi^2_3 = 271.432$; $P < 0.001$), and examination of the Table shows there is a much higher proportion of homosexuals among cases with syphilis (0.52) and gonorrhoea (0.24) than among cases with non-specific genital infection (0.06) and other infections (0.08). Secondly, homosexuals and heterosexuals were compared on the basis of the different stages of syphilis. This comparison was also significant ($\chi^2_3 = 26.400$; $P < 0.001$) confirming that

TABLE II *Disease distribution of homosexual and heterosexual cases*

Diagnosis	Homosexuals	Heterosexuals	Total
Syphilis			
Primary	6	9	15
Secondary	10	0	10
Latent	11	3	14
Other	1	14	15
Gonorrhoea	110	341	451
Non-specific genital infection	156	2,283	2,439
Others	189	2,169	2,358
Total	483	4,819	5,302

there are differences between the proportions of homosexuals amongst the various stages of syphilis.

The distribution of cases according to country of birth is given in Table III. The two distributions for homosexual and heterosexual men are significantly different from each other ($\chi^2_{11} = 42.889$; $P < 0.001$). It is apparent from the Table that there is a comparatively high proportion of homosexuals amongst men from Eire, Spain, and North America (0.13, 0.21, and 0.16 respectively), and a relatively low proportion among men from Europe (excluding U.K., Spain, and Eire), Asia, Africa, and the West Indies (0.03, 0.06, 0.01, and 0.04 respectively).

TABLE III *Country of origin of homosexual and heterosexual men*

Country of origin	Homosexuals	Heterosexuals	Total
U.K.	414	3,853	4,267
North America	14	76	90
Eire	17	113	130
Spain	5	19	24
Africa	1	129	130
India and			
Pakistan	4	67	71
Other Asia	5	78	83
Other Europe ^a	6	206	212
West Indies	4	104	108
Oceania	7	75	82
Other America ^b	4	33	37
Others	2	66	68
Total	483	4,819	5,302

^aOther Europe: Europe excluding U.K., Eire, and Spain

^bOther America: Central and South America

The district in which the men lived was examined (Table IV) and the distributions for homosexual and heterosexual men were found to be significantly different from each other ($\chi^2_{14} = 96.913$; $P < 0.001$). The relatively high proportion of homosexuals among men from West London boroughs, both north and south of the River Thames, is apparent, the

TABLE IV *District of residence of homosexual and heterosexual men*

District of residence	Homosexuals	Heterosexuals	Total
Hammersmith	16	90	106
Kensington and Chelsea	51	239	290
Lambeth	19	145	164
Wandsworth	27	108	135
Westminster	38	183	221
City	11	299	310
Hackney	11	186	197
Islington	47	588	635
Southwark	3	93	96
Camden	29	234	263
Lewisham	9	97	106
Newham	4	54	58
Tower Hamlets	7	52	59
Other London	102	1,066	1,168
Others	109	1,385	1,494
Total	483	4,819	5,302

proportions of homosexuals in Westminster, Kensington and Chelsea, Hammersmith, Lambeth, and Wandsworth being 0.17, 0.18, 0.15, 0.12, and 0.20 respectively. The proportions of homosexuals amongst men living in the boroughs of Hackney, Islington, and Southwark, and in the City were comparatively low, *i.e.* 0.06, 0.07, 0.03, and 0.04 respectively.

The way in which the men came to attend the clinic was also reviewed (Table V). The distributions for homosexual and heterosexual men were found to be significantly different from each other ($\chi^2_3 = 13.428$; $P < 0.004$). Among those who attended of their own accord, or as a result of contact action, there were relatively high proportions of homosexuals (0.10 and 0.12 respectively), whereas among those referred by another doctor or hospital department the proportion of homosexuals was comparatively low (0.05).

TABLE V *Source of attendance of homosexual and heterosexual men*

Attendance	Homosexual	Heterosexual	Total
Self referral	427	4,064	4,491
Contacts	25	191	216
Referral by another doctor	29	519	548
Others	2	45	47
Total	483	4,819	5,302

Discussion

Overall 9.1 per cent. of the 5,302 cases in men were recorded as homosexual. Nicol (1960) reported from this clinic that, in 1954, 1.2 per cent. of 838 cases in men were homosexual and, in 1959, 5 per cent. of 813 cases were homosexual. At that time homosexuals were liable to prosecution so were less open about their homosexuality than they are now. Despite this it is apparent that the increase in the proportion of homosexuals has not continued to rise at the same rate as the total number of cases in men.

The age distribution in the present series showed fewer younger homosexuals and more older homosexuals than heterosexuals (Table I). However, in 1959 the age distribution of homosexuals attending this department and the clinic at St. Thomas' Hospital (Nicol, 1960) resembled the age distribution of heterosexuals. Jefferiss (1956) also reported that the age distribution of homosexuals in his series was similar to that of heterosexuals. The higher proportion of older men in the present series is probably related to the pattern of homosexual sex contacts which involves casual relationships with many men which in turn is likely to lead to infection. This behaviour continues as the homosexual grows older but heterosexuals usually develop stable partnerships before middle age, so are then less likely to become infected. In the present social climate the middle-aged homosexual probably feels freer to attend the clinic

and this may explain the larger proportion of older homosexuals in the present series.

The lower proportion among younger homosexuals is more interesting and the reasons are not entirely clear. Some young homosexuals may take time to resolve their personal preference for homosexuality or heterosexuality. Some young men may take time to admit to themselves, let alone to others, that they are homosexual. Perhaps the homosexual starts his sexual activity later than the heterosexual, but this appears to be unlikely.

Homosexuals accounted for just over half (52 per cent.) of the cases of syphilis in men, including 60 per cent. of primary syphilis, all cases of secondary syphilis, and 64 per cent. of primary plus secondary syphilis (Table II). A high incidence of early infectious syphilis among homosexuals has been noted for some time (Jefferiss, 1956; Nicol, 1960) and in many western countries (Harris, Mahony, Holland, and McCann, 1972). Nicol (1960) reported that in 1959 eight (67 per cent.) of twelve cases of early syphilis in men attending this clinic were homosexuals. This percentage is remarkably close to the figure obtained in the present study.

The British Co-operative Clinical Group (1973) reported that the highest incidence of homosexually acquired primary and secondary syphilis (in England, Scotland, and Wales) was in the clinics in West London where they accounted for 73 per cent. of male cases. The figure for the rest of London was 37 per cent. It is interesting that this clinic situated near the eastern edge of London's West End should have a percentage nearly as high as the West End clinics.

The very high proportion (79 per cent.) of homosexuals among men with latent syphilis is of note. Furthermore all men with secondary syphilis were homosexuals and this continues to be true up to the time of writing. This reflects the difficulty of diagnosing primary syphilis in homosexuals because the chancre is hidden in the rectum, mouth, or throat. When latent or secondary syphilis is suspected the patient must be carefully questioned about homosexuality if this has not already been recognized, and he must be carefully examined.

Homosexuals accounted for 24 per cent. of cases of gonorrhoea in men studied here. Nicol (1960) reported from this clinic that, in 1954, 4 per cent. of 118 male cases and, in 1959, 11 per cent. of 136 male cases of gonorrhoea occurred in homosexuals. The British Co-operative Clinical Group (1973) found that the highest incidence of homosexually acquired gonorrhoea was in London's West End (28 per cent.). In the rest of London 8 per cent. of cases occurred in homosexuals and the proportion was lower elsewhere in the country. Again it is interesting that the percentage for this clinic was close to the figure for the West End clinics. Homosexuality must be

considered in any man found to have gonorrhoea in this clinic.

The high proportion of homosexuals among men with syphilis and gonorrhoea has been ascribed to factors such as:

1. The promiscuous behaviour of homosexuals.
2. Their lack of symptoms and so awareness of infection.
3. Lack of awareness among doctors.
4. Failure to diagnose and treat these conditions.

These factors should also affect the incidence of other sexually transmitted diseases, but the proportion of homosexuals among men with these other conditions was actually less than the average. Possibly homosexuals themselves are more concerned and perhaps know more about syphilis and gonorrhoea than about other conditions. In addition more contact action is taken in cases of syphilis and gonorrhoea than in cases of other conditions.

A relatively high proportion of the men born in Eire, Spain, and North America were homosexual, while a relatively low proportion of men from Europe (excluding U.K., Spain, and Eire), Asia, Africa, and the West Indies were homosexual (Table III). Jefferiss (1956) and Nicol (1960) both reported a low proportion of homosexuals among 'coloured' patients. The large community of homosexuals in West London will attract homosexuals from elsewhere while particular national groups will tend to attract more of their own nationals.

There was a relatively high proportion of homosexuals among men living in the London Boroughs of Westminster, Kensington and Chelsea, Hammersmith, Lambeth, and Wandsworth (Table IV). The five clinics which reported the high incidence of homosexually acquired syphilis and gonorrhoea to the British Co-operative Clinical Group (1973) are situated in Westminster and Hammersmith, supporting the suggestion that a relatively high proportion of men living in London's West End are homosexual. Obviously many factors affect attendances at a small clinic in London, but the findings here are in general

agreement with those of the British Co-operative Clinical Group (1973) and also indicate that the area with a high proportion of homosexuals extends from the West End across the River Thames into Lambeth and Wandsworth. Furthermore, in his report for 1973, the Chief Medical Officer of Health (1974) commented on the increase in early syphilis among homosexuals in the north-west and south-west Metropolitan Regions. It is interesting that the boroughs with a relatively low proportion of homosexuals were all nearer the clinic than the boroughs with a high proportion.

Among men attending the clinic of their own accord or as contacts there was a relatively high proportion of homosexuals (Table V). The relatively low proportion of homosexuals among men referred by other doctors is probably to be expected. It suggests that homosexuals are more likely to admit this form of behaviour in an STD clinic than in another department. Although homosexuality is almost certainly under-reported this suggests that the degree of under-reporting here may not be too great.

The importance of recognizing homosexuality is well-known to psychiatrists and venereologists, but failure to recognize homosexuality in a male is important in other medical and related disciplines. The observations reported here cannot be interpreted as showing characteristics of a typical homosexual but they do indicate when homosexuality should be suspected if it is not already recognized. These findings apply to London, and it would be interesting to know if similar patterns exist elsewhere.

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