emphasize the need for prompt and vigorous corticosteroid therapy. Complications are rare with this approach, because most patients respond promptly and the steroid dose can be reduced. However, in a patient with severe bronchospasm who is slow to respond to aggressive corticosteroid therapy, the potential benefits of continued high-dose therapy must be assessed against the risks. Opportunistic infection is a risk of prolonged high-dose corticosteroid therapy in patients with asthma even in the absence of other impairments of host defenses.

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Physician Attitudes Toward Homosexuality

TO THE EDITOR: Recent attention in the United States has been focused on the life-styles of patient groups with acquired immune deficiency syndrome (AIDS). Homosexual men constitute the largest known group with the syndrome; they have experienced, at times, strong negative attitudes from those in health delivery occupations. Attitudes of physicians toward homosexual persons rarely have been assessed.[1] We studied such attitudes prior to the widespread publicity of the AIDS phenomenon.

In February 1982 questionnaires were mailed to all 2,364 members of California's San Diego County Medical Society. Of the physicians 43% (a total of 993) responded. Included in the survey were four attitudinal questions. A letter from the physician member of our survey team accompanied the questionnaire; it read in part:

Since 5% to 10% of the general population may be classified as having homosexual orientation, there are few practicing physicians who have not cared for or worked with homosexual persons, whether or not so recognized. The enclosed confidential survey is designed to assess physician attitudes toward homosexual patients and colleagues.

Our first question was "Should a highly qualified homosexual applicant be admitted to medical school?" Seven physicians in ten (69.5%) said that they should be admitted, but it seems significant that almost three physicians in ten (29.0%) had negative attitudes about the entry into medicine of "highly qualified" homosexual applicants.

Table 1 shows the results of the second question: "Should homosexual physicians be discouraged from seeking residency training in pathology, pediatrics, general surgery, psychiatry, radiation therapy?" The specialties were selected to test stereotypical concerns about homosexuals; specialties such as pediatrics and psychiatry, necessitating involvement with children or individual psyches, can be looked at in contrast to specialties such as general surgery, pathology or radiation therapy where such involvement is much more limited. Indeed, more than two fifths of the physicians thought homosexuals should be discouraged from pediatrics; almost two fifths would discourage their entry into psychiatry; slightly more than a fifth would discourage entry into general surgery, and more than a tenth would discourage entry into pathology or radiation therapy.

The physicians were even more negative toward homosexuals in the third hypothetical question asked than the second one (see Table 2). More than two fifths of all physicians would stop referrals to homosexual pediatricians and psychiatrists. General surgeons who are homosexual would find more than a fourth of their colleagues discontinuing patient referrals. Even in a restricted patient-contact field, almost a fifth would stop referring patients to homosexual radiation therapists.

A final question was asked: "How do you feel about treating homosexual patients?" Those with "no negative feelings" represented six physicians in ten (60.4%); those who indicated they were "sometimes uncomfortable" represented one physician in three (32.9%). About 7% of the physicians were "often uncomfort-

TABLE 1.—*Should Homosexual Physicians Be Discouraged From Seeking Residency Training in Any of the Following Specialties?*

	Pathology (percent)	*Pediatrics (percent)*	*General Surgery (percent)*	*Psychiatry (percent)*	*Radiation Therapy (percent)*
YES, should be discouraged	11.3	45.2	22.7	39.7	13.5
NO, should not be discouraged	88.7	54.8	77.3	60.3	86.5
TOTAL	100.0	100.0	100.0	100.0	100.0
N	(908)	(962)	(911)	(948)	(910)

TABLE 2.—*Suppose You Learned That a Physician-Colleague Is a Homosexual. Would You Continue to Refer Your Patients to This Physician if He or She Worked in Any of the Following Specialties?*

	Pediatrics (percent)	*General Surgery (percent)*	*Psychiatry (percent)*	*Radiation Therapy (percent)*
YES, would continue to refer	53.5	74.5	56.4	81.0
NO, would discontinue referral	46.5	25.5	43.6	19.0
TOTAL	100.0	100.0	100.0	100.0
N	(964)	(936)	(956)	(936)

able." Almost two fifths (39.7%) of all physicians admitted to feeling sometimes or often uncomfortable treating homosexual patients.

The preliminary results of this survey of the San Diego County Medical Society indicate a substantial prevalence of negative attitudes toward homosexual persons as both colleagues and as patients. We wonder how the recent publicity about AIDS has affected these attitudes.

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Thromboembolic Complications of Knee Arthroscopy

TO THE EDITOR: Although arthroscopy of the knee is considered to be a relatively safe procedure, reported complications have included minor articular cartilage damage, saphenous nerve injury, hemarthrosis, subcutaneous emphysema, deep vein thrombosis and pulmonary embolism. Of these, thromboembolism presents the greatest potential harm to patients. The incidence of clinical deep vein thrombosis following arthroscopy of the knee is reported to be as high as 1.6%, but subclinical thromboembolism may be much greater.[1]

Reports of Cases

We report three recent cases of thromboembolic complications following arthroscopy of the knee. The first patient was a 33-year-old man in whom pain in the left calf, swelling and pleuritic chest pain developed three days after meniscectomy. A radionuclide ventilation-perfusion scan was positive for pulmonary embolism. A 16-year-old man noted pain in his left calf four days after arthromeniscectomy, and contrast venography showed obstruction of a deep popliteal vein. And, finally, a 28-year-old man required evaluation of calf paresthesia and pain ten days following arthroscopy of the same knee. Again, a contrast venogram showed popliteal deep venous thrombosis. All patients responded quickly to anticoagulation.

It is important for physicians to realize that this potentially life-threatening complication of knee arthroscopy, deep vein thrombosis, occurs with some frequency and should be suspected promptly when calf pain occurs after the procedure.

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Individualism Versus Collectivism

TO THE EDITOR: From the manner in which you framed your understanding of how we got where we are (editorial: "America's Ways of Doing Things"[1]), I have some difficulty fitting historical events into your framework. From our long period of individualism with a free market, limited government, private responsibility and traditional social and moral values, we changed to the current collectivism with its all powerful central government and a planned economy, variously known as socialism, and a welfare state. My intent is to provide a few observations on what trends, what currents of ideologic dissemination, underlay this change. It took many decades of masterful activity by intellectuals advancing reforms to alter our traditional concepts of the proper role of government in our social order.

Following on the heels of Chancellor Bismarck's reforms in Germany and almost coincidental with Fabian socialism in England, the 1890's in the United States were productive in books on utopian thought. Following one such book—Edward Bellamy's *Looking Backward* (published in 1888 and still in print)—162 "nationalist" clubs were formed in 27 states in 1890 to discuss what was (but was denied as being) "obviously (a) socialist system." Bellamy's followers were "college professors, editors, artists and authors."[2]

The real intellectual impetus, however, occurred in 1905 with the organization of the Intercollegiate Society of Socialists. Its aims were to acquaint collegians not only with collectivist doctrines but also to influence college-bred men and women who were assuming a growing role in government. In 1921 the society was reorganized into the Student League for Industrial Democracy with the avowed purpose of "education for a new social order based on production for use and not for profit." By the 1930's, there were 125 institutions of higher learning with chapters of the organization. The graduates exerted their influence in the classroom, from the pulpit, in labor circles, media and politics. Collectivism became the dominant social creed in the universities.

(Parenthetically, much of this ideology reached the councils of the American Medical Association between 1916 and 1920. See Morris Fishbein's history of the AMA for details on the reversal [1920] of its approval of state medicine.[3] This, of course, did not occur overnight. As far back as March 25, 1893, a *JAMA* article endorsed state medicine.[4])

The majority of the key government positions were filled by President Franklin Roosevelt from the ranks of universities where the new order was taught. It is to their influence that collectivism can be attributed. To be sure, the citizenry did not vote for such a change or clamor for it; the Democratic platform of 1932 was a guide to what was intended. The platform was a complete antithesis to what followed. (It was amusing to hear Senator Goldwater's remarks about the similarities of the 1932 platform to his of 1964.) After Roosevelt's reelection in 1936, it became obvious that the "creeping