Author's response to reviews

Title: Medical Students' Attitudes toward Gay Men

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Author's response to reviews: see over
Dear Editors,

Please find a further revision of our manuscript, which we hope you will find suitable for publication. The follow-up recommendations (addressed point-by-point below) made by both reviewers have greatly improved the flow and overall presentation of the paper.

Reviewer 1 (Mary E Kite):

1. As I noted in my earlier review, I encourage the authors to change the term "homophobic" throughout their paper. For example, the term "prejudice" could replace "homophobic" in this sentence on p. 3 "Further, studies assessing... " and the one that follows it with no loss in meaning. The authors did change this in many places, but not completely.

Also on the issue of terminology, please change "sexual preference" to "sexual orientation." Finally, it is better to use "race/ethnicity" than just "race" and it's better not to refer to "the races" (p. 8); instead, refer to differences between "racial/ethnic groups."

I know these issues can seem like minor points, but they reflect the current terminology used in this literature and are seen as very important points to many scholars.

- We truly appreciate the reviewer for pointing this out and have addressed these terms throughout the paper.

2. Also on p. 3, it appears that in the editing process, some transitions/context was lost. So, in the second paragraph, several ideas appear to be lumped together that don't necessarily follow from one another. So, the point about patient outcomes is followed by a statement
about social desirability with no clear connection between the two. Similarly, on p. 11, links between the ideas covered in the first full paragraph could be clearer.

Also, on p. 10, there is a disconnect in the discussion of response rates. The authors correctly note that they have a high response rate, but the next sentence addresses the non-response rate. Again, some simple editing would take care of this (e.g., despite the high response rate, it is possible that those who did not respond are less comfortable...)

- Transitions have been added to those areas pointed out by the reviewer as needing further elaboration. Additionally, the discrepancy in the discussion of response rate has been changed accordingly.

3. From my perspective, I think it's important for everyone (including medical students) to have training in how to communicate with other groups. So, it might be worth mentioning this on p. 10. How would one ask patients with a gay or bisexual orientation health-related questions? In other words, how would those questions be different from those asked of homosexuals?

Page 10 now includes further discussion on the need for social and cultural cognizance on the part of medical students for interacting with all groups (in order to ask specific, pertinent questions).

4. Why is it important to discuss masculinity? (p. 12) Also, I really didn't follow the idea of focusing on the arts as a way to address prejudice. This needs to be explained more fully or dropped.

    We have expanded upon the relationship of masculinity (or widely held beliefs therein) and the relationship with heterosexism. Additionally, we agree with the reviewer regarding the discussion of the arts as a way of addressing prejudice and have removed that section.

5. Some really minor points, but on p. 4, the line beginning "to date..." needs a "should" before "be discussed" and method is singular. on p. 5, n should be italicized. In Table 3, the P in the last column should be lower case.

    This has been done.

Discretionary revisions

1. I strongly encourage the authors to include the item means and standard deviations in Table 2. These are especially helpful for meta-analysts who might use this data in their research. Relatedly, the percent responding to the other scale points is missing so that the reader only has part of the picture. What percentage responded in a neutral way, for example? What percentage used 1 or 2 on the scale? Also, are these percentages reflect the data before or after recoding? Finally, I strongly encourage the authors to report the value of the statistic on which the p value is based in Table 3 for both the
significant and the non-significant results. Again, these data are useful for readers and for meta-analysts.

We appreciate these suggestions. The means and standard deviations have been added to Table 2. We have added in the % neutral for table 2 to provide a more fair portrayal of the responses. We have also added in all p values in table 3 as requested.

2. I still disagree that the age analysis is appropriate, but hope that, in the least, the authors will discuss the issue of restriction of range (p. 12) and emphasize more clearly the limitations of the reported analysis. I don't think the discussion now offered is complete on this point.

This is a great suggestion and one that we have now addressed further in “limitations” of the study.

3. I also respectfully disagree that the results show that sexual prejudice is prevalent among medical students (p. 12) or that most respondents endorsed positive attitudes toward gay persons (p. 7). I also note that the statements on these two pages are actually contradictory. The authors do not have normative data, so have no basis for concluding that the responses are, overall, negative or positive.

We have addressed this in light of Reviewer 2’s similar comments (staying away from making an overall gestalt of student opinion and relying instead on predictors of “more negative” responses for the scales we used).
Reviewer 2 (Todd Morrison)

1. Replace “internal consistency” with “scale score reliability” (i.e., Cronbach’s alpha provides an estimate of internal consistency but does not guarantee it).

   This has been done.

2. The authors mention that the Kruskal-Wallis test was used to examine differences in medians on various categorical variables including sexual preference. Weren’t individuals identifying as non-heterosexual removed from the analyses?

   This has been done.

3. On Table 2, the authors report the proportions that “strongly agree/agree” with scale items. Do the remaining proportions reflect those that “strongly disagree/disagree” or is “don’t know” included in the latter category? For example, 82.3% agree/strongly agree with the item, “Male homosexuality is as natural a sexual expression in men as heterosexuality.” Does that mean 17.7% disagree or does this percentage reflect both “don’t know” and “disagree”?

   Addressed above for Reviewer 1 (had asked for % who were neutral)

4. The authors report “men were more variable in their attitudes than women in these two scales” (p. 8). Which ones?

   Sentence has been rewritten for clarity to specify that “behavior” and “male toughness” were significantly higher for men (in terms of scoring)

5. The authors state, “sexual prejudice is prevalent” (p. 12). However, inspection of Table 1 suggests this isn’t the case.

   Addressed above for Reviewer 1.

6. Page 4, line 2: delete “that”

   This has been done.

7. Page 6, line 12: add “to” before “their”

   This has been done.

8. Page 7, line 19: replace “showed” with “suggested”

   This has been done.
9. Page 7, line 21: replace “in part” with “perhaps” (i.e., low Cronbach alpha coefficients may be attributable to a small number of scale items).

This has been done.

10. Page 10, line 9: the dash after “of” should be deleted.

This has been done.

11. Page 21: For the item, “I won’t associate with gay men if I can help it,” the authors report that 0.0% agreed with this item. Given that the maximal score observed was 7, I would recommend presenting endorsement for this item to the third or forth percentage point.

This has been done.

On behalf of all authors, we’d like to thank both reviewers for their time and thoughtful suggestions.

Sincerely,

Kabir Matharu