sician background and attitudes might affect the decision for referral are not warranted by the results of their study.

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1. Hartz A, Deber R, Bartholomew M, Midtling J. Physician characteristics affecting referral decisions following an exercise tolerance test. *Arch Fam Med.* 1993; 2:513-519.
2. Weiner DA, Ryan TJ, McCabe CH, et al. Exercise stress testing: correlations among history of angina, ST-segment response and prevalence of coronary-artery disease in the coronary artery surgery (CASS). *N Engl J Med.* 1979;301: 230-235.
3. American College of Cardiology/American Heart Association Task Force on Assessment of Cardiovascular Procedures, Subcommittee on Exercise Testing. Guidelines for exercise testing. *J Am Coll Cardiol.* 1986;8:725-738.
4. American College of Physicians/American College of Cardiology/American Heart Association Task Force. Clinical competence in exercise testing: a statement for physicians from the ACP/ACC/AHA Task Force on Clinical Privileges in Cardiology. *J Am Coll Cardiol.* 1990;16:1061-1065.
5. Podrid PJ, Graboys TB, Lown B. Prognosis of medically treated patients with coronary artery disease with profound ST-segment depression during exercise testing. *N Engl J Med.* 1981:305:1111-1116.
6. Grauer K. Silent myocardial ischemia: dilemma or blessing? *Am Fam Physician.* 1990;42(suppl):13S-28S.

In reply

There were four major issues raised by Grauer:

First, Grauer states that the scenario was incomplete because the results of the exercise tolerance test (ETT) were inadequately described. Grauer acknowledges, however, that 2 mm of downsloping ST-segment depression with moderate exercise (8 metabolic equivalents of exercise) is a "markedly abnormal result." More details about the stress test might have confirmed the result, but during extensive pilot testing of this scenario, no clinicians required additional information. The clinicians also seemed satisfied that no ST-segment depression after the patient achieved 90% of maximum predicted heart rate was a normal test. Thus, we do not believe the results of our study would have been substantially affected if we had added additional information that confirmed the impression given in the scenario.

Second, Grauer is correct in stating that there were no middle ground results. The intent of our study was to describe the variation in physician behavior and find reasons for this variation. By using extreme ETT results, we reduced the likelihood that physician variation was caused by uncertainty about how to interpret the results of the test. Finding associations or lack of associations of physician characteristics with responses to ambiguous ETT results would be more difficult to interpret.

Third, Grauer states that the ETT was appropriate for diagnosis. Grauer used diagnosis in a different way than we used it in our questionnaire. We used the term diagnosis to refer to the process of establishing the patient's disease. In our questionnaire, we contrasted diagnosis with several other possible uses of the ETT, including the determination of baseline for following the response to medical therapy. In the context in which we used the term diagnosis, the ETT would not be a useful diagnostic tool for patients with definite angina.

Finally, Grauer says the conclusions of the article were unwarranted because all patients with extremely abnormal test results should undergo cardiac catheterization. Although the physicians in this study may have made the wrong decision by not referring the patient, this does not invalidate our study of what physician factors influence decision making.

The most important finding in this study was that physician decision making differed despite clear-cut results from a well-understood diagnostic test. Finding variations in decision making following an ambiguous test result would have been less interesting.

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Homosexuality Does Not Cause Acquired Immunodeficiency Syndrome

The article by Parra et al[1] contains language that might easily mislead the casual reader about what does, and what does not, cause acquired immunodeficiency syndrome (AIDS). In the "Knowledge of AIDS" section,[1(p605)] the authors note that "most subjects (correctly) knew that homosexuality was the primary cause for AIDS among men."

No evidence I know of indicates that homosexuality is the proximate cause of any disease. If an uninfected gay man had sex, exclusively, with a dozen uninfected gay men every day for a year, the individual would not contract AIDS through his homosexual activity.

The authors should instead reinforce the risks presented by any nonmonogomous sexual relationship.

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1. Parra EO, Shapiro MF, Moreno CA, Linn L. AIDS-related risk behavior, knowledge, and beliefs among women and their Mexican-American sexual partners who used intravenous drugs. *Arch Fam Med.* 1993;2:603-610.

In reply

Feldman pointed out that in the "Knowledge of AIDS" section, the authors may have been misleading in writing that "most subjects (correctly) knew that homosexuality was the primary cause for AIDS among men." He is correct. The actual question subjects were asked to respond "correct" or "incorrect" to was "Most of the men in the U.S. who have AIDS got it by having sex with other men who were infected with the AIDS virus?"