

Virtual Mentor

American Medical Association Journal of Ethics
November 2014, Volume 16, Number 11: 861-954.

November 2014

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American Medical Association Journal of Ethics
November 2014, Volume 16, Number 11: 864-869.

FROM A VIRTUAL MENTOR SPECIAL CONTRIBUTOR

Religious Exemptions in Insurance Coverage and the Patient-Clinician Relationship

Adam Sonfield, MPP

The June 2014 decision by the US Supreme Court in *Burwell v. Hobby Lobby* granted certain for-profit employers a religious exemption from a federal requirement that private health plans cover the full range of contraceptive methods, services, and counseling [1]. That decision and other religious exemptions related to contraceptive insurance coverage have serious implications for the relationship between patients and their clinicians. Moreover, the logic behind religious exemptions to covering contraception could also apply to coverage of a wide range of other health care services and to coverage for specific populations. These implications have not been given sufficient attention by lawmakers, courts, the media, and the public.

The Federal Contraceptive Coverage Guarantee

The *Hobby Lobby* case stems from a provision of the Patient Protection and Affordable Care Act of 2010, commonly known as Obamacare. That provision requires private health plans (unless they are “grandfathered,” i.e., temporarily exempt from the new rules) to cover dozens of preventive care services completely, without any out-of-pocket costs to the patient such as copayments and deductibles [2-4]. Included among those services is the full range of contraceptive methods, services, and counseling for women.

The federal contraceptive coverage guarantee built upon earlier policies, including similar requirements for private insurance coverage in 28 states [5], contraceptive coverage requirements under Medicaid and the insurance program for federal employees [6-8], and a December 2000 decision by the US Equal Employment Opportunity Commission that failure of an employer-sponsored health plan to cover contraception when it covers other preventive care and prescription drugs constitutes illegal sex-based discrimination [9, 10].

In response to objections from opponents of contraceptive coverage, the Obama administration established an exemption to the new requirement for health plans sponsored by houses of worship and other religious employers, narrowly defined [11]. Most of the state requirements include similar exemptions that vary in their scope; several of these exemptions have been challenged in court as too narrow but have been upheld [5].

Beyond that, the administration crafted what it called an “accommodation” for a broader range of religiously affiliated nonprofit organizations, such as universities and hospitals [11]. Employees of those organizations and their family members are still guaranteed contraceptive coverage, but it must be provided by the organization’s insurance company or arranged through its third-party administrator. The organization itself does not have to “contract, arrange, pay or refer” for any contraceptive coverage to which it objects on religious grounds [11].

Despite these measures, more than 100 lawsuits have been filed challenging the federal requirement as an infringement on the religious rights of employers [12]. Roughly half have been filed by nonprofit organizations requesting a full-fledged exemption under which employees and their dependents would be denied contraceptive coverage. The other half have been brought by for-profit employers, such as the craft-store chain Hobby Lobby, requesting that the exemption or the accommodation be extended to for-profit employers.

In its June 2014 decision, a majority of the US Supreme Court found that, under the Religious Freedom Restoration Act of 1993, the federal contraceptive coverage requirement could not be enforced against “closely held” for-profit employers with religious objections [1]. Specifically, Justice Samuel Alito, writing for the majority, and Justice Anthony Kennedy, in a concurring opinion, pointed to the accommodation for nonprofits as an alternative that would be less burdensome on the employers’ rights. As of August 2014, the Obama administration was seeking comments on how to expand the scope of the accommodation to encompass for-profit employers [13].

Effects on the Patient-Physician Relationship

One of the standard talking points from those supporting religious exemptions for employers is that the employers are merely seeking to remove themselves from being complicit with behavior they find immoral, not trying to either prevent the behavior itself or interfere with the health care employees receive. Despite these protestations, however, a religious exemption could have a real impact on employees’ and their dependents’ access to and use of contraception and could infringe on the discussions they have with their clinicians and the decisions they make.

From the perspective of clinicians, religious exemptions to insurance coverage throw into question whether the services they provide and the prescriptions they write will actually be covered. Navigating patients’ coverage is already complex, expensive, and time-consuming for clinicians in private practice, many of whom must hire staff devoted to understanding insurance, coding, and billing. When individual employers are exempt from the otherwise standard policies of a given health insurer, the opportunities for confusion multiply.

By ignoring these issues and, for example, writing a prescription for a drug that is not covered by the patient’s health plan, a clinician may cost the patient significant money and undermine both the patient’s trust in him or her and use of the prescribed

treatment. In some cases—particularly for methods with high up-front costs, such as IUDs, implants, and sterilization—the financial burden may be large enough that the patient is unable to pay, resulting in losses for the practice.

Contraception-Specific Effects

From an ethical standpoint, a clinician should, instead, help the patient understand whether any or all methods of contraception are excluded from her health plan. Differences in cost are unfortunate but important considerations for a patient in making an informed decision about her health care. In fact, eliminating cost as a consideration is precisely the point of the federal contraceptive coverage guarantee: it is designed to allow every woman to choose the contraceptive method that best fits her health needs and her personal circumstances without regard to her socioeconomic status, which is critical for practicing contraception consistently, correctly, and effectively [14].

The results of those discussions have multiple implications. If the clinician and patient decide that the best method for her is one that is excluded from her health plan, one option might be to send the patient elsewhere for that care—for example, to a safety-net clinic that can provide the services and supplies at no cost or at a discount. That may create hurdles for the patient, such as delays in receiving care, additional time off from work, or costs for transportation or child care. It also may mean losses for the referring clinician, especially if the patient concludes she is better served permanently at the safety-net clinic. And it is a greater burden on the already-strained taxpayer-supported safety net. (Insurance plans, meanwhile, would reap a windfall; they would gain the financial benefits of averted unplanned pregnancies without incurring the cost of the contraceptive care.)

Alternatively, the clinician and patient may decide on a contraceptive method with fewer up-front or long-term costs, which tend to be less effective than more costly methods. For example, with typical use, a couple relying on oral contraceptives is 45 times as likely to have an unplanned pregnancy in a given year as a couple relying on a hormonal IUD [15]. Beyond average effectiveness, a woman's choice of methods may also depend on factors such as concerns about side effects and drug interactions, how frequently she expects to have sex, her perceived risk for STIs, and concerns about partner knowledge and interference. So using a second- or third-choice method may result in less consistency; according to one study, women who are less than satisfied with their contraceptive method are more than twice as likely to have a gap in use that leaves them at risk of an unplanned pregnancy [16].

A third possibility, particularly if a plan excludes all contraceptive methods, might be for the clinician and patient to settle on her paying out of pocket for the method of her choice. That may also lead to gaps in use or inconsistent use and higher risk of unplanned pregnancy, especially for low-income women. A survey of women during the recent recession found that substantial numbers of low-income women resorted to tactics like delaying refills of their birth control prescriptions to save money [17].

One final concern for the patient-clinician relationship and the informed consent process is that some employers—including the plaintiffs in the recent Supreme Court case—assert religious objections not only to coverage of some or all contraceptive methods but also to coverage of the counseling and education pertaining to those methods [18]. It is unclear how those employers envision their objection playing out, and it was not mentioned in the Court’s decision. Put into practice, it might mean a gag rule: a ban on talking with patients about the full range of contraceptive options if the office visit is to receive any insurance reimbursement. That would constitute a clear threat to a woman’s ability to provide informed consent to her care and to a clinician’s ability to practice in accordance with ethical medical standards and legal obligations.

Potential Impact beyond Contraception

The logic behind religious exemptions to health insurance clearly extends well beyond contraception, with all of the same implications for patients, clinicians, and the patient-clinician relationship. Justice Alito’s majority opinion singles out two other services for which a religious exemption to coverage would clearly be required, in the majority’s view: third-trimester abortion and assisted suicide [1]. Justice Ginsburg’s dissent highlighted a range of other services to which some religious groups have objections, including “blood transfusions (Jehovah’s Witnesses); antidepressants (Scientologists); medications derived from pigs, including anesthesia, intravenous fluids, and pills coated with gelatin (certain Muslims, Jews, and Hindus); and vaccinations (Christian Scientists, among others)” [19]. Moreover, religious objections could also be used to discriminate against specific groups of people in a health care context—for example, denying coverage of certain services for those of a given sexual orientation, marital status, or age.

In a practical sense, whether the restriction is imposed by the employer for religious reasons, the government for ideological reasons (for example, bans on public or private coverage for abortion), or an insurer for cost reasons (such as recent moves to limit coverage of an effective but expensive new treatment for hepatitis C [20]), the effect on patients and clinicians is the same: interference in quality care. In all of these cases, whatever the motive, restrictions on insurance coverage can interfere with patients’ and clinicians’ considering what services are medically appropriate and necessary. The ethical principle at stake is the same whether the excluded service is contraceptive care, abortion care, or expensive pharmaceuticals. The implications can be significant and deserve serious attention and consideration by policymakers, health plans, the courts, and other key actors as they regulate and restructure public and private health coverage going forward.

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Acknowledgment

The author thanks Susan A. Cohen and Rachel Benson Gold, also with the Guttmacher Institute, for reviewing drafts of this article.

Related in VM

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Virtual Mentor

American Medical Association Journal of Ethics
November 2014, Volume 16, Number 11: 870-871.

FROM THE EDITORS

Sex: Where Morals and Medicine Collide

Discussing sex, even in the medical context, isn't merely a matter of facts. As Lenore Tiefer wryly comments in her piece for this month's issue of *Virtual Mentor*, "patients' 'is it normal?' questions are...more or less transparent requests for moral authority." But is medicine equipped or entitled to occupy this place of moral authority? The November issue of *Virtual Mentor* takes up this and related questions about sexual health.

Edward Shorter discusses the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, arguing that its pathologizing of atypical sexual interests, which it has historically conflated with criminal sexual behavior, is inappropriate and should be discarded. Indeed, the *DSM*'s slowness to change its stance on homosexuality discredited its sexuality-related diagnoses. As Richard Weinmeyer's piece on sodomy laws explains, sodomy began to be decriminalized in the US in the 1960s. But it wasn't until 1973, Shorter tells us, that the *DSM* removed homosexuality from its list of diagnoses.

Virtual Mentor special contributor Adam Sonfield explicates further how the law—in this case the US Supreme Court decision in the *Burwell v. Hobby Lobby* case—can influence shared decision making between physicians and patients around available and affordable birth control options for women.

Turning from medical codes and legal decisions to public advocacy, the winning and runner-up entries in the 2013 Conley Ethics Essay Contest, written by Abigail Cline and P. Justin Rossi, respectively, opine that the profession of medicine must tread carefully around the issue of sex education in schools: while some abstinence-only programs promulgate misinformation, which it is physicians' duty to rectify, the profession does not have the authority to decide which norms and mores public programs should convey.

Even when medicine is not navigating the gray zone between scientific and moral authority, it influences sexual behaviors and norms through other channels, such as medical innovations. Arthur Caplan argues that, in addition to improving untold numbers of sexual relationships, the introduction of Viagra helped to dispel stigma and silence surrounding certain forms of erectile dysfunction, which he contends is a significant social good. Jill Blumenthal and Richard H. Haubrich raise the question of whether widespread availability of the new antiretroviral pre-exposure prophylaxis (PrEP) for HIV will lead to riskier sexual behavior.

Overall, discussing sex-related matters with patients is, by many accounts, an underdeveloped skill for most physicians. This month's case commentaries give practical guidance for discussing sensitive topics with patients and their families. Charles Moser discusses techniques for interviewing patients who may be experiencing intimate partner violence. Mary A. Ott advises the reader on how to counsel teens engaged in risky sexual behavior. Philip Zachariah, Gregory S. Blaschke, and Melissa Weddle discuss gentle attempts to dissuade a patient's parents from putting him through potentially damaging "conversion therapy" to attempt to change his sexual orientation.

Someone who stands as an exception to the judgment that physicians have "underdeveloped skill" in communicating about sex is "Dr. Drew" Pinsky, who has been educating the public about love, sex, and relationships in his radio program *Loveline* for more than 25 years. *Virtual Mentor* interviewed Dr. Pinsky for this month's podcast.

Lastly, two articles discuss how to train physicians to be able to handle these delicate topics. Lenore Tiefer discusses the importance of medical students' developing self-awareness and exploring their own values as preparation for counseling patients on these matters. Eli Coleman underscores these ideas in his discussion of the Program in Human Sexuality at the University of Minnesota.

As Coleman states in his article about the Minnesota curriculum, "There is a crisis in medical school education about sexual health in the US." He explains that the desire for more training in lesbian, gay, bisexual, and transgender (LGBT) issues is sparking some interest in sex education in general. We hope the need for better physician training that is underscored in this issue of *VM* provides another boost in the right direction for comprehensive sex education across the educational continuum.

The *Virtual Mentor* Editors

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Virtual Mentor

American Medical Association Journal of Ethics
November 2014, Volume 16, Number 11: 872-876.

ETHICS CASE

Interviewing a Patient about Intimate Partner Violence

Commentary by Charles Moser, PhD, MD

Melinda is visiting with Dr. Sherman, her internist, for a well-woman check-up. After the exam, Dr. Sherman asks Melinda whether she has any concerns about her health or well-being that she wants to discuss. Melinda nervously and hesitatingly says that her husband of many years has begun “demanding more and more of me,” as she puts it.

“How do you mean?” Dr. Sherman asks.

“He is a good father,” Melinda says first. Then she says, “But he is more and more aggressive in bed. He didn’t used to be like this. If I say I’m scared or that I don’t want to have sex, he doesn’t stop. He just keeps going. I don’t want to make him mad. I don’t want to ruin things between us.”

Dr. Sherman says, “I’m concerned for you, Melinda. No one should be frightened into having sex when she doesn’t want to. Do you feel unsafe? Do you think your husband might get abusive if you refused?”

Melinda withdraws at these questions and says dismissively, “Guess it’s just how men are. I’ll figure it out.”

Commentary

It seems obvious that this was not the best way to handle the situation. Dr. Sherman was not able to get answers to her questions and Melinda did not feel that she could confide in Dr. Sherman. Melinda left without resolution, follow-up, referral, or plan; she also left with the impression that Dr. Sherman did not understand her.

When reading this case, domestic violence (DV) or intimate partner violence (IPV) immediately comes to mind, and it should. All health care workers need to consider DV in the differential diagnosis, even when there are no obvious physical injuries. DV is related to numerous undesirable health outcomes [1], but some interventions by health care workers have been shown problematic [2]. We are just beginning to ask women what interventions are helpful [3].

Dr. Sherman seems to have made the determination that DV is the issue, but I think that may be a bit premature, and her approach obviously was not helpful. Let me suggest another approach.

If Melinda came in and said, “I am having knee pain,” almost reflexively we would start taking a history. Is it one knee or both? Is the pain sharp, dull, or burning? Is the pain constant or episodic? How frequent are the episodes? How long do the episodes last? When did it start? Was there a precipitating event? Does anything make it better or worse? To make a diagnosis or prescribe treatment without this type of history is just poor medical practice.

Likewise, in Melinda’s case, the first step is to take a history in a nonjudgmental manner and using a style that will build trust with Melinda. Ideally the history should take place before the physical exam and before the patient disrobes: the history may unveil concerns that require attention during an exam, and we want to be sensitive to vulnerability the patient might experience. Discussions about sexual concerns that take place between an unclothed patient and a clothed health care practitioner are fraught with problems, both practical and ethical.

There are two separate but related aspects to the sexual history: how do you talk about sex with a patient in a professional manner and what information do you need? The exact wording and order of the questions will depend on the patient and the jargon and slang with which the patient and physician are most comfortable.

Questions for History

- When did your husband start disregarding your feelings? (Melinda indicated that this was a new behavior.)
- Was there an event that precipitated his becoming more aggressive with you? (For example getting fired, or the death of a family member. Note that Melinda described the behavior as aggressive. It can be helpful to use the patient’s own words.)
- How often (or what percent of the time) is he aggressive with you in bed?
- Is the behavior increasing in *frequency*?
- Is the behavior increasing in *intensity*?
- Can you predict when it is going to happen? If so, what do you notice?
- Does anything make it better or worse?
- Is he aggressive with you outside of the sex? (Again, using her language.)
- Is the sex painful?
- Prior to his becoming more aggressive, how would you describe your sex life?
- If he was not so aggressive, would you want to have sex with him more frequently?
- Do you agree to sex to avoid making him mad? How frequently?
- How often do the two of you have sex now?
- How often did the two of you have sex before he became so demanding?
- Do you ever initiate sex *now*?
- Did you initiate sex *in the past*?
- Has he asked for new or different sex acts?
- What do you think has led him to change the way he treats you?

We want to be careful not to blame the victim, but Melinda's own medical concerns may play a role in the couple's problems. The assumption is that something has changed with her husband, but it is possible that Melinda has changed as well. These questions may lead to exploring Melinda's medical concerns, which may need to be addressed as well.

- Is she perimenopausal or menopausal? (This might signal a change in her sexual response pattern.)
- Does she have vaginismus?
- Does she have vulvodynia?
- Has she noticed decreased lubrication, difficulty having orgasm, decreased desire, or pain with sex?

Answers here may lead to questions about her husband and what brought about the changes in him.

- Has he been drinking alcohol to excess or using drugs?
- Has he been having trouble controlling his temper in general?
- Is he having problems at work?
- Are there money problems?
- Does he have any new medical or psychiatric problems?
- Do you think he is having sex with anyone besides you?

These questions allow Melinda to feel heard. They are not judging her or her husband; they are obtaining the history and setting the stage to solve problems. At some point, Dr. Sherman may ask, "How can I help? What are you hoping I will do?" By asking Melinda about her own goals, the physician is actively engaging her in the process and empowering her to be part of the solution. The physician cannot and should not be the "savior." We can present her with options that she can explore. Of course, if she is in imminent danger, then we need to act. Until then, we have some time for problem solving with Melinda.

Physicians who are not equipped to help need to refer. This might be as simple as referring the patient to a social worker or crisis line as a first step. It may require researching the resources and options that are available locally. Obviously, it can be more complex.

Physicians may have another issue to contend with: their own uneasiness discussing sex and intimacy with patients (or with their own partners). Admittedly, not all physicians are interested in or willing to discuss these topics with patients (or in their own lives). Medical school and residency training programs often do not teach these skills. Without some experience exploring our own biases and learning about alternatives, we fall back upon our own life experiences and moral beliefs. In the same way as we learn about normal variations in blood pressure, we need to learn about "normal" variations in sexual interests and practices. We want to avoid clueless or unintentionally inflammatory statements.

Ideally, a short sexual history is part of every new patient history and physical. The purpose is to uncover information that may have medical ramifications and to establish a level of trust, so the patient feels comfortable confiding in us if a new sexual concern presents itself. I ask a series of questions scattered through the history:

- Do you have sex with men, women, or both? (Remember, it's what a person does—*not* how she or he identifies—that impacts risk.)
- Are you partnered? If yes, do you have sex with anyone besides your partner? (Remember, romantic partnerships can be between two men, two women, or man and a woman. Some people also use the term “marriage” to describe relationships that involve more than one partner.)
- Any sexual concerns? (Just three words that I believe should be part of any review of systems.)
- Do you have medical questions about any of the sexual activities in which you engage or want to engage?
- Is there anything else you want me to know about your sexual interests that will help me give you the best care possible? (It is also important to ask patients a similar question about gender.)
- Would you like me to test you for sexually transmitted infections today? (You need to clarify which orifices need to be swabbed for gonorrhea and chlamydia.)

Aside from eliciting information, all these questions let the patient know that you are open to discussing and treating sexual concerns. Patients sometimes want to talk about sex but are uneasy discussing all the “gory” details. Here is a technique that promotes openness when a patient indicates reticence. It also can be used to broach “alternative” sexual behaviors or lifestyles: “I do not need to know the specifics about what you do sexually, but are you having the type of sex that you want to have? If not, could you have that type of sex with your partner? Is the problem related to your partner specifically, or would it be a problem with all partners?” Talking about problems abstractly and seeing how you handle the information builds trust to discuss specifics.

The theme of this issue of *Virtual Mentor* is “validating sexual norms.” For me, that raises the question: *should* physicians be validating sexual norms and on what basis? Probably the most common sexual question that physicians and sex therapists hear is, “Am I normal?” but normal has many meanings. It can be statistical, but blond hair is statistically abnormal. It can be natural, but if it occurs in nature it is natural. “Usual” is misleading; most individuals that we think of as sexually unusual respond to the usual stimuli as well. Normal can imply “healthy,” but there are no data to suggest atypical sexual interests are per se unhealthy [4]. The concept of “normal” also varies across groups or subcultures.

Without an evidence basis, are we acting as professionals or just promulgating our personal biases? There are a great many “normal” heterosexuals who experience a variety of sexual and relationship problems. A great many people who do not fit the

sexual norm do not suffer from these problems. Do not make the assumption that a problem is due to the individual's unusual sexual interests. Individuals with problems seek us out; those without problems do not. Correlation is not causation.

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Virtual Mentor

American Medical Association Journal of Ethics
November 2014, Volume 16, Number 11: 877-883.

ETHICS CASE

A Request for “Conversion Therapy”

Commentary by Philip Zachariah, MD, Gregory S. Blaschke, MD, MPH, and
Melissa Weddle, MD, MPH

Michael is visiting his pediatrician, Dr. Smith, with his parents. After Dr. Smith performs a well-child exam, Michael’s mother asks whether she and her husband can talk with Dr. Smith alone. They leave Michael in the exam room to dress and go into Dr. Smith’s office.

Michael’s mother, Mary, is concerned because Michael mentioned having a “crush” on his school friend Steven. Both boys are 12 years old and in the seventh grade. “We’re a religious family,” Mary explains, “and we want to do what’s right for Michael now and in the future. We want to save him from this sinful lifestyle before it’s too late, and we have heard there has been some success with the One Choice Conversion Therapy Camp. We are ready to make him work hard at this.”

Dr. Smith is also concerned. He, too, wants what’s best for Michael, but his knowledge of behavioral therapies that attempt to change sexual orientation does not accord with Mary’s. “I share your concern for Michael’s well-being and future. He’s a great kid. He’s healthy and seems to be happy, which is what parents hope and pray for. We don’t know much about his sexuality at the present, but if it is different than yours, we still want him to be able to choose the life that makes him healthiest and happiest. Do you agree?”

“Not if that means being homosexual,” Michael’s dad replies. “It’s a sin. It’s our job to protect him and keep him on the right path.”

Dr. Smith offers what he has read about conversion therapies. “They have been shown to be ineffective and even psychologically damaging. One of the originators of the method later renounced it. I can give you some literature on the therapy, if you’d like.”

“Well, we must do something to prevent Michael from being gay,” Mary interjects, as her husband nods, “and we were hoping that you, as Michael’s doctor, would help us.”

Dr. Smith’s suggestion that the family see a therapist who specializes in children’s developing sexuality is rebuffed by Michael’s parents. “We don’t need counseling,” they say. “We know what the right path is here.”

Commentary

This case presents a common challenge faced by clinicians who care for adolescents. Michael's parents express concern to their pediatrician, Dr. Smith, about same-sex attraction voiced by their 12-year-old son and ask for advice about a "conversion therapy camp" as a therapeutic intervention. Michael's apparent comfort in revealing his "crush" to his parents reflects a generational shift in views of sexual orientation due in part to the public education and awareness efforts of the lesbian, gay, bisexual, and transgender (LGBT) rights movement and the increasing legalization of gay marriage [1].

This scenario allows us to explore the dilemma posed when parental beliefs run counter to their child's developing sexual identity and clinician recommendations. We approach these questions by first outlining the current scientific evidence about conversion therapy. We then examine the relevant ethical and legal principles that can guide Dr. Smith.

Is Dr. Smith Practicing Evidence-Based Medicine?

The intervention proposed by Michael's parents comes under a broad group of behavioral approaches termed sexual orientation change efforts (SOCE). Often conducted within a psychotherapeutic or religious environment, these have long been disavowed by major medical organizations, including the Society for Adolescent Health and Medicine (SAHM), the American Academy of Pediatrics (AAP), the American Psychiatric Association (APA), and the American Medical Association (AMA) [2-5]. A comprehensive review of the evidence about conversion therapy in 2007 by the American Psychological Association concluded that there was no evidence showing that SOCE had any impact on adult sexual orientation or gender identity and that these therapies were often based on developmental theories with questionable validity [6]. More importantly, conversion therapy may cause harms that include depression, anxiety, and self-destructive behavior, fostered by the negative self-image that these efforts create [6]. In this case, Dr. Smith is cognizant of the evidence and appropriately counsels Michael's parents. Their moral objections are, however, unaltered by his counsel. What are his ethical obligations to his patient Michael at this point?

Is Dr. Smith Being Ethical in His Opposition?

The first ethical principle to guide Dr. Smith is that of nonmaleficence (do no harm). This requires Dr. Smith to advise against an ineffective intervention that exposes the patient to risk of harm. Dr. Smith adheres to this principle when he explains the current medical understanding of sexual orientation and conversion. Though Dr. Smith advises against conversion therapy, is that enough to ensure Michael's well-being? Does his ethical responsibility end here?

Dr. Smith also has the ethical duty to consider Michael's best interests (beneficence). In this case, he must go beyond merely advising against the ineffective and potentially harmful intervention that the parents favor. This situation requires a

nuanced strategy, a delicate balance between supporting Michael as his sexuality develops and not antagonizing his parents.

The final principle at play in this case is that of respect for autonomy. At age 12, Michael is not yet considered to have the capacity for informed consent, a requisite condition for exercise of decision-making autonomy. Parents are allowed by law to serve as surrogate decision makers for their minor children in most health care situations because they are considered most capable of determining their children's best interests [7]. If a parental decision places a child at risk, when should the state intervene? What legal protections does Michael have if his parents proceed with the conversion therapy?

Are there Legal Protections for Michael?

Some legal scholars have proposed that, because emotional trauma qualifies as abuse under state child abuse and neglect statutes, conversion/reparative therapy when initiated by parents without assent from a minor can be considered abuse if a court agrees that the harms arising from the therapy would be evident to a "reasonably prudent" parent [8]. Others contend that the inadmissibility of psychological evidence in court proceedings and the difficulty of proving a substantial risk of harm from the therapy make legal protection uncertain for LGBT children and youth faced with involuntary or coercive religion-based treatment, particularly in LGBT-unfriendly jurisdictions [9].

Minors do have legal protections without having to prove abuse or risk of harm, however; state law with judicial sanction now increasingly regulates conversion therapy offered by licensed professionals. In 2012, California became the first state to ban conversion therapy for minors by licensed professionals [10]. A legal challenge to this law was upheld by the Federal 9th Circuit Court of Appeals [11] and allowed to stand by the Supreme Court of the United States [12]. The appeals court noted that these professional activities were within the state's authority to regulate and did not violate the free speech rights of practitioners or minor patients or the parents' fundamental rights [11]. New Jersey has passed a law similar to California's [13], and legislation is pending in eight more states and Washington, DC [14]. These laws could make it easier for doctors to report clinicians who offer conversion or reparative therapy.

In our case, however, unless the "conversion camp" employs licensed professionals, its activity is well within the law.

What Can Dr. Smith Do?

Dr. Smith could end his discussion with the parents after he has counseled the family and offered resources, but this would only partially fulfill his ethical responsibility. First, Dr. Smith needs to talk with Michael privately. This is essential for every encounter with an adolescent that involves sensitive topics. Dr. Smith will build trust with Michael through confidential interviews both during this visit and in the future. If, at some point, Michael tells Dr. Smith that he is attracted to boys, Dr. Smith can

proceed to ask Michael more about his emerging sexual orientation. He should ask Michael about health risks such as suicidal ideation or bullying. He should reassure Michael and give information about local (e.g., gay-straight alliances at schools or community youth centers) and national resources for LGBT youth [15], including LGBT youth-specific suicide helplines (e.g., the Trevor Project). Michael's trusting relationship with his doctor can help build resilience and nurture the development of his sexuality.

In our opinion, the next step is for Dr. Smith to initiate an ongoing dialogue with Michael's parents, acknowledging their beliefs while encouraging them to support their son through this challenging period. Evidence supports the importance of parental acceptance of their children's sexuality. Compared with LGBT young people who were not rejected or were only slightly rejected by their parents and caregivers because of their identity, highly rejected LGBT young people are eight times as likely to have attempted suicide and nearly six times as likely to report high levels of depression [16]. Highly rejected LGBT youth also have higher rates of homelessness, as a result of family conflict or being forced out of the home [17], risky sexual activity and drug abuse [16].

It is important to understand the diversity of parental emotional reactions and also to ascertain what they understand or perceive about same-sex attraction. In addition to accurately summarizing the current scientific recommendations, it may be helpful in this case to direct the parents to inclusive religious organizations that could counter their moral objections as well as to parent-specific resources such as the local chapter of Parents, Families and Friends of Lesbians and Gays (PFLAG), where parents can meet other parents and receive ongoing support. It is unrealistic, however, to expect that the parents' moral objections to homosexuality will change after a single primary care visit.

Dr. Smith also risks alienating Michael's parents if his objections are too forceful. A parallel may be drawn with vaccine-hesitant parents: recent evidence shows that well-intentioned efforts to convince them to vaccinate their children often have counterproductive effects [18]. At the same time, Dr Smith should not underestimate his influence as a trusted professional, particularly if he has an established relationship with the family. Scheduling repeat visits may be beneficial for Michael and his parents. Though referral for counseling is advisable in the setting of obvious mental distress or clinical depression, this should not be seen as a means to divest oneself of the responsibility of working with the family.

Here we provide a sample dialogue that Dr. Smith could use with the parents after he has spoken with Michael:

I am glad that you came in to talk to me. Michael has felt comfortable talking to you about this, and this tells me that he trusts you and that he feels safe talking to you. His attraction to his friend is very normal. Some boys this age who are attracted to boys continue to be attracted

to boys as they get older, some develop attraction to girls, and some will be attracted to both. What is most important is Michael's health and safety and his feeling supported by the important people in his life. I hope that you will read and think about the information I am giving you today before you make a decision about the camp. I would like to see you back soon to talk about this further.

Conclusion

Culturally competent care and religious sensitivity do not imply that the clinician fails to be a strong advocate for his patient whose well-being is his first responsibility. Given the uncertain legal protections from conversion therapy for minors, Dr. Smith's efforts may be confined to sensitively educating the parents and providing reassurance and support to Michael. If he can preserve a trusting relationship with Michael's parents, it is possible that over time their views may change, and their relationship with their son strengthen.

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Virtual Mentor

American Medical Association Journal of Ethics
November 2014, Volume 16, Number 11: 884-890.

ETHICS CASE

Teen Pregnancy and Confidentiality

Commentary by Mary A. Ott, MD, MA

Jennifer, 15, is a sophomore at Middlefield High School who has made an office appointment with Dr. Wilson, an ob-gyn, for the first time. During the new patient history, Dr. Wilson asks, “Are you sexually active now, or do you plan to be?”

Jennifer hesitates to answer. Instead, she tells Dr. Wilson that the visit will be charged to her parents’ insurance and asks whether what she says will be confidential.

Dr. Wilson replies, “Conversations that teens have with their physicians about matters of sexuality and drug use are kept confidential. We want you to be able to discuss things that are of concern to you and your health without fearing that we will ‘tell on you’ to you parents or anyone else.”

“Whew,” Jennifer says. She then tells Dr. Wilson that she recently entered a pact with her friends. Each girl promised the others she would get pregnant within the next year. “And I want you to be my doctor,” she concludes.

“My goodness, Jennifer. That is quite a serious pact. We must talk some more about this. We must think about how having a child will influence the rest of your life, and how profound and difficult the consequences of this decision can be, especially at your age. How many of your friends are in this pact?”

Jennifer responds, “Four of them. Our families will help us take care of the kids. We all know that. We just want to go through this together, before we separate and go to college or something.”

Commentary

When Adolescents Push the Limits of Confidentiality

Confidential care for adolescents, particularly in the area of reproductive health, is a core tenet of adolescent health care. It is strongly supported in best practices guidelines such as the American Academy of Pediatrics’ and the US Maternal and Child Health Bureau’s *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents* [1], and most major medical professional associations that work with adolescents have issued or endorsed position statements supporting confidential care for adolescents (for example, the American College of Obstetricians and Gynecologists [2], the Society for Adolescent Health and Medicine [3], and the American Medical Association [4]). Confidentiality is the idea that the

personal and health information a patient reveals to a clinician is private and that there are limits on how and when the information can be disclosed to a third party [5]. Adult patients' confidentiality is subject to few restrictions. For adolescents, however, confidentiality is limited, in large part, because of our ethical duty to provide care in their best interests until they have the legal right to make decisions for themselves. The case of Jennifer and Dr. Wilson illustrates the difficulties inherent in navigating confidential care for adolescents.

Arguments In Support of Confidentiality for Adolescents

The ethical arguments supporting confidential care for adolescents are strong and focus on respect for emerging autonomy, recognition of evolving decision making capacity, allowing teens to learn responsibility in health decision making, and improving safety and access to care. Adolescence is a time of intense developmental transition. During adolescence, an individual will move into a peer group, develop intellectually and emotionally, enter the workforce or higher education, and, in many cases, become socially or financially independent. When physicians provide confidential care for adolescents, they are giving them the opportunity to learn how to interact with clinicians and to become responsible for their own health care, and they are respecting and supporting the development of an emerging autonomous self. Research supports this claim: when clinicians discussed sensitive topics with a group of surveyed adolescents, the adolescents reported that the clinicians listened to them and that they felt more engaged in their own health care [6].

Most adolescents have sufficient cognitive capacity and emotional maturity to make many health care decisions. Research suggests that by approximately age 14 to 15 years, adolescents make health-related decisions similar to those that adults make in controlled decision-making situations (see, for example, [7] and [8]). Because of differences in maturation between the cognitive and affective systems, adolescents may have more difficulty in situations with high emotional arousal or peer distraction [8, 9] and may need more decision-making support in these circumstances.

Medical decision-making capacity includes the ability to understand the issue, weigh risks and benefits, appreciate the consequences of choices, and make a voluntary choice based upon understanding of the information [10]. Adults are presumed to have capacity, and, as long as they demonstrate the above four abilities, they are permitted to make their own decisions, even if the clinician disagrees or believes it is not in their best interest [11]. It is important to note that the threshold for decision-making capacity for adults is not very high, and that clinicians do in some cases tolerate decisions they disagree with from adults. In this case, Jennifer demonstrates a somewhat limited understanding of risks, benefits, and consequences related to her plans to become pregnant. This is an area that Dr. Wilson can address through counseling.

Improved safety and access to care are important public health arguments for adolescent confidential care. One randomized controlled trial demonstrated that

adolescents provided with confidentiality assurances are more likely to disclose risk behaviors to their physicians [12]. Such disclosures are necessary for prevention and treatment. Dr. Wilson's statement about confidentiality most likely made Jennifer's disclosure possible and makes it easier for Dr. Wilson to help her. On a public health level, confidentiality has been linked to increased utilization of services, particularly related to contraception and family planning [13]. Research suggests that most parents desire confidential care for their adolescents [14], in large part for safety reasons: if adolescents are not able to tell their parents about risk behaviors, parents would like them to talk to trusted professionals.

Adolescent Confidentiality and the Law

The law underpins adolescents' right to confidential care. The strongest legal support is state health care consent laws, which provide adolescents with the right to consent to and receive confidential care. All 50 states and the District of Columbia (DC) have laws allowing minor adolescents to consent to STD diagnosis and treatment; similarly, 26 states and DC allow minors to consent to receive contraceptive services; and 32 states and DC allow minors to consent to prenatal care [15].

When state law is silent on contraception for minors, constitutional arguments support a minor's right to reproductive privacy and confidential care. The US Supreme Court's *Gault* decision established that minors have constitutional rights [16]. Subsequent cases in federal courts established that a minor's constitutional rights include the right to reproductive privacy, including confidential care [16]. Twenty states allow some or all minor parents to consent to health care for themselves [16]. For Dr. Wilson, the specifics of state laws are important in defining the limits of confidential care for Jennifer.

Limits to Adolescent Confidentiality

Confidentiality is never absolute, particularly for adolescents. Just as we have an ethical obligation to support adolescents' emerging autonomous selves, so we have a (sometimes competing) ethical obligation to protect and act in the best interest of adolescents, who have limited life experiences to help them make judgments. A physician might break confidentiality when he or she has a legal obligation to report, as with child abuse; when the child is a danger to him- or herself, as with an actively suicidal or psychotic adolescent; and when there is a danger to others, as in the case of a homicidal adolescent. Dr. Wilson must decide at what point the benefits of involving Jennifer's parents or authorities would outweigh the harms—to Jennifer or others—of breaking confidentiality. There are no absolutes in this assessment, and these ambiguities are recognized in guidelines such as the *AMA Code of Medical Ethics*, which states that “ultimately clinical judgment, ethical principles, and moral certitude guide decisions about individual cases” [4].

Breaking adolescent confidentiality is something that a physician should take very seriously. The therapeutic alliance with adolescents is particularly fragile, and the resulting mistrust will not be easily repaired [17]. Of particular concern is that an adolescent whose confidentiality is betrayed by a clinician may be less likely to trust

other health care professionals with the confidential information necessary for optimal health care and thus may not seek care for sensitive issues. Breaking confidentiality also sends a signal to the adolescent that the doctor does not respect his or her emerging autonomy or decision-making capacity.

The Art of Adolescent Medicine

Adolescent pregnancy is associated with potentially serious health risks and poor social, educational, and economic outcomes for both adolescent parents and their children [18, 19]. Best practices focus on delay of sexual activity, particularly in younger adolescents, while promoting effective methods of contraception for those adolescents who are or plan to be sexually active. However, unprotected sex is common among adolescents. Nearly half of US high school students have had sex, with less than 60 percent of that group reporting condom use at last sex and less than 30 percent of sexually experienced female students reporting contraceptive use at last sex [20]. While an individual adolescent expressing a desire to become pregnant or disclosing unprotected sex is something a clinician must address (and, ideally, encourage the patient to consider delaying), that does not, in and of itself, rise to a level of harm that would compel Dr. Wilson to break confidentiality.

Dr. Wilson should start with a careful sexual and reproductive history. Has Jennifer ever had sex? What are her sexual practices? Has she ever used contraceptives? Is she engaged in a relationship now? There are also some potentially life-threatening dangers seen in sexually active adolescents that would warrant breaking confidentiality, and Dr. Wilson should assess these more immediate threats, such as whether Jennifer is being coerced by her partner or is involved in sex trafficking.

Dr. Wilson will want to search for a solution that involves both respect for Jennifer's confidentiality and autonomy and the support and services she needs. Using motivational interviewing techniques, Dr. Wilson can inquire further into her plans for becoming pregnant, her commitment to becoming pregnant, and the social and relationship contexts of her decision making. Dr. Wilson may be able to work with Jennifer to delay pregnancy until after a certain date—e.g., graduation from high school, or reaching age 18. If a patient is amenable, clinicians can provide access to long-acting reversible contraceptives (LARCs), which have better continuation rates and lower rates of subsequent pregnancy than other methods.

Another possible solution that allows Dr. Wilson to respect patient confidentiality is encouraging Jennifer to use available resources and talk to others. Has she spoken to her parents or other trusted adults about her desire to become pregnant or how she would care for a child if she became pregnant? Although it can be a very difficult conversation, if the adolescent brings up the topic, many families are willing to discuss sex and adolescent pregnancy, its consequences, and prevention. Is Jennifer willing to speak to a counselor or social worker who could minimally help her prepare for or, ideally, delay a pregnancy?

Finally, Dr. Wilson will need to search for the problem behind the problem. In 2008,

a northeastern city received national media attention about a supposed pregnancy “pact” when 18 young women in one high school became pregnant in a single year [21]. When individual adolescents were interviewed, however, it was found that no pact had led to the pregnancies but rather the usual suspects—high poverty, poor school performance, lack of opportunity, early and consistent dating, lack of adult supervision, limited sex education, and lack of access to effective contraceptives. It is likely that exploring the details of the “pact” will help Dr. Wilson discover modifiable factors that are contributing to Jennifer’s desire to become pregnant.

The “pact” is a splashy and newsworthy topic; adolescent pregnancy is an age-old problem whose amelioration will take concerted efforts by communities, schools, families, and medical and health care professionals. Confidentiality is a tool that clinicians can use to engage adolescents in their care and provide access to effective sexual health services, such as long-acting reversible contraceptives. Dr. Wilson’s best chance at engaging Jennifer in pregnancy prevention thus lies in building a therapeutic alliance upon the foundation of confidentiality.

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Virtual Mentor

American Medical Association Journal of Ethics
November 2014, Volume 16, Number 11: 891-895.

CONLEY ESSAY CONTEST

2013 Winning Essay

Medicine's Authority to Advocate: Responsibilities and Limitations

Abigail Cline, PhD

Dr. Molleur is a family doctor in a state that accepts federal funding for abstinence-only sex education in its public schools. She believes that abstinence-only sex education is harmful to adolescents and to society because it results in unplanned pregnancies, the spread of STDs, psychological harm to those who don't conform to the norms of the curriculum, and reversal of decades of progress in the social status of women and gay people.

Dr. Molleur submits a resolution for consideration at her state medical society's annual meeting entreating the society to adopt a position urging the state's governor to reject federal funding for abstinence-only education programs and to replace them with comprehensive sex ed, which would include abstinence but also cover such topics as correct use of condoms. Her resolution discusses not only what she views as problems with the factual information in the abstinence-only curriculum (for example, the assertion that HIV can get through pores in condoms) but also her objections to the sexual mores promulgated in the abstinence-only curriculum (for example, that nonmarital, nonheterosexual sexual activity is likely to have harmful psychological and physical effects and that abstaining from sexual activity outside of marriage is the expected standard). "This," her proposal concludes, "is misinformation, and, as highly educated professionals devoted to promoting the health and welfare of the public, we have a responsibility to combat the teaching of inaccurate and problematic beliefs."

Getting a cup of coffee before the meeting begins, she runs into her friend Dr. Baxter in line and asks him, "Did you see the resolution I submitted?"

Dr. Baxter hesitates. Eventually he says, "I did see it. But I'm not sure I'm with you on this. Is it appropriate for a physician group to be making judgments about what constitutes healthy or normal—or moral—sexual behavior? Who are we to prescribe sexual norms for society?"

Response

Dr. Molleur's proposal brings to the forefront questions about the rights and responsibilities that physicians have—especially when acting through a professional organization—in the realm of public discourse. If doctors choose not to address factual assertions that they know to be scientifically inaccurate, both people's health and the public's respect for and trust in the medical profession are at risk. Physicians

are uniquely equipped, by both their training and their experience, to promote public health and welfare by challenging improper, deceptive, and unprofessional practices of medicine. However, they must recognize that their position in society is not a soapbox from which they should preach their own beliefs. Therefore, medical professional organizations should address topics that are circumscribed by what is, and what ought to be, considered “medicine.” In the specific case of Dr. Molleur’s resolution the organization’s rights and responsibilities, as well as its limits, are brought to bear.

The Authority to Speak

Physicians have the right to speak publicly on issues within the proper scope of medicine as a consequence of their being especially well informed on medical topics. By and large, doctors are very well educated. Even after considerable training in medical school and residency, physicians in nearly every state are required to take continuing medical education classes with the purpose of learning the most current scientific research and techniques [1]. The field of medicine is constantly incorporating new research and reevaluating old knowledge. Thus, doctors are accustomed to keeping themselves up to date on recent literature. And of course, physicians learn from what they experience in their own practices. This ongoing medical education, both formal and informal, not only gives physicians a solid grounding in medical knowledge, but helps them to be more aware of recent developments than the general public. This entitles physicians to comment on health-related matters. Since they are often the most aware of the most accurate information, their expert opinions hold value.

Beyond their specialized knowledge, physicians share a culture of respect and professionalism that makes their collective voice a welcome one in public discourse. Whether it is through deliberate effort or exposure-based desensitization, physicians must learn to address issues that most people may find uncomfortable, including the body, sexuality, disability, and death. This makes doctors even better equipped to contribute to broad public conversations that may implicate these topics.

The Duty to Advise

Doctors, acting individually or as a group, are well positioned to offer information to benefit people’s health. One can even argue that they have an obligation to do so. Historically, the role of the physician has been to advise patients on health-related matters, providing treatment when necessary [2]. At the beginning of their careers, medical students undergo a rite of passage by reciting a version of the Hippocratic Oath, which describes the duty of a physician not only to patients, but to the profession and to society [3]. Physicians hold a privileged social status, and in return, they are expected to use their specialized training and experience both to treat and to educate their patients and the public. The missions and guiding principles of professional medical associations, including the American Medical Association, recognize the importance of physicians’ leadership in appropriate contexts, and the need for ethical standards delineating when to exercise it. Section 9.012 of the AMA’s *Code of Medical Ethics* notes the obligation physicians have to examine and

reform laws related to health care and stresses that physicians should keep themselves informed about political changes affecting it [4, 5]. When health-related issues arise in public discourse, people want and expect doctors to weigh in with an opinion based on their expert knowledge. It is part of the profession's ethical mandate to offer that information [4, 5]. If doctors remain silent on medical issues, they jeopardize the medical profession's standing in society. Just as patients depend upon their doctors' remaining up to date on education and practice, so also does the public trust the medical field to make its voice heard on health-related concerns.

In the case of the resolution against abstinence-only sexual education programs, Dr. Molleur is correct in asserting that physicians have an obligation to contest some of the propaganda presented by the program. Specifically, physicians should challenge the scientifically inaccurate information, such as HIV transmission through condoms [6]. The CDC reports that research has demonstrated that consistent and correct use of condoms is highly effective in preventing the spread of STD pathogens, including HIV [6]. The general public is unlikely to have a more reliable source for this information, and it falls within the purview of physicians: it is directly health-related and based on the kind of scientific research that regularly informs a doctor's work. That condom use is a prophylactic measure rather than a treatment does not make it any less appropriate for a doctor to address. Ethical guidance is quite clear on this point [7]. Therefore, Dr. Molleur's resolution asking the group to combat this misinformation is in line with her responsibilities as a physician to protect her community from improper, scientifically unsound information.

Appropriate Limits

Physicians have a broad social privilege to speak and be heard on matters of health, but they must recognize the limits of that privilege. Dr. Baxter brings up an important point about Dr. Molleur's resolution. In particular, he asks whether physicians have the right to dictate societal norms about sexual behavior. It's a fair question. Part of Dr. Molleur's objection is to the sexual mores propagated by the abstinence-only curriculum, such as that nonmarital, nonheterosexual sexual activity can have harmful psychological effects. Though she believes that this is also misinformation, it is on much less sure footing, both in terms of its scientific grounding [8, 9] and also its falling within the proper sphere of medical opinion. She is asking the organization to overstep its role by opining about sexual norms for society. Dr. Baxter questions Dr. Molleur's resolution because he is aware that a physician's role does not include prescribing social standards.

Doctors are trained to promote, maintain, and ameliorate patients' health through advice, study, and treatment. Of course, there are many aspects of a patient's life that a physician is neither equipped nor entitled to treat. Due to their position in society, physicians should combat scientifically inaccurate information, but they may not dictate what should be considered sexually normal. To offer a comparison, few would contend that it is a physician's role to decide which people are fit to raise children. This is a decision that implicates health-related concerns, but it relies on so many variables outside of a doctor's expertise that we leave it up to society (in this

case, more qualified institutions such as Child Protective Services and the courts) or individuals (putative parents). Questions about sexual norms and mores are similar—best left to society, if not individuals themselves.

Shaping Social Behavior

It should be noted that doctors' opinions may indirectly influence social norms. To the extent that norms develop in social environments partly comprising a body of shared knowledge, any contribution to that body of knowledge may, in a roundabout way, serve as a contribution to the norm. To make an example of the present case, as medicine discovers and publicizes ways to make sex less risky (e.g., condoms to prevent the spread of sexually transmitted infections, birth control to reduce the chance of pregnancy), individuals may choose to engage more readily in sex outside of marriage. As this behavior becomes widespread, society may determine that sex outside of marriage is normal and healthy. This is not an invalidation of (or even an exception to) the limitation on physicians described above. Instead, it is an illustration of a process of how society's norms may change organically, drawing, in part, on the contributions physicians make to society within their area of competence.

Conclusion

This situation presents a debate surrounding physicians' role in society and their obligation to monitor social behaviors that affect the health of the public. The training, experience, and professional culture of the medical field allow doctors to address medical issues. That allowance may even grow to an ethical responsibility to speak out against scientifically inaccurate information that can cause harm to the safety and welfare of the public. But that responsibility is limited to health-related matters, and physicians must recognize the line between health-related matters and strongly held beliefs that fall outside the realm of health. In this specific case, Dr. Molleur believes she is acting within these limits by submitting her resolution. Dr. Baxter points out that Dr. Molleur's resolution goes too far; it oversteps the bounds of the medical profession's role. Even though doctors do hold a high position within society, they should not use that position to make judgments about societal norms.

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Virtual Mentor

American Medical Association Journal of Ethics
November 2014, Volume 16, Number 11: 896-900.

CONLEY ESSAY CONTEST

2013 Runner-Up Essay

The Challenge of Physician Civic Engagement: Promoting Health While Preserving Public Trust

P. Justin Rossi

Dr. Molleur is a family doctor in a state that accepts federal funding for abstinence-only sex education in its public schools. She believes that abstinence-only sex education is harmful to adolescents and to society because it results in unplanned pregnancies, the spread of STDs, psychological harm to those who don't conform to the norms of the curriculum, and reversal of decades of progress in the social status of women and gay people.

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Response

The difference of opinion between Drs. Molleur and Baxter illustrates the complex nature of physician engagement with public issues related to health. Sex education can have important health implications, but it is a topic not easily separated from the social and moral dimensions of sexuality—opinions on which vary widely in society

[1]. Dr. Molleur is rightly concerned that young people could be misled and acquire preventable health problems because her state's sex education program does not accurately and fully reflect the knowledge that medicine has worked to discover and make available. Dr. Baxter presents an equally valid concern: that the resolution may exceed the physician group's mandate by championing certain social or moral viewpoints over others. To resolve these issues, the medical society will have to consider its public engagement in the context of two ethical duties: the stewardship of medical knowledge and an unbiased presentation of health information in the public domain.

Medical Knowledge and the Duty of Stewardship

Given their unique education, training, and experience, physicians acquire specialized knowledge and privileges. Along with this, physicians incur responsibilities. Among them is a duty to steward medical knowledge to inform society as it decides public issues of health importance [2, 3].

The concept of stewardship in medicine is often used in the context of the responsible allocation of limited health-related resources. However, stewardship—the notion of safeguarding the valuables of others—can apply more broadly in medicine. Medical knowledge, for example, is a public good that is advanced, preserved, and promulgated primarily by the medical profession. If medical knowledge is to retain its public value, physicians must work collectively to ensure the integrity of this knowledge, speak candidly about its limitations, and communicate it willingly when appropriate. Stewardship of medical knowledge is critical to meriting public trust in the collective voice of medicine as the authority on questions of health. It is this trust that ultimately allows physicians the opportunity to influence public debate.

However, physicians must humbly accept that society may need to weigh the interests of health against other concerns and in so doing may adopt policies that do not promote health per se. If physicians as a profession advocate for specific policies they run the risk of being seen as narrow-minded or mischaracterized as yet another interest group competing in the political arena. Such a perception could jeopardize the public trust upon which the real opportunity for physicians' impact is predicated—that of a neutral and objective voice that merits the public's attention and respect.

Championing a specific policy presumes the capability to perform the economic, cultural, and moral—among other—calculations necessary to determine if the policy is a wise way forward for society. Despite profound knowledge about health, the medical community may not be equipped to make these calculations. Moreover, while physicians might achieve consensus regarding a policy's implications for health, diversity of opinion concerning the relative merits of nonhealth considerations make policy advocacy by the medical community a challenging, if not divisive, proposition.

Public Trust and Physician Neutrality

It is appropriate to examine physicians' roles and responsibilities in the context of the physician-patient relationship as an entry point into a discussion of an ethical framework for physicians' broader engagement with society. In the clinic, a physician's advocacy of healthy choices and behaviors should be neither coercive nor manipulative but, rather, take place in the context of a conversation that is forthright, scientifically informed, and considerate of patient values and goals. In short, the physician must act with due regard for the autonomy of the patient, informing him or her and letting him or her make decisions based on that information [4]. Truly respecting autonomy requires that the physician honor a duty to render therapeutic care no matter the patient's choices.

Similarly, the *profession* of medicine should focus on providing relevant and objective information to the public and public servants about the consequences of policies so as to aid democratic decision making. Medicine's duty to promote health is balanced by a duty to uphold the autonomy of those whom medicine seeks to help. By the nature of the specialized knowledge it stewards, the medical profession exerts significant social authority. This authority must be wielded cautiously; it offers the opportunity to bring important health issues to the public's attention, but it may also permit manipulation of the public discourse at the expense of other viable concerns. Moreover, certain policies (e.g., prohibitions on the consumption and sale of certain foods or beverages or behaviors perceived as personal health risks) may be proscriptive—in effect limiting the autonomy of individuals or segments of society to make choices [5]. While it may be appropriate for society to affirm such proscriptions in the context of public debate, I posit that direct support of proscriptive measures conflicts with physicians' duty to uphold autonomy. Rather than advocate for specific policies, physicians should educate the public and public decision makers about the health implications of policy choices.

Resolving These Concerns

Dr. Molleur's proposal presents an apparent conflict between the two principles outlined above for physician engagement of public issues: stewardship of medical knowledge and political neutrality. When speaking out in their professional capacity, physicians should willingly provide full and accurate medical knowledge to inform public deliberation but avoid advocating for proscriptive policy positions to give due regard to social dialogue on such issues.

Dr. Molleur's resolution is intimately tied to the idea of stewardship of medical knowledge. Observing misinformation and incompleteness in the current sex education program, she calls upon her colleagues to unite and fulfill their duty to "combat inaccuracies and problematic beliefs." However, Dr. Molleur's resolution does not merely call decision makers' attention to the inadequacy of the current system and initiate a public dialogue. Instead, she specifies and supports a new education paradigm that fulfills health-related goals. The scenario highlights the

important distinction between disseminating knowledge and advocating for a particular policy.

But the scenario is complicated by the informational component of sex education: the prevailing policy provides information to young people inconsistent with medical knowledge. If physicians do not speak out on this issue, they risk violating their duty to inform and bring accurate medical knowledge into the public sphere. In determining the extent of their involvement, physicians will need to engage the question of young people's right to access the best available medical knowledge [6]. However, going so far as to prescribe a new educational paradigm may conflict with other nonhealth-related concerns that society may be compelled to consider regarding how sexual education is pursued. These may include the rights of parents or local sociocultural mores. Although nonhealth concerns may conflict with physicians' perspectives on health promotion, an attempt to bypass the broader debate in society by putting the profession's weight behind a particular measure may initiate an adversarial relationship between medicine and other interests in society, generate social and political resentment of the medical profession, and undermine future efforts to inform the public.

Conclusion

To resolve the conundrum of how physicians should fulfill their duty to steward medical knowledge without overstepping their role, the physician group should educate lawmakers and the public on the factual inconsistencies in the current sex education program and the potential negative health consequences of this failure to properly inform young people. In the end, it is the purview of the legislature to take this information conveyed by physicians into account and weigh the health issues against other concerns.

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Virtual Mentor

American Medical Association Journal of Ethics
November 2014, Volume 16, Number 11: 901-902.

THE CODE SAYS

AMA Code of Medical Ethics' Opinion on Adolescent Care

Opinion 5.055 - Confidential Care for Minors

Physicians who treat minors have an ethical duty to promote the autonomy of minor patients by involving them in the medical decision-making process to a degree commensurate with their abilities.

When minors request confidential services, physicians should encourage them to involve their parents. This includes making efforts to obtain the minor's reasons for not involving his or her parents and correcting misconceptions that may be motivating their objections.

Where the law does not require otherwise, physicians should permit a competent minor to consent to medical care and should not notify parents without the patient's consent. Depending on the seriousness of the decision, competence may be evaluated by physicians for most minors. When necessary, experts in adolescent medicine or child psychological development should be consulted. Use of the courts for competence determinations should be made only as a last resort.

When an immature minor requests contraceptive services, pregnancy-related care (including pregnancy testing, prenatal and postnatal care, and delivery services), or treatment for sexually transmitted disease, measures to prevent sexually transmitted disease, drug and alcohol abuse, or mental illness, physicians must recognize that requiring parental involvement may be counterproductive to the health of the patient. Physicians should encourage parental involvement in these situations. However, if the minor continues to object, his or her wishes ordinarily should be respected. If the physician is uncomfortable with providing services without parental involvement, and alternative confidential services are available, the minor may be referred to those services. In cases when the physician believes that, without parental involvement and guidance, the minor will face a serious health threat, and there is reason to believe that the parents will be helpful and understanding, disclosing the problem to the parents is ethically justified. When the physician does breach confidentiality to the parents, he or she must discuss the reasons for the breach with the minor prior to the disclosure.

For minors who are mature enough to be unaccompanied by their parents for their examination, confidentiality of information disclosed during an exam, interview, or in counseling should be maintained. Such information may be disclosed to parents when the patient consents to disclosure. Confidentiality may be justifiably breached in situations for which confidentiality for adults may be breached, according to

Opinion 5.05, “Confidentiality.” In addition, confidentiality for immature minors may be ethically breached when necessary to enable the parent to make an informed decision about treatment for the minor or when such a breach is necessary to avert serious harm to the minor.

Issued June 1994 based on the report “[Confidential Care for Minors](#),” adopted June 1992; updated November 2013 based on the report “[Amendment to E-5.055, ‘Confidential Care for Minors,’](#)” adopted June 2013.

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[The AMA Code of Medical Ethics’ Opinion on Confidentiality of Patient Disclosure and Circumstances under Which It May Be Breached,](#) June 2012

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Virtual Mentor

American Medical Association Journal of Ethics
November 2014, Volume 16, Number 11: 903-908.

MEDICAL EDUCATION

Sexual Health Education in Medical School: A Comprehensive Curriculum

Eli Coleman, PhD

There is a crisis in medical school education about sexual health in the United States [1]. Recent studies indicate that efforts to educate medical students about sexual health may have decreased in the last decade [2]. There is also little consensus about the content and skills that should be covered in sexual health curricula [3, 4]. Recently, interest in more training in LGBT (lesbian, gay, bisexual, and transgender) health has increased, but it is rarely sufficient and rarely connected to a broader integrated curriculum in sexual health [5, 6]. For their part, medical students express dissatisfaction about their sexual health education [7]. Proposals for enhancing sexual health education seem to gain little traction [1, 8, 9].

Finding models of integrated and effective curricula can be challenging. To fill the void, the American Medical Student Association has developed an innovative curriculum that is used in its Sexual Health Scholars Program to train medical students in sexual health [10]. The Morehouse School of Medicine, University of Virginia, and Case Western Reserve University have instituted model curricula on the topic, although these are unpublished and difficult to find [1].

A Comprehensive Curriculum at the University of Minnesota Medical School

This paper offers a description of a comprehensive model of sexual health education used at the University of Minnesota Medical School. Prior to 1970, many medical students had great difficulty talking to patients about matters of sex, especially when the patients' sexuality differed from their own. They struggled with ethical issues in dealing with their own sexual morality and the vast cultural changes that were occurring regarding social mores during the 1960s. In response to this challenge, the University of Minnesota and many other medical schools around the country began to develop courses to prepare students to better address the sexual health needs of their prospective patients and to deal with their own discomfort and struggles with ethical issues. The University of Minnesota course, developed in 1970, was one of the first comprehensive courses and has remained one of the premier courses in the country ever since [11].

The Human Sexuality course is designed to prepare physicians to render effective primary care when addressing the sexual concerns of patients. Primary care consists of providing patients with basic information and helpful suggestions and referring patients who want or need more specialized forms of care. The course introduces clinical skills that should be part of every physician's armamentarium regardless of specialty.

Over the years the course has evolved in content and methodology, but the backbone principles have remained. The block course in the preclinical years is combined with clinical electives and externships (e.g., in transgender medicine), and sexual health content is integrated into other courses over the four years of medical school. Over the years the block course has been reduced (from 32 hours to 19 hours) but remains a foundational element of year one.

The course begins with a sexual health seminar that deals with sexual attitudes. Physicians need to be fully aware of their sexual attitudes and comfortable discussing sexuality. It introduces basic topics in sexual health throughout the lifespan [12]. The seminar relies heavily on panel discussions and thus cannot be duplicated by any reading or alternative coursework.

This seminar was originally based upon a two-day seminar called a sexual attitude reassessment (SAR) seminar [13]. Topics covered in the SAR seminar included: communication about sexuality; taking a sexual history; sexuality throughout the lifespan, including masturbation and fantasy; components of sexual health; intimacy; cross-cultural aspects of sexuality; adaptation to illness and infection (HIV, cancer, radical surgeries, and physical disabilities); safer sex guidelines; and sexual health promotion.

A key component of this seminar initially was the use of sexually explicit films and media, the use of which found to be effective [14]. Over the years we have felt less need to overwhelm the students with these films to desensitize them and get them in touch with their feelings and have discovered that patient panel discussions are far more so for today's medical students. This two-day seminar has been shortened to two half-days and renamed the sexual health seminar.

The course also uses lectures, patient groups, smaller interactive and case-based sessions, and skills-building tutorials. Lecture topics include men's sexual health, women's sexual health, contraception, abortion, adult and child victims of sexual abuse, paraphilias and impulsive/compulsive sexual behaviors, and chronic illness and disability. Students work in small groups with a physician and a psychologist with a sexual health background to learn how to take sexual histories and address common clinical problems.

Besides the seminar and lectures, there are four small group tutorials that use cases to explore various attitudes, ethics, and values and to develop effective clinical skills in interviewing about difficult sexual issues. Through role playing of cases in these small group tutorials, students are able to assess gaps in their knowledge and receive feedback from peers and tutors.

Course Objectives

The overall course has both affective/attitudinal objectives and clinical knowledge and skills objectives.

Affective/attitudinal objectives. The student is responsible for:

- A. Development of a professional, nonjudgmental attitude toward a wide range of sexual behaviors, attitudes, and values encountered in clinical practice, regardless of the student's own value system. Students will understand how their own sexual attitudes and values can differ from those necessary for effective clinical practice
- B. A recognition of the need for attention to patients' sexual concerns
- C. An appreciation for how human sexuality is integral to other aspects of medical health care
- D. Recognition of the boundaries of the patient-doctor relationship

Knowledge and skills objectives. The student is responsible for:

- A. Mastery of basic information about sexual health
- B. Development of skills in interviewing techniques and responding to patients' sexual concerns
- C. Recognizing a patient's sexual concern or complaint, whether presented directly or indirectly
- D. Judging accurately the components of a sexual problem that require or are amenable to clinical intervention with a biomedical emphasis and those that will require an educational or counseling intervention
- E. Developing a realistic planned approach for dealing with sex-related symptoms not immediately recognizable as connected to an organic disease state or a known type of sexual dysfunction
- F. Giving accurate and relevant information to patients regarding their sexual concerns or problems
- G. Making effective referrals, when appropriate, to specialized resources for the treatment of sexual dysfunctions or sex-related problems
- H. Learning about the duty to report

Assignments and Evaluation

Some articles, particularly regarding interviewing patients about sexual matters, are assigned. There are also two recommended optional texts [15, 16].

Requirements include attendance at the sexual health seminar and active participation in small group tutorials. While lecture attendance is encouraged, students can view these lectures online or gain the information from other sources.

There are three multiple-choice formative assessments: two quizzes and a lengthier examination covering the entire course.

Strengths and Areas for Further Development

The strength of our first-year block course is that students are able not only to acquire foundational knowledge for other courses in obstetrics and gynecology, urology, psychiatry, and primary care but also to explore their own sexual health values and ethics to develop comfort with, and empathy and respect for, people

different from them. The knowledge gained in the course follows many of the competencies identified by the AMSA curriculum.

The curriculum also includes LGBTI health issues. There is debate about where LGBTI issues should be located in the overall curriculum of medical school, but we believe these topics have a place in discussions of *both* health disparities or cultural competence and sexual health issues and care. The most important thing is to ensure that these topics are integrated throughout the medical school curriculum.

One weakness of the Minnesota curriculum is that the integration of sexual health content in other courses throughout the four years of medical school is not very clearly specified. It can be challenging to coordinate with other course directors inasmuch as all courses are in flux and directors may change from year to year, but with tools such as Blackbag we are now better able to track how the topic is being taught in the various courses.

Another weakness is that we do not yet have a good mechanism to evaluate students' attainment of the sexual health curriculum's objectives. Medical educators need to develop an Objective Structured Clinical Examination (OSCE) with standardized patients and checklists to assess behavior and skills.

Conclusion

My hope is that this description will assist other medical schools in developing similar curricula in sexual health education. More detailed guidance is contained in the report on a summit on medical school education that was held in December 2012 [1] and will be held again in December 2014. Under the guidance of the Joycelyn Elders Chair in Sexual Health Education in the Program in Human Sexuality at the University of Minnesota, we hope to foster comprehensive and effective sexual health curricula in medical schools around the world and certainly here in the United States.

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Virtual Mentor

American Medical Association Journal of Ethics
November 2014, Volume 16, Number 11: 909-915.

STATE OF THE ART AND SCIENCE

Will Risk Compensation Accompany Pre-Exposure Prophylaxis for HIV?

Jill Blumenthal, MD, and Richard H. Haubrich, MD

Thirty years into the HIV epidemic, feasible and effective prevention strategies that can be implemented in populations with high incidences of new infection are still needed. An ideal prevention package should meet the needs of each subgroup in a population and be acceptable, accessible, and effective. Control of HIV will be best accomplished by combining several proven prevention strategies, including condom use, medical male circumcision, HIV antibody testing, antiretroviral therapy (ART) for treatment as prevention (TasP) for those infected with HIV, pre-exposure prophylaxis (PrEP) for those not infected with HIV [1], and postexposure prophylaxis. Biomedical interventions incorporating ART are most likely to have the greatest impact on the epidemic: they have been shown to be effective in several randomized placebo control trials [2-6] and open-label extensions, in which researchers and participants knew the active drug was being used [7].

Risk Compensation

As the evidence for the success of these HIV prevention interventions increases, concern has emerged about how users of these interventions, particularly TasP and PrEP, may change their HIV sexual risk behaviors. This concern is best explained by the prevailing theory about how individuals manage their personal risks. Risk “homeostasis” is defined as “a system in which individuals accept a certain level of subjectively estimated [or “perceived”] risk to their health in exchange for benefits they expect to receive from [an]... activity” [8]. In short, individuals maintain an approximate risk “set point.” However, introduction of an intervention that reduces the perceived risk of the behavior or activity may cause a person to increase risky behavior—this is called “risk compensation” [9]—so that the discrepancy between the level of risk the person takes and the perceived risk increases. While taking ART, for example, individuals perceive that they are protected from transmitting or acquiring HIV. Risk compensation thus may occur when prophylactic technologies are used to prevent HIV acquisition. If risk compensation does indeed occur, it has the ability to mitigate the potential benefits of ART-based HIV prevention strategies.

Has Risk Compensation Occurred in Other Realms?

Historically, similar arguments have been raised regarding risk compensation after introduction of other interventions that lessen the consequences of risky behavior. The extensive availability of female contraceptives has been criticized for promoting risky sexual behavior, but studies have not supported the contention that contraceptive provision leads to increased risk behavior. Just this year, Secura et al. found that giving women free birth control did not result in increased promiscuity

[10]. Needle exchange programs (NEP) for injection drug use (IDU) were met with similar arguments about enabling and prolonging IDU [11], but subsequent studies found that associations between NEP use and HIV risk could be explained by the fact that NEPs attract high-risk injection drug users [12, 13]. More recently, there was concern that earlier sexual debut and greater numbers of sexual partners would follow use of the human papillomavirus vaccination, but increased sexual activity has not been observed [14-19].

Risk Compensation around HIV

HIV may be different from these previous examples. Unlike hepatitis C and cervical cancer, HIV is fatal without lifelong therapy. Moreover, HIV acquisition through sexual activity is often conceptualized as a direct consequence of risky sexual behavior. Accordingly, if the perceived threat of HIV infection is reduced, more risk compensation is likely to occur. But *is* HIV different—namely, has risk compensation been observed to follow HIV-related interventions in ways that it has not been observed to follow, for example, HPV-prevention interventions? Let us examine the three applications of antiretroviral therapy individually.

nPEP. In theory, giving HIV medications after a risky sexual encounter, also known as nonoccupational postexposure prophylaxis or nPEP, could unintentionally increase an individual's sexual risk behavior by giving the individual a sense of postrisk protection. However, a cohort study in England that followed participants longitudinally found no overall increase in sexual risk behaviors among individuals who were provided an advance supply of nPEP [20].

Treatment with ART. Risk compensation could also theoretically result from the widespread dissemination of ART to those already infected with HIV, which has been proposed to reduce the overall population likelihood of HIV transmission by suppressing population plasma HIV RNA levels. In the developing world, however, this appears not to have occurred. Current data from cross-sectional and observational cohort studies in developing countries suggest that better access to ART has not led to significant risk compensation [21].

The impact of ART on sexual risk compensation in *developed* countries, however, may not be the same. Mathematical modeling studies have suggested that HIV incidence in men who have sex with men (MSM) in the United States and other industrialized nations may be increasing because of increased risk behavior in the era of ART [22]. Furthermore, there has been an increase in syphilis and gonorrhea rates in MSM across the United States [23], particularly among HIV-infected people, which could be an unintended consequence of risk compensation associated with greater access to and use of ART. In a large meta-analysis of HIV therapy and risk behavior literature, it was found that individuals who thought ART reduced the likelihood of HIV transmission or for whom the availability of ART reduced concerns about having unsafe sex were more likely to engage in unprotected sex. Additionally, unprotected sex was associated with the belief that an undetectable viral load affords protection against transmission of HIV [24]. Finally, several

studies in developed countries have found increases in unprotected anal intercourse after ART with casual partners in both HIV-infected and uninfected individuals [25-27]. Findings from these studies suggest that some risk compensation has occurred in the United States with increased use of ART for treatment.

PrEP. Given the evidence of risk compensation seen with readily accessible ART in the United States and other developed countries, it is reasonable to posit that PrEP used to prevent HIV in uninfected individuals could have a similar effect on sexual behavior. Prior to the FDA approval of PrEP, potential users were surveyed and reported that they believed taking PrEP could decrease their use of condoms [28-30]. But risk compensation after PrEP implementation has been examined in several trials and to date has not been associated with increased sexual risk behavior or sexually transmitted infections in the majority of these studies [3-5, 7, 31-34]. In the iPrEx trial, in which subjects receive blinded PrEP medication or placebo, there was no change in reported sexual practices from baseline through followup and no difference in overall syphilis incidence in the perceived treatment group [34]. Qualitative findings from the iPrEx open-label extension parallel these results, with participants reporting no significant changes in their sexual practices [35].

However, assessments of risk compensation within clinical trials, including open-label extension programs, must be viewed cautiously. Notably, all randomized and open-label trials of PrEP medications have provided and emphasized the use of condoms, as well as HIV testing; this model may not be fully implemented in clinical practice. As noted above, sexual risk behaviors have been shown to increase following significant HIV biomedical breakthroughs, particularly in the industrialized world, and few rigorous data have been collected to definitively answer risk compensation concerns for biomedical HIV prevention.

Based on studies looking at risk behaviors after widely available ART and newly introduced PrEP, it is certainly possible that risk compensation could occur with PrEP implementation. It will be necessary to examine the degree to which individuals change their risk behaviors as PrEP advances from randomized trials to implementation in the community, particularly as more evidence for PrEP efficacy emerges.

It must be emphasized that behavioral disinhibition will only increase HIV transmission if the prevention strategy has low efficacy, which has not been seen in most of the oral-medication PrEP studies [3-7]. The efficacy of PrEP medications has been shown to be as high as 100 percent if taken daily as prescribed, even with occasional missed doses [7]. In other words, even if riskier sexual behavior does occur, the added protection of PrEP, correctly used, should still lower HIV incidence.

Further Investigation

Although risk compensation can be studied, the most rigorous methodological designs are ethically flawed and would be difficult to implement [36]. The ideal

study design for assessing risk compensation would be a randomized control trial in which one arm was made to believe the intervention would lower their risk and the other was made to believe that it would not change their risk. Under this design, any behavioral differences seen between arms would be attributable to the messages that participants receive, not to the intervention itself [36]. However, this design would require deceiving some or all participants and feigning uncertainty about the merits of two conditions in a randomized trial. Problems of deception and clinical equipoise limit precise methodological testing for risk compensation [37]. Moreover, it may be challenging to evaluate whether potential PrEP-related risk compensation has the ability to reverse gains made in HIV prevention at a population level, which is ultimately the most important question.

As PrEP rolls out into the real world, there must be an open channel of communication between policymakers, health care professionals, advocates, and PrEP users, and the discussion around HIV prevention with PrEP needs to become less punitive and derogatory and more nonjudgmental and understanding. It will be essential to monitor STI rates, HIV seroconversions on PrEP, and drug resistance mutations expected from PrEP medications to determine possible consequences of risk compensation. The numerous PrEP demonstration projects throughout the United States will evaluate risk compensation in various populations and will include methodological strategies designed to assess changes in risk behavior. Clearly, an overall strategy will require clinicians to implement combination prevention packages, promote condom use and other risk reduction strategies, test regularly for HIV and STIs, and monitor PrEP adherence. The uniqueness of each demonstration project will allow us to better understand the factors associated with PrEP-related risk compensation and tailor risk reduction strategies to meet the needs of different subgroups.

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Disclosure

Richard H. Haubrich receives honoraria or consultant fees from BMS, Gilead Sciences, Janssen, and Merck and research support (to UCSD) from Abbott, GlaxoSmithKline, Pfizer, and Merck.

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Virtual Mentor

American Medical Association Journal of Ethics
November 2014, Volume 16, Number 11: 916-922.

HEALTH LAW

The Decriminalization of Sodomy in the United States

Richard Weinmeyer, JD, MPhil

Introduction

Laws prohibiting sodomy existed in the penal codes of numerous US states for more than 100 years, criminalizing this sexual behavior between same-sex and opposite-sex partners. Two challenges to these laws ultimately made their way to the Supreme Court [1, 2], illuminating not only how the Court viewed the laws' purpose and utility but also how American social norms had evolved since the laws were first placed on the books.

A Short History of Sodomy Laws in the United States

Sodomy laws in the nineteenth century. Although debates about sodomy laws during the latter half of the twentieth and the early twenty-first centuries focused almost entirely on their criminalization of homosexual conduct, nineteenth-century laws broadly construed sodomy as “crimes against nature, committed with mankind or with beast” [3]. This affront to nature was typically not defined by penal codes, so American courts relied on well-established common-law meanings of sodomy that involved the penetration of a “penis inside the rectum of an animal, a woman or girl, or another man or a boy” [3].

Punishing “homosexual sodomy” was not the driving force behind the implementation of these laws [4], which were intended to achieve two purposes. First, sodomy laws sought to protect “public morals and decency”; sodomy was listed along with bigamy, adultery, the creation and dissemination of obscene literature, incest, and public indecency [5]. Second, these laws were used to protect women, “weak men,” and children against sexual assault [6]. Court records from the nineteenth century reveal that these laws were used to prosecute nonconsensual activity and that consenting adults who engaged in sodomy within their homes were considered immune from prosecution [7].

Sodomy laws in the twentieth century. The nature and enforcement of sodomy laws changed dramatically in the next century. The addition of oral sex to many sodomy laws—which expanded the group of potential violators to include, for example, men engaging in sexual activity with other men in public places like bathrooms—and the creation of police forces in America’s rapidly growing urban areas fueled arrests and imprisonment for violations of these statutes [8]. City and state governments vigilantly apprehended supposed criminals in response to public outcry against indecency, sexual solicitation in the nation’s cities, and the predation and molestation of minors [9, 10]. During the 1950s, McCarthyism resulted in state- and nationwide

witch hunts of male “homosexuals” in which the acts of oral and anal sex between consenting adult men were conflated with child molestation [11].

This persecution of private sexual acts between consenting adults generated criticism from highly influential legal authorities such as the American Law Institute—an organization comprising legal scholars, practitioners, and judges responsible for drafting the Model Penal Code (MPC), which state legislatures often adopted in part or in its entirety in developing their criminal laws—and several state commissions that argued for the decriminalization of private sodomy between consenting adults [12].

In 1955 the American Law Institute voted to decriminalize consensual sodomy, and the MPC subsequently did not include such laws in its statutory language. During the 1960s and 1970s, the United States Supreme Court established that, within the Due Process Clause of the Fourteenth Amendment, there exists a right to privacy that prevents states from “interfer[ing] with people’s control of their own bodies, disrupt[ing] personal relationships, and intrud[ing] into the innermost sanctum of the home, the bedroom” [3]. From the foundation of this right, the Court struck down state laws that attempted to prohibit the use of contraceptives and intruded into marital privacy [13], limited access to contraceptives for unmarried people [14], and restricted a woman’s right to obtain an abortion [15]. Although these rulings did not touch existing sodomy laws, the ’60s and ’70s saw momentous action in decriminalization: eighteen states decriminalized consensual sodomy consistent with the MPC [16]. Kansas, Texas, Montana, Kentucky, Missouri, Nevada, and Tennessee decriminalized opposite-sex consensual sodomy, leaving consensual same-sex sodomy as a misdemeanor crime [16].

Other states, however, balked at such proposed reforms, arguing that changes to sodomy laws promoted homosexuality and unnatural conduct [16]. States that adopted the revised MPC saw tremendous protests from religious groups and right-wing political interests [16]. States such as Idaho reinstated the previous version of the MPC (containing the criminalization of consensual sodomy), and Arkansas, which adopted the revised MPC, responded to public outrage by recriminalizing same-sex consensual sodomy with the approval of then-State Attorney General Bill Clinton [16].

Bowers v. Hardwick (1986)

Facts of the case. In 1982, a 29-year-old gay man named Michael Hardwick was working as a bartender in a gay bar in Atlanta, Georgia [17]. One night, as Hardwick was leaving the bar, he threw a beer bottle into a trash can in front of the establishment [17]. Seeing this, police officer Keith Torick cited Hardwick for drinking in public despite Hardwick’s protestation that this was not the case [17]. Officer Torick inadvertently wrote down the wrong court date on the summons, and, when Hardwick did not appear in court, an arrest warrant was issued [17]. Torick’s first attempt to track down Hardwick at his home was unsuccessful, but, on the second attempt, Torick entered Hardwick’s unlocked apartment and opened a

bedroom door, where he found Hardwick engaging in oral sex with another man [17].

Torick arrested both men, who were then charged with violating Georgia's sodomy law [17]. The statute, Georgia Annotated Code section 16-6-2, specified that "a person commits the offense of sodomy when he performs or submits to any sexual act involving the sex organs of one person and the mouth and anus of another" [18] and "a person convicted of the offense of sodomy shall be punished by imprisonment for not less than one nor more than 20 years" [19].

Initial court proceedings. Michael Hardwick's challenge to the Georgia sodomy law was dismissed without a trial by a federal district court, but, on appeal to the US Court of Appeals for the Eleventh Circuit, a divided panel of judges looked to the reasoning of those cases during the 1960s and 1970s in which the US Supreme Court had found and refined a fundamental right to privacy [20]. The appeals court found that the Georgia sodomy statute violated Hardwick's fundamental rights because his homosexual activity was a "private and intimate association that is beyond the reach of state regulation by reason of the Ninth Amendment and the Due Process Clause of the Fourteenth Amendment" [20]. Georgia's Attorney General disagreed with the ruling of the Eleventh Circuit, because other federal circuit courts of appeals had upheld the constitutionality of similar state statutes, and he petitioned the Supreme Court to review the case to resolve the differences among the courts.

US Supreme Court. The controlling opinion of the Supreme Court did not frame the question before it in terms of a fundamental privacy issue. Writing for the majority, Justice White framed the issue as "whether the Federal Constitution confers a fundamental right upon homosexuals to engage in sodomy and hence invalidates the laws of many states that still make such conduct illegal and have done so for a very long time" [21]. The answer to this question was "no." Even though the Georgia sodomy law criminalized the behavior of both heterosexuals and homosexuals, the Court's majority fixated on the fact that the case before them involved a gay man.

In its analysis, the court cited the precedent that fundamental liberties under the Constitution are "implicit in the concept of ordered liberty," such that "neither liberty nor justice would exist if [they] were sacrificed" [22] and that these liberties could be characterized as "deeply rooted in the Nation's history and tradition" [23]. Yet, in this case, the court announced that "it is obvious to us that neither of these formalities would extend a fundamental right to homosexuals to engage in acts of consensual sodomy" [24]. The Court grounded its reasoning in the fact that states had had sodomy laws in place since the nation's founding, and, therefore, a right to homosexual sodomy could not be "deeply rooted" in tradition or history [25].

While Hardwick also challenged the statute because his conduct was carried out in the privacy of his home, the Court responded that "victimless crimes, such as the possession and use of illegal drugs do not escape the law where they are committed at home" [26]. Finally, Hardwick asserted that the law must have a rational basis for

its existence and that there is none for the Georgia statute besides the public's view that homosexuality is immoral and unacceptable. Once again, the Court disagreed, stating "The law...is constantly based on notions of morality, and if all laws representing essentially moral choices are to be invalidated under the Due Process Clause, the courts will be very busy indeed" [27].

The court thus upheld and deemed constitutional the Georgia sodomy law. This conclusion, which surprised many in the legal and civil rights communities, would not be revisited by the US Supreme Court for 17 years.

Lawrence v. Texas (2003)

Facts of the case. On September 17, 1998, John Lawrence spent the day with Tyrone Garner and Robert Eubanks, who were in a tumultuous relationship [28]. After a drunken argument erupted over whether Eubanks, Garner, or both could stay the night at Lawrence's place, Eubanks stormed out of the apartment [28]. Later that night, the Harris County sheriff's office received a call saying that a black man was "going crazy with a gun" in Lawrence's apartment [28]. Minutes later, four sheriff's deputies entered the unlocked apartment and made their presence known, but heard and saw nothing [28]. Only when the deputies entered a back bedroom did they find Lawrence and Garner supposedly engaged in a sexual act [28].

Both Lawrence and Garner were arrested and charged with violating the Texas sodomy law. The Texas law in question, Texas Penal Code Annotated section 21.06(a), stated that "a person commits an offense if he engages in deviate sexual intercourse with another individual of the same sex," with "deviate sexual intercourse" defined as "any contact between any part of the genitals of one person and the mouth or anus of another person" or "the penetration of the genitals or the anus of another person with an object" [29].

Initial court proceedings. The loss before the Supreme Court in *Bowers v. Hardwick* dealt a devastating blow to the gay community in the US. In an effort to prevent the Court from viewing the transgressions as purely sexual and to frame the legal issue in a different light, the brief for Lawrence and Garner focused on intimacy, privacy, and relationships [28]. In their trial before a Justice of the Peace following their arrests, Lawrence and Garner pled no contest to the charges—meaning they admitted to the facts of the charges but not their guilt—so that they could challenge the legality of the law. From there, Lawrence and Garner's lawyers were tenacious in appealing rulings against them, taking the case to the Texas Criminal Court, the Texas Fourteenth Court of Appeals, the Texas Criminal Court of Appeals, and, finally, to the US Supreme Court. The petitioners asserted that the Texas law policed citizens' homes, intruding into "their most intimate and private physical behavior and dictating with whom they may share a profound part of adulthood" [30].

US Supreme Court. Writing for the majority, Justice Kennedy framed the question before the Court as one of "whether the petitioners were free as adults to engage in private conduct in the exercise of their liberty under the Due Process Clause of the

Fourteenth Amendment to the Constitution” [31]. After reviewing the Court’s understanding of the basis of the fundamental right to privacy, Justice Kennedy turned his attention to how the sodomy statutes in both *Bowers* and the present case sought “to control a personal relationship that, whether or not entitled to formal recognition in the law, is within the liberty of persons to choose without being punished as criminals” [32]. The court characterized laws aimed at same-sex couples as motivated by animus towards homosexuals that arose from religious and moral condemnation. Despite the importance of these beliefs to some, Kennedy argued, they should not be applied to the whole of society [33]. He wrote, “*Bowers* was not correct when it was decided, and it is not correct today. It ought not to remain binding precedent. *Bowers v. Hardwick* should be and now is overruled” [34].

Finally, the court’s majority then struck down the Texas sodomy law, and, ultimately, all laws of its kind:

The petitioners are entitled to respect for their private lives. The state cannot demean their existence or control their identity by making their private sexual conduct a crime. Their right to liberty under the Due Process Clause gives them the full right to engage in their conduct without intervention from the government [34].

Conclusion

The rise and fall of sodomy laws in the United States exemplify the ways in which the law has been used to legitimize the sexual norms of a society or represent the idealized norms it seeks to promote. But these laws, like many legal instruments, became mainly tools of oppression that were wielded by the majority towards members of minority groups, and the sexual norms they promulgated came to bear less and less resemblance to the prevailing beliefs in US society. The demise of these laws through the legal challenges of *Bowers v. Hardwick* and *Lawrence v. Texas* not only brought legislation more in line with contemporary sexual norms, but also demonstrated how far acceptance of gay citizens had come.

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Virtual Mentor

American Medical Association Journal of Ethics
November 2014, Volume 16, Number 11: 923-927.

MEDICINE AND SOCIETY

Medicine, Sexual Norms, and the Role of the *DSM*

Leonore Tiefer, PhD

Sexuality is tricky territory—for individuals, couples, society—and for professionals. Some aspects are harmful, criminal, and stigmatized, while others are central to identity, deeply pleasurable, and bonding. That’s quite a range. It’s hard to make that argument for any other topic in medicine, and it predicts some unusual complexities in dealing with sexual complaints.

Physicians listen to people who come with complaints to office or clinic. They help people think more clearly about their complaints by exploring their origins, details, and possible resolutions through history taking, physical exam, and laboratory testing. Something hurts. Something isn’t functioning properly.

When it comes to sexuality, tricky elements enter the picture. Despite the avalanche of sexual subjects in the media, when it comes to a one-on-one conversation with a doctor, most patients are tongue-tied and embarrassed about their complaints (“I don’t know what’s the matter”), and many use mysterious euphemisms (“Doc, my nature isn’t right”). People who might actually be bold in bed can feel paralyzed when trying to speak about their sexual habits or problems. Shame and self-consciousness often result in misleading descriptions (saying “I can’t perform” when it would be more accurate to say “I can’t perform with my new girlfriend although I can perform quite well with my wife”). Because sexuality is so private, most people have unanswered questions about their own experience and let these questions persist, unanswered, for decades until finally they get to an “expert.”

Because sexuality is so politically controversial, most people receive little formal education and remain astonishingly ignorant about sexual anatomy and physiology. Don’t be surprised when they call everything between the navel and the knee “the vagina” or “private parts” or “lady bits” and consistently use vague, imprecise, or inaccurate language. Don’t be surprised when patients appear to be amazed by seemingly commonsense information—for example, that factors like health, alcohol, sleep, and worries can affect sexual interest, function, and experience. Sexologists learn early never to overestimate the public’s knowledge base about sex.

Above all, people often disguise their problems by asking the doctor factual-ish questions that begin, “Is it normal...?” “Doc, is it normal to masturbate after you are married, to look at Internet porn at 3 in the morning, to ejaculate during foreplay, to like to wear girlie underwear during sex, to hate oral sex, to want only oral sex, to cry after orgasm, to lose interest in sex after the first baby,” and on and on and on. How should the doctor handle such inquiries and what are the resources to consult? (Please, don’t say “the Internet.”) Is the doctor really supposed to be an expert on all

of this? Are there sexual complaints that physicians are not equipped to address or details they shouldn't delve into? And, in that case, where should people go for help?

Unfortunately, doctors are expected to have skills and knowledge in the area of sexuality despite very little formal training. (Note to reader: Please agitate in your school for better and more comprehensive sex ed. And please ask that the instructors be really knowledgeable.) Back in the 1970s, when I began teaching medical and nursing students, many schools scheduled a "sex week" in the second year, when, in addition to faculty and guest lectures, students were assigned diverse readings and saw films depicting many forms of sexual expression. This was pre-Internet and even prevideotapes, so few students had seen erotic activity on film before. There would also be many small group discussions examining the sexual attitudes and values students brought from their own cultural and religious backgrounds. Exploring "sexual myths" was emphasized, since limited knowledge combined with strong opinions seems to produce enduring myths, for both patients and professionals. "Sex week" has gone by the boards for many reasons and it's a shame. The American Medical Student Association (AMSA) has tried to fill the breach with an excellent online course [1].

These values clarification exercises are important precisely because patients' "is it normal?" questions are not requests for factual or scientific answers but are more or less transparent requests for moral authority. If physicians aren't self-aware and broadly informed, their answers to these questions could well be projections of their own values. A question like "Is it normal to masturbate after you are married?" sounds like a request for advice based on scientific evidence, but think again. What type of epidemiology would provide sound evidence on that question? What sample drawn from what population? What (cultural, religious, ethnic, regional) assumptions about marriage lie behind the question—and how is a physician supposed to know the patient's expectations about appropriate marital behavior?

Furthermore, what definition of "normal" is implied in the question? In a 1986 essay called "Am I Normal? The Question of Sex," I wrote about five different definitions that apply to sexuality: subjective, statistical, idealistic, cultural, and clinical [2]. Most often, patients want some hybrid scientific-moral answer that they can use to defend their own behavior to themselves or their partners ("The doctor said it's normal for desire to decrease after a few years of marriage, so leave me alone"). The more experience the medical student acquires with subtly answering these questions ("Some people continue masturbating after marriage, others don't. Tell me why you are asking"), the better able he or she will be to explore the particular concerns of each patient without closing off conversation with hasty and superficial science-y generalizations ("Well, of course, when hormones drop after menopause many women lose interest in sex").

Another reason why small group discussions centering on values clarification are so important is that research (then and now) shows that medical students by and large do not have wide sexual experience and often tend towards conservative values [3, 4]. Maybe they studied too much biochemistry and not enough anthropology in

college or maybe they had fewer sexual experiences because of cramming for the MCATs. In any case, people with limited experience and unexplored values are not well prepared to answer urgent and anxious sexual questions, alas.

Although it is difficult to find resources that will specify what is sexually normal (“How hard is hard?” “How wet is wet?”) or that discuss the many challenges involved with defining sexual normalcy, there is no shortage of resources that list sexual disorders and abnormalities. As a consequence, without even thinking about the complexities involved in drawing these lines of demarcation, medical students may simply learn that if something isn’t classified as a disorder, it’s likely to be normal. Ouch! That is a simple answer to a complex question, and it’s good to remember journalist H. L. Mencken’s saying, “There is always an easy solution to every human problem—neat, plausible, and wrong” [5].

Nowadays the lines between healthy and deviant sex are globally dictated by the American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, a huge tome now in its fifth edition [6]. There are many places to learn the fascinating history of the *DSM*—I recommend an extremely readable *New Yorker* magazine profile that is available online [7]. It deals mostly with the revolution in psychodiagnostics represented by the *DSM-III* (in 1980), and it doesn’t even mention sexuality nomenclature (except for the APA members’ vote to declassify homosexuality in 1973—yes, they took a vote, which tells you in a nutshell how difficult it is to be scientific about sexual norms), but nonetheless this profile will give you some idea of the many issues and controversies in psychodiagnostics.

It’s hard to understand exactly how it is that the American Psychiatric Association became the global arbiter of sexual norms—we’ll have to wait for the history books on that—but the short answer is that they moved into a vacuum. As society was liberalizing, doctors became more interested in sexual topics, and, furthermore, conducting the changing business of medicine in the insurance era required a list of conditions for which consultation and treatment would be reimbursed. The *DSM-III* was developed at the moment when classification moved from being an adjunct to medicine and research to being a necessity for a new institutional world of bureaucratic economic arrangements. These trends have only continued in the subsequent 35 years. Some sort of nomenclature was needed—and nomenclature was found.

There are currently three main categories of sexual disorders listed in the *DSM*: gender dysphoria, paraphilic disorders, and sexual dysfunctions. The chances are that the first two categories of disorders will never come up outside a psychiatric practice (well, maybe endocrinologists and plastic surgeons are getting more involved with transgender patients), but, in the absence of any “sex week” educational exposure, it is important for every physician to know that erotic pleasures occur in more diverse situations than you can imagine and that gender identity is a very complicated idea, so it would be good to read through those sections in the *DSM* online [8-10].

The subject of sexual dysfunctions will be more relevant for every physician. The history of the specific diagnoses in these categories in *DSM-III* and *IV* is long and complex and includes the views of some who criticize the origins of the very category itself [2]. What, after all, is “sexual function”? If that can’t be defined—and many have tried and failed—how do we define “sexual dysfunction”? The *DSM-5* has attempted to dispense with all theory and just list, alphabetically, ten disorders and their specific diagnostic criteria. This seems rather arbitrary, on the one hand (why these ten?), but at least it removes criticisms of the weak theoretical background, on the other.

It may seem overly easy to apply these ten diagnoses, but understanding how to use them in a clinical context takes practice. For example, hearing that a man is complaining about ejaculating quickly during intercourse, the clinician looks up “premature ejaculation,” and sees that the major criteria are “ejaculating within 1 minute following vaginal penetration” on at least 75 percent of occasions, for at least 6 months, being distressed about it, and not having a severe relationship or stress problem. If the one-minute rule seems arbitrary (and it does to me, since men from the Caribbean have different standards for the appropriate duration of intercourse than men from Europe, as I learned through working with hundreds of men in a Bronx, New York, hospital-based urology department), it might be worthwhile to take a look at the cultural issues section in the *DSM-5* introduction: “The boundaries between normality and pathology vary across cultures for specific types of behaviors. Thresholds of tolerance for specific symptoms or behaviors differ across cultures, social settings, and families” [11]. While I think this was intended more for psychopathological symptoms, it applies very well to symptoms of sexual dysfunction.

The physician has a great deal of influence in the consulting room when it comes to the anxious and poorly informed patient with a sexual complaint. Don’t rush to label distress a sign of a disorder. It might lead to needless stigmatization and misdirection of intervention [12]. Ask a lot of questions and answer them briefly. Sexual dysfunctions are often adaptive solutions within relationships (“I’m sorry, honey, I can’t” rather than “I don’t want to”), which is tricky to diagnose and trickier to treat. Did Tiger Woods have a sexual addiction (fortunately not listed in the *DSM-5*, though there are various other tantalizing possibilities in the paraphilic disorders section), or was he just exhibiting arrogance, self-indulgence, and bad judgment influenced by celebrity status and easy access? Or all of the above? It’s tricky.

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Virtual Mentor

American Medical Association Journal of Ethics
November 2014, Volume 16, Number 11: 928-931.

MEDICINE AND SOCIETY

Ethical Implications of Drugs for Erectile Dysfunction

Arthur Caplan, PhD

The Challenge of Male Sexual Dysfunction Prior to Viagra

Sex for many men before the appearance of erectile dysfunction drugs was a terrifying experience. They could not satisfy themselves or their partners. Aging leads to trouble: a high proportion of men age 60 and over cannot maintain an erection. Other men encounter problems due to stress, mental disorders, prostatectomies, drug and alcohol abuse, diabetes, multiple sclerosis, smoking, and even bicycling. Impairment in nerve function or blood circulation have long been known to be responsible for hindering blood flow to the penis, leading to difficulty in having or maintaining an erection [1].

About 30 million men in the United States and hundreds of millions worldwide suffer from some degree of sexual dysfunction due to the inability to maintain an erection. Fifty percent of US men over age 40 have some degree of dysfunction [1, 2].

Prior to the appearance in 1998 of the first FDA-approved drug treatment for erectile dysfunction, Viagra, treatments included injections into the penis or the insertion into the penis of a permanent implant. Neither treatment was cheap or viewed with much enthusiasm [2]. Indeed, for most of the twentieth century, male impotence was rarely mentioned by patients or identified as a potential problem by physicians.

Viagra, known generically as sildenafil, is a PDE5 inhibitor that relaxes smooth muscle present in the lining of blood vessels, which dilates the vessels and increases blood flow [3, 4]. That was the idea behind using the compound as an antihypertensive drug, which is the purpose for which Viagra was originally tested. The drug was not intended for men who could obtain erections.

Possible Ethical Challenges of an Erection-Related Drug

In 1998, I was hired by Pfizer as a consultant to provide them with ethical advice about moving Viagra forward in a responsible manner from clinical trials to FDA approval. There were a slew of ethical issues that surrounded a new drug for impotence. Pfizer was very aware of the potential for misuse of Viagra. They knew that men who did not need it might rush to buy it and that it might be used by adolescents or women suffering from sexual dysfunction thinking that they might benefit. They wanted to make sure the public understood that the drug was intended for the treatment of a specific problem—erectile dysfunction caused by inadequate

blood flow—and that not all types of erectile dysfunction had this cause. Some causes are emotional, and some are due to the abuse of alcohol or tobacco.

There was also concern that some men might take huge doses—especially those for whom the drug initially did not work. In clinical trials, side effects, including impairment of vision, had been reported at high doses. Pfizer addressed the issue of overuse via education, packaging, and marketing. In addition to being accompanied by a typical informational insert, the drug was packaged in bubble-wrapped doses that made the recommended dose very clear. That information was also in all materials sent to doctors, and Pfizer salespeople were trained to make clear the appropriate dose and the ineffectiveness as well as the risk of using larger doses.

I raised other ethical questions that the company had not considered. Who should be prescribing Viagra—urologists or family doctors? What sort of work-up was appropriate for those seeking the drug? Would counseling always be a part of the prescription process, or would doctors simply write prescriptions on demand (something that later happened especially on the Internet with both real and fake Viagra)? What if someone raped or abused someone else while on the drug—what would the company say? What if an older sex offender were found in possession of the drug? Would elderly residents of nursing homes, both married and single, fully competent and not, be offered the chance to use the drug?

The Challenges of Advertising a Sex-Related Drug

But the main ethical issue as I saw it then was whether Pfizer could hold the line on making sure that Viagra was sold as a drug to treat erectile dysfunction and not as an aphrodisiac or a performance-enhancing drug. Could the company resist the temptation to make promises about the drug—that it might help women, that many younger men might benefit [5]—that did not square with the actual pharmacological action of the drug? Would ads suggest that men can solve all their sexual problems via a pill—and that this pill would turn any man into a sexual superman [6]?

The company wanted to use direct-to-consumer marketing since they had data to confirm that few men talked about sexual dysfunction with their doctors or anyone else. Nor did doctors typically ask about the sex lives of their patients. Ultimately, the initial advertising and marketing focused on older men in heterosexual relationships—this being the largest group of probable users and the least controversial for a company looking to avoid a conservative backlash. The early commercial ads for Viagra, which were the first of the massive direct-to-consumer ads for drugs and devices, showed an older couple dancing. The man's wedding ring was clearly visible. The implicit message was this is a drug for older (married) men who might be having erectile problems, not a performance-enhancing drug or an aphrodisiac [1]. Viagra opened the door to large-scale, direct-to-consumer ads—a strategy that may have made sense for this drug, given the stigma associated with impotence, but one that remains ethically dubious today.

The Social Worth of Viagra

Many Americans are not comfortable talking about sex. There are restrictions on using federal funds to support studies of sexual behavior in adolescents. For decades the entire subject of sex was off-limits in academia. It was and is unfair that many other treatments related to sex, including infertility treatment, psychological counseling, and contraception information, are often not covered by insurance. And, prior to the appearance of a pharmacologic intervention, few men were willing to discuss the problem of sexual dysfunction with anyone—including their doctors. Before Viagra, men were left not only without a key aspect of their emotional life but often also with frustrated partners. Given the bleak standing of sexuality in American medicine [1], I felt comfortable supporting efforts to bring forward a drug that would help many men suffering from a problem of great importance to them.

Ultimately, Viagra took the taboo out of impotence. Former presidential candidate and Kansas Senator Bob Dole admitted in national advertisements that he suffered from erectile dysfunction. Once he and his wife appeared in these commercials, it became easier for many men and indeed for American culture to acknowledge male sexual dysfunction. Having an easy-to-use treatment transformed the embarrassment and silence that surrounded impotence into far more open, frank, and even sometimes funny discussions of the malady [1].

Viagra may also have a use in nursing homes, even by older men with mild dementia or mild Alzheimer's disease. Do they not have a right to sexuality? My view is that older people do have a right to be sexual as long as they are competent enough to be responsible for their sexual activity. But most nursing homes in the US are not set up to allow older persons to have much privacy. And to this day I am not sure how many nursing homes include such drugs in their pharmacies, offer it to residents, or routinely discuss its possible use with the families of residents.

Conclusion

Studies show that sexuality remains important to older people and that it is a key aspect of emotional satisfaction [7]. Despite efforts to introduce discussions of sex into the routine care of patients, promoting maintenance of sexual function and satisfaction remains a challenge for medicine. Although the marketing and sale of erectile dysfunction drugs have evolved in some ways toward “disease mongering” [8], the fact remains that the treatment of actual sexual dysfunction should be a key part of patient care.

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Virtual Mentor

American Medical Association Journal of Ethics
November 2014, Volume 16, Number 11: 932-937.

HISTORY OF MEDICINE

Sexual Sunday School: The *DSM* and the Gatekeeping of Morality

Edward Shorter, PhD

On the face of it, psychiatry is a clinical discipline grounded, like the rest of medicine, in science. Yet cultural values play a greater role in psychiatry than they do in the rest of medicine when it comes to deciding what constitutes a “disorder.” Nowhere is this more apparent than in psychiatry’s treatment of putative sexual disorders, or “paraphilias.” These passages in the American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, the first edition of which appeared in 1952 [1], are reflections of US culture as it existed when the values of many of the first *DSM*’s drafters were formed. The *DSM*’s treatment of sex certainly does not reflect the values of today. Sexual practices have changed, and the prevailing mores surrounding how we label and discuss sexual behavior have changed as well.

Psychiatry’s meddlesomeness in sexual behavior has a long history. There was a time when medicine, an inherently conservative field, opposed many kinds of sexual expression on the grounds that they induced “hysteria” in women or “neurasthenia” in men. Masturbation, for example, was seen as deeply pathological. Foremost in the assault upon sexual expression was Vienna psychiatry professor Richard von Krafft-Ebing, who, in *Psychopathia Sexualis* (1886), not only opposed homosexuality and fetishism but linked them to genetic “degeneration”: those who took part in unapproved sexual activities were said to be born “degenerate” and to pass the bad seed on to their children [2]. Sigmund Freud, the founder of psychoanalysis, had a similar horror of many kinds of sexuality; he believed that masturbation caused neurasthenia [3] and that paranoia arose as a result of sexual developments in early childhood [4].

It was against this background of European hostility to certain forms of sexual expression that US psychiatry took over global leadership of the field after the Second World War. In psychiatry, the major American leadership instrument was the abovementioned *Diagnostic and Statistical Manual of Mental Disorders* [1]. American psychiatry has notably failed to make a distinction between atypical sexual interests and harmful treatment of other people (whether that be a violation like rape or merely subtle coercion), grouping together such disparate ideas as sexual assault and attraction to people of the same sex under the general banner of mental disorders.

The *DSM-I* quickly dispatched what it called “sexual deviation”: “The diagnosis will specify the type of the pathologic behavior, such as homosexuality, transvestism,

pedophilia, fetishism and sexual sadism” [5]. Thus from the get-go two major areas of human sexuality were declared off-limits: attraction to people of the same sex and what is today called non-vanilla sexuality, or kink. The *DSM-I* also declared “rape, sexual assault, and mutilation” to be part of “sexual sadism,” thus completely conflating the innocuous—for example, the people who like to dress up on Saturday afternoon and play domination-submission in bed—with the terrible [5].

The *DSM-II* in 1968 expanded the range of “sexual deviations” to include “exhibitionism” and “voyeurism,” alongside fetishism and homosexuality. The second-edition manual helpfully explained that it considered sexually deviant those “individuals whose sexual interests are directed primarily towards objects other than people of the opposite sex” or towards “bizarre” sex, such as “sexual sadism and fetishism” [6].

Meanwhile, a veritable sexual revolution was sweeping American and West European society in the 1960s [7]. The taboos against sex outside of marriage were weakening. Likewise, sexual interests and behaviors that previously had been seen as hideous perversions had become widespread: by the end of the century, oral sex came to be practiced by the vast majority of people and some kind of anal sex by almost half. (According to US government statistics, in 2002, 90 percent of men and 88 percent of women aged 25-44 practiced oral sex; the respective figures for practice of anal sex were 40 percent and 35 percent [8].) What, in general, had been “pornography” was now becoming adult entertainment—one scholar speaks of the “mainstreaming” of adult content [9]. Leather became part of the sexual repertoire of straights, gays, and lesbians alike [7]. The 1960s marked the beginning of the ascent of sadomasochism, now commonly known as BDSM (bondage/domination/sadism/masochism) or roleplaying, onto the spectrum of normal.

The Stonewall riots in New York in 1969 gave gays and lesbians the stimulus to “come out of the closet,” and many did so. Acting under political pressure, in 1973 the American Psychiatric Association decided to remove homosexuality from its list of sexual disorders [10]. By the end of the 1970s, the US sexual scene looked quite different from its appearance in 1950 [7].

Few of these changes in sexual practices and mores were reflected in the *DSM* that appeared in 1980 (*DSM-III*), a volume that in other respects brought dramatic changes to psychiatric diagnosis with the creation of such illnesses as “major depression,” “bipolar disorder,” and “attention deficit disorder.” Under the leadership of Robert Spitzer at the New York State Psychiatric Institute, the subcommittee that drafted the chapter on “psychosexual disorders” went into great detail about what it disliked, which is to say, what it found “pathological.”

First of all, the transsexuals came under the gun when the *DSM-III* endorsed a “gender identity disorder” called “transsexualism,” which, happily, turned out to be “rare.” It was defined as “a persistent sense of discomfort and inappropriateness

about one's anatomic sex and a persistent wish to be rid of one's genitals and to live as a member of the other sex" [11]. In the liberal community today, a substantial consensus exists that to be transgender is not pathological but a variant of normal.

Then the *DSM-III* revived Viennese psychoanalyst Wilhelm Stekel's old term "paraphilias" for fetishes and BDSM-type interests, which it described as "unusual or bizarre imagery or acts...necessary for sexual excitement." To be sure, the manual conceded, "the imagery...such as simulated bondage, may be playful and harmless and acted out with a mutually consenting partner," but it speculated this would be true only in a minority of cases: "More likely it is not reciprocated by the partner" or, even worse, the partner would be "nonconsenting" [12].

The manual thus continued the American psychiatric tradition of conflating crime with consensual pleasure. The section on "sexual sadism" reeked of this conflation, lumping "nonconsenting partners" and partners who suffer "extensive, permanent, or possibly mortal" bodily injuries together with the Saturday-afternoon-in-the-bedroom set. BDSM was, in the *DSM-III*, right up there with zoophilia (bestiality) and pedophilia [13]. Only a complete divorce from the realities of American sexual life in these years could have led to this kind of thinking.

It also turned out that, with "ego-dystonic homosexuality," the *DSM-III* had not entirely given up on pathologizing homosexuality after all. "Generally individuals with this disorder have had homosexual relationships, but often the physical satisfaction is accompanied by emotional upset because of strong negative feelings regarding homosexuality" [14]. Psychiatry was still unwilling to give up its stigmatization of homosexuality: the "ego-dystonic" angle—oddly treating negative feelings about one's sexual orientation as somehow diagnostically different than negative feelings about other aspects of one's self—was merely a subtler way of suggesting that homosexuality was probably a bad idea. It was gone in the next edition of the *DSM*.

The *DSM-III* take on "psychosexual disorders" became dominant not just in the United States but in much of the world, as this edition of the manual was translated into many languages and became the global gold standard of diagnosis. The *DSM-III* thus dragged not just US psychiatry but much of the western world into Sexual Sunday School.

Further editions of the *DSM* changed little of this picture. The whole approach to sexuality remained naïve, censorious, and puritanical. Yet some of the refinements in these later editions show what can happen in ethical terms when one gives nosologists who apparently have little real-world experience absolute free rein.

The *DSM-III-R* in 1987 introduced "frotteurism" as a disorder (subway groping, which, however distasteful, qualifies more as assault than a psychiatric disorder). "Transvestic fetishism," too, was discovered as the field became increasingly alarmed about growing transexuality. The fetish section became more explicit,

explaining that “among the more common fetish objects are bras, women’s underpants, stockings, [and] shoes” [15]. The *DSM* contributors appear shocked that “the person with Fetishism...may ask his sexual partner to wear the object during their sexual encounters” [15]. Leather, which according to my research had become by far the commonest fetish in the world, was not even mentioned. (Today, latex has almost overtaken leather: a Google search in August 2014 yielded for “leather fetish” 1.49 million hits and for “latex fetish” 1.07 million).

To the credit of the disease-designers of the *DSM-IV* in 1994, the section on disorders of performance (hyposexuality) was amped up considerably [16]. *These* can cause considerable disruption in a person’s sexual and romantic life. This at least shows some concern for a person’s experience of sex.

All this brings us to the current edition, the *DSM-5*, published in 2013 and the catechism of what psychiatry today considers to be pathological in bed. Once again, the sexual landscape has undergone something of an earthquake, almost comparable to the sexual revolution of the 1960s. Fetish/BDSM is currently rushing onto center stage. Things previously considered taboo are now practiced with pleasure by millions of people. Numbers are hard to come by, but, for example, according to a 2014 survey of 2,000 people in the UK, 66 percent of university graduates and 37 percent of non-graduates had tried bondage [17]. The *Fifty Shades* trilogy, too, has had an epochal impact. In 2011 the novel *Fifty Shades of Grey* was published [18], and the sales, which by 2014 amounted to more than a hundred million copies worldwide [19], rocketed the trilogy to the most popular literary composition of modern times. *Fifty Shades*, of course, is about sadomasochism [20]. It has made roleplaying socially more acceptable and greatly accelerated the demand for sexual “toys” and roleplaying-themed adult entertainment [21].

Now, one would think that a real-world tremor of this kind would somehow shake the sheltered studios of the disease-designers. Not a bit of it. The *DSM-5* left the list of “paraphilia” categories almost entirely untouched. (Oh, not entirely: they added the qualifier “asphyxophilia” to the discussion of “sexual masochism disorder” to take account of a subset of adventurous types who practice “breath control” [22]. Dangerous? Possibly, but so is motorcycle racing. A psychiatric disorder? Probably not.) The new *DSM* makes a distinction between “paraphilias” and “paraphilic disorders” that is essentially without a difference. When this purported distinction was first proposed, JP Fedoroff commented, “Once a person is ascertained [i.e., labeled by a clinician as having a paraphilia], it is hard to imagine that he will not be regarded as having been diagnosed” [23]. The point is that, as long as these categories are retained in the *DSM*, it will not have relinquished the idea of pathologizing atypical sexual interests.

The history of psychiatry’s encounter with sexual diagnoses calls into question the role of psychiatrists as society’s moral gatekeepers, one for which the study of histiocytes in medical school poorly qualifies them. The history of the *DSM*’s otherworldly, judgmental, and completely unscientific approach to sex would be

risible if the consequences in the real world of making behavior into medical diagnoses were not so serious: for example, partners in divorce cases risk losing access to their children on the grounds that their sexual behavior qualifies them as “perverts” [24]. It’s time for psychiatry to bow out of the bedroom.

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Virtual Mentor

American Medical Association Journal of Ethics
November 2014, Volume 16, Number 11: 938-951.

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Virtual Mentor

American Medical Association Journal of Ethics
November 2014, Volume 16, Number 11: 952-954.

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