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SECOND THOUGHTS

Should US Physicians Support the Decriminalization of Commercial Sex?

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Abstract

According to the World Health Organization, "commercial sex" is the exchange of money or goods for sexual services, and this term can be applied to both consensual and nonconsensual exchanges. Some nonconsensual exchanges qualify as human trafficking. Whether the form of commercial sex that is also known as prostitution should be decriminalized is being debated contentiously around the world, in part because the percentage of commercial sex exchanges that are consensual as opposed to nonconsensual, or trafficked, is unknown. This paper explores the question of decriminalization of commercial sex with reference to the bioethical principles of beneficence, nonmaleficence, and respect for autonomy. It concludes that though there is no perfect policy solution to the various ethical problems associated with commercial sex that can arise under either criminalized or decriminalized conditions, the Nordic model offers several potential advantages. This model criminalizes the buying of sex and third-party brokering of sex (i.e., pimping) but exempts sex sellers (i.e., prostitutes, sex workers) from criminal penalties. However, ongoing support for this type of policy should be contingent upon positive results over time.

Introduction

The term "commercial sex" is a depoliticized way to refer to sexual services that are exchanged for money or goods, also known as sex work or, in some cases, prostitution [1]. Commercial sex might involve consensual transactions or be the result of force, fraud, or coercion (i.e., trafficking, exploitation). The form of commercial sex also known as prostitution was widely tolerated in the US until the turn of the twentieth century, when feminists, Christians, and physicians united to oppose it [2]. In 1906, the *Journal of the American Medical Association* published an opinion that a full criminal ban on prostitution was the most appropriate solution to the mounting problem of venereal disease because experiments in government-regulated prostitution in Europe had failed [3]. Today the form of commercial sex also known as prostitution is a criminal activity in all 50 states, with the exception of some sparsely populated counties of Nevada, where it is legal in local government-regulated brothels [4].

In the contemporary discourse about commercial sex, the phrase "person who sells sex" or "seller" is used to refer to the person who provides the sexual service (i.e., prostitute), the "buyer" is the term used for the person purchasing sex (i.e., a john, customer), and "third-party broker" refers to the pimp, madam, or human trafficker who arranges the commercial terms of a sexual encounter between other people [1, 5-7]. In this paper, the term "seller" is used to describe all people who provide sexual services, whether they are consenting or not.

Despite global controversy about the regulation of commercial sex, there is widespread agreement that whether trafficked or not, sellers are at risk for a range of negative health and social consequences including homicide [8], physical assault [9], sexual assault [10], sexually transmitted infections (STIs) [11], and stigma [12, 13]. Trafficked and nontrafficked sellers are also at increased risk for substance misuse, posttraumatic stress disorder, and suicide [11, 14-20], and recent research has begun to explore the health consequences for children born to either consenting or trafficked sellers [21]. The risks of engaging in commercial sex are amplified for "street" sellers as compared to "indoor" sellers [9, 22] and, in the US, for people of color and transgender sellers [23, 24].

In this paper, the ethical considerations of changing the legal status of commercial sex in the US are considered in light of the several unknowns, including the percentage of commercial sex sellers who are trafficking victims or financially induced to sell sex and the lack of empirical information about the impact of decriminalizing commercial sex in the US context compared to other nations. The pros and cons of the four primary legislative choices—criminalization, legalization, decriminalization, and the Nordic model—are also explored.

Fundamental Ethical Problems in Commercial Sex Policy Decision Making

Commercial sex policy decision making must address a number of ethical problems. Here, we discuss three: understanding of consent, financial inducements, and vulnerability.

Defining sexual consent in commercial contexts. One pressing problem is that there are no trustworthy estimates of the percentage of sellers who sell sex willingly in the US or any nation. A seller may be doing so with (a) consent; (b) financially induced consent; (c) nonconsent because of force, fraud, or coercion by a third party (i.e., being trafficked); or (d) as a minor child, which in the US is automatically considered trafficking victimization [25]. There are numerous reasons why it's virtually impossible to estimate the percentage of sellers who fall into each of these categories, a barrier that limits evidence-based decision making [26-28]. Moreover, the assumption that sellers can be classified under one of these four categories is predicated on the idea that a person either consents or does not consent to being a seller. A more nuanced perspective on the

concept of consent as it applies to commercial sex is that people might consent to a particular paid sexual encounter but not consent to specific sex acts that are forced upon them during that encounter. Whether people who engage sexually should be regarded as consenting or nonconsenting is important because opinions about decriminalization assume that most paid sexual encounters are entirely consensual from start to finish.

Understanding financial inducements. Amnesty International considers people "who live on the outskirts of society who are forced into sex work" to be consenting sellers because "it may be their only way to earn a living" [29]. The idea that financial inducements are inherently coercive, and thus exploitative, has been a central consideration in the debate about whether people should be permitted to sell their own organs [30]. Commercial sex has been referred to as "renting an organ" [31], which raises an ethical question: *For those living in poverty, are financial inducements to permit someone to have sexual access to their body inherently coercive, given that the sexual contact would be unwanted in the absence of payment and that they will receive no other benefit from the transaction?* According to Amnesty International, poverty does not necessarily undermine a person's capacity to consent, which is a position at odds with the Belmont Report, which states that undue influence "occurs through an offer of an excessive, unwanted, inappropriate or improper reward or other overture in order to obtain compliance" [32].

Vulnerability. A related ethical problem is that there has been no consideration of the capacity of people who are cognitively or psychiatrically impaired, or intoxicated, to consent to paid sex. In medicine, it is accepted that there is heterogeneity in the capacity of people with psychiatric and cognitive disorders to consent to medical treatment or research [33, 34], and special protections are put in place to safeguard them. People with psychiatric and cognitive disorders also sell sex [35] and might even be overrepresented among sellers [36]. Some sellers also drink and use drugs and therefore might be impaired when negotiating paid sexual encounters. In fact, one strategy that traffickers use to subdue their captives is to force alcohol and other drugs on them [37]. Many US states now recognize that people's sexual decision making can be impaired due to intoxication and that sex with a person too intoxicated to consent constitutes rape [38, 39]. Ethicists are needed, then, to help explore the question of whether it is possible for intoxicated people, or people with severe psychiatric and cognitive disorders, to consent to sell sex.

Policy Options for Addressing Commercial Sex

There are four main policy options for addressing commercial sex. The first option is criminalization, which means that buyers, sellers, and third-party brokers ("pimps") can all be penalized. The second option is the criminalization of buying or brokering sex, but not selling it (the Nordic model). The third option is legalization, which is distinct from decriminalization because it entails some form of government regulation such as

requiring sellers' permits. The fourth option is full decriminalization, which entails having no restrictions on commercial sex other than usual business laws.

Criminalization. The primary rationale for supporting this model is that it restricts the size of both the legal and illegal market and therefore should reduce trafficking, although the evidence to support this contention has been criticized [40-42]. Some form of criminalization appeals to those who are concerned that people who are economically dependent on paid sexual encounters have insufficient power to stop those encounters, or to object to aspects of them, once the encounters have been initiated and are therefore subjected to frequent sexual assault and rape. From this perspective, supporting some form of criminalization has the potential to reduce harm to those who are financially induced or coerced. It also appears that criminalization discourages buyers [43, 44], reducing the demand for sellers, which in turn worsens commerce for traffickers and reduces trafficking [45]. However, arrest can compound adversity for sellers, particularly those from marginalized populations [46], and enforcement can be selectively used against buyers and brokers [47] in a racist way. Criminalization can also create dangerous conditions in which sellers must collude with buyers and brokers to hide them from law enforcement [48]. On the whole, there appears to be little advantage to criminalizing the acts of both buyers and sellers.

The Nordic model. The Nordic model, which was first employed in Sweden, is now endorsed by the European Parliament. Although there is variation in how the Nordic model is implemented across countries [49], it is often promoted by those involved in anti-trafficking advocacy [50, 51]. Four separate studies have found that sex trafficking is reduced under this model [40, 41, 45, 52], and some analyses indicate that the Nordic model provides better support services to sellers than other systems [53, 54], although the results have been called into question [42, 48]. One criticism of the Nordic model is that any supposed benefit of legalizing selling is offset by the fact that buyers are still penalized, which means that sellers must continue to meet buyers under dangerous conditions [55]. However, this model has two potential advantages from the perspective of medical ethics. Sellers, including those who have been trafficked, receive many of the putative benefits of decriminalization—such as not being arrested or jailed—but the conditions discourage traffickers. The second advantage is that the model does not signal to the public that the commodification of sex is endorsed by the government. These advantages could appeal to physicians who want to balance the benefits and risks of state sanctions and try to cultivate more robust responses to patients they suspect are being trafficked.

Legalization. Under this model, either sellers or buyers or both parties can be required to obtain licenses, undergo health examinations, operate in specific zones, and comply with other restrictions. The theoretical benefits of legalization are that neither buyers nor sellers risk criminal penalty, but there are nevertheless strategies in place to control STI

transmission, improve sellers' safety, and quash trafficking. Primary objections are that trafficking increases [40, 45] and that sellers remain at unacceptably heightened risk of violence whether commercial sex is criminalized or legalized and may be harassed by government agents [56] and exploited by brokers [57]. Like criminalization, legalization is not clearly consistent with beneficence; complying with government regulation can be oppressively burdensome for individual sellers and the benefit to the community in terms of reduced STI transmission remains questionable, given that there is still too little evidence demonstrating conclusively that legalization is an effective method of preventing epidemics.

Decriminalization. This model is preferred by most sellers' political advocacy groups because it is the least restrictive and thus consistent with the principle of autonomy [58]. For example, the World Health Organization (WHO) and Amnesty International have taken the position that every nation in the world should repeal or refrain from introducing any law that criminalizes any aspect of consensual commercial sex between adults, irrespective of local conditions [6, 29]. It should be noted, however, that sellers have diverse opinions about regulation [59, 60]. The primary arguments in favor of decriminalization are that it reduces HIV and other sexually transmitted infections by reducing violence and enabling more consistent condom use [61, 62], offers sellers police protection [63], reduces stigma, could afford sellers employment benefits such as sick leave and workers' compensation [64], and realizes the rights of adults to choose to sell sex. Some have also argued that decriminalizing commercial sex may improve consensual sellers' ability to aid trafficking victims whom they meet in commercial sex venues [58]. However, counter to expectations, the decriminalization or legalization of commercial sex in New Zealand, the Netherlands, and Germany has not resulted in uniformly safer conditions [65, 66], successful seller unions [64], destigmatization [67], reduced trafficking victimization [68], or substantially increased seller satisfaction [66]. Moreover, countries where commercial sex is not criminal appear to experience higher trafficking inflows, according to economists' analyses [40, 69]. An additional concern is that from a social norms perspective, it is not yet clear if decriminalization increases the public's moral disengagement, exacerbates the sexual objectification of people, or counteracts efforts to educate the public about the importance of consent during sexual encounters. Because these effects could increase health disparities, these possibilities are important to investigate.

Conclusion

Although paternalistic approaches in matters of public health are always controversial, it has been argued that "too little state intervention in the cause of improving population health can violate individuals' rights, just as too much can" [70]. On the question of decriminalizing the form of commercial sex known as prostitution in the US, the potential harms to individuals and the public must be considered as carefully as the benefits of the expansion of individuals' rights. The commercial sex criminalization and legalization

models seem largely inconsistent with the principles of beneficence, nonmaleficence, and autonomy, because these policies disempower and burden sellers. Moreover, support for decriminalization could be inconsistent with the principle of nonmaleficence if it encourages trafficking and puts vulnerable people at increased risk for harm. The Nordic model, though imperfect, offers the advantage of eliminating punishments for sellers while potentially preventing the expansion of the commercial sex market and limiting the number of people trafficked. If new commercial sex policies of any type are enacted in US states, rigorous evaluation of their impact will be critically important and should be the basis for future decision making.

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