

Virtual Mentor

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Clinical Case

Physician Values and Clinical Decision Making

Commentaries by Jack Drescher, MD, and Andrew Fergusson, MB, MRCP

Karl Harris is a relatively new patient in Dr Breck's practice. Dr Breck knows that Karl, who is 20 years old, moved to the city from his rural hometown just over a year ago. Karl has been waiting tables and has talked about pursuing a college degree. He comes to Dr Breck's office complaining of a burning sensation when he urinates, but seems uncomfortable speaking about his chief symptoms.

During the course of the history, Dr Breck asks Karl about his sexual interactions. Karl is very hesitant to speak about this, but eventually admits that he has had several unprotected homosexual encounters in the past year. Dr Breck also asks Karl about his obvious anxiety, and Karl eventually opens up about how he left home soon after telling his family that he was homosexual. Karl states that his family was not at all supportive and that he immediately felt ostracized by his friends. He admits that much of their rejection was based on religious ideology. "I just couldn't take their constant judgment anymore, so I decided to leave," he says.

The physical examination leads Dr Breck to suspect an infection, possibly a form of gonorrhea. He takes a few samples for culture to confirm his clinical suspicion and places Karl on a course of ceftriaxone and azithromycin as initial therapy. Dr Breck schedules Karl for a follow-up visit to go over the lab results and "talk about some of the issues that might be affecting your physical, emotional, and spiritual health."

When the results of the cultures return, Dr Breck finds that Karl did have a gonococcal infection with a strain that is responsive to the antibiotic therapy he prescribed. Nonetheless, Dr Breck has his office staff confirm the follow-up appointment with Karl.

At that next appointment, Karl is relieved that his symptoms are resolving. At that point, Dr Breck brings up his concerns about Karl's sexual behavior and speaks about blood testing for HIV and hepatitis C. Karl seems hesitant to have any blood tests, stating that "no one I have been with would have any of those diseases."

Dr Breck then brings up the issue of Karl's family and their response to his sexuality. "I understand that your experimentation with homosexuality has caused a major rift between you and your family," Dr Breck says, suggesting that his parents' reaction was most likely "one of shock at seeing a child lose his way." Dr Breck then recommends

that Karl see Dr Talbert, a local psychotherapist and personal friend of Dr Breck's, well known for his work in "conversion therapy"—counseling interventions focused on eliminating homosexual thoughts and behaviors.

Commentary 1

by Jack Drescher, MD

During his visit with Dr Breck, Karl revealed a fact related to his medical problem: he is a sexually active gay man. But being gay is a secret so volatile that its revelation to his family and friends (colloquially referred to as "coming out of the closet") led to strong judgmental responses and Karl's ultimate decision to leave home.

Given the "religious ideology" of Karl's background, it is reasonable to presume that his understanding of sexuality is limited. For example, it is likely that he does not know how to use a condom, has had little sex education, and was advised to remain abstinent until marriage. Frank conversations about same-sex behaviors were probably out of the question, with such activities strongly discouraged by quotes from Leviticus and threats of punishment in the afterlife.

But now, estranged from his lifelong support system and with limited tools or knowledge of the wider world—for example, he thinks he can spot someone with hepatitis or HIV—20-year-old Karl contracts an STI and he seeks a physician's help. Dr Breck conscientiously takes a sexual history, makes a diagnosis, and prescribes appropriate antibiotic treatment. He also encourages Karl to undergo further testing for other STIs. In a follow-up visit, Dr Breck expresses concern about Karl's "major rift" with his family and their "shock at seeing a child lose his way." He refers Karl to a "conversion" therapist who claims to change sexual orientations.

Is it ethical for Dr Breck to interject his own values (strong identification with his adult patient's parents antihomosexual beliefs) into this clinical encounter?

No physician can claim to practice value-free medicine. Undoubtedly, physicians are raised with values, religious or otherwise, that shape their decisions to become professional caretakers. Their training is further influenced by professional values, embodied in the Hippocratic Oath, the Oath of Maimonides, and the AMA's Principles of Medical Ethics. In addition, mainstream practitioners choose evidence-based, as opposed to faith-based interventions—another medical decision that cannot be viewed as value neutral. Consequently, I think it unreasonable, if not impossible, to ask physicians to practice "value-free" medicine.

Nevertheless, while being aware of our own values, we must also respect those of our patients, even those with which we might disagree. Otherwise, there is a risk that our personal values may interfere with medical judgment. How this happened in Dr Breck's case requires a brief, sociocultural analysis of contemporary debates about homosexuality.

Attitudes toward Homosexuality

Today's moral and legal debates about homosexuality are embedded in the "culture wars" whose opposing sides argue either that (1) homosexuality is normal and acceptable or that (2) homosexuality is neither normal nor acceptable.

The first position I call a *normal/identity* model [1]. It regards homosexuality as a normal variation of human expression, analogous with left-handedness, and views a homosexual orientation as a distinguishing feature of a gay or lesbian identity. Acceptance of this position is an outgrowth of the 1973 American Psychiatric Association (APA) decision to remove homosexuality from its diagnostic manual (DSM) [2]. Following the APA decision, shifting cultural perspectives had medical support: if homosexuality is not an illness, and if one does not literally accept biblical prohibitions against homosexuality, and if gay people are able and prepared to function as productive citizens, then what is wrong with being gay? The normal/identity view is accepted by the American Medical Association, national, state, and local governments that provide civil rights protections for gay people, and religious denominations that sanctify same-sex relationships.

Some segments of society strongly oppose homosexuality's removal from the DSM. They advocate an *illness/behavior model* that regards any open expressions of homosexuality as either (1) behavioral symptoms pathognomonic of psychiatric illness; (2) a moral failing; or (3) some combination of the 2. This position, that illness or immorality cannot provide a foundation for creating a normal identity, is held by "conversion" therapists and religious and political groups opposed to the normalization of homosexuality. While the mental health mainstream has depathologized homosexuality, sexual conversion therapists criticize the mental health and medical fields and believe individuals can modify their behavior to reflect a more acceptable heterosexual norm. Their arguments often dismiss scientific facts that disagree with religious dogma, focus on gaps in scientific knowledge to discredit the entire scientific enterprise, and confuse the general public about the current state of accepted scientific knowledge. Furthermore, the religious and social conservatives who market conversion therapies as a viable alternative to being gay seem to be unaware of, uninterested in, or dismissive of warnings of the possible harms such "therapy" can do [3-6].

Subscribing to the illness/behavior model, Dr Breck refuses to perceive Karl as gay—an identity. Instead, he refers to Karl's "experimentation with homosexuality"—a behavior. Dr Breck's advice is an attempt to convince Karl to change his sexual orientation. (The question of whether such treatments are either effective or ethical is not the focus of this discussion.) From the illness/behavior perspective, Karl can reduce his risk of contracting STIs, and perhaps be reunited with his family and religious community by changing his homosexual "behavior." A physician who believes homosexuality is a sin, an illness, or both, might reasonably believe he has discharged his professional duties by challenging the patient's sexual identity. However, in choosing Karl's homosexuality rather than unsafe sexual practices as the object of the therapeutic intervention, Dr Breck provides 2 examples of poor practice.

The majority of HIV cases worldwide are heterosexually transmitted, yet we do not advise heterosexual patients to change their orientation to avoid AIDS (or other STIs). Counseling gay patients to change their sexual orientation to avoid disease is both a form of medical excess and poor public health policy. The more prudent, medically conservative, and nonjudgmental alternative would have been to counsel Karl about safer sexual practices, including sexual restraint—just as one does with a heterosexual patient.

A second example of poor practice stems from Dr Breck's imposing his own antihomosexual beliefs on the patient. Karl has already left family and friends who do not accept him as gay. Why would a physician who barely knows the patient use his medical authority in this way? One possible outcome of this intervention is losing Karl to follow-up and, perhaps, Karl's avoidance of future medical treatment. There may be other consequences as well. In February 2006, a lesbian patient sued her Florida doctor's practice for giving her unsolicited religious, antigay literature [7].

Physicians, like everyone else, are entitled to their personal and religious beliefs. But physicians are constrained in the exercise of those beliefs by state laws and professional, ethical guidelines. In other words, our medical authority derives from secular, not religious sources. In this case, Dr Breck confused the 2 sources of his authority. Acting on personal beliefs led to an error in medical judgment and possible alienation of his patient.

References

1. Drescher J. Ethical issues in treating gay and lesbian patients. *Psychiatr Clin North Am.* 2002;25:605-621.
2. Bayer R. *Homosexuality and American Psychiatry: The Politics of Diagnosis.* New York, NY: Basic Books; 1981.
3. American Psychiatric Association Commission on Psychotherapy by Psychiatrists (COPP). Position statement on therapies focused on attempts to change sexual orientation (Reparative or conversion therapies). *Am J Psychiatry.* 2000;157:1719-1721.
4. Drescher J, Zucker KJ, eds. *Ex-Gay Research: Analyzing the Spitzer Study and Its Relation to Science, Religion, Politics, and Culture.* Binghamton, NY: The Haworth Press Inc; 2006.
5. Haldeman DC. The practice and ethics of sexual orientation conversion therapy. *J Consult Clin Psychol.* 1994;62:221-227.
6. Shidlo A, Schroeder M, Drescher J, eds. *Sexual Conversion Therapy: Ethical, Clinical and Research Perspectives.* Binghamton, NY: The Haworth Press Inc; 2001.
7. Lesbian files complaint against doctor for prescribing unwanted anti-gay "treatment" [press release]. Kissimmee, Florida: National Center for Lesbian Rights; February 2, 2006. Available at: <http://www.nclrights.org/releases/pr-doctor020206.htm>. Accessed April 3, 2006.

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Commentary 2

by Andrew Fergusson, MB, MRCP

How frustrating it can be to have to comment when the material in the case history is sometimes so tantalizingly brief at key points. Those of us asked to respond will inevitably read into the gaps from our own presuppositions, and that of course is what this discussion on physician values in clinical decision making is all about.

When I was taking the membership examination for the UK Royal College of General Practitioners some 25 years ago, I was required to make in every primary care consultation a diagnosis with 3 elements: the physical, the psychological, and the social. As a committed Christian who often had to struggle with situations where patients' value systems conflicted with mine (though I would have faced other conflicts had I been a committed atheist) I wanted to add a fourth element: the spiritual. Since 1998 the World Health Organization has been encouraging physicians to do so.

Until recently the health professions have largely followed a medical model, which seeks to treat patients by focusing on medicines and surgery, and gives less importance to beliefs and to faith—in healing, in the physician and in the doctor-patient relationship. This reductionist or mechanistic view of patients is no longer satisfactory. Patients and physicians have begun to realize the value of elements such as faith, hope, and compassion in the healing process [1].

This rediscovery reminds us of the historic concept of the doctor-patient relationship, that it is a covenantal one which goes far beyond the merely contractual [2]. On the (regrettably) ever more dominant contract basis, the physician is reduced to being the garage mechanic of the human body, offering a menu of options with their prices and their penalties. The patient is the customer who selects the physical fix they most feel they want at that time. But the recent WHO guidance reinforces the traditional covenantal model, and there is now a renewed recognition that it is ethical to approach our patients' needs holistically.

The fictitious Dr Breck handled the initial physical diagnosis and treatment correctly, and I commend him for conscientiously taking a sexual history. Sadly some physicians are still too embarrassed to broach the topic. Unfortunately he did it in the wrong way. Beyond counseling Karl about “safer sexual practices, including sexual restraint” he should have explored the wider aspects of Karl's sexuality far more holistically. In the catchphrase of the famous British sociologist, Professor Margaret Stacey, who devoted much of her life to patient-physician relationships, Dr Breck is an example of those many doctors who “mean well, but do badly.”

As a profession we continually need to acknowledge that our corporate and individual assumptions, presuppositions, and biases need to be remembered and reviewed. After all, we might be wrong. And that is perhaps particularly true in the highly politicized field of sexual ethics. It should be obvious (though it often is not) that secular biases are as value-laden as the religious biases we attribute to Dr Breck. The imperative to review

and acknowledge the effects of our beliefs and values on patients binds all physicians—Dr Breck and those whose biases differ from his.

Let me end with Karl, because I think so far we have not really considered him adequately. He is the patient who came for help. He is the one who should be receiving compassion in the healing process. What approach best respects his autonomy? What approach most recognizes and increases his sense of dignity? It strikes me that, after the initial treatment of his infection, what this young man most needed was a good listening-to.

So far, it sounds like he's only had good talkings-to—from his family who were “not at all supportive,” his friends who “ostracized” him, from Dr Breck who uses the language of “major rift” and “shock” and possibly recommends “conversion therapy,” and, perhaps, from a gay community interested in recruiting members and molding their individual identity in order to maintain the community's corporate identity.

Letting Karl tell his story, and listening to him in a nonjudgmental way, would in itself have helped him to understand himself more and explore his options. If he then chose, in the way of fully informed consent, to continue living according to a value system that conflicted with the physician's, then the physician has to accept that. But at least their relationship would have some of that holism the WHO encourages, and would probably continue healthier for both of them.

References

1. World Health Organization. *WHOQOL and Spirituality, Religiousness and Personal Beliefs: Report on WHO Consultation*. Geneva, Switzerland: WHO; 1998.
2. See, for example, Adam MB. Physician unions: guardians of the covenant or keepers of the contract? In: Kilner JF, Orr RD, Shelly JA, eds. *The Changing Face of Health Care: A Christian Appraisal of Managed Care, Resource Allocation, and Patient-Caregiver Relationships*. Grand Rapids, Mich: William B. Eerdmans; 1998.

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