

*Virtual Mentor*  
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Sexual Orientation, Gender Identity, and Patient Care

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# Virtual Mentor

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## FROM THE EDITOR

### Politics, Religion, and Sex—Social, Legal, and Medical Equality for LGBTQI Americans

Human sexuality and sexual behavior have long been a focus of research and debate, eliciting controversy within the academic, political, and religious communities. From Alfred Kinsey's work in the 1930s and 40s, to the *Diagnostic and Statistical Manual of Mental Disorders* categorization of homosexual behavior as pathologic in the 1960s, to the codified homophobia which led to *Lawrence v. Texas* in 2003, people engaging in sexual behavior considered outside the heterosexual "norm" have faced misunderstanding, discrimination, and hostility. The medical profession is by no means insulated from shifting societal norms and perceptions regarding the LGBTQI (lesbian, gay, bisexual, transgender, queer, questioning, and intersex) community. It is difficult to imagine that any physician would encourage or perpetuate overt bias, yet the unique needs of the LGBTQI community are often neglected.

One reason for this may be a general discomfort surrounding sex-related topics. Physicians and other medical professionals routinely inquire, without trepidation, into intensely personal, delicate matters—death and suicide, intravenous drug use, bodily functions—but somehow the age-old maxim that one should "avoid talking about politics, religion and sex" in polite conversation seems to hold true even within the clinical relationship. But it may be easier to raise such topics than we assume. When a group of teens was asked how clinicians could best facilitate discussions with them about sex and sexual orientation, the overwhelming response was: "All you have to do is ask."

Why should we ask? Why do we need to know? Though of course sex-related matters are important to discuss with all patients, regardless of orientation, it is particularly crucial that we bring up these topics for the benefit of LGBTQI patients. The ostracism and marginalization of many LGBTQI patients within the community may make the physician's office one of the only forums in which they can voice their medical and social needs. Many LGBTQI adolescents face threats of homelessness and bullying upon coming out; ultimately, they are at higher risk for substance abuse, depression, and suicide. The clinical setting should be a safe haven where those concerns are competently and compassionately addressed, not silenced or compounded.

Clinicians must also be familiar with risks specific to LGBTQI populations and know what screening and counseling is appropriate for the individual patient. For instance, if a physician assumes that a lesbian patient is heterosexual and counsels her about HPV transmission in the context of heterosexual activity, the lesbian

patient might assume that HPV cervical cancer screening—not to mention annual gynecologic exams—do not apply to her. This assumption may well put her health at risk.

In addition to being informed about the sexual and mental health of LGBTQI patients, clinicians must also be aware of the inequities in the medical setting itself. LGBT patients—particularly those in the military—may encounter certain legal barriers that their heterosexual counterparts do not face. Physicians should be informed about such sensitive issues as accepted surrogates for end-of-life decision-making, reproductive and visitation rights, and child custody concerns.

Finally, we must consider the frequently overlooked needs of LGBTQI health care professionals. Lesbian, gay, and bisexual physicians and other health care professionals may feel that nondisclosure of their sexual orientations to their colleagues and peers is the safest course of action when a pervasive assumption of heterosexuality exists. While no LGBTQI person should feel compelled to out himself or herself, if and when a person wishes to share that integral part of his or her identity, he or she should be able to do so in a safe, supportive environment, without negative repercussions or ostracism.

Even more important than medicine's awareness of LGBTQI issues is communication between patients and their physicians. Understanding patients' sexuality—like compassionately acknowledging race, culture, and socioeconomic status—allows medical professionals to treat the complete patient. In this issue of *Virtual Mentor*, we hope to provide health care professionals with the information, tools, and resources they need to talk about sexuality with *all* patients.

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# Virtual Mentor

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## CLINICAL CASES

### Gay Adolescents and Confidentiality

Commentary by Patricia D. Quigley, MD, and Megan A. Moreno, MD, MEd, MPH

Richard had been seeing Dr. Moore, his pediatrician, since he was a small child. Richard, now 15, came to the office one day with a sore throat. Before Dr. Moore stepped in to see him, Richard's mother pulled him aside. She expressed concern that Richard had not been "acting like himself" lately and that he had become increasingly withdrawn and uncommunicative over the past few months. "I've tried talking to him but he just won't open up," she told Dr. Moore. "I know that he trusts you, so if you can find out what's wrong, it would be so helpful."

Dr. Moore entered the exam room and began talking with Richard. After some questioning, Richard revealed that he had recently become romantically and sexually involved with another boy at school. He told Dr. Moore that he was afraid he had "caught something" from his current partner. When Dr. Moore mentioned that Richard's mother was concerned about his low mood, Richard immediately implored Dr. Moore not to reveal what he had confessed. Dr. Moore reassured Richard about confidentiality during doctor visits, noting that most minors are protected or emancipated under state law in situations like this, and, after checking, he knew that Richard's family's health insurance bills would not reveal confidential information about the visit.

Richard was still worried. "I don't want my mom to know about, uh, this relationship. I mean, I don't even know if I'm gay, I'm just really confused right now. I know that she would just look at me differently if she knew."

### Commentary

As physicians, we rarely take care of our patients in isolation. Frequently, concerned family members want to understand what is going on with their parents, spouses, children or siblings. Sometimes, it seems in the best interest of the patient to share information, particularly when family members can provide much-needed support during emotionally trying times. This may be the case for Richard, our 15-year-old patient whose mother is concerned about his general mood over the last few months. While it may be helpful for Richard's mother to share her concerns with Dr. Moore, principles of quality adolescent health care dictate that confidentiality is imperative and that Dr. Moore cannot give Richard's mother information about Richard.

Confidentiality is essential in adolescent health care for disclosure of risky behaviors, particularly those concerning sexual behavior and use of illicit substances [1, 2]. At the beginning of any visit, the physician must inform the adolescent patient

that any information shared, unless suggestive of harm to the patient or someone else, will remain confidential [3]. When adolescents are suspicious that their behaviors will be judged or revealed, they are unlikely to disclose them, resulting in missed opportunities for counseling, intervention, or, even worse, needed medical care [2, 3].

Richard may have good reasons for his reluctance to tell his mother that he is questioning his sexuality. At the moment, Richard is unsure about his sexual orientation, and his family may or may not be comfortable with homosexuality. It has been well documented that homosexual teens face rejection from family and peers alike, leading to rates of depression, substance abuse, and suicide much higher than those of their heterosexual peers [4-6]. Recent evidence suggests that rejection by family during adolescence increases negative health outcomes in young adulthood [6].

As with any adolescent who shows signs of depression, risk-taking behavior, or difficulties at home, at school, or with friends, Richard needs access to resources. Many adolescents benefit from counseling or therapy to discuss their day-to-day experiences at home or school. Lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth support groups can be particularly beneficial [5].

At the same time, Richard's perception that his mother "would look at me differently if she knew" may not be accurate. Often, adolescents' presumptions that their parents will not support their actions, behaviors, or life choices are not based in reality. Furthermore, even parents who do not support particular actions often find ways to support their child. Most importantly, parents and families can be the best sources of strength during times of emotional turmoil. Therefore, it is Dr. Moore's responsibility to examine Richard's beliefs about how his mother would respond, help Richard think critically about those beliefs, and ultimately encourage Richard to be honest with his mother.

It is best to start this discussion by assessing the home situation. Richard has already mentioned that his mother would view him differently. What exactly does that mean? Will she be unsupportive? Abusive? Would he be thrown out of the house? And what about other family members—how does he anticipate they might react? If Dr. Moore learns that Richard would be promptly disowned, the discussion and guidance will be different than it will be if he learns that Richard's parents have LGBTQ friends and family members.

Because of the harsh realities for LGBTQ teens, physicians have two responsibilities: (1) ensure that the teenage patient has the support needed during this journey of self-discovery; and (2) encourage open communication between the patient and family.

Naturally, Dr. Moore would like to reassure Richard's mother that Richard is fine and will make it through adolescence unscathed. Of course, Richard isn't fine now

and may or may not reach adulthood without any consequences. Dr. Moore may even wish he could divulge why Richard chose to see him and the source of his recent moodiness, but this isn't an option either. So then, what exactly can Dr. Moore say to Richard's mother?

There are two issues to be addressed: the cause of Richard's sore throat and his mood. The key to both is to remain very general, without misrepresenting the information. The details to be divulged to Richard's mother should be agreed upon by Richard and Dr. Moore before she comes into the room. Again, honest communication should be encouraged, but always with the patient's permission.

With regard to the sore throat, if Dr. Moore thinks it is mononucleosis, for example, he may say: "I think it is a viral infection called mononucleosis. There are lots of ways to catch it, including sharing a friend's drink..." Dr. Moore hasn't revealed any sensitive information, yet he has given a reasonable explanation for how Richard got sick.

There are other possible scenarios as well. Richard may or may not have any physical symptoms about which he is concerned. If he doesn't have any symptoms but reported a sore throat as an excuse to visit the doctor, Dr. Moore may need to reassure Richard's mother that "everything looks normal." It is also possible that Richard reported a sore throat to his mother but has a different symptom altogether—burning with urination, for example. In this case, the same principles apply, but it will be up to Richard to decide whether or not he and Dr. Moore will discuss this with his mother during the visit.

Addressing the mood changes with Richard's mother is more challenging. Acknowledging his mother's concerns and observations about his mood can be a useful tool to encourage Richard to seek counseling. Many adolescents benefit from counseling for the many issues that arise during this time of life. Having a neutral third party with whom to discuss their feelings and experiences can be extremely useful.

If Richard agrees to it, speaking to his mother about the need for counseling in general terms and referring to her observations can be helpful. Dr. Moore might say: "Your observations that Richard's mood has been different are right. He has noticed it too. This isn't unusual; many adolescents experience sadness or moodiness for one reason or another. They often find it helpful to talk to a counselor about it." By framing it in this way, Dr. Moore has provided a way for Richard to obtain community support without divulging Richard's secret.

In this scenario, we are still faced with the challenge of encouraging Richard to discuss his sexuality with his family. Because LGBTQ teens suffer much higher rates of depression, substance abuse, and suicide, it is crucial to encourage all potential sources for support [6]. Of course, it is also important for Dr. Moore to know if that same home environment would be unsafe should Richard choose to reveal his

sexuality. It may take months or years and many visits with Dr. Moore before Richard feels comfortable sharing this information with his mother.

At 15, Richard may not be ready to understand the long-term effects of the challenges he is likely to encounter as an LGBTQ adolescent. He is likely to think concretely at this age, in which case understanding consequences is difficult [7]. Explaining to Richard that he is at greater risk for being depressed, abusing drugs, or committing suicide than his heterosexual peers may be lost completely on him. In contrast, an older adolescent or adult would be more likely to understand the challenges he faces and establish healthy behaviors to prevent depression, drug abuse, or suicide. Because Richard is too young to appreciate these risks, Dr. Moore can successfully demonstrate to Richard why social support is essential by asking some well-posed questions. “Why have you been sad lately?” might just help Richard identify the emotions he’s experiencing. Asking about friends’ alcohol or drug use and why they are using substances may also inform Dr. Moore’s guidance of Richard. Dr. Moore must also ask about safety at home and school, inasmuch as LGBTQ adolescents are at particularly increased risk for bullying [8].

This highlights the challenges of working with adolescents in general and LGBTQ teens in particular. Confidentiality is imperative to providing quality health care. If not maintained, a therapeutic patient-physician relationship may be lost and the patient may not receive necessary health care in the future. Even worse, for some patients, it may mean going home to an unsafe environment.

Ultimately, when caring for adolescents, the goal is to help them become well-adjusted, healthy adults who contribute to society. Encouraging a healthy family support network is part and parcel of that goal. Should Richard ultimately identify himself as gay, Dr. Moore can help him recognize that open and honest communication is best and that eventually he will need to tell his family. Dr. Moore might help Richard tell his parents or help him determine when the best time to do so might be. For the time being, until Richard is ready to share the information, Dr. Moore’s most important role is to ensure that Richard has a safe place to visit any time he needs to.

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#### **Related in VM**

[Counseling Gay and Questioning Minors about Coming Out](#), August 2010

[Gynecological Care for Adolescents](#), April 2003

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## Virtual Mentor

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### CLINICAL CASES

#### **Should a Gay Physician in a Small Community Disclose His Sexual Orientation?**

Commentary by Henry Ng, MD

Dr. James is a young primary care physician starting out in the rural community of Cedar, where he shares a practice with one other physician; the next nearest outpatient care center is 35 miles away. Dr. James was sorely needed in Cedar. His colleague is minimally trained in obstetrics and gynecology, and Dr. James has a special interest and training in women's health. He likes the size of the community and believes he makes a difference in the health of his patients. He has become Cedar High School's sports medicine physician and volunteers at other civic events within the community. Dr. James is gay, and although he was out during medical school and residency, he has not been open about his sexual orientation within the Cedar community for fear of the reception he might receive.

Dr. James sees Mrs. Raymond often. She is a friendly woman having a complication-riddled pregnancy. One day after her exam, Mrs. Raymond and Dr. James were chatting about Cedar High, where Mrs. Raymond's oldest child was due to start in a couple of months. Mrs. Raymond alluded to a recent controversy in a nearby town over a student's desire to bring a same-sex date to his senior prom and said, "I'm just worried...how can we be sure kids here aren't...that way? Dr. James, is there anything you can do to make sure there's nothing like that going on at Cedar High? You try to keep your kids safe, to protect them, but you never know what bad influences are out there." Dr. James did not speak, so Mrs. Raymond continued, "I mean, if I ever found out that there was one of them here—especially a teacher or a coach—I don't know what I'd do."

#### **Commentary**

This case raises some fundamental ethical questions about the patient-physician relationship, including: What constitutes physicians' private information? Is this information germane to informed consent or patient communication, and are patients entitled to know private details about their physicians? Do physicians have a duty to disclose such information? What are the pros and cons of disclosure?

#### **Homophobia in the Patient-Physician Relationship**

To understand the nuances of disclosure of sexual orientation by health care professionals, it is important to review the impact of homophobia on health care. Homosexuality was considered a pathologic disorder by the *Diagnostic and Statistical Manual of Mental Disorders* until 1973 [1]. To this day, societal bias against gay physicians persists. In one 1998 study, more than one in 10 patients responded that they would refuse to see a gay, lesbian, or bisexual ("GLB")

physician. More than 50 percent of the 346 respondents reported that “GLB physicians would be incompetent” and that they (the respondents) would feel “uncomfortable with a GLB physician” [2]. Ten years later, Lee et al. found that more than 30 percent of respondents would change doctors if they found out that theirs was gay, and more than 35 percent would change providers if gay clinicians were employed where they received health care [3].

Disclosure of sexual orientation provides an opportunity for discussion and education about gender, sexuality, and other social contributors to health status. Yet, do physicians have a duty to engage in such discourse when it pertains to themselves and not patients? Many considerations factor into this very personal decision, including one’s comfort level with discussing sexual orientation in general, one’s sense of perceived threat, and one’s willingness to disclose personal characteristics and information.

### **Physician Privacy: What Is It?**

While some laws and codes [4-6] ensure a measure of professional privacy for information about physicians’ performance, finances, and clinical practices, there is no existing legal provision for personal privacy for physicians—i.e., the protection of information or details not arising from or pertaining to the physician’s professional qualifications and obligations or clinical knowledge, performance, and judgment—probably because that information is not related to performance.

### **Is Personal Disclosure Necessary for Patient Informed Consent?**

There is no reason to believe that a physician’s sexual orientation would impact performance rates or health outcomes any more than would other characteristics, for example, the physician’s sex. What sexual orientation *can* affect is some patients’ perceived comfort and health behaviors. On the one hand, disclosure to a gay patient can demonstrate affinity and lead to improved communication and an enhanced patient-doctor relationship; on the other hand, with a conservative patient, such disclosure can lead to requests for chaperones or gender concordant clinicians.

But to what degree should particular patients’ possible comfort levels be indulged? Patients do not have any medical reason to know their care giver’s sexual orientation or any other invisible characteristic that does not affect patient care or outcome.

### **Other Consequences to Consider**

Though Dr. James does not have an obligation to inform Mrs. Raymond of his sexual orientation, her question about gays in Cedar should lead him to consider his long-term strategy for managing the overlap between his professional role and personal life. In a conservative community, disclosure of sexual orientation can ruin a gay physician’s practice if patients with homophobic beliefs decide to seek care elsewhere. Physicians who are gay or bisexual could face discrimination, loss of practice, and the loss of income or, at least strain the patient-doctor relationship. If Dr. James is the only doctor who provides obstetric care in the community, it is less

likely that pregnant patients would leave his practice, but the potential for discrimination from this patient and others remains.

At the same time, the costs of nondisclosure are not to be discounted. Loss of personal integrity, the emotional and psychological costs of “pronoun switching” and actively managing one’s presentation can be time-consuming and exhausting. Evasions and omissions of commonly discussed topics in social situations can add to awkwardness in the patient-physician relationship. Innocuous social and friendly questions can lead to the need for disclosure or lying. Abha Agrawal writes of the challenges of answering a patient’s questions about her personal life—she had lived with her woman partner for 20 years and considered herself married—during a pelvic exam. Having told the patient in question she was married, she was then asked follow-up questions about her “husband,” and, in the heat of the moment, answered as though her partner were a man. “In that split second, that was the best decision I could make. Would it have been better to tell her the truth” [7]?

In a 2004 editorial in the *British Medical Journal*, David Hughes writes

Although health professionals may resolve in advance either to be open about their sexual orientation (to “out” themselves) or to avoid disclosure...it would be unrealistic to think that every routine consultation could be prefaced by an explanation of sexual preference. Most practitioners find themselves carefully negotiating their way through interactions, making decisions from one moment to the next about how relevant their sexual identity may be to the situation and just how open to be [8].

On the positive side, Jennifer Potter writes that being “out” with one’s patients can be empowering. “It allows me to be myself, to integrate my public and private lives, voice my opinions and celebrate all my achievements, and work passionately to increase tolerance and acceptance” [9]. Moreover, the patient-doctor relationship is based on trust, and “upfront disclosure avoids embarrassing people who might otherwise assume heterosexuality” [9].

Dr. James, in some ways, is lucky about the circumstances in which the topic has come up. It would be easy to evade the topic with Mrs. Raymond in this particular moment because of the way she raised it, but what if the next patient asks about his wife? He must prepare for the future. Ideally, a physician planning to practice in a close-knit town—particularly a conservative one—would prepare for questions like, “Are you married?” to avoid having to make on-the-spot decisions. It also may be wise to investigate the general atmosphere of a town and consider it before relocating there.

Dr. James’s decision to disclose his sexual orientation is a personal, subjective, and complicated one with risks and benefits that only he can weigh. He must ask himself the following questions—and maybe others:

- Who knows he’s gay? Does his business partner know? Other people in town? (The implication seems to be that nobody knows, but maybe Dr. James’s personal friends do.)
- Does he want Mrs. Raymond to know? (He must weigh her potential reaction in the moment.)
- Does he want other people to know? (He can’t expect her not to tell anyone.)
- Can he stand to lose her as a patient?
- Can he stand to lose other patients?
- How would his practice partner react? Could he lose his practice altogether?
- Has he lied to or misled people in Cedar about his personal life (e.g., putting a picture of a woman on his desk)—which would endanger his credibility if or when he decided to come out—or has he merely been private about his personal life?
- Is he ready to deal with the worst-case potential fallout? (Loss of job, social ostracism, and so on.)
- Is he in a relationship with anyone? If so, is the partner eager to be acknowledged or does he desire to keep the relationship private or are they ambivalent? What are the stressors on that relationship from being closeted? Furthermore, do they live together? How is that cohabitation publicly acknowledged? (“Roommates”?)
- Are there other gay folks in town who would benefit from having a respected professional authority in town come out?—including gay patients, who he may or may not know about and who might benefit (generally or in terms of health behavior) from knowing their physician is gay? Does Dr. James have an obligation to any degree to advocate for other gay people?
- Is he putting himself or any partners or friends in physical danger by coming out? (i.e., how violently homophobic can things get in this town?) Are there any measures he can take before or after coming out to protect himself and others, if need be?
- How long was he originally planning on living and practicing in Cedar? Is he building a life there? Just toughing out a few years before seeking to practice somewhere else? Could he live in another town but keep his practice in Cedar?

Dr. James should come out “whenever and wherever it feels safe...lesbian, gay, and bisexual physicians join others in the workplace in the casual, honest conversations that pertain to career, family, and personal choices” [10]. From what others quoted here have said, it seems best that Dr. James not create a deception that he then must remember and add to, ultimately risking all credibility if he later decides to change his personal story. Dr. James has more work to do in discovering what he wants for himself in the long term—but coming out is not a destination. It’s a process; it will happen repeatedly throughout his personal and professional life, and all of the factors discussed above will be in play each time it does, but each situation is different. It is probably best to be consistent, but more important to take into account his safety in each circumstance.

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## Related in VM

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# Virtual Mentor

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## CLINICAL CASES

### Homophobic Jokes and Patient Care

Commentary by Kate O'Hanlan, MD

Melinda is in the midst of her third-year rotations. She has been following a patient, Debbie, who is on the medicine service recovering from pneumonia and found out during her last admission that she is HIV positive. Melinda noticed that Debbie rarely has visitors, so she has spent most of her downtime visiting with her. Debbie has told Melinda much about her personal life, in particular the difficult time she had revealing her HIV status to her partner of 10 years.

One day while Melinda was writing a progress note, she overheard several residents making fun of Debbie. One resident joked that he couldn't figure out how Debbie acquired HIV, because "by the looks of it" she had been a lesbian her entire life. Another resident quipped that Debbie's haircut and clothing were "dead giveaways." A third said sarcastically, "Hey, whatever floats your boat, right?" and they all laughed. It bothered Melinda to hear the residents talking about Debbie in this way, in part because of the close relationship she had developed with her. But Melinda didn't know whether to say anything to the residents or not. What if Debbie had heard? What if anyone had heard?

### Commentary

Melinda's compassion for this lonely patient and concern for professionalism made her want to defend Debbie upon hearing the other residents making fun of her, albeit in "private."

### Privacy and the Workplace

Residents are certainly entitled to have private conversations between themselves, with the expectation that their confidentiality be maintained—but the work environment isn't a sufficiently private place for that expectation to be applicable. As evidenced by Melinda's overhearing them, they're not really in a private place. (They don't appear to be taking precautions to make sure Debbie doesn't hear them, either.) They are in space shared among colleagues, and the assumption by these residents that their co-workers concur with their views or find their jokes appropriate is wrong, and can harm their collegial relationships [1]. They run the risk of offending or discomfiting or alienating LGBT colleagues, those with different views, and even people who may share their opinions about Debbie but not their standards for professional behavior.

More specifically, residents are role models for students like Melinda and, as such, have a duty be particularly attentive to their conduct and the example it sets. Many

students report that everything they learned about ethics and professionalism in their first 2 years of medical school was contradicted the day they started their clinical rotations. We will have a self-defeating model of medical education, unless each person gives up the temptation to say whatever pops into his or her head and begins to substitute professional restraint.

### **Disdain, Discrimination, and Patient Care**

Cracking jokes about patients can be a way to cope with stress, but it is unprofessional and can compromise the quality of care when the messages carry disdain for the patient. Certain kinds of humor are just not OK when they pertain to the patient-physician relationship. A patient's sexual orientation has clinical relevance and is therefore important for caregivers to know, but should be treated like other salient information gathered in the privacy of the clinical relationship, not made the subject of jokes or innuendo. The American Medical Association's "Principles of Medical Ethics" specifies that medical care be given with "compassion and respect for human dignity and rights" [2]. These residents' views evince a lack of respect for Debbie as a patient and as a person. Discrimination based on gender expression or sexual orientation has no place in medicine [3].

The residents also appear unaware that such remarks affect patient care. Research shows that such remarks can both directly and indirectly harm patient care. Cynicism toward patients with HIV on the part of resident trainees has been correlated with homophobic attitudes, an aversion to intravenous drug users, and a cynical attitude by supervising faculty [4], all of which undermine communication and trust in the patient-physician relationship.

One study found that androgynous lesbians, in particular, are more likely than those with more traditionally feminine presentation to avoid medical care out of fear of disdain by healthcare practitioners [5]—apparently for good reason. Ruth McNair writes that such discrimination can corrode the patient's view of her care and reduce her trust in the caregivers [6]. Patients are vulnerable to clinicians' judgments of them. Overhearing such comments about themselves can cause severe emotional injury to patients and destabilize clinical relationships.

### **Other Considerations—Medical Education**

The residents' comments may indicate anxiety about the transmissibility of HIV in the clinical context due to lack of adequate preparation in their training thus far. In a 1999 survey of students at an American university-affiliated medical school, 60 percent felt unprepared to treat HIV-positive patients safely. Furthermore, the study authors found that "AIDS-phobia was significantly associated with homophobia," and, unfortunately, additional clinical education about AIDS patients and about modes of transmission did not contribute significantly to reducing those phobic beliefs; the authors suggest that such fears must be addressed separately before the students will benefit from advanced clinical learning on the subject [7]. In some cases, homophobia may be partly due to anxiety or insecurity about with one's own gender identification or "measuring up" to socially conditioned gender roles [8].

### What Should Melinda Do?

Melinda must speak up—most urgently to make sure Debbie is not exposed to (further) discriminatory treatment, but also to address her own discomfort about the residents' comments. Confronting her colleagues privately is likely, as in any workplace environment, to engender embarrassment and animosity and is relatively unlikely to change their views or behavior. Since the residents appear to need further education (about professionalism and possibly about HIV-positive or LGBT patients), changes to their views and improvements in their conduct are more likely to occur if there is an impetus from above and if they are not singled out. Asking faculty for formal training for the group about ethics topics pertinent to HIV, homophobia, and the GLBT population could raise the awareness of the entire class [9].

Melinda should avoid passive-aggressive or pointed remarks (e.g., “*Some people* in the group seem to be uninformed about cultural sensitivity” or complaints such as “I don’t think you’ve prepared us for this”), but neither should she attempt to minimize conflict through self-deprecating comments. She should merely ask the attending physician if it might be possible to have a group discussion or informational session about clinically appropriate treatment for and sensitive behavior toward lesbians, HIV-positive patients, and other demographic groups represented on their unit. In such dilemmas as this, addressing the faculty and trainees, *en groupe*, while not naming names, may significantly raise the level of professionalism.

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**Related in VM**

[The Medical School Curriculum and LGBT Health Concerns](#), August 2010

[Conscience Must Not Undermine Patients' Autonomy and Access to Care](#), August 2010

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## Virtual Mentor

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### CONLEY ESSAY CONTEST 2009 WINNING ESSAY

#### Justice in Medicine—Conscience Must Not Undermine Patients' Autonomy and Access to Care

Carolyn W. April

Melanie was a patient at City Fertility Clinic, Inc. She had been trying to conceive for more than a year and had gone through two cycles of in vitro fertilization (IVF) and embryo implantation. Although neither effort had succeeded, Melanie had not given up hope. She had confidence in Dr. Boyles' professional competence. He had helped her arrange for sperm donation and implantation. Melanie decided to introduce him to her partner, knowing that it might be a surprise to him because, when she started treatment, it was as a single parent. Melanie was now happily in love with Bridget and they lived together. A baby would complete their household, she told Dr. Boyles, and they could share the parenting responsibilities.

A few days after the visit, Melanie received a letter from Dr. Boyles' office asking that she find another doctor and recommending other clinics. Dr. Boyles wrote that he could not, in conscience, help in bringing a child into a same-sex household and hoped she'd understand that these beliefs were deeply held and grounded in his religious faith. He thought that another physician could act in Melanie's behalf with greater understanding and enthusiasm than he could.

Shocked at what she read and angry at being abandoned by her physician, Melanie called his office. "I need to speak to Dr. Boyles," she told the receptionist. "I just got a letter telling me to find another doctor. How can Dr. Boyles dump his patient after more than a year? Just where am I going to find another clinic? You've got all my records. It will take weeks to sort this out. You can tell him that I'm reporting him to the state licensing board. This can't be legal. It's discrimination."

#### Response

*It behooves every man who values liberty of conscience for himself to resist invasions of it in the case of others: or their case may, by change of circumstances, become his own.*

*Thomas Jefferson*

In the United States there is a long tradition of legislation protecting physicians' right to opt out of providing medical services they find morally objectionable. For example, soon after the Supreme Court handed down its ruling in *Roe v. Wade* in 1973, the Church Amendments (named for the senator who introduced the bills) were passed to allow objecting physicians to opt out of participating in abortion [1]. Similarly, Oregon's 1997 Death with Dignity Act included a clause allowing doctors

to refuse to be involved in assisted suicide [2]. More recently, physicians have appealed to similar so-called “conscience clauses” in refusing to participate in other treatments they find objectionable, such as performing *in vitro* fertilization (IVF) or prescribing oral contraceptives.

Given the controversial nature of many recent medical advances, allowing physicians who have religious objections to opt out of participating in certain treatments appears to be a good compromise. As a society we applaud people who are willing to stand up for their moral convictions and act in accordance with their consciences. Striking a compromise also has practical appeal: if doctors were required to offer services they found objectionable, it is possible that many would choose other careers instead of joining the nation’s ranks of health care professionals.

In recent years, however, a number of incidents have surfaced that underscore the problem this compromise poses to patients’ access to care. One case involved a team of doctors in California who refused to artificially inseminate a patient because she was unmarried [3]. The government has recently become embroiled in the controversy surrounding conscience clauses: the California Supreme Court ruled in 2008 that the doctors who refused to inseminate their unmarried patient were not justified in withholding infertility treatment based on their religious beliefs [3]. Only hours before the conclusion of his second term, President Bush’s Department of Health and Human Services (HHS) issued the Provider Refusal Rule, which allows any health care worker to decline to participate in any “health services or research activities that may violate their consciences” [4]. Soon after assuming office, President Obama moved to overturn this rule. This contentious debate warrants further examination of an important medical ethics issue: is it ethical for physicians to choose which nonemergent treatments to provide based on their religious beliefs?

It must be emphasized that this difficult question only becomes an ethical issue when practical measures fail. So long as objecting physicians can refer patients to other physicians who are willing to assume responsibility for their care, most problems can be avoided. As long as patients’ access to care is not compromised, physicians’ religious concerns can and should be accommodated. Rare cases do arise, however, in which willing professionals are not available, and, more troublingly, some of those who object have refused to refer patients elsewhere and have actively interfered with patients’ attempts to get treatment from other professionals. One such case involved a pharmacist who not only declined to dispense oral contraceptives to a college student but also refused to tell her which pharmacies would fill her prescription and objected to giving the prescription back so she could take it elsewhere [5]. In such cases, the ethical question concerning professionals’ duties to their patients must be confronted.

Physicians generally decline to provide services they find objectionable for two reasons: they either find the treatment *itself* to be morally troubling, or they object to treating a particular *patient*. The first category can be termed *treatment objections*. In accordance with the notion of respecting autonomy, an important value in medical

ethics, objecting physicians claim their choices should be protected. The obvious problem is that some objecting physicians claim that acting in accordance with their consciences requires refusing even to inform patients of their options or to refer them to other doctors, and this clearly undermines patients' access to care.

Accommodating physicians' beliefs to this extent would thus deprive many patients of the ability to act in accordance with their own beliefs. Those physicians who want their own beliefs respected have an ethical obligation to ensure that patients' beliefs enjoy the same respect, thus all medical professionals who object to offering certain treatments are nevertheless ethically obligated to inform patients of their options and refer them elsewhere.

During the Bush administration, the Department of Health and Human Services framed conscience clauses as a matter of preventing religious discrimination, arguing that hospitals were punishing workers for their religious beliefs if they discipline providers who refused to be involved in certain procedures [4]. There is an important difference, however, between discriminating based on *beliefs* and holding professionals accountable for their *actions*. Clearly, it is unethical to refuse to hire people based on their religion or punish them for expressing their beliefs.

Nevertheless, our society generally protects the right to express beliefs only up to the point at which doing so begins to harm others. Because the state licenses medical professionals and grants them sole authority to provide medical services to patients, physicians assume a positive obligation to provide these treatments to the public [6].

While simply *holding* a particular religious belief does not interfere with this duty, failing to *do* certain things—like answering patients' questions truthfully, obtaining informed consent for treatment, and keeping records confidential—undermines health professionals' ethical obligations and causes significant harm to patients. Practical measures must be put in place to ensure timely referrals so patients' access to care is not compromised if some physicians object to providing certain services. When practical measures are not sufficient to ensure reasonable access to care, hospitals may then be justified in disciplining or declining to hire any physician who refuses to perform the services necessary to fulfill the health professions' collective obligation to patients.

Doctors who are disciplined for refusing to perform procedures are not being discriminated against because of their religious beliefs; they are being held accountable for acting in ways that undermine the basic ethical duty of their profession to provide equal access to care. As Martin Luther King Jr. said, people who stand on principle must be willing to face the consequences [7]; physicians who decide not to participate in certain treatments must not force their patients to bear the burden of their choices [8]—if they have resolved to act in accordance with their beliefs at their patients' expense, they are ethically obligated to accept the ramifications.

Even though conscience clauses occasionally lead to grievous failures that harm patients, some physicians might argue that they are entitled to conscientiously object

to providing certain medical services, just as conscripts conscientiously objected to going to war. This line of reasoning neglects an important distinction between those drafted into military service against their will and physicians who choose their profession voluntarily. Aspiring physicians who are troubled by the ethical duties inherent in certain specialties should make one of two choices: either they should not go into those fields, or, if they do choose those fields, they should live up to their professional responsibilities by providing any legal, medically indicated services patients need and seek to change practices they find troubling only through the appropriate policy-level discussions [9].

Perhaps the most serious problem with conscience clauses is that their widespread application could lead to truly disastrous consequences. A flaw of many conscience clauses is their implication that religious beliefs deserve more protection than other deeply held, albeit secular, moral commitments. Paradoxically, the Provider Refusal Rule, which claims to prevent religious discrimination, ends up committing exactly this sort of discrimination when it treats religious beliefs as more worthy of respect than other moral convictions.

To be consistent, any conscience clause that allows, say, Christian physicians to refuse to perform abortions should also concede that it is ethically acceptable for vegetarian internists to refuse to prescribe any drugs that have been tested on animals, for surgeons troubled by blood transfusions to decline to provide them for their patients, and for pediatricians who object to vaccination to refuse to immunize children.

Indeed, as written, the Provider Refusal Rule must accommodate all these examples of treatment objections, since the rule says that *any* health care provider who conscientiously objects to *any* health service has a right to opt out of being involved [4]. Conscience clauses thus walk a precarious line: they must be infinitely vague about which conscientious convictions are to be protected in order to avoid discrimination, but in doing so they necessarily create an impossibly slippery slope that threatens to undermine patient care significantly.

Implementing practical measures to accommodate physicians' treatment objections unfortunately fails to circumvent all of the ethical minefields surrounding this issue. Some of the most controversial cases, it turns out, are not treatment objections at all. This second category of objections involves physicians who refuse to participate in patient care not because they object to the *treatment* in question but rather because they object to the *patient* receiving it. The scenario of Dr. Boyles, who has no objection to IVF in principle but strongly objects to helping Melanie, who is a lesbian, epitomizes a *patient objection*. These patient objections could be handled the same way as treatment objections—by accommodating objecting physicians via referral of patients to other doctors. This would be an egregious mistake, however, inasmuch as it would signal that it is ethical for health professionals to refuse to help people they find to be “unacceptable.” Patient objections, such as Dr. Boyles' refusal to treat Melanie, clearly constitute wrongful discrimination.

Physicians like Dr. Boyles may argue that they cannot in good conscience treat patients they view to be living immorally. But it has long been established that doctors have a duty to treat *everyone* who is in need of medical assistance, even patients who arguably qualify as the most heinous of moral offenders, including convicted murderers and enemy soldiers [10]. Objecting providers may reply that, though they have a duty to provide lifesaving treatment to enemy soldiers, they are under no ethical obligation to provide nonemergency services to facilitate “lifestyle choices” they find objectionable.

Again though, given that the state grants physicians a monopoly on providing medical services like IVF, the health professions must fulfill their public obligation and uphold the ideal of providing equal access to care [6]. In addition to undermining the health professions’ commitment to justice, bowing to providers’ patient objections would also violate the other key principles of medical ethics [11]: accommodating these objections would unfairly restrict the autonomy of patients like Melanie, forcing them to shop for a doctor who finds them to be “acceptable.”

Such a policy would almost certainly cause psychological harm to the patients who suffer discrimination at the hands of those whose stated mission is to come to their aid. Finally, accommodating physicians who object to treating certain patients would make it much more difficult for *all* doctors to act in their patients’ best interests, since patients would most likely be more hesitant to reveal details about their personal lives out of fear that doing so could lead to their being abandoned by their doctors—just as Melanie was.

Nobody wants to see doctors, nurses, or pharmacists forced out of their jobs because they cannot in good conscience provide treatments they find morally troubling. Practical solutions can and should be implemented to accommodate professionals’ treatment objections, but these accommodations must be circumscribed by a prior duty to ensure patients’ access to care. Physicians who object to certain treatments, therefore, have an ethical obligation to inform their patients about the availability of legal medical services and to refer patients to other willing clinicians. Physicians who object to treating certain patients, however, are a different matter entirely. Physicians who choose to help “acceptable” patients while refusing to care for others fail to live up to their ethical duty as doctors, and within the medical profession such behavior must be actively discouraged.

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### **Related in VM**

[Applying the Concept of Judicious Dissent in Matters of Conscience](#), August 2010

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## Virtual Mentor

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### CONLEY ETHICS ESSAY CONTEST 2009 RUNNER-UP ESSAY **Applying the Concept of Judicious Dissent in Matters of Conscience** Patrick C. Beeman, MD

Melanie was a patient at City Fertility Clinic, Inc. She had been trying to conceive for more than a year and had gone through two cycles of in vitro fertilization (IVF) and embryo implantation. Although neither effort had succeeded, Melanie had not given up hope. She had confidence in Dr. Boyles' professional competence. He had helped her arrange for sperm donation and implantation. Melanie decided to introduce him to her partner, knowing that it might be a surprise to him because, when she started treatment, it was as a single parent. Melanie was now happily in love with Bridget and they lived together. A baby would complete their household, she told Dr. Boyles, and they could share the parenting responsibilities.

A few days after the visit, Melanie received a letter from Dr. Boyles' office asking that she find another doctor and recommending other clinics. Dr. Boyles wrote that he could not, in conscience, help in bringing a child into a same-sex household and hoped she'd understand that these beliefs were deeply held and grounded in his religious faith. He thought that another physician could act in Melanie's behalf with greater understanding and enthusiasm than he could.

Shocked at what she read and angry at being abandoned by her physician, Melanie called his office. "I need to speak to Dr. Boyles," she told the receptionist. "I just got a letter telling me to find another doctor. How can Dr. Boyles dump his patient after more than a year? Just where am I going to find another clinic? You've got all my records. It will take weeks to sort this out. You can tell him that I'm reporting him to the state licensing board. This can't be legal. It's discrimination."

#### **Response**

Much of what can be said about the topic at hand is applicable to the broader question of whether modern medicine can or should tolerate moral dissenters within its midst. The world in which doctors practice is marked by a pluralism of beliefs heretofore unseen. Thus, complete agreement between a doctor and her patients is no doubt a rare achievement, especially in the area of reproductive medicine. Still, many observers view idiosyncrasies of practice motivated by religious or moral beliefs as roguish or discriminatory.

Despite the diversity, when it comes to ethics many seek solutions that will please everyone. Certainly, this desire for consensus springs from a basic human desire for justice. One suspects that nobody truly wants to trample over another's deeply held beliefs or belittle another's personal identity. Nevertheless, it is likely that ethical

proposals are not going to please all parties and that some measure of tension will accompany ethical guidelines as long as our society enjoys the aforementioned pluralism, with all its benefits and occasional burdens.

Conscientious objection can be thought of as a refusal to perform a given act out of the personal conviction that such an act is objectively wrong. In health care, it takes the form of a medical professional's refusal to provide a given service or facilitate its accomplishment. For example, society permits physicians to opt out of certain activities such as elective abortion. The present case differs from this more common form of conscientious objection in that the physician here is not opting out of a given procedure, but refusing to provide it for a particular type of patient. The question, then, must be asked: is it discrimination for a doctor to recuse himself from some aspect of a patient's care due, not to his belief that the procedure is wrong, but to his belief that the patient's lifestyle is wrong? This particular question and the broader question of the rightness of conscientious objection go to the very nature of medicine as a profession.

Addressing the President's Council on Bioethics in 2008, Farr Curlin, an internist and ethicist at the University of Chicago, observed that "at the heart of every controversy about physician refusals lies a debate about what medicine is for" [1]. Put simply, should doctors act as functionaries of their patients or does the "doctor know what's best?" Which model of the patient-physician relationship is correct: patient sovereignty, paternalism, or something in between?

Views regarding conscientious objection lie along a spectrum from the liberal—health care professionals may object to anything as a matter of conscience—to the restrictive. One notable proponent of the restrictive view is Julian Savulescu, director of Oxford's Uehiro Centre for Practical Ethics, who holds that, "If people are not prepared to offer legally permitted, efficient, and beneficial care to a patient because it conflicts with their values, they should not be doctors" [2]. One suspects that most people's opinions fall somewhere between these two extremes: that is, society should tolerate some, but not all, conscientious objections to certain practices within medicine.

Consider two approaches to conscientious objection in the case of IVF for lesbian couples: one restrictive and the other liberal [3]. In November 2007, the American College of Obstetricians and Gynecologists (ACOG) ethics committee released a controversial ethics opinion entitled, "The Limits of Conscientious Refusal in Reproductive Medicine" [4]. ACOG offered guidelines for physicians who conscientiously object to some practices in reproductive medicine (e.g., prescribing contraception or participating in fertility services for lesbian couples) and advocated a more restrictive view of conscientious objection.

According to ACOG, physicians should provide patients with prior notice of their moral commitments and should use four criteria to determine whether or not conscientious objection is licit: (1) the potential for imposition of the physician's

beliefs on the patient, (2) the effect on the patient's health, (3) scientific integrity, and (4) the potential for discrimination. In sum, the first of these requires respect for autonomy; the second precludes conscientious objection when the patient's health is at risk; the next limits conscientious objection when scientific misinformation is the impetus; and the fourth entails fair treatment of all patients.

Apropos the present case, ACOG considers conscientious objection in the setting of infertility services for same-sex couples. Commenting on the justice criterion (4), the committee observes that, "Another conception of justice is concerned with matters of oppression as well as distribution. Thus, the impact of conscientious refusals on oppression of certain groups of people should guide limits for claims of conscience as well" [4]. Recognizing the nonemergent setting of the present situation and the likelihood that no physical harm would result from conscientious objection here, the committee nevertheless concludes that "allowing physicians to discriminate on the basis of sexual orientation would constitute a deeper insult" and might even reinforce "the oppressed status of same-sex couples" [4]. Ultimately, on this model, conscientious refusal to provide infertility services—for whatever motivation, be it religious or moral—to lesbian couples is deemed illicit because it violates the ethical principle of justice that requires fair treatment of all persons. Hence, refusal here would indeed be wrongfully discriminatory.

By contrast, organizations such as the Christian Medical and Dental Association (CMDA) advocate a liberal invoking conscientious objection. CMDA maintains that, while some artificial reproductive technologies are considered morally permissible, they are only so within the context of traditional marriage. Hence, the organization concluded in a 2004 statement, "CMDA believes it is morally inappropriate to use reproductive technologies to produce children outside the boundaries of the traditional Biblical family model," and elucidates further that, "The following alternative family forms do not meet this Biblical model: Same-sex couples, Domestic partners, Polygamy, Polyandry, Incestuous unions, Open marriages, and the like" [5].

Part of the CMDA's mission is to "[advance] Biblical principles in bioethics and health to the Church and society" [6]. Here, conscientious objection to providing infertility services to lesbian couples proceeds not from malice but from a desire to be faithful to a religious belief. This can certainly be construed as *de facto* discrimination, but only in the descriptive sense.

Another theory of conscientious objection—arguably in the middle of both of the above views—can be found in the work of Edmund Pellegrino, bellwether of bioethics and former chair of the President's Council on Bioethics. His important essay, "The Physician's Conscience, Conscience Clauses, and Religious Belief" [7], presents a practical approach to conscientious objection. In general, conscience is a reasoned judgment about the rightness or wrongness of a moral act to be performed or already performed. Beginning with the conundrum of how to balance pluralism and the right to freedom of conscience, Pellegrino offers three alternatives to this

dilemma: dissenting physicians may adopt a value-free stance that separates the personal from the professional life; they might abandon medicine as a profession (e.g., the Savulescu option); or they may adopt the position of “judicious dissent” while maintaining moral integrity.

Pellegrino criticizes the first two options as inadequate in that they do not respect the moral agency of both physician and patient. At the same time, the “value neutrality” assumption elevates secularism, says Pellegrino, to the “level of social orthodoxy” [8]. Authentic pluralism, then, would be abandoned in favor of, in the words of the late Richard John Neuhaus, a kind of “naked public square” that exalts secularism at the expense of diversity. For many physicians, religion impels professional activities and inspires care for patients. For these, and other conscientious objectors, “to practice medicine that contravenes religious teaching would be to subvert conscience to secular society and its “values,” to act hypocritically, and to violate moral integrity intolerably” [8].

Instead, Pellegrino maintains the idea of judicious dissent in implementing conscientious objection. The rationale for this lies in the common humanity of both physician and patient who are equally entitled to person autonomy. He recognized the inherent imbalance in the patient-physician relationship and has done much to flesh out the ethical implications of this inequality and the responsibilities it imposes on the physician. Nevertheless, “respecting a physician’s conscience claims,” he observes, “does not mean that the physician is empowered to override the patient’s morally valid claim to self-determination. . . . Neither one is empowered to override the other” [9]. The issue of conscientious objection is not about imposing the physician’s personal beliefs on the patient or violating his or her right to informed consent, but rather of the physician’s “right not to participate in what she thinks morally wrong, even if the patient demands it” [9].

The ethical foundation for Pellegrino’s solution rests on the assumption that the patient’s “moral and legal right to self-determination has limits” [9]. Of course there is truth to this; medicine recognized that not every patient request should be honored: antibiotics for a viral syndrome, growth hormone to boost athletic performance, or surgery that imposes too great a risk for a patient. Many other examples could be adduced.

When objecting on the basis of conscience, the physician must always treat her patient with respect, avoid moralizing condemnations, and explain the reasons for her moral objections. She must also be aware that every matter of conscience is not of equal gravity. Choosing when to take a morally dissenting stand is crucial if one’s exercise of conscience is to be valid and respected [10].

Some physicians fail in this connection. For instance, when the issue is abortion, there are stories of physicians refusing to manage the complications of abortion in fear of somehow being implicated in or contributing to an act believed to be morally wrong.

In the present case, Melanie and Dr. Boyles hold fundamental beliefs about the nature of the family that are at odds with those of the other. Melanie views Dr. Boyles' refusal to treat her as an affront to her civil rights. Dr. Boyles' refusal stems from a desire to be faithful to his religion. What to do?

On the judicious dissent model, Dr. Boyles' refusal is justified on the basis of the plurality of beliefs—society's disagreement—regarding the nature of the family. Though his refusal is certain to be distasteful to some—especially considering the loathsome marginalization and even criminalization homosexual persons have experienced even in the recent past—it seems to be the “least worst” option. It preserves Dr. Boyles' moral and religious integrity, respects diversity, and Melanie is still free to seek infertility treatment from someone willing to provide it to her. Melanie's autonomy is preserved, even if she is inconvenienced.

Because Dr. Boyles' objection is not to IVF itself but to its use by a particular class of persons, his justification is more tenuous. If the prevailing social and professional mores move toward at least near unanimity regarding the use of IVF in lesbian relationships, it will become more difficult for him to maintain this stance. In important ways, society sanctions who may practice medicine, and Dr. Boyles could find himself in an increasingly small minority of professionals and eventually be forced out of at least some aspects of practice—particularly since he has chosen reproductive medicine as his field.

In fine, as consensus regarding many fundamental moral issues is not likely to be achieved in our pluralistic world, the medical profession will require deep introspection into its philosophical foundations—its reason for being, its purpose, and its goals—to determine whether moral homogeneity among providers will be ultimately beneficial or detrimental to the profession, society, and patients. On the whole, preserving conscientious objection will no doubt inconvenience and offend some patients, but when inconvenience is the main outcome, it is a more tolerable one than requiring doctors to choose between personal integrity and their profession. There will always be disagreement; the challenge is to discern how we can best live together while extracting the good that comes from the strengths of our diversity. Judicious dissent does not solve these tensions, but it does simultaneously preserve, to the greatest extent possible, the autonomy of patient and physician.

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### **Related in VM**

[Conscience Must Not Undermine Patients’ Autonomy and Access to Care](#), August 2010

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# Virtual Mentor

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## ON CALL

### Medical Team Responses to a Newborn with Ambiguous Genitalia

Commentary by Kabir Matharu and Ryan C. VanWoerkom

Stuart and Beth awaited the arrival of their first baby with great anticipation. Testing weeks earlier had revealed that the baby would be a girl. Excitedly, the couple prepared their house for Belinda's arrival. The nursery was beautifully adorned with pink walls and yellow flowers and a baby bed handcrafted by Stuart's father.

Beth's pregnancy had been uneventful, and she opted for a natural birth without anesthetics. In the delivery room, Stuart stood by to capture every moment on video.

When the nurse said, "Push harder," Beth made a final effort and sighed with relief when at last her baby arrived. The umbilical cord was cut.

The obstetrician first emphatically and then cautiously exclaimed: "Belinda is such a beautiful...baby." There was whispering among the nursing staff. Exhausted, Beth wondered what was going on.

The doctor took a moment to choose his words: "Congratulations on your new child. We are not exactly sure of the sex at this point, so we'd like to run some tests. One test in particular will look at levels of 17-hydroxyprogesterone, which can be a marker for a condition called congenital adrenal hyperplasia (CAH). This is a common cause of individuals' being born with genitalia that does not aid us in determining their sex."

Stuart stopped the camera's filming as Beth cried.

### Commentary 1

Kabir Matharu

The doctor's reaction to the situation is disappointing, especially given that the process of having a child is stressful even without unexpected surprises. The obstetrician's inappropriate response was probably due to his overt discomfort with the situation. Though the diagnosis, presumably of congenital adrenal hyperplasia (CAH), was unforeseen, health care professionals should not respond to unlikely events with surprise. In all cases, they should be confident and courteous, with no sense of awkwardness. The therapeutic relationship depends upon candor and calmness.

Yet, when I hear of a case like this one, I am not surprised about the responses of the physician and nurses. As a gay Indian medical student, I believe those responses

reflect a wider discomfort some members of the medical profession have with issues of sexuality and gender identity in general. They respond with awkwardness and unease because they are thinking, “Oh, this poor child,” or “How sad for these parents to have a child like this.” If all topics of sexual identity were better understood within the field, physicians would learn to cope more easily with variations in sex characteristics and would realize that this birth is not a tragedy by any means.

Accordingly, I think it is fitting to discuss the visibility of LGBTQI physicians as a way to improve understanding of individual differences, an area where medicine often comes up short. Disclosure of sexual orientation and gender identity by physicians who identify as gay, lesbian, bisexual, and transgender is a recent phenomenon. The trend can be attributed in part to the American Psychiatric Association’s decision to remove homosexuality from its list of “deviant behaviors” in the *Diagnostic and Statistical Manual of Mental Disorders* and in part to greater efforts within the LGBT community for improved awareness of social, cultural, and ethical concerns that affect sexual minorities.

One unique aspect of being in the LGBT community is that, unlike members of other minority groups (ethnic, racial, linguistic, among a myriad of others), LGBT physicians can choose whether to disclose their sexual orientations to others. Heterosexuality (being “straight”) is usually assumed until one states or acts otherwise.

Despite steadily improving social tolerance and increasing visibility of LGBT concerns in mainstream media and through anti-hate laws, LGBT people in medicine still face the conundrum of whether to come out. What are the ramifications of doing so? Will disclosing sexual preference lead to professional consequences? In a 1993 survey of out lesbian physicians, 18 percent reported harassment during graduate medical education, and 18.5 percent reported harassment during medical practice [1].

How patients deal with their physician’s sexuality is another important consideration. Respect for patients dictates that no one should be made to feel uncomfortable at his or her physician’s office. Upon many visits to the physician, a patient usually sees pictures of loved ones, spouses, and children. Should LGBT physicians keep this part of their lives secret so as not to alienate some patients and to protect themselves from discrimination? In one study conducted in an urban area in Canada, 12 percent of 500 randomly selected people said they would refuse to see an LGBT family physician. Their reasons were mainly emotional and based on perceptions that LGBT physicians were “incompetent” and that they would “feel uncomfortable” around their doctor [2].

Though patient comfort remains the mainstay of adequate communication and good clinical outcomes, it is difficult to accept subjective patient attitudes about one’s sexual orientation as a valid reason for not coming to one’s office. Such attitudes and discomfort should be dealt with through patient communication and education.

The questions facing LGBT physicians are not easily answered; they affect both the personal and professional lives of physicians. What can we, as physicians-in-training, do to help? Advocating for increased education and information about LGBT issues, both medical and social, would be one step in the right direction. The continually increasing diversity of our country further facilitates and fosters improved awareness of those who are different from ourselves, thus providing an excellent opportunity to embrace social and cultural minorities.

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Kabir Matharu is a third-year student at UC Davis School of Medicine. His plans include residency training in internal medicine with a focus on LGBT and minority health.

### Commentary 2

Ryan C. VanWoerkom

A medical student's experience in his or her clerkship rotations can be fraught with embarrassing situations, unexpected news, and surprises, by virtue of his or her relative lack of experience. These situations have an upside—they can engender seeds of genuine compassion, empathy, and understanding. It largely depends upon the student's adaptive response to novel situations and circumstances and the time a student makes for reflection.

A critical provision of many oaths in the modern medical field stems from the Latin phrase *primum non nocere*, or first do no harm. "Harm," in this sense, can come from looks of surprises or phrases of exclamation in response to unexpected or emotional information. I have seen many physicians who choose to wear a mask of objectivity or indifference when communicating emotional news with patients. One explanation for this might be the routine nature of delivering unexpected news, but perhaps these physicians think the mask protects them and the patient from the news. A student might choose instead to model his or her professional behavior on a physician who, rather than masking fear, disappointment, or embarrassment replaces that expression with one of kindness, warmth, and understanding. If the medical student in the case under discussion had taken time to get to know the family before the delivery, he might have been able to place his hand on the father's shoulder and say, "You have a beautiful baby," providing some reassurance to the family without making any promises.

Timing is also critical. The physician could have refrained from making statements about testing the infant until the family had time to adjust to the news that there was uncertainty about their baby's sex. Individuals are often drawn to medicine because of their desire to do something to alleviate the suffering of humankind, and this desire can "kick in" automatically in times of distress, shock, and surprise. Hence physicians may be too quick to offer to test and find answers or "fix" the problem. Instead, the remedy may be allowing everyone time to adjust to the new information or situation. When the latter is the case, a medical student, physician, or nurse may allow the family time alone before suggesting treatment or testing options.

Whispering in particular is completely unprofessional. Should information need to be communicated privately between staff, there are polite ways for caregivers to briefly take their leave of patients. I have heard professionals say, "Please excuse us for a minute while we talk shop." This may allow for clarifications and explanations to ensure accuracy. Sometimes the patient or family is invited to hear if they wish to.

Addressing the matter directly and in a timely manner often successfully opens communication between patients and health professionals. When the topic involves unexpected or sensitive material, such as Belinda's ambiguous sex, compassion, empathy and a direct approach, properly timed, are best.

Ryan C. VanWoerkom is a fourth-year student at the University of Utah School of Medicine and chair of the Committee on Bioethics and Humanities of the American Medical Association's medical student section. His plans include residency training in internal medicine, followed by cardiology training.

Medical students who wish to submit cases and commentaries on upcoming Virtual Mentor themes should visit the [On Call Guidelines for Submission](#).

#### **Related in VM**

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[Should a Gay Physician in a Small Community Disclose his Sexual Orientation](#), August 2010

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# Virtual Mentor

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## MEDICAL EDUCATION

### The Medical School Curriculum and LGBT Health Concerns

Shane Snowdon

Despite their very tightly packed curricula, medical schools throughout the U.S. have recently begun to make room for a long-overlooked set of health concerns: the needs of lesbian, gay, bisexual, and transgender (LGBT) patients.

This development reflects several notable trends. First, LGBT lives have become far more visible in society and, thus, in health care. Most physicians and medical students now realize that, regardless of their specialty or region, they will encounter patients who are gay, lesbian, bisexual, and transgender. Recognizing this, they want to be knowledgeable about and sensitive to this group's needs.

Second, the challenges faced by LGBT people in accessing health care are receiving much wider recognition. Many, for example, delay or avoid medical treatment for fear of encountering bias in health care settings. Others seek treatment, but are turned away either overtly or more subtly, despite laws in a number of states prohibiting discrimination on the basis of sexual orientation and gender identity [1]. Still others receive suboptimal treatment in medical encounters with practitioners who feel uncomfortable, insufficiently knowledgeable, or even biased toward LGBT patients. Obtaining health insurance may also be difficult: many employers offer health coverage for employees' spouses, but not for their same-sex partners (59 percent of the Fortune 500 offer domestic partner health benefits, but only 40% of the Fortune 1000 do so, and most smaller employers do not) [2], and most employee health policies (93 percent of the Fortune 500's and 97 percent of the Fortune 1000's) refuse to cover surgery and hormone treatment for transgender patients [3], despite a 2008 AMA resolution calling for such coverage [4].

Third, a growing body of research has documented the disparities in health status between LGBT and "straight" patients. Some of these differences are relatively well-known: greater prevalence of STIs and substance use among men who have sex with men (MSM) and transgender individuals, and higher rates of depression, anxiety, smoking, and alcohol use among LGBT people as a group. Disparities like these, which have significant consequences, have long been attributed to stigma and stress. Other disparities, however, are more mysterious in origin, and require more research. For example, lesbian, gay, and bisexual respondents in the 2007 California Health Interview Survey (CHIS) were 50 percent more likely to report having been diagnosed with cancer in their lifetime. Data collection in these and other areas of interest is not yet robust, however, because most health research does not yet ask participants to identify their sexual orientation [5].

These and other pressing LGBT health issues are receiving increasing attention. The Institute of Medicine has convened a Committee on LGBT Health Research Gaps and Opportunities [6], the American College of Physicians has published a comprehensive LGBT health text [7], the Joint Commission has issued a standard requiring hospitals to prohibit sexual orientation- and gender identity-based discrimination at their facilities [8], and the AMA has launched a number of related efforts [9], including a report on LGBT health and an ongoing survey of member attitudes toward LGBT patients and colleagues.

These wider developments have been matched by heightened attention to these concerns in medical education, partly sparked by students and faculty who have chosen to “come out” and advocate for LGBT health needs, despite possible negative consequences. They have been joined by large numbers of “ally” classmates and colleagues who have become concerned about the needs of LGBT patients. Recent efforts to highlight the health needs of other groups who have historically faced discrimination have also helped promote awareness.

In response to these developments, the Association of American Medical Colleges (AAMC) disseminated “Recommendations Regarding Institutional Programs and Educational Activities to Address the Needs of GLBT Students and Patients” to medical school deans in the U.S. and Canada in 2007 [10]. A number of these recommendations focused on institutional climate, asking schools to create “a safe learning environment” for LGBT medical students and faculty via explicit nondiscrimination policies, inclusive admissions materials, and more. The curriculum recommendations urged medical schools to “prepare students to respond effectively, compassionately, and professionally” to LGBT patients, providing them “excellent, comprehensive health care.” The curriculum recommendations also called for “training in communication skills with patients and colleagues regarding [LGBT] issues,” faculty and resident development programs addressing these concerns, and “comprehensive content addressing specific health care needs of LGBT patients” [10].

Medical schools have responded in a variety of ways to these internal and external requests. Prodded by a survey recently sent to schools nationwide by the student-led Stanford LGBT Medical Education Research Group, a number of institutions scanned the content in their curriculum. The final results of the Stanford survey are not yet available, but the great majority of schools reported that their curriculum contains some content related to LGBT issues. This content is often limited, however, to units covering STIs (particularly HIV), mental health, and sexual history-taking.

LGBT health experts point out that being mentioned in these curriculum areas, while important, does not cover the full range of patient needs—and, poorly handled, may even reinforce stereotypes or engender confusion. For example, an interviewer may view a transgender patient as mentally unstable simply because she is transgender, or may focus too heavily on HIV testing for an HIV-negative male patient who

identifies himself as gay, regardless of his actual sexual behavior or presenting symptom. And students newly taught to ask patients “Are you having sex with men, women, or both?” may not have been trained how to respond when a patient answers, “Both.”

These pitfalls, together with the breadth of LGBT health concerns, point to the importance of well-conceived, wide-spectrum curriculum offerings in this emerging area. To meet this need, many schools are studying the approach of the School of Medicine at the University of California in San Francisco (UCSF). Located in the U.S. city estimated to have the highest LGBT population, UCSF has been a pioneer in LGBT health—and as founding director of UCSF’s LGBT Resource Center, the only such office in a health education or health care setting in the nation, I have had the opportunity to design and evaluate many of UCSF’s curricula on these topics.

A critical first step in was to create map of existing curricular offerings. Rising second-year students, guided by the UCSF LGBT Center, examined each preclinical curriculum unit, noting whether it included any LGBT-related content (and, if so, what). The resulting grid, complete with faculty contact information, was then carefully reviewed to identify each area in which LGBT content might be added, augmented, or revised. Identified areas included not only infectious disease, mental health, and sexual history-taking but also cancer, endocrinology, cardiovascular disease, neurological development, addiction, tobacco use, hypertension, nutrition, geriatrics, pediatric and adolescent medicine, social determinants of health, ethics, patient communications, and a host of other topics.

UCSF then adopted a multi-level strategy for infusing LGBT-related content into the curriculum. The most notable infusion was a 3-hour session dedicated to these issues in the school’s second-year Life Cycle course. This unit includes readings, a lecture, an LGBT patient panel, and mandatory small-group discussions of clinical vignettes, facilitated by “out” UCSF physician faculty. The block is among the most highly rated at the school, with students reporting that the information provided is both compelling and useful.

UCSF also recognized the need to infuse this content into other areas. For example, a patient experiencing abdominal pain in an early first-year case turns out to be a lesbian reluctant to be tested for pregnancy and anxious that her partner have full access to her medical information, a scenario that raises general ethical and communication questions while also increasing students’ sensitivity to LGBT concerns. Likewise, the “standardized patient” who visits some first-year students’ small groups with a complaint of non-specific pelvic pain is a transgender woman, although her transgender status turns out not to be related to her complaint.

The students who developed the curriculum map then systematically contacted the faculty responsible for units in which inclusion of LGBT-related information seemed appropriate. Offering data relevant to the faculty members’ teaching areas, the students asked, for example, whether they would be willing to include information

about the particular health risks, disparities, and inequities faced by LGBT youth and adults. The great majority of faculty were receptive to incorporating the new content.

Like many schools, UCSF already made mention of LGBT concerns in teaching sexual history-taking, the point in the medical interview when many patients “come out” (although increasing numbers now self-identify prior to the interview, thanks to new, LGBT-inclusive patient registration forms). In this area, UCSF’s curriculum initiative focused on ensuring that students respond appropriately when patients come out in the course of a sexual history, use unfamiliar terms, ask questions about specific practices, or have concerns about confidentiality. Students report to me and other instructors that the sensitivity training they receive—via written materials, role plays, videos, and facilitated small-group discussion—prepares them for difficult conversations of all kinds.

It is more challenging, of course, to make systematic changes in the clinical years of medical education. It is often in these years, however, that many students see the real-world need for LGBT-related training. To respond to this need, UCSF schedules talks by attending physicians or visiting faculty on relevant aspects of particular rotations, and uses sessions between clerkships to debrief difficult or troubling interactions with LGBT patients that students may have experienced or witnessed.

As LGBT health concerns begin to receive more attention in medical schools’ formal curricula, it should be noted that student groups at many institutions are organizing co-curricular programs designed to teach their colleagues about LGBT needs—efforts supported by AMSA’s Gender and Sexuality Committee. While generally seen as stopgap or interim offerings, these student-driven co-curricular programs play a vital role in heightening awareness of the needs of these populations and speeding up formal curriculum change.

When organized efforts to infuse these concerns into medical education began some 15 years ago, LGBT patients declared, “There’s more to us than AIDS!” In 2010, a growing number of medical schools agree—and have expanded their curricula to embrace the full spectrum of LGBT health concerns.

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**Related in VM**

[Adolescent Medicine Training for Medical Students](#), March 2005

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## THE CODE SAYS

### **The AMA *Code of Medical Ethics*' Opinions on Respect for Civil and Human Rights**

#### **Opinion 9.03 Civil Rights and Professional Responsibility**

Opportunities in medical society activities or membership, medical education and training, employment, and all other aspects of professional endeavors should not be denied to any duly licensed physician because of race, color, religion, creed, ethnic affiliation, national origin, sex, sexual orientation, gender identity, age, or handicap.

Updated November 2007.

#### **Opinion 9.12 Patient-Physician Relationship: Respect for Law and Human Rights**

The creation of the patient-physician relationship is contractual in nature. Generally, both the physician and the patient are free to enter into or decline the relationship. A physician may decline to undertake the care of a patient whose medical condition is not within the physician's current competence. However, physicians who offer their services to the public may not decline to accept patients because of race, color, religion, national origin, sexual orientation, gender identity, or any other basis that would constitute invidious discrimination. Furthermore, physicians who are obligated under pre-existing contractual arrangements may not decline to accept patients as provided by those arrangements.

Based on the report, "[Modification of Ethics Policy to Ensure Inclusion for Transgender Physicians, Medical Students, and Patients](#)," adopted November 2007.

#### **Related in VM**

[Should a Gay Physician in a Small Community Disclose His Sexual Orientation?](#)

August 2010

[Homophobic Jokes and Patient Care](#), August 2010

[The Medical School Curriculum and LGBT Health Concerns](#), August 2010

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# Virtual Mentor

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## JOURNAL DISCUSSION

### Suppression of Puberty in Transgender Children

Jason Lambrese, MD

**Giordano S. Lives in a chiaroscuro. Should we suspend the puberty of children with gender identity disorder? *J Med Ethics*. 2008;34(8):580-584.**

As society becomes more accepting of lesbian, gay, bisexual, and transgender (LGBT) people, the needs of this group—notably, specific health care needs that are underrecognized by the medical establishment, underrepresented in research, and underaddressed in medical training [1]—are becoming more visible. One of the conditions that can affect members of this community is gender identity disorder (GID), defined by “a strong and persistent cross-gender identification” and “persistent discomfort with his or her own sex or sense of inappropriateness in the gender role of that sex” that causes “clinically significant distress or impairment” [2]. Current treatment of GID involves both hormonal and surgical modalities and has been well defined for adult patients [3]. Although the signs can be seen in children [2], there is disagreement about the appropriateness of treatment in minors [4]. The treatment option for the pediatric population entails suppression of puberty using exogenous hormones before the patient significantly develops the secondary sex characteristics of his or her biological sex [4], but it is still experimental, and some practitioners question the ethics and safety of this treatment strategy.

In “Lives in a Chiaroscuro: Should We Suspend the Puberty of Children with Gender Identity Disorder?” Simona Giordano discusses the controversy surrounding suppression of puberty in children with GID and cogently presents the evidence for and against this treatment option. Giordano tackles areas of uncertainty about this treatment; namely, what are the risks of suppressing puberty in an otherwise normally developing child? Is it the role of the health care system to interfere in this process? Are children and adolescents able to make informed choices about their care? Answers to these questions must inform the treatment protocol for pediatric GID. After an extensive review of the literature, Giordano argues that “suppression of puberty should be offered when the long-term consequences of delaying treatment are likely to be worse than the likely long-term consequences of treatment” [5].

To appreciate the ethical questions posed by treatment of pediatric GID, it helps to understand the extant treatment protocol for adult patients. Medical/surgical and psychological interventions are considered to be necessary components of effective management. The goals of medical and surgical treatments are to align the patient’s physical appearance with his or her internal gender identity. Medical treatment involves the administration of cross-sex hormones (i.e., administering estrogen to a

biological male or testosterone to a biological female). Surgical interventions (i.e., mastectomies, salphingo-oophorectomies/hysterectomy, and the creation of a neophallus in female-to-male transsexuals and orchiectomies with the creation of a neovagina in male-to-female transsexuals) permanently alter the patient's body. Patients may choose to undergo only medical treatment or both medical and surgical interventions. Importantly, regular psychotherapy is coupled with medical/surgical treatment as a means of helping patients navigate the psychological components of this disorder.

In the prepubertal population, there is an additional treatment possibility: the suppression of puberty using continuous gonadotropin-releasing hormone (GnRH) agonists, which have the effect of blocking the release of follicle stimulating hormone (FSH) and luteinizing hormone (LH) from the pituitary gland. This, in turn, prevents the secretion of endogenous sex hormones (testosterone and estrogen) from the gonads, halting the progression of puberty, including the development of secondary sex characteristics. During this time, patients are medically monitored and receive regular psychotherapy. Giordano says that the fundamental benefit of this treatment strategy is that “children gain time to reflect over their gender identity, without becoming trapped in a body that is experienced as alien” [5]. The bulk of this reflective process occurs with the help of a psychotherapist, who oftentimes asks the child to have a real-life experience living as the other gender (i.e., in dress and behavior) to help determine whether or not he or she desires the transition [6].

The importance of preventing development of secondary sex characteristics during this period cannot be overstated. Once these children, who are already experiencing considerable distress over their gender incongruence, undergo the pubertal development of the “wrong” sex, their psychological well-being deteriorates significantly, and many develop depression and suicidal ideation [7]. They can experience alienation and harassment at school if they are unable to participate in cross-gender activities or use cross-sex restrooms. They can be bullied and abused. Such circumstances can lead these youths to drop out of school [8] and develop significant psychiatric morbidity [9]. Because these risks can be so great, the need for medical and psychological intervention is paramount. Suppressing puberty and allowing children the opportunity to explore their true gender identities decreases their risk for suicide [10].

A child who decides to change his or her sex then starts cross-sex hormones. Because puberty was arrested before development of secondary sex characteristics, the child will achieve a “more normal and satisfactory appearance” after the transition [5] than if he or she had waited until adulthood, in which case many irreversible features (e.g., height) or solely surgically reversible features (e.g., breast and genital development) would have formed. Giordano also believes children who have been treated before puberty have better psychosocial outcomes, such as greater comfort with their physical selves, better social adjustment, and fewer psychiatric complications. Should they decide not to change sex, “puberty suppressant drugs can be withheld and development restarts as normal” [5].

Giordano then turns to concerns about the safety of what is still an experimental treatment. First, are we putting children at risk for short- or long-term adverse events? It is worthwhile to note that exogenous continuous GnRH administration is the standard of care for the treatment of precocious puberty, and its safety and efficacy have been extensively studied [11]. Children with GID can be said to have another type of incorrect puberty and therefore qualify for GnRH agonist treatment. Research has shown that suppression of puberty is safe, causing minimal side effects [6]. If parents become concerned about this treatment, they can safely and easily stop treatment and allow development to restart normally in the biological sex. Though, as one prominent British physician points out, the fact of having given a child GnRH agonists is not reversible (i.e., we cannot make it “un-happen”); nonetheless, the effects of the treatment are both “temporary and reversible” [12].

Nevertheless, GnRH agonists are an experimental treatment for pediatric GID, and children cannot be forced into receiving experimental treatment without their consent. Given this situation, are these prepubescent children able to provide consent for the treatment? Giordano says that they can, so long as the clinician discusses all potential risks and benefits, as he or she must do with any experimental drug. Because this is the only therapy available for children with GID, it might be considered unethical to *deny* this treatment option.

Another concern in suppressing puberty comes from the idea that arresting an otherwise normally developing body interrupts a development that might further elucidate a patient’s true gender identity. It is possible that discovery of one’s gender identity occurs during a specific or predetermined developmental stage, which is actually halted when puberty is suppressed. Some ask, is there an age at which we can be reasonably sure someone has a sufficiently clear understanding of his or her gender identity to make a decision of this kind? Finding a generalized answer to this question would certainly simplify the GID treatment process, but, of course, chronologic age does not correspond to a specific level of physical or psychological maturity or guarantee that a child has had particular experiences. Hence, the individual nature of readiness for a decision of this kind makes the psychotherapeutic element of the treatment all the more important.

It is currently recommended that treatment be initiated when the patient is in the Tanner II or III stage of puberty, when it is felt that “the child has had some experience of his/her biological gender” [10]. Data indicate that children who continue to experience gender dysphoria into early adolescence will maintain a transgender identity [13], so it is prudent to wait until this time to initiate treatment—but not much longer. If treatment is postponed too long, children may experience significant distress over the incongruities between their physical and psychological selves, and pubertal changes that are irreversible or only reversible by surgical means may occur, causing greater medical difficulties. It is currently recommended that children continue with GnRH agonist treatment until the age of 16, at which point administration of cross-sex hormones can begin [5]. Giordano underscores the

importance of frank discussions of potential risks and benefits—both of treatment and no treatment—throughout this process.

Giordano concludes that “if allowing puberty to progress appears likely to harm the child, puberty should be suspended” [14]. It would be unethical to allow a patient to suffer through the distress of pubertal development when we have a way of preventing the distress it causes. Children and adolescents who suffer from gender identity disorder face significant physical, psychological, and social challenges, and receiving an inconsistent standard of medical care adds to those challenges. Unfortunately, many clinicians are uncomfortable with the option of puberty suppression for these children, which inhibits their access to care; it is imperative that health care professionals become familiar with this treatment option. As health care professionals, we have an obligation to alleviate suffering—and for our pediatric patients with GID, who are undoubtedly suffering, suppression of puberty is a safe and easy way to begin to do so. Furthermore, if legitimate medical treatment is not available, those with GID will seek it through other channels, which are much more likely to be unsafe and will certainly not involve an appropriate level of monitoring or adjustment to manage complications [10]. This makes it all the more clear that we are professionally duty-bound to provide this treatment to those in need of it.

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# Virtual Mentor

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## CLINICAL PEARL

### Let's Talk about Sex

Titus L. Daniels, MD, MPH

Despite the fact that some 30 or 40 percent of adult men and women, respectively, experience sexual problems that negatively affect their quality of life [1, 2], most clinicians seem to be less than adept at obtaining a sexual history and discussing sexual health. Most likely, this is due to poor training, as evidenced by one nationwide survey, which found that 44 percent of medical schools lacked formal training in how to obtain a sexual history [3]. Further complicating matters in many instances is health professionals' lack of understanding about the psychosocial and sexual issues particular to the lesbian, gay, bisexual, transgender, queer, questioning, and intersex community (LGBTQI).

Though most understand the many advantages of taking a sexual history, some physicians object to spending time discussing sex-related topics, claiming it is uncomfortable for both patient and practitioner and takes time away from "real" medical topics. Not infrequently, however, medical concerns are linked to sexual health, which can be both an indicator of otherwise unnoticed medical conditions or itself significantly affected by lifestyle behaviors (e.g., smoking) and health conditions (e.g., diabetes, hyperlipidemia) and their treatments. Hence, failure to inquire about sexual health may allow important medical issues to go unnoticed. Moreover, accurate knowledge of a patient's behaviors provides relevant and useful advice about disease screening and individualized counseling about risk reduction.

### Laying the Groundwork: Good Communication

Effective communication is fundamental to taking a sexual history. While merely asking patients about their sex-related activity sounds simple enough, basic principles for good communication must be employed in discussing sensitive issues.

Ensuring a private setting is essential. Others should be asked to leave the room. A request from the clinician is more likely to guarantee privacy than asking the patient if he or she wants others—which could include family members, sexual partners, and other intimates—to leave. If the patient allows anyone to stay, he or she may withhold information or lie outright; if the patient asks them to leave, it could cause tension or suspicion between them. Not only does the physician's making the request remove that burden from the patient and reduce the likelihood of uncomfortable situations in the exam room, it contributes to an environment of trust and communicates the physician's commitment to serve as the patient's advocate.

Inform the patient that some sensitive and deeply personal questions are about to be asked and explain why they are important (e.g., “I ask these questions of all my patients so that I can provide the most individual and complete care for them”). Ask the patient whether he or she has any questions before you begin and remind the patient that all information is strictly confidential and only available to the patient and care providers. At this point, a patient might say, “I don’t see how my sex life has anything to do with my high blood pressure” (or other condition), and you can explain how it may or how, conversely, blood pressure may affect sexual desire.

How the question is phrased is as important as the question itself. One possible misstep in this area is the leading question. A question like “You’re not sexually active, are you?” implies the clinician anticipates or even prefers a negative answer, either in the hopes of shortening an uncomfortable discussion or because of moral beliefs or expectations about the patient. No matter the reason, the phrasing communicates discomfort with the topic or with possible answers. Physicians’ discomfort can present a real obstacle to good treatment; in a 1992 survey of more than 3,000 men and women aged 18 to 59, 68 percent of respondents reported they would not bring up sexual topics for fear of embarrassing their doctor [2].

If the patient gives an incomplete or untrue response out of a desire to smooth things over, make the situation easier for the physician, or avoid judgment, potentially critical information is lost. The patient should not have to factor the physician’s feelings into deciding how to answer such questions; it is the clinician’s responsibility to set the tone and put the patient at ease, not vice versa. Neutral introductory questions include “Are you currently sexually active?” and “Have you been sexually active in the past?” A time reference (e.g., “in the past year”) avoids ambiguity about what constitutes being “currently” sexually active.

### **Topics to Cover**

Determining the number and sex of sexual partners helps establish risk for specific STIs. Clinicians frequently make the mistakes of assuming heterosexuality (e.g., asking a teenage boy, “Do you have a girlfriend?”), and subtly communicating negative beliefs about homosexuality with questions like, “You’re not gay, are you?” This can be particularly damaging to teenagers and others who are still exploring their sexuality. If patients sense that their doctors harbor bias or prejudice towards members of the LGBTQI community, they understandably may be unable to be honest, for fear of mistreatment. Moreover, the use of labels can compromise the efforts of the most well-intentioned physician. The process of determining one’s sexual identity is a deeply personal, and sometimes fraught, experience. Even if the clinician uses these labels in a nonbiased, nonjudgmental way, patients may not identify with particular categories or labels (e.g., a male patient who has sex with men but may not consider himself gay). Using labels has no value in the medical risk assessment, but can absolutely alienate patients.

To learn about the sex of a patient’s partners, begin by asking “Do you have sex with men, women, or both?” This allows the patient to answer without being assigned a

specific label. Second, identifying the number of sexual partners, both current and past within in the last year, is useful for understanding risk-behavior. The precise number of partners (e.g., six rather than seven) is less important than establishing the level of risk associated with the behaviors. So if a person tells you he or she has been sexually active during the last year, you might ask, “What have your relationships been with your sexual partners?”

The assessment of specific sexual practices is the area that has the greatest potential to cause discomfort among clinicians. Asking “What kind of sexual contact do you have?” avoids making assumptions and minimizes embarrassment for both parties. But the clinician must be able to adjust these follow-up questions based on the patient’s answers about partners. To assess practices adequately, it is necessary for health professionals to have some basic understanding of what kinds of sexual behaviors are likely to occur among particular populations. The sexual practices of men who have sex with men (MSM) are quite different from those of women who have sex with women (WSW). For example, a MSM should be asked about oral and anal intercourse practices. High-risk sexual behaviors are common with MSM, especially during periods of sexual identity discovery when social networks may not yet be in place to provide guidance. For WSW, it is important to ascertain whether sex toys are shared, especially when educating patients about the need for regular screening for cervical cancer.

Next, the patient should be asked about current and past sexually transmitted infections (STIs). A history of STIs indicates prior high-risk activity and may point to current risks. Further, understanding what STIs the patient has or had, whether they sought medical care before the current visit, and what, if any, treatment was administered provides the clinician with a more complete picture of the patient’s current health and future risks (e.g., the development of neurosyphilis years after an initial poorly treated syphilis infection). And it facilitates both the dispensing of advice and screening for recurrence or complications of STIs. For women in particular, an untreated STI or infected partner increases risk for pelvic inflammatory disease and future fertility problems.

Asking patients about how they protect against STIs and, when relevant, pregnancy, completes an assessment of their risks. For patients who report use of methods intended to prevent pregnancy, STIs, or both, this time serves as an opportunity to evaluate the patient’s adherence to safe sex practices and knowledge of appropriate use. Surprisingly, not everyone knows how to use condoms, dental dams, or oral contraceptives properly. Determine whether there are any barriers to the patient’s access to the desired prevention strategy. If a clinician has personal moral or religious objections to supplying condoms, oral contraceptives, and other safe sex supplies, particularly to certain types of patients, it is incumbent on him or her to refer those patients to a colleague or clinic where they may receive the medical care they desire.

## Conclusion

A fundamental principle of sexual history taking, not to mention patient interaction in general, is to approach patients in the manner in which you would wish to *be* approached. Many people become understandably uncomfortable, upset, or offended when asked deeply personal questions by a clinician whom they perceive to be judgmental or disrespectful. Asking questions in an unbiased, compassionate way will not only result in the collection of better and more complete information and lead to more thorough care, but will enhance trust and satisfaction in the patient-physician relationship.

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# Virtual Mentor

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## CLINICAL PEARL

### Counseling Gay and Questioning Minors about Coming Out

Kay Heggestad, MD, and Paul Wertsch, MD

The physician treating a gay or questioning minor whose family is unaware of his or her sexual orientation needs to know how to take a thorough history, conduct a sensitive physical exam, and obtain the needed lab evaluations while maintaining confidentiality. The responsible clinician has good resources on hand to give to the adolescent and can balance communication with parents and his or her primary responsibility to the patient.

#### History-Taking, Physical Exam, and Opening the Dialogue

When the patient confides in the physician about questioning his or her sexuality, particularly if the family does not know, the physician should acknowledge the courage it took to disclose this personal information and communicate to the patient as soon as possible that being gay is normal and OK, that a person is never too young to recognize his or her sexual orientation, and that the physician will accept the patient regardless of sexual orientation or gender identity. History-taking and discussion about the patient's sexual orientation must proceed in a nonjudgmental manner and with the assurance that the doctor will not "out" the patient to anyone, including family members [1].

#### Laboratory Tests and Sexual Health Counseling

Depending on what is found in the history and physical exam, some testing may be indicated, including some or all of the following: serology for hepatitis A, B and C, venereal disease research laboratory test (VDRL), and HIV; throat and cervical cultures for gonococcal (GC) and chlamydial infections; urethral culture for GC, chlamydia, and lympho-granuloma venereum (LGV); and anal culture for GC and human papilloma virus. This is a good time to make sure that the patient is up to date on immunizations, including hepatitis A and B. Although HPV immunization is only recommended for adolescent girls, it should be offered to male patients after they have come out, when the physician can discuss it with their parents [2].

The doctor needs to be frank about the extent of confidentiality. Depending on the clinic, descriptions like "rectal GC culture" may appear on bills. (In some cases, patients can access information about their visits and tests via a clinic Web site—and, if they are minors, so can their parents.) If there are serious symptoms or exam findings (e.g., a high temperature, a syphilitic chancre, a large abscess), the patient's parents will probably need to be told about those findings so they can give permission for the necessary treatments.

If the testing cannot be kept confidential at the doctor's office, another source of testing can be identified. Planned Parenthood offers testing for sexually transmitted infections in all 50 states and in Washington, D.C. [3]. They also offer immunizations for sexually transmitted infections (STIs) and safe sex counseling and supplies. There may be other local clinics that perform these tests and immunizations. (Access to and payment for these services, however, may present a problem. Getting into a free clinic can be difficult, but it should be encouraged if the patient must have privacy from his or her parents.)

All teenagers would be well served by an in-depth discussion about safe sex practices, including abstinence.

### **Coming Out**

*Consider mental health.* As part of the history and exam, it is key that the physician evaluate the adolescent's mental health as well. Coming out can increase the stress, depression, and anxiety of the already turbulent adolescent years, especially if the adolescent feels ostracized, isolated, or rejected by friends or family. If the teen is agitated and there is a concern about suicide, an emergency admission might be in order. A severe but less acute depression might warrant a visit to a psychiatrist or psychologist. If the doctor refers the adolescent to a mental health professional, it must be understood that the object is not to change the patient's orientation, but to help him or her with self-acceptance and coping skills and to supply resources outside the home if he or she feels alienated from, abandoned by, or in conflict with loved ones.

The physician should also make patients aware that GLBT people have a somewhat higher rate of depression and substance abuse, probably related to society's prejudicial attitudes [4]. This knowledge may help motivate the patient to develop appropriate coping skills early on in order to avoid these pitfalls.

*Provide resources and support.* The physician should have community resources and other information, such as booklets or Web sites, about coming out at hand.

- Parents, Families, and Friends of Lesbians and Gays (PFLAG) has an excellent Web site [5] with informative, free, printable booklets for teens and parents. (For teens considering coming out, we recommend "Be Yourself" [6], and for their parents, "Our Daughters and Sons" [7].) Many cities have PFLAG chapters, which can be contacted through the Web site, and the national office can find local contacts for people who live in places that do not.
- Local GLBT centers may also exist where the patient lives. Some of these have teen groups with adult facilitators for kids who are questioning their sexual orientation or gender identity and considering coming out.
- The Trevor Project operates the only accredited, nationwide, round-the-clock crisis and suicide prevention helpline for LBGTQ youth [8].
- Many high schools and some middle schools have gay-straight alliances [9].

- If the patient has gay relatives or supportive adult relatives and older siblings, he or she should be encouraged to seek support from them.

*Bear in mind the patient's safety.* Before any teen comes out to his or her parents, an assessment must be made of whether it is safe to do so. Some parents already suspect their child is gay and welcome the chance to acknowledge the fact. If there is a chance the teen would be thrown out of the home, coming out should probably wait until he or she is financially self-sufficient or has some other reliable long-term source of room and board. And what about discrimination? A 2006 paper published by the National Gay and Lesbian Task Force noted that a disproportionately high number of GLBT kids are homeless, possibly because they were kicked out or just found life intolerable at home after coming out [10]. A physician who knows the patient's family well may be able to guess how they would take the news.

*Protect the patient's confidentiality when communicating with parents.* This brings us to the question of just what the patient's family should be told. The doctor and patient should plan together what they will say, bring parents or other accompanying people into the exam room, and tell them together. The doctor should explain to the parents that to provide the best care and keep open communication with a teen, he or she must respect the teen's need for confidentiality. This will allow the patient to feel free to discuss anything. Parents will need to be reassured that medical conditions are being tested for and treated and that the patient's mental health is being evaluated. If possible, the adolescent should have another appointment in a week or two to follow up about any symptoms or concerns and continue to explore how, and if or when, he or she might come out.

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## HEALTH LAW

### The LGBT Community, Health Policy, and the Law

Ryan Bailey

Equality under the law does not always apply to the LGBT community. Battles over same sex marriage and equal adoption rights continue to be fought. In 2003, the law inched closer to realizing the proverbial equality. Justice Kennedy of the United States Supreme Court, in his famous *Lawrence v. Texas* opinion, extended to homosexuals a fundamental right now held by all citizens—the right to privacy [1]. This opened the door to legal acceptance of rights for LGBT people.

The field of health care is at the forefront of the LGBT battlegrounds. In California, a 1950 law requiring the state to conduct research to find a cure for homosexuality is under review and teetering on the edge of death [2]. On the national stage, President Obama issued a memorandum in April of this year urging hospitals to allow LGBT persons the same visitation rights enjoyed by other patients [3]. In June, the Centers for Medicare and Medicaid followed suit, proposing new regulations that would protect patients' rights to choose their own visitors, including same-sex partners [4].

This article will look at the *Lawrence* decision and the recent legislative and regulatory efforts to extend equality under the law to the LGBT community.

#### **Lawrence—The Facts**

In 1998, officers of the Harris County Police Department were dispatched to a private residence in response to a reported weapons disturbance. Shortly thereafter, they entered into John Geddes Lawrence's Houston apartment, where they observed Lawrence and Tyron Garner engaging in a sexual act. Enforcing what was then a Texas law, the officers arrested the two men. In the complaints, the officers described the crime as deviate sexual intercourse, namely anal sex, with a member of the same sex" [1].

The law in question stated, "A person commits an offense if he engages in deviate sexual intercourse with another individual of the same sex" [1]. The statute defined "deviate sexual intercourse" in part as "any contact between any part of the genitals of one person and the mouth or anus of another person" [1].

The men challenged the conviction at trial, alleging that the applicable statute violated the equal protection clause of the Fourteenth Amendment. The trial court rejected the contention, and the appellate court affirmed the convictions. The men were fined \$200 for their class C misdemeanor. But the minor offense carried with it a stigmatization: at this time in Texas, an adult convicted for private, consensual

homosexual conduct was required to register as a sex offender in at least four states. Lawrence was determined to fight this stigmatization. He and Garner appealed their case to the United States Supreme Court.

### **The Right to Privacy**

Lawrence couched his argument on the equal protection and due process clauses of the Fourteenth Amendment. The prosecution cited the precedent *Bowers v. Hardwick*, a Georgia case in which the Supreme Court upheld a statute criminalizing deviant sexual conduct. This time around, however, a major distinction existed. In *Bowers*, the Georgia statute applied to all deviant sex acts, whereas the Texas statute expressly singled out same-sex activity.

In a 1996 decision, *Romer v. Evans*, the Court had ruled that all class-based legislation directed at homosexuals was invalid [5], so Texas could not have on its books a statute singling out homosexual activity. This ruling allowed Kennedy to strike down the Texas law. Had the Court stopped here, Texas could have rewritten its statute to criminalize any “deviant sexual activity” between any persons, effectively recriminalizing homosexual conduct.

But the Court did not stop there; rather, Kennedy took the major step of overruling *Bowers*. To do this, he carefully analyzed past decisions concerning the Fourteenth Amendment’s due process clause—an area of law known as substantive due process. Prior to *Lawrence*, the Court had expanded the meaning of due process to include certain fundamental rights. In *Griswold v. Connecticut*, the Court invalidated a law criminalizing use of contraceptives by married couples and held that a fundamental right to privacy exists in the marital relationship and family life [6]. In *Eisenstadt v. Baird*, the Court went further and “invalidated a law prohibiting the distribution of contraceptives to unmarried persons” under the right to privacy [7]. The landmark decision legalizing abortions in *Roe v. Wade* was also decided under this right [8]. In *Lawrence*, Kennedy boldly extended the right to privacy to “homosexual persons” through substantive due process.

It suffices for us to acknowledge that adults may choose to enter upon this relationship in the confines of their homes and their own private lives and still retain their dignity as free persons. When sexuality finds overt expression in intimate conduct with another person, the conduct can be but one element in a personal bond that is more enduring. The liberty protected by the Constitution allows homosexual persons the right to make this choice [1].

Kennedy’s emphasis on the private and intimate nature of sex extended due process beyond its traditional scope of protecting family life and marriage under *Griswold* and procreation under *Eisenstadt* and *Roe*. By making consensual sexual activity part of the right to privacy, the Court was able to overrule *Bowers* and make it unlawful to criminalize homosexual conduct, setting a firm foundation for actual equality under the law.

## **Equality and Health Care**

Recently enacted state laws and influential moves by the current Presidential administration have used health-related topics to gain ground for the LGBT community. One such state action is under way in California. In 1950, California passed a law that classified homosexuals as “sexual deviants” and potential child molesters. The law directed the state to conduct research into “the causes and cures of homosexuality” [2]. The law was written after the highly publicized rape and murder of a 6-year-old girl. Although the perpetrator was not a gay man, homosexuality was included in the law’s list of sexual deviations.

In April of this year, a bill to repeal the “cures of homosexuality” clause passed the California Assembly with a vote of 62-0. Assemblymember Bonnie Lowenthal led the charge, stating, “Even [in 1950], there was no legal justification to say that gay people needed to be understood and cured in the exact same way as sexual predators who rape and kill children. For us to leave it there would be wrong” [9]. The bill to repeal the clause will now go to the Senate for review, where it almost certainly will pass. By removing this stigmatization of LGBT persons from its books, California is following the trail blazed by *Lawrence*.

At the federal level, President Obama issued a memorandum in April to the secretary of health and human services suggesting all “hospitals that participate in Medicare or Medicaid respect the rights of patients to designate visitors” by allowing LGBT patients “visitation privileges that are no more restrictive than those that immediate family members enjoy” [3]. Obama further suggested that the HHS “should also provide that participating hospitals may not deny visitation privileges on the basis of ...sexual orientation [or] gender identity” [3]. In June, the Centers for Medicare and Medicaid (CMS) proposed new rules in accordance with Obama’s suggestions. The proposed rules specify that the same visitation privileges of immediate family members should apply to anyone the patient chooses. The proposed rules would update the Conditions of Participation, which are minimum health and safety standards all Medicare and Medicaid participating hospitals and critical care hospitals must meet [4]. Further, the Joint Commission, which accredits and certifies health care facilities, recently announced new patient standards language that prohibits discrimination based on sexual orientation and gender identity [10].

Yet, even in our nation’s capital, some hospitals have not done all they can. A study by the Human Rights Campaign Foundation found that nearly half of 17 D.C.-area hospitals did not include “sexual orientation” or “gender identity” in their patients’ bills of rights or nondiscrimination policies [10]. Tom Sullivan, a co-author of the report, explained that including the explicit nondiscriminatory language in a codified commitment to full inclusiveness and likewise training hospital staff is important. There is evidence that LGBT persons delay seeking care because of perceived discrimination; if so, explicit commitment to inclusiveness on the part of health care organizations may remedy this behavior. The group also reviewed a representative sample of 200 of the largest hospitals in all 50 states and found that 93 percent do not

have fully inclusive nondiscrimination policies for lesbians, gay men, bisexuals, and transgender people [10].

Once the CMS regulations effectuating Obama's memorandum come into play, however, those figures will dramatically change if hospitals want federal Medicare and Medicaid funds.

### **A Minor Setback**

Since *Lawrence*, some courts have strictly construed one 7-word phrase in Kennedy's opinion, "the present case does not involve minors," which has been referred to as "the minor exception" [11]. This phrase has been interpreted to limit the reach of *Lawrence* by excluding consensual sex between minors from the decision's scope, which was most likely not Kennedy's intention. The subsequent sentence speaks of issues regarding consent, giving more support to the argument that Kennedy intended *Lawrence* to reach only consensual homosexual activity while allowing states to criminalize anything nonconsensual [1].

Most courts do not read the *Lawrence* in this restrictive light. Yet, the few that do force the LGBT community to remain dissatisfied. By propelling the ideals in *Lawrence* forward in the field of health care, the California Assembly and the current Presidential administration have stolen ground from under the opposition. Inch by inch, the LGBT community pushes toward the equality promised in the Constitution.

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# Virtual Mentor

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## POLICY FORUM

### **Repealing Don't Ask, Don't Tell—A Step Forward in Patient-Physician Trust**

Frederick Nagel, MD

Now that the U.S. military's "Don't Ask, Don't Tell" policy is set for repeal, a great deal of research has been dedicated to the inclusion of gay, lesbian, and bisexual soldiers in the military, carefully exploring the possible effects on unit cohesion, morale, and security, and the experiences of allied countries, many of which have made transitions to more inclusive policies in recent years [1]. Less discussion has been devoted to the experience of health care professionals functioning under the current system or the changes they may face in a transition to "open service."

#### **Service Restrictions Based on Sexual Orientation**

To understand the implications of such a policy change, it is imperative to examine the current system. While the contributions of gay soldiers have been recorded in our history as far back as the Revolutionary and Civil Wars, the U.S. military first officially prohibited their participation in 1919 [2]. In the 1940s, psychiatry considered homosexuality to be a marker of mental instability or an illness in its own right, and a screening process was developed to filter out recruits with "homosexual proclivities" [2, 3]. In 1982, a Department of Defense Directive explicitly stated that:

Homosexuality is incompatible with military service. The presence in the military environment of persons who engage in homosexual conduct or who, by their statements, demonstrate a propensity to engage in homosexual conduct, seriously impairs the accomplishment of the military mission. The presence of such members adversely affects the ability of the Military Services to maintain discipline, good order, and morale; to foster mutual trust and confidence among servicemembers, to ensure the integrity of the system of rank and command; to facilitate assignment and worldwide deployment of servicemembers who frequently must live and work under close conditions affording minimal privacy; to recruit and retain members of the Military Services; to maintain the public acceptability of military service; and to prevent breaches of security [4].

With the advent of the gay rights movement, the past decades have seen a policy shift in many countries, including our own. In 1993, the policy change that came to be known as "Don't Ask, Don't Tell" (DADT) upheld the legitimacy of the presence of gays in the military and allowed them to serve, as long as they remained closeted. The regulation, actually the Military Personnel Eligibility Act of 1993, prohibited asking prospective inductees or members about their sexual orientation [5]. More recently, President Obama campaigned under the promise to remove any obstacle to

open service of gay and bisexual personnel, and the American Medical Association has recently voiced its support for the effort [6].

While there have always been gay men, lesbians, and bisexual people in the military, they were often victims of abuse and intimidation with little recourse. Traditionally, military policy has been strongly influenced by a number of assumptions about gay people. They were believed to be inherently unstable, it was felt that their presence would cause a crisis of morale and cohesion within the ranks, and they were portrayed as security risks because of their supposed vulnerability to seduction or blackmail [7]—the same arguments that were made against the integration of African Americans and women into the military [8]. Exclusionary policies were relaxed during wartime, when need for recruits was greater, and homosexuals were summarily discharged, or “separated,” in military terms, once they were no longer needed [9]. While DADT was theoretically a gesture of recognition of the legitimacy of the presence of gay men, lesbians, and bisexual people in the military, the threat of expulsion still looms large, and the number of discharges for homosexuality actually *increased* in the wake of DADT [10].

Repeal alone will not necessarily bring full equality either. While social science teaches that contact between two groups—in this case hetero- and homosexual soldiers—can reduce hostilities between them, it is only possible when the groups have equal standing [11]. Studies show that in countries with “open service” militaries, relatively few servicemembers choose to reveal their sexual orientation and prefer instead to serve in a discreet, if not closeted, manner. The same is true for analogous domestic institutions, such as police and fire departments [12-14]. This reluctance to serve openly is indicative of the pervasive heterosexism which—as evidenced by the controversy about the wording and assumptions of the Pentagon’s repeal-related survey of troops [15, 16]—is likely to persist in the American military despite the reversal of DADT.

### **Effects on Military Medicine and its Practitioners**

Discriminatory policies against gay, lesbian, and bisexual servicemembers have long challenged the trust and confidentiality components of the patient-physician relationship. From the early days of psychiatric screening, confessions of homosexual orientation to a physician would be used in separation proceedings to discharge gay soldiers [17]. Given the homosexuality taboo, medical professionals can hardly perform the outreach and screening necessary to protect the health of closeted individuals. Because HIV seropositivity is also a reason for separation from the military, servicemembers who may be at risk receive neither the preventive care they require, nor proper health maintenance. Lesbian, gay, and bisexual soldiers have been known to seek medical attention outside the military community in an effort to maintain privacy [18]. It is logical to suspect that many more forgo medical attention altogether. In the words of one physician, current policy “ensures inadequate health care with a delay in diagnosis, treatment and preventative counseling” [19]. Only within recent months has the military, in the spirit of “fairer handling,” decreed that information given to medical professionals in confidence may not be used for the

purpose of discharge [20]. Implicit in this reversal is the acknowledgment that military policy has up to now infringed on a central tenet of medical professionalism: patient confidentiality.

The medical community has been complicit in this breach of ethics. The fiduciary relationship of physician to patient charges the former with a responsibility to advocate, even when it is uncomfortable or inconvenient, for the best patient health care possible. Upholding a policy that discourages lesbian, gay, and bisexual patients from seeking care due to the threat of loss of employment and social stigma is an affront to the primacy of dedication to the patient's best interest, as outlined in the American Medical Association's "Principles of Medical Ethics" [21] and the "Physician Charter" created by American and European internists' organizations. The charter emphasizes that patient welfare is to be protected despite forces to the contrary, including administrative pressures. Both documents espouse the principle of social justice, enjoining physicians to eliminate discrimination within the health care system, and promote a commitment to patient confidentiality [22]. It is clear that the military medical community has failed gay, lesbian, and bisexual patients in fundamental ways. With the repeal of discriminatory military policy, opportunities arise to redress these wrongs.

Under a full repeal of DADT, military physicians will have to make profound changes in their approach to patients. They must be open to patients coming out to them as gay or lesbian, including closeted individuals with whom they may already have an established relationship. They should not only accept such revelations without judgment, but must invite these confidences, as physicians are meant to do. Some health care workers, however, may be unaccustomed to asking patients about sexual behavior in a manner that is sensitive to different sexual orientations. Medical education, especially in the training of military physicians, must be adapted at all levels to facilitate this transition.

The particular medical concerns facing the members of the military who are gay, lesbian, and bisexual, including those related to sexual and mental health, will certainly need to be addressed. Civilian public health initiatives have struggled to reach individuals who engage in sex with same-sex partners, but are reluctant to identify themselves as gay or bisexual, and this is likely to be especially true in the military [23]. As discussed above, the larger questions of institutional heterosexism and internalized homophobia manifest themselves in particular ways for those servicemembers, and those responsible for their health must be sensitive to pressures faced by their patients.

Gay, lesbian, and bisexual patients will need assurance that their doctors, once executors of a discriminatory policy, are now allies and committed to their particular health care needs; LGBT physicians may take a leading role in this transition. The change in official AMA policy [23]—notably, 20 years after similar declarations by comparable organizations such as the American Psychiatric Association—may be a harbinger of a new era in the medical community, one which finally embraces the

primacy of patient welfare and social justice for all patients.

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# Virtual Mentor

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## POLICY FORUM

### Addressing Gay Men's Health—The Script Needs a Rewrite

Jim Pickett

Since the first cases of a strange, new illness among gay men were reported to the U.S. Centers for Disease Control and Prevention (CDC) in 1981, the parameters and measures of gay men's health have unfortunately been defined by a disease-centered, myopic concentration on the area between the navel and the knee.

As a public health strategy for the control of sexually transmitted diseases such as HIV and syphilis, such a narrow focus has proven ineffective. We have failed to address the mental, physical, and spiritual lives of gay men and their connection to sexual health and wellness. And this failure has had consequences.

With regard to HIV/AIDS, gay men and other men who have sex with men (MSM) have always been the most affected population in the United States and throughout most of the global North. We are just beginning to understand fully the severe disparities in health status between gay men and MSM in the global South and that of other men in their demographic. Internationally, gay men and other MSM are 19 times more likely to be HIV-positive than members of the population at large.

While it is estimated that gay men represent 4 percent of the overall U.S. male population, they account for more than half of all new HIV infections in the country. More than 300,000 gay men and other MSM in the U.S. have died from AIDS since the beginning of the epidemic [1].

These appalling disparities can be explained in a number of ways. First, unprotected anal intercourse is simply a much more efficient means of transmitting and acquiring HIV. It is 10 to 20 times more likely to result in HIV infection than unprotected vaginal intercourse and accounts for the vast majority of HIV infections among gay men.

Next, the funding has not followed the epidemic, according to the CDC's own data [2]. CDC spends approximately \$650 million per year on HIV prevention activities, approximately \$300 million of which goes to state and city health departments that have consistently underfunded services for gay and bisexual men. Between 2005 and 2007, only 29 percent of federal risk-reduction funding managed by state and local health departments supported services for gay men and other MSM. Similarly, state and local health departments directed only 11 percent of the total federal funds earmarked for counseling, testing, and referral (CTR) during the same period to gay and other MSM. Most of the CTR allocation went to the general population, and the

majority of that money was directed to low-risk heterosexuals, according to the CDC. Globally, only 20 percent of gay and other MSM had access to HIV prevention services in 2009 [3].

The lack of resources has been exacerbated by pervasive stigma, structural and societal homophobia and racism, lack of access to health care, homelessness, untreated mental illness and substance abuse, civil rights inequality, and childhood sexual abuse—among other factors—all of which contribute to the HIV burden gay men confront. In the face of all this, gay men have often been characterized as reckless, careless, mentally ill, diseased, and infantile—narcissistic children who can't be trusted and need to be told what to do. While inaccurate, this mindset forms the foundation upon which public health has addressed the lives of gay men—if it addresses them at all. Enter the Gay Men's Health Movement (GMHM).

### **Working on a New Script**

Since the early 1970s, with the formation of volunteer-based STD and community health clinics, gay, bisexual, and transgender (GBT) men and allies have been engaged in creating culturally appropriate health care services for our communities. These early efforts, influenced to a large degree by the women's Our Bodies, Ourselves health movement, have expanded to a nation-wide system of LGBT health care centers in many of our major urban areas. These centers have been at the frontlines of the community's response to the HIV epidemic, providing care and prevention services when no one else would or could. Many of these centers continue to serve valiantly, but also suffer from inadequate financial support. Numerous smaller cities and rural areas are in need of such services.

From the mid-1990s to the present, leaders in the GMHM have organized a number of national and regional conferences and meetings in the U.S. to share information and resources, caucus, brainstorm, visualize, and strategize—all with an eye to developing plans for improving the health of gay male communities. Often these forums have been held in partnership with lesbians, transgender women, public health providers, medical and other clinical providers, scientific and policy communities, community leaders from other sectors, and other activists. Significant outcomes of these efforts include the founding of the National Coalition for LGBT Health, the formation of a working group on LGBT health at the U.S. Department of Health and Human Services (HHS), and the National Gay Men's Health Summits.

Unofficially founded by Eric Rofes (longtime educator and activist), the GMHM has centered on nonhierarchical, grassroots organizing at the biennial National Gay Men's Health Summits, promoting an inclusive, affirming, and asset-based approach to the lives and health of GBT men. The GMHM is informative, empowering, celebratory, multicultural, and relationally focused. Within this paradigm, sexual health is not simply defined as an absence of disease, but encompasses wellness and pleasure, and is inextricably tied to an individual's physical, mental, and spiritual health.

Six foundational principles distinguish the GMHM.

1. Replace the HIV-centric paradigm of health advocacy for gay men with holistic models that integrate (but do not default to) HIV.
2. Exit the crisis paradigm of HIV work, and embrace contemporary understandings, meanings, and implications of HIV for gay men of all colors and classes.
3. Replace deficit-based models for work with gay men with asset-based approaches.
4. Strategically confront political and structural forces that challenge the well-being of gay men.
5. Embrace a “big tent” vision of community, respecting diverse ways of organizing sex and relationships. Shame and guilt are the health hazards, rather than specific sex practices and sex cultures.
6. Launch only efforts that are neither overtly or covertly sanitizing, sanctimonious, fear-based or moralistic.

GMHM core priorities are the support of healing from trauma (e.g., AIDS, homophobia, addiction); grappling with the emotions, pleasures, and wounds from childhood; exploration of the needs for intimacy, connection, and belonging between men and the structures that both promote and prevent that; and tapping into the resilience, creativity, and determination of gay men to take care of each other. Developing an understanding of the psychological significance and values associated with anal intercourse is another key component that is almost universally overlooked elsewhere.

In 2008, movement leaders across the country undertook a year-long process to develop a National Gay Men’s Health Agenda, soliciting input both electronically via the gay men’s health blog LifeLube and through interaction on other web portals. In-person brainstorming occurred at the 2008 National Gay Men’s Health Summit. Dozens of ideas were pared down into eight policy objectives:

1. Fund and expand social, behavioral, and biomedical research.
2. Develop and financially support data collection efforts on sexual orientation and gender identity in all federally funded research.
3. Fund campaigns to combat homophobia, biphobia, and transphobia.
4. Immediately repeal Section 2500 of the federal Public Health Service Act (42 U.S.C. Section 300ee(b), (c), and (d)) that prohibits the “promotion” of any type of sexual behavior—heterosexual or homosexual.
5. Create an office for LGBT health at HHS.
6. Develop and implement a strategy to reduce disparities in health status that affect gay, bisexual, and transgendered (GBT) men through direct programmatic funding.
7. Create and fund sexual health and wellness campaigns directed toward GBT communities, utilizing an array of public and private resources.
8. Develop and implement a strategy to remove barriers to health care among transgender people.

After years of concerted organizing efforts nationally, we are beginning to see the adoption of many of the main tenets of the GMHM—including but not limited to the priorities outlined in the National Gay Men’s Health Agenda—into large, mainstream organizations and governmental institutions.

Released by the Gay Men’s Health Crisis (GMHC) on July 12, 2010, the report *Gay Men and HIV: An Urgent Priority* provides recommendations for addressing the epidemic that go well beyond condom-centered social marketing campaigns and regular HIV testing, care, and treatment. These include promoting comprehensive, accurate sex education for youth in all public schools, Gay-Straight Alliances, and other safe schools programs; fostering family acceptance and community connectedness; acknowledging gay men’s needs for love, relationships, and intimacy; dismantling societal and structural homophobia and racism; and providing readily accessible, culturally competent treatment of substance abuse and mental illness.

The CDC recently began sharing plans for a new sexual health framework to address sexually transmitted diseases, including HIV. A major departure from previous deficit-based, disease-centered models, their new approach positively connects sex and sexuality to physical and mental health, with the goal of increasing healthy, responsible, and respectful sexual behaviors and attitudes.

Institutions such as GMHC and the CDC have powerful influence and a reach that extends around the world. If they advocate and implement guiding principles and objectives that jettison outmoded, fragmented, disease-focused approaches—strategies which have only served to reinforce stigma, foster silence, and diminish access to critical health care services with resulting poor health outcomes—everyone wins. People of all genders and sexual identities will benefit from policies that promote understanding of the social determinants of health and an integration of the individual’s sexual, physical, mental, and spiritual health with that of the family—in all its iterations—and the community.

It would be a stretch for the GMHM to claim total credit for such transformation, but the movement should be recognized for the years of planting and tending the seeds of change that are being reaped in ways that gay men’s health activists only dreamed of a decade ago. While the script rewrites have been accepted, and adopted, the real work begins with implementation. Beyond just learning their lines, the actors will need to walk the talk. And the GMHM and allies will be paying attention, encouraging, cajoling, pushing, and holding feet to the fire to get it done until we have a society in which it is safe to be whoever you are wherever you are, where your health care needs are met with dignity, respect, and integrity, and where sex is not a four-letter word.

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# Virtual Mentor

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## MEDICINE AND SOCIETY

### Proposed DSM-5 Revisions to Sexual and Gender Identity Disorder Criteria

Robert Marvin, MD

Psychiatry is a medical specialty that operates at the junction of the biological, psychological, and social sciences. As such, our definitions of illness and “disorders” reflect our understanding of these overlapping arenas. This is particularly evident in the areas of gender and sexual disorders, in which data are rapidly increasing and psychological and social paradigms are evolving.

The American Psychiatric Association (APA) has embarked on a major revision of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM). The most extensive revision in almost 20 years, DSM-5 has a projected publication date of 2013 [1]. As part of this process, APA has convened 13 work groups to propose revisions to the current diagnostic criteria. The Work Group on Sexual and Gender Identity Disorders (WGSGID) has announced the proposed revisions to the DSM-IV-TR diagnoses of gender identity disorder and paraphilias [2]. These changes reflect an extensive review of the current research, expert consensus from clinicians working in the field, and input from the community.

#### Revisions: Gender Identity Disorder

Under the proposed revision, what is currently called gender identity disorder (GID) in the DSM-IV-TR will be renamed “gender incongruence” in DSM-5. For adults and adolescents, the proposed criteria are:

a marked incongruence between one’s experienced/expressed gender and assigned gender, of at least 6 months duration, as manifested by 2 or more of the following indicators:

1. a marked incongruence between one’s experienced/expressed gender and primary and/or secondary sex characteristics (or, in young adolescents, the anticipated secondary sex characteristics)
2. a strong desire to be rid of one’s primary and/or secondary sex characteristics because of a marked incongruence with one’s experienced/expressed gender (or, in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics)
3. a strong desire for the primary and/or secondary sex characteristics of the other gender
4. a strong desire to be of the other gender (or some alternative gender different from one’s assigned gender)

5. a strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender)
6. a strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender) [3].

The two major changes to the criteria are: (1) framing of the disorder in terms of the incongruence between experienced gender and assigned gender, instead of a “cross-gender” identification and (2) the removal of distress or impairment as a requirement for diagnosis. These changes refine the criteria to be more reflective of the current clinical presentation of people with GID [4]. The criteria for gender incongruence in children are similarly revised, removing the distress or impairment criterion [5, 6].

### **Revisions: Paraphilias**

The paraphilias comprise a broad range of atypical sexual behaviors that include exhibitionism, fetishism, frotteurism, pedophilia, sexual masochism, sexual sadism, transvestic fetishism, voyeurism, and “paraphilia not otherwise specified.” The proposed changes to these criteria for the DSM-5 better reflect the range of presentations and degree of distress or disability found in this population [2]. For example, what is now called exhibitionism would be changed to “exhibitionistic disorder”:

- A. Over a period of at least six months, recurrent and intense sexual fantasies, sexual urges, or sexual behaviors involving the exposure of one's genitals to an unsuspecting stranger.
- B. The person is distressed or impaired by these attractions, or has sought sexual stimulation from exposing the genitals to three or more unsuspecting strangers on separate occasions [7].

In these revised criteria, the paraphilia is defined in criterion A. To meet the definition of a “disorder,” an individual would also have to meet criterion B, which includes both a distress component and an action component with specific numbers of incidents. This separation represents a major shift in the DSM, reflecting the current understanding of clinical presentations of these disorders and an attempt to measure the extent of the disorder by quantifying paraphilic behaviors. The proposed revisions for all the paraphilias are presented at the APA website and discussed in detail by several authors [2, 8-14].

### **Should These Still be Considered Disorders?**

Currently, the DSM-IV-TR defines a mental disorder as “a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or with a significant increased risk of suffering death, pain, disability, or an important loss of freedom” [15]. The challenge presented with gender identity and sexual behaviors is that we lack a clear definition of “normal,” from either a biological or psychological

standpoint. This generates a moving target for pathology, which is therefore in need of ongoing review and discussion.

With regard to gender identity disorder, a parallel to homosexuality has been used to argue for the elimination of this disorder from the DSM. Homosexuality was removed over the course of revisions to the DSM in the 1970s and '80s due to pressure from both inside and outside the APA. This reflected the growing research data that depathologized homosexuality and the development of a greater social consciousness within the organization. For further background, see Drescher's comprehensive review of this parallel [16].

Similar arguments are being made for removing GID, namely that continued labeling of expressions of gender as pathological is discriminatory and perpetuates stigma, causing harm to transgender individuals [17]. There is growing evidence that the increased incidence of psychiatric problems in transsexual individuals is related to stigma and that many individuals have nonclinical levels of distress or impairment [18]. There is also concern over the lack of data to support the attribution of an "inherent distress" to gender incongruence [19]. A recent survey of organizations concerned with the welfare of transgender people found that a majority, 55.8 percent, believed that the diagnosis should be removed but that, if it were to be retained, the name and language should be revised to minimize stigma by better reflecting the experience of transgender people. [20].

One important argument in favor of keeping a gender identity disorder in the DSM is the concern that its removal would lead to denial of medical care for transgender individuals, hamper their ability to pursue discrimination claims, and deprive people, including children, with GID of the counseling and medical treatments demonstrated to be beneficial, which will likely continue to require a psychiatric assessment for justification [19].

There is less controversy about keeping the paraphilias in the DSM because, unlike GID, they can manifest with behaviors that harm the self or others—one major area in which the domain of the psychological overlaps the arena of the legal. The revised criteria distinguish between those whose actions towards others are invasive or harmful—those who would receive the diagnosis—from those who merely have atypical sexual fantasies, thoughts, and private or consensual behaviors, who formerly met the criteria for a disorder but now would not. The more precisely quantified behavioral criteria will also assist those working in forensics [8, 12-14].

So where does that leave us? These proposed revisions seek a balance between our growing understanding of these disorders and the changing societal and personal views of behavior, while attempting to meet the need to define conditions that benefit from intervention. Do they go far enough? I would argue yes. The paraphilias are likely to remain based on their association to legal consequences. With regard to GID, we are not ready for a complete removal of the diagnosis. Physicians and surgeons are likely to be uncomfortable prescribing treatments without confirmation

of the diagnosis from a psychiatrist or psychologist. I am hopeful that ongoing social, political, and insurance reform will one day allow for its removal. The APA's goal of making the DSM-5 a "living document," responsive to ongoing scientific discovery, will likely encourage such an adoption [21].

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#### **Related in VM**

[Suppression of Puberty in Transgender Children](#), August 2010

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# Virtual Mentor

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## MEDICAL NARRATIVE

### In the Closet—A Close Read of the Metaphor

Hannah L. Kushnick

One persistent issue in gay life in general, and in the medical treatment of LGBTQ patients more particularly, is that widespread intolerance leads people to conceal their sexual behaviors or identities, leading to incompleteness or inaccuracy in their histories and impairing the ability of their physicians to treat them. In English, a person concealing his or her sexual identity is said to be “in the closet.” This phrase can tell us quite a bit about the experience it describes. Let’s go through it backwards, word by word.

#### Why the “Closet?”

The etymology book *The Insect That Stole Butter?* provides the following definition for “closet:”

**closet** Although closet is now the usual word in American English for a cupboard or wardrobe, it originally referred to a small private room, such as one for study or prayer. This idea of privacy led to the sense of hiding a fact or keeping something secret, which goes right back to the beginning of the 17th century. A person who is hiding the fact that they [sic] are gay has been described as **in the closet**, or as a closet homosexual, since the late 1960s. To **out** someone, meaning to reveal that they [sic] are gay, is a shortened way of saying “to force them out of the closet”. Closet comes from **close**, which both in the sense “near” and “shut” goes back to Latin *claudere* “to shut,” also the source of **recluse**, someone who shuts themselves [sic] away [1].

The closet is an extremely evocative metaphorical location. As the above definition emphasizes, its meaning derives from the idea of privacy. A closet is a space of domestic concealment, the idea of which conjures up anything from shoving kids’ toys behind the door before a dinner party (the separation of private self from public presentation) to the wife locked in the attic in *Jane Eyre* (the concealment of shameful depravity, both to preserve reputation and protect the house’s other inhabitants) to the sheltering of persecuted Catholic priests during the reign of Elizabeth I (protection from persecution).

As to the purpose of the closet, we can look to the “near” and “shut” meanings mentioned above. The location of a closet is near at hand—things are stored there in the short term, implying in some way that the natural progression is for things in the closet to come out and be used. Furthermore, its location in the home not only hints that its contents reflect on the identity of the home’s possessor, but—more

immediately—bespeaks the unreliable, dangerous nature of such a concealment: as we sense from the related idiom “skeletons in the closet,” you can’t rely on things in the closet to remain unexplored by others or not to reveal their own existence.

The closet also has less legitimacy than a room. It’s a decidedly nonsocial space (whether you think of the initial tiny private study or the modern storage nook); it enforces isolation. (Except, of course, for the cliché of the janitorial-closet tryst, which is itself another example of sexual behavior concealed out of shame or a desire for privacy.) Though things may inevitably find their way out of the closet, while they’re in it, they’re barred from full participation in what’s going on outside.

All this paints a picture of what it’s like to conceal one’s sexual identity: difficult, unnatural, dark, precarious, isolating, and probably doomed to failure. But it’s also safer than the outside—enclosed and controllable, the closet protects its contents from exposure and harm.

### **“In” the Closet: A Space, A Group, An Experience**

*Metaphors We Live By* offers three examples of the way the word “in” is commonly used in English:

Harry is in the kitchen.

Harry is in the Elks.

Harry is in love.

The sentences refer to three different domains of experience: spatial, social, and emotional [2].

In other words, “in” is used (1) literally, to talk about Harry’s location (and locations, as the authors point out, also form the basis of a great number of English-language metaphors for social status, such as “he’s in the doghouse”) and (2) metaphorically, to describe *what* he is or belongs to (his nature or category) and his state of mind.

Being closeted is all of those things—a strategy for living, a status, a self-designation, and an experience. To *be inside something* is to have it surround you, to dictate the terms of your experience and actions. When we say someone is closeted, this is very much what we mean—he or she is locked away in, concealed in, hiding in, and to some degree, defined by that state of being. This is the opposite of being *out*, of being *openly* gay.

In contrast, the related phrase “on the down low” (describing men who have sex with men while maintaining purportedly monogamous relationships with women) evokes intentional stealth. In English language, “on” refers to the condition of being above something or in a superior position to it, which connotes having a degree of control over the thing (e.g., “I’m on it,” “she’s on my case”). This obviously differs from being “in the closet,” which connotes denial (in the senses of “negate,” “refuse to allow,” and “repress one’s own knowledge of,” in addition to “hide”) more than deception (allow but conceal). “In the closet,” moreover, doesn’t specifically indicate anything about what, if any, sexual activity someone engages in. Both, however, involve the concealment of something significant.

### **What's Behind the Door?**

As to the extent of what is denied by being closeted, we need only turn to the pronouns that accompany this phrase. We say not “her sex life is in the closet,” but “he is in the closet,” just as we would say “he is Muslim, I’m Japanese, we’re Republicans, she’s a salesperson, they’re golfers, I’m a woman”—all of which show how fundamental we consider sexual orientation to be to identity, especially as the myth that sexual orientation is a choice loses credibility. This illuminates some of what is so painful about being in the closet: it feels like—it is—a denial of the self. (The degree to which this is true sheds some light on why egodystonic sexuality—sexuality which doesn’t fit one’s ideal self-image—causes such distress.)

### **Out of the Closet and Off the Bench**

So how can physicians help people get from “in the closet” to out in the world? Asking “Do you have sex with men, women, or both?” instead of “Are you gay, straight, or bisexual?” indicates that the physician is informed and nonjudgmental. This may be a case where being “half in the closet” is actually possible—not only is confidentiality key, but, as some of this issue’s [other contributors](#) discuss in more detail, so is giving patients space to discuss sexual activity without forcing possibly uncomfortable labels on them.

Outside the office, of course, people may still hide or punish themselves for their orientations; they are likely to continue to be subject to hostility and discrimination; and they may delay or deny fulfilling sexual and romantic relationships. But in the patient-physician relationship, there is no reason why gay patients should not get the full participation, recognition, and acceptance—the full measure of existence outside the closet—they are entitled to.

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### **Related in VM**

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# Virtual Mentor

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Jim Pickett is director of advocacy for the AIDS Foundation of Chicago. He has worked in the gay community for nearly 20 years, the last 11 of which have been in public health. His current domestic and international portfolio consists of gay men's health, advocacy for the development of new tools to prevent the sexual transmission of HIV, and pushing for sound, sane legislation, in addition to adequate resources, for people living with and at risk for HIV.

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