

THE PHYSICIAN'S APPROACH TO THE PATIENT WITH SAME SEX ATTRACTION

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As a physician, I know that certain questions I ask patients are bound to elicit a false response. I no longer ask a woman how much she weighs or a drinker how much he drinks. The answers I'd get would lead me to believe that no one in my practice is overweight and that all my patients were teetotalers.

I must admit that I lie about those things too. When I used to smoke, I don't think I ever gave an accurate account of the number of cigarettes I smoked in a day.

Patients are evasive about a lot of things, but over time, the doctor-patient relationship allows a patient to open up and to confide in his doctor in ways that are unique to that relationship. In order to promote patient confidence in the physician and to ensure comfort in the doctor's office, the doctor should listen carefully to the patient's concerns and address those concerns in a way that will benefit the patient. It is easy for a doctor to tell a patient what he thinks the patient wants to hear, but that can be harmful to the doctor-patient relationship and to the patient.

In sexual matters it is often difficult to be honest and open, especially in politically correct times when there can be as much fear of affronting the zeitgeist as there is of harming an individual. In my practice, people often ask about sex. Sometimes they feel they have to after seeing one television commercial after another telling them "go on, what are you waiting for?". When asked about such topics I used to worry that too precise an answer might offend someone or impose upon their sensibility. That was foolish. If a patient had a strong ideological opinion about something he wouldn't be asking me for advice in the first place. A patient is not asking me for my own opinion or how the editorial page of the city paper weighs in on the subject. He specifically wants some information and advice that can benefit him.

Questions about homosexuality are among the most sensitive issues that are addressed between doctor and patient. The physician, no matter what his own sexual identity may be or what his opinions about homosexuality are, should be provident and understanding when he speaks to a patient with same sex attraction. The physician needs foremost to be honest. How he informs and educates his patient should be determined by what is best for the patient, and not by polite opinion or political consensus.

Good medical practice should reflect the cardinal virtues of faith, hope and charity. Both the doctor and the patient exhibit these qualities. The patient believes that the doctor will do the right thing for him. He hopes that whatever that right thing is, it will restore him to health. In an act that comes as much from a sense of love as it does from a sense of trust, the patient acknowledges that his well-being is in the doctor's hands as much as it is in his own. The patient is, in effect, telling the doctor that he is handing his life over to him. The physician, in turn, has faith in the patient as a fellow human being who has the capacity and the will to heal. He hopes that his efforts, as well as those of the patient, will be to the patient's benefit. The physician's love is reflected in his willingness to safeguard the patient's life, and to do everything he can to comfort and to heal him. It can be difficult for a physician to love or even to like all of his patients all of the time, but it is essential to respect them, and to love them as fellow human beings. Honesty is an important

part of that respect and love. The physician has a responsibility to be honest with the patient, to inform him of the state of his health, and tell him what needs to be done to maintain or to improve that state.

By law, a physician must provide a patient with informed consent whenever the physician treats the patient. An informed consent explains what the risks and benefits of a given treatment are, and whether or not there are alternatives to that treatment. If I develop back pain and the doctor diagnoses a herniated disc in my spine, he may decide that the most effective treatment for the condition is a surgical procedure that would remove the herniated disc. Before I agree to the surgery the doctor would explain: 1) what the surgery entails and how he feels it would benefit me, 2) what the risks of the procedure would be; these might include the possibilities of infection, excessive bleeding, a reaction to the anesthetic, possibly even death, and 3) alternatives to the operation such as bed rest or physical therapy. The physician is obligated to help me weigh the risks and the benefits of the surgery, and to assist me in deciding if the benefits sufficiently outweigh the risks for me to confidently proceed with his recommendation.

In the above example, I have discussed an elective form of surgery. Back pain is usually not an emergency in the way a heart attack or a diabetic coma or acute appendicitis are. In those situations, informed consent is also required for medical treatment to begin, but the discussions of the risks, benefits, and alternatives of treatment are necessarily abbreviated. However, whenever a physician agrees to take care of a patient informed consent is a necessary first step in the treatment process.

Should the principles practiced in obtaining informed consent play a part when a physician finds himself discussing life style choices and sexual practices with his patient? If a patient informs his physician that he is a sexually active homosexual or that he is sexually attracted to members of the same sex although he has not acted on those attractions, how should the physician proceed? Giving the patient fact-based information while maintaining understanding and prudence requires a delicate balanced and may not be accomplished with one short office visit. As with any treatment, or any kind of counseling, monitoring and follow-up are necessary.

Idealism is part of the human condition. My ideal is to perfect the way I practice medicine. I fall short of that ideal because my human failings often get in the way of that quest for perfection. Those defects don't tarnish the ideal; they help me understand it better. I improve when I learn from my mistakes, and I grow when I understand both my strengths and my limitations. The imperfections, as well as the ideal, helps me to keep pride, the worst of all my failings, in constant check.

When we lose sight of our true ideals, we tend to make up false ones, or to accept the false ideals that others have placed before us. Bad ideals often come wrapped in gold, but when the wrapping comes off, we're left with an empty box. Proponents of false ideals need to ensure that the box is never unwrapped. As long as they keep our focus on the surface, the package will not lose its sparkle.

The homosexual life style has attained a kind of gold plated idealism in society today. It enjoys chartered status in the tonier sections of cosmopolitan areas, inside the art house division of the entertainment industry, and on many university campuses, but it's also gaining ground in rural areas, on prime time television, and in public high schools and elementary schools. I don't think this is just a pop phenomenon in which there is a bourgeois need to identify with whoever comprises the outsider class of the moment. Gay chic has a staying power that ghetto chic, antiwar chic, and

radical chic did not. Homosexuality has taken on an everyday and everywhere aura. Columnist Pat Buchanan updated Oscar Wilde's 19th Century description of homosexuality with the quip: "the love that dare not speak its name has become the love that won't shut up". There is a laissez-faire attitude toward homosexuality, a live and let live attitude, that may be naïve, but it's also rooted in compassion for the plight of someone who suffers rejection of any kind. Compassion, like idealism, is part of the human condition, but in this case, compassion is the gold wrapper that keeps us from looking objectively at the contents of the box.

Compassion is defined as a feeling and as a desire. A compassionate person feels sympathy for another's distress and has a desire to relieve that distress. Compassion breeds cynicism when sympathy is devoid of a desire to take initiative. Someone must act in order to relieve someone else's distress. The physician understands this; however, a physician's compassionate ACT can sometimes butt heads with a world view that consists mostly of compassionate FEELING. The "feeling" world view that has no real stake in the game is always ready to attack those who move in compassionate ways. Those attacks are at the ready for anyone who approaches the subject of homosexuality in a truly compassionate way.

The Catholic Church, the Salvation Army, the U.S. military, the Boy Scouts of America, supporters of Proposition 8 in California, beauty contestants who speak in favor of traditional marriage, and many others have taken a stand that can be considered a well-reasoned and even compassionate one have been attacked by others who themselves claim the mantle of compassion for themselves.

What role does the physician play in the debate about what is and what is not a compassionate approach to homosexuality? Is a patient's sexual orientation something a physician should consider in his assessment of his patient's health? Does a physician have a role in counseling a patient about a homosexual life style choice? Does the physician have a responsibility to discuss with the patient the risks, benefits, and alternatives of living such a life style?

Marital status, marital contentment, sexual activity, fertility, family planning and many other issues related to sexuality are factors that need to be known in order to determine a patient's well-being. If a young woman confides to her doctor that she has more than one sexual partner, the doctor has a duty to inform her of the risk of sexually transmitted diseases and of the risk of cervical cancer. Should a woman request oral contraception the physician needs to explain that in addition to preventing pregnancy, the pill also has side effects that may include blood clots and, on occasion, strokes. Heterosexual men need to be aware that being sexually active carries the risk of sexually transmitted diseases that include herpes, gonorrhea, syphilis, venereal warts, hepatitis, and tinea pubis. Though not as life threatening as Human Immunodeficiency Virus (HIV), the effects of these infections can be painful, long lasting and sometimes permanent.

The Food and Drug Administration, the Environmental Protection Agency, the National Institute of Health, and the Occupational Health and Safety Administration work to protect U.S. citizens from the consequences of risks that exist in our everyday lives. These agencies have no reservations about warning us about the risk of asbestos in pipes or arsenic in drinking water or trans-fats in French-fries. There nonetheless do seem to be quite a few reservations about communicating the risk of certain lifestyles and sexual practices.

Lifestyle and practice are not necessarily synonymous. Heterosexuals can be promiscuous, but not to the degree that

male homosexuals are. Anonymous sex is unlikely to occur among heterosexuals, but is familiar to most homosexuals, especially those who “cruise” to find sexual partners. Staples of gay culture such as bath houses, back rooms, and parking lot, public lavatory, and gym locker room sex are non-existent in the heterosexual community. The percentage of gay men who pursue such activities is unknown, but whatever the actual percentage is, it is probably not small. And the risk involved in engaging in those activities is likewise not small.

Since HIV became known in the 1980s the public has been told that it is both a heterosexual and a homosexual disease, that the virus does not discriminate. Evidence compiled over the last 25 years has revealed that the HIV virus may, in fact, be guilty of discrimination. The disease is relatively rare in non-intravenous drug using women and almost nonexistent in non-intravenous drug using heterosexual men. The HIV virus is almost always blood born, and most infections result from the exchange of blood and semen during anal intercourse. Heterosexuals occasionally engage in anal intercourse, but the practice is much more common among homosexuals. The majority of HIV related illnesses, and HIV related deaths, have always been and continue to remain highest in homosexual men.

The public is often told that the best means of preventing the transmission of HIV is condom use. Activist groups, community organizations, government agencies, and even schools are getting into the act of promoting condoms. A lot has been invested in the effort, but no hard evidence exists that condom use has resulted in lowering HIV infection rates.

I remember vividly a TV news segment I saw a few years ago in which an obviously intelligent and well informed young man was speaking about his positive HIV status. When asked about how he contracted HIV, he responded: “Mine was a case of a broken condom”. This man was someone who paid attention to the suggestions of the pro-condom experts, and did what, according to them, he was supposed to do in order to protect himself against the disease. I don’t know what the statistics are for how likely a condom is to break, but the chance of infection for that young man was not 0.5% or 10% or 50%. It was 100%. Young people who are constantly told that “if you are going to have sex, use a condom” need to know that a condom does not ensure complete protection against disease. Physicians know from experience that no medical device or treatment ensures an expected outcome 100% of the time.

Condom use implies that sexual contact is a planned activity, something like playing bridge or going to a picnic. Even teenagers know that it doesn’t always work that way; in fact, it almost never does. It’s hard to know how often sexually active individuals actually use condoms. Asking a patient such a question is likely to get the kind of response I spoke of earlier when asking about weight, alcohol, smoking, or any number of things that we aren’t completely truthful about because we know how we should behave can contrast a little and oftentimes a lot from how we actually do behave. Oftentimes, teenagers, and even adults, explain a sexual experience as something that “I didn’t see coming”, “it caught me off guard”, and “it just happened”. Where does the thought, time and effort needed to put a condom on fit into such a mindset?

A recent National Institute of Health study headed by psychiatrist Jay Giedd found that the part of the human brain that restrains risky behavior is not fully developed in teenagers; in fact, it is not fully developed until age 25. The media, the medical community, and the insurance industry seized on this data to highlight the fact that teenagers tend to drive cars in a more reckless fashion than adults do. Who would have guessed? Teenagers are four times more likely to be involved in car accidents and three times more likely to die in them than adults according to the Insurance Institute for Highway Safety. I understand the connection the study makes between brain development and teenage driving risk. I

am, however, puzzled that no one has come forward to suggest a connection between teenage brain development and teenage sexuality. Could it be that such a connection would put a dent in the “if you’re going to have sex, use a condom” doctrine. Is it logical that a teenager, or even a 22 year old, who drives eighty miles an hour while talking on his cell phone after drinking a few beers will nonetheless fully comprehend the risk of unprotected sex should the opportunity arise?

We are constantly told that sex is a part of everyday life, even teenage and young adult life. We know that there are risks to premarital sex, and that those risks are both physical and emotional. Young patients instinctively understand those risks, and seek guidance when they try to assess them. They often look to their physician for guidance. Informing a patient that abstinence from sex outside of marriage is the best protection against disease and emotional harm is not preaching or proselytizing. Nor is it pie in the sky wishful thinking. I would argue that it is good medicine. The starting point of discussing the risks, benefits and alternatives of sex before marriage or of a homosexual life style should be the fact that refraining from sexual activity offers the most complete protection against disease and emotional harm than any of the other modalities that would be considered and discussed.

Societal institutions, and especially the public schools, have not adequately informed the public, especially the young public, about the risks of certain lifestyle choices as well as certain sexual practices. The medical community has a responsibility to inform the public as well, and a physician in a practice setting has a good opportunity to provide such information. There are standards of care that serve as guidelines to how a physician should practice medicine in a community, but a physician is not bound by the same institutional and bureaucratic methodology that teachers and social service employees are bound by. Despite changes in medical practice, the public still has an idealized view of physicians. Individual patients in particular tend to hold their own personal physician or primary care doctor in high esteem. They trust their doctor and believe what their doctor tells them. I am not suggesting that such a relationship gives the physician the right to cajole or convert or threaten or scare. He should, however, inform.

A young patient may have questions about homosexuality that are not answered truthfully by the school system, the media, or even the family. The physician can help the patient process information that is often conflicting. Many publications, even school textbooks, publish the statistic that ten percent of the population is homosexual. This comes from a study that was done in the 1940s by sex researcher, Alfred Kinsey, a study whose findings have not been replicated, and one that most experts today admit is exaggerated. Yet that ten per cent number continues to be thrown about as if it were settled dogma. Some gay organizations have even adopted the name “Ten” as a way of identifying themselves. If I were to ask a teenager with same sex attractions to tell me how many other homosexuals there are in his class at school he would have trouble naming 2 or 3 in a class of 25. A small sample, granted, but no matter how much we extend it, I believe that youngster would have a hard time coming up with 10 %. Most gay teens tell a story of isolation and detachment, feeling as though there is no one to relate to, “no one like me” in the whole school. On its face, the teen can see that the 10 % statistic is false. If it wasn’t, he wouldn’t feel so alone. A physician can explain how statistics in medicine work. This can be done in a straightforward way, the same way we might explain to an adult how statistics have shown that drinking red wine may reduce the risk of heart disease. It is important to let the patient know that statistics give us an impression, but not always a truth, and by nature, statistics and the conclusions we draw from them can, and usually do, change.

The other dubious claim we constantly hear is that homosexuality is genetically determined. There is no scientific proof that heredity plays a role in determining sexual orientation. As with percentages in the population, we can deduce this concept from what we see around us every day. There are many environmental factors, including family

dynamics, sexual experimentation at an early age, and peer reinforcement, that certainly come into play in determining sexual preference. The argument for genetic determination is used to strengthen the claim that homosexuality is an immutable condition. Recent studies have shown that this is not the case. Dr. Robert L. Spitzer, a psychiatrist who was instrumental in having homosexuality removed from the catalogue of mental disorders in the 1970s published a study in 2003 that showed that homosexual men and women were able to change their sexual orientation from homosexuality to heterosexuality. Those patients remained heterosexual for the 5 years they were followed after the initial study was concluded. The physician should inform his patient that the American Psychiatric Association does not consider homosexuality an abnormal condition; however, a number of homosexuals do seek, and are capable, of changing their orientation if they so desire. Another way to refute the genetic argument is just by reading gossip pages in newspapers and watching celebrities on television. There are countless stories of celebrities who go from homosexual to heterosexual relationships, and sometimes back again. Evidently in the entertainment industry, change is possible, and like so many things in that world, it can happen overnight. Even in Hollywood, where the only reality seems to be that nothing is in fact real, a bit of truth can once in a while peak through.

In addition to the physical dangers that a patient may face in choosing a homosexual life style, there are emotional risks that need to be considered as well. A doctor can tell his patient that there are a number of experts, most of them I would venture to say, who claim that the healthiest approach to a same sex attraction would be to accept that attraction and to try to live a happy life as a homosexual. Those same experts would say that attempting to change one's sexual orientation would be burdensome, traumatic, and ultimately harmful. The patient's doctor should explain the opposite view, as well, the one that believes that homosexuality often causes loneliness, unhappiness and despair. Gay culture idolizes youth and beauty, but not everyone is young or beautiful. Many gay men have said they feel more isolated in the gay world than they ever did in the straight world. Sexual addiction rehab centers and sexual compulsive anonymous meetings usually have as many homosexuals present as they have heterosexuals even though the latter far outnumber the former outside the meeting halls.

A number of organizations help the homosexual who wants to change his or her sexual orientation. Others assist homosexuals who want to live lives that are compatible with the teachings of their religion. Catholicism does not condemn homosexuality, but teaches that homosexual acts are disordered and that gay marriage is inherently evil. Islam, although it has been spared the religion critics' wrath in a way that Christianity has not been, emphatically condemns homosexuality and calls for harsh punishments for those who engage in the practice. Judaism and the Protestant Churches take a more liberal and secularized view. In the Protestant Churches, the issue of homosexuality has been the cause of conflict and division in recent years. Outreach to the gay community by these Churches has not helped eased those conflicts.

A Catholic organization known as Courage helps men and women with same sex attraction to live in accordance with the teachings of their religion. An organization called NARTH (National Association of Research and Therapy of Homosexuality) is an organization of psychiatrists and psychotherapists who assist individuals who deal with unwanted homosexual attractions.

If patients receive information about gay community centers, gay outreach programs, and gay health crisis centers, they should also have information about organizations that provide alternatives to the gay life style. Physicians have a responsibility to instruct and to guide their patients in these sensitive but vital matters. Not to do so increases the risk of doing harm to the patient, and it widens the gulf between a physician's role in the community and the physician's ideal of doing what is truly in the best interest of every patient.