



THE NEWSLETTER OF COLLEGIUM AESCULAPIUM

A special edition to inform and connect the LDS Medical Professional Community

July 2009

3 Year Conference/Event Plan:

2009 Fall—Southern Utah, “Broadway in the Desert”

2010 Spring—Salt Lake City

2010 Tour—Israel late April to early May

2010 Fall—Nauvoo or Independence

2011 Spring—Salt Lake City

2011 Fall—Laie, Hawaii

2012 Spring—Salt Lake City

2012 Fall—Nauvoo or Independence

More conference news on page 8

Editorial

Zicam[®] and Loss of Smell

by Bruce W. Jafek, MD, FACS
Philippines AMA

On June 16, 2009, the Food and Drug Administration (FDA) warned consumers to stop using and discard three zinc-containing Zicam[®] intranasal products. The products may cause a loss of sense of smell. The news was reported nationally. The FDA's action affected Zicam[®]'s three intranasal products that contain zinc: Zicam[®] Cold Remedy Nasal Gel, Zicam[®] Cold Remedy Swabs, and Zicam[®] Cold



Remedy Swabs, Kids Size. The three Zicam[®] products claim to reduce the duration of the common cold and the severity of cold symptoms. The FDA noted that they “are not aware of any data establishing that the Zicam[®] Cold Remedy intranasal products are generally recognized as safe and effective for the uses identified in their labeling.”

The rest of the story (paraphrasing the Paul Harvey approach): The company and FDA first became aware of complaints of loss of smell in 1999. We first saw cases of loss of smell due to the intranasal use of zinc in 2002. Collecting and analyzing additional cases, we reported our findings to the scientific community in September, 2003, at the national meeting of the American Rhinological Society and they were published.(1)

A brief summary follows:

Zinc is an essential mineral. Beneficial zinc absorption takes place via enteral, parenteral, or cutaneous routes. However, direct application to the olfactory epithelium has been reported to cause loss of smell. Recently, intranasal zinc gluconate has been recommended as a treatment for the common cold. Severe posttreatment hyposmia and anosmia have been observed. **METHODS:** The case report of a typical patient is presented and analyzed in detail, followed by a series of patients with severe hyposmia or anosmia after the use of intranasal zinc gluconate. **RESULTS:** Although interindividual variation in drug response and drug effect is apparent, the severe hyposmia or anosmia appears to be long lasting or permanent in some cases. The mechanism of olfactory loss is thought to be the direct action of the divalent zinc ion on the olfactory receptor cell.

CONCLUSIONS: Zinc ions are toxic to olfactory epithelium. Reports of severe hyposmia with parosmia or anosmia have occurred after intranasal use of zinc gluconate.

We made additional presentations to the national meetings of the AAO-HNS and Triological Society.(2,3) Others published series as well.(4)

The actual history of zinc toxicity to olfactory epithelium is fascinating as it was first used in the 1930's to try

to control polio.(5) While it was found to be ineffective, prolonged loss of smell was discovered, leading to an article in the 1937 JAMA, recommending against the use of intranasal zinc for this reason.(6)

As George Santayana noted, however, “Those who cannot remember the past are condemned to repeat it.”(7)

The company was given 15 days to institute corrective action for the violations. The zinc-containing Zicam[®] products were withdrawn for the market on June 16, 2009, the last of 10 intranasal zinc products to be withdrawn from the market.(6)

Notes

- 1 Jafek BW, Linschoten MR, Murrow BW: Anosmia after intranasal zinc gluconate use. *Am J Rhino* 18:137-141,2004.
- 2 Jafek BW, Linschoten MR, Murrow BW, et al: The Mechanism of Loss of Smell Associated With Intranasal Zinc Gluconate. Poster Presentation to Middle/Western Combined Section Meeting of Triological Society, San Diego, February, 2006.
- 3 Jafek BW, Linschoten MR, Murrow BW: Experiments on the Cause of Zinc-Induced Loss of Smell. Poster Presentation to AAO-HNS Annual Meeting, Toronto, September, 2006.
- 4 Alexander TH, Davidson TM: Intranasal zinc and anosmia: the zinc-induced anosmia syndrome. *Laryngoscope* 116:217-220, 2006.
- 5 <http://george-eby-research.com/anosmia/anosmia.html>
- 6 Schultz EW, and Gebhardt LP. Zinc sulfate prophylaxis in poliomyelitis. *JAMA* 108:2182-2184, 1937.
- 7 “Notable Quotations from George Santayana” *Life of Reason, Reason in Common Sense*, Scribner's, 1905, page 284.

Homosexuality: WHAT SCIENCE CAN AND CANNOT SAY

From the Collegium Aesculapium Conference, April 3, 2009

by A. Dean Byrd, Ph.D., MBA, MPH

Introduction

Homosexuality is a controversial topic, particularly in light of Proposition 8 and the aftermath. There were good, well-meaning people on both sides of this issue as well as not-so-good and not-so-well-meaning people. There has also been such a politicalization of the issues that it is hard to separate fact from fiction. There is some unrest even in the Academy of Pediatrics with the breakaway group the American College of Pediatricians over this issue. Similar divisiveness seems to be occurring in many of the national organizations. In fact, many of the national organizations appear to be losing membership because of resolutions and statements they make about such issues without the requisite science or clinical support.

Maybe a brief status report on what science can and cannot say about homosexuality would be helpful. Though historically the national organizations have claimed an essentialist position (homosexuality is innate and immutable), there appears to be some moderation. For example, for the past 10 years, the American Psychological Association (APA) has offered the following: "There is considerable recent evidence to suggest that biology, including genetic or inborn hormonal factors play a significant role in a person's sexuality"¹

This statement was eliminated from their official brochure in February 2008. Of sexual orientation, the APA now declares:

There is no consensus among scientists about the exact reasons ... Although much research has examined the possible genetic, hormonal, developmental, social, and cultural influences on sexual orientation, no findings have emerged that permit scientists to conclude that sexual orientation is determined by any particular factor or factors. Many think that nature and nurture both play complex roles.²

Perhaps the best summary of the research on the genesis of homosexuality was offered by Dr. Francis S. Collins, Director of the Human Genome Project. Collins concluded that homosexuality "is genetically influenced but not hardwired by DNA and that whatever genes are involved represent predispositions, not predeterminations."³

Such a summary comment is very interesting because the same could be said of a variety of challenges.

The time allocated does not allow a discussion about all the research that likely influenced both the new APA statement as well as the research summary by Dr. Collins. Suffice it to say that the conclusions that some may have been led to believe may not be as anchored to science as we would have liked.

Mental Illness/Physical Disease

With this brief introduction, it might be well to focus on the mental illness/physical disease implications of homosexuality as we examine some of the research findings that relate health risks to homosexuality. Perhaps, in creating relevance for this audience, a paraphrase from William Osler might be appropriate. He indicated that in terms of health care, it was important to know about the disease as well as the person who has the disease. So knowing something about an individual even from a population perspective can help provide the context within which care can be provided. Disease and illness really do not occur in isolation and ignoring the context has potential to cause harm.

It is important to note that the allopathic model or the medical model that certainly has merit for infectious diseases or conditions works less well in examining risk factors associated with chronic diseases or conditions or with certain populations. While there may be some interest in a discussion about a state or condition model of health/health care with this population, to take such a view would fall into the same realm of normal versus non-normal (actually, what constitutes normality seems to be more of a political discussion than a scientific one). What seems to be the case is that homosexuality is an adaptation than can be distressful for some, particularly those whose faith tradition may not easily accommodate acting on such attractions. Nonetheless, health care providers need to understand what the research can and cannot say about the risk factors associated with homosexual orientation and behaviors.

Mental Illness Implications

Research demonstrates that homosexual orientation and homosexual behaviors do indeed place individuals at risk for certain mental illnesses.

From the *Archives of General Psychiatry*, Herrell et al. posited: "Same gender sexual orientation is significantly associated with each of the suicidality measures ... The substantial increased lifetime risk of suicidal behaviors in homosexual men is unlikely due to substance abuse or other psychiatric co-morbidity"⁴

In other words, suicidality is associated with homosexual orientation and not to some other co-existing condition like substance abuse or depression.

Also from the *Archives of General Psychiatry*, Ferguson, et al. : "Gay, lesbian and bisexual young people were at increased risks of major depression ... generalized anxiety disorder ... conduct disorder ... nicotine dependence ... multiple disorders ... suicidal ideation ... and suicide attempts."⁵

Subsequent to reanalyzing the data from both of these studies, Bailey, Remafedi and Friedman determined that there was indeed a strong association between homosexuality and mental illness. In fact, Bailey notes, "These studies contain arguably the best published data on the association between homosexuality and psychopathology, and both converge on the same unhappy conclusion: homosexual people are at a substantially higher risk for some forms of emotional problems, including suicidality, major depression, and anxiety disorder."⁶

Among the hypotheses suggested by Bailey that might explain such significant differences was the notion that increased depression and suicidality among homosexual individuals are consequential to society's negative view and treatment of this group.⁷

This hypothesis generated some public support but not much scientific support because of a study referenced by Bailey and published later in the *Archives of General Psychiatry*. The study was conducted by Sandfort et al. in the Netherlands, arguably the most gay-affirming society in the world. With more robust data, these researchers concluded:

Psychiatric disorders were more prevalent among homosexually active people compared to heterosexually active people. Homosexual men had a higher prevalence of mood disorders ... than heterosexual men. Homosexual women had a higher 12-month prevalence of substance abuse disorders than heterosexual women ... More homosexual than heterosexual persons had 2 or more disorders during their lifetime ... The findings support the assumption that people with same-sex sexual behavior are at greater risk for psychiatric disorders.⁸

Of particular concern are the studies which address suicidality and other problems associated with adolescents. The research by Remafedi et al. provides some interesting insight into labeling. The following conclusions are from their research published in *Pediatrics*:

- “For each year’s delay in bisexual or homosexual labeling, the odds of suicide attempt diminished by 20%.”⁹
- “...suicide attempts were not explained by experiences with discrimination, violence, loss of friendship, or current personal attitudes towards homosexuality.”¹⁰
- “...gender nonconformity and precocious psychosocial development were predictive of self-harm. Compared with peers, suicide attempters recognized homosexual attractions and told other persons at younger ages. First sexual experiences with males and females also occurred at younger ages than peers.”¹¹

Remafedi’s research finds support in the data from Friedman and Downey. These researchers found that boys who later identify as heterosexual reported their first sexual experience at the mean age of 15.7. However, boys who later identify as homosexual reported their first sexual experience the mean age of 12.7.¹² This premature introduction to sexuality carries with it substantial risks for other problems, the relationship of which is not clear. Nonetheless, the data from Garofalo et al.¹³ offered the following regarding GLB and non-GLB students and high-risk behaviors:

	GLB	non-GLB
Alcohol use (High school)	59.1%	30.4%
Cocaine use	17.3%	1.2%
Inhalants	47.6%	18.5%
Sexual intercourse	81.7%	44.1%
Sexual contact against will	32.5%	9.1%

Care needs to be exercised with this data because correlation is not causation. Although there are links, it is not possible to conclude that delaying self-labeling will prevent suicide, or that postponing sexual experience will prevent suicide. It may not. However, it would seem prudent to

- Discourage early sexual experiences.
- Discourage early self labeling.
- Discourage activists who promote early self-labeling.

Perhaps rather than prematurely affirming such labels during a developmental time when most everything is fluid, health care providers might be wise to affirm adolescents as people worthy of respect and love—while encouraging them to wait until adulthood to make choices about expressions of their sexuality.

Dr. George Rekers, Professor of Neuropsychiatry at the University of South Carolina, concluded: “No service is done to our children by offering them lifestyle options before they are properly able to make informed choices about them.”¹⁴

There are always legal issues involved when such data is provided to health care professionals. Would health care providers be held liable if they failed to take into account the above data and a death resulted?

Activism often prevents such data from even being discussed in the public arena. Bailey makes this point when he notes that activism often overshadows good research in such controversial areas. He notes, “It would be a shame if sociopolitical concerns ... prevented researchers from conscientious consideration of any reasonable hypothesis.”¹⁵

Bailey’s socio-political concerns find significant support in a carefully referenced text, *Destructive Trends in Mental Health*. The book is edited by two of the most credible researchers/clinicians in the world, Drs. Rogers Wright and Nicholas Cummings, and it features an academy award roster of authors. Considering themselves to be lifelong liberal activists, Wright and Cummings noted the following: “Though we lived through the abominable McCarthy era and the Hollywood witch hunts, still there was not the insidious sense of intellectual intimidation that currently exists under political correctness—political correctness tethers our intellect.”¹⁶ Unfortunately, such political correctness seems to extend to this topic. Perhaps the greatest evidence of such activism masquerading as science was recently revealed in a Harvard University Press publication. The researcher, a self-identified lesbian, notes, “It may be for now, the safest way to advocate for lesbian/gay/bisexual rights is to keep propagating a deterministic model: sexual minorities are

born that way and can never be otherwise. If this is an easier route to acceptance (which may in fact be the case) is it really so bad that it is inaccurate?"¹⁷

Such activism masquerading as science as well as an emphasis on political correctness tends to discourage even the investigation where the data suggest that there indeed may be vulnerabilities to disease among homosexuals. Are there explanations for such vulnerabilities? The vulnerabilities to mental illnesses, which we have noted in the above data regarding homosexuality, may be explained by the emotional traumas often associated with mental illness found in the backgrounds of some homosexual men and women. For example, there is research suggesting that a higher percent of homosexuals than heterosexuals were molested when they were children. In a non-clinical population, Tomeo et al. found that in a sample of 465 individuals, 46% of gay men and 22% of lesbians were sexually abused as children, compared to 7% of matched heterosexual men and 1% of matched heterosexual women. Particularly intriguing was the finding that 68% of the gay men and 38% of the lesbians did not self-identify as gay or lesbian until after the molestation.¹⁸

Greenwood et al. found rates of battering among homosexual men to be substantially higher than among heterosexual men.¹⁹ Lie and Gentlewarrior found that lesbians reported greater rates of violence perpetuated by their female partners than by their male partners (many lesbians have relationships with men).²⁰

Health care providers need to be alerted to issues of domestic violence, particularly when other signs and symptoms are present. Domestic violence causes havoc in the lives of individuals, particularly children. In fact, researchers now conclude that children who are exposed to chronic domestic violence have underdeveloped frontal lobes while the sensory areas of the brain overdevelop.

Physical Disease

What of physical diseases among the gay and lesbian population? Public health and medical researchers have produced disease and death data for those engaged in homosexual practices. Their extensive medical evidence demonstrates elevated rates of physical disease among those engaged in homosexual behaviors.

Diggs offered one of the more comprehensive yet concise papers on the health risks of homosexual practices. Of particular concern is promiscuity. Diggs summarizes the research data:

A far ranging study of homosexual men published in 1978 revealed that 75 percent of self-identified, white, gay men admitted to having sex with more than 100 different males in their lifetime: 15 percent claimed 100–249 sex partners; 17 percent claimed 250–499; 15 percent claimed 500–999; and 28 percent claimed more than 1,000 lifetime male sex partners. By 1984, after the AIDS epidemic had taken hold, homosexual men were reportedly curtailing promiscuity, but not by much. Instead of 6 partners per month in 1982, the average non-monogamous respondent in San Francisco reported having about 4 partners per month in 1984.²¹

The data reported by Diggs finds support in other studies as well. Consider the following:

- Michael et al. noted “It is extremely rare for a heterosexual who is not a prostitute to have 1,100 lifetime sex partners, as the average gay man infected with HIV had in the beginning of the epidemic.”²²
- Bailey quoted a 1981 Centers for Disease Control (CDC) statistic: “AIDS patients with an age of 35 years reported an average of 60 sex partners per year, or approximately 1,000 lifetime partners.”²³
- Thirty percent of all gay black men are HIV positive. Forty-six percent of the gay black men in this study had unprotected anal sex during the previous month, and fewer than 30 percent knew that they were infected.²⁴

Such promiscuity has medical consequences. Extensive medical evidence reveals greater rates of physical disease among homosexual than among heterosexual people. For example, the rate of anal cancer infection in homosexual men is ten times the rate in heterosexual men.²⁵ Other medical conditions where there is an overrepresentation of disease among homosexual males include damaged sphincter tissue leading to incontinence, hemorrhoids, and anal fissures; anorectal trauma; retained foreign bodies; rectosigmoid tears; allergic proctitis; and penile edema.²⁶

A study of registered male homosexual partners in Denmark likewise showed an elevated risk of cancer incidence when compared to the general population.²⁷ Lesbians have higher rates of hepatitis B & C, bacterial vaginosis, heavy cigarette smoking, intravenous drug use, and abuse of alcohol.²⁸

Other infections associated with homosexual practices are many including the high rate of parasitic and other intestinal infections associated with oral-anal contact. Increases in sexually transmitted diseases, including gonorrhea and syphilis, are rampant among gay men.²⁹

The June 2003 issue of the *American Journal of Public Health* was devoted entirely to health risks associated with homosexual practices. Article after article in this flagship journal of the American Public Health Association provided a bleak picture of homosexuality and HIV/AIDS.

Consider the following brief summaries from several of these articles.

- Michael Gross’s editorial, “When Plagues Don’t End,” focuses on the resurgence of HIV/AIDS among homosexual men in the United States.³⁰ The highest rates of HIV transmission are among African American men and Hispanic men who self-identify as gay.³¹ Gross concludes, “To prevent HIV transmission, we have little more today than we had two decades ago, when it became clear that the virus causing AIDS is sexually transmitted: behavioral interventions.”³²

- In his article on “Black Men Who Have Sex with Men and the HIV Epidemic: Next Steps for Public Health,” David J. Malebranche addressed risk assessment and risk reduction. He referenced a six-site U.S. metropolitan area study that concluded that 93% of African American Men who were HIV infected felt that they were at low risk for HIV and did not know they had contracted the virus.³³
- Malebranche’s study contradicts the view that coming out of the closet or disclosing one’s homosexuality is associated with improved mental health, responsible behavior, and lower rates of HIV infection. To the contrary, African American men who disclose their homosexuality have a higher rate of HIV prevalence than those who do not choose to do so (24% versus 14%). They also engage in more unprotected anal sex (41% versus 32%) than those who do not disclose.³⁴

The title of Michael Gross’s second article in this journal comes with an ominous warning, “The Second Wave Will Drown Us.” Citing a Centers for Disease Control statistic of a 14% increase of HIV/AIDS among homosexual men in the United States between 1999 and 2001, Gross provided data from California and New York (two states that were excluded from the CDC report) that focused on unprecedented outbreaks of syphilis and alarming rates of rectal gonorrhea among homosexual men. Gross noted an emerging subculture of “barebacking” (anal intercourse without condoms) among homosexual men.³⁵ Gross offers the following comparison:

On the same day that seven astronauts and fragments of the vehicle that failed them plummeted to the fields and woods of East Texas, six times as many US MSM [men who have sex with men—politically correct term for gay men] became infected. Maybe the number is higher, since it occurred on a weekend; perhaps lower if news of the catastrophe interrupted libidinous pursuits.³⁶

On the basis of CDC estimates of the lifetime expenditures for treating a single case of HIV infection, MSM infections acquired that single day will cost \$6.5 million. The cost in human potential need not enter the calculus even for a voodoo economist, unless so muddled by moral outrage that he thinks sex between men is indeed something to “die for.”³⁷

Perhaps the most alarming study in this journal of the American Public Health Association was that reported by Koblin et al. titled, “High-Risk Behaviors Among Men Who Have Sex With Men in 6 US Cities: Baseline Data from the EXPLORE Study.”

The authors describe the prevalence of risk behaviors at baseline among MSM who participated in a randomized behavioral intervention study conducted in six US cities: Boston, Chicago, Denver, New York, San Francisco, and Seattle. The data

gathered involved homosexual men who were HIV-negative and who reported engaging in anal sex with one or more partners during the previous year.³⁸ The results were staggering among the 4,295 men:

“...48.0% and 54.9%, respectively reported unprotected receptive and insertive anal sex in the previous six months. Unprotected sex was significantly more likely with one primary partner or multiple partners than with non-primary partners. Drug and alcohol use were significantly associated with unprotected anal sex.”³⁹

A final study in this public health journal was conducted by Ciccarone et al. on “Sex Without Disclosure of Positive HIV Serostatus in a US Probability Sample of Persons Receiving Medical Care for HIV Infections.” This study provides additional alarming data to support the conclusion that “risky sex without disclosure of serostatus is not uncommon among people with HIV.”⁴⁰ The authors of the study conclude:

The results of this study indicate that sex without disclosure of HIV status is relatively common among persons living with HIV. The rates of sex without disclosure found in our sample of HIV-positive individuals translate into 45,300 gay or bisexual men, 8,000 heterosexual men and 7,500 women—all HIV infected—engaging in sex without disclosure in our reference population who were in care for HIV ... These numbers should be considered a lower-bound estimate.^{41, 41}

Of particular concern are the alarming numbers of homosexual men who actually “seek” to become HIV infected. In an article featured in *Rolling Stone Magazine*, the Director of Behavioral Health for San Francisco County, Dr. Robert Cabaj, told the magazine that at least one quarter of the newly infected gay men may have sought out the fatal disease.⁴² According to Gregory A. Freeman, the author of the article, some gay men say being HIV-positive “opens the door to Nirvana” because they need no longer worry about safe sex, while others say they can’t stand the idea of being different from their HIV-infected lover. The magazine article entitled “In Search of Death” tells the story of Carlos, a man who considers HIV transmission, “the most erotic thing I can imagine.”⁴³ “As sick as it sounds,” Carlos said, “killing another man slowly is exciting.”⁴⁴

Dr. Marshall Forstein, Medical Director of Mental Health and Addiction at Fenway Community Health, an arm of Beth Israel Deaconess Medical Center that specializes in care for gay and lesbian patients, notes that the phenomenon of intentionally transmitting the virus—called “bug chasing”—is growing.⁴⁵ Evelyn Ullah, the director of HIV/AIDS in the Miami-Dade County Health Department in Florida agrees. She cited “conversion parties” in the Miami-Dade area in which the goal is to have HIV-positive men infect HIV-negative men.⁴⁶ Forstein is quoted as saying,

What frustrates health care professionals the most is that gay men who are doing this, haven't a clue what they are doing. They are incredibly selfish and self-absorbed. They don't have any idea what's going on with the epidemic in terms of what the world or society or what impact their actions might have. The sense of my brother's keeper is never discussed in the gay community because we've gone to the extreme of saying gay men with HIV can do no wrong. They're poor victims, and we can't ever criticize them.⁴⁷

Forstein further notes, "We're killing each other. It's no longer just the Matthew Shepards that are dying at the hands of others. We're killing each other. We have to take responsibility for this as a community."⁴⁸

Such actions do not bode well for the progress being made in the epidemic. In fact, with the failure of recent vaccines, HIV/AIDS can only be viewed as a behavioral epidemic—one that is poised to cause more destruction as scientists are finding more and more strains of the virus that are resistant to intervention.

The editor of this public health journal summarized the current state of the efforts: "Having struggled to come to terms with the catastrophic HIV epidemic among MSM in the 1980's by addressing the pointed issues of sexuality and heterosexism, are we set to backslide a mere 20 years later as HIV incidence rates move upward, especially among MSM?"⁴⁹

Why the Higher Rates of Disease and Death Among the Homosexual Population?

While there is not likely a single, simplistic answer to the above question, the evidence to support two of Bailey's other hypotheses might be worth reviewing.⁵⁰

1. Homosexuality is a deviation from normal heterosexual development and thereby creates vulnerability to illness.⁵¹ The whole idea of what is "normal" causes controversy; however, it is clear that homosexuality is not consistent with the continuation of the species and therefore is really an enigma even to the evolutionist. Perhaps the better definition of what is normal is that which functions according to design (whether the adopted view is a Creator's divine design or the impersonal theory of evolution). Diggs makes it clear in his paper that human physiology simply does not accommodate anal intercourse, the primary sexual relationship for homosexual men. The differences in physiology makes those engaged in homosexual practices at substantially greater risk for infections, not limited to sexually transmitted diseases such as HIV/AIDS and to immunosuppressive diseases, but also to physical, internal injury.⁵² Thus the greater disease and death rate is associated with the homosexual practices themselves.

2. Homosexual lifestyles are responsible for the greater rates of disease and deaths.⁵³ A particular characteristic of the homosexual lifestyle for which there is good documentation is promiscuity.⁵⁴ In addition to the research previously noted, repeated studies of homosexuals and homosexual couples

have revealed significant concerns about promiscuity. In fact, 66% of gay men report having sex with someone other than their partner within the first year of their relationship, rising to approximately 90% if the relationship endures over five years.⁵⁵ Although not as promiscuous as homosexual men, lesbians are 4.5 times more likely to have had 50 lifetime male sex partners than their heterosexual controls, Australian researchers reported.⁵⁶

In homosexual relationships, monogamy is so rare both in terms of reality and expectation that the term "monogamy without fidelity" has been coined. Translated, this term simply means that for homosexual couples to survive they must permit sexual relationships outside the relationship. Rotello, a gay author, noted, "Gay liberation was founded ... on a sexual brotherhood of promiscuity and any abandonment of that promiscuity would amount to a communal betrayal of gargantuan proportion."⁵⁷ And Bailey adds, "Gay men who are promiscuous are expressing an essentially masculine trait. They are doing what most heterosexual men would do if they could. They are in this way just like heterosexual men, except that they don't have women to constrain them."⁵⁸

Summary Implications for the mental illness and physical disease data for homosexual practices

The implication of the above data for those who engage in homosexual practices is simply this: a shortened life span.

Hogg and Strathdee offered the following summary:

In a major Canadian centre, life expectancy at age 20 for gay and bisexual men is 8 to 20 years less than for all men. If the same pattern of mortality were to continue, we estimate that nearly half of gay and bisexual men currently aged 20 years will not reach their 65th birthday. Under even the most liberal assumptions, gay and bisexual men in this urban centre are now experiencing a life expectancy similar to that experienced by all men in Canada in the year 1871.⁵⁹

The cultural implications are many. As the barriers to homosexual practices are removed and data such as that presented in this chapter is relegated to the back rooms of media outlets, the subsequent social approval of homosexual practices (primarily associated with lack of accurate data accompanied by gay activism) leads to increases in such practices. And such practices extend to younger and younger ages.

Implications for Health Care Providers

When health care is provided for individuals, sensitivity to values and worldviews offers the context within which such care is provided. The conflict between sexual orientation and faith tradition is a real one. In an excellent article by Michael Benoit titled "Conflict Between Religious Commitment and

Same-Sex Attraction: Possibilities for a Virtuous Response,” he concludes with the following: “Respect for religious diversity demands that [health care providers] give as much weight to belief as to sexual identity.”⁶⁰

This respect is particularly important when care is provided to children and adolescents. The family’s involvement and respect for family values becomes an important part of providing that care. Ethical researchers and health care practitioners should recognize the importance of autonomy and patient self-determination, allowing the patient to fully participate in his or her care. In fact, the new APA statement contains the following:

“Mental health organizations call on their members to respect a person’s right to self-determination.”⁶¹

Summary

In an environment of political correctness where even Continuing Medical Education (CME) committees render judgment on what is appropriate and what is not appropriate, it might be important to provide a succinct statement from a premier psychiatry/psychology textbook, 2009 edition, which summarizes the status of homosexuality in the scientific community.

Although homosexuality (homosexual orientation or homosexual behavior patterns) by itself is no longer listed as a mental disorder, individuals with “persistent and marked distress about sexual orientation” (whether homosexual or bisexual) are diagnosed with “sexual disorder not otherwise specified”? Using the DSM-IV-TR, and diagnosed as “Egodystonic Sexual Orientation” in the International Classification of Diseases (ICD) published by the American Medical Association and World Health Organization (American Medical Association, 2005; World Health Organization, 2007). Egodystonic sexual orientation is used in the ICD when the individual desires that his or her orientation is used in the ICD when the individual desires that his or her orientation “were different because of associated psychological and behavioral disorders, and may seek treatment in order to change it” (World Health Organization, 2007, p. F66.1). While many mental health care providers and professional associations have expressed considerable skepticism that sexual orientation could be changed with psychotherapy and assumed that therapeutic attempts at reorientation would produce harm, recent empirical evidence demonstrates that homosexual orientation can indeed be therapeutically changed in motivated clients, and that reorientation therapies do not produce emotional harm when attempted. (e.g., Byrd & Nicolosi, 2002; Byrd et al., 2008); Shaeffer et al., 1999; Spitzer, 2003).⁶²

The research seems clear that homosexuality is not invariably fixed in all people and that those who engage in homosexual practices are at risk for mental illness and physical disease. Health care practitioners need to be guided by the research, not political correctness. Our patients deserve as much.

Endnotes

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Events

2009 Collegium Aesculapium Fall Meeting—Southern Utah Broadway in the Desert and Shakespeare Tour

Dates: Sept. 29-30

Cost: \$350 per person

Registration includes: private motor coach transportation from SLC and/or Provo, overnight hotel in St. George, 1 lunch, 2 dinners (1 with play actors), hot breakfast, backstage tour, meeting space, Center/Orchestra seating at 3 plays, drivers gratuities, entrance fees as listed, all taxes, etc. CME Meeting certificate included.

Schedule:

1. Leave SLC 8 a.m. Tuesday September 29 from the Fashion Place Mall area.
2. Pick up Provo people 9 a.m. at the University Mall in Orem

3. Arrive in St. George 1 or 2 p.m. - [Bring your own lunch to eat on the bus] [we will have water/goodies on bus]
4. Check in hotel and Free time 2-5 p.m. [bus will continuous circuit to golf course to Factory Outlet to Temple on 20 min intervals]
5. Leave hotel 5 p.m. for dinner and Tuacahn - [all included] [Front section seats] [Aida]
6. Return to hotel in St. George
7. Wednesday September 30 breakfast [included]
8. CME 8-11:30 a.m. To be Collegium sponsored with an attendance certificate [no additional charge]
9. Board bus for Cedar City 11:30 a.m.
10. Lunch [included] in Cedar City
11. 1 p.m. PRIVATE BACKSTAGE TOUR OF BOTH THEATRES, OR IF LATE, THIS WILL BE BETWEEN SHOWS
12. 2 p.m. Shakespeare Play [Complete Works of Shakespeare]
13. 4:30 p.m. Dutch Oven Dinner with actors [included]
14. 7:30 p.m. Shakespeare Play [Woman in Black]
15. 10 p.m. Board bus for return trip home

The trip is all inclusive, except for the lunch you will

bring to eat on the bus going to St. George. If you can't join us on the bus, then the cost will decrease by about \$45.00 per person. Family members are welcome.

You may register at the Collegium Aesculapium website —www.collegiumaesculapium.org and selecting the Conferences Tab—or at Boomerang Tours. Additional information is posted on the Collegium Aesculapium website.

Israel Trip

The Israel/Jerusalem trip is in the planning process. The draft schedule and plan are as follows:

Time: Late April into May (working around as many graduation dates as possible)

Days: 10, plus 5 optional days in Egypt

Cost: \$2,500-\$5,000

It is likely that the tour can handle a maximum of 80 people.