

Optimizing Primary Care for Men Who Have Sex With Men

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OVER THE PAST 2 DECADES, THE LITERATURE ON THE health care needs of gay men and those who may not identify themselves as such, but are men who have sex with men (MSM), has been dominated by issues related to human immunodeficiency virus (HIV) prevention and care. This focus on HIV remains critically important; at least a quarter million MSM are living with HIV in the United States and approximately 20 000 more will likely become infected this year.¹ Nevertheless, the vast majority of MSM are not HIV-infected but still require high-quality medical care that is culturally competent and targeted to their needs. Unfortunately, the most comprehensive articles about the medical care of MSM who are not HIV-infected date from the dawn of the AIDS epidemic more than 20 years ago.² Current standard sources of practical medical information for primary care practitioners do not sufficiently address the routine care of MSM.³ This is true even though the Department of Health and Human Services' *Healthy People 2010*, a document produced each decade to outline national health goals for the years ahead, identifies gay men and lesbians as 1 of the 6 most underserved groups.⁴

Although it is difficult to quantify precisely how many gay-identified men and other MSM live in the United States,⁵ it is clear that they are present in virtually all communities and likely, every primary health care practice. For instance, the US Census in 2000 found same-sex households in more than 99% of counties throughout the country with the highest densities ranging from 5% to 7% of households in many urban centers.⁶ Studies that describe the prevalence of male homosexual behavior and sexual identity often vary based on demographic and geographical variables, as well as the fluidity of sexual behavior, desire, and identity in the course of a lifetime. In 1994, Laumann et al⁷ found that 2.8% of men identified themselves as gay, whereas 9.1% described having had same-sex sexual activity at some point in their lives. In several urban centers, the prevalence of men with a gay identity was as high as 9.2%, with 15.8% of men reporting some sexual contact with other men since pu-

berty. There have been no population-based studies of non-gay identified MSM; however, while some men will eventually identify as gay, many, particularly individuals from ethnic minority communities, do not choose to identify with gay culture for a variety of reasons, ranging from subcultural tolerance of bisexuality to internalized homophobia or the perception that gay identity is conflated with being white.^{8,9} Outside of the United States and Europe it is even more common for MSM to not identify as gay.¹⁰

Given the range and fluidity of sexual behavior and identity among MSM, it is important for clinicians to recognize the medical implications of sexual behavior, as well as to identify patients whose sexuality may be evolving and who may want help identifying themselves as gay to friends, family, and society, ie, "coming out." At the same time, physicians and other clinicians must appreciate the need to provide care and support for MSM for whom social and cultural reality may preclude coming out or the desire to do so.

Specific Health Care Needs of MSM

Even though most major health care issues for MSM are similar to the routine health recommendations for all men, independent of sexual orientation or sexual behavior, there are unique issues to consider, including screening for and immunizing against hepatitis A and B virus; routine screening for sexually transmitted diseases (STDs); routine screening for certain cancers (ie, anal human papillomavirus [HPV]-related neoplasia); assessing drug, alcohol, and tobacco use; screening for psychological health and mental health disorders, domestic violence, hate crimes, and post-traumatic stress; and helping patients deal with stigma associated with being a sexual minority as well as the social and psychological issues of coming out.¹¹

The Centers for Disease Control and Prevention (CDC) provides updated, basic guidelines for health promotion and prevention of STDs among MSM.¹² Some MSM are at high risk for HIV infection and other viral and bacterial STDs. Younger men and men of color have been particularly af-

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fect. Black MSM are experiencing a disproportionate increase in the number of new cases of HIV.¹³ Although the frequency of unsafe sexual practices and STDs had declined substantially among MSM after the recognition of AIDS, more recently, increased rates of syphilis, gonorrhea, and chlamydia among MSM, and, in particular, HIV-infected MSM have been reported in many cities in the United States and other industrialized nations. These data suggest that despite on-going educational efforts, some MSM continue to engage in high-risk sexual behaviors placing them at risk for HIV and other STDs.^{14,15} Adherence to safer sexual practices that were inculcated in the early days of the AIDS epidemic appear to be waning, perhaps related to “safer sex burnout,” beliefs that improved treatment reduces infectiousness or makes HIV a less serious disease (therapeutic optimism), increases in substance abuse, or the coming of age of young MSM in an era in which AIDS seems remote and HIV treatment seems manageable.¹⁶

Therefore, all MSM, independent of HIV status, should routinely undergo straightforward, nonjudgmental STD/HIV risk assessments and patient-centered prevention counseling to reduce the likelihood of acquisition or transmission of HIV and other STDs. Routine screening for STDs should be considered for MSM even in the absence of physical complaints or symptoms. Current CDC guidelines¹⁷ recommend that the following studies should be performed at least annually for sexually active MSM: HIV serology, if HIV-negative or not previously tested; syphilis serology; urethral culture or urine nucleic acid amplification test for gonorrhea; a urethral or urine test (nucleic acid amplification) for chlamydia; pharyngeal specimen collection to test for gonorrhea in men with oral-genital exposure; and rectal gonorrhea and chlamydia screening in men having receptive anal intercourse.¹⁷

In addition, the CDC guidelines^{13,17} recommend immunization of sexually active MSM for hepatitis A and B virus. More frequent STD screening, eg, at 3- or 6-month intervals, may be indicated for MSM at highest risk, eg, those having multiple partners, those having sex in conjunction with recreational drug use, or patients whose sex partners participate in these activities. Screening is indicated regardless of a patient's stated history of consistent use of condoms for insertive or receptive anal intercourse because some STDs, like syphilis, may be transmitted by oral sex and condom protection is not 100% effective. Clinicians should also be knowledgeable about common manifestations of symptomatic STDs in MSM (ie, genitourinary and anorectal abnormalities). If these symptoms are present, other specific diagnostic tests are indicated. It is also important for clinicians to educate MSM that STDs may be asymptomatic and can spread without the presence of any abnormalities.

Counseling MSM to avoid STD risk may require careful and nuanced discussions.¹⁸ Although syphilis, gonorrhea, and chlamydia are commonly spread by oral-genital con-

tact, many patients may be unaware of this and may be resistant to using condoms for oral sex. Clinicians can play an important role in motivating patients to reduce risky behaviors by discussing the recent increase in STDs among gay men, by explaining the transmission synergy between HIV and STD infections, and by helping them understand how STDs are contracted.

Human papillomaviruses are also sexually transmitted and common in MSM.¹⁹ Human papillomavirus is most commonly associated with the development of anal and genital warts. Unfortunately, the same strains of HPV that are associated with cervical cancer (usually types 16 and 18) can also develop into anal carcinoma.¹⁹ Anal carcinoma is increasingly common among men infected with HIV and other gay men who engage in high-risk activity, so it is important to consider screening on a regular basis.¹⁹ Anal Papanicolaou smears are recommended yearly for men who are infected with HIV due to growing evidence that HIV-infected individuals are at increased risk for HPV-related neoplasms. Screening of HIV-uninfected MSM should likely occur every 2 to 3 years.¹⁹ The recent licensure of a safe and effective vaccine to prevent oncogenic HPV infection is being studied in MSM and may become another useful preventive health intervention for MSM who engage in anal intercourse.

Beyond STDs and HIV, there are very few specific recommendations for routine medical risk assessment of MSM. However, MSM smoke more on average than the general population, making risk assessment and counseling in this area important.¹¹ The prevalence of alcohol and drug abuse problems in this population also exceeds rates found in the general population.¹¹ Although particular drugs of choice change over time, crystal methamphetamine is currently popular, particularly among urban MSM. In addition to the cumulative effects of the drug, which can lead to significant physical and psychological impairment, methamphetamine has been associated with increased sexual risk taking, resulting in the acquisition of HIV infection and other STDs.²⁰ Risk assessment, frank discussion about the short-term and long-term effects of these drugs, and referrals for prevention options including harm reduction are critical in helping patients avoid serious sequelae from substance abuse. Other behavioral issues are also common. For example, intimate partner violence occurs at the same rate in same-sex relationships as it does in opposite-sex relationships, making discussing with patients whether they feel physically safe in their relationships an important part of the care of MSM.²¹

Challenges for Clinicians

Clinicians should take an active role in determining who among their male patients are having sex with other men as well as who are having sex with both men and women. This information will help guide discussions of preventive sexual health and assist in identifying those who may need

additional supportive services. When MSM feel comfortable disclosing their sexual behavior, clinicians can provide effective health promotion and risk reduction counseling.²²

Clinicians should elicit their patients' sexual history and, for some, their sexual desires. These are areas of inquiry often overlooked by clinicians compared with other issues more frequently discussed during routine assessment of health, such as smoking or alcohol use.²³ Answers to questions regarding sexual behavior, such as "Do you have sex with men, women, or both?" have clear implications for medical care. However, questions about sexual desire can be particularly important for men not comfortable discussing issues related to their sexual identities. Physicians may encounter patients who may initially appear uncomfortable but express relief when given an opportunity to talk about their desires and possible conflicts regarding wanting to be with another man or about wanting to come out. Exactly how to begin such a conversation is difficult to prescribe, and questioning patients along these lines can be challenging to fit in a 15- or 20-minute clinical session. Listening is a good start, in addition to asking open-ended, nonjudgmental questions. For example, asking, "Do you ever have any attraction to members of the same sex?" can be a useful way to begin this discussion. Such inquiry may yield productive conversation with some patients. Many patients who have come out or who are struggling to do so express having lingering demons regarding work or their family, which keep them from being completely comfortable with themselves and their evolving sexuality. Displaying empathy and making referrals for counseling can help those experiencing conflicting feelings. Having a list of mental health professionals in the community who are open and accepting of patients in need of this type of counseling may be helpful.

Clinicians should keep in mind that patients may come out at all ages, even those who are middle-aged or older and may have been in heterosexual marriages or other long-term relationships. Coming out at any age can be complex; however, more has been studied about adolescents and young adults. Among all adolescents, including male youth who identify as gay or bisexual, identity formation is an important developmental task that is not unidimensional, but rather encompasses a mosaic of multiple identities within various realms of life (eg, occupation, gender, sexuality, religion).²⁴ Understanding the emergence of a gay or bisexual orientation and integrating this into an overall personal identity can be a challenging and distressing task for many adolescents. For some gay and bisexual male youth, this process can be long, painstaking, and complicated by experiences of heterosexism, stigma, homophobia, and prejudice.²⁴ This process can be particularly difficult for MSM who are from communities of color who may experience a dual stigma associated with being both a sexual and racial/ethnic minority. As with adult MSM, a

knowledgeable and caring physician can be an important resource helping gay youth overcome the challenges associated with a sexual minority identity and to lead happy, healthy, and productive lives.

Conclusions

Much work remains to determine how to help gay men and non-gay-identified MSM engage in healthy lives that include embracing a positive image and minimizing sexual risk. Despite the complexities involved and the need for further research, clinicians can listen to these patients openly and without judgment and become better educated about current recommendations for the care of gay men or other MSM.³

It is also important to consider the environments in the practice setting and whether they are welcoming to MSM and those from other diverse backgrounds. Are there inviting pictures, relevant educational materials, and inclusive forms that make all patients, including MSM, feel as though they are desired as patients? Office personnel who or documents that simply ask if the patient is single, married, or divorced are still too common and give patients who may not think in these terms an unwelcoming message, as do forms or policies that do not accept names of partners or close friends as opposed to blood relatives for notification purposes. These may not seem like large issues but are essential for helping patients feel safe and welcomed when seeking health care. The Gay and Lesbian Medical Association has developed helpful guidelines for practice environments (<http://www.glma.org>).

Although clinicians may face challenges to complete required tasks in increasingly short patient visits, they may consider referring patients to self-learning resources, such as those that are also on the Gay and Lesbian Medical Association Web site. Also, it is possible that some physicians and practices might not be able to provide welcoming and nonjudgmental care for gay men or other MSM; in those cases, referral of the patient to another physician who can provide such care is imperative.

Primary care clinicians should never underestimate their importance in their patients' lives and how they can help promote healthful behavior by appearing open to discussing sexuality and making this as normative as reviewing smoking, diet, or exercise in the primary care clinical encounter. With adequate education and training, clinicians not only will provide appropriate routine care for their sexual minority patients but also will help patients avoid internalizing stigma associated with homosexuality, access the optimum health care they need and deserve, and lead more satisfying and healthy lives.

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Fatherhood as a Component of Men's Health

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MODERN MEDICINE INCREASINGLY UNDERSTANDS phenomena specific to men's health. The notion of "men's health," as distinguished from "women's health," often centers on differences related to diseases of the reproductive organs, to conditions such as cardiovascular disease that manifest differently in part because of the influence of sex-specific hormones, or to shorter life expectancy for men vs women. This conceptualization of men's health, however, overlooks a central aspect of many men's lives—fatherhood.

The physical and mental health effects of being a father are understudied and largely unknown. This gap in current understanding is important because of its potential magnitude. Of the 108 million adult men in the United States, 66.3 million are fathers and the majority of men younger than 55 years have children in their homes.¹

In addition, marked sociodemographic shifts in the US population are reminders that the stereotypical image of a

traditional family, including a wage-earning father and a stay-at-home mother, is fading. In fact, there is no one picture of fatherhood in the United States today. Fathers may be in 1- or 2-parent families; they may be single, married, widowed, divorced, or cohabiting; they may be gay or straight; or they may become new fathers as adolescents or in mid-life. Fathers may raise their own children with 1 partner or with different partners, or may raise others' children as a social, step-, adoptive, or foster parent. They may be unemployed, work full time or part time, and may work inside or outside the home. Some live with their children, some live nearby, some live across the country, and some may be incarcerated. If social context has meaning for men's health, these multiple structural variations of fatherhood would be expected to affect men's health—but in ways that are only beginning to be understood.

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