Some moral problems posed by sexually transmitted disease

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The prevalence of each sexually transmitted disease in the community is due to interaction between the seed (or agent), the soil (or host), and the social and moral climate.

Both syphilis and gonorrhoea are perhaps milder diseases than formerly. This may be due to changes in the host, and also to the fact that an infection that produces severe symptoms is more likely to be diagnosed, treated, and cured than one that does not, so that the latter is selectively bred in the community. Gonorrhoea is more often clinically silent in women and in passive homosexual men than in heterosexual men; thus only 22 of 100 infected women who attended a clinic came because of symptoms (Dunlop, 1963). Hence the reservoir of that disease is found largely in women, so that, if the social climate encourages promiscuity by women or by homosexual men, the incidence of the infection in that group must increase.

If sexual intercourse were to be carried on with one partner only, syphilis and gonorrhoea would disappear. Promiscuity may be heterosexual or homosexual; thus no less than 72 per cent. of the cases of infectious syphilis diagnosed in 1962 in men at St. Mary's Hospital occurred in homosexuals (Jefferis, 1963). It is clear that successful marriage protects both partners from many of the difficulties of life including sexually-transmitted disease; it is also likely that those persons more able to stand the stresses of life make the more stable marital partners. The concept of a sexual morality based upon the value of fidelity to the individual, to the family, and to the community supports the exclusive relationship of marriage; but such a 'community morality' appears much more tenuous and fragile than sexual morality based on religious belief—which is now declining.

If promiscuity is accepted morally and practised by the community, then many other new factors in the social climate increase the infection rate; these include the increasing mobility of the population, the growth of large towns, the removal of the fear of pregnancy by effective contraception and abortion, and the removal of the fear of infection by easily available and effective treatment. As people will run risks of infection they must be taught what these risks are and how they may be minimized. However, a programme to reduce the incidence of venereal disease based upon fear would be morally unacceptable and probably ineffective. Some people deliberately seek risk. Thus the painter, Pierre-Auguste Renoir, said that 606 (the first effective treatment for syphilis) would knock the fun out of leading a fast life because 'it's the risk that adds spice to the affair' (Renoir, 1962).

While early infectious syphilis is now well controlled in England and Wales, the incidence of gonorrhoea and of non-gonococcal genital infection has been increasing rapidly (CMO's Report, 1970; Welsh Office, 1970) and has reached the highest levels ever recorded in these areas. Perhaps some at least of this difference is due to knowledge about syphilis and to fear of the disease: the patient with a genital sore often fears that he has syphilis and this spurs him to attend for diagnosis, treatment, contact-tracing, and follow-up. Uréthral discharge is regarded more lightly by patients and doctors; the ready availability of antibiotics may result in treatment without diagnosis, contact-tracing, or follow-up. Other factors affecting the social climate are: promiscuous intercourse as part of protest against family and society, materialism and the depersonalization of sex, the gap between the generations, the use of alcohol and drugs, and prostitution.

PROSTITUTION AND VENEREAL DISEASE

For heterosexual men who now attend The London Hospital because of gonococcal urethritis, the amateur is the main source of infection. In 1960 a paid prostitute was the source of gonorrhoea in 31 per cent. of cases compared with only 14 per cent. in 1969; a 'girl-friend' was the source in 27 per cent. in 1960 but for 49 per cent. in 1969 (Dunlop, Lamb, and King, 1971).
Controlled prostitution has been repeatedly proposed as a method of reducing the incidence of venereal disease. Morally, this method would be entirely unacceptable: it would create a group of ‘second-class citizens’ who would have to have their names recorded in a special register, who would have to submit to examination and to treatment, and who would have to practise their trade in particular places. The state would presumably have to recruit and control them; the controllers would be exposed to corruption. Moreover, even if the moral objections were regarded as unimportant, the evidence suggests that the method would not control venereal disease.

THE DOUBLE STANDARD OF SEXUAL MORALITY

A double standard of morality with regard to sexual behaviour has long obtained, particularly for men and women in the middle classes. It implied that the men would get their sexual experience from prostitutes and from ‘social inferiors’, but that they themselves would expect their marital partners not to have had sexual experience at the time of marriage. If sexually transmitted disease were to arise in marriage, it would usually be the husband who had continued casual sexual relationships and who had infected his wife. Perhaps for this reason a double standard has spread to medical practice. Thus, if a married man presents with gonorrhoea the doctor will not usually think of concealing the diagnosis from him, but when a married woman is found to have gonorrhoea it is common practice for the diagnosis in her case to be concealed from her.

With regard to this point, I have recently seen a successful businessman suffering from gonococcal urethritis. He denied recent extramarital intercourse so could not understand how he could be infected with gonorrhoea.

When I saw his wife she had clinically silent gonorrhoea. She said her husband had ‘lost interest’ in her, and that marital intercourse was only infrequent. It had been shortly after the date of the last marital intercourse that her husband had developed gonorrhoea. Her husband, incidentally, had had a pattern of occasional extramarital intercourse throughout the marriage. His wife had been an actress before marriage and both she and her husband had had considerable premarital sexual experience. Her story was that about 6 weeks before attendance she had had sexual intercourse with a visitor to her home.

It seems that her husband’s occasional infidelities made him less motivated to developing their joint sexual lives fully. His wife’s pattern of previous sexual experience had been with different partners. This made her less resistant to casual contact than if she had developed a pattern of sexual response restricted to the one person. While the wife is occasionally the source of sexually transmitted infection in a marital partnership, the much more usual source, as yet, is the husband.

Mrs. T was 30 years of age and had been married for 6 years; she had had a baby 4 months before attendance. At her post-natal examination she had been found to have a vaginal discharge for which she and her husband had both been treated with metronidazole. When I saw her she was suffering from gonorrhoea. Mrs. T asked to know the diagnosis in her case, and when told, she said that, as she had never had sexual intercourse with anyone other than her husband, she must have caught the infection from him. But she felt that it was really her fault because she had ‘lost interest in sex’ during her pregnancy and so had then had intercourse only infrequently; she thought that this had been stupid and an unfair strain on her husband. This patient was entitled to know her diagnosis; she used her knowledge to repair her marriage.

CONTACT TRACING

Beach (1949), who studied the sexual behaviour of mammals other than man, reported an increase in sexual activity in the male animal after coitus with a receptive female. It seems that the man who has a regular sexual partner and who acquires infection from another person behaves in much the same way, because he often exposes his regular partner to infection. He may feel considerable moral guilt about this and may even conceal that he has a regular sexual partner or indeed that he is married.

We are of course dependant on the male who presents with disease for information about his sexual contacts.

The moral stigma attached to a genital infection such as gonorrhoea depends more upon the fact that it is caught as a result of an act of sexual infidelity than upon the disease itself. There is a ‘transfer of shame’ from the act to the disease. For this reason, even if we changed the name of the specialty and the names of the diseases themselves, so long as sexual fidelity is regarded by society as better than infidelity, there is bound to be some stigma attached to sexually transmitted diseases; the necessity for confidentiality in management must continue.

If a man feels unable to bring his wife or consort to the ordinary clinic at this hospital he is offered an appointment for her at the ‘Diagnostic Clinic’ in the general outpatient department; patients are seen there
by venereologists, for tests for sexually transmitted disease, by appointment as for any general outpatient clinic. The problem lies in getting the consort there in the first place; once she is there few difficulties arise. A husband can be told only that all the details in his case are confidential and will not be divulged to his wife. No promise is made to him that his wife will not be informed of the diagnosis in her case. If the wife is free from infection no problem arises. However, if the wife is found to be suffering from infection, she is entitled to know the diagnosis in her own case. It may be clear that she does not wish to know, and in that case the information is not forced upon her.

In the United Kingdom the widespread network of clinics plays a major part in the control of sexually transmitted disease, by the treatment of disease in patients and in their sexual contacts. As the public, and particularly women and passive homosexuals, come to learn that sexually transmitted disease may be clinically silent, so they should learn that the indication for attendance at a clinic is having run a risk of infection. When a person is found to be infected that person has a moral responsibility to bring any sexual contact for examination.

Gonorrhoea and non-specific urethritis are often clinically obvious in the infected male only. He is much more likely to feel some sense of moral responsibility for a 'girl-friend' than for a prostitute; moreover, he is more likely to be able to identify her and to persuade her to attend for examination. The increasing role of the 'girl-friend' as the source of infection makes contact tracing more effective; improved contact tracing at The London Hospital has led to a decrease of 20 per cent. in the numbers of cases of gonorrhoea seen there in 1969 compared with 1960, despite the marked increase in England and Wales in the same period (Dunlop and others, 1971). As it is the male who often supplies the only indication that the woman is infected, the infected woman who has only casual sexual contacts is less likely to be brought for treatment than the woman who forms more stable relationships.

THE 'GENERATION GAP'

The gap between the generations is probably of increasing importance at the present time. Often it arises as a result of a moral withdrawal by the older generation rather than by the younger generation. A case in point was that of Miss X aged 21, a student. Nine months before attendance she had returned from the university where she had been studying. While there she had fallen in love for the first time, with a man much older than herself, and had become pregnant, perhaps deliberately. Her friend had tried to arrange an abortion for her, which she had refused; he had then left her. She had carried her baby to term and had then had the child adopted. After her return she had felt badly in need of advice, so she had tried to speak to her mother about her experience; she sounded out the ground by obliquely enquiring what the reaction would be if she were to become pregnant. Her mother said, 'I would expect you to know enough not to get into trouble'. So she felt she couldn't talk to her mother about it and went to their family doctor instead. While she was telling him about her problems, he started to write, and then handed her what he had written. It was a prescription for 'the pill'. After this, she had intercourse with two different partners, but 2½ months before I saw her she had stopped taking 'the pill', and had stopped having intercourse, because she felt that casual sexual relationships were damaging to her. When I saw her she had two sexually transmitted diseases, but it wasn't infection or the fear of infection that had stopped her having intercourse, it was that she had herself reached the conclusion that casual sexual relationships were destructive.

This gap between the generations is made worse by ill-considered comment and advice from members of the older generations. For example, Charles A. Reich, a professor of law at Yale University, has written a study of the new generation entitled The Greening of America (Reich, 1970). This is a best-seller in the United States. One of the points he makes in it is that the new generation has learnt to live with technological advances and to make use of them. He lists technological advances that include a pill that can make sexual intercourse safe and implies that the new generation has learnt to live with these advances, to make use of them, and to live by them. It is frightening to see such a separation from all moral context, as though 'the pill' has solved the moral problems of sexual relationship, and as though the U.S.A. wasn't having the biggest epidemic of gonorrhoea in its history.

SEXUALLY TRANSMITTED DISEASES AND CHILDREN

The detection of sexually transmitted disease may be an indication of sexual activity that may be damaging to the normal development and happiness of the child. Morally it is essential to pay regard to the underlying cause as well as simply to treat the result. Continuing advice and support may be necessary. Delinquent girls who have not met with disaster settle down into the community in their early twenties, so that support for the girl even over a prolonged
period of years may be necessary. It is important to consider who is best capable of giving such support. Even if a girl’s relationship with her mother is poor, that personal relationship is often more valid for the girl than any she can achieve at this time with another person.

A 16-year-old girl is regarded by the law of this country as being mature enough to give consent to sexual intercourse. So she is entitled to complete confidentiality about all matters relating to her attendance at a clinic for sexually transmitted disease; this confidentiality is guaranteed by the National Health Service (Venereal Disease) Regulations 1948. Nevertheless, this age of 16 is a somewhat arbitrary point. Many a girl over 16 may have problems, for the solution of which she needs just as much assistance as the girl who has not yet reached the ‘age of consent’. Here again her mother is often the person best able to give this assistance. One 19-year-old girl attended as a result of a sexual experiment which she had undertaken because she feared that she was a lesbian. She felt great shame about the matter and until then had not been able to discuss it with her mother or with her father; indeed she was particularly frightened of doing so with her father, who was a doctor. After considerable persuasion she brought her mother with her; the matter was discussed fully with them both, and the mother proved to be most understanding and helpful. The daughter felt great relief at being able to discuss with her mother what had been to her a shameful and oppressive problem.

The legal situation with regard to a girl who has not yet reached 16 years of age is not clear, whatever the doctor may consider his moral obligation to be. There are two opposing views. One is that the 1948 Regulations guarantee complete confidentiality to ‘persons’ (without mention of age) who attend clinics for sexually transmitted disease. Thus, while informing the parents and enlisting their aid may be even more necessary for the proper care of a patient in this group than in any other, it is not possible to so inform them without the agreement of the girl concerned. If she refuses, no information can be given. The other view is that an offence has been committed against the person of such a child under the ‘age of consent’, and that a parent or legal guardian should be informed.

If we take an extreme example, it is clear that the first rule of complete confidentiality at all ages is illogical and would mean that the doctor would have to abandon his moral responsibility for doing the best that he can for his patient. Such an example would be that of a 10-year-old boy brought for examination by an adult man and found to have gonococcal proctitis. Clearly, whether the boy agrees or not, part of the management of this problem is to inform the parents.

In the case of the child under 16 it seems to me that, as always, we have a moral responsibility to the patient to investigate the whole situation and to decide each case on its merits. While it may well be in the child’s best interests that the parents are informed in some cases, in others it may not be.* Thus, a particular girl may be in revolt against her parents: she may have a very poor relationship with her mother and she may state that she would run away from home if her mother were informed; in such circumstances, after consideration, it may well be felt that giving information to the mother in this particular case would be against the best interests of the child.

The difficulty of communication with her mother is often very greatly overstated by a girl with a problem. Once communication has been opened, this may be followed by a very great sense of relief for the girl; she may come to realise that her problem (however dreadful it may have seemed to her) is not unique, nor has it cut her off from her mother to whom she may turn for help and advice. A situation in point was that of a 14-year-old girl and her 17-year-old sister who had been forced by their father to have intercourse with him over a period of 3 years. They had been ‘too ashamed’ to talk to their mother about it. They were both greatly relieved after the matter had been discussed.

There is a tendency for adults to lay the moral blame for the increase in venereal disease upon the young. It is always easier for any group to blame ‘them’ than ‘us’. In fact there has been an increase in sexually transmitted disease in all groups; although as is to be expected the increase has been most marked in persons at the age of maximal sexual activity. Much has been said about young children, but cases of infection in those under the age of 16 form only a small part of the total incidence of disease: at the Whitechapel Clinic of The London Hospital in 1970 no cases of gonorrhoea in boys under 16 were diagnosed, compared with 1,270 cases in males over 16; there were five cases in girls under 16 compared with 608 cases in females over that age.

We have concentrated on the young girl as she is so vulnerable to social and medical disaster. The girl who persists in having casual intercourse without any contraceptive precaution is particularly liable. In such a case, full discussion with her mother, and with her family doctor, may at least prevent her from presenting herself for abortion later.

* This interpretation has been agreed to by the Medical Protection Society and by the Medical Defence Union.
The boy who manages to catch gonorrhoea from a girl in the back row of a cinema at the age of 15 is socially less vulnerable than the girl; it would seem that little useful medical or moral purpose would be served by informing his parents.

IMMUNIZATION AGAINST SEXUALLY TRANSMITTED DISEASES

There has been much discussion about the possibility of immunization against sexually transmitted disease (Dunlop, 1970). Well-substantiated cases have been reported of re-infection (or superinfection) with syphilis of patients suffering from congenital syphilis. One of the cases reported by Grimble and Hahn (1952) was that of a 29-year-old man suffering from untreated congenital syphilis who acquired darkfield-positive secondary syphilis. It is clear, therefore, that if methods of immunization are to provide prolonged and effective immunity they will have to do more than the disease itself does. Nevertheless, there has been progress in this field; Miller (1967) has produced measurable immunity to challenge with T. pallidum in rabbits immunized with suspensions of irradiated T. pallidum. Kuhn, Varela, Chandler, and Osuna (1968) have succeeded in infecting the chimpanzee with T. carateum, the cause of pinta, and this agent might be suitable for use in a vaccine.

With regard to gonorrhoea, the repeated attacks that we see in some patients do not lead us to believe that the disease itself produces much protective immunity. Perhaps some method of immunization may do more than the disease itself, but this has yet to be seen.

With regard to infection by Chlamydia, immunization has reduced the incidence of fresh trachomatous lesions for a limited period of time in certain areas in which trachoma is endemic. It may be that the incidence of genital infection by Chlamydia could be reduced in a similar manner.

In animal experiments there is evidence that severe disease may occasionally result in sensitized animals when they are challenged with the agent with which they were immunized. Apart from questions of effectiveness and of the possible medical hazards of immunization, there are the moral questions that would arise should effective methods be developed.

Exposure to disease, say to diphtheria, may be inevitable, irrespective of what the patient does. In contrast to this, exposure to sexually transmitted infection is dependent on what the patient and his or her sexual partner do. Moreover, it seems that the patterns of behaviour that lead to the sexual transmission of disease may be even more damaging to human happiness than the disease itself. Nevertheless, if it became possible to prevent sexually transmitted infection from developing in people who were anyway running the risk of infection, this would be an undoubted advantage to them, to their contacts, and to the community.

Summary

The incidence of sexually transmitted diseases in the community are due to the interaction between the seed (or agent), the soil (or host), and the social and moral climate. If sexual intercourse were to take place with one partner only, syphilis and gonorrhoea would disappear. Sexually transmitted infection, particularly gonorrhoea, tends to be clinically silent in women and in passive homosexual men, so that increasing promiscuity among these groups will result in an increasing incidence of infection. For heterosexual men the 'girl-friend' is now a more common source of gonorrhoea than the prostitute. State-controlled prostitution is proposed repeatedly as a means of reducing the incidence of sexually transmitted disease, but besides being morally unacceptable, the evidence suggests that it would not be effective. The 'girl-friend' is more accessible to contact-tracing than the prostitute, so that this major weapon in the control of gonorrhoea is proving more effective than formerly.

The 'generation gap' is probably of increasing importance and is due to the actions of the older generations as well as those of the younger.

In dealing with sexually transmitted disease in children we must be concerned with the underlying cause as well as the disease. Support for the child over a period of years may be necessary. However poor a girl's relationship with her mother may be, it is often a more valid relationship than any she can achieve at this time with another person. At 16 years of age and over confidentiality is absolute. In the case of the girl under 16, the mother or legal guardian should be informed if this is considered to be in the best interests of the child.

References


GRIMBLE, A. S.; and HAHN, R. D. (1952) Amer. J. Syph., 36, 439
Quelques problèmes posés par les maladies sexuellement transmissibles

SOMMAIRE

L’incidence des maladies sexuellement transmises dans la communauté est due à l’interaction entre la graine (ou agent), le terrain (ou hôte), et la température (ou climat social et moral). Si les rapports sexuels ne devaient s’échanger qu’avec un seul partenaire, la syphilis et la gonococcie disparaîtraient. Les infections sexuellement transmises, particulièrement la gonococcie, ont une tendance à être cliniquement silencieuses chez les femmes et chez les homosexuels masculins, si bien qu’une promiscuité accrue dans ces groupes entraînera une incidence accrue de l’infection. Pour les hommes hétérosexuels, la ‘girl-friend’ est maintenant une source de gonococcie plus habituelle que la prostituée. La prostitution réglementée est proposée à répétition comme un moyen de réduire l’incidence de maladies vénériennes mais, en dehors que ceci est inacceptable moralement, l’évidence suggère que ce serait inefficace. Il est plus facile de suivre les contaminations chez les ‘girl-friends’ que chez les prostituées, si bien que notre arme principale dans le contrôle de la gonococcie se montre plus efficace qu’auparavant.

Pour ce qui concerne les maladies sexuellement transmises chez les jeunes, nous devons nous intéresser aussi bien aux causes sous-jacentes qu’à la maladie elle-même. Il faut aider l’enfant pendant une période de plusieurs années. Si faibles que soient les rapports de la fille avec sa mère, c’est souvent une qualité de rapports plus valable que ce qu’elle peut obtenir à ce moment avec n’importe qui d’autre. À seize ans et plus, on doit accorder une confiance absolue. Au-dessous de seize ans, la mère ou le responsable légal doit être informé si ceci est considéré comme le meilleur intérêt de l’enfant.
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