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If a Man Needs a Gynecologist, Will He Be Able to Find One?

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In September 2013, the American Board of Obstetrics and Gynecology (ABOG) revised its definition of “obstetrician-gynecologist.” With few exceptions, gynecologists risked losing their board certification if they treated men. Anoscopy (on men) and vasectomy were explicitly prohibited (1). Pressure from the public and media (1), National Institutes of Health (NIH) and private letter-writing campaigns (2) resulted in the ABOG’s reversing its stance step by step until it fully reversed itself in January 2014 (2, 3, 4).

Although it may seem that restricting specialists in women’s medicine to treating only women should create neither hardship nor protest, it is in fact a problem. Gynecologists often provide essential treatment that men cannot easily obtain from other practitioners—for example, high-resolution anoscopy (HRA). The incidence of anal cancer is increasing in both women and men and is especially high in HIV-infected men who have sex with men (5). HRA-directed biopsy is an important part of the diagnostic evaluation for anal cancer and its precursors. A relatively new procedure, HRA utilizes advanced colposcopic skills and requires significant training and experience. Gynecologists, with their expertise in colposcopy, have been the quickest to master HRA and thus make up a large percentage of the limited number of clinicians qualified to perform the procedure in this country (1).

Gynecologists also play an important role in performing vasectomies. Although it is one of the safest and most cost-effective methods of contraception, vasectomy accounts for only 1 of 3 sterilizations in this country and is utilized preferentially by high-income white men (6). In rural and low-income areas, insufficient access to providers is one of the primary barriers to vasectomy. Gynecologists trained in the procedure during a family planning fellowship may be the only qualified, accessible providers in these areas (7).

There are other situations in which gynecologists are the most appropriate physicians for men. For example, debilitating pelvic pain can affect men (albeit less prevalently than

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women). With their wider exposure to this problem, gynecologists are often the only practitioners able to properly diagnose and treat pelvic pain in men (8).

Although, as noted, the ABOG has reversed all of these restrictions, we are troubled by the fact that a specialty board would attempt to limit the otherwise lawful and ethical practice of its diplomates. These restrictions raise ethical problems that go well beyond a simple public relations failure. Indeed, it is only in the context of an ethical failure that the ABOG's attempted policy initiative can be fully understood.

First, the restrictions relied on an untenable distinction between men and women. A division of humans into 2 sexes or genders is perforce arbitrary. Any such classification must account for at least 4 factors: chromosomal sex, genitalia present at birth, genitalia currently present, and lived identity (which may or may not be made to conform to expected appearances with hormones or other means). It is not necessary to list all of the possible combinations of these factors to see that only 2 unequivocally fit the male–female dichotomy the ABOG's edict created—intersexuality and transsexuality are completely unaccounted for. Although this may seem to be only an intellectual or practical problem, it is also an ethical one. By ignoring intersexual and transsexual persons when limiting the practice of gynecology, the ABOG ensured that such patients would be treated, or not treated, arbitrarily—in other words, unfairly. That the ABOG's policy had an exception for the treatment of “transgender conditions” (webpage no longer active) did not solve the problem. This exception was sufficiently vague it was unclear who could be treated for what. Moreover, it did not seem to cover intersexual nor transgender persons who may feel more comfortable with a gynecologist treating matters not related to their “transgender conditions.” By failing to account for these groups, the ABOG betrayed the trust of a vulnerable group of patients, who often receive their care from gynecologic endocrinologists.

Second, the ABOG's restrictions compelled individual practitioners to abandon active patients who may not have had adequate alternatives for care (1, 8). By forcing a physician to put identifiable patients at unnecessary risk, it goes to the heart (and abridges) the physician–patient relationship. In addition to being unethical (9), it could be considered malpractice (10).

Third, the restrictions discriminated against specific disadvantaged groups. As noted, gynecologists are especially important providers of vasectomy in underserved areas. In the case of HRA, those at greatest risk for anal cancer, and thus most in need of skilled HRA providers, are HIV-infected men who have sex with men.

A fourth issue is that the ABOG's action could have interfered with important NIH-sponsored research. Although HRA has been increasingly accepted as an important part of screening for anal cancer, optimal management of anal cancer precursors is unknown. A major NIH-funded study of HRA in anal cancer prevention is about to start, and restricting investigators to enrolling only women threatens the integrity of the study. The ABOG's reversal has resolved this problem, but its willingness to scuttle a valuable study of public interest should raise serious concern.

Nor did the ABOG's stated reasons for their action support the restriction they imposed. The ABOG wanted to address the problem of gynecologists branching out into practices for which they are not trained and that are not covered by their board certification, such as administering testosterone injections to men and practicing cosmetic medicine (1, 3). Many physicians performing these procedures are apparently claiming that they are board-certified without indicating that their certification is in gynecology, which is irrelevant to those areas (3). In addition to protecting the public, the ABOG wanted to protect its specialty's reputation from gynecologists who perform procedures for which they are unqualified (1). The ABOG also wanted to ensure an adequate supply of physicians to treat women and that women's health is not short-changed in research (3). However, none of these concerns justified a ban on treating men. If the goal was restricting gynecologists from performing procedures in which they are untrained or not board-certified, then that should have been the prohibition. A ban on treating men still allowed the problematic behavior to occur with female patients. Those few gynecologists treating male patients would not have materially reduced the number of physicians treating women, nor would it have affected research agendas or funding.

For all of these reasons, we believe that the ABOG's initial decision to impose restrictions on its diplomates' practice was deeply flawed, and are pleased it has made a full reversal. The ABOG should not have prohibited gynecologists from treating patients who need their help by performing skilled procedures for which these physicians are uniquely qualified. Medicine is constantly evolving, and arbitrary limitations on practice inhibit this development. The primary function of a medical board is to evaluate candidates in its primary specialty and to certify those qualified as "diplomates" of that board. In this way patients can be assured that a board-certified physician has kept up with the changes in his specialty. Medical boards should not attempt to interfere with qualified physicians rendering appropriate care to their patients.

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