THE MEDICALISATION OF SEXUALITY : THE CASE OF VIAGRA. Reply to the Secretary of State for Health

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The Secretary of State for Health, Bernard KOUCHNER, on June 23, 1998, referred to the French National Consultative Ethics Committee (CCNE) consideration of an innovative drug for the purpose of alleviating human erectile dysfunction. Marketing such products is evidence of a medicalisation of sexuality and consequently of social involvement in access to healthcare in this respect. Sildenafil was approved by the US Food and Drug Administration on April 27, 1998 and was approved for marketing in France, and more generally in Europe, in May 1998. It has been available for sale since October 1998, and therefore there is more than a year's experience of its use in France (250 000 users in 1998 and 1999, aged 20 to 88, according to the Pfizer Laboratories who market the product).

From the outset it was proffered as a therapeutic response to a new individual pathology, as though erectile dysfunction was independent of any relational or emotional context. In fact, the target population was composed of those suffering from the physiological attenuation of sexuality which is a consequence of ageing, thus giving the impression that younger men are not confronted with this problem. In targeting a particular group of often affluent people, the medical inference of accompanying comment was also an enhancement of the logic of performance, which has been presiding over sexuality for a generation. **Pathology, medicalisation, market-oriented thinking, and reference to a certain notion of performance, are the sociocultural characteristics surrounding the launch of the "sexuality drug".**

Sildenafil is a new therapeutic adjunct for impotence, in particular in the framework of neurological and vascular disorders, which are frequently combined with psychological complaints. It is a complement to other existing but more constraining treatment (local injection or prosthesis). Studies are in process to evaluate whether the ease of oral administration is a factor for greater efficacy. Like any other medication it has side effects and contra-indications which are now known. Besides organic pathologies, epidemiological studies have all demonstrated that the prevalence and severity of erectile dysfunction increase with advancing age. This in itself is sufficient to motivate reflection on the ease of use of the therapy for a large section of the population.

In this Opinion, CCNE considers the medical and sociocultural aspects connected to the use of Sildenafil.

Sexual activity, well-being and medicalisation

For each and every one of us, sexuality is an emblem of our personal history. A successful sex life is part of our well-being - even though an accomplished life may be an achievement in itself apart from sexuality - and the opposite is also true : a feeling of well-being is generally an essential contribution to sexual activity.
Recognition that sexual activity is not just linked to reproduction but is also an expression and a factor of well-being implies that its failure can be medically controlled. Seeking medical help is an obvious step when pathological infertility requires treatment to be decided on a case by case basis. On the other hand, sexual activity affected by age and various individual psychological circumstances suggests a return to the essential concept of personal self-appraisal. Quality and frequency of the sexual act are frequently broached as though referring to standards, but this approach does not necessarily have referential significance for a given individual. **It therefore appears obvious that medicalisation cannot aim to achieve a standard recommended by the medical profession or more generally designated by a societal choice.**
Recourse to medication in these circumstances may have other consequences besides correcting a disorder :
- *inter alia* , **creating a pathology, erectile dysfunction,** because a drug exists. The risk then arises of neglecting all the symbolic and environmental factors, and also the sexual partner;
- **restricting sexuality to the sole erectile function** through a reductive regression which could confuse the dysfunction of desire and mechanical functional disorders;
- encourage **striving for "performance"** - as is already visible in certain cases of very demanding sexual activity - or even dependence through the false promises of identity lost and found again.

Demand and medical management

Erectile dysfunction is part of impotence, but a part only. Isolating erectile dysfunction may sometimes lead to dissociating desire and erection and thus paradoxically, to conflict between partners. Reducing the sexual act to a simple mechanical erection is certainly a frequent attitude, but could lead to seeking help from the drug in the event of any sexual failure. Difficulty to achieve erection is part of a context which frequently requires a multidisciplinary approach with the participation on a case by case basis of urologists, sexologists, geriatricians, endocrinologists, psychologists, psychiatrists, cardiologists, and internists. In the absence of this multiple approach, if Sildenafil were to fail to produce results, the patient would be placed in a situation of behavioural psychic responsibility which would be difficult to accept whereas organic parameters are the cause of the problem.

Sildenafil is a "medication" for relationships . It concerns the most intimate part of a person's behaviour in life, and addresses one of the most secret and symbolic components of inter-personal alliances. In this respect, a partner may be confronted with various situations, ranging from lack of desire with no frustration to sexual dissatisfaction with far reaching repercussions on the history of a couple. When Sildenafil is prescribed, the sexual partner may paradoxically be disagreeably surprised in the first case by the revival of previously failing sexual activity, worry about new sexual vagrancy, or on the contrary flourish. The partner is therefore implicated in the therapeutic process and society must include the notion of a couple, without of course attributing legitimacy to one or other sexual option, but not forgetting that access to relational sexuality is quite obviously an important component of contentment.
It is therefore of the utmost importance that when a physician is faced with a request for therapy, he is able to distinguish between **an individual appeal from a man and a step taken by a couple** on the one hand, and between requests induced by organic pathology - particularly in the case of accidental trauma - and those subsequent to progressive

alteration of physiological competence, on the other hand. In the case of an individual appeal, desire may be confused with erectile dysfunction within a concept of masculine sexuality confined to erection "which can be seen and measured", a far cry from relational sexuality. An appeal made by a couple is reason enough to take into account the motivation and disquiet of each partner. It is not limited to requesting a pill. In any event, prescription unaccompanied by an appreciation of not just organic or vascular, but also psychological damage, is not acceptable for fear of giving the person and the couple concerned an illusion of reclaimed identity and creating a regrettable situation of dependence on a drug which would delay possible recovery.

For those reasons, any prescription must come after, if at all possible, a **reconstruction of the patient's personal case history** , which is an essential assignment for the family physician who can call on medical specialists and psychologists to provide an assessment, if needs be. If impairment is apparently a consequence of age, a gerontologist could act as an appropriate coordinator for the various disciplines involved. It is indisputable that Sildenafil broadens therapeutic horizons when authentic erectile dysfunction is concerned, insofar however as performance anxiety can be eliminated if possible.
In the circumstances, it should be possible to organise **truly educational courses** , including information on the **complexity** of sexual disorders and their psycho-social implications, for the benefit of health professionals, so that they may be trained to interpret the significance of a given sexual behaviour. Furthermore, CCNE considers that secondary school is not too early to provide information about sexual behaviour. This would help to give young people more individual understanding and personal empowerment in this respect.

Sociocultural aspects

Widely broadcast media prominence granted to this therapy is an encouragement to use it in situations of fragility which have no connection to the organic aspects of the symptom, and without taking into account the more complex factors discussed above.
Furthermore, CCNE is concerned about the impact of sociocultural factors which could partly explain why treatment improving the sex life of women, for the organic disorders caused by the menopause, have not given rise to the same amount of media coverage as treatment for age-related sexual dysfunction in men. Indeed, it is worth recalling that in menopausal women, hormone secretion cessation generates not just considerable organic alterations, but also sometimes hinders their sexual activity. In men, the age-related organic impact is much more progressive and the problem is limited to the functional aspect of sexual activity.
Another issue is to enquire into the non-spoken aspects of attitudes which either seek to facilitate or to censure the use of the drug. There is a visible shift from the marketing of a substance which is active in a given pathological situation, to a "convenience" drug, for the benefit of a larger number of individuals who are not in necessarily pathological circumstances. In this way, media coverage may induce or create a new pathology, which would be of benefit to major pharmaceutical corporations. Furthermore, it creates the illusion of a right based on individual needs and demands to which society is obliged to respond. One might well suppose that pressure of this kind will develop and create new needs. The existence of vulnerable targets could then lead to conditions akin to drug addiction.
The diversity of reimbursement policies adopted by various countries is testimony to the unease and cultural diversity presiding over management of this therapy (1). Generally speaking, most Western countries accept as legitimate that a pathology recognised as generating erectile dysfunction should give rise to the supply of a few pills (4 to 6) per month once a practitioner or specialist physician has taken the responsibility of prescribing them.
Sildenafil is thus a notable example of the more general issue **of medical management of well-being** , and of the **difficulty of establishing standards** , taking into account individual variations, divergent appreciation by an individual and society of the limits to be set upon a function, a performance, and consequently the therapeutic regimen applicable.

The subject is in fact germane to the issue of collective healthcare choices which CCNE has already explored (2). In this respect, for those whose task it is to make policy choices in the context of limited resources, Sildenafil raises the problem of which degenerative pathology to select for funding.

Summary and conclusions

CCNE emphasises that any alleviation of sexual dysfunction contributes to the well-being of an individual. However, sexual activity differs from other individual functions in that it is not vital, it is supported by the complex interaction of physical and mental factors, and frequently refers to another being's complementarity. It follows that this complementarity may signify in therapeutic terms more than is contained in the simple act of swallowing a pill.
CCNE has already formulated recommendations for drafting a law on the prevention and repression of sex abuse against minors and has reported on the sterilisation of the mentally handicapped. These are as many precedents for the medicalisation of sexuality which already seems irreversible.
The Committee sees as legitimate that society should help to reimburse Sildenafil in those cases where it is clear that erectile dysfunction is organically generated (surgical or medical disorder). However, it does not believe that society is obliged to take on the burden of alleviating any derangement in an individual's or a couple's sexuality in the absence of any known specific pathology, it being clear that ageing should not be equated to a pathology.
CCNE does consider that in a specific pathological context, Sildenafil and future similar substances now being evaluated for marketing, should be recognised as having medical status, but recalls that prescription of these drugs must remain under medical control, and insists that in this matter, the role of the physician cannot be restricted to a purely technical response. On the contrary, when the need arises, the medical profession must be ready to assist in achieving better management of the full complexity of sexuality.

Notes
(1) :On the same theme, in certain countries considerable reluctance to accept funding was observed as regards oestroprogestative contraception, contrasting sharply with the speed with which Sildenafil was authorised for use.

(2) Report n° 57 (May 25, 1998) **Technical progress, health and societal models : the ethical dimension of collective choices.**
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