COMMENTARY

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Paternalism in practice: How we create obstacles for sexual, reproductive, and menopausal healthcare despite our best intentions

Pa·ter·nal·ism: *the policy or practice on the part of people in positions of authority of restricting the freedom and responsibilities of those subordinate to them in the subordinates' supposed best interest*.[1]

Hopefully, you haven't judged this article by the title, because the aim is not to single out any gender, as we have *all* likely made paternalistic recommendations to patients based on our personal beliefs or fears, as opposed to evidence-based principles. As I reflect on close to 30 years of patient care, I have seen many examples of this within my field of women's health.

In theory, we all understand the concept of shared decision-making, but in practice, clinical recommendations are often still dictated, as opposed to being discussed. Patients are now better informed than ever before and may wish to discuss a variety of options. A perceived lack of choice has led patients to seek alternative sources for care, some of which may be harmful owing to less evidence or regulation. If a treatment is not within the doctor's comfort zone, of course there should be no obligation to prescribe. But in many circumstances, there are lost opportunities to align plans more closely with patient's priorities. Using specific women's health topics as representative examples, this article aims to show how clinical care may be improved using 3 principles: humility, advocacy, and flexibility.

MENOPAUSE MANAGEMENT: A CASE FOR HUMILITY

The evolution of the evidence on menopausal hormone therapy (MHT) safety and the response of the medical community to the unfolding of these data are great examples of the need for humility when proclaiming what we know to be medical "truth." After years of observational data suggesting strong cardiovascular benefits of MHT use, the initial results of the Women's Health Initiative (WHI) randomized placebo-controlled trial,[2] outlining the risks and benefits of MHT use, brought shockwaves to the clinical care of women, landing on the 2002 covers of Newsweek and Time magazines. Before this landmark trial, 1 of every 5 US women over the age of 40 was using MHT, and after this publication, close to 90% of women discontinued their hormones.[3] As doctors' offices were flooded with phone calls, the medical community was wondering how could we have been so wrong?

Those of us working as menopause specialists were trying to explain the limitations of the WHI data to colleagues, the subgroups with lesser risks, etc., but I suspect we sounded like rambling anarchists to the vast majority of clinicians who had already decided that MHT was associated with far too much risk to justify its use. But just because MHT was no longer "in," this did not change the fact that women were continuing to suffer with symptoms. Patients were encouraged to tough it out until symptoms subsided (which on average lasts over 7 years for most, and about a decade for Black women)[4] or go on nonhormonal treatment alternatives that were not nearly as effective and had their own list of side effects. As a US medical community, we tend to be risk-averse, which left many feeling that mainstream medicine had turned its back on them. This became fertile ground to foster an entire new industry of wellness clinics promoting the use of custom compounded hormones

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that came with big claims, celebrity endorsements, no scary package inserts, and potential for serious harm, including a possible increased endometrial cancer risk compared with conventional US Food and Drug Administration (FDA)-approved MHT.[5]

So was the observational evidence really so wrong?

Not really. Even though a full discussion on MHT is beyond the scope of this commentary, it is important to note that strong observational studies had shown 30% to 50% lower cardiovascular risk in MHT users, with an already known small increase in breast cancer risk.[6,7] As follow-up WHI publications were published over 20 years, the main messaging about the results evolved significantly. Initial concerns in 2002 about "substantial risks for cardiovascular disease and breast cancer"[8] were followed in 2003 by "the suggestion of a slight overall increase" in the risk of coronary heart disease (CHD),[9] changed in 2007 to "with no apparent increase in CHD risk for women close to menopause" and "total mortality reduced among women aged 50 to 59 years,"[10] and in 2017 to "no adverse influence on CHD, venous thromboembolism, or all-cause mortality" (for Black postmenopausal women with a hysterectomy).[11]

The grand finale is that US and European cardiac medical societies, who were often the most concerned about MHT risks, now note the acceptable safety profile in newly menopausal women (defined as women in their 40s and 50s or within a decade of menopause), specifically highlighting the favorable benefits of lower rates of diabetes, insulin resistance, and fracture.[12,13] It is again accepted that the time when MHT is initiated and the type of formulation used can guide whether there is an overall better risk-benefit ratio. Even the WHI authors noted how their own data have been used "inappropriately" in making decisions about treatment for women in their 40s and 50s who have distressing symptoms.[14] MHT is again officially considered an acceptable alternative to prevent fracture in those with low bone density,[15] though it has never come off my list of offered options.

But what about breast cancer risk?

We still see similar "lumping" of MHT fears regarding breast cancer risk, even though the 20-year WHI follow-up clearly shows that individuals using estrogen alone in this trial had a significant reduction in breast cancer incidence and mortality.[16] Though estrogen is not recommended for breast cancer prevention in those at high risk of developing breast cancer, it is notable that the medications used for this purpose, tamoxifen and aromatase inhibitors, have not yet shown a similar reduction in breast cancer mortality. The addition of a progestin to the MHT did indeed increase breast cancer risk after 3 to 5 years in the WHI study,[7] although other randomized controlled trials (RCTs) and observational studies have not shown similar risk increases.[6] The increase in breast cancer risk when progestin is used beyond 5 years is within the medical "rare" category of risk (less than 1 of 1,000 cases),[6,7] comparable to the increase in breast cancer risk seen with the consumption of a few alcoholic drinks per week. This degree of risk is considered acceptable to many patients who are carefully counseled in clinic.

No harm in avoiding hormones, right?

Interpreting the MHT data over time has not been easy. Discussions of complex data and concerns of scary diagnoses like heart disease and cancer make these conversations difficult to implement in a busy practice. With clinicians not having either the expertise or the time to address these concerns in clinic, not only were thousands of symptomatic women ill cared for, but also several generations of trainees were without exposure to menopause management with MHT. Most of us in menopausal medicine have noted colleagues making strong recommendations for our mutual patients to discontinue MHT, which had been prescribed after careful weighing of risks and benefits (including those practicing in a completely unrelated medical specialty, often causing a disproportionate degree of alarm for the patient). Given that several RCTs have suggested a 30% reduction in mortality with MHT use,[6] it is estimated that denial of estrogen-only therapy (with its better safety profile compared with estrogen-progestin therapy) may have led to more than 91,000 women who underwent hysterectomy (who would have needed estrogen alone) dying prematurely between 2002 and 2011.[17]

It has been 20 years since the first WHI publication, yet continuity of care in menopause clinics remains problematic, as there are far too few of us trained or certified in menopausal medicine (lists available at **menopause.org**). Every day, well-intentioned yet overly protective advice continues to unnecessarily limit MHT use in appropriate candidates. Luckily, the tide is turning, and new generations of trainees are being exposed to the most updated information, recognizing that there is an age-related window of opportunity for MHT use. In other words, when patients start therapy in their 40s or 50s, or within a decade of menopause, benefits are optimized, and risks are lower.

Unfortunately, this acceptance has come a little too late, with at least one-third of patients navigating toward unregulated products that can cause supraphysiologic hormone levels. We regularly see women in our clinics with male testosterone levels after compounded use of discouraged treatments such as hormone injections or pellets. It is important to help guide these patients back toward clinicians who are prescribing MHT in a safer, evidence-based approach, with adequate counseling about potential risks. Yet some patients have simply lost faith in "mainstream" medical care. Strong fluctuations in recommendations for or against a therapy over time (with exaggerated discussions of risks, while minimizing potential benefits) breed distrust not only in the clinician but also in the science itself. Most developments in medicine, when interpreted within the context of limitations, typically do not show that we were previously wrong but rather add pieces to a puzzle that make the picture clearer.

The humility lessons learned from the MHT story clearly concede that we are likely to be surprised by how medicine evolves and must acknowledge our patients' right to have open conversations and consider treatments that deviate from current mainstream thinking. We need to remember that even the most "true" medical recommendations may change with the evidence (aspirin use is a good example). Both risks *and benefits* of a treatment should be clearly discussed and the individual empowered to make their decision based on their own value system.

TREATING SEXUAL DYSFUNCTION: A CASE FOR ADVOCACY

Close to half of US women report some sort of sexual dysfunction that is reported as distressing in 1 out of 8.[18] Despite this, there were no treatments for hypoactive sexual desire disorder (HSDD) until the approval of the oral drug flibanserin in 2015.

Approval for flibanserin was tumultuous, as the FDA had unanimously rejected approval twice before. Before 2015, there were already 7 products to enhance male sexual health on the market. (I am not including testosterone, because it was not labeled for use for male low libido, although commonly used in clinical practice for that reason.) The FDA committee published its concerns about flibanserin, including "medicalizing" low sexual desire,[19] an argument that I believe questions the impact and validity of the HSDD diagnosis. Concerns about effectiveness were raised, even though the most validated tool to assess sexual health, the Female Sexual Function Index, had shown improvement. The committee noted that "an effect on daily recall of sexual desire was preferable,"[19] with a value judgment made that the primary end point of number of satisfying sexual events was not improved enough (despite recommendations otherwise by sexual health experts). In clinical practice, the most important factors to assess a woman's sexual health are more closely tied to what is measured on the Female Sexual Function Index (desire, arousal, lubrication, orgasm, satisfaction, and pain) as well as validated distress scoring systems, as opposed to the number of extra times she chooses to have sex that month.[19] If she had sex only one additional time, yet was happy with that outcome based on increased satisfaction and decreased distress, why would we think this is not good enough for her?

But shouldn't we protect female patients from harm?

Other FDA concerns were related to safety and tolerability. Before approval, there were several unusual stipulations imposed, most notably being subjected to additional studies focused on alcohol interactions with *substantial* alcohol servings (≥ 5 units). More specifically, individuals were asked to fast overnight, eat a light breakfast, then drink the alcohol equivalent of at least half a bottle of wine (typically within 10 minutes), while taking a dose of flibanserin (though package labeling calls for nighttime dosing). In these initial studies (some which consisted predominantly of men), concerns about orthostasis and hypotension prompted a risk evaluation and mitigation strategy, mandating that only certified prescribers and pharmacies could treat the patient, and that patients sign paperwork promising to avoid *any* alcohol intake.

I believe that all of this played a role in few pharmacists becoming certified due to unsubstantiated concerns (eg, that this could be used as a "date-rape drug") based on discussions on pharmacy LISTSERVs. In the postmarketing experience, we understand that alcohol use in real-world situations does not cause any more hypotension than placebo, and flibanserin has a side-effect profile that is comparable to, if not less than, that in women taking antidepressant medications (most common side effects are sedation and nausea).[20,21]

Barriers to wider uptake

There have been jokes made about flibanserin use. If it has minimal benefit but is going to make you nauseated and put you to sleep, what's the point? Yet for a woman distressed by her HSDD, who has chronic

insomnia and would like some of the appetite-suppressing effects of the medication (which may lead to ≥ 5% body weight loss),[21] it can be a great adjunct to her care, alongside traditional biopsychosocial management of sexual dysfunction. Postmarketing safety experience has allowed for the strict alcohol restrictions to be lifted, and package labeling now indicates only the need to space the medication and last drink apart by 2 hours. However, widespread utilization of flibanserin remains limited by cost and ongoing concerns about safety, and the need to avoid all alcohol is still noted within the top results following a quick Internet search.

Lack of awareness of flibanserin has also contributed to low uptake. Part of the FDA approval was contingent on the company agreeing to not run commercial advertisements for 18 months after its approval, with continued strict marketing oversight since that time.[22] As we hold this medication to a high standard of advertising ethics (which isn't a bad thing), my brain is bombarded with images of couples holding hands in adjoining bathtubs, one of the estimated 500 billion US television advertising impressions on erectile dysfunction between 2006 and 2009.[23] These advertisements have been criticized for their explicit content and lack of regulation; further, depending on the venue or timing, they have exposed minors to developmentally inappropriate information approximately 20% of the time—despite recommendations otherwise by the American Academy of Pediatrics.[23] Companies making male erectile dysfunction treatments have been some of the top spenders in direct-to-consumer advertising, leading to widespread use of these medications both clinically and recreationally, and they have even been linked to an increase in birth rates associated with television promotion.[24]

Holding female and male sexual health products to the same standards

So how is this tied to advocacy? It is important that female and male sexual health products are held to the same standards.

When the initial approval of sildenafil was fast-tracked in 1998, it was known to cause deaths when taken with nitrates, and hypotension when taken with alpha-blockers. However, female products have been subjected to unusually selective protocols and additional safety procedures. We now have a second FDA-approved treatment for HSDD, bremelanotide, self-administered by subcutaneous injection. Although bremelanotide was approved in 2019, insurance coverage remains a major barrier for both treatment options.

In contrast, there are 26 FDA-approved products for male sexual dysfunction. The concern is not simply the difference in number of treatment options between the sexes, but also the struggles of the approval and marketing processes, which have led some sexual health experts to raise concerns about paternalism within the FDA—ie, men get the choice of whether medication risks are worth it, and women need an additional layer of "protection" from harm.[25] I hesitate to speak negatively of any processes to ensure safety, but what is clear to me is that the voices of advocacy groups likely had a role in moving the approval process along, so much so that the FDA committee members felt compelled to publish their perspective and defend their processes in the *New England Journal of Medicine*.[19]

The approval process for first-in-class treatments for a new medical indication is clearly challenging. However, it is equally important to note that different sociocultural backgrounds and beliefs can contribute to biases, leading to differences in interpretation of overall treatment risk vs benefit,[25] and I suspect biases impact even more so the topic of female sexuality.

We need to advocate for more treatment options for HSDD, several of which are currently being studied. Even though RCTs have consistently shown the benefits and tolerability of testosterone replacement in women (when used at physiologic doses), the FDA has unanimously rejected the request to approve a testosterone patch. Ten US and international professional societies have come to the consensus that testosterone replacement may be tried for female HSDD, with several clinical recommendations on safe use.[26] Because there continues to be no FDA-approved way to replace testosterone in women, doing this safely remains a challenge,[27] again steering women toward unregulated and potentially harmful treatments such as high-dose pellets. And yes, these products have celebrity endorsements.

FAMILY PLANNING: A CASE FOR FLEXIBILITY

Like politics and religion, the topic of women's reproductive rights ignites passionate debates. The road to family-planning autonomy has been met with hurdles of all sorts, far too many to address here. In the absence of effective contraception, every time a female has sex with a sperm-producing partner (consensual or not), she may perceive it as a risk to her life, health, finances, career, or social support net-

TABLE 1
US Centers for Disease Control and Prevention Medical Eligibility Criteria for contraceptive use

Pre-existing condition	Contraceptive method											
	Cu-IUD		LNG-IUD		Implant		DMPA		POP		CHC	
	I	C	I	C	I	C	I	C	I	C	I	C
Nonmigraine headache (mild, severe)	1		1		1		1		1		1[a]	
Migraine without aura (includes menstrual migraine)	1		1		1		1		1		2[a]	
Migraine with aura	1		1		1		1		1		4[a]	
Stroke (history of cerebrovascular accident)	1		2		2	3	3		2	3	4	

1 No restriction (method can be used)
2 Advantages generally outweigh theoretical or proven risks
3 Theoretical or proven risks usually outweigh advantages
4 Unacceptable health risks (method not to be used)

[a] Additional stroke risk factors may change recommendation, shared decision-making advised.

C = continuing treatment; CHC = combined hormonal contraceptive; Cu-IUD = copper intrauterine device; DMPA = depot medroxyprogesterone acetate; I = initiating treatment; LNG-IUD = levonorgestrel intrauterine device; POP = progestin-only pill

Based on information in reference 28.

works. (For brevity, I'm referring to female or women as those individuals capable of becoming pregnant.) Effective contraception is underutilized among some of the women who need it the most: those with complex medical histories.

The establishment of the US Centers for Disease Control and Prevention (CDC) Medical Eligibility Criteria has been a great resource for clinicians who want to expand their knowledge of appropriate candidates for various contraceptive methods.[28] However, the pink and red sections of the CDC Medical Eligibility Criteria tables that show potential contraindications to a method in the setting of various medical comorbidities (**Table 1**)[28] can cause clinicians to be overly restrictive in their prescribing. For example, the use of estrogen-containing combined hormonal contraceptives (CHCs) in those who have migraines with aura is strongly discouraged because of a potential increased stroke risk (though absolute risks are low with the use of modern methods).[29] Certainly, for pregnancy prevention alone, if a progestin-only option is tolerated, that would be preferred. However, women may need (or prefer) CHCs to treat a medical condition, in which case the risk-benefit ratio changes. Not uncommonly, I will prescribe a method with a known contraindication, but only after a detailed discussion about pros and cons of different contraceptives—and after the patient verbalizes understanding and provides consent.[29,30]

Two guiding principles of reproductive care

As a consultant for the contraceptive and hormonal needs of our medically complex patients, I follow 2 guiding principles in managing patient care. First, the contraceptive that the patient prefers is the one she is most likely to use after she leaves my office. Second, no matter what the risks of any contraceptive, the risks of an unintended pregnancy are always far greater. Fortunately, some guidelines do soften language to address necessary variations in practice (eg, newer migraine guidelines since the publication of the CDC eligibility criteria) and emphasize the importance of shared decision-making, as opposed to a universal recommendation to withhold CHCs in those with migraine with aura.[29,31]

The contraceptive that the patient prefers is the one she is most likely to use, and whatever the risks of any contraceptive, the risks of an unintended pregnancy are always far greater

In the absence of contraindications, clinicians also withhold prescriptions because patients are not up-to-date with health screenings such as Papanicolaou tests or breast examinations. Removing barriers to effective contraception is not only evidence-based, it is also encouraged by guidelines.[32] For example, to qualify a patient for CHCs, a prescriber needs only

a medical history and a recent blood pressure reading, which can be obtained outside of the office. With excessive restrictions from doctors' offices, patients have turned to online prescribing companies that use online questionnaires to offer CHCs in an evidence-based way, with an average appointment time of 7.5 minutes, for a total average yearly cost of $313 per prescription, including cost of visit and 1 year of refills.[33] There has been a call for more widespread expansion of over-the-counter contraceptives, which is already a reality in many US states but has had slow uptake. Thus, improving access with virtual visits is encouraged, especially visits during nonbusiness hours.

Fear as an obstacle

The fear of a serious thrombotic complication from a preventive medication in a young healthy woman is understandable. The US medical-legal environment is a hostile one. Between 2008 and 2015, approximately $2 billion in litigation was disputed against the most popular CHC of that time, with ads on social networking platforms soliciting participation in lawsuits directed at the manufacturer, as opposed to individual clinicians.[34] (Interestingly, settlements were related to risks clearly outlined in the product package insert.) I suspect that much of the litigation was not related to altruistic concerns about safety, as the evidence is not convincing of a major difference in risk of this CHC compared with others, but was instead attracted by the "deep pockets" of the pharmaceutical company producing the brand- name pill. Not surprisingly, the lawsuits quickly fizzled after the medication became generic.

We cannot let medical-legal fears get in the way of listening to the patient and providing for her contraceptive choices. Flexibility in addressing contraceptive preferences is now even more critical in the setting of limited access to abortion throughout different regions of the country.

CARING FOR EACH INDIVIDUAL PATIENT

Throughout my career, I may have raised the eyebrows of some colleagues who considered my prescribing to be careless, when in fact that prescription was written after careful thought and discussion, but ultimately leaving the final decision in the hands of the informed person that is impacted most by that prescription. In embracing flexibility and humility in practice, I have moved another step away from paternalistic care, which I believe has positively affected the lives of those I have had the privilege to care for. I hope this article moves me one step closer to being a better advocate.

DISCLOSURES

The author reports no relevant financial relationships which, in the context of her contributions, could be perceived as a potential conflict of interest.

REFERENCES

1. **Oxford English Dictionary.** 'art, n. 1.' OED online. Oxford University Press.
2. **Rossouw JE, Anderson GL, Prentice RL, et al.** Risks and benefits of estrogen plus progestin in healthy postmenopausal women: principal results From the Women's Health Initiative randomized controlled trial. JAMA 2002;288:321–33
3. **Sprague BL, Trentham-Dietz A, Cronin KA.** A sustained decline in postmenopausal hormone use: results from the National Health and Nutrition Examination Survey, 1999–2010. Obstet Gynecol 2012; 120(3):595–603. doi:10.1097/AOG.0b013e318265df42
4. **Avis NE, Crawford SL, Greendale G, et al.** Duration of menopausal vasomotor symptoms over the menopause transition. JAMA Intern Med 2015; 175(4):531–539. doi:10.1001/jamainternmed.2014.8063
5. **Davis R, Batur P, Thacker HL.** Risks and effectiveness of compounded bioidentical hormone therapy: a case series. J Womens Health (Larchmt) 2014; 23(8):642–648. doi:10.1089/jwh.2014.4770
6. **Lipold LD, Batur P, Kagan R.** Is there a time limit for systemic menopausal hormone therapy? Cleve Clin J Med 2016; 83(8):605–612. doi:10.3949/ccjm.83a.15161
7. **Pederson HJ, Batur P.** Use of exogenous hormones in those at increased risk for breast cancer: contraceptive and menopausal hormones in gene carriers and other high-risk patients. Menopause 2023; 30(3):341-347. doi:10.1097/GME.0000000000002136
8. **Rossouw JE, Anderson GL, Prentice RL, et al.** Risks and benefits of estrogen plus progestin in healthy postmenopausal women: principal results from the Women's Health Initiative randomized controlled trial. JAMA 2002; 288(3):321–333. doi:10.1001/jama.288.3.321
9. **Manson JE, Hsia J, Johnson KC, et al.** Estrogen plus progestin and the risk of coronary heart disease. N Engl J Med 2003; 349(6):523–534. doi:10.1056/NEJMoa030808
10. **Rossouw JE, Prentice RL, Manson JE, et al.** Postmenopausal hormone therapy and risk of cardiovascular disease by age and years since menopause [published correction appears in JAMA 2008; 299(12):1426]. JAMA 2007; 297(13):1465–1477. doi:10.1001/jama.297.13.1465
11. **Chlebowski RT, Barrington W, Aragaki AK, et al.** Estrogen alone and health outcomes in black women by African ancestry: a secondary analyses of a randomized controlled trial. Menopause 2017; 24(2):133–141. doi:10.1097/GME.0000000000000733
12. **El Khoudary SR, Aggarwal B, Beckie TM, et al.** Menopause transition and cardiovascular disease risk: implications for timing of early prevention: a scientific statement from the American Heart Association. Circulation 2020; 142(25):e506–e532. doi:10.1161/CIR.0000000000000912
13. **Maas AHEM, Rosano G, Cifkova R, et al.** Cardiovascular health after menopause transition, pregnancy disorders, and other gynaecologic conditions: a consensus document from European cardiologists, gynaecologists, and endocrinologists [published correction appears in Eur Heart J 2022; 43(25):2372]. Eur Heart J 2021; 42(10):967–984. doi:10.1093/eurheartj/ehaa1044
14. **Manson JE, Kaunitz AM.** Menopause management—getting clinical care back on track. N Engl J Med 2016; 374(9):803–806. doi:10.1056/NEJMp1514242
15. **The NAMS 2017 Hormone Therapy Position Statement Advisory Panel.** The 2017 hormone therapy position statement of the North American Menopause Society. Menopause 2017; 24(7):728–753. doi:10.1097/GME.0000000000000921

16. **Chlebowski RT, Anderson GL, Aragaki AK, et al.** Association of menopausal hormone therapy with breast cancer incidence and mortality during long-term follow-up of the Women's Health Initiative randomized clinical trials. JAMA 2020; 324(4):369–380. doi:10.1001/jama.2020.9482
17. **Sarrel PM, Njike VY, Vinante V, Katz DL.** The mortality toll of estrogen avoidance: an analysis of excess deaths among hysterectomized women aged 50 to 59 years. Am J Public Health 2013; 103(9):1583–1588. doi:10.2105/AJPH.2013.301295
18. **Shifren JL, Monz BU, Russo PA, Segreti A, Johannes CB.** Sexual problems and distress in United States women: prevalence and correlates. Obstet Gynecol 2008; 112(5):970–978. doi:10.1097/AOG.0b013e3181898cdb
19. **Joffe HV, Chang C, Sewell C, et al.** FDA approval of flibanserin—treating hypoactive sexual desire disorder. N Engl J Med 2016; 374(2):101–104. doi:10.1056/NEJMp1513686
20. **Millheiser L, Clayton AH, Parish SJ, Kingsberg SA, Kim NN, Simon JA.** Safety and tolerability of evening ethanol consumption and bedtime administration of flibanserin in healthy premenopausal female subjects. Sex Med 2019; 7(4):418–424. doi:10.1016/j.esxm.2019.08.003
21. **Kingsberg SA, McElroy SL, Clayton AH.** Evaluation of flibanserin safety: comparison with other serotonergic medications. Sex Med Rev 2019; 7(3):380–392. doi:10.1016/j.sxmr.2018.12.003
22. **Department of Health and Human Services.** The Office of Prescription Drug Promotion (OPDP) of the US Food and Drug Administration (FDA). Warning letter to Sprout Pharmaceuticals, Reference ID: 4664256. https://www.fda.gov/media/142146/download. Accessed March 2, 2023.
23. **Arnold DG, Oakley JL.** The politics and strategy of industry self-regulation: the pharmaceutical industry's principles for ethical direct-to-consumer advertising as a deceptive blocking strategy. J Health Polit Policy Law 2013; 38(3):505–544. doi:10.1215/03616878-2079496
24. **Kim T, Diwas KC.** Can Viagra advertising make more babies? Direct-to-consumer advertising on public health outcomes. J Marketing Research 2020; 57(4) 599–616.
25. **Dooley EM, Miller MK, Clayton AH.** Flibanserin: from bench to bedside. Sex Med Rev 2017; 5(4):461–469. doi:10.1016/j.sxmr.2017.06.003
26. **Davis SR, Baber R, Panay N, et al.** Global consensus position statement on the use of testosterone therapy for women [published correction appears in Climacteric 2019; 22(6):637]. Climacteric 2019; 22(5):429–434. doi:10.1080/13697137.2019.1637079
27. **Smith T, Batur P.** Prescribing testosterone and DHEA: the role of androgens in women. Cleve Clin J Med 2021; 88(1):35–43. doi:10.3949/ccjm.88a.20030
28. **Curtis KM, Tepper NK, Jatlaoui TC, et al.** US medical eligibility criteria for contraceptive use, 2016. Updated recommendations MMWR Recomm Rep 2016; 65(3):1–103. doi:10.15585/mmwr.rr6503a1
29. **Batur P, Yao M, Bucklan J, et al.** Use of combined hormonal contraception and stroke: a case-control study of the impact of migraine type and estrogen dose on ischemic stroke risk. Headache 2023. [Epub ahead of print] doi:10.1111/head.14473
30. **Calhoun AH, Batur P.** Combined hormonal contraceptives and migraine: an update on the evidence. Cleve Clin J Med 2017; 84(8):631–638. doi:10.3949/ccjm.84a.16033
31. **Sheikh HU, Pavlovic J, Loder E, Burch R.** Risk of stroke associated with use of estrogen containing contraceptives in women with migraine: a systematic review. Headache 2018; 58(1):5–21. doi:10.1111/head.13229
32. **Batur P, Berenson AB.** Are breast and pelvic exams necessary when prescribing hormonal contraception? Cleve Clin J Med 2015; 82(10):661–663. doi:10.3949/ccjm.82a.15055
33. **Jain T, Schwarz EB, Mehrotra A.** A study of telecontraception. N Engl J Med 2019; 381(13):1287–1288. doi:10.1056/NEJMc1907545
34. **Batur P, Casey PM.** Drospirenone litigation: does the punishment fit the crime? J Womens Health (Larchmt) 2017; 26(2):99–102. doi:10.1089/jwh.2016.6092

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