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The human sexuality education of physicians in North American medical schools

DS Solursh[1], JL Ernst[1], RW Lewis[2], L Michael Prisant[3], TM Mills[4], LP Solursh[1], RG Jarvis[5], WH Salazar[1,5]*The Human Sexuality Multispecialty Group, Medical College of Georgia

[1]*Department of Psychiatry and Health Behavior, Medical College of Georgia, Georgia, USA;* [2]*Department of Surgery/Urology, Medical College of Georgia, Georgia, USA;* [3]*Department of Medicine/Cardiology, Medical College of Georgia, Georgia, USA;* [4]*Department of Physiology/Surgery (Urology), Medical College of Georgia, Georgia, USA; and* [5]*Department of Medicine, Medical College of Georgia, Georgia, USA*

Individuals seeking treatment for sexual problems frequently would like to turn to a source they consider knowledgeable and worthy of respect, their doctor. The objective was to assess how well the 125 schools of medicine in the United States and the 16 in Canada prepare physicians to diagnose and treat sexual problems. A prospective cohort study was carried out. The main outcome results were description of the medical educational experiences, teaching time, specific subject areas, clinical programs, clerkships, continuing education programs in the domain of human sexuality in North American medical schools. The results were as follows. There were 101 survey responses (71.6%) of a potential of 141 medical schools (74% of United States and 50% of Canadian medical schools). A total of 84 respondents (83.2%) for sexuality education used a lecture format. A single discipline was responsible for this teaching in 32 (31.7%) schools, but a multidisciplinary team was responsible in 64 (63.4%) schools (five schools failed to respond to the question). The majority (54.1%) of the schools provided 3–10 h of education. Causes of sexual dysfunction (94.1%), its treatment (85.2%) altered sexual identification (79.2%) and issues of sexuality in illness or disability (69.3%) were included in the curriculum of 96 respondents. Only 43 (42.6%) schools offered clinical programs, which included a focus on treating patients with sexual problems and dysfunctions, and 56 (55.5%) provided the students in their clerkships with supervision in dealing with sexual issues. In conclusion, expansion of human sexuality education in medical schools may be necessary to meet the public demand of an informed health provider.
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Introduction

The diagnosis, evaluation, and treatment of sexual problems are no longer a subject that patients avoid in approaching their physician for help. Affecting a significant proportion of men and women, sexual dysfunction is associated with aging, medical and psychological problems, trauma, and surgical and drug therapies.[1–6] The consequences include depression, altered interpersonal relationships, and nonadherence to treatment.[3,6,7]

In 1993, the National Institute of Health's Consensus Statement on Impotence concluded that the health professions are relatively uninformed or misinformed about sexual matters and fail to deal candidly with them.[8] To improve professional knowledge, the NIH Consensus Conference recommended: (1) human sexuality courses in the curricula of graduate schools for all health care professionals, emphasizing a detailed sexual history as part of the medical history; (2) diagnosis and management of sexual dysfunction in continuing medical education courses; and (3) an interdisciplinary approach to the diagnosis and treatment of sexual dysfunction. While erectile dysfunction was the focus of the 1993 Consensus Statement, an even broader view is now necessary to encompass the totality of sexual dysfunction since sexual dysfunction is more prevalent for women (43%) than men (31%).[1]

People experiencing such distress, when they do reach the point of deciding to seek help, most frequently would like to seek help from a physician, someone they respect and trust, commonly a family practitioner, psychiatrist, urologist, or gynecologist. However, the physician approached often feels

*Correspondence: WH Salazar, Department of Psychiatry and Health Behavior, Medical College of Georgia, 1120, 15th Street, Room HB-2010, Augusta, Georgia 30912, USA.

neither comfortable with the topic of sexuality, nor competent to deal with the questions and sexual problems identified by the patient. A recent article reports that 75% of patients believe that their doctors would dismiss their sexual health concerns and 68% thought they would embarrass their physician.[9] Why is it that physicians are so uncomfortable with sexuality? And why do they not feel better prepared to respond to sexual issues presented by their patients? How much training in human sexuality do medical practitioners receive? In the 1970s, Harold Lief and his colleagues attempted to survey medical schools at a time when the sexual revolution of the 1960s had sexologists optimistic about sexuality becoming a basic component of medical training.[10] By 1995, when Barratt reviewed medical school calendars, the optimism had faded. 'Ninety percent of medical schools are doing virtually nothing (in the area of human sexuality)' he wrote in his unpublished dissertation.[11]

Purpose of the present study

A survey was conducted among North American medical schools in order to assess the current status of how well the 125 medical schools in the United States and 16 medical schools in Canada prepare physicians to diagnose and treat sexual problems.

Method

Study population

A questionnaire was constructed to assess the educational experiences related to Human Sexuality for undergraduate medical students of North American medical schools. This simple one-page checklist, designed to maximize the response rate, was sent to 125 medical schools in the United States and 16 in Canada (AAMC).[12] The person who coordinated or had some sort of overview of the total undergraduate curriculum for the medical students at each particular medical school was asked to respond to the survey. Respondents were asked to return by e-mail, fax, or mail the completed survey instrument. Failure to return the survey resulted in multiple attempts to contact the institution to maximize the number of medical school responses.

Survey content

With respect to educational experiences on human sexuality for undergraduate medical students, the survey questioned the type of educational experiences (lectures, courses, or series of courses), whether the educational experiences were required or elective, whether a single discipline (anatomy, physiology, urology, psychiatry, etc) or multiple disciplines were responsible for the educational experiences, and the total number of hours of lecture or course time that was devoted to human sexuality topics. We also asked about specific subject areas included in the curriculum (ie the causes of human sexual dysfunction, the treatment of sexual dysfunction, issues of sexuality and sexual function among persons who are chronically ill or disabled, and altered sexual identification). Furthermore, we inquired if there was a clinical program that specifically focused on treating patients with sexual problems and dysfunctions and whether medical students had the opportunity to work with those patients. We also queried about the provision of continuing medical education programs for professionals interested in human sexual function, sexual dysfunction or related subjects. Finally, an opportunity was provided for comments and additional information.

Results

From June through August 1999, the survey was sent to the existing 125 American and 16 Canadian medical schools. (Follow-up phone calls/e-mails took place from October, 1999, to May, 2000.) Numerous calls were sometimes required to find someone who would take responsibility for filling out the questionnaire. In a number of instances, there did not seem to be one person who had an overview of the curriculum. Sometimes there was such a person designated, but they recognized deficiencies in their program, were embarrassed by the prospect of returning a blank survey instrument to us, and simply failed to respond, as we determined with follow-up phone calls. Occasionally, the failure to respond meant that no human sexuality program was in existence at a particular school. For example, two schools that did respond admitted they did not devote any time to human sexuality in their training of medical students.

A total of 103 responses (including two duplicate responses from the same medical school) were received. Thus, there were 101 valid responses (71.6%) from a potential of 141 medical schools. Of the 101 surveys, 93 (74.4%) of a potential 125 medical schools came from the United States (including two from Puerto Rico), and eight (50%) from 16 medical schools in Canada. Figure 1 shows the geographical distribution of the respondents, which reflects the actual distribution of medical schools in North America.

The educational experience reported most often was a lecture format for 84 respondents (87.5%), which was a curriculum requirement in 82 medical schools and elective for two. Human sexuality was taught as a course in 31 schools and was required by 26 of them. In five medical schools, there were a series of courses required. Five medical schools did not indicate the specific education format.

Ninety-six medical schools indicated who taught human sexuality. A single discipline was responsible in 32 (31.7%) schools and multiple disciplines in 64 (63.4%) schools. Psychiatry was the discipline most frequently involved, teaching in 75.3% of the medical schools.

Figure 2 shows the distribution of actual hours taught. As noted above, two schools specifically stated that they did not provide instruction relating to human sexuality, and four more said they had no idea how many actual hours of instruction they gave. Almost all the other schools had at least 3 h of training, with the majority (54.1%) having 3–10 h. Surprisingly, a third of the schools (32.7%) had 11 or more hours devoted to such teaching. Five respondents actually commented that they were embarrassed by how little time their schools gave to the topic of sexuality or that the instructional time was being reduced.

Causes of sexual dysfunction (94.1%), the treatment of sexual dysfunction (85.2%), altered sexual identification (79.2%) and issues of sexuality and sexual function in illness or disability (69.3%) were included in the curriculum of the 93 respondents. Other topics covered by some medical schools included sexually transmitted diseases, infertility, sexual abuse, and sex across the life span.

Although 81% of the responding schools listed human sexuality as a lecture requirement for their medical students, only 43 (42.6%) medical schools offer a specific clinical program in which patients with sexual problems and/or dysfunctions are treated. It is interesting to note that, of these 41 schools, 14 (34%) did not report supervised clerkship experiences in these focused programs. Overall, 56 (55.5%) medical schools allowed medical students in their clerkships to have an opportunity to work under supervision with patients receiving treatment and/or education for sexual problems or dysfunctions. As far as continuing medical education is concerned, only 45 (44.6%) of the medical schools offered courses about sexuality for professionals interested in human sexual function or dysfunction or related topics.

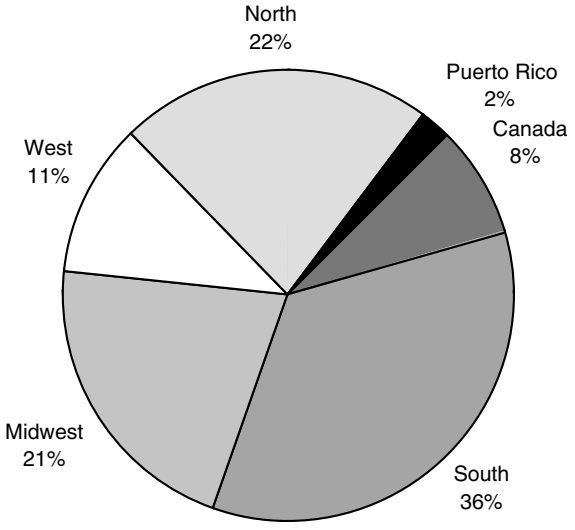

Figure 1 Geographical distribution of the respondents.

Comment

While some medical schools offered their students very little training in the area of human sexuality, there were others, which offered extremely sophisticated programs. For example, the Universite de Sherbrooke in Quebec, Canada, requires medical students to attend a 4-day 'Human Sexuality Camp,' a type of retreat led by a Clinical Sexologist and a Urologist. At the retreat, medical students begin an intensive self-examination of their attitudes and sensitivities toward various aspects of sexuality and sexual problems. It is hoped that by so doing, the students will become more generally comfortable with sexual issues and correspondingly more open to questions presented to them by patients. This

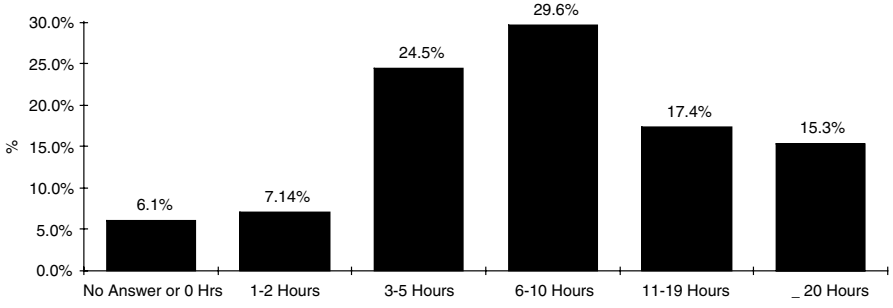

Figure 2 Distribution of hours of human sexuality taught in medical schools.

focus on attitude seems to be a particularly Canadian dimension of medical student training and was mentioned by several of the Canadian respondents.

Limitations of this study

Our survey is an initial attempt to establish a picture of human sexuality training currently offered to American and Canadian medical students.

To encourage responses, the survey instrument was intentionally brief, rather than comprehensive (and therefore lengthy) in composition. This may have limited the amount of information received, although comments were solicited. Results indicated that there is enormous variability in how much and what training in human sexuality is offered to medical students at different schools. No curriculum guidelines pertaining to human sexuality education were found. There are no standardized tests. Overall, it would appear that more is being offered than we originally expected. However, we are limited in a complete picture by the fact that 28% of medical schools did not respond to the survey, despite repeated attempts to obtain a response to our questionnaire. Thus, the number of hours of instruction reported here may be inflated since it could be that the nonrespondents offered little in human sexuality education. (Reinforcing this impression is the fact we were able to do online reviews of the calendars for 16 of the nonresponding schools. Only one mentioned 'Sexuality' in the curriculum description, a course on 'Sexual Orientation' offered at the Residency level.)

A second limitation of the current study is that 'human sexuality' is not specifically defined in either our survey instrument or by those responding to it. The hours of instruction could be embedded in courses on reproduction, infectious disease, etc. Therefore, comparability of schools reporting similar results cannot be assumed. Ideally, a select subsample of respondent schools (such as those reporting 20 or more hours of instruction) could be followed up to determine the specific allocation and content of instruction time.

Conclusions

In training clinicians, one must bear in mind the tripartite goal of developing appropriate knowledge, skills, and attitude—all three of equal importance for training an effective practitioner. American medical schools appear to stress the knowledge component and secondarily that of skills. Canadian schools appear to have a somewhat more balanced approach, in the sense that they spend proportionally more time exploring attitudes and beliefs relating to sexuality. Whether American or Canadian, in the end the student must be open and willing to listen to and take to heart the personal messages contained in sexuality lectures and courses, in assigned readings, in the comments of attendings and supervisors, in cases presented at rounds, and most importantly in 'clinical moments' with patients of all kinds.

Reflecting back to the National Institute of Health's 1993 Consensus Statement on Impotence, how close to the NIH recommendations are the medical school programs we surveyed? From these survey results, it would appear less than a third of the respondent medical schools offer a required course on human sexuality and even fewer teach medical students how to take a detailed sexual history. Furthermore, about half of the survey respondents (48.5%) do not offer continuing medical education courses on sexuality. Finally, just 63.4% of the respondent schools use multidisciplinary faculty to teach about sexuality. It is important for the medical professional to integrate sexual physiology and sexual dysfunction into the global health of patients. The starting point is how we educate in medical schools.

Summary

This report provides the first direct survey of sexuality education in medical schools that has been done since Lief's work in the 1970s. Efforts at education in human sexuality is occurring in most responding medical schools using a multidisciplinary approach. Most medical schools provide 3–10 h of instruction. Most schools do not provide specific clinical programs or continuing medical education. The public desire for professional help demands expanded efforts by medical schools.

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