Sexual Addiction & Compulsivity, 18:1–11, 2011

ISSN: 1072-0162 print / 1532-5318 online
DOI: 10.1080/10720162.2011.560035

Routledge
Taylor & Francis Group

EDITORIAL

Human Sexuality and Health Professions Students—Lessons Learned from an Electronic Bulletin Board

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INTRODUCTION

In Fall 2010, I was asked to be the course director for the human sexuality unit of the medical students' and physician assistants' curriculum at the medical school where I am on faculty. Given my clinical and academic interests, I was honored and excited to teach the subject matter. I soon learned, however, that this was not an easy task. The class consisted of more than 220 students, both second year medical students and first year physician assistant students. These students have not chosen their medical specialties nor had they had much clinical exposure. Furthermore, the large class size prohibited me from using a seminar style of teaching which might have been better suited for such a complex topic. The curriculum was limited to a total of 18 hours, spliced between other courses such as pharmacology, biochemistry, etc. Human sexuality is not directly covered on the United States Medical Licensing Exam (USMLE) or the licensing exam for physician assistants. Hence, the course was not viewed by many students as an essential medical education topic.

Given that is was my first time teaching this course, I wanted to ensure that I was able to get feedback from the students in a safe and confidential manner. I also wanted the students to have a forum where they could share diverse viewpoints and dialog about topics related to human sexuality that interested them. Since this was not easily done in the lecture hall, I created an online bulletin board where students could post (either anonymously or by name) their thoughts both on the content and process of the course. While I allowed anonymous postings in order to preserve a "safe" environment, I also moderated the forum to ensure that inappropriate, irrelevant, or personally offensive comments were not posted.

In this editorial, I would like to share with you some of these comments along with my thoughts on their meaning and the implications they have for the medical professions' approach to both human sexuality education and clinical practice.

BACKGROUND

It has long been recognized that many physicians do not feel comfortable addressing the sexual problems of their patients (Sciolla, Ziajko, & Salguero, 2010; Sholursh et al., 2003). Up to 62% of medical students indicate that they do not feel they have received adequate training in sexual health (Wittenberg & Gerber, 2009). It is estimated that anywhere from 14 to 44% of US and Canadian medical schools have no formal curriculum in human sexuality, and of those schools many "curriculums" are under 11 hours and are predominantly lecture-based (Malhotra, Khurshid,Hendricks,& Mann, 2008; Sholursh et al., 2003; Tamas, Miller, Martin, & Greenberg, 2010). A review of model curriculums have also found important missing elements in almost all of them (Galletetly, Lechuga, Layde, & Pinkerton, 2010). It also has been found that a high percentage of medical students both identify feeling uncomfortable addressing sexual topics and, when observed, fail to ask important questions about sexual behaviors to standardized patients (Cook et al., 1998; Frank, Coughlin, & Elon, 2008). Finally, patients perceive that their doctors will not be interested in or uncomfortable with their sexual problems even though sexual health was important to them (Marwick, 1999).

The above data along with epidemiological data surrounding STI's, unwanted pregnancy, and sexual violence have lead both the Surgeon General and the Journal of the American Medical Association to charge physicians and medical schools to develop strategies to improve sexual health (Satcher, 2001; Swartzendruber & Zenilman, 2010).

The Human Sexuality Curriculum at GW

The original human sexuality curriculum was developed in the late 1970s as a way of exposing medical students to diverse sexual practices. Fondly labeled "Sex Week," the curriculum predominantly was comprised of educational pornographic movies. The thought was that many of the students came from "sheltered" backgrounds and needed to be exposed to sexual practices that might arise in their clinical practices.

In subsequent years, the curriculum developed into a more formal educational experience with patient/provider panels, videos, lectures, and discussions. The course includes faculty from various healthcare professional backgrounds (MD, PA, NP, PhD, LICSW) as well as disciplines (Psychiatry, Social Work, Internal Medicine, Ob/Gyn, Urology, Adolescent Medicine, Geriatrics, and Infectious Disease).The background and reasoning on what topics to include (or exclude) in a sexual health curriculum for healthcare professionals is outside the scope of this editorial. The curricular units can be found in Table 1. An effort was made to move away from didactics and emphasize panels, movies, discussions, and demonstrations. The large student to teacher ratio along with limited room availability and limited allotted

TABLE 1 GW Human Sexuality Curriculum 2010

Unit 1: Human Sexuality Overview
Lecture: Introduction to Human Sexuality/Sex on the Net
Lecture: Male Sexual Response
Lecture: Female Sexual Response
Lecture: Sexual Dysfunction
Unit 2: Human Sexuality in the Primary Care Setting: A Developmental Approach
Panel Discussion: Adolescent Medicine, Internal Medicine, Ob/Gyn and Geriatrics
Unit 3: LGBQ Healthcare
Lecture: Sexual Orientation
Panel Discussion: LGBQ Physical and Mental Health
Unit 4: Diverse Sexual Practices and the Sexual Disorders
Lecture: Sexual Disorders and Paraphilias
Movie and Discussion: *Addicted to Sex*
Unit 5: Transgender Healthcare
Lecture: Gender Identity
Transgender Health 101
Transgender Healthcare Patient/Provider Panel Discussion
Unit 6: Applying Human Sexuality to Clinical Practice
Demonstration and Discussion: Sex Therapy
Lecture and Discussion: Sex and Culture
Unit 7a: Safer Sex Practices
Demonstration: Safer Sex Practices/nPEP
Scenario 1: Newly Diagnosed HIV
Scenario 2: High Risk Sexual Behavior
Unit 7b: Professional Boundaries
Movie and Discussion: *Hazardous Affairs*

Note: LGBQ = Lesbian, Gay, Bisexual, and Queer.

time all prevented small group teaching, role plays, or supervised clinical interactions.

For 2010, I made course attendance required. Most lecture courses in the pre-clinical years are voluntary based on the adult learning principle that students should find the way they learn best. Since human sexuality is more a clinical course, involved guest clinicians and patients, and presented material that would not be presented elsewhere in the medical school curriculum, I determined that mandatory attendance was warranted. I also wanted to ensure that those students who were most uncomfortable with the topic would not skip it—a problem observed in previous years.

Student Reactions/Lessons Learned

I have selected a sample of comments (out of several hundred received) to help demonstrate some of the lessons learned. I have tried to select comments that are representative of major themes that appeared on the electronic bulletin board. At the time of publication, the final course evaluation data for the course was not available. While many of the comments below represent negative perceptions and experience, the overall preliminary feedback has been that the course was well received. I am focusing on the problem areas because I believe such areas offer insight into some of the challenges

and barriers of teaching human sexuality, particularly in the medical school setting.

1. Course Process is as Important a Course Content

Much of the "chatter" on the bulletin board focused on my policies and procedures. While this was not my initial intention for the bulletin board, it soon became apparent that these comments demonstrated an important "hidden curriculum." Much like psychotherapy, I used the tone and content of the comments as a vehicle to discuss larger issues related to course content—namely what it means to be a healthcare professional.

STUDENT COMMENT: I 100% agree with you when you say that we shouldn't reduce our medical learning process to a "bunch of multiple choice tests." However, we also have to be realistic. Exams are what we are all about at THIS stage of our medical learning.

ANOTHER STUDENT COMMENT: Quite frankly, I feel as if the requirements of this class do not take into full account what is best for us as medical students. Time is such an important factor, and having to sit 3.5 hours for a class in which we get very little right before we have other exams, in my opinion is quite ludicrous.

A THIRD STUDENT COMMENT: When planning a class, I think instructors can't just think about novel or creative ways to teach, but also what the most effective and very importantly efficient methods are. If those are the tried and tested lecture formats or chalk talks, that is fine. We don't need to dive into panel discussions and *Youtube* videos to learn when other more succinct and useful methods are easily available. Also, having 5 classes on this one topic is completely unnecessary. It takes up a disproportionate amount of class time compared to other topics we cover . . . which are just as important such as heme-onc, pulm, and ophtho.

MY RESPONSE: I appreciate the comment in this post that if the material is not presented in a way that engages students or makes it accessible to them, they won't have motivation to pay attention or attend. It is for this very reason that I have diversified the teaching strategies to try to appeal to multiple learning types. However, with that said, I am concerned that at this point in your medical education, you really don't know what merits your full attention or not. You think you know . . . but you really don't. I am disappointed in the lack of trust in me and your other professors that we are not choosing material that we think is important for your career as a doctor. I am sure some of us, myself included, could do a better job at delivery and efficiency. With that said, having been out of medical school for over a decade, I regret that I did not pay closer attention to some of those lectures I blew off because at the time, I didn't see the relevance. Patients don't come into your office packaged in specialty bundles. As a physician your patients will expect you to be experts in medicine and health and my

hope is you will always strive for what is best for your patients. Learning as much as possible is what will make you a skilled physician! Sexuality affects all patients!

LESSONS LEARNED: It is very clear that even the best intentions can be thwarted if attention is not paid to meeting the students "where they are at." The first two years of medical education are the "basic science" years. Most students have had no clinical exposure outside of structured patient histories and physical exams. Hence, they don't see the relevance in the material. Of important note, the United States Medical Licensing Exam (USMLE), which is administered after the second year, does not have a human sexuality component. Hence, the students are not accountable for the material and, in fact, find it a distractor to doing well on the licensing exam. The physician assistant curriculum is similar.

Furthermore, the mandatory attendance requirement proved to be a huge distraction for some students. Despite explaining my rationale, from the comments above it is apparent many students let the policy dictate their experience with the course. Hence, a policy trumped learning.

In return, this discussion provided a useful forum to discuss what it means to be a healthcare professional. I was able to discuss stages of training, lifelong learning, and broadening perspectives. In drafting my responses, I was always careful to acknowledge students' concerns and to be respectful in my communication. It offered me a chance to model for the students' professional behavior and to teach them about how I handle people in my own clinical practice.

2. It's More Powerful When the Students Say It!

Due to the backlash of my mandatory attendance policy, I initiated a discussion about respect for the guest lecturers who were volunteering their time to teach and how much of ones' medical career had mandatory components. I also pointed out how the learning environment (attendance, paying attention) could help foster better lecturers. I tried to equate this "respect" to the clinician/patient relationship. Fortunately, I didn't need to be the first to respond—other students spoke up.

STUDENT COMMENT: No, I personally do not feel that the professor voluntarily giving up their time to teach me in person for a session I do not feel I am getting anything out of deserves the same respect as a patient who is putting their personal trust in me to help them at a time of crisis. It is really that simple. Some people do not learn from class. Some people do. Not going to class if you do not learn from class is not disrespectful to the professor.

A STUDENT'S RESPONSE: I think your comments are a little rude and disrespectful! The clinicians in the panel are doctors, something we are not.

They are telling us what is important in regards to human sexuality (more important in patient care than you seem to think). We should appreciate and respect the fact that these clinicians are taking time out of their busy schedule to talk with us. And if they deem it necessary that we need 5 sessions of Human Sexuality, then who are we to question them. I think your attitude will not carry you very far in medicine. I'm not sure if I want colleagues with your outlook.

ANOTHER STUDENT'S RESPONSE: This is taking up 2.5 hours per week for 6 weeks, half of which is being given by patients and/or clinicians—currently our mentors, and in the near future our colleagues—talking candidly about the profession we chose to be a part of. The only words I can use to describe my feelings about people complaining about required attendance for 2.5 hours per week for 6 weeks are ridiculous, immature, and snotty. Get over yourselves.

A THIRD STUDENT'S RESPONSE: I have also observed many students looking at notes for non-Human Sexuality courses, browsing the "Web" on their smart phones looking up non-Human Sexuality related information, or generally chatting about non-Human Sexuality related material (which makes it very difficult to listen to the panel discussions). This lack of commitment and focus makes me question their overall commitment towards medicine.

LESSON LEARNED: When I held back in my comments, other students often would "rise up" and challenge students who were being particularly obnoxious, inappropriate or who were simply uninformed. As an educator, this is an important concept since I imagine hearing these comments from peers can, at times, be more powerful than hearing it exclusively from their professor.

3. Even the Smallest Decisions Can Sometimes Have the Biggest Reaction!

I sometimes play music videos prior to class to help get students to class on time, to reach out to the *Youtube* generation, and to just put a positive spin on rather monotonous days. Here is a discussion about my choice of music videos on the LGBQ healthcare panel day.

STUDENT COMMENT: Why was Abba the song of choice for this session? Is there an implication that Abba has any correlation with sexual preference? I find that this only perpetuates stereotypes about the lifestyles and characteristics of those with various sexual preferences. Should a heterosexual male feel that some unsubstantiated assumptions will be made if they are caught listening to Abba while working out or driving down the street?

MY RESPONSE I can't take away the fact that *Dancing Queen* is identified by society, whether we like it or not, as a gay anthem. Your points are valid, but only in a vacuum. History writes itself. As to why I chose it? I just think it's a damn good song. Dance and be happy!

A STUDENT'S RESPONSE: Really? Are we now going to complain about a song choice that is, as Dr. Samenow also said, very well known to everyone on planet earth as the gay anthem?

LESSON LEARNED: As ludicrous as I found this comment, it made me realize how every decision I made was under scrutiny. I believe that student's discomfort with the topic of sexuality caused them to be on "pins and needles" about the course. During the course, it was suggested that I was racist, anti-gay, anti-Islam, and anti-women. In most instances, other students were quick to come to my defense. This is a difficult topic, hence it requires tremendous thought. Again, the bulletin board was instrumental in bringing these discussions out. The dialogue below demonstrates how even the order of my lectures was under scrutiny.

STUDENT COMMENT: I want to suggest that next year, you could start the class with the last 2 lectures from this year. This way, we would cover more of the heterosexual sexuality first (like the lecture on couple's therapy) and then move into the homosexual sexuality part of the course. Then you could progress to the sexual deviants like paraphilias, and end with the prophylaxis lecture like we did this year. While everything could still get the same amount of time, this might help some students perceive the course differently because then you will right away introduce what we are more likely to see in our practice and then move onto the statistically less frequent cases.

A STUDENT'S RESPONSE: I would be concerned that a class on human sexually that begins with heterosexual issues and then moves to LGTB issues would reinforce the cultural normativity of being heterosexual and reinforce the cultural "other-ness" of the LGTB community.

ANOTHER STUDENT'S RESPONSE: I understand the point about statistics and what we are most likely to see, but this doesn't necessarily dictate what order we should be taught in. The (mostly) unspoken cultural hierarchy with white heterosexual males at the top is important to be mindful of (especially if you fall into one or more of those categories). It may not seem obvious nor important to some, but for others it may be acutely obvious that a course were to progress in that manner.

4. Real Time Feedback Can Lead to Real Changes!

Another major goal of the bulletin board was for me to receive feedback on the course as it went along. This allowed for me to address issues as they arose, make changes when necessary, and strategically plan for future years. Feedback allowed for both process and content changes.

PROCESS

STUDENT COMMENT: There seems to be lack of cohesion between medical students and physician assistant students. Perhaps the Class Councils

of the 2 student bodies could meet and organize some sort of "mixer" or "social event" in the new student lounge or possibly an external venue or establishment of some sort.

Based on this comment, I made two changes. First, at the request of the poster, I worked with the classroom representatives to organize a Physician Assistant/Medical Student mixer at the end of the class. Second, during the class, I broke the class into small groups that included both medical students and physician assistant students. These teams were given discussion questions to foster cross-disciplinary dialog.

CONTENT

STUDENT COMMENT: As I take a minute to ponder today's lecture and panel, I find myself a bit frustrated with the content presented as well as the manner in which it was conveyed. I think that it is very important to discuss that many of our gay (and straight) patients will engage in sexual behaviors which put them at risk for sexually transmitted diseases and I applaud Dr. Samenow for including this discussion in our Human Sexuality courses.

That said, I was struck by the overwhelming amount of time spent discussing "anonymous sex" and the "kinkiness" of gay men and lesbian women during the panel discussion. Although this does occur and we should be aware of the resulting health issues that might present in practice, I assure you that this is not the only type of interaction you will have with your gay and lesbian patients and does not reflect what many gay and lesbian people believe to be the norm. Just as important to discuss during class today is the role of the [future] obstetrician/gynecologist when a gay couple and their surrogate are scheduled for a New OB Appointment; or, the role of the [future] primary care physician when discussing the biopsychosocial stressors that a lesbian couple has in navigating two high-powered careers and the desire to spend time with their children. Although 19%* of gay men participating in a study were found to be HIV-positive, 81% of gay men are not. Please consider how the majority of your gay and lesbian patients will respond if you see them in the light that was presented today.

**This was the "20%" statistic mentioned multiple times in class today. This study, released in September 2010 by the CDC, is of only 21-major cities in the US and has significant selection and participation biases.*

This well thought-out comment was true and helpful and provided me concrete changes to implement in future versions of the curriculum

DISCUSSION

The first reaction of most individuals outside of medical education with whom I share these comments is one of shock and disbelief. "These are

our future doctors and healthcare providers?" Of course, to understand these comments, they must be put into perspective.

First, I have only included a fraction of the several hundred comments posted to the online bulletin board. My focus has been on the more critical comments that tended to populate the board. There were many positive comments and in reality, the overall evaluations of the course were excellent. This leads me to believe that the bulletin board over-represented a vocal minority of students who used the anonymous forum as a means to vent their frustrations.

Second, these students are all pre-clinical and have had almost no exposure to real patients. They are the product of a system that emphasizes scoring well on standardized tests that only test certain content.

With that said, I do have some concerns. It would be interesting to have a camera follow those students who were most dismissive of the course and observe them in clinical practice. What specialties do they choose? What questions do they ask their patients? What do patients feel comfortable telling them? Are these perspectives simply a lack of maturity, discomfort with sex, or do they represent a legitimate professionalism concern?

Preliminary data from medical students demonstrate that certain students may be at more risk than others for being uncomfortable, or even incompetent, in matters of sexual health. These include low self-esteem, shyness, and anxiety (Merrill, Laux, & Thornby, 1990) as well as perceived inadequate training, limited sexual experience and having one's own sexual problems (Shindel et al., 2010). Of course the challenge is how to identify these students and then tailor education to their specific needs.

It is also disappointing that even outside of the context of clinical care the public health message of this course was lost in concerns over standardized tests and required attendance.

CONCLUSION: THE FUTURE OF HUMAN SEXUALITY AT GW

Of course, I will await the formal course evaluations before making major changes to the curriculum. But, the comments have already helped me think about future years. There are certain things about the course I cannot change, such as the class size and the timing in the curriculum. My hope is that I can improve upon helping these students connect the dots between human sexuality, clinical care, and public health. While they may not be clinically experienced yet, my hope is that they can all relate to the important public health implications of studying human sexuality.

I also believe the online bulletin board was an essential feature of the human sexuality curriculum. I have used bulletin boards in other classes and they have not generated as much chatter. As the movies, Powerpoint slides, lectures and panels played in class, floating in cyberspace were the

real ideas, perspectives, beliefs, and biases that needed to be addressed. Any medical student can learn the clinical material from a textbook. What is more challenging is to be aware of the emotional, psychological, and even unconscious attitudes, beliefs, and behaviors that shape our view of our own sexual health and that of those we treat. My hope is that I can find ways to more actively bring these perspectives into the classroom so students can dialogue more fully on these issues and learn from each other.

The bulletin board also allowed students the chance to have a voice, which given the size and structure of the course was very much welcomed.

STUDENT COMMENT: While many of us may argue with the class and all, we all have to admit that it is pretty awesome that Dr. Samenow has a forum where he allows the blatant, scathing, and often times immature criticisms that he does. Even if I don't agree with him on everything about his course, I do respect him for opening up a open forum like this.

On a final note, I was very careful on the bulletin board to always model respectful behavior and to provide solid scientific evidence (when available) to back up my comments. This was not always easy given the tone and content of the postings. I also always tried to be transparent in my own limitations as a clinician and course director to help students recognize that sexual health is not like treating an infection—the shades of gray are infinite. Hence, the bulletin board offered another venue for learning not just about human sexuality, but also what it means to be a compassionate and caring professional. I am excited to see that some students walked away with that message:

COMMENT #10: So I was complaining today about attendance. I was tired after going to class and wanted to go home. However, I'm actually glad I went because it was very interesting. I think panels that include patients have been some of my most informative moments in class during medical school. The experience of seeing and hearing from the patient crystallized ideas in ways that lectures weren't able to do. I'm happy Dr. Samenow is in charge of the Human Sexuality course :) I think whatever you do, you do it with style!

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