



An established medical school human sexuality curriculum: description and evaluation

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ABSTRACT *The human sexuality course at Robert Wood Johnson Medical School is unique with respect to its goals, structure, content and format. It provides a comprehensive and concentrated opportunity for students to become knowledgeable and comfortable in dealing with a critical though sensitive aspect of human behavior—one that is typically shrouded in myth, misinformation, controversy and prejudice. No single department or discipline can address all aspects of human sexuality and adequately address the material that must be covered. One of the greatest strengths of the course is its interdisciplinary focus and its emphasis on case-based and experiential learning. Student evaluations suggest that the course is successful in promoting greater comfort, increased knowledge and more tolerance and respect for individuals with different life styles and sexual beliefs. Many have also privately asserted that it has added immeasurably to their personal lives.*

Introduction

There is little doubt that health care professionals must develop comfort and expertise in dealing with issues related to sexuality. Questions about sexual dysfunction, sexual disease transmission, sexual side-effects of medications and chronic diseases, child and adolescent sexual abuse, to name only a few 'hot' issues, concern and alarm patients. HIV/AIDS continues to remain a major public health problem and questions about what constitutes 'safe sex' perplex patients. Like it or not, physicians are seen as 'sexperts' and are expected to provide information, medication and referrals for sexual difficulties of all kinds.

Yet most medical schools devote only a few hours of curriculum time to human sexuality education. For example, a recent survey of North American medical schools found that the majority (61%) provided 10 hours or less of human sexuality education, 17% provided 11–19 hours of instruction while a mere 15% mandated 20 hours or more (Solursh, 2000). A recent review of sexuality education for health

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Received for publication 20 September 2000; accepted with revision 16 October 2000.

ISSN 1468-1994 print/ISSN 1468-1479 online/01/010059-12

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DOI: 10.1080/14681990020021566

care professionals noted that there has been dwindling interest in research in this area over the past three decades (Weerakoon & Stiernborg, 1996).

Medical personnel who are uncomfortable or ignorant about handling patient questions in these areas will be vulnerable to offering inadequate, insensitive, and/or ineffectual treatment to their patients. For example, a recent study conducted in the UK revealed that 10%–15% of medical students held very negative views about homosexuality and that these homophobic students were also significantly more likely to report fear of treating HIV/AIDS patients (Parker & Bhugra, 2000).

Not only is patient care influenced by the sexual attitudes, beliefs and knowledge of medical professionals, but physicians and other health care providers play a significant role in shaping public attitudes toward sexual minorities and/or unconventional sexual behaviors (Parker & Bhugra, 2000).

Given the fact that there is at least some recognition and attempt to provide instruction in human sexuality, it is notable that there are few standardized curriculum guides, course formats or even evaluation of existing programs (Weerakoon & Stiernborg, 1996). Programs appear to differ in terms of when the subject matter is introduced, to whom they are made available (medical students vs interdisciplinary groups of students in the health professions), the degree or extent of faculty involvement, the use of small groups vs didactic lectures, and whether the course is mandatory or elective. For instance, elective courses can vary from optional two-day workshops to year-long programs (Gammon & Zisook, 1980).

This article will describe the Human Sexuality Program (HSP) at Robert Wood Johnson Medical School, Piscataway, NJ, arguably one of the longest running medical school human sexuality courses in the USA. The program was launched in 1973 and has been a *required* course for second-year medical students ever since. It began as a three-day program but since 1975 has been a 40-hour, full week course which is held in the middle of the basic science second-year curriculum, just after the seasonal holidays. While the format and emphasis of the course has changed to a degree over the past several decades, the course has continued to thrive.

The purpose of this article is threefold: (1) to describe the course as it currently exists; (2) to present course evaluations from 1996, 1997 and 1998; (3) to consider the future of education in human sexuality at medical and professional schools.

Program description

The sexuality course at Robert Wood Johnson Medical School is offered jointly by the Departments of Psychiatry, Environmental and Community Medicine and the Graduate School of Public Health to second-year medical students and graduate students in related disciplines (nursing, psychology, physician assistant training, nurse-midwifery, theology and public health). Faculty from several departments within the medical school (gynecology, family medicine, pediatrics) as well as guest faculty from other institutions participate in both planning and teaching the course. A small faculty–student committee works throughout the year to develop the program, which is revised annually.

Teaching methods include traditional lectures, panel discussions, and small

discussion groups composed of 10–12 students and two facilitators. A handbook of readings is provided and one or two afternoons are devoted to specialized workshops on topics of interest to the current class.

From the inception of the program, an emphasis was placed on both experiential and didactic learning. Taking as a model the Sexual Attitude Reassessment programs that were popular in the 1970s, the first several years of the course began with a multiscreen projection of explicit sexual erotic and pornographic films. Many, if not most, of the students had never been exposed to this avalanche of sexual images and the small group discussions initially focussed on reactions to this material. Over the years, however, the viewing of explicit sexual media has diminished—it was felt that there was less need for such exposure, given that most US students have been bombarded with similar material on MTV, movie trailers and the internet. Nevertheless, some sexually explicit videos are shown throughout the week—either as optional lunchtime material or to highlight particular practices, e.g. gay or lesbian sexual relationships. The judicious use of ‘visual media’ stimulates and provokes animated discussion in a way that lectures do not. And it is still the case that there are many students coming from fundamental religious backgrounds who have not been exposed to this material.

Currently, the program has become an amalgam of formal lectures by recognized academic or lay experts, panel discussions, sexual inquiry and role-playing exercises, and ‘processing’ the day’s presentations in the safety of the small groups. There is a commitment to providing adequate time for small group discussion in which students from various disciplines meet once or twice daily to share reactions, raise questions and exchange points of view. It is also in the small groups that students have the opportunity to rehearse sexual inquiry and discuss the clinical dilemmas that are presented to them. While in the early years of the course, small group time occupied fully half of the scheduled course hours, it now occupies about one-third of the total time.

The course is broadly designed to familiarize participants with all aspects of sexual health and illness, including male and female sexual anatomy and physiology, sexual inquiry, sexual response, male and female sexual dysfunction—assessment and treatment—and the sexual concomitants of medical illness, domestic violence and sexual abuse. In addition to providing up-to-date information on a variety of topics relevant to sexual medicine, a major course objective is to increase student comfort in conducting sexual inquiry and to become more tolerant of lifestyles and beliefs different from their own.

Course objectives

Broadly, there are four main objectives of the Human Sexual Program:

1. To provide and update knowledge of basic content areas in human sexuality. It is hoped that greater knowledge about sexuality will positively influence sexual attitudes and beliefs.
2. To develop proficiency in sexual interviewing and greater skill in interacting

with patients and to learn how to make appropriate referrals to other health professionals.

3. To develop an awareness of the importance of relationships—healthy and destructive, personal and professional—in promoting health and preventing illness.
4. To develop increased respect and tolerance for individuals who have different sexual lifestyles and/or who come from different cultural, religious or ethnic backgrounds. Towards that end, desensitization to sexual material and understanding and articulation of personal sexual attitudes is emphasized.

An example of the most recent program is provided in Appendix 1.

Changes over time

Over the past two decades the course has changed in several respects as a reaction to changes in society and popular culture, as well as in response to the needs of the student body. For example, 20 years ago we did not discuss cross-cultural attitudes towards sex and gender because our student body was predominantly homogeneous—that is, male and Caucasian. Now, fully half of our students are female and more than one-third come from diverse non-White cultural and religious backgrounds. Similarly, in the 1980s an entire panel was devoted to HIV/AIDs with an emphasis on the reactions of both patients and physicians. As AIDs has become more of a chronic disease, like other chronic diseases, it is included in a more general panel dealing with the sexual concomitants of medical illness.

Overall, the major changes that have taken place over the nearly three decades of the course include the following:

1. Fewer formal lectures and more time allocated for ‘active’ learning in the small groups. We believe lectures tend to encourage an attitude of passivity on the part of medical students and reinforce their tendency to focus on facts rather than feelings. Consequently, we try to encourage more active involvement from the students. For example, we have developed a series of controversial clinical vignettes which invite debate and discussion on ethical, legal, moral and health issues. There are vignettes focusing on whether or not to provide contraception to a 13-year old girl without informing her parents, counseling a 15-year-old who is concerned about his cross-dressing, dealing with a man who has just received a diagnosis of HIV but does not want to tell his fiancée, etc. Students are asked to assume the role of the various participants, e.g. the patient, the physician, the teen, the parent or partner. These role-plays are usually quite lively, with advice and feedback offered to the ‘players’ from the small group members who observe the interactions.
2. More panel discussions in which individuals of different backgrounds and disciplines debate and discuss topical issues (e.g. a sexual medicine panel consisting of a urologist, cardiologist, gynecologist, family practitioner and nurse; an alternative lifestyle panel which might include a male to female transsexual, a sadomasochist, participants in a *ménage à trois* and a

TABLE I. Sample of workshop offerings

Sexually retired or sexy senior citizen
The living canvas: body art
Paedophiles to paraphilia: defining sex offenders
The slippery slope
Coitus interruptus & BC: contraceptive update from A to V
Pillow talk: developing erotic communication skills
Issues of domestic violence and elder abuse
Ups and downs! Ins and outs of impotence and premature ejaculation
Sexual health in differently abled persons
Male and female sexuality: vive la difference!
Raising a sexually healthy child
Are there more than two sexes?
Current issues in intersexualism
Sexuality issues and adolescents: learning how to talk to adolescents about sex
Sexually transmitted infections
Sex and gender roles
Treating rape patients
HIV
Child sex abuse
Female circumcision

cross-dresser.) These panels seem to elicit more attention and provoke more controversy than any individual lecturer.

3. More curriculum time devoted to workshops which are held on one or two afternoons during the week. Students from the current medical school class solicit specific workshop requests from the student body and the student-faculty planning committee invites appropriate personnel to conduct the workshop. Each year there is a varied group of different offerings; the workshops typically receive highly positive ratings from the participants (see Table I for a sample list of workshops that have been offered in recent years).
4. There is less emphasis on sexual behavior *per se* and greater emphasis on the importance of *relationships—both personal and professional—in promoting health and preventing illness*. This is in response to the students' questions and concerns about their own relationships and about the difficulty of maintaining healthy relationships while in medical school. It is also in response to the fact that nowhere else in the medical school curriculum is any serious attention paid to relationships as a major health ingredient.

Small group training

Since time spent in the small discussion groups is such an integral and important aspect of the course, a three-hour training session is held with group facilitators in the month before the course. This training session is devoted to anticipating

problems that might occur in the small group (e.g. a student who monopolizes small group discussion and/or speaks disparagingly about sexual minorities) and permits time to train and rehearse facilitators in handling the sexual inquiry and role-plays.

Small group facilitators are unpaid volunteer professionals, many of whom are therapists or sexuality educators—they are all comfortable with small groups and with discussion of sexual material. They include social workers, medical school faculty, advanced graduate students, Planned Parenthood staff and family life educators. Each year, a new group of facilitators is invited as well as ‘veterans’ of the program. There is an attempt to pair experienced with inexperienced facilitators to give the course continuity.

Results

Course participants are asked to evaluate each presentation at the end of every day and then to provide a final course evaluation at the conclusion of the program. Space is provided for personal comments. All rating scales are based on a 1–7 Likert scale with 1 = not at all and 7 = very much.

Course evaluations from the years 1996, 1997 and 1998 are presented in Tables II–VI. The overall ratings vary somewhat from year to year as speakers and topics change. The composition of the student body also changes year to year, with more conservative attitudes prevailing in some years and in others, more sexually liberal attitudes.

TABLE II. To what extent did this course increase your comfort level in talking about sexuality?

	1996	1997	1998
Medical students	5.0	5.8	5.2
Graduate nurses	6.1	6.3	–
Physician’s assistants Assistants	5.6	5.5	5.7
Nurse/midwives	4.9	6.4	5.9
MPH students	6.6	5.9	–
Other health care professionals	5.7	6.6	5.8

TABLE III. To what extent did this course help you understand your own values and how they affect the patient?

	1996	1997	1998
Medical students	5.0	5.4	5.5
Graduate nurses	6.4	6.5	–
Physician’s assistants	5.8	5.5	5.5
Nurses/midwives	4.7	6.5	6
MPH students	6.5	5.8	–
Other health care professionals	5.8	6.2	5.8

TABLE IV. To what extent did this course increase your understanding of and tolerance for the variety of human sexual behavior?

	1996	1997	1998
Medical students	5.0	5.4	5.4
Graduate nurses	6.4	6.6	–
Physician's assistants	5.8	5.6	5.6
Nurses/midwives	4.3	6.6	6
MPH students	6.8	5.8	–
Other health care professionals	6.1	6.4	5.9

TABLE V. To what extent did this course increase your basic knowledge of sexual practices and behaviors in diverse populations, e.g. medical populations, ethnic populations, etc?

	1996	1997	1998
Medical students	4.8	5.4	5.3
Graduate nurses	6.4	6.6	–
Physician's assistants	5.4	5.6	5.5
Nurses/midwives	5.5	6.6	6
MPH students	6.3	5.8	–
Other health care professionals	5.8	6.5	5.9

TABLE VI. Overall, how beneficial did you find the human sexuality course?

	1996	1997	1998
Medical students	4.9	5.4	5
Graduate nurses	6.4	6.3	–
Physician's assistants	5.5	5.4	5.6
Nurses/midwives	4.8	6.1	5.9
MPH students	6.5	4.3	–
Other health care professionals	5.9	6.2	5.6

As is evident from the results, graduate nursing students and health professionals other than medical students tend to give the highest ratings on all the dimensions assessed, while the medical students tend to give the lowest ratings. For instance, graduate nurses are very positive about the degree to which the course increased their comfort level in talking to patients about sex as well as increased their understanding of how their own values influenced patient care. Similarly, the group of 'other health professionals', which consists of social workers, psychology and theology graduate students and outside 'guests' tends to give high and positive ratings on all these dimensions as well. On the other hand, the medical students report the least positive change in questions relating to increased tolerance for others' sexual behavior, basic knowledge, likelihood of inquiring about sexual

problems, increased understanding of their own values as these might affect patient care and the overall benefit of the course. While all their ratings are positive, they are clearly less positive than their peers in other health-related professions.

Why should this be so? We believe there are several factors mitigating their total positive reactions to what is generally considered a very successful course.

Firstly, the graduate nursing students and students from other health professions tend to be older and to have had more experience in direct patient care. They know that issues of sexuality arise in their professional contact with patients and they are aware of feeling deficient in their knowledge of how to handle both factual and interpersonal issues involving sex. On the other hand, the medical students are in the middle of their basic science years and have had little, if any, direct patient contact. They do not miss what they do not know, and in fact, are quite unaware of how a patient's concerns about sex might arise in the course of their medical career. Consequently, the nurses find the course immediately useful while the medical students do not.

Secondly, the medical students already feel pressured to learn a diverse and extensive set of material and any topic, which seems 'soft' like psychiatry or human sexuality tends to be under-valued. They do not want to be told that there is 'yet one more thing' they need to remember to do in their work-up of new patients or their interactions with established patients. They are worried about and reminded that time is at a premium in their work with patients and they are ambivalent, at best, about taking time to deal with a patient's sexual concerns.

Thirdly, the course is required for medical students and optional or elective for students from the other health professions. Since the course is mandatory and a passing grade must be received, attendance is taken both in the lecture hall and in the small groups. The medical students are not completely happy with this but we found it necessary since each year there would be a small group of students who were either uncomfortable with the material or who felt that they 'knew it all' who tended to absent themselves throughout the week. Thereby, we require daily attendance for a "pass" in the course.¹ It is clear that the level of motivation to learn and be influenced by the material is vastly different between the medical students and others and may contribute to the lower ratings of the medical students.

The uncertain future of sexuality education

In recent years there has been growing recognition that sexuality plays a major role in quality of life, that sexual problems cause (and are the result of) both physical and emotional distress, and that sexual inquiry and education are essential components of responsible and comprehensive health care. Primary care physicians are on the front lines in this regard.

Patient demand for information and intervention for common sexual dysfunctions such as erectile failure and loss of desire, as well as STD and HIV/AIDS education and prevention, will support the continued necessity for sex education in medical schools. Already, pharmaceutical companies are recognizing the importance of physician skills in sexual inquiry and are underwriting the cost of this education for practitioners of family medicine, urology and cardiology.

Nevertheless, despite the importance of sexuality education in medical schools, the trend has been for there to be *less* time devoted to human sexuality. While the human sexuality program appears to be securely in place at our medical school by virtue of its longevity and positive reputation, overall, sexuality education faces an uncertain future for the following reasons: (1) curriculum hours are jealously guarded by different departments and the overall trend is to *reduce* the amount of time spent in lecture halls; (2) there are fewer available faculty who are willing and able to teach these courses; (3) sexuality education, generally, elicits feelings of discomfort and anxiety on the part of school administrators and senior faculty; and (4) physicians are genuinely squeezed for time in the current 'managed care' environment. The expectation that they routinely introduce another topic with their patients, particularly one that elicits anxiety, is not embraced enthusiastically. Unfortunately, while sexual problems and concerns are prevalent among patients, there continues to be a tendency to avoid dealing with them. Consequently, requiring sexual education to be a mandatory part of the medical curriculum is at variance with the willingness of academic faculty to actively deal with issues involving sexuality.

Without strong institutional support from deans and administrators, it is unlikely that sexual education will receive the attention it deserves. It is regrettable that the low priority given to sexuality education in the curriculum by both faculty and administration sometimes results in sexuality courses being offered as an elective rather than as mandatory and at non-ideal times in the curriculum. Moreover, unless references to the importance of sexual inquiry and patient sexual concerns are made throughout all courses and clerkships, the net result of an isolated one-week program on human sexuality will be modest. It is clear that there needs to be both vertical and horizontal integration of sexuality education, i.e. inclusion over the four years and across all rotations. We still have a long way to go in implementing this goal.

Finally, sexuality education must increasingly capitalize upon the resources afforded by computers for supplementing lectures and enabling interactive case-based learning (Weerakoon, 1999). While we are just at the beginning at our medical school, we are trying to develop a useful website with links to community and national resources and we are hoping to create independent instructional units on topics of relevance. This is a challenging enterprise, however, in terms of limited funds, resources and time to devote to this project.

Discussion

Education in human sexuality is a necessary requirement for health care professionals since sexual health has a profound and intimate connection not only with public health but also with personal quality of life. While most students tend to believe they are sufficiently knowledgeable about human sexuality because they are sexually active or are comfortable viewing sexually explicit material, there is much they do not know. They typically fail to comprehend that sexuality education encompasses a broad and complex multidisciplinary body of knowledge that

includes everything from anatomy to pharmacology. It is of note that medical students tend to assume they are the most knowledgeable of all health care professionals, yet they are typically quite uncomfortable in talking to patients about their intimate or personal sexual concerns (McKelvey *et al.*, 1999).

It must be noted that our student body is extremely heterogeneous in terms of religious, cultural and ethnic backgrounds and hence explicit attention must be paid to issues of cultural and religious diversity. Sexual beliefs and values differ widely. For instance, each year Moslem students ask to be excused from the course during Ramadan, their religious month of abstinence, while Orthodox Jewish students object to the posters adorning the walls of the auditorium because they contain images of naked bodies. Most surprisingly, one female Moslem student insisted that she only wanted to conduct physical examinations on female patients during her medical school career! It is clear that a medical school human sexuality course must be prepared to acknowledge and deal with very different sensibilities and comfort levels.

The Human Sexuality course at Robert Wood Johnson Medical School is unique with respect to its goals, structure, content and format. It provides a comprehensive and concentrated opportunity for students to become knowledgeable and comfortable in dealing with a critical though sensitive aspect of human behavior—one that is typically shrouded in myth, misinformation, controversy and prejudice. No single department or discipline can address all aspects of human sexuality and adequately address the material that must be covered. One of the greatest strengths of the course is its interdisciplinary focus and its emphasis on case-based and experiential learning. Student evaluations suggest that the course is successful in promoting greater comfort, increased knowledge and more tolerance and respect for individuals with different lifestyles and sexual beliefs. Many have also privately asserted that it has added immeasurably to their personal lives.

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Appendix 1. Program of the Robert Wood Johnson Medical School human sexuality course

From the personal to the public: sex, love and relationships in the new millennium
Monday, 3 January 2000

Objectives:

- 1 The learner will be able to describe the impact of sexual issues on public health.
- 2 The learner will observe how cultural and religious views/backgrounds affect sexual health.
- 3 The learner will understand the process of sexual development in childhood and adolescence.

9:00 Welcome and Introductions

9:30 Public Health Issues for Sexuality in the New Millennium

10:15 MultiCultural Issues and Sex: A Panel

11:30 Perspective on Sexuality, Values and Religion

1:30 Becoming a Sexual Person

3:00 Small groups

5:00 Adjourn

Adolescent sexuality

Tuesday, 4 January 2000

Objectives:

- 1 The participant will understand adolescent sexual health issues and concerns.
- 2 The participant will be able to identify current trends in contraceptive research and emergency contraception.
- 3 The learner will identify the steps necessary for taking a comprehensive sexual history and making sexual referrals.

9:00 Adolescent Sexuality: Focus on Teen Pregnancy

9:45 Adolescent Sexuality Panel

10:30 Update on Contraception & Medical Termination

11:30 Taking a Sexual History: Do's and Don't's

1:30 Workshops

3:00 Small Groups

5:00 Adjourn

Adult sexual health

Wednesday, 5 January 2000

Objectives:

- 1 The learner will identify the sexual health concerns arising across medical disciplines.
- 2 The learner will identify the major steps in male and female sexual development.
- 3 The learner will observe a variety of sexual lifestyle choices

9:00 Sexual Problems in Medical Practice: A multidisciplinary panel.

10:15 Female Sexuality: Problems and Treatments

11:30 Male Sexuality: Problems and Treatments

12:45 Sexuality Film Festival

1:30 Sexual Variations Panel: Alternative sexual lifestyles

3:00 Small Groups

5:00 Adjourn

Sexuality and violence

Thursday, 6 January 2000

Objectives:

- 1 The learner will identify the ways in which violence impacts sexual health.
- 2 The learner will gain awareness of the dangers of crossing sexual boundaries.
- 3 The learner will identify the signs of possible child sexual abuse.

9:00 Child Sexual Abuse

10:00 Relationship Violence

11:00 Sexual Boundaries: The No-Crossing Zone

1:00 Workshops

3:00 Small Groups

5:00 Adjourn

Sexuality and (in?)visibility

Friday, 7 January 2000

Objectives:

- 1 The learner will identify the particular sexual health needs of gay, lesbian, bisexual and transgendered patients.
- 2 The learner will identify psychosocial and treatment concerns of people with disabilities.

9:00 Sexual Health Needs of Gay, Lesbian and Bisexual Patients: Panel discussion

10:00 Sex and Disability

11:00 The Robert Wood Johnson Medical School Award for Distinguished Contribution to Human Sexuality Education

1:00 The Funny Thing about Sex ...

2:00 Sex, Love and Relationships

3:00 Concluding Comments

3:30 Small Groups

5:00 Adjourn