

**Annotated Bibliography
for**

**Candid Conversations: Talking with Female Patients
about Sexual Health**



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Core communication skills: Reflective listening & open-ended inquiry

Miller, W. R., & Rollnick, S. (2002). *Motivational interviewing: Preparing people to change addictive behavior*, 2nd ed. New York: Guilford Publications.

DESCRIPTION OF CONTEXT: An intervention for facilitating behavior change in the area of addiction.

TOPIC/SCOPE: In preparing people to change addictive behaviors, there are two phases with specific tasks which individual progress through. Phase I focuses on building the patient's motivation to change. This can be accomplished by: (1) asking open-ended questions; (2) listening reflectively; (3) directly affirming and supporting the patient; (4) summarizing statements, and (5) eliciting self-motivational statements from the patient who presents the argument for change. Phase II focuses on strengthening patients' commitment to change. This can be accomplished by: (1) summarizing the patient's current situation; (2) asking open-ended questions; (3) offering a cluster of the best information/advice upon request, but being careful not to fall into the "yes, but..." trap and (4) negotiating a plan and arriving at the plan. When helping patients go through Phase I and Phase II, five principles of motivational interviewing must be considered: (1) express empathy; (2) develop discrepancy; (3) avoid argumentation; (4) roll with resistance, and, (5) support self-efficacy.

CONCLUSIONS/RECOMMENDATIONS: Motivational interviewing has been empirically tested and shown to be an effective intervention in preparing people to change addictive behaviors.

Miller, W. R. (2000). Rediscovering fire: Small interventions, large effects. *Psychology of Addictive Behaviors* : *Journal of the Society of Psychologists in Addictive Behaviors*, 14(1), 6-18.

DESCRIPTION OF CONTEXT: Unexpected findings are often the spark for new discoveries and theories. A puzzle emerged from a series of unanticipated findings over 3 decades, indicating that for problem drinkers (a) relatively brief interventions can trigger significant change, (b) increasing the intensity of treatment does not consistently improve outcome, (c) therapist empathy can be a potent predictor of client change, and (d) a single empathic counseling session can substantially enhance the outcome of subsequent treatment.

TOPIC/SCOPE: These phenomena are considered in light of other findings in the addictions-treatment-outcome literature.

CONCLUSIONS/RECOMMENDATIONS: There is, at present, no cogent explanation for the efficacy of brief interventions. An ancient construct is explored as one possible factor in how some brief encounters may exert large effects in human change. That construct is *agape*, or unconditional love.

Rollnick, S., Heathe, N., & Bell, A. (1992). Negotiating behaviour change in medical settings: The development of brief motivational interviewing. *Journal of Mental Health*, 1, 25-37.

DESCRIPTION OF CONTEXT: A brief intervention for medical settings using a form of motivational interviewing. The intervention is patient-centered and developed for patients with varying degrees of readiness to change.

TOPIC/SCOPE: The interviewer (or clinician) selects a strategy from a menu of the following to match the patient's degree of readiness to change: (1) address issues of lifestyle, stresses, and substance use; (2) address health and substance use; (3) discuss a typical day; (4) discuss the pros and cons of engaging in the behavior; (5) provide information; (6) discuss the future and the present; (7) explore concerns, or (8) help with decision-making. Implications and criticism of the approach are provided as well as suggestions for further research.

CONCLUSIONS/RECOMMENDATIONS: Motivational interviewing can be an effective strategy to help patients articulate their reasons and arguments for and against a behavior change. The goal of motivational interviewing is to work with the patient's need for autonomy through the encouragement of an exploration of his/her ambivalence towards behavior change.

Rollnick, S., Mason, P., & Butler, C. (1999). *Health Behavior Change: A Guide for Practitioners*. Edinburgh: Churchill Livingstone.

DESCRIPTION OF CONTEXT: A wonderful book that provides the key principles of motivational interviewing as applied to general medical settings.

TOPIC/SCOPE: The authors have developed a model remarkably similar to the conviction and confidence model (called instead the importance and confidence model, but also depicted as interacting in a 2 x 2 table).

Core communication skills: Empathy

Bonvicini, K.A., Perlin, M.P., Bylund, C.L., Carroll, J.G., Rouse, R., & Goldstein, M.G. (2009). Impact of communication training on physician expression of empathy in patient encounters. *Patient Education and Counseling*, 75:3-10.

OBJECTIVE: To examine whether an educational intervention that focused on physician communication training influenced physician empathic expression during patient interactions.

METHODS: This study used a quantitative research method to investigate the influence of communication training on physician-expressed empathy using two measures (global and hierarchical) of physician empathic behavior.

RESULTS: The differences in global empathy scores in the physician training group from baseline to follow-up improved by 37%, and hierarchical scores of physician empathic expression improved by up to 51% from baseline scores for the same group.

CONCLUSIONS: The results strongly supported the hypotheses that training made a significant difference in physician empathic expression during patient interactions demonstrated by both outside observer measures of global ratings and hierarchical ratings of physician empathic behavior.

PRACTICE IMPLICATIONS: These findings have significant implications for program design and development in medical education and professional training with the potential to improve patient outcomes.

Coulehan, J. L., Platt, F. W., Egener, B., Frankel, R., Lin, C. T., & Lown, B. et al. (2001). "Let me see if I have this right..." Words that help build empathy. *Annals of Internal Medicine*, 135(3) 221-227.

Emphasized the importance of the choice of words and sentences in the facilitation of empathy in the medical encounter. Difference between empathy and sympathy; Components of empathic communication; Potential empathic opportunities; Guidelines for clinical empathy in the cross-cultural setting.

Easter, D. W., & Beach, W. (2004). Competent patient care is dependent upon attending to empathic opportunities presented during interview sessions. *Current Surgery*, 61(3), 313-318.

OBJECTIVE: Core competencies in surgical education and clinical care rely on effective patient-physician communication. We aim to develop quantitative and empirical tools for understanding critical communication tasks during patient interviews.

METHODS: Residents in surgical training and attending physicians were separately video recorded during stressful, first visit oncology patient interview sessions. Taped sessions (n = 16) were analyzed in detail to identify and label patient-initiated actions (PIAs), or "empathic opportunities," that call for recognition or action from the caregiver. Doctor-responsive actions (DRAs) were labeled as matching to, or missing from, each empathic opportunity. Missed empathic opportunities occurred when a PIA did not have an associated DRA. Pre-session and post-session surveys queried the patient's perception of how well their health-care needs were met.

RESULTS: Resident trainees and attending physicians missed 70% of 160 clearly identified empathic opportunities. There was no clear association with the level of physician training. This pilot study did not have enough power to discern differences in patient satisfaction.

CONCLUSIONS: Physicians are often not very attentive to empathic opportunities offered by patients.

Individual feedback and training regarding empathic opportunities in recorded patient communication encounters may improve resident and physician core competencies. These improvements may affect patient satisfaction related to these encounters.

Levinson, W., Gorawara-Bhat, R., & Lamb, J. (2000). A study of patient clues and physician responses in primary care and surgical settings. *JAMA : The Journal of the American Medical Association*, 284(8) 1021-1027.

OBJECTIVE: To explore the nature and frequency of patient clues during medical encounter and physician response among primary care physicians and surgeons.

DESIGN: Descriptive study of audio-taped office visits (data set was part of a larger research project that examined the relationship between physician-patient communication and medical malpractice).

SETTING: Community-based practices of primary care physicians and surgeons in Oregon and Colorado.

SUBJECTS: 116 randomly selected routine office visits to 54 primary care physicians and 62 surgeons (94% male, 91% Caucasian, 67% group practice). Ten patients per physician were selected sequentially from the waiting rooms (54% female, 88% Caucasian, 71% married, average age=54).

INTERVENTIONS: None.

MEASURES: Audio-taped interactions and transcripts were reviewed to identify and describe segments of the interview in which there were clues about patients' emotional or social concerns. Clues that were initiated by the patient were coded for type and timing and nature of physician response. In addition, physician questions that encouraged patient to discuss a personal topic were also coded as physician-initiated clues. Length of visit was also recorded.

RESULTS: Clues occurred in 52% of the primary care visits (mean number of clues =2.6) and in 53% of the surgical visits (mean number of clues = 1.9). Patients initiated approximately 70% of those clues and physicians initiated approximately 30%. Of the patient led clues in primary care visits, 76% were emotional and 60% in the surgical setting. Physicians missed the opportunity to respond to patient led clues 79% of the time in primary care and 62% in the surgical setting. In 50% of those interviews where the physician missed the opportunity to respond to the patient-led clue, the patient brought up the same issue (clue) a second or third time. In addition, in primary care, visits were longer when there was a missed opportunity to respond by the physician compared with visits where the physician responded with a positive response (mean time, 20.1 min vs. 17.6 min).

CONCLUSIONS/RECOMMENDATIONS: Patients offer clues to physicians that provide rich opportunities for empathy and a greater understanding of patients' lives. In primary care and surgery settings, physicians tend to miss these clues and thus overlooking opportunities to strengthen the doctor-patient relationship. Two aspects of the medical encounter uncovered in this study - patient clues and physician responses, should be recognized as being interdependent and necessary in building a trusting relationship between physician and patients and impacting health outcome.

Quill, T. E., Arnold, R. M., & Platt, F. (2001). "I wish things were different": Expressing wishes in response to loss, futility, and unrealistic hopes. *Annals of Internal Medicine*, 135(7) 551-555.

Physicians who care for patients encounter many powerful and painful emotions, including anger, sadness, fear, grief, loss, hopelessness, and blame. Many studies suggest that physicians should express empathy in response to emotion-laden patient statements to ensure that patients feel listened to and understood. These physician responses usually consist of efforts to comprehend how things feel to the patient and to express that understanding back to the patient. Situations that evoke loss, guilt, or hopelessness are particularly hard for physicians to respond to empathically. Physicians who think that they have failed a dying patient and who fear depriving the patient of hope may respond by avoiding the topic entirely, by overcompensating with overtreatment, or by apologizing for not "saving" the patient. When a patient expresses overwhelming anger or disappointment with limitations in medicine, physicians may be afraid that any explicit response to the patient's emotion may be construed as evidence of their failure, mistake, or inadequacy. In these challenging situations, we have observed that many physicians attempt to respond empathically by stating "I'm sorry." This well-intentioned

response, although frequently appropriate, may be misinterpreted and misdirected. We have found that saying “I wish...(things were different)” to the patient and family is a more effective initial response. We explicate some of the challenges of saying “I’m sorry” and explore the potential benefits of joining with patients and families and saying “I wish...” in specific, difficult clinical scenarios.

Spiro, H. M. (1993). *Empathy and the practice of medicine : Beyond pills and the scalpel*. New Haven, Conn.: Yale University Press.

DESCRIPTION OF CONTEXT: A book of essays by physicians, philosophers and nurses.

TOPIC/SCOPE: The book is divided into three sections. The introduction begins with a discussion of the definition of empathy and a debate about whether or not it is a teachable skill. Section one deals with the history of empathy being weakened or lost in the process of medical education and provides some suggestions for alleviating this problem. Section two describes the historical origins of empathy and arguments are presented for and against its place in medicine. The last section is a collection of stories of how physicians’ lives and the lives of their patients are affected by their empathy for their patients.

CONCLUSIONS/RECOMMENDATIONS: Empathy is an essential quality of the physician.

Core communication skills: Providing education effectively

Bennett, C. L., Ferreira, M. R., Davis, T. C., Kaplan, J., Weinberger, M., Kuzel, T., Seday, M. A., & Sartor, O. (1998). Relation between literacy, race, and stage of presentation among low-income patients with prostate cancer. *Journal of Clinical Oncology : Official Journal of the American Society of Clinical Oncology*, 16(9) 3101-3104.

PURPOSE: Diagnosis of advanced prostate cancer is a major health problem, especially among low-income men. Opportunities vary for early detection of prostate cancer for low-income black and white men because of financial, cultural, and social factors. In this study, we evaluated the association of poor literacy skills with higher rates of presentation of advanced stages of prostate cancer among low-income black and white men who received care in equal-access medical systems.

PATIENTS AND METHODS: Literacy and stage at diagnosis of prostate cancer were evaluated in 212 low-income men who received medical care in Shreveport, LA, and Chicago, IL. The patients’ literacy was assessed with the Rapid Estimate of Adult Literacy in Medicine (REALM), an individually administered reading screening test designed specifically for use in the medical setting. Logistic regression models were used to evaluate predictors of metastatic disease at presentation as a function of patient age, race, literacy, and city.

RESULTS: Whereas black men were almost twice as likely to present with stage D prostate cancer (49.5% v 35.9%; $P < .05$), they were significantly more likely to have literacy levels less than sixth grade (52.3% v 8.7%; $P < .001$). However, after adjustment for differences in literacy, age, and city, race was not a significant predictor of advanced-stage prostate cancer.

CONCLUSIONS: Low literacy may be an overlooked but significant barrier to the diagnosis of early-stage prostate cancer among low-income white and black men. The development of culturally sensitive, low-literacy educational materials may improve patient awareness of prostate cancer and improve the frequency of diagnosis of early-stage cancer.

Bessell, T. L., McDonald, S., Silagy, C. A., Anderson, J. N., Hiller, J. E., & Sansom, L. N. (2002). Do internet interventions for consumers cause more harm than good? A systematic review. *Health Expectations : An International Journal of Public Participation in Health Care and Health Policy*, 5(1) 28-37.

OBJECTIVE: To systematically review the effect of consumer use of online health information on decision-making, attitudes, knowledge, satisfaction and health outcomes and utilization.

SEARCH STRATEGY: Electronic databases searched included the Cochrane Controlled Trials Register, MEDLINE, PREMEDLINE (to 14 March 2001), CINAHL, Australian Medical Index, Health and Society, National Institutes of Health Clinical Trials Database and CenterWatch.

INCLUSION CRITERIA: All post-1995 comparative studies (including controlled studies, before and after studies, and interrupted time series analyses) of Internet users vs. non-Internet users and other communications mediums, and Internet characteristics such as e-mail vs. other communication mediums, were included. Outcomes included consumer decision-making, attitudes, knowledge, satisfaction and measurable changes in health status or health utilization.

DATA EXTRACTION AND SYNTHESIS: One reviewer screened all papers then two reviewers independently assessed studies against the selection criteria and any discrepancies were resolved by discussion with a third reviewer. No attempt was made to combine the data for further statistical analysis.

MAIN RESULTS: We identified 10 comparative studies. Studies evaluated the effectiveness of using the Internet to deliver a smoking cessation programme, cardiac and nutrition educational programmes, behavioural interventions for headache and weight loss, and pharmacy and augmentative services. All studies showed some positive effects on health outcomes, although the methodological quality of many studies was poor.

CONCLUSIONS: Despite widespread consumer Internet use to obtain health-care information, there is almost a complete lack of evidence of any effects this may have on health outcomes.

Davis, T. C., Crouch, M. A., Wills, G., Miller, S., & Abdehou, D. M. (1990). The gap between patient reading comprehension and the readability of patient education materials. *The Journal of Family Practice*, 31(5) 533-538.

Patient education materials and hospital forms are given to patients with little regard for their ability to read them. Nationwide sampling and data from the 1980 census suggest that a high proportion of patients cared for in public hospitals are functionally illiterate. In this study, 151 adult primary care patients in five different ambulatory care settings were tested for reading comprehension. Patient education materials and forms from each clinic were analyzed for readability using a standard computer program. A large discrepancy was found between the average patient reading comprehension and the ability levels needed to read patient education materials. The average reading comprehension of public clinic patients was 6th grade 5th month. Most tested patient education materials required a reading level of 11th to 14th grade, and standard institutional consent forms required a college-level reading comprehension. In the public clinics there was a gap of more than 5 years between patient reading levels and the comprehension levels required by written patient materials.

Davis, T. C., Williams, M. V., Marin, E., Parker, R. M., & Glass, J. (2002). Health literacy and cancer communication. *CA: A Cancer Journal for Clinicians*, 52(3) 134-149.

Health literacy is increasingly recognized as a critical factor affecting communication across the continuum of cancer care. We reviewed research on health literacy and examined its impact on cancer outcomes and communication. According to the National Adult Literacy Survey (NALS), considered the most accurate portrait of literacy in our society, about one in five American adults may lack the necessary literacy skills to function adequately in our society. As patients, such individuals are at a disadvantage in their capacity to obtain, process, and understand cancer information and services needed to make appropriate health care decisions. Patients with poor health literacy have a complex array of difficulties with written and oral communication that may limit their understanding of cancer screening and of symptoms of cancer, adversely affecting their stage at diagnosis. In addition, these barriers impair communication and discussion about risks and benefits of treatment options, and patient understanding of informed consent for routine procedures and clinical trials. More research is needed to identify successful methods for educating and communicating with patients who have limited health literacy. Based on our own experience, we offer practical communication aids that can help bridge the cancer communication gap.

Dreger, V., & Tremback, T. (2002). Optimize patient health by treating literacy and language barriers. *AORN Journal*, 75(2) 280-5, 287, 289-93; quiz 297-300, 303-4.

More than 90 million Americans have limited literacy skills. Almost two million US residents cannot speak English, and millions more speak it poorly. The stigma of illiteracy or the inability to speak a country's predominant language may keep patients from disclosing their limitations. Recognizing these facts is an important first step in improving health education for this vulnerable population. By adapting teaching techniques to patients' special needs, nurses can ensure that patients understand their health problems and plan of care. Statistics dramatically demonstrate the high cost of neglecting these needs. Patients who do not understand their plan of care do not comply with instructions and, therefore, suffer unnecessary complications. Health care providers who can communicate with their patients through multilingual, low literacy patient education materials and with the use of qualified interpreters markedly improve the quality of care for their patients and the resulting outcomes.

Fox S, Rainie L. The Engaged E-patient Population, Washington, DC: Pew Internet and American Life Project; 2008. Available at: http://www.pewinternet.org/pdfs/PIP_Health_Aug08.pdf

This latest Pew Internet Project survey confirms that information gathering has become a habit for many Americans, particularly those in the 55% of households with broadband connections. Home broadband has now joined educational attainment, household income and age as the strongest predictors of internet activity. For example, 78% of home broadband users look online for health information, compared with 70% of home dial-up users. Home broadband users are twice as likely as home dial-up users to do health research on a typical day—12% vs. 6%. High-speed, always-on connections enable frequent and in-depth information searches, which is particularly attractive if something important is at stake.

Hay MC, Strathmann C, Lieber E, Wick K, Giesser B. (2008). Why patients go online: multiple sclerosis, the internet, and physician-patient communication. *Neurologist*. Nov;14(6):374-81

BACKGROUND: The online information seeking of multiple sclerosis (MS) patients, their reasons for doing so, and its importance for physician-patient communication have not been described.

METHODS: Patients (n = 61) presenting for the first time at an MS clinic from December 2003 to July 2005 were interviewed pre- and post-appointment and administered standard measures of pain and health quality of life. Consultations were audio recorded. Quantitative data were analyzed in light of qualitative data.

RESULTS: Eighty-two percent of patients reported gathering medical information online before their first appointment; 36% discussed this information with their physician. Qualitative reasons for Internet information seeking and for not communicating it show some signs of wariness of health care potentially leading to non-adherence.

CONCLUSIONS: Most MS patients are informed by online information, but are unlikely to discuss that research with physicians for reasons that may have implications for patient adherence.

Kemp, E. C., Floyd, M. R., McCord-Duncan, E., & Lang, F. (2008). Patients Prefer the Method of "Tell Back-Collaborative Inquiry" to Assess Understanding of Medical Information. *J Am Board Fam Med*. 2008;21(1):24-30.

PURPOSE: The goal of this study was to determine which approach to assessing understanding of medical information patients most prefer and perceive to be most effective.

METHODS: Two videos were shown to participants: (1) a physician explaining a medical condition and its treatment and (2) a physician inquiring about patient understanding of the medical information the patient had been given using 3 different types of inquiry: Yes-No, Tell Back-Collaborative, and Tell Back-Directive.

RESULTS: The Tell Back-Collaborative inquiry was significantly preferred over the other 2 approaches.

CONCLUSIONS: Patients strongly prefer the Tell Back-Collaborative inquiry when assessing their

understanding. We recommend that physicians ask patients to restate what they understand using their own words and that they use a patient-centered approach.

Tai-Seale M., McGuire T.G., & Zhang W. (2007). Time allocation in primary care office visits. *Health Service Research*, Oct;42(5):1871-94.

OBJECTIVES: To use an innovative videotape analysis method to examine how clinic time was spent during elderly patients' visits to primary care physicians. Secondary objectives were to identify the factors that influence time allocations.

DATA SOURCES: A convenience sample of 392 videotapes of routine office visits conducted between 1998 and 2000 from multiple primary care practices in the United States, supplemented by patient and physician surveys.

RESEARCH DESIGN: Videotaped visits were examined for visit length and time devoted to specific topics—a novel approach to study time allocation. A survival analysis model analyzed the effects of patient, physician, and physician practice setting on how clinic time was spent.

PRINCIPLE FINDINGS: Very limited amount of time was dedicated to specific topics in office visits. The median visit length was 15.7 minutes covering a median of six topics. About 5 minutes were spent on the longest topic whereas the remaining topics each received 1.1 minutes. While time spent by patient and physician on a topic responded to many factors, length of the visit overall varied little even when contents of visits varied widely. Macro factors associated with each site had more influence on visit and topic length than the nature of the problem patients presented.

CONCLUSIONS: Many topics compete for visit time, resulting in small amount of time being spent on each topic. A highly regimented schedule might interfere with having sufficient time for patients with complex or multiple problems. Efforts to improve the quality of care need to recognize the time pressure on both patients and physicians, the effects of financial incentives, and the time costs of improving patient-physician interactions.

Waitzkin, H. (1984). "Doctor-patient communication: Clinical implications of social scientific research." *Journal of American Medical Association*, 252:2441-2446.

Description of context: Review of the literature on several areas of doctor-patient communication: information giving and withholding; non-verbal communication; and the sociolinguistic structure of medical communication.

Topic/Scope: In the area of information giving and withholding, the author examined the effect of patients' characteristics and doctors' characteristics on this process. Women tended to request and to receive more information than men. College-educated and upper class individuals received more information than those of lower class or those who did not go to college. Patients with uncertain or unfavorable prognoses received more time and information than other patients. Regarding doctors' characteristics, doctors of upper-class background gave more information than those of lower-class background. The income of internists was a strong indicator of informative behavior; doctors who were wealthy gave less information than those who earned less income. This is probably related to the number of patients the doctor sees each day. In the area of nonverbal communication, the presence of tension or anxiety in the physician is associated with greater patient satisfaction, and may reflect patients' perceptions that their concerns are being taken seriously. The doctors' nonverbal abilities - to recognize nonverbal cues in patients and to convey nonverbal messages - also contribute to patient satisfaction. On the sociolinguistic structure of medical communication, the interrogative mode adopted by many physicians is subtly dominating and may interfere with a mutual exchange of information. Interestingly, female doctors interrupt their patients to a much lesser degree than do male doctors, and therefore, provide a less "control oriented" style.

Conclusions/Recommendations: Training programs and standards of clinical practice should emphasize that improved doctor-patient communication is both desirable and possible.

Attitudes and barriers to discussion

Berman L, Berman J, Felder S, Pollets D, Chhabra S, Miles M, Powell JA. Seeking help for sexual function complaints: what gynecologists need to know about the female patient's experience. *Fertility and Sterility*, 79:3, 572-576, March 2003.

OBJECTIVE: To further explore the patient experience of seeking help for a sexual function complaint.

DESIGN: Survey administered on a Web-based instrument.

SETTING: Healthy volunteers visiting an online Website.

PATIENT(S): The majority of participants were married (73%), Caucasian (88%), and premenopausal (67%). Most commonly reported sexual complaints included low desire (77%), low arousal (62%), and difficulty achieving orgasm (56%).

INTERVENTION(S): None

MAIN OUTCOME MEASURE(S): Patient experience survey on a women's sexual health website.

RESULT(S): Although 40% of the women reported that they did not seek help from a physician for sexual function complaints, 54% reported that they would like to. Although only a minority of the women internalized their experience with extremely negative emotions like shame, devaluation, or disgust, the experience was not a particularly emotionally positive one along the lines of relief, optimism, or confidence, and a great deal of frustration and anxiety about treatment was reported.

CONCLUSIONS: The extent to which health professionals currently receive exposure to training in human sexuality as well as the way in which female sexual complaints are handled in the medical setting remain ambiguous. The inflow of patients with sexual function complaints only will increase, and it is time for physicians to start to acknowledge women's sexuality with the same importance their patients do.

Magnan MA, Reynolds KE, Galvin EA. Barriers to Addressing Patient Sexuality in Nursing Practice. *Dermatology Nursing*. 2006; 18:5, 448-454.

An important and unexpected finding of this study was that the majority of nurses surveyed did not believe that patients expected nurses to ask about sexual concerns. Most nurses (70.2%) in this study reported not making time to discuss sexuality with their patients. Nearly half of the nurses in this study (47.9%) were uncomfortable discussing sexuality. The sample in this study comprised nurses working with oncology, medical and surgical patients. The majority of nurses in this study (74.1%) did not believe patients were too sick to be concerned about sexuality, but less than half of the nurses surveyed believed that discussing sexuality was essential to patient health outcomes. What nurses believe patients expect from them, time availability, personal comfort, and confidence in the ability to address issues related to human sexuality were important barriers to incorporating sexuality assessment and counseling into nursing practice.

Moreira ED, Brock G, Glasser DB, Nicolosi A, Laumann EO, Paik A, Wang T, Gingell C. Help-seeking behavior for sexual problems: the Global Study of Sexual Attitudes and Behaviors. *International Journal of Clinical Practice*, Volume 59 Issue 1, Pages 6 – 16. Published Online: 27 Jan 2005.

SUMMARY: The Global Study of Sexual Attitudes and Behaviors (GSSAB) investigated various aspects of sex and relationships among 27,500 men and women aged 40–80 years. Here, we report help-seeking behaviours for sexual problems in this population. A questionnaire was administered using the accepted survey method in each country. Although almost half of all sexually active respondents had experienced at least one sexual problem, less than 19% of them (18.0% of men and 18.8% of women) had attempted to seek medical help for their problem(s). The most frequent action taken by men and women was to talk to their partner (39%). Only 9% of men and women had been asked about their sexual health by a doctor in a routine visit during the past 3 years. Although sexual problems are highly prevalent, few men and women seek medical help for these problems. Overall, men and women show similar help-seeking behaviours.

Nusbaum M., Gamble G, Skinner B, Heiman J. The High Prevalence of Sexual Concerns Among Women Seeking Routine Gynecological Care. *J Fam Pract* 2000; 49:229-23.

BACKGROUND: Sexuality is an important part of health, quality of life, and general wellbeing. Studies indicate that less than half of patients' sexual concerns are known by their physicians, and physicians are unaware of how common these sexual concerns are in their practices. The objective was to determine the prevalence and type of sexual concerns among women seeking routine gynecological care.

METHODS: Of 1,480 women seeking routine gynecological care from the departments of Family Practice and Obstetrics and Gynecology at Madigan Army Medical Center between August 1992 and January 1993, 964 responded. The main outcome measures were self-reported sexual concerns and their experiences with discussing these concerns with a physician.

RESULTS: A total of 98.8% of the women we surveyed reported one or more sexual concerns. The most frequently reported concerns were lack of interest (87.2%), difficulty with orgasm (83.3%), inadequate lubrication (74.7%), dyspareunia (71.7%), body image concerns (68.5%), unmet sexual needs (67.2%), and needing information about sexual issues (63.4%). More than half reported concerns about physical or sexual abuse, and more than 40% reported sexual coercion at some point in their lives.

CONCLUSIONS: Our results suggest that sexual health concerns are prevalent for women seeking routine gynecological care. Sexual health inquiry should be a regular and important part of health care maintenance.

Sobecki JN, Lindau ST. Female Patient-Physician Communication about Sexuality: A Systematic Review of the Literature Comparing the United States and other Western Countries. Poster Session; International Society for the Study of Women's Sexual Health, St Petersburg, FL, February 2010.

The authors conducted a search of the international medical literature from 2000-2010. Search terms included sexual behavior, sexual dysfunction, sexuality, physicians, patients, female, communication, physician practice patterns, physician's role, medical history taking, etc.

In the United States, the most frequently cited barriers to discussing sexuality with female patients were: physician discomfort, lack of training or knowledge, lack of time, and lack of therapeutic options. In other Western countries, the most frequently cited barriers were: lack of training or knowledge, lack of time, physician discomfort, and fear of offending the patient.

Temple-Smith, M.; Hammond, J.; Pyett, P.; Presswell, N. (1996). Barriers to sexual history taking in general practice. *Australian Family Physician*, 25(9 Suppl 2), S71-S74.

This study identified common barriers to the taking of a sexual history in general practice. It found they included lack of time, fear of intrusion, age and sex of both GP and patient, fear of own inadequacy, patient's offending behaviours, cultural differences (ethnic, gay and youth), presence of a third party and lack of appropriate training. It concluded that GPs may need assistance in education about the range of sexual practices; understanding how to deal with their own discomfort; the use of appropriate and non-judgmental language; and resources for further information and referral.

Female sexual dysfunction

Brown P, Still H. Identifying Sexual Dysfunction. *Can Fam Physician*, 1985; 31:819-820.

Summary: Many patients present sexual concerns, which they may express openly or in various overt ways. Identifying sexual dysfunction is therefore an important part of family practice. All family doctors must be sexual counselors at some time, and their effectiveness or lack of it will influence patients' lives. In order to maintain patients' confidence, the family physician must have empathy, non-judgmental counseling skills, and up-to-date information on sexuality.

Burri A, Cherkas L, Spector T. The Genetics and epidemiology of Female Sexual Dysfunction: A Review. *J Sex Med* 2009, 6:646–657.

INTRODUCTIONS: Female sexual dysfunction (FSD) is an often underestimated and common problem with serious effects on women's quality of life. Despite a high overall prevalence in the female population—exceeding that of male sexual dysfunction—until recently, little research has focused on this area. In contrast to the successful advances of genetic research in a wide variety of human diseases, genetic exploration in FSD lags far behind.

AIM: The aim of this review is to acquaint the reader with the current behavioral and molecular genetic research in the field of FSD.

METHODS: Because of the heterogeneity of the included studies, we are providing a nonsystematic review.

RESULTS: Recent epidemiological and candidate gene studies have suggested a strong genetic influence on female sexual functioning. While these findings provide a clear rationale for more genetic research in the field, they need to be replicated on a much larger scale to be definitive.

CONCLUSIONS: Successful identification of biomarkers and novel genes underlying FSD should improve the diagnosis, identification, and treatment of different subgroups. Future pharmacotherapeutic approaches to FSD will benefit from novel targets and the concept that individual variations have a genetic component may help destigmatize our views of sexual problems.

Kingsberg S, Althof S. Evaluation and treatment of female sexual disorders. *Int Urogynecol J* (2009) 20 (Suppl 1):S33–S43.

ABSTRACT: Prevalence data suggest that more than 40% of women experience sexual problems and that 12% of these women are distressed by the problem. In the 1960s, Masters and Johnson introduced what is now considered the classic linear model of female sexual response based on a physiologic foundation. Recently, Rosemary Basson introduced a nonlinear interconnected model which emphasizes the importance of emotional intimacy and satisfaction as integral components of the female sexual response cycle. According to the Diagnostic and Statistical Manual (DSMIV TR), there are six female sexual disorders: hypoactive sexual desire disorder, aversion disorder, sexual arousal disorder, female orgasmic disorder, vaginismus, and dyspareunia. Despite the high prevalence, few healthcare professionals take the time or feel adequately trained to assess and treat these sexual problems. Sexuality questionnaires play an integral role in the diagnosis and treatment of male and female sexual dysfunctions. They are used to (1) identify/diagnose individuals with a particular dysfunction, (2) assess the severity of the dysfunction, (3) measure improvement or satisfaction with treatment, (4) examine the impact of the dysfunction on the individual's quality of life (relationship satisfaction, mood, sexual confidence), and (5) study the impact of the dysfunction on the partner and his or her quality of life. Patient-reported outcomes (PRO) are increasingly important in both clinical practice and research settings. The instruments reviewed have played a significant role in furthering our understanding of the impact of female sexual function on the patient and partner and its treatment. It is important for the clinician and researcher to familiarize themselves with the best available measures for identifying specific dysfunctions, measuring distress due to the sexual dysfunction, assessing treatment efficacy, and objectively evaluating the quality of life issues of women with these dysfunctions. However, even the best PRO cannot replace the clinician–patient interview and the careful gathering of the patient's sexual history. PROs should always be interpreted and integrated with the woman's history.

Laumann EO, Paik A, Rosen RC. Sexual Dysfunction in the United States: Prevalence and Predictors. *JAMA*. 1999;281(6):537-544.

CONTEXT: While recent pharmacological advances have generated increased public interest and demand for clinical services regarding erectile dysfunction, epidemiologic data on sexual dysfunction are relatively scant for both women and men.

OBJECTIVE: To assess the prevalence and risk of experiencing sexual dysfunction across various social groups and examine the determinants and health consequences of these disorders.

DESIGN: Analysis of data from the National Health and Social Life Survey, a probability sample study

of sexual behavior in a demographically representative, 1992 cohort of US adults.

PARTICIPANTS: A national probability sample of 1749 women and 1410 men aged 18 to 59 years at the time of the survey.

MAIN OUTCOME MEASURES: Risk of experiencing sexual dysfunction as well as negative concomitant outcomes.

RESULTS: Sexual dysfunction is more prevalent for women (43%) than men (31%) and is associated with various demographic characteristics, including age and educational attainment. Women of different racial groups demonstrate different patterns of sexual dysfunction. Differences among men are not as marked but generally consistent with women. Experience of sexual dysfunction is more likely among women and men with poor physical and emotional health. Moreover, sexual dysfunction is highly associated with negative experiences in sexual relationships and overall wellbeing.

CONCLUSIONS: The results indicate that sexual dysfunction is an important public health concern, and emotional problems likely contribute to the experience of these problems.

Female sexuality (general)

Female Sexuality: What DOs Need to Know (A Roundtable Discussion, Parts 1 and 2); Female Sexuality, Parts 1 and 2. *American Osteopathic Association*, January and May 2005. Available on line at: http://www.cecity.com/aoa/women_well/may_05/print2.pdf (Accessed 17 July 2011)

Sexual Health Fundamentals: Clinical Competencies for Sexual Health. *Association of Reproductive Health Professionals*. http://www.arhp.org/uploadDocs/SHF_Competencies.pdf (Accessed 17 July 2011)

Sexual Health Fundamentals: Common Myths about Female sexual Health. *Association of Reproductive Health Professionals*. http://www.arhp.org/uploadDocs/SHF_Myths.pdf (Accessed 17 July 2011)

Sexual Health Fundamentals: The Top 10 Things You Need to Know About Female Sexuality. *Association of Reproductive Health Professionals*. http://www.arhp.org/uploadDocs/SHF_Top10.pdf (Accessed 17 July 2011)

Potter J, et alia. Beth Israel Deaconess Medical Center, Boston. Talking with Patients About Sex. Part 1: Introduction. Part 2: Taking a Sexual History. Part 3: Responding to Patients – Providing Risk Reduction Counseling. Part 4: Assessing Satisfaction and Addressing Problems. Part 5: Boundaries in the *Medical Encounter* – Finding the Right Balance. PowerPoint slides. Video chapters. <http://talkingwithpatientsaboutsex.org/ppt.html> (Accessed: 17 July 2011)

Patient (and Professional) Resources

Guide to Taking a Sexual History. United States Department of Health and Human Services. <http://www.cdc.gov/std/see/HealthCareProviders/SexualHistory.pdf> (Accessed 17 July 2011) 24 pp.

Silence about sexual problems can hurt relationships. (Patient Page): *JAMA*. 1999; 281(6):584.

The Women's Sexual Health Foundation, <http://www.twshf.com/pamphlets.html> (Accessed 17 July 2011); Are You a Woman Experiencing SEXUAL Difficulties? ; Are You a Woman Experiencing DESIRE Difficulties?; Hysterectomy & Your Sexual Response; Talking With Your Healthcare Provide About Sexuality (Tri-fold brochures, PDF format, in English, Spanish and German).

Your Sexual Health. ACOG – The American Congress of Obstetricians and Gynecologists. Text available on-line, copy-protected, and in quantity from ACOG. http://www.acog.org/publications/patient_education/bp072.cfm (Access 17 July 2011)

PLISSIT and Ex-PLISSIT modes of intervention

Albough J, Kellogg-Spadt S. Sexuality and Sexual Health: The Nurse's Role and Initial Approach to Patients. *Urologic Nursing* (2003) Vol. 23:3, 227-228.

Annon JS. Behavioral Treatment of Sexual Problems: *Brief Therapy*. Hagerstown, MD: Medical Department, Harper & Row, Publishers, 1976.

Bitzer J, Brandenburg U. Psychotherapeutic interventions for female sexual dysfunctions. *Maturitas* 63 (2009) 160–163.

ABSTRACT: This summarizes basic elements of psychotherapeutic interventions in women with female sexual dysfunction. Many women can be helped simply by being allowed to talk about their concerns in a safe and sympathetic environment or by being provided with basic information about female physiology and the sexual response. For other women, biomedical treatment (e.g., sex hormone therapy) may be appropriate. For those women who require more intensive or sustained psychotherapy, a variety of different approaches can be combined in a treatment program.

Dixon KB, Dixon PN. The PLISSIT Model: Care and Management of Patients' Psychosexual Needs Following Radical Surgery. *Lippincott's Case Management*: March/April 2006 - Volume 11 - Issue 2 - p 101-106.

ABSTRACT: Patients who have undergone invasive medical procedures requiring radical body changes often experience feelings of worthlessness and particularly negative feelings about their sexuality. Their initial contact with the healthcare team is frequently a nurse who may be poorly equipped, too busy, or too embarrassed to help address the patients' sexual issues; therefore, vital information may be lost to the healthcare team. The PLISSIT Model offers nurses or case managers a concise framework for intervention to address patients' concerns at the earliest stages of their distress, and helps assure informed feedback to the healthcare team regarding the patients' sexual issues.

Finger B. Sexuality and Chronic Illness. Quillen Veterans Affairs Medical Center, East Tennessee State University. <http://members.aapa.org/aapaconf2006/syllabus/6039FingerChronicIllnessSex.pdf> (Access 18 July 2011)

Hodern A. Intimacy and Sexuality After Cancer: A Critical Review of the Literature. *Cancer Nursing*, Vol. 31, No. 2, 2008, E9-E17.

ABSTRACT: Experiencing a diagnosis of cancer may dramatically alter the way a person feels about themselves, their body, and their significant relationships with others at sexual and intimate levels. The purpose of this article is to provide a critical analysis of the way patient sexuality and intimacy has been constructed throughout cancer and palliative care literature. A critique of 3 well-cited communication frameworks for health professionals: the PLISSIT, ALARM, and BETTER models, will be offered. In summary, a dominant emphasis throughout the literature explores the narrow relationship between cancer treatments and the impact of those treatments on patient sexual function or dysfunction, so that patient sexuality and intimacy are inextricably limited to fertility, contraception, menopausal, erectile functional, or capacity for intercourse. Few studies explore sexual or intimate issues that have arisen in the face of life-threatening illness, particularly when patients are older than 65 years. Despite being well cited during the past 30 years, the PLISSIT and ALARM counseling models are outdated in terms of more reflective, patient-centered, and negotiated forms of communication promoted throughout clinical practice guidelines and patient feedback in qualitative research. The BETTER communication model provides a significant step in assessing and documenting the patient's experience of sexuality after cancer.

Jiwa M, O'Shea C, Merriman G, Halkett G, Spilsbury K. Psychosexual problems in general practice: measuring consultation competence using two different measures. *Quality in Primary Care*, 2010; 18:243-50.

BACKGROUND: Psychosexual problems are a common presentation in general practice. Given that the cornerstone of assessment is excellent consultations skills, it may be assumed that general practitioners (GPs) will perform skillfully for such presentations.

AIM: To determine if there is a significant difference in consultation skills assessed using a generic test of consultation performance compared to one which has been specifically developed for experts in psychosexual care, albeit modified for general practice consultations.

METHODS: Six GPs were video recorded consulting six standardised patients at their respective practices. Two assessors independently rated the consultation performance using the Leicester Assessment Package (LAP), a generic tool to assess GP consultation performance. Four sexologists, blind to the review by the LAP assessors, assessed the same consultations deploying the Permission, Limited Information, Specific Suggestion, Intensive Therapy (PLISSIT) framework. The PLISSIT is routinely used to teach health professionals communication skills when consulting people with psychosexual problems.

RESULTS: Thirty-four consultations were successfully recorded. The mean duration of consultations was 12 minutes and 10 seconds (range 7 m. 54 s. to 16 m. 54 s.). Three GPs differed significantly in core competencies as measured by the LAP. Similarly, three GPs differed in competencies as measured by the PLISSIT. There were significant differences in mean LAP scores and PLISSIT scores observed for different doctors. Mean LAP scores varied by actor – scenario after adjusting for doctor clustering, whereas PLISSIT scoring did not vary significantly by actor–scenario in this small study with limited power. There was no evidence that mean LAP scores were associated with PLISSIT scores.

CONCLUSIONS: Two measures of consultation competence revealed different outcomes when applied to the same consultations. We found evidence that general practitioners vary significantly on different measures of consultation competence when consulting patients with psychosexual problems in the context of a cancer diagnosis.

Leach M, Bethune C. Assisting sexually abused adults: Practical guide to interviewing patients. *Canadian Family Physician*, 1996;42:82-86.

SUMMARY: Millions of adults have been sexually abused. Patients often confide in their family physicians concerning their abuse. Physicians must understand their own issues surrounding sexual abuse and its sequelae before they attempt to treat sexually abused patients. The PLISSIT model offers a practical guide for assisting abused adult patients.

Otis-Green S, Sherman R, Perez M, Baird P. An Integrated Psychosocial-Spiritual Model for Cancer Pain Management. *Cancer Practice* (American Cancer Society) May/June 2002, Vol. 10, Suppl. 1.

PURPOSE: Cancer pain is known to be a multidimensional and complex experience that can cause severe suffering and can lessen quality of life. The psychosocial and spiritual aspects of cancer pain play an important role in this phenomenon. This article describes a multidisciplinary model for cancer pain management that focuses on the psychosocial and spiritual aspects of cancer pain and the needs of patients.

DESCRIPTION OF PROGRAM: This multidisciplinary model has been organized to provide the most effective pain management to a variety of patients within a comprehensive cancer center. Our model includes multiple oncology mental health professionals, including psychologists, social workers, spiritual care providers, and psychiatrists. Each discipline provides a unique assessment and an evaluation of the needs of patients with cancer pain and their support system that is integrated into a comprehensive treatment plan. Regular collaboration occurs between disciplines to ensure that the patients receive optimal pain management.

Clinical Implications: This model provides a framework from which treatment interventions can be implemented. The emphasis on consistent collaboration between disciplines is a vital component in

providing effective cancer pain management. This multidisciplinary psychosocial-spiritual model can be replicated, modified, or both, to become standard practice in other comprehensive cancer centers.

Taylor B. The Extended PLISSIT model addressing sexuality. *Royal College of Nursing, RCN Fertility Nurses Group*, Spring 2007. http://www.rcn.org.uk/_data/assets/pdf_file/0004/194557/spring07.pdf (Accessed 18 July 2011)

Taylor B, Davis S. The Extended PLISSIT Model for Addressing the Sexual Wellbeing of Individuals with an Acquired Disability or Chronic Illness. *Sex Disabil*, (2007) 25:135–139.

ABSTRACT: This paper discusses the limitations in the way that healthcare practitioners may use Annon's PLISSIT model in meeting the sexual wellbeing needs of individuals with an acquired disability and presents the merits of the extended model, Ex-PLISSIT. Key features of this model include explicit Permission-giving as a core feature of each of the other stages, the requirement to review all interactions with patients, and the incorporation of reflection as a means of increasing self-awareness by challenging assumptions.

Taylor B, Davis S (2006) Using the Extended PLISSIT model to address sexual healthcare needs. *Nursing Standard* (Royal College of Nursing, Great Britain). 21,11,35-40.

Wallace MA. Assessment of Sexual Health in Older Adults: Using the PLISSIT model to talk about sex. *American Journal of Nursing*, July 2008, Vol. 108, No. 7, 52-60. <http://www.nursingcenter.com/pdf.asp?AID=800532> (Accessed 18 July 2011).

Weerakoon, P., Wong, M. Sexuality Education On-line for Health Professionals. *Electronic Journal of Human Sexuality*, Volume 6, May 6, 2003. <http://www.ejhs.org/volume6/SexEd.html> (Accessed 18 July 2011).

Weerakoon P. On-line sexuality education and health professional students' comfort in dealing with sexual issues. <http://ses.library.usyd.edu.au/handle/2123/5002> (Accessed 18 July 2011).

ABSTRACT: A study of comfort level for sexually related topics in a sample of allied health professional students shows an improvement in their comfort level after completing an online sexuality unit. This finding supports the argument that modern technology can offer an excellent opportunity and means to develop personal and professional skills in sexually related issues. Raising the comfort levels of health professional students will better prepare them for professional interaction on sexually related issues they could encounter with their clients. Future research examining different ways to build not only comfort levels but also professional communication skills is warranted. The current and future research would aid in development of new programs based on distant education platforms, which could provide effective ways of appropriate sexual interventions education for health professionals in clinical settings.

Weerakoon P, Skowronski D. Effective of on-line sexuality education on health professional students' comfort in provision of sexual health care. Presentation; World Association of Sexual Health, Sydney, Australia, April 2007. http://ses.library.usyd.edu.au/bitstream/2123/2656/1/WAS_PWee_SexEd.pdf (Accessed 18 July 2011).

INTRODUCTION: The unit of study "Sexuality for Health Professionals" is offered on-line unit as an elective to all students enrolled in the Health Sciences Faculty of the University of Sydney. The unit utilises the PLISSIT management model to present an interactive learning unit on the Web CT learning platform. This paper presents the analysis of a pre and post learning evaluation of the unit.

METHODS: An on-line questionnaire was linked to the Web CT learning site. Students were requested to complete the questionnaire in the first week of the unit (pre-test) and the final week (post-test). The questionnaire consisted of 10 scenarios of client sexual health concerns. Students rated their comfort in dealing with these scenarios.

RESULTS: There were 106 students enrolled in the unit. Of these 102 responded to the pretest (96%)

and 62 to the post-test (58.5%). Students reported a significant improvement ($F = 5.733$; $df = 1$; $p = 0.018$) in their comfort levels when 'dealing with client questions related to sexuality'. Comfort in dealing with specific scenarios varied. The largest improvements in comfort were in 'asking a client about sexual practice' ($F = 9.646$; $df = 1$; $p = 0.002$), 'talking to a 70 year old widow on sexual practice' ($F = 9.566$; $df = 1$; $p = 0.002$) and 'discussing sexual options with a handicapped client' ($F = 7.899$; $df = 1$; $p = 0.006$). There was no improvement in the item 'comfort with physical examination'.

CONCLUSIONS: These results suggest that on-line learning in sexuality education is an effective method of improving health professional student's comfort in dealing with sexual health issues. It also demonstrates the need to recognise the weakness of on-line learning in skill development. Future research will explore the effect of individual student characteristics and professional roles in this area.

Sex Therapy for Non-Sex Therapists

Reamy K. Sexual counseling for the nontherapist. *Clin Obstet Gynecol*. 1984 Sep;27(3):781-8.

ABSTRACT: Sexual health is a part of total health. Sexual problems can cause marital dissolution and emotional impoverishment. The physician is seen as a wise authority figure often and one who can provide sexual guidance and counsel. To be an effective counselor, an obstetrician/gynecologist must acquire sexual knowledge, comfort, and counseling skills. A sexual history is a recommended routine--as part of the new workup, when management of organic problems and treatment (mastectomy, hysterectomy, radical vulvectomy) necessitate inquiry into the patient's sexual practices and sexual value system, and when the patient presents with suspected "functional" or obscure complaints (hyperventilation, palpitations, chronic pelvic pain, recurrent vaginal discharge without obvious pathogens, chronic concerns that everything is all right "down there", cancerphobia). The sexual problem history is readily applicable, especially when a patient presents with an explicit sexual concern. The PLISSIT method is a paradigm that can be utilized effectively with usual referral for intensive therapy (sex therapy) if sexual counseling is ineffectual. The obstetrician/gynecologist can play an important role in facilitating healthful sexual changes in women and couples, enhancing intimacy, and enriching the marital bond.

Sexual Health Fundamentals: Sex Therapy for Non-Sex Therapists. Association of Reproductive Health Professionals. http://www.arhp.org/uploadDocs/SHF_Therapy.pdf (Accessed 18 July 2011).

Sexuality and aging

AHRP – Clinical Proceedings – Women's Sexual Health in Midlife and Beyond: Introduction. <http://www.medscape.com/viewarticle/506390> (Posted 6/16/2005 and Accessed 18 July 2011). Full proceedings (32 pp.) available in PDF format on request from AHRP. See: <http://www.arhp.org/Publications-and-Resources/Clinical-Proceedings/CP-Archives>.

Gott M, Hinchliff S, Galena E. General practitioner attitudes to discussing sexual health issues with older people. *Social Science & Medicine* 58 (2004) 2093-2103.

ABSTRACT: How health professionals perceive and manage later life sexual problems remains relatively unexplored and, in particular, little is known about the attitudes of GPs, who represent the first point of contact for most older people in the UK who experience sexual health concerns. This paper draws on qualitative data generated from in-depth interviews with 22 GPs working in demographically diverse primary care practices in Sheffield, UK. Analysis identified that GPs do not address sexual health proactively with older people and that, within primary care, sexual health is equated with younger people and not seen as a 'legitimate' topic for discussion with this age group. However, it was apparent that many beliefs held about the sexual attitudes and behaviours of older people were based on stereotyped views of ageing and sexuality, rather than personal experience of individual patients. The discussion considers the implications of these findings for primary care, particularly in relation to education and training.

Laumann EO, Paik A, Glasser DB, Kang J-H, , Wang T, Levinson G, Moreira ED, Brock G, Nicolosi A, Gingell C. A Cross-National Study of Subjective Sexual Well-Being among Older Women and Men: Findings from the Global Study of Sexual Attitudes and Behaviors. *Archives of Sexual Behavior*, Vol. 35, No. 2, April 2006, pp. 145–161.

ABSTRACT: Subjective sexual well-being refers to the cognitive and emotional evaluation of an individual's sexuality. This study examined subjective sexual well-being, explored its various aspects, examined predictors across different cultures, and investigated its possible associations with overall happiness and selected correlates, including sexual dysfunction. Data were drawn from the Global Study of Sexual Attitudes and Behaviors, a survey of 27,500 men and women aged 40 to 80 years in 29 countries. The cross-national variation of four aspects of sexual well-being (the emotional and physical satisfaction of sexual relationships, satisfaction with sexual health or function, and the importance of sex in one's life) was explored using cluster analysis, and relationships among sexual well-being, general happiness, and various correlates were examined using ordinary least squares regression and ordered logistic regression. Results from the cluster analysis identified three clusters: a gender-equal regime and two male-centered regimes. Despite this cultural variation, the predictors of subjective sexual well-being were found to be largely consistent across world regions.

Lindau ST, Schumm LP, Laumann EO, Levinson W, Muirheartaigh CA, Waite LJ. A Study of Sexuality and Health among Older Adults in the United States. *N Engl J Med* 2007; 357:762-74.

BACKGROUND: Despite the aging of the population, little is known about the sexual behaviors and sexual function of older people.

METHODS: We report the prevalence of sexual activity, behaviors, and problems in a national probability sample of 3005 US adults (1550 women and 1455 men) 57 to 85 years of age, and we describe the association of these variables with age and health status.

RESULTS: The unweighted survey response rate for this probability sample was 74.8%, and the weighted response rate was 75.5%. The prevalence of sexual activity declined with age (73% among respondents who were 57 to 64 years of age, 53% among respondents who were 65 to 74 years of age, and 26% among respondents who were 75 to 85 years of age); women were significantly less likely than men at all ages to report sexual activity. Among respondents who were sexually active, about half of both men and women reported at least one bothersome sexual problem. The most prevalent sexual problems among women were low desire (43%), difficulty with vaginal lubrication (39%), and inability to climax (34%). Among men, the most prevalent sexual problems were erectile difficulties (37%).

Fourteen percent of all men reported using medication or supplements to improve sexual function. Men and women who rated their health as being poor were less likely to be sexually active and, among respondents who were sexually active, were more likely to report sexual problems. A total of 38% of men and 22% of women reported having discussed sex with a physician since the age of 50 years.

CONCLUSIONS: Many older adults are sexually active. Women are less likely than men to have a spousal or other intimate relationship and to be sexually active. Sexual problems are frequent among older adults, but these problems are infrequently discussed with physicians.

Nusbaum M, Singh A, Pyles A. Sexual Healthcare Needs of Women Aged 65 and Older. *J Am Geriatr Soc* 52:117-122, 2004.

OBJECTIVES: To compare prevalence and type of sexual concerns and interest in and experience with discussing these concerns with physicians for women younger than 65 and 65 and older.

DESIGN: Cross-sectional survey.

SETTING: Departments of Family Practice and Obstetrics and Gynecology at Madigan Army Medical Center, Tacoma, Washington.

PARTICIPANTS: Of 1,480 women seeking routine gynecological care, 964 (65%) responded; 163 (17%) were aged 65 and older.

MEASUREMENTS: Self-reported sexual concerns and interest in and experience with discussing these concerns with their physicians.

RESULTS: Older women had a similar number of sexual concerns as younger women and were more

likely to be concerned about their partner's sexual difficulties. Older women were less likely to have ever had the topic of sexual health raised during healthcare visits. Even though these women were more likely to report youthful-appearing physicians as hindering the topic of sexual health, the majority indicated that they would have discussed their concerns had the physician raised the topic and were interested in a follow-up appointment to do so.

CONCLUSIONS: Although the types of sexual concerns vary in frequency, women aged 65 and older have a similar number of sexual concerns as younger women. Older women want physicians to inquire about their sexual health. This discussion should include inquiries about their partner's sexual functioning. To overcome age as a barrier to this discussion, younger physicians should be particularly attentive to initiating the topic of sexual health.

Wallace MA. Assessment of Sexual Health in Older Adults: Using the PLISSIT model to talk about sex. *American Journal of Nursing*, July 2008, Vol. 108, No. 7, 52-60.
<http://www.nursingcenter.com/pdf.asp?AID=800532> (Accessed 18 July 2011).

Sexuality and disability

Fronek P, Booth S, Kendall M, Miller D, Geraghty T. The Effectiveness of a Sexuality Training Program for the Interdisciplinary Spinal Cord Injury Rehabilitation Team. *Sexuality and Disability*, 23: 2 (Summer 2005)51-63.

ABSTRACT: While there is evidence to support consideration of client sexuality needs in the provision of rehabilitation services to people with spinal cord injury (SCI), the interdisciplinary team rarely receives training in this area. The current study aimed to examine the effectiveness of a consumer-driven sexuality training program in improving staff knowledge, comfort (general and personal) and attitudes. Using a local needs assessment to identify training needs and the Permission, Limited Information, Specific Suggestions and Intensive Therapy (PLISSIT) model as a training framework, a sexuality training program was developed in one Australian SCI service. A randomized controlled trial was conducted and significant improvement was found in all domains for the treatment group – Knowledge ($\chi^2 = 46.141$, $p < 0.001$), Comfort ($\chi^2 = 23.338$, $p < 0.001$), Approach ($\chi^2 = 23.925$, $p < 0.001$) and Attitude ($\chi^2 = 15.235$, $p < 0.001$) compared to the control group. Changes were found to be maintained at three month follow-up – Knowledge ($Z = -5.116$, $p < 0.001$), Comfort ($Z = -3.953$, $p < 0.001$), Approach ($Z = -4.103$, $p < 0.001$) and Attitudes ($Z = -2.655$, $p < 0.001$). These results support the use of an individualized needs-based sexuality training program in fostering staff knowledge, comfort and attitudinal change in an interdisciplinary SCI rehabilitation service.

Hodern A. Intimacy and Sexuality After Cancer: A Critical Review of the Literature. *Cancer Nursing*, Vol. 31, No. 2, 2008, E9-E17.

Keefe S. A Delicate Matter. *Advance for Nurses*, vol 8:25, 27. <http://nursing.advanceweb.com/Article/A-Delicate-Matter.aspx>. Posted 11/6/2006 (Accessed 18 July 2011).

McInnes RA. Chronic illness and sexuality. *MJA* 2003; 179:263-266.
http://www.mja.com.au/public/issues/179_05_010903/mci10673_fm.html (Accessed 18 July 2011).

ABSTRACT: Sex remains an important contributor to quality of life in many patients with chronic illness and their partners. The effects of chronic illness on sexuality are multifactorial and can impact on all phases of sexual response. Sexual dysfunction and dissatisfaction in chronically ill patients are underdetected and undertreated because of barriers to doctor-patient discussion about sex and lack of medical training in human sexuality. For doctors to become more motivated to broach the topic of sex, they need to recognise that people may be sexually interested even though they are old, ill or disabled. The PLISSIT model provides a graded counseling approach that allows doctors to deal with sexual issues at their own level of expertise and comfort.

Rubin A. Communication about sexual problems in male patients with multiple sclerosis. *Nurs Stand*. 2005 Feb 23-Mar 1;19(24):33-7.

AIM: To explore the reasons given by a disability, assessment and rehabilitation team (DART) for perceived difficulties in discussing sexual problems with male patients with multiple sclerosis (MS), and to compare them with the views of a sample of patients.

METHOD: Data were gathered from a multidisciplinary team who were responsible for assessment and rehabilitation of patients with MS, using a focus group and semi-structured interviews with 11 male patients. Data were analysed thematically, with reference to Annon's (1976) PLISSIT model of communication.

FINDINGS: Patients felt a need to discuss problems with sexual dysfunction, and would welcome the introduction of the topic in a straightforward way. Health professionals were worried about intrusiveness and lack of information and training. Team members and the patients indicated that nurses are the best people to deal with these issues.

Conclusion: Rehabilitation teams need training to deal with patients' sexual problems, and the nurse is likely to be identified as the specialist in this area.

Taking a sexual history

Brandenburg, U., Schwenkhagen, A. "Sexual history." In Goldstein, I., Meston, C., Davis, S.R., Traish, A., eds., *Women's Sexual Function and Dysfunction: Study, Diagnosis and Treatment*, Informa Healthcare, 2005, pp. 343-346.

Bushman SA. Bridging the Communication Gap. *Women and Wellness*. American Osteopathic Association. May 2005, 6 – 7. http://www.cecily.com/aoa/women_well/may_05/print6.pdf (Accessed 18 July 2011).

Futterman L. Why Sexual History Is Important for the Female Patient. *Women and Wellness*. American Osteopathic Association. May 2005, 11-12. http://www.cecily.com/aoa/women_well/may_05/print3.pdf (Accessed 18 July 2011).

Jennings PR, Bachman L. Yes, the sexual history IS important. <http://www.jaapa.com/yes-the-sexual-history-is-important/article/124531/> (Accessed 18 July 2011).

Keller A, McGarvey E, Clayton A. Reliability and Construct Validity of the Changes in Sexual Functioning Questionnaire Short-Form (CSFQ-14). *Journal of Sex & Marital Therapy*, 32:43-52, 2006.

ABSTRACT: The Changes in Sexual Functioning Questionnaire (CSFQ) is a 36-item clinical and research instrument identifying five scales of sexual functioning. This study documents the internal consistency and factor structure of a 14-item version of the CSFQ (CSFQ-14), which yields scores for three scales corresponding to the phases of the sexual response cycles (i.e., desire arousal, and orgasm) as well as the five scales of the original CSFQ-14 as a global measure of sexual dysfunction. The CSFQ-14 and the individual scales exhibit strong internal reliability.

Mick JA, Hughes M, Cohen MZ. Using the BETTER Model to Assess Sexuality. *Clinical Journal of Oncology Nursing*, 8:1 (Feb 2004), 84-86.

Nusbaum MRH, Hamilton CD. The Proactive Sexual Health History. *American Family Physician*, 66:9 (Nov 1, 2002) 1705-1712. <http://www.aafp.org/afp/2002/1101/p1705.html> (Accessed 18 July 2011).

ABSTRACT: Family physicians must proactively address the sexual health of their patients. Effective sexual health care should address wellness considerations in addition to infections, contraception, and sexual dysfunction. However, physicians consistently underestimate the prevalence of sexual concerns in their patients. By allocating time to discuss sexual health during office visits, high-risk sexual behaviors that can cause sexually transmitted diseases, unintended pregnancies, and unhealthy sexual

decisions may be reduced. Developing a routine way to elicit the patient's sexual history that avoids judgmental attitudes and asks the patient for permission to discuss sexual function will make it easier to gather the necessary information. Successful integration of sexual health care into family practice can decrease morbidity and mortality, and enhance well-being and longevity in the patient.

Potter J, et alia. Beth Israel Deaconess Medical Center, Boston. Talking with Patients About Sex. Part 2: Taking a Sexual History. PowerPoint slides. Video chapters.
<http://talkingwithpatientsaboutsex.org/ppt.html> (Accessed: 17 July 2011)

Talking about sex in primary care

Bonvicini KA, & Perlin MJ (2003). The same but different: Clinician-patient communication with gay and lesbian patients. *Patient Education and Counseling*, 51:115-122.

Surveys estimate that 3-6% of the patients seen by physicians are gay or lesbian. There are unique health risks of gays and lesbians that are important to the clinician in determining an accurate diagnosis, providing patient education, and arriving at an appropriate treatment plan. One of the most significant medical risks of these populations includes avoidance of routine health care and dissatisfaction with healthcare. Many of these healthcare risks are not addressed because of lack of communication based on a number of common assumptions including the assumption that the patient is heterosexual. This article includes a summary of the medical literature through computerized searches to March 2002 in MEDLINE, PsychInfo, HEALTHSTAR, and bibliographies in articles on health care with gay and lesbian patients. The search strategy included health care of gays and lesbians and clinician-patient communication, partner and family issues. Secondly, it will examine common communication barriers and provide strategies for enhancing communication with patients in a gender-neutral, non-judgmental manner including suggestions for enlisting the inclusion of patients' families.

Brandenburg U, Bitzer J. The challenge of talking about sex: The importance of patient-physician interaction. *Maturitas* 64 (2009) 124-127.

ABSTRACT: Sexuality is a complex phenomenon, with physical, psychological, and social components. In evaluating and counseling the patient with sexual problems, it is important for the physician to communicate effectively and to be open to the patient's own experience of sexuality. This paper provides an overview of important issues related to evaluation of these patients and presents a stepwise approach to the clinical evaluation suitable to the limited time frame of a medical consultation.

Brandon WR. National Health Service Corps Educational Program for Clinical and Community Issues in Primary Care: HIV/AIDS Module. www.amsa.org/AMSA/Libraries/Committee_Docs/hiv aids.sflb.ashx (Accessed 18 July 2011).

Communicating With Patients: A Quick Reference Guide for Clinicians. Association of Reproductive Health Professionals. 2004. Available on request from ARHP at www.arhp.org.

Houge DR. Sex problems in family practice. *Fam Pract Res J*. 1988 Spring;7(3):135-40.

ABSTRACT: This study surveyed a group of 76 practicing family practice physicians and a group of 139 residents. They were asked the importance of sex counseling, the value of different kinds of education, who and when they asked about sexual problems, and their ability to deal with 24 problems or issues. Dealing with patient sexual problems was seen as important to both groups and they estimated 20% of their patients to have a problem or concern. A major concern of both groups was sexual abuse. Since the majority indicated they only ask about sexuality if there appears to be a "psycho-sexual sign," it is critical that they receive training in recognizing the signs of sexual problems. Continuing medical education courses were seen to be the most valuable form of training by the practicing family physician in learning about dealing with patient sexual issues and problems.

Kingsberg S. Just ask! Talking to patients about sexual function. *Sexuality, Reproduction and Menopause*, 2:4 (Dec 2004), 199-203.

Kingsberg A, Kellogg-Spadt S. The essentials of assessing the sexual concerns of your female patients. MedscapeCME Ob/Gyn & Women's Health. Available at: <http://cme.medscape.com/viewarticle/710343> Accessed 18 July 2011.

Nease DE, Liese BS. Perceptions and Treatment of Sexual Problems. *Fam Med* 1987; 19:468-70.

ABSTRACT: In this research, perceptions and beliefs which affect the family physician's treatment of sexual problems were studied. A 66-item questionnaire, the Survey of Sexual Problem Care (SSPC), was completed by 68 individuals. Respondents reported that they would be more likely to consult a family physician for the treatment of sexual problems than any other individual; however, few (11%) of those surveyed had actually sought treatment for sexual problems. Confidentiality was reported to be the most important characteristic in persons consulted for sexual problems, and treatment was more likely to be sought from family physicians when problems were believed to have a physical (vs. psychological) etiology. The implications of these results are discussed.

Peck S. The Importance of the Sexual Health History in the Primary Care Setting. *JOGNN*, 30, 269-274; 2001.

ABSTRACT: Nurses often are apprehensive when inquiring about women's sexual health issues. A comprehensive sexual health assessment, however, is an important part of the health history and interview. Ensuring confidentiality and maintaining professionalism will create the trusting, comfortable environment necessary for a thorough evaluation of a client's sexual health risks. Nurses who are familiar with diverse sexual issues can help women deal with the changes that may occur during the life span.

Politti MC, Clark MA, Armstrong G, McGarry KA, Sciamanna CN. Patient-Provider Communication About Sexual Health Among Unmarried Middle-aged and Older Women. *J Gen Intern Med* 24(4):511-16 (2009).

BACKGROUND: Although past studies have highlighted the importance of patient-provider communication about sexual health and intimate relationships (SHIR), much of the research has focused on young women's or married women's experiences when discussing SHIR with their providers.

OBJECTIVE: To describe experiences of unmarried, middle-aged and older women in communicating about SHIR with their health care providers.

DESIGN AND PARTICIPANTS: Qualitative interviews were conducted with 40 unmarried women aged 40-75 years. We compared the responses of 19 sexual minority (lesbian and bisexual) women and 21 heterosexual women.

RESULTS: Women varied in their definitions of intimate relationships. Not all women thought providers should ask about SHIR unless questions were directly related to a health problem, and most were not satisfied with questions about SHIR on medical intake forms. However, the themes women considered to be important in communication about SHIR were remarkably consistent across subgroups (e.g. previously married or never married; sexual minority or heterosexual). Sexual minority women were more hesitant to share information about SHIR because they had had prior negative experiences when disclosing their sexual orientation or perceived that clinicians were not informed about relevant issues.

CONCLUSIONS: Some women felt that providers should ask about SHIR only if questions relate to an associated health problem (e.g. sexually transmitted infection). When providers do ask questions about SHIR, they should do so in ways that can be answered by all women regardless of partnering status, and follow questions with non-judgmental discussions.

Quilliam S. 'The Cringe Report': Why Patients Don't Dare Ask Questions, and What We Can Do About That. *J Fam Plann Reprod Health Care*. 2011;37(2):110-112 Posted 06/28/2011 at http://www.medscape.com/viewarticle/743689_9 (Accessed 5 July 2011).

Sanchez A, Shewchuk R, Parish S, Cheatham C, Williamson, Abdolrasulnia M. Predictors of OB/GYN Intentions to Initiate a Discussion About Women's Sexual Health with Premenopausal Patients. CEOutcomes, Inc., September 2009, http://www.ceoutcomes.com/pubs/posters/Sanchez_ASRM09Poster_FINAL.pdf (Accessed 18 July 2011).

- CONCLUSIONS:
- OB/GYNs feel initiating a discussion is appropriate and are relatively comfortable doing so but feel it is a lower priority and benefit.
 - OB/GYNs would be more inclined to initiate a discussion if there was sufficient time during the visit and if there was an available approved treatment.
 - Results of the study indicate that attitudes as well as internal and external barriers significantly predict OB/GYN intentions to initiate a discussion about sexual health with their premenopausal patients.
 - Attitudes play a more significant role in explaining OB/GYN intention to initiate such a dialogue when compared to the impact of perceived barriers.

Steward D. Talking to Patients About Sex. *Canadian Family Physician*, Editorial,31 (April 1985) 683-685.

Talking to Patients About Sexuality and Sexual Health. *Association of Reproductive Health Professionals*, April 2008. <http://www.arhp.org/publications-and-resources/clinical-fact-sheets/sexuality-and-sexual-health> (Accessed 18 July 2011).

Wimberly YH, Hogben M, Moore-Ruffin J, Moore SE, Fry-Johnson Y. Sexual History-Taking among Primary Care Physicians. *Journal of the National Medical Association*, 98:12 (Dec 2006), 1924-1929. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2569695/> (Accessed 18 July 2011).

BACKGROUND: Because many people seek sexual healthcare in settings where they seek primary healthcare, the extent to which primary care physicians take sexual histories is important. We surveyed Atlanta-area primary care physicians to estimate the extent to which they take sexual histories as well as the components of those histories and the circumstances under which they are taken.

METHODS: Four-hundred-sixteen physicians in four specialties (obstetrics/gynecology, internal medicine, general/family practice, pediatrics) responded to a mail survey conducted during 2003-2004. Respondents answered whether they asked about sexual activity at all, including specific components of a comprehensive sexual history such as sexual orientation, numbers of partners and types of sexual activity, during routine exams, initial exams, complaint-based visits or never. Respondents also reported their opinions on whether they felt trained and comfortable taking sexual histories.

RESULTS: Respondents (51% male, 58% white) saw an average of 94 patients per week. A majority (56%) felt adequately trained, while 79% felt comfortable taking sexual histories. Almost three in five (58%) asked about sexual activity at a routine visit, but much smaller proportions (12-34%) asked about the components of a sexual history. However, 76% of physicians reported asking about sexual history (61-75% for various components) if they felt it would be relevant to the chief complaint.

CONCLUSIONS: Most physicians report feeling comfortable taking sexual histories and will do so if the patient's apparent complaint is related to sexual health. But sexual histories as part of routine and preventive healthcare are less common, and many physicians miss essential components of a comprehensive sexual history. Structural changes and suggestions for training to enhance sexual history-taking are discussed.

Zitner D. Sex Education for Patients. *Canadian Family Physician*, 1985; 31:833-836.

SUMMARY: Sex education evokes a wide variety of responses in the community and from teachers. Consequently, physicians have a responsibility to present sex education material in a factual, objective way. Many people are misinformed about sexual behavior. Physicians can help patients and the community by being aware of appropriate sex education for each age group. A curriculum for sex education, and opportunities to provide sex information for patients of different ages and stages in the lifecycle, are described.

Teaching clinicians about sexuality

Baraitser P, Elliott L, Bigrigg A. How to talk about sex and do it well: a course for medical students. *Medical Teacher*, 20:3 (1998)237-240.

SUMMARY: Sexual health consultations require good general communication skills and an ability to discuss issues such as sexual orientation and sexual practices sensitively and without embarrassment. Whereas the former are usually taught at medical school the latter are not. This paper describes the development and evaluation of a sexual health communication skills course for fifth-year medical students. It documents students' limited experience of discussing sexual health issues with patients and the significant decrease in their feelings of discomfort about doing so after a single two-hour training session. Some 97% of students felt that the course was relevant to clinical practice and all found it enjoyable. On the basis of this information the authors recommend that other medical schools run similar courses.

Clinician Competencies for Sexual Health. Association of Reproductive Health Professionals, March 2010; <http://www.arhp.org/publications-and-resources/clinical-fact-sheets/shf-competencies>, (Accessed 18 July 2011).

Cushing A, Evans D, Hall A. Medical Students' attitudes and behavior towards sexual health interviewing: short- and long-term evaluation of designated workshops. *Medical Teacher*, 27:5 (2005) 422-428.

Abstract: Workshops aimed at promoting fourth-year medical students' attitudes towards and subsequent behaviour in talking to patients about sexual health are reported on. Improvements in attitudes are reported following the workshops in 1999-2000 with students being more likely to see the relevance of sexual health enquiry, feeling more confident and competent about broaching the subject and expressing greater intention to do so. One year on, comparison of the intervention and non-intervention group for attendance at the workshop showed no difference in the proportion who had subsequently asked patients questions about sex. The proportion of students asking patients rose from 47% in the fourth year to 92% by the fifth year. Issues of long-term evaluation and the importance of the informal relative to the formal curriculum are discussed.

Dunk P. Everyday Sexuality and Social Work: Locating Sexuality in Professional Practice and Education. *Social Work & Society* (International Online-Only Journal), vol. 7(2009) no. 2. http://www.socwork.net/2007/2/articles/dunk/index_html/?searchterm=dunk (Accessed 18 July 2011).

ABSTRACT: Social work has seen increased intellectual interest in sexuality. However, little attention has been paid to the relevance of everyday sexuality for professional practice or how this might be integrated within existing social work curricula. This paper proposes that knowledge about everyday sexuality is vital to social workers as they deal with a variety of clients faced with the increasing complexities brought about by late-modernity. Additionally, it is argued that this knowledge base is congruent with the ethical and political dimensions of the profession. The PLISSIT model is presented as a possible pedagogical framework for social work education in this area.

Leiblum SR. An established medical school human sexuality curriculum: description and evaluation. *Sexual and Relationship Therapy*, 16:1 (2001), 59-70.

<http://www.hawaii.edu/hivandaids/An%20Established%20Medical%20School%20Human%20Sexuality%20Curriculum%20%20%20%20Description%20And%20Evaluation.pdf> (Accessed : 29 June 2011).

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.

Lindau ST, Goodrich KG, Leitsch SA, Cook S. Sex in the curriculum: the effect of a multi-modal sexual history-taking module on medical student skills. *Sex Education*, 8:1 (Feb 2008), 1-9.

PURPOSE: The objective of this study was to determine the effect of a multi-modal curricular intervention designed to teach sexual history-taking skills to medical students. The Association of Professors of Gynecology and Obstetrics, the National Board of Medical Examiners, and others, have identified sexual history-taking as a learning objective for medical students.

METHODS: Between 2001 and 2003 the sexual history-taking skills of two sequential cohorts of second-year medical students were compared. Cohort I (n = 95) received a traditional physical diagnosis curriculum. Cohort II (n = 99) received the same curriculum in addition to a multi-modal sexual history-taking module. Both groups were evaluated at one year as part of a general clinical skills evaluation involving three standardized patient cases. The apparent relevance of the sexual history varied per case.

RESULTS: In the obvious-relevance case, nearly every student in Cohort II initiated a sexual history, performing significantly better than Cohort I (98% versus 86%, p less than 0.05). A significant positive association was found between the curricular intervention and the number of screening sexual history questions asked (odds ratio, 2.8; 95% confidence interval, 1.3-6.0). In the case with least-obvious relevance, no student in either cohort initiated a sex history.

CONCLUSION: Under conditions of a general clinical skills evaluation, the intervention significantly improved second-year medical students' sexual history-taking skills in a case of obvious relevance but had less impact in cases where the relevance of the sex history was less obvious.

Peabody JW, Luck J, Glassman P, Dresselhaus TR, Lee M. Comparison of Vignettes, Standardized Patients, and Chart Abstraction: A Prospective Validation Study of 3 Methods for Measuring Quality. *JAMA*, 2000; 283:1715-1722.

CONTEXT: Better health care quality is a universal goal, yet measuring quality has proven to be difficult and problematic. A central problem has been isolating physician practices from other effects of the health care system.

OBJECTIVE: To validate clinical vignettes as a method for measuring the competence of physicians and the quality of their actual practice.

DESIGN: Prospective trial conducted in 1997 comparing 3 methods for measuring the quality of care for 4 common outpatient conditions: (1) structured reports by standardized patients (SPs), trained actors who presented unannounced to physicians' clinics (the gold standard); (2) abstraction of medical records for those same visits; and (3) physicians' responses to clinical vignettes that exactly corresponded to the SPs' presentations.

SETTING: Outpatient primary care clinics at 2 Veterans Affairs medical centers.

PARTICIPANTS: Ninety-eight (97%) of 101 general internal medicine staff physicians, faculty, and second- and third-year residents consented to be randomized for the study. From this group, 10

physicians at each site were randomly selected for inclusion.

RESULTS: The quality of care, as measured by all 3 methods, ranged from 76.2% (SPs) to 71.0% (vignettes) to 65.6% (chart abstraction). Measuring quality using vignettes consistently produced scores closer to the gold standard of SP scores than using chart abstraction. This pattern was robust when the scores were disaggregated by the 4 conditions ($P < .001$ to $< .05$), by case complexity ($P < .001$), by site ($P < .001$), and by level of physician training (P values from $< .001$ to $< .05$). The pattern persisted, although less dominantly, when we assessed the component domains of the clinical encounter--history, physical examination, diagnosis, and treatment. Vignettes were responsive to expected directions of variation in quality between sites and levels of training. The vignette responses did not appear to be sensitive to physicians' having seen an SP presenting with the same case.

CONCLUSIONS: Our data indicate that quality of health care can be measured in an outpatient setting by using clinical vignettes. Vignettes appear to be a valid and comprehensive method that directly focuses on the process of care provided in actual clinical practice. Vignettes show promise as an inexpensive case-mix adjusted method for measuring the quality of care provided by a group of physicians.

Potter JE. Do Ask, Do Tell. *Ann Intern Med.* 2002; 137:341-343.

ABSTRACT: As a consequence of bias and ignorance within the medical profession, lesbians and gay men frequently receive suboptimal health care. Knowledge of each patient's sexual orientation and behaviors is critical for the development of a productive therapeutic relationship, accurate risk assessment, and the provision of pertinent preventive counseling. However, clinicians often forget to ask about this information, and many lesbians and gay men are reticent to reveal the truth. I present vignettes from my personal experiences as a lesbian patient and doctor to illustrate the importance of creating an environment in which such disclosure can occur and to portray the challenges and rewards of coming out as a gay physician.

Potter JE, Kahn M. Beth Israel Deaconess Medical Center, Boston. Talking with Patients About Sex. Part 5 Setting Boundaries: A Little Distance Can Be Healthy. PowerPoint slides. Video chapters. <http://talkingwithpatientsaboutsex.org/ppt.html> (Accessed: 17 July 2011)

Sansone RA, Wiederman MW. Sexuality Training for Psychiatry Residents: A National Survey of Training Directors. *Journal of Sex & Marital Therapy*, 26(2000), 249-256.

ABSTRACT: The current status of training in human sexuality is relevant to all health care professionals. The purpose of the current study was to determine the extent of sexuality training offered in psychiatric residency programs. The training directors of psychiatry residencies were surveyed with regard to the number of expert faculty in sexuality training as well as resident exposure to seven related curricular areas. Of the 69 respondents, the majority reported expert faculty in sexual dysfunctions, sex therapy, therapy with gay/lesbian patients, and HIV/AIDS. For each sexuality topic, approximately 80% of programs reported curricula offerings through either didactics or clinical rotations. For didactics, most topics were presented in the context of a broader course. With the exception of HIV/AIDS, it was rare for programs to offer a clinical rotation involving sexuality issues. In conclusion, the majority of training programs in psychiatry provide curriculum offerings in sexuality training, primarily through didactic education. Results are discussed with regard to comparison to training in professional psychology and the need for assessment of sexuality training in health care professionals generally.

Skelton JR, Matthews PM. Teaching sexual history taking to health care professionals in primary care. *Medical Education* 2001; 35:603-608.

OBJECTIVES: Although it is accepted that history taking is central to correct diagnosis, little work has been undertaken on the development of sexual history taking, particularly in a primary care context where sexual health may not occur to the patient. Embarrassment is recognized as one major problem. This paper reports on a series of teaching interventions designed to help primary health care professionals (doctors and nurses) to identify and deal effectively with sexual health issues in the

consultation.

METHODS: 141 participants took part in nine different courses, with 114 returning evaluations. All courses involved tutorial teaching on clinical and ethicolegal issues and role play with trained professional role-players; some involved video-based dramatizations to particularize principles in context. During role play sessions, which were followed by detailed, contextualized feedback, clinical issues, attitudinal issues (e.g. articulating a sense of personal embarrassment, and the risk of stereotyping), and ethicolegal issues were all discussed, as were examples of words and phrases which participants were invited to try out.

OUTCOMES: The overall quality of the courses was rated by participants, on average, at 89.95 (maximum 100), and the relevance of the topic at 91.40. Free text comments centered on the power of the training as a consciousness raiser, on the need to alter communication strategies, the need to change existing clinical practice and the value of role play as a methodology. Interactive courses on sexual health are highly acceptable to participants.

Solursh DS, Ernst JL, Lewis RW, Prisant LM, Mills TM, Solursh LP, Jarvis RG, Salazer WH. The human sexuality education of physicians in North American medical schools. *International Journal of Impotence Research* 15 (2003), Supp5, S41-S45.

ABSTRACT: 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.

Spagnoletti CL, Bui T, Gischer GS, Gonzaga AMR, Rubio DM, Arnold RM. Implementation and evaluation of a web-based communication skills learning tool for training internal medicine interns in patient-doctor communication. *Journal of Communication in Healthcare*, 2:2 (2009) 150-172.

ABSTRACT: Doc.com© is the American Academy of Communication in Healthcare's web-based resource for learning core communication skills. To date, very few doc.com© modules have been evaluated formally. This study sought to assess four modules' effectiveness at improving internal medicine interns' communication skills knowledge. Interns were asked to complete four modules early in internship and complete web-based five-item pre/post multiple choice tests and a satisfaction survey for each module. The participation rate was 97 per cent (31 of 32 interns). Knowledge improved significantly with module completion (average pre-test score 89 per cent versus post-test 95 per cent, $p = 0.006$). Most (86 per cent) felt that the modules were clearly presented and met stated learning objectives, 67 per cent felt that completing the modules would improve their out-patient communication skills, and 62 per cent their inpatient skills. However, only 16 per cent indicated that the modules should replace faculty-led communication skills instruction. Although baseline knowledge of basic patient–doctor communication skills among interns was high, the use of four basic doc.com© modules improved interns' communication skills knowledge on multiple choice tests. Interns were satisfied with

the modules as a curricular intervention. Use of the doc.com© modules may be a valuable adjunct to faculty-led communication skills training aimed at helping trainees achieve competency in the areas of interpersonal and communication skills.

Women and their clinicians

Berman L, Berman J, Felder S, Pollets D, Chhabra S, Miles M, Powell JA. Seeking help for sexual function complaints: what gynecologists need to know about the female patients' experience. *Fertility and Sterility*, 70:3 (March 2003), 572-576.

OBJECTIVE: To further explore the patient experience of seeking help for a sexual function complaint.

DESIGN: Survey administered on a Web-based instrument.

SETTING: Healthy volunteers visiting an online Website.

PATIENT(S): The majority of participants were married (73%), Caucasian (88%), and premenopausal (67%). Most commonly reported sexual complaints included low desire (77%), low arousal (62%), and difficulty achieving orgasm (56%).

Intervention(s): None

MAIN OUTCOME MEASURE(S): Patient experience survey on a women's sexual health website.

RESULT(S): Although 40% of the women reported that they did not seek help from a physician for sexual function complaints, 54% reported that they would like to. Although only a minority of the women internalized their experience with extremely negative emotions like shame, devaluation, or disgust, the experience was not a particularly emotionally positive one along the lines of relief, optimism, or confidence, and a great deal of frustration and anxiety about treatment was reported.

CONCLUSION(S): The extent to which health professionals currently receive exposure to training in human sexuality as well as the way in which female sexual complaints are handled in the medical setting remain ambiguous. The inflow of patients with sexual function complaints only will increase, and it is time for physicians to start to acknowledge women's sexuality with the same importance their patients do.

Ellingson LL, Buzzanell PM. Listening to women's narratives of breast cancer treatment: A feminist approach to patient satisfaction with physician-patient communication. *Health Communication*, 11 (1999), 153-183.

Houle C, Harwood E, Watkins A, Baum KD. What women Want from Their Physicians: A Qualitative Analysis. *Journal of Women's Health*, 16:4 (2007), 543-550.

BACKGROUND: Despite increased efforts to improve the education of trainees in women's health, little information exists about what women want from their healthcare providers. Existing information from studies focuses on patient care and medical knowledge rather than on all six competencies mandated by the Accreditation Council of Graduate Medical education (ACGME).

OBJECTIVES: To identify what adult female patients want their physicians to know and be able to do in all ACGME competency areas in order to guide development of graduate women's health curricula.

Methods: We conducted two focus groups with 18 volunteer adult female patients and one focus group with 5 community advocates. Questions addressed all six competency areas. The same female researcher moderated all three sessions. Two researchers analyzed session transcriptions for themes.

RESULTS: Female patients and community advocates consistently stressed the need for their physicians to be able to navigate the healthcare system and to be their advocates. They also noted the need for physicians skilled in working with patients from a variety of cultures and for developing and maintaining respectful doctor-patient relationships, including good interpersonal communication.

CONCLUSIONS: Patients' expectations of physicians extend beyond medical knowledge and patient care into the areas of communication, systems-based practice, and professionalism. Curricular changes in women's health at the postgraduate level should emphasize skills in these competencies, and needs assessment processes would do well to include patient viewpoints in the future.