Sexual Health Education in U.S. Physician Assistant Programs

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ABSTRACT

Introduction. Since the 1950s, sexual health education in medical schools has been evaluated and reported upon, but there has never been an assessment published about sexual health curricula in U.S. physician assistant (PA) programs.

Aim. The aim of this study was to gain better understanding of how PA programs cover sexual health topics.

Methods. Between January and March 2014, 181 accredited PA programs received a mailed survey inquiring about their sexual health curriculum.

Main Outcome Measures. The survey assessed general sexual health topics; lesbian, gay, bisexual, transgender (LGBT) topics; teaching methods; and the amount of time spent on sexual health education.

Results. A total of 106 programs responded (59%). Ten programs offered a required, discrete course on human sexuality. The majority incorporated training into other coursework, which is consistent with most medical schools. LGBT topics were covered less thoroughly than the general sexual health topics. Total amount of time spent on sexual health topics varied widely among programs, from a minimum of 2–4 hours to a maximum of 60 hours, with a median of 12 hours.

Conclusions. PA programs in the United States appear to compare favorably with the training offered to medical students in regard to time spent on sexual health education. Transgender issues were least well-covered of all the topics queried. Seaborne LA, Prince RJ, and Kushner DM. Sexual health education in U.S. physician assistant programs. J Sex Med 2015;12:1158–1164.

Key Words. Reproductive Health; Sexual Health Education; Physician Assistant Education; Physician Assistant Training

Introduction

Medical costs related to sexual health in the United States are substantial. It has been estimated that there is a public cost of $11.1 billion associated with unintended pregnancies [1] and in 2010 the estimated cost related to sexually transmitted infections (STI) in the United States was $16.9 million [2]. Sexual dysfunction is a common reason for clinical visits by patients in the United States. When sildenafil was approved in 1998, Medicaid was required to cover the drug, and by 2005, the program was spending $15 million a year on phosphodiesterase inhibitors [3]. These medications have not been covered with federal funds since 2005, but clearly, men are concerned about sexual dysfunction. Likewise, women suffer from problems related to sexual function. One study showed that women diagnosed with hypoactive sexual desire disorder had health care expenses approximately 16.8% higher than controls [4].

While sexual health issues have a financial impact, they also play a large role in the social and emotional well-being of individuals. It is important that health care providers feel comfortable discussing and are knowledgeable about issues related to their patients’ sexuality. However, there are barriers that sometimes prevent those discussions from happening. Religious and moral beliefs,
embarrassment, and “perceived and actual time constraints” [5] can prevent providers from bringing up the topic. Additionally, providers may not feel that sexual health is important, or they may not have received adequate sexual health education themselves. According to Lief, “many doctors are not much better informed than the patients they counsel.” [6]

It can be awkward for health care professionals to talk with their patients about sex, but patients do think sexual health is important. A survey of U.S. adults revealed that 94% felt that sexual enjoyment improved quality of life, and that 90% believed sexual problems contributed to depression and emotional distress [7]. The vast majority (85%) would want to talk to their physician if they had a sexual problem, but 71% thought their doctor would dismiss their concerns [7]. Another survey published in 2009 showed that 76.6% of respondents prefer to get their sexual health information from their health care provider [8].

More than 66% of the physicians who routinely asked their patients about sexual health concerns found that over half of their patients had an issue they wanted to discuss. In contrast, over 75% of the physicians who never took a sexual history estimated that less than 10% of their patients would have a sexual problem [9].

In December 2012, the Program in Human Sexuality from the University of Minnesota hosted a summit on sexual health education. The meeting included medical school educators from the United States and Canada, and members of the Center for Disease Control and Prevention and the American Medical Association. One of the stated goals of the meeting was the revitalization of sexual health education [10]. One of their recommendations was integrated care—“Working together should be the norm and not the exception. Sexual health is an important area for many types of health care providers apart from physicians, including nurses, physician assistants . . . and physical therapists. These professionals also need sexual health education . . . ” [10]

The summit concluded that “there are major public health problems in the United States and Canada related to sexual behavior. Repeated studies show that medical students and health professionals do not feel comfortable or able to adequately address patients’ sexual health needs. To build a healthier society, part of the solution is training physicians in sexual health.” [10]

Since the 1950s, sexual health education in medical schools has been evaluated and reported upon in various journals, but to our knowledge, there has never been an assessment published about sexual health curricula in U.S. physician assistant (PA) training programs. According to a 2010 curriculum survey administered by the Physician Assistant Education Association, an average of 7.8 hours of combined lecture and lab hours were offered on sexual health topics in U.S. PA programs [11]. The goal of this project was to assess in more detail the teaching methods and topics covered, as well as the time allotted to sexual health topics in accredited PA programs in the United States.

Methods

An institutional review board exemption was granted October 1, 2013 from the University of Wisconsin (exemption number 2013-1298) for the project titled “Sexual Health Education in U.S. PA Programs.”

A 24-question survey was developed based on previously published articles regarding similar surveys of medical schools. The University of Wisconsin Survey Center was consulted regarding best practices in survey design. The survey tool was then reviewed by sexual health experts outside our institution to confirm validity. Between January and March 2014, 181 U.S. PA programs were contacted. Accredited programs were identified on the website for the Accreditation Review Commission on Education for the Physician Assistant, Inc. Communication was directed to the program director, chairperson, or other faculty member who had knowledge of the program’s curriculum. No incentives were offered in exchange for participation. The initial survey was mailed in early January, including a cover letter, a seven-page survey, and a first-class postage-paid return envelope. The questions covered a range of issues, including sexual health topics covered, teaching methods used, the disciplines covering sexuality content, and total hours spent on sexual health curriculum. A reminder postcard was sent 3 days later. The same packet was sent 3 and 6 weeks later to nonresponders.

Data were received from the University of Wisconsin Survey Center as a Statistical Package for the Social Sciences (SPSS) data file. Simple frequencies were performed using IBM SPSS v22 (IBM Corp., Armonk, NY, USA) and relevant tables and figures created. Categories for missing responses were included in tables where relevant.
Results

By the end of March 2014, a total of 106 responses were received, for a 59% response rate. Of these, two respondents removed the identifier from the survey and did not indicate their state, so geographic location could not be determined. Of the 104 remaining, there was at least 50% response from all regions of the country, with the highest rate of response from the Northeast (74%). The position of the person responding to the survey was most often the Program Director (90).

Ten programs reported that they offered a discrete course in human sexuality, and in all 10 cases, the course was required. It was far more common for PA programs to incorporate sexuality and sexual health topics into their other coursework, which is consistent with most medical schools. Figure 1 presents the disciplines into which sexual health topics were typically incorporated—the most common was gynecology, followed by urology and psychology.

Seventy-two programs (68%) reported that they did dissection of sexual anatomy in their gross anatomy labs. Dissection of both male and female sexual anatomy was done in almost identical numbers. Of the respondents, 12–15% reported they did not know if these structures were dissected.

Specific general sexual health topics were presented to respondents, who were asked whether those topics were covered, and if so, whether they were covered briefly or thoroughly. Figure 2 represents responses to that question. Sexually transmitted infection and birth control topics were covered most commonly, followed by topics related to normal sexual development and function.

All respondents reported that coverage of these individual topics was at least somewhat important, and most thought they were very or extremely important. More than 50% of respondents felt that their institution covered these topics very or extremely well (see Table 1).

Several general sexual health topics were covered minimally or not at all by at least 50% of respondents. Those include elective abortion, aging and menopause, sexual pleasure, and sexuality among the geriatric, chronically ill, and disabled populations. Female sexual dysfunction was covered thoroughly by 40% of respondents, while male sexual dysfunction was covered thoroughly by approximately 57%.

In general, lesbian, gay, bisexual, transgender (LGBT) topics were covered less thoroughly than the general sexual health topics (see Figure 3). The most commonly covered LGBT topics were sexual orientation, gender identity, and sexually transmitted infections among LGBT populations. Topics related to transgender issues were covered least well, with 33–41% not covering them at all.

Table 2 shows that 11% considered LGBT topics to be not at all or only slightly important to cover, and an additional 35% considered them only somewhat important. It also shows that 38% of respondents felt that their programs cover these topics not at all or only slightly well.

Almost all programs (98.1%) reported that students were taught nonjudgmental ways to obtain information from their patients, such as regarding same-sex relationships.

The total amount of time dedicated to sexual health topics varied widely among programs, from a minimum of 2–4 hours, reported by five programs, to a maximum of 60 hours, reported by two programs. The mean was 16.5 hours, and the median was 12 hours. Thirteen programs did not report the total amount of time dedicated to these topics.

Lectures were almost universally used as instruction for sexual health topics. Group discussions and
guest lecturers were also quite common at 72% and 78%, respectively. Written exams were most widely used to evaluate teaching efficacy (92%). Standardized patients were used in 47% of programs, and another 45% used a faculty member observing a student’s interaction with a patient. Ninety programs (84.9%) reported that their students had the opportunity to perform a pelvic exam on a female

<table>
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<th>Coverage of sexual health topics</th>
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<td>Table 1 Coverage of sexual health topics</td>
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<td>How important?</td>
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<td>Total</td>
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Figure 2 Extent of coverage of sexual health topics

Figure 3 Extent of coverage of lesbian, gay, bisexual, transgender topics
teaching assistant, and 83 programs (78.3%) offered this opportunity with a male teaching assistant.

**Discussion**

There is wide variability in the amount of sexual health education that is offered to PA students in the United States. This is consistent with previous surveys that have evaluated sexual health education in medical schools.

A 2003 survey of medical schools showed that 54.1% offered between 3 and 10 hours of instruction and 1/3 of schools offered 11 or more hours [12]. Our data showed that fewer PA programs offered between 3 and 10 hours of instruction (39.8%), but 1/3 of respondents offered at least 20 hours. It is important to keep in mind that medical students receive their education over 4 years, while most PA programs are only 2 years long, indicating that PA programs are prioritizing these topics during the more limited amount of time they have with their students.

General sexual health topics are seen as more important to cover, and are covered by more programs, than the topics specifically related to LGBT issues. That is not a surprise, given that the more broad topics are generalizable to a larger percentage of the population. In a curriculum with much to cover, it makes sense to devote more time to more common issues.

Several general topics that apply to a large percentage of the population were not covered thoroughly by over half of respondents. Sexual health after menopause and in chronically ill, disabled, and geriatric populations were frequently neglected. Particularly interesting was the discrepancy noted in the coverage of female vs. male sexual dysfunction. It is possible that easy access to medical treatment for erectile dysfunction plays a role in this difference. Female sexual dysfunction is often multifactorial, and there are currently few U.S. Food and Drug Administration-approved treatment options. The availability of medical therapies may also partly explain why STIs, HIV, and reproductive health are almost universally covered.

Of all the topics queried, transitioning and sex reassignment surgery were the least often covered. A recent article on the effects of violence on transgender people noted that over 2/3 of transgender individuals report suicidal ideation, and up to 30% have attempted suicide at least once. This is compared with suicidal attempts in 1–6% of the general population [13]. There are high rates of unemployment and poverty, which may contribute to a lack of health care coverage. There are high substance abuse rates among transgender individuals. HIV rates among male-to-female transgender people exceed the 25% rate among men who have sex with men [14]. In a recent survey of gynecologists, 80% of respondents did not receive any training regarding the care of transgender individuals, and only approximately one-third were comfortable caring for them [15]. Given these issues, it seems logical that adding more instruction during the training of medical professionals would lead to more knowledgeable providers and could have a positive impact on transgender health.

As noted by very early advocates of sexual health education, discussing these topics can be controversial. One factor that may play a role in deciding if these topics are discussed with students is whether the program is affiliated with a faith-based institution. These programs may have limits placed on them, especially regarding the most controversial topics. One respondent commented, “This is a faith-based university and discussion on LGBT issues and therapeutic abortion are frowned upon. While I did discuss having these conversations and as PAs we need to be non-judgmental . . . I was reprimanded.”

In light of this, one of the limitations of our study is that we did not inquire about whether the respondents were affiliated with a faith-based institution. The sensitive and sometimes controversial nature of the survey in general may have been a barrier for some recipients.

It is also possible that the faculty members who chose to answer the survey represented those institutions who offer the most comprehensive instruction, and if the non-responders were factored in, the topics covered and the hours offered could be altered.

In addition, the terms “sexual health” and “sexuality” were not defined in the solicitation informa-

**Table 2** Coverage of lesbian, gay, bisexual, transgender-related sexual health topics

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<tr>
<th>How important?</th>
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<tr>
<td>N</td>
<td>%</td>
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<tr>
<td>Not at all</td>
<td>1</td>
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<tr>
<td>Slightly</td>
<td>11</td>
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<tr>
<td>Somewhat</td>
<td>37</td>
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<td>Very</td>
<td>48</td>
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<td>Extremely</td>
<td>9</td>
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<td>Total</td>
<td>106</td>
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tion sent to the programs. One respondent commented, “The survey would benefit from a definition of what specifically the investigator means by ‘sexuality and sexual health’.” It was left to the interpretation of each individual respondent to determine how to define the terms. Also, in the questions asking about how well certain topics were covered, the choices were “covered minimally” and “covered thoroughly,” and these terms were not further defined. Because the emphasis was on covering a broad variety of potential topics, it was felt that it would be a barrier to request that the respondents define in minutes or hours how much time was devoted to each topic.

One of the strengths of this study was the comprehensive nature of the survey instrument. The UW Madison Survey Center was involved in the development of the highest quality instrument possible, and the questions were peer-reviewed. In addition, there was a 59% response rate for this survey, which is within the range of responses received for similar surveys of medical schools.

The most important strength of this study is the fact that such a review of sexual health education in PA programs has never before been done. This information not only fills an important gap in the literature, it is hypothesis-generating for further investigation.

The final question on the survey asked whether the respondent would be interested in incorporating a comprehensive sexual health curriculum, if one existed for PA programs. Of those responding, only 44% stated that they were very or extremely interested in such a curriculum (see Table 3). This seems somewhat incongruous with the information in Table 1, which indicates that 72% believed that coverage of general sexual health topics was very or extremely important. It is clearly a much simpler prospect to state that one believes it is important, and another thing altogether to consider the effort involved in implementing a comprehensive plan to cover sexual health topics.

### Conclusion

While there is variability in the extent to which PA training programs cover sexual health topics in the United States, PA programs do appear to compare favorably with the training offered to medical students. Only 20 of the responding programs (18.8%) offered less than 10 hours of instruction, and the top third offered 20 or more hours.

Every day, PAs encounter patients with a multitude of health concerns, and are not hesitant to interview, examine, diagnose, treat, and educate their patients about those issues. However, when it comes to normal or problematic sexual function, different sexual practices, or dealing with STI counseling, many PAs feel uncomfortable. It is important that PA students learn the information and skills necessary to address these important issues with their patients, just as they are taught to perform an abdominal exam, take a history of present illness, and determine when antibiotics are indicated.

Going forward, emphasis needs to be placed on the normalcy of humans as sexual beings. PAs are on the front lines of patient care and are in a unique position to offer education, counseling, and a safe place for patients to discuss their sexual questions and concerns. One area that could potentially offer the greatest benefit is the addition of comprehensive education regarding LGBT health.

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Conflict of Interest: The author(s) report no conflicts of interest.

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(a) Final Approval of the Completed Article
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References

Supporting Information

Additional Supporting Information may be found in the online version of this article at the publisher’s web-site:

Appendix S1. Physician assistant sexual health education study.