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☐ Yes ☐ No ☐ Not Sure

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Sexual History Taking Curriculum: Lecture and Standardized Patient Cases

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Abstract

This sexual history taking module engages medical students in discussion and practice with standardized patients in taking an inclusive (orientation- and gender-neutral) sexual history. An inclusive sexual history is critical to providing comprehensive patient care and an environment supportive of lesbian, gay, bisexual, and transgender (LGBT) patients. This case was developed for first- and second-year medical students who have had basic communication skills training. This session was designed to be delivered in one 40-minute large-group session followed by three 1-hour-long small-group sessions (with one third of the class participating in each session) with standardized patients. Four students per group is optimal. Faculty training should take approximately 30 minutes prior to the session as well as participation in the large-group session.

The materials associated with this publication include guidelines for faculty facilitators and students to prepare them for the large-group discussion and small-group practice sessions with standardized patients. Also included are four standardized patient cases, a slide presentation using an audience response system for the large-group session, and an evaluation form.

The average response to "Overall, this session was effective in improving my sexual history taking skills" has been 4.3 out of 5. Our communication needs assessment has shown a statistically significant improvement in those reporting increased importance, confidence, and performance of a sexual history between the first and second year of medical school (before and after the curriculum). In addition, students reported performing more components of the sexual history after the session. This sexual history taking module has been incorporated into our Foundations of Doctoring communications curriculum and has been rated as highly effective by learners. Performing an inclusive sexual history is critical to providing comprehensive patient care as well as providing an environment supportive of LGBT patients.

Please see the end of the Educational Summary Report for author-supplied information and links to peer reviewed digital content associated with this publication.

Introduction

It is well known in the literature that health care providers do not routinely perform a complete sexual history.[1,2] One of the most commonly cited reasons is lack of education and lack of comfort around how to do this. We recognized that our core communications curriculum did not include sexual history taking. Thus, this session was created to address this need and to allow students to practice a challenging communications skill.

In addition, an inclusive sexual history is one method lesbian, gay, bisexual, and transgender (LGBT) patients use to recognize a health care provider as being LGBT-friendly.[3] A secondary goal of this educational session was to improve student awareness of LGBT health disparities and to provide foundational skills in caring for LGBT patients, predominantly from a cultural standpoint. Most medical schools, including our own curriculum, provide minimal education on LGBT health topics.[4]

In 2008, we conducted a needs assessment of our communications curriculum. We found that while 87.7% of our students felt a sexual history was important, only 70.1% ($p < .0001$) felt confident in conducting and 51.9% ($p < .0001$) routinely performed a sexual history. Of the students, 72% and 85% reported wanting to learn about and practice sexual history taking skills, respectively. Thus, this curriculum was developed to address this need.

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This curriculum was implemented at the University of Colorado School of Medicine in 2009 and has been held annually since. The original materials were based on existing literature on sexual history taking and were modified using the Centers for Disease Control 5 "P"s model.[5-7] This session can be held at any point in the medical school curriculum after basic communications have been covered. At the University of Colorado, the curriculum has been implemented during the second year of training.

The session consists of a brief lecture followed by standardized patient (SP) cases for immediate skills practice. We chose SP interviews over role play for two main reasons. First, we were concerned that many students would not be comfortable in a role play on this topic. Second, these scenarios cover a wide diversity of sexuality and sexual expression; in particular, the roles may be difficult to learn in an abbreviated time frame given the complexity of the cases, and with SPs, we can train to avoid stereotyped behaviors.

Materials & Methods

Target Audience: Intermediate/advanced learners with the following prerequisites:

- Introductory/intermediate level communications training, including introductory counseling skills.
- Basic knowledge about sexual functioning.
- Basic knowledge about sexually transmitted infections/prevention.
- Exposure to issues of culturally responsive care and diversity.

NOTE: Our course is held during a curricular block that covers sexual development over the ages, sexuality, and sexual functioning.

Logistics: Due to our curriculum and class-size constraints, we have held this session for the entire class in one afternoon. Certainly, if time and space allow, more time for the SP practice session would be helpful (no more than 20 minutes for the interview and 10 minutes for feedback should be needed) based on the feedback we have received.

Our original schedule (see Appendix A: Sexual History Taking SP Rotation Sample 1) was as follows:

1:00-1:40 p.m.: Didactic session on taking a sexual history.
1:45-2:45 p.m.: Group 1 (one third of class, in small groups of four students each).
2:50-3:50 p.m.: Group 2 (one third of class, in small groups of four students each).
4:00-5:00 p.m.: Group 3 (one third of class, in small groups of four students each).

Each hour is subdivided into four 15-minute sessions, each session with one SP. The interview portion is 10 minutes. Students should still ask their open-ended questions at the beginning of the interview but should know that the cases are designed for them to focus predominantly on the sexual history.

Due to feedback, we have created alternative SP rotation schedules to allow more time for interviews. Pros and cons of each option have been listed on the rotation schedule. Each slot on the sample rotation schedule would be filled by one SP case.

Preparation: SPs do not need to self-identify as LGBT but do need to be trained several months in advance of the session with practice runs to ensure quality. We have generally had three SPs for each patient scenario, to run 13 small groups simultaneously (for class size of 156) and allow the SPs a brief break. Because of the tight time line, the SPs rotate from room to room.

Speakers should review the PowerPoint presentation to ensure the audience response system is functional.

Many facilitators may also be uncomfortable with the material being presented. We have had many respond that they are doing this so they can learn the materials themselves. We send out the facilitator guide and links to the readings about two to three weeks in advance so facilitators can ask questions. We also do a faculty preparation session to review the components of the sexual history, review logistics, and answer any questions faculty may have.

For each SP practice scenario, the small group should select one student to be the timer, providing a two-minute warning (at eight minutes), time up (10 minutes), and feedback conclusion (15 minutes) notice. The timer will still need a proctor to assist groups that struggle to remain on time.

Deployment and Lessons Learned: We have successfully deployed this curriculum for four years. Our feedback has been consistently positive, with most students requesting more time to practice their skills. This biggest issue has been the tight time schedule we have been allotted for the session. In

addition, we have several faculty and students who do not believe that these are cases based on actual patients.

From our post-session faculty debriefs, most report a positive experience. Many report that they initially felt awkward as these were not skills they had learned in their prior training, but they recognized the importance of teaching this topic. For those who struggle with the cases, Danni Allen and Gerald Moore seem to spark the most feedback.

With regards to the Danni Allen case, some will respond by questioning her self-esteem, suggesting that she is having sex with multiple partners to gain acceptance. Our response has been that she has a normal sexual life and it is not unusual for people to practice serial monogamy. It is also not uncommon for people to initiate sexual intercourse relatively early in a relationship. The purpose was to demonstrate that even with serial monogamy, the number of exposures and sexual partners can add up over time and that patients should be counseled regarding their risks.

For the Gerald Moore case, most are incredulous that someone could self-identify as straight and yet have a large number of sexual contacts with men. Many struggle with both his self-identification of sexual orientation and the number of contacts he reports. While this may be a relatively extreme (but true) case, there are many individuals whose sexual behavior does not match their self-identified sexual orientation. The other teaching point is that sexual expression is extremely varied and this is why it is critical to ask patients what they are doing.

Limitations: This is only a one-day session for students to practice a difficult communications issue. The variety of student background and experience in this area is vast such that some will find this extremely difficult and others will find it too simple. We also have struggled with students who felt that the sexual history and the information provided on varying sexual expressions/gender identity were not consistent with their moral and social beliefs.

Further, our evaluation is completed immediately after the session. A more robust evaluation would include a case where the sexual history was required as part of an objective structured clinical examination. From the literature, it has been shown that students will ask about sexual history when they are told to do so but still struggle with recognizing when a sexual history may be applicable in the clinical setting.

Results

Over the years, the sexual history taking session has been highly rated. The average response to "Overall, this session was effective in improving my sexual history taking skills" has been 4.3 out of 5. Our communication needs assessment has shown a statistically significant improvement in those reporting increased importance, confidence, and performance of a sexual history between the first and second year of medical school (before and after the curriculum). In addition, students reported performing more components of the sexual history after the session.

Comments for the session have been generally positive. Some students liked the shorter format but many others preferred to have more time for the patient interactions:

- I liked the shorter format, it kept us on track and moved us along, as a consequence, however, I believe the feedback was not quite as deep as usual.
- More time would be nice. Although, as we discussed in our group, if you can do it in 8.5 minutes, you can do it in 15. It actually felt more realistic having 8.5 minutes each because it had to be focused, effective, and all questions had to be relevant. We were forced to manage our time and questioning to maximize information collection and ensure patient comfort with the questions. It was a welcomed challenge that was met well.
- Great session. Amount of time was perfect!
- Although I enjoyed the condensed patient encounters, it would have been nice to have maybe five minutes more for feedback and "debriefing"-maybe only 15-20 minutes more for the whole session.
- I wish we had a little more time- the session was rushed and we did not have enough time to give good feedback to one another or ask questions.
- We needed way more time for this! We probably could have used around double the amount of time we were given. We were hardly able to receive any feedback, and most of us also could have used longer to simply talk to the SPs.

After the earlier sessions, we received comments requesting more content:

- I think it would be really nice to have this session in coordination with some basic sexual health principles. For example, if my patient is a woman who has sex with only women, what are some of the things I would discuss with her versus a woman who has sex with only men? Clearly

in one situation contraception is likely to be less of a concern, but both need a method of protection from STIs. Who even knows what a dental dam is and how to use it? It would have been nice to get some of this information along with this session.

- This is an extremely important aspect of history taking, an aspect that was reinforced during the introductory lecture; however, there was not enough time given to practicing. Considering this is a safe environment to explore the students' comfort with this process and their own biases there could have been more patients who would be reaction-inducing: MTF or homeless youth who practice trading sex for housing. It is a difficult session to conduct in a short period of time, especially as patients in real life can take a long time to open up and be comfortable talking about their problem in a deeper context.

In response to the feedback we received, the sessions were altered to allow students more time to interview each patient case (see Appendix B: Sexual History Taking SP Rotation Sample 2). In addition, we began to include more content on the health issues facing LGBT and sexual minorities. However, given time constraints, complete content on these topics could not be included.

Discussion

These cases could be used with a variety of learners across the health professions, at the graduate medical education level, and potentially as continuing medical education as part of a communication skills building course. The greatest challenges are the time and cost associated with running such an activity.

We chose the original cases based on our clinical experience and to provide exposure to a spectrum of sexuality and sexual behavior. A key issue we wanted to focus on was diversity, highlighting the important issues around stereotypes and the fact that sexual behavior does not always correlate with self-identification of sexual orientation. We did not include a transgender case because this was felt to be too complex an issue given our time constraints. We did not feel we could adequately address the health issues and transition history (hormonal and surgical) needed for students to be able to perform this adequately.

Given more time and money, we would expand the curriculum to include additional lectures, including overview of LGB health disparities, transgender health, sexual health issues (to cover erectile dysfunction, sexuality around various health issues—heart disease, orthopedic issues, depression, medications, etc.), and creating an inclusive practice. The standardized patient cases should also be expanded to cover a broader diversity of sexual health issues that providers are likely to see in practice such as a transgender man, a transgender woman, a bisexual patient, a lesbian who is interested in becoming pregnant, or an older patient with either a cardiac problem or arthritic condition impacting the ability to have intercourse. This would enrich the learning experience, reflect the spectrum of patients more accurately, and potentially help with discussions around the ethics and confidentiality issues that can arise when taking a sexual history.

From the evaluations we have received, an interview time of 15-20 minutes with 10-15 minutes of feedback/debrief for each case would be optimal. Ideally, each student would perform one interview and be exposed to three other cases—this would allow the students to see a broader spectrum of gender/sexual expression and a greater variety of sexual history taking skills in practice.

Educational Objectives

By the end of this module, the learner will be able to:

1. Describe the rationale and steps for performing a gender- and orientation-neutral sexual history.
2. Recognize the breadth of expression of sexuality and gender identity.
3. Practice performing a gender- and orientation-neutral sexual history.

Keywords

Sexual History, Communication Skills, LGBT, Standardized Patient Cases, Audience Response, Lectures

Appendices

A. Sexual History Taking SP Rotation Sample 1.pdf
B. Sexual History Taking SP Rotation Sample 2.pdf
C. Sexual History Taking SP Rotation Sample 3.pdf
D. Sexual History Taking Lecture.pptx
E. Sexual History Communication Session-Faculty Guide.pdf
F. Danni Allen Case.pdf
G. Daphny Chick.pdf
H. Edward Stone Case.pdf
I. Gerald Walter (Walt) Moore.pdf
J. Sexual History Taking Session Evaluation Form.pdf
K. Instructions for Special Clearance Publications.pdf
L. Copyright License.pdf

All appendices are considered an integral part of the peer reviewed MedEdPORTAL publication. Please visit www.mededportal.org/publication/9856 to download these files.

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References

1. Maheux B, Haley N, Rivard M, Gervais A. Do physicians assess lifestyle health risks during general medical examinations? A survey of general practitioners and obstetrician-gynecologists in Quebec. CMAJ. 1999;160(13):1830-1834.
2. Tao G, Irwin KL, Kassler WJ. Missed opportunities to assess sexually transmitted diseases in U.S. adults during routine medical checkups. Am J Prev Med. 2000;18(2):109-114.
3. One Colorada Education Fund. Invisible: the state of LGBT health in Colorado. http://www.one-colorado.org/wp-content/uploads/2012/01/OneColorado_HealthSurveyResults.pdf
4. Obedin-Maliver J, Goldsmith ES, Stewart L, et al. Lesbian, gay, bisexual, and transgender-related content in undergraduate medical education. JAMA. 2011;306(9):971-977.
5. Nussbaum, MRH, Hamilton CD. The proactive sexual health history. Am Fam Physician. 2002;66(9):1705-1712.
6. Kingsberg SA. Taking a sexual history. Obstet Gynecol Clin North Am. 2006;33(4):535-547.
7. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. Taking a sexual history. http://www.cdc.gov/std/treatment/SexualHistory.pdf

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