Sexual Medicine *in* Primary Care

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To my loving wife, Rosamund, who has been enormously supportive, accepting, patient (as is usual for her), and tolerant over the missed times together and missed holidays (not to mention the papers strewn about in my office and elsewhere).

FOREWORD

Rarely has a book been so timely! With the advent of Viagra and the resulting interest in female sexuality, questions, concerns, and discussion about sexual function and dysfunction have come to dominate the media in explicit and sometimes colorful language. Grandparents and their grandchildren both are suddenly equally interested in what their genitals are capable of and neither group is willing to settle for anything less than their "personal best." The interest in drugs to provoke desire, speed up (or slow down) arousal, facilitate orgasm, and reduce sexual discomfort has never been greater, and the pharmaceutical industry is working overtime to meet the demand. Physicians are in the vanguard of this fever, because patients request and expect sound advice, thoughtful recommendations, and effective interventions from their primary care providers — whether covered by managed care or not!

It is certainly the case that the HIV/AIDS epidemic served as the "wake-up call" to health professionals to begin explicit discussion of sexual behavior in routine office practice. The recognition that heterosexual and homosexual individuals were often unwittingly engaging in unsafe sex prompted the introduction of sexual history taking and sexual education as a means of disease prevention. It is only in the last decade that physicians have been called upon to initiate sexual inquiry to prevent illness and to enhance pleasure for their patients. There has been growing recognition that sexuality plays a significant role in quality of life, that sexual problems cause both emotional and physical distress, and that sexual inquiry and education are essential components of responsible and comprehensive health care.

It is also true that many physicians feel inadequately trained or prepared for dealing with the sexual concerns of their patients. Medical schools have not routinely included courses in human sexuality in their curriculum, and, in fact, educators are often uncertain of how best to teach the necessary skills. Even as ubiquitous a subject as physical examination diagnosis has caused consternation as educators debate whether or not to use live patients or paid actors for teaching genital examination. In many programs, the curriculum dealing with the review of systems deals with sexual matters, if it deals with it at all, in a fairly cursory and perfunctory fashion.

It is not surprising, then, that primary care physicians faced with time constraints, managed care demands, and inadequate training often feel unprepared to tackle the topic of sexual health in the detail and with the sensitivity it deserves. Concerns about offending (or embarrassing) patients, crossing boundaries, and risking legal repercussions have also contributed to the unwillingness of many physicians to open this particular "can of worms."

And yet, patients are clamoring for information and guidance in dealing with sexual problems and complaints. Questions about the impact of medication on sexual response, safe and unsafe sexual practices, unreliable erections and inadequate lubrication, and even talking to children about sex have become regular currency in physician offices.

Most patients expect their health care provider to be an expert in all aspects of sexual health, even if their provider feels ill prepared and leary of the job.

It is for this reason that *Sexual Medicine in Primary Care* is such a timely and welcome volume. All the issues, questions, and concerns that physicians may encounter in dealing with the sexual concerns of their patients are addressed, including how to initiate and conduct sexual inquiry, and how to do so in a fashion that respects the privacy and enhances the comfort of their patients. It deals with such neglected topics as how to modify questions to include sensitivity to the age, gender, sexual orientation, and activity level of patients. The inclusion of sample dialogue between physician and patient illustrates the words to be used and the detail necessary to obtain an accurate picture of the patient's sexual behavior and concerns.

This book addresses topics that are often neglected: the distinction between sexual complaints and sexual dysfunctions, the difference between crossing boundaries and actual sexual violations, the need to avoid pigeonholing patients as either exclusively heterosexual or homosexual. It reviews the impact of physical illness and disability on sexual function and helps clarify how and whether sexual problems are the result of physical illness or exacerbated by it. Also included are such topics as nonparaphiliac and paraphiliac sexually compulsive behavior, an increasingly common source of concern among patients (and their partners), gender identity disorders, and child and adult sexual abuse.

Clinical vignettes highlight the enormous array of problems and issues that patients bring to their primary care physician. Dr. Maurice provides suggestions and recommendations as to how to deal with the myriad of issues presented. Moreover, in each and every chapter, the available clinical and research literature on the topic under discussion is reviewed and summarized. The chapters on the assessment and treatment of male and female sexual dysfunctions provide an outstanding review of common but often complex problems.

It is unusual to find so much practical information on such a long-neglected topic in one volume. *Sexual Medicine in Primary Care* is likely to become one of the books that primary care physicians not only purchase but actually use in their daily practice. It is a book that is well worth reading and one that is an excellent source book for consultation on a subject that touches the lives of all patients.

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FOREWORD

Most primary care physicians lack formal education in the diagnosis and management of sexual problems, yet patients with concerns about sex visit primary care physicians regularly. Every day patients seek information and explicit help for sexual concerns, others hope the doctor will ask them about these personal issues, and still others seek, with their physician's collusion of avoidance, explanations for their symptoms other than a sexual disorder.

Medical schools include courses in human sexuality during the first or second years. Medical students learn the biology of the sexual response cycle, the endocrinology of reproduction, and even some psychology and sociology of sexuality. These valuable courses prepare the student to enter clinical training with a solid factual foundation about sex. Additionally, courses in medical ethics, physical diagnosis, and medical interviewing transform the student from a layman to a budding professional. As such, the student learns that all patient concerns may be respectfully and confidentially explored, all body parts and cavities examined while the doctor-to-be's response remains genuinely human, caring, therapeutic and altruistic. This delicate integration of human responsiveness and clinical acumen challenges professional development most when the topic turns to sex. Usually, the young doctor's knowledge is academic and experience is intensely personal, not professional. To be fully human in such circumstances risks, at best one's acting unprofessionally, and at worst, one's offending by appearing to cross a sexual boundary. It is not surprising that the medical profession remains slow to learn how to help patients with sexual problems, and why so many doctors simply avoid the topic entirely.

It is easy to understand how training in the clinical skills of interviewing, counseling, and physical examination applied to sexual problems may not occur during clinical education. One fortunate outcome of the HIV epidemic has been the systematic education of physicians to use screening interviews to ask patients about potentially risky sexual behaviors. Additionally, educational programs now teach primary care physicians how to counsel patients about safer sex practices. Unfortunately, when it comes to other sex problems, most physicians, whether in residency training or it practice, give them glib and superficial focus, a rapid referral, or a quick change in the subject. The 1998 meteoric rise of Viagra in the pharmaceutical sky empowered physicians, with a flick of the pen, to help patients with impotence. No interview was needed, both patient and physician understood "the problem" and believed there was a safe, quick fix. For the American public, the magnitude of mail erectile dysfunction became the constant focus for jokes, news stories, and commentaries.

Sexual Medicine in Primary Care could not have been published at a better time. It combines common sense wisdom and medical facts with an extensive review of a literature not easily found by the physician-reader. Sexual problem diagnosis, treatment reports, and scientific studies are uncommonly published in medical literature. Instead,

they are the topics for journals in psychology, social work, and sex therapy. Dr. William Maurice deftly brings an extensive academic and practical knowledge base within reach of the average physician and medical student.

Talking about sex is difficult and Dr. Maurice provides model dialogues that guide the physician between possibly offensive common language of sexual experience and the jargon of medical physiology. Furthermore, his approach to interviewing a patient about sex demonstrates the necessary balance between direct questions and open-ended facilitation. With medical dialogue about sex, he advises to first ask permission, then to pose direct screening questions before proceeding to open-ended questions or facilitation of a patient's discourse.

The clear description of the medical conditions that interfere with sexual health provide guidance in diagnostic decision making and treatment. Although it is unlikely many primary care physicians will learn some of the sex education and counseling techniques described, the new advances in the use of medications and simple patient education will vastly increase the physician's medical effectiveness. Furthermore, the clear recommendations for referral and the description of the many types of professionals who may be of service to patients will raise awareness for all physicians. Teachers of primary care medicine should find this readable text full of useful interview tips, algorithms for diagnosis and treatment, and models for counseling and referral. The Appendix V is particularly useful, because it provides an extensive table of the multiple medications that interfere with sexual function.

As medical care moves increasingly into arenas of health maintenance and even to health enhancement, the patient's sexual health will continue to move into the domain of the primary care physician. The health care professional will need the knowledge, communication skill, and network of professional specialists to help patients achieve their desired level of sexual health. *Sexual Medicine in Primary Care* will certainly contribute by providing the information and suggestions for physicians' interaction with their patients about these problems.

F
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PREFACE

When, as a young man, I began listening to people talk about sexual problems, I had a very limited frame of reference, namely, my own personal life experiences, fantasies, and attractions. Listening for the past twenty-eight years to the sexual stories of thousands of men and women (individuals and couples, people who were otherwise physically and mentally healthy, well people and those who were unwell, people of different ages and from many cultures other than my own) I learned that the panorama of what is sexual for people extended far beyond my own personal boundaries.

The element that allowed me the privilege of entering this private sanctuary of patients* has been the evolving capacity to listen to others talk about sexual difficulties and developing the ability of speaking to others about this subject in a manner as neutral as talking about the weather. Use of these listening and talking skills provoked both greater patient trust ('here was a person who know what he was talking about') and greater interest on my part (evident before, but socially constrained). My personal curiosity was only satisfied, in turn, by more reading and listening.

Listening and talking skills in relation to sexual issues did not arise (unfortunately) from my medical school education or my specialty training in Psychiatry. Instructors in both settings were tongue-tied when considering anything sexual, but then again, this was the rule rather than the exception during those years. (One wonders how much has really changed since then beyond the surface. For example, health professionals can often now talk of "sexual abuse" but many seem unable to go beyond this phrase, or "chapter title", to ask about the details). I am thus deeply grateful to Masters and Johnson for allowing me a unique (literally at that time) opportunity to be in their clinic and for their generosity in letting a naive psychiatry resident into their midst for a research and clinical elective. One could not ask for more hospitality, generosity, and wisdom than I received from them. They helped me in getting my "feet wet" and I have not looked back since.

Over the years, I've learned from patients that sexual desires and actions are a source of great pleasure, but they may also entail much private pain when a problem exists. This is the central rationale for the incorporation of questions by a health professional about this otherwise private area into whatever else is being discussed with that patient. In my opinion, questions about sexual matters are a necessity for almost all patients. Those questions are part of the job.

*The word "patient" is used throughout this book simply because that is what I am used to calling people who consult me for professional reasons. However the content of this book has equal relevance to health professionals who use some words differently than I do. Some (including some physicians) are used to using the words "client" or "consumer," and these words could easily be used as substitutes for "patient" in most areas of this book.

The pain experienced by patients with sexual difficulties extends in a variety of different directions — from a fear of becoming infected with HIV, to having erection problems with a new partner after thirty-five years of monogamous sexual activity with another who recently died; from having been sexually attacked as a child to a fear of death during "sex" after a heart attack; and from thinking that one has been born into the wrong body from a gender viewpoint, to an irresistible impulse to expose one's genitalia in public. Those who are professionally engaged in talking to individuals about these difficulties know that when the inhibitions lift, they are often told of private thoughts, experiences, and fantasies that have never been revealed to anyone else, not even a loved sexual partner. Ironically, two people may engage in what is almost universally acknowledged as potentially the most intimate of human connections, and at the same time, have trouble talking about what just occurred. As curious as it might seem, it often seems easier to talk about sexual difficulties with a stranger, such as a health professional. Whatever the reasons (e.g., trust and no expectation of being judged), health professionals are in a particularly advantageous position to hear about those troubles.

Given this unique position of the health professional, one might wonder how medical and other health professional schools have responded in providing the necessary educational experiences to their students. The professional school that I know best is the one to which I'm attached, The University of British Columbia. Judging by informal conversations with teachers in other medical schools, our program seems to be not typical. We have an intricate lecture program in Sexual Medicine for our students, lectures that are integrated into preexisting courses. This is capped by clinical opportunities for students to practice sex history-taking and interviewing skills with other students and with simulated patients and for some to participate in the process of talking to a person or couple referred to a sex-specialty clinic because of a sexual concern. Residents (physicians in specialty training) in a variety of disciplines have similar experiences. This book is partly the result of requests from medical students and residents for a greater degree of preparation before actually being confronted with the unfamiliar task of talking to a patient about sexual matters.

The main impetus, however, for this book has been my clinical practice. Primary care physicians have been the source of over ninety percent of the thousands of clinical referrals that I've received over the years. Most commonly, I was sent a brief letter stating the main sexual problem with some other information about the patient's health and physical status. On some occasions, I was able to be extremely helpful in one or two visits. On other occasions, while the patients indeed had sexual difficulties, I've puzzled over why they were referred to anyone who focuses on sexual issues, since this seemed quite subsidiary to some other set of difficulties (medical, relational, or intrapersonal). On yet other occasions, the clinical situation proved more complex in that the sexual problem turned out to be plural (i.e., problems). In all these situations, I was repeatedly struck by how much I thought could have been accomplished on a primary care level with a bit more time and a few more questions. A given patient may never have had to see me because, for example, the problem was quickly solved or the initial assessment resulted in a conclusion that the patient should be referred for some other kind of care, or I might have seen the patient but for a shorter period of time because of preparatory work that had gone before.

PART I of this book is the result of requests from clinicians, medical students, and residents for written information on issues of sex history-taking. Topics include what questions to ask and words to use, how to ask the questions, and what paths to follow in clarifying some particular concern. However, there is a paradox inherent in the notion of learning skills from a book. Such phenomena are usually learned in the manner of an apprentice (see quote from Aaron Copland at the beginning of the Introduction to Part I). In fact, as helpful as a book might be (and I obviously hope this one will prove substantially so), nothing substitutes for hearing *directly* from people about their sexual thoughts, dreams, fantasies, and hopes; their sexual activities when alone or with others; their sexual worries, fears, dread, or even terror; and, most of all, the pain of not feeling like a "normal" woman or man.

Sometimes, the main concern of a patient in a primary care setting is sexual. Most other times, talking about sexual issues usually involves grafting this topic onto an interview that is already taking place on some other topic. An assumption made here is that the reader is familiar with the literature on interviewing in health care generally, so that little attempt has been made to review this subject in detail. The rationale for this particular book is that, usually, little is said in general texts on the subject of talking to patients about sexual matters. One can easily obtain a list of references to general texts on interviewing by consulting one of the available books.[1]

As much as one might promote the notion of encouraging discussions with patients on sexual matters, many primary care clinicians declare unease at raising this issue without knowing what to do with the answers and without being able to provide some level of treatment. Caring for patients with sexual difficulties is the purpose of Part II of this book — the treatment of common sexual dysfunction in primary care. Although some of the suggestions made may seem mechanistic and cook-bookish, that is not what is intended. In no other area of human enterprise is there such intricate connections between mind and body as is the case with anything sexual. It seems so much easier to write about sexual toys or gizmos than about the human relations part of the treatment of sexual problems, but there are no therapeutic circumstances in which the latter do not play a prominent part.

It should not surprise readers that this book is written from a physician's perspective, since it represents my own professional background. However, when considering the care of people with sexual difficulties, physicians may be in a minority. Many sex-experts have been educated in a variety of health care disciplines apart from medicine, especially psychology, social work, and nursing. Physicians tend to specialize in particular areas such as STDs and HIV/AIDS, erectile dysfunction, and gender identity disorders. Since professional attention to sexual problems is inherently interdisciplinary, this book was written with much consideration given to clinicians and students in *all* of the health sciences. Hence the phrases "primary care clinicians" or "primary care health professionals" have been used throughout this book.

Finally, I would like to add a comment about the word "sex." Multiple meanings for this word is the usual reason for placing it in quotation marks in the text. It would be a gross understatement to say that defining the word is difficult. When used in a clinical setting, "sex" generally has two meanings: the nature of the patient as male or female (although the word "gender" is increasingly being used for this purpose), and as a synonym for the specific practice of intercourse. When used to describe

one particular sexual practice such as intercourse, it takes little reflection to agree that the word "sex" really encompasses so much more. When, for example, a man and woman engage in sexual activity that involves "everything but," almost everyone still considers the activity to be sexual. Likewise, when a man and a woman are passionately kissing and both people experience the physical manifestation of sexual arousal (erection and vaginal lubrication among other things) who would not also call that sexual? And when a man or woman masturbates alone and is orgasmic, isn't that also "sexual"?

What about the definition of the seemingly broader term, *sexuality*? Is it the same as "sex" and "sexual"? Of "sexuality" (and it probably could be said of all three words), "everyone either grasps the definition from contextual cues, assigns it a private meaning, or simply pretends to understand".[2] "Sexuality" involves physiological capabilities, sexual behavior, and sexual identity — among other things.[2] (pp. 3-4). The reader will find the word "sexuality" infrequently used here because its meaning seems even less precise than "sex" and "sexual." The word "sexual" seems most comfortable and is used most often, perhaps because being an adjective rather than a noun or verb, it modifies another word.

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W. Maurice

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ACKNOWLEDGMENTS

I am profoundly indebted to the many patients with sexual problems (who, to preserve confidentiality, must remain anonymous) that I have treated over the past 28 years. This is more than ritual intellectual appreciation. The emotional part of my gratitude was "brought home" to me by a phone call I recently received from a woman asking to see me because of a sexual concern. She explained that her parents consulted me about 25 years ago, that her call now was on their suggestion, and that, in turn, was because of their thankfulness at my having been so helpful to them many years before in preserving their marriage! As appreciative as her parents evidently were, I was touched and even beholden to them because of what they gave to me.

I am particularly grateful to Marjorie Bowman for having worked as a consultant on this book, and for the care that she took in scrutinizing what I had written. She provided the perspective of someone on the "front lines" of family practice, which I, as a specialist, was obviously unable to do. When I began searching for a consultant, I felt strongly that whoever filled this position should be a woman in order to provide balance to the perspective I would inevitably present as a man. I also thought that she should be an American to provide balance to the cultural perspective that I would inevitably present as a Canadian. On all three counts, I (and readers) have been generously rewarded. Above all, her sensitivity to patient needs was repeatedly made obvious to me, as was her passionate concern for the way women patients, in particular, should be treated.

Some friends and colleagues read and critiqued parts of the manuscript, and while no one apart from myself bears responsibility for the finished product, this review process was particularly valuable to me. My psychiatrist friends and colleagues, Jon Fleming and Sheldon Zipursky, gave me their considerable wisdom and time. Irv Binik, Phillis Carr, Sandra Leiblum, Jamie Powers, Ray Rosen, and Ruth Simpkin, provided detailed and useful comments. Others, Eli Coleman, Bill Coleman, Christine Harrison, Mike Myers, Oliver Robinow, Tim Rowe, Bianca Rucker, Roy O'Shaughnessy, and Noelle Vogel, either advised me on specific issues or offered important general observations on this, or an earlier version of the manuscript. Many medical students and psychiatry residents offered substantial ideas over the past years and many of these have been incorporated into the manuscript.

George Szasz (now retired) was a colleague for 20 years, and over that period of time, we shared so many ideas that it sometimes became difficult to know the source. I have known my other colleagues in the UBC Division of Sexual Medicine for fewer years and yet their contributions to my education and this book have also been substantial. Stacy Elliott was particularly helpful in reading part of the manuscript and advising me about ejaculatory disorders involving reproduction. As well, Rosemary Basson, Donna Hendrickson, and Ron Stevenson have all given me useful ideas, more so than they may even realize.

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Bill Maurice

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