Everywhere and nowhere simultaneously: The ‘absent presence’ of sexuality in medical education

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Abstract
A comprehensive history of medical sex education in the USA is missing from the literature, and much of the recent literature on sexuality education within medical training in the USA relies on survey research, which reveals little about the nature and content of medical sex education, and the meanings of sexuality that are produced and transmitted within it. In this article I provide a brief historical overview of medical sex education in the USA to provide context for my ethnographic study of the ways in which sexuality education was conceptualized and executed at a top-twenty American medical school. Although faculty members at this medical school believed that sexuality was important to medical practice and thus important to teach about within medical education, teachings about sexuality were fragmented and did not produce a consistent set of messages about what sexuality means or how it might matter to medical practice. I show how formal knowledge about sexuality has been and continues to be as elusive within medical education as anywhere else, and discuss historical continuities in the perceived barriers to providing medical sex education. In addition to increasing our understanding of how medical knowledge about sexuality is produced and transmitted, this research expands the study of sex education beyond contexts in which its intended purpose is to influence the personal behavior of its subjects.

Keywords
Formal curriculum, knowledge production, medical education, sex education, sexuality

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Introduction

Social scientists agree that sexuality is inherently difficult to define and is often knowable primarily through its unknowability (Hearn and Parkin, 1995). How do professionals whose scopes of practice intersect with sexuality grapple with this ambiguity and create collective understandings about what sexuality means and how it matters to their work? Sociologists agree that ‘sex’ usually pertains to something that people do, but what that something is can vary tremendously (e.g. Jackson, 2006; Weeks, 1986). If we say that ‘sex’ involves ‘erotic body work’ (Plummer, 2003: 527) or ‘carnal acts’ (Jackson, 2006: 106), difficulties remain, since ‘erotic’ and ‘carnal’ are synonymous with ‘sexual’. ‘Sexuality’ may refer to ‘all erotically significant aspects of social life and social being, such as desires, practices, relationships, and identities’ (Jackson, 2006: 106), which are vast swaths of social experience. In sum, as Ken Plummer writes, ‘human sexuality – as opposed to biological functioning – only comes to exist once it is… defined as sexual’ (1982: 228, emphasis in original). While this complexity or ambiguity is widely recognized by social scientists, there has been little empirical research on the ways in which professionals who rely on conceptual terra firma to do their work negotiate sexuality’s ambiguity and definitional challenges.

Sexuality has the potential to be relevant to the work of many professionals, from dentists to social workers to nurses to lawyers to doctors, and their collective understandings about what sexuality is and how it pertains to the work they do stand to impact the experiences of their patients or clientele and, subsequently, shape social life in patterned ways. Perhaps nowhere is this more apparent than within the profession of medicine. Although the medical profession in the USA may not actively claim the task of dealing with sexuality – whether sexuality writ large, or particular elements of it – as part of its professional responsibilities, sexuality is something that most doctors cannot completely or necessarily avoid. Doctors diagnose and treat sexually transmissible infections, prescribe contraceptives and drugs for erectile dysfunction, and are asked to answer questions about how medical procedures may impact sexual functioning – and this does not begin to approach an exhaustive list of the myriad and potentially unpredictable ways that sexuality could become relevant within clinical encounters. Medical schools’ charge to train students to meet the ‘total needs of patients’ (Hafferty, 2000: 16) compels a certain amount of attention to patients’ social selves. A substantial empirical literature demonstrates that patients experience sexuality to be germane – and sometimes, incredibly so – to health-care encounters in a broad range of ways (e.g. Beehler, 2001; Berman et al., 2003; Dewey, 2008; Emlet, 2006; Halley et al., 2014). Patients’ experiences illustrate the relevance of sexuality’s multidimensional nature – behavior, identity, desire, emotions, the body, and power relationships, both between intimates and clinical providers – to health care encounters. But we know less about what might be happening on the other end of the stethoscope in this regard. How do contemporary medical professionals make sense of sexuality’s potential meanings and significance, and come to a set of working understandings about what sexuality is – or is not – and how they should approach it within clinical practice?
Doctors’ knowledge about sexuality may derive from many sources, but this article is concerned with the collective production of knowledge about sexuality that occurs within medical education. Medical education is considered a powerful site of professional socialization (Bloom, 1988; Freidson, 1970), thus whatever medical students learn or do not learn about sexuality in this context may significantly comprise their total understandings about sexuality. We know that some medical educators over the course of the last several decades have believed as much, and that something understood to be medical sex education has existed in varying amounts within North American medical schools since at least as early as the 1960s. But the substance of these teachings, the meanings of sexuality transmitted within them, and the processes by which sexuality-related curricula have been developed and delivered are not well understood within the medical community (Coleman, 2012) and have not been studied extensively by social scientists. In this article I help address this gap in the literature through an ethnographic examination of the processes by which sex education was conceptualized and delivered at a medical school in the USA that I call ‘Buena Vista’, and the content of the intentional and unintentional teachings about sexuality within the formal curriculum, or the ‘stated, intended, and formally offered and endorsed curriculum’ (Hafferty, 1998: 404).

Sexuality had what I call an ‘absent presence’ within the formal curriculum at Buena Vista. Faculty members generally believed that doctors needed to know about sexuality, and therefore that medical students needed some sexuality education. However, faculty were much less certain about what exactly it was necessary to teach – nor did they agree about when knowledge about sexuality could or should be acquired within a student-physician’s overall trajectory of professional development. Whether because or in spite of this confusion, a set of messages about sexuality were put forth within required classes that were not insubstantial in the aggregate. There were some intentional teachings about sexuality that included definitions of sexuality and considerations of specific ways in which sexuality could be relevant to clinical practice. But these teachings were not organized into a self-conscious, collectively determined sexuality curriculum with a consistent set of messages or a clear set of objectives. And in addition to the more intentional efforts to teach about sexuality, messages about sexuality were also constructed and transmitted outside of moments in which sexuality was the officially designated topic of consideration during classes. The meanings or messages presented in these instances were not congruent with those put forth during the deliberate efforts to treat sexuality as a designated topic of inquiry, and reinforced sexuality’s ambiguity and unknowability rather than any particular definitions or meanings associated with it.

In the next section I sketch the history of medical sex education in the USA to provide context for my study of Buena Vista. Because a comprehensive, analytic history of medical sex education in the USA is missing from the literature, this synthetic overview, gleaned from the academic medicine literature, limits its focus to North America (the emphasis is on the USA, but some of the research I cite
includes Canada). We do know that medical sex education exists outside of North America, for instance in Brazil (Rufino et al., 2014), Germany (Turner et al., 2014; Turner et al., 2016), and the UK (Clegg et al., 2016; Faulder et al., 2004; Reader, 1994; Wylie et al. 2003), and we have some sense of what these sexuality-related curricula look like on paper. We also know that like in the USA, observers of medical education in Brazil, Germany, and the UK have remarked upon the need for more sexuality-specific training for medical students (this is also true of Turkey; see Ozan et al., 2005). But the empirical study of international medical sex education is limited, and we know nothing of the medical sex education that occurs – or may not occur – in many other countries (Sciolla et al., 2010). Moreover, sociological analysis of the meanings of sexuality that are present within medical sex education, and empirical examination of the processes by which sexuality-related knowledge is produced are not the emphases of the aforementioned studies. Thus for the sake of economy of scope, I do not attempt to systematically integrate insights from the literature on medical sex education outside of the USA into this article. Future research might usefully explore international trends in medical sex education, and comparisons between medical sex education in the USA and elsewhere.

A brief history of medical sex education in the USA

As of the late 1960s there was agreement on the part of at least some medical educators that medical schools had a definite responsibility to train medical students to deal with the ‘marital and sexual’ problems of their patients (Coombs, 1968). Doctors of this era recognized that whether or not physicians wanted to engage in discussion or treatment of sexuality-related concerns, patients expected this information and care from their physicians. They also recognized that doctors were unlikely to develop knowledge of and comfort with the subject of sexuality in the absence of training designed to accomplish these goals (Coombs, 1968; Golden and Liston, 1972; Lief, 1970). Marcotte et al. (1976) noted that doctors lacked ‘basic sexual knowledge’ and tended to respond to the subject of sexuality with ‘emotional reactions such as fear and anxiety,’ rendering them unable to address patients’ sexual concerns (Marcotte et al., 1976: 117; see also Golden and Liston, 1972). Medical students were likely to ‘have a block on the subject of sex,’ according to Coombs’s faculty interviewees, and would retain their reluctance to discuss the topic unless specific educational endeavors were undertaken to help dissolve this discomfort.

Although faculty considered medical school the obvious place to address medical students’ discomfort, faculty members themselves tended to be uncomfortable with sexuality, and thus likely to avoid teaching about it (Coombs, 1968; Marcotte et al., 1976). Medical school faculty felt they knew little more than the average person did about sexuality, thus they could hardly be expected to inculcate their medical students with expert knowledge on the subject (Coombs, 1968). Their ignorance of sexuality became a reason in and of itself for avoiding the subject,
out of a desire to avoid revealing their lack of expertise. The result was ‘a circular system... where medical teachers who received their medical education devoid of sex education determined curriculum and all too frequently devalued its importance’ (Marcotte et al., 1976: 117). Some of the medical faculty Coombs interviewed also questioned the importance of sexuality education relative to their other professional concerns and obligations. They felt that learning about the biology of acute and widespread diseases probably took precedence over learning about ‘emotional’ conditions like sexuality (Coombs, 1968).

Perhaps because of these difficulties, it seems that only one medical school in the USA had a required course in human sexuality as of 1964, and only one other offered a sexuality course as an elective (Coombs, 1968; Lief, 1970). But the formation of the Sex Information and Education Council of the United States (SIECUS) in 1964, with many physicians serving on the board of directors, sparked change. SIECUS invoked the legitimating power of biomedical authority to define sexuality as a natural, normal component of health, and to normalize open discussion about sexuality (Irvine, 2004 [2002]). In March 1965 the American Medical Association (AMA) issued a statement expressing the need for medical schools to incorporate ‘appropriate learning experiences for physicians in the area of counseling related to sexual attitudes and behavior,’ and the American College of Obstetricians and Gynecologists issued a pamphlet entitled *Sex Education is a Professional Responsibility* (Lief, 1970).

Medical schools responded quickly, resulting in what some observers called a ‘dramatic upsurge’ in medical sex education (Golden and Liston, 1972: 761; Marcotte et al., 1976). Lief reported that by the end of the 1960s at least 44 American medical schools offered courses in human sexuality (1970). According to Marcotte et al. (1976), 95% of 112 medical schools in the USA offered either required or elective sex education classes in 1974. A study conducted by Lief and Ebert in 1976 found that 60% of US medical schools included sexuality education within required courses while another 32% offered such material within electives (Rosen et al., 2006). By the mid-1970s, discussions of medical sex education emphasized growth and positive change, and often credited the efforts of Lief and his colleagues for inspiring these changes (Marcotte and Logan, 1977). However, we know little of what these medical sex education efforts consisted of in practice – what meanings were transmitted, and by what processes – because aside from a few case studies of specific programs (Golden and Liston, 1972; Tyler, 1970), discussions of the rise of medical sex education said little about their content. Analysts also point out that surveys of the prevalence of medical sex education yielded data that were hard to reconcile. Some indicated that medical sex education was indeed becoming more prevalent while other data suggested that it was rarely a requirement (Rosen et al., 2006).

The fate of medical sex education in the 1980s and 1990s is even less evident. Some authors claim that by the 1980s, medical sex education was on the decline (Rosen et al., 2006) while others argue that there was not so much a decline as a perception of decline (Dunn and Alarie, 1997). Rosen et al. (2006) argue that under
the pressures of curriculum reform and the growth of basic science and clinical
topics, medical sex education programs were shortened or eliminated in the 1980s
and 1990s. It seems likely that the ever-expanding growth of scientific and techno-
logical knowledge would have posed a mounting challenge to medical educators in
the 1980s and 1990s, threatening time that might have been allocated to medical sex
education, but it also seems likely the HIV/AIDS epidemic and the political mobil-
ization of the Christian Right around sexual issues might have shaped the course of
medical sex education during this time. The dearth of discussion within the aca-
demic medicine literature during this time frame contributes to the uncertainty on
the subject.

Journal articles pertaining to medical sex education began to crop up again in
the academic medicine literature in the late 1990s, revisiting themes from previous
decades. Writers in the 1990s and 2000s echoed the comments that medical educa-
tors had made in the 1960s and 1970s. Parish and Clayton’s comments, published
in 2007, could easily have been written in 1967:

Sexual health education is an example of an often neglected, but very important topic.
Sexuality is important to almost all patients; yet this topic is not adequately repre-
sented in most undergraduate and residency training programs. Healthcare providers
are becoming increasingly aware of the importance of addressing male and female
sexual health. (Parish and Clayton, 2007: 259)

In the 2000s, advocates for medical sex education argued that patients are likely to
perceive doctors to be their primary resource for sexuality-related treatment or infor-
mation – just as their predecessors did in the 1960s. ‘Like it or not,’ Sandra Leiblum
wrote, ‘physicians are seen as “sexperts” and are expected to provide information,
medication, and referrals for sexual difficulties of all kinds’ (2001: 59; also see
Berman et al., 2003; Solursh et al., 2003; Swartzendruber and Zenilman, 2010).

Survey research shows that some medical sex education was offered in the 1990s
and 2000s, although its advocates considered its provision lacking, relative to its
importance to patient care and medical students’ likely ignorance (Ford et al.,
2013; Parish and Clayton, 2007; Solursh et al., 2003; Swartzendruber and
Zenilman, 2010). A survey conducted by Solursh et al. in 1999 found that 32.7%
of the responding schools provided 11 or more hours of human sexuality training,
and 32% provided 1–5 hours (2003). Some medical schools offered little or no
sexuality education; two reported that they, to their embarrassment, did not pro-
vide any sexuality-related curricula at all (Solursh et al., 2003). And while there are
critical questions to ask about distinctions between ‘sexuality’ curricula and
‘LGBT-specific’ curricula (Murphy, 2014), to the extent that ‘sexuality’ curricula
and ‘LGBT specific’ curricula are either understood to be distinct or are actually
different in practice, both are considered to be deficient (Eliason et al., 2011;
Obedin-Malevir et al., 2011; O’Hanlan et al., 1997). Obedin-Malevir et al.’s
survey of LGBT-related content in North American medical schools during the
2009–2010 academic year revealed that North American medical schools devoted a
median of 5 hours to these topics, but the placement of these hours (i.e. in required vs. elective courses) varied widely between the medical schools that responded to their survey.

But however much of it there is, we still don’t really understand what medical sex education is (Coleman, 2012). Recently developed recommendations give us some sense of how medical professionals currently conceptualize medical sex education in the abstract (Coleman et al., 2013; Shindel and Parish, 2013). Shindel and Parish articulate a set of attitudes (including reflection on personal beliefs and how they may impact patient care), knowledge (including reproductive biology anatomy and physiology of human sexual response, the impact of medical illnesses and their treatment upon sexual function, and sexual abuse and violence), and skills (including taking a sexual history and integrated diagnosis of sexual dysfunction) that students should master (for the complete list see Shindel and Parish, 2013: 7). But these recommendations do not provide inductively generated, empirical insight into how or if curricula on these topics are developed and delivered in medical schools – or if other messages about sexuality are transmitted additionally or instead, and with what degree of intentionality.

Social scientists have had little to say about the production of medical knowledge about sexuality within medical education, and even less about medical sex education as a self-conscious curricular initiative, although several exceptions deserve mention. Scully and Bart (1973) and Kapsalis (1997) examine representations of women’s sexuality in gynecology texts and teachings. Smith and Kleinman (1989) argue that faculty responses to the ‘sexual’ body parts in the context of cadaver dissection send the message that the avoidance of these parts of the cadaver – and forgoing their examination on live patients – is acceptable. Murphy (2014) and Robertson (2016) analyze the production of heteronormativity in medical education. None of these studies endeavor to understand how faculty conceptualize and deliver sexuality education, broadly defined, in medical training.

Sociologists of education in general and medical education in particular agree that teaching and learning occur at multiple levels of curricular processes (e.g. Hafferty and Castellani, 2009), and this was certainly the case for the production of knowledge about sexuality at Buena Vista. Here I am concerned primarily with the formal curriculum (Hafferty, 1998), and specifically, the classes that all students were ostensibly required to take, because this is the place sexuality education is delivered most overtly (as opposed to being transmitted through latent messages, i.e. through a hidden curriculum), and collectively (as opposed to the more idiosyncratic processes of the informal curriculum), and the aspect of curriculum that is designed most deliberately – at least potentially. It is also the level of curricular processes that survey research examines. Ethnographic study of the formal curriculum shows that surveys may both over- and under- estimate the amount of sexuality education that occurs within medical schools, and provides insight into its content and delivery that survey research cannot. Thus, although Buena Vista is a single case and unlikely to be completely representative of all other medical schools
in the USA, findings from this study will help set the agenda for future research, and some may be applicable to other cases.

**Field site and methods**

This article is drawn from a larger study of the processes by which teaching and learning about sexuality were accomplished at Buena Vista, including the dynamics which might contribute to the (re)production of sexuality-related inequalities. Buena Vista is a top-twenty medical school in the USA, and is situated in part of the country that does not have a reputation for either particularly liberal or particularly conservative attitudes towards sexuality. Buena Vista has a reputation for excellence in the basic sciences and, historically, had not been known for placing a strong emphasis on humanistic medicine or the social aspects of medicine. At the time of my research all students were required to take a social aspects of medicine course sequence (hereafter SAM), which included classes called The Physician–Patient Dynamic, Stages of the Life Course, Introduction to the Practice of Doctoring, and Psychopathology. Each of these quarter-long classes met weekly for 3–4 hours and included a large-group lecture, a small-group discussion, and sometimes intermediary medium-sized group ‘seminar’ featuring guest speakers. ‘Buena Vista’ is a pseudonym, as are the names of the aforementioned ‘SAM’ course sequence and the individual classes within it.

According to faculty members, the SAM classes were the primary if not the only place in which sexuality-related content appeared, so I focused my participant observation on these courses. Although I know that I did not capture all of the discussion about sexuality that occurred within the formal curriculum (for instance, one student told me about sexuality-related jokes that were told when an X-ray of a patient with a Coke bottle stuck in their rectum was shown in a radiology class), interviews with faculty members and students suggested that I captured most of the intentional teachings about sexuality and many unintentional teachings about sexuality as well.

My participant observation in the SAM classes took place during the 2009–2010 academic year and totaled approximately 100 hours of field work. I complemented this field work with in-depth, semi-structured interviews with Buena Vista students (19), faculty members (17), one staff member, and two guest lecturers. These interviews ranged from 40 minutes to two hours in length, and covered a range of topics including interviewees’ definitions of sexuality, their sources of knowledge about sexuality within and outside of medical education, and their experiences of teaching or learning – depending on their role – about sexuality at Buena Vista. I also asked about beliefs about the relevance of sexuality to overall human health, and to doctors’ responsibilities within medical practice. All participants’ names are pseudonyms.

Field notes were written immediately after participant observation, and interviews were recorded and transcribed. These data were stored, organized, and coded
using ATLAS.ti. Data were coded iteratively, utilizing a mixture of deductively and inductively generated codes (Abramson, 2009).

This study was approved by the appropriate institutional review boards/human research protections programs.

**Medical sex education at Buena Vista**

*Faculty members’ beliefs about the importance of sexuality to medical practice and medical education*

Buena Vista faculty members were not compelled by external forces to provide sexuality-related curricula. Neither the AMA nor the American Association of Medical Colleges mandated that medical schools provide a certain type or amount of sexuality-related training at the time this research was conducted. The AMA urged medical schools to include LGBT-specific content, and encouraged physicians to assist parents in their provision of sexuality education to children and adolescents (see policies H–170.968; H–170.966) – but did not stipulate how physicians themselves should become prepared to do this. Nor did Buena Vista have an internally generated set of guidelines for teaching about sexuality. There was no deliberate effort to figure out what should be taught about sexuality, how these teachings would be delivered, and whether or how their impact would be evaluated. Faculty members were free to include sexuality-related content into the courses or teaching segments they were responsible for, and they were also free to not include it.

The lack of a collectively planned sexuality curriculum was not based upon an explicit agenda to exclude sexuality education, or a considered belief that sexuality was not important. Nearly all of the Buena Vista faculty members I interviewed believed that sexuality was important to medical practice and important to teach about within medical education. However, they also struggled to determine just how important sexuality was, relative to other important topics. Dr Miriam Elizondo expressed concerns of this sort during our interview.

**Interviewer:** How do you make critical decisions about how best to utilize limited teaching time? I’ve heard other faculty members say that sexuality education [within medical training] is important in so many ways, but compared to other things –

**Dr Elizondo:** *(Interrupting the interviewer)* Is it more important than diabetes? Is it more important than well exams on babies? Is it more important than infectious disease? Yeah, I don’t, I can’t... I don’t think you can answer that.

The valorization of bioscience and with it the general disregard for the social aspects of medicine at Buena Vista combined with the ubiquitous problem of too much to teach and too little time in medical education (Becker et al., 1961;
Coombs, 1968), put sexuality-related content in a precarious place. Dr Nancy Green, co-organizer of the Stages of the Life Course class described the problem this way:

**Dr Green:** You know the issue of sexuality doesn’t – I wouldn’t say it’s taboo, I just don’t think it’s… all the basic science guys, that’s just nothing they’re going to – I mean they’re just not going to do it.

**Interviewer:** So it’s not taboo, it’s just not relevant.

**Dr Green:** It’s just not relevant, yeah, you know it’s not relevant in physiology, organ pathology, or anatomy, or histology, in microbiology, it’s not [seen as] relevant in any of those courses. So I think really the only places you end up being able to fit it in are the SAM classes.

The SAM course directors’ decisions about course content were based upon shrewd assessments of how best to maximize limited teaching time, and thus, decisions about whether or not to include sexuality within a given course were never only about the importance accorded to sexuality. Dr Ronald Davidson, co-organizer of Stages of the Life Course, told me that as he and Dr Green had determined the content of their course, they had wanted to include a lecture devoted to sexuality, but chose not to: upon learning that a lecture was devoted to sexuality within the Physician–Patient Dynamic, they decided to dispense with plans for a sexuality lecture in their course to make room for another topic that wasn’t receiving coverage anywhere else.

Similar to medical school faculty members in the 1960s and 1970s (Coombs, 1968; Marcotte et al., 1976), Buena Vista faculty also felt that a collective lack of expertise hampered their efforts to teach about sexuality. Like their predecessors, some Buena Vista faculty members remarked that they had not received any sex education while they were in medical school themselves, and that neither they nor anyone else they knew really had the capacity to offer sexuality-specific curricula. The perception of a dearth of expertise was in a sense a fair reflection of faculty members’ lack of formal sexuality education and uncertainty about what sexuality meant, but it was also somewhat ironic because Dr Gil Zimmerman, a self-described specialist in ‘sexual medicine,’ held his practice near Buena Vista and made frequent overtures to one of the deans at Buena Vista, offering to help integrate more sexual medicine into the curriculum – and several of the faculty members I interviewed were well aware of Dr Zimmerman’s willingness to serve as a resource. The extent to which his expertise was put to use was unclear; according to the dean, Dr Zimmerman had been very helpful, and according to Dr Zimmerman, the dean had not been receptive to his offers to help. Finally, and perhaps most importantly, the notion that it was difficult to teach about sexuality because of insufficient expertise on the part of faculty members belied the fact that a few Buena Vista faculty members did intentionally devote teaching time to sustained discussions of sexuality.
**Intentional teachings about sexuality**

There were several curricular moments in which faculty intentionally made sexuality a primary object of inquiry, attempted to define or explore definitions of sexuality, and make the relevance of sexuality to medical practice explicit. One lecture within The Physician–Patient Dynamic was devoted to an interactive discussion in which the lecturer, Dr George Sorin, led the students through considerations of the meanings and definitions of ‘sex’ and polled the students (anonymously) about their own sexual experiences. Dr Sorin’s intention behind leading students through these exercises was to demonstrate the empirically occurring diversity within understandings about what sex means, and in people’s sexual experiences, and to give students the opportunity to talk about sex out loud in public – something, he knew from experience, many students might never have done before. My interviews with students suggested that the latter goal was achieved: talking about sex in public was indeed a new experience for many of them, which they found a little unnerving but also valuable as preparation for talking about sex with their future patients. There was, however, less indication that the messages about the potential for ‘sex’ and ‘sexuality’ to mean very different things to different persons, that is, their future patients, had gained as much traction.

A panel of transgender guest speakers immediately followed Dr Sorin’s interactive lecture. While transgender is not necessarily best understood as a manifestation of sexuality (Valentine, 2007), several of the students I interviewed were quick to mention this panel when I asked them what they had learned about sexuality since entering medical school, and moreover, this panel might reasonably count as an hour of LGBT-specific education if Buena Vista were surveyed about its provision thereof. This panel of guest speakers came about because a faculty member who had served as a facilitator for the Physician–Patient Dynamic class for several years running recognized a need for transgender education, and sought approval from the course director to include these guest speakers. There had not been any top-down mandate or collective decision to include transgender-specific content.

Similarly, Dr Michelle Thompson used her Stages of the Life Course lecture (whose primary, official topic was adolescence) as an opportunity to talk about LGBTQ youth, based on her own perception of the need for students to gain some exposure to this population. Dr Thompson’s lecture was the most extensive discussion of sexuality, sexual diversity, and their relationship to clinical practice in the formal curriculum; however, if Buena Vista had been surveyed about sexuality-related or LGBT-specific curricular hours, this lecture might not have counted as time devoted to either but, instead, registered as time devoted to ‘adolescence.’ Dr Thompson was the only lecturer who articulated a concrete definition of sexuality (as a combination of behavior, identity, and desire). Dr Thompson considered the potential relationships between behavior, identity, and desire, and explained to the medical students that sexuality in general, or any of its specific components, needed to be understood as a continuum. She discussed LGBTQ youth and explained why providers needed to be prepared to encounter them and attuned
to the experiences and needs common to this population, but she also urged the medical students to think beyond a stark binary between heterosexual and LGBTQ patients. She emphasized to her audience that non-heterosexual youth would be members of their patient population, and they needed to be prepared to encounter them and understand both their unique experiences, along with their similarities to their heterosexual peers.

Aside from whatever praise or critique these sustained moments of teaching about sexuality merited, they were not explicitly linked together in any way. They were presented in isolation, rather than as components of an overarching topic. Less sustained discussions of sexuality contributed to the amount of teaching time sexuality received, but not to the consistency of the messages put forth.

**Unintentional teachings about sexuality**

Spontaneous mentions of sexuality within the formal curriculum outnumbered the intentional efforts to deliver teachings about sexuality. Sexuality came up regularly, if not frequently, in conjunction with other topics; however, many of these references posited ‘sex’ and ‘sexuality’ as concepts that were straightforward or self-explanatory. During the Psychopathology lecture on the topic of depression, the lecturer mentioned that ‘sexual side effects’ were a common side effect of drugs designed to treat depression. But the lecturer said nothing else, about the nature of the side effects or what might be done about them. Similarly, in another Psychopathology lecture concerning alcohol abuse, the lecturer stated that ‘sexual performance problems may be related to alcohol,’ and said nothing more, leaving the nature of ‘performance’ just as ambiguous as the nature of sexuality. During a brief discussion of the *Diagnostic and Statistical Manual (DSM)*, one Psychopathology lecturer mentioned that homosexuality was once included in the manual, but it was dropped because of changes in ‘the criteria for inclusion,’ without any discussion of what these criteria were, or what the implications of removing homosexuality from the DSM might be.

These brief mentions of sexuality in conjunction with an array of topics illustrated that sexuality can be relevant to many aspects of medical practice, and that it might be important for a doctor to be aware of the relevance of sexuality in many patient care scenarios that are not primarily or directly about sexuality – but this possibility was never raised explicitly. Nor were meanings of sex and sexuality explicated or explored within these curricular moments, and this is important because most Buena Vista students and faculty I interviewed had a very hard time articulating definitions of sexuality when I asked them to during our interviews. While this can be partially attributed to the fact that sexuality *is* difficult to define, it is still noteworthy that the curriculum functioned to reinforce a state of not-knowing, rather than offering some concrete means of gaining traction on sexuality’s ambiguity.

The lectures within which each of these relatively brief mentions of sexuality were contained ended early, meaning that time was, theoretically, available to say
more about sexuality and delve into its meanings and relevance to the topics at hand. This casts a slightly different light on the common perception among faculty members that time constraints were a significant barrier to teaching about sexuality. In practice, there was time available to integrate discussion of sexuality into teaching segments devoted primarily to other topics, or to devote time to discussing it in some detail when it came up spontaneously. But in the absence of a shared sense among faculty about what to teach about sexuality and why and how, it is easy to understand why these small chunks of free time were not leveraged as opportunities to say a little bit more – even if sexuality was a topic that was theoretically considered important.

Occasionally, unintentional transmissions of sexuality-related messages were more sustained. In a urology lecture, Dr Arnold Jun’s overview of the ‘male anatomy’ was replete with jokes and references to sexual functioning and activity. Dr Jun’s intention was not to teach about sexuality; rather, he tried to use sexuality-related humor as a heuristic for helping students get past their discomfort surrounding the subject matter and remember his teachings.

Interviewer: So tell me a little bit about the lecture.
Dr Jun: The lecture is kind of fun because it’s about male anatomy. And...
Interviewer: What’s fun about male anatomy?
Dr Jun: Well... a lot of the jokes that people tell have to do with, you know, anatomy. And more so when you’re dealing with sexuality. Sexuality is a funny subject for some people. It’s funny because when you laugh it kind of displaces the nervousness and you can kind of – it’s something about laughter that if you’re nervous you can... if we’re nervous, we laugh. So it’s something about sexuality that’s uncomfortable for people, so it’s something we can make kind of light, you know, and once I make it facetious then it’s easier for them to digest, I think. So it’s a fun lecture in that sense.

Dr Jun was one of the few interviewees who directly acknowledged that sexuality might provoke discomfort, and he was one of the few faculty members who proposed a mechanism for addressing this discomfort. Given the extraordinary discomfort with sexuality in general and non-normative sexuality in particular in the USA (Epstein, 2007), there is likely great value in explicitly acknowledging this discomfort within medical training, perhaps particularly when preparing students to examine the ‘sexual’ body parts for the first time, as Dr Jun’s lecture was designed to do. Yet Dr Jun’s comments were tautological. Was sexuality funny because it makes you nervous? Did it make you nervous because it is funny? Dr Jun did not consider the possible consequences of associating sexuality with nervousness that only humor could resolve. Dr Jun’s remarks constituted a powerful set of teachings about what sexuality is and the kinds of feelings it provokes – and how to deal with those feelings – even though he did not set out to teach about sexuality. This lecture did not register as a component of ‘medical sex education’ on anyone’s radar, but it was a curricular moment in which messages about sexuality were produced and transmitted.
Theoretically, the various messages about sexuality that were communicated in the formal curriculum might have automatically congealed into a set of working understandings about sexuality shared by students, but there was little evidence that this happened in practice. The students that I interviewed – even those who attended lectures consistently and held reasonably favorable views of the SAM classes – had a hard time remembering any instances of sexuality-related instruction in their courses, much less a collection of teachings about or mentions of sexuality.

**Faculty beliefs about the ideal placement of sexuality education within the overall trajectory of medical training**

Whether or not students’ state of not-knowing, or semi-knowing about sexuality is cause for concern depends in part on medical educators’ understandings about what student-physicians need to know about sexuality, and when. Even recent suggestions for what medical sex education might usefully include (e.g. Coleman et al., 2013; Shindel and Parish, 2013) provide little discussion of when medical students should acquire certain knowledge or competencies. What knowledge or skills should a medical student bring with them to medical school, and what do they need by the very first time they interact with patients, and by the time they graduate? Does it matter – for example – if a medical student makes initial contact with patients having never previously interacted with sexual/gender minority persons? Does it matter if a newly minted OB/GYN resident is uncomfortable asking patients detailed questions about their sexual practices? Should all students be given a structured opportunity to examine their own beliefs and potential biases about sexuality, and some means for reckoning with them in order to mitigate their potential impact on patients – and if so, when? What sort of sexuality training is essential for all doctors to have, and what might be suitably situated within particular residency trainings? Answers to these questions are elusive at best within the academic medicine literature, and Buena Vista faculty held competing perspectives.

Buena Vista faculty had the sense that most of their students came into medical school with limited formal knowledge about sexuality, limited exposure to sexuality as an aspect of social experience, and limited personal experience with sexuality (and my interviews with students indicated that this impression was accurate). They acknowledged that students’ lack of knowledge about sexuality or inability to talk comfortably about sexuality had consequences for patient care, but their sense of how exactly patient care might be impacted was vague, and they disagreed about how and when it was most appropriate, or most feasible, for this problem to be rectified. The faculty members who were responsible for the coursework portion of medical education tended to believe that the early years of medical education were a difficult time for faculty to teach and students to learn about sexuality. Aside from the problem of time constraints, some faculty believed that students were not able to absorb teachings about sexuality so early in their career, because they were still professionally quite young. But this incapacity to learn about sexuality at this stage of medical education wasn’t necessarily perceived to be a problem, because it
was believed that sexuality was one of those things that could best, if not only, be learned about ‘on the go’, over time, and through experience – within their residencies, perhaps. And of course this perspective makes a certain amount of sense. Within any profession and trajectory of professional training, there is bound to be some knowledge that can only develop incrementally, over time, through the gradual accumulation of wisdom and perspective.

However the faculty members who worked with residents believed that medical students needed to be capable of having conversations about sexuality by the time they finished medical school and started their residencies. Dr Elizondo put it this way:

**Dr Elizondo:** You know, plenty of medical students get through medical school and they can’t ask people about their sexual history. They can’t even ask a patient simple questions like how many partners they’ve had, or if they use condoms… not to mention more in-depth sexual questions that might be more anxiety-provoking [for the resident].

**Interviewer:** Like what?

**Dr Elizondo:** Like what sexual practices the patient engages in. You know, do they use sexual toys, do they have anal sex, do they have oral sex? And so when we talk about STDs or specific kinds of preventative things, those questions might come up, and I think those prove to be very difficult sexual questions [for the residents to ask]. They can’t ask, ‘What kind of a partner do you have? How many kinds of partners do you have?’

Opportunities to bring residents who lacked the capacity to have these kinds of conversations with patients up to speed were scarce at best. Like the faculty who were involved with the development of the undergraduate medical curriculum, faculty who worked with residents faced time constraints. They too had to juggle the need for teaching specifically about sexuality with the need to also teach about many other important topics and procedures.

Some of the faculty who worked with residents identified residents’ discomfort with the topic of sexuality as the main issue underlying their ability to talk about sexuality with patients (as opposed to a simple lack of knowledge). ‘With many residents, it seems like they find some of the routine things we have to talk about kind of shocking,’ observed Dr Samantha Whitman, an OB/GYN. Faculty recognized that residents’ discomfort had direct implications for patient care, but in the absence of knowing how to systematically address residents’ discomfort, it inhibited spontaneous discussion about sexuality. Dr Bernard Lumumba, a family physician, worried that talking about sex openly with residents could be risky:

**Dr Lumumba:** I had a female resident here. I tried to ask her why this [female patient] is having a recurrent bladder infection all the time. ‘I don’t know, I don’t know,’ [the resident said]. I said – I broached the idea that maybe it has something to do with the patient’s sexual activities, both anal and vaginal – ‘Have you asked about that?’
[The female resident] turned beet red in the chair. So I said to myself, now I’m going to be accused of sexually harassing the residents.

**Interviewer:** Really?

**Dr Lumumba:** It depends on the upbringing of the residents. If they don’t know anything about sex in their family, they didn’t think that their father and mother had sex…[they think] they just came out of the bark of a tree. Or they are a fundamentalist from North Carolina. So what do you do, so should I teach them about the positions with sex? Should I? No. In about two seconds I have to go over to the patient that has been sitting there waiting forever and so that told me that [the resident] has no clue, and then yet this [patient] entrusts, gives [the resident] a window of opportunity to talk about sexual problems. And the resident can’t handle it. So I pinch myself for opening my big mouth as usual.

Other faculty members, as well as students, described situations they encountered on clinical rotations which sounded like occasions when teaching or learning on the go about sexuality would be likely to occur – for instance, a patient with a dildo stuck in their rectum, a patient resistant to using protection when having sex, a patient with a genital piercing, and so on – but did not. Although I did not directly observe faculty–student or faculty–resident interactions on rotations, interviews suggested that learning on the go about sexuality was more hypothetical possibility than empirical reality. Moreover, faculty members’ vague understandings about sexuality suggested that their own experiences of learning on the go had not yielded a distinct corpus of sexual knowledge.

Finally, one faculty member, Dr Bob Harrison, believed that the solution to the problem of trying to figure out where and when to teach about sexuality in medical education was to ensure that students knew about sexuality before coming to medical school. He told me a story of a resident that came to him, asking incredulously if it was true, as he had been told just moments earlier, that doctors should not have sex with patients. Dr Harrison was astounded that the resident could have made it all the way through medical school without learning that doctors should not have sex with patients, but reasoned that since faculty may not have time to cover such topics in medical education and students really should know that doctors should not have sex with patients by the time they enter medical school, a nationally standardized, pre-med curriculum should cover such topics. Even when a particular piece of knowledge about sexuality was considered incredibly important, the time and place to impart that knowledge was always somewhere else.

**Discussion**

This study is not a systematic historical comparison, but it is reasonable to point out that medical sex education at Buena Vista was strikingly similar in some respects to American medical sex education efforts of previous decades. Some of the reasons why medical sex education has been considered important by medical
educators – sexuality is both ambiguous and socially sensitive, if not taboo – have been and remain among the reasons why medical educators find it difficult to provide. In addition, biomedical knowledge continues to take precedence over other subjects and competencies, and the problems of too much to teach, too much to learn, and too little time, only grow worse as biomedical knowledge proliferates. Even if some medical educators continue to be convinced of the need for medical sex education, and even if sexuality becomes increasingly visible in society at large (Attwood, 2006), medical training may not be a space in which sexuality education automatically evolves, or evolves in predictable ways.

One of the faculty members that Robert Coombs interviewed in the mid-1960s described his medical school’s instruction pertaining to sexuality as ‘dribbles and drabs in various courses; but it is hit-and-miss, and nobody calls it sex education’ (Coombs, 1968: 272). Depending on the criteria for ‘dribbles and drabs’, Buena Vista’s sexuality instruction might have fit a similar description. Its messages were fragmented, and even the planned, sustained moments of teaching about sexuality were based on individual faculty members’ idiosyncratic perceptions of what might be useful, rather than collective deliberation about what to teach, and how, and when. Gaining a better understanding of the extent to which this is the case in other medical schools, and the content of teachings that result from individual impetus, is one of the reasons why additional ethnographic study of medical sex education is so important. This need remains even if recommendations about what medical sex education might include become more detailed in the guidance they provide, and more widely implemented.

In addition to further study of what medical schools teach about sexuality, there is also a need for more research on what medical students and doctors know and believe about sexuality, and where and how they come to these understandings. Measuring what medical students learn from deliberate medical sex education would be an important component of those efforts, but so too are studies of other potential influences on sexual knowledge and capabilities related to the provision of health care.

This article expands the conversation about sex education and the production of formal knowledge about sexuality across contexts. Much of the sociological study of sex education has focused on school-based sex education (e.g. Fields, 2008; Irvine, [2002] 2004; Kendall, 2013; Luker, 2006; Thorogood, 2000), and other contexts (e.g. Gill, 2012) in which the primary goal is to influence or control the behavior of its subjects. We know less about the existence and nature of sex education efforts whose purpose – presumably – is to prepare students to respond to the sexuality-related needs of others. It seems likely that this sort of training would occur in other programs of professional education, beyond medicine but, as this research demonstrates, the potential utility of sexuality education is no guarantee that it will occur in a particular way, if it occurs at all. Future research might usefully explore the range of contexts in which formal knowledge about sexuality is produced and transmitted, both inside and outside of traditional educational institutions.
Notes

1. Most of the faculty members I interviewed were involved in the teaching of the SAM classes, and thus by definition were supportive of teaching about the social aspects of medicine. Had my sample included more faculty members who had nothing to do with the SAM courses – who, in keeping with the trends at Buena Vista, were likely to have considered the social aspects of medicine unworthy of teaching time – I might have captured a different set of perspectives about the importance of sexuality education.

2. Although ‘sexual medicine’ is sometimes considered a distinct specialty or approach, it was not recognized as such at Buena Vista during the time of my research. Aside from Dr Zimmerman, none of the faculty at Buena Vista referred to ‘sexual medicine’ during interviews or lectures that I observed.

References


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