The Sexual Responsibilities of Physicians

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ABSTRACT

Sexual problems are medical problems and, therefore, the responsibility of the practicing physician regardless of his specialty. This article looks into the expectations and needs of the patient and the responsibility of the doctor. Suggestions are made on dealing with overt and covert sexual problems, attitude modifying, sexual education, history taking, and aims of sexual counselling.

The myth that the population of the western world is open in their sexuality and, therefore, free of sexual problems was dramatically refuted in 1978 when the New England Journal Medicine published its first and probably only article on sexual problems and dysfunctions. In their article "Frequency of Sexual Dysfunction in 'NORMAL' Couples" Frank, et al at the University of Pittsburgh School of Medicine, made the following observation. "In analysing the responses of 100 predominantly white, well educated and happily married couples to a self-report questionnaire, this study examined the frequency of sexual problems experienced and the relations of those problems of sexual satisfaction. Although over 80% of the couples reported that their marital and sexual relations were happy and satisfying, 40% of the men reported erectile or ejaculatory dysfunction, and 63% of the women reported arousal or orgasmic dysfunction. In addition, 50% of the men and 77% of the women reported difficulty that was not dysfunctional in nature."[1] These are rather striking and scarey statistics.

Other statistics show that physicians who are uncomfortable and who do not ask about sexual health estimate that only 2 to 10% suffer from sexual problems. Physicians who routinely ask and are comfortable, identify significant sexual problems in at least 50% of their patients.

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We are all well aware that our patients look to us for mending their broken bones, soothing their aches and pains, and curing all kinds of diseases, but they also turn to us for help with behavioural problems : the tantrums of the two year olds, adolescent defiance, drug and alcohol abuse, anxiety, depression, and now the sexual partner's inability to please or their inability to perform. Why shouldn't they expect us to handle that ? After all, we are the repository of all their ultimate intimacies : defecation, urination, menstruation. We inquire, and they usually feel free to ask us about these subjects.

What about their other ultimate intimacy, their sexuality ? Maybe because of the liberation of women, maybe because of the openness about birth control, maybe because of articles in ladies' magazines, patients are now saying things to us like, "Doctor I can't have orgasms and I want to". Or "A couple of times lately I just can't get it up. What's wrong ?" Or "It's been hurting when we have intercourse recently". If you are uncomfortable with overt sexual complaints such as these, many patients will sense your discomfort and hold back their questions. What about the patient with symptoms without organic cause ? Are you ready and comfortable to explore with them the possibility of a sexual origin. Remember, if you make a connection with the complaint of headache, backache or abdominal distress with an underlying sexual frustration and do something to alleviate the patient's distress, you are practicing good medicine and you will not be handing out placebos or tranquilisers that may or may not work.

No one can deny that a physician like any other person is entitled to his or her own views on sexuality. The doctor does, however, have a responsibility to keep those views from unwittingly reducing his effectiveness in the care of his patients. The common problem among physicians is over-control and avoidance of sexual matters rather than the other end of the spectrum, under-control and

exploitation. We as good physicians, as usual, should be somewhere in the middle. More importantly our own sexual value system should be left outside the door of our consultation room. In other words, when we enter our consultation room and relate to our patients, we must maintain an unbiased, non judgemental attitude, and actually get into the value system of our patients. Furthermore, it is imperative, that we be secure in our own sexuality.

How can our sexual attitudes be modified ? In the West there are many seminars and workshops on human sexuality in their continuing medical education system. This needs also to be done in the Arab world. Until a continuing medical education program in sexuality is started, we as individuals can help ourselves by reading more about human sexuality in medical books and journals as well as lay magazines to increase both our clinical knowledge as well as make us more comfortable with the subject and help us to adjust our thinking. In addition talking with our spouses or our peers on the subject, although difficult at first, will help us prepare for talking with our patients.

Our position of authority in our patients eyes enables us to dispel many deeply ingrained misconceptions. As our attitudes improve and our clinical knowledge increases, we will be able to help our patients in dispelling these misconceptions. As you read this, be honest with yourselves and see if you consider the following statements myths or truths :

— Intercourse is always harmful the last six weeks of pregnancy and the first six weeks post-partum.
— Masturbation is physically and mentally damaging.
— Men and women respond to sexual activity very differently.
— Women can obtain three different types of orgasm : clitoral, vaginal, and G-Spot.
— People who have had myocardial infarctions should curtail or abstain from sexual intercourse.
— Simultaneous orgasm is the indication of sexual competency.
— Sexual performance is governed mainly by physical factors.
— Sex drive is reduced after menopause.
— Ability to have intercourse disappears in old age in both sexes.
— Sexual pleasure is reduced by hysterectomies and vasectomies.

These are all myths and we could go on and on and on.

As doctors we must realize that our patients as well as ourselves grow up with many cultural taboos no matter where we are in the world. As we grow up with these taboos, we find that facts are unavailable or distorted, therefore making us ignorant regarding sexual matters. This results in anxiety, fear, and guilt which we take into our marriage and, thereby, develop sexual problems and dysfunctions. It is our responsibility as physicians to re-educate our patients to the best of our ability.

Our position of authority also, enables us to give needed reassurances such as :

— The patient is not responsible for his or her mates sexual response and/or orgasm or lack of same.
— Orgasm by manual stimulation of the mate is normal.

It is worthwhile noting here that between 30 and 50 percent of women are not coitally orgasmic but may be helped by the "clitoral assist" technic. Finally, I would like to say that for all practical purposes essentially everything is normal between consenting married couples as long as no physical damage occurs. If you cannot accept that for yourself, at least in your practice of medicine it would be a good guideline.

What I am basically suggesting is that our position as a physician automatically makes us a sex educator in the eyes of our patients; and our intimate relationship with our patients makes them more comfortable with us than with anyone else. With only a little encouragement and acceptance, initial reticience or embarrassment dissipates.

Many physicians feel that family physicians, gynaecologists, and urologists are the only physicians involved in human sexuality and the sexual problems of patients. It is my feeling that every physician should be ready and willing to become involved in human sexuality and the sexual problems of their patients. The cardiologist should be aware of the adverse effects of many of the anti-hypertensive drugs on sexual response. He should also inform his patients with myocardial infarction, as soon as they are alert, that he will let them know when they can resume sexual relations. Many Coronary Care Unit

nurses find men masturbating the first night in the Coronary Care Unit. If they were informed that it is dangerous at this stage of their recovery period to do this and that later on they would be able to function normally we would not have many of the problems that we do with patients with myocardial infarction. The obstetrician-gynaecologist should realize that some of the oral contraceptives have an effect on many women's emotions and capacity for orgasm. The psychiatrist should be aware of the sexual dysfunction that may result from the use of tricyclic antidepressants, anti-psychotic drugs, MAO inhibitors, lithium, and the tranquilizers. The paediatrician should be aware of the normal, variant, and deviant possibilities of childhood and teenage development as well as the early life disablements such as cerebral palsy and mental retardation. They should be ready and willing to talk with parents about their child's sexuality. The surgeon should be cognizant of the sexual effects of disfiguring surgery, all the ostomies and ectomies. The neurologist must be aware of the sexual and marital consequences of disabling illnesses like MS, paraplegia, and cerebrovascular accidents. The urologist should explain to his patients who are going to undergo a prostatectomy, except for radical prostatectomies, that it should not result in erectile dysfunction but only retrograde ejaculation. The physician in a detoxification or rehabilitation center for chemical dependance should know that his patient's sexual dysfunction could be due to the chemicals that he is using. It is obvious that family physicians can be involved with all of these phychosexual repercussions not only for the patient but for the patients spouse, children, parents other relatives and friends.

In this article I have shown by statistics that many physicians fail to identify sexual dysfunctions in their practices. There are three reasons for this :

1. A need to deny the existence of any sexual problems of their own. Reading some of the aforementioned books and discussions with peers or spouse could help if this is the case.

2. A lack of confidence that they can do anything about sexual problems; again reading from the book list might help.

3. Concern that their patients or colleagues will consider their interest prurient. All I can say to that is that if they are honest and ethical in their practice those ideas will vanish with time and their satisfaction will far outweigh anything else.

Most of us who do any type of sexual counselling in our office were anxious at first and that is to be expected. Remember though that all of us practicing medicine for a while have considerable experience in coping with anxiety. No other person in society is confronted with as many anxiety producing situations as a physician. All of us have massive experience at overcoming anxiety : the first venipuncture, pelvic delivery, coronary, death, etc. It is the same with sex. We just need experience.

Of course your patient will invariably be a little anxious too. Your response is of prime importance. Suppose you startle and say "I don't handle that problem. You need a marriage counsellor or a psychiatrist." Your patient will not feel any better and his anxiety may well be increased. He/she might back off and not consult anyone else. If so, you will have done a real disservice. Just hearing your patient out with a concerned empathetic attitude will help to relieve some of his/her anxiety and you might find that you really can handle the problem; or in a calm reassuring way you might refer them to a specialist in the field just as you would any other medical problem that is beyond your scope of expertise.

If your patient cannot bring himself to talk about the subject, the physician should let him know that he believes sexual problems are medically important and that he will be available for consultation at anytime the patient is ready.

The art of medicine is defined as the ability to respond effectively to clues : facial appearance, body language, evasions, and so on. We must always assume that any sexual question has some personal relevance for the patient and should not be answered casually. The common approach is for the patient to tell you about the problem "her friend" has and she wonders if you could suggest anything that she could do to help. You have certainly had patients tell you about the problem their neighbour is having with their children when really she's talking about her own children. It is exactly the same with sex. In taking the sexual history the physician should be honest, consistent, non-judgmental and sensitive to the patient's feelings and attitudes. He should be

aware that he can suppress or elicit information by his manner as well as by his words. To quote Masters and Johnson : "If the interviewing physician can project sincere interest in the patient's problems, and even more important, exhibit no personal embarrassment in an open sexual discussion, almost any individual's sexual history will be reported with sufficient accuracy and adequate detail for treatment purposes." This is exactly what doctors are trained to do : be honest, consistent, non-judgmental, sensitive, and show sincere interest. We can be the ideal sex counsellor with only a little effort in gaining knowledge and experience.

How should we take a sexual history? We start with the same kinds of questions we would ask about any elusive symptom, such as abdominal pain. We find out when the complaint first occurred, under what conditions it happens, how long it lasts, what it feels like, etc. Sexual dysfunction is a medical problem and you can approach it in exactly the same manner you would approach abdominal pain. You take a history to get the clues that will lead you in one direction or another.

Matters of sexuality should not be set aside by the physician nor discussed with more or less emphasis than any other normal physiologic function. If you deal with them this way, your patient will be more relaxed and able to communicate with you better.

In taking a good medical history we ask a lot of questions when going through a review of systems. Do you avoid in your system review any questions regarding your patients sex life ? If you do, you may be eliminating the only chance to cure your patients present complaint. For many of you this is a difficult subject to get into and if not approached properly your patient may think you are a pervert of some kind. I have found it fairly easy in men to go from urological problems to sexual problems and in women to go from menstrual and pregnancy history to sexual satisfaction. Some doctors find it easier to ask these questions during the social history.

Whenever you feel most comfortable, it is worthwhile having a sexual history opener that you are familiar with and which is open ended rather than closed ended. Open ended questions force the patient to stop and think giving you more complete verbal answers as well as non verbal answers. I would suggest one of the following :

— Is the sexual side of your life living up to your expectations ?

— Are you satisfied with your sexual functioning ?

— How do you feel about the sexual side of your life ?

— Are you happy with the sexual part of your life ?

— Have you had any difficulty in your sexual relationship ?

— Do you, like most people, have any questions or concerns about sex and/or your sexual activity ?

These are openers that you can use and then go into specifics if indicated. It is best of course to develop a question that is more congruent with your style of practice and personality. You will be surprised how with just a little question like those above, asked with no more or less emphasis than any other in your review of systems, and asked just after the urological or menstrual questions, or in the social history, you will be relaxed and so will your patient.

In review, and quoting from Harold Leif's book, *Sex Education in Medicine*, the aims of a physician involved with human sexuality "include the ability to :

— Be comfortable with sexual topics and put patients at ease in discussing them.

— Listen well, remember to take a sexual history and know how to take an accurate and useful one.

— Remain aware of patients' feeling and thus avoid creating shame and embarrassment.

— Recognize masked psychosexual problems and the sexual implications of various dysfunctions and courses of treatment.

— Judge whether the sexual problems or implications are within the physician's competence.

— If not within his competence, refer the patient to an appropriate professional person.

— If within his competance, set up a plan of treatment with the patient's full knowledge and consent.

— Take advantage of the educational and preventive aspects of medical sexual knowledge."[12]

In conclusion, I think that the treatment of sexual dysfunction is an important ingredient of good medicine. Some physicians will disregard sex as being important in their practice because "nobody ever dies of it" but pain and anguish is considerable. Our job is not only to prevent death but to relieve distress. As you become more skilled with this intimate part of your patients' lives, you will develop a new level of relationship with your patients. Trust in you will increase, capacity to communicate with you will increase, and it will be a very rewarding experience for you. There will be no area of their lives that they will be too embarrassed to talk about with you.

REFERENCES

1. Frank E, Anderson C, Rubinstein D. Frequency of sexual dysfunction in "normal" couples. N Engl J Med 299:111–115,1978.

2. Lief H, ed. Sexual problems in medical practice. Chicago: American Medical Association, 1981.

3. Masters W, Johnson V. Human sexual response. 1st ed. Boston: Little, Brown and Company, 1966.

4. Masters W, Johnson V. Human sexual inadequacy. 1st ed. Boston: Little, Brown and Company 1970.

5. Masters W, Johnson V. The pleasure bond. 1st ed. Boston: Little, Brown and Company, 1970.

6. Kolodny R, Masters W, Johnson V. Textbook of sexual medicine. 1st ed. Boston: Little, Brown and Company, 1979.

7. Kaplan H. The new sex therapy. New York: Brunner/Mazel, 1974.

8. Medical aspects of human sexuality. New York.

9. Riley A. British Journal of sexual medicine. London.

10. Belleveau F, Richter H. Understanding human sexual inadequacy. New York: Bantam Books 1971.

11. Zilbergeld B. Male sexuality. New York: Bantam Books, 1978.

12. Lief H, Karlen A, eds. Sex education in medicine. New York : Spectrum Publications, 1976:7.