

# FEMALE HYPOACTIVE SEXUAL DESIRE DISORDER IN PRIMARY CARE: A CONTINUING MEDICAL EDUCATION (CME) CURRICULUM

Michael Krychman, MD<sup>1</sup>; Marissa Seligman, PharmD<sup>2</sup>; Nike Gazonas, MS<sup>3</sup>; and Wendy Gloffke, PhD<sup>3</sup>

<sup>1</sup>Southern California Center for Sexual Health and Survivorship, Newport Beach CA; <sup>2</sup>pmiCME, Boston, MA; and <sup>3</sup>Athena Education Group, LLC, Lambertville, NJ.

## ABSTRACT

**Purpose:** Hypoactive sexual desire disorder (HSDD) is often overlooked by health care professionals (HCPs). Despite the heavy toll on women's relationships, self-esteem, and overall quality of life, patients are rarely, or ineffectively, screened. HCPs lack awareness, knowledge, and confidence, and often feel personal discomfort in discussing sexual issues with their patients. The objectives of this curriculum were: (a) to model communication skills that facilitate the discussion of sexual health issues; (b) to provide tools to help HCPs assess sexual health issues; and (c) to describe the role of the HCP in screening and treatment of female patients with HSDD.

**Methods:** Assessment included immediate measurement of specific changes relative to baseline prior to the activity and subsequent follow-up to discern the implementation of program tactics in clinical practice.

**Results:** Through this multi-component curriculum, we were able to demonstrate increases in HCP knowledge and competency as well as confidence in their performance relative to clinical identification of the causes of HSDD in women, communication with female patients on sexual dysfunction in routine exams and initiation of management strategies for affected females. HCPs committed to change their practices relative to securing and assessing effective sexual histories, use of evidence-based screening tools and "normalizing" strategies and referrals to specialists, including sexual counselors and therapists.

**Conclusions:** After participating in a program that includes physicians modeling communication tactics, HCPs report improved awareness of HSDD and confidence in their ability to communicate more comfortably about sexual health issues.

## BACKGROUND

Hypoactive sexual desire disorder (HSDD) is an under-recognized and under-treated condition that is often overlooked by health care professionals (HCPs). Women with HSDD are receiving inadequate healthcare, in part because training in sexual medicine is absent or inadequate in most medical schools. Despite the heavy toll on women's relationships, self-esteem, mental health, and overall quality of life, patients are rarely screened for HSDD or diagnosed with the condition. HCPs are lacking awareness, knowledge, and confidence, and often feel personal discomfort in discussing sexual issues. Communication between HCPs and female patients regarding sexual issues seldom occurs unless initiated by the patient.

Improving physician comfort and communication skills regarding HSDD will increase the practice of screening patients for HSDD in routine exams. Continuing medical education is needed to update HCPs on the prevalence and impact of HSDD, as well as the importance of physician-patient communication in order to address critical issues of sexual health and sexual dysfunction.

There is a significant need to educate HCPs to:

- Comfortably communicate with patients about sexual problems and HSDD
- Create an open practice environment that encourages patient disclosure of sexual concerns
- Screen women for the presence of HSDD as part of their routine exams
- Gain interviewing skills that yield useful clinical information for patient assessment

## OBJECTIVES

We identified specific knowledge and clinical practice objectives based upon the challenges associated with screening for HSDD and communicating with women patients about sexual issues. The overall goals of these continuing medical education (CME) activities were to increase HCPs' awareness of the prevalence and impact of HSDD on women's lives, to improve their ability to communicate comfortably with women about their sexual health, to include sexual health assessment as part of routine examinations, and to support implementation of tactics to identify and support women with HSDD.

By participating in these CME activities, we expected HCPs would be able to:

- Discuss the prevalence and causes of HSDD in women
- Communicate comfortably with their female patients in order to increase screening for sexual dysfunction during routine exams
- Discuss differential diagnoses and outline treatment strategies and options

## METHODS

### Primary Care Hyposexual Desire Disorder Education Plan

We utilized integrated and interactive learning activities incorporating elements that supported different clinician learning styles and provided opportunities for patient assessment and discussion with sexual health experts. The live activities featured a blend of didactic presentations, patient-HCP video scenarios, audience participation via interactive audience response system (ARS), and immediate feedback from peers. Assessment included immediate measurement of specific changes relative to baseline prior to the activity, and subsequent follow-up to assess application of program concepts and tactics in clinical practice.

We have successfully utilized this model in other clinical education settings and achieved a far greater level of competency than would have been achieved via lecture-only didactic presentations. In one recent CME program on the topic of skin cancer, outcomes assessment showed that the percentage of participants who were able correctly identify skin lesions improved from a baseline of 19% prior to the activity to 62% after working with real patients during the program. In addition, prior analyses have shown that participants exceeded learning expectations and achieved more than the baseline learning objectives.

The incorporation of real patient-HCP video scenarios into the educational design of this series of CME activities was based upon sound adult learning and medical education principles.<sup>1,2</sup>

- The use of real patient scenarios in the live activity setting is critical for effective education.
- Real patient scenarios create learner motivation by promoting and supporting relevance and for providing clinical context.

The incorporation of real patient scenarios in the educational setting is a very powerful teaching tool that supports the new ACCME criteria that emphasize custom learning in CME. (Table 1) Despite the potential for improved learning, this tactic is not frequently used in CME. CME providers should explore how to use this model in different therapeutic settings; the best use in varied clinical scenarios may be different.

Table 1. New ACCME Criteria Emphasizing Custom Learning

	OLD CME	NEW CME
TOPICS	Based on general interests, surveys	Targets closing defined healthcare gaps
FOCUS	Knowledge	Performance
METHODS	Passive	Interactive
CREDIT	Hours in seats	Performance Improvement demonstrated by chart audits or surrogate
METRICS	Participation and satisfaction	Measurement of changes in knowledge, skills, practice patterns, and patient outcomes

This CME curriculum included the following components:

- Expert sexual medicine faculty who were knowledgeable about the diagnosis and treatment of HSDD
- Didactic presentations which covered prevalence of HSDD, screening and diagnostic criteria, impact of HSDD on women's lives, models of HCP-patient communication approaches, tools to facilitate the discussion of sexual health with female patients
- Pre-test and post-test outcomes studies
- Audience response systems (ARS) used strategically throughout each live activity to capture the opinions/choices of the learners and facilitate interaction between the faculty and learners
- A real doctor-patient scenario that was videotaped and played on a large screen in short time increments of 20-60 seconds.



Educational objectives included knowledge, competence, and performance indices.

## RESULTS

To date, outcomes results are available from 5 live meetings:

- Anaheim, CA
- Baltimore, MD
- Boston, MA
- Rosemont, IL
- New York City, NY

### Participants and Professional Demographics

- 3,192 learners have participated in these CME activities
- The majority of participants (55%) were MDs or DOs
- About two-thirds of participants (67%) practice in either internal medicine or family practice settings
- Practice types vary widely (Figure 1)
- Number of years in practice for learners was evenly distributed
- Learners are highly active in patient care (Figure 2)
  - Average # patients seen per week: 65
  - 55% of respondents see more than 50 patients per week

Figure 1. Professional Practice Settings of Learners

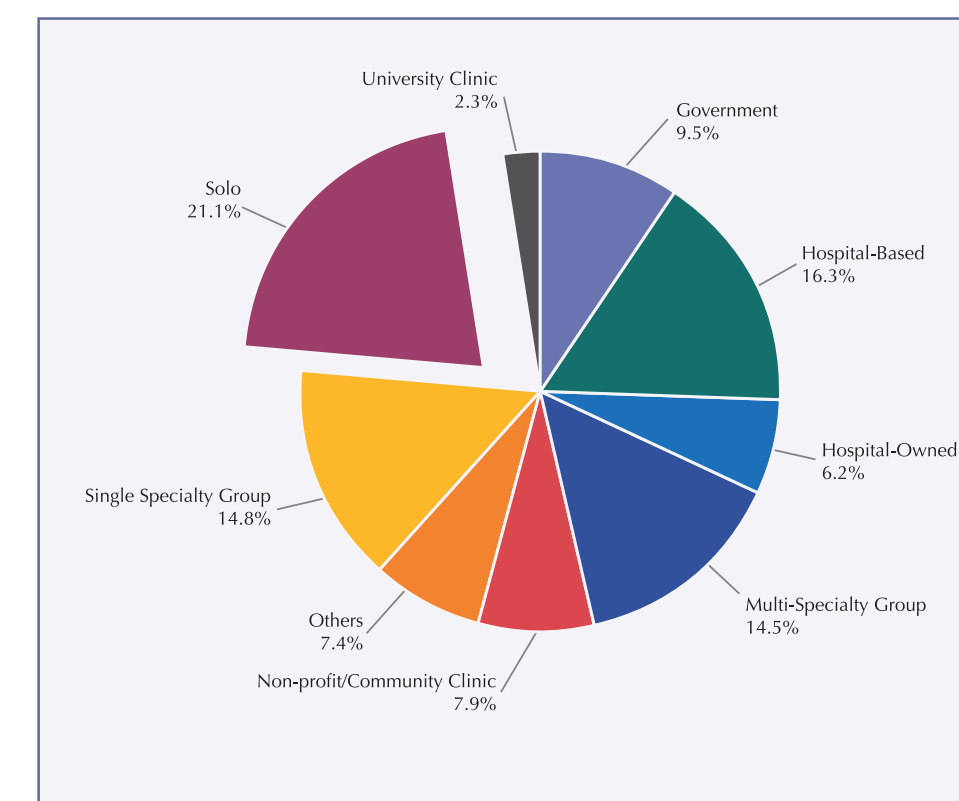
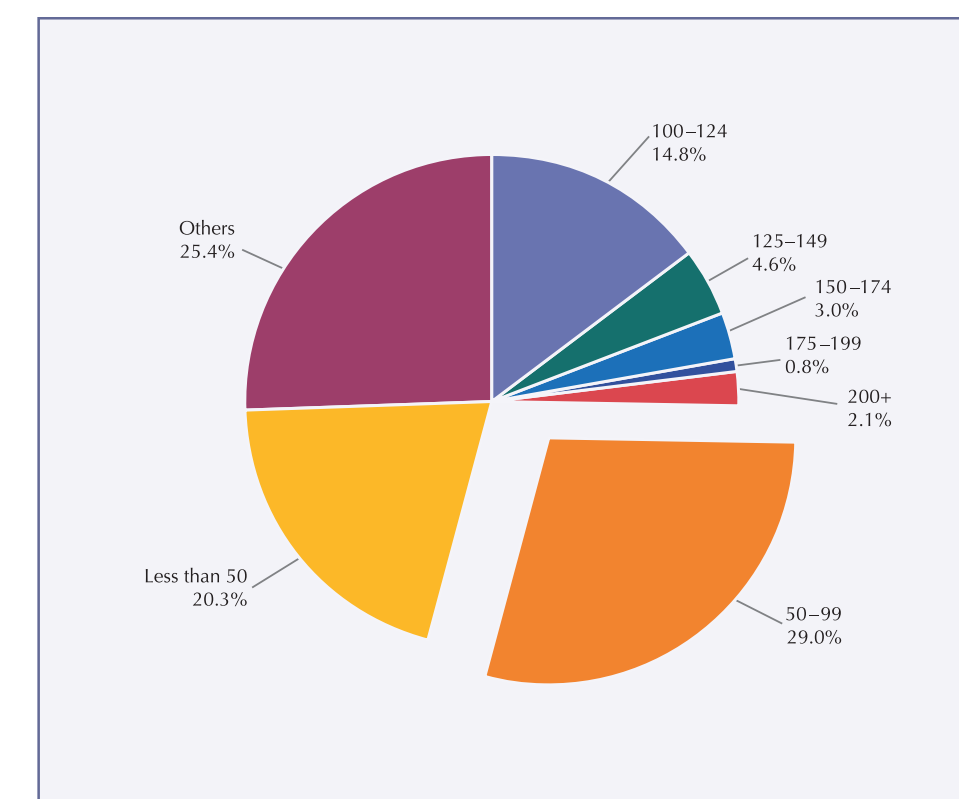


Figure 2. Number of Patients Seen Per Week



### Activity Evaluations and Feedback

- The use of real patient case scenarios and video patient cases stimulated critical thinking by the participants and made the content more valuable and clinically relevant as shown by selected representative post-activity comments (Table 2)
  - *Improvements in Confidence: Pre-and Post-Activity Responses*
    - » Prior to the activity only 40% of respondents reported being "somewhat confident" or "very confident" with respect to screening and diagnosis of sexual dysfunction in their female patients.
    - » After the activity, that percentage more than doubled to almost 90% reporting being "somewhat confident" or "very confident" with respect to screening and diagnosis of sexual dysfunction in their female patients. (Table 2)

Table 2. Pre- and post-activity response to the question: What is your level of confidence with respect to screening/diagnosis of sexual dysfunction in your female patients?

	Pre-Activity (N=739)	Post-Activity (N=699)
Scared to death	6%	2%
Not very confident	54%	9%
Somewhat confident	34%	67%
Very confident	6%	22%

– *Impact on Practice*

- » Prior to the activity, 41% of participants reported they did not screen for sexual dysfunction in their female patients and almost 75% reported they "sometimes/rarely/never" assessed sexual health in their female patients.
- » After the activity:
  - » 61% of learners indicated they planned to regularly assess sexual health in their female patients (Table 3)
  - » The percentage of learners who would did not plan to screen for sexual dysfunction decreased (Table 3, Table 4)
  - » 63% of learners indicated they would incorporate open-ended questions about sexual health into their practice (Table 5)
  - » Post-activity comments indicated that learners would integrate key learning points into their practices. (Table 6)

Table 3. Post-activity responses to the question: When do you (plan to) assess sexual health in your female patients?

	Pre-Activity (N=700)	Post-Activity (N=642)
At every visit.	2%	4%
Routinely (e.g., at annual checkups).	20%	61%
When the patient brings it up.	38%	12%
When I suspect a problem.	22%	13%
I don't assess sexual health.	19%	10%

## CONCLUSIONS

- Post-activity responses suggested that more learners would integrate an assessment of a woman's sexual health into routine exams
- The use of a real patient scenario in video format stimulated critical thinking and increased the value and clinical relevance of the content.
- The incorporation of real patient scenarios into the educational setting is a very powerful teaching tool and should be employed more frequently in CME.

## FUTURE DIRECTIONS

- Through our work on this CME curriculum, we have determined that additional education is warranted for PCPs treating female patients, particularly as it relates to screening for sexual dysfunction, treating sexual dysfunction, and referral to a sexual health specialist when warranted.
- We recommend making this education available with additional patient scenarios and with additional learning formats (i.e., online), including with a measurable performance improvement (PI) component.

## ACKNOWLEDGEMENTS

Athena and pmiCME gratefully acknowledge the many valuable contributions from the following faculty (in alphabetical order):

- Anita L. Clayton, MD, University of Virginia Health System, Charlottesville, VA;
- Leonard R. Derogatis, PhD, Sheppard Pratt Health Systems, Baltimore, MD;
- Sheryl A. Kingsberg, PhD, Case Western Reserve University School of Medicine, Cleveland, Ohio;
- Michael L. Krychman, MD, Southern California Center for Sexual Health and Survivorship Medicine, Newport Beach, CA, and;
- Sharon J. Parish, MD, Montefiore Medical Center, New York, NY.

## REFERENCES

1. Spencer J, Blackmore D, Heard S, et al. Patient-oriented learning: a review of the role of the patient in the education of medical students. *Med Educ.* 2000 Oct;34(10):851-7.
2. Bokken L, Reithans J, Scherpbier AJ, et al. Strengths and weaknesses of simulated and real patients in the teaching of skills to medical students: a review. *Simul Healthc.* 2008 Fall;3(3):161-9.

Athena and pmiCME gratefully acknowledge an educational grant from Boehringer-Ingelheim Pharmaceuticals Inc. in support of this primary care CME curriculum.

Table 4. Post-activity responses to the question: Which screening tools have you used (do you plan to use) in your practice to screen for sexual dysfunction in your female patients?

	Pre-Activity (N=708)	Post-Activity (N=425)
I just work it into the conversation; I do not use formal screeners.	46%	49%
I use questions on my intake form.	10%	12%
I use the Decreased Sexual Desire Screener (DSDS).	1%	20%
I use the Female Sexual Function Index (FSFI) or FSFI).	0%	7%
I use a different screening tool (not DSDS or FSFI).	1%	1%
I do not screen for female sexual dysfunction.	41%	11%

Table 5. Post-activity responses to the question: After this CME activity, what will you change in your practice to better screen/diagnose sexual dysfunction in your female patients?

	Post-Activity (N=627)
I will use screening tools at annual checkups.	11%
I will ask my patients more open-ended questions about their sexual health.	63%
I will refer more patients to a specialist when needed.	8%
I will not change my practice at this time.	5%
Not applicable.	13%

Table 6. Representative Post-Activity Comments

Actual Post-Activity Comments
■ Will initiate discussion and utilize more open-end questions
■ Plan to take a good history of sexual desire and treat the patients with distress
■ Now feel more comfortable discussing and diagnosing female sexual dysfunction as well as treatment
■ Will include the questioning at time of visit each time — especially if surgical menopause is in the patient's history
■ Will be more apt to incorporate sexual history into the history taking
■ Gained insight and concrete techniques on approaching female patients regarding their sexual functioning
■ Excellent — this topic was more relevant than realized
■ Will consider using a screening tool (do not currently use one to screen for HSDD)
■ Plan to use some of the "normalizing" strategies discussed to address for this issue in my patients
■ Woo hoo! Thank you for your expertise...there is hope!
■ Ask more specific questions regarding women's sexuality and difficulties with sex
■ Ask if any problems with sexual drive or function with most patients
■ Rule out medical issues and/or psychological issues that may be affecting sexual functioning/desire
■ Plan on referring more patients as needed to sex therapist/counselor