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Talking about sexuality with the physician: are patients receiving what they wish?

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Summary

QUESTIONS UNDER STUDY/PRINCIPLES: Little is known concerning patients' expectations regarding sexual history taking by doctors: to ascertain expectations and actual experience of talking about sexuality among male patients attending outpatient clinics, and their sexual behaviour.
METHODS: Patients consecutively recruited from two outpatient clinics in Lausanne, Switzerland were provided with an anonymous self-administered questionnaire. Survey topics were: patients' expectations concerning sexual history taking, patients' lifetime experience of sexual history taking, and patients' sexual behaviour.
RESULTS: The response rate was 53.0% (N = 1452). Among respondents, 90.9% would like their physician to ask them questions regarding their sexual history in order to receive advice on prevention (60.0% yes, 30.9% rather yes). Fifteen percent would be embarrassed or rather embarrassed if asked such questions. Nevertheless, 76.2% of these individuals would like their physician to do so. Despite these wishes, only 40.5% reported ever having a discussion "on their sexual life in general" with a doctor. Only one patient out of four to five was asked about previous sexually transmitted infections (STIs), the number of sexual partners and their sexual orientation.
No feature of their sexual life distinguishes those who had discussed sexual issues with a doctor from those who had not, except a history of previous consultation for health problems related to sexuality. Conversely, being embarrassed about conducting this discussion was significantly associated with lack of discussion regarding sexuality.
CONCLUSIONS: This study highlights the gap existing in the field of STI prevention in terms of doctors' advice and patients' wishes.

Key words: *sexual history taking; patients' expectation; counselling; primary health care; sexually transmitted infections (STI)*

Introduction

The importance of family practitioners in preventing sexually transmitted infections (STIs) has been emphasised for many years. The spread of HIV/AIDS has dramaticallyincreased the need for family practitioners to inquire into their patients' sexuality and STI prevention. Furthermore, the incidence of many STIs, after a period of decline, is rising in Europe [1].
In many countries health authorities and medical associations recommend physicians to be proactive in this field by educating and counselling their patients, supporting them in their efforts to remain in good health, investigating their exposure to risk, screening for STIs, treating diagnosed disorders, and preventing STI transmission to others [2–4]. In Switzerland, individual prevention advice is an essential component of the National AIDS Prevention Strategy [5], and it is expected that physicians will identify patients at risk of STIs and offer them advice on prevention.
Nevertheless, physicians often do not take sexual histories from their patients [6–14]. Barriers reported by physicians concerning this issue include insufficient training, lack of time, patients' embarrassment, fear of intrusion or inadequacy, gender and cultural factors. Physicians assume reluctance on the patients' part [15, 16]. Little is known concerning patients' expectations regarding sexual history taking and preventive advice.
In 2005–2006 we conducted a study in the two main outpatient clinics of Lausanne, in the French-speaking part of Switzerland, a culturally diverse agglomeration with 330 000 inhabitants of whom some 35% are migrants. The aim was to obtain information on male patients' sexual behaviour, their wishes concerning sexual history taking and

experience with doctors on this topic. The two main outpatient clinics were: 1) the University Department of Ambulatory Care and Community Medicine, a primary care setting for general practitioners (GPs) training in a multicultural context, which includes five units (general internal medicine consultation, medical emergencies, travel medicine/vaccines, anonymous HIV testing, and dental) and 2) a private medical outpatient clinic with an emergency department and five practising GPs.

This article focuses on the concordance between patients' expectations regarding sexual history taking and actual experience of such discussions with a physician. It also identifies features associated with never having had such a discussion.

Methods

A consecutive recruitment survey was conducted among all male patients aged 18–70 who attended the two main outpatient clinics in Lausanne from October 2005 to February 2006. Patients were excluded if they were severely ill, psychologically disturbed, illiterate, or unable to understand one of the questionnaire languages (Albanian, English, French, German, Italian, Portuguese, Serbo-Croat, Spanish, and Turkish). The questionnaire was pre-tested for cultural adaptation with experts in each of the languages. The anonymous self-administered questionnaire was supplied by clerical staff before the medical visit (in travel/vaccine clinics and emergencies) or by the doctor (in general consultation and dental clinics) or nurse (in the HIV anonymous testing clinic) after the consultation, with a short briefing on the study. Patients mailed the completed questionnaires directly to the research team. The total number of consultations with male patients and reasons for not offering the questionnaire were recorded to ascertain non-participation.

The main topics addressed were:

– Patients' expectations regarding sexual history taking by doctors
– Patients' lifetime experience of sexual history taking
– Patients' sexual behaviour

On their expectations regarding sexual history taking, patients responded to the following questions: "Would you find it normal for a doctor to ask you questions on your sexual life?" and "Would you wish your doctor to ask you this type of question in order to give you advice that is better adapted to your circumstances?" Patients were also asked whether they would feel embarrassed about discussing sexuality with a physician (yes, rather yes, rather no, no).

We explored patients' experience of sexual history taking with the following question: "Which of the following issues have you already discussed with your doctor?" Proposed response modalities were: your sexual history in general; the number of sexual partners you have had; protection against sexually transmitted diseases; protection against unwanted pregnancy (contraception); your partners' gender (women, men); previous history of sexually transmitted diseases. For these items response modalities were yes/no.

We also investigated sexual behaviour, defined as: with a stable partner, with casual partners, and with sex workers (SW). Concurrent relationships during the last twelve months were also examined. A variable was constructed to analyse the potential risk of exposure to an STI: "patients at risk" were defined as those that had not systematically used condoms with casual partners in the last 6 months, or those that had not used a condom during the last intercourse with a paid partner in the last 12 months.

The variable "had never discussed sex-related matters with a physician" (none vs at least 1 topic) was built using the question "Which of the following issues have you already discussed with your doctor?" Those answering "no" to all topics were coded 1 and 0 otherwise (see table 1).

Patients who had never discussed sex-related matters with a physician were compared with those who had done so in a bivariate analysis using Pearson's chi-square. Alpha level was .05 without Bonferroni correction [17].

We then used multiple independent variables logistic regression to identify the features associated with never having discussed sexual topics with a physician (dependent variable "had never discussed sexuality with a physician" [none vs at least 1 topic]).

Variables included were: recruitment site (recruited from the HIV anonymous testing clinic/all other departments), age (modelled as linear age, age squared, and age cubed to account for possible non-linear effects), origin (Swiss/other), declared religion (none/any religion), education (vocational training/less/further education), living situation (alone/with a partner), age at first intercourse (below 16/16 and over), ever had same sex intercourse (yes/no), number of partners in the last 12 months (continuous), any casual sexual partners in the last 6 months (yes/no), paid for sex in the last 12 months (yes/no), sexual concurrency in the last 12 months (yes/no), sexual risk behaviour (yes/no), ever been paid for sexual intercourse (yes/no), ever tested for HIV (yes/no), any STI symptoms in the last 12 months (yes/no), feel informed on AIDS (well/poorly), feel informed on STI (well/poorly), patient's embarrassment about discussing sexual topics (yes/no), and patient's expectation regarding sexual history taking (yes/no). A total of 389 respondents (26.8%) who had missing information on one or more of the variables were excluded from this analysis by listwise deletion.

This study has been approved by the Ethics Committee of the University Hospital Centre of the Canton of Vaud (CHUV), Lausanne, Switzerland.

Results

The response rate was 53% (N = 1452). Respondents did not differ from the total eligible in age (mean 37.6/37.7), and the Swiss were only slightly overrepresented compared to non-Swiss respondents (69.6%/65.1%).

More than nine out of ten patients (95.0%) reportedly found it normal for a doctor to ask them questions on their sexual history in order to receive counselling (63.4% yes and 31.5% rather yes) and 90.9% would like their physician to do so (60.0% yes, 30.9% rather yes). Moreover, 59.8% think this should be done at the first appointment as a part of medical history taking.

85% of respondents would be embarrassed not at all or not very if asked such questions by their physician; 15% would be rather embarrassed or embarrassed. Despite their embarrassment, three out of every four patients that reported feeling embarrassed (76.2%) would like their physician to ask them about their sexuality.

Despite these wishes, fewer than half of respondents reported ever having experienced a discussion “on their sexual life in general” with a doctor. Only one in four to one in five patients were asked about previous STIs, the number of sexual partners, and their sexual orientation (table 1).

More than one-third had never discussed a sexual topic with a physician. A total of 19.6% had discussed only one sexual topic, 13.3% two, 10.5% three, 8.3% four, and 9.3% at least five.

We compared patients’ wishes concerning sexual history taking and their experience of ever having discussed at least one sexual topic with a physician (table 2).

For more than half of the patients there was concordance on sexual history taking during the medical encounter and their wishes, i.e. desiring discussion of sexuality with a physician and the fact that they had ever experienced such a discussion. However, for more than one third of the patients there was discrepancy between their wishes to discuss sexuality with a physician and their experience (never had experienced such a discussion). Only 4.7% had experienced the opposite.

Bivariate analysis indicates that having never talked of sexuality with a physician was more frequent in patients who reported no wish to do so, who reported feeling embarrassment about doing this, those that had never had intercourse with a man, those that reported no intercourse with casual partners in the previous 6 months and no intercourse with an SW in the previous 12 months, those with no concurrent relationship in the last 12 months, patients with no STI symptoms in the last 12 months, and patients who reported never having had an HIV test. Other variables associated with the likelihood of never having a discussion on sexuality in a medical consultation were: department in which patients received the questionnaire, questionnaire completed in language other than French, religion, and a poor self-assessed level of information on STIs (table 3).

Origin, educational level, current living situation and sexual risk behaviour were not significantly associated with the likelihood of never having discussed sex with a physician (table 3).

Table 3 shows characteristics associated with not having had any discussion on sexual topics during a medical encounter. After checking for sample design we found, as expected, a highly significant association with features relating to consultations where sexuality was necessarily discussed: patients that had not experienced STI symptoms in the last 12 months (OR 2.4) and had never been tested for HIV (OR 2.9) were more likely to have never discussed sexual topics with a physician. Patient embarrassment about discussion of sexual topics (OR 1.7) and a self-estimated poor information level on STIs (OR 1.5) were also associated with never having had a sexual history taking.

We found no association with expectations concerning sexual history taking or with demographic characteristics and never having discussed sexual topics with a physician. Nor did we find an association with an indicator of sexual behaviour.

Discussion

Our study, conducted among male patients attending the two main outpatient clinics of Lausanne, shows that patients expect to discuss sexuality with their doctor. Despite this expectation, only a minority reported having experienced sexual history taking, thus highlighting many missed opportunities for prevention.

The vast majority of the patients wish their physicians to be interested in their sexual life and desire to receive counselling. Moreover, many patients consider that this issue should be addressed at the very first clinic visit.

Only a minority of patients reported feeling embarrassed about discussing sexuality; among those that did report em-

Table 1: Proportion of patients ever having discussed sexual issues with a physician (n = 1433*).

Topics discussed	**%**
Your sexual life in general	40.5
Protection against sexually transmitted diseases	39.6
Previous history of sexually transmitted diseases	26.6
The number of sexual partners	19.5
Protection against unwanted pregnancy	19.3
The gender of your partners	18.4
At least one of these topics	61.0
None of these topics	39.0

*19 patients with no response to the six topics were excluded.

Table 2: Concordance between patients’ wishes about discussion on sexual topics and patients’ experience of discussing on at least one sexual topic with a doctor.

Ever having discussed a sexual issue with a physician	**Would you wish your doctor to ask you questions on your sexual life?**		
	No or rather no	**Yes or rather yes**	**Total**
	%	**%**	**%**
Yes (one topic at least)	4.7	56.2	60.9
No	4.4	**34.7**	39.1
Total	9.1	90.9	100.0

n = 1430

Table 3: Proportion of patients never having discussed sexual issues with a doctor and predictors of this situation.						
Characteristics	**n**	**Never discussed sexual issue with a doctor %**	**p***	**Sig.**	**OR Adj.**	**CI 95.0%**
Socio-demographic characteristics						
Dept. in which patient received the questionnaire			0.04	.01		
Anonymous HIV testing in the public clinic (ref.)	247	37.7			1.00	
Dental clinic in the public clinic	45			0.93	0.96	0.42–2.20
Medical emergencies in the public clinic	129	38.0		0.12	0.63	0.35–1.12
General consultation in the public clinic	141	34.0		0.03	0.51	0.28–0.94
Travel medicine in the public clinic	458	41.9		0.59	0.89	0.59–1.35
Emergency dept. in outpatient private clinic	302	43.0		1.00	1.00	0.63–1.58
Private group medical practice	111	26.1		<0.01	0.37	0.19–0.71
Age						
Mean (in years)	1418	37.4†	0.80	0.99	1.00	0.74–1.36
Squared				0.93	1.00	0.99–1.01
Cubed				0.83	1.00	1.00–1.00
Origin			0.06			
Swiss	992	37.3			1.00	
Other	427	42.6		0.09	1.31	0.96–1.77
Religion			<0.01			
Any religious affiliation	1112	40.6			1.00	
None	299	31.1		0.11	0.76	0.55–1.06
Educational level			0.45			
Compulsory school or vocational training	485	40.2			1.00	
Technical school or university	936	38.1		0.77	1.05	0.78–1.40
Current living situation			0.08			
Living with a partner	744	41.1			1.00	
Living alone with or without partner elsewhere	670	36.6		0.29	1.18	0.87–1.61
Sexual behaviour						
Age at first sexual intercourse			0.20			
<16 years	251	34.7			1.00	
16 years and more	1120	39.0		0.78	1.05	0.73–1.52
Ever had same sex sexual intercourse			<0.01			
Yes	162	29.0			1.00	
No	1236	39.6		0.35	1.25	0.79–1.98
Casual sexual partner(s) in the last 6 months			<0.01			
Yes	447	31.3				
No	922	41.3				
Ever been paid for sexual intercourse			0.09			
Yes	49	26.5				
No	1303	38.5				
Number of sexual partners in the last 12 months			0.11			
Mean (number)	1372	2.6‡		0.77	1.00	0.96–1.03
Sex. intercourse with a SW in the last 12 months			0.05			
Yes	172	31.3			1.00	
No	1175	39.3		0.45	1.21	0.74–1.96
Sexual risk behaviour			0.28			
Yes (no condoms with casual partners or SW)	191	35.1			1.00	
No (no occas. partner/SW or always condom use with them)	1222	39.2		0.57	0.88	0.57–1.37
Concurrent partnership during the last 12 months			<0.01			
Yes	356	31.2			1.00	
No	925	41.9		0.16	1.32	0.90–1.94
Symptoms of STIs during the last 12 months			0.01			
Yes	121	28.1			1.00	
No	1236	39.5		**<0.01**	**2.41**	**1.42–4.08**
HIV test, patients' expectations, information						
Ever been tested for HIV			<0.01			
Yes	913	30.9			1.00	
No	496	52.8		**<0.01**	**2.59**	**1.92–3.49**

Patient's embarrassment in discussing sexual topics			<0.01			
Yes	215	51.6			1.00	
No	1215	36.8		**0.01**	**1.69**	**1.13–2.52**
Wish to be asked questions by the doctor about his sexual history			0.02			
Yes	1300	38.2			1.00	
No	130	48.5		0.33	1.27	0.79–2.04
Patient's estimation about his level of information on AIDS			0.04			
Well or rather well informed	1263	38.9			1.00	
Poorly or rather poorly informed	104	49.0		0.34	1.30	0.76–2.21
Patient's estimation about his level of information on STIs			<0.01			
Well or rather well informed	606	35.0			1.00	
Poorly or rather poorly informed	805	42.0		**0.01**	**1.48**	**1.10–2.00**

* Pearson's Chi-square by bivariate cross tables, except for mean age and mean number of partners in the last 12 months, where the t-test was used.
† Mean age in the group 'ever had such a discussion': 37.6.
‡ Mean number of partners in the group 'ever had such a discussion': 3.1.
For each modality of categorical variables, we report the number involved. Of this number, the proportion who have never discussed sexual issues with a doctor are reported. The Chi-square relates on the cross table 'To have had such a discussion or not'.
Note: Non responses have been omitted.

barrassment the majority wished physicians would take the initiative to do so anyway. These findings diverge from the view that patients are reluctant and embarrassed to talk about sexuality. Patients' willingness to be asked about sexuality has been observed in other studies [18, 19] . In a study among civilians in the United States, Gerbert et al. [20] found that only 7% reported that they would be unwilling to answer a physician's questions about their sexual behaviour, and 67% would be very comfortable talking with their physician about AIDS.

In spite of this favourable context, two out of every five patients have never had the opportunity to talk about sexuality during a medical encounter. Moreover, while sexual history taking should explore all dimensions of sexuality [21], this study showed that it was frequently incomplete [12–17, 21, 22]. Similar observations can be found in other studies. This confirms that sexual history taking may be performed more or less in depth and that, if too superficial, it may not elicit the information needed for appropriate counselling of patients [8, 10, 23, 24].

Some obstacles are regularly evoked by physicians to explain their apparent disinterest in their patients' sexuality. In particular, they are afraid of generating embarrassment among their patients if they broach topics of a sexual nature, or feel they should know the patient well before discussing such issues. In an Australian study among GPs, Temple-Smith reported that two out of every five doctors are of this opinion [25]. Other studies reported similar findings. Our study does not support this fear of embarrassing the patient. Moreover, patients are prepared to discuss sexuality at the first consultation. However, in this respect, Marwick [26] reports the result of a survey among the general US population, which establishes that two-thirds of the patients are afraid to embarrass their physician by talking about their sexual problems. Consequently there are a range of obstacles on the side of both doctor and patient that result in a situation of 'missed appointment' where each waits for the other to take the initiative.

In our study, being embarrassed in such a discussion was significantly associated with the lack of discussion regarding sexuality, despite the fact that the majority of embarrassed patients want a discussion. Reported by a minority of patients, this discomfort may be perceived by the doctors and may result in the physician refraining from evaluating the patient's sexual history.

Conversely, other than having previous consultations for health problems related to sexuality (HIV test, STI symptoms during the last twelve months), no feature of patients' sexual life distinguished those who had discussed sexual issues with a doctor from those who had not. Patients who considered their knowledge of STIs poor were more likely to report the absence of such a discussion. These findings may suggest that doctors have been unable to detect situations in which there is a need for advice on prevention.

The study has several limitations. The data collection was carried out using a self-administered questionnaire, which excluded persons with a low level of literacy and, consequently, the population most likely to be marginalised. The response rate is not high but is reasonable in a study not using reminders to improve the response rate. However, respondents did not differ from the eligible population in age or origin (Swiss versus migrants). Moreover, the response rate may be negatively affected by the staff's unawareness of the patients' literacy level: patients with low literacy may have been given the questionnaire and failed to mention their inability to participate.

In conclusion, our study highlights the existing discrepancy in the field of STI prevention advice by doctors concerning actual practice and patients' wishes. Since the incidence of STIs is increasing and sexual health is more readily recognised as a fundamental component of overall health, there is a need to include sexual history taking in routine evaluation by primary care physicians. Our study indicates that the integration of routine sexual history taking in the medical encounter is not only a theoretical standard advocated by the health authorities and medical associations, but also a response to the majority of patients' real expectations.

Given the leadership role that patients frequently attribute to physicians in organising the consultation, it appears essential to better inform practitioners concerning their patients' expectations. This would enable them to take the initiative in discussing sexuality, given that there is a strong likelihood that their patients desire this discussion. In this regard, a further study of obstacles as perceived by physicians (including TARMED pricing of this medical procedure) would provide needful information on what should be

changed to allow physicians to better focus on their patients' sexuality in history taking.

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