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CLINICAL PEARL

Let's Talk about Sex

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Despite the fact that some 30 or 40 percent of adult men and women, respectively, experience sexual problems that negatively affect their quality of life [1, 2], most clinicians seem to be less than adept at obtaining a sexual history and discussing sexual health. Most likely, this is due to poor training, as evidenced by one nationwide survey, which found that 44 percent of medical schools lacked formal training in how to obtain a sexual history [3]. Further complicating matters in many instances is health professionals' lack of understanding about the psychosocial and sexual issues particular to the lesbian, gay, bisexual, transgender, queer, questioning, and intersex community (LGBTQI).

Though most understand the many advantages of taking a sexual history, some physicians object to spending time discussing sex-related topics, claiming it is uncomfortable for both patient and practitioner and takes time away from "real" medical topics. Not infrequently, however, medical concerns are linked to sexual health, which can be both an indicator of otherwise unnoticed medical conditions or itself significantly affected by lifestyle behaviors (e.g., smoking) and health conditions (e.g., diabetes, hyperlidemia) and their treatments. Hence, failure to inquire about sexual health may allow important medical issues to go unnoticed. Moreover, accurate knowledge of a patient's behaviors provides relevant and useful advice about disease screening and individualized counseling about risk reduction.

Laying the Groundwork: Good Communication

Effective communication is fundamental to taking a sexual history. While merely asking patients about their sex-related activity sounds simple enough, basic principles for good communication must be employed in discussing sensitive issues.

Ensuring a private setting is essential. Others should be asked to leave the room. A request from the clinician is more likely to guarantee privacy than asking the patient if he or she wants others—which could include family members, sexual partners, and other intimates—to leave. If the patient allows anyone to stay, he or she may withhold information or lie outright; if the patient asks them to leave, it could cause tension or suspicion between them. Not only does the physician's making the request remove that burden from the patient and reduce the likelihood of uncomfortable situations in the exam room, it contributes to an environment of trust and communicates the physician's commitment to serve as the patient's advocate.

Inform the patient that some sensitive and deeply personal questions are about to be asked and explain why they are important (e.g., "I ask these questions of all my patients so that I can provide the most individual and complete care for them"). Ask the patient whether he or she has any questions before you begin and remind the patient that all information is strictly confidential and only available to the patient and care providers. At this point, a patient might say, "I don't see how my sex life has anything to do with my high blood pressure" (or other condition), and you can explain how it may or how, conversely, blood pressure may affect sexual desire.

How the question is phrased is as important as the question itself. One possible misstep in this area is the leading question. A question like "You're not sexually active, are you?" implies the clinician anticipates or even prefers a negative answer, either in the hopes of shortening an uncomfortable discussion or because of moral beliefs or expectations about the patient. No matter the reason, the phrasing communicates discomfort with the topic or with possible answers. Physicians' discomfort can present a real obstacle to good treatment; in a 1992 survey of more than 3,000 men and women aged 18 to 59, 68 percent of respondents reported they would not bring up sexual topics for fear of embarrassing their doctor [2].

If the patient gives an incomplete or untrue response out of a desire to smooth things over, make the situation easier for the physician, or avoid judgment, potentially critical information is lost. The patient should not have to factor the physician's feelings into deciding how to answer such questions; it is the clinician's responsibility to set the tone and put the patient at ease, not vice versa. Neutral introductory questions include "Are you currently sexually active?" and "Have you been sexually active in the past?" A time reference (e.g., "in the past year") avoids ambiguity about what constitutes being "currently" sexually active.

Topics to Cover

Determining the number and sex of sexual partners helps establish risk for specific STIs. Clinicians frequently make the mistakes of assuming heterosexuality (e.g., asking a teenage boy, "Do you have a girlfriend?"), and subtly communicating negative beliefs about homosexuality with questions like, "You're not gay, are you?" This can be particularly damaging to teenagers and others who are still exploring their sexuality. If patients sense that their doctors harbor bias or prejudice towards members of the LGBTQI community, they understandably may be unable to be honest, for fear of mistreatment. Moreover, the use of labels can compromise the efforts of the most well-intentioned physician. The process of determining one's sexual identity is a deeply personal, and sometimes fraught, experience. Even if the clinician uses these labels in a nonbiased, nonjudgmental way, patients may not identify with particular categories or labels (e.g., a male patient who has sex with men but may not consider himself gay). Using labels has no value in the medical risk assessment, but can absolutely alienate patients.

To learn about the sex of a patient's partners, begin by asking "Do you have sex with men, women, or both?" This allows the patient to answer without being assigned a

specific label. Second, identifying the number of sexual partners, both current and past within in the last year, is useful for understanding risk-behavior. The precise number of partners (e.g., six rather than seven) is less important than establishing the level of risk associated with the behaviors. So if a person tells you he or she has been sexually active during the last year, you might ask, “What have your relationships been with your sexual partners?”

The assessment of specific sexual practices is the area that has the greatest potential to cause discomfort among clinicians. Asking “What kind of sexual contact do you have?” avoids making assumptions and minimizes embarrassment for both parties. But the clinician must be able to adjust these follow-up questions based on the patient’s answers about partners. To assess practices adequately, it is necessary for health professionals to have some basic understanding of what kinds of sexual behaviors are likely to occur among particular populations. The sexual practices of men who have sex with men (MSM) are quite different from those of women who have sex with women (WSW). For example, a MSM should be asked about oral and anal intercourse practices. High-risk sexual behaviors are common with MSM, especially during periods of sexual identity discovery when social networks may not yet be in place to provide guidance. For WSW, it is important to ascertain whether sex toys are shared, especially when educating patients about the need for regular screening for cervical cancer.

Next, the patient should be asked about current and past sexually transmitted infections (STIs). A history of STIs indicates prior high-risk activity and may point to current risks. Further, understanding what STIs the patient has or had, whether they sought medical care before the current visit, and what, if any, treatment was administered provides the clinician with a more complete picture of the patient’s current health and future risks (e.g., the development of neurosyphilis years after an initial poorly treated syphilis infection). And it facilitates both the dispensing of advice and screening for recurrence or complications of STIs. For women in particular, an untreated STI or infected partner increases risk for pelvic inflammatory disease and future fertility problems.

Asking patients about how they protect against STIs and, when relevant, pregnancy, completes an assessment of their risks. For patients who report use of methods intended to prevent pregnancy, STIs, or both, this time serves as an opportunity to evaluate the patient’s adherence to safe sex practices and knowledge of appropriate use. Surprisingly, not everyone knows how to use condoms, dental dams, or oral contraceptives properly. Determine whether there are any barriers to the patient’s access to the desired prevention strategy. If a clinician has personal moral or religious objections to supplying condoms, oral contraceptives, and other safe sex supplies, particularly to certain types of patients, it is incumbent on him or her to refer those patients to a colleague or clinic where they may receive the medical care they desire.

Conclusion

A fundamental principle of sexual history taking, not to mention patient interaction in general, is to approach patients in the manner in which you would wish to *be* approached. Many people become understandably uncomfortable, upset, or offended when asked deeply personal questions by a clinician whom they perceive to be judgmental or disrespectful. Asking questions in an unbiased, compassionate way will not only result in the collection of better and more complete information and lead to more thorough care, but will enhance trust and satisfaction in the patient-physician relationship.

References

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Further Reading

American Medical Student Association (AMSA) Web site. http://www.amsa.org. Accessed July 19, 2010.

Centers for Disease Control and Prevention. A guide to sexual history taking. http://www.cdc.gov/std. Accessed July 19, 2010

Gay and Lesbian Medial Association (GLMA) Web site. http://www.glma.org. Accessed July 19, 2010.

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