

# HIV Risk Assessment

## Physician and Patient Communication

In this issue of the *Journal*, Gerbert and colleagues discuss the evidence for HIV transmission via oral sex, the difficulties in interpreting these data, and counseling strategies that can be used in the primary care setting.<sup>1</sup> The evidence and its interpretation are described thoroughly, as are counseling strategies for changing behavior. We believe that further discussion of counseling strategies, however, is prudent. In particular, we focus on two areas: the discomfort providers and patients experience when discussing sexual matters; and the complex process of changing behavior that starts with the provider's risk assessment, continues with a discussion about the patient's apparent risk and ends with the patient's decision to change or not change behavior.

The first area that deserves more comment is discomfort. Not all health care providers feel comfortable speaking to patients about a subject as private as oral sex. Patients are usually uncomfortable as well, if not more so, and therefore, they are likely to sense the provider's discomfort. Practical methods for alleviating the discomfort are available.

Physicians who have been trained in human sexuality and in taking sexual histories are likely to be more at ease with assessing their patients' sexual risk.<sup>2</sup> Workshops on these topics are offered at many regional and national conferences by primary care professional organizations. For those who cannot attend these workshops, new technologies such as interactive videodisks and CD-ROMs or experiential activities such as role playing may provide alternative methods for becoming more comfortable discussing private sexual matters with patients.<sup>3,4</sup>

Several office-based cues may notify patients that their provider is comfortable discussing patients' concerns about sexual risk.<sup>5</sup> Written materials and condoms should be available in the public areas of the office or in the examination rooms and restrooms where patients can pick them up privately. Local health departments, medical societies, and community-based organizations often produce written information that is culturally and visually suitable for this purpose. The intake questionnaire that patients complete in the waiting room also can state that patient questions about HIV-related risk are welcome and that the provider usually does a sexual risk assessment. These structural cues may go a long way toward re-

ducing the discomfort patients experience when initiating or entering into discussions of sexual risk.

Verbal cues also reduce discomfort. Simple, nonjudgmental questions are, perhaps, the most important verbal cue. For example, one might ask, "Do you have sex with men, women, or both?" rather than asking, "You aren't gay, are you?"; or one might ask, "Have you ever put your penis in someone's mouth" rather than asking, "Have you ever been fellated?" Patients' expressions of surprise, humor, discomfort, and even disgust should not be unexpected, nor should they be curbed (unless inappropriate).

The second area that deserves more comment is the complexity of the process of changing behavior. This process begins, in the case of HIV risk behavior change, with risk assessment. Risk assessment should involve the identification of the potential adverse effects and the potential benefits associated with an activity. As practiced, however, risk assessment typically entails quantifying the probability of experiencing an adverse effect.<sup>6</sup> This quantitative measure of "risk," however, does not incorporate beliefs that make an individual seek or avoid particular types of behavior, regardless of the adverse effects or the benefits. Qualitative factors enter into the decision-making process that are unique to each individual. Therefore, although quantifying the probability of an adverse effect is necessary for decision making, it is not sufficient. Hard science must be coupled with personal values, which leads to the next step in the process—communicating with the patient about the risk behavior.

Traditionally, risk communication has been a message that is developed by technical experts and addressed to uninformed nonexperts. This model of risk communication is familiar to most clinicians and accurately describes the primary care clinician's longtime role in risk assessment. As Gerbert and colleagues point out, clinicians would serve their patients better by engaging in an interactive process that emphasizes the exchange of information. The interaction should include messages about the nature of risk as well as expressing concerns, opinions, or reactions to risk messages. As these authors clearly state, successful risk communication ensures that the patient will understand what is known about the health implications of the available options and will make an informed decision. This type of risk communication goes beyond a discussion of the odds to explore personal beliefs and values that affect how much risk an individual is willing to assume. In this new model, risk communication raises the level of understanding so the patient is adequately informed within the limits of available knowledge.<sup>6</sup>

The realities of primary care practice in an era of cost containment, however, make prolonged communication impractical and other resources can be used. AIDS hotlines have been established across the United States, in-

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cluding the Centers for Disease Control National AIDS Clearinghouse (1-800-458-5231). These resources are useful for identifying further information, counseling services, and HIV antibody testing sites.<sup>7</sup> In many areas, a search in the telephone book under the entry "AIDS" will produce useful resources for patients. Administrative systems should facilitate referrals and a team approach to HIV prevention by helping to connect patients with nurses, community health educators, and other health professionals. The primary care provider can refer patients for more counseling concerning HIV risk, just as providers refer patients for help with smoking cessation, nutritional counseling, and fitness programs.

Clinicians should not be discouraged if risk communication does not always lead to the intended change in behavior. Communication is only a small part of risk assessment, which is necessary but not sufficient to produce a change in behavior. Risk communication can help reduce risk in a gradual and appropriate way, producing sustained behavior changes, rather than abrupt changes that tend to be abandoned. Because people attach different values to life's activities and risk, patients' decisions regarding risk taking are not always the ones that the health care provider favors. Patients nevertheless deserve the opportunity to make decisions regarding their own health with the help of information that only health care providers can give them. HIV risk reduction is a complex topic, involving both self-protection and responsibility toward others. The ethical dilemmas faced by patients differ depending partly on their HIV status. Similarly, the ethical dilemmas faced by the clinician differ depending on whether or not the patient's behavior places others at risk.<sup>8</sup>

Most of the guidelines used by health care professionals to provide risk assessment for their patients produce a degree of uncertainty. Recommendations of changes in exercise and diet do not guarantee a good outcome or an improvement in health. Rather, following these guidelines only

improves the chances for a positive health outcome. Most practitioners acknowledge this limitation and still feel comfortable with their risk assessments. However, the same uncertainty can cause the provider to feel uncomfortable when providing risk assessments for HIV transmission. In sharing the reasons for this uncertainty, the provider can encourage the patient to participate in the risk assessment process. Only an open, interactive dialogue will help patients assess their risks for HIV infection and thus help them prevent HIV transmission.—**JOSHUA SCHECHTEL, MD**, and **THOMAS COATES, PhD**, *University of California, San Francisco Center for AIDS Prevention Studies*; **KENNETH MAYER, MD**, *Department of Medicine and Community Health, Brown University School of Medicine, Providence, RI*; and **HARVEY MAKADON, MD**, *Department of Medicine, Beth Israel Deaconess Medical Center, Boston, Mass.*

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