Briefs

Sexual Health Risk Assessment and Counseling in Primary Care: How Involved Are General Practitioners and Obstetrician-Gynecologists?

Nancy Haley, MD, FRCP(C), Brigitte Maheux, MD, PhD, Michèle Rivard, ScD, and André Gervais, MD, FRCP(C)

ABSTRACT

Objectives. This study examined physicians' evaluation of sexual health risks during a general medical examination and sexually transmitted disease (STD) counseling during consultations for adolescent contraception and treatment of an STD.

Methods. An anonymous mail survey was conducted in 1995 with a stratified random sample of 1086 general practitioners and all 241 obstetrician-gynecologists practicing in Quebec, Canada.

Results. Fewer than half of the respondents reported routinely inquiring about condom use and number of sexual partners during a general medical examination. Female general practitioners engaged in more sexual health risk assessment and counseling than male general practitioners.

Conclusions. This study suggests a low level of involvement in STD prevention by generalists and obstetrician-gynecologists. (*Am J Public Health.* 1999;89:899–902)

Sexually transmitted diseases (STDs) are important causes of pelvic inflammatory disease, infertility, ectopic pregnancy, and neonatal morbidity in North America.[1] Each year, more than 12 million cases of STDs occur in the United States, and infections are occurring at younger ages than in the past.[2,3] The advent of HIV has added an incurable infection to the long list of preventable STDs.[3]

Risk behaviors associated with STDs are present in a large segment of the population. A recent survey found that 11% of heterosexual adults reported having multiple sexual partners and using condoms inconsistently.[4] Another study showed that at-risk sexual behaviors are frequent among college and university students, with 65% of sexually active male students and 47% of sexually active female students having had 3 or more partners and more than 15% of respondents having engaged in anal intercourse.[5] Only a minority of these students used condoms most of the time or always.[5]

The general medical examination provides an ideal occasion for physicians to assess a patient's sexual risk behaviors and provide individualized STD prevention counseling. During recent years, several guidelines have been developed to promote sexual history taking during medical visits.[6–8] Surveys of physicians show, however, that fewer than half assess sexual history during a general medical examination of a new adult patient and that only a minority report assessing specific STD/HIV risk behaviors.[9–11] Physicians have many opportune occasions to provide patients with sexual health counseling, such as during consultations for contraception or STD treatment, yet little is known about their preventive practices during these visits.

This study of general practitioners and obstetrician-gynecologists examined (1) physicians' practices and perceived barriers regarding assessment of sexual history during a general medical examination and (2) their counseling about STD prevention during specific consultations for adolescent contraception and treatment of an STD.

Methods

Data are presented from a 1995 anonymous mail survey conducted in the province of Quebec, Canada. Physicians' demographic and professional data were provided by the Collège des médecins du Québec. To be included in the study population, physicians had to be general practitioners or obstetrician-gynecologists, active in patient care, licensed subsequent to 1964, and French speaking. The survey involved a stratified random sample of 1111 general practitioners and all of the province's obstetrician-gynecologists (n = 241). Twenty-five general practitioners could not be located, reducing the number of general practitioners contacted to 1086. Overall, 963 physicians returned their completed questionnaires. Response rates for the 805 general practitioners and 158 obstetrician-gynecologists were 74% and 66%, respectively.

Nancy Haley is with the Department of Pediatrics, Université de Montréal, and the Direction de la santé publique de Montréal-Centre, Montreal, Quebec, Canada. Brigitte Maheux is with the Department of Social and Preventive Medicine, Université de Montréal, and the Direction de la santé publique de Montréal-Centre. Michèle Rivard is with the Department of Social and Preventive Medicine, Université de Montréal. André Gervais is with the Department of Medicine, Université de Montréal, and the Direction de la santé publique de Montréal-Centre.

Requests for reprints should be sent to Nancy Haley, MD, FRCP(C), Direction de la santé publique, Unité Maladies infectieuses, 1301 Sherbrooke St E, Montreal, Quebec, Canada H2L 1M3.

This paper was accepted December 16, 1998.

Editor's note. Please see related editorial by Van Devanter (p 815) in this issue.

TABLE 1—Percentage of Physicians Who Routinely Assess the Sexual History of Adult and Adolescent Patients During a General Medical Examination, by Physicians' Gender and Specialty: Quebec, Canada, 1995

Sexual History Item	General Practitioners: Men (n = 311), %	General Practitioners: Women (n = 436), %	General Practitioners: *P*	Obstetrician-Gynecologists: Men (n = 105), %	Obstetrician-Gynecologists: Women (n = 43), %	Obstetrician-Gynecologists: *P*	Specialty Differences (*P*): Men	Specialty Differences (*P*): Women
With adult patients								
Contraception method	37	69	<.0005	79	82	.70	<.0005	.07
Condom use	22	39	<.0005	47	48	.91	<.0005	.27
No. of sexual partners	16	35	<.0005	23	30	.39	.11	.45
STD risk of partners	17	29	<.0005	28	23	.54	.01	.37
Sex of partners	15	20	.05	17	23	.43	.57	.71
History of sexual abuse	2	3	.70	2	0	.36	.89	.28
With adolescent patients								
Sexual activity	47	71	<.0005	53	79	.003	.32	.24
Contraception method	67	81	<.0005	87	88	.82	<.0005	.24
Attitudes concerning condom use	29	46	<.0005	50	49	.90	<.0005	.67
History of sexual abuse	6	4	.14	7	2	.28	.81	.62

Note. Routine assessment was defined as assessment involving 90% or more of patients.

Among generalists, more women than men responded.

Data were collected via a self-administered pretested questionnaire consisting mainly of closed-ended questions. In answering the questionnaire on their practices, physicians had to refer to their most recent 6 months of practice. Sexual health risk assessment was measured by asking physicians to indicate, on a 4-point scale, the percentage of adult patients (aged 19–55 years) and adolescent patients with whom they assessed selected sexual history items during a general medical examination: 25% or less, 50%, 75%, or 90% or more (the last category constituted the study definition of routine assessment). Respondents were also asked, through 8 closed-ended questions, why physicians in general would not assess sexual history during a general medical examination. Physicians' counseling practices in regard to STD prevention were measured in the context of 2 frequent clinical situations related to sexual health: an adolescent presenting for contraception and an adult consulting for an STD. Again, physicians were asked to refer to their most recent 6 six months of practice.

The practices of physicians are reported according to respondents' gender and specialty. Given the sample design for general practitioners, weights that took into account probability of sampling were used in deriving estimates for male general practitioners and for female general practitioners. The Pearson χ^2 test was used to determine whether there were practice differences according to gender and specialty.

Results

Examination of respondents' demographic and professional characteristics showed, as expected, that female physicians in both specialties were younger than male physicians and that female generalists were more likely than male generalists to have a salaried practice in a local community health care center. There was also a tendency for female obstetrician-gynecologists to be more involved in obstetrical care than their male colleagues.

Sexual History Taking

Contraception was the sexual health topic most frequently reviewed by physicians in a general medical examination; fewer than half of general practitioners and obstetrician-gynecologists reported that they routinely inquire about condom use and about number, gender, and STD risk of sex partners (Table 1). Respondents reported rarely screening for a history of sexual abuse during general medical examinations with either adult or adolescent patients.

Physicians' gender was a more important variable in terms of sexual risk assessment than their specialty. Among general practitioners, women inquired more frequently than men about method of contraception, condom use (including attitudes toward condom use), and number, gender, and STD risk of sex partners. Sexual risk assessment practices of female general practitioners were similar to those of male and female obstetrician-gynecologists.

The reasons most cited by respondents that physicians do not take a sexual history during a general medical examination were the assumption that the patient was not at risk for STDs and physicians' reported personal or perceived patient discomfort with the subject. Difficulty knowing how to ask questions about sexual history appropriately, fear of offending patients, and lack of time were reported by more than half of physicians. Fear of being accused of sexual misconduct was the least-cited reason, and this issue concerned more male physicians than female physicians.

Counseling About STD Prevention

More than 80% of physicians reported routinely discussing the importance of regular vaginal cytology during consultations about contraceptives with adolescents, but fewer physicians reported talking about STD prevention (Table 2). Female general practitioners discussed with adolescents perceptions about condoms and their benefits and the frequency of STDs among youth more readily than their male colleagues. There was little evidence that obstetrician-gynecologists provided more counseling than general practitioners during consultations about contraceptives with adolescents.

The percentages of general practitioners and obstetrician-gynecologists who reported routinely discussing various aspects of STD prevention during an STD consultation averaged about 80% for treatment and notification of sexual partners, 60% for barriers to condom use, 40% for HIV screening, and 20% for hepatitis B vaccination (Table 2). Among general practitioners, women brought up partner treatment and notification and patient barriers to condom use more readily, while male generalists discussed hepatitis B vaccination more frequently. Except for notification of partners, counseling provided for an STD patient did not differ in comparisons of the practices of general practitioners and obstetrician-gynecologists.

Discussion

This study shows that while most physicians review a patient's method of contracep-

TABLE 2—Percentage of Physicians Who Routinely Provide Counseling About STD Prevention During Consultations for Adolescent Contraception and STD Treatment, by Physicians' Gender and Specialty: Quebec, Canada, 1995

Sexual Health Topic	General Practitioners			Obstetrician-Gynecologists			Specialty Differences (*P*)	
	Men (n = 306), %	Women (n = 440), %	*P*	Men (n = 107), %	Women (n = 46), %	*P*	Men	Women
During an adolescent contraceptive consultation								
Importance of regular vaginal cytology	81	83	.53	87	85	.73	.19	.78
Benefits of consistent condom use	48	66	<.0005	52	61	.33	.39	.53
Perceptions about condom use	21	30	.01	33	30	.78	.02	.89
Frequency of STDs among youth	37	49	.0007	40	35	.53	.52	.06
Consequences of STDs for women's health	39	41	.48	39	46	.46	.93	.57
High-risk sexual practices	31	33	.49	36	37	.86	.37	.61
During an STD consultation								
Treatment of sexual partners	79	86	.007	81	87	.35	.63	.86
Notification of sexual partners	66	76	.004	78	78	.97	.02	.72
Difficulties concerning regular condom use	55	62	.05	60	72	.15	.39	.19
Screening for HIV infection	39	44	.16	44	30	.11	.34	.08
Hepatitis B immunization	19	14	.05	22	15	.33	.55	.83

Note. Routine provision of counseling was defined as counseling involving more than 90% of patients.

tion as part of the general medical examination, only a minority of general practitioners and obstetrician-gynecologists routinely discuss condom use and barriers (fewer than 50%) and number, gender, and STD risk of partners (fewer than 35%). This finding supports earlier studies noting poor integration of sexual history during general medical examinations[9–16] and suggests that improvement among physicians is needed in the area of STD prevention. History of sexual abuse is rarely assessed during a general medical examination, despite its prevalence in the population[17] and its association with substantial psychosexual, psychosocial, and medical morbidity.[18]

In this study, the major reasons given for not reviewing sexual history were the assumption that patients were not at risk for STDs and physician discomfort and perceived patient discomfort with discussing sexuality. If these are major barriers, then increasing physicians' awareness of the prevalence of risk behaviors in the patient population and fostering better training in sexual history taking may improve physicians' involvement in STD prevention.

Visits for oral contraception are one of the most frequent adolescent consultations, and physician-delivered information about STD prevention at this time is especially relevant.[19,20] The present study suggests that more should be done to take advantage of this clinical visit to provide adolescents with counseling on STD prevention. Similarly, a visit for STD treatment offers physicians an important counseling opportunity, since patients presenting with a sexual health problem may be more receptive to individualized preventive messages.

In this study, physicians' gender appeared to be a more important predictor of sexual risk assessment and counseling than their specialty. Our finding that female general practitioners integrate preventive screening and provide counseling more readily than male physicians supports the results of other studies.[9,21,22] The increasing feminization of general medical practice should have a positive impact on the amount and quality of sexual health assessment and counseling provided in general practice. Obstetrician-gynecologists in our study did not appear to be more involved in sexual health evaluation than female generalists. This is unsettling, since many women of childbearing age have an obstetrician-gynecologist as their primary care provider and major source of sexual health information.

Our results reflect the screening practices of general practitioners and obstetrician-gynecologists in Quebec. There is, however, little reason to believe that the findings would be very different elsewhere in Canada or in the United States. Although there are differences in the specifics of health care delivery systems that may affect the delivery of preventive health services, reasons given by physicians for not assessing their patients' sexual history related more to issues of medical training than to organizational factors.

This study suggests that despite an ongoing STD epidemic during the last 2 decades, physicians' practices in regard to sexual health risk assessment and counseling do not appear to be improving. Sexual history is still not taken routinely during a general medical examination, and minimal STD prevention counseling is given during consultations relating to sexual health. Physicians' underestimation of patient risk behaviors and their continuing discomfort when discussing sexuality merit increased attention by medical educators. □

Contributors

N. Haley and B. Maheux contributed to conception and realization of the project, analysis and interpretation of the data, review of the literature, and writing of the paper. M. Rivard contributed to analysis and interpretation of the data and revision of the paper. A. Gervais contributed to development of the questionnaire, interpretation of the data, and revision of the paper.

Acknowledgments

This study was supported by a grant from the Fonds de la recherche en santé du Québec.

We would like to thank the Collège des médecins du Québec for its assistance in the sampling of physicians, Sylvie Desjardins and Michèle Paré for their collaboration in data collection and data analysis, and Sylvie Gauthier for reviewing the manuscript. We are also deeply grateful to all of the physicians who agreed to participate in the survey.

References

1. Kassler WJ, Cates W Jr. The epidemiology and prevention of sexually transmitted diseases. *Urol Clin North Am.* 1992;19:1–12.
2. Yankauer A. Sexually transmitted diseases: a neglected public health priority. *Am J Public Health.* 1994;84:1894–1897.
3. Aral SO, Holmes KK. Epidemiology of sexual behavior and sexually transmitted diseases. In: Holmes KK, ed. *Sexually Transmitted Diseases.* New York, NY: McGraw-Hill Book Co; 1990: 19–36.
4. Catania JA, Binson D, Dolcini M, et al. Risk factors for HIV and other sexually transmitted diseases and prevention practices among US heterosexual adults: changes from 1990 to 1992. *Am J Public Health.* 1995;85:1492–1499.
5. MacDonald NE, Wells GA, Fisher WA, et al. High risk STD/HIV behavior among college students. *JAMA.* 1990;263:3155–3159.
6. Centers for Disease Control and Prevention. 1998 guidelines for treatment of sexually transmitted diseases. *MMWR Morb Mortal Wkly Rep.* 1998;47(RR-1):1–116.

7. Social and Sexual Issues Committee. Committee opinion—sexual health counselling by physicians. *J Soc Obstet Gynecol Canada*. 1996;18:1160.
8. Canadian Task Force on the Periodic Health Examination. HIV antibody screening. *Can Med Assoc J*. 1992;147:867–876.
9. Boekeloo BO, Marx ES, Kral AH, Coughlin SC, Bowman M, Rabin DL. Frequency and thoroughness of STD/HIV risk assessment by physicians in a high-risk metropolitan area. *Am J Public Health*. 1991;81:1645–1648.
10. Maheux B, Haley N, Rivard M, Gervais A. STD risk assessment and risk-reduction counseling by recently trained family physicians. *Acad Med*. 1995;70:726–728.
11. Centers for Disease Control and Prevention. HIV prevention practices of primary-care physicians—United States 1992. *MMWR Morb Mortal Wkly Rep*. 1994;42:988–993.
12. Lewis C, Freeman HE. The sexual history-taking and counseling practices of California primary care physicians. *West J Med*. 1987;147:165–167.
13. Boekeloo BO, Rabin DL, Coughlin SS, Labbok MH, Johnson JC. Knowledge, attitudes, and practices of obstetricians-gynecologists regarding the prevention of human immunodeficiency virus infection. *Obstet Gynecol*. 1993;81:131–136.
14. Calabrese LH, Kelley DM, Cullen RJ, Locker G. Physicians' attitudes, beliefs, and practices regarding AIDS health care promotion. *Arch Intern Med*. 1991;151:1157–1160.
15. Wenrich MD, Curtis JR, Carline JD, Paauw DS, Ramsey PG. HIV risk screening in the primary care setting: assessment of physicians' skills. *J Gen Intern Med*. 1997;12:107–113.
16. Gemson DH, Columbotos J, Elinson J, et al. Acquired immunodeficiency syndrome: prevention knowledge, attitudes, and practices of primary care physicians. *Arch Intern Med*. 1991; 15:1102–1108.
17. MacMillan HL, Fleming JE, Trocmé N, et al. Prevalence of child physical and sexual abuse in the community. *JAMA*. 1997;278:131–135.
18. Green AH. Child sexual abuse: immediate and long-term effects and intervention. *J Am Acad Child Adolesc Psychiatry*. 1993;32:890–902.
19. *Proceedings of the National STD Consensus Meeting and National Goals for the Prevention and Control of Sexually Transmitted Diseases in Canada*. Ottawa: Health Canada; 1997.
20. Gully P. Chlamydial infection in Canada. *Can Med Assoc J*. 1992;147:893–896.
21. Woodward CA, Hutchison BG, Abelson J, Geoffrey N. Do female primary care physicians practise preventive care differently from their male colleagues? *Can Fam Physician*. 1996;42: 2370–2379.
22. Maheux B, Haley N, Rivard M, Gervais A. Do women physicians do more STD prevention than men? Quebec study of recently trained family physicians. *Can Fam Physician*. 1997; 43:1089–1095.

Involving Men in Reproductive Health: The Young Men's Clinic

Bruce Armstrong, DSW, Alwyn T. Cohall, MD, Roger D. Vaughan, DrPH, McColvin Scott, MD, Lorraine Tiezzi, MS, and James F. McCarthy, PhD

ABSTRACT

Objectives. This report describes the population of young men who use the Young Men's Clinic in New York City, presents a profile of their reproductive behaviors, and describes the clinic's model of service delivery.

Methods. Data were gathered through a routine clinic visit form administered by clinic staff.

Results. The clinic sees approximately 1200 predominately Dominican young men each year for a wide range of clinical and mental health services. Two thirds of clients had ever been sexually active, three quarters had ever used birth control, and 69% had used birth control at their last sexual encounter.

Conclusions. The Young Men's Clinic may serve as a model for health care delivery to adolescent and young adult males. (*Am J Public Health*. 1999;89:902–905)

In recent years, efforts to target and address the reproductive health needs of young men have increased,[1–3] although few of these service programs have been sustained.[4] This is unfortunate, because adolescent and young adult males represent the other half of the equation for the reproductive health problems affecting millions of young people each year, and they may serve as vectors for possible solutions to many of these problems.

There are many reasons for the lack of sustained development of affordable, developmentally and culturally appropriate reproductive health programs for men, as well as for men's reluctance to approach available services. Adolescent males typically see themselves as too old for the pediatrician but too young for the internist. Because they are young, many are uninformed about how to gain access to health care on their own or are reluctant to do so because of embarrassment or cultural proscriptions that equate seeking help with inappropriate masculine behavior. Moreover, unlike females who must visit a reproductive health care provider for most contraceptive methods, males may perceive fewer reasons to use reproductive health care. Even young men who are sufficiently motivated to gain access to reproductive health services face formidable structural barriers to receiving care, and health care staffs are often inadequately trained to address the needs of adolescent and adult young men.[5]

As a result of both individual and environmental factors, young men often wait a long time before seeking needed reproductive health services. The consequences of this inattention and the magnitude of the reproductive health diseases experienced by US adolescents and young adults are enormous, and

Bruce Armstrong, Roger D. Vaughan, Lorraine Tiezzi, and James F. McCarthy are with the Center for Population and Family Health, Joseph L. Mailman School of Public Health of Columbia University, New York, NY. Alwyn T. Cohall is with St. Luke's–Roosevelt Hospital, Joseph L. Mailman School of Public Health of Columbia University, and the Harlem Center for Health Promotion and Disease Prevention, New York, NY. At the time of the study, McColvin Scott was with St. Luke's–Roosevelt Hospital.

Requests for reprints should be sent to Roger D. Vaughan, DrPH, Center for Population and Family Health, J. L. Mailman School of Public Health, Columbia University, 60 Haven Ave, Level B-2, New York, NY 10032.

This paper was accepted January 27, 1999.