Original article

Attitudes to taking a sexual history in general practice in Victoria, Australia

M J Temple-Smith, G Mulvey, L Keogh

Objective: To examine general practitioners' (GPs') attitudes towards taking a sexual history.
Methods: Questions on sexual history taking were included in a random survey on the STD knowledge, attitudes, and practices of 600 GPs practising in Victoria, Australia.
Results: Most GPs commonly asked patients about safe sex (79%), number of sex partners (63%), and injecting drug use (60%) while fewer asked about recent overseas travel (50%) and sex with sex workers (31%). GPs who performed sexual health consultations daily or weekly identified barriers to sexual history taking to be of less concern than those who performed such consultations infrequently. Most GPs (92%) would take a sexual history from a man presenting as the sexual contact of an infected partner, but less than a third would do so for a patient routinely requesting the contraceptive pill (28%), a Papanicolaou (Pap) smear (30%), or advice about immunisation before overseas travel (30%). Female GPs were significantly more likely than male GPs to take a sexual history in those clinical situations involving a female patient and also to perceive these patients as experiencing less embarrassment.
Conclusions: This study highlights both the lack of opportunistic sexual history taking and the main barriers to sexual history taking in general practice in Victoria, Australia. The importance of educating both patients and GPs about sexual history taking are discussed.
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Keywords: general practitioners; sexually transmitted diseases; health services

Introduction

General practitioners (GPs) who are not thorough in assessing behaviour which places their patients at risk of sexually transmissible diseases (STDs) may underdiagnose, misdiagnose, or mistreat these diseases. Unless a GP has special training or interest in STDs, however, he or she may not feel confident of assessing a patient's STD risk status, particularly if the patient presents with unrelated problems.[1 2] Yet general practice offers many opportunities for practitioners to discuss STD/HIV prevention in consultations which relate to other sexual health issues such as Papanicolaou (Pap) smears or pelvic examinations, or in consultations where other risk taking behaviours such as alcohol and drug use are discussed. There is evidence to suggest that patients do not object to discussing their sexual behaviour with the GP[3] yet one US study showed that only 11% of doctors routinely assess patients for behaviours which may place them at risk of STDs.[4]

Although it appears that sexual health caseloads of Australian practitioners are increasing,[5] little is known about the frequency of sexual history taking in the general practice setting. A number of barriers to sexual history taking in general practice have been identified. These include a low priority of disease prevention, time constraints, fear of patient embarrassment, insufficient training, fear of intrusion, age and sex of patient relative to that of the practitioner, cultural differences, and patient's offending behaviours.[1 2 6 7] To quantify the extent to which these barriers exist in the general practice setting, questions on sexual history taking were included as part of a larger study of their knowledge, attitudes, and behaviours in relation to STDs.

Methods

A random sample of 600 GPs residing in Victoria was drawn by the Australian Medical Publishing Company's national database of medical practitioners. Low activity GPs (fewer than 1500 consultations per annum) and those over 65 years of age were excluded from the study. A subsample of 40 GPs was used in the pilot study. Of the remaining 560 GPs, 40 were excluded because the doctor was on extended leave or was unable to be contacted at the address provided. Thus, 520 GPs were sent a questionnaire and received a telephone call alerting them to its imminent arrival.[8] GPs were offered continuing medical education points as an incentive to participate. Two attempts were made to follow up non-responders.

The 52 item questionnaire included questions on clinical features of STDs, investigations, treatment, public health issues, epidemiology, and demographic information. This paper discusses responses to the sexual history taking questions only. Results from other parts of the survey are reported elsewhere.[9–11]

Our earlier qualitative research identified the range of barriers to sexual history taking experienced by Victorian GPs.[2] In the present quantitative study, GPs were asked to what extent they considered each barrier to be a problem. Also included were questions on the likelihood of the GP asking about five different risk behaviours, the likelihood of the GP taking or updating a sexual history, and the level of embarrassment they believed a patient would

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Table 1 Frequency (No (%)) of asking about potential risk behaviours

Behaviour	Frequency of inquiring about each behaviour		
	Very common	*Medium*	*Not common*
Having safe sex (n=442)*	350 (79)	53 (12)	39 (9)
Having a number of sex partners (n=442)	279 (63)	102 (23)	61 (14)
Injecting drug use (n=442)	266 (60)	125 (28)	51 (12)
Recent overseas travel (n=442)	220 (50)	143 (32)	79 (18)
Having sex with sex workers (n=440)	136 (31)	129 (29)	175 (40)

*Denominator variations from 444 are because of missing values.

feel if a sexual history was requested. SPSS was used to generate descriptive statistics. The χ^2 statistic was used as a measure of association between dependent and independent variables. A p value of less than 0.05 was considered significant.

Results

The response rate for the survey was 85% (444/520), of which 73% were male GPs, and 27% female GPs. Two thirds (68%) of respondents were employed in group practice; nearly a quarter (23%) worked in solo practice and 9% were employed in other types of practices such as community health centres and extended hours clinics. The majority of respondents (78%) worked in urban areas, while 22% were employed in rural areas.

OPPORTUNITY FOR SEXUAL HISTORY TAKING OR SEXUAL HEALTH PROMOTION

Two per cent of respondents diagnosed STDs daily, 17% did so weekly, 36% monthly, 45% infrequently, and 1% never. These data were corroborated by a second question asking GPs to estimate the number of STDs they had diagnosed in the previous 4 weeks. Fifty eight per cent of GPs said they had diagnosed at least one STD in this period.

The frequency of diagnosing STDs was strongly associated with performing other sexual health practices such as providing safe sex advice, contraceptive advice, and performing Pap smears.[10]

CURRENT SEXUAL HISTORY TAKING PRACTICE

GPs were asked to estimate how commonly they inquired about different behaviours in the case of a patient whom they considered to be at risk of acquiring an STD (table 1). GPs who frequently diagnosed STDs were significantly more likely to ask about safe sex (85% *v* 72%, p<0.001). Rural GPs were less likely than urban GPs to ask patients about numbers of sexual partners (47% *v* 67%, p<0.05), injecting drug use (48% *v* 64%, p<0.05), and sex with sex workers (24% *v* 33%, p< 0.05).

GPs were asked whether they would be likely to take or update a sexual history in four different clinical situations (table 2). Nearly all GPs would take a sexual history from a man presenting as the sexual contact of an infected partner, but less than a third would do so for a female patient routinely requesting the contraceptive pill, a Pap smear, or a male patient requesting advice about immunisation before overseas travel. GPs were also asked how embarrassed they thought patients would be if they took a sexual history in these same clinical situations (table 3).

The relation between embarrassment and likelihood of taking a sexual history was significant in all clinical situations other than the one where the patient presented as the sexual partner of a woman with an infection. Thus, in the case of a woman presenting for a contraceptive pill prescription, doctors who perceived her to be very embarrassed were much less likely to take a sexual history than those who perceived her as not at all embarrassed (10% *v* 53%, p <0.001). Similar significant results were obtained for a woman requesting a Pap smear (8% *v* 55%, p <0.001), and a man requesting immunisation (27 % *v* 48%, p <0.001).

Female GPs were significantly more likely than male GPs to take a sexual history from a female patient presenting for a contraceptive pill prescription (50% *v* 20%, p <0.001) or a Pap smear (45% *v* 24%, p <0.001) (table 4). Female GPs were less likely than their male colleagues to perceive these female patients as quite or very embarrassed (27% *v* 43%, p <0.001, and 25% *v* 40%, p <0.001, respectively). Where the presenting patient was male, significantly fewer male than female GPs perceived the patient as quite or very embarrassed (30% *v* 53%, p <0.001 for a man requesting immunisation advice and 10% v 27%, p <0.001 for a man with a girlfriend with a vaginal infection). Despite this perception,

Table 2 Likelihood (No (%)) of taking a sexual history

Presentation	Likelihood		
	Very likely	*Medium*	*Not at all likely*
A 32 year old man presents because his girlfriend has a vaginal infection (n=443)	409 (92)	29 (7)	5 (1)
A 45 year old man requests advice about immunisations before going to Bali (n=443)	135 (30)	162 (37)	146 (33)
A 26 year old woman presents for a routine Pap smear (n=443)	131 (30)	152 (34)	160 (36)
A 24 year old woman presents for a routine pill prescription (n=443)	126 (28)	150 (34)	167 (38)

Table 3 Patient's level of embarrassment as perceived by GP (No (%))

Presentation	Patient's level of embarrassment		
	Very embarrassed	*Medium*	*Not at all embarrassed*
A 32 year old man presents because his girlfriend has a vaginal infection (n=441)	66 (15)	125 (28)	250 (57)
A 45 year old man requests advice about immunisations before going to Bali (n=442)	162 (37)	173 (39)	107 (24)
A 26 year old woman presents for a routine Pap smear (n=442)	159 (36)	148 (33)	135 (31)
A 24 year old woman presents for a routine pill prescription (n=442)	173 (39)	146 (33)	123 (28)

Table 4 Sex differences in the likelihood of taking a sexual history and perception of the patient's level of embarrassment

Sexual history taking behaviour	*Male*	*Female*	*p Value*
Likelihood of taking a sexual history for (% very or quite likely):			
24 year old woman, routine pill prescription	65/321 (20)	61/121 (50)	0.000
26 year old woman, routine Pap smear test	77/321 (24)	54/121 (45)	0.000
45 year old man, immunisation before Bali	96/321 (30)	38/121 (31)	0.662
32 year old man, partner has infection	292/321 (91)	116/121 (96)	0.088
GPs' perception of patient's level of embarrassment for (% very or quite embarrassed):			
24 year old woman, routine pill prescription	139/320 (43)	33/121 (27)	0.000
26 year old woman, routine Pap smear test	128/320 (40)	30/121 (25)	0.000
45 year old man, immunisation before Bali	97/320 (30)	64/121 (53)	0.000
32 year old man, partner has infection	32/319 (10)	33/121 (27)	0.000

male GPs were no more likely to take a sexual history from these patients than their female colleagues.

BARRIERS TO SEXUAL HISTORY TAKING

GPs identified on a six point scale the extent to which they saw various factors as barriers to taking a sexual history (table 5). Male GPs were significantly more likely to find the first consultation to be a barrier than female GPs (44% *v* 36%, p <0.05), while female GPs were significantly more likely to rate the patient's being of the opposite sex as a barrier (22% *v* 10%, p <0.001). Knowing a patient outside the surgery was more likely to be perceived as barrier to sexual history taking by urban than rural GPs (40% *v* 28%, p <0.05). Doctors who had completed a continuing medical education course on STDs were significantly less likely to find the first consultation (30% *v* 45%, p <0.001) or the patient being of the opposite sex (8% *v* 15%, p <0.05) to be a barrier to taking a sexual history.

OTHER ISSUES

Less than a quarter of the GPs mostly or always discussed with the patient whether or not to record the patient's sexual history in their notes (13%), who would handle and transport pathology specimens (12%), and who has access to the patient's medical file and test results (24%). The desirability of excluding a third party in consultations was mostly or always discussed with the patient by 39% of GPs.

Although the majority of respondents felt comfortable treating an STD in a patient regardless of whether the patient was heterosexual (94%), a homosexual man (74%), or a lesbian (75%), a few felt very uneasy (1%, 7%, 5%) respectively.

In relation to strategies to overcome barriers to sexual history taking, almost all GPs (97%) believed they would give patients leaflets on STDs if they were provided with them, although only 26% currently always or mostly did so. While the majority of respondents supported the concept of appropriate posters in the waiting room (54%) or consulting room (54%), significantly more female GPs (64%, 63%, p<0.05) did so. Seventy five per cent of respondents agreed that a prompt sheet or routine checklist would assist them in taking a sexual history.

Table 5 Barriers to sexual history taking (No (%))

Factors	*Proportion of GPs who perceived the factor as a major barrier*		
	Males	*Females*	*p Value*
Presence of a third party	233/320 (73)	89/121 (74)	0.876
Issues related to language	176/316 (56)	70/120 (58)	0.611
First consultation with patient	142/320 (44)	43/120 (36)	0.034
Know patient outside of surgery	109/320 (34)	53/121 (44)	0.113
Issues related to culture	119/320 (37)	38/121 (31)	0.519
Not enough time	82/319 (26)	41/119 (34)	0.076
Patient of opposite sex	33/320 (10)	26/121 (22)	0.000
An age difference between GP and patient	26/320 (8)	19/121 (16)	0.063
Fear of uncovering a difficult problem	10/319 (3)	7/121 (6)	0.435

Discussion

In Australia, while patients with STDs may seek treatment from a variety of health services, the two major providers of sexual health services are GPs and sexual health clinics.[12] The sexual health clinic offers anonymity for the patient as well as specialist attention and free treatment. In such a clinic, both patient and practitioner have similar expectations about the need for discussion of the patient's sexual history.

This is not the case in general practice. This study found 39% of GPs thought that their patient would be very embarrassed if they were to take a sexual history. Our results show that although GPs are unlikely to take a sexual history from a young woman asking for a pill prescription or a Pap smear, they are very likely to do so for a man who states that his partner has an STD, indicating that GPs feel more confident about taking a sexual history where the need to do so is obvious to the patient. Finding an acceptable way of making the patient aware of the need for sexual history taking is therefore a key to facilitating the role of the GP as a case finder.

Nearly half of the respondents believed that the first consultation with a patient was a difficult context in which to ask about sexual issues. It is likely that a factor contributing to this is the length of the standard consultation which allows insufficient time to take a sexual history, especially as sexual topics are often raised by patients towards the end of a consultation.[2] This may be particularly the case in a bulk billing or extended hours clinic where there is likely to be more pressure to keep consultations brief.

Our past research has shown that many GPs see their lack of training as a major barrier to taking a sexual history from a patient.[2] This, coupled with the infrequent STD consultations experienced by many GPs,[10] may serve to compound their lack of confidence in this area.

In Australia, the teaching of sexual health to medical undergraduates has not been consistent.[12] While it is tempting to recommend that all GPs be encouraged to seek further education to improve their sexual history taking skills, the reality is that there will always be some doctors for whom such sexual discussion is uncomfortable, and others with a patient profile that does not include many patients at STD risk. Improving sexual history taking in a GP who finds it difficult to discuss sexuality involves a major behaviour change that may be difficult to achieve. There may be some advantage in offering GPs the option of referral of patients thought to be at risk of

STDs to GP colleagues with a special interest in STDs. While it is true that such patients could simply be referred to sexual health clinics, not all patients feel comfortable with this alternative, particularly in rural areas where the sexual health clinics are less accessible.

There has been little research published examining the contexts in which patients feel comfortable discussing their sexual history and until this is done alternative ways of sensitising the patients to the need for a sexual history should be sought. One possible facilitator could be the display of posters advertising the importance of sexual behaviour to the patient's overall health, and suggesting the GP may ask the patient about this during the consultation.[13] This could alert the patient to the possibility of the practitioner inquiring about their sexual health. It additionally offers the GP an opening statement such as "Did you notice the poster about sexual health in the waiting room?" This strategy was judged as having potential by GPs in this study. Research to evaluate the usefulness of such facilitators for GP sexual history taking are urgently needed.

New ways need to be found of informing both patient and practitioner of the importance of the sexual history. Ideally, this would involve a combination of practice based strategies as well as targeted community education highlighting risk behaviours and the need for screening. In this way doctors would not carry all of the responsibility for initiating discussion in this sensitive area.

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