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Sexual Health Discussions with Older Adult Patients During Periodic Health Exams

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Abstract

Introduction—Sexual health is an integral part of overall health across the lifespan. In order to address sexual health issues, such as sexually transmitted infections (STIs) and sexual functioning, the sexual history of adult patients should be incorporated as a routine part of the medical history throughout life. Physicians and healthcare professionals cite many barriers to attending to and assessing the sexual health needs of older adult patients, underscoring the importance of additional research to improve sexual history taking among older patients.

Aim—The purpose of this paper is to explore the content and context of physician-patient sexual health discussions during periodic health exams (PHEs) with adults aged 50–80 years.

Methods—Patients completed a pre-visit telephone survey and attended a scheduled PHE with their permission to audio-record the exam. Transcribed audio recordings of 483 PHEs were analyzed according to the principles of qualitative content analysis.

Main Outcome Measures—Frequency of sexual history taking components as observed in transcripts of PHEs. Physician characteristics were obtained from health system records and patient characteristics were obtained from the pre-visit survey.

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Results—Analyses revealed that approximately one-half of the PHEs included some discussion about sexual health, with the majority of those conversations initiated by physicians. A two-level logistic regression model revealed that patient-physician gender concordance, race discordance and increasing physician age were significantly associated with sexual health discussions.

Conclusion—Interventions should focus on increasing physician self-efficacy for assessing sexual health in gender discordant and race/ethnicity concordant patient interactions. Interventions for older adults should increase education about sexual health and sexual risk behaviors, as well as empower individuals to seek information from their health care providers.

Keywords

sexual health; older adults; sexual history; and patient-physician communication

Introduction

Many older adults continue to be sexually active throughout their lives. In fact, 73% of persons aged 57–64 years and 53% of persons aged 65–74 years reported that they were sexually active in the previous year.[1] Several positive outcomes are associated with sexual activity during late adulthood, including increased quality of life and maintenance of healthy personal relationships.[2] However, the risk for sexually transmitted infections (STIs), including human immunodeficiency virus (HIV), is a concern among aging populations. Older adults are more likely to have limited knowledge about STIs and HIV[3] and less likely to practice safe sex than younger adults, which makes them particularly vulnerable to STIs.[4–7] Indeed, the number of persons aged 50 years and older living with HIV/AIDS has increased in the last decade and accounts for 15% of new HIV/AIDS diagnoses[8], which will likely continue to increase with a growing aging population.[8,9] Healthcare providers must be prepared to identify individuals at risk and screen accordingly to prevent disease morbidity and mortality.

HIV and STI prevention and control guidelines require a comprehensive sexual history, emphasizing the need for all adult patients to be advised about STI risk and ways to reduce that risk.[10,11] This includes inquiry about sexual activity and related behaviors that may indicate risk—number of sexual partners, frequency of sexual intercourse, injection drug use, sexual orientation, types of sex, history of STIs, and sexual abuse. Despite these recommendations, rates of sexual history taking remain suboptimal[12,13], particularly among older adults.[14] A recent study revealed that few men (38%) and even fewer women (22%) had discussed sex with a physician since age 50.[1] Also, a survey of 135 primary care physicians found that 60.8% of physicians rarely or never discuss HIV/AIDS with patients over the age of 50, whereas 72% of them regularly discuss HIV risk factors with individuals under age 30.[15]

Sexual health is an integral part of overall health; therefore, the sexual history of patients is an important aspect of patients' medical history. Nonetheless, researchers find that healthcare providers underestimate the prevalence of their patients' sexual concerns,[16] often equating sexual health needs with younger people and expressing discomfort with discussing sexual health with their older patients.[17] In fact, research has shown increasing age to have

an inverse relationship with documented sexual history.[20] Gott, Hinchliff and Galena[18] found that practitioners' beliefs about sexual behaviors of older adults were based on stereotypes of aging and sexuality, rather than experience with patients. Wimberly and colleagues[13] report that although most of the physicians in their study conveyed feeling comfortable taking sexual histories, sexual histories were seldom part of their routine and preventive healthcare exams. Furthermore, many physicians missed essential components of comprehensive sexual history taking, including history of STIs, gender of sexual partners over a lifetime, and sexual behaviors.[19] Loeb and colleagues[20] found that the strongest demographic factor associated with a documented sexual history was patient age. Specifically, increasing age had an inverse relationship to documented sexual history.[20]

Physicians taking comprehensive sexual histories also serve to enhance quality of life among older adults by identifying sexual concerns. Sexual dysfunction is common among older adults—approximately 25% for men and 47% for women[1]—especially those with chronic medical conditions.[21] Furthermore, patients prompted by their healthcare provider are more likely to report issues with sexual functioning,[14,22] which makes communication with healthcare providers that much more important.

Our understanding about how older adults and healthcare providers engage in dialogue about sexual health is limited. To date, most studies regarding sexual history taking have relied on self-report measures, standardized patients, and chart reviews, with no studies identified that have directly investigated the dialogue between healthcare providers and older patients during routine health exams. An exploration of physician-patient sexual health discussions during periodic health examinations (PHE) may help with the development of more effective interventions to increase screening and testing for at-risk older adults. By doing so, we can determine the frequency of sexual history taking and content that is most commonly addressed/neglected; and begin to understand how healthcare providers and their older adult patients participate in sexual health conversations.

Aims

The purpose of this paper is to explore the content and context of physician-patient sexual health discussions during periodic health exams (PHE). Specifically, we posed the following questions: "At what frequency are components of sexual history taking addressed?", and "What patient, physician and visit factors contribute to sexual history taking?". This study fills a gap in the literature wherein few examples of direct observations of physician-patient discussions about sexual health exist.

Method

This paper reports data collected from a larger study of patient–physician decision making and colorectal cancer screening.[23,24] The Institutional Review Boards of Virginia Commonwealth University and the Henry Ford Medical Group approved the study protocol. Informed consent was obtained from all participants (patients and physicians).

Study Setting and Sample

Family and general internal medicine physicians located in Detroit and the surrounding suburbs were identified using an integrated delivery system, which includes a 1000-member, medical group that staffs 26 clinics. Patients of study-participating physicians were eligible to participate if they were insured by a health system–affiliated HMO for the past 5 years, aged 50–80 years and due for colorectal cancer screening at the time of a scheduled PHE. Data collection occurred from February 2007 to June 2009. Study recruitment has been described previously.[23,24]

PHEs are appropriate to assess sexual history taking, because a sexual history is necessary to determine the need and frequency of Papanicolaou testing for cervical cancer, STI testing, and sexual performance. Approximately 20% of the U.S. population receives a PHE each year.[25] Importantly, patients agree that discussion of health habits and risk factors should occur during a PHE along with a physical examination and various health-screening tests.[26]

Main Outcome Measures

Patients completed a pre-visit telephone survey and attended a scheduled PHE with their permission to audio-record the office visit. Prior to the exam, patients were asked to complete a survey about their demographic information and various patient-reported health factors. Physician demographics were obtained from medical group records. Audio recordings were used to capture patient-physician communication during the PHE. For the purpose of this paper, only data regarding sexual health is discussed.

Data Analysis

Transcribed audio recordings of the PHE were analyzed according to the principles of qualitative content analysis.[27,28] Data analysis started with computer-assisted searches for occurrences of sexual health topics using words such as sex, partner, and protection. Frequency counts were calculated. Components of sexual history taking were derived from sexual history-taking literature,[19,29] including guidelines from the CDC and USPSTF for sexual history and HIV counseling.[10,11,30] Items were scored on a yes-no format, with one point being given for a yes on each checklist item to indicate the frequency at which each component was addressed (see Table 1 for coded components).

A systematic classification process of coding and identifying themes relating to sexual health dialogues between patients and physicians was then used to provide a subjective interpretation of the data. Two members of the research team read a subset of the transcripts carefully, highlighting text that described sexual health and noted keywords or phrases that best captured the participants' words. After open coding of forty transcripts, preliminary codes were determined. Two coders reviewed the same subset of interviews to check intercoder reliability and to develop a codebook that would be used for the analysis of all transcribed PHEs, which were used to code the remaining transcripts. New codes were added when data was encountered that did not fit into an existing code. Once all transcripts had been coded, members of the research team examined all data within a particular code. Some codes were combined, whereas others were split into subcategories. Discrepancies

during this process were clarified and resolved by comparing each coder's results with raw data until consensus was reached.

Using Mplus 7.11 software, a two-level logistic regression model was used to determine the relationship between patient, exam, and physician characteristics and sexual health discussions.

Results

Five hundred patients (with visits to 64 primary care physicians) consented to participate in the study; 483 of the office visit recordings were audible. Physician and patient participants/nonparticipants are described in detail elsewhere.[24] The mean age of physicians was 48 years (range: 34.8–57.6), 56% were female and 48% were white, 17% African-American, and 34% other race. Seventy percent were general internists; 30% were family physicians. On average, 7.6 office visit recordings were recorded for each physician (range: 1–20). Overall, 73% of PHEs had patient-physician gender concordance, and 49% of the exams were racially concordant. Patient sociodemographic characteristics are described in Table 2.

Approximately 50% (n =245) of the 483 PHEs had some discussion about sexual health, but only 10% of patients were specifically asked if they were sexually active. Physicians initiated sexual health topics 83.3% of the time. Most sexual health conversations were initiated during the history-taking portion of the exam (69.7%), followed by the physical exam (22.9%) and summary of the exam (7.4%). See Table 3 for sexual health topic frequencies.

Chi-square tests for independence (with Yates Continuity Correction) were used to determine if there were significant differences between sociodemographic characteristics of patients who discussed sexual health with their physicians and those who did not. The only sociodemographic characteristic that was significant was patient's gender, χ^2 (1, n = 483) = 9.02, p = .002, phi = −0.14. Refer to Table 1 for means of sociodemographic characteristics by sexual health discussions. Female patients comprised 71.8% (n=176) of the exams where sexual health was discussed. The most frequently discussed sexual health topic was history of abnormal Pap smears (n=99; 20.5%). Pap history was initiated by the physician 83.8% of the time, which most often occurred during the history-taking portion of the PHE.

The second most common sexual health topic discussed was sexual performance, which happened in 94 PHEs (17.2%). Physicians initiated conversations about sexual performance two-thirds of the time. This topic was most often approached during the history-taking portion of the PHE (64.8%). A Chi-square test revealed that an association between patient gender and whether the patient or doctor initiated conversations about sexual performance approached significance, χ^2 (1, n = 71) = 3.54, p = .06, phi = −0.26. Physician-initiated conversations about sexual performance accounted for 20.5% of sexual health conversations with female patients and 79.5% of conversations with male patients. See Table 3 for sexual performance issues by patients' gender.

Physicians made vague references to sexual health during 4% (n=17) of the PHEs. Vague references included statements such as "is everything ok down there" and "are you having

any vagina problems?" In 4.5% (n=22) of the exams, physicians made a risk statement regarding the patients' sexual health. These statements were mostly directed towards cervical cancer risk (n=16; 72.7%); 18.2% (n=4) of these statements were related to HIV risk. For example, one physician asked, "do you have any HIV risks?" All, but one of the risk statements were made towards women.

A two-level logistic regression model with a random intercept was fit to assess the impact of patient, exam, and physician characteristics on the likelihood that sexual health would be discussed during the PHE, while accounting for the non-independence of samples caused by physicians attending to multiple patients. The level one model included the following patient and exam characteristics: age, marital status, visited physician in previous year, gender, education, race, income, and patient-physician gender and race concordance. Level 2 modeled physician characteristics' effect on the intercept and included: gender, race, specialty and age. Table 5 provides a summary of the model results. Significant patient/exam factors included gender concordance ($p < .01$), race discordance ($p < .01$), and being of "other" race ($p < .01$). Patient's gender (female) and race (Black) approached significance. Physician's age was the only physician characteristic that was significant, $p < .05$; older age was associated with an increase in sexual health discussions. Physician's race (Black) also approached significance.

Conclusions

The present study extends previous knowledge by conducting a qualitative analysis of audio-transcripts to directly examine the content and context of physician-patient sexual health discussions during PHEs. Approximately one-half of the PHEs included discussion about sexual health; the physicians initiated the majority of those conversations. Sexual health discussions occurred more frequently with female patients. Most sexual health conversations with women revolved around cervical cancer screening, whereas men's conversations focused on sexual performance, most commonly erectile dysfunction. Sexual performance conversations with female patients tended to be initiated by the patient, while physicians often initiated these conversations with male patients. This may, in part, explain the lower frequency of sexual performance discussions among older adult females, as patients are more likely to discuss sexual health when the conversation is prompted by the physician.[14,22] Thus, sexual performance concerns among older adult female patients may be more likely to remain undetected and, subsequently, underrepresented.

STIs, including HIV are increasing among older adults, which warrants attention from physicians who are in the position to provide an HIV risk assessment and information. Notably, several recommended sexual health and risk-related topics were infrequently discussed with older adult patients. Overall, only 10% of patients were asked if they were sexually active, and there were no conversations about anal or oral sex. Physicians asked about STIs in approximately 17% of PHEs; however, the most common STIs (e.g., gonorrhea, chlamydia) were discussed least frequently. In addition patients' marital status was not a predictor of sexual health discussions, although these conversations often take place within the context of marital relationships.

The present findings are in agreement with previous studies that have found sexual health discussions between physicians and older adults to be suboptimal.[13,19] Healthcare providers report many barriers to taking a comprehensive sexual history, including inadequate training, insufficient knowledge of sexual health, time constraints, lack of privacy, and personal factors such as age and gender.[20,31,32] Training in this area may significantly improve these outcomes as brief interactive workshops that deliver sexual history and HIV counseling curriculum to medical students have been associated with students asking more thorough sexual histories and providing more HIV counseling.[29]

In attempts to clarify unknown relationships, the present study was able to identify patient and physician-related factors that predict sexual health discussions with older adults, which also can be used to inform future physician training. Factors associated with sexual health discussions in PHEs were gender concordance, race discordance and doctors' age, with older doctors being more likely to discuss sexual health. Patients' race and gender approached significance suggesting that being White and female are associated with engaging in sexual health discussions more often. Given that physician-patient gender and race concordance/discordance predicted sexual health discussions, extra attention should be paid to training medical students to be comfortable in gender *dis*cordant and race *con*cordant patient interactions.

Although this study was unique in offering a direct analysis of physician/patient interactions, it has some limitations, which may limit generalizability. There was a relatively small sample of physicians and most patients had seen their physician previously; it is possible that the physicians had previous sexual health conversations with these patients. However, it should be noted that one's sexual risk can change; thus, ongoing assessment is important. Future research could examine conversations that happen in new patient exams or span multiple visits. Another potential limitation is that audio-transcripts do not allow for analysis of nonverbal communication, which could provide insight into the context of the conversations. Moreover, we do not know to what extent patient's sexual history information is taken during patient intake or what is recorded on their electronic medical record. Future research could also compare transcripts of other types of medical visits in order to understand whether there are certain types of visits that are more likely to spur sexual health discussions. It would also be useful to assess whether physicians provide older adults with written information about sexual health and what information is collected on pre-exam surveys or paperwork.

In conclusion, older adult sexual health is an important area of research and should be a target for public health interventions. This is particularly important given the new HIV/AIDS recommendations that all adults at risk for HIV/AIDS need to be screened.[33] Physicians are in an optimal position to help address sexual risk by taking comprehensive assessments and providing sexual health information to older adults. Both the physician and the patient need to be supportive of sexual health conversations for these conversations to include what is needed for a thorough sexual history. Physician interventions should focus on increasing physician self-efficacy for assessing sexual health in sociodemographic discordant and concordant patient interactions. Interventions for older adults should provide

education about sexual health and risk behaviors, as well as empower individuals to seek information from their health care providers.

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Table 1

Sexual History Taking Components.

Whether patient is sexually active (time since last sexual activity)
Number of current partners
Number of partners in a specific time period (e.g., 6 months/1 year)
Number of partners in lifetime
Frequency of intercourse and/or sexual activity
Gender of current partner
Gender of previous partners in a specific time period
Gender of previous partner(s) in lifetime
Type of sexual behaviors (vaginal, anal, oral)
Partner's sexual history
Condom use and/or safe sex behaviors (e.g., female condom)
Birth Control
History of sexually transmitted infections, general
History of sexually transmitted infections, specific
Issues with sexual well-being
Issues with sexual performance
History of sexual abuse
History of intravenous (IV) drug use
Partner's history with IV drug use.
Other sexual concerns

Table 2

Patient sociodemographic characteristics (N=483), % unless otherwise indicated.

	Total	Sexual Health was Discussed	Sexual Health was Not Discussed
Age in years, M (SD)	59.25 (7.86)	58.53 (7.75)	59.89 (8.64)
Female	65.3	70.6	60.5*
Married	64.7	63.2	66.0
Race			
African American	27.9	29.4	26.6
White	65.5	65.4	65.6
Other	6.6	5.3	7.8
Education			
< High school diploma	4	3.5	4.3
High school diploma	24.3	22.4	26.1
Some college or more	71.7	74.1	69.6
Mean household income ($)			
<20,000	7.9	7.5	8.3
20,000 – 39,999	17.3	18.1	16.6
40,000 – 59,999	21.5	21.2	21.7
60,000 – 79,999	18.4	18.1	18.6
>80,000	34.9	35.0	34.8
Received care from Physician in the last 12 months	82.3	79.6	84.8

Note. M = Mean; SD = Standard Deviation.

* $p < .05$.

Table 3

Frequencies of Sexual Health Topics

Topic	Frequency	Percent
Sexual health was discussed	228	47.1%
Patient is sexually active	51	10.5%
Number of partners	44	9.1%
Current	22	4.5%
Lifetime	10	2.1%
Since last exam	3	0.6%
Last 2–3 years	3	0.6%
Before age 16	6	1.2%
Frequency of intercourse	4	0.8%
Gender of partners, current	17	3.5%
Partner's sexual history	1	0.2%
Condom use	6	1.2%
Family Planning/Birth Control	10	2.1%
Sexually transmitted infections	83	17.4%
General	28	5.8%
Hepatitis	15	3.1%
Herpes	10	2.1%
HPV	8	1.7%
HIV/AIDS	7	1.4%
Genital Warts	5	1.0%
Chlamydia	4	0.8%
Syphilis	2	0.4%
Gonorrhea	2	0.4%
Trichomoniasis	2	0.4%
Sexual performance	88	18.2%
History of physical/sexual abuse	2	0.4%
History of drug use	37	7.6%
Pap history	99	20.5%
Vague reference to sexual health	17	3.5%
Other sexual health topic	76	15.7%
Discharge (in genital area)	31	6.4%
Dryness (in genital area)	10	2.1%

Topic	Frequency	Percent
Bleeding (in genital area)	6	1.2%
Pain (in genital area)	5	1.0%
Itching (in genital area)	4	0.4%
Importance of Pap	12	2.5%
Yeast infection	5	1.0%
Urinary tract infection	2	0.4%
Burning (in genital area)	1	0.2%
Risk statement	22	4.5%

Note. Percentages calculated from total number of PHEs (N=483)

Table 4

Sexual Performance Issues by Patient Gender

Issue	Male Patients		Female Patients	
	Frequency	Percent	Frequency	Percent
Erectile Dysfunction	50	53.2%	1[+]	1.1%
Problems with functioning, unspecified	12	12.8%	5	5.3%
Libido	4	4.3%	6	6.4%
Dryness during sex			10	10.6%
Pain during sex			4	4.3%
Bleeding during sex			1	1.1%
Emotional Duress			1	1.1%

Note. Percentages based off total number of PHEs that discussed sexual performance (N=94).

[+]Conversation was about patient's husband.

Table 5

Two-level linear model predicting sexual health discussion during period health exam.

Level 1	Estimate	Standard Error	Estimated Standard Error	Odds Ratio	Two-Tailed P-Value
Age	−0.016	0.012	−1.375	0.984	0.169
Married	0.029	0.264	0.110	1.030	0.912
Seen physician in previous year	−0.365	0.365	−0.998	0.694	0.318
Gender	−0.578	0.310	−1.863	0.561	0.062
Education					
High School	0.193	0.458	0.422	1.213	0.673
College	0.403	0.495	0.814	1.497	0.416
Race					
Black	−0.404	0.232	−1.741	0.668	0.082
Other	−1.045	0.375	−2.786	0.352	0.005*
Income	−0.017	0.082	−0.207	0.983	0.836
Gender Concordance	1.000	0.314	3.185	2.718	0.001**
Race Concordance	−0.873	0.269	−3.249	0.418	0.001**
Level 2					
Gender	−0.049	0.362	−0.134		0.893
Race					
Black	0.838	0.440	1.905		0.057
Asian	−0.560	0.440	−1.273		0.203
Other	−0.368	0.463	−0.794		0.427
Specialty	−0.106	0.289	−0.367		0.713
Age	0.039	0.019	2.040		0.041*

Note. Level 2 does not include odds ratios because it predicts the effect of the independent variables on the intercept, not the effect of the independent variables on the log odds of discussing sexual health.

* $p < .05$.

** $p < .01$.