Clinical Medicine

The Sexual History-Taking and Counseling Practices of Primary Care Physicians

CHARLES E. LEWIS, MD, ScD, *and* HOWARD E. FREEMAN, PhD, *Los Angeles*

As part of a statewide survey of experiences related to the acquired immunodeficiency syndrome and competencies of a random sample of primary care physicians in California done in early 1986, we interviewed 1,000 internists, family and general practitioners about their sexual history-taking and counseling practices. Less than 4% have patients complete a history form that includes questions about sexual orientation or practices, and only 10% ask new patients questions specific enough to identify those at high risk of exposure to the human immunodeficiency virus. Internists, women and younger physicians and those expressing little discomfort in dealing with gay men more often took adequate sexual histories and gave appropriate advice. Among those physicians with patients at risk of becoming infected, only half recommended the use of condoms and 60% advised a reduction in the number of partners. More than 15% recommended abstention from sexual intercourse, and 8% suggested these patients should switch to a heterosexual life-style.

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Control of the acquired immunodeficiency syndrome (AIDS) epidemic at present depends on preventing infection with the human immunodeficiency virus (HIV) through a reduction in risks of exposure.[1] Various groups are currently engaged in efforts directed at public education and the counseling of well-defined high-risk populations. Little is known, however, about the efforts of practicing physicians in the primary prevention of AIDS.

Primary care providers could play an important role in the struggle to contain AIDS. To do so, however, they must know who among their patients is at risk and how to advise them. This requires that physicians take appropriate sexual histories* and obtain data on other possible exposures through blood products and intravenous drug use. They also must know how to counsel and the relative risk of exposure to HIV in different sexual practices—that is, what constitutes "safer sex."

As part of a survey of the AIDS-related competencies of primary care physicians in California, we inquired about their sexual history-taking practices and their counseling efforts in behalf of patients at risk for AIDS. We report the findings of that survey.

Physicians and Methods

A random sample of primary care physicians (general practitioners, family practitioners and general internists) throughout California was drawn using the American Medical Association's directory file, which includes members and nonmembers. The sample was stratified by geographic region, and physicians in nonurban areas were oversampled to assure their adequate representation in the study.

A survey instrument developed in a study of Los Angeles County physicians was used with minor modifications.[2] Telephone interviews, conducted early in 1986, lasted an average of 25 minutes. About two thirds of the way through the interview, physicians were asked, "Do you have a standard medical history that new patients in your practice fill out?" (if yes) "Does this form include sexual history questions?" (if yes) "What do these questions cover?" Interviewers probed for additional responses, but did not provide specific examples of types of questions. Physicians subsequently were asked, "Do you usually ask new patients questions about their sexual history as part of the evaluation?" An affirmative response was followed by "What do these questions usually cover?" (again, repeated probes).

In an earlier section of the interview, physicians were asked if they had any patients at risk of HIV infection. Those with such patients were asked if they had counseled any of these persons about ways of decreasing their risk. If they responded in the affirmative, they were asked, "What specific things have you recommended?" Again, physicians were not offered alternatives, but interviewers probed for additional responses until none were forthcoming.

Results

Slightly more than 60% of the physicians in the sample completed an interview. There were no significant differences in the known characteristics of those who participated in the telephone survey versus those who did not. Of the respondents, 9% were women, 35% were in the practice of general internal medicine, 47% were family physicians and 18% de-

*Appropriate sexual histories, like any other area of history taking, do not involve asking the same detailed list of questions of all patients. More information is sought only as indicated by responses to previous questions.

From the Departments of Medicine (Dr Lewis) and Sociology (Dr Freeman), Center for the Health Sciences, UCLA School of Medicine, Los Angeles.
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Reprint requests to Charles E. Lewis, MD, ScD, Department of Medicine, UCLA Center for the Health Sciences, Los Angeles, CA 90024.

ABBREVIATIONS USED IN TEXT

AIDS = acquired immunodeficiency syndrome
HIV = human immunodeficiency virus

scribed themselves as general practitioners. In all, 53% of respondents were in solo practice and 26% practiced in groups of four or more physicians. The median number of years in practice of those interviewed was 15 years. As indicated, physicians in the non-Standard Metropolitan Statistical Area counties in California were oversampled; they represented 31% of respondents. Almost 28% of the respondents were from Los Angeles, 20% from San Francisco and the rest (21%) were from other metropolitan areas throughout the state of California.

The telephone interviews were conducted by Marylander Marketing Associates, a firm with extensive experience in telephone surveys. Professional interviewers (N = 23) working for this firm completed a special training program before starting the survey.

About a third of the 1,000 physicians interviewed had seen and evaluated, or referred for evaluation during the previous six months, at least one patient whose symptoms were consistent with a diagnosis of the AIDS-related complex or AIDS. More than 75% of these physicians had one or more patients express concern about acquiring AIDS, and 52% indicated they had one or more patients in their practice at risk of exposure to HIV.

Table 1 summarizes sexual history-taking practices in response to the three questions posed.

The most common item on medical history forms inquired about sexual difficulties (loss of libido, failure to achieve orgasm or to maintain erections). Less than 4% of these physicians had intake forms that would identify persons at risk for AIDS by inquiring about the sex of their partners or the type of sexual practices in which they engaged.

A sexual history was taken from new patients by only 36% of the respondents, and 39% said they made such inquiries at the time of periodic examinations of continuing patients. The content of these inquiries most often related to difficulties with sexual function.

Table 2 illustrates the counseling practices used by physicians with patients at risk for becoming infected with HIV by region in the state.

Advice other than that listed—that is, avoiding oral sex—was offered, but these recommendations were made by less than 3% of respondents. Counseling about three rational and appropriate risk-reducing behaviors—avoiding anal intercourse, reducing the number of partners and using condoms—was not evenly distributed geographically among physicians throughout the state. Almost 1 out of 6 physicians, however, suggested sexual abstinence, and 1 in 12 advised their gay patients to switch to a heterosexual life-style.

Appropriate counseling and sexual history-taking practices were associated significantly with the age, gender and specialty of a respondent. Younger physicians do more counseling ($P < .001$) and more frequently take sexual histories (49% of those in practice less than 5 years compared with 34% of those in practice more than 30 years, $P < .005$). Women do more counseling than men (79% versus 61%, $P < .005$) and score higher in competency on sexual history taking (40% versus 33%, $P < .05$). Among the three specialties, internists do more counseling (73% versus 59% of family physicians and 50% of general practitioners, $P < .001$). The types of advice and specific questions asked did not vary by age, gender or specialty.

Physicians who said they experienced a great deal of discomfort dealing with homosexuals in their practice took sexual histories (21% versus 37%, $P < .01$) and provided adequate counseling less often (13% versus 38%, $P < .01$) than those who expressed little or no discomfort.

TABLE 1.—*Sexual History-Taking Practices of 1,000 Primary Care Physicians in California*

Interview Question	*Physicians Interviewed, Percent*
Uses a questionnaire for new patients that contains sexual history items	44.5
Content of these items	
"Difficulties"	10.5
Enjoyment	6.0
Frequency of intercourse	3.5
Type of sexual practices	3.7
Sex of partners	3.4
Takes sexual history from new patient	36.2
Content of interview	
"Difficulties"	8.6
Enjoyment	6.3
Frequency of intercourse	5.6
Type of sexual practices	9.7
Sex of partners	10.0
Takes supplemental sexual history on continuing patient	38.8
Content of interview	
"Difficulties"	0.1
Enjoyment	2.4
Frequency of intercourse	2.5
Type of sexual practices	0.3
Sex of partners	0.6

Discussion

The data presented are self-reported and must be interpreted in context. That is, physicians were asked about their sexual history-taking practices during an interview that focused on their experiences with and knowledge of AIDS. Certainly this should produce an inflationary effect. This, in addition to the social desirability of certain responses, should cause the data to be viewed as maximum estimations, if not exaggerations, of actual practices.

The 32% prevalence of sexual history-taking reported by physicians under circumstances similar to this—that is, in the context of a potentially sensitizing study[3]—is similar to the 36% reported in this survey.

The results suggest only a small fraction of primary care physicians in California take sexual histories from their patients. Almost two thirds of physicians indicate they did not take sexual histories on patients new to their practice. At most, only 10% of these physicians are specific enough in their history taking to obtain relevant information for assigning risks and counseling patients. The counseling practices reported leave much to be desired, as it would appear that only 60% of the physicians with patients at risk could have provided appropriate counsel useful in reducing risks.

Discomfort in dealing with gay men is a significant deter-

TABLE 2.—*Counseling Practices by Those Having Patients at Risk for AIDS (N = 654), Percent*

	Area		Other	Non-	
Advice	*Los Angeles*	*San Francisco*	*SMSA*	*SMSA*	*Total*
Use condoms	50	57	50	53	52
Reduce number of partners	64	59	72	48	61
Avoid anal intercourse	33	20	30	17	25
Abstain	17	18	11	17	16
Switch to heterosexual life-style	7	13	9	8	9

AIDS = acquired immunodeficiency syndrome, SMSA = Standard Metropolitan Statistical Area

minant of sexual history-taking practices. The finding that adequate sexual histories are taken more often by women physicians is consistent with the data summarized by Morin and Garfinkle[4] that indicate most studies have found that men tend to have more negative attitudes or to feel threatened by gays than women. In a survey of physicians in San Diego, Mathews and co-workers found that younger physicians were less homophobic.[5] In this survey, younger physicians were less discomforted by gay patients and more often took sexual histories.

The associations between attitudes (homophobia) and competency in sexual history-taking and counseling with demographic variables (age and gender) present interesting challenges to those concerned with medical education and control of the spread of AIDS. Early medical school courses in sexual history taking need to be reinforced with specific attention to these skills and those of sexual counseling in residency training. Those physicians whose negative attitudes may reflect an age-cohort effect—that is, a function of prevailing societal values—or to be due to intrapersonal concerns should become aware of their disability. Consistent with the position of the American College of Physicians on AIDS, these physicians can discharge their ethical responsibilities to gay patients by referring them to practitioners who are able and willing to counsel them.[6]

"Counseling" is a term frequently used but seldom well defined. Recent studies by Lewis and associates suggest that operational definitions of this activity are possible and include not only the indications used by physicians for counseling and the techniques or strategies used, but also the intensity of their efforts to persuade patients to alter their behaviors.[7] Despite the importance of counseling, few postgraduate residency training programs provide structured learning experiences for house staff to teach them how to carry out this important function. As indicated by the responses of physicians in this study, counseling often reflects a physician's biases (switch to a heterosexual life-style) or failure to provide specific details of *how* to change a behavior. Those who would effectively counsel their patients must be able to describe in detail the specific desired behavior changes they are advocating and the means of adopting and maintaining these behaviors.

There is some evidence that personal counseling of patients by physicians is an important factor in affecting patients' behaviors with regard to other risk factors.[8] It is time for professional societies and educational institutions to increase their efforts in teaching the skills of sexual history taking and counseling through continuing medical education activities.

Seminars on retroviruses and the results of drug trials with patients with AIDS may be easier to present (and more comfortable to receive). To maximize our efforts to limit the spread of HIV infection, however, it is essential that physicians learn to assess their patients' risks of exposure to HIV and to counsel them appropriately or refer them to someone who can and will.

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