

# Discussing STIs: doctors are from Mars, patients from Venus

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**Background.** Primary care plays an important role in promoting sexual health, but in this setting counselling regarding sexually transmitted infections (STIs) is rarely performed and often inadequate.

**Objective.** Our aim was to identify and quantify the barriers physicians encounter in discussing STIs with their patients.

**Methods.** A postal questionnaire-based survey was carried out in a random sample of 200 primary care physicians in Antwerp, Belgium.

**Results.** The response rate was 68%. Among the 122 respondents, only 44.3% provide some form of counselling (asking about sexual history, informing about safe sex or informing about STIs) regularly, at least once a week. Major barriers are language and comprehension problems (for 74.2% of respondents), ethnic differences (68.4%), insufficient training (69.4%), lack of time (60.8%), presence of the patient's partner (89.2%) or mother (94.2%), first contact with a patient (60.8%), fear of embarrassing the patient (30.6%) and a patient without genital complaints (71.4%). About half of the GPs fail to counsel an asymptomatic patient with obvious STI risk, and as many give no safe sex advice in a first contraception consultation.

**Conclusions.** Physicians have many and various barriers to discussing STIs with their patients. Features of contemporary STI counselling and solutions to its problems are discussed. Education of health care providers should be given priority.

**Keywords.** Counselling, preventive medicine, sexual health, sexual history, sexually transmitted infections.

## Introduction

At the beginning of the 21st century, sexually transmitted infections (STIs) continue to be a threat to public health. Although the human immunodeficiency virus (HIV)-related 'safe sex' message is widely disseminated and public awareness of sexual health issues has grown, STIs are rising again. Declining trends in the 1980s and early 1990s have come to an end: today chlamydial infection is considered as an important health issue,<sup>1</sup> HIV incidence in extended population groups is again of great concern<sup>2</sup> and syphilis resurgence is reported.<sup>3</sup> Furthermore, viral STIs such as herpes, hepatitis and genital warts have become more

important, causing lifetime infections with no cure at present.

In a recent survey of sexual attitudes and lifestyles in Britain (Natsal 2000), an increase of risky sexual behaviour is observed.<sup>4</sup> These findings invite a wide range of health care providers to reconsider their possible role in promoting sexual health. Especially in a primary care setting, valuable opportunities for raising STI issues are present, because most individuals of the target group find their way to this type of health services, and often to those only.

However, society adopts an ambiguous attitude towards sex; in spite of the uninhibited presence of sexuality in the media and daily life, many people, including physicians, continue to regard sexual issues as 'personal', even in a health care setting.<sup>5</sup> Sexual matters generally are believed to be difficult to discuss with patients,<sup>6</sup> and it is well documented that STI counselling in primary care is rarely performed and often inadequate.<sup>7,8</sup> An additional problem for doctor–patient communication is

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the shift towards asymptomatic STIs such as chlamydial infection. This forces physicians to raise the subject with patients who are without complaints, who often have not considered the possibility of having an STI.<sup>9</sup>

In Europe, little research has been done to elicit the nature of the difficulties physicians encounter when raising STI matters with their patients. However, this knowledge evidently is crucial for improving primary sexual health care.

This study identifies and quantifies the problems physicians encounter in discussing STI issues with their patients.

## Methods

### Questionnaire

A 69-item questionnaire was designed to identify problems and difficulties in sexual counselling. Items were selected on the basis of previous, almost all non-European, study reports on the subject<sup>10–13</sup> and on our findings in a recent chlamydia screening project in primary care.

The following subjects were raised: sexual counselling practices, circumstances and patient characteristics influencing counselling situations, perception of the atmosphere in which the counselling process takes place, and assessment of competence in the field. The questionnaire was tested for relevance and clarity in a pilot study. An English version of the originally Dutch questionnaire can be consulted as supplementary data on the *Family Practice* Website (<http://www.fampra.oupjournals.org/content/vol20/issue1/>).

### Study population

The study was carried out among GPs in Antwerp, Belgium. A random sample of 200 GPs was generated from the list of GPs officially registered in Antwerp.

GPs over 65 years of age were excluded. The sample fitted the age and sex distribution of GPs in Antwerp, as reported by the Belgian Health Department.<sup>14</sup> All doctors were contacted by phone, and were asked if they were willing to fill in a postal questionnaire. They were informed that the questionnaire was designed to identify problems and difficulties in sexual counselling. Participants received the questionnaire and were asked to return it anonymously and post-free. Reminders were sent after 2 weeks and after 1 month. Descriptive statistics and chi-squares were generated in SPSS 10.0. Our sample consisted of female GPs who were often younger and male GPs who were on average older, reflecting the distribution in the field. When comparing subgroups (e.g. younger versus older GPs or male versus female GPs), possible confounding was dealt with by performing logistic regression analysis. All correlations shown in our report were corrected for age, sex and practice location (city versus rural practices).

## Results

Of 200 selected physicians, 192 could be reached by telephone. Eight did not answer their phone after several calls and had probably moved or discontinued their practice. Thirty-one were not willing to participate, mostly because of lack of time or no interest in the subject. Ten were not eligible, because they worked in paediatric health services (three) or in industry (two), because they were retired (four) or because they had a long-term illness (one). A total of 123 questionnaires were returned. The response rate of all contactable and eligible GPs was 68% (123/182). One questionnaire was not included in further analysis because it was not completed properly; consequently, 122 questionnaires were included in further analysis.

### Respondents' characteristics

Sixty-eight per cent of respondents were men and 32% were women. Male physicians were aged 29–63 and female physicians 28–53. The mean age of male and female doctors was 45.9 and 36.7 years, respectively. Approximately one-third worked in inner city practices, one-third in suburban and one-third in rural areas. The age and sex distribution of respondents and non-respondents did not differ significantly.

### Sexual health care practices

Sexual health care practices are shown in Figure 1. Most physicians are consulted frequently for routine sexual health care, but they often do not seize the opportunity to discuss STIs with their patients. A sexual history (actively asking the patient about his/her sexual behaviour) is taken infrequently. Only 44.3% of respondents provide some form of counselling (asking about sexual history, informing on safe sex or informing on STIs) regularly, at least once a week.

Diagnostic tests are performed mostly for HIV, although other infections such as chlamydial infection are far more common.

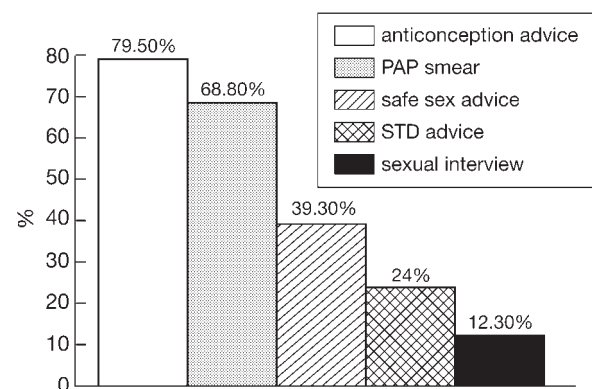


FIGURE 1 % of respondents ( $n = 122$ ) who regularly (> once/week) perform sexual health practices

In our survey, GPs were asked to indicate on a scale from 1 to 4 or 5 to what extent particular items were a barrier for them to talk about STIs. Barriers can be divided into patient-, situation- and doctor-related barriers.

*Patient-related barriers.* Language and comprehension problems (the patient not speaking Dutch fluently) are a major barrier for 74.2% of respondents. Ethnic differences (patients of Turkish or Moroccan origin) are problematic for 68.4% of GPs. The age difference between GP and patient is a barrier for 31.4% of GPs; a very young patient (<16 years) is a barrier particularly for older physicians (>45 years) ( $P < 0.05$ ). Patients of the opposite sex are more often a barrier for female doctors (for 23% of female versus 13% of male GPs,  $P < 0.05$ ). Homosexual/lesbian patients were not indicated as being a barrier.

*Situation-related barriers.* The presence of the patient’s partner or mother is a barrier for 89.2 and 94.2% of GPs, respectively. A close professional relationship with a patient is a barrier for 71.4% of GPs, and 60.8% state that a patient visiting for the first time is a barrier. This is problematic because many patients prefer to visit a doctor other than their regular doctor for sexual problems.

*Doctor-related barriers.* Nearly seven in 10 (69.4%) GPs feel they are not sufficiently trained to carry out effective STI counselling, 43% feel they are not familiar enough with certain sexual practices (e.g. in gay patients), 60.8% do not have enough time to raise STI issues in a routine consultation (men versus women: 68.2 versus 44.7%,  $P < 0.05$ ), and 79.3% find it difficult raising STI issues with patients who have no genital complaints.

*Casuistics*

Five cases were presented to the physicians, and they were asked how often they would give STI/safe sex advice and ask sexual history questions (Table 1).

No difference in likelihood for STI/safe sex advice was observed for different patient presentations. GPs were significantly more likely to ask questions on sexual history in the case of the homosexual man, compared with the cases of a woman asking for the morning after pill (MAP) or for a first pill prescription ( $P < 0.05$ ).

*Atmosphere in which counselling takes place*

Almost one in five physicians (18.3%) mentioned that they regularly feel uncomfortable when taking a sexual history, and 30.6% were concerned that questions on STI might be regarded as intrusive by their patients. GPs who often feel uncomfortable themselves are especially worried about embarrassing their patients (52.4 versus 24%,  $P < 0.05$ ).

Forty-three per cent of physicians perceive their male patients often to be embarrassed when taking a sexual history; female patients are believed to be uncomfortable by 39.5% of GPs.

Physicians were asked whether they would feel uncomfortable when taking a sexual history in the patients mentioned above (Table 2). GPs feel most uncomfortable with the homosexual man with anal fissures; female physicians feel far more uncomfortable than their male colleagues when a male visits for an HIV test (53.8 versus 23.2%,  $P < 0.05$ ).

**Discussion**

In order to obtain as reliable a picture as possible of GPs’ barriers in STI counselling, efforts were made to maximize the response rate. A 68% response is satisfying for this type of research, but still one-third of physicians approached refused to participate, mostly because of lack of time but also often because of ‘no interest in the subject’. This suggests that our findings might underestimate the extent to which the reported barriers influence physicians’ practices in the field. Other reports confirm the limited engagement of physicians in sexual health promotion;<sup>8</sup> therefore, sensitizing professionals is

TABLE 1 Likelihood of giving STI/safe sex advice and taking a sexual history in five patient presentations

| Patient presentation                                         | Likelihood (very likely) |                |
|--------------------------------------------------------------|--------------------------|----------------|
|                                                              | STI/safe sex advice      | Sexual history |
| A 45-year-old man asks for an HIV test                       | 62.5%                    | 67.8%          |
| A 24-year-old woman asks for a first pill prescription       | 53.7%                    | 23.5%          |
| A 27-year-old woman visits for emergency contraception (MAP) | 56.2%                    | 51.3%          |
| A 22-year-old woman presents with vaginal discharge          | 50.8%                    | 62.0%          |
| A 33-year-old homosexual presents with anal fissures         | 63.2%                    | 67.2%          |

TABLE 2 *Proportion of physicians feeling uncomfortable in five patient presentations*

| Patient presentation                                         | % Physicians feeling uncomfortable |                             |
|--------------------------------------------------------------|------------------------------------|-----------------------------|
|                                                              | Male GPs ( <i>n</i> = 83)          | Female GPs ( <i>n</i> = 39) |
| A 45-year-old man asks for an HIV test                       | 23.2%                              | 53.8%                       |
| A 24-year-old woman asks for a first pill prescription       | 30.5%                              | 28.2%                       |
| A 27-year-old woman visits for emergency contraception (MAP) | 29.3%                              | 25.6%                       |
| A 22-year-old woman presents with vaginal discharge          | 25.6%                              | 17.9%                       |
| A 33-year-old homosexual presents with anal fissures         | 56.1%                              | 64.1%                       |

as important as finding solutions to the barriers revealed in this survey.

In the past few decades, the clinical picture of STIs has changed substantially: asymptomatic infections such as chlamydial infection and HIV have become more important, requiring new skills on the level of communication.<sup>9</sup> Infections are no longer diagnosed on the basis of signs and symptoms; thus, physicians need to assess infection risk by raising STI issues ‘out of the blue’ with their asymptomatic patients. The finding that seven in 10 GPs mention ‘absence of symptoms’ as a major barrier suggests that they are not yet adapted to their changing role in sexual health promotion.

The problem is illustrated by the GPs’ different approach in two patients with evident risky behaviour: a sexual history is taken significantly more often in a patient asking for an HIV test (to whom the risk is obvious), than in a woman asking for emergency contraception, who is more worried about being pregnant. Whether safe sex and STIs are discussed depends more on the patient’s explicit demand than on medical necessity; this is also illustrated by the disconcerting finding that safe sex advice is given by only half of the GPs to a young woman in a first contraception consultation.

Embarrassment and fear of being intrusive tend to obscure communication when sexual issues are discussed. When dealing with their patients, physicians inevitably are influenced by their own values, which sometimes are contrary to the patient’s behaviour.<sup>5</sup> Physicians feel more uncomfortable in such situations: embarrassment in sexual history taking is greater in the case of a male asking for an HIV test (for female doctors), or a homosexual presenting with anal fissures (for both sexes), than in the case of a young woman visiting for a first pill prescription. However, the young woman would probably be more confounded by interrogation on her sexual behaviour than the other two, who would surely expect to be questioned. Being aware of one’s own values and trying to adopt a non-judgemental attitude would facilitate communication on delicate issues. Furthermore, GPs often experience embarrassment in their patients, which clearly is also an inhibitory factor.

To what extent patients actually are embarrassed if a sexual history is taken is not well documented. A few reports suggest that patients usually consider questions on their sexual history legitimate,<sup>15</sup> even if those questions are somehow embarrassing.<sup>16</sup> In particular, those GPs who feel uncomfortable themselves are worried about embarrassing their patients, a fear that might not always be legitimate.

Most physicians do not feel adequately trained to take a sexual history. Indeed, communication skills in this area often are not developed naturally, and are influenced, among other things, by a physician’s personality.<sup>10</sup> However, skills can be taught and practised; reports evaluating educational programmes on this subject show a better performance of physicians, at least in the short term.<sup>17,18</sup> In our investigation, GPs who had attended postgraduate workshops on sexual health felt more comfortable taking sexual histories and perceived less embarrassment in their patients (data not shown). Falling back on a structured interviewing technique will help physicians to feel more confident and might help overcome barriers such as lack of time, or an age or sex difference.

Interpretation of our data should take into account the obvious limitations of the study design. The quality of sexual history questions was not assessed. Furthermore, self-reported practices will probably paint a rosy picture of GPs’ activities: it would make an unprofessional impression if a doctor agrees to the statement that homosexuality is problematic for him, so most GPs do not agree. However, faced with a ‘real’ homosexual in casuistics, considerable discomfort becomes apparent in our respondents.

This study reveals that the majority of GPs have substantial difficulties in STI counselling. In the UK, a national strategy for sexual health has been developed,<sup>19</sup> and attempts are being made worldwide to introduce screening strategies for chlamydial infection and other STIs. Primary care can either be an Achilles’ heel or play a key role in such control programmes; therefore, education of the medical staff should be a priority.

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