Difference in Obtaining Sexual History among Residents of Ain Shams University Hospitals

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Abstract

Sexuality is a complex process; it incorporates family, social and religious beliefs, its expression intimacy remains important throughout life span. Many patients have questions and concerns about their sexuality. Medical illnesses and medications may alter the sexual ability which requires physicians to inquire about any sexual dysfunction in their patients. Attitude of doctors vary regarding obtaining sexual history and determining any dysfunction. For it requires certain training and skills. Determine Ain Shams residents' attitude regarding obtaining sexual history from their patients. A special questionnaire was designed in 3 parts, part I: covering sexual dysfunction history obtaining in general and in detail, part II: reasons for not obtaining sexual history, part III: determine knowledge about effect of illness and medication on sexual function. 100 questionnaire sheets were randomly distributed among residents of Ain Shams University in different departments. Response rate 49%, Within the medicine group 24.5% were in the dermatology department, 16.3% in the general medicine department, 4.1% in cardiology, 8.1 % in neuropsychiatry; whereas within the surgery group 22.4% were in gynecology, 16.3% in general surgery, plastic, vascular and orthopedic surgery and 6.1% in urosurgery department. 51% obtained detailed sexual history being highest in dermatology & endocrinology 100%, followed by urology & urosurgery 100% then gynecology & obstetrics 54.5%. Asking about use of sexually enhancing drugs in urology & urosurgery 100% dermatology & endocrinology92.3% followed by gynecology & obstetrics 36.4%. Female sexual history (pubertal and contraceptive), showed highest level of acceptance by residents, gynecology & obstetrics, followed by neuropychiatrists. Reasons for not obtaining sexual dysfunction history not included patient data sheet, finding this topic unimportant. Discrepancy in the attitude of Ain-Shams University hospital residence towards obtaining sexual dysfunction history reflects the need for a curriculum change to high light the importance of sexual history from patients and care should be paid toward managing reasons for not engaging in providing the patient with needed data concerning their sexual life

Introduction

Sexuality is a complex process, coordinated by the neurologic, vascular and endocrine systems. Individually, sexuality incorporates family, societal and religious beliefs, and is altered with aging, health status and personal experience. In addition, sexual activity incorporates interpersonal relationships, each partner bringing unique attitudes, needs and responses into the coupling. A breakdown in any of these areas may lead to sexual dysfunction **(Phillips 2000).**

Sexuality and its manifestations constitute some of the most complex of human behavior. The expression of sexuality and intimacy remains important throughout life span **(Roodsari et al, 2005).**

Many patients have questions or concerns about sex, but few talk directly about the subject with their physician. Including a

sexual history during the physician-patient encounter is one way to indicate to the patient that discussing sexual concerns is appropriate **(Driscoll.et al, 1986).**

Sexual dysfunction is common at any age. The most common problems are loss of sexual drive, anorgasmia, vaginismus in women, and erectile failure and premature ejaculation in men. Up to 38% of women report anxiety and inhibition during sexual activity, 16% complain of lack of pleasure, and 15% have difficulties reaching orgasm. Up to 40% of middle aged men report some kind of sexual dysfunction. The dysfunction may be purely psychological or physical but is usually a mixture of the two **(Lewin & King 1997)**

Sexual dysfunction is a particular problem for physically ill or handicapped people. Half of middle aged men with insulin dependent diabetes report erectile dysfunction. Between 50% and 90% of patients with multiple sclerosis will develop sexual difficulties. Dyspareunia is twice as prevalent in women with inflammatory bowel disease as in healthy matched controls **(Lewin & King 1997).**

Attitudes to sexuality in society are becoming more relaxed, and people expect their doctor to be able to ask them about sexual problems. Many doctors, however, find it difficult to discuss the sexual details of their patients' lives **(Lewin & King 1997).**

Many people believe that their doctor is a suitable professional in whom to confide their sexual difficulties, but few doctors are taught how to manage them **(Ross & Channon-Little, 1991)**

The lack of undergraduate and postgraduate training in managing sexual problems is one reason for the under-recording in general practice notes of consultations about sexual problems. The medical model of history, examination, diagnosis, and treatment is a poor tool when faced with "dysfunction" of what is fundamentally a psychosomatic event—sexual activity and orgasm **(Whitmore, 2003).**

Primary care physicians, skilled in the treatment of medical and psychologic disorders, often feel unqualified to treat patients with sexual dysfunction. However, with an understanding of sexual functioning and application of general medical and gynecologic treatments to sexual issues, sexual dysfunction may be effectively approached with the same skills. The latter includes obtaining a complete patient history, conducting a physical examination, application of basic treatment strategies, providing patient education and reassurance, and recommending appropriate referral when indicated **(Phillips 2000).**

Healthcare practitioners should be able to deliver sex information ranging from advising on sexually transmitted infections or sexual dysfunctions to helping people for whom sexual contact is difficult or who may have missed out on sex education. This does not mean that they have to book their patients a prostitute or conduct a sex education class, but they should know where to refer them **(Boynton 2004).**

We aimed to find out the attitude of residents of Ain Shams University towards obtaining a full and comprehensive sexual history as reflected upon the frequency of asking their patients.

Subjects and Methods:

After reviewing available literatures to cover possible questions needed to be asked **(Schmidt 1987, Naus 1989, Morris 1995, Fisher 1998)**, a self administered

questionnaire, in order to avoid forced best answer bias, was designed to be filled by residents of different specialties of Ain Shams University Hospitals. It was composed of three parts addressing the following:

1. If residents positively obtain general and/or detailed sexual history (14 questions).
2. The possible reasons for not obtaining sexual history, those possibilities were designed based on available literatures (7 reasons).
3. Physician awareness of effect of medical illness and medications on sexual performance (2 items).

A total of 100 sheets were randomly distributed on residents of different specialties from Ain Shams University hospitals.

Results:

Forty nine residents, nearly half of those who entered the study, responded by completing a self administered questionnaire about sexual history taking (see appendix)

Descriptive data are summarized in the following table:

Table 1: descriptive data of the sample:

		n (%)
Marital status	single	36 (73.5%)
	married	13 (26.5%)
Department	surgery	21 (42.9%)
	medicine	28 (57.1%)
		mean (±std.)
Duration of residency in months		18.57 (±10.0)

Within the medicine group 24.5% (n = 13) were in the dermatology department, 16.3% (n = 8) in the general medicine department, 4.1% (n = 2) in cardiology, 8.1 % (n = 4) in neuropsychiatry; whereas within the surgery group 22.4% (n = 11) were in gynecology, 16.3% (n = 8) in general surgery, plastic, vascular and orthopedic surgery and 6.1% (n = 3) in urosurgery department.

Of the residents who handed their questionnaires, only one (2%) resident in general surgery department failed to ask about any of the questions of sexual history obtaining whether sexual cycle or female sexual history. On the other hand, only 2 (4.1%) of the residents, one in gynecology & obstetrics and the other in endocrinology ask about all the questions of sexual cycle and female sexual history.

67.4% (n = 33) ask at least 3out of 5 questions about female sexual history. On the other hand, 36.8% (n = 18) ask at least 5 out of 9 questions about sexual cycle and satisfaction. 63.5 (n=31) ask less than 7 out of 14 questions.

Residents were compared regarding their attitude to sexual history obtaining using chi square test and results were as follows.

Table 2: Number and percentage within department of residents who responded "yes" for Sexual cycle questions:

	dysfunction	desire	excitement	orgasm	resolution	PCP
Endocrine & dermatology.	13 (100%)	11 (84.6%)	12 (92.3%)	11 (84.6%)	5 (38.5%)	8 (61.5%)
Urology & urosurg.	3 (100%)	2 (66.7%)	1 (33.3%)	1 (33.3%)	0	1 (33.3%)
Neuropsychiatry	0	0	0	0	0	0
cardiology	0	0	0	0	0	0
General medicine	1 (12.5%)	0	0	0	0	0
General surgery	2 (25%)	1 (12.5%)	0	0	0	0
Gynecology & obstetrics.	6 (54.5%)	5 (45.5%)	1 (9.1%)	1 (9.1%)	1 (9.1%)	9 (81.8%)
Total yes	25 (51%)	19 (38.8%)	14 (28.6%)	13 (26.5%)	6 (12.2%)	18 (36.7%)
X2	28.58	23.89	36.75	32.23	11.90	25.85
P value	0.001	0.001	<0.001	<0.001	0.06	<0.001

PCP= post coital problems

In detailed sexual history obtaining, there has been a very highly significant association between the specialty of residency and obtaining sexual cycle history except for resolution phase where association was not statistically significant. It was obvious that residents of dermatology & endocrinology followed by urology & urosurgery then gynecology & obstetrics were the most frequently group obtaining detailed sexual history. Neuropsychiatry and cardiology residents do not ask a detailed sexual history (table 2).

Detailed sexual cycle history obtaining results showed that asking about sexual dysfunction was the main concern for residents (n=25, 51%) while the least to be questioned is the resolution phase (n=6, 12.2%).

Asking about frequency and satisfaction of partners and the use of sexually enhancing drugs in history obtaining the results were as follows:

Table 3: Number and percentage within department of residents who responded "yes" for Frequency and satisfaction:

	Frequency	satisfaction	SED
Endocrine & dermatology.	13 (100%)	11 (84.6%)	12 (92.3%)
Urology & urosurg.	1 (33.3%)	1 (33.3%)	3 (100%)

Table (2): continue:

	Frequency	satisfaction	SED
Neuropsychiatry	0	0	0
cardiology	0	0	0
General medicine	0	0	2 (25%)
General surgery	0	0	0
Gynecology & obstetrics.	9 (81.8%)	4 (36.4%)	4 (36.4%)
Total yes	23 (46.9%)	16 (32.7%)	21 (42.9%)
X2	39.75	26.69	14.89
P value	<0.001	<0.001	0.02

SED= sexually enhancing drugs

Regarding questioning frequency and satisfaction of sexual behavior of the patient, there has been a very highly significant association between the specialty of residency and questioning except for use of sexually enhancing drugs where association was statistically significant (P=0.02). It was again obvious that residents of dermatology & endocrinology followed by urology & urosurgery then gynecology & obstetrics were the most frequently group tackling these issues. Neuropsychiatry, cardiology and general surgery residents do not pose those questions (table 3).

As shown in the table, while gynecologists and obstetricians are more interested in the frequency of sexual intercourse (n=9, 81.8%), urologists, urosurgeons (n=3, 100%), endocrinologists and dermatologists (n=12, 92.3%) are more concerned with the use of sexually enhancing drugs.

Table 4: Number and percentage within department of residents who responded "yes" for female sexual history:

	menarche	Duration of menses	contraception	Involve of partner in choice	Satisfaction in Presence contraception
Endocrine & dermatology.	7 (53%)	9 (69.2%)	12 (92.3%)	4 (30%)	4 (30.8%)
Urology & urosurg.	2 (66.7%)	2 (66.7%)	1 (33.3%)	0	1 (33.3%)
Neuropsychiatry	4 (100%)	3 (75%)	4 (100%)	1 (25%)	0
cardiology	0	1 (50%)	2 (100%)	1 (50%)	0
General medicine	7 (87.5%)	8 (100%)	8 (100%)	1 (12.5%)	0

Table (3) continue

General surgery	5 (62.5%)	4 (50%)	2 (25%)	0	0
Gynecology & obstetrics.	11 (100%)	11 (100%)	11 (100%)	6 (54.5%)	1 (9.1%)
Total yes	36 (73.4%)	38 (77.5%)	40 (81.6%)	13 (26.5%)	7(14.3%)
X2	14.89	10.59	28.39	9.89	8.56
P value	0.02	0.1	<0.001	0.12	0.2

Regarding questions specific for female menstrual cycle and contraception, there has been a very highly significant association between the specialty of residency and questioning the use of contraception where general surgery and urosurgery were the least to ask. A statistically significant association existed between questioning the time of menarche and residency where none of the residents of cardiology ask about it. On the other hand, there has been no statistically significant association between questioning involving partner in the choice of the contraceptive method or sexual satisfaction in the presence of contraception and site of residency. It is worth mentioning that those two issues are the least concerned by the residents altogether (table 4).

Part two of the questionnaire was addressing why residents don't take sexual history. Out of 7 reasons, 21 (42.9%) did not mention a reason. Cultural boundaries and embarrassment were not a cause for not asking by any of the residents. Other reasons that were mentioned by residents are included in (table 5).

Table 5: Number and percentage within department of residents who responded "yes" for Reason for not asking

	sheet	**Un-import.**	**Know.**	**wording**	**Oppo. sex**
Endocrine & dermatology	1 (7.7%)	0	0	1 (7.7%)	0
Urology & urosurg	2 (66.7%)	0	0	2 (66.7%)	0
Neuropsychiatry	2 (50%)	1 (25%)	1 (25%)	1 (25%)	0
cardiology	0	0	0	0	0
General medicine	5 (62.5%)	1 (12.5%)	1 (12.5%)	3	1 (12.5%)
General surgery	8 (100%)	1 (12.5%)	1 (12.5%)	1 (12.5%)	0
Gynecology & obstetrics.	3 (27.3%)	0	0	1 (9.1%)	0
Total yes	21 (42.8%)	3 (6.12%)	3 (6.12%)	9 (18.4%)	1(2%)
X2	21.86	21.05	5.50	8.99	5.23
P value	0.001*	0.002*	0.48	0.17	0.51

Un-import.: Un-important

Know. : Knowledge

Opps.sex: Opposite sex

Of all who do not ask most of the questions, 21(42.8%) residents, mostly in the general surgery urosurgery, general medicine and neuropsychiatry do not as it is not included in patient history sheet, and 3(6.12%) residents, mostly in neuropsychiatry, general medicine and general surgery due to thinking it is unimportant or irrelevant to the problem of the patient. Those two factors are highly significantly associated with department of residence.

In part three of questionnaire that determines residents' knowledge about impact of illness and medication prescribed on sexual life of patients, the results were as follow

Table 6: Number and percentage within department of residents who responded with "yes" for Knowledge about impact of:

Department	sexual dysfunction on patient condition	prescribed drug on sexual life
Endocrine & dermatology.	12 (92.3%)	12 (92.3%)
Urology & urosurg.	1 (33.3%)	1 (33.3%)
Neuropsychiatry	0	0
cardiology	0	0
General medicine	0	0
General surgery	0	0
Gynecology & obstetrics.	8 (72.7%)	8 (72.7%)
Total yes	21	21
X2	33.59	33.59
P value	<0.001	<0.001

Knowledge about the impact of sexual dysfunction on patient medical condition and the effect of prescribed medication on sexual life of the patient was highest in endocrinology and dermatology departments followed by gynecology & obstetrics residents, then urologist. Association between Knowledge and specialty of residency was of a very high statistical significance

Discussion

Sexual dysfunction is an important aspect of sexual health that is prevalent in the population but frequently goes undetected **(Humphery & Nazareth 2001).** Between 25 and 50 per cent of difficulties have an organic cause, the remainder are emotional or psychogenic in origin and most general practitioners will have to deal with these diagnostic challenges **(Richardson, 1989).**

Many patients have questions or concerns about sex, but few talk directly about the subject with their physician **(Driscoll et al, 1986).** In a recent global study of sexual attitudes and behaviors among people aged 40- 80 years, although almost half of all sexually active respondents had experienced at least one sexual problem, less than 19% of them (18.0% of men and 18.8% of women) had attempted to seek

medical help for their problem(s). Only 9% of men and women had been asked about their sexual health by a doctor in a routine visit during the preceding 3 years **(Moreira et al, 2005).**

Including a sexual history during the physician-patient encounter is one way to indicate to the patient that discussing sexual concerns is appropriate **(Driscoll et al 1986).** Yet, what is the attitude of residents to obtaining sexual history from patients? In an attempt to answer this question, hundred residents were asked to complete a self administered questionnaire on the issue (see appendix).

Response rate was 49% with only 49 residents were interested and handed back the questionnaire. Moreover, of those who responded a total of 31 residents (63.5%) ask less than half of the questions of sexual history. Our results indicate that residents in general have a disinterested attitude towards sexual history obtaining same as in a previous study by **(Humphery and Nazareth, 2001)** who studied general practioners (GPS) views on their management of sexual function. They found that out of 133 GPs who responded to the questionnaire, only 8 had special interest in sexual health. Most GPs (87) categorized sexual dysfunction as medium priority, 25 as high priority and 18 as low priority; three GPs did not respond to this query.

In our study, in general, asking about sexual problem showed marked discrepancy between residents of different departments. Sexual history is most frequently asked by residents of endocrinology, dermatology, urology and gynecology and obstetrics and least frequently asked by residents of cardiology, neuropsychiatry, general surgery and general medicine. This reflects that mainly it is not within the general system of data obtaining when dealing with patients, and that whether residents neglect or not obtaining the sexual history resulted from high awareness in certain departments and total lack of awareness in other departments.

When we asked further deep in sexual cycle, the results showed still that the main focus is on dysfunction and desire problems which is consistent with the most frequent sexual complaints, as **Nazareth et al, 2003** assessed prevalence of ICD-10 sexual disorders; the most common problems were erectile failure and lack or loss of sexual desire in men and lack or loss of sexual desire and failure of orgasmic response in women. It seems that physicians tend to ask and pay attention to problems which have a handy solution by which we mean sexually enhancing drugs. **Barrett, 2004** believes that staff in primary and secondary care, are not adequately trained in issues surrounding sexual intercourse, particularly interpersonal relationships, awareness, and respect of sexual difference. They also lack the confidence to communicate comfortably on sensitive topics. Unsurprisingly they either avoid discussion of the issue or do not handle it well.

Our suggestion is most likely based on the fact that asking about sexual practice frequency and satisfaction revealed that physicians give little interest to detect satisfaction, while the use of enhancing drugs was 100% in urology and urosurgeons, which may be explained by the pharmaceutical awareness programs. In recent years, the pharmaceutical industry has become very interested in sex as a focus for drug development and marketing. Many sexologists have embraced this new trend particularly because of greatly welcomed

research funding and increased professional opportunities (**Tiefer, 2000)**. That point's to the fact that pharmaceutical companies are playing major role in shifting physician's attitude towards asking questions to their patients. On the contrary, gynecologists and obstetricians are more interested in the frequency of sexual intercourse (n=9, 81.8%). This can be explained by their concern about inappropriate timing of intercourse and ovulation as a cause of infertility.

Again asking about involvement of partner in choice of method of contraception and sexual satisfaction in the presence of a specific contraceptive method was the most overlooked. The neglect of this most important humanistic issue may be the main cause of non compliance on contraception and of contraceptive failure in many circumstances.

Total of 31 residents (63.5%) of the sample ask less than half of the questions of sexual history, and they attributed it to not being included in the master history taking sheet, finding this topic un-important or irrelevant and lack of finding the proper wording to ask In Arabic which indicates a lack of sexual health training in our university same as in many other health service providers world wide. **Whitmore** 2003 stated that "The lack of undergraduate and postgraduate training in managing sexual problems is one reason for the under-recording in general practice notes of consultations about sexual problems."

When asked about knowledge of impact of illness on sexual life, Knowledge was highest in endocrinology and gynecology & obstetrics residents, followed by urologist. This reflects that although there is a high level of knowledge, still the level of involvement in obtaining sexual history of patient shows reluctance or neglect in some aspects of sexual life.

This survey has its limitation, small size of sample due to lack of cooperation of residents, that may reflect their viewing sexual life as of minor priority, and another limitation was failure to determine exact number of questionnaires distributed to each department, which was reflected in lacking the exact drop out rate of each department, still the results may be indicative of the need to integrate sexual health in post graduate training, and emphasize the need to either obtain history or referral to specialized service provider.

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اتجاهات الأطباء المقيمين في الأقسام المختلفة في مستشفيات جامعة عين شمس نحو الاستعلام عن التاريخ الجنسي للمريض .

تؤثر الأمراض العضوية و العقاقير على القدرة الجنسية للمرضى مما يلزم معه أن يسأل الطبيب عنها و على الرغم من ذلك نجد تفاوتا في اتجاهات الأطباء نحو الاستعلام عن التاريخ الجنسي للمريض.يهدف البحث إلى التعرف على اتجاهات الأطباء المقيمين في الأقسام المختلفة في مستشفيات جامعة عين شمس نحو الاستعلام عن التاريخ الجنسي للمريض.تم تصميم استبيان من ثلاثة أجزاء و تم توزيعه عشوائيا على مائة طبيب أعاد نصف الأطباء الاستبيان و أتت أعلى نسبة للاهتمام بهذا الجزء من التاريخ المرضى في أطباء الأمراض الجلدية و الغدد الصماء و تليها المسالك البولية و أمراض النساء و التوليد. و كان أكثر سؤال توجيها يختص باستخدام عقاقير محفزة جنسيا كذلك كان السؤال عن سن البلوغ و الحيض و استخدام وسائل لمنع الحمل و كانت أهم أسباب إهمال هذا الجزء من التاريخ المرضى عدم تدوينه في مذكرة المرضى أو اعتباره غير هام بالنسبة لحالة المريض.يدعو هذا التباين في اتجاهات الأطباء المقيمين في الأقسام المختلفة في مستشفيات جامعة عين شمس نحو الاستعلام عن التاريخ الجنسي للمريض إلى الحاجة الماسة إلى القيام بتعديلات في مناهج التدريس لتوضيح أهميته للمرضى. و كذلك معالجة أسباب عدم الاهتمام به.