Viewpoint

So you want to talk about sex? – a brief guide to taking a sexual history for Acute Physicians

OE Williams

Introduction

It's a Monday morning; the week-end has seen the re-admission of a retired teacher with a dry cough, increasing dyspnoea and no physical signs. His chest X-ray ten days previously didn't show any abnormalities. The course of amoxicillin given by his GP has not helped. He has an oxygen saturation of 89% at rest. Something doesn't add up?

Your next patient is 19 years of age, she has a fever, rash and her left elbow is swollen and hot. She says that her joints have generally been sore especially her wrists. She is very weepy and the admitting doctor suspected there was more to the history than she had been able to glean.

The title of the article gives it away –case one has *Pnemocystis jirovecii* pneumonia –his HIV having been acquired whilst working in Sub Sahara Africa years previously. Case two has Disseminated Gonnococcal infection and had been sexually assaulted. Sexually Transmitted Infections and HIV can manifest as systemic illnesses mimicking multiple other conditions which the Acute Physicians needs to be aware of. In days of old, it was routine to ask everyone if they had had syphilis or whether they had been jaundiced. This practice has fallen by the wayside and interestingly hasn't been replaced by 'Have you ever had a HIV test' despite UK guidelines.[1] .We shy away from asking the questions often because we are embarrassed, do not want to cause offence or just don't think it's appropriate. We have scant training in our curricula unless ones practices Genitourinary Medicine.

But how, on a busy unit, with high turnover of patients and limited private facilities do you instigate taking a sexual history?

Aim

Taking a sexual history can be a daunting task for those who are unfamiliar with the process. This article aims to cover some of the salient points that will facilitate the process in an Acute Medicine environment

Purpose

The purpose is to help improve the assessment of patients presenting via acute medicine take with sexual health related illnesses.

Background

In the 21st century we have seen the emergence of Sexually Transmitted Infections (STIs) including HIV becoming a major public health issue.[2, 3] The resurgence of Syphilis, multi resistant Gonorrhea and ongoing late presentation of HIV, suggest that individuals will present via the acute medical take with the squeal of these infections . An awareness of the changing behaviors and practices within the population is essential to avoid potentially missing a treatable condition. STIs are no longer the diseases of young people with older people now presenting with acute infections. There is ongoing evidence between the links between alcohol consumption and poor sexual health in young women[4] and concerns regarding CHEMSEX, HIV and Hepatitis B & C in men who have sex with men.[5] The use of PReP –in non HIV positive individuals is set to become widespread. The health needs of refugees, sex workers[6] and transgender individuals need to be considered. Taking a sexual history not only helps identify those potentially in need of testing and treating for STIs and blood borne viruses (BBV), it also identifies those individuals who require sexual risk-reduction counseling. It may highlight a sexual dysfunction secondary to systemic disease or side effect of medication.

Consideration must be given to disclosure of a sexual assault, intimate partner violence or past history of sexual abuse. The consultation needs to be sensitive to the age, cultural and religious beliefs of the individual.

It is imperative that the Acute physician can sympathetically illicit a sexual history and appropriately manage the individual. For most non –sexual health doctors this can be an awkward and potentially embarrassing situation for both doctor and patient alike. Done badly, a consultation about sex in the clinical setting can cause offence, lead to break down of the doctor –patient relationship and might even lead to a concern being raised. Whilst sexual history taking is taught in most Medical Schools, a cadre of doctors in training may not have had that training in the clinical setting. It is important to recognize this and it may be of value practicing taking a sexual history in a role play scenario with colleagues/ actors, video-recorded consultations,

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patient feedback or observing in a Sexual Health clinic.

The British Association of Sexual Health and HIV (BASHH) UK national guideline for consultations requiring sexual history taking[7] are comprehensive but apply mainly to STI/contraceptive services and general practice. Whilst there are some transferable principles, some elements such as the confidentiality are mandatory. There are some basic rules that should be followed

The Setting

Whilst one acknowledges that the Acute Medical Unit is a busy environment, it is essential that the sexual history is taken in a quiet, private space where the conversation cannot be overheard. Ideally the consultation should be one to one, but with the patient given the option of partner, family/carer or friend being present after the sensitive nature of the questions been explained .

The Consultation

Setting the scene - Always start the consultation by introducing yourself '*Hello my name is….XY, I'm a doctor on the team'*, or words to that effect. Establish a rapport -ensure good eye contact and adopt appropriate body language and tone of voice. Avoid euphemisms and do not make assumptions regarding the individual's sexuality, sexual orientation or gender. Use neutral words like 'partner' as opposed to girl/boy friend, husband /wife.

Often individuals will be concerned regarding confidentiality, and may be reluctant to disclose personal facts. The General Medical Council (GMC) has specific guidance.[8] Reassure the patient that only in specific scenarios when it's in the patient's or public's interest, for example certain child protection cases, will their confidentiality be broken.

Opening question is often as with all medical histories – 'What is your current problem?' or if you are not the first to take a history you might start with 'I see from your notes that you have had a fever/ cough/joint swelling/rash…..tell me more about these symptoms', then explain that you wish to ask some personal questions that relate to their current medical condition. As they may not have presented with a complaint directed linked to sex they may be a little mystified. At this point you may wish to say that you wish to 'rule out' a specific condition which presents with symptoms and signs similar to what they have. Explain that the discussion will be confidential.

Establish whether the individual is currently sexually active, whether they are in an ongoing relationship and when they last had sex, what type of sex and whether they used a condom. One needs to ask when they had sex with another individual, when and what type of sex. At this point , one might need to explain that these questions will help decide which further tests are required and which parts of the body need to be examined and samples taken from. Remember, 'oral sex' is often not perceived as being 'sex'! The gender of the sexual partners is essential, you might have to ask, do not assume. One might ask whether sex was consensual or not.

Asking about past history of STIs, HIV testing, and vaccination against Hepatitis B is essential. In women, enquire regard contraception, menses and obstetric history. A recreational drug (injecting and non-injecting) and alcohol history is important as both are linked to poor sexual health and risk of blood borne viruses. Enquiring into work as a commercial sex worker (CSW) or used the services of a CSW can be phrased as 'Have you ever been paid or paid for sex?' In addition a medication and drug allergy history should be taken

Enquiring into the mental health of the individual may reveal a past history of self harm or mental illness. Its important to establish if currently in contact with services especially in adolescents and young adults . Often, self harm, post sexual assault is observed (personal observation author)and in line with Acute care toolkit 13[9] there should be seamless cover of the Acute Medical Unit

Different clinical scenarios require slight modifications of approach, however both open and closed questioning will be required. Language may have to be adapted –many individuals do not know the correct anatomical names of their bodies and will use slang for both body parts and sexual practices. Asking 'what do you mean by that?' rather than assuming you understand is essential. New slang words such as 'slamming' -injecting intravenous recreational drugs in order to have a heightened sexual experience also means miss-selling telephone services! 'Giving' and 'receiving' are words most commonly used for 'Insertive' and 'receptive' oral and anal intercourse.

There is no role for exploring who the sexual contacts are, other that ascertaining from the patient whether they were aware of their HIV status –partner notification or contact tracing should be left to the Sexual Health team to do at a later stage if an STI or BBV is diagnosed

If the patient's preferred language is one you cannot speak then, there should be access to translation services if necessary. To maintain confidentiality, having the patients' family or partner translate is inappropriate. People with Learning Disabilities , Sensory loss or in Care may require advocates.

Once one has completed the history, it is important to ask the patient if they have any questions

or concerns. Advise them of the next steps whether its having blood taken for specific infections such as HIV , a clinical examination and tests or a referral to specialist in Sexual Health. An agreed method of communicating the results of any tests should occur especially as the patient may be discharged or moved to a ward in the intervening time.

Resources

To ensure seamless management of individuals presenting via Acute Medical Units with either acute manifestations of STIs, HIV, or Sexual Assault , the Unit should have a list of named contacts within integrated Sexual Health and HIV Services and their local Sexual Assault Referral Unit (SARC). Access to on-line resources, such as patient information on STIs and BASHH Clinical Effective Guidelines via www.BASHH.org/guidelines, should be readily available. Consideration to including training in sexual history taking as part of the AMU teaching would improve doctors confidence.

Conflit of interest

Nothing to declare.

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