Integrating sex-related questions into routine medical history-taking has become necessary due to many socially and medically pernicious problems, such as sexually transmitted diseases (including HIV and AIDS), child sexual abuse, teenage pregnancy, sexual dysfunctions, and adult sexual assault. In spite of the apparent need, physicians still find it difficult to initiate such discussion.¹⁻³

Reasons for this difficulty are not always clear. It could be that physicians lack interviewing skills in sex-related matters or are embarrassed. What is apparent is that the inability to talk to patients about sexual matters can result in inadequate care or even calamity for patients, as well as censure and legal vulnerability for physicians.⁴

The need to talk to patients about sexual issues is often outweighed by restraining social factors. For example, despite liberal social attitudes regarding public sexual discourse (eg, Viagra and the Clinton-Lewinsky imbroglio), Laumann and colleagues⁵ found substantial barriers to obtaining public funding for a community-based, AIDS-related survey in which respondents were interviewed about their sexual attitudes and experiences; the research was eventually funded privately. As with researchers, physicians in clinical practice are not immune to the effect of these same forces.

The environment in which physicians practise also has a strong influence on how they function, determined in part by institutions that provide medical malpractice insurance. In Canada, the Canadian Medical Protective Association (CMPA) is pre-eminent in protecting physicians against malpractice actions. Thus, CMPA policies might, understandably, greatly influence physician practices.

What's a physician to do?

What is the policy of the CMPA regarding physicians talking to patients about sexual matters? Some direction was given to members during the early 1990s through a commentary on physician sexual misconduct in Canada. The CMPA issued an information letter outlining various actions by physicians that would constitute sexual abuse of patients.⁶ One item on the list was “requesting details of sexual history or sexual preferences when not clinically indicated for the type of consultation or presenting problem.”

If physicians were to strictly heed this directive, details of sexual problems would be obtained only when patients spontaneously revealed sexual concerns or when sexual difficulties had already become a symptom of a particular medical disorder (eg, diabetes in men).

In other words, physicians were advised to react rather than initiate. The juxtaposition of these two distinct issues, talking to patients about sexual matters and physician sexual misconduct, suggested a link for which there was little evidence. In promoting this policy, the CMPA unwittingly put a chill on such discussions, thereby adding to the already limited capacity of the health care system to respond to sex-related personal and public health issues.

Case in point

In the early 1990s, the Canadian medical community witnessed a catastrophic example of the outcome of skirting sexual issues in medical care. The case involved a married man who underwent cardiac surgery, received a blood transfusion that was contaminated by HIV, was not told of his possible infection (when the physician eventually knew some years later), and was therefore unable to protect his wife from a similar fate. On the basis of minuscule evidence, the physician mistakenly thought the patient was sexually inactive with his (the patient’s) wife and, therefore, that she was safe from infection; however, she was eventually found to be HIV-positive.

While the inability of the physician to discuss sexual issues with his patient was not cited by the judge in the ensuing civil action, it is conceivable that, had the physician possessed that skill, the medical outcome might have been radically different for the patient’s wife and for him. The physician lost a civil suit and had his licence revoked by the College of Physicians and Surgeons of Ontario.⁴⁻⁷

Talking about sexual matters with patients
Time to re-examine the CMPA’s policy

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Editorials

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History-taking in medical education
Recognizing the difficulties many physicians have in discussing sexual issues with patients, some medical educators have recently included sex history-taking skills in their curricula while maintaining the previous focus on knowledge and attitudinal issues. Although contrary to the CMPA information letter, such teachers promote the notion that providing almost any patient the opportunity to talk about this subject, regardless of the nature of the visit, represents high-quality medical practice.8 For example, students might be told that AIDS prevention requires physicians to take the initiative in talking about sexual issues and asking about sexual practice details, such as engaging in anal intercourse and using condoms.

Rethinking the CMPA’s policy
The CMPA’s concern about physicians’ sexual misconduct committed through either actions or words is, no doubt, legitimate. But the CMPA must distinguish between when physicians’ behaviour goes beyond the boundaries of medical practice (eg, conducting a pelvic examination without gloves) and when behaviour becomes abusive depending on the methods used and the context (eg, talking in detail about sexual concerns without sexual issues as the presenting problem). The modest sex history-taking response of physicians to the HIV-AIDS pandemic attests to the fact that the CMPA policy needs to be re-examined.9 If more rationale is needed to restudy the issue, the problem of linking the process of talking to patients about sexual matters with physician sexual misconduct could be added. New techniques for asking sex-screening questions and for eliciting details of sexual behaviour, which are respectful, sensitive, brief, and effective, have been established.10

The CMPA policy is surely not the only factor interfering with physicians talking to patients about sexual issues. But in view of the existing factors that discourage sex history-taking, the last thing patients need is someone encouraging their physicians to avoid the subject altogether. The CMPA needs to clarify for its members the methods and conditions under which talking with patients about sexual problems and practices would provide both high-quality medical care and avoid legal liability, which might happen if such issues are omitted from a medical history. Such a goal might be achieved if the CMPA consulted with medical educators and public health officials to develop a new, constructive, and innovative policy.