

# How to Ask Sex Questions During a Medical Interview

Charles A. Moser, PhD, MD

*"Doctor, please make sure that antibiotic covers sexually transmitted infections."*

—An 80-year-old female patient with an exudative pharyngitis.

Possibly the two biggest hurdles to the physician incorporating a sexual history during the medical interview are the fear that the physician will offend the patient and the fear of not knowing how to ask the question tactfully. Although it is possible to offend some patients, the fear is much greater than the actuality. Asking questions becomes easier and smoother with practice. Many serious medical problems can present with sexual symptoms, so the real danger is missing the diagnosis. This article will suggest some ways to ask sexual questions and, possibly more important, what to do if the patient takes offense.

A real concern that patients have is the belief that most physicians are very conservative; patients fear that revealing any, especially unusual, sexual information will lead to the physician judging them negatively. This reservation can be combated by asking open-ended questions about sexual behavior during the initial interview. When the physician demonstrates the ability to hear the patient's answer without judgment, the patient's comfort increases and volunteering more information becomes easier.

Physicians can create a more inviting atmosphere to discuss sexual issues by crafting their intake forms to avoid sexist or sex-negative language. Some patients

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do not have a spouse, but could have one or more significant other. Some patients are transgendered and do not identify as male or female. Patients with alternative sexual behavior do notice the language used on the forms and by your staff.

If the patient seems uncomfortable, you can explain the purpose of the question. Of course, that presupposes that your question has a medical purpose. For example, we often ask patients with foreign objects lodged in their rectums how "it" happened; the usual and unhelpful answer is, "I slipped in the shower." Whatever the answer, it is not clear how the physician would use that information. If concerned about the possibility of domestic violence, ask about domestic violence. If concerned about the possibility of trauma or other injuries, ask about pain or bleeding when the object was inserted. If concerned that this is a frequent event, discuss the safety of anal insertions and safer ways to insert objects. (All objects should have flanges to prevent them from being sucked into the rectum and a long string firmly attached to aid retrieval. Lubrication and the necessity of seeking medical help for bleeding, pain, and signs of infection should be emphasized!)

Explaining the reason for the question prior to asking it can also be helpful. "Sexually transmitted infections can require different treatments, so I need to know if you have had sex with anyone. Is your partner monogamous?" It is easy to fall into euphemisms like faithful or fidelity, but some patients do not want to label their partner unfaithful or guilty of

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infidelity. A factual statement has less emotional impact, but obviously the same medical ramifications.

A young woman with abdominal pain was furious that my intern asked her about sexual activity, because he assumed the patient was not a virgin. The patient was reassured when I told her I would have asked the same question even if she had been a nun. It is much more important to risk offending a patient and make a diagnosis than to avoid offending the patient and miss the diagnosis. Physicians cannot recognize who has or has not had sex without asking, or who is having sex with multiple partners.

The form of the actual question is important. If you ask, "have you ever . . .," it is easy for the patient to just say no. This is especially true about sexual issues, as being guarded about one's sex life is common. Phrasing the question such as, "When was the last time you . . . or How often do you . . .," presupposes that the clinician thinks it is a socially common occurrence and allows the patient to admit to the behavior more readily.

Another way of achieving the same objective is by giving the patient a series of options. For example: "Do you have sex with men, women, or both?" Occasionally, it is necessary to inquire as to the frequency of a behavior, which leads to questions such as, "Do you pick up a new partner once a day, a week, a month?"

It is important never to assume that patients fit their own self-identification labels. Lesbians may need birth control; happily married people have extramarital relationships, and evangelical Christians go to orgies. If it is medically relevant, you need to ask the question. Ask religiously observant women if they need birth control. Do not dismiss the possibility of acute HIV seroconversion in a happily married woman.

Assume everyone is sexual. If the patient is offended, explain that many people of their age and backgrounds have sex, and it is your job to protect their health. If you do not inquire about their risks, you can miss detecting a serious illness. If patients are still offended, I ask if sex is a problem for them. Often, patients can begin to discuss their sexual

concerns?" All physicians must find their own way of asking the questions comfortably. If one cannot bring up the topic, referral is always an option. Ignoring the issue is no longer the standard of care.

Some physicians like to distinguish between psychogenic and physiological causes of sexual dysfunction. In general, this distinction is rarely clinically useful.

First, most individuals with physiologically based dysfunctions also will have psychological ramifications. Those with psychologically-based dysfunctions eventually will have physiological ramifications; as my sex therapist colleagues say, use it or lose it.

It is also important to recognize that both sex therapy and PDE5 inhibitors work with both psychogenic and physiologically based erection problems. It is not appropriate to just give a PDE5 inhibitor without follow-up, nor is it appropriate to give a referral to a sex therapist without checking to be sure the patient went to the therapist and the problem has resolved. The patient's partner ideally should be involved in the decision to treat, should know the nature of the treatment, and

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beliefs or laugh at the thought of themselves having sex. The physician should also be aware that not everyone wants to be sexual; it is a perfectly valid choice to have a nonsexual lifestyle.

The advent of PDE5 inhibitors (Viagra, Levitra, and Cialis) and the association of erectile dysfunction with other serious medical problems have made medical questions about sexual functioning much more common. Many physicians find it easier to bring up the question by starting as follows: "Many of my patients with your medical problem (e.g., hypertension, diabetes mellitus, hypercholesterolemia) also report sexual difficulties. Are you experiencing anything like that?" Other physicians have no problem asking, "Any sexual

should support the treatment plan.

The decision to treat sexual dysfunction in one patient usually means that a partner also is being treated. That partner may have his or her own sexual dysfunction or other problems in the relationship that may have conspired to create a nonsexual status quo. A well-meaning physician can upset that relationship status just by handing the patient a PDE5 inhibitor sample. The result can be a patient who never uses an effective drug again, a couple who miss an opportunity to confront their relationship issues, or a relationship that goes from bad to worse.

At present, there is little interaction between sex therapists and sexual

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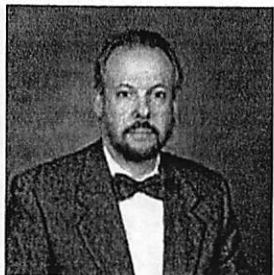
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medicine physicians. Fears of the "medicalization" of sex, turf battles, and little understanding of what the other professional does are all responsible. I hope this will change, as the interdisciplinary approach is most likely to be the most effective.

Asking questions about sex is like any other area of medicine. Physicians learn to discuss their patient's bowel habits, incise and drain an abscess, tell the family that there is no hope of recovery for the patient, discuss code status, and do rectal exams. Asking sex questions seems easy in comparison.

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and sexual medicine in San Francisco. He is also an LCSW and had a private psychotherapy practice specializing in the treatment

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The April issue of *San Francisco Medicine* will feature authors and articles on the subject of cancer. For more information, contact Managing Editor Edare Carroll at [ecarroll@sfms.org](mailto:ecarroll@sfms.org).

## Are We Giving Children All They Need?

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food stamps and research on chronic diseases, what's responsible about increasing funding for ineffective abstinence-only education? According to the most recent statistics, 822,000 women 15 to 19 years old got pregnant in 2000; each year, approximately 9.1 million 15- to 24-year-olds get sexually transmitted infections, including one half of all new HIV infections. Texas, Pennsylvania and other states that have evaluated their abstinence-only programs have found they have had little impact on helping teens to delay having sex. Indeed, a study by Columbia University researchers of "virginity pledges," as well as other "abstinence-only" studies, show evidence of increasing risk-taking behaviors among sexually active teens.

In contrast, studies published by the National Campaign to Prevent Teen Pregnancy, among others, show that comprehensive programs can help delay the start of sexual activity and increase condom use among sexually active teens.

Defending his budget, Bush rightly asserted, "A taxpayer dollar ought to be spent wisely or not spent at all." In continuing to fund abstinence-only education and in further asking for an increase in spending, the Bush administration has shown that it is not interested in spending wisely or responsibly.

When it comes to protecting America's youth, the REAL Act is clearly the wise choice. America's youth must not pay the high price for government irresponsibility about sex education.

Margaret C. Crosby is a staff lawyer and David Robertson is a volunteer lawyer with the ACLU of Northern California ([www.aclunc.org](http://www.aclunc.org)). This article was first published in the *San Francisco Chronicle* on February 22, 2005, Page B - 7, URL: <http://sfgate.com/cgi-bin/article.cgi?file=/c/a/2005/02/22/EDGUTBE73D1.DTL> ☞

## In Memoriam

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Francisco Orthopedic Residency Program. He began practice at Kaiser in 1973 and remained there throughout his career. He was certified by the American Board of Orthopedic Surgery, and was a member of the American Academy of Orthopedic Surgeons, the Western Orthopedic Association, the San Francisco Medical Society (since 1980) and the California Medical Association.

He is survived by three sisters, Josephine (Spanich), Dolores (Frankovich), Lillian (Korilko) and his twin brother, John, as well as numerous nephews, nieces and great nephews and nieces. ☞

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