

The Physicians' Attitudes and Barriers to Proactive Sexual History Taking During Comprehensive Geriatric Assessment

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Abstract

Objective: The purpose of this study was to assess the geriatricians' attitudes and perceived barriers to proactive sexual history taking during comprehensive geriatric assessment (CGA).

Materials and Methods: A self-administrated survey was delivered to 150 geriatricians in Cairo, Egypt. Fifty-six were returned (response rate=37.33%). The demographic data, attitudes, and barriers to discussing sexuality were probed.

Results: All the participants thought that sexual history should be taken during the first office visit as a part of the CGA process, however, 13 (23.2%) participants have never obtained a sexual history and 43 (76.78%) obtained it out of necessity. None of the respondents obtained sexual history on a routine basis. The reported barriers included fear of the patients' impressions, presence of major comorbid health problems, and lack of privacy during interview. The physicians' gender and marital status did not affect their attitudes towards proactive sexual history. However, the patients' educational level and social status can affect physicians' attitudes towards sexual history.

Conclusion: This study highlights both the lack of proactive sexual history taking and the main related barriers in geriatric practice in Egypt.

Keywords: Culturally competent care, geriatric assessment, geriatricians, health services for the aged, sexual health

Introduction

Sexuality is an integral aspect of emotional and physical wellbeing across lifespan. For older adults, it is an important contributing factor to the quality of life and successful ageing (1). Yet, it remains a neglected issue by both the patient and the physician during health assessment (2,3).

Against the popular belief that older adults lack sexual desires or that they are physically unable to perform (2), many adults remain sexually active into later life (3), even though many age related physiological changes, comorbid medical disorders, medications, and psychosocial factors might interfere with the sexual performance among older patients (4).

Yet, sexual problems are common among both elderly men and women. The prevalence of sexual dysfunction in men and women aged 40-80 years, across 29 countries was 28% and 39%, respectively (5).

In Egypt, men with moderate erectile dysfunction (ED) comprised 10.3% and those with complete ED were 13.2%. Twenty-six percent of men with complete ED were in their 50s, 49% of them in their 60s and 52% were 70 years or older (6). Data regarding sexual dysfunction in elderly Egyptian women is lacking.

In order to early detect and intervene with sexual problems, the sexual history taking is becoming an indispensable part of the comprehensive geriatric assessment (CGA). However, many geriatricians feel uncomfortable to incorporate sexual history into patient assessment (7). In the United States, only 38% of men and 22% of women had discussed sex with a physician since age 50 (8).

Several obstacles can make sexual history taking a challenge for clinicians. These obstacles include clinician, patient, and setting related barriers (9). One of the most important physician related barrier to sexual history taking is the inadequate or insufficient

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training in sexual health (10). The embarrassment, fear of being insensitive and cultural issues may also hamper proactive sexual history (11).

The attitudes of geriatricians towards discussing sexuality in Egypt may be affected by cultural sensitivity, but other administrative barriers should not be underestimated e.g. inadequate training, time restraint or privacy issues.

The aim of this study was to assess the Egyptian geriatricians' attitudes and barriers to taking a proactive sexual history in clinical practice.

Materials and Methods

The study methodology was reviewed and approved by the Research Review Board of the Ain Shams University Faculty of Medicine, Department of Geriatrics and Gerontology (GG-ASU-2019/18a).

Fifty-six geriatricians (consultants, specialists, and registrars) responded to a self-administered closed-question survey related to sexual history taking during the CGA. The participants were included in the study as a convenience-based sample of geriatricians in Egypt. The total number of geriatricians registered in the Egyptian medical syndicate is 150 with about (30) 20% of them working abroad, 12 working in the ministry of health, and the rest are working in university hospitals.

The survey was distributed through online form and through hand-to-hand approach. Those hand-delivered were placed in an opaque envelope to ensure anonymity.

The authors created the questions based on previous researches related to this issue. Part I recorded personal information. The participants were asked about their age, gender, years of experience, marital status, and if they consider themselves as conservative persons. Part II recorded the attitudes and barriers to obtaining sexual history during CGA.

The participants were asked if they routinely took a sexual history and the reasons, if any, for not obtaining it routinely from elderly patients e.g. lack of time during office assessment, lack of training, embarrassment, or not knowing how to manage patients' concerns. Moreover, the respondents opinion whether sexual history taking should become a routine practice during CGA was obtained (Appendix 1).

Statistics

The collected data were coded, tabulated, revised and statistical analyzed using SPSS program-version 16 (SPSS Inc., Chicago, IL, USA). Data were analyzed using counts and proportions. The qualitative variables were compared by using the chi-square test. Independent samples t-tests were used to explore gender differences in mean age. ANOVA test was used to compare age

between different staff categories. A p value less than 0.05 was considered statistically significant. Regression analysis for predictors of never taking a sexual history was performed.

Results

In total, 56 of the 150 Egyptian geriatricians responded to the survey with a response rate of 37.33%, 15 (26.8%) were males and 41 (73.2%) were females. They included 15 (26.8%) registrars, 17 (30.4%) specialists and 24 (42.9%) consultants. Their mean age was 26.26 ± 0.96 , 30.7 ± 3.15 , 40.45 ± 3.48 years, respectively ($p < 0.0001$) (Table 1).

Many of the participants worked in public hospitals. Although, all the participants thought that sexual history should be taken during the first office visit as a part of CGA, none of them routinely did so (Table 1).

Eighteen (32.14%) of the geriatricians obtained sexual history only when the patient had a certain sexual issue, 30 (53.71%) of them obtained sexual history when the patient had a related health problem, and 13 (23.2%) of them have never obtained a sexual history (Table 1).

Surprisingly, eighteen (32.14%) of our sample thought that sexual problems were uncommon among older adults, and 19 (33.95%) reported that older adults are not sexually active. Only one third of our sample considered themselves properly trained to address sexual issues. None of the registrars considered themselves adequately trained to address sexual concerns. Only 27% of the respondents reported that their supervisors encouraged them to obtain proactive sexual history (Table 1).

The most common reported barriers to proactive sexual history taking were the fear of the patients' impression, the presence of major comorbid health problems, and the lack of privacy during the interview in 76.8%, 71.4%, and 71.4% of the responses, respectively (Table 1).

Despite being more trained, more consultants viewed low education and low social class as major obstacles for taking sexual history during CGA (Table 1). Likewise, female geriatricians reported more difficulties when addressing sexual problems in patients with low education or low social class compared to males. Otherwise, there was no gender difference in other perceived barriers (Table 2).

Using a regression analysis, being a registrar and the underestimation of sexual problem among older adults were the independent predictors for never obtaining a sexual history during CGA (Table 3).

Discussion

In Egypt, while elderly patients seek treatment for a variety of health related problems, they remain very hesitant when

Appendix 1: The questionnaire form applied to the participants

Demographic data:

- Age
- Gender: Male Female
- Marital status Married Single Divorced
- Place of practice Urban Rural

Private sector Public sector

- Current position Registrar Specialist Consultant
- Do you consider yourself conservative Yes No

When performing a comprehensive geriatric assessment:

- When do you obtain sexual history:
 - o As a routine
 - o I obtain sexual history, only if there was a presumed association of Sexual History with Current Health Problems.
 - o Only if the patient enquires about a certain concern
 - o Never obtained sexual history from my patients
- Do you think sexual problems are common among elderly patients?
- Do you think that you have enough information about sexual health in older adults?
- Did you receive adequate training to comprehensively address sexual concerns?
- Do your supervisors recommend you to take sexual history from your elderly patients?
- Do you think sexual history taking should be routine practice during CGA?
- Do you think elderly patients are less sexually active?

Why don't you routinely obtain sexual history? (the barriers)

1. I don't have enough time during the daily practice Yes No
2. I don't consider it appropriate Yes No
3. I think my patient may consider it inappropriate Yes No
4. I think elderly patients have little interest in sexuality Yes No
5. I think elderly patients have major health concerns that is more important than sexuality
Yes No .
6. I think lack of privacy during interview interferes with sexual history taking Yes No
7. I am concerned about not being able to cope with the issues raised Yes No

In your opinion, which of the previously mentioned barriers prevented you to routinely obtain sexual history?1 2 3 4 5 6 7 Do you find it more difficult to obtain sexual history from patients of opposite gender? Yes No Do you find it more difficult to obtain sexual history from patients of low educational level? Yes No Do you find it more difficult to obtain sexual history from patients of low social status? Yes No

Table 1. Demographic data and barriers in different geriatric practitioners' categories					
Variables		The practitioners' categories			p
		Registrars 15 (26.8%)	Specialists 17 (30.4%)	Consultants 24 (42.9%)	
Age in years (mean ± SD)		26.3±0.9	30.7±3.2	40.5±3.5	<0.001*
Gender, n (%)	Male	3 (20.0%)	8 (47.1%)	4 (16.7%)	0.075
	Female	12 (80.0%)	9 (52.9%)	20 (83.3%)	-
Clinical practice, n (%)	Public	14 (93.3%)	8 (47.1%)	15 (62.5%)	0.026*
	Private	0	2 (11.8%)	0	-
	Both	1 (6.7%)	7 (41.2%)	9 (37.5%)	-
Marital status, n (%)	Married	4 (26.7%)	10 (58.8%)	20 (83.3%)	0.004*
	Single	11 (73.3%)	7 (41.2%)	3 (12.5%)	-
	Divorced	0	0	1 (4.2%)	-
Physicians who considered themselves conservative, n (%)		12 (80.0%)	12 (70.6%)	20 (83.3%)	0.611
Physicians who have never taken sexual history, n (%)		6 (40.0%)	3 (17.7%)	4 (16.7%)	0.198
Physicians who obtained sexual history, only if there was a presumed association of sexual history with current health problems, n (%)		9 (60.0%)	12 (70.6%)	9 (37.5%)	0.094
Physicians obtained sexual history, only if the patient enquires about a certain concern, n (%)		2 (13.3%)	3 (17.7%)	13 (54.2%)	0.009*
Physicians who thought sexual problems are not common in older adults, n (%)		5 (33.3%)	6 (35.3%)	7 (29.2%)	0.912
Physicians who thought older adults are not sexually active, n (%)		7 (46.7%)	8 (47.1%)	4 (16.7%)	0.061
Physicians who received adequate training to address sexual concerns, n (%)		0	5 (29.4%)	12 (50.0%)	0.004*
Physicians who were recommended to obtain sexual history during CGA by their supervisors, n (%)		5 (33.3%)	5 (29.4%)	5 (20.8%)	0.663
Physicians who thought sexual history taking should be a routine practice during CGA, n (%)		15 (100.0%)	17 (100.0%)	24 (100.0%)	-
Causes for not taking a sexual history from physicians' perspectives (more than one cause can apply)					
The lack of adequate time during the daily practice, n (%)		7 (46.7%)	10 (58.8%)	9 (37.5%)	0.403
Considering sexual history inappropriate, n (%)		8 (53.3%)	3 (17.7%)	7 (29.2%)	0.090
Patient may be offended, n (%)		13 (86.7%)	12 (70.6%)	18 (75.0%)	0.540
Older adults patients have little interest in sexuality, n (%)		8 (53.3%)	7 (41.2%)	6 (25.0%)	0.192
Older patients have major health concerns that is more important than sexuality, n (%)		8 (53.3%)	12 (70.6%)	20 (83.3%)	0.130
Lack of privacy during the interview, n (%)		10 (66.7%)	13 (76.5%)	17 (70.8%)	0.826
Inability to manage sexual problems, n (%)		13 (86.7%)	12 (70.6%)	15 (62.5%)	0.266
Obtaining sexual history from patients of opposite gender is rather difficult, n (%)		9 (60.0%)	12 (70.6%)	19 (79.2%)	0.434
Obtaining sexual history from patients of low educational level is rather difficult, n (%)		8 (53.3%)	8 (47.0%)	22 (91.7%)	0.004*
Obtaining sexual history from patients of low social status is rather difficult, n (%)		7 (46.7%)	8 (47.0%)	19 (79.2%)	0.050*
n: number, SD: Standard deviation, CGA: Comprehensive geriatric assessment *p<0.05: Statistical significance					

seeking medical help for a sexual problem. This may be due to embarrassment or perceiving sexual problems as normal part of ageing process. Thus, it is mandatory for geriatricians to become proactive when approaching sexual issues with their patients.

Unfortunately, many geriatricians feel ill at ease to take sexual history during health assessment; many factors might contribute to this discomfort (7).

Table 2. Gender difference in physicians' attitudes and perceived barriers

Variables	Male 15 (26.8%)	Female 41 (73.2%)	p
Age years (mean ± SD)	33.0±7.0	33.9±6.8	0.646
The type of clinical practice, n (%)	Public health care service	6 (40.0%)	0.045*
	Private health care service	1 (6.7%)	
	Both	8 (53.3%)	
Marital status of the participants n (%)	Married	8 (53.3%)	0.229
	Single	6 (40.0%)	
	Divorced	1 (6.7%)	
Physician category, n (%)	Registrars	3 (20.0%)	0.075
	Specialists	8 (53.3%)	
	Consultants	4 (26.7%)	
Physicians who have never took sexual history, n (%)	1 (6.7%)	12 (29.3%)	0.076
Physicians who obtained sexual history, only if there was a presumed association of sexual history with current health problems, n (%)	12 (80.0%)	18 (43.9%)	0.036*
Physicians obtained sexual history, only if the patient enquires about a certain concern, n (%)	5 (33.3%)	13 (31.7%)	0.908
Physicians who thought sexual problems are not common in older adults, n (%)	6 (40.0%)	12 (29.3%)	0.446
Physicians who thought older adults are not sexually active, n (%)	6 (40.0%)	13 (31.7%)	0.562
Physicians who received adequate training to address sexual concerns, n (%)	5 (33.3%)	12 (29.3%)	0.770
Physicians who thought sexual history taking should be a routine practice during CGA, n (%)	15 (100.0%)	41 (100.0%)	-
Causes for not taking a sexual history from physicians' perspectives (more than one cause can apply)			
The Lack of adequate time during the daily practice, n (%)	10 (66.7%)	16 (39.0%)	0.066
Considering sexual history inappropriate, n (%)	5 (33.3%)	13 (31.7%)	0.908
Patient may be offended, n (%)	11 (73.3%)	32 (78.0%)	0.711
Older adults patients have little interest in sexuality, n (%)	5 (33.3%)	16 (39.0%)	0.697
Older patients have major health concerns that is more important than sexuality, n (%)	12 (80.0%)	28 (68.3%)	0.390
Lack of privacy during the interview, n (%)	9 (60.0%)	31 (75.6%)	0.252
Inability to manage sexual problems, n (%)	4 (26.7%)	12 (29.3%)	0.849
Obtaining sexual history from patients of opposite gender is rather difficult, n (%)	11 (73.3%)	29 (70.7%)	0.844
Obtaining sexual history from patients of low educational level is rather difficult, n (%)	6 (40.0%)	32 (78.0%)	0.007*
Obtaining sexual history from patients of low social status is rather difficult, n (%)	5 (33.3%)	29 (70.7%)	0.011*

n:number, SD: Standard deviation, CGA: Comprehensive geriatric assessment
*p <0.05: Statistical significance

Table 3. Regression analysis for predictors of never taking a sexual history

Variables	Standardized β coefficients	SE	p	Odds ratio	95% CI for Odds ratio
Age	0.3	0.1	0.064	1.1	0.9-1.3
Female gender	2.4	1.5	0.105	0.1	0.0-1.4
Being single	21.7	4.0	1.000	0.9	0.1-6.0
Being a registrar	5.6	2.5	0.028*	1.4	0.9-1.9
Having conservative personality	-0.2	1.3	0.892	0.9	0.1-9.8
Inadequate training	18.6	1.9	0.999	0.1	0.0-0.7
Underestimating sexual problems in older adults	3.5	1.5	0.019*	1.3	1.1-1.9
Considering older adults as sexually inactive	0.6	1.5	0.692	1.1	0.1-16.1
Constant	-54.4	4.4	0.999	-	-

SE: Standard error, CI: Confidence interval
*p <0.05: Statistical significance

To our knowledge, this is the first study to address the Egyptian geriatricians' attitudes and barriers to proactive sexual history in clinical practice. Moreover, it is the first study to assess geriatricians' attitudes towards sexual history taking as part of the CGA in an Arab country.

Arab geriatricians may exhibit negative attitude towards sexual history taking as discussing sexuality is considered a cultural taboo. The cultural bias may exhibit prejudice against sexual orientation and sexually transmitted diseases. Yet, other administrative barriers should not be underestimated when addressing barriers to sexual health assessment.

In this survey, all interviewed geriatricians agreed that taking a sexual history should become a routine practice during CGA. Yet, 23% of them have never taken one, and about 70 % did not receive adequate training to address sexual concerns of their elder patients.

These findings agree with a previous study conducted in UK reported that geriatricians generally fail to take a sexual history from their patients. The barriers affecting the communication about sexual topics were embarrassment, being irrelevant, being inappropriate, and fear that patient may feel offended (12).

In this survey, the most common barriers were the fear of the patients' impression, the presence of major comorbid health problems, and the lack of privacy during the interview in 76.8%, 71.4%, and 71.4% of the responses, respectively.

In another study performed in Brazil, the main reasons for not obtaining a sexual history were the lack of time, fear of embarrassing the patient, and feelings of technical inaptitude (3).

Another important factor that may affect geriatricians' attitudes towards sexual history taking is proper training. About one third of our sample considered themselves properly trained to address sexual issues. In Egypt, like many other countries, the teaching of sexual health to medical undergraduates has not been consistent (13). Moreover, the training in sexual history taking and sexual health assessment and treatment remains inadequate for physicians (14). Thus, creating a uniform and standardized sexual health education program that provides geriatricians with the needed skills to address older adults sexual concerns need to be promoted.

Furthermore, we found that 18 (32.14%) of the respondents underestimated the prevalence of sexual problems in older adults and 19 (33.95%) of them reported that in their opinion older adults are not sexually active. This gap of knowledge may be attributed to underreporting of sexual issues in this age group.

In this study, interviewing a patient of opposite gender, low educational level, and low social class were perceived difficult by 71.4%, 67.9%, and 60.7% of the respondents, respectively.

The patients' education and social status affected the attitudes of female geriatricians and the consultants.

Study Limitations

This study has limitations, one being the small sample size, which is due to non-popularity of geriatric specialty in Egypt, as well as, the low response rates, which may result in non-response bias. Two, the survey did not address the patient related barriers for discussing sexuality.

Conclusion

Many geriatricians in Egypt ignore the proactive sexual history taking due to lack of training, time pressure and personal bias. The findings of our study provide information allowing better understanding of factors affecting geriatrician's attitudes in order to improve sexually related prevention practices.

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Ethics

Ethics Committee Approval: The study methodology was reviewed and approved by the Research Review Board of the Ain Shams University Faculty of Medicine, Department of Geriatrics and Gerontology (GG-ASU-2019/18a).

Informed Consent: Informed consent was obtained from all physicians participating in this study.

Peer-review: Externally and internally peer-reviewed.

Authorship Contributions

Concept: D.R., M.M., Design: D.R., Data Collection or Processing: D.R., M.M., Analysis or Interpretation: D.R., M.M., Literature Search: D.R., M.M., Writing: D.R.

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