

BASHH 2006 National Guidelines – consultations requiring sexual history-taking

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SCOPE AND PURPOSE

- This guideline outlines the suggested best practice for undertaking consultations requiring sexual history-taking. It is primarily intended for use in UK Genitourinary (GU) Medicine/Sexual Health settings, but can be applied or adapted for use in other settings where sexually transmitted infection assessments are undertaken.
- This guideline is for use by all GU medicine clinicians (medical, nursing and health adviser).
- Unlike other Clinical Effectiveness Group guidelines, this is not a tool for decision-making after establishing a diagnosis; rather, it describes best practice for establishing the facts on which clinical decision-making is based.
- The purpose of the guideline is to improve the sexual health of individuals attending GU medicine clinics by encouraging high standards of sexual risk assessment.
- The guideline offers recommendations on best practice regarding sexual history for both men and women including adolescent patients.
- The guideline has also been developed to allow the assessment of sexual history taking by GU physicians to be undertaken as one of the two service-specific standards for GU medicine physicians proposed by the Royal College of Physicians.¹
- The content of the sexual history includes some but not all the information for the proposed National Sexual Health Data Set.² It excludes data items not directly relevant to the care of an individual patient such as a partner number, but includes items such as sexual orientation and a history of unprotected sex that are essential for the provision of appropriate care.
- The detail and the exact content of the sexual history will depend on the setting in which it takes place, the role of the clinical service and the needs of the individual patient.³
- The guideline includes recommendations on the environment for sexual history-taking, the mechanisms for sexual history-taking such as the use of proformas, and the specific content and scope of the sexual history.

Stakeholder involvement

The Sexual History Working Party membership includes GU medicine clinicians and representatives from general practice, nursing and sexual health advising. Prior to publication, the final draft of the guideline was placed on the British Association for Sexual Health and HIV (BASHH) website, and copies were circulated to the genitourinary medicine regional audit, Genitourinary Nurses Association (GUNA) and Society of Sexual Health Advisers (SSHA) chairs for comment and peer review. The draft guideline was posted on the SSHA and GUNA web pages for comment.

Recommendations from this consultation exercise were fed back to the Sexual History Working Party and Clinical Effectiveness Group for consideration and discussion.

Rigour of development

The guideline was predominantly based on what a broad range of clinicians believe constitutes reasonable best practice. Because of the limited evidence regarding best practice in sexual history taking in GU medicine clinic settings, evidence is cited from non-UK sexual health settings and from other settings outside sexual health care.

A literature search was undertaken using the terms 'sexual history', 'sexual history-taking' and 'sexual risk assessment' on Medline and Pubmed databases. In addition, chapters on sexual history-taking and the National Standards for Sexual Health Service in the UK were examined for relevant evidence. Forward and backward searching from key references was also used.

CONFIDENTIALITY

General medical confidentiality

All National Health Service (NHS) employees are expected to adhere to the Caldicott Principles for confidentiality,⁴ and guidance from the General Medical Council stresses the importance of confidentiality.⁵ General medical confidentiality in the UK is a common law duty. The duty of confidentiality to the patient is absolute except in very specific circumstances, such as when it is in the patient's or public's interest. This might include child protection cases,

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or cases where another individual is placed at risk of an infection.

Some infections diagnosed in GU medicine clinics (particularly viral hepatitis) require statutory notification irrespective of the site of diagnosis.

Venereal diseases acts

The particular vulnerability of patients attending a GU medicine clinic is reflected by the requirements for confidentiality within a GU medicine clinic, which are even more stringent than in other parts of the NHS. These are defined by statute in the Venereal Diseases Acts of 1917⁶ and subsequent NHS regulations.⁷

Patient notes in GU medicine clinics are kept separately from other hospital notes, and General Practitioners (GPs) are not routinely informed of a patient's attendance, unless the patient has been initially referred by letter.

If it is in the patient's interest for another health care worker to be informed, their consent to disclosure should be sought.

The physical environment for sexual history-taking

- A welcoming, comfortable, confidential physical environment is likely to encourage openness when discussing sensitive issues, such as sexual behaviour.^{3,8} To facilitate this, the following measures should be adopted.
- Services may find that clearly displaying literature that stresses confidentiality of the clinic and the non-judgemental nature of assessment improves the consultation.
- Clinic administration procedures (storage/visibility of clinic files and clinic lists, etc.) should be designed to ensure that confidentiality is maintained between patients. Clinics should decide on the most appropriate way of calling patients for consultations such as calling by first name, full name, forename or number. Care should be taken to confirm that patient identification is correct.
- Consultations should take place in private settings and behind a sound-proofed closed door.^{9,10}
- Students and observers should be present only with the patient's consent, and the wishes of the patient should be respected if the presence of a student or observer is declined.¹¹

Recommendation: Sexual history-taking should take place in a confidential, private environment⁸⁻¹⁰ IV, C

Recommendation: All clinics should have a confidentiality policy that should be displayed in the waiting area or otherwise made available to patients.⁸ IV, C.

Management of sexual contacts

- The utmost care should be taken to preserve the patient's and sexual contacts' confidentiality during the consultation. This can be difficult in certain situations, for example, where a patient attends as a contact of an infection, but does not know the reason for their attendance.¹²

- The index patient must not be identified. The clinician must not confirm the identity of the index, even if raised by the patient, or reveal any details about a contact's attendance (or non-attendance) or clinical condition.

COMMUNICATION

Clinic access and external communication/advertising

- Although many individuals who are referred to or refer themselves to sexual health/GU medicine clinics will expect to be asked sensitive questions regarding their sexual behaviour, this may not be the case for all patients.
- Clinic advertising, including the use of websites and clinic leaflets displayed in other settings outside the GU clinic (i.e. GP surgeries, contraceptive clinics, schools, colleges, etc.), should explain the role of the clinic and what should be expected during a consultation. This may improve the acceptability of asking questions which may otherwise be perceived as being intrusive.

Recommendation: Clinic literature/advertising leaflets should include sections regarding the need to take a sexual history.⁸ IV, C

Communication skills

- Good communication skills are required by all clinicians and may be important in improving health outcomes.¹³ On the initial contact with a patient, there are some particularly important aspects of communication skills that are required and may be particularly important in obtaining an accurate sexual history: These skills include the following components: initial greeting of the patient; maintaining eye contact and using appropriate body language; initiating a consultation with open questions followed by exploration of initial concerns and more closed questions as the consultation continues; awareness of the signs of anxiety and distress from the patient; recognizing non-verbal cues from the patient.¹⁴
- Particular issues that require training for sexual history taking include addressing attitudinal issues to sexual behaviour, specific knowledge about the range of sexual practice and developing an understanding of the need to maintain confidentiality within consultations.¹⁵
- Although there are well-recognized models of best practice in communication skills training,¹⁴ assessment of the quality of communication skills is complex.^{16,17} A variety of different mechanisms for assessing communication skills have been proposed including patient questionnaires, direct or video-recorded consultation with patients or simulated patients.
- *Recommendation: Assessment of clinician communication skills should form part of the assessment of service quality. IV, C*

Communication difficulties

Availability of sign language interpreters, foreign language interpreters and access to Language Line are all strategies that may need to be adopted.

- *Recommendation: All sexual health clinics should have policies in place to address the needs of patients with whom there are communication problems, including patients whose first language is not English, deaf patients and patients with learning difficulties.*⁸ IV, C

COMPONENTS OF A SEXUAL HISTORY

The appropriate detail of the sexual history will vary between services but should allow:

- A careful assessment of symptoms to guide the examination and testing.
- An exposure history to elucidate which sites need to be sampled and the sexually transmitted infections (STIs) to which the patient may be at risk.
- An assessment of use of contraception and risk of pregnancy.
- Assessment of other sexual health issues (also allowing a discussion of psychosexual problems).
- Assessing HIV, hepatitis B and C risk for both testing and prevention.¹⁸
- Assessment of risk behaviours, which will then facilitate health promotion activity including partner notification and sexual health promotion.
- A summary of a suggested ‘core sexual history’ is in Table 1.

Reasons for attendance

It is best to start the sexual history with less intrusive questions regarding presenting concerns and symptoms before asking more sensitive questions regarding sexual behaviour. The reason for attendance should be ascertained. After this has been elucidated, the clinician should ask direct questions regarding any associated GU symptoms. All clinicians will ask further questions regarding the duration and nature of any reported symptoms.^{3,19,20}

Symptom review

It is uncertain whether a symptom review in patients not reporting symptoms is useful. However, many GU

medicine clinicians ask about specific genital symptoms in case this reveals overlooked or ignored problems.

Many clinicians would routinely ask women presenting to GU medicine clinics if they had the following symptoms:

- a change in vaginal discharge;
- vulval skin problems;
- lower abdominal pain;
- dysuria;
- changes in menstrual cycle or irregular bleeding.

Many clinicians would routinely ask men presenting to GU medicine clinics if they had the following symptoms:

- urethral discharge;
- dysuria;
- genital skin problems;
- peri-anal/anal symptoms (in gay men).

Sexual history

- The more detailed parts of the sexual history outlined below may be elucidated during the initial discussion with the patient. However, they will more often be ascertained while asking more ‘closed’ questions later in the consultation.
- Services primarily undertaking STI screening may undertake a brief core sexual history to establish whether someone is at any risk to STIs and take a more detailed history if the STI screen is positive.
- Using ‘bridging’ questions, which link general lifestyle questions to sexual history questions or ‘universal’ questions (questions which are explicitly asked of all patients), may also help when introducing sensitive questions.²¹ The need to ask important questions regarding risk taking (such as homosexual relationships and injecting drug use), which some patients may find offensive, should be clearly explained to all patients.²⁰

Last sexual intercourse (LSI)

All individuals should be asked:

- Gender of partner.
Rationale: to identify gay/bisexual men in order to take rectal and pharyngeal samples, undertake hepatitis screening and vaccination and offer HIV testing and counselling.
- Type of sexual intercourse/sites of exposure (oral, vaginal, anal).
Rationale: to identify which sites need to be sampled and in those gay men reporting anal intercourse to offer HIV testing and risk reduction.
- Condom use/barrier contraception during sexual intercourse (and whether the condom was consistently used and remained intact).
Rationale: facilitation of condom promotion and risk assessment.

Table 1 Core sexual history components

Symptoms/reason for attendance
Last sexual intercourse (LSI), partner gender, sites of exposure, condom use
Previous sexual partner details as for LSI
Previous STIs
For women: last menses period (LMP), contraceptive and cytology history
HIV risk history
Hepatitis B and C risk assessment
Establish mode of giving results
Establish competency/child protection concerns (if age <16 years)

- Relationship with partner (long-term partner – record duration of relationship, non-traceable casual partner, traceable casual partner, etc.), IV, C.

Rationale: to facilitate partner notification.

- Problems or symptoms of partner
Rationale: to identify STI diagnosis, or symptoms suggestive of an STI, in partners.

Previous sexual partner (before partner of LSI last partner change)

All individuals should be asked:

- gender of partner;
- site of exposure;
- use of barrier contraception;
- relationship to partner (as for last sexual intercourse – above.), IV, C;
- problems or symptoms of partner;

Rationale: as for 'Last sexual intercourse (LSI)'.

Time period of sexual history

- The sexual history should include all partners within the previous three months.²² Taking a three-month risk history would identify HIV risk behaviour not covered by a negative HIV antibody test.¹⁸
- If no partners are reported during this time, the last time the patient had sexual intercourse should be noted.
- If the patient is symptomatic, the sexual history should include all partners during the incubation period of STIs that may be the cause of the symptoms with which the patient presents.
- All patients who report no unprotected penetrative oral, vaginal or anal intercourse during this period should be asked the last time that this took place.
- All men should be asked if they have had sex with another man in the past.

Rationale: to establish which STIs the patient may be at risk of, and to inform partner notification.

Other components of history

Previous STIs

Recommendation: all individuals should be asked about a history of STIs. IV C.

- The diagnosis and approximate date of and diagnosis should be recorded.
- Patients with a previous history of syphilis should have the date of diagnosis, stage of syphilis, treatment given and clinic of treatment recorded.²³

Rationale: to allow the interpretation of positive syphilis serology in patients with a previous history of syphilis.

Past medical and surgical history

Rationale: to identify conditions that may be associated with or influence the management of STIs.

Drug history and history of allergies

Recommendations:

- All patients should have a history of current medication. IV, C.
- All patients should be asked for history of previous allergies particularly to antibiotics. IV, C.

Rationale: to identify drugs that cannot be given safely.

Contraceptive and reproductive health history

Recommendation: All women should be asked the following questions:

- contraceptive use and compliance;
- last menstrual period and usual cycle IV, C;
 - *Rationale: to identify pregnancy or pregnancy risk.*
 - To avoid drugs contraindicated in pregnancy.
 - To provide post coital contraception if indicated.
 - To give advice regarding contraception if necessary.
 - To advise regarding the reduced efficacy of the oral contraceptive pill if antibiotics are given.
 - Previous pregnancies.
- When last cervical cytology was taken (if aged more than 25 years). Result, and if ever abnormal. IV, C.
Rationale: to determine whether to recommend cervical cytology.

Risk assessment

Recommendation: All individuals should have the following questions asked:

- Current or past history of injecting history of injecting drug misuse; sharing of needles, syringes or drug preparation equipment ('works'). IV, C.
Rationale: to identify the need for hepatitis B, hepatitis C and HIV testing and hepatitis B vaccination.^{24,25}
- Whether they have ever had sex abroad, other than with a travelling partner; the nationality or country of birth of their sexual partners.
Rationale: to identify sexual partners at higher risk of STIs and identify the need to test for STIs that are significantly less common in the UK. IV, C.
- Whether they have ever had medical treatment abroad.
Rationale: to establish the need to test for nosocomial blood-borne virus acquisition.
- HIV testing history.¹⁸
Rationale: to determine whether HIV testing is necessary.
- All individuals at risk for Hepatitis B (including sex workers, gay men and IDUs) should be asked for Hepatitis B vaccination history.²³ IV, C. *Rationale: identification requires serological testing of hepatitis B and vaccination.*
- Men and women may be asked whether they have ever exchanged money in return for sex. IV, C.

Rationale: to allow appropriate health promotion and hepatitis B testing and vaccination.

Under 16s

Competency

Recommendation: All patients less than 16 years of age should have their competency to consent to history taking and examination assessed and this assessment should be documented in the clinical notes.^{26,27} IV, C.

Child protection concerns

Where there are any concerns regarding a child's safety, there should always be serious consideration given to liaison with the local Child Protection Team.²⁸

Answers to the following additional questions may flag up the need for further assessment and liaison with the local Child Protection team:

- whether parents/carers are aware of their sexual activity;
- whether parents/carers are aware of their attendance at the clinic;
- whether they have ever had sex against their will;
- age of partner;
- vulnerability (e.g. self-harm, psychiatric illness, drug or alcohol misuse).

Where children under the age of 13 years report sexual activity, this should be discussed with a senior colleague and there is an expectation that this will be discussed in confidence, with the local child protection lead. Reporting to the children's social care and police may be indicated but is not mandatory.^{27,29,30}

Closing the sexual history

Recommendation: After the sexual history is completed, the clinician should:

- Check with the patient that they have no other concerns that have not yet been discussed.
- Explain the need for and nature of a clinical examination and the clinical test sampling and other investigations.
- Explain the need for and offer a chaperone for the examination to all patients. If the chaperone is declined by the patient, this should be recorded.^{31,32} IV,C.
- The mode of communicating results to the patient should be clearly established.

DOCUMENTATION

- *Recommendation:* record keeping of a sexual history should be in keeping with the recommended national good standards of practice.^{11,33}
- Many clinicians and medical services now employ proformas (see appendix). It has been suggested that sexual health services may also benefit from employing proformas,^{8,34} which may
 - assist this record keeping;
 - make history taking more systematic;

- reduce the chance of omitting important pieces of information;
- facilitate audit.

APPLICABILITY

- This guideline should apply to sexual history-taking within GU medicine/sexual health settings. It is intended for a framework for sexual history-taking and different settings will require the guideline to be adapted accordingly. It is likely that services in outreach settings and offering rapid access to screening will need to make compromises in terms of the detail of sexual history-taking appropriate to their level of service.

AUDITABLE OUTCOME MEASURES

- (1) Proportion new/rebook patients asked about gender of last sexual partner. Ascertained by retrospective notes review. Target >95%.
- (2) Proportion of new/rebook patients who are asked about condom use at LSI. Ascertained from retrospective case notes review. Target >95%.
- (3) Note taking audits to establish the legibility and comprehensiveness of history taking should be undertaken. Target >90% of new/rebooked patients should have comprehensive histories taken and legibly recorded.
- (4) An HIV risk assessment should be taken in all new/rebooked patients (>90%).
- (5) A sexual history shall be obtained and documented in all persons presenting to genitourinary medicines (GUM) services with a new clinical problem. The sexual history should be retaken and documented at least every six months in those being followed up for infections conditions. Target 100%.

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Disclaimer

The recommendations in this guideline may not be appropriate for use in all clinical situations. Decisions to follow these recommendations must be based on the professional judgement of the clinician and consideration of individual patient circumstances and available resources.

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APPENDIX

MEMBERSHIP OF THE SEXUAL HISTORY-TAKING GUIDELINE WORKING PARTY

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Proformas: A range of different proformas from GU medicine clinics is available on the BASHH website to inform the development of local proformas.

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