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Original article

Are geriatricians guilty of failure to take a sexual history?†

Joyce S. Balami, MD, MSc, MRCP *

Department of Medicine and Clinical Geratology, John Radcliffe Hospital, Oxford, UK

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ABSTRACT

Background: As individuals live longer, they may have many medical, physical, psychological, and related issues that can impact on their sexual functioning. The sexuality of older patients is a topic that is generally not foremost in the minds of geriatricians.
Methods: This study was designed to determine the current practice of geriatricians regarding taking sexual histories from older patients and the further management of patients with sexual symptoms or deficits. Geriatricians (consultants, specialist registrars, staff grades, and associate specialists) were invited to complete a questionnaire on the taking of a sexual history and the further management of older patients with sexual problems.
Results: Geriatricians take a sexual history infrequently: 57.5% of them take a sexual history only occasionally. Although 96.7% are of the opinion that elderly patients with sexual problems should be managed further, opinion was divided, with uncertainty, especially among trainees (registrars), as to who should manage such patients.
Conclusions: These findings indicate that geriatricians generally fail to take a sexual history. However, geriatricians do generally agree that elderly people with sexual problems should receive appropriate referral and treatment. Aged sexuality is an area that requires more attention during the training of registrars and as part of continuing professional development.

1. Introduction

Sexuality is a multidimensional construct that is not easily defined. However, a World Health Organization working definition has described sexuality as a central aspect of being human throughout life that encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy, and reproduction. Sexuality has also been defined as a process of integrating emotional, somatic, intellectual, and social aspects in ways that enhance one's own self.[1] It incorporates intimacy, romance, sensuality, eroticism, and relationships and is an important contributing factor to the individual's quality of life and sense of well being, which applies to both younger and older people.[2] The need to be touched, to be an object of affection, to care about, and to be cared for is perhaps the most basic human need. The person who is denied touch, affection, or connection with another human being slowly deteriorates and dies physically and emotionally.[3,4] Sexuality is an aspect of human development often ignored in later life, and society often seems to imply that sexuality does not have a place in the lives of older people. It is unfortunate that this is a little understood area of gerontology, despite the aging of the population resulting from increased longevity, improved health, and rising affluence.[5] Health care professionals, health researchers, and government policy agendas have been known to overlook sexuality and sexual views of older people.[6,7] For older people, sexuality needs to be seen as more than the biology of the genitalia, hormones, or intercourse but rather as a function of all that contributes to the whole person.[1]

Population-based studies indicate that sexual function usually declines with age.[8,9] The reasons for this decline are multifactorial but perhaps the most prominent cause involves the interaction of underlying physical diseases and the physiology of aging.[1,10,11] Studies, including those of younger adults,[12–14] have shown how sexual dysfunction is associated with poor health. Chronic medical conditions such as hypertension,[15,16] cardiovascular disease,[17] diabetes mellitus,[18] arthritis,[19] Parkinson's disease,[20,21] stroke[22] and many others can impact or limit intimacy or sexual expression. These could be either indirectly through changes in self-esteem, self-image, mood, energy, and pain level or directly through changes in vascular, pulmonary, neurological, or hormonal systems.[23] Furthermore, these chronic conditions may impact on

* Corresponding author. Department of Medicine and Clinical Geratology, John Radcliffe Hospital, Oxford, OX3 9DU, UK.
E-mail address: josalbal@doctors.org.uk.
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sexual health and well being through depression, anxiety, and loss of self-esteem and psychological factors, such as myths about age and illness.[23] Unfortunately, many medications used to treat these chronic diseases can themselves impact on sexual desire and function, as well as energy and mood.[24–27] Sadly, chronic illness may not only impact on the patient but also on the partner through loss of desire, avoidance, fear, and change in role from partner to caregiver.[23]

With an increasing elderly population and further medical advances, patients are likely to have greater expectations for both sexual performance and information to improve the overall quality of their lives. Taking a sexual history from older people is an area that is often ignored by doctors. Sexual history of an older patient involves that part of their history concerned with both sexual function and dysfunction as well determining the factors responsible for the dysfunction. A sexual history will enable early detection of problems and delivery of advice and knowledge about normal functioning that can be both diagnostic and therapeutic. The creation of a climate for older people to express concerns and identify limitations (situational, physical, and psychological) will ensure a holistic approach to older people's care.

The aim of this study was to investigate the attitudes and perceived clinical practice of geriatricians with regards to taking a sexual history and the possible subsequent management of identified sexual problems.

2. Methods

A questionnaire was designed that asked geriatricians about their attitude and practices concerning screening and further management of sexual health issues among their patients.

2.1. Participants

The survey included consultants, registrars, staff grades, and associate specialists in Elderly Care Medicine. A total of 120 geriatricians took part in the survey. The questionnaires were distributed randomly and 54 consultants, 52 specialist registrars, and 14 staff grades/associate specialists completed them during local and national British Geriatrics Society meetings.

2.2. Design

The survey questionnaire (Appendix 1) contained questions relating to the frequency with which they took sexual histories and the reasons, if any, for not taking a sexual history. Participants were asked to decide whether if sexual problems existed, they should be managed further, and if so by whom. Further questions explored whether sexual history taking should be routine and who should take such a history. Complete anonymity was maintained and the data collected were entered into a database. Data were analyzed using basic descriptive statistics and a χ^2 test for the effects of participant category on answers given using SPSS version 17.0 (SPSS Inc., Chicago, IL, USA). A p value less than 0.05 was considered statistically significant.

3. Results

All 120 returned questionnaires were fully completed. The response to Question 1 revealed that 51 (42.5%) admitted to never taking a sexual history with 69 (57.5%) occasionally taking a sexual history and no one routinely took a sexual history (Table 1). The reasons for not taking a sexual history, with more than one reason given in some cases, are shown in Table 2. Comparing the different groups, consultants were less likely to take a sexual history when compared with trainees (registrars, staff grades, and associate specialists). Most, 116 (96.7%) of the geriatricians studied, were of the opinion that elderly patients with sexual problems should be managed further. However, there was divided opinion and uncertainty, especially among registrars, as to who should manage these patients further. The most common suggestions were: urologist (11.7%), gynecologist (10%), genitourinary medicine (15%), psychiatrist (5%), general practitioner (3.3%), sexual health clinic (1.7%), and appropriate specialty (8.3%). Around 45% of those studied had no idea as to whom further specialist referrals should be made. When considering the registrars separately, 29% were unable to decide on the most appropriate referral route.

Table 1
Do you regularly take a sexual history?

	Consultants, *n* (%)	Registrars, *n* (%)	Others, *n* (%)	Total, *n* (%)
Never	26 (48)	20 (38.5)	3 (21.4)	49 (40.8)
Occasional	28 (52)	32 (61.5)	11 (78.6)	71 (59.2)

A χ^2 analysis gave a p value of 0.174, indicating that there was no association between participant category and questioning of sexual history.

Regarding the frequency of sexual history taking, 76 (63.3%) of the total group were of the opinion that sexual history taking should not be routine, 32 (26.6%) thought it should be routine, and 11 (9.1%) would take a history where they felt it was appropriate. Finally, most geriatricians felt that this area of history should be taken by the doctor when first seeing the patient and few were of the opinion that it should be taken by a junior doctor or nurse in the ward setting.

4. Discussion

The present study is the first of its kind to look at the attitude and perceived practice of Elderly Care Medicine physicians regarding sexuality issues among their patients and the further management of sexual problems. Taking a sexual history should be an integral part of an elderly persons assessment. Numerous studies from different parts of the world, for example, Europe,[6,28,29] the United States,[30] Australia,[31] and Asia,[32] have all independently confirmed that sexual activity and interest is important to many older people. In addition, many older people perceive sexuality to be an important quality-of-life issue.[28] Therefore, because many older people do continue to be sexually active and maintain sexual interest, identification of sexual problems, their etiology, and planned subsequent treatment are vital.

This study indicates that geriatricians infrequently take a sexual history, claiming it to be irrelevant and not routinely indicated. The

Table 2
Reasons for not taking a sexual history (more than one reason given in some cases)

	Consultants, *n* (%)	Registrars, *n* (%)	Others, *n* (%)	Total, *n* (%)	*p*
It is irrelevant	29 (53.7)	27 (51.9)	8 (57.1)	64 (53.3)	0.939
It is inappropriate	11 (20.4)	9 (17.5)	4 (28.6)	24 (20.0)	0.643
Fear of complaint	1 (1.9)	1 (1.9)	0 (0)	2 (1.7)	0.874
It is embarrassing	5 (9.3)	10 (19.2)	1 (7.1)	16 (13.3)	0.246
The patient might feel offended	15 (27.8)	9 (17.3)	2 (14.3)	26 (21.7)	0.330
It is not a priority	1 (1.9)	0 (0)	0 (0)	1 (0.8)	0.540
No reason	1 (1.9)	0 (0)	0 (0)	1 (0.8)	0.540
Time constraint	1 (1.9)	1 (1.9)	0 (0)	2 (1.7)	0.874
I have never thought of it	1 (1.9)	1 (1.9)	0 (0)	2 (1.7)	0.874

findings are in line with a study that showed that taking a sexual history is often omitted in the psychiatric assessment of elderly men by psychiatrists.[33] In a study of sexual history taking among Primary Care physicians, about 76% of them admitted to asking about sexual history from their older patients where they felt it appropriate,[34] compared with only 9% of geriatricians admitting to doing so when relevant. Furthermore, this study reveals that geriatricians are guilty of failure to take a sexual history, with a difference in the frequency of sexual history taking between consultants and registrars.

Taking a sexual history is not easy as symptoms are rarely volunteered by the patients because of conflicting attitudes and perceptions, with many people being too embarrassed to discuss sexual concerns. However, geriatricians may hold myths regarding sexual function in old age, have time restraints, or lack both expertise and experience in discussing sexual problems. Many consultants and trainees lack specialist education and training in managing sexual problems and therefore have not incorporated this routine evaluation in their clinical skills repertoire. Given the broad spectrum of physiological, social, and psychological reasons for sexual problems, it is clear that inquiring into sexual function will often be productive both for the patient and those caring for him or her. The sexual history should include general questions followed by more specific ones to elicit specific sexual concerns and incorporate a thorough review of medication.

Most geriatricians are of the opinion that elderly patients with sexual problems should be managed further, but unfortunately most have no idea about who should best manage these patients. A referral to an urologist, gynecologist, or psychiatrist, depending on the specific sexual problem and gender of the patient, can assist in identifying issues affecting sexuality. Although not widely available, a sexual clinic in general, and sexual therapy in particular, is regarded as the most suitable place for referral of sexual problems, with a moderate to good outcome in most patients of any age.[35,36]

Finally, this study reveals how geriatric medicine training appears to be inadequate in the area of elderly sexuality. This is much in line with a study, which showed a deficiency in teaching sexual history taking in psychiatry training.[37] The authors of that study suggested that taking a sexual and relationship history should be an integral part of psychiatric assessment, with a further recommendation that doctors in training grades across all specialties be encouraged to inquire and discuss matters of sexuality and relationships with their patients, partners, and supervisors.[37] This recommendation is also definitely of paramount importance to geriatric training.

Future geriatricians need to be taught the importance of sexuality in older people, as well as the potential effects of loss of sexual function, especially in light of the increasing elderly population. As patients live longer and have a healthier life span, there is a need for geriatricians to include a routine evaluation of sexual health and function, where appropriate, and add the management of sexual complaints to their repertoire of clinical skills.

5. Conclusions

This study has limitations, one being the small sample size, which is not representative of all geriatricians. Another limitation is that the survey relied on convenient samples and may be subject to a self-selection bias. Despite these limitations, the findings show that geriatricians generally fail to take a sexual history from their patients and that sexuality in the elderly is an area that requires more attention during the training of junior doctors and as part of continuing professional development.

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Appendix 1. Questionnaire

Position: Consultant (), Registrar (), Staff grade (), Others ()
Please state
Sexual history asked: Routinely (), Occasionally (), Never ()
Reason(s) for not taking sexual history:
Embarrassing (), Patient may feel offended (), Irrelevant ()
Inappropriate (), Fear of complaint being made ()
Others……
Should elderly patients with sexual problems be managed further?
Yes (), No ()
Comments
If yes, whom would you refer them to?
Should taking a sexual history become a routine in geriatric assessment of elderly patients?
Yes (), No ()
Comments……
Who should take the sexual history?