Original Article

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'Sexual History Taking'– Difficulties Faced by Undergraduate Medical Students and their Preferred Teaching Learning Methods

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Abstract

Background: Sexual history taking (SHT) for instance is described as an important clinical skill that formal medical school curricula have historically neglected. However, such skill deficit might not be overcome even after graduation. The deficiency in learning SHT skills might eventually affect students' career choices. *Aim:* To assess the difficulties faced by undergraduate medical students while eliciting sexual history and to identify the pitfalls and the students preferences in the teaching learning methods for taking sexual history perceived by the students. *Methodology:* A cross-sectional study was conducted in our medical college hospital between Jan 2016 and June 2016 involving the students of final year medical students and CRRI'S. Total numbers of participants were 220 students. Questions related to their comfort and confident level in eliciting sexual history along with general history, prerequisites in obtaining sexual history and the ideal age and gender according to the students perception was all obtained in the questionnaire. Questions for assessing the barriers in eliciting sexual history among the medical student's and the current teaching methods which were followed for obtaining the sexual history was obtained. Likerts scale was used for assessing the student's attitude towards asking the sexual history. Finally suggestions were also asked in improving the teaching methods for obtaining the sexual history. *Results:* The CRRI's were found to be more confident in eliciting sexual history than the final year MBBS students, as they had one more additional year of exposure and females in both the groups were found to be slightly more confident than the males in eliciting the sexual history. Most of the students in both the groups felt that cultural and religious differences are the major barriers in eliciting the sexual history and they were also able to recognise their own limitations. Majority of the students agree to the point that they had not been adequately trained in eliciting sexual history. Students felt that they have to be taught by means of role play, video clips and simulated patients which would practically guide them in eliciting sexual history to the patient in a much more skilful and confident manner. *Conclusions:* Lack of confidence in approaching the subject of sexual health, inadequate preparation were some of the barriers identified. The delivery of sexual health education program should incorporate confidence building and to make students feel comfortable to take a sexual history from patients.

Keywords: Under Graduate Medical College Students; Sexual History Taking; Teaching Learning Methods.

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Introduction

In the course of his or her professional life, a clinician will conduct between 100,000 and 200,000 patient interviews [1,2]. The medical interview is the most common task performed by physicians. Thus, for good reason, Engel and Morgan called it "the most powerful and sensitive and most versatile

instrument available to the physician" [3]. History taking and communication skills programmes have become cornerstones in medical education over the past 30 years and are implemented in most US [4],Canadian [5], German [6] and UK [7] medical schools. National accreditations and expert panel consensus guidelines have stressed the importance of educational interventions addressing history taking [8,9]. Today, it is a proven fact that interview skills can be taught if effective methods are used. Even 25 years ago, articles and consensus statements outlined the assumed essential elements of effective interview skills courses, despite not having much experiential evidence for their recommen-dations [10].

Earlier studies reported that teaching and learning of history taking and physical examination (including intimate area examination) of entire human body were incorporated into the undergraduate medical curriculum to facilitate the students' to acquire clinical skills.[1]Previous studies reported that many medical graduates completely failed to perform any intimate area examinations (including genital, rectal, female breast, and pelvic examinations) before graduation; also, they did not obtain sexual histories from their patients unless it was urgently needed [11,12]. Sexual history taking (SHT) for instance is described as an important clinical skill that formal medical school curricula have historically neglected [13]. However, such skill deficit might not be overcome even after graduation. The deficiency in learning of Intimate area examination (IAE) and SHT skills might eventually affect students' career choices [14]. Moreover, the problem continues and becomes more severe when these unskilled physicians start their actual practice of medicine; reluctance to acquire sexual information was reported in primary care settings. According to a number of studies, such conditions are attributed to embarrassment for both, clinicians and patients [11,13,15]. Another study reported that general practitioners avoided taking histories because of inadequate training [11].

SHT skills are essentially important even in primary healthcare settings especially for proper identification and treatment of sexually transmitted diseases (STDs) [11]. Sexual history of the patient gives an opportunity to educate and counsel the patient about human immunodeficiency virus (HIV), STDs, and viral hepatitis. These "silent" diseases can go unnoticed for longer periods of time until they lead to more serious illnesses.

No standard minimum set of questions has been defined to provide the essentialsexual history, although a range of advice on the topic has been offered in the literature [16,17]. For a sexual history relating to STIs, generally questions would cover issues such as current and past sexual practices, history of STIs, gender and STI history of current and past sexual partners, condom and contraceptive use, and sexual abuse.

There are probably three types of GPs: those who never had training in sexualhistory-taking and don't do it, those who have personal difficulties and should refer patients elsewhere, and the remainder, who should be capable of taking a good sexual history. It is often assumed that GPs do not pursue a discussion of sexuality because they fear a negative reaction from the patient. While studies on sexual history taking from the patient's perspective are uncommon, their findings consistently demonstrate patients' approval [18,19]. If a patient is distressed about a sexual problem, discussing it in a confidential, safe, and non-judgemental environment can bring significant relief [20].

We were unable to find any published accounts of examining sexual history taking. In India as of today no such studies had been conducted in eliciting the difficulties faced by medical students in eliciting a sexual history and the pit falls in teaching learning methods for medical students in asking questions related to sexual history among the patients.

Aim

To assess the difficulties faced by undergraduate medical students while eliciting sexual history and to identify the pitfalls and the students preferences in the teaching learning methods for taking sexual history perceived by the students.

Methodology

A cross-sectional study was conducted in our medical college hospital between Jan 2016 and June 2016 involving the students of final year medical students and CRRI'S. Total numbers of participants were 220 students. Only the final year and CRRI'S were included in the study as they had completed most of their training within the curriculum. Participation was on a voluntary basis, and confidentiality was assured. The students were briefed on the purpose of the study, and, for those who agreed to participate, written consent was obtained. Consent forms were collected separately, and the participants were then given the questionnaires to complete anonymously. Ethical approval was obtained from the institutional ethical committee.

A pre-tested semi-structured questionnaire was used to collect the demographic data and their attitude and perception of undergraduate medical students regarding taking sexual history. Questions related to their comfort and confident level in eliciting sexual history along with general history, prerequisites in obtaining sexual history and the ideal age and gender according to the students perception was all obtained in the questionnaire. Questions for assessing the barriers in eliciting sexual history among the medical student's and the current teaching methods which were followed for obtaining the sexual history was obtained.Likerts scale was used for assessing the student's attitude towards asking the sexual history. Finally suggestions were also asked in improving the teaching methods for obtaining the sexual history.

Data analysis was conducted using SPSS, Version 20.0. The frequency distribution, measures of central tendencies, and measures of distribution were produced. A descriptive analysis was conducted for all sections.

For the analysis, the Likert scale responses were grouped into three categories: "strongly agree" and "agree" were grouped as "agree", "strongly disagree" and "disagree" were combined into "disagree", and neutral remained. Using the mean score for each item, the Mann–Whitney test was used to analyze the significance of variables with two response values (e.g., gender). The Mann–Whitney test uses z-scores below "1.96 and above 1.96 to reject the null hypothesis. The significant level was set at $p = 0.05$.

Results

Table 1 shows the distribution of the study subjects based on their year of study and gender. Final year MBBS students constitute for 56% of the study subjects and 44% of them are CRRI's. The mean age in both the groups was between 22 – 23 years. Males and females in both the groups were almost equal in distribution. The medical student's attitude in eliciting sexual history was assessed by asking a set of ten questions (Table 2 and 3) and the response was measured by using Likert's scale. The CRRI's were found to be more confident in eliciting sexual history than the final year MBBS students, as they had one more additional year of exposure and females in both the groups were found to be slightly more confident than the males in eliciting the sexual history.

Majority of them agree that doctors should know how to take sexual history and it should be routinely taken along with the general history and they also felt that they feel more comfortable in taking sexual history to the same gender than the opposite gender. Most of the students in both the groups felt that cultural and religious differences are the major barriers in eliciting the sexual history and they were also able to recognise their own limitations. Embarrassment, lack of proper knowledge and training, lack of professionalism while addressing confidential matters of patient and lack of maturity on behalf of the student, lack of knowledge regarding homosexuality, ethnic differences and adequate proficiency in communicating language are some other hindering factors for students in eliciting sexual history.

They also agree to the point that maintaining the confidentiality of the patient is very important. There was no difference of opinion in any of these above mentioned points between the final year students and CRRI's as well as between the males and females (Table 2 and 3).

Most of the CRRI's agreed (57%) that they feel that they have adequate skills in asking sexual history to the patients. But majority of the students agree to the point that they had not been adequately trained in eliciting sexual history and also felt that it is very important for the patients to discuss about sexual problems with the doctors (Table 4).

Most of the students felt that routine class room teaching and lectures are not the best method to teach sexual history for the students and they want them to be taught by means of role play, video clips and simulated patients which would practically guide them in eliciting sexual history to the patient in a much more skilful and confident manner (Table 5).

Table 1: Distribution of the study subjects based on their year of study and gender

Class	Males	Females	Total
Final year	60 (56%)	63 (55.7%)	123 (56%)
CRRI's	47 (44%)	50 (44.2%)	97 (44%)
Total	107 (100%)	113 (100%)	220 (100%)

Table 2: Medical student's attitude towards eliciting sexual history based on their year of study

Factor	Final year (n=123)			CRRI's (n=97)			P value
	Disagree	Neutral	Agree	Disagree	Neutral	Agree	
A	76	15	32	45	2	40	.0278
B	3	18	102	0	2	95	0.725
C	2	7	114	4	9	84	0.682
D	0	3	120	0	0	97	0.816
E	0	3	120	0	2	95	0.842
F	113	8	2	94	2	1	0.791
G	3	12	108	0	3	94	0.769
H	0	9	114	0	0	97	0.693
I	0	4	119	1	6	90	0.795
J	2	12	109	0	0	97	0.696

P value derived by Mann-whitney U test

A – highly confident in eliciting sexual history
B – taking sexual history along with general history should be practiced routinely
C – taking sexual history for same gender is more comfortable than the opposite gender
D – I think it is important for doctors to know how to take sexual history
E – I think it is important to be non-judgemental when eliciting sexual history
F – I feel comfortable in taking a sexual history from patients who are uneasy in discussing sex
G – I feel cultural differences are a barrier when discussing sexual health problems with patients
H – I feel religious differences are a barrier when discussing sexual health problems with patients
I – I recognise my own limitations in discussing sexual health issues with patients
J – I believe it is important to maintain patient confidentiality

Table 3: Medical student's attitude towards eliciting sexual history based on the gender

Factor	Males (n=107)			Females (n=113)			P value
	Disagree	Neutral	Agree	Disagree	Neutral	Agree	
A	68	7	32	63	10	40	0.074
B	2	16	89	1	4	108	0.082
C	1	4	102	5	12	96	0.371
D	0	3	104	0	0	113	0.521
E	0	3	104	0	2	111	0.692
F	98	3	3	106	7	0	0.542
G	3	6	98	0	9	104	0.718
H	0	5	102	0	4	109	0.826
I	1	6	100	0	4	109	0.723
J	1	7	99	1	5	107	0.764

P value derived by Mann-whitney U test

A – highly confident in eliciting sexual history
B – taking sexual history along with general history should be practiced routinely
C – taking sexual history for opposite gender is more comfortable than the same gender
D – I think it is important for doctors to know how to take sexual history
E – I think it is important to be non-judgemental when eliciting sexual history
F – I feel comfortable in taking a sexual history from patients who are uneasy in discussing sex
G – I feel cultural differences are a barrier when discussing sexual health problems with patients
H – I feel religious differences are a barrier when discussing sexual health problems with patients
I – I recognise my own limitations in discussing sexual health issues with patients
J – I believe it is important to maintain patient confidentiality

Table 4: Students perception regarding their skills and training in eliciting sexual history on the patients

Factor	Final year (n=123)			CRRI's (n=97)			P value
	Disagree	Neutral	Agree	Disagree	Neutral	Agree	
A	73	5	45	38	3	56	<.001
B	72	3	48	35	2	60	0.472
C	83	2	38	53	0	44	0.596
D	37	1	85	44	0	53	0.695
E	4	6	113	1	2	94	0.793

P value derived by Mann-whitney U test

A – I have adequate skills to take sexual history
B – I have adequate skills to put a patient at ease when discussing their sexual health issues
C – I have enough training in my medical college in eliciting sexual history among the patients
D – I feel that I had not been trained in medical college in eliciting sexual history
E – I feel patients like to discuss their sexual problems with the doctors

Table 5: Medical student's perception on different type of teaching learning methods in eliciting sexual history

Type of teaching learning methods	Final year students (n=123)		CRRI's (n=97)		P value
	Frequency	Percentage	Frequency	Percentage	
Class room lectures	3	2.4%	0	0	0.329
Clinical classes	83	67.4%	74	76.2%	0.547
Role play	104	84.5%	88	90.7%	0.613
Video clips	110	89.4%	95	97.9%	0.683
Simulated patients	114	92.6%	96	98.9%	0.836

P value derived by Mann-whitney U test

Discussions

The current study had clearly highlighted that medical students are interested and are ready to recognize the importance in attaining skills in taking sexual history. The results are similar to the studies conducted among medical students and practitioners [21]. This is encouraging because it represents a positive attitude toward the subject and other studies had shown that high awareness and positive attitudes among doctors are the starting point for the good delivery of sexual health care [22].

Consultations involving sexual health with adolescents, patients of the other sex, and unmarried sexually active patients, as well as discussions on sexual orientation are seen as barriers in taking sexual histories. These findings are similar to other studies where feeling of embarrassment, ill-preparedness, and the lack of a nonjudgmental approach may be barriers in sexual history taking [23,24]. It is clear that the training programs in medical schools need to address these issues, teaching students on how to handle uncomfortable situations and how to remain nonjudgmental.

Overall, the patient's opposite sex was found to have a significant impact on medical students' learning sexual history taking. It was found that opposite sex remains a social stigma in this particular cultural setting. For example according to the religious teachings of Islam, it is prohibited to look at or touch the private parts of another adult without a justified purpose, even if they are of the same sex [25]. Similarly, the female patient like to be examined by a female doctor, especially, when it comes to the private parts of the body.

The studies from western culture also reported the similar observations, for example, male students are more comfortable to examine the male genital parts than females, whereas, females are more comfortable to examine the female breast or pelvic [26]. It was found that male students gain significantly less experience and exposure than female students in taking sexual history and intimate area examination; this could result in a disparity among physicians, particularly on their future career choices, as well as disparities in the clinical care of patients [27].

Cultural and religious differences between the doctor and the patient were identified as a barrier in discussing sexual health. This finding is echoed in studies involving healthcare professionals. This is a significant finding within a multicultural society, where cultural and religious differences are inevitable. The concern is that, because of these barriers, doctors may shy away from taking sexual histories from patients and, thus, be unable to identify patients' health needs. Cultural competency training has been shown to improve knowledge, attitudes, and skills of health professionals, as well as patient satisfaction [28]. It is therefore recommended that such training could be incorporated within the sexual health undergraduate training module.

Nearly half of the student population in this study felt unprepared to take a sexual history and that the training they received was inadequate to provide them with the necessary skills. The importance of undergraduate training in taking sexual histories has been recognized in many medical schools around the world, but there are great differences in the extent to which this topic is covered [29]. In India, sexual history training remains an ad hoc topic covered by various specialties such as obstetrics and gynecology, primary care medicine, and general medical postings. In this study, students regarded these specialties as better than others at preparing them for sexual history taking. This finding raises the question of whether these specialties should take the lead in training medical students on taking sexual histories or whether other specialties should also be encouraged to explore such training within their curriculum to give students a broader understanding of sexual health.

In this study, most of the students agreed that videos and real patients were the most effective methods of learning the sexual history taking skills. This was also endorsed with previous finding wherein Choi et al [30] reported that the retention of audiovisual information is better than the theoretical information.

It was promising that unanimously most of the medical students indicated that sexual history taking (SHT) module might play an important role in enhancing the effectiveness of SHT training and would improve their SHT learning skills. Clinical classes, videos clipings and patient-simulated learning would be effective in sexual history taking training was concluded in this study as well as in earlier international studies [31,32].

Conclusions

This study identifies the gaps in sexual health training among undergraduate medical students. Lack of confidence in approaching the subject of sexual health, inadequate preparation were some of the barriers identified. The delivery of sexual health education program should incorporate confidence building and to make students feel comfortable to take a sexual history from patients. The barrier caused by differences in culture or religion between a doctor and a patient can be overcome through cross cultural and cultural competency training and this is important for multi-faith, multi cultural societies such as India. Students preferred to learn sexual history taking through clinical classes, video clippings and by patients simulated exercises. Our experience indicates that it is possible to teach and assess sexual history taking in a structured and objective fashion, even within the constraints of the current busy undergraduate training and examination schedule.

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