

'He said he had been out doing the traffic': general practitioner perceptions of sexually transmitted infection and HIV testing strategies for men

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ABSTRACT

INTRODUCTION: Sexual health is an important component of primary care, and optimal sexually transmitted infection (STI) and HIV testing by doctors could help improve sexual health outcomes for men. Currently, little is known about general practitioners' (GPs') assessment of STI and HIV risk, particularly in relation to male patients, and the degree to which current advice can be translated into consistent testing protocols. The aim of the study was to explore STI and HIV testing strategies for men in general practice and opportunities and barriers to more optimal testing.

METHODS: This study used a qualitative, multiple-case methodology, incorporating 17 distinct GP cases, drawing on in-depth, semi-structured interviews, and using thematic analysis.

FINDINGS: The following themes were identified: sexual health consultations by men in general practice are usually initiated by the patient; GPs appear to have a consistent rationale for their risk assessments in terms of STI testing; the nature of the doctor's interaction with men influences the quality of sexual health services utilisation; optimal sexual health consultations require sufficient time and a recognition of the 'delicacy' of the consultation content for both patient and health practitioner.

CONCLUSION: The stratified testing strategies undertaken by GPs appeared appropriate given the risk profiles of their patients. Constraints to optimal sexual health consultations were identified, including inadequate consultation time, male utilisation of GP consultations, and challenges in discussing sexual health topics within the consultation. Prioritising men's sexual health as a topic in CME may be helpful.

KEYWORDS: General practitioners; health communication; HIV; men; sexual health; sexually transmitted infections

Introduction

While men's health is recognised as important to overall national health outcomes, developing men's awareness of their health, and the role of general practice in maintaining and advancing it, remains complex.¹⁻³ This article focuses attention on the role general practitioners (GPs) play in men's sexual health. This is an important clinical topic, relevant to a wide age range of male patients. High rates of chlamydia, multi-resistant gonorrhoea and the risk of syphilis and HIV mean sexually transmitted infections

(STIs) are a major problem for the New Zealand health sector.⁴⁻⁹

Increasing appropriate men's STI and HIV test rates by GPs is a key preventive method to reducing transmission of infection.^{5,9,10-12} This is because testing leads to immediate access to treatment in primary care for common infections, such as chlamydia, and as a point of entry to referral for HIV infections.¹²⁻¹⁴

GPs are ideally placed to be a first point of contact for sexual health consultations. They will often

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have known the patient for a long time, and have an existing doctor–patient relationship that can facilitate conversations about delicate topics.^{1,15,16} However, there are also a number of obstructions that may reduce testing rates among men in this setting. These include the fact that men consult GPs less frequently than women, and that many consultations contain multiple competing demands for patient and doctor time.^{1,17}

Currently, little is known about GPs' testing behaviour for men in primary care.^{11,18–19} This study explores STI and HIV testing strategies for men by GPs, and provides new insights into the testing behaviour and test strategies of GPs in relation to STI and HIV and men.

Methods

This study used a qualitative, multiple-case methodology. It incorporates 17 distinct GP cases, drawing on in-depth, semi-structured interviews.

The GP cases were selected based on a cross-sectional survey of the testing patterns of GPs from multiple primary health care organisations in the Wellington region of New Zealand. The results of this determined the numbers of those who frequently test for HIV and STI and those who infrequently test, stratified by practice size, geographical location and doctor's gender (see Table 1). This purposive, maximal sampling method identified doctors with diverse patient populations.²⁰

WHAT GAP THIS FILLS

What we already know: General practitioners play a significant role in men's sexual health by assessing sexually transmitted infections and HIV risk and testing for them. However, little is known about the extent of sexually transmitted infections and HIV risk assessment in general practice, the consistency of questioning or the extent to which doctors identify patients with risk behaviours. There is also limited knowledge of what a doctor's rationale is for testing for sexually transmitted infections and HIV in men.

What this study adds: This study provides new insights into the testing behaviour and test strategies of general practitioners in relation to sexually transmitted infections and HIV with male patients. General practitioners describe an appropriate rationale for their sexually transmitted infection testing based on disease prevalence and knowledge of their practice populations.

Test frequency classification was calculated from doctor STI test request aggregated data (including chlamydia [first void urine], gonorrhoea [rectal, throat, and urethral swabs], genital herpes [viral swab], non-specific urethritis [urethral swab], syphilis and HIV [serology]) for male patients between 2006 and 2011 (Aotea Pathology, Wellington's testing laboratory). Cut-off points at the first and third quartiles of the distribution of testers were used. These were as follows: a high frequency tester (≥ 230 test requests) and a low frequency tester (≤ 130 test requests).

Participant recruitment was initiated by mail, and through a follow-up email and phone call requesting a face-to-face interview. In this process, participants were provided with a detailed study

Table 1. Cross-tabulation (stratified) sampling criteria*

	City-based practice		Suburban-based practice	
High-frequency STI/HIV testers	Male GP Large practice	Female GP Large practice	Male GP Large practice	Female GP Large practice
	Male GP Small practice	Female GP Small practice	Male GP Small practice	Female GP Small practice
Low-frequency STI/HIV testers	Male GP Large practice	Female GP Large practice	Male GP Large practice	Female GP Large practice
	Male GP Small practice	Female GP Small practice	Male GP Small practice	Female GP Small practice

Large practice: 4 or more GPs, including practice nurse, pharmacists, counsellors, and other health professionals

Small practice: 2–3 GPs, including practice nurse

* Data from the pilot case was included in the final results, resulting in a total of 17 cases

overview. Of 50 potential participants, 17 agreed and were recruited, while nine were unable to participate due to time pressures.

Sixty-minute, audio-recorded, semi-structured interviews were conducted by the principal investigator. The interviews explored risk assessment and perceptions of risk, pre- and post-testing conduct, and the operation and functions of the practice, during the previous five years. Interview transcripts were reviewed by participants for confirmation and accuracy.

Coding (using N-Vivo software) and thematic analysis was undertaken by the principal investigator to describe the behavioural patterns of the different cases within the cohort of GPs. While the interview questions provided a point of reference for coding, new data emerging from participants' answers were also taken into consideration. A hierarchy of codes were developed from 19 codes, and then consolidated into six broad themes. The thematic analysis process enabled the identification of common themes in answering the research question. In addition, divergence within the data were noted and presented in the findings.

The study was granted ethics approval by the Central Regional Ethics Committee (Ref. CEN/11/EXP/031).

Findings

The themes identified are discussed in this section with selected illustrative quotes.

Frequency and pattern of attendance at general practice

GPs identified that many men in their practice attended infrequently, reluctantly, or did not attend at all.

...the men, you know, at the best of times their attendance is infrequent and poor. (GP #6; Low frequency tester; Male; Small city practice)

Respondents reported that they tended to see men for sexual health issues when they were sick or concerned. That is, when men do present,

patient concern drives or initiates a sexual health consult, rather than it being doctor led.

The most common reason would be a conversation that is initiated by the patient. Basically they come with concern. (GP #13; Low frequency tester; Male; Large city practice)

The normal way would be if they are actually complaining of a specific issue, whether it is a discharge or dysuria or any sort of urinary problem or other symptoms. (GP #2; High frequency tester; Female; Large suburban practice)

However, the GPs reported that they may also initiate the sexual health conversation if prompts during history taking (for example, alcohol and drug use, chaotic lifestyles, mental illness) or examination indicated this to be appropriate.

Risk assessment

The GPs felt that they undertook a logical and rational risk assessment for their patients based on epidemiology and prevalence, building a framework that differentiated testing behaviour for very rare conditions, such as HIV and more common STI.

Respondents recognised that a stratification of risk exists. For example, GPs were aware of the risks, behaviours, and groups of most concern in regard to STI and HIV. GPs perceived the most 'at-risk groups' were young people for more common STIs (particularly chlamydia), and gay men or men who have sex with men (MSM) for HIV (an older group by comparison).

It [STI] is more commonly associated with teens and early 20s... Obviously, I see STI in people that are older than that. By and large, it is the single, socially mobile people... but not exclusively. For HIV it is the same. It is more prevalent in the gay community. (GP #8; High frequency tester; Male; Small city practice)

GPs also recognised that the asymptomatic nature of STI/HIV increases the difficulties of accurately establishing men's risk and therefore undertaking appropriate tests.

We might be missing them at a time when they are asymptomatic. (GP #12; High frequency tester; Female; Small city practice)

Usually we check or do the test if the patient presents with some symptoms. We do not routinely do it. (GP #3; Low frequency tester; Female; Large suburban practice)

Given STI/HIV testing is often not routine and/or there is no screening for men, the risk asymptomatic STI presents to men's health is further increased.

We routinely ask people do they smoke or how much alcohol do they drink, for example... but we don't [or] rarely ask about sexual behaviour. (GP #8; High frequency tester; Male; Small city practice)

With regard to HIV specifically, one doctor noted:

I have not asked much about HIV really. But it seems like it is rare in this area... or because we do not check routinely... it may be the reason. (GP #3; Low frequency tester; Female; Large suburban practice)

Time and timing

Successful sexual health consultations require time within a consult, appropriate lead-ins to that discussion, having the right experience, and asking the right question at the right time. However, opening discussions on sexual health during a routine consult may be difficult.

Often there is a lack of time in consultations due to competing demands. Most GP respondents commented that, with an average general practice consult time of 15 minutes, for non-patient-driven, non-sexual-health consults, the topic of sexual health would be unlikely to be broached.

I think in general practice there is such a wide breadth of things that you try to address, that it is hard within 15 min to address all of that. (GP #10; High frequency tester; Male; Large suburban practice)

Respondents reported this situation was different for women, who are more regularly engaged

with their GP for routine consults including oral contraception, cervical smear tests and pregnancy. While the discussions may be no less sensitive, being sexual health-related consults they offer appropriate lead-ins to a sexual health conversation.

I just see so many women say for contraception, which is a common reason for them coming to see me. So that is a perfect opportunity to say 'Well are you sexually active? Who are you sexually active with?' (GP #2; Low frequency tester; Female; Large suburban practice)

Respondents also raised the important issue of the doctor's gender in relation to asking about sexual health matters. Some female doctors recognised sexual health consultations with male patients as potentially difficult.

I think that women coming in for smears creates an opportunity to do routine screening that does not tend to exist for men. I am not in the habit of just raising it [sexual health]... I am a woman, obviously, so that may influence that sort of thing. (GP #15; High frequency tester; Female; Large city practice)

Respondents also recognised that sexual health would be placed as a lower priority if other competing demands were present.

For men, I am seeing them for their diabetes... It's a much harder intro [opening for discussion]. I know with me, I am just not gonna ask it...and it is only when they come in and say that they are worried or they are having dysuria that I would even broach the topic. (GP #2; High frequency tester; Female; Large suburban practice)

Finding the right language, interactional delicacy, and disclosure of risk

The right language

A number of GPs in the study noted that because of the sensitive nature of sexual health, asking the right question, and at the right time, was challenging in a sexual health consultation. This included the best way to ask a question, how questions should be phrased so as not to be offensive, and what the best time is to do so.

I think one of the most difficult problems is having the right question to ask that doesn't sound ridiculous or offensive or whatever... and whenever I have read that sort of stuff, you think, OK that is good... that question is a nice way to phrase it. But then you have got to try to remember it when it comes to the consult. (GP #2; High frequency tester; Female; Large suburban practice)

GP respondents differentiated between sexual health discussions and other lifestyle behaviours, which were easier to discuss. Further to this, GPs often perceived questioning male patients on sexual health as invasive and inappropriate if there was no patient concern or if they presented without symptoms or examination findings.

Well I do not question unless it is what they have come in for... unless they have got symptoms that might be suggestive of an STI. (GP #9; High frequency tester; Female; Large city practice)

Interactional delicacy

These GPs felt that the doctor-patient interaction in the consultation influences the doctor's risk assessment and testing behaviour.

I guess sometimes figuring out how to introduce this topic of conversation [sexual health] with individuals who have come in about something totally different... That can be quite tricky. (GP #15; High frequency tester; Female; Large city practice)

Disclosure of risk

Disclosure of risk behaviour or the lack of it can determine whether testing for STI/HIV takes place.

The risk is that people often are not going to tell you the full story because it is stuff that is embarrassing or stuff that there is a lot of stigma attached to... But they may not disclose to anyone ever. It is highly personal stuff. (GP #17; High frequency tester; Male; Large city practice)

Interviewees noted that specific risk behaviours and related information arise from within conversations, rather than being told directly about them. Conversely, at times patients are candid

about acknowledging risk behaviours, although they may not describe the risk in direct language.

A classic quote one of the guys made was, he said he had 'been out doing the traffic' ['cruising' in public places for a sexual partner or casual sex]. He did not have to give an explanation of what he had been up to. (GP #1; High frequency tester; Male; Small suburban practice)

Continuing medical education

Both formal and informal sexual health continuing medical education (CME) is regularly available to New Zealand GPs from a number of sources, including specialist sexual health services, GP professional societies, best practice guidelines, conferences, quizzes and online learning packages.

CME on sexual health was often seen by respondents to lack some essential elements, including a focus on men and men's issues, how to access men, and how to pose sexual health questions to them.

They [CME] are just sort of STIs in general... [that is] chlamydia, gonorrhoea, HIV management or whatever, rather than targeting getting men in, getting a specific population to get checked, or approaching men or that kind of thing. (GP #14; Low frequency tester; Female; Large suburban practice)

I think it is more clinical. What tests you need to do, and how you treat it. The whole kind of difficulties of how you introduce the subject and how you get the patient to provide the information, that is not actually gone into in any depth... If you don't know how to broach it and you are scared about embarrassing yourselves or embarrassing the patient, you don't go there [discuss it]. It is a lost opportunity. (GP #15; High frequency tester; Female; Large city practice)

Given GPs' current access to modern communication technology, many could benefit from accessing formal CME online, pitched at a level relevant to their experience and level of skill.

It would be good to do more online really, and then you could just flick through the stuff that you

know, do it in your own time and speed through it if you wanted to. (GP #12; High frequency tester; Female; Small city practice)

Discussion

This study highlights that it is male patients themselves who tend to initiate sexual health consultations in general practice settings, rather than health practitioners; and also that GPs appear to have a considered rationale for risk assessment in their strategies for diagnostic testing. In addition, the GPs in this study recognised that sexual health consultations may be difficult for both doctor and patients in terms of the sensitivity and delicacy of the topic area. Successful sexual health consultations thus require sufficient time and appropriate 'lead-ins' to ask the right questions in the right way and at the right time.

GPs are well positioned to drive initiatives to control communicable disease, working as they do within the areas of both personal and population health.²¹ This study confirms the previously identified importance of men's patterns of attendance at general practice, and its application to the field of sexual health care where GPs assess STI and HIV risk and test for them.^{1,10,13,15} Testing for STI in this setting remains a cornerstone of prevention efforts in sexual health care; the results of this study suggest that the current approach to discussing sexual health matters with men could be strengthened.

Study respondents highlighted that even when men do present in general practice, the challenge remains of raising the topic of sexual health amongst the list of other competing demands.^{15-16,18} This may be compounded by previous clinical perceptions 'unless the patient's chief complaint is 'sexual' specific, questioning may not be appropriate.' (p.22)¹⁵ There is then the further challenge of constructing realistic, pragmatic and effective STI/HIV testing and screening protocols for men.^{11,13,19,22-23}

The GPs in this study emphasised that patients without risk factors, for example no STI infection or documented history of STI, and those who do not initiate conversation about sexual risk behaviours or sexual activity, are unlikely to

be tested for STI/HIV. This is of some concern given that testing is the cornerstone of prevention efforts.^{5,9,14}

GPs in the study identified a range of factors influencing their management of male patients' sexual health, in particular, that good communication within a sexual health consultation is a complex matter. In this regard, this cohort of doctors recognised that disclosure is a requirement of any successful risk assessment, and often determines whether testing is undertaken. Doctors in this study also stated that asking the right questions can be difficult. The difficulty extends to the best language or way to phrase the question, how not to be offensive, and the best time to ask. These findings echo those of other work on men's health and patient engagement.^{1,6,8-18,24}

Doctors in this study also stated that asking the right questions can be difficult. The difficulty extends to the best language or way to phrase the question, how not to be offensive, and the best time to ask

While GPs felt that their approach to risk assessment and testing was undertaken within a logical framework of disease prevalence and probability, they also felt a greater focus on men's specific sexual health issues in CME is warranted. At present, most GP respondents commented that there is inadequate CME provided with a male-specific sexual health focus—for example, on how to access men and provide a conducive consultation environment, how to open discussion with men and how to pose sexual health questions.

In this regard, novel approaches to online learning and information access for GPs could be helpful, such as CME directed at GPs offering flexible online learning options, provided in multiple formats, and in modules pitched at an appropriate level to experience.^{16,25}

This research provides new insight into the risk assessment and testing behaviour of GPs

in relation to STI and HIV in men, including the strengths and weaknesses of current test strategies. We are not of the opinion that these results or any current evidence-based guidelines suggest a case for routine or population health screening for STI/HIV for men in general practice settings. Rather, we agree with the doctors in this study who highlighted the importance of encouraging men to attend general practice. This study also confirms the need for appropriate communication about sexual health in consultations in order that GPs can tailor testing strategies to meet men's needs.

Strengths and limitations

This study focused on city and suburban areas in a major New Zealand city (Wellington) and did not include a rural practice context. However, many of the findings of this study align closely to other research in sexual health conducted in New Zealand and elsewhere and may have general applicability.

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COMPETING INTERESTS

None declared.

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