Viewpoint

Sexual health in general practice: history and the partner history

Philippa Matthews

Mad Men
The 50th anniversary of the contraceptive pill has been much discussed, and women of the generation that obtained ‘the pill’ in its earliest days have been telling how they had to pretend they were married or had a fiancé.

A brief fictionalised account of this era was given in one of the earliest episodes of the nuanced television series, Mad Men, set at around this time in New York. The single Peggy has been tipped off by her colleague Joan about a gynaecologist who will give her contraception. We find Peggy in a hospital gown sitting on the doctor’s couch, studying an information booklet entitled ‘It’s Your Wedding Night’. The cover has a picture of a bride in full regalia, carried in the arms of her groom.

The doctor enters the room, lights up a cigarette and puffs. “I see from your chart – and your finger – that you’re not married.” “That’s right”, responds the nervous Peggy. Her doctor recommences in a way that gives us some hope for Peggy: “I’m not here to judge you – nothing wrong with a woman being practical about the possibility of sexual activity. Although as a doctor I would like to think that putting a woman into this position will not turn her into some kind of a strumpet”. Hopes dashed – and by this time he is inserting a speculum. “I will warn you now that I will take you off this medicine if you abuse it. It’s for your own good really. The fact is, even in our modern times, easy women don’t find husbands.” Peggy assures him she is responsible. He gives her the prescription, saying: “They are eleven dollars a month, so don’t think you have to go out to become the town pump just to get your money’s worth. Excuse my French”.

Swinging 60s
It is apparent that in the UK women faced similar, often worse, experiences, and I heard from one family planning clinic doctor that the clinic staff would, after providing contraception to a woman, investigate whether she had actually got married when she had said she would.

So one can quite imagine, as the 1960s and 1970s rolled on, the effect this legacy might have on those pioneer doctors and nurses who were trying to give women control over their reproductive health. I can imagine there would be a strong and natural inclination not to ask a woman about her partner – or lack of partner. None of their business, judgemental, irrelevant. Many of our teachers and role models might, quite justifiably, have actively avoided this area of questioning.

This avoidance of taking a partner history might have been compounded by the historical, and profound, separation of ‘venereal disease (VD)’ clinics from ‘family planning’ clinics, despite the fact were both were working to minimise the unwanted consequences of sex. Clinics to tackle and treat sexually transmitted infections (STIs) were established partly in response to the needs of soldiers returning from World War I. In the publicity and information the men were, to a degree, portrayed as the innocent victims – of the other service users: female prostitutes. By the time of World War II, ‘manly’ men were being encouraged to use protection. Efforts to control infection through partner notification were already being made (although there were hopes that peace time would render this unnecessary). In other words, these services had recognised a clinical need to take partner histories.

The attendees of genitourinary (GUM) clinics, and indeed the specialty as a whole, remained seriously stigmatised for many years, many would say decades, after World War II. In the 1940s and 1950s, when barrier contraceptive methods, such as cervical caps, were beginning to be available to women, it would have been inconceivable to link together these
two spheres of sexual health. Contraception was for
nice, married women – and clearly nothing to do with
STIs. Oral contraception arrived in this environment.

Sexual behaviour changed, and herpes and geni-
tal warts were becoming a great deal more common
through the 1960s and 1970s. But perhaps many doc-
tors and nurses providing contraceptive services were
deskilled – almost deliberately deskilled – in sexual
history taking? The clinical value was not appreciated
in the context of the provision of contraceptive care.
And still, perhaps, it sounded altogether too much like
prying, too much as though a woman’s marital status
might be being determined?

Why ask?
In fact there is great clinical value in taking a partner
history as part of a full sexual history. Large studies tell
us that those who have had a change of sexual partner
in the last 3 months, or those who have had two or
more partners in the last 12 months, are at higher risk
of having chlamydia (though with any given individual
one must not be too literal in interpreting what are
rules of thumb). The gender or country of origin of
the sexual partner(s) may help us weigh up risk of HIV,
and we may need to consider the partner history quite
far back if we are worried about a late presentation
of HIV. We may find that the patient is in a mutually
first, mutually monogamous relationship – and at no
apparent risk of STIs. And, as we ask and listen, we
may learn things about the quality of the relationship
that are important to our patient – their relief as they
confide their fears that their partner might be having
sex with other people, and should they have tests for
infections? Or we may become concerned if a young
person reveals the much greater age of their partner. If
a diagnosis of an STI has been made we may act on the
partner history to explain the need for partner notifi-
cation and treatment (if the STI is one for which this is
indicated: this is not necessarily the case for some STIs
such as genital warts or herpes).

Being able to take a partner history (indeed a full
sexual history – other aspects will be covered in future
articles in this series) is a key skill of the modern ‘family’
doctor. The value of taking partner histories becomes
more apparent the more you ask, and, once strategies
have been developed, it takes very little time.

What to ask
So which questions work? A 24-year-old newly reg-
istered patient tells me she has “Just come for some
more pills”. We have personal lists in our practice – so
I will take pride in using this very first consultation to
get to know her – just a little – and start to build our
relationship. Has she just moved? What brought her to
the area? Is she working? Is she living alone? How is
she finding life in London?

If I have asked a few ‘social’ questions to get to know
her and her personal circumstances; I might already
have been told that she has a partner, but, if not, I
cannot assume that she has one simply because she is
on the pill. It is interesting how many women choose
to carry on with the pill even when they have no con-
traceptive need, as a ‘just in case’ or because periods
were heavier or more painful without it. I look after
women who have lived in, or are from, an array of
other countries. Sometimes they have been told the pill
is indicated for a reason we would not necessarily rec-
ognise, for example, “I had an ovarian cyst that went
after I was given the pill”.

I find the GUM traditional opening question for
the sexual history “When did you last have sex?” or
“When did you last have sex with someone who wasn’t
your regular partner?” a little too bald for my clinical
context. I prefer “Do you have a partner at present?”
“How long have you been together?” The questions so
far from a ‘family doctor’ will probably feel quite natu-
ral for a patient. In fact they are almost ‘safe’ social
questions. However, if I want to move on to take a
more detailed partner history I think I need to explain
to my patient why, I need to reveal my agenda. So I
might say: “We find quite a few under-25s have sexu-
ally transmitted infections, have you ever had a test
for chlamydia? Do you think you could be at risk? Could
I ask you some questions to check?” Or I might say:
“We find sexually transmissible infections to be quite
common, so we are trying to talk to our patients using
contraception to see if they could be at risk”.

Whatever my motivation for taking a sexual history, I will want
my patient to understand it – as was discussed in the
preceding article in this series. Then (if she has been
with her current partner more than a few weeks) I
will return to the partner history. “You said you have
been with your boyfriend 18 months – have you had
sex with anyone else in that time?” I can then ask the
mirror question: “Has your partner had sex with any-
one else in that time? This is one of the most useful
questions to ask, because I will then gain insight into
the woman’s own sense of risk. “Well you know what
men are like” frees me to discuss STIs and offer test-
ing, whereas a calm and confident “No” means I will
assess risk on the basis of other aspects of the history
and clinical picture.

I will explore the partner history back to the most
recent risk. If she is not currently in a sexual relation-
sip I will find out when she last had sex or if she has
had a sexual partner. This short sequence of questions
making up a partner history brings helpful informa-
tion surprisingly fast – whether the patient is at rea-
sonably high risk, because they had a partner change
quite recently, or whether they have been in an appar-
ently mutually monogamous marriage for 9 years:
one can establish the situation quickly. How far back I
take the history, and what other questions I might ask,
will be influenced by my original motivation for tak-
ing the history – the patient with possible HIV-related
symptoms might be asked: “Have you ever had sex
with someone from a country where HIV is common?” “Have you ever injected drugs?” “Have you ever had an HIV test?” alongside other aspects of the sexual history, such as assessing condom use and asking about sexual practices.

What to believe?
Providing a confidential service – and being seen to provide it – are essential components to helping patients feel able to talk. This is going to be even more important if your practice serves a small and stable community. But even if we provide a most secure space for talking, how do I know if the patient is lying to me? And anyway, how would someone know if their partner was secretly having sex with other people? I don’t; they may not. The approach I take is invariable: I believe what the patient has told me. This works, treats the patient with respect and avoids causing offence. I find that if the patient has understood why I am asking my questions (i.e. why it is relevant to their health) then they will also understand the implications if some of the information is wrong. If the patient is asymptomatic, and I have found no evidence of risk of STI, I will leave it there: “From what you tell me you are not at risk of having an STI, but I am quite happy to do tests for chlamydia or HIV anyway if you would like these”. Alternatively I might have been taking a sexual history because a patient has symptoms which might, or might not, be caused by an STI – a young man with troublesome mouth ulcers, or a 40-year-old woman with intermenstrual bleeding. I might need to exclude HIV or chlamydia, respectively, but non-STI causes might be much more likely. So finding a ‘no apparent risk’ sexual history I might say: “From what you tell me you are not at risk of having [HIV, chlamydia]. Would you like me to do a test to rule that option out altogether, or shall we look into other possible causes first?”

The ‘no apparent risk’ group are important to us in general practice. If a GUM clinic attender is at no apparent risk, it simply begs the question: “Why are they there then? Surely they must be?” “Everyone is at risk of an STI” makes perfect sense from a GUM perspective – there is no point in assessing risk, except to identify those at highest risk who might need more detailed health promotion advice. In general practice this is not the case. Sexual histories taken frequently, normalised, in the general practitioner (GP) context reveal there really are a lot of people at no, or very low, risk of having an STI. In fact our service users populate the entire spectrum of sexual health risk, with plenty at the high end too.

Once he had established Peggy had the ‘wrong’ marital status, Peggy’s doctor took a ‘No questions asked’ (but lecture nonetheless delivered) approach. We know nowadays that lecturing is not a strategy for health promotion (let alone the imposition of moral values!). We should also have confidence that a ‘No questions asked’ approach belongs to times past.

If you would like to learn more about partner history-taking in general practice see e-GP on http://www.e-GP.org.uk – sessions 11_001 through 11_003.

Future articles
This series of articles will explore a variety of the practical aspects of providing sexual health care as a GP or practice nurse.

Competing interests None.

Provenance and peer review Commissioned; internally peer reviewed.
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*J Fam Plann Reprod Health Care* 2011 37: 68-70
doi: 10.1136/jfprhc.2011.0087

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