

# Talking with the patient:

## risk assessment and history-taking

<b>Sarah Huffam</b>	Technical Advisor for HIV Treatment and Care, National Center for HIV/AIDS, Dermatology and STDs, Ministry of Health, Cambodia; and Senior Lecturer, National Centre in HIV Epidemiology and Clinical Research, University of New South Wales, Sydney.
<b>Paul Haber</b>	Head of Drug Health Services, Royal Prince Alfred Hospital, Camperdown, New South Wales.
<b>Jack Wallace</b>	Researcher, Australian Research Centre in Sex, Health and Society, LaTrobe University, Melbourne, Victoria.
<b>David Bradford</b>	Visiting Medical Officer and former Director, Cairns Sexual Health Clinic, Cairns Base Hospital, Cairns, Queensland.

### Introduction

Rapport, trust and effective communication are vital components of the doctor-patient relationship and contribute significantly to a clinician's ability to take a comprehensive history, particularly in the context of the sensitive issues around human immunodeficiency virus (HIV), sexually transmissible infections (STIs) and viral hepatitis. A thorough sexual and drug-use history is required to identify specific risk factors and behaviours regarding HIV, STIs and viral hepatitis, to establish a diagnosis and to provide a setting for targeted prevention and harm reduction messages and strategies.

Effective communication skills permit and encourage patient involvement in decision-making processes. This participation is associated with greater patient satisfaction, increased compliance with treatment and the creation of a relationship in which the patient feels comfortable raising issues such as death, grief and relationship or sexual problems.<sup>1,2</sup>

### General issues

Taking a sexual and drug-use history helps to ascertain the patient's risk of blood-borne viruses and STIs. To be effective, the process needs to be thorough and several factors should be considered before starting the interview.

The physical environment needs to be conducive to private discussion and adequate time must be set aside. If one appointment is not sufficient, allow for further discussion when the patient returns for his or her test results or follow-up, or suggest that the patient return another day to complete the interview.

Key elements of effective communication are listening carefully and being interested, non-judgemental and observant. Taking notice of the patient's unspoken cues and reflecting together on the most salient points may assist communication. Reflection is a very simple technique that gives the patient the opportunity to correct any misunderstandings and allows the clinician to check that he or she is on the right track.

### Key points

- Sexual and/or drug history-taking begins with general issues and progresses to more detailed and specific questioning regarding risk behaviours
- Factors that will assist effective communication during sexual and drug history-taking include:
  - A comfortable space and adequate time
  - Privacy and the absence of interruptions
  - Assurance and explanation of confidentiality
  - A non-judgemental attitude
  - Knowledge about alternative lifestyles and a willingness to learn
  - A willingness to discuss sexual and drug-use behaviour in detail
  - Listening carefully to the patient
  - A focus on the goals of the interview
- The cultural appropriateness of sexual history-taking may require consideration, particularly with regard to the gender of the clinician

One approach is to introduce the topic and explain to the patient the reasons for such detailed and private questioning. An opening statement that normalises the discussion may be useful. For example: 'Do you have any concerns about your risk of exposure to hepatitis C, HIV or other sexually transmitted infections?' The clinician may then state that it is important to raise these issues with all patients. Initial, open-ended questions should be followed by more detailed questioning. The clinician may begin by addressing the least confronting issues, followed by specific questions when the patient appears comfortable.

Communication style and language will vary depending on the clinician and the patient. The clinician is advised to use language with which he or she feels comfortable and familiar, and that takes account of the language used by individual patients. If the clinician doesn't understand a word or phrase the patient has used, an explanation should be requested. This helps to develop trust and a sense of engagement, as well as clarity of information.

The clinician should assure clients that confidentiality will apply to all information obtained in the context of clinical service delivery. Confidentiality issues may be especially important for adolescents and those living in smaller communities. While reassuring the patient, make clear early on that there are limitations to confidentiality in every jurisdiction, such as the requirement to report individuals who deliberately and repeatedly put others at risk of HIV infection, or to notify authorities where there is evidence of child abuse.

A major barrier to effective communication is awkwardness and embarrassment of patient and clinician when discussing sexual practices or recreational/injecting drug use. In particular, a clinician who has a long-standing relationship with a patient may be unable to broach certain topics. Alternatively, he or she may have difficulty raising sexual matters with patients of the opposite gender or of a different sexual orientation or age group. Lack of training, time constraints and limited knowledge of cultural and lifestyle issues can result in a reluctance by the clinician to persevere with these interviews.<sup>3,4</sup> A simple lack of practice also may impede a clinician in successfully taking a sexual and drug-use history. For issues that challenge the values or beliefs of the clinician, discussion with a colleague may help to familiarise him or her with unusual or challenging language or concepts.

Patients are often reluctant to report behaviour that is stigmatised and they may feel unable to discuss their behaviour with friends or family. If they feel they can trust the doctor, they may be happy to talk about their risk behaviours in the clinical setting, but the clinician may need to initiate this discussion.

It is useful to consider strategies for managing conversations that become awkward or difficult (Table 3.1). Breakdown in communication is very common and may result in a change of topic. If the interview is progressing poorly, it may be helpful for the clinician to consider his or her own responses to the content of the discussion. It is vital to be aware of the cues the patient is giving and to try to ensure his or her needs are met by the consultation. Empathy, humour and digression may help to dissipate anxiety. Clarifying or redirecting statements, such as 'Could I ask another question about HIV?' can help to structure the interview.

Despite knowledge and experience, interviews don't always go well. It's important to remember that 'Rome wasn't built in a day', and obtaining a full sexual and drug-taking history will often require several visits and gradual development of respect and trust between patient and clinician. Striving to ensure that the patient goes away from the initial consultation with the feeling that it was a positive experience and that the prospect of a return visit is not too onerous is far more important than pushing on with unfruitful lines of enquiry. Sometimes, however, referral to another clinician or service may be appropriate.

**TABLE 3.1 What prevents effective communication?**

• Inadequate physical environment (lack of privacy, lack of time, interruptions)
• Uncertainty about confidentiality
• Insufficient language skills or lack of a satisfactory interpreter
• Inability to persevere through awkward times in the interview
• Assumptions about sexuality and behaviour
• A judgemental attitude (displaying prejudice or lack of interest)
• Not listening to the patient
• Inappropriate use of open and closed questions
• Interrupting the patient excessively
• Ignorance and prejudice about alternative lifestyles

## Risk assessment

### General medical history

It is less threatening to discuss general medical history first and then lead into a more specific sexual and drug-use history. Early in the interview, non-threatening questions relating to HIV, STIs, hepatitis B and hepatitis C may be asked. These questions may address:

- A history and dates of blood transfusions (including major trauma or surgery, during which the patient may have been unaware of blood transfusion)
- Tattoos (including where, when and whether done professionally)
- Country of birth and residence
- Cultural practices (such as initiation ceremonies)
- Family history
- Vaccination history
- Piercing and other body modification
- Current baseline knowledge about HIV, STIs, hepatitis B virus (HBV) and hepatitis C virus (HCV)

**TABLE 3.2 Drug history checklist**

• Drug use (past and present)
• Type of drugs used (prescription, alcohol and tobacco, illegal)
• Routes of administration
• Sharing of injecting equipment (including swabs, filters, water, etc.)
• Associated harms and evidence of dependence
• Motivation to cease drug use or use non-injecting routes of administration

### Drug-use history

Table 3.2 provides a checklist of information to gather when taking a drug-use history. General questioning may address the use of prescription medications, tobacco and alcohol, followed by use of non-prescription and illicit drugs. High levels of alcohol consumption

**TABLE 3.3 Injecting drug use equipment and language**

**Common injecting equipment**

The drug(s); water; spoon; filter; swab; tourniquet; syringe; needle; disposal container.

**Language**

The mix (drug and water); mixing; jacking back (obtaining a blood flashback in the syringe); pick (needle or needle and syringe); fit (needle and syringe); whack (either needle and syringe or the drug or the injection); whacked or hit (an injection of drugs); user (person who injects drugs); works (equipment); smack (heroin); gear (illicit drugs generally); ice, goey, whiz, speed, meth, d-meth, crystal, crystal meth, shabu, batu, tina and glass (amphetamines).

**TABLE 3.4 Safe injecting procedures<sup>7</sup>**

**1. Preparation**

- Choose a safe place to inject—avoid injecting alone
- Clean the area where you will be mixing
- Have everything you need within reach
- Wash hands (with soap and water or swabs)

**2. Mixing up**

- Clean the spoon with a swab
- Put the drugs into the spoon
- Use a new sterile fit to draw up water from new ampoule of water (or cooled boiled water in a clean glass)
- Do not put a used syringe into a group mix
- Add water to the spoon with the drugs; mix
- Add filter to mix
- Draw solution up through filter to remove impurities
- Remove air bubbles

**3. Injecting**

- Wipe injection site with swab
- Place tourniquet around arm above injection site (don't leave it on too long)
- Put the needle into your arm at 45° angle
- Pull back the plunger; blood should appear in the needle. If no blood appears, remove needle, stop blood flow and try again
- When you are sure the needle is in a vein, loosen tourniquet and depress the plunger, injecting solution
- Remove needle and apply pressure to site to stop blood flow

**4. Clean up**

- Rinse your fit with cold water (reduces contamination risk and gets rid of some blood in case fit is to be used again. See Appendix 4)
- Dispose of rinsing water
- Dispose of fit (recap your own, never recap another person's syringe)
- Wipe down the area where you have mixed up
- Wash hands and arms with soapy water (if not possible use swabs) Appendix 4 provides instructions on cleaning injecting equipment.

can play a significant role in sexual risk-taking and may be a target for discussion about risk reduction. Non-prescription drugs may also alter judgement and be a factor in the assessment of sexual risk. In addition, the sharing of straws or other equipment used to snort drugs has some risk of HCV transmission.

## Injecting drug-use history

Important information to obtain about injecting drug-use includes:

- Whether and when any needles or other drug injecting equipment (such as swabs, waters or filters) were shared
- The types of drugs injected
- The frequency of drug use
- The duration of drug use
- The most recent occasion of use

Interviews about drug-use should be informed by a basic knowledge of common injecting drug-use equipment and practice, and the potential for HCV transmission at all stages of the injecting process. Table 3.3 contains a summary of drug-use language and equipment and Table 3.4 has a summary of safer injecting practices. Chapter 15 provides details of some relevant referral and information services.

Gathering detailed information will assist the clinician to assess the patient's risk of acquiring and transmitting infections, as well as the possible duration of infection. Drugs that may be injected include performance-enhancing substances such as steroids, as well as amphetamines, ecstasy, benzodiazepines and opiates such as heroin. Frequency and duration of use vary considerably; risk behaviour may consist of a few episodes of sharing injecting equipment many years ago, which the patient may be reluctant to disclose. It may be useful to suggest: 'Many people have indicated that they have injected only one or two times many years ago—could this be the case with you?'<sup>11</sup> Other useful questions regarding drug history are outlined in Table 3.5.

Health promotion about harm or risk reduction with regard to injecting drug use requires the clinician to have knowledge of safe procedures and information about local services, such as needle and syringe programs (Table 3.4 and Chapter 15). It is appropriate to discuss whether the patient wishes to reduce or cease drug use, and whether he or she would like a referral to an appropriate treatment service. Alternatively, non-injecting routes of drug administration, such as snorting and swallowing drugs, may reduce risk. If the patient is drinking alcohol at hazardous or harmful levels you should discuss strategies such as alternating their alcoholic drinks with either water or a soft drink. Patients and clinicians can access a range of agencies and resources providing information, advice and support for minimising harmful substance use. These include: Alcohol and Drug Information Service (ADIS), Alcoholics Anonymous (AA), Reachout, NHMRC Alcohol

**TABLE 3.5 Useful questions about injecting drug use**

• Have you ever injected?
• What do you inject?
• How often do you inject?
• Do you inject alone, or with other people?
• Have you shared needles or other injecting equipment?
• Do you know how to inject safely?
• Have you ever overdosed?
• Do you binge on drugs at certain times?
• Do you know how hepatitis C is transmitted?
• Are you concerned about your drug use?

Guidelines<sup>5</sup>, and Lifescrpts.<sup>6</sup> Details for ADIS, AA and Reachout are included in Chapter 15.

## Sexual history

The purpose of taking a sexual history is to assess and limit the risk of acquiring an infection with HIV or another STI. Sexual orientation or identity does not always equate with particular behaviour, therefore information about sexual practices, barrier and condom use and the risk behaviours of sexual partners is more specific and useful than the patient's stated sexual orientation and marital or partnership status. Common and often incorrect assumptions are related to heterosexuality, monogamy and preferred sexual practice.

The clinician should ascertain whether vaginal or anal penetration has taken place. Questions about anal sex should be asked of both men and women and, in the case of male-to-male sex, it should be determined whether penetration was receptive, insertive or both, e.g. was the patient a 'top', a 'bottom' or was he 'versatile'? Oral sex confers a lower risk of HIV transmission, but several STIs including herpes simplex virus (HSV), syphilis, gonorrhoea and chlamydia are readily transmitted by oral sex, which may take the form of oro-penile (fellatio), oro-vulval (cunnilingus) and oro-anal (rimming/anilingus) sex.

Penetration of the vagina or anus with sex toys, fingers and hands, or a full fist and forearm ('fisting') is generally considered low risk for HIV. However, this type of penetration may result in trauma that can provide a portal of entry for infection. As well, even without trauma, STIs can be transferred via contaminated fingers from anogenital sites of an infected partner even if no actual penile penetration occurs. The clinician may need to establish the precise nature of non-penetrative practices. Some non-penetrative practices such as mutual or non-shared masturbation are low-risk

<b>TABLE 3.6 Risk assessment – useful questions</b>		
<b>Sexual practice</b>	<b>Condom usage</b>	
<ul style="list-style-type: none"> <li>Do you consider that you might be at risk of HIV or another sexually transmitted infection? (Detail what activities may put someone at risk if necessary)</li> </ul>	<ul style="list-style-type: none"> <li>Do you or your partner/s use condoms? Always, or how often?</li> </ul>	
<ul style="list-style-type: none"> <li>Do you have any concerns about HIV or other STIs (e.g. chlamydia, herpes)?</li> </ul>	<ul style="list-style-type: none"> <li>Do you know about female condoms? Have you ever used them?</li> </ul>	
<ul style="list-style-type: none"> <li>When did you have sex last? (An important question for women if there is any chance of pregnancy)</li> </ul>	<ul style="list-style-type: none"> <li>When did you start using condoms?</li> </ul>	
<ul style="list-style-type: none"> <li>Who was it with – someone you knew well, or a casual contact?</li> </ul>	<ul style="list-style-type: none"> <li>When don't you use condoms?</li> </ul>	
<ul style="list-style-type: none"> <li>How many sexual partners have you had over the last three months? Since the last STI screen?</li> </ul>	<ul style="list-style-type: none"> <li>What are your reasons for not using condoms?</li> </ul>	
<ul style="list-style-type: none"> <li>When did you last have a regular sexual partner?</li> </ul>	<ul style="list-style-type: none"> <li>Do you have any problems using condoms?</li> </ul>	
<ul style="list-style-type: none"> <li>Have you had any other sexual partners?</li> </ul>	<ul style="list-style-type: none"> <li>Do they fit well?</li> </ul>	
<ul style="list-style-type: none"> <li>Are your sexual partners male, female or both?</li> </ul>	<ul style="list-style-type: none"> <li>Do you use a water-based lubricant?</li> </ul>	
<ul style="list-style-type: none"> <li>What types of sexual activity do you engage in with your partner? Vaginal? Oral? Anal? (Clarification may be needed)</li> </ul>	<ul style="list-style-type: none"> <li>Have any condoms broken?</li> </ul>	
<ul style="list-style-type: none"> <li>Have you ever had an STI (e.g. chlamydia, herpes, gonorrhoea) or a check-up for STIs?</li> </ul>	<ul style="list-style-type: none"> <li>When do you put the condom on? When the penis is erect?</li> </ul>	
<ul style="list-style-type: none"> <li>Do you know whether your sexual partners have been at risk for HIV or STIs? Have your male partner/s had sex with other men? Have your sexual partner/s ever injected drugs? Have your sexual partner/s lived in an area where many people have HIV?</li> </ul>	<ul style="list-style-type: none"> <li>Do you (or does your sexual partner) sometimes only put a condom on when he is near to climaxing (coming)? (This practice is known as 'dipping' and can obviously be risky)</li> </ul>	
<ul style="list-style-type: none"> <li>Have you ever been a sex worker?</li> </ul>	<th><b>Other transmission risks</b></th>	<b>Other transmission risks</b>
<ul style="list-style-type: none"> <li>Have you ever been the client of a sex worker?</li> </ul>	<ul style="list-style-type: none"> <li>Did you have a blood transfusion or use blood products before 1990 in Australia?</li> </ul>	
<ul style="list-style-type: none"> <li>For MSM – do you use 'beats'; do you go to saunas or sex clubs? How frequently? What sexual activities do you take part in there?</li> </ul>	<ul style="list-style-type: none"> <li>Have you had a medical procedure or blood transfusion overseas? Where and when?</li> </ul>	
	<ul style="list-style-type: none"> <li>Do you have tattoos? (Ask for details) In which country were they done, and were they done professionally?</li> </ul>	
	<ul style="list-style-type: none"> <li>Have you had ever had a piercing or other body modification done? In which country was this done, and was it done professionally?</li> </ul>	
	<ul style="list-style-type: none"> <li>Have you ever had a sexual partner or household member who had hepatitis B or C?</li> </ul>	
	<ul style="list-style-type: none"> <li>Have you ever had a sexual partner or household member who was at risk of hepatitis B or C?</li> </ul>	
	<ul style="list-style-type: none"> <li>Have you ever been in prison?</li> </ul>	

activities. Other non-penetrative sexual practices, such as sadomasochism and piercing during sex (which may involve mucosal trauma or blood-to-blood contact), may have a moderate-to-high risk of transmission for HIV. Examples of questions to be asked during sexual risk assessment are listed in Table 3.6.

While engaging in sex work may not be common for the clientele of most primary care practitioners, it is considerably more common than most clinicians imagine. Both women and men may engage in sex work for varying periods of time for a variety of different reasons. Experienced sex workers will probably know more about safe sex practices than most clinicians, but the young, those 'working' opportunistically, those working on the street (perhaps to support a drug habit) and some sex workers newly arrived in Australia or those with a poor grasp of English may be putting themselves at risk through unprotected sex. Clinicians should keep the possibility of sex work in the back of their minds and also, with male patients, whether they are clients of sex workers. Questions about these matters need to be asked sensitively and only when very good rapport has been established with the patient—probably not on the first visit.

When discussing sexual practices it is important that the clinician and patient understand each other. The clinician may seek to maximise understanding through specific questioning, explanation and clarification. 'Have you been sexually active?' may be taken to mean only vaginal or anal penetrative sex, so it may be appropriate to indicate that the question also relates to oral or other sexual activity. Specific questions such as 'Do you ever have oral sex, where you suck on his penis? Does he ejaculate (or come) when his penis is in your mouth?' or 'Does your partner ever bleed following vaginal penetration?' may be useful in establishing the level of risk. Table 3.7 provides a checklist of information to gather when taking a sexual history.

Where appropriate, condom use, including use of the female condom, should be explored in detail. Female condoms are more expensive, less readily available, noisy during use, and for some people have an unacceptable appearance and feel, but they are effective and suit some patients (especially those allergic to latex). They should not be forgotten. Questions relating to condom usage, as outlined in Table 3.6, form part of risk assessment and provide an opportunity to discuss effective safer sex practices. In addition, discussion may address other safe sex measures.

For example, cervical diaphragms may offer some protection and latex dams can be used for oral-anal and oral-vaginal sex by men and women. Latex gloves or condoms can be used for digital and sex toy penetration. Lubricants may reduce the risk of vaginal trauma and subsequent infection.

**TABLE 3.7 Sexual history checklist**

• Number of sexual partners and their gender
• Any same-sex sexual activity ever, even if uncommon or intermittent
• Specific sexual practices
• Presence of a sexual partner with an STI or with risk factors for infection
• Awareness of risk reduction techniques and extent of compliance with these
• Sexual health check-ups in the past
• Past STIs and their treatment
• Sex work or being a client of sex workers
• If MSM, use of 'beats' or visits to sex on premises venues (SOPVs)

Every primary care clinician will have in their practice some men who have sex with men (MSM) and some women who have sex with women (WSW) even if those patients do not always, or even often, engage in same-sex sexual activity. These patients have particular sexual health needs and clinicians should gain some basic knowledge about homosexually active men and women—it is counter-productive to reveal ignorance about lifestyle and sexual practices when trying to take a sexual history.

Some MSM (including those who have a regular female partner or wife) seek male sexual partners in risky situations like public toilets ('beats') or sex-on-premises venues (SOPVs) which include male saunas and sex clubs. If, as is often the case, the behaviour is impulsive or unplanned, condoms may be unavailable and unprotected sex may take place.

In SOPVs, sex with more than one partner may occur and even if condoms are used for penetrative anal sex, other STIs may be acquired through oral sex (including syphilis, herpes, urethral gonorrhoea or chlamydia). Believing lesbian women to be at low risk for STIs generally, clinicians sometimes provide WSW with a false sense of security and even recommend that routine Papanicolaou smears are unnecessary. A significant percentage of WSW do have sex with men throughout their lives and are therefore exposed to transmission of STIs (including high risk human papillomavirus (HPV) types like 16 and 18) from male partners.

Oral sexual practices and sharing sex toys will lead to STI transmission risk and this includes WSW. Even exclusively lesbian women are at increased risk of bacterial vaginosis.

### Prevention and harm reduction messages

Opportunities for educating about harm reduction and safe sex often arise during an assessment of risk. The primary care clinician may take these opportunities to ensure the patient understands the risks of sexual activity and drug use, as well as safe practices. Many people will be well informed about safer practices but may not adhere to these all the time. Occasions of risk-taking can be identified and explored. It is important that the patient feels he or she can discuss episodes of unsafe behaviour without being judged or lectured. Gaining an understanding of the patient's perspective and responding to his or her emotions will help in facilitating behavioural change. Common themes in a discussion of risk-taking may include negotiating safer sex with partners, drug and alcohol consumption, or apathy and depression.

The clinician may engage the patient in generating his or her own solutions to unsafe practices. Questions such as 'Has this happened before?', 'What did you think or do on that occasion?', 'What were the outcomes?' and 'How did you feel?' may assist the patient to identify and avoid particular situations and reinforce safe practices. Acknowledgement of the difficulties a person may face in trying to adopt or negotiate safe sex or safe injecting may facilitate a more productive discussion. Consideration should be given to the difficulty in challenging entrenched cultural norms such as 'men are in charge of condoms' or 'he looked young and healthy, so he couldn't have HIV'.

Encouraging patients to have sexual health check-ups can be a harm reduction strategy in itself. This may seem paradoxical and defeatist at first, implying that lapses in safe sex practices are to be expected. However, safe sex practices which allow unprotected oral sex do not always protect patients from common STIs like chlamydia, gonorrhoea, genital herpes and HPV. For MSM, those who change partners frequently or those with multiple partners, it is sensible to recommend regular check-ups. For others, the recommendation should be that a sexual health check-up should follow the break up of a relationship, a casual encounter or the commencement of a new sexual partnership.

Clinicians need to think about members of special groups in their practice, learn about such groups and tailor their preventive and harm reduction messages so they are appropriate and relevant for their special needs. Such groups include MSM, WSW, adolescents and young adults, Indigenous Australians, physically and intellectually handicapped people and people from culturally and linguistically diverse communities.

**TABLE 3.8 Tips on safe sex and harm reduction messages**

<ul style="list-style-type: none"> <li>• Check the patient's base line knowledge about HIV, STIs, HBV, HCV. Correct misconceptions and, if necessary, provide basic information</li> </ul>
<ul style="list-style-type: none"> <li>• Check the patient's understanding about sexual and drug-use behaviours that carry risk of transmission</li> </ul>
<ul style="list-style-type: none"> <li>• Explore safe sex and safe using options (such as non-injecting techniques) specific to the patient's needs</li> </ul>
<ul style="list-style-type: none"> <li>• Discuss correct use of condoms (including the female condom and non-latex condoms) and where they can be obtained</li> </ul>
<ul style="list-style-type: none"> <li>• Discuss where new fits can be obtained and the correct method of cleaning fits (Appendix 4)</li> </ul>
<ul style="list-style-type: none"> <li>• Discuss circumstances in which unsafe practice has taken place or is likely to occur</li> </ul>
<ul style="list-style-type: none"> <li>• Discuss the link between alcohol and other drug use and unsafe sex</li> </ul>
<ul style="list-style-type: none"> <li>• Encourage regular sexual health check-ups except for those in stable monogamous relationships</li> </ul>

Being able to show empathy and to convey an understanding of the patient's situation is an essential component of the clinician's repertoire. As an example, when dealing with young patients, although it is hard for many of us to project ourselves back into our teens, it is helpful to even catch a distant memory of how emotionally overwhelming early sexual encounters can be and how difficult it is for young people caught up in the passion of the moment to think rationally about risk reduction and harm minimisation. In the long run, empathy and understanding achieve the best outcomes when talking with patients about sex and drug use. If a clinician chooses not to explore safe sex and harm-reduction strategies with a patient during a consultation, the topics may be noted and raised during a subsequent appointment.

Alternatively, the clinician may decide to refer the patient to another service or clinician, a community group or a specialist counsellor or educator (Chapter 15). Having written information can be useful in ensuring that a patient can have information to take away with them. This information is available through Hepatitis Councils, peer based injecting drug-user groups and State and Territory AIDS Councils. Table 3.8 provides a check-list of general tips on safe sex and harm reduction education.

## Cross-cultural issues

There is great potential for misunderstanding and communication breakdown when talking to patients about sexual practice and drug use in a culturally and linguistically diverse country such as Australia. Use of interpreters may help communication. For clinicians who work with a significant number of patients from a particular ethnic or cultural group, it can be useful to learn about relevant attitudes and practices prevalent in that cultural group.

Alternatively, the clinician can ask the patient whether the line of questioning is appropriate. In situations where it is difficult to consult with a patient of the opposite sex, arrangements should be made for the patient to see another clinician if possible.

## Patients with disabilities or psychiatric problems

People of all ages and abilities may be sexually active. Some individuals, such as people with intellectual or physical disabilities, may have particular problems accessing information and harm reduction and safe sex measures, such as condoms. They may also have particular difficulty negotiating safer sex. Ensuring adequate knowledge and support for people with disabilities or psychiatric problems may require involvement with family and carers, and consideration of issues specific to the patient's particular situation.

## Summary

Detailed drug-use and sexual history-taking may be conducted over several consultations and provides the basis for an accurate assessment of risk for HIV, STIs, HBV and HCV infection, as well as other infections. Clear and non-judgemental communication facilitates accurate history-taking and appropriate management. Impediments to history-taking may be overcome by application of good communication techniques, consideration of the patient's particular needs, consultation with colleagues and a willingness to learn about alternative lifestyles. However, if impediments persist, referral to another clinician or service is recommended.

## References

- 1 Curtis JR, Patrick DL, Caldwell E, Greenlee H, Collier AC. The quality of patient-doctor communication about end-of-life care: a study of patients with advanced AIDS and their primary care clinicians. *AIDS* 1999;13:1123–31.
- 2 Roberts KJ, Volberding P. Adherence communication: a qualitative analysis of physician-patient dialogue. *AIDS* 1999;13:1771–8.
- 3 Epstein RM, Morse DS, Frankel RM, Frarey L, Anderson K, Beckman HB. Awkward moments in patient-physician communication about HIV risk. *Ann Intern Med* 1998;128:435–42.
- 4 Epstein RN, Frarey BA, Beckman HB. Talking about AIDS. *AIDS Patient Care, STDs* 1999;13:545–53.
- 5 National Health and Research Medical Council. Australian alcohol guidelines. Health risks and benefits. Canberra, Department of Health and Ageing, 2003. Available at [www.alcoholguidelines.gov.au](http://www.alcoholguidelines.gov.au)
- 6 Australian Government. Department of Health and Ageing. Lifestyle Prescriptions: Alcohol Use Assessment. Available at [http://www.health.gov.au/internet/wcms/publishing.nsf/content/phd-pub-lifescrpts-practitioner-cnt.htm/\\$FILE/tools-alcohol.rtf](http://www.health.gov.au/internet/wcms/publishing.nsf/content/phd-pub-lifescrpts-practitioner-cnt.htm/$FILE/tools-alcohol.rtf).
- 7 Australian Injecting and Illicit Drug Users League. Cleaning Fits. Canberra: National Hepatitis C Education and Prevention Program, Australian National Council on HIV/AIDS and Related Diseases; 2001. Australian Intravenous Injecting League. Safer Injecting. Canberra: National Hepatitis C Education and Prevention Program, Australian National Council on HIV/AIDS and Related Diseases; 2001.