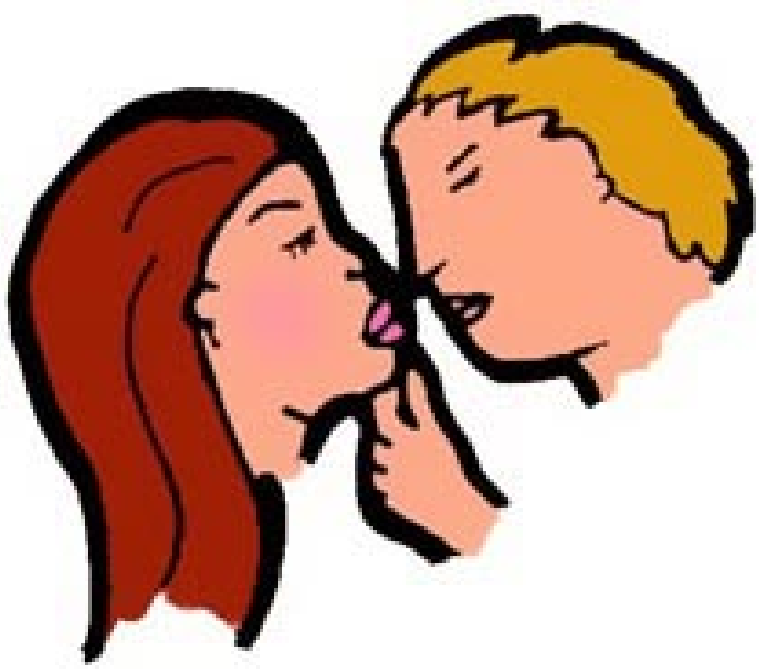
CLINICAL COMMUNICATION SKILLS THEME

STAGE/LEVEL 2: 2011-2012

GENITO-URINARY MEDICINE: THE SEXUAL HISTORY
(MAJOR ADULT DISEASES)



FACILITATORS' PACK V.16 (03/05/2011)

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THE SEXUAL HISTORY (GENITO-URINARY MEDICINE)

Introduction

The sexual history session of the Clinical Communication Skills theme occurs within Stage/Level 2 of the Major Adult Diseases module and has been jointly planned by the G.U Medicine department (Attachment Director: Chris Carne) and the CCS team.

Format of the sexual history session:

Each three hour session will be facilitated by a communication facilitator. The sessions will usually occur in weeks 3 and 7 of the students' eight week block.

The attachment group will be divided into three sub-groups of approximately seven students.

Three simulated patient cases will be available and the actors will rotate through each sub-group over the afternoon. The overall plan is to use all three actors. However, you can if necessary decide to miss out one of the three acting slots and instead explore any difficulties that have already arisen.

Please note that student packs now contain the following information:
Facilitators have been asked to adhere to strict timekeeping for all CCS sessions. Therefore, you can expect this session to start and finish on time. Please ensure that you arrive at least 5 minutes before the start of the session as students arriving after the initial group introductions may not be allowed to join the group.

Verbal feedback is provided to individual students throughout the session. Students wanting to discuss/request further feedback may wish to speak to the facilitator privately. Similarly, if the facilitator has additional feedback for individuals they may request a meeting at the end of the session. Facilitators will aim to finish the session with 10 minutes to spare to allow time for this and student evaluation/feedback.

Student feedback on the sessions will be made using the CCS system.

Recording equipment will be used in all sessions but, please not that there probably won't be time to watch the recordings back during the sessions.

Aims of the sexual history session:

Aims of the G.U. medicine attachment:

1. to provide an opportunity for students to have safe, observed practice in taking the sexual history
2. to enable students to explore the content areas of:
    a. vaginal discharge
    b. male dysuria
    c. vulval irritation /soreness.
3. to enable students to communicate in a non-judgmental way about sexual matters and exhibit non-judgmental attitudes to the spectrum of sexual behaviour
4. to raise awareness that effective communication is essential in discussing and managing Genito-Urinary problems whether in the G.U. medicine clinic or elsewhere

The students will already have received an introduction to the Genito-Urinary medicine interview from Chris Carne and his team. They will mostly have observed a Genito-Urinary medicine out-patients clinic. This session aims to cement students' learning by safe observed practice and to introduce the need for sensitivity to individual patients when dealing with such personal areas of clinical practice.

Aims of the CCS course:

1. helical reiteration of the students' communication skills learning in the introductory course: initiating the session, gathering information, structuring the interview and building the relationship
2. exploration of the specific communication issue of the sexual history, with further emphasis on the core skills of gathering information and of building the relationship and exploration of the specific components of the sexual history

At this stage in the students' development, we are concentrating more on information gathering than information giving skills. The three scenarios chosen will provide a history-taking interview format and provide students with an opportunity for helical reiteration of the skills learnt in the introductory course. Setting the scenario within Genito-Urinary medicine will allow us to highlight some of the specific communication challenges of taking the sexual history and emphasise the importance of the core skills of gathering information and building the relationship. The sexual history enables us to explore the need for sensitivity with regard to personal and sexual questions, the need to utilise both closed and open questions to enter this arena successfully (and how the normal open to closed cone may need reversing here) and the need to explore the feelings, ideas, beliefs and expectations of each individual patient.

Objectives of the sexual history session:

Helical review and refinement from Stage/Level One
At the end of the session, the student will be able to:

Initiate an interview by:
- establishing a supportive environment and initial rapport
- developing an awareness of the patient's emotional state
- identifying as far as possible all the problems or issues that the patient has come to discuss
- establishing with the patient a mutually agreed agenda or plan for the consultation
- developing a partnership with patient, enabling the patient to become part of a collaborative process

Gather information by:
- exploring the disease perspective so as to obtain an adequate "medical" history
- exploring and understanding the patient's perspective so as to understand the meaning of the illness for the patient
- ensuring information gathered about both frameworks is accurate, complete and mutually understood
- ensuring that the patient feels listened to, that their information and views are welcomed and valued

Structure the consultation by:
- summarising, signposting, sequencing and timing

Build the relationship by:
- developing rapport to enable the patient to feel understood, valued and supported
- ensuring reduction in potential conflict between doctor and patient
- encouraging an environment that maximises accurate and efficient initiation, information gathering and explanation and planning
- ensuring the development and maintenance of a continuing relationship over time
- involving the patient so that he understands and is comfortable with the process of the consultation

New skill acquisition
At the end of the session, they will have:

Identified and practiced the core skills of gathering information and building the relationship that need particular emphasis in discussing sexual matters e.g.:
- eye-contact
- use of language
- the balance and timing of open and closed questioning (reversal)
- signposting the need for difficult questions
- non-judgmental acceptance
- not making assumptions

Explored and practiced specific components of the sexual history e.g.:
- discussing sexual practice explicitly
- discussing sexual orientation
- discussing infidelity
- the embarrassed student and the unembarrassed patient
- the embarrassed patient and the unembarrassed student
- both student and patient attitudes and feelings
- the sexual history outside the GU medicine clinic e.g. in general practice or rheumatology – potentially even more difficult
- age differences
- patient concerns re examination
- psychosexual issues

HANDOUT I

Incorporating the specialist functional enquiry into the structure of the medical interview (the Calgary-Cambridge guide) using appropriate skills and timing

The genito-urinary medicine functional enquiry:

1. **Vaginal discharge**
    a. how long?
    b. improving or worsening?
    c. colour
    d. associated mal-odour
    e. irritation
    f. pelvic pain
    g. sores or ulcers
    h. inter-menstrual bleeding
    i. history of previous genital infections
    j. current medications
    k. LMP
    l. Pregnant?
    m. last cervical smear, abnormalities?
2. **Urethral pain**
    a. severity
    b. how long?
    c. improving or worsening?
    d. discharge: how much, colour
    e. scrotal discomfort
    f. sores or ulcers
    g. history of previous genital infections
    h. current medications
3. **Sexual history and orientation**
    a. last sexual intercourse
    b. was this with a regular partner?
    c. someone known or a casual acquaintance
    d. male or female
    e. has partner mentioned any genital symptoms
    f. what contraception used
    g. condom used
    h. when last sex with someone other than this partner
    i. was this someone known well
    j. any other sexual partners in last three months, how many
    k. heterosexual, gay or bisexual
    l. any sexual contact with partners abroad, which countries
4. **Sexual practice**
    a. penetrative sex
    b. vaginal intercourse
    c. anal intercourse: which way round or both
    d. oral sex: which way round or both
    e. mutual masturbation
    f. use of condoms or dental dam
5. **HIV exposure concern**
    a. previous partners HIV positive
    b. high risk groups
    c. previous HIV test
    d. Hep B vaccination

Patient roles and commentaries

1. Young sexually active woman with vaginal discharge, probably sexually acquired (one regular partner, one indiscretion) – a straightforward case of sexually transmitted disease in a young woman in which to practice open and closed questions

2. Young man, homosexual or bi-sexual, with pain on passing urine and urethral discharge - a more difficult case with a potentially embarrassed student trying to discover about sexual practice, anal intercourse, oral sex etc, HIV risk

3. 70 year old woman, with vulval irritation, not sexually acquired -an embarrassed patient where relationship building is all-important and where the student needs to be able to discuss that she is not now sexually active because it is too sore, concern that husband may have had sex outside of marriage

CASE 1
Chlamydial pelvic inflammatory disease

Presenting symptoms: Yellow discharge
Pelvic discomfort
Deep dyspareunia
(Gonococcal PID usually causes more severe symptoms)

Essential questions: How long discharge present? (also see
Colour of discharge? original
Associated mal-odour? check
Any irritation or soreness? list)
Any pelvic pain?
Intermenstrual bleeding?
Sexual history - as previously described: important for students to practise asking if patient is having sex with a male or female partner to prevent assumptions been made

Management: Perform full screen for genital infection
Vaginal swabs for candida, bacterial vaginosis and trichomonas vaginalis
Cervical and urethral swabs for chlamydia and gonorrhoea

Treat with Ofloxacin plus metronidazole for 14 days
Sexual partner must be seen and treated

CASE 2
Gonococcal urethritis

Presenting symptoms: Purulent urethral discharge
(Less common for NSU to be heavy purulent discharge)

Essential questions: How long symptoms present?
Dysuria
Any 'testicular' pain (epididymitis)?
If receptive anal sex, any anal symptoms (discharge, soreness/rectal, gonorrhoea)?
Any fever, rash, joint pains (gonococcal septicaemia)?

Sexual history and orientation - as previously described
Sexual practice – as previously described
HIV exposure - as previously described
Raise issue of HIV testing
Raise issue of Hepatitis B testing/vaccination

Diagnose by microscopy of urethral discharge
(Gram negative diplococci in pus cells)
Confirm by growing Neisseria gonorrhoeae on culture

Management: Ceftriaxone 250mg im stat
(also give doxycycline to cover possible Chlamydia/NSU acquired at same time)

CASE 3
Vulval lichen sclerosus

Presenting symptoms:	Itch Soreness Changes in the appearance of affected skin
Essential questions:	How long symptoms present? Keeping awake at night? Any bleeding from the vulval skin? Any other skin problems? What treatment have you used to date? Interfering with sex? Little need to ask about sexual practice or orientation here May need to perform a vulval biopsy if uncertain about diagnosis on clinical examination
Management:	Treat with Dermovate (Clobetasol propionate). Keep under regular review because of risk (1 - 4%) of developing vulval squamous cell carcinoma

Special care in facilitation in this sexual history session:

The need for support of participants:

When facilitating your sessions please take time to consider how best to meet the possible emotional needs of the participants. Take care with normal ground rules and ensure that learners are not pressurised to contribute or respond in a way that makes them feel uncomfortable. Think about:

- How are 'sexual minority' participants likely to feel during the session?
- How can you make sure that 'sexual minority' participants are able to voice their responses and opinions and reactions and are able to intervene if derogatory remarks are made?
- In what way will you be able to reinforce positive things about people with differing sexual orientations to reduce stereotyping?
- how can you support participants if others are hostile either personally or in general
- Will you have a closer relationship to people in your own sexual orientation group to others – will this be difficult for you?
- How to deal with conflict, anger, general discomfort, silence: emotional reactions are likely to occur as prejudices and discomfort appear

However, this teaching session is too short and rushed to enable us to explore attitudinal issues in any depth. Our main aim is to develop non-judgemental acceptance of sexual behaviour which we ourselves are uncomfortable with. This is a skill which will be of use in many other situations in interviewing patients.

Plan

Three hour session 2.00 – 5.00pm
The timings are tight but very important – **we must start each role on time to allow the actors to rotate.**
We will not have time to explore the students' attitudes to sexuality in this session to any great extent. This session should in an ideal world be preceded by such a session in students as yet non-existent personal and professional development programme

2.05 Introduction: 5 mins

The general introductions are really important - there is no doubt that the students in phase two are less used to collaborative working than they were in the introductory course - they start quietly and may need a lot of help from us in settling them in. So we need to gain their confidence. We also need to move at quite a pace: this is a very fast session.

- Welcome, introduce your self, explain how this session fits in with their overall learning
- Round of names
- Outline a temporal plan for the session and explain the joint GU and CCS aims and signpost methods of the session.
  Really helpful to have the plan of the session on a flipchart so that they can keep a structure in their heads and what happens when
- Emphasise equally the sexual history, general communication and GU content areas of the session

2.10 Difficulties in taking the sexual history 20 mins

1. **Have you all watched outpatients in the GU clinic? What have you seen so far?**
2. **Brainstorm problems that they might have themselves in taking the sexual history – difficulties they have had or could anticipate experiencing in communicating with patients in the GU clinic if they were the doctor. Do as a round**
3. **Look at handout of functional enquiry questions. What questions would be difficult to ask? Tick those which they would personally find difficult**
4. **What questions would they like to practise?**

Explain that this is a chance to practise something difficult before they have to in real life. It is not a judgmental exercise in any way but a golden opportunity.

Facilitator to summarise the following areas with the guides

1. Where the GU questions fit into the guide and the problems GU questions pose in general
2. The communication areas in the sexual history settings that you need to consider even more than usual: gathering information and building the relationship
3. The skills you can use to help in these situations: some hints (see objectives page – the importance of reversing the open to closed cone needs to be discussed here in particular)

Re-visit the **plan of stages of the interview** on the CC guide

2.30 First simulated patient 45 mins

Then get started as soon as possible to maximally use the actor

Facilitator to set up communication session:

- Describe the specific scenario in enough detail to orientate the group (setting, information already known, GP letter etc.)
- Specifically explain who the learners are and what their role is in the scenario (i.e. medical students in GU out-patients or in general practice)
- **It is a good idea in this session to guide the students about the difficulty of each role. For instance, with the young woman, it is reasonable to say that in this scenario you will able to practise asking the basic but difficult questions with a young woman. With the bisexual man, you can say that this is going to be more difficult – the clinic nurse says there is a real cheeky chappy here!**

- **Consider the group's needs and negotiate with the group and the actor how difficult to make the task, especially if you start with the bisexual man first – the actor will be able to tone down the component about deliberately trying to shock the student although he will still use graphic words as this is his own language and will certainly not amend the content of the sexual behaviour**
- Try to get the group to explore what the difficulties might be for the doctor and patient and to look at the functional enquiry list and explore which questions they need and don't need to ask and which ones they would feel reluctant to do so
- It is helpful for the facilitator to have two or three objectives for each role clearly in his or her mind
- Explain that the interviewer can stop and start and break for help whenever they would like
- When the learner rejoins the group, provide communication skills feedback on the interview so far

This interview should allow you to helically review beginnings, information gathering, structuring the session and building the relationship. It will be interesting to see how much learning from the introductory course has been undone by their ward experiences so far.

Chunk this into small aliquots. Although the flow of the interview is truncated this way, you can get many more participants involved and the feedback on communication skills works much better. You can remember what happened in each small bit, give more focused feedback, use the actor's feedback better, use the tape more and do re-rehearsal of different approaches much more. This latter makes the students see the importance of working with the actor - instead of being on trial, they really discover how to do the stages of the interview and find different ways to do so.

Stop each person at a pre-determined point e.g. at the end of the introductions and establishing rapport. Again after taking an open history and before asking detailed questions. At each stage do good well paced communication skills teaching. It will be much easier to do revisiting the intro course stuff if we break it down into sections and get everyone involved - five minutes or so each rather than 40 minutes for one!

It will be essential to balance their exploration of the disease aspects within the interview with their exploration of the patient's perspective. Overall, we need to work with effective ways of gathering information about both disease and illness.

Remember to:

- look at the micro-skills of communication and the exact words used
- practise and rehearse new techniques after suggestions from the group
- make sure to balance positive and negative feedback
- bring out patient centred skills (both direct questions and picking up cues) as well as discovering facts
- utilise actor feedback

Encourage one of the students to start the process:

- What would be the particular issues for you here (try to get the participant to hone them down)
- What are your personal aims and objectives for the role-play
- What would you like to practice and refine and get feedback on
- How can the group help you best
- How and what would you like feedback on

Emphasise to the "doctor" that OK to stop and start whenever. Take time out or start again, as required. Re-play a section or re-play the whole lot, or just stop when help needed.

Feedback

- Start with the learner –
  How do you feel?
  Can we go back to the objectives? Have they changed?
  How do you feel in general about the role-play in relation to your objectives?
  Tell us what went well, specifically in relation to the objectives that you defined?

What went less well in relation to your specific objectives?
Or "you obviously have a clear idea of what you would like to try."
Would you like to have another go?
What do you want feedback on?

- Then get descriptive feedback from the group
- If participants make suggestions, ask prime learner if they would like to try this out or if they would like the other group member to have a go. Try to get someone else to role-play a section if they make a suggestion for doing it differently. "Would anyone else like to practise?"
- Bring in the actor for insights and further rehearsal: ask actor in role questions that the group has honed down

As the session proceeds, ensure that equal emphasis is given to the problem of communication and GU history taking.

3.15 – 3.30 Tea	**15 mins**

3.30 Second simulated patient (or possibly group discussion)	**45 mins**

In this section, you may elect not to use the actor if it would be preferable to discuss problems that have already arisen

4.15 Third simulated patient	**35 mins**

4.50 Closure	**10 mins**

Rounds of what learnt

Summary from facilitator

Handouts

Your evaluation of the session

There is a feedback form provided for your comments on the session as a whole and to feedback on any student who is struggling and requires extra help in any way. If a student has been referred for help on more than 2 occasions in any one stage/level of their clinical studies, they will be contacted by the Senior Tutor in Clinical Communication and offered an appropriate programme of remedial support.

Please inform the student that you are being referred for support but that they will only be contacted on receiving the third referral. If they have any concerns about this they should be advised to contact Mandy Williams (mw480@medschl.cam.ac.uk), Senior Tutor in Clinical Communication.

It is important that you state why you are highlighting a student for help and what you have observed. This will assist the team in ensuring appropriate and timely support is provided.

We would also like you to identify any student who is clearly performing at a high level and you would like to nominate for the CCS prize

Sexual history session– simulated patient role 1

Name: Kim Clarke **Age:** 33

Setting:
You are waiting in the waiting room of your GP surgery to see Dr. Jones, a GP who you have not met before: it is quite a big surgery and you tend to see whoever is available. That doesn't worry you as you don't come to the doctors often and in fact in the past you have mostly seen the nurse for repeat pill checks and for smears. You rang for this appointment today: you told the receptionist that it was urgent because you didn't want to go through the weekend without getting something done about your problem. You've been waiting about twenty minutes. You have already been asked by the receptionist if you would mind seeing a student doctor before seeing the doctor and you have agreed.

Clinical details:
For the last 10 days, you have had a vaginal discharge. You always get some discharge but this is different – it is heavier than usual and yellow rather than white. There is no smell. It is not itchy but makes you feel uncomfortable – like you're constantly wet. You are wearing protection. You have had very slight pelvic pain: a low dragging but not much. It was a bit uncomfortable deep inside when you last had sex four days ago. It's getting worse rather than better. It doesn't hurt when you pee.

Your periods are regular, lasting 5 days and coming every 28 days. They are light since you went on the pill, about 8 years now. You have no bleeding between your periods or after intercourse. You have had smears in the past: the last one was three months ago and it had some mild changes on it which the nurse said could have been due to mild infection – you have to have it repeated in another three months but you are happy about that. You have never been pregnant. Your last period was three weeks ago.

You live alone but have a regular boy-friend who you have been going out with for six months or so. You sleep over at his house at weekends but have no plans to move in together. You have sex at weekends and occasionally in the week. You would describe yourself as definitely heterosexual and quite sexually active: you enjoy and initiate sex. You can be a bit flirtaceous but you wouldn't like to be thought of as a slapper: you have had quite a few partners over the years but always one at a time. However, a month ago, you spent the night with a man you know and are fond of - it was a one off after a mid-week night out with some friends. You didn't use a condom. You did have oral sex which you think of as quite normal for you: he licked you but you didn't suck him. You haven't told your partner about this.

Past medical history:
Any previous operations: no operations in the past
Any previous illnesses: no serious illness, you get the odd urinary infection and have had thrush after antibiotics and when you have been abroad which is not like this – thrush is always really itchy with a thicker white discharge – you get Canesten cream from the chemist and it goes. You have tried Canesten this time to no effect

Medication:
On the contraceptive pill, microgynon 30
Nil else

Family history:
Any family history of serious illness: no
Smoking: you smoke at parties only
Alcohol: you drink at weekends
Drugs: no

Social history:
Occupation: you work in an office, typist
Where do you live: in cambridge

Type of housing: rented unfurnished flat – small but great for you
Background: parents quite working class from london, moved to haverhill before you were born

Patient's framework:

- **Ideas and thoughts:**

What do you think might have caused your problem: most likely sexually acquired from the one night stand but could be a simple infection and a coincidence – you hope so

- **Concerns**:

What are you concerned about: your main concern is that you may have picked up a sexual disease and that you may have given it to your boyfriend
Have you any underlying fears: worried in the back of your mind re hiv but pretty certain that the man you slept with would be ok – you've never come across anyone with aids

- **Expectations:**

What are you hoping for: a diagnosis and treatment there and then and to be told it is not sexually acquired

- **Feelings:**

How are you feeling about all this: reasonably composed

Behaviour:
You are a reasonably confident person and quite self-assured socially with your friends. Talking about this sort of thing with a doctor is different though: it is a little embarrassing although you cope quite well. You're not quite sure what words to use if the doctor asks you about having sex – will it be OK to use the words you normally use or should you speak in more technical language: with your friends you would use 'making love', 'coming', 'snogging', 'licking' etc. You think of yourself as reasonably liberated about discussing these things but anal sex is abhorrent to you and you've never done it. If the doctor asks you that insensitively or asks you if you are gay (which you also would never try), you would cope but only just and you definitely don't want to be thought of as promiscuous.

Presenting symptoms or problem:
Start off quite confidently but about the condition only. If the medical student asks you "what problems brought you to the hospital today", answer; 'well I've been having a lot of discharge just lately and I'd really like to get it checked out'. Stop there and smile. See where the student then goes and be happy to tell him/her your story. At first, stick to the symptoms and don't describe your sex life at all. When prompted about your sex life by the doctor, talk about your partner but as you don't want to be seen as 'easy', you don't mention the casual sex until asked if you have had any other partners. The doctor will have to ask you some specific questions to get you to talk about these things.

Sexual history session– simulated patient role 2

Name: Andy Cartwright **Age:** 35

Setting:
You are waiting in the waiting room of clinic 1A at Addenbrooke's to see a doctor. You have been waiting for about half an hour. This is your first clinic 1A appointment at the hospital – you rang up and fixed it just 2 days ago. But you have been to other GU medicine clinics in London before in the past. You are quite blasé about it. You are visiting a friend this week in Cambridge and staying at her house. You have already been asked by the receptionist if you would mind seeing a student doctor before seeing the doctor and you have agreed, somewhat mischievously.

Clinical details:
For the last five days, you have had mild pain in passing urine and have noticed quite a bit of yellow discharge from your penis which stains your underwear and this is getting more. You have no pain in the scrotum and have not noticed any ulcers or sores. You have had a couple of episodes of NSU (non-specific urethritis) in the past which you have been to other clap clinics in London about – you've had the antibiotics and been OK.

You are bisexual but at present are having homosexual relationships almost exclusively although you did have sex with a woman three weeks ago which you didn't enjoy very much – you didn't use contraception then as you were sure she was safe and she was on the pill. You live alone and do not have a regular partner. You are fairly promiscuous but not as bad as some others you know and you know all about safe sex until its coming out of your ears. Sex isn't the be all and end all for you but it is a quite important part of your life. You wouldn't dream of not using a condom with another man although they do split. You go to known gay bars in London and have used toilets as pick up points – you aren't embarrassed about this. You enjoy anal sex both ways and oral sex – sometimes you use a dental dam but not always. You had sex last week with someone you don't know which was oral sex both ways, unprotected.

You had an HIV test about a year ago – you were pleased that you were OK. You don't know for sure whether your partners have been HIV positive but it looks like the steps you take are enough. You have not been vaccinated against Hepatitis B if asked. You have had sex on holiday abroad in Greece last year.

Past medical history:
Any previous operations: no operations in the past
Any previous illnesses: no serious illness, you are fit

Medication:
Nil

Family history:
Any family history of serious illness: no
Smoking: you smoke 10 per day
Alcohol: moderately
Drugs: you use cannabis and es, occasionally have used cocaine, smoked heroin a couple of times, never injected

Social history:
Occupation: you work in 'the music business', all a bit vague; something to do with sound sets in recording studios
Where do you live: in Earls Court
Type of housing: rented flat – pretty grotty area

Patient's framework:

- **Ideas and thoughts**

What do you think might have caused your problem: probably nsu again although more discharge this time

- **Concerns**

What are you concerned about: your main concern is that you may have picked up another sexual disease like the clap
Have you any underlying fears: not much, you don't worry about the future

- **Expectations**

What are you hoping for: a diagnosis and treatment there and then

- **Feelings**

How are you feeling about all this: blasé and a bit bored

Behaviour
You are amused at having to see a student. You reckon they will be some middle class kid with no experience of life who wouldn't know a bum from a vagina. You are un-embarrassed about this and bet the student will be more embarrassed than you. You lay on the use of colloquial terms and use just what you would do with your friends – 'fucking' 'rimming' etc. And rather hope he or she has no idea what you are talking about. You react with amused consternation and condescension if the student makes the normal mistakes and assumptions about not including bisexuality as a possibility, about saying are you 'active' or 'passive', about not understanding about dental dams, about being shocked by cottaging. You are quite graphic about what you do!

Presenting symptoms or problem:
Start off about your symptoms and let the poor student find out what your sexuality is – this could be fun! When you get going, if he/she is shocked, begin to feel a bit guilty and tone it down.

Sexual history session– simulated patient role 3

Name: Joan Wright **Age:** 70

Setting:
You are waiting in the waiting room of clinic 1A at Addenbrooke's to see a doctor. You have been waiting for about fifteen minutes. This is your first clinic 1A appointment at the hospital – your GP sent off for an appointment three weeks ago. He said it was the genito-urinary clinic and that they specialised in the sort of problems that you have and not to be put off by the name. You didn't quite realise what he meant but it is clear now looking at the walls around you that this is a clinic for people with sexual diseases and everyone else here is much younger than you. The people are quite poorly dressed and you feel uncomfortable and embarrassed at being here. You have already been asked by the nurse if you would mind seeing a student doctor before seeing the doctor and you have agreed, somewhat reluctantly.

Clinical details:
For the last year, you have had irritation of your vaginal lips, more on the right side which is getting quite sore. You scratch it in bed at night – it is difficult not to. It feels to be on the outside and you can feel that it is a little thickened there but you really can't see what it looks like in the mirror. You went to the GP ages ago who said it might be thrush and gave you some cream and pessaries (which you found most awkward) but it made no difference. You plucked up courage to go back recently and were rather worried when he said he thought it might be a common condition that women get that needs treatment from a specialist. He said that it wasn't cancerous but the way he said it made you feel that it might be.

You didn't tell your GP because you were too embarrassed but until this year you had a regular sex life and have had to give it up since this started as it has been too sore to have sex. You are dry and the area on the lips hurts. Your husband has a strong sex drive but he has been very good about this, possibly too good. You are concerned now that he might be having sex with another woman and that he has passed this on to you.

You do not have a discharge and your periods stopped twenty years ago. You have had no bleeding since except once when you tried to have sex six months ago.

You would be mortified if anyone asked you about your sex life. You have never discussed this with anyone. You have sex in the missionary position and have not considered anything else. If asked if you have had sex with anyone else, you would be offended but answer no.

Past medical history:
Any previous operations: no operations in the past
Any previous illnesses: no serious illness, you are fit

Medication:
Nil

Family history
Any family history of serious illness: both parents are dead, one from a cva and one from old age
Smoking: nil
Alcohol: high days and holidays

Social history:
Occupation: housewife, two grown up children
Where do you live: in a Cambridgeshire village
Type of housing: own house

Patient's framework:
- **Ideas and thoughts:**

What do you think might have caused your problem: probably old age but possibly cancer

- **Concerns**:

Have you any underlying fears: see above re your husband's behaviour

- **Expectations:**

What are you hoping for: to get home as soon as possible without being seen

- **Feelings:**

How are you feeling about all this: embarrassed

Behaviour:
You are well dressed. You are a little surprised at having to see a student but too compliant to complain or show it. You are much more embarrassed than the student who sees you.

Presenting symptoms or problem:
You start off with your symptoms of irritation and soreness. You speak in quite an exact way using as much proper terms as you can (irritation not itch, vaginal infection not thrush). You are clearly embarrassed to be here and give this away early on by saying that you are not sure you are in the right place. You only mention about the sex problem and your concern if asked directly re your sex-life. You are embarrassed but relieved to be asked and will talk about your concerns about your husband if the student shows concern and kindness

HANDOUT II

REFERRING GP:
DR. JAMES ALBERT
THE MEDICAL CENTRE,
FEN DITTON
CAMBRIDGE

TO:
DR CHRIS CARNE
CONSULTANT IN GENITO-URINARY MEDICINE
ADDENBROOKE'S HOSPITAL

DATE:

RE MRS JOAN WRIGHT

AGE 70

HOSPITAL NUMBER 374910

CATEGORY: IN TURN

DEAR CHRIS,

Thank you very much indeed for seeing this 72 year old woman with persistent vulval irritation and a slight thickening which has not responded to treatment with Canesten.

THANK YOU VERY MUCH,

BEST WISHES

YOURS SINCERELY

DR. JAMES ALBERT