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ORIGINAL ARTICLE

How do women want their gynaecologist to address sexual function? A cross-sectional survey among outpatients

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Abstract

Aim: Our aim was to examine women's attitudes towards addressing and documenting sexual function in a Nordic gynaecological and obstetric outpatient setting.

Materials and Methods: We performed a cross-sectional, anonymous survey amongst women referred to the gynaecological or obstetric outpatient clinic at the University Hospital in Trondheim, Norway. The women completed a written, self-developed questionnaire with 10 questions.

Results: During a 5-month period, 494 out of 700 distributed questionnaires were completed (response rate 71%). Of the participating women, 87% would accept that a gynaecologist routinely asked them about sexual function during an outpatient appointment. Significantly more women 40 years and older (postreproductive), compared to women below 40 years (reproductive) did not want to be asked about sexual function [a difference of 6.7% (95% confidence interval (CI): 0.6, 13)]. Between 90% and 98% of the women would also accept specific questions about problems with sexual desire, arousal, orgasm and pain during intercourse. Women were most likely to accept questions about pain during intercourse. More women in the postreproductive age group compared to women of reproductive age did not accept questions about desire [a difference of 6.2% (95% CI: 1.9, 11.5)], arousal [a difference of 6.4% (95% CI: 0.7, 12.6)] and orgasm [a difference of 5.4% (95% CI: 0, 11.5)]. Women attending different clinics or from different cultural backgrounds did not answer significantly differently. More than half of the respondents preferred a medical journal with restricted access for documentation for general information (52.9%) as well as for specific information (60.1%) on sexual function. There was a tendency for women from the Nordic countries, compared to women from other European countries, to prefer this information to be stored in the restricted medical record, while this response was similar for women of the postreproductive and reproductive age group, or for women attending different clinics.

Conclusion: The large majority of women in this study accept that the gynaecologist asks general and specific questions about sexual function. Just over half of the women preferred information about sexual function to be documented in a medical journal with restricted access.

KEYWORDS

attitudes, dyspareunia, gynecologist, outpatients, restricted medical record, routine gynaecological examination, sexual dysfunction, sexual function

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INTRODUCTION

Problems with sexual function are common and are experienced by as many as 40% of women during their lifetime, and 12% of women are significantly distressed by these problems.[1] This distress and a persistence of the problem of more than 6 months qualifies for a sexual dysfunction diagnosis according to the most recent definition of the American Psychiatric Association.[2] Sexual dysfunctions are associated with reduced quality of life, with treatment options available.[3] As Kingsberg et al. pointed out, the start of treatment is to ask.[4]

Women may be reluctant to initiate a conversation about sexual function. A study among gynaecological outpatients in Latvia reported, that a gynaecologist had addressed sexual function only in about one-third of the women, while 80% would like the gynaecologist to broach this topic.[5] In a study from back in 1989, only 3% of women themselves initiated this topic, while 19% acknowledged sexual problems when asked.[6] The main responsibility of initiating such a conversation may lie with the medical practitioner rather than the patient.[7]

Gynaecologists appear to be aware of their obligation, 94% of gynaecologists in a German study reported feeling a particular responsibility to enquire about sexual problems among their patients.[8] Reasons for a physician to be reluctant to address sexual function may be apart from time constraints and lack of own knowledge, insecurity on how detailed a woman would like to talk about these issues.[4,7] The authors failed to identify publications addressing women from Nordic countries.

Another problem for the gynaecologist is, where to document this sensitive information. Two alternatives are commonly used in public medical institutions in the Nordic countries. One option is the general medical record with open access to all health professionals involved with the patients' treatment. The other option is a medical record with restricted access, currently commonly used for sensitive information such as sexual assault, legal abortions or assessments by a clinical sexologist. Only a limited number of health care personnel have access to such restricted medical records. The access and use of both types of medical records is commonly electronically traceable in modern Nordic hospitals.

Our aim was to examine women's attitudes towards addressing and documenting sexual function in a Nordic gynaecological and obstetric outpatient setting (Figure 1).

MATERIALS AND METHODS

This was a cross-sectional, anonymous survey at the Department of Obstetrics and Gynecology, at the St. Olav University Hospital in Trondheim, Norway, with inclusion

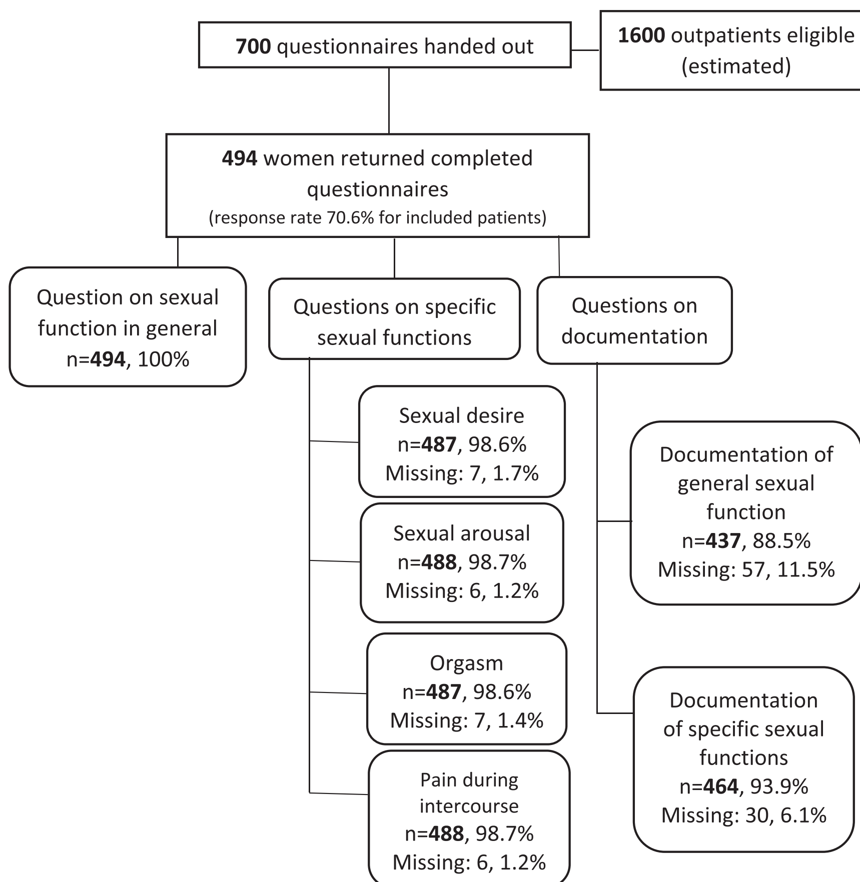

FIGURE 1 Flowchart for inclusion- and response-rate of respondents of surveryon attitudes of women towards routine questions about sexual function during elective gynaecological or obstetric outpatient appointments at a University Hospital in Trondheim, Norway.

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between November 1st, 2015, and March 31st, 2016. Women 18 years and older, with elective outpatient appointments to the outpatient clinics for general gynaecology, urological-gynaecology, fertility, gynaecological oncology and obstetrics were eligible. Women referred for legal abortions, emergency appointments, as well as not being able to read Norwegian were excluded. All eligible women received a paper copy of the questionnaire at the reception of the gynaecological outpatient clinic by the receptionist. If they were interested to participate, they completed the questionnaire in the waiting room while waiting for or after their appointment and handed the questionnaire back to the receptionist.

The questionnaire contained 10 questions designed for the study by the authors, see Supporting Information Appendix A (Norwegian) and B (English). A pilot study had been performed among a convenience sample of five health and nonhealth professionals of different ages, to ensure that questions were understood as intended and had resulted in minor modifications of the questionnaire.

For the demographic background, the women were asked to indicate their age group within a 10-year interval; their geographic origin (six different options); and the type of scheduled outpatient clinic.

The women were asked if they would want the attending gynaecologist to routinely ask about problems with sexual function. Response alternatives were 'yes', 'I do not mind', 'no' or 'I do not want to answer this question'. Further, women were asked in four separate questions if they would find it acceptable to be routinely asked about desire, arousal, orgasm or pain during intercourse. These four categories were chosen based on the different female sexual dysfunction diagnoses in the *Diagnostic and Statistical Manual* (DSM-V).[2] Answer options were identical to the prior four alternatives with an additional fifth alternative: 'yes, but only if I have indicated a problem with sexual function'.

Finally, women were asked if they would prefer information about sexual function in general, and if more specific sexual problems, to be documented either in an open access or in a restricted medical record. Short descriptions of these two record types were supplied in the questionnaire. Answer alternatives were: 'In the general medical record', 'in the medical record with restricted access', 'I do not mind' or 'I do not want to answer this question'.

The questionnaires were collected in a locked box. The completed questionnaires were read automatically into an SPSS spreadsheet at the end of the inclusion period.

Statistical analysis

Statistical analyses were performed with SPSS version 26 (SPSS Inc.). Descriptive characteristics were reported by frequencies and proportions. We computed 95% confidence intervals for the difference between proportions using the Newcombe hybrid score method.[9]

All tests were two-sided with a 5% significance level. Missing answers were calculated but excluded from the analyses.

For analytic purposes, age intervals were dichotomized into two age groups: reproductive (18–39 years) and postreproductive (40 years and above). Very few women were from Africa, Asia or the Americas, therefore we merged this group into 'Outside Europe'.

For appropriate statistical comparison (to avoid type 1 error, considering multiple subgroup analysis) and assuming the same clinical consequence, the two alternatives 'yes' and 'I do not mind' for the questions if women would mind questions about general and specific sexual functions, were summarized into one category, termed 'acceptable'.

RESULTS

In the outpatient clinics, receptionists handed out 700 questionnaires, 494 women returned a completed questionnaire and were included in the study, resulting in a response rate of 70.6%. Because of the anonymous nature of the study, no precise numbers of eligible women are available. We estimate that as many as 1600 women with elective appointments in the relevant outpatient clinics were eligible within the timeframe, resulting in an estimated inclusion rate of 30.9%. Background characteristics of the 494 included women are shown in Table 1. The median age decade was 30–39 years.

Just above half of the women ($n = 261$, 52.8%) indicated, that they did not mind being asked about sexual function in general terms, while about on third ($n = 166$, 34.6%) of women would like to be asked. Only 64 (12.9%) women explicitly would *not* want to be asked about sexual function, see details in Table 2. Two of the women (0.4%) selected the alternative that they did not want to answer this question. This resulted in a total of 427 (86.4%) women finding it *acceptable* to be asked by the gynaecologist about sexual function during an outpatient appointment. More women above the age of 40 (postreproductive) compared to below 40 years (reproductive age) said, that they did not want to be asked about sexual function, see Table 2, or for more details the Supporting Information Table.

Considering more specific questions about problems with desire, arousal, orgasm, or pain during intercourse, the large majority would find it acceptable to be asked in Table 2. A question about pain during intercourse was most likely to be accepted ($n = 476$, 96.4%), while a question about arousal was least likely to be acceptable ($n = 437$, 88.4%), see Table 2 or the Supporting Information Table for specific answers per subgroup.

There were no significant differences for these answers comparing Nordic—to women from the rest of Europe or from outside Europe, nor for women attending gynaecological versus obstetric clinics

For documentation, just above half of the women preferred the medical record with restricted access

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TABLE 1 Background of the 494 respondents attending the gynaecological or obstetric outpatient clinic at the St. Olavs University Hospital in Trondheim, Norway, included in survey on attitudes towards gynaecologists addressing sexual function.

Women's characteristics	*N* = 494 (%)
Age, years	
18–29	164 (33.2)
30–39	137 (27.7)
40–49	95 (19.2)
50–59	57 (11.5)
60–79	41 (8.3)
Missing	0
Geographic background	
Nordic countries	420 (85.0)
Europe	61 (12.3)
Outside Europe	7 (1.4)
Missing	6 (1.2)
Type of outpatient	
Obstetric	137 (27.7)
General gynaecology	259 (52.4)
Urogynecology	69 (14.0)
Gynaecological oncology	14 (2.8)
Fertility clinic	13 (2.6)
Missing	2 (0.4)

(*n* = 231, 52.9%) for the answer to the question on *sexual function in general*. A quarter of the women (*n* = 111, 25.4%) preferred the medical record with open access for this question and roughly another quarter (*n* = 95, 21.7%) responded that they did not mind the type of medical record. These answers were similar for women below and above age 40 and for women attending gynaecologic compared to obstetric outpatient clinics, see Table 2. More women from the Nordic countries compared to women from other European countries preferred this information to be stored in the medical record with restricted access, see Table 2.

For the answers to the *specific questions on desire, arousal, orgasm and pain* during intercourse, well over half of the women (*n* = 279, 60.1%) women preferred the medical record with restricted access, a quarter (*n* = 111, 23.9%) the medical record with open access, the remainder (*n* = 74, 15.1%) did not mind. Again, answers were similar for women below and above age 40 as well as for women attending gynaecologic compared to obstetric outpatient clincs but more women from the Nordic countries preferred storage of this information in the record with restricted access compared to women from other European countries, see Table 2.

DISCUSSION

This study demonstrates that most women attending a gynaecological or obstetric outpatient clinic in a Norwegian University hospital find it acceptable to be asked about sexual function in general terms, as well as about specific problems with sexual desire, arousal, orgasm, or pain during intercourse. However, about half of the women would prefer information about sexual function to be recorded in a medical record with restricted access.

In the current study, 34% of the women *would like* to be asked about sexual function. This is consistent with the result of an international online. survey on dyspareunia, where 45% of respondents would prefer the practitioner to initiate the conversation about this topic.[10] Similar studies from Israel and Latvia report, that around 80% of women *would like* to be asked about sexual function.[5,11] However, in the other studies, the only answer alternative was 'yes' and 'no', while in the current study `I do not mind' and 'I do not want to answer this question' were additional alternatives, and a total of 86% women either selected 'I do not mind' or 'yes'. We interpret this as equivalent to 'yes' when 'no' is the only alternative and therefore consider this result consistent with other findings. It is however noteworthy, that 'I do not mind' was the most frequently chosen answer.

Women's most frequent responses to the questions addressing specific sexual dysfunctions like desire, arousal, orgasm, and pain problems in our study was 'yes, but only if I have acknowledged a sexual problem'. This appears to support findings from an American study, where gynaecologists were recommended to be 'trained to calibrate their sexual-history taking to individual patients' needs'.[12]

On the other hand, a substantial proportion of women would like to be asked directly about sexual function. Based on our results, a practical and acceptable approach for gynaecologists could be to ask all women about sexual problems in general and dyspareunia specifically. If a woman acknowledges a problem, it appears justified to ask further about problems with the specific sexual subfunctions, such as desire, arousal, orgasm, and pain during intercourse. This 'sensitivity' towards each patient's needs fits with the current aim to individualize treatment and should be stressed in the education of medical students and specialists in obstetrics and gynaecology.

In a subgroup analysis, women over the age of 40 were less likely to accept a question about sexual function in general, as well as questions about desire, arousal, and orgasm, compared to women under the age of 40. Prior research on the topic report that perimenopausal and postmenopausal women have less frequent sexual activity, and those post-menopausal, not sexually active women experience less sexual distress.[13,14] Therefore, the topic may be less relevant for some of these women, and hence, they do not want to be bothered. Another plausible explanation may be sociocultural factors within this age group, restricting communication about sexual function with a

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TABLE 2 Comparing women not accepting routine questions on sexual function by the gynaecologist during an outpatient visit and preference of documentation of information on sexual function.

Answer on questionnaire	Postreproductive age, ($N = 193$[a]) No. (%)	Reproductive age ($N = 301$[b]) No. (%)	Difference in % (95% CI)	Other European women, ($N = 61$[c]) No. (%)	Nordic women, ($N = 420$[d]) No. (%)	Difference in % (95% CI)	Gynaecological clinic ($N = 355$[e]) No. (%)	Obstetrical clinic ($N = 137$[f]) No. (%)	Difference in % (95% CI)
No, I do **not accept that my gynecologist asks** questions about sexual function in general	33 (17.1)	31 (10.4)	**6.7 (0.6, 13)**	8 (13.1)	52 (12.5)	0.6 (−6.6, 11.7)	47 (13.3)	17 (12.5)	0.8 (−6.5,6.8)
No, I do **not accept** that my gynecologist asks questions about sexual **desire**	18 (9.6)	10 (3.3)	**6.2 (1.9, 11.5)**	2 (3.3)	25 (6.0)	−2.7 (−6.3, 5.6)	19 (5.5)	8 (5.8)	−0.4 (−6.0, 3.7)
No, I do **not accept** that my gynecologist asks questions about sexual **arousal**	27 (14.4)	24 (8.0)	**6.4 (0.7, 12.6)**	6 (10.0)	41 (9.9)	0.1 (−6.1, 10.6)	40 (11.5)	10 (7.3)	4.2 (−2.2. 9.2)
No, I do **not accept** that my gynecologist asks questions about sexual **orgasm**	24 (12.8)	22 (7.4)	**5.4 (0, 11.5)**	5 (8.3)	39 (9.4)	−1.1 (−6.8, 9.0)	37 (10.6)	8 (5.8)	4.8 (−1.2. 9.4)
No, I do **not accept** that my gynecologist asks questions about sexual **pain**	7 3.7)	5 (1.7)	2.1 (−0.8, 5.9)	2 (3.3)	9 (2.2)	1.2 (−1.9, 9.3)	10 (2.9)	2 (1.5)	1.4 (−2.5, 4.0)
I prefer that information on sexual function in **general** should be stored in the **restricted** medical record	88 (53.7)	143 (52.4)	1.3 (−8.3, 10.8)	24 (42.1)	204 (55.0)	−12.9 (−25.8, 1.0)	165 (52.4)	65 (54.2)	−1.8 (−12.0, 8.7)
I prefer that information on **specific questions on sexual function** should be stored in the **restricted** medical record	104 (59.1)	175 (60.8)	−1.7 (−10.9, 7.4)	28 (48.3)	246 (62.4)	**−14.2 (−27.4, −0.7)**	194 (58.6)	84 (64.1)	−5.5 (−14.9, 4.4)

Note: Difference in proportions (%) and 95% confidence interval (CI). Statistically significant differences printed bold.
[a]*N* vary between questions from 164 to 193, see Supporting Information Table for details.
[b]*N* vary from 273 to 300, see Supporting Information Table for details.
[c]*N* vary from 57 to 61, see Supporting Information Table for details.
[d]*N* vary from 371 to 417, see Supporting Information Table for details.
[e]*N* vary from 315 to 353, see Supporting Information Table for details.
[f]*N* vary from 120 to 137, see Supporting Information Table for details.

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physician. However, this was not the case for the question about pain during intercourse, or dyspareunia. A reason for this may be that the prevalence of dyspareunia is generally high in postmenopausal women.[15] It may also be that dyspareunia is a problem that is perceived more somatic in nature than desire and arousal, and that this symptom causes concern about cancer or infection. A general belief among women may be that a gynaecologist may not be able to help with problems with sexual desire or arousal, as the approach to these problems is psychological treatment The above mentioned online survey on dyspareunia reported, that approximately 80% of women had talked about this topic with their gynaecologist [10] It is however important to point out, that still, the majority of women above the age of 40 would accept to be asked about sexual function both in general terms and with questions specifically directed at the currently recognized sexual dysfunctions.

The finding that more than half of the women overall would rather prefer information on their sexual function to be documented in the medical record with restricted access, suggests that those details should be handled with care. It also highlights a dilemma, because use of the restricted record may add to the stigma when it comes to sexuality. A possible alternative could be to discuss where to document this sensitive information during the appointment. It should be pointed out to the patient, that to allow for a sensitive approach during future examinations, sexual pain and other problems should probably also be available to other health care personnel.

Compared to other European women, more Nordic women preferred the documentation in the restricted medical record. This may be due to cultural differences, but we cannot exclude selection bias or by chance, because of the small number of women from other than Nordic countries and these findings should be confirmed with similar studies in other settings.

The strengths of the study are a relatively large number of women and few exclusion criteria, possibly resulting in an unselected sample of gynaecological and obstetric outpatients. The included outpatient clinics cover a large proportion of specialist referrals in this region in Norway. We assume, therefore, that the results can be generalized to women in similar settings in Norway, in other Nordic countries and with cultural background. Another strength is that we had no upper age limit for women to be included in this study, consistent with the notion that sexual function can be important for postmenopausal woman. To the authors' knowledge, no other study has been published in any setting on the topic of women's preference of medical documentation of sexual function.

The main limitation of the study is the estimated overall inclusion rate of only 30.9% of eligible patients. Shortly after commencing the study, a new, electronic log in system had been introduced and caused substantially fewer women to receive the questionnaire at the registration counter. Short time spent in the waiting room may be another reason. These causes are not expected to have caused selection bias. An unknown proportion of patients may not have participated in the survey because they found the subject uncomfortable or irrelevant. These women would be expected to increase the proportion of women not interested in discussing sexual function with the gynaecologist routinely. Because the survey was anonymous, no detailed information on nonresponders is available. The age distribution of the survey participants appears representative for the outpatient clinics. However, the gynaecological oncology patients are considerably underrepresented in the survey. This was surprising and we can only speculate that maybe sexual function was not a priority at that stage. Results may therefore not be applicable to these patients. Women from Asian and African countries are underrepresented too, we expect that most were not eligible due to the language barrier.

The unvalidated questionnaire is another weakness, although a small pilot study had been performed, resulting in small adjustments of the questionnaire. A formal validation would have been optimal. On the other hand, the questionnaire included the five recognized sexual dysfunctions.

A further weakness of the study is that we omitted to ask women if the gender of the gynaecologist would make a difference with respect to the questions on sexual function. The above-mentioned internet survey found, that 41% respondents preferred a female practitioner to talk about sexual pain.[10] A question about whether the women had a partner have been purposefully avoided, because we hypothesized that this would prevent some women to participate.

CONCLUSION

Most women attending gynaecological or obstetrical outpatients clinic in a Nordic setting would accept the gynaecologist to ask about sexual function in general, and about specific problems with desire, arousal, orgasm, and pain during intercourse. Considering the high prevalence, impact on quality of life, and possible treatment options, gynaecologists should consider including such questions when taking the routine gynaecological history. Likewise, asking about sexual function should be stressed in the education of medical students and specialists in obstetrics and gynaecology.

Just above half of the women preferred that information about their sexual function should be documented in a restricted medical record. These results may indicate the need to review the current routines of documentation of this sensitive topic in gynaecologic/obstetric practice in Nordic countries.

AUTHOR CONTRIBUTIONS

Risa A. M. Lonnée-Hoffmann conceived the study. Risa A. M. Lonnée-Hoffmann and Silje Sandanger Christensen designed and organized, while Risa A. M. Lonnée-Hoffmann and

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Cecilie T. Hagemann supervised the study. Silje Sandanger Christensen collected the data. Silje Sandanger Christensen, Cecilie T. Hagemann and Risa A. M. Lonnée-Hoffmann analyzed the data. Silje Sandanger Christensen wrote the first draft of manuscript. Risa A. M. Lonnée-Hoffmann and Cecilie T. Hagemann revised and edited further drafts.

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CONFLICTS OF INTEREST

The authors declare no conflicts of interest.

DATA AVAILABILITY STATEMENT

The data is available upon reasonable request.

ETHICS STATEMENT

Women were given written information leaflets about the ongoing study by the receptionists and signed an informed consent form before inclusion. The project was approved by the Regional Committee for Medical Research Ethics (2015/1477).

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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