“Opening a can of worms”: GP and practice nurse barriers to talking about sexual health in primary care

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Background. There is evidence that health professionals do not discuss sexually related issues in consultations as often as patients would like. Although primary care has been identified as the preferred place to seek treatment for sexual health concerns, little is known either of the factors that prevent GPs and practice nurses initiating such discussions or of how they feel communication in this area could be improved.

Objective. The purpose of the present study was to identify barriers perceived by GPs and practice nurses to inhibit discussion of sexual health issues in primary care and explore strategies to improve communication in this area.

Methods. Semi-structured interviews were conducted with 22 GPs and 35 practice nurses recruited from diverse practices throughout Sheffield.

Results. The term ‘can of worms’ summarized participants’ beliefs that sexually related issues are highly problematic within primary care because of their sensitivity, complexity and constraints of time and expertise. Particular barriers were identified to discussing sexual health with patients of the opposite gender, patients from Black and ethnic minority groups, middle-aged and older patients, and non-heterosexual patients. Potential strategies to improve communication about sexual health within primary care included training, providing patient information and expanding the role of the practice nurse; however, several limitations to these approaches were identified.

Conclusion. GPs and practice nurses do not address sexual health issues proactively with patients, and this area warrants further attention if policy recommendations to expand the role of primary care within sexual health management are to be met.

Keywords. Primary care, sexual health, sexuality, sexual problems, training.

Introduction

The National Sexual Health Strategy has identified a ‘broader role’ for primary care in sexual health management.13 Whilst some commentators agree that “general practice is the only hope to improve [sexual health] services as it is the only provider with the capacity needed,”15 others acknowledge that “primary care already feels overburdened” and practitioners may be unenthusiastic.3 Indeed, there is evidence that this broader role may be a significant departure from the current low prioritization of sexual health at a practice level. The Royal College of General Practitioners, for example, whilst recognizing that sexual health is an important issue within general practice, also recognize that it is rarely prioritized.4 Similarly, the Royal College of Nursing identifies that sexual health relates to the holistic care of patients and clients,5 but again there is evidence that issues pertaining to sexuality are not routinely addressed in nursing practice.5,7 Training for doctors and nurses in managing sexual health at both undergraduate and postgraduate levels has also been deemed inadequate.8

There has been little published about patient–professional communication about sexual issues in primary care, particularly empirical research studies. However, the little information available indicates that this is a problematic area. A questionnaire survey of 133 GPs, for example, reported that most participants identified more than one barrier to managing sexual dysfunction, with the most commonly cited barriers including concerns...
about their own knowledge and expertise in this area, fears of opening a ‘floodgate’ and personal embarrassment. A questionnaire survey of 234 practice nurses (PNs) identified similar barriers, including lack of time, lack of training and concerns about not being able to cope with the issues raised by the patient. A postal survey of oncology nurses and a qualitative study involving staff nurses working in acute surgical wards indicate that nurses will only discuss sexual health issues if such discussions are initiated by the patient.

Although data are not available regarding patient attitudes towards PN health management, limited data are available regarding patient attitudes towards GPs. A survey of 170 patients attending a London general practice, for example, identified that 35% of male and 42% of female participants reported some form of sexual dysfunction, but that despite 70% of participants seeing the GP as an appropriate person with whom to discuss sexual health issues, such discussions were only recorded in 2% of the participants’ GP notes. A Swedish study of older women’s sexual health needs identified that none of the 33 patients with diabetes interviewed had been informed by their GP that this condition could cause sexual problems, although most would have welcomed such a discussion. Similarly, a UK study which involved discussing sexual issues with people aged 50–92 years identified that the GP was seen as the main source of professional help if sexual health concerns were experienced. However, none reported that their GP had mentioned the sexually related side effects of health conditions and prescribed medications which had led to a high proportion of the sample to experience sexual problems. Again, most wanted to have this discussion, but felt unable to raise sexual issues proactively with their GP.

Several commentators have therefore recommended that GPs and PNs need to be more proactive in managing sexual health needs, and this is certainly true if the recommendations of the National Sexual Health Strategy are to be met. However, overall, little is known about how GPs and PNs view sexual health management within primary care, why they may be unwilling to raise sexual issues within patient consultations and how they feel communication in this area could be improved. The study discussed in this paper aimed to address this gap in current knowledge.

Our aims were to identify barriers perceived by GPs and PNs to inhibit discussion of sexual health issues in primary care and identify those strategies they feel have the potential to overcome these barriers.

Methods

Potential participants were identified from a published list of GPs and PNs covering all primary care practices within Sheffield, and purposive sampling was used to maximize diversity of participant characteristics. We felt it important to include GPs working both in single-sex and mixed-sex practices given the impact that gender of GP and patient may have on willingness to discuss sexual health concerns. A key concern also was to ensure participation from practitioners working within different areas of Sheffield given the wide variety in socio-economic circumstances within the city, and efforts were made to recruit approximately equal numbers of practitioners from each Primary Care Trust (PCT). As there is also variation in socio-economic factors within PCTs, efforts were made to sample across each PCT area. Variables guiding sampling therefore included: practice type, including single-handed practices, single-sex practices and mixed-sex practices; and location of practice. The selection of GP participants was also stratified by gender (all PNs listed were female). Unfortunately, no further demographic information was available for practitioners, including age and ethnicity.

All GPs, and the first 35 PNs who responded positively to the invitation to participate, were included in the study, resulting in semi-structured interviews being conducted with 13 male and nine female GPs aged 34–57 years and 35 female PNs aged 32–60 years. Participants were recruited from all four PCTs within Sheffield and worked at a socio-demographically diverse range of practices. Interviews with GPs were conducted between November 2001 and April 2002, and with PNs between April and October 2002. All interviews were conducted by experienced female research associates aged between 24 and 32 at the time of the interviews (SH, EG and HE). Interviews took place at the participants’ practice and lasted between 45 and 90 min. The interviews followed a ‘guided conversation’ format and covered the following themes (although not necessarily in this order): the meaning of sexual health within primary care and the role of primary care within sexual health management; GP/PN barriers to discussing sex; patient barriers to discussing sex; the influence of external factors on sexual health management within primary care (including national policies and guidelines); potential strategies to overcome perceived barriers; demographic details about the participant; and further information about their practice. Although the original intention had been to explore barriers to discussing sexual health with middle-aged and older adults, this was done within a broad context and all participants were asked about, and referred to, their attitudes and experiences of consultations with patients of all ages. The professional barriers we identified to talking about sex within primary care are therefore applicable to

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patients of all ages and, where barriers were identified to be specific to particular demographic groups, including middle-aged and older patients, this is clearly indicated. Interviews were tape-recorded with permission, and additional field notes were taken after the interview. These incorporated interviewers’ reflexive accounts of the interview process and were used as aids to analysis. Participant confidentiality was ensured at all stages of the research and the study had the approval of the local ethics committee.

Data analysis
Interviews were transcribed verbatim and transcripts anonymized. In the analysis, the broad themes developed for the interview guide were used as the major categories for the organization of data, although more detailed coding and analysis within each of these categories was pursued. This approach to analysis is akin to ‘selective coding’ which uses a mix of inductive and deductive thinking to identify conceptual patterns and relationships in the data and enables the identification of unexpected themes. To be certain of consistency within analysis and that similar views were held regarding the interpretation of data and the formation of themes, each researcher initially focused on the analysis of one theme. The resultant themes were then exchanged and the researchers checked that they shared an understanding and interpretation of the many meanings within the data. Once such cohesiveness had been reached, the data were analysed further to develop more thematic categories which encompassed all the issues raised by participants and explored in the interviews. As a result of this process, six core categories were identified. A qualitative data software package was used to assist the analytical process: QSR NUD*IST.

Results

The role of primary care within sexual health management
Overall, participants perceived the role of primary care within sexual health management as encompassing a range of tasks from diagnosing and treating sexual health problems, having general discussions about sexual health concerns, providing referrals to other sexual health services and promoting safe sex. Primary care was identified as the first point of contact with health services for most people with sexual health concerns and, as such, as playing an important role in sexual health management, particularly for middle-aged and older patients who were seen as less willing to access Genitourinary Medicine and Family Planning services. When asked whether primary care fulfilled its role in sexual health management effectively, views were mixed. Participants acknowledged the demands of other priorities and perceived that sexual health management tended to focus on the prevention and management of sexually transmitted infections (STIs), providing contraceptive advice and performing smear tests; sexual dysfunction received very low priority. Moreover, although most participants were happy to address sexual issues when raised by a patient, a majority of both PN and GP participants identified that they did not routinely initiate discussions of sexual health issues within consultations. Despite a general recognition that sexual health could be an important part of some people’s lives and an area with which primary care could be effectively involved, pressures of time and resources, as well as the complex and difficult nature of issues pertaining to sexuality, were acknowledged to result in sexual health being afforded low priority within both primary care policy and day to day clinical practice. The specific barriers to discussing sexual issues with patients, particularly if these were not presented as the main reason for the consultation, are discussed in detail below.

The role of sexual health in medical and nursing care
A key difference to emerge between the attitudes of GPs and PNs related to the perceived role that sexual health was seen to play within each specialty. Nurse participants regarded sexual health to form part of holistic nursing care and, as such, as an important aspect of their role.

“If we’re going to look after people as a whole then that [sex] is part of it, part of life and we can’t ignore it.” (PN: aged 30–39)

In contrast, some GPs expressed concerns about whether sexual health was actually a ‘medical’ issue or not.

“Again, thinking about issues that you have raised, how much of this is health-related, how much of it is outside our sphere all together and should we be trying to influence things which are especially outside our control and more particularly outside our gift? I think it’s one of the things that was very clearly highlighted when Viagra did become available, it was something very accessible and all of a sudden it seemed to be creating a demand which was previously not seen as a health problem at all, it was seen as a social problem or a relationship problem or whatever, but not specifically to do with doctors and nurses, and all of a sudden it was, it was like taking over that area. Are we the appropriate people to be doing it? Should we be doing it?” (male GP: aged 40–49)

This sentiment was also apparent in concerns expressed by GP, but not PN participants, as to whether patients would perceive sexual issues as legitimate topics for discussion within a medical consultation. Fears were expressed that mentioning such issues could transgress the public–private boundary and, potentially, offend the patient by “prying into something that’s none of my business” (male GP: aged 40–49). The risks inherent in
so doing were discussed in relation to the doctor–patient relationship and, in extreme cases, this was felt to be in danger of being jeopardized:

“If you mention this will affect your sex life to an older woman who hasn’t slept with her husband for years and years, you know she might be quite sensitive to the fact that she hasn’t slept with her husband for years and years and might be quite upset if you said that and I think that’s going to break down your doctor–patient relationship if somebody says that. You have to be very careful sometimes or you’ll never see them again. They’ll go to see somebody else.” (female GP: aged 30–39)

Although PN participants also discussed the potential to cause offence, risks to the patient–professional relationship were not mentioned and, overall, this was not felt to be a significant deterrent to initiating a discussion of sexual issues.

‘The can of worms’

When discussing the key barriers to talking to patients about sexual issues within primary care, both GP and PN participants referred to sexual health as a ‘can of worms’ or ‘Pandora’s box’. This analogy was seen to characterize participant’s feelings about addressing sensitive and complex problems within the time and resource limitations of primary care. As one nurse participant identified:

“It is difficult, especially if it opens up a can of worms, because once you’ve opened up that can of worms you’ve got to follow it through, you can’t then say oh ‘I haven’t time for this you need to make another appointment’, you can’t do that especially where it’s sexual health that’s involved.” (PN: aged 40–49)

Time constraints were identified as critical. For both GPs and PNs, limited time available within consultations was the key barrier identified to initiating discussions of sexual health issues. PNs felt that there was insufficient time available during consultations to build up a good rapport with the patient, something seen as essential if sensitive issues such as sexual health were to be discussed. For GPs, tight limits on consultation times were seen as significantly limiting the opportunities afforded to GPs to explore issues beyond that with which the patient was immediately presenting. As one participant commented:

GP: “Hypertensives for instance, gosh a lot of them cause impotence… I haven’t got anything to back this up with, but my feeling is that the sexual side effects would be mostly neglected, cause it’s a sort of Pandora’s box isn’t it?”

R: “…you don’t sort of want to open up all sorts of thing?”

GP: “No because normally sexual problems take up a long time and therefore are best avoided.” (female GP: aged 50–59)

Concerns about expertise were also expressed in this context. The fact that sexual health management often could require specialist knowledge and skills was seen to limit professionals’ ability to address these concerns adequately. This left some participants wondering whether it was actually fair to the patient to broach a subject that they felt ill-equipped to deal with.

“There is another issue that you haven’t raised yet and this is a can of worms issue in if you’re running to a schedule and you broach areas which are potentially incredibly complicated and insoluble and maybe you’re outside the ability to do anything about it anyway and then what good does it do you or them?” (male GP: aged 40–49)

Particular concerns were expressed about choosing the language to use to address sexual issues and being up to date with the latest developments in the field. Nurse participants also identified that their inability to prescribe, as well as for some the inability to refer to specialist clinics, limited the extent to which they could address patient’s sexual concerns and, as a result, their motivation to raise such issues in the first place.

Primary care priorities

GP participants identified that the time pressures they worked within meant that their priority had to be diagnosing health conditions and prescribing medication, meaning little, if any, time was available to discuss the impact of the condition upon the patient’s life, including their sex life:

“[Time] is a major factor to how much you explore ill health on people’s lives in general and I think we often really limit what we offer patients; we don’t really understand the impact of even quite straight forward problems, how it affects people day to day, because we don’t really have the time to do that… it’s sort of little bits that are often again tagged on the end, they might talk about whatever condition and by the time you’ve talked about the disease and the drugs and the side effects, you know how it actually affects somebody’s life disappears or is sort of on the bottom of the list and how it affects their sex life, you know if it’s there at all.” (female GP, aged 40–49)

Moreover, wider policy developments were also seen to influence the issues that both GPs and PN had to prioritize within their clinical practice. Although the impact of initiatives such as the National Service Frameworks upon day to day working was disputed, there was a general feeling that these channelled time and resources away from areas not prioritized in this...
way. As one PN identified:

R: “So when you say you’ve got enough on your plate, does that mean time constraints are a big factor?”

PN: “Oh I just haven’t got the time, I just have not got the time. The issues at the moment are with the National Service Frameworks, that is bogging us down without adding in other things like sexual health etc. I’m afraid that’s the way things are, we are just too over-laden with chronic disease management to be able to go into the other aspects of health.” (PN: aged 60–69)

A national focus on the prevention of management of STIs among younger people and the prevention of teenage pregnancy within UK sexual health policy was also seen to translate into day to day practice, with issues such as sexual dysfunction and other non-STI-related sexual problems receiving very low priority.

**Barriers to talking about sexual issues with particular patient groups**

In addition to general barriers to discussing sexual issues identified above, both GP and PN participants raised specific concerns about addressing such issues with particular patient groups. These included patients of the opposite gender, middle-aged and older patients, patients from Black and ethnic minority groups, and non-heterosexual patients. As explored below, these barriers related to the main to practitioner attitudes.

**Gender.** Overall, a preference for same-gender consultations about sexual health issues was identified. This was seen as both a professional and a patient preference and was consistent for both GPs and PNs. Some participants identified that their preference stemmed from feeling more comfortable discussing sexual issues with same-gender patients and concerns that patients of the opposite gender may sexualize the consultation (some GP participants gave examples of when this had happened). However, a more common theme to emerge was that the tendency of patients to self-select along gender lines when presenting with sexual concerns mean that both GPs and PN could become de-skilled in certain areas of sexual health management. As one PN identified:

“I would feel much more comfortable with a woman because I think would know what to say to her, whereas to the man, I don’t know enough about the devices to help.” (PN: aged 40–49)

The pattern of same-gender consultations meant that PNs tended mainly to manage, and certainly felt more comfortable managing, women’s sexual health concerns; the implications of this for the expansion of nursing input into primary care sexual health management are explored below.

**Ethnicity.** When participants were asked to reflect on barriers to talking about sex with particular patient groups, issues specific to ethnicity were raised. (‘Black and ethnic minority group’ is the term we are using to characterize the group of patients to which participants were referring in this context. Participants themselves did not use this term, but referred to ‘ethnic minority’, ‘Asian’, ‘Afro-Caribbean’ and ‘Muslim’ patients.) There was a common perception that sex was something that was less openly discussed by people from certain Black and ethnic minority groups:

“I think maybe a lot of the Asian and similar folk probably have been brought up not to discuss these types of things because they were brought up in a less liberal society.” (male GP: aged 30–39)

Participants also related potential differences in attitudes amongst patients from Black and ethnic minority groups to religious beliefs (although in many instances participants did not indicate to which religion they were referring). For example, one PN stated that “with some religions it’s not always looked upon to have someone look down below and start probing into things like that.” (PN: aged 40–49). However, interestingly, very few participants reported actually having held discussions about sexual issues with this patient group, indicating that their discussions were based upon pre-existing beliefs rather than direct experience. Indeed, participants who had held such discussions reported that these perceived difficulties did not reflect their experiences. One GP, for example, reported that when she moved to a practice with a high proportion of Pakistani patients, she was “surprised… [because] they are ready to discuss it [sex]” (23223, female GP), although this related only to female, not male patients.

Difficulties of discussing a sensitive subject such as sex when a common language was not shared were also raised. Indeed, the use of an interpreter, although essential in certain circumstances, was identified as problematic. In particular, difficulties in translating specific medical terms, fears that the interpreter could compromise patient confidentiality and the risk that the presence of a third party could depersonalize the consultation were identified as complicating factors introduced when an interpreter was used. Furthermore, in relation to discussions of sexual health issues, the potential for the translator to be embarrassed themselves by the discussion was also acknowledged. The use of relatives as translators was also identified as highly problematic within this context. Overall, both GP and PN participants and, in particular those working at practices with a high proportion of non-English-speaking patients, identified the sexual health management of these patients as a training priority.

**Age.** As already mentioned, the role of primary care in terms of sexual health management was seen to assume
increasing importance with patient age due to the limited availability/accessibility of other sexual health services for older people. However, older age was seen to present a significant barrier to discussing sexual health issues within a primary care context, both for professionals and for patients. Indeed, overall, participants acknowledged that they raised sexual issues far less often with older patients than with younger patients.

“I suppose you would realistically be more likely to raise issues like that with a 30 year old than an 80 year old yeah, I mean sometimes you might do but I would look for more distinct cues from them, in an older person, before I raise the issues, whereas in a younger person I might be more inclined to raise the issues myself I think yeah [...] yeah I think that’s probably true.” (PN: aged 40–49)

Interestingly, when participants talked about the impact of age upon their management of sexual health, it became apparent that perceptions of ‘older patients’ within this context included, for many participants, patients in their 40s and over. This age group was considered by most participants to perceive sexual issues as more personal and sensitive than younger people and, potentially, be more easily offended if such issues were raised. However, there was a recognition that the professionals’ attitude may form the largest barrier to raising sexual issues with this age cohort of patients:

R: “Do you think that your approach or attitude is affected by the age of somebody, the patient, younger or older?”

GP: “Yes I think I find it more difficult with older people.”

R: “Why do you think that?”

GP: “It’s strange isn’t it. Why do I think that? Perhaps it’s me and not them, I think they are more likely to be offended, but I recognize that may well be to do with me not them, I somehow feel it’s harder to raise it.” (male GP: aged 30–39)

It is also worth noting that discussions about sexual risk taking were not initiated routinely with this age group. Issues specific to the sexual health management of middle-aged and older people by GPs are discussed in more detail in a separate publication.18

Non-heterosexual patients. A significant number of GP participants identified that they felt uncomfortable discussing sexual health issues with non-heterosexual patients, with some expressing concerns about how to reconcile their own views about non-heterosexuality with their clinical practice. (We use the term ‘non-heterosexual’ to characterize the group of patients to whom participants are referring within this theme. Participants themselves did not use this term, but commonly referred to ‘gay’, ‘homosexual’ and ‘lesbian’ patients.) One participant, for example, questioned the ethics of prescribing Viagra to gay men, particularly if they were not in a stable relationship. However, in the main, discussions centred around how GPs could sensitively manage the needs of their non-heterosexual patients. Within this context, some GP participants raised worries about their own ability to do so appropriately.

“I think especially in homosexual relationships where the phrases they use for certain sexual acts can be quite or what we would feel is inappropriate but it is the common terms and sometimes you have to alter the way you talk to them and say you know ‘this is what I want to talk to you about, do you understand that?’ and if they don’t understand what we would say is the normal phrase or clean phrase then I would go and use whatever words they use to refer to their sex act.” (male GP: aged 30–39)

It was apparent through the language typically used by participants that most were positioning themselves as heterosexual (although we did not ask participants to disclose their sexual orientation). For example, in the above extract, the GP participant talks about ‘homosexuals’ as ‘they’, rather than ‘we’. Moreover, his discussion also indicates that he believes non-heterosexual relationships are not ‘normal’ or ‘clean’, indicating an underlying, perhaps subconscious prejudice. The implications of beliefs such as these for training and education of practitioners are considered in the Discussion.

Again, the importance of choosing the right language to address sexual issues was perceived as highly important, and a potential area where training input would be useful. Although most PN participants felt that they had few problems managing the sexual health needs of non-heterosexual patients appropriately, there was a low level of awareness that they may have non-heterosexual patients, again indicating a need for training.

Overcoming barriers

Training. All participants were asked to consider how the barriers they identified to sexual health management within primary care could be addressed. Although many of these barriers, and in particular time and resource pressures and competing priorities, were seen to be structural and, as such, beyond their control, the value of training in this area was considered. Views about this were mixed. Several PN participants in particular identified a need for, and desire to, pursue training opportunities if they arose. However, the time and resource pressures within primary care led them to question how feasible pursuing such options would be.

“It’s not always easy to get the time off for training because there are so many new things coming up all the time and it’s prioritizing and you have to look at
your workload and try and define which are the most important of the aspects of that to focus on.” (PN: aged 40–49)

This was also a key barrier for the minority of GP participants who would have liked to take up training in this area. Indeed, although there was a recognition of the value of communication skills training in enabling GPs to discuss these issues in consultations and an awareness that training currently provided in this area was not adequate, again competing time and resource demands were seen to limit training opportunities.

Providing patient information. Providing information was seen as an important means of enabling patients to initiate discussions of their sexual health concerns during consultations. Within this context, written information such as leaflets or posters was seen as valuable, particularly as a means of bypassing awkwardness and embarrassment in consultations for both the patient and the professional. One PN, for example, talked about how she used this strategy to encourage women to talk about vaginal dryness during smear tests:

“There’s a poster by where the wall is where we do the smears, and they will often be so relieved to be able to talk about it and they don’t really want to take HRT and then I say why not use KY jelly, try these samples and they go off with KY jelly, or whatever, and they’ve got an answer to it and its not something that you can easily come out with I don’t suppose, its only in that setting that you would discuss it.” (PN: aged 40–49).

However, participants acknowledged that, on the whole, there were few sources of written information available that covered sexual health issues, apart from in relation to STIs, and even in this instance it was identified that this tended to be targeted at young people. In addition, concerns were expressed that patients may feel too embarrassed to pick up a leaflet about a sexual problem in the practice waiting room and that if information was provided, someone had to be available to answer any questions it may raise for patients.

Expanding the role of the PN. As noted earlier, policy recommendations have identified the potential for the role of nurses to be expanded within sexual health management, and this was an issue we addressed with all participants within the context of primary care. GP participants were overwhelmingly supportive of this idea, not only because of the implications it may have for their workload, but also due to a recognition by many participants that nurses may be better equipped to manage sexual concerns than doctors.

“They certainly have appointment times longer than mine and I always see the nurses as more holistic than doctors, doctors do tend to have more of a medical sort of model don’t they and they home in on various diagnoses [laughs], whereas I often imagine practice nurses to be chatting about things and maybe asking more questions.” (male GP, aged 40–49)

PN participants, however, disputed the idea that they had significantly more time to spend with patients, although they were in the main happy to consider assuming a broader role in sexual health management. However, as identified earlier, they tended mainly to manage the sexual health concerns of female patients and certainly felt that both they and the patient felt most comfortable with this arrangement. In addition, structural barriers such as an inability to refer to specialist clinics (although this varied by practice) and an inability to prescribe led participants to question how their role in this area could expand. A real need for such an initiative to be supported with training was also identified.

Discussion

Our findings confirm, and significantly extend, previous work and commentary which indicate that sexual health represents a very difficult topic for GPs and PNs to address proactively within primary care consultations. Participants identified similar barriers to discussing sexual problems as reported by questionnaire surveys of GPs and PNs, including time pressures, complexity and lack of training. However, the qualitative methodology adopted allowed a more in-depth understanding of how these barriers operate. For example, the ‘can of worms’ analogy could be unpicked to gain an understanding of how pressures of time, concerns about medical legitimacy and worries about personal expertise, in addition to the sensitive and often complex nature of sexual health issues, combine to make this a highly problematic topic to raise within primary care consultations.

Certain limitations of the study must be acknowledged. First, participation rates were relatively low, particularly amongst GPs, and it is likely that professionals who took part in the study would be more interested in sexual health issues than non-participants, although it was evident that many were not. The sample was drawn from only one UK city, although there is little to suggest that the situation differs elsewhere. Finally, a wide range of conditions were discussed under the terms ‘sexual health’; however, the barriers to discussing this range of conditions were similar, as their complexity and sensitivity were related to the fact they were sexually related.

Particular barriers were identified to discussing sexual issues with patients of the opposite gender, patients from Black and ethnic minority groups, middle-aged and older patients, and non-heterosexual patients. Preferences for same-gender consultations about sexual
issues were reported by PNs participating in a UK survey and are known to influence some patients' decisions to consult GPs for any condition. Professional difficulties in talking to middle-aged and older patients about sexual issues are evident in patient accounts and professional commentary, but have not been explored in detail previously within a primary care context. Similarly, there is a lack of research addressing how the sexual health needs of patients from Black and ethnic minority groups can be met, although Serrant-Green confirms that men from minority ethnic groups, although perceived as at particular risk of contraction of an STI, are not having their needs met appropriately by sexual health services. However, overall sexual health management with ethnic minority groups represents an under-researched area and warrants more attention. Similarly, little work has looked at professional attitudes towards addressing the sexual health needs of non-heterosexual patients within primary care, although a lack of skills and awareness training in this area has been noted. Indeed it is likely that the situation in the UK is similar to that in the USA, where a survey identified that the average time devoted to this issue in undergraduate medical curricula was 3 h in 4 years training.

It was apparent from the interviews we conducted that many of the participants were prevented from mentioning sexual issues within a consultation by stereotyped ideas about particular patient groups. For example, a commonly voiced opinion about both older patients and patients from Black and ethnic minority groups was that mentioning sex could 'cause offence'. However, when questioned, few participants could give examples of when they had caused offence in this situation and it was apparent that their attitudes and behaviours were based more upon preconceived ideas about these patient groups than direct experience of individual patients. Lupton argues that the pressures of time within clinical consultations encourage medical students to categorize patients into 'unidimensional stereotypes'. However, it was also apparent that such stereotyping reflected underlying, often prejudicial beliefs. For example, in the Results, we cite the example of a GP who talks of his need to learn the terminology of sex and sexuality is required. Another means of overcoming barriers to talking about sexual issues, particularly with patient groups such as these, was seen to be empowering patients through the provision of information about sexual issues so as to enable them to feel more able to raise sexual issues within consultations. The need for an expanded range of sexual health information suitable for a diverse audience has also been voiced by patients themselves.

Overall, improving communication about sexual issues within primary care must be prioritized if primary care is to adopt a broader role in sexual health management, particularly if this role is to be proactive. The recommendation within the National Sexual Health Strategy that nurses may be able to become more involved in this area was explored in this study, and we identified that, although many PNs were interested in this idea in principle and GPs were overwhelmingly supportive, key barriers to this being achieved within primary care were identified. These included structural issues of nurses' ability to refer to secondary services, prescribe relevant medications and issues of time, as well as something more potentially insoluble, namely patient and professional preference for same-gender consultations about sexual issues. The potential for male sexual health needs to be marginalized as a result of increased nursing involvement in this area must therefore be recognized.

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