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Gender and sexual health in clinical practice in Lebanon

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Abstract

This study examines the readiness of obstetricians/gynecologists (Ob/Gyns) in Lebanon to provide sexual consultation, their degree of comfort when discussing issues of sexual health, and their attitudes regarding assessment, treatment, and referral. Data on these concepts were collected through face-to-face interviews with 286 randomly selected Ob/Gyns. Most Ob/Gyns reported feeling comfortable discussing sexuality during consultations, which they attributed much more to professional experience than to training. Most Ob/Gyns reported giving proper time for management of sexual health issues and follow-up, as these issues are brought up frequently by their women clients. However, results suggest that only one-third (31%) of Lebanese Ob/Gyns nearly always take the initiative in asking patients about their sexual health. Moreover, almost 45% of participating Ob/Gyns did not recognize a strong relationship between reproductive health and sexual functioning. Gender was not found to be an important predictor for any of the indicators measured in the present study. Ob/Gyns in Lebanon are significant consultants on various sexual issues, and they need better postgraduate training, continuing medical education, and access to medical congress resources on the topic of sexuality and its relationship to reproductive health.

Keywords

Sexual consultation; Lebanese Ob/Gyns; Reproductive health

1. Introduction

Sexuality is an integral part of human life and general well being [1]. It encompasses feelings that are experienced and expressed in language, thoughts, beliefs, attitudes, values, behaviors, practices, and relationships [2]. Sexual health is an important part of total health [1,3], as sexual problems can disrupt health, quality of life, and general wellbeing, causing in many instances marital problems or marriage dissolution, and emotional impoverishment [1,4]. As awareness on issues of sexuality is increasing, more women want to discuss their concerns with their obstetrician/gynecologists (Ob/Gyns), thus encouraging better understanding and willingness on the part of Ob/Gyns to address these concerns in medical practice [5].

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While routine screening and management of sexual health issues should be a regular and crucial part of the health care of women [6,7], a review of literature does not support this in reality. In fact, some studies on women's sexual health in the United Kingdom [8] and the United States [1] indicate that Ob/Gyns know less than half of their patients' sexual concerns, and, in many instances, are unaware of how common these concerns are in their practice. This is disturbing because many women of child-bearing age may rely on their Ob/Gyns in matters related to sexuality and sexual health. Many women even perceive their provider as a "wise authority figure" giving sexual guidance and counseling [4]. As such, the Ob/Gyns' role is so broad that they could treat women with sexual dysfunction, and also provide counseling for women and (when appropriate) their husbands to enhance intimacy and the conjugal bond [4,5]. However, it has been found that the Ob/Gyns' discomfort in discussing sexuality impedes adequate sexual health assessment and management of sexual problems [7].

It appears that this discomfort varies with cultural norms concerning gender relations and communication styles. In a study of providers in the United Kingdom, Haboubi and Lincoln [8] found that, even when providers acknowledged the importance of incorporating sexual health issues within "a broader holistic approach," nearly all (94%) were unlikely to discuss sexual health issues with their patients. Another study done in Egypt, an Arab country with cultural features similar to those of Lebanon, Ob/Gyns—mostly men—stated that they rarely asked their female patients about sexuality and sexual practices or problems, mainly due to time restriction, gender-based cultural sensitivities, and fear of loss of patients [9]. In her anthropological work on social conditions of women's reproductive health in Egypt, Khattab [10] reports on women's complaints regarding a lack of communication with health care providers, and relates it to work circumstances and cultural and gender issues. Available studies in Europe reveal that female Ob/Gyns were found to perform longer physical examinations, agreed more often with the patient, and asked fewer medical questions [11,12].

Whether the discomfort of providers in discussing sexuality issues is related, in part, to gender issues remains a subject open to further research. Early studies in social, psychological, and clinical settings document gender differences in relation to health provider—patient communication [13]. Some studies suggest that female and male physicians differ in their communication characteristics such as time spent in the interview, counseling, listening, style of instruction, and approach [11–13]. By contrast, other studies found that the physician's gender was not one of the significant predictors of patient complaints and poor adherence to treatment, regardless of whether the physicians practiced in rural or urban areas [14]. Some current data suggest that medical specialty may play a significant role in sexuality-related consultations, as physicians specialized in internal and in family medicine have reported significantly less comfort and lower levels of skills than Ob/Gyns when performing pelvic examinations or obtaining a sexual history from women [15].

At present, there is a paucity of research concerning the effects of gender and specialty on physician readiness and communication style in the gynecological setting. As such, although a significant body of research has examined the attitudes and perceived health care needs of women presenting to Ob/Gyns for sexuality concerns [1,6,7,16], few studies assess the provider's perspective regarding women's sexual health [8,17], and there is a dearth of research on gender differences in relation to sexuality and sexual health in the gynecological setting. A review of the literature in the Arab world produced no systematic studies of the physician's perception and attitudes regarding sexuality and sexual health.

The present study aims to elucidate the perception of sexuality and sexual health by Ob/Gyns practicing in Lebanon. It investigates Ob/Gyn's readiness to provide sexual

consultation, their reported degree of comfort when discussing sexual health, their attitudes regarding assessment, treatment, and referral in of women with sexual problems, as well as their sources of information on sexuality and sexual health. It will also examine the impact of the Ob/Gyns' gender on these indicators.

2. Data and methods

This study was part of a Wellcome Trust-funded project on "The Changing Childbirth Practices in the Arab Region" carried out at the Faculty of Health Sciences, American University of Beirut. Data were collected through face-to-face interviews with randomly selected obstetricians and gynecologists in Lebanon. One trained female nurse holding a Masters degree in Public Health conducted all the interviews.

The sample was designed to be representative of the population under study. The sampling frame consisted of a list of all obstetricians and gynecologists ($n=614$) obtained from the Lebanese Order of Physicians, a constantly updated list of physicians in Lebanon. The sample was chosen from the five governorates (Beirut, Bekaa, Mount Lebanon, North, and South), in proportion with the distribution of these physicians in each governorate. Three hundred Ob/Gyns were selected by stratified random sampling. Of those, 286 were successfully interviewed, accounting for a 95% response rate. Table 1 provides information on the study and the sample population.

The part of the questionnaire on sexual health in the questionnaire included items regarding (1) frequency of consultations on sexual problems, (2) type of problems raised, (3) women's willingness to bring up sexual concerns and problems and their partners' involvement, (4) management of sexual problems, (5) Ob/Gyns' readiness to provide sexual consultation, and (6) Ob/Gyns' sources of information.

Multivariate statistical analyses were used to test the impact of gender on these indicators. Both unadjusted and adjusted odds ratios were estimated. In addition to gender, place of practice and place and year of specialization were controlled for as potential covariates with Ob/Gyns' gender. The statistical program STATA 7.0 for Windows [18] was used.

3. Results

Tables 1 and 2 show the characteristics the sample of Lebanese Ob/Gyns. There were more male (75.7%) than female (24.3%) Ob/Gyns. About one-third (36%) of Ob/Gyns had their practice in Beirut, the capital city. Although the rest of the Ob/Gyns practiced in areas characterized as semiurban or rural, unfortunately, classification as urban, semiurban, and rural setting could not be done because Ob/Gyns did not provide information on their exact place of practice within each governorate. Differences by gender and place of practice also emerged, female Ob/Gyns being more predominant in Beirut.

Approximately 70% of Ob/Gyns received their specialization in Europe (about equal numbers mentioned Western and Eastern Europe); about one-fourth in an Arab Country; and only a very small percentage in North America. More female Ob/Gyns were found to have received their training in Eastern Europe and North America. Receiving specialization in Western Europe appears to be more common among male Ob/Gyns. There were no differences by gender for those who had received their training in the Arab region. About 16.8% of the sample graduated between 1952 and 1979; 40.9% between 1980 and 89; and 42.3% between 1990 and 2000. A significant increase in the number of female graduates was seen over time, rising from a low of 8.7%, to 22.2%, to 57.9% in each of the three cohorts interviewed.

All Ob/Gyns reported being consulted on sexual concerns and problems by all their patients regardless of their marital and/or reproductive status. Most Ob/Gyns categorized “patients married outside the pregnancy” as the most frequently consulting on sexual health/problems, followed by “unmarried patients,” “married menopausal patients,” and, finally, “married pregnant patients.”

Table 3 shows the prevalence of the most important indicators that measured the Ob/Gyns’ readiness to provide sexual consultation and their management skills of sexual problems in the Lebanese context. When asked whether they took the initiative to ask questions on sexual health/problems, 31.1% of the 286 Ob/Gyns successfully interviewed reported “nearly always,” 41.6% reported “sometimes,” and 27.3% reported “almost never.” Despite a substantial proportion of Ob/Gyns who did not take the initiative themselves, almost all (93.4%) Lebanese Ob/Gyns reported feeling “very comfortable” when consulted on sexual health and/or problems, with only 0.7% reporting feeling “not comfortable.” About 61% of the Ob/Gyns reported that the reason for their “feeling comfortable” was their “experience,” compared with 28% who attributed it to “training,” and 11.2% to “personal interest” in sexual health issues.

The first indicator of management skills is the time the Ob/Gyns allocated to the treatment of sexual problems compared with other problems. About 24.1% of the Ob/Gyns reported allocating “less time” to the management of sexual problems while 50% and 25.9% reported allocating “more time” or the “same time” compared with the conditions the women were consulting for.

Another indicator was the degree of the Ob/Gyns’ involvement at follow-up visits. Whereas 92.3% reported “nearly always” asking their patients about treatment effectiveness, only 19.2% reported a willingness to refer their patients to other specialists for the treatment of sexuality problems.

As shown in Table 3, 56.3% of the Ob/Gyns reported that their training contributed “a lot” to their abilities to manage their patients’ sexual problems, whereas 43.7% reported a more “modest” contribution of their training.

Ob/Gyns were also asked about the extent of interrelationship between reproductive and sexual health. This was an overarching question that reflected on the Ob/Gyns’ readiness and ability to provide consultation on sexual health. About 55.6% of the Lebanese Ob/Gyns believed that reproductive health has a “great effect” on sexual health, whereas 37.4% reported a more “moderate” effect and 7% believed that it had “no effect.”

The resources generally used by Ob/Gyns to update and improve their knowledge and skills in the area of sexual health include scientific publications, as reported by 70.3% of the Ob/Gyns, whereas 12.6% reported “conferences” and 9.8% reported “knowledge” as appropriate tools. When asked about the tools they were currently using to improve knowledge and skills, most (85.7%) reported “reading scientific publications”. Ob/Gyns in Lebanon rarely rely on continuing medical education courses to update or improve their knowledge and skills.

Table 4 presents the effect of gender on selected outcome variables related to the Ob/Gyns’ practice skills. Gender was not found to be an important predictor of any of the outcome variables related to readiness and management when providing sexual consultation. Moreover, this lack of gender-effect was sustained in multinomial regression controlling for other predictors (results not shown).

4. Discussion

This study focuses specifically on Ob/Gyns' encounters with their patients' sexuality and sexual health issues. Regarding their readiness, the results showed that while most Ob/Gyns reported feeling very comfortable when consulted on sexuality and sexual health issues, yet less than one-third reported "nearly always" asking their patients about such issues. The present data thus support earlier research in the Arab world reporting that most Ob/Gyns rely on their patients to initiate issues related to sexuality and sexual health, believing that these issues will ultimately "come out" [9]. This finding is particularly worrying, as it also suggests a lack of sexual history taking, important as it is for a general medical assessment of patients by Ob/Gyns. This finding also confirms to previous studies that noted the inadequate integration of sexual history in the overall medical record [19]. This is further corroborated by the finding that only about 55.6% of Ob/Gyns reported a "great effect" of reproductive health on sexual health (and vice versa), reflecting again the inadequate understanding of the integration of reproductive and sexual health.

The study has revealed the weak role of training in contributing to the skills of the Ob/Gyns in addressing sexuality and sexual health issues. This finding might also reflect inadequate exposure to sexuality and sexual health issues in the medical school curricula and/or in residency programs, leaving it to the personal interest of Ob/Gyns.

Another interesting finding, on the other hand, was that most Ob/Gyns (80%) would not refer cases to other specialists. Some reasons may be their claimed ability to manage all cases, their fear of losing their patients to the referred physicians (in view of the fierce competition), and lack of a well-developed system of referral in Lebanon. The finding that referral rates vary by geographic area, with referral mostly occurring in Beirut, also suggest that the lack of referral may be related to the disproportionate availability of subspecialists in Lebanon's governorates. Similarly, Humphery and Nazareth [17] concluded that low referral rates were associated with "limited availability of secondary care referral services." Lack of referral might also be associated with low severity of cases. In fact, when Ob/Gyns were asked about conditions for referral and which specialists they referred patients to, most stated that they referred mostly cases of unexplained sexual problems and most often to psychiatrists (results not shown). The present investigation did not collect data on the severity of cases.

Half of the Ob/Gyns considered the contribution of their residency training to the management skills as major, and the other half as modest. This suggests the need for additional means of improving skills, e.g., timely introduction of training algorithms and evidence-based management. An identification of training needs in sexuality and sexual health for General Practitioners using self-rating was described by Wakley [20].

Gender was not an important predictor for any of the indicators measured in the present study. Existing literature shows contradictory effects of gender on women's health care. In a Middle East setting, we would have expected that female Ob/Gyns would have shown more readiness to, at least, raise matters related to sexuality in their consultations. It may be that, in our society, providers are under the effects of certain sociocultural factors (religiosity, residency, traditions, and place of practice) that look at sexuality as too sensitive an issue to discuss with patients.

It appears that, in Lebanon, the growing number of female Ob/Gyns does not lead to gender effects in sexuality consultations. In this regard, the latent preference for female physicians, women reflects traditional and sociocultural effect compelling women to be examined by female physicians only, and not necessarily the need to seek a consultation on sexuality.

The present study has some limitations. Within the structure of the questionnaire, it was not possible to inquire in depth about, for example, reasons for being “very comfortable” and “always following up” management of sexual complaints, and “not referring.” Further probing into these matters may have elicited more differentiated and revealing answers. Furthermore, when we asked practitioners about referral to other specialists, we did not control for case severity in the referral pattern. Another limitation is having only one female nurse conducting the interviews, which could have affected the objectivity of the answers depending on the gender of the Ob/Gyn.

Despite these limitations, the study shows the need for reassessing the medical school curricula and residency programs, adding clinical guidelines regarding incorporation of sexuality and sexual health in teaching, patient care, and medical charts, particularly in countries with social norms that discourage discussions on sexuality. Further research concerning sexuality within reproductive health services is needed.

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Table 1

Information on population and sample: Lebanese Ob/Gyn

	Study	Sample
<i>Gender</i>		
Male	464 (75.6)	227 (75.7)
Female	150 (24.4)	73 (24.3)
<i>Place of practice</i>		
Beirut	220 (35.8)	108 (36.0)
Bekaa	52 (8.5)	24 (8.0)
Mount Lebanon	177 (28.8)	87 (29.0)
North	65 (10.6)	32 (10.7)
South	100 (16.3)	49 (16.3)
Total	614 (100.0)	300 (100.0)

Table 2

Other background characteristics of Lebanese Ob/Gyns

Characteristics	Frequency	Percent (%)
<i>Place of specialization</i>		
Arab Region (including Lebanon)	74	25.9
Eastern Europe	101	35.3
North America	12	4.2
Western Europe	99	34.6
<i>Year finishing specialty</i>		
Lowest to 1979	48	16.8
1980–1989	117	40.9
1990+	121	42.3
Total	286	100.0

Table 3

Measures of the Ob/Gyns' readiness and management in providing sexual consultation

	Frequency	Percent (%)
<i>Readiness</i>		
Ask questions about sexual problems		
Nearly always	89	31.1
Sometimes	119	41.6
Almost never	78	27.3
Extent of physician comfort		
Very comfortable	267	93.4
Somehow comfortable	17	5.9
Not comfortable	2	0.7
Reason for being comfortable		
Experience	174	60.8
Personal interest	32	11.2
Training	80	28.0
<i>Management</i>		
Time allocated for management of sexual problems vs. others		
More	143	50.0
Same amount	74	25.9
Less	69	24.1
Ask women about effectiveness of management in follow-up visit		
Nearly always	264	92.3
Sometimes	19	6.6
Nearly never	3	1.0
Referral to other specialist		
No	231	80.8
Yes	55	19.2
Training contribution to knowledge and skills		
Contributed a lot	161	56.3
Somehow contributed	125	43.7
Degree of effect of reproductive health on sexual health and vice versa		
Affects a lot	159	55.6
Affects somehow	107	37.4
Does not affect	20	7.0
Total	286	100.0

Table 4

The effect of gender on selected outcome variables

	Male		Female		P-value
	N	Percent (%)	N	Percent (%)	
Readiness					
Ask questions about sexual problems					0.196
Nearly always	65	30.0	24	34.8	
Sometimes	87	40.1	32	46.4	
Almost never	65	30.0	13	18.8	
Reason for being comfortable					0.261
Training	60	27.6	20	29.0	
Experience	129	59.4	45	65.2	
Personal interest	28	12.9	4	5.8	
Training contributed to knowledge and skills					0.284
Contributed a lot	126	58.1	35	50.7	
Somehow contributed	91	41.9	34	49.3	
Management					
Time allocated for sexual problems vs. others					0.267
More	112	51.6	31	44.9	
Same amount	51	23.5	23	33.3	
Less	54	24.9	15	21.7	
Referral to other specialist					0.798
Yes	41	18.9	14	20.3	
No	176	81.1	55	79.7	
Total	217	75.9	69	24.1	