IN PRACTICE

Who declines to give a name at a sexual health service?

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Objective: To characterise patients who decline to provide their surname at a public sexual health centre.

Methods: A case-control study of all patients first attending the Sydney Sexual Health Centre from 1998 to 2004, using proforma-collected electronic data to compare patients who did not provide their surname with those who did. In addition, the frequencies of the 10 most common surnames in the Sydney telephone directory were compared with the frequency of those names in the patient database.

Results: Of 27 241 patients, 1350 (5%) declined to provide their surname. The most common surnames were also over-represented, suggesting that aliases remained pervasive among the centre's patients. Sex workers, married people and people requesting HIV, hepatitis or sexually transmissible infection (STI) screening were all more likely to decline to provide a surname. By contrast, patients with symptoms, patients who were referred with a prior STI diagnosis and patients with a new bacterial or non-HIV viral STI or were a known contact with STI were all significantly more likely to provide a surname. Among patients who declined to provide a surname, 20 tested HIV positive.

Conclusion: The anonymous option did not seem to eliminate the use of aliases. Although limited, there seems to be a market for anonymous sexual health screening, particularly for the asymptomatic.

Confidentiality concerns may act as a barrier to accessing healthcare for people at risk of sexually transmissible infections (STIs), including HIV.¹ For this reason, public sexual health services worldwide allow patients to register without proof of identity, often resulting in incomplete or false information being provided. From a clinical perspective, working with patients who are anonymous or are using aliases can be problematic, particularly when care is shared with other agencies.

To justify the policy of allowing patient anonymity, it would be useful to determine if the policy conferred a public health advantage. Studies in the US have produced conflicting results about the importance of anonymity for those seeking HIV testing.^{2–3} Thus, we sought to characterise patients who declined to provide a surname at an inner-city public sexual health service.

METHODS

Since 1991, as an alternative to the previous practice of inviting false names, the Sydney Sexual Health Centre, Sydney, New South Wales, Australia, has explicitly allowed patients to register without providing a surname by simply entering the patients' surname as "declined" into the patients' record and the centre's database if the patient exercised this option. This has the advantage of reducing the number of patients using (often forgotten) false names at each visit. The files of these "declined" patients can be retrieved by searching other demographic variables such as date of birth. For this study, data on all new patients between 1 January 1998 and 31 December 2004 were extracted from the centre's database. The "declined" patients were compared with the rest of the clinic population for demographics, risk behaviour, reasons for attendance, STI testing rates, and current and future diagnoses.

In addition, to determine whether some patients may have provided a false surname despite having the option of providing none, the frequencies of the most common surnames in the Sydney telephone directory⁴ were reviewed to see if these surnames were over-represented among the centre's patients. This exercise was based on the assumption that people tend to use a more common name if adopting a false identity. The local Area Health Service provided ethical clearance for the study.

Data were analysed with Stata V.8.0 for Windows. We modelled associations by univariate and multivariate logistic regression analyses, and used Wald tests and related confidence intervals (CIs) to assess statistical significance and precision.

RESULTS

Of 27 241 new patients who attended the centre between 1998 and 2004, 1350 (5%) overtly declined to give a surname (the "declined" group). This "declined" rate did not vary significantly during the study period (data not shown). The "declined" group were older (mean age 32.3 v 29.8 years, $p < 0.001$) than the 25 891 patients who provided a surname. Table 1 details the other characteristics of the "declined" group. At the univariate level, the "declined" group were more likely to be women, but after controlling for sex work and other variables, multivariate analysis showed no difference in sex. As none of the 28 transgender patients declined to provide a surname, they were excluded from further analysis.

Reporting a current (adjusted odds ratio (AOR) 1.59) or previous (AOR 1.55) marriage or defacto relationship or—more potently (AOR 5.47)—failing to report marital status were predictive of patients being in the "declined" group compared with those who had never been married (table 1). Exclusively heterosexual men were less likely to be in the "declined" group at univariate analysis but significantly more likely (AOR 1.33; 95% CI 1.14 to 1.54) at multivariate analysis.

The reasons for patients' presentation to the centre and the current diagnoses were not mutually exclusive, so these characteristics were not amenable to multivariate analysis. At univariate analysis, patients reporting symptoms (OR 0.75), known contact with a STI (OR 0.6) or management of a previously diagnosed condition (OR 0.46) were significantly less likely to be in the "declined" group. By contrast, patients requesting screening for HIV, hepatitis or STIs were more likely to be in the "declined" group (table 1).

Patients, male or female, who reported any same sex partners in the past 12 months were more likely to be in the "declined"

Abbreviations: AOR, adjusted odds ratio; STI, sexually transmissible infection

Table 1 Characteristics of patients who declined to provide a surname (1350 of 27 241; 5% declined overall)

Characteristic	Declined group, n (%)	Univariate analysis			Multivariate analysis		
		Unadjusted OR	95% CI	p Value	Adjusted OR	95% CI	p Value
Sex							
Male	742 (5)	1*			—	—	
Female	607 (5)	1.16	(1.04 to 1.29)	0.01	—	—	NS
Sexuality grouping							
Men who have sex with men	272 (6)	0.99	(0.85 to 1.14)	0.86	1.22	(0.89 to 1.66)	0.21
Heterosexual men	467 (4)	0.75	(0.67 to 0.85)	<0.001	1.33	(1.14 to 1.54)	<0.001
Women	611 (5)	1*	—	—	1*	—	—
Marital status							
Never married	796 (4)	1	—	—	1	—	—
Married/defacto	236 (6)	1.6	(1.35 to 1.82)	<0.001	1.59	(1.36 to 1.86)	<0.001
Separated/divorced/widowed	184 (7)	1.9	(1.59 to 2.22)	<0.001	1.55	(1.3 to 1.84)	<0.001
Missing	134 (18)	5.1	(4.21 to 6.28)	<0.001	5.47	(4.43 to 6.78)	<0.001
Reason for presentation							
Post-exposure prophylaxis	7 (6)	1.24	(0.57 to 2.68)	0.59	Not included in MVA†		
STI contact	64 (3)	0.58	(0.45 to 0.8)	<0.001			
HIV test	364 (9)	1.64	(1.43 to 1.88)	<0.001			
Genital/anal symptoms	439 (4)	0.75	(0.65 to 0.85)	<0.001			
STI screen	676 (7)	1.42	(1.26 to 1.60)	<0.001			
Hepatitis test or vaccination	106 (8)	1.28	(1.03 to 1.59)	0.024			
Review/HPV/HSV	28 (2)	0.46	(0.31 to 0.67)	<0.001			
Other	155 (4)	0.78	(0.65 to 0.93)	0.006			
Same sex partner (past 12 months)	320 (6)	1.27	(1.12 to 1.45)	<0.001	1.49	(1.12 to 2)	0.007
Number of sex partners in past 3 months							
0	210 (7)	1.52	(1.29 to 1.78)	<0.001	1.2	(0.99 to 1.43)	0.05
1	646 (5)	1*	—	—	1*	—	—
2–5	379 (5)	0.96	(0.85 to 1.1)	0.58	1.01	(0.88 to 1.16)	0.89
≥5	84 (5)	1.17	(0.93 to 1.48)	0.18	1.04	(0.8 to 1.35)	0.76
Missing	31 (5)	1.1	(0.75 to 1.6)	0.63	1.32	(0.9 to 1.94)	0.16
Drug injecting (ever)	65 (5)	0.93	(0.72 to 1.2)	0.59	0.76	(0.58 to 0.99)	0.04
Current sex work	329 (18)	5.4	(4.72 to 6.18)	<0.001	5.68	(4.79 to 6.74)	<0.001
Tested at this visit for							
HIV	801 (7)	1.85	(1.65 to 2.08)	<0.001	1.53	(1.36 to 1.73)	<0.001
Chlamydia	1022 (5)	0.99	(0.87 to 1.14)	0.96	0.94	(0.82 to 1.08)	0.38
Current diagnosis							
Bacterial STI	76 (5)	0.76	(0.6 to 0.96)	0.021	Not included in MVA†		
Viral STI (not HIV)	154 (3)	0.55	(0.46 to 0.65)	<0.001			
HIV	20 (6)	1.18	(0.75 to 1.86)	0.48			
Other genitourinary condition	272 (5)	0.90	(0.78 to 1.03)	0.12			
Psychosexual/social	68 (6)	1.14	(0.88 to 1.46)	0.32			
Sexual assault	14 (5)	1.12	(0.65 to 1.92)	0.69			

HPV, human papilloma virus; HSV, herpes simplex virus; STI, sexually transmissible infection.

*Referent group.

†These characteristics were not included in the multivariate analysis (MVA) as the responses were not mutually exclusive.

group (AOR 1.49), although the reported number of non-paying sexual partners in the previous 3 months or a history of injecting drugs had no association (table 1). Current engagement in sex work was the strongest single predictor of a patient being in the “declined” group (AOR 5.68). These 329 sex workers comprised 24.4% of the total “declined” group.

Perhaps because they were more likely to be symptomatic, patients diagnosed with a current bacterial or non-HIV viral STI were significantly less likely to be in the “declined” group.

Being initially in the “declined” group was not associated with being diagnosed during a later episode with HIV (OR 1.28; 95% CI 0.8 to 2.05) or a bacterial STI (OR 1.18; 95% CI 0.99 to 1.42; data not shown).

When the frequencies of the 10 most commonly used surnames in the Sydney telephone directory⁴ were compared with the frequency of surnames used by patients at the centre

(table 2), the most common names were found to be moderately over-represented among the centre's patients. One name—the Vietnamese family name of Nguyen—was obviously under-represented. Sydney's two concentrations of Vietnamese Australians are located 10 and 30 km away and are served by local sexual health clinics.

DISCUSSION

We found that 1 of the 20 patients at this inner-city sexual health clinic declined to provide a surname when they were explicitly given the option. Additionally, the most common surnames in the telephone book were over-represented among the centre's patients when they did provide a surname. These findings indicate that large minorities of public sexual health patients have a desire for anonymity even within this confidential inner-city clinical setting.

Table 2 Proportions of Sydney Sexual Health Centre patients using the 10 most common names in the Sydney telephone directory

Surname	Telephone directory, n (%)	Patients, n (%)
Smith	7857 (0.715)	207 (0.799)
Lee	4992 (0.454)	155 (0.598)
Nguyen	4136 (0.376)	19 (0.073)
Jones	4035 (0.367)	116 (0.447)
Williams	3910 (0.356)	87 (0.336)
Brown	3822 (0.348)	104 (0.401)
Wilson	3262 (0.297)	84 (0.324)
Taylor	3188 (0.29)	82 (0.317)
Wong	2530 (0.23)	65 (0.251)
Johnson	2524 (0.23)	77 (0.297)

To place these findings in context, most STI and HIV testing and management in Australia occurs in general practice,⁵ wherein anonymity is not a practical option because costs have to be claimed on a named basis from Australia's universal health insurance scheme, Medicare. Thus, public clinics would tend to attract disproportionate numbers of patients who may have a heightened desire for anonymity, as well as those who are ineligible to claim medical costs against Medicare.

All of the transgendered people gave a surname at registration. As many transgendered people socially function with an adopted name, this may simply reflect their comfort with using an alias.

Current sex work was the strongest predictor of being in the "declined" group. Anecdotally, many sex workers who do provide a surname at the centre use their adopted "working" name rather than their birth name: an observation that we were unable to quantify. Although sex work is decriminalised in Sydney⁶ it remains socially stigmatised. Confidentiality concerns may be further magnified for migrant sex workers.⁷

Marriage or defacto status, current, past or undisclosed, also predicted a patient being in the "declined" group. As >95% of other demographic variables are available in the patient database, so many patients failing to disclose their marital status and being in the "declined" group suggests that most were married. We interpret this as indicating a heightened demand for anonymity for social and relationship reasons.

Interestingly, the presence of genital symptoms, known STI contact, referral for management of a previously diagnosed STI, or a new diagnosis of a bacterial or non-HIV viral STI were all associated with a reduced likelihood of being in the "declined" group. This can be interpreted as an example of clinical imperatives over-riding the patients' confidentiality concerns. Many would have been referred by other services where anonymity was not an option. In our experience, patients who are familiar with our service readily revert to using their full names if they need to be referred elsewhere or if they require treatment for their HIV infection. Subsidised drugs for HIV mandate the patient producing a Medicare identity card.

By contrast, being a patient who is requesting HIV, hepatitis or STI screening—or accepting HIV testing when offered—was associated with being in the "declined" group, suggesting an ongoing concern about issues of confidentiality in less clinically driven patients. It is not known whether these patients would have refused testing for HIV if they were not given the option of anonymity or whether more would simply have given false names. Over the 7-year study period, a total of 20 patients in the "declined" group tested positive for HIV either at the initial

Key messages

- Sexual health services often have to manage patients who are anonymous or using aliases. Little is known about these patients.
- At this clinic, 1 in 20 patients opted not to provide a surname. Such patients were more likely to be sex workers, married or asymptomatic when compared with patients who did provide a surname.
- Despite the option of anonymity, some patients seemed to persist in using aliases.
- Providing an anonymous service may be of public health benefit by helping to attract sex workers and other asymptomatic patients for screening.

visit or during a subsequent episode, a yield similar to patients who gave a surname (table 1; $p = 0.48$).

From a public health perspective, the patients in the "declined" group in our clinic were not conspicuously at higher or lower risk than the patients who provided a surname. However, in settings where sex workers have higher STI rates, offering an anonymous option could have a marked public health benefit. In many settings, sex workers are disproportionately affected by HIV/AIDS, and healthcare services need to adapt to their needs.⁸ Although limited, there seems to be a market for anonymous sexual health screening, particularly for the asymptomatic.

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HCS developed the protocol, assembled the data and wrote the first draft of the manuscript. AMM helped with protocol development and input into the manuscript. HW and KT performed the statistical analysis and had input into the manuscript. BD provided the original idea for the study, designed the patient database, helped with protocol development, oversaw the analysis and had input into the manuscript.

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