

Virtual Mentor

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Clinical Case

Too Much Information?

Commentaries by Christopher Kodama, MD, and by Kathryn M. Conniff and Ligia Peralta, MD

Andy Hanson was admitted to Shady Grove Hospital with a pneumonia that progressed to an empyema. He was assigned to the teaching service with Dr David Lee attending, along with a second-year resident, Dr Mary Weiss. Dr Weiss did an initial interview and recorded her history and physical in the chart. She presented her findings to Dr Lee and they agreed upon a plan to have the empyema drained and antibiotics started.

The following day, Dr Jan Krause, a physician colleague of Dr Lee's approached him to express some concerns. She had been on call the night before and was asked a question about Andy's care. Upon reviewing his chart she noted the sexual history that was documented by Dr Weiss. Dr Weiss' full sexual history included documentation that Andy was a homosexual, became sexually active about a year earlier at age 15, and "mostly" used condoms. The history also noted that Andy had several sexual partners in the last year and documented his typical sexual practices. Dr Krause told Dr Lee that she felt that the history was too graphic and was inappropriate for inclusion in the chart. She explained that she felt obligated to refer this case to the hospital ethics board and was going to do so.

Dr Lee reviewed the chart. He and Dr Weiss had discussed the patient's sexual history, and, based on his risk factors and his disease presentation, they had already decided to order additional testing, including an HIV test.

A few days later Andy was recovering well after drainage of his empyema. He was feeling better and was excited to go home soon. In checking his morning lab results, Dr Weiss noted that Andy's HIV test had come back positive. Dr Weiss and Dr Lee counseled Andy about this result, arranged for the HIV clinic coordinator to see him, and began to plan his outpatient follow-up. The following week Andy was discharged. Because of the complaint lodged by Dr Krause in regard to the medical records, Drs Lee and Weiss were asked to sit before the hospital ethics board.

Commentary 1

by Christopher Kodama, MD

In this case involving Andy Hanson, Dr Krause takes issue with the level of detail of the sociosexual history rather than the possible implications of the documentation of sexual orientation and behaviors in the medical record. The case raises 2 issues: first, how thorough a sexual history should be taken? Second, if patient information is

obtained verbally, how much should be recorded verbatim in the medical record and how much can be paraphrased, eg, “The patient engages in sexual activities that place him at greater risk for acquiring a sexually transmitted disease (STD).” Paraphrasing raises a related question; does paraphrased information maintain the integrity of the narrative from a legal perspective? Before discussing these questions, we must first understand the definition of a medical record.

What is a health record?

The medical record, or the Legal Health Record (LHR) as it is referred to by the American Health Information Management Association, serves both the medical and the legal functions of documenting a narrative of a patient’s health history. It is a protected forum for communicating clinical care plans, and “it documents and substantiates the patient’s clinical care and serves as a key source of data for outcomes research and public health purposes” [1]. Many additional definitions exist and are constantly being refined, particularly with the advent of electronic medical records (EMR), but the essence remains the same: the LHR helps caregivers organize thoughts about a patient’s health.

How thorough a sexual history should be taken?

In taking an accurate sexual history, medical students are taught to know the difference between open-ended versus closed-ended questions. However, as many who work with adolescents can attest, open-ended questions are often met with limited monosyllabic answers which are both frustrating to the clinician and not particularly helpful in identifying potential medical issues that warrant further investigation. Most have heard the anecdote of the adolescent who, when asked whether or not she is sexually active, responds “No.” When her pregnancy test returns positive and the patient is confronted about her response, she answers that she is essentially “passive” during intercourse. Clearly this disconnect could be avoided by asking question in a more direct manner: “Do you engage in vaginal intercourse?”

One can be accurate without being pornographic in obtaining a detailed sexual history. HIV switchboard operators are trained to ask about specific practices to help the caller determine his or her level of risk and avoid misunderstandings based on cultural, age, sexual orientation or gender variation. The American Academy of Pediatrics implies the need for detailed questioning as described in a 2004 clinical report on nonheterosexual adolescents: “Discuss the risks associated with anal intercourse for those who choose to engage in this behavior, and teach them ways to decrease risk” [2].

The caveat to this argument for historical accuracy is that this portion of the history must be approached with the same level of sensitivity and insight that the rest of the adolescent history receives to avoid alienation of the patient and false negative responses to questions. In her article “The Proactive Sexual Health History,” Margaret Nusbaum outlines how important it is for clinicians to become comfortable with addressing an area of health that is often a source of potential anxiety for patients though no less important to them [3]. Regardless of whether this discussion takes

place in an inpatient or outpatient setting, it is an opportunity for potential treatment and prevention counseling.

How should the sexual history be documented in the LHR?

There is no legal mandate that states that verbal history must be transcribed verbatim so long as the paraphrase maintains the essence of the communication. However, if the LHR is a place for clinicians to communicate thought processes clearly, providing detail in the LHR about sexual practices may be relevant. For example, documenting that a patient admits to oral sex (ie, performing on a partner) but not anal sex places that patient in a different risk category for contracting HIV, but is an increased risk factor for gonococcal pharyngitis. This level of documentation can be useful for other clinicians as well as for the billing/coding department in terms of substantiating related studies or management strategies. It also allows more specific counseling to be given to the patient about possible repercussions of a specific sex act.

One could also paraphrase this information in more general terms, but at the expense of truly knowing this patient's risk factors. This omission might also subject the patient to redundant questioning at a later time about sensitive issues or dilute a counseling process that is based on unfounded assumptions about the patient's risk factors.

Furthermore, in the age of the EMR, research and data gathering may be facilitated by the use of catchphrases or keywords to identify patients for inclusion in a study. For example, a health department study on specific STDs may seek out particular behaviors that are relevant to the goals of the study.

Given the above discussion, there is no significant difference whether information is documented in the inpatient or outpatient record, as they are equally important threads of a patient's health narrative.

Counseling the Resident

When speaking to the resident who took the adolescent's sexual history, it may be prudent to support the use of clinical and objective terms, rather than slang, in the LHR. Another point worth reviewing is that one can ask the patient directly what information he would feel comfortable having documented in the medical record. This obviates the need for the explanation of basic confidentiality and HIPAA guidelines that otherwise should occur at the beginning of any adolescent interview [4]. Last, it may be protective for the clinician to have a nursing chaperone present so that information discussed, although confidential, is witnessed in case a question is raised about whether the history was obtained in an appropriate manner (though what is considered appropriate or inappropriate may be highly subjective, as highlighted by this case).

Conclusion

In the context of this specific case, it seems that the physician reported this case to the review board because of concerns about the possibly inappropriate graphic nature of the documentation. If the above recommendations about relevance and appropriate

(non-slang) documentation have been met then it would suggest that the complaint was based more on individual style and discomfort regarding the subject matter. If that was the case, and the report does not raise ethical concerns about confidentiality or disclosure, then there is not a role for the ethics board.

Squeamishness and embarrassment on the part of the physician about discussing the sexual history may be understandable given the dissimilarity of his or her background and that of the patient, but the embarrassment must be overcome in the best interest of the patient. Ultimately, it is the responsibility of the physician to use common sense in determining if the information obtained and the way it is documented is relevant to the patient's care and outcomes.

References

1. Amatayakul M, Brandt M, Dennis JC, et al. Practice brief—definition of the health record for legal purposes. *J AHIMA*. 2001;72:88A-H.
2. Frankowski BL, and the American Academy of Pediatrics Committee on Adolescence. Sexual orientation and adolescents. *Pediatrics*. 2004;113:1827-1832.
3. Nusbaum MR, Hamilton CD. The proactive sexual health history. *Am Fam Physician*. 2002;66:1705-1712.
4. American Academy of Family Physicians. *Adolescent Health Care*. Available at: <http://www.aafp.org/x6613.xml>. Accessed July 22, 2005.

Christopher Kodama, MD, is a pediatric hospitalist at Mary Bridge Children's Hospital, Tacoma, Washington.

Commentary 2

by Kathryn M. Conniff and Ligia Peralta, MD

Dr Weiss should be commended for making Andy feel comfortable enough to disclose his sexual history. It is difficult for many clinicians to elicit information about sexual practices and risk behaviors from an adolescent—straight or gay. It is the clinician's responsibility, however, to gather detailed information during the interview process in order to identify risk behaviors and to ensure that a proper diagnosis is made and that the patient receives the best possible care and counseling. Had Dr Weiss not completed a full sexual history, the presenting problem alone may not have led to the diagnosis of human immunodeficiency virus (HIV). This would have been a disservice not only to Andy but also to his past, present, and future sexual partners.

A Comprehensive Sexual History

A comprehensive sexual history is a vital part of the medical evaluation of all adolescents. The clinician should ask questions in a nonjudgmental manner, beginning with less personal questions and progressing to more sensitive areas [1]. In addition to Dr Weiss' questions (sexual orientation, age of onset of sexual intercourse, condom use, number of sexual partners, and typical sexual practices), a complete sexual risk history should include age of partner(s); sexually transmitted infection (STI) history including symptoms, treatment, and prevention measures; partner's risk factors for STIs; drug or alcohol use before or during sex; history of sex in exchange for food,

money, drugs, or a place to sleep or live; and history of sexual abuse or negative sexual experiences [2]. These details are necessary to assess the patient's risk of HIV infection, and their relevance has been corroborated by multiple studies, which showed that:

1. Adolescents who have unprotected intercourse, especially those who begin at younger ages, with multiple and older partners, or in geographic areas with a high HIV seroprevalence are at greater risk for HIV infection [3].
2. STIs are highly correlated with and predictive of HIV infection, leading some researchers to use STIs as a surrogate marker for behaviors associated with HIV infection. Certain STIs may also increase susceptibility to HIV infection, particularly those associated with genital ulcers, which provide easy access to HIV entry through the compromised skin barrier. The increased incidence of syphilis and chancroid parallel the rise in HIV rates [3].
3. Certain types of sexual practices are associated with a greater risk of HIV transmission. For example, receptive anal intercourse may be a more efficient means of transmission than vaginal intercourse, which in turn may be more efficient than oral intercourse [3].
4. For sexually active persons, condoms are the only form of protection against HIV infection, yet a national survey of 17-to-19-year-old males revealed that only 3 out of 5 in this age group had used them the last time they had intercourse. Condom use was lowest among males who reported 5 or more sexual partners or intravenous drug use [4]. Another survey conducted among middle-class urban adolescents showed that only 8 percent of males used condoms every time they had intercourse [5]. When used properly, latex condoms are an effective barrier against STIs, so adolescents lower their risk for HIV infection if they consistently use condoms during intercourse [3].
5. Alcohol and drug use impairs judgment and therefore further increases the probability of unprotected sex [6]. Adolescents who use alcohol before intercourse are 2.8 times less likely to use condoms, while those who use marijuana before intercourse are 1.9 times less likely to [7].

Sexual Risk Assessment

The primary purposes of the sexual risk assessment are to identify and triage high-risk adolescent youth into appropriate services and to tailor interventions for prevention and risk reduction to the needs of a particular adolescent [3]. All information obtained during the sexual history should be documented in the chart regardless of the setting (inpatient and outpatient) so that any future clinicians are fully aware of the patient's risk-related behaviors and can screen, treat, and counsel him or her accordingly.

Special Considerations for Gay and MSM Adolescents

Gathering a detailed sexual history from a male adolescent who has unprotected sex with other males (MSM) is especially crucial because these partners are at particularly high risk for contracting HIV [5]. MSMs ages 20 and older represent the largest HIV transmission category [6]. In 2003, the CDC estimated that 63 percent of newly diagnosed HIV cases in the US were among MSMs [8]. More recent data from 5 of the 17 cities participating in the National HIV Behavioral Surveillance (NHBS) system from July 2004 to April 2005 indicated that 25 percent of the MSMs surveyed were infected with HIV. Forty-eight percent of those who tested positive were unaware of their infection. The proportion of unrecognized HIV infection was highest among MSMs under 30 years of age [9].

The stigma associated with homosexuality often drives gay or MSM adolescents to explore their sexuality in “secretive and sometimes unsafe ways” [5]. Although safe-sex messages aimed at the gay community are ubiquitous, MSM adolescents often do not have access to or ignore the messages because they do not identify themselves as gay [5]. For example, in a study of 72 MSMs between the ages of 16 and 25, 69 percent self-identified as gay, while the remainder self-identified as bisexual (14 percent), gay or bisexual (6 percent), ambivalent or exploring (6 percent), transgendered (3 percent), or heterosexual (1 percent). MSMs who did not self-identify as gay reported a lack of acceptance by the gay community. Furthermore, many MSMs of color did not consider themselves gay if their MSM activity was limited to receptive oral sex [10]. The discrepancy between sexual orientation and behavior can lead to false assumptions about risk behavior and misguided counseling, so it is imperative that clinicians distinguish between sexual identity and activity [6].

Consent and Confidentiality

Although this case does not make specific reference to HIV counseling, testing, and referral, these topics should be addressed. Clinicians should counsel *all* sexually active adolescents about the significance of HIV testing and offer voluntary testing with informed consent (most states permit minors to give their own consent for STD testing and treatment) [11]. The federal Health Insurance Portability and Accountability Act (HIPAA) protects patient information from inappropriate disclosure by health care clinicians, insurers, and certain government programs (eg, Medicaid) [12]. Many states have additional laws that limit parents’ rights to access their children’s medical information, but the specifics of such regulations vary from state to state [11]. Clinicians should become familiar with HIPAA and the laws of their particular state, as it is their responsibility to ensure that adolescents are fully informed about disclosure requirements. This is vital because the fear of inappropriate disclosure causes many adolescents to avoid or delay needed care [6]. For gay youth, this anxiety is compounded by the possibility that they will face homophobic discrimination, loss of close personal relationships, or even banishment from home, upon disclosure of their sexual orientation [6].

Pretest Counseling

Before adolescents sign the consent form, clinicians should present to them the advantages and disadvantages of testing and available testing options in “simple,

culturally and developmentally appropriate language” [6]. Adolescents should be encouraged to involve a supportive adult in the testing process. In addition to discussing the test itself, the pretest counseling session gives clinicians the opportunity to talk to adolescents about sexuality, to identify high-risk behaviors, and to devise a personalized risk reduction plan [6, 13].

Post-Test Counseling

Clinicians should provide results in a straightforward manner, allow plenty of time for the adolescent to respond, validate the response, and then ensure that the adolescent understands the meaning of the results. Other important aspects of post-test counseling include helping adolescents identify support systems and offering assistance in notifying partners and parents. Counselors should emphasize risk reduction behaviors and develop short- and long-term plans to address adolescents’ emotional and medical needs such as mental health or drug rehabilitation referrals or both. In addition, clinicians may provide services such as a contact list with phone numbers for emergency mental health services, a 24-hour crisis hotline, and follow-up appointments [6].

Conclusion

The sexual risk history is a relevant and indispensable part of the medical interview that aids the clinician in his or her understanding of the patient’s risk for HIV infection. The clinician should err on the side of documenting more detail, not less, to aid other clinicians in the continued care and counseling of the patient. Protective measures such as HIPAA ensure patient confidentiality, so the information Dr Weiss documented in Andy’s chart does not present any ethical concerns. Thus, Dr Krause’s referral of Drs Weiss and Lee to the hospital ethics board was inappropriate.

Dr Weiss’s “graphic” sexual history was merited because it led to the discovery that Andy was infected with HIV, a diagnosis that not only shed light on the cause of his current problem but also opened up an opportunity for a public health intervention. As a result of Dr Weiss’s history and diagnosis, Andy may be linked to appropriate continuous care, allowing him to live a healthier life and take measures to prevent further transmission of the virus. The hospital ethics board should therefore dismiss Dr Krause’s complaint. Instead, the board might recommend implementing a workshop aimed at improving clinician’s competency in approaching and managing sexual minorities and the importance of eliciting a comprehensive sexual history from all patients.

References

1. Bidwell RJ, Deishre RW. Gay and lesbian youth. In: McAnarney ER, Kreipe RE, Orr DP, Comerci GD, eds. *Textbook of Adolescent Medicine*. Philadelphia, Pa: WB Saunders Company; 1992:234.
2. Futterman DC, Hein K. Medical management of adolescents. In: Pizzo P, Wilfert C, eds. *Pediatric AIDS: the Challenge of HIV Infection in Infants, Children and Adolescents*. Baltimore, Md: Williams & Wilkins; 1990:757-772.
3. Kipke MD, Hein K. Acquired immunodeficiency syndrome and human immunodeficiency virus-related syndromes. In: McAnarney ER, Kreipe RE, Orr DP,

- Comerci GD, eds. *Textbook of Adolescent Medicine*. Philadelphia, Pa: WB Saunders Company; 1990:713-714.
4. Centers for Disease Control and Prevention. Youth risk behavior surveillance—US 1993. *MMWR*. 1995;44:1.
 5. Futterman D, Hoffman N, Hein K. HIV infection and AIDS. In: Friedman SB, Fisher MM, Schonberg SK, Alderman EM, eds. *Comprehensive Adolescent Health Care*. 2nd ed. St. Louis, Mo: Mosby; 1998:565-566.
 6. Ryan C, Futterman D. *Lesbian and Gay Youth: Care and Counseling* New York, NY: Columbia University Press; 1998:34,103,106,113.
 7. Leigh BC, Stall R. Substance use and risky sexual behavior for exposure to HIV. *Am Psychol*. 1993;48:1035-1045.
 8. Centers for Disease Control and Prevention. *HIV/AIDS Surveillance Report (15) 2003*. Atlanta, Ga: US Department of Health and Human Services, Centers for Disease Control and Prevention; 2004:6. Available at: <http://www.cdc.gov/hiv/stats/2003SurveillanceReport.pdf>. Accessed July 16, 2005.
 9. Centers for Disease Control and Prevention. HIV prevalence, unrecognized infection, and HIV testing among men who have sex with men—five US cities, June 2004–April 2005. *MMWR*. 2005;52:597-601.
 10. Seal DW, Kelly JA, Bloom FR, Stevenson LY, Coley BI, Broyles LA. HIV prevention with young men who have sex with men: what young men themselves say is needed. *AIDS Care*. 2000;12:5-26.
 11. Gudeman R. Adolescent confidentiality and privacy under the Health Insurance Portability and Accountability Act. *Youth Law News*. 2003;3:1-2. Available at: http://www.youthlaw.org/downloads/adolescent_confidentiality.pdf. Accessed July 15, 2005.
 12. US Department of Health and Human Services. Fact sheet: privacy and your health information. *HHS Office for Civil Rights Web site*. Available at: http://www.hhs.gov/ocr/hipaa/consumer_summary.pdf. Accessed July 19, 2005.
 13. Peralta L, Constantine N, Griffin Deeds B, Martin L, Ghalib K. Evaluation of youth preferences for rapid and innovative human immunodeficiency virus antibody tests. *Arch Pediatr Adolesc Med*. 2001;155:838-843.

Kathryn M. Conniff is a second-year medical student at the University of Maryland School of Medicine.

Ligia Peralta, MD, is associate professor of pediatrics and epidemiology at the University of Maryland and chief of the Division of Adolescent and Young Adult Medicine as well as director of the Adolescent HIV Program at University of Maryland Hospital for Children, University of Maryland School of Medicine.

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