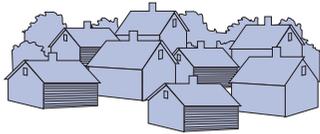


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# Patient-Centered Care: A Model for Managing Sexually Transmitted Infections

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Sexual behavior is one of the most personal and individual aspects of the human experience. It also is the means by which many important and devastating diseases are spread. Accounts of syphilis, like those of other sexually transmitted infections (STIs), are embedded in human medical history. Although the origin of syphilis is a topic of controversy,<sup>1</sup> features suggestive of congenital syphilis have been found in Neanderthal bones.<sup>2</sup> In 1493, Christopher Columbus' sailing crew is thought to have introduced syphilis to Europe from the Americas; further spread from Spain to Italy caused eventual dissemination worldwide.<sup>3</sup>

After a decade of federal efforts to eliminate syphilis, it and other STIs are once again on the rise in the United States. This resurgence is of special concern because STIs facilitate the transmission of HIV infection. Many individuals with an STI present first to their primary care clinician, who can play a key role in identifying, managing, and/or curing the infection. Clinicians therefore must be sensitive to the emotional impact of this disease on their patients and be able to perform a nonjudgmental assessment of their patients' sexual behavior. A bond of trust that enables the patient to consider and discuss very personal issues honestly and without inhibition must be created.

In a patient-centered model of care, the patient feels supported and empowered during the interview and examination, and the clinician serves as an effective listener and motivator as well as the patient's clinical and emotional ally. This author has found a patient-centered model of care to be very effective for STI screening and treatment, and clinical evidence supports this view. In a randomized-controlled trial that compared patient-centered care with the standard approach of physician-directed STI education, Kamb et al<sup>4</sup> demonstrated that brief counseling sessions that included motivational interviews and personalized risk reduction plans resulted in increased use of condoms and greater prevention of subsequent STIs. The researchers concluded that such counseling could be implemented even in busy public health clinics. Given the current rise in STIs and rising rates of new HIV infection in the United States it is critical that clinicians engage their patients in the assessment of their

sexual health and risk behaviors and work towards reducing sexual risk behavior, if present.

### THE INTERVIEW

The patient-centered interview should be conducted in a comfortable, carefully constructed office setting designed to put the patient at ease. The presenting complaint or the need for routine screening should be discussed in a private, confidential space. Sitting face-to-face with the patient on a chair of the same or lower height can be helpful. The patient should remain fully clothed, rather than wear an examination gown. The clinician should use body language that conveys an open and positive attitude (eg, by sitting with arms and legs uncrossed, looking the patient in the eyes, nodding in concurrence) and should let the patient talk. The clinician should explain how personal information about sexual behavior assists in his/her care of the patient. Careful listening and a supportive, nonjudgmental response are essential. The confidentiality of information should be emphasized. However, patients should be informed that diagnoses of some STIs, including syphilis, gonorrhea, and chlamydia, require reporting to the local health department.

The patient's specific sexual practices (oral, anal, vaginal), gender of sex partners, and methods used to reduce the transmission of STIs and/or prevent pregnancy should be discussed. Nothing should be assumed about the patient's sexual conduct or preferences. Many patients may not reveal some aspects of their sexual behavior in response to direct questions during the initial interview; further discussion in subsequent interviews in a nonstressful environment can yield essential information.<sup>5</sup>

### SCREENING

After the interview, screening can be recommended as indicated. The clinician should explain the tests or examinations available and encourage the patient to be tested, perhaps by asking, "Would you like to get these screening tests today, while you are here?" Many patients assume that a routine examination always includes testing for syphilis and other STIs. It is important to confirm to each patient, before they leave the office, which tests were or were not performed and how/when the results will be available. Sexual behavior that reduces the risk of disease transmission until the test results become available should be discussed. Obtaining results should be made simple for patients. A telephone results line or a confidential and protected Internet-based system of obtaining results might be particularly useful for larger clinics.

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### Patient-Centered Approach to Screening for Sexually Transmitted Infections in Primary Care

#### Do:

- Remain aware of the local epidemiology of gonorrhea, chlamydia, and syphilis
- Understand the recommendations for STI screening
- Remain nonjudgmental about your patients' sexual behavior
- Develop questions to obtain information about every patient's sexual history, sexual risk behavior, and cofactors such as substance abuse and mental health issues
- Demystify the clinician-patient relationship and encourage the idea among patients that discussing their sexual behavior with a clinician is health proactive
- Establish rapport with each patient and ensure that he or she feels supported and empowered during the interview, assessment, and (if necessary) treatment
- Emphasize that each patient's medical information is confidential but that a diagnosis of an STI must be reported to the local health department
- Recognize adolescents as potentially sexually active individuals and include an assessment of sexual health in their evaluation

#### Don't:

- Apply your moral or ethical personal codes to your patients' sexual behavior
- Display emotion when patients report their sexual behavior
- Respond to the patient in a paternalistic, judgmental, or directive manner
- Assume that any patient, known or new, is exempt from acquiring any STI

### WHEN THE TEST RESULT IS POSITIVE

Depending on state law positive test results for syphilis, chlamydia, or gonorrhea may be reported by the laboratory to local and state health departments, which may contact the patient's medical provider to confirm that appropriate treatment is administered and may also contact the patient to assist with partner notification. For some patients, receiving a diagnosis of an STI like syphilis is a life-changing event. During the office visit and all subsequent follow-up appointments, the patient should be treated nonjudgmentally and with respect and compassion. Sufficient time should be allotted to review of the meaning of the diagnosis, the efficacy of treatment, and any adverse effects of therapy. The patient should feel at ease during the appointment and should be encouraged to ask questions at any time. Using terms in the patient's vocabulary provides reassurance that he or she is being understood. The clinician should ask open-ended questions such as, "What might you be doing that would put you at risk for syphilis or any STI?" or "Which sexual behaviors do you believe are risky?"

It is important to explain how and when the patient should expect the symptoms of the STI to resolve after the initiation of treatment. The patient should be encouraged to consider and suggest personal and achievable methods of avoiding risky sexual behavior (eg, using condoms, reducing the number of sex partners, uncoupling drug use and sexual activity, scheduling regular STI screenings that include his/her

sex partner). In some situations it may be necessary for the clinician to suggest various methods. It also is essential to discuss ways of informing the patient's recent sex partners about the need for medical evaluation and treatment. The need to protect current or future partners from infection and the importance and frequency of follow-up visits should be emphasized. Because repeat infection is very common in certain STIs, newly diagnosed patients with gonorrhea or chlamydia should be retested at 3 months. Patients with newly diagnosed syphilis should be tested for HIV infection and screened for other STIs. This author's recommendation is that patients with syphilis return 1 week after the initial treatment to discuss clinical response and review partner management and again 3 months later for physical and serologic evaluation and repeat HIV or other STI testing, if indicated.

Treating the patient during the same office visit and offering treatment for recent sex partners assures treatment and encourages adherence to follow-up. Before the patient leaves the office, the clinician should confirm that the key information provided during the office visit has been understood. Supplying printed take-home materials—in the patient's primary language of reading at a sixth-grade level—about the course of the infection and its treatment is very helpful. Illiterate patients should receive special assistance to ensure their understanding of this information. Providing a card that lists a phone number or an e-mail address through which the patient can ask questions establishes a connection that is very important to many patients.

Although most STIs can be cured, the diagnosis of any STI can be emotionally traumatic for the patient and his or her partner. The assessment of sexual health through a patient-centered approach establishes the necessary bond between the patient and clinician that enables forthright communication—which is crucial to the early screening and diagnosis of STIs, and instrumental to the prevention of their spread.

### CONCLUSION

Patient-centered care is the ideal way to provide care for patients with STIs, and is especially important for effective communication and care regarding sensitive or emotional health issues. Data suggest that this approach can improve patient outcomes. Furthermore, this model of care can be implemented in a busy clinic setting usually with only minor modifications to practice.

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