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CLINICAL ARTICLE

Obstetrician–gynecologists' beliefs about safe-sex and abstinence counseling

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ABSTRACT

Objective: To examine obstetrician–gynecologists' beliefs about safe-sex and abstinence counseling. **Methods:** Between October 2008 and January 2009, a survey was mailed to a national randomized sample of 1800 practicing US obstetrician–gynecologists. Study variables were agreement with 2 statements. (1) "If physicians counsel patients about safe-sex practices, the patients will be less likely to engage in risky sexual behaviors". (2) "If physicians counsel patients about abstinence, the patients will be much less likely to engage in sexual activity". Covariates included demographic, clinical, and religious characteristics of the physician. **Results:** The response rate was 66% (1154/1760 eligible physicians). Most respondents somewhat (62%) or strongly (25%) agreed that counseling patients about safe-sex practices makes patients less likely to engage in risky sexual behaviors. Fewer agreed strongly (3%) or somewhat (28%) that counseling patients about abstinence makes patients less likely to engage in sexual activity. The belief that safe-sex counseling reduces risky behaviors was less common among males (odds ratio [OR] 0.6) and more common among immigrants (OR 2.0). Religious physicians were more likely to believe that abstinence counseling reduces sexual activity (OR 2.2–5.3). **Conclusions:** Most obstetrician–gynecologists believed that counseling about safe sex is effective, and a significant minority endorsed abstinence counseling.

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1. Introduction

None would challenge the principle that physicians should counsel their patients, especially regarding sexually transmitted infection (STI)—an ongoing source of much morbidity and mortality [1]. Indeed, physicians are uniquely positioned to help patients reduce their risk [2]: their specialized knowledge opens doors for educating patients about risk reduction; a confidential relationship enables patients to discuss sexual topics that they may be unwilling to discuss elsewhere; and patients are accustomed to getting advice from their physicians, often making positive changes as a result [3–6].

However, physicians disagree about the effectiveness of such counsel. Two streams of thought emerged in a recent qualitative survey among obstetrician–gynecologist physicians [7]. Some believed that patients are unlikely to be influenced by directive counseling, with 1 physician saying: "Chances are no matter how long I talk to [the patient] and tell her what I think is important, she's still going to have sex, and she's still going to get pregnant, and she's still going to get sexually transmitted diseases". Alternatively, others believed that many patients look to their physicians "for guidance [and] direction". These physicians thought that they might influence

patients who had not made up their minds or, if a patient was settled on a decision, at least prompt her to reassess her choice.

The aim of the present study was to measure the distribution of these 2 views of physician counseling in a national sample of US obstetrician–gynecologists. Special attention was paid to the religious commitments of the physicians, because religion is often pertinent to discussions about sexuality [2,8,9], and religious beliefs are known to influence the clinical practices of physicians [10,11]. Physicians' beliefs about directive counseling in general were also considered, because sexual counseling touches on issues about the role of the physician.

2. Materials and methods

The present study of the beliefs of practicing obstetrician–gynecologists was carried out in the United States from October 15, 2008, to January 30, 2009. A confidential, self-administered questionnaire was mailed to a national, stratified, random sample of 1800 obstetrician–gynecologist physicians aged 65 years or younger. The sample was generated from the American Medical Association Physician Masterfile, a database intended to include all practicing US physicians. The sample size was selected so that a 60% response would yield a margin of error of approximately 3%. The study was approved by the Institutional Review Board of the University of Chicago.

To increase minority representation (especially minority religious perspectives), validated surname lists were used to create 4 strata

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[12–14]. Within each stratum, names were arranged in random order and then systematically sampled by using a random starting point. Random sampling was used to select 180 physicians with typical south Asian surnames, 225 physicians with typical Arabic surnames, 180 physicians with typical Jewish surnames, and 1215 other physicians. Each stratum was sized to yield at least 100 responses, which would provide a maximum margin of error of +10% or –10% at the 95% level of confidence (95% CI) per group.

Physicians received up to 3 separate mailings of the questionnaire: the first mailing included a \$20 bill, and the third mailing offered an additional \$30 for participation. Physicians were excluded from the final data set if they were retired, had deceased, or had an invalid address. Data were double-keyed, cross-compared, and corrected against the original questionnaire.

The primary criterion measures assessed the physicians' agreement with 2 statements. (1) "If physicians counsel patients about safe-sex practices, the patients will be much less likely to engage in risky sexual behaviors". (2) "If physicians counsel patients about abstinence, the patients will be much less likely to engage in sexual activity". The response options were agree strongly, agree somewhat, disagree somewhat, and disagree strongly.

The covariates included the following religious beliefs and practices. Religious affiliation was classified as none/no affiliation, Hindu, Jew, Muslim, Catholic (including Roman Catholic, $n = 237$; and Eastern Orthodox, $n = 25$), Evangelical Protestant, non-Evangelical Protestant, and other ($n = 9$ Buddhists). The importance of religion in the physician's life was categorized by 4 response options ranging from "not very important in my life" to "the most important part of my life". Attendance at religious services was categorized as never, once a month or less, and twice a month or more.

Additional covariates were demographic characteristics (gender, race, age, region, and immigration history), and clinical characteristics (board certification, membership of the American College of Obstetricians and Gynecologists [ACOG], working primarily in an academic medical center, and percentage of patients younger than 18 years). Whether the physician was married and whether they had children was also considered, because a previous study has indicated that physicians who are parents are more likely to encourage minors to remain abstinent [15].

The physicians' beliefs about directive counseling in general were included as covariates [16]. This variable was generated by asking whether physicians agreed with 4 statements. (1) When dealing with typical medical decisions, a physician should provide all relevant facts without trying to influence the patient's decision one way or another. (2) When dealing with typical medical decisions, a physician should encourage the patient to make the decision that the physician believes is best. (3) When dealing with morally controversial medical decisions, a physician should provide all relevant facts without trying to influence the patient's decision one way or another. (4) When dealing with morally controversial medical decisions, a physician should encourage the patient to make the decision that the physician believes is best.

Case weights were incorporated to account for the oversampling strategy (the design weight), and to correct for differences in response rates among the surname categories and between US and foreign medical school graduates (the post-stratification adjustment weight). Weights were the inverse probability of a person with the relevant characteristic being in the final data set. The final weight for each case or respondent was the product of the design weight and the post-stratification adjustment weight. This method of case weighting, which is widely used in population-based research [17], allows an adjustment for sample stratification and variable response rates in order to generate estimates for the population of US obstetrician-gynecologist physicians. The χ^2 test was used to examine the associations between each background variable and the physicians' beliefs about safe-sex or abstinence counseling.

Multivariable logistic regression using physicians' sex, race, age, region, immigration history, and board certification status as covariates was conducted via the survey-design-adjusted commands of Stata SE statistical software version 10.0 (Stata Corporation, College Station, TX, USA). $P < 0.05$ was considered to be statistically significant.

3. Results

The response rate was 66% (1154/1760) after 40 potential respondents who were retired or had invalid addresses were excluded. The response rate varied by sample, and between US and foreign medical training (details described elsewhere) [16]. Post-stratification adjustment case weighting was used to account for these differences. The demographic characteristics of the respondents are reported in Table 1.

Table 1
Respondent characteristics.

| | Data ^{b, c} |
|---|----------------------|
| Sex | |
| Female | 537 (47) |
| Male | 617 (53) |
| Race | |
| White | 774 (69) |
| Black | 67 (6) |
| Asian | 202 (18) |
| Hispanic | 64 (6) |
| Other | 22 (2) |
| Age, years | 47.8 ± 9.2 (26–65) |
| Age range, years | |
| 25–40 | 291 (25) |
| 41–47 | 305 (26) |
| 48–55 | 281 (24) |
| 56–65 | 277 (24) |
| Region | |
| South | 373 (32) |
| Midwest | 249 (22) |
| Northeast | 288 (25) |
| West | 242 (21) |
| Immigration history | |
| US born | 817 (72) |
| Immigrated to US | 323 (28) |
| Medical training | |
| US medical graduate | 932 (81) |
| International medical graduate | 222 (19) |
| Religious affiliation | |
| No affiliation | 119 (11) |
| Hindu | 91 (8) |
| Jew | 160 (14) |
| Muslim | 54 (5) |
| Catholic/orthodox | 262 (23) |
| Evangelical Protestant | 91 (8) |
| Non-Evangelical Protestant | 300 (27) |
| Other religion | 48 (4) |
| Importance of religion | |
| Not at all important | 272 (24) |
| Fairly important | 321 (28) |
| Very important | 385 (34) |
| Most important thing | 157 (14) |
| Attendance at services | |
| Never | 123 (11) |
| ≤1 a month | 547 (48) |
| ≥2 a month | 466 (41) |
| Clinical/personal characteristics | |
| ACOG member | 1052 (92) |
| Board certified | 963 (83) |
| Practice primarily in academic medical center | 305 (27) |
| Parent | 973 (86) |
| Married | 965 (84) |
| ≥10% weekly patients <18 years | 678 (61) |

Abbreviation: ACOG, American College of Obstetricians and Gynecologists.

^a Values are given as mean ± SD (range) or number (percentage).

^b Responses were not adjusted for survey design.

^c Percentages may not sum to 100% owing to rounding error.

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