

## EDUCATION

## Doctors Talking About Sexuality: What Are the Patients' Feelings?

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## ABSTRACT

**Introduction:** Many medical practitioners avoid discussing the subject of sexuality with their patients because they are afraid of invading their privacy.

**Aim:** This study was carried out to discover what patients feel when asked about their sexuality by their GP.

**Methods:** A qualitative study was carried out that involved 96 patients aged 18 to 86. The patients were recruited from 4 medical offices in the South of France. A substitute general practitioner asked the patients, "How is your sexuality these days?" during routine consultations. The patients were then asked how they felt about that question in semi-structured interviews.

**Main Outcome Measures:** This study highlights the existence of a discrepancy between physicians' beliefs and patients' expectations. Indeed, physicians fear that they would embarrass their patients if they address the subject of sexual intimacy. As it turns out, 93% of the patients would have welcomed that question.

**Results:** 34 patients (35%) were surprised by the question. 7 patients (7%) found the question unwelcome. 89 patients (93%) had a neutral or positive feeling. 78 patients (81%) deemed that sexual history should form an integral part of GP consultations (50% were in favor of systematic screenings for sexual dysfunctions, while 31% preferred targeted screenings). 2 patients (2%) found that the question had boosted their confidence and strengthened the doctor-patient relationship.

**Conclusion:** Most patients do not deem that their GP is invading their privacy if the GP touches upon the subject of sexuality, even if the patient's visit was for a different reason. Before addressing the issue, the GP must ensure that an appropriate framework of trust, care, and empathy is in place. If this framework is present, the patient will be able to overcome his/her feelings of surprise and know that there is a safe space to talk freely about this topic. **Zéler A, Troadec C. Doctors Talking About Sexuality: What Are the Patients' Feelings?. *Sex Med* 2020;8:599–607.**

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**Key Words:** Sexuality; General Practitioners; Physician-Patient Relations; Projection; Emotions

## INTRODUCTION

For a long time, society's interest in an individual's sexuality was limited to 2 matters: the prevention of sexually transmitted diseases and birth control. In recent years, more issues turned up, and the concept of sexual health emerged. Sexual health is now considered a full-fledged area of physical and psychological well-being, and of health in general. The behavior of the medical community has also evolved. Indeed, the medical community now considers

the occurrence of sexual dysfunction as a potential marker for underlying pathology.<sup>1</sup> However, when facing a sexual problem, the patient very rarely consults a doctor.<sup>2–4</sup> Patients prefer to suffer in silence and hope that a doctor will, on occasion, address the issue.<sup>5,6</sup>

The active screening of sexual disorders should be an integral part of good clinical practice, according to some authors.<sup>7</sup> In a number of countries, including France, health authorities and medical associations recommend that physicians be proactive in this regard.<sup>8,9</sup> In contrast, however, few of them actually approach the subject.<sup>10–12</sup> This is despite being more aware of the role that doctors play in the screening process and the initiation of discussion about sexuality.

A review of the literature based on 8 British studies revealed that British doctors believe that patients would find it improper for care professionals to address such a subject, and they think that raising the issue of sexuality might be perceived as intrusive or inappropriate.<sup>13</sup>

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A French survey that involved 176 general practitioners shows that 75% of them feel comfortable talking about problems of sexuality to their patients.<sup>14</sup> Nevertheless, while 57% of doctors find it relevant to ask such questions, only 30% admit having ever addressed them. The reasons for not addressing the subject of sexuality are the fear of being intrusive (42%), the lack of knowledge (21%), the lack of time (19%), the discomfort caused by the subject itself (13%), and the feeling that it is not their duty to discuss this subject (5%).<sup>14</sup>

In an American study, 7% of the adults surveyed by telephone said they would not be willing to answer their doctor's questions about their sexual behavior, while 59% said they would appreciate the opportunity to discuss the subject of sexuality with their doctor.<sup>15</sup>

In a Swiss study, 15% of the patients felt that they would be embarrassed if their doctor asked them about their sexuality.<sup>16</sup> Nevertheless, 95% considered it to be a normal question, 91% stated that they would like that their doctor ask them that question, and 60% thought that the question should be asked during the first consultation, during the medical history review. Yet, 39% of the patients had never addressed the subject of sexuality with a doctor.<sup>16</sup> Those who had did not specify whether it was the doctor who had initiated the discussion about sexuality, or whether it was their doing. In addition, patients who had never tackled the subject of sexuality with a doctor were more likely to say that they would feel embarrassed by it and that they would not want their doctor to bring it up.<sup>16</sup>

Therefore, general practitioners are faced with a dilemma. On the one hand, despite the practitioner's role to help the patient as a caregiver, a patient with sexual difficulties will rarely speak spontaneously about these difficulties. Similarly, doctors are faced with their limitations. These limitations may include the lack of knowledge on how to approach the subject of sexuality, or the lack of time at hand to explore the subject in a relaxed manner, and finally, the fear of offending the patient by being intrusive.

The main question of this study asks if the proportion of patients embarrassed by a doctor's initiation of a discussion about sexuality is considerable and if that would justify doctors to consider omitting this discussion from their consultations.

## MATERIALS AND METHODS

### Preliminary Study

A preliminary study was conducted in May 2015 on a sample of 23 patients, to the point of qualitative data saturation. The

preliminary study made it possible to create an interview guide that was then used for the rest of the study (Table 1).

### Population

The patients were recruited from 4 different GP offices, during 5 replacement periods in 2 departments in the south of France, the Hérault and the Gard. The recruitment days were decided randomly. Afterward, familiarization with the consultation timetable took place. The inclusion criteria were patients aged 18 and over who, for whatever reason, had a consultation at the practice, and who were not accompanied by a third party. Couples who consulted together were included in the study. During the recruitment days, every patient who satisfied the inclusion criteria had to be interviewed. Selections according to a particular affinity or risk factor were forbidden.

### Intervention Method

During the consultation, the subject of sexuality was systematically brought up. Where possible, it was linked to the reason for the consultation (eg the renewal of a treatment that might negatively affect sexual performances, the reason for the gynecological or urological consultation, etc.). Otherwise, the topic was raised after the clinical examination as follows: "How is your sexuality these days?" That question was sometimes preceded by an introductory sentence that varied from "How about the rest? that is, regarding your sexuality" to "By the way, how are things? How is your sexuality?"

Then, at the end of the consultation, the patient was asked whether he/she wanted to be included in the study. The request was made as follows: "I would like to know whether you could give me a few minutes of your time regarding a study that I am currently undertaking. A few moments ago, I asked you a question on the subject of sexuality. I would like to know how you felt when I asked you that question."

### Measures

The interviews were recorded with the dictaphone application. The elements pertaining to the context in which the consultation took place (the reason for the consultation and the place where the consultation took place), as well as the patient's characteristics (sex, marital status, sexual orientation, medical history, and major treatments) were recorded on plain paper. The interviews were then transcribed word-for-word in their entirety in a word-

**Table 1.** Interview guide

As part of my thesis, I am investigating patients' reactions when doctors raise the question of sexuality during a consultation. So, when I asked you that question a few moments ago, what was your instant emotional reaction?
(If the patient does not spontaneously mention his or her feeling): Did you feel the question was intrusive? Inappropriate? Welcome?
(If the patient does not spontaneously mention a feeling of surprise): Were you surprised? Yes? No? Why?
Has a doctor ever asked you that question?
Do you think that it is the doctor's role to ask that question?
Do you think that the attending physician should always ask the patient that question?
If you had a sexual concern, would you spontaneously talk about it?

processing program to generate a verbatim transcript of the responses.

**Ethical Considerations**

Anonymity was guaranteed to the participants because no personal nominative information was saved. The audio file names were automatically created by the application (“New recording 1,” “New recording 2,” etc.). Complementary information were indexed using the same incrementation (“Patient 1,” “Patient 2,” etc).

**Evaluation**

The verbatim transcript was analyzed longitudinally by the investigator, one interview at a time. The following big themes were emphasized: the patient’s feelings regarding being asked that question, the meaning he/she attributed to the question, his or her expectations in case of sexual difficulties, and the doctor’s role regarding the systematic screening for sexual dysfunctions.

A thematic, transversal, constant, comparative analysis was then performed to sequence and code the data in a spreadsheet. This step was jointly carried out by 2 researchers to ensure data triangulation. The first researcher was the investigator, while the second one was a clinical psychologist trained in sexology. The statistical calculations were performed on BiostaTGV.

**RESULTS**

**The Sample’s Characteristics**

96 patients were selected. 100% of them accepted the interview. The interviews lasted a total of 6 hours and 45 minutes. The shortest interview was 2 minutes long. The longest one was 15 minutes long. The average duration of the interviews was

4 minutes and 13 seconds. The youngest patient was 18 years old. The oldest one was 86 years old. The average age of the patients included in the study was 55 years.

As far as the following characteristics are concerned, namely: sex, age, and nature of the treatment (Table 2), the sample is comparable to that of the French general practitioners’ patient population that took part in a DREES study.<sup>17</sup>

**The Patients’ Feelings**

The principal emotion expressed by the patients was a surprise (n = 34; 35%). Table 3 shows the varying emotions that patients felt when asked the question.

In addition to their feeling of surprise, patients received the question in 3 ways: positively, negatively, or neutrally. 30 patients (31%) used a positive language style, suggesting that the question was welcome. 7 patients (7%) used a negative language style, suggesting that the question was unwelcome. 59 patients (61%) used a neutral language style.

For 2 patients (2%), addressing that issue helped them build confidence and strengthen the doctor-patient dialogue.

Only 3 patients explicitly used the word “embarrassment” to describe their initial reaction. One patient used the term “upset.” One patient used the word “weird.” As far as sex and age groups are concerned, no statistically significant differences in the patients’ feelings related to their sex were found (Table 4). The terms used by the patients to express their feelings are detailed in Table 5.

**The Meaning Given to the Question by the Patients**

10 patients (10%) thought that the question had been asked because it was related to the reason for the consultation and 6

**Table 2.** The sample’s characteristics

	Current study		DREES 2002		P†
	(n = 96)	%	(n = 44,000)	%	
Sex					
Male	44	46%	19,800	45%	0,870
Female	52	54%	24,200	55%	
Age*					
13–24 years old	8	8%	3,520	9%	0,823
25–44 years old	24	25%	9,240	24%	0,746
45–69 years old	36	38%	14,080	36%	0,753
>70 years old	28	29%	12,320	31%	0,629
Reason for the consultation					
Check-up or monitoring of a chronic condition	39	41%	18,480	42%	0,785
Acute condition	34	35%	13,640	31%	0,350
Other	9	9%	5,720	13%	0,291
Destabilization of a chronic condition	7	7%	3,520	8%	0,798
Condition currently under examination	4	4%	1760	4%	0,795
First diagnosis of a condition	3	3%	880	2%	0,445

\*The patient proportion was recalculated after the age group 0-12 years had been removed from the numbers obtained from the DRESS survey.

†The values of P > .05 indicate that there is no statistically significant difference between the groups.

**Table 3.** Emotions felt by the patient when asked the question

	<i>n</i>	
Surprise	34	35%
It is the first time that a doctor has asked me that question	7	
It is unusual/rare to ask that question	9	
It felt strange	1	
The question appeared absolutely insane	1	
I wondered why that question was asked	2	
It surprised me a bit, but I was not embarrassed	2	
I was surprised, given the reason I came for a consultation	1	
It would not have occurred to me to talk about it to a general practitioner.	1	
It is normally a taboo question	2	
We do not expect someone like a doctor to ask us that question	1	
Why did he/she ask me that question (out of nowhere)?	2	
Surprised, did not give any specific detail	5	
Delight	3	3%
I was glad you that asked me that question	1	
I was very glad that we addressed that question	1	
It made me smile	1	
Anger	1	1%
It upset me	1	

patients (6%) thought it was related to their medical history. 26 patients (27%) considered that the role or status of the doctor alone justified the question. 54 patients (56%) did not give an opinion. It can be deduced that 44% of the patients spontaneously understood why their doctor had asked the question, without having to back it up with a justification. [Table 6](#) shows the different justifications mentioned by the patients.

### The Patient's Active or Passive Role in Cases of Sexual Difficulties

In reply to the question, "If you had sexual difficulties, would you talk about them to a doctor?" thirty-one patients (32%) said

that they would spontaneously raise the issue with their doctor. 50 patients (52%) would wait for their doctor to ask them the question. One patient (1%) would speak directly to a specialist but would not discuss the subject matter with a general practitioner. For 3 patients (3%), it does not matter who brings up the subject matter, be it their doctor or themselves. 11 patients (11%) did not answer the question.

### Systematic Screening

48 patients (50%) were in favor of the general practitioner performing a systematic sexualological examination on each patient. 30 patients (31%) were in favor of targeted screening, on a case-by-case basis, and depending on the particular relationship between the patient and the doctor or the patient's particular circumstances. 12 patients (13%) would not want a general practitioner to perform a screening for sexual dysfunctions. 6 patients (6%) did not answer that question. [Table 7](#) shows the different opinions encountered.

### DISCUSSION

This study is one of the first to analyze patients' feelings in the real-life context of a consultation where the subject of sexuality has been proactively addressed by the doctor. It shows that beyond the initial feeling of surprise, for the most part, patients do not deem the sexual intimacy question to be intrusive. They are able to overcome their feeling of surprise by giving either a medical meaning or a contextual meaning to the question, so as to be ready to participate in that unusual patient-doctor discussion. Addressing such a topic would also, according to some patients, tend to strengthen the patient-doctor relationship by allowing the consultation to explore the realm of intimacy.

Maddowall et al made a similar analysis. In that study, 55–70% of the patients interviewed about their sexual history found that this focused history reinforced their beliefs that the doctor cared for them and their health.<sup>18</sup>

In this study, only 7% of the patients found the "How is your sexuality these days?" question unwelcome. 81% of patients deemed it desirable that sexual history become an integral part of general medical practice consultations.

### Methodological Strengths

This study's methodological strengths lie in the spontaneity of the data collected, the anonymity that was guaranteed to the

**Table 4.** 1: Patient's feelings by gender

	Male		Female		Total		<i>P</i>
	(n = 44)		(n = 52)				
Positive feeling	13	14%	17	18%	30	31%	0,740
Neutral feeling	26	27%	33	34%	59	61%	0,661
Negative feeling	5	5%	2	2%	7	7%	0,241

The values of  $P > .05$  indicate that there is no statistically significant difference between the groups.

**Table 5.** Cognitive feelings concerning the GP proactively asking the question

	n	%
Positive feelings	30	31%
Welcome/appropriate	2	
It reassured me, gave me confidence	1	
I was pleased/very pleased that you asked me that question	2	
It is good/great that you ask that question	19	
It is good practice to ask that question	1	
It is not easy for one to talk about oneself	1	
It was good that you delved deeper during the examination/went into details	1	
I found it super interesting that you asked me that question	1	
I do not see the harm in doing that, quite the contrary	1	
Would have liked to have been asked that question sooner	1	
Negative feelings	7	7%
It upset me	1	
I felt a little bit/some embarrassment	3	
Outside the scope of the consultation/No relevance to the consultation	1	
I found it weird/improper	2	
Neutral feelings	59	61%
It did not bother/perturb me	10	
It did not embarrass me	12	
It is a question like any other/I find it normal	11	
It did not shock/traumatize me	6	
It is part of your job to ask such a question	7	
It is part of life/part of human health	5	
There is no problem in asking that question/I do not have any trouble with that	4	
I did not find it improper	1	
It did not offend me	1	
Unspecified	2	

patients, and the sample size. Rather than prompting the patients to answer an after-the-fact questionnaire, we chose to question them during the consultation.

2 factors allowed the responses to be spontaneous and the participation rate to be extremely high: the data was collected during the consultation, and no personal information regarding the patient was saved. Indeed, 100% of the patients interviewed agreed to participate in the study.

The fact that the subject of sexuality was addressed during the first part of the consultation played a role in certainly increasing the rate of favorable responses to the systematic screening for

**Table 6.** Meaning given to the question by the patients

	n	%
Justification related to the reason for the consultation	10	10%
Gynaecology/urology	4	
Mood/fatigue/overwork	2	
Follow-up of pregnancy	1	
Contraceptive pills	1	
General screening	1	
Sexually-related concern	1	
Justification related to the patient's health history and risk factors	6	6%
Hypertension	2	
Menopause	1	
Undergoing a treatment that affects sexuality	1	
Risk factors for sexual dysfunctions	1	
Taking a lot of medicine for already present conditions	1	
Justification related to the doctor's role	26	27%
It is the doctor's job/role to ask that question/You are doing your job	11	
You are a doctor	9	
I thought it was one of your standard questions/It is part of the consultation	3	
It is normal for a doctor to know his patient well/be interested in those things	2	
You are from the newest generation of doctors	1	

sexual dysfunctions by the attending physician. By asking that question during the interview, we have, in effect, removed the beliefs/stereotypes/prejudices component, thereby allowing the patient to reflect on how he/she really felt, and not how he/she thought he/she would have felt.

Using a sample that is larger than that of the usual qualitative studies—which average 11 to 12 interviews when the number of patients is determined until data saturation—allowed this study to benefit from sample representativeness.<sup>19</sup> This enabled us to extend the observed results to the rest of the population with a confidence level of 95% and an error margin of 5.1%.

**Limitations**

The fact that the author of the study is both the experimenter and the reporter may have induced an analytical bias called the “experimenter effect.”<sup>20</sup> Experimenters tend to influence the outcome of the experiment, depending on their degree of involvement in it. In order to minimize that type of analytical bias, the following rule was adhered to: merely interpret the patient’s answer from a medical perspective and refrain from analyzing the patient’s reaction during the consultation. This is why the “How is your sexuality these days?” question was asked

**Table 7.** Patients' opinions regarding systematic sexological interrogations

	n	%
In favor of systematic screening	48	50%
Every time and involving every patient		29%
Because sexuality is part of life/well-being/health	5	
Because it is an important subject	4	
Because it is good practice to ask that question	1	
It would be useful/It would add value to the consultation	1	
Because it strengthens the doctor-patient relationship/It shows that the doctor cares for the patient	1	
Because the doctor has a duty to inquire, given the side effects of medications	1	
Because patients will not dare address the question themselves/taboo subject	8	
You should question every patient, but some might be shocked/embarrassed/surprised	3	
Because it may allow the patient to confide in the doctor	4	
Not every time but "at least once" or "from time to time" and involving every patient	11	11%
Unspecified	9	9%
In favor of selective (case-by-case) screening	30	31%
Depending on the doctor in question		13%
If I do not know the doctor/If he or she is a substitute doctor	1	
If the doctor uses the right words	1	
If the doctor is open to that type of inquiry	2	
The doctor should know whether or not it is necessary to address the question	1	
If it is useful for the diagnosis	1	
According to gut feeling/if there is a good relationship	6	
Depending on the patient's circumstances		19%
Chronic pathologies/regular follow-up	2	
Drugs that affect sexuality	1	
Contraception	1	
Only for men (women have gynaecologists)	1	
Only for elderly patients	2	
Ask everyone over a "certain age" that question	1	
Only for women ("Men have their male pride at stake")	1	
Only for patients who have a risk factor for sexual dysfunctions	4	
If the patient displays a certain "emotional" state (fatigue/anxiety/depression)	2	
If the doctor believes that the patient can still have a sex life	1	
Depending on the reason for the consultation: general assessment	1	
Depending on the reason for the consultation: urology, gynaecology	1	
Not in favor of screening by the general practitioner	12	13%
Must be done by a specialist (gynaecologist, midwife, sexologist)	2	
It might embarrass some patients	1	
Young people do not have sex-related problems	1	
It is the patients themselves who must initiate the conversation	8	
No response or no opinion	6	6%

in the most neutral and direct way possible, with no window dressing or artifice. Then, at the end of the consultation, the goal was to let the patient describe his/her feelings without influencing him/her in any way. Finally, once the audio recording had been transcribed, the verbatim transcript was analyzed jointly with a second researcher who had not attended the consultation. Another method that could have been used would have been to have an external reporter take charge of the semi-directed interview at the end of the consultation.

However, that would have been a time-consuming step for the participating patient. Indeed, instead of returning home at the

end of the consultation, he/she would have had to speak in another room, with another interviewer. Such a lengthy procedure would have, therefore, encouraged those who are the most interested in that topic to more readily respond positively to this additional request, hence inducing an auto-selection bias.

This study's other limitation lies in the fact that it was performed during replacements, which implies that the consultation was the patient's first contact with that physician and that the question was not asked by the usual attending physician.

For that reason, it is conceivable that the feeling of surprise—which was present in 35% of the cases examined in this

study—might be even more prevalent if a doctor who has consulted a patient for years began to ask this question when he/she had never done so before.

However, the relational and emotional aspects of consultations, together with the act of permissive and benevolent listening by the physician, likely play a more important role than the doctor's age or status as a newly established practitioner, as far as the capacity to make the patient feel confident is concerned.

### Why Are Doctors Afraid to Address the Subject of Sexuality?

Many physicians fear that they would be intrusive, were they to raise the issue of sexuality. The existence of such apprehension is probably linked to misrepresentations and physicians' own projections regarding the subject of sexuality.

Some doctors adopt an evasive stance when it comes to the subject of sexuality.<sup>21</sup> Doctors are said to create a loop system in which they explain their refusal to address sexuality by posing that patients do not proactively raise these topics. Doctors base their attitudes on a similarity between their own inclinations and those that are attributed to patients.<sup>21</sup>

In a study undertaken by Dyer and Nairs, physicians who found it illegitimate to go over the subject of sexuality with their patients were unable to give concrete examples of patients who were offended by their doctor's initiative to tackle those questions.<sup>13</sup> This, therefore, suggested that their choice not to engage in discussions on this topic was based more on their own beliefs and stereotypes than on direct, negative experiences.

### Insights

This study shows that there is potentially a big gap between doctors' fears and patients' expectations. Several arguments are regularly invoked by doctors to justify their apparent disinterest in their patients' sexuality. In particular, they fear to embarrass their patients or think they have to wait to get to know their patients better before addressing such intimate issues.<sup>13,14,22</sup>

This study clearly invalidates those fears, in so far as the patients have overwhelmingly welcomed that question, even though the consultation was, for most of them, their very first contact with that doctor. Apart from the fear of being intrusive, the other reasons advanced by general practitioners for not addressing the subject of sexuality are the lack of knowledge and the lack of time. Nevertheless, those reasons are perhaps, to a large extent, unfounded concerns and projections.

The doctor who has never been confronted with the question of sexuality might then be tempted to avoid addressing it by hiding behind the lack of training and competence. Many sexual difficulties are simple and can be solved by the general practitioner, especially if the patient's perceived sexual difficulty arises from a lack of education or is caused by false beliefs and prevents the individual from feeling fulfilled. Knowing to such a degree as to how physiological sexuality functions, to be able to educate

and advise patients, will be sufficient in those cases. Educating and counselling are the first 2 levels of care for which the general practitioner is the guarantor.<sup>23</sup>

Finally, doctors fear that, by addressing the subject of sexuality, they would open a Pandora's box that would give way to endless complaints.<sup>24</sup> It is likely that those fears are representations or the reminder of a bad experience with a patient who, having had sexual difficulties for years, needed to have his problem discussed.

It usually does not take any more time to record a patient's sexual history than to note down their other details. If that question is asked on a regular basis, and a sexual difficulty is diagnosed at an early stage, the sexual difficulty will not have had the time to crystallize and cause complex repercussions that require a time-consuming analysis of the situation. By contrast, when a patient purposely comes to consult for a sexual problem, it is because the situation has become unbearable due to a combination of several problems or because of their long-term recurrence.<sup>7</sup> In such a case, the consultation will probably be more time-consuming.

Although we did not specifically consider these parameters in our study, we did not notice any loss of time or extra workload that could be linked to the conduct of an examination of the patient's sexuality during his or her first consultation. However, it might be useful to study this data more precisely as part of a specific study.

Physicians should be better informed of their patients' expectations so as to be able to initiate discussions regarding the subject of sexuality, should the need arise.

Doctors could simply start by systematically going over their patient's sexual history: "Are you single or in a relationship?" and "What is your sexual orientation?". Those questions are all the more legitimate in the context of a general medical consultation that the French High Council of Public Health (HCSP) has recently recommended, which is that HPV vaccination be extended to men who have sex with men.<sup>25</sup>

The doctor could then follow up with the next question: "Do you have, or have you ever had any sexual difficulty?" If that question is answered affirmatively, it would be best to suggest having a discussion of that sexual difficulty during another visit specifically dedicated to that topic<sup>9</sup> or to refer the patient to a specialist (a psychologist, sexologist, or relevant specialist practitioner). This is even more so because the patient will prefer, especially in the context of such a sensitive subject, to be taken care of by a trusted person, in this case, his/her doctor, rather than having to seek information in an unsafe way and risk postponing his/her treatment by seeking other unconventional methods of treatment from untrustworthy sources.

### CONCLUSION

Most of the patients (93%) did not feel that their general practitioner was intrusive when he/she asked them about their sexuality, even if their visit was for a different reason. On the

contrary, they consider sexuality to be a subject that should be examined more systematically by the attending physician.

Nevertheless, 7 patients (7%) reacted negatively to that intimate inquiry. For that reason, it is necessary to keep in mind that intimacy remains a subject that requires an appropriate framework and context. The latter must combine trust, kindness, and empathy. If those elements are present, a patient questioned about his or her sexuality will be able to overcome a feeling of surprise and answer the question.

Addressing the subject of sexuality is also an opportunity to restore intimacy in the unique relationship that is the doctor-patient relationship in a society, where the general practitioner tends to be considered as a simple doctor, whose task is to give prescriptions rather than to lend an ear to patients.

Health professionals have an educational role to play with regards to their patients, by integrating the subject of sexuality in a more systematic way in their inquiries in order to get closer to a concept of “global health” inclusive of a notion of “sexual health” that should not be defined merely as the absence of sexual difficulties. By asking that question, the doctor primarily opens a door; the patient might not necessarily grant immediate access to his sexual intimacy history but will know that a zone of freedom has been offered to him/her.

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## STATEMENT OF AUTHORSHIP

Arnaud Zéler: Conceptualization, Methodology, Investigation, Resources, Writing - Review & Editing, Funding Acquisition; Catherine Troadec: Writing - Review & Editing, Formal Analysis; Arnaud Zéler: Conceptualization, Methodology, Investigation, Resources, Writing - Review & Editing, Funding Acquisition.

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