Patient and Provider Perspectives on Sexual History Taking During Gynecological Care: A Pilot Study in an Academic Family Medical Setting in New York City

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PATIENT AND PROVIDER PERSPECTIVES

ON SEXUAL HISTORY TAKING DURING GYNECOLOGICAL CARE:
A PILOT STUDY IN AN ACADEMIC FAMILY MEDICAL SETTING IN NEW YORK CITY

A DISSERTATION

by

ASHLEY M. CHASTAIN

Concentration: COMMUNITY, SOCIETY, AND HEALTH

Presented to the Faculty at the Graduate School of Public Health and Health Policy in partial
fulfillment of the requirements for the degree of Doctor of Public Health

Graduate School of Public Health and Health Policy
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ABSTRACT

Patient and Provider Perspectives on Sexual History Taking During Gynecological Care:
A Pilot Study in an Academic Family Medical Setting in New York City

by

Ashley M. Chastain

Advisor: Betty Wolder Levin

**Background:** In the United States (US), women face a number of serious issues concerning sexual health. Current surveillance data indicates that overall rates of bacterial sexually transmitted infections (STIs) are increasing rapidly. While rates of new diagnoses have decreased, the risks of acquiring HIV are still relatively high for some females, specifically Black/African-American women. In New York City (NYC), where this dissertation research was conducted, similar HIV/STI rates exist among females of reproductive age (aged 15-44). Among women in the US, there are also high estimated rates of other sexual health problems, such as sexual anxiety, sexual dysfunction, and intimate partner violence (IPV). For those reasons, current clinical practice guidelines (CPGs) from international and national entities take a broad and integrated approach to sexual healthcare, and include sexual history taking guidance for healthcare providers regarding assessing a patient’s risk for and/or presence of HIV/STIs and other sexual health issues.

Previous studies have shown that the frequency of sexual history taking and documentation of sexual histories vary widely during medical exams. Based on that prior research, there appears to be a disconnect between published recommendations and real-world implementation of CPGs around sexual history taking during medical encounters, similar to what has been shown with recommendations for other health issues. To help determine what gaps exist, previous studies have examined the barriers and facilitators to sexual history taking through surveys, focus groups and
interviews with either providers or, more rarely, patients. However, few researchers have attempted to explore both patient and provider lived experiences and perspectives of sexual history taking within the same study. Therefore, due to an increased emphasis on integrating family planning and sexual and reproductive health care in primary care settings, this pilot study was developed to examine sexual history taking and sexual health discussions during gynecological care encounters from the perspectives of family medicine providers and their patients.

Specifically, this dissertation research examined: 1) how female patients (of reproductive age) and family medicine providers navigate sexual history taking during gynecological care; 2) barriers and facilitators to sexual history taking and sexual health discussions from the perspectives of female patients and their providers; and, 3) their suggestions for improvements to the sexual history taking process and subsequent discussions. Additionally, in order to better understand how sexual health issues are talked about during medical encounters, this study explored how female patients and their providers define and think about (frame) sexual health and behaviors. Finally, specific factors (intrapersonal, interpersonal, institutional, and structural) were identified as influencing their framing of sexual health and experience of gynecological care.

Methods: Family medicine providers and female patients were recruited at two clinics in an academic family medical setting in NYC to participate in individual, in-depth interviews. Eligible providers (physicians and nurse practitioners) must have provided regular gynecological care. Eligible patients were aged 18-44 years, identified as female, reported sexual activity in their lifetime, were not currently pregnant, and had a recent medical visit involving a pelvic exam. Interviews were conducted after screening and obtaining written consent. Similar, though separate, interview guides were developed for patients and providers with open-ended questions to capture a number of domains, including: expectations for and overall perceptions of a recent medical visit;
framing of sexual health and behavior; perceptions of, acceptability of, and navigating sexual history taking; knowledge schema around sexual health; and suggestions for improvements. Interviews were recorded, transcribed, and thematically analyzed for similarities and differences between patients and providers.

**Results:** 18 patient and 9 provider interviews were conducted; all participants identified as female. In their interviews, patients and providers described numerous ways in which they navigate sexual history taking during medical encounters. Most of these findings were similar to what has been reported previously; however, there were a few findings which have been rarely mentioned or not previously reported in the literature.

First, for most patient interviewees, sexual health was described as protection (e.g. condoms, testing, birth control, etc.) from HIV, STIs and pregnancy, as well as an individual’s risk of acquiring STIs and/or becoming pregnant, which was coded as a risk-based/protection framing. Provider interviewees appeared to mirror this protective view of sexual health when talking about discussions with their patients. Conversely, providers revealed a broader, holistic framing of sexual health when asked what sexual health meant to them personally during their interviews. Only a few patients also framed sexual health and behavior using this broader definition.

Second, when examining how they navigate sexual history taking and sexual health discussions, overall, the perspectives of patients and providers were similar, with many thematic parallels. However, one area of difference was that patients often described a profound responsibility to be honest and open during conversations with providers about sexual health. In contrast, while providers mentioned appreciating honesty during these discussions, they questioned the utility of some patients’ openness. They found that receiving copious amounts of personal information was often not useful for risk assessment or diagnosis, which was particularly
problematic during time-limited medical encounters. This revealed a tension between honesty and openness on behalf of the patient and a perception of oversharing on behalf of the provider during sexual history taking.

Third, when describing barriers and facilitators to sexual history taking and sexual health discussions, most of thematic findings were similar among patients and providers. The interviewees primarily discussed the onus for reducing barriers to be on the providers, as opposed to the patients. One variation, however, was that some provider interviewees described patients and providers as using different definitions for types of sexual behavior. Some patients mentioned disengagement on behalf of providers as a major barrier to patient-provider communication during sexual health discussions. Regarding facilitators, providers often stressed the importance of creating an open, receptive environment when discussing sensitive topics, such as a patient’s sexual history. Most patients described a positive and respectful provider approach and demeanor as facilitating patient-provider communication during sexual health discussions.

Fourth, there were several suggestions from patient and provider interviewees on how to improve sexual health discussions and the implementation of CPGs. Namely, patients described numerous ways in which providers and clinic sites could offer additional resources, support and education around sexual health, including printed informational materials, educational workshops, and visual aids. Provider interviewees discussed their desire for clinically-relevant and suitable sexual history taking questions to aid them in gathering the information needed to assess, diagnose and treat patients to the best of their ability.

Lastly, the patient and provider responses led to the identification of various interpersonal, institutional, and structural factors that influence sexual history taking and sexual health discussions. For patients, the most important interpersonal factors were the influence of family
members and others in their personal social networks upon their conceptualization of sex and sexuality, their perceptions of judgement, shame and stigma, as well as their perceptions of provider compassion and empathy. For providers, the most salient factor was their perceptions regarding the importance of patient honesty and openness. Several institutional factors were mentioned, including: 1) social desirability around number of sexual partners, and 2) encounter length. Regarding structural factors, patient and provider interviewees mentioned their desire for increased/improved education, resources and training which they believed would positively influence sexual history taking and sexual health discussions.

**Discussion:** This pilot study presented a distinct opportunity to learn about female patient and family medicine provider experiences, perspectives and needs during gynecological care. Furthermore, this study helped identify gaps in the implementation of CPGs around sexual history taking during medical encounters. Providers reiterated their specific goals (risk assessment, provision of contraception and identification of certain sexual health issues) during these time-limited encounters, which are narrower in scope than current CPGs that approach sexual healthcare in a holistic way. Interviewees also described the need for additional education and training materials to improve patient knowledge and understanding about sexual health and to help providers navigate these oftentimes difficult discussions. The results from this study can be used to make modifications to history giving/taking guidance to incorporate these real-world experiences, perspectives and needs, with the goal of improving patient-provider communication, as well as increasing the frequency of sexual history taking and documentation, and improving sexual health outcomes.
DEDICATION

To the patients and providers who participated in this study.

Thank you for trusting me and sharing your experiences, perceptions, and ideas.
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SECTION I: BACKGROUND, THEORY AND METHODOLOGY

PREFACE

The impetus for this dissertation was a story on National Public Radio (NPR) in 2007 which explained that we were nearing the end of antibiotic treatment options for *Neisseria gonorrhoeae* (gonorrhea). As I was listening to the story, it dawned on me that, like many researchers, I was working within a siloed environment and seldom exploring research outside of a narrow topic. At the time, I was a microbiologist, researching a related topic, and, yet, did not know that antibiotic resistance in gonorrhea was that dire. It also struck me that, in the 21st century, with the advances in medicine and public health, we get lulled into a sense of security.

Antibiotics have been in use for over 70 years and the discovery of penicillin has been lauded as one of the greatest medical advances. Consequently, resistance to and failure of antibiotic treatment is quite alarming, particularly when the ultimate impact to public health is unknown. That element of unknown led me to wonder: “what is currently being done at point-of-care with regard to testing and treatment for gonorrhea?” Prior to then, research on point-of-care testing for gonorrhea and antibiotic alternatives was scant. When I started my doctoral studies almost four years after the NPR story, there was still not much research, despite alarm bells from the Gonococcal Isolate Surveillance Program (GISP) team at the Centers for Disease Control and Prevention (CDC). However, in 2012, more attention began to be paid with the release of new recommendations for treatment of gonorrhea in the Morbidity and Mortality Weekly Report (MMWR). These treatment guidelines were revised just 5 years after the previous recommendations that fluoroquinolones were not advisable anymore.

It is with that in mind that I conceived of this exploratory study, not focused solely on gonorrhea testing and treatment, but with attention paid to a larger gap in our understanding of
patient-provider communication around sexual history taking. History taking is a tool used by healthcare providers to gather information and assess risk and, thus, prescribe testing and treatment from that assessment. To understand what is happening at point-of-care with gonorrhea testing and treatment, I felt we must examine the basics of the clinical encounter. This dissertation research aimed to inform the manner in which the clinical encounter is conducted, and, thus, perhaps aid in the timely testing and treatment of gonorrhea and other sexually transmitted infections.
CHAPTER 1 - Background and Significance

BACKGROUND

Sexually Transmitted Infections in the United States and New York City

In the United States (US), current surveillance data indicates that overall rates of bacterial sexually transmitted infections (STIs), such as *Treponema pallidum* (syphilis), *Chlamydia trachomatis* (chlamydia), and gonorrhea, are increasing rapidly ([Figure 1](#)).\(^1\) If left untreated, these infections can develop into severe disease, which disproportionately affect females and their newborns.\(^2\) Untreated primary and secondary syphilis infections in pregnant females have also increased significantly, and, consequently, cases of congenital syphilis among newborns have increased.\(^1\) Women who are infected with STIs often experience multiple medical complications, infertility, and devastating socio-economic consequences, due to productivity losses, healthcare costs and stigma.\(^3\) Females in the US are also heavily affected by human immunodeficiency virus (HIV) and its associated acquired immunodeficiency syndrome (AIDS); recent data estimated that 1 in 43 African-American and 1 in 132 Latina women will be infected with HIV in their lifetimes.\(^9\)

In New York City (NYC), where this dissertation research was conducted, there were 71,690, 23,491 and 7,993 annual infections reported for chlamydia, gonorrhea and syphilis, respectively, in 2018.\(^10\) Similar to national trends, chlamydia infection rates were highest among females aged 15-24, while rates of gonorrhea and syphilis were highest among males, aged 20-34.\(^10\) Additionally, females comprised 18.3% of new HIV diagnoses in NYC in 2017, and 20.9% of those women diagnosed with HIV received concurrent AIDS diagnoses.\(^11\) Unfortunately, many of those cases received additional concurrent diagnoses, whereby the individual was infected with
2 or more STIs at the same time; in a 2012 analysis, co-infection with syphilis and HIV happened most frequently, followed by syphilis, chlamydia, and gonorrhea infections (Table 1). 12

For women residing in some neighborhoods of NYC, the risks of acquiring HIV and other STIs are much greater than for individuals residing in other localities due to high prevalence among social networks (Figure 2). 13,14 Within these neighborhoods, medical providers regularly see female patients with varying degrees of health needs and barriers to accessing care. 15 Even with recent healthcare reforms implemented in the US, 16 gender differences, in addition to racial/ethnic and economic disparities, still exist concerning access to care and health status among patients at risk for HIV/STIs. 17-23 For at-risk patients, as well as those who are already infected, limited access to medical care directly impacts the ability to secure primary, secondary and tertiary prevention, as well as appropriate, timely treatment and high-quality care and support. 23-25

Sexual History Taking as Prevention

Due to severity of disease if HIV or STIs are left untreated, 5,26-30 healthcare providers working with patient populations with high HIV/STI incidence are advised to regularly test patients (and subsequently provide treatment for positive results), as well as initiate conversations about overall sexual health and prevention of future infections. 29,31-35 To initiate that conversation, providers often ask patients to provide details about their health history. Classically, a comprehensive adult health history includes seven key components, whereby sexual history questions reside under the following topics: chief complaint(s), present illness(es), past history, family history, personal and social history, and review of biological systems. 36 According to the literature, an ideal sexual history and risk assessment approach involves a provider assessing a patient’s risk for HIV/STIs and other sexual health issues, conducting HIV/STI screening (if
appropriate), and counseling them on safer sex, family planning, sexual anxiety, sexual
dysfunction, and intervening if the patient is experiencing intimate partner violence (IPV).36-42

With regard to STI testing and treatment, extra time spent on sexual history taking can
elicit important clues for the provider about which anatomical sites to test, partner notification if
they are found to have an infection, treatment adherence and preventive measures to take, thereby
reducing so-called “missed opportunities”.40 Notification, testing and/or treatment of past and
current sexual contacts is critical, as it has been estimated that 19-20% and 11.7% of females
become re-infected with chlamydia or gonorrhea, respectively, within 12 months of another
infection.6 Additionally, timely testing and treatment is particularly essential with gonococcal
infections due to antibiotic resistance in currently circulating strains in the United States.43,44
Furthermore, with the emergence of Zika virus as a sexually-transmitted infection, the need for
sexual history taking, preconception counseling and testing of women of child-bearing age and
their partners has increased in order to prevent illness in adults and poor health outcomes in
babies.45,46 Comprehensive sexual history taking also generates opportunities for primary
prevention, identification, and treatment of associated conditions, such as depression, anxiety or
diabetes, all of which impact patient health outcomes.40,47

Current Sexual History Taking Recommendations and Guidance

In the US, a broad and integrated approach to sexual and reproductive health has become
a national priority.48 Several international and national entities, including the Centers for Disease
Control and Prevention (CDC), United States Preventive Services Task Force (USPSTF),
American College of Obstetricians and Gynecologists (ACOG), and American Academy of
Family Physicians have published clinical practice guidelines (CPGs) for identifying, testing for
and treating HIV/STIs. Specifically, the USPSTF recommends sexual risk assessments during
medical encounters, in concordance with history taking and a physical exam, to identify demographic and behavioral risk factors (gender, age, sexual activity/practices), which, in turn, determine the need and frequency of HIV/STI testing. With regard to HIV testing, ACOG, the Institute of Medicine and other medical professional organizations support annual opt-out screening for patients aged 13-65, whereby testing occurs during routine medical care but patients have the opportunity to opt-out or decline the test. Routine screening protocols for other STIs vary by age, gender, and risk category, and are periodically revised based on epidemiologic evidence. Additionally, as a result of the Zika virus, the World Health Organization and the CDC expanded their clinical guidance for sexual history taking, preconception counseling and testing of women of child-bearing age and their partners. Some of the entities have also published broader CPGs around sexual healthcare. Guidance from ACOG includes recommendations for routine risk-based screening for non-coital sexual activity, sexual assault and IPV. Additionally, the organization also published patient-level recommendations that encourage female patients to discuss sexual health concerns with providers, in the context of well-woman examinations.

While these recommendations do not include targets or goals for sexual history taking or frequency of documentation, they state that providers should document a complete sexual history at initial visits with brief updates at periodic medical exams. In the past, guidance for how providers should conduct a comprehensive sexual history was limited; oftentimes, the recommendations were offered under the umbrella of adolescent health or identification of sexual dysfunction, and were intended to be adapted to a general audience, which presented issues for providers addressing multi-faceted sexual health questions or patients with complex STI risk profiles. However, in recent years, the guidance has become more nuanced and tailored to
specific patient populations. In 2002, a detailed document regarding best practices for sexual history taking was published by Nusbaum and Hamilton (not affiliated with a governmental or professional organization). “The Proactive Sexual History” details general approaches, appropriate transitions in conversation, specific questions, possible responses, and opportunities for further conversations.40 Later, the Centers for Disease Control and Prevention developed a short guide for physicians on sexual history-taking based on the “5 P’s”: Partners, Practices, Protection from STDs, Past history of STDs, and Prevention of pregnancy.37 Both documents recommend that sexual histories should be taken when a patient presents with signs or symptoms of STIs, as well as during routine examinations and during initial visits with that particular provider.37,40 Subsequent CPGs from international and national entities (cited above) reference these documents as main resources for guidance.

Currently, the “5P’s” sexual history taking guide, along with the 2015 STI testing, treatment and follow-up recommendations for various populations, are available on the CDC website for physicians in an application for mobile devices (STD Treatment (Tx) Guide app).65 In NYC, two comprehensive guides, “Take Action – Stop the Spread” and “Preventing Sexually Transmitted Infections” were written for providers in 2013 and 2014 by the New York City Department of Health and Mental Hygiene (NYCDOHMH).66,67 In 2017, an updated guide called “Making the Sexual History a Routine Part of Primary Care” was published for providers.68 The NYCDOHMH guides are tailored for patient populations in the five boroughs and detail specific sexual history-taking questions, opportunities for further conversations, screening and vaccination guidelines, prevention counseling and partner management.66-68 Apart from committee reports and governmental agency guides, there are also a few continuing medical education (CME) modules aimed at improving sexual history taking.69-71 However, to-date, it is not known if specific
components and modules have been evaluated for improved sexual health outcomes, nor has appropriate research been conducted to identify what skills and approaches should be included.\textsuperscript{72}

\textit{Previous Research on Sexual History Taking During Medical Encounters}

Despite these recommendations, previous studies have shown (mostly through provider surveys) that the frequency of sexual history taking and documentation of sexual histories vary widely during medical exams; these variations can be attributed to a number of factors, including: encounter length, multiple health concerns to be addressed, provider specialty, and patient socio-economic status.\textsuperscript{32,73-82} Specifically, there appears to be a disconnect between the recommendations and real-world implementation of CPGs around sexual history taking and sexual health discussions,\textsuperscript{83,84} which has been shown with other health issues such as diabetes, high blood pressure, cholesterol and obesity\textsuperscript{85,86}.

Through focus groups and surveys (separately validated through chart reviews),\textsuperscript{34,35,87} providers admit preconceptions, such as those about STI and pregnancy risk patterns, related to patients’ socioeconomic background and ethnicity.\textsuperscript{73,88} Providers also described that presumptions often are made when the patient does not present with any sexual or reproductive/urinary tract complaints (i.e. are asymptomatic), which can impede an objective examination of each patient.\textsuperscript{82}

Among obstetrics/gynecology (OB/GYN) specialists, physicians cite reduced sexual history-taking with pregnant patients during prenatal visits.\textsuperscript{81} This finding can be compared with reviews of insurance data which cite that up to 40\% of women never receive recommended STI testing (gonorrhea/chlamydia) during pregnancy even when accessing prenatal care.\textsuperscript{5,89} These gaps in recommended testing highlight an interesting oversight regarding sexual activity among pregnant women; almost all pregnant women engage in some sexual activity during pregnancy\textsuperscript{90} and have similar STI risk profiles to the general female population.\textsuperscript{81} Interestingly, when compared with
physicians who primarily practice obstetrics or a mixture of both obstetrics and gynecology, those who primarily practice gynecology appear to ask patients more frequently about sexual histories despite the initial health concern. Despite this, testing recommendations are not always followed with every patient; for chlamydia, it has been found that up to 42% of sexually-active females do not receive recommended screenings during routine medical visits.

Apart from medical specialty, provider gender can also affect the quality and discourse of medical encounters. According to the literature, female physicians spend longer than male physicians on recording medical histories from patients. Not only do female physicians spend longer on medical histories, but, through self-report, female physicians conduct sexual history taking with more frequency (despite patients’ initial health concerns) than male physicians. Analyses of chart notes have also indicated that these differences exist between male and female physicians. Furthermore, according to a survey of nearly 1,000 general practitioners (GPs) and OB/GYNs, provider gender was cited as more important than medical specialty in influencing the likelihood of conducting sexual histories. However, these differences decrease as both patients and providers age; older providers and patients (regardless of gender) rarely discuss sexual health issues even though the risk for STIs remains. Providers may underestimate sexual activity rates among older adults, even as STI rates among older adults have increased exponentially. Additionally, protection against STIs (condoms) is primarily thought of as contraception which is not applicable for women who have experienced menopause.

In addition to gender and age, differences in race, ethnicity and religion between patients and providers have been shown to negatively impact conversations about sexual health. Furthermore, there are also difficulties in patient-provider communication when patients’ general and health literacy is not accounted for. Ideally, conversations with providers should be matched
with the health literacy levels of the patient, to provide patients with opportunity to describe symptoms and medical history accurately, as well as adhere to treatments. Frequently, there are assumptions made by providers about the health literacy levels of patients. Providers have been known to communicate with patients using medical terms, which are not part of the everyday vernacular. Communication between two individuals whereby literacy levels are different provides a barrier which is difficult to overcome during medical encounters. The issue is so widespread that the Affordable Care Act, Plain Writing Act, and Healthy People 2020 all name health literacy as a major barrier to achieving better health outcomes. In the US, a third of adults possess basic literacy skills which are often mismatched with the level of information they receive during medical encounters. Consequences of misunderstanding or misinterpretation can be dire when patients are faced with medical conditions, such as STIs. Various tools have been created for physicians and patients to assess and aid in literacy-appropriate conversations, but their use within time-constrained medical encounters has been shown to be limited.

In addition to the variations cited above, there are difficult topics for some providers to address with patients, and past and present sexual activity is one of those topics. In a US study which analyzed audio-recorded medical encounters for evidence of sexual health discussions, it was found that only 10% of older female patients (aged 50-80 years) were asked about current sexual activity by family and general internal medicine providers during periodic health examinations. Various reasons have been given as to why sexual activity is a difficult topic; researchers have named cultural sensitivities, gender bias, social desirability bias, uncomfortable feelings on the part of the provider, and not knowing how to successfully question or answer the patient as the main barriers to performing complete sexual histories with most patients. Similarly to sexual activity, there is evidence that other topics may be difficult to
breach with patients. In a study of general practitioners (GPs) in the UK, only 2% of physicians mentioned that they recorded sexual concerns, issues or dysfunction in chart notes. In the US, a survey of OB/GYNs reported that 40% routinely asked patients about sexual problems, but fewer asked about sexual satisfaction (28.5%), sexual orientation/identity (27.7%), or pleasure with sexual activity (13.8%). Furthermore, several studies have found that just 15% of women are asked by healthcare providers about IPV or sexual trauma. One study among GPs in the UK highlighted stigmatizing views held by some providers, as well as the fact that questions about IPV were more likely to be asked if the provider knew the patient had children. However, one study found significant associations between positive, supportive beliefs about providing health services for IPV victims and the following provider characteristics: younger age, fewer years in practice, female gender, and OB/GYN specialty.

Interestingly, few researchers have attempted to understand patient perspectives regarding sexual history taking during medical encounters, or patient and provider perceptions of and communication during gynecological care. In the few studies that have been published there have been noted gender differences among patients. Female patients tend to broach the subject of sexual health with providers more frequently than male patients. Because some women visit gynecologists, who are known to address sexual health more frequently than other medical specialties, female patients may feel more comfortable addressing concerns and questions within that context. Interestingly, patients of both genders have noted that they are more likely to initiate conversations about sexual health with female providers than male providers.

Additionally, in the US, there is also a nationally-representative dataset which provides information from men and women (aged 15-49) about general and reproductive health, pregnancy,
infertility, use of contraception, family life, marriage, and divorce. Respondents of the National Survey of Family Growth (NSFG) are asked in-person by trained interviewers about communication with their provider (in the past 12 months, and during lifetime) regarding a variety of reproductive health topics. Specifically, for female respondents, topics include: if and where they received a pap smear and/or pelvic exam in past 12 months, and discussions about contraception options during visit with pap smear and/or pelvic exam. To date, an analysis of the most recent data (2015-2017 survey) has not yet been reported; however, a descriptive analysis was done for this dissertation (Table 2). These analyses were conducted with the female only sample from 2015-2017, and was restricted to respondents aged 18-44 who were not pregnant at the time of the survey (4,167 respondents), similar to the dissertation study sample. All analyses were done with a weighted sample per the instructions provided in the public use data file documentation; the weights adjust the sample with US Census Bureau projections of the number of persons in age-sex-race-ethnicity subgroups. The sample was stratified by age groups (18-24, 25-34, 35-44). The analyses represent the female household population (aged 18-44) in the US at the midpoint of interviewing during the 2015–2017 survey cycle (n=54,098,989).

Age was a factor in reproductive health service utilization and which medical setting those health services were received. Over half of women aged 25-44 reported having a pelvic exam and/or Pap smear during the past 12 months, in contrast to about a third of females aged 18-24. Furthermore, approximately 40% of women aged 18-34 received testing for an STI in the past 12 months, but this declined with age, as only a quarter of females aged 35-44 reported receiving testing in the past year. A majority of women received reproductive health care in a private doctor’s office or from in-network providers with a health maintenance organization (HMO). During these medical encounters, younger females, aged 18-24, reported that providers talked about birth
control, emergency contraception, and condom usage more often than women in the older age groups. This age difference was also seen in lifetime communication with providers about sexual health and HIV/STI risk. Besides the NSFG, limited evidence from other surveys and interviews with patients does reveal similar difficulties with communication, such as: decrease of sexual health discussions as the patients age, lack of provider initiation of such discussions, as well as patient discomfort about sexual health topics.\textsuperscript{33,99,140}

Specifically, some patients are uncomfortable discussing sexual problems or dysfunction (defined as not being able to fully enjoy sexual activities). Worldwide, it is estimated that between 16 to 43\% of women have experienced sexual problems or dysfunction,\textsuperscript{141,142} and many become understandably distressed by the symptoms.\textsuperscript{142,143} As a result, it has been reported that depression, anxiety, and/or overall reduction in quality of life can occur.\textsuperscript{42} However, of those experiencing these issues (both men and women), it was found via international surveys that only 19\% sought medical care for sexual concerns.\textsuperscript{144} For patients with sexual dysfunction, in one study, only 9\% of surveyed patients (aged 40-80 years) reported being asked about sexual health in the previous 3 years.\textsuperscript{144}

Another difficult topic is that of domestic or intimate partner violence (IPV). An essential component of a comprehensive sexual history\textsuperscript{36} is the assessment for past, long-term, and acute intimate partner violence (IPV) and sexual trauma. While police officers are typically first responders to and reporters of domestic violence assaults, healthcare providers also play an important role in identifying patients at risk for IPV or in need of medical attention and/or legal intervention. In 2017, there were 25,140 total domestic violence assaults reported by police agencies in New York City, not including violation of protective orders.\textsuperscript{145} Of these assaults, 65\% (16,476) were committed by intimate partners; females were the victim in 74\% of these assaults.\textsuperscript{145}
In one US study, 69% of women screened (at clinics) for the research reported a history of sexual trauma. Of those women who ultimately enrolled in the study, participants who accessed medical care for gynecological problems were more likely to report childhood sexual abuse and experience sexual assault as adults, as well as increased rates of stress. Correlations with eating disorders and substance use were also found.

Few studies have explored whether disclosing IPV and/or sexual trauma to healthcare providers helps victims to receive desired treatment (physical or psychological). Consistently, research has shown that most women support routine screening for physical or sexual abuse during medical encounters, and prefer a patient-centered approach to screening. However, two studies conducted in the US reported that women who disclose IPV during medical encounters are less likely to report feeling respected and accepted by the provider, compared to women who did not report IPV. Those women also negatively rated several aspects of the encounter, as well as the quality of patient-provider communication.

Despite these obstacles, a majority of women report being interested in discussing sexual health topics with their providers. Thus, to address barriers within medical encounters, multiple interventions have been conducted over the years with patients, medical students, residents, attending physicians, and other healthcare providers. Fundamentally, these studies and recommendations aimed to improve and enrich patient-provider communication about sexual health. However, most of the previous studies have targeted providers and have had limited success.

**STUDY PURPOSE AND RESEARCH QUESTIONS**

Even with the advent of rapid and increasingly accurate diagnostic testing, the most powerful tool remains effective conversation among patients and providers during medical
In the case of HIV/STI prevention, the increasing availability of self-testing options would appear to decrease the need for medical visits for many individuals. However, sexual healthcare needs of individuals can be varied and multifaceted, and HIV/STI prevention is just one aspect of what can be addressed during sexual health discussions between patients and providers. Adding to that complexity is interpersonal communication; each individual arrives at the conversation with varying degrees of differences in communication skills, emotional state, life experiences, socio-cultural contexts, among other influences. These differences affect how individuals make sense of and convey information, leading to consensus or misunderstandings. For patients and providers, misinterpretations during a medical encounter can lead to increased morbidity and mortality.

For that reason, to address gaps in the literature, this study explored how patients and their providers (physicians, nurse practitioners, physician assistants, etc.) describe sexual health and behavior. To do so, I drew upon a core facet of cognitive psychology, called framing; frames are short cognitive tools that individuals utilize to make sense of and convey complex information. In this study, I aimed to elicit how patients and providers frame sexual health and behavior, and analyze whether those frames were in consensus or disagreement. Few studies have simultaneously examined patient and provider perspectives; therefore, in this study, patients and providers were recruited from the same two clinic sites. In the interviews, I explored how patients and providers navigated sexual history taking/giving during a recent visit, what barriers and facilitators to sexual history taking and sexual health discussions that study participants had experienced and/or felt that others experience, as well as any suggestions for improvements. Due to challenges with recruitment, patients and providers were not paired dyads (meaning the providers who participated were not always the same as the patient’s provider due to challenges with participant
However, the interview guides contained the same or similar questions for both types of participants so that comparisons could be made.

Routine gynecological care, defined as pap smears, endometrial biopsy, collection and interpretation of vaginal and cervical samples, and placement of long-acting reversible contraception (LARC), among other procedures,\textsuperscript{179} appeared particularly well positioned for such a study based on clinical guidance and recommendations around sexual history taking within such encounters. Furthermore, women seek gynecological care for many reasons, including: annual well-woman exams, sexual dysfunction/anxiety, HIV/STI counseling, testing and treatment, contraceptive options, menopausal issues, and preconception care.\textsuperscript{180} While OB/GYNs provide a majority of gynecological care, are particularly positioned to address sexual problems with women, and appear to ask patients about sexual concerns more often than other specialties,\textsuperscript{75,181,118} it is important to understand how other healthcare providers discuss these issues when delivering health education, gynecological care, and sexual risk assessments. With greater emphasis on integrating family planning and sexual and reproductive health care in primary care settings, I felt it was important to explore perspectives of family medicine providers in this study.

The specific research questions that this study aimed to address were:

1. How is sexual health framed by female patients and family medicine providers during gynecological care encounters, and what influences these frames?
   a. **Aim 1:** To examine the framing of sexual health by female patients and family medicine providers, and describe any similarities and differences

2. How do women aged 18-44 and family medicine providers navigate sexual history taking during gynecological care?
a. **Aim 2**: To examine the sexual history taking process and sexual health discussions from the perspectives of female patients and family medicine providers, and describe any similarities and differences

3. What are the barriers and facilitators to sexual history taking and sexual health discussions from the perspectives of women aged 18-44 and family medicine providers in NYC?

   a. **Aim 3**: To describe common facilitators and barriers to sexual history taking during gynecological care encounters

   b. **Aim 4**: To describe suggestions for improvements to the sexual history taking process and sexual health discussions from the perspectives of female patients and family medicine providers

**SIGNIFICANCE**

This pilot study presented a distinct opportunity to learn about female patient and family medicine provider experiences, perspectives and needs during gynecological care. In this study, I explored sexual health framing by patients and family medicine providers and learned about additional barriers and facilitators to giving or receiving appropriate care and treatment. Additionally, findings from this study include suggestions for improved methods of communicating about sensitive topics during medical encounters, particularly in time-constrained environments. Furthermore, from these findings, I described other factors (interpersonal, institutional and structural) that may be influencing sexual history taking and sexual health discussions. Ultimately, this study helps identify gaps in the implementation of CPGs around sexual history taking during medical encounters. With this information, modifications can be made to history giving/taking guidance that incorporates these real-world experiences, perspectives and
needs, with the overall goal of improving patient-provider communication, as well as frequency of sexual history taking and documentation of sexual histories.
Figure 1. Annual percentage growth of syphilis, chlamydia and gonorrhea cases per 100,000 population in the US, 2007 to 2017.

![Bar chart showing the annual percentage growth of syphilis, chlamydia, and gonorrhea cases per 100,000 population in the US from 2007 to 2017.](image)

Figure 2. Geographic co-occurrence of HIV/AIDS, hepatitis B, hepatitis C, chlamydia, gonorrhea, syphilis, and TB in New York City – Rates of diseases in the top quintile (by zipcode), 2010.

![Map showing the geographic co-occurrence of HIV/AIDS, hepatitis B, hepatitis C, chlamydia, gonorrhea, syphilis, and TB in New York City.](image)
Table 1. Total number of individuals with concurrent STD diagnoses in New York City, 2000-2010

<table>
<thead>
<tr>
<th>Disease</th>
<th># of individuals</th>
<th>% with concurrent diagnoses</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Chlamydia</td>
<td>Gonorrhea</td>
</tr>
<tr>
<td>Chlamydia</td>
<td>366,409</td>
<td>14%</td>
</tr>
<tr>
<td>Gonorrhea</td>
<td>109,050</td>
<td>46%</td>
</tr>
<tr>
<td>Syphilis*</td>
<td>14,216</td>
<td>18%</td>
</tr>
<tr>
<td>HIV^</td>
<td>140,606</td>
<td>5%</td>
</tr>
</tbody>
</table>

*Early, primary, and secondary infections only; ^Existing and new cases alive as of January 1, 2000 and reported on or at any time before December 31, 2010

Table 2. Summary statistics of US female household population, aged 18-44, from the National Survey of Family Growth, 2015-2017

<table>
<thead>
<tr>
<th>Health Services Utilization, Past 12 months</th>
<th>Total</th>
<th>Respondent’s Age Category</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N (% of total)</td>
<td>18-24 years</td>
</tr>
<tr>
<td></td>
<td>Weighted Estimates</td>
<td></td>
</tr>
<tr>
<td>Pelvic Exam</td>
<td>30,284,396</td>
<td>5,159,639</td>
</tr>
<tr>
<td>Pap Smear</td>
<td>29,732,392</td>
<td>5,129,309</td>
</tr>
<tr>
<td>Birth Control Method or Prescription</td>
<td>18,211,034</td>
<td>6,298,144</td>
</tr>
<tr>
<td>Any STD Test</td>
<td>18,993,762</td>
<td>5,277,766</td>
</tr>
<tr>
<td>Chlamydia Test</td>
<td>14,817,261</td>
<td>4,520,364</td>
</tr>
<tr>
<td>HIV Test</td>
<td>746,427</td>
<td>237,855</td>
</tr>
</tbody>
</table>

Where Received Services in Past 12 months

<table>
<thead>
<tr>
<th>Pelvic Exam</th>
<th>N (% of age group)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private doctor's office or HMO</td>
<td>24,864,972 (82.1)</td>
</tr>
<tr>
<td>Other medical setting</td>
<td>4,049,847 (78.5)</td>
</tr>
<tr>
<td></td>
<td>10,331,973 (78.9)</td>
</tr>
<tr>
<td></td>
<td>10,483,152 (87.1)</td>
</tr>
<tr>
<td>Pap Smear</td>
<td>5,419,425 (17.9)</td>
</tr>
<tr>
<td></td>
<td>1,109,792 (21.5)</td>
</tr>
<tr>
<td></td>
<td>2,758,792 (21.1)</td>
</tr>
<tr>
<td></td>
<td>1,550,841 (12.9)</td>
</tr>
</tbody>
</table>

Where Received Services in Past 12 months

<p>| Private doctor's office or HMO             | 24,081,341 (81.0)   |
| Other medical setting                      | 3,933,442 (76.7)    |
|                                           | 10,036,291 (78.8)   |
|                                           | 10,111,608 (85.2)   |
| Other medical setting                      | 5,651,052 (19.0)    |
|                                           | 1,195,867 (23.3)    |
|                                           | 2,698,640 (21.2)    |
|                                           | 1,756,545 (14.8)    |</p>
<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>18-24 years</th>
<th>25-34 years</th>
<th>35-44 years</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Birth Control Method or Prescription</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private doctor's office or HMO</td>
<td>14,466,061 (79.4)</td>
<td>4,872,074 (77.4)</td>
<td>6,265,417 (78.7)</td>
<td>3,328,570 (84.2)</td>
</tr>
<tr>
<td>Other medical setting</td>
<td>3,744,974 (20.6)</td>
<td>1,426,070 (22.6)</td>
<td>1,695,879 (21.3)</td>
<td>623,025 (15.8)</td>
</tr>
<tr>
<td><strong>STD Test</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private doctor's office or HMO</td>
<td>13,739,808 (72.3)</td>
<td>3,532,026 (66.9)</td>
<td>6,369,371 (72.9)</td>
<td>3,838,411 (77.0)</td>
</tr>
<tr>
<td>Other medical setting</td>
<td>5,253,955 (27.7)</td>
<td>1,745,741 (33.1)</td>
<td>2,363,307 (27.1)</td>
<td>1,144,907 (23.0)</td>
</tr>
<tr>
<td><strong>Communication with Provider, Past 12 months</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provider talked about BC during Pap/pelvic exam*</td>
<td>17,624,473 (54.3)</td>
<td>3,742,906 (64.6)</td>
<td>8,396,776 (60.6)</td>
<td>5,484,791 (42.9)</td>
</tr>
<tr>
<td>Provider talked about EC during Pap/pelvic exam*</td>
<td>3,497,943 (10.8)</td>
<td>875,013 (15.1)</td>
<td>1,624,771 (11.7)</td>
<td>998,159 (7.8)</td>
</tr>
<tr>
<td>Provider talked about using condom to prevent disease during STD test*</td>
<td>9,669,465 (50.9)</td>
<td>3,797,126 (71.9)</td>
<td>4,160,067 (47.6)</td>
<td>1,712,272 (34.4)</td>
</tr>
<tr>
<td><strong>Sexual Health Communication with Providers, Lifetime</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient asked about sexual orientation or sex of her partners</td>
<td>12,421,946 (23.0)</td>
<td>4,415,121 (32.4)</td>
<td>4,982,380 (24.1)</td>
<td>3,024,445 (15.3)</td>
</tr>
<tr>
<td>Patient asked about her number of sexual partners</td>
<td>15,744,74 (29.1)</td>
<td>5,507,996 (40.4)</td>
<td>6,572,691 (31.8)</td>
<td>3,664,059 (18.5)</td>
</tr>
<tr>
<td>Patient asked about her use of condoms</td>
<td>17,872,974 (33.0)</td>
<td>5,955,627 (43.7)</td>
<td>7,491,466 (36.3)</td>
<td>4,425,881 (22.3)</td>
</tr>
<tr>
<td>Patient asked about the types of sex she has</td>
<td>8,929,279 (16.5)</td>
<td>3,470,911 (25.5)</td>
<td>3,628,416 (17.6)</td>
<td>1,829,952 (9.2)</td>
</tr>
<tr>
<td><strong>HIV/STI Risk Communication with Providers, Lifetime</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ever talked about HIV/AIDS with provider</td>
<td>20,954,745 (38.7)</td>
<td>6,521,604 (47.9)</td>
<td>7,583,214 (36.7)</td>
<td>6,849,927 (34.5)</td>
</tr>
<tr>
<td><strong>HIV Topics Covered – All Mentions</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How HIV/AIDS is transmitted</td>
<td>17,668,524 (32.7)</td>
<td>5,994,668 (44.0)</td>
<td>6,142,743 (29.7)</td>
<td>5,531,113 (27.9)</td>
</tr>
<tr>
<td>Other STIs (i.e. gonorrhea, herpes, Hepatitis C)</td>
<td>15,655,468 (28.9)</td>
<td>4,976,541 (36.5)</td>
<td>6,014,302 (29.1)</td>
<td>4,664,625 (23.5)</td>
</tr>
<tr>
<td>&quot;Safe sex&quot; practices (abstinence, condom use, etc.)</td>
<td>14,248,542 (26.3)</td>
<td>4,667,322 (34.3)</td>
<td>5,303,725 (25.7)</td>
<td>4,277,495 (21.6)</td>
</tr>
<tr>
<td>Getting tested and knowing your HIV status</td>
<td>12,428,398 (23.0)</td>
<td>3,757,920 (27.6)</td>
<td>4,655,358 (22.5)</td>
<td>4,015,120 (20.3)</td>
</tr>
</tbody>
</table>

*% total out of those individuals who received those services; weighted estimates of US females who were not pregnant at time of survey, and were 18-44 years old
CHAPTER 2 - Research Design and Methodology

This study was exploratory in nature, and involved individual in-depth, semi-structured interviews with female patients and family medicine providers about their perspectives regarding sexual history taking and sexual health discussions during gynecological care encounters. This study was guided by Grounded Theory, which allowed for the research questions and analyses to be iteratively refined throughout the study as I learned from previous research, my own observations in the field, and the study participants themselves. Before beginning data collection, I held a number of assumptions regarding patient-provider communication based on my own experiences as a woman accessing gynecological care, hearing stories from friends and family, and reading literature that included patient and medical provider voices. Namely, I assumed that: 1) framing of sexual health and behavior would be considerably different among patients and providers; 2) the frequency of sexual history taking and content in sexual health discussions would vary widely depending on the patient and provider within the encounter; 3) patients would have to fill out a health history form (including their sexual history) prior to their visit which might influence their sexual history narrative during the visit; and, 4) institutional and other structural factors, such as government (local, state and federal) and clinic policies, would be named as influences during patient and provider interviews. While these original assumptions helped me to create the research plan, as the study progressed, these beliefs and expectations transformed into a more nuanced view of gynecological visits and how communication during medical encounters may be improved. This chapter describes this research process and the theoretical underpinnings of the study.
RESEARCH METHODS

Site Characteristics

This study was conducted in an urban academic family medicine setting; the two research locations were part of a federally-qualified health center (FQHC) network, which was also a patient-centered medical home. While some specific information cannot be provided about the research sites to protect patient and provider confidentiality, the overall clinic system (including the two sites) served over 100,000 patients (over 50% were females of reproductive age, 15-44 years old) per year. The clinics offered comprehensive medical care, including primary, behavioral health, dental and social services. Some locations focused on particular medical issues, while others are for patients for wide-ranging health issues and concerns. A majority of clinic system patients identified as Hispanic/Latino or Black/African American, resided in public housing, had incomes at or below 200% of poverty level, and the primary payer source for clinic services was Medicaid, followed by private insurance. The patient populations at both research sites were comparable, and the sites were located in the same county.

At the research sites, patients could make appointments to be seen by specific medical providers (i.e. their established PCP, or specialist), or they could come to the clinic during walk-in hours to be seen by on-call clinicians. Without a specific appointment, wait times were longer, as patients were triaged in a separate area by another medical provider before being sent to a specific provider based on their medical complaint. At each research site, there was a primary care team comprised of a practice administrator, family medicine providers (medical doctors [MD], nurse practitioners [NP], doctors of osteopathic medicine [DO], and physician assistants [PA]), a nurse manager, nursing staff (registered nurses [RN] and licensed practical nurses [LPN]), and medical office assistants (MOA).
As far as reproductive health services, the two research sites specifically offered comprehensive care, including: contraception (pills and LARCs), HIV/STI screening and treatment, Pap smears, colposcopy and endometrial biopsy, and other obstetric and gynecological care. The clinic system offered a number of fellowships for providers, including one in reproductive health care for family medicine. Furthermore, in-house trainings were offered to clinical staff regarding women’s reproductive health and trauma-informed care. For female patients needing reproductive health services, there were specific days at the research sites when gynecological procedures (colposcopy, biopsy, IUD placement, etc.) were scheduled. Patients were also seen for gynecological care if they made a specific appointment with a provider, or if they had an acute gynecological complaint during walk-in hours. If a female patient had an appointment for an annual medical check-up, the electronic health record (EHR) would alert the provider if the patient was overdue for a Pap smear, and a pelvic exam and testing could be done at that visit.

Theoretical Frameworks for Study and Interview Guide Development

I used the following theories and constructs to develop this study and the interview guides used to collect the qualitative data: framing theory, narrative ethnography, phenomenological psychology (specifically, autobiographical theory), and feminist theory. However, as the study progressed, I revised the theory base that I used during the later stages. I will discuss each theory or construct briefly below.

To develop my research protocols, I began with framing theory, which was particularly useful for understanding sexual health and behavior from the perspectives of patients and providers. Frames are short cognitive tools that individuals utilize to make sense of and convey complex information. Influencing these frames are scripts, which are commonly shared
gender- and culture-specific guides for behavior\textsuperscript{184}; gendered sexual scripts and language are shown to dominate at the cultural level, but may not at the individual level.\textsuperscript{185} Therefore, how individual patients and providers frame certain concepts and issues, such as those included in sexual histories, can impact meaning conveyed and understood by either participant in the encounter.\textsuperscript{176,186} I used this approach to develop my research question pertaining to Aim 1.

Subsequently, I developed additional research questions for Aims 2, 3, and 4 which sought to explore the significance of lived experiences upon medical interactions, as well as the context in which medical interactions take place. Narrative ethnography\textsuperscript{187,188} seeks to balance storytelling with the social context in which important everyday life experiences take place; hence, both narratives and ethnographic descriptions are equivalent to the other during analysis and discussion.\textsuperscript{189} Autobiographical theory\textsuperscript{190-192} seeks to describe how stories about self are influenced by temporality, trauma, society, culture, and other factors.\textsuperscript{193} These approaches, in addition to the ecological model,\textsuperscript{194} were highly relevant to conceptualizing if and how intrapersonal, interpersonal, institutional, and structural factors and policies impact framing of sexual biographies and behaviors, and the experience of gynecological care for both patients and providers.

With regard to research in gynecological care settings, early work in the 1960’s through the 1980’s applied feminist theoretical constructs to understanding power dynamics between female patients and gynecologists, who were overwhelmingly male, at that point in time.\textsuperscript{195-201} Since then, feminist approaches have rarely been applied to how patients and providers communicate, interact, and understand and gain information about sexual health.\textsuperscript{131,132,202,203} Oftentimes, these approaches have been used to better understand communication and care between patients and nurses.\textsuperscript{204,205} Feminist theory constructs aim to dispel gender hierarchies by promoting full, empowered participation of patients and providers in communication, as well as
ensuring that patient well-being is defined as including equitable access to material and symbolic resources and a voice in the distribution of those resources. Furthermore, constructs suggest alternatives to socially normative, gendered communication processes during medical encounters and in other contexts, as well as promoting relationships that are fulfilling and honoring of men and women as full and equal human beings. Due to the cited differences in how gender affects conversations around sexual histories, applying feminist theoretical constructs to health communication and narrative research about this topic seemed worthwhile.

From the above theories and concepts, I generated a conceptual framework for this study (Figure 3). At the time, I anticipated that patients might have to provide a written sexual history during intake; other clinic systems and private doctor’s offices often provide health history forms for patients to fill out prior to their medical visit. I hypothesized that the written sexual history influences the sexual history taking process within the medical encounter. Both the written and narrative sexual history can be affected by the health and fundamental literacy level of the patient, which is included in the framework.

Based on this conceptual framework I was using, I developed separate interview guides (Appendix A) for patients and providers with open-ended questions to capture a number of domains (Table 3). I also included a few questions directly from other studies or modified them to address this study’s research questions and audience. The aim was to explore how patients and providers think about and describe certain sexual health concepts and issues during gynecological care encounters, as well as their perspectives on the sexual history taking process and sexual health discussions.

Before the study began, it was apparent that it would not be feasible to match providers with a participating patient, and interview both after the same encounter. Providers were limited
in time; after a visit with a participating patient, they almost always had other patients to see, charting, a hospital rotation, or their shift at the clinic had ended. Therefore, during their interviews, participating providers were asked to recall a recent medical encounter involving a pelvic exam (for any reason). Nevertheless, 5 participating patients were interviewed after encounters with providers who also took part in the study (although they were not interviewed on the same day). In lieu of matching, patients and providers were recruited from the same clinic sites, and therefore, their experiences should represent the experiences of other providers and patients at those clinics. Additionally, the questions in both interview guides are exactly the same or only slightly modified based on respondent type so that comparisons could be made between patients and providers. A few domains included in the interview guides, such as where study participants received sexual health education in the past and sexual health discussions outside of the medical environment, are not described in this dissertation; the findings will be presented elsewhere.

**Recruitment and Informed Consent Procedures**

In May 2017, after receiving IRB approval from the City University of New York (CUNY) Graduate School of Public Health and Health Policy (Appendix B) and the overall clinic system (not shown), a research assistant (RA) with expertise in public health and I recruited patients and providers once a week at the two research sites; study enrollment and interviews occurred concurrently. At the beginning of the study, the RA and I were introduced by physician champions during team meetings at the beginning of each shift change. Physician champions were a select number of providers at each research site who were involved with refinement of study procedures prior to gaining research site and IRB approval, and assisted with recruitment of study participants. Towards the end of the study, introductions and study updates during team meetings were not necessary, as the RA and I were already known to clinic staff.
Patients were recruited in-person by clinic staff. At team meetings and throughout clinic sessions, the RA and I briefly discussed the study and patient recruitment targets with staff who were present. Providers and nursing staff were given patient recruitment flyers and a short recruitment script; those providers and nursing staff were encouraged to mention the study and provide flyers to female patients who just received or recently had a visit involving a pelvic exam (a proxy for gynecological care). All recruitment materials included the study name (P³ Study: Patient and Provider Perspectives on Sexual History Taking) and a logo (with pink and green colors) for branding purposes.

Since we were only present at the research sites once a week (or less towards the end of the study), the RA and I tried to be at the clinics on specific days when gynecological procedures were scheduled, as there was a greater likelihood of visits involving pelvic exams. For recall purposes, interviews with patients took place immediately after or up to 1 week after the visit. The flyer stated that, if patients were interested in participating, they should let a clinic staff member know about their interest. The provider or nursing staff member then notified me or the RA about a potential participant.

After notification, the RA or I introduced ourselves to the potential participant (usually in an exam room), discussed the purpose and procedures of the study, and asked the patient to complete a brief eligibility screening instrument, if they were interested in study participation. The screener was programmed as a survey (Qualtrics International, Inc.), and patients used a tablet to input their answers to maintain confidentiality; during the screening process, often, a clinic staff member was still in the exam room collecting blood samples from the patient or administering immunizations. Patients were asked about the following: 1) current age; 2) gender identity; 3) race and ethnicity; 4) county of residence; 5) type of health insurance; 6) current religious affiliation;
7) if they were a new or established patient; 8) if they had a pelvic exam during the visit; 9) if they had engaged in sexual activity during their lifetime; and, 10) pregnancy intention during study period.

Eligible patients had to meet the following criteria: identify as female; aged 18 to 44 years old; a new or established patient at either research site; recent medical visit (within 1 week) with a pelvic exam (for any reason); reporting sexual activity (oral, vaginal, anal sex) in their lifetime. In addition, patients needed to be able to speak and read English, since screening procedures and interviews were conducted in English. Patients were ineligible for the study if they were pregnant at the time of recruitment, and had evidence of active severe mental illness that would interfere with the ability to participate. Evidence of mental illness was assessed by the providers and nursing staff who offered flyers to female patients who just received or recently had a visit involving a pelvic exam. A total of 22 patients completed the screening process, and 4 patients were not eligible for the study based on their answers to the screener, and thus, were not able to participate in the study.

After screening, the RA or I further discussed the purpose and procedures of the study with eligible patients, and we informed them that their decision to participate had no impact on the care they receive(d) at the clinic, and that their identity would remain confidential. We discussed the incentive for study participation which was $35 cash and a round-trip transit card. Interested, eligible patients were given a consent form to read and sign before participating in the study; any questions about study participation were answered by me or me.

We aimed to recruit 18 female patients between the ages of 18-44 years of age who had a recent medical visit with a pelvic exam. The patient sample was stratified by age (18-24, 25-34, 35-44). Once all of the planned interviews were completed for each age group (n=6 interviews),
no additional enrollment or interviews took place with participants in that category. We attempted to enroll equal numbers of patients (3 patients from each age group) from each research site (n=2); however, this was not possible due to one of the clinic sites moving to a different location during the study. The new clinic location was not well-structured for patient recruitment and interviews, and thus, we ended our recruitment efforts at that site, and focused on the other clinic location. In reality, we were able to recruit 15 patients from site 1, and 3 from site 2. Despite those recruitment difficulties, we were able to interview 6 patients from each age group. Since the providers and nursing staff approached patients with study flyers prior to the RA and I, the actual number of non-respondents is unknown; however, after we discussed study participation with patients indicated they were interested, there were 4 patients who were no longer interested or who did not have time that day to participate, and thus could be considered non-responders. Recruitment of patients ended in January 2019, after a gap in recruitment from August to December 2018 due my work schedule.

Providers were recruited in-person through brief presentations (by me, the RA or physician champions) at team meetings at the beginning of each shift change, recruitment flyers placed in provider mailboxes, and using departmental email announcements (with a recruitment flyer attached). The clinic system itself encouraged providers to participate in research activities being conducted at the clinics. Interested providers were directed to contact the RA in-person, or me by email or phone to determine eligibility. Once notified of their interest, I arranged to meet the providers at one of the two research sites in a private room (office, exam or conference room), discussed the purpose and procedures of the study, and asked the provider to complete a brief eligibility screening instrument on an iPad, if they were interested in study participation. The questions were programmed as a survey (using Qualtrics) and the providers used a tablet to input their answers. Providers were asked about the following: 1) gender identity; 2) provider type; 3)
provider specialty; 4) clinic locations where they practice; 5) clinic location where they spend a majority of their time; and, 6) number of pelvic exams conducted per week (categorical answer).

Providers were eligible to participate in the study if they were an attending family medicine physician, fellow, or nurse practitioner within the overall clinic system, and provided gynecological care (average of 3 or more pelvic exams per week) at one (or both) of the research sites. Given that some of the providers practiced at multiple clinic locations, during the screening process, they were asked what percentage of their time is spent at either of the two research sites. The provider was classified as providing care at the location where they spent the most time. Providers also needed to be able to speak and read English, since screening procedures and interviews were conducted in English. Providers were ineligible if they conducted an average of less than 3 pelvic exams per week, and/or practiced obstetric care exclusively. A total of 9 providers completed the screening process, and all were eligible for the study based on their answers.

After screening, I further discussed the purpose and procedures of the study with eligible providers, informed them that their decision to participate had no impact on their employment with the clinic system, and that their identity would remain confidential. I also discussed that there was no incentive provided for participation except for snacks at a future staff meeting. Interested, eligible providers were given a consent form to read and sign before participating in the study; I answered any questions they had prior to study participation.

We aimed to recruit 12 providers from the two research sites, and attempted to enroll equal numbers from each location (6 providers from each site); this was not possible due to recruitment difficulties discussed later. In actuality, we were able to recruit 5 providers from site 1, and 4 from site 2. We also attempted to enroll equal numbers of male (n=6) and female (n=6) providers;
however, this was also not possible. We had difficulties recruiting male providers and, after attempting for several months, we decided that recruiting additional female provider participants would be necessary. There were approximately 30 female and 25 male providers at both sites, and so there were approximately 21 and 25 non-respondents, respectively. Therefore, this study includes the perspectives of 9 providers who identified as female. Recruitment of providers ended in August 2018.

**Participant Characteristics**

A Grounded Theory approach informed the sampling procedures in this study (range of age groups and provider types); thus, various perspectives and experiences of gynecological care were collected so patterns of and relationships to social structures and processes could be explored.\(^{210}\) Non-probability sampling methods (purposive, non-proportional quota sampling) were used to select study participants via inclusion and exclusion criteria.

**Female Patients**

Eighteen female patients participated in the study (*Table 4*). The mean age of the patients was 29.2 years. A majority of participants identified as African American (44.4%) or Latina (27.8%), and most (72.2%) lived in the same county as the clinic they visited. For a few patients (11.1%), it was their first time visiting that clinic location. A majority were insured by Medicaid (55.6%), and more than half (55.6%) were agnostic or did not have a current religious affiliation.

**Family Medicine Providers**

Nine providers participated in the study (*Table 5*). All identified as female, and the mean age was 35.3 years. A majority identified as White, Caucasian or European American (66.7%). Most were trained as family medicine physicians (66.7%), and more than half had specialized
training in reproductive health (55.6%). Participants had a wide range in practice experience from 2 to 16 years.

*Interview Procedures*

As stated above, patient and provider interviews were conducted separately. Interviews were conducted in a similar manner with a few exceptions. For patients, if they decided to participate in the study, I conducted the interview immediately after the screening and consent processes were completed, or scheduled the interview within a week after their exam. If providers decided to participate in the study, I conducted the interview immediately after the screening and consent processes. Interviews were conducted in a private room (office, exam or conference room) at either research site. The in-depth, semi-structured interviews ranged between 30-90 minutes, and they were recorded using a digital voice recorder for clarity. Study participants were able to end the interview, and thus, the audio-recording, at any point. However, no participant expressed a desire to end their participation in the study. After the interview, providers were also asked to provide some demographic information (patient demographics were included in the eligibility screener). Much like the eligibility screening instrument, demographic questions for providers were programmed as a survey and the provider used a tablet to input their answers. Providers were asked to provide the following: 1) current age; 2) race and ethnicity; 3) if they completed training in a sub-specialty(ies); 4) if they completed a fellowship; 5) any additional training; 6) length of practice; 7) average hours worked per week; 8) average patient load per week; and, 9) average number of pelvic exams conducted per week (see Table 5).

All interviews were transcribed (Landmark Associates, Tempe, AZ). Transcripts were redacted to exclude names and any other identifying information the interviewee divulged. Confidentiality was further maintained by keeping audio-recordings and transcripts separate from
consent forms and any other potentially identifying information, such as receipts for incentives. And, to better ensure confidentiality, the study incentive receipt form for patients only required participant initials. Audio-recordings were given a code number, and there was no file linking participants' names to recordings. Recordings, transcripts and qualitative analyses were stored in a password-protected file only accessible to approved study team members.

Qualitative Data Analyses

Analyses were conducted with the assistance of NVivo 12 Plus (QSR International, Melbourne, AU), a qualitative analysis software package. Initial coding of select transcripts was conducted by 3 physician champions, myself, and the RA, while data collection was still ongoing. This coding was combined with a more thorough process conducted by a coding team of three members (myself, the RA, and a medical student [MS] with expertise in narrative medicine). During this process, we openly coded randomly-selected interview transcripts to generate some initial concepts emerging from the data itself.211-213 Next, we engaged in multiple rounds of discussion (consensus coding) during 6 separate meetings to agree upon a list of defined codes, otherwise known as a codebook.211,214 This was an iterative process, which constantly incorporated revisions from new observations during any subsequent interviews and transcript coding sessions.211 Once the initial codes were defined, the categories were consolidated and separated into core concepts and preliminary themes (see Tables 6-9).211,215 Throughout this process, patient and provider transcripts were analyzed separately. Inter-rater reliability was calculated by checking the agreement between two coders (myself and RA), and was found to be adequate (i.e., >88%).211,215 Additionally, since it was hypothesized that there may be similarities and differences between how patients and providers frame sexual health concepts and navigate sexual history taking and sexual health discussions, the constant comparison method was used to identify
categories that were related; this method requires that a pattern of language be recorded, then separated into discrete concepts that are compared between participants.211,216,217

In the data analysis phase, I revisited the aforementioned theoretical concepts from framing theory, narrative ethnography, autobiographical theory, and feminist theory. Grounded Theory allows data collection and preliminary findings to guide an iterative review and revisions of the researcher’s initial conceptual framework.218 During the re-evaluation, I felt that narrative ethnography would not be the best fit for this study. It was evident that, while the medical environment (in a broad sense) is relevant and important to keep in mind, patients and providers did not view the actual clinic spaces as important factors. While the general concept of narrative ethnography can still be applied to this study, it is not a strong focus, and the other theories (framing, autobiographical and feminist), as well as a new addition (sexual scripting) are more relevant.

Scripting theory posits that there are commonly shared gender- and culture-specific guides for behavior among individuals within a society.184 This theory has been specifically applied to understanding sexual behavior and the language used around sexual behavior. Sexual scripting theory suggests that, while those gender-specific guides may direct sexual behavior and language around sex at the cultural level, there may be more variation at the individual level.185 When applying this theoretical framework to coding and data analysis in this study, I was interested in patient and provider definitions of sexual health, how those definitions are influenced by society-at-large and the culture in which the patients and providers were situated, and how patients and providers have modified or internalized the gender- and culture-based sexual scripts to create their own meaning around sexual health.
In addition to sexual scripting theory, framing theory, as discussed earlier, was applied to the qualitative analysis of patient and provider interviews. Upon reexamination of the literature, I was reminded that there are varying approaches to framing, and those approaches have been described as difficult to distinguish from each other. Despite that, most sources cite Bateson and Goffman as the seminal works,\textsuperscript{219,220} thereby influencing subsequent work in linguistics, cognitive psychology, sociology and anthropology. However, I would be remiss if I did not acknowledge the influence of Bartlett,\textsuperscript{221} Chafe,\textsuperscript{222} and Shank and Abelson\textsuperscript{184} upon subsequent work and my conceptualization of framing.

In searching for a way to describe how perceptions and knowledge contribute to the construction of meaning, the work of Deborah Tannen (who draws from Bateson and Goffman) seemed the most applicable to analyzing the framing of sexual health and behavior by patients and providers within and outside of the medical encounter.\textsuperscript{223} In her book, “Framing in Discourse,” Tannen describes a dynamic interplay between perceptions, expectations, and interpretations, and subsequent language production.\textsuperscript{223} She also provides her definition of knowledge schemas which are dynamically influenced by an individual’s expectations of the world around them. Additionally, I found Cicourel’s views on history taking during medical encounters and the ways in which medical histories illuminate belief structures of patients and providers applicable to this study.\textsuperscript{177} Also, the overviews of framing theory and how it has been applied to medical discourse provided by Chenail\textsuperscript{224} and MacLachlan and Reid\textsuperscript{225} were particularly helpful.

In **Figure 4**, I have included a schematic of the various elements, and how I conceptualized them working together for the patients and providers to produce the outcome (framing of sexual health). I visualized cultural or social scripts (commonly shared gender- and culture-specific guides for behavior) influencing the medical encounter, as a whole.\textsuperscript{184} Both the speaker and listener
arrive to the encounter with knowledge schemas (stores of information and beliefs from prior experiences) that form their structures of expectations (measuring perception of new experiences against knowledge schema) around the medical exam and conversation within the encounter.\textsuperscript{177,223}

For both participants of the conversation (speaker and listener), social scripts, prior knowledge/beliefs, expectations and the context or situation in which verbalization takes place (i.e. medical encounter) provide a framework for establishing meaning.

According to Tannen, meaning is generated from relating new persons, objects or events to similar ones from the past.\textsuperscript{225} In my schematic, the frame (generated from the framework) envelopes the conveyed information comprised of a message (meaning of words) and metamessages (linguistic and paralinguistic cues which guide interpretation of the message).\textsuperscript{223}

The process of framing and conveying information is interactive, indicated by the circular arrows. For the listener, interpretation of the speaker’s frame is influenced by the listener’s expectations and the context or situation. This process of interpretation is also dynamic, as there is a feedback loop between interpretation and the listener’s framework for understanding (social scripts, prior knowledge/beliefs, expectations and the context or situation). Comprehension of the speaker’s conveyed information occurs if there is consensus with the speaker’s frame and the listener’s interpretation of framing, and misunderstanding happens if there is disagreement. For this study, this conceptualization of framing (Figure 4) was used to code and analyze similarities and differences in the patient and provider interviews.

In addition to the theoretical frameworks, interrelated elements of discourse analysis, narrative analysis and phenomenological psychology were also used in the coding and analysis of patient and provider interviews. These analytic approaches specifically emphasize study participants’ stories, perceptions, and words, thus, prioritizing their lived experiences, rather than
focusing on the generation of theoretical concepts from the data. Discourse analysis was utilized to explore large sections of text (or speech) from the interviews, and to examine the context in which the meaning was created, such as the framing of sexual health by patients and providers. Narrative analysis was used to examine concrete narratives (from study participants) around highly subjective and very specific life situations, such as asking questions of a patient or provider during medical encounters, barriers and facilitators to accessing care, conducting or receiving a pelvic exam during a recent medical encounter, as well as past gynecological care experiences. Similarly, phenomenological psychology was utilized to simply describe what the experience of sexual history taking is like for female patients and their providers (i.e. how they navigate the process), and subsequently, use this description to identify common experiences and examine the sexual history taking process, as a whole.

SUMMARY OF STUDY DATA

While this study did not have the goal of generating theory, some theoretical precursors (i.e., core concepts and preliminary themes) were identified (see Chapters 3-6), as well as tentative linkages with other data described below. These linkages were generated by data triangulation, which is an analytic strategy that merges information from different sources to describe a phenomenon and test validity. Combining more than one method via triangulation helps to compensate for some of the biases and errors that arise with qualitative data collection. Firstly, the comprehensive literature review (Chapter 1) described specific intrapersonal, interpersonal, institutional and structural factors existing in current gynecological care specifically relating to sexual history taking and HIV/STI testing and treatment procedures. A significant part of the review involved a summary of national, state, and local policies and clinical practice guidelines from professional organizations. Aspects of these policies and guidelines will be
triangulated with lived experiences illustrated by patients and providers in interviews (see Chapter 7).\textsuperscript{211,231,232} Secondly, participant demographic data assisted in describing the research population and applicability of findings to similar populations. Descriptive statistics (Tables 4 & 5) were generated in SPSS from recruitment screeners and provider demographic surveys (after interviews).

Chapters 3-6 describe and provide examples of the preliminary themes generated from the qualitative analyses of patient and provider interviews. In Chapters 7 and 8, I will provide a synthesis of the data described above which will identify specific interpersonal, institutional and structural factors which may impact framing and gynecological care experiences, and propose future directions.
<table>
<thead>
<tr>
<th>Domain</th>
<th>Patient Question(s)</th>
<th>Provider Question(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Structural/Institutional influences</td>
<td>• When you first arrived at the clinic, what did you experience?</td>
<td>• When you first arrive at the clinic, what do you experience?</td>
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<tr>
<td></td>
<td>• What is it like in the waiting room?</td>
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<tr>
<td>Self-reported emotional state prior to visit</td>
<td>• What it is like to wait?\textsuperscript{207,208}</td>
<td>• What is it like before each session?</td>
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<tr>
<td></td>
<td>• Before going to the clinic, what did you expect to happen during the visit?</td>
<td>• Before going into the exam room, what did you expect to happen during the visit?</td>
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<tr>
<td>Expectations for medical visit</td>
<td>• Before going to the clinic, what did you expect to happen during the visit?</td>
<td>• Before going into the exam room, what did you expect to happen during the visit?</td>
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<tr>
<td></td>
<td></td>
<td>• Were you planning on doing a pelvic exam?</td>
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<tr>
<td>Influence of nursing staff</td>
<td>• Describe to me what it was like before you saw [the provider], when someone first took you into an exam room to ask you questions and take your blood pressure…</td>
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<tr>
<td></td>
<td>• Did they ask you about your sexual health?</td>
<td>Not included for providers</td>
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<td></td>
<td>• Tell me about the questions they asked…</td>
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<td></td>
<td>• How did you feel when they asked you those questions?</td>
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<tr>
<td>Framing of sexual health and behavior</td>
<td>• What does it mean to you when someone talks about “sexual health”?</td>
<td>• We’ve talked a lot about “sexual health”, but what does it mean to you?</td>
</tr>
<tr>
<td></td>
<td>• We’ve talked a lot in detail about “sexual health”, but do you have any further thoughts about what it means to you?</td>
<td>• How would you describe “sexual health” to a friend?</td>
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<td></td>
<td>• How would you describe “sexual health” to a friend?</td>
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<tr>
<td>Recall and overall perceptions of the visit</td>
<td>• Tell me about how the visit with [the provider] actually went...</td>
<td>• Tell me about how the visit actually went...</td>
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<td></td>
<td>• What went well?</td>
<td>• What went well?</td>
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<td></td>
<td>• What could have gone differently?</td>
<td>• What could have gone differently?</td>
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<td></td>
<td>• Did anything surprise you?</td>
<td>• Did anything surprise you?</td>
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<tr>
<td>Overall patient-provider communication</td>
<td>How did you feel overall about the experience?</td>
<td>How did you feel overall about the experience?</td>
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<td>How did you bring up any issues or concerns during the exam, if you had any?</td>
<td>How did you respond to the patient’s issues or concerns?</td>
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<tr>
<td>Perceptions of sexual history taking</td>
<td>Did you and [the provider] discuss your sexual health?</td>
<td>Did you talk about sexual health?</td>
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<tr>
<td>How did you feel during the discussion?</td>
<td>Did you feel during the discussion?</td>
<td></td>
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<tr>
<td>Have you discussed your sexual health with healthcare providers in the past?</td>
<td>Have you discussed sexual health topics with this patient in the past?</td>
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<tr>
<td>How was this discussion similar or different?</td>
<td>How was this time similar or different?</td>
<td></td>
</tr>
<tr>
<td>Patient-provider communication about sexual health</td>
<td>Did you and [the provider] discuss your sexual health?</td>
<td>Did you talk about sexual health?</td>
</tr>
<tr>
<td>Who started the conversation?</td>
<td>Did you initiate the discussion about sexual health or did the patient?</td>
<td></td>
</tr>
<tr>
<td>What did you discuss?</td>
<td>Did the EHR assist you with this?</td>
<td></td>
</tr>
<tr>
<td>When you and [the provider] discussed [cited topics], were things explained in a way that made sense?</td>
<td>Tell me about what was discussed and how…</td>
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<tr>
<td>Was anything confusing?</td>
<td>Were there any sexual health topics not brought up that you wished had been?</td>
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<tr>
<td>Did you ask the provider any questions?</td>
<td>Why do you think they didn’t come up?</td>
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<tr>
<td>Were there any sexual health topics not brought up that you wished had been?</td>
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<tr>
<td>Why do you think that is?</td>
<td></td>
<td></td>
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<tr>
<td>Navigating sexual history taking</td>
<td>Did you find it easy or difficult to discuss sexual health matters with [the provider]?</td>
<td>In your experience, what is an effective way to gather sexual history information from patients?</td>
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<tr>
<td>Did you initiate the discussion about sexual health or did the patient?</td>
<td>How do your patients respond to this method of history taking?</td>
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<tr>
<td>Did the EHR assist you with this?</td>
<td>How do you navigate/explain complex medical terminology during discussions with your patients?</td>
<td></td>
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<tr>
<td>Sexual history taking guidance</td>
<td><strong>Not included for patients</strong></td>
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<td></td>
</tr>
<tr>
<td><strong>Personal</strong>...</td>
<td><strong>In the past, from which sources, if any, have you received guidance about how to discuss sexual health with patients?</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Why do you think that is?</strong></td>
<td><strong>How do you think that guidance impacted your sexual history taking “style”?</strong></td>
<td></td>
</tr>
<tr>
<td><strong>What would need to change in order for it to be easier?</strong></td>
<td><strong>Where did you first learn how to take a sexual history?</strong></td>
<td></td>
</tr>
<tr>
<td><strong>What was your experience?</strong></td>
<td><strong>What information did you need, if any, in order to ask those questions?</strong></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Knowledge schema</th>
<th><strong>What do you think they wanted to know when they asked about [topics from the questions the patient mentions]?</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Why do you think they ask those questions about sexual health before you see the doctor?</strong></td>
</tr>
<tr>
<td></td>
<td><strong>What pieces of information did you think were important to tell [the provider]?</strong></td>
</tr>
<tr>
<td></td>
<td><strong>How do you think the information you provided affected (positively or negatively) the care you received?</strong></td>
</tr>
<tr>
<td></td>
<td><strong>What information did you need, if any, in order to ask those questions?</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Acceptability of sexual history taking</th>
<th><strong>Do you think it’s [the provider’s] job to ask questions about your sexual health? Why or why not?</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>At what point should a provider ask questions about the patient’s sexual health?</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Perceptions of sexual healthcare</th>
<th><strong>In your opinion, what are the kinds of sexual health concerns healthcare providers can help patients with?</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>In your experience, what are the kinds of sexual health issues providers can help patients with?</strong></td>
</tr>
<tr>
<td>Communication preferences</td>
<td>Are there any sexual health concerns that, maybe, a provider may not be able to help with?</td>
</tr>
<tr>
<td>---------------------------</td>
<td>------------------------------------------------------------------------------------------</td>
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<tr>
<td></td>
<td>Can you describe what would be an ideal conversation about sexual health between a patient and their provider, in your opinion?</td>
</tr>
<tr>
<td></td>
<td>What would a bad conversation look like?</td>
</tr>
<tr>
<td></td>
<td>What would be the most comfortable way for you, personally, to get sexual health information?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Suggestions for improvements</th>
<th>In your opinion, what would make discussions with [the provider] about sexual health matters better?</th>
<th>With regard to sexual health topics, what questions, if any, should providers ask patients?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>With regard to sexual health topics, what questions, if any, should providers ask patients?</td>
<td>What topics, if any, should providers stay away from?</td>
</tr>
<tr>
<td></td>
<td>What topics, if any, should providers stay away from?</td>
<td>In your opinion, what are the kinds of things patients should tell providers about?</td>
</tr>
<tr>
<td></td>
<td>What are the kinds of things patients should tell providers about?</td>
<td>Is there anything patients shouldn’t tell providers?</td>
</tr>
<tr>
<td></td>
<td>Is there anything patients shouldn’t tell providers?</td>
<td>What questions, if any, should patients ask providers?</td>
</tr>
<tr>
<td></td>
<td>What questions, if any, should patients ask providers?</td>
<td>What are some ways patients can improve sexual health discussions during medical visits?</td>
</tr>
<tr>
<td></td>
<td>In your opinion, what information do patients need, if any, in order to ask questions?</td>
<td>In your opinion, what are some ways providers could improve how they ask about sexual health issues?</td>
</tr>
<tr>
<td></td>
<td>In your opinion, what are some ways patients can improve sexual health discussions during medical visits?</td>
<td>How could providers improve giving sexual health information to patients?</td>
</tr>
<tr>
<td></td>
<td>What are some ways doctors and nurses could improve how they ask about sexual health issues?</td>
<td></td>
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<tr>
<td></td>
<td>How could providers improve giving sexual health information to patients?</td>
<td></td>
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</tbody>
</table>
## Table 4. Interview participant characteristics, patients

<table>
<thead>
<tr>
<th>Total Number of Participants</th>
<th>N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Site 1</td>
<td>15 (83.3)</td>
</tr>
<tr>
<td>Site 2</td>
<td>3 (16.7)</td>
</tr>
</tbody>
</table>

### Demographics

<table>
<thead>
<tr>
<th>Age (mean)</th>
<th>29.2 years</th>
</tr>
</thead>
</table>

### Race/Ethnicity

<table>
<thead>
<tr>
<th>% of total</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>African-American or Black</td>
<td>44.4%</td>
</tr>
<tr>
<td>Hispanic or Latina</td>
<td>27.8%</td>
</tr>
<tr>
<td>White, Caucasian or European American</td>
<td>11.1%</td>
</tr>
<tr>
<td>Multiracial</td>
<td>11.1%</td>
</tr>
<tr>
<td>Caribbean or West Indian</td>
<td>5.6%</td>
</tr>
</tbody>
</table>

### Residing in Same County as Clinic

<table>
<thead>
<tr>
<th></th>
<th>72.2%</th>
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</table>

### First Time Visiting Clinic Location

<table>
<thead>
<tr>
<th></th>
<th>11.1%</th>
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### Health Insurance Status

<p>| | |</p>
<table>
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<tr>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Medicaid</td>
<td>55.6%</td>
</tr>
<tr>
<td>Employer-Sponsored or Private Insurance</td>
<td>33.3%</td>
</tr>
</tbody>
</table>

### Current Religious Affiliation

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Not religious or agnostic</td>
<td>55.6%</td>
</tr>
<tr>
<td>Roman Catholic</td>
<td>11.1%</td>
</tr>
<tr>
<td>Christian</td>
<td>16.7%</td>
</tr>
<tr>
<td>Baptist</td>
<td>5.6%</td>
</tr>
<tr>
<td>Hindu</td>
<td>5.6%</td>
</tr>
</tbody>
</table>
Table 5. Interview participant characteristics, providers

<table>
<thead>
<tr>
<th>Total Number of Participants</th>
<th>N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Site 1</td>
<td>5 (55.6)</td>
</tr>
<tr>
<td>Site 2</td>
<td>4 (44.4)</td>
</tr>
</tbody>
</table>

Demographics

<table>
<thead>
<tr>
<th>Age (mean)</th>
<th>35.3 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender % of total</td>
<td>% of total</td>
</tr>
<tr>
<td>Female</td>
<td>100%</td>
</tr>
</tbody>
</table>

Race/Ethnicity

| White, Caucasian or European American | 66.7% |
| Other Race and Ethnicity*             | 33.3% |

Years in Practice (median)

| 4 years |

Professional Training

| Physician | 6 |
| Nurse Practitioner | 3 |

Specialized Training#

| Obstetrics/Gynecology | 2 |
| Reproductive Health   | 5 |
| Sexual Health and/or Sexuality | 2 |
| HIV Treatment & Care  | 1 |

Average Hours Worked Per Week

| 41.7 hours |

Average Patient Load Per Week

| 56.1 patients |

*Aggregated to protect confidentiality; #Participants were able to select more than one response
Figure 3. Conceptual Framework

Gynecological Care Experience

Structural Factors: Governmental Policies, Economic, Laws, Past scientific research, Professional Associations, Cultural/Sexual Scripts, Social Norms

Institutional Factors: Practice Policies, Medical Environment, Insurance Policies

Prior to Exam

During Exam

Interpersonal Factors: Cultural Expressions, Stigma, Social/Emotional Support, Social Networks

Intrapersonal Factors: Gender, Age, Race/Ethnicity, Primary Language, Bias, Perceptions, Literacy Level, Emotional State, Parity, Past and Current Medical Conditions, Insurance Status, Past medical encounters, IPV, Sexual assault

Provider

Action: Sexual History Taking

Outcomes:
Quality of Care
Patient Well-being

Patient

Action: Sexual History Narrative

Influences on Written Sexual History:
- Health Literacy Skills
- Fundamental Literacy Skills
- Current and Past Health Concerns
- Emotional State
- Past Medical Encounters

Influences on Sexual History Narrative:
- Knowledge
- Memories
- Concerns
- Family, Friends, Media
- Current and Past Intimate Relationships
- Written Sexual History
- Health Literacy Skills
Figure 4. Schematic of framing during medical encounters
SECTION II: FINDINGS

As described in Chapter 2, this study drew upon a number of theories to better understand patient and physician perspectives about sexual history taking and sexual health discussions. Firstly, framing and sexual scripting theories were applied during coding and analysis of how patients and providers define sexual health, and those findings are presented in Chapter 3: Framing of Sexual Health by Patients and Providers. Secondly, autobiographical theory was primarily utilized during the analysis of patient and provider descriptions of and feelings about gynecological care encounters. The findings are presented in Chapter 4: Navigating Sexual History Taking and Chapter 5: Barriers and Facilitators to Sexual History Taking and Discussions During Gynecological Care Encounters. Lastly, feminist theory was applied during the analysis of descriptions of medical encounters presented in Chapter 5, as well as to highlight the opinions and ideas of patients in Chapter 6: Suggestions for Improvements in Communication. Throughout Chapters 3-6, pseudonyms (chosen from common names in the decade that patients were born, and random street names in New York for providers) have been used to protect participant confidentiality, and are indicated by an asterisk (*).
CHAPTER 3 - Framing of Sexual Health by Patients and Providers

In the interviews, patients and providers were asked specifically about how they describe the term “sexual health”. Although the term was used liberally throughout the interviews and on recruitment materials, interviewees were never offered a definition of the term, but rather, were asked to define what they thought the term meant to them. Patients were asked twice during the interview, once at the beginning after they were asked about clinic experiences before they saw the provider (“Because we’ll be talking about it a lot, what does it mean to you when someone talks about ‘sexual health’?”), and at the very end of the interview (“We’ve talked a lot in detail about ‘sexual health’, but do you have any further thoughts about what it means to you?”). Providers were asked about their description of the term only at the very end of the interview; the last question being: “We’ve talked a lot about “sexual health”, but what does it mean to you?” The thematic findings from these questions during interviews with patients and providers are discussed below and are outlined in Table 6.

PATIENTS

In response to the questions above, patients shared varying descriptions of what sexual health meant to them. Some definitions were given with conviction, others were a result of contemplation and reflection, and a few were explained with hesitancy or doubt about their correctness. Often times, the second question elicited a richer explanation of sexual health, but interviewees were generally consistent in their descriptions. When asked if they had further thoughts about what sexual health meant to them, some patients would preface their response in a contemplative way, such as “as we’ve been talking, I’ve been thinking…”. While there were variations within their own descriptions throughout the interviews and among interviewees, patients did share common ways of talking and thinking about sexual health and behavior. Three
themes emerged regarding how sexual health was defined by patients, which we coded as: 1) Risk-based/Protection Definition; 2) Holistic View of Sexual Health; and, 3) Internalized Messages (see Table 6). There were also sub-themes that we coded within the Risk-based/Protection Definition: 1a) “Take Care of Your Organs”, as well as within the Internalized Messages theme: 3a) Hyper-alert, Fear and Danger; 3b) Shame and Stigma; and, 3c) Following the Rules. Next, these themes will be described and exemplar quotes will be presented.

Risk-based/Protection Definition

A majority of patients (16 out of 18) described sexual health and behavior through what we interpreted as a risk-based and/or protection lens. We coded this as a Risk-Based and/or Protection Definition when the patient’s description of sexual health almost exclusively referenced protection (e.g. condoms, testing, birth control, etc.) from HIV, STIs and pregnancy, as well as an individual’s risk of acquiring STIs and/or becoming pregnant. Some interviewees gave lengthy explanations, while others were quite succinct. In the case of those who gave brief responses, the interviewer prompted clarification around what a patient meant by protection, prevention or risk.

When asked about her definition of sexual health at the end of her interview, Alisha*, aged 25-34, reiterated the framing she used throughout, which included protection and prevention of HIV/STIs and remaining healthy. However, here, she expounds upon her description of prevention to include pregnancy intention and timing.

*Interviewee:  What does sexual health mean to me? I feel like I’m repeating myself, but to me sexual health—everyone, not everyone, but the majority of people are born healthy. I think sexual health to me is just maintaining that healthiness and just being preventive—preventive measures, as much as possible. That’s what sexual health means to me….

*Interviewer: So, preventing…
Interviewee: Preventing anything that you do not want to happen as far as STDs, even pregnancies. Not everyone wants to get pregnant or it’s the right time to get pregnant, so all types of prevention. Just maintaining your sexual health.

After asking me how I would define sexual health (a definition was not given) at the end of her interview, Carmen*, aged 25-34, offered further thoughts on what sexual health meant to her. She qualified her description by stating that, in the medical context, she viewed sexual health as reproductive health issues and how HIV/STIs can be transmitted. While explaining her definition, without pausing, she also felt it was important to suggest patient education around HIV/STI transmission, particularly when a patient is asking for and/or receiving testing.

To me, it’s [sexual health] just everything that has to do with, well, in this context, concerns... Like sexual concerns with the reproductive system, with HIV/AIDS. The list of things that can be transmitted and how. I think that information should be shared if the person doesn’t know what’s going on. Often times, people don’t know how things are transmitted from one person to another. I think that when they’re [medical providers] asking [about testing], even for HIV/AIDS, if a person was to get it [testing] they [medical providers] should at least provide some information even if the person knows about the importance of getting that checked and things like that.

Another patient, Marissa*, aged 18-24, acknowledged that she had not thought about what sexual health meant prior to the interview, and reflected on how her medical visit that day affected her understanding of the term. Particularly, she mentions the word of caution told by her provider, as well as current and future implications of STIs to one’s health.

Sexual health, I guess... At first, I didn’t even really take any time to think about sexual health in all reality until... Even just now, I mean, I’ve had an idea about what it was, but just now, this doctor... It’s my first time actually seeing her. She made it so graphic, I guess. “If you’re having sex and you have a certain kind of STD, or urinary tract infection,” she’s like, “that can affect your fertility stuff.” It can have different effects on you future-wise or just taking a toll on your health and you being sick, being a teen.

Another patient, Rocio*, aged 35-44, was tentative throughout her interview, and hesitated to give a detailed definition of sexual health when asked at the beginning of her interview.
However, when prompted, she did slightly expand her description to include how an individual is protecting themselves from STIs and other unnamed risks.

*Interviewer:* Since we'll be talking about it a lot, what does it mean to you when someone talks about sexual health?

*Interviewee:* I mean—using protection and [laughter]—

*Interviewer:* Just using protection. Anything else that comes to mind?

*Interviewee:* I mean, like the—all the stuff that's going on basically, like with the STDs and all that, yeah.

*Interviewer:* Using protection and then STDs?

*Interviewee:* Yes. How are you protecting yourself and all…

For some patients, recent medical issues shaped their framing of sexual health. At the beginning of her interview, Tania*, aged 18-24, pondered what sexual health meant to her, and ultimately, talked about how recently testing positive for an STI influenced her current view of sexual health. She also described what she considers safe sex to be, including reasons why she believes certain methods are not protective.

*Interviewee:* I think when sex—the word, or it's actually two words—but when sexual health comes up is basically—

*Interviewer:* Take your time…

*Interviewee:* What it means to me is, basically you have to keep… Just like the situation with me [testing positive for an STI], you have to check up on yourself. You have to make sure that you're having safe sex… Because sex could lead to diseases, STDs, HIV, things that you didn't want, you know?

*Interviewer:* So, what would you consider safe sex to be?

*Interviewee:* Safe sex would be using a condom, honestly speaking. Because Depo, like birth control, those are only ways to stop you from getting pregnant. That's not something that stops you from receiving a disease, or chlamydia, gonorrhea, things like that. Using a condom does.
One patient, Kelsey*, aged 18-24, described sexual health with a precautionary mindset. During her interview, she talked about getting HIV/STI testing and a Pap smear (at the recommended interval) during her medical visit that day. Perhaps, for that reason, her definition includes prevention of cervical cancer. She goes on to explain that she views sexual health as seeking care before any health issues arise, in addition to assessing during sexual activity how one can better be protected.

I think it’s like thinking about safe sex practices and making sure you’re regularly checking up on if you have an STD or if you’re pregnant or if you might have a risk of cervical cancer - those sorts of things… I would describe it as proactive care as well as when you are having sex thinking about ‘how can I be protecting myself?’

“Take Care of Your Organs”

Within the Risk-based/Protection Definition theme, there was a sub-theme that existed throughout patients’ descriptions of sexual health. We coded this as “Take Care of Your Organs,” or the feeling of responsibility to self-monitor and/or to perform self-care by scheduling regular or emergency medical appointments to get checked by a healthcare provider (via pelvic exam, HIV/STI testing, pap smear, etc). Some patients described a rather systematic approach to making sure they were free from HIV/STIs, cervical cancer, pregnancy, and any other gynecological problem that they felt may occur. Along with discussing risk and protection, the phrases “take/taking care” and/or “make/making sure” were repeated throughout these descriptions, which we felt was important to distinguish from the higher level code of Risk-based/Protection Definition.

At the beginning of her interview, Ines*, aged 35-44, explained that her view of sexual health involves HIV/STI and number of sexual partners, but that, ultimately, it is determined by her own health. She went on to describe how often she gets medical checkups, and the self-assessment of risk and other reasons that drive her to seek medical care at specific intervals.
[Sexual health means] STDs, how many partners, HIV test, just making sure that my girl area is perfectly fine and stuff like that. It's always been just to make sure that—you know, even though that you have one partner, you never know what they're doing, so making sure I'm 100 percent okay... I'm in the clinic every six months, every three months.... It gets to the point that the doctors are like, why are you here now? You explain it to them like, listen, I might be just with one person, but that one person might be with ten other people because you never know. Listening to my mom and seeing what's been going on through the years makes you realize that you have to take care of yourself because nobody else is going to take care of you. Especially if you have kids, after that you're like, I'm going to be around for them. I don’t want to, God forbid, get a disease and not know about it and not do a follow up or a checkup. Then you're in your sick bed and you don’t even know why.

At the end of her interview, Tasha*, aged 35-44, restated her view of sexual health with additional detail and conviction. Similar to Ines, Tasha explained that she seeks medical care regularly for sexual health concerns, which is driven by a fear of HIV/AIDS to a certain degree.

Sexual health means a lot to me. That's why I'm always making sure, if I have any little issue, I'm taking care of myself or making sure I'm okay, because I think that your health is very important overall, but sexual health is very important. HIV and AIDS are here, I'm very afraid to catch. I think it's important. I think everyone should be well aware of what's going on with them sexually.

Another patient, Brittany*, aged 18-24, had asked for her IUD to be checked during her medical visit that day. At other points in the interview, she explained that there have been issues in the past during sexual activity, so she prefers to get checked occasionally to make sure the IUD has not shifted position. She went on to talk about how, for her, sexual health involves HIV/STI testing for both her and her partners. She emphasized that she feels frequent HIV/STI testing is crucial because a future health issue she may think is minor may turn out not to be.

I think the most I mentioned [to the provider] was about the IUD and just like I wanted to again 'cause I'm active and I’ve been active for a while, I wanted to check to make sure nothing was going under my radar. I'm concerned for sex health and my partners 'cause whatever I have I'm just, “Okay, your turn to get tested.” Yes, I'm very aware because I wouldn't want something that I would think is insignificant to really ruin my day or my week or whatever. I think it’s important to get tested as often as you can.

Throughout her interview, Lourdes*, aged 25-34, shared her previous gynecological care experiences and feelings about a past diagnosis with HPV. However, at the beginning of her
interview, she offered this vigilant definition of sexual health and explained the reasons for why she feels she (and others close to her) should seek medical care regularly.

Taking care of your organs. Going to the doctor, making sure everything is good and running well. I mean, for me, I think it’s a slightly different experience than for other people, because I’ve had HPV. I’ve had—what are they called? The lesion things removed where I’ve gone through surgery for that. I’ve had a rather traumatic experience with that, so I feel like I have a very different experience of that word. Yeah, for me, it all comes back to that. For me, it’s like take care of that, and make sure it never happens again. Be hyper-alert for me. For other issues, be responsible and take care of yourself. You wouldn’t drink soda 24/7. Take care of that. I’m thinking of my sister who has probably cysts in her ovaries or something, and she won’t never go to the doctor. She doesn’t take care of any of that stuff. I’m like that’s so scary. Yeah, that’s what I think when I think of sexual health. Condoms, birth control, take care of all that.

“Hand in Hand”: Holistic View of Sexual Health

In this study, a few patients did express a different view of sexual health. We coded this as a Holistic View, or a perception that sexual health involves one’s entire body (physical, mental, spiritual, etc.). However, having a holistic conceptualization of sexual health was not mutually exclusive to also describing sexual health through a risk-based or protective lens.

Throughout her interview, Brittany*, aged 18-24, gave multi-faceted explanations of sexual health, mentioning both the holistic and risk-based perspectives. However, at the very end, she summarized how she thought about sexual health, which we coded as a Holistic View.

Sexual health to me means like just like your mental and your physical health ‘cause to me like I said in the previous question, sex is both a mental and physical thing. It’s fairly important because maybe if I have a bad sex life, that could interfere with your personal relationships with friends, coworkers, acquaintances. A bad sex life could probably lead to a disease that could leave you maybe infertile. Definitely, a bad maybe like a negative sexual experience could take an impact on your physical self and mind and body already work together. Maybe if you can't get pregnant, but you wanna get pregnant, you’ll get depressed.

Another patient, Kristen*, aged 18-24, described sexual health primarily with a holistic perspective, and rarely referenced sexual health within a risk-based/protection framework. At the end of her interview, she explained that she recently experienced intimate partner violence, and
how that impacted her definition of sexual health as not only physical, but also affecting one’s mental health.

I was in a very abusive relationship that I wish—I’ve been to doctors, and there's marks in me. I wish a doctor would have said something to me, and so I think sexual health is, again, not just about your physical feature, like your organs and your period. It is about the—cuz sex is so mental as well, that it's very much also and mental health go hand in hand.

Another patient, Monique*, aged 35-44, reflected upon her body as she aged, and how that impacted her sexual health and understanding of her body as a whole. At the end, she reiterates how sexual health means more to her than just STIs, and for that reason, we coded it as a Holistic View.

Sexual health for me is just you basically understanding your body and understanding the different effects that could happen with your body, and seeing the signs that when you do get this that you could have something really going wrong with you… To me, if you’re not understanding what sexual health is, and the different changes your body can take cuz, as I say, from 18 to maybe 22, 25, you have the same body. From 25 to 30 it changes. Then once you hit 30 everything goes different. People don’t understand that. I said, “But this is why you need to understand sexual health, because some things that you might get nervous about, it’s really nothing wrong. It’s just your body changing, because you’re going through a different era…” For me, that’s why I feel like sexual health is you understanding your body and the different changes, and just the things that go on with you, but some people don’t understand that. They just think sexual health is all about sex and STDs. It’s more than that. It’s that, STDs, and just you understanding your body.

Internalized Messages

As part of these descriptions of sexual health, there were specific ideas from personal experiences and observations or external sources that appeared to be internalized as facts and reality by some patients. Internalization, from the field of developmental psychology, refers to the continual process of blending and adopting others’ influences into our own beliefs, attitudes, and values specifically around morally-perceived behaviors. Other studies that have explored this phenomenon with adolescent sexual behavior. In this study, patients described these sources and ideas about sexual health very saliently, even if the messages were heard many years ago.
Particularly, messaging from parents and other family members, as well as personal observations or experiences, seemed to deeply impact patients’ thoughts and feelings about sexual health and behavior. Friends and media sources were mentioned as less impactful sources of messaging. Some patients even described how the experiences and messages positively and negatively impacted their past and current actions with sexual partners. Previous research has indicated that individuals who have high degrees of internalization may delay sexual activity for fear of consequences (STIs, pregnancy, being caught by parents, etc.).\textsuperscript{236-238} In this study, we coded these significant ideas as \textit{Internalized Messages}, and categorized them into sub-codes by main ideas contained in the messages recalled by patients: a) \textbf{Hyper-alert, Fear and Danger}; b) \textbf{Shame and Stigma}; and, c) \textbf{Following the Rules}.

\textbf{Hyper-alert, Fear and Danger}

There were particularly salient messages mentioned by patients that invoked fear and danger around sexual health and behavior. For these patients, internalization of these messages caused them to be particularly vigilant about their sexual behavior. They explained that, for that reason, they took certain precautions (i.e., practicing monogamy, using protection, etc.), and sought regular medical care. We coded these particular recollections about sexual health messaging as \textbf{Hyper-alert, Fear and Danger}.

For one patient, Erika*, aged 25-34, her family’s expectations of her future sexual behavior and her own observations of relatives living with HIV/AIDS made her fearful and cautious with regard to her own sexual health. She also mentioned passing these messages onto the next generation.

Pretty much from family, they pretty much like only one sexual partner. They made sure that was very clear, one sexual partner. They also -- because I have family members that have contracted the AIDS virus, so it's just like their whole body just changed. So that was kind of scary, too… It just made me just stay alert at all times, not to jump from one partner
to another partner, like stay with one person. It made me pretty much -- I mean, I have a 15-year-old son, sit down and share what I've learned with him.

For an older patient, Tasha*, aged 35-44, her mother’s messaging around sexual health carries through to present day, and almost causes an anxiety for the patient around the current state of her sexual health.

She [mom] always told me, whoever you're with sexually, protect yourself. Be careful. You should really only be with one person, and hope that that one person is just with you. Overall, just protect yourself… It really made me more aware. It also made me a little nervous, on edge. Anytime I have an itch, a discharge, anything, I'm just running straight to the clinic and get checked out.

During her description of sexual health, Cheryl*, aged 35-44, described that her parent’s restricted view when she was younger has made her want to learn more about sexual health as an adult. She also mentioned that sex has an element of danger, which she talked about later in the interview as important for others to know, and educate themselves about.

Sexual health. It’s important to be informational about things. I try to learn everything I can because it just is becoming an open world. Back in the days, my parents, they were kinda closed with it [sexual health], but things are getting more and more dangerous, I would say, and I think a lot of people should know what they gettin’ into when it comes to sex…

Shame and Stigma

A few patients also spoke about specific shameful and stigmatizing messaging from either family members or current society around sexual health and behavior. For these patients, it was evident from the repetition within the interviews that the messages, as well as the bearer of these messages, shaped their thoughts and feelings around sex. We coded these particular recollections about sexual health messaging as Shame and Stigma.

For an older patient, Paola*, aged 35-44, negative messaging from her grandmother around sex was in direct conflict with positive feelings that the patient has experienced with past and current partners.
In the personal [sense], you have sex when you love someone. I talked already about [how] I [was] raised with my grandmother—so she’s more strict like, “Don’t speak to the sex because it’s bad.” I feel like, if you talk about sex, it’s bad. If you do the sex, it’s bad. If you do, how you feel, it’s bad—but [in] the personal [sense], when I have sex with, [it’s] when I have chemical love for the person, my partner.

Another patient, Lourdes*, aged 25-34, mentioned fear throughout her interview, but here, she also mentions feelings of shame related to messaging from society-at-large.

There’s still a lot of paranoia. Just fear of getting pregnant and getting an STD, especially because of my first experience with STDs was by getting one. Yeah, a lot of like fear. I think there is—I do have a lot of fear around sex in general. Yeah. I mean that’s—coming from all those experiences, and the media and society. The patriarchy and how sexuality in women is treated in society. Yeah, there’s a lot of fear and shame, obviously. A lot of discomfort in that.

Following the Rules

Finally, some patients mentioned messages around compliance with a set of rules that were not explicitly described, which we coded as Following the Rules. These patients expressed feeling a duty to follow or obey these unspoken guidelines, and some almost felt remorseful or penitent if they deviated.

One of the younger patients, Tania*, aged 18-24, was particularly reflective upon her past behavior, even going so far as to say she was “a disobedient child.” While she does not specifically name the source of this messaging, in other parts of the interview, she discussed the influence of family members and their view that sex should be “saved until marriage”.

Because honestly speaking, when I went to college, I just lost my morals a little bit. I mean, looking back though now, I see, I do notice how I should have listened, I guess, more so. Granted, I could be in a worse position right now. Now, I'm just taking it all in and I'm just—actually, I'm about to listen and slow down a little bit. Actually use condoms, you know, because you can't trust everybody, honestly speaking. I got it in—unless it's probably your boyfriend for two years, or something, you know? It kind of informed me, but then I didn't listen, because I was being a disobedient child. Now, I'm listening now. I guess it's a lesson learned.
Another younger patient, Kelsey*, aged 18-24, ruefully mentioned a recent conversation with a medical professional about the patient’s sexual health in which she was reminded of the guidelines or rules that she perhaps had not been following. “My doctor gave me a little bit of a lecture. [Laughter] Got me on the right path…I felt like it’s what I needed to hear.”

An older patient, Cheryl*, aged 35-44, described that compliance meant that she was taking care of her gynecological care needs. While the rules or needs were not described further in this portion of the interview, later on, this patient discussed previous pregnancies, terminations, and health issues that arose during them, which may have influenced her feelings around gynecological care. “I try to take care of myself as best I can, following the rules of all that needs to be taken care of, as far as my gynecology.”

PROVIDERS

While providers were only asked once about what the term “sexual health” meant to them, much like the patients, they shared rich, contemplative explanations of sexual health and behavior in response to the question. However, during their interviews, providers also described how they talked about sexual health and behavior with their patients. From these descriptions, two themes emerged regarding how sexual health was defined by providers, which we coded as: 1) Risk-based/Protection Definition; and 2) Holistic View of Sexual Health (see Table 6). Interestingly, we did not hear the same type of internalized messaging that was mentioned by patients. Nevertheless, there were early life experiences (data not shown here) that were mentioned by some providers as deeply impacting their current view of sexual health and behavior. Next, the two themes will be described and exemplar quotes will be presented.
**Risk-based/Protection Definition**

Similar to the patients, providers described sexual health and behavior through a risk-based and/or protection lens. However, with the exception of one provider, these definitions were only mentioned within the context of medical encounters, i.e. how they spoke about sexual health with their patients. We coded these descriptions as a Risk-based/Protection Definition if they almost exclusively referenced an assessment of a patient’s risk of acquiring HIV/STIs and/or becoming pregnant, as well as protection (e.g. condoms, birth control, etc.) from HIV, STIs and pregnancy.

At the end of the interview, when asked what the term meant to her, one fellow, Dr. Eldridge*, thought through her definition and parsed out how she saw sexual health fitting under the umbrella of reproductive healthcare. She also illustrated how she thinks about sexual health during medical encounters with her patients, particularly when taking a sexual history.

“It’s funny, because I’m thinking now… there is reproductive health, and sexual health is a component of reproductive health, but there’s also preconception care, and other things that are a component of it. When I think of sexual health, specifically, I’m thinking of STDs. That is my main thing, but then I also could think about the contraception part of it, too, like, “Are you using anything to protect yourself, like condoms? If you’re on birth control, what are you using?” that’s the main really thing. When I think sexual history, I’m thinking, “Okay, well, what are your risks?” You know?”

Contrastingly, one attending physician, Dr. Nassau*, described that she thinks about sexual health differently within medical encounters. She also mentioned that this definition is based on what she, as a medical provider, is able to accomplish within encounters. Throughout her interview, she describes time as being a major barrier to addressing more health concerns with patients. “I always differentiate the two, that there’s pregnancy prevention and STI prevention. As a family physician, my most common—‘cuz what I can do something about in a very short time with the widest range of people is pregnancy prevention or promotion, STI screening and treatment. That’s what I can do.”
Likewise, another provider, an attending physician, Dr. Thayer*, talked about risk assessments being a focus of her discussions with patients. “Most of the time, I’m trying to—and in this case too, I’m trying to elicit risk, and then, if we need to, have a conversation about risk reduction, so like who is your partner or partners, and is there some type of—is there a risk of pregnancy or a risk of STI and just do counseling around that.”

One nurse practitioner, Nurse Wheeler*, mentioned a specific focus on STIs and the importance of educating patients about their risks. “Generally, when I’m focusing on sexual health, I’m focusing on STDs, because it’s so prevalent and the needing to protect yourself from those. Making patients aware that you can get chlamydia and gonorrhea in other places other than just vaginally. I generally cover all the bases, especially on a well-woman exam.”

Finally, another attending physician, Dr. Fulton*, was more reflective about the emphasis placed upon risk within encounters and thought she could be expanding her conversations to include other elements of sexual health. “I think it would be like an assessment of risk factors. Also, what I think I do probably a pretty poor job of, is an assessment of pleasure and benefit from sexual activity. I think we focus a lot on risk, but not so much on empowering people to have pleasurable sexual experiences, to make sure that they’re engaging in sexual activity that’s safe, sane, consensual, all that stuff.”

Holistic View of Sexual Health

At the very end of their interview, providers were asked about their definition of sexual health. Their responses, which were different than descriptions mentioned throughout the interview, were coded as a Holistic View, or a perception that sexual health involves one’s entire body (physical, mental, spiritual, etc.).
One nurse practitioner, Nurse Delancey*, who mentioned that she had not thought about what sexual health meant to her before, fluctuated between expressing that sexual health was inconsequential because it is ever-present to saying that it influences one’s overall health in various ways. Unfortunately, she does not finish her thought process about her description, even when prompted by the interviewer.

“Sexual health. Gosh, it means so much. [Laughter] It’s funny, ‘cause you ask what it means to me. I’m like, it’s just part of us, it’s nothing—it’s just it’s part of our overall health. It’s nothing special, right? It’s very, very special, but so is—I don’t know. That’s a really good question. I never really thought about it… It’s part of our—I mean, yeah. It’s something, yeah, it’s part of our overall well-being. Right? Both physical, mental—It can guide our lives in so many different ways that…”

Another provider, an attending physician, Dr. Thayer*, also mentioned sexual health as having physical and mental impacts, but also includes an element of safety in her description. “I guess for me, sexual health means really the physical and emotional aspects of one’s sex and sexuality and partnering, and the goal being to identify things that can improve your safety and improve your wellbeing.”

Safety was also mentioned by another nurse practitioner, Nurse Gresham*, who emphasized that sexual health meant pleasure and enjoyment without fear of the aftermath, for which she named numerous outcomes. “Just being able to enjoy your physical body in a way that’s safe with another person, without worrying about consequences, I guess; physical consequences, psychological consequences, disease consequences, baby consequences. [Laughter] Letting it be a safe space for you to enjoy yourself and your partner.”

After asking the interviewer what their definition of sexual health was (which was not answered by the interviewer), one attending physician, Dr. Nassau*, offered a multifaceted explanation of what she considers the term to be.
We can talk about relationship and healthy relationships. We can talk about understanding your boundaries as part of relationship and healthy relationship, understanding your boundaries, what you do and don’t wanna do, where you’re comfortable and not comfortable, how you respond to different situations, management strategies, support structure, all this… We can talk about physical health, whatever in the genital area. We can talk about gender identity. We can talk about partner attraction or not partner attraction. When we talk about it, is it intimate partner, relationship, your relationship even with your body? How do you feel about your body, body image? I mean, if we’re gonna go all over the place, we can go to the very concrete things we already talked about, but I guess your empowerment, even. I don’t know. I mean, it can be so, so broad, a woman’s place in society, a woman’s worth, a value, men for their respecting—what does masculinity mean? What does it mean to be a man and the sort of toxic ways that we’ve defined this also many times in our society, so giving very much to another female. It can be really quite broad and integrated.

Another nurse practitioner, Nurse Wheeler*, thought about sexual health through personalized and non-judgmental lens, where STIs are on the same level as common, less stigmatized health conditions.

Sexual health is basically just however you have sex is fine and how often or with who—it doesn’t matter, ‘cause it’s just the same way as your medical history. It doesn’t matter if you have diabetes or hypertension. It doesn’t matter if you’ve had chlamydia, if you haven’t had chlamydia. It’s individualized, and nothing is bad. It’s individualized towards you, and it’s not something you should be ashamed of.

Much like the previous provider, an attending physician, Dr. Odell*, thought about the term in a non-judgmental sense, but added an element of comfort to her definition. “Feeling comfortable living whatever sexual side of your life, you want to live.”

CONCLUSIONS

By asking patients and providers how they conceptualize the term “sexual health”, we learned that, even though specific examples varied, there were many thematic similarities. Patients primarily use a risk-based/protection framework to describe sexual health, and providers also talked about describing sexual health in that manner with their patients during medical encounters. This reflected the influence of HIV/STI messaging that Americans have heard repeatedly during and after the HIV/AIDS epidemic,239,240 as well as the fact that “health” is still conceptualized
within the biomedical model of illness and disease.\textsuperscript{241,242} Interestingly, providers thought about sexual health differently in a personal sense. This broader, holistic view of sexual health, which was also shared by a few patients, is similar to the integrated approach recommended in current CPGs for sexual healthcare. This common ground offers insights into how consensus around sexual health definitions could be reached, and suggests areas for further exploration with patients and providers.
<table>
<thead>
<tr>
<th>Theme/Sub-Theme</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk-Based/Protection Definition of Sexual Health</td>
<td>Elements of protection (e.g. condoms, testing, birth control etc.) regarding risk for acquiring HIV and/or STIs, and becoming pregnant in description of sexual health used by patients and providers. May include assessment using epidemiological categories, such as men who have sex with men, individuals from endemic countries, low-risk heterosexuals, etc.</td>
</tr>
<tr>
<td>Take Care of Your Organs</td>
<td>For patients, feeling responsibility to self-monitor or to perform self-care by scheduling regular or emergency medical appointments to get checked (via pelvic exam, HIV/STI testing, pap smear, etc.)</td>
</tr>
<tr>
<td>Holistic View of Sexual Health</td>
<td>View of sexual health as encompassing the whole body (physical, emotional, spiritual, etc.)</td>
</tr>
<tr>
<td>Internalized Messages</td>
<td>Messaging, norms and values about sexual health and behavior that are established by other individuals, groups, or society as a whole</td>
</tr>
<tr>
<td>Following the Rules</td>
<td>Elements of obedience/following the rules contained in description of sexual health and behavior; perception (by patient) that sexual behaviors that adhere to medical/public health/societal teachings/guidance or family/friends expectations = obedience/compliance with medical guidelines; elements of morality</td>
</tr>
<tr>
<td>Hyper-Alert, Fear and Danger</td>
<td>Elements of preparedness, vigilance, danger and awareness contained in description of sexual health and behavior</td>
</tr>
<tr>
<td>Shame and Stigma</td>
<td>Elements of shame/stigma contained in description of sexual health and behavior; linked to views, beliefs, religion</td>
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CHAPTER 4 - Navigating Sexual History Taking: Perspectives from Patients and Providers

History taking has been named as an integral task in medical encounters, but prior research has shown wide variation in the frequency of sexual history taking and documentation of sexual histories during medical exams due to physician gender and specialty, patient socio-economic status, and other influences. To better understand those variations, this study aimed to elicit details from female patients and their providers about how they navigate various aspects of sexual history taking, as well as their interpretation of sexual health discussions during gynecological care encounters.

For patients, interviews took place after a medical visit, which included a pelvic exam (a proxy for gynecological care). Patients were asked a series of questions about the recent visit to give the research team a sense of what transpired and their perceptions about and feelings during the exam (Did you and your provider discuss your sexual health? What did you discuss?; How did you feel during the discussion?; What pieces of information did you think were important to tell your provider?; and, How did you bring up any issues or concerns during the exam, if you had any?).

Providers were interviewed when available, and therefore, were asked to recall a recent visit that involved a pelvic exam (I’d like you to think about a recent patient encounter during which you did a pelvic exam… Did you talk about sexual health? Tell me about what was discussed and how… How did you feel during the discussion?). We were also interested where providers learned how to conduct a sexual history and how that guidance influenced their current way of taking a sexual history (In the past, from which sources, if any, have you received guidance about how to discuss sexual health with patients? How do you think that guidance impacted your sexual history taking “style”?).

We were only able to interview female providers as no male providers
agreed to participate; however, some patients did offer perspectives on conversations with male providers during their visit. The thematic findings from these questions during interviews with patients and providers were coded under *Navigating Sexual History Taking* and are outlined in Table 7.

**PATIENT PERSPECTIVES**

Within these encounters, a number of topics related to sexual health were raised and a variety of questions were asked by patients and providers. For the most part, patients mentioned feeling comfortable during these discussions with their providers. However, there were a few topics that were described as difficult and awkward to talk about. Additionally, there were common feelings of honesty, openness, trust, stigma and shame, which were experienced by patients during these discussions. Five themes emerged for patients under *Navigating Sexual History Taking*: 1) *Questions Asked and Conversation During Encounter*, 2) *Uncomfortable Topics*, 3) *Honesty and Openness*, 4) *Trust*, and 5) *Shame and Stigma*. Next, I will describe each theme and provide exemplar quotes from patient and provider interviewees.

*Questions Asked and Conversation During Encounter*

When prompted, patients recalled specific sexual health questions and topics of discussion from these encounters, which we coded collectively under *Questions Asked and Conversation During Encounter*. Since this study relied on participants’ memory rather than recording the medical encounter directly, these recalled discussions are important and notable as far as what was prioritized and salient according to the patient. From a psychological standpoint, these memories and reflections give us an insight into what each patient understood and absorbed from the medical encounter. We heard descriptions of wide-ranging conversations around HIV/STI testing,
pregnancies, terminations, IUD placements, Pap smears and sexual risk reduction, some of which are shown below.

Renee*, aged 25-34, discussed HIV testing and a current concern of hers with her male provider, as well as gravidity and parity. Later in her interview, she mentioned how appreciative she was that the provider listened to and addressed her concern because she had expected the concern to be dismissed.

He asked me if I wanted to take the HIV test and I told him, yeah, I needed an updated one, but I brought up the ovarian [cancer] screening… I just asked him like if they did ovarian screenings here and he just asked me why, what happened, and I explained to him the whole situation with my supervisor [ovarian cancer diagnosis], and he was like that he would find out for me if they did it here or not. Yes, he asked me if I had any children and I told him, and he asked me if I -- if -- how many pregnancies I had. I told him. Yeah. He asked me how many was living and how many was terminated and I explained to him. That was pretty much it.

Another patient, Cheryl*, aged 35-44, also discussed prior pregnancies and associated health conditions with her provider (also male). While the patient gave a lengthy description during the interview, she mentioned that the conversation with her provider was relatively quick.

He did asked me about my past health. I told him I have an occurrence with my feet swelling in the past, since I first knew, I had a—he asked me about my pregnancies, and I told him that I had five all together. I had three successful. Two of them were regular birth. The last one was Cesarean… There was one abortion, and the other one was a tubular pregnancy, where they had to operate and terminate. I told him that, and yeah. Pretty much, I had hypertension. That’s what I’m coming to. My last pregnancy, I had hypertension, so that’s where they had to do a C-section and take him right away. I was currently taking three pills. I told him that my feet would swell up. They still swell sorta now… He asked if I used condoms. Yeah, and I told him yeah. He asked my nature of what sex do I have sex with. I told him I was heterosexual, and a couple other things, but I can’t remember… He asked me have I had gonorrhea, chlamydia, or syphilis—I told him no—and different questions of that nature. Very short.

Much like the first patient, Alisha*, aged 25-34, had particular concerns that she raised with her provider (female) during the visit. Specifically, Alisha* wanted to make sure she received HIV and STI testing at the visit. Unlike the previous patient, Alisha* described that she had to
assert over and over why she wanted the tests she felt she needed. She also mentioned the differences in what the nurse asked her versus what the provider wanted to know about her concerns.

Sexual health? Yeah, she [the provider] did. She asked me all those [questions]. How many sexual partners I have. What other stuff? What did I want to get out of the appointment as far as the test that I needed, that I wanted, and things of that nature… It’s just basically asking me about my sexual activity. What I’ve been doing, who I’ve been doing it with, that stuff. Who, what, when, where. [Laughter]… One of the issues I had was I just really wanted to get tested for all the STDs. They just kept asking me why and I was just like, “I just wanna know. I wanna know my status. It’s been a while since I’ve had a test, so I just wanted to make sure I was getting tested for everything top to bottom…” Yeah, because I think everything was just on the computer, so she [the provider] was just like, “Okay, the nurse already asked you about this,” and she just basically wanted to know why I wanted to have all the tests done. That was her whole thing. Whereas the nurse just asked me what tests I wanted to have done, she asked me why I wanted to have them done.

During her visit, Brittany*, aged 18-24, felt it was important to bring up a concern of hers related to her IUD. She mentioned earlier how she has broached this same subject with other providers at different clinics, and how she has been told that her IUD appears to be placed correctly; her current provider (male) similarly assured her during this visit.

I think the most I mentioned was about the IUD and just like I wanted to again ’cause I’m active and I’ve been active for a while, I wanted to check to make sure nothing was going under my radar… I think what was important to tell the doctor is definitely my experience and ’cause my experience it’s like—how do I explain it? Like how I said that it’s poked me a couple of times where it’s like, “Hey, Doc, you know my Paragard stabs me and my boyfriend. No blood was drawn, but it caused an immense amount of pain. What kind of concerns would that be for?”

Based on an unexpected reaction from a previous provider, Kelsey*, aged 18-24, thought a different piece of information was important to tell her current provider (female) before her pelvic exam.

I had just told her I haven’t really had sex recently very much… I think I was mostly making a joke because the last time that I had gotten a pap smear two years ago it was right before I moved. My boyfriend and I at the time had been holed up for a couple of days and there was some swelling. [Laughter] The last doctor who did it was freaked out by what was going on, so I was like, “Well, this time not gonna be much to see.” [Laughter]
Ines*, aged 35-44, mentioned being asked fewer sexual health questions by her current provider (male) than during previous visits. She wondered if it was due to the reason for her visit that day (annual physical vs. GYN appointment). And, although she received a Pap smear that day, she was not asked about previous results on this occasion; for that reason, the patient felt it was important to mention that she has had positive Pap smears in the past.

“He asked me how many partners like other doctors have. I guess it's different when you do a GYN appointment because when you do a GYN appointment, they ask how many partners, do you use condoms. He asked that. He did do a Pap smear… If it's just a GYN appointment, I get asked everything, but I guess since it was just a physical and a Pap, he didn’t even ask, but I don’t lie about it, so I tell them the truth… I had to let him know like, listen, I've done this before and some tests come back with cancer cells or whatever and they have to call me back. I feel like he should have asked, like why is it that you want to do this test today? What's going on? Are you having problems, or do you feel that you did have a STD, or something like that.”

Another patient, Tania*, aged 18-24, contrasted the lack of a discussion with her provider (female) that day with previous discussions about sexual risk reduction with other providers at the same clinic.

No, she didn't ask if I was having—she didn't ask anything about, well, I guess, am I sexually active, or if I use condoms. Like, she didn't really—she didn't go into that… The last time I came, the doctor kind of did bring up using condoms, “There's condoms here for you. You can take as many as you want,” and things like that. This wasn't really—she didn't really, I guess, hint on, like, “You can take as many condoms as you want. If you have sex, use condoms. Use condoms.” Yeah, she didn't.

Finally, Marissa*, aged 18-24, reflected on the conversation she had with her provider (female), and the guidance she received that day. She also mentioned that she was not asked (what she perceived to be) private or intimate questions during the encounter.

“She didn’t really ask me personal, personal questions. She just asked me what was wrong and if I was having sex. She just wanted to make sure I was using condoms and stuff… Literally we just talked the whole time. She just gave me some motherly advice in a way. It wasn’t really doctorly advice. It was more of a mother advice like, ‘Why are you doing this? You should think before.’”
Uncomfortable Topics

For a few patients, specific sexual health topics were named as difficult to discuss with their providers. They mentioned these topics in response to two questions asked by the interviewer: How did you feel during the discussion [about sexual health]?, and What [sexual health] topics, if any, should providers stay away from? We coded some of the patient responses to these questions under the theme: Uncomfortable Topics. In this study, we did not see commonalities in their responses, but have noted the findings below, as other women may share these viewpoints.

Carmen*, aged 25-34, mentioned how she was concerned that a specific topic (pregnancy intention) would be raised during her exam. She insinuated that her discomfort may be due to her own fertility issues. Later in her interview, she explained her feelings around being asked “Are you on birth control?” that day, and gave suggestions for improvements (see Chapter 6) which would make her feel more comfortable if asked during a future visit.

  Interviewee: I was a little bit worried that she [the provider] was going to say something that was going to make me feel uncomfortable—but she didn’t. She was pretty good.

  Interviewer: Mm-hmm. What would have made you feel uncomfortable during that discussion?

  Interviewee: The topic about pregnancy [intention].

  Interviewer: Okay. That is a particular topic that is difficult for you?

  Interviewee: Mm-hmm.

Another patient, Lourdes*, aged 25-34, explained her reaction to a common question asked during sexual history taking: “Are you sexually active?”. Even though she described herself as “very open”, this particular question produced an adverse response. However, unlike the previous patient, she did not offer alternative phrasing to the question.
**Interviewee:** Yeah, it’s a bit like—I don’t know, I feel like I’m a very open person, and I don’t mind answering that, but it is a bit of a—jolt like talking about that kind of thing with a complete stranger. I say I’m a very open person, but I don’t talk about my sexual life with my friends. Then you talk about that, we are complete stranger. It’s like eh. It’s fine because of the context, because of the setting. I’m ready for it. I know they’re going to ask that, but yeah, it’s a little like eh.

**Interviewer:** Yeah. It causes a reaction for you. Yeah.

**Interviewee:** Yeah, it’s a bit of an underlying reaction. Yes.

For Erika*, aged 25-34, questions about gravidity and parity were difficult, particularly when she had to talk about pregnancies that were not brought to term. While this topic was not easy to discuss with her provider, she did state that it was customary to ask women during gynecological care encounters. “I mean, it was routine. They supposed to ask. As far as the terminations, I mean, nobody want to speak about pregnancies that were terminated, but it had to be asked, so he had to get an answer.”

Cheryl*, aged 35-44, had some discomfort around telling her provider when she had been sexually active this past year. She mentioned that she was not specifically asked during the encounter, but if she had been, perhaps there would have been some difficulty answering.

It was a question he asked me where I had to tell him, yes, I do use condoms. The last time I had—had I been sexual active this past year, and I said, yes, I have. He didn’t wanna know specifically when, but he said, “Well, in this past year,” so I answered him yes, cuz I didn’t wanna tell him exactly when.

“An Open Book”: Honesty and Openness

When asking patients how they navigate sexual health discussions with their providers, the overwhelming response was that they considered honesty and openness (on their part) to be critical to receiving quality medical care, which we coded as “An Open Book”: Honesty and Openness. This was a theme throughout almost all interviews, not only as a commentary on how they conduct themselves during visits, but how other patients should behave during medical encounters (see
Chapter 6). We coded how patients described their attitude and behavior during their recent visit, as well as previous visits, under Navigating Sexual History Taking.

Tania*, aged 18-24, described her view that truthfulness with one’s provider is almost a reflection of honesty with oneself. She also added that, despite fearing the consequences, this honesty is accompanied by an element of ownership and acknowledgment of one’s actions.

I kind of—I'm a straight-forward person, so it's, like, I really don't really hold anything back. It's, like, I'm not really—even though I am scared of the outcome, I was always told just be honest, you know. Because you can't go wrong with being honest. Nothing could go wrong, you just—that's what happened. You got to take it as it is. After the day, yes, it was part of your fault. Now if you was more careful, then this would have never happened. You have to be honest. If you can't be honest to yourself, how are you going to be honest to people, you know?

Another young patient, Kelsey*, aged 18-24, shared her concise reasoning that withholding health history information may prevent providers from being able to accurately help her. “I’m pretty much very open about these things… I get that you’re not helping anybody by being shy and not disclosing information.”

Renee*, aged 25-34, mentioned particular topics that she would be frank about with providers. Much like the previous patient, her belief that honesty allows the provider to diagnose and treat her better shines through.

How are they gonna help you if you don’t be honest? … Well, all my providers—I’d be honest with them. I tell them the truth, from the jump, so that there’s nothing hiding; nothing—you know what I mean? If I had sexual relations with multiple men, I’ll tell them. If I had sex with one guy and didn’t use a condom and his dick kind of stinked, I would tell them [laughter]. You know what I mean?

While she mentioned specific examples of sexual health questions that she would answer accurately during medical encounters, Ines*, aged 35-44, also stated that the topic was irrelevant to whether she would provide straightforward answers to questions posed by medical providers.
How many partners you've had, how long you've been with them, if you do use condoms, you don’t, and that it. I mean, I let them know whatever. Whatever they ask me, I'm an open book. Whatever they ask me, I let them know about it and that’s it…

For Erika*, aged 25-34, being truthful about her gravidity and parity was a consistent theme throughout her interview. However, here, she offered a concrete explanation for why honesty was important to her in that context.

I felt all of it was important to tell him as far as my terminations because you never know what might happen. There's probably -- I have probably -- they probably left something in there that needed to be taken out. So, he could have seen that as he was doing the pelvic exam…

Another patient, Cheryl*, aged 35-44, reflected on gynecological care received earlier in her life, and, as time went on, how she became more outspoken during medical encounters. She also mentioned that she discusses sexual health differently with medical professionals than with her friends.

Well, when I was young, growing up, I did ask my gynecologist. I try to be straightforth with them. I had a baby when I was young, so at the beginning, my mother would be there, but as I started growing up, she wasn’t, so I started asking more because it was just one-on-one. I’m pretty much comfortable asking questions when it comes to someone that knows about what I need to know… With a professional [compared to friends], I would be more subtle about talking about that [sexual health], because they’re professionals. Coming from them, I will be very ethical, but as I grew, you have to know. I’ve become more open with it, so if I felt I had to ask a question to a professional, I just come out with it.

Trust

Along with being honest and open, patients described feelings of trust with various providers during sexual health discussions and gynecological care. While these feelings were not as ubiquitous as the previous theme, we coded these descriptions as Trust under Navigating Sexual History Taking to convey what patients experience during these discussions.

Brittany*, aged 18-24, described the discussion with her provider that day, and compared it to what she had experienced with previous providers. Earlier in the interview, she mentioned
that these discussions have been consistent, in a “good way”, and here, she explained that she has confidence in and expectations around providers during medical encounters.

I always encounter a very trust feeling doctor like a doctor I could talk to or if I had any questions, I won't feel awkward or uncomfortable. I definitely felt like whatever was going to happen [today], if I like whatever news he [the provider] might have told me I was definitely ready to hear it. I definitely I only trusted them [providers] to write things down for me and help me absorb it if I didn’t exactly understand the answer they have given my question.

Similarly, Alisha*, aged 25-34, explained her confidence in the clinic itself to provide accurate health information, whereas she believes other sources may not be as trustworthy. Additionally, as in the previous theme, she explains that honesty on her part facilitates receiving that accurate information.

*Interviewee:* Because you guys are the only ones who can help me. It’s the only place I can get help, so I’d rather just be completely honest and open so I can get the best help that I can.

*Interviewer:* So for you, this is a place where you can just get some answers.

*Interviewee:* Right, and the right answers… Answers from outside that may not be 100 percent accurate, whereas you trust your doctor. I feel like you’re answering the question.

For Cheryl*, aged 35-44, trust is named as being built over specific time period, and much like the other patients, she talked about this trust facilitating her own openness. “I would trust my doctor if I’d been seeing him for over three or four years, and I would be more comfortable with asking him any and everything.”

*Shame and Stigma*

A few patients described stigmatizing and humiliating experiences during gynecological care in the past (not at sites where we conducted the study), which we felt were important to note. We coded these experiences as *Shame and Stigma* under *Navigating Sexual History Taking* to convey what patients have encountered during sexual health discussions.
Kelsey*, aged 18-24, mentioned feelings of shame around disclosing specific information to a provider during a previous visit. Upon reflection, she wondered if perhaps she should have been more self-assured.

“When I got my last pap smear I just disclosed that I haven’t really gotten STD testing before. I hadn’t really thought about it, worried about it or anything… I was pretty recklessly sexually active for quite a while. I was kind of embarrassed. I should’ve probably felt like I could go in and handle it.”

Another patient, Kristen*, aged 18-24, did not identify a specific instance like the previous patient, but spoke about stigmatizing behavior from older providers. While she stated that her health is more important, she mentioned being fearful of encountering stigma around certain sexual health topics.

“I think it can be difficult, especially when they're [provider] older and you think they might not relate to you as much, or are they gonna judge me because I've had X number of sexual partners, or done this, or something like that, or had an abortion, or whatever it may be, but I try and put my own health above those fears and just hope that they don't.”

**PROVIDER PERSPECTIVES**

For medical providers, the act of taking a patient’s medical history, specifically asking about sexual health and behavior, can invoke a variety of feelings and thoughts on behalf of the provider, and can be rife with challenges. In the interviews, providers mentioned various ways in which they approached sexual history taking and sexual health discussions, and where they have received guidance over the years. They also offered their views on the timing of sexual history questions and sexual health discussions within medical encounters. Like the patients we interviewed, providers described feeling comfortable during these discussions with patients. However, there were a few topics (different from those identified by patients) that were named as challenging. Additionally, some providers wondered about the utility of certain sexual history questions for risk assessment purposes. Four themes emerged for providers under *Navigating*
Sexual History Taking, which we coded as: 1) Personal Style and Journey, 2) Timing of History Taking During Encounter, 3) “What is and isn't your business”, and 4) Challenging Topics. These themes will be subsequently described and exemplar quotes from provider interviewees will be presented.

Personal Style and Journey

When prompted, providers recalled specific benchmarks throughout their education and training where they learned and/or observed how to take a sexual history. Some providers almost described a journey in which they learned repeatedly from various sources over time, until present day. Providers were asked to reflect on how they felt that guidance had impacted their current way of sexual history taking. We coded these descriptions under the theme: Personal Style and Journey.

Physicians appeared to describe more varied learning experiences and less foundational knowledge than the nurse practitioners we interviewed. Here, we included a number of responses, as other providers may share the same experiences.

Nurse Delancey*, a nurse practitioner, described how nursing school gave her a good foundation for history taking and communicating with patients, and that methodology is adaptable to a variety of topics during medical encounters.

I mean, in nursing school, I will say what is wonderful about it is how they really, you focus on how to interview a patient. Right? I think that helps regardless what the subject is. Because it’s always very intimate and personal, right, obviously, sexual—maybe a little bit. Not for everybody. Some people are super open, but then when you ask about their headache, they clam up… In nursing school, just how do you be an active listener, and ask those open-ended questions, and try to—that way, that’s something that I definitely, [learned in] nursing school.

Likewise, another nurse practitioner, Nurse Wheeler*, learned the basis of history taking from nursing school and stated that her style has not evolved much since then. She also mentioned her own experience as a patient as influential to the way she currently conducts sexual histories.
When I was in school, I’d done a lot of pediatric rotations, so it was probably a lot from them, ‘cause that tends to be a population that’s not as forthcoming about their sexual history... From my pediatric preceptors and stuff when I was in school. Then just in my own experience going for my own exam and how they do it. Generally, just I guess—I would say that’s probably mostly, like from my own experience and then just from my teachers in school... I haven’t changed it since I first learned, ‘cause I personally liked the way they’d done it, so that’s why I’ve done it. It gave me a good foundation, too, for how to conduct an exam. It’s not really changed much over the years.

For Dr. Eldridge*, a fellow, medical school and subsequent rotations did not offer the same foundation as was described by the nurse practitioners. Rather, she talked about her personal journey during residency in great detail where she developed her personal style by trial and error.

Well, med school, definitely. I know they had those mock videos. I don’t feel like those are at all realistic... [In] my OB/GYN rotation, I did get to observe, gratefully, what the history taking was, but it mostly was for patients coming in for their initial prenatal visits, so they were already pregnant... Then... my family-medicine rotation was my first rotation of med school, so they just had me doing a whole physical, and that was just part of the physical, to just do it myself... Once I learned how people were starting to respond to just on how I was phrasing the questions, I would just change it up on my own. That’s how I really started to get a sense of how I like to phrase certain questions... I’ve just developed my own style, by the end of my first year [of residency], I would say, after seeing— I don’t know how many I saw that first year. Was it 300? 400? I don’t know—how many, but then, definitely, I was just like, “Well, this is how I like to phrase it...” No one was ever there to say you need to ask that, that, or that, because they don’t—when I presented [a patient], usually, they [the preceptor] didn’t really—if it was for an OB/GYN-type visit, usually, they were very direct, to the point, in terms of like, “Oh, what was she here for presentation-wise? When I would go into it, they were like, “Well, okay. We don’t need to know all of that.” I was just like, “If you don’t need to know all of that, then am I asking?”

For many of the attending physicians, medical school seemed like a long time ago, and recalling various learning experiences during that time was not easy. Dr. Fulton*, an attending physician, reflected on the various sources she remembered learning from over the years, and how she was much more comfortable with sexual health discussions that she had been prior to medical school. Also, she speculated, as she did throughout her interview, that she could improve her history taking and communication skills.

I’d say certainly in medical school, like classes and things, and residency we had some formal training on it. One of our prenatal coordinators was actually a health educator in
sexual health, so that was really cool. She taught me a lot of stuff. That was kind of informal, your colleague teaching. I go to a lot of reproductive health conference-y stuff, so stuff I’m in discussed in conferences and things like that… Before my medical school career, I would have died to even have a conversation like this… I think it’s like anything else. The more you do it, the more comfortable you become with it… I got a lot of public training at the epicenter of the AIDS epidemic. I feel very comfortable with it. I think if I had not had the training I had, it probably would feel less comfortable, for sure. I think it’s certainly something I could still do better with. I think compared to the rest of my medical training, it was still a fairly minimal piece of it.

Another attending physician, Dr. Odell*, described specific instances outside of medical school which helped her develop her current sexual history taking style.

I’m sure we had some sort of training in medical school, but I don’t really remember it… Then in residency, at one point, our medical director sat us down with one of her patients and actually modeled taking a sexual history, and so I found that was helpful. Then another rotation that I found really helpful actually was we rotated at a teenage homeless shelter that also has a lot of teenage patients who are trans, so a lot of those visits end up focusing on sexual history and different kinds of things that might also be relevant to the person, like whether or not they’re on hormones or how’s that going or any drug use or anything like that, so I felt like that was really helpful for getting a better sense of how to take a sexual history… I think it helped me probably ask simultaneously both more open-ended questions and more direct closing questions, and also to play with language that might be more suitable depending on what I perceived about the person in front of me.

Much like the previous provider, Dr. Pinehurst*, an attending physician, reflected on how she learned to tailor conversations with patients and rephrase questions early in her medical career. However, she also mentioned the ultimate instructors in communication are the patients themselves.

Ways of talking, ways of phrasing your questions... I think sometimes you get that during residency then that’s cool, and you get people who are kinda inputting all throughout, but as an attending I really haven’t had—I think the patients are the biggest teachers in that scenario because you’ll see sort of how they request things and how they react to ways, and what information you’re getting from them which you ask this question versus that way. So, I think they’re like the biggest teachers in that scenario, yeah.

Another attending physician, Dr. Nassau*, felt the same way about her patients, and also added that she has learned from her colleagues at the clinics and virtually.
My colleagues and my patients, actually. I learn from both because this patient—she has been resonating with me, the one I said whose partner—she was a lesbian with a female partner. Then who knows what she is with the gender-non-binary partner. Now again she’s like, “I don’t know what I am with a trans-male partner.” Patients teach me all the time. I was like, “I know.” From my colleagues’ conversations that we’ll have, whether it’s in the precepting room, some listservs I’m on around reproductive health stuff and language, scope-of-practice issues, these things, yeah.

Finally, Dr. Thayer*, an attending physician, mentioned multiple influences to her history taking style, which many of her colleagues above also experienced. She also stated that, while her style may have evolved some over time, she feels that she remains true to how she was trained early in her career.

It’s mostly from people, like instructors, and mentors, and things like that, and of course, in medical school, and even in residency, we have these practice patients who let us know all the things that we did wrong, so I learned a lot from those experiences, but it’s mostly learning from other people and seeing that modeled… I think it influenced it a lot, just in that I wasn’t really sure how to do any of this stuff before, but I think I was trained by people to be really open-ended and non-judgmental, and I certainly don’t think the way I do it now is exactly how I learned it, but it’s pretty close.

“It Depends”: Timing of History Taking During Encounter

In this study, we were curious to learn how providers at these clinics navigated the timing of sexual history taking within medical encounters. Clinical guidelines and previous literature often offer vague instructions and insights into this issue. As reported previously, these providers explained that asking patients about potentially sensitive topics is complicated, and there is no correct or right time during the visit to take a sexual history. They also offered their experiences and opinions about the issue, which we coded as Timing of History Taking During Encounter.

Dr. Pinehurst*, an attending physician, explained that, for her, the reason for the visit may assist with leading into sexual history taking, but that sometimes, the patient may be resistant to such conversations despite a sexually-related health concern. She also mentioned that patient age and rapport plays a role for her with regard to frequency of sexual history taking.
If someone’s asking for STD testing or prep or something like that, then you need to get into it and figure it out. If someone is not asking for it, I think it’s always good to check in, like would you like STD testing today? Are you sexually active? Kind of more general questions, and that I think can be prefaced with oh, this is just part of the physical, we ask you a million questions, this is one of them. But, in terms of, I think you kind of take what the patient offers you in those general questions and then it’s hard sometimes because sometimes someone wants HIV testing and you know that there’s something behind it the way that they’re acting, but they’re not kinda giving you too much. So, I feel like you’ve got to just take the patient’s cues in some ways. If they are sort of withdrawn then it’s difficult to kinda get at that. I think you need to ask the questions in a very neutral way and kinda frequently. I mean, maybe your 80-year-old, you’re asking once a year or something, but it sorta depends on how you know them as well.

Likewise, another attending physician, Dr. Fulton*, stated that there is no clear answer, but that the reason for the visit influences the timing of sexual history taking, as well as whether the patient is new or established at the clinic. She also mentioned that, for patients with specific sexual health concerns, a sexual history should be conducted within a certain timeframe.

I think it really depends. We have a lot of --- we share patients a lot, so if I’m seeing a patient once for their asthma exacerbation, I probably won't ask about it. I mean certainly new patient in the clinic, I feel like that day, that should be assessed as part of the whole health history, or annually at your physical exam…. If you feel organized enough to come in for an annual physical exam with any symptoms that would be, well you know, discharge, burning, whatever. Obviously like, “My partner has chlamydia, what do I do?” I don’t know that there's a number. I’d say by the third or fourth visit to the clinic, certainly someone should have addressed that.

For Dr. Thayer*, an attending physician, sexual history taking is often done in the middle or end of the visit. She explains that the timing depends upon patient concerns, her relationship with the patient, and when she remembers to ask the patient during the visit.

I don’t know that there’s a really specific time. I try not to open with that because it catches people off-guard. Sometimes the patients come in bringing that up immediately, and that opens the door to talk about it, but I usually wait until—for no good reason, other than I’m trying to build a little rapport and help people relax a little bit first, so it’s somewhere in the middle of the visit, or sometimes even toward the end, if I just forget until then.

Finally, another attending physician, Dr. Odell*, described the pros and cons that she has encountered when asking patients about their sexual histories at various times during medical
encounters. Her conclusion (*not shown here*) was the same as the other providers in that timing depends on a variety of factors, which the provider may or may not gauge correctly for every patient.

Sometimes it can be the elephant in the room and so it’s helpful for someone to bring it up, and then it opens up a lot more discussion. Sometimes I feel like people didn’t bring it up because they don’t wanna talk about it, and so then you’re prodding someone in a way that they don’t wanna go… Sometimes I feel like someone comes in for something that to me seems incredible connected to a sexual history, and then when you start asking about it people may feel like it’s inappropriate, or it’s a violation of a social contract you have between the doctor and the patient, because I haven’t yet explained why it seems to connected to the concern that brought them in that day.

“What is and isn’t your business”

In this study, we also were curious what sexual history questions were acceptable to patients and providers; the patient responses are presented in Chapter 6 under *Suggestions for Improvements*. During the provider interviews, the utility of certain sexual history questions was questioned by a few providers. Since they talked about weighing which questions are applicable during specific medical encounters and what information providers need in order to make a diagnosis, we coded their answers as “What is and isn’t your business” under *Navigating Sexual History Taking*. The providers also suggested improvements of common sexual history questions, which, like the patient responses, are described in Chapter 6.

One fellow, Dr. Eldridge*, explained that patients’ answers to a common sexual history question do not affect the care she provides or conversations during medical encounters. She also mentioned another question about STI diagnoses in the past and her reasoning for asking that particular question.

I know a common question is just like how many partners you’ve had in the past year. I don’t think they necessarily need to say—I don’t think it’s one of those, “Oh, we need to know,” kind of things. I don’t feel like it has that much of an impact --That’s for me, at least. I know, in med school, they were like, “Oh, yeah, how many …” What does the number really mean, really? You know, cuz they were still gonna talk about safe sex
anyway. We’re still gonna talk about pregnancy prevention, if they don’t wanna be pregnant. I really don’t see how that number affects how I’m gonna counsel you. The reason I ask about the history of STDs, cuz if they have had, really, they are more at risk of getting it. That’s the only reason why I would ask the history, moreso than how many partners you’ve had.

Conversely, for Dr. Fulton*, an attending physician, the question about STI diagnoses in the past is often overlooked. She also wondered about whether asking the question more regularly would elicit more clinically relevant information than she already gathers from patients.

Have you ever been diagnosed with a sexually transmitted infection?” That is one that I probably forget to do a lot, unless someone’s coming in with symptoms of an STD. I also feel sometimes, like I’m not sure how that information would change my, like more deeper information would change my practice. If someone’s like, “Yeah, I have anal sex all the time.” Do I do anything with that information, or no? If I don’t, then why am I asking it? I sometimes don’t—you wanna’ find that balance of knowing what’s going on with your patients, but also asking information that’s relevant to your clinical decision-making as a physician.

Another attending physician, Dr. Odell*, described her difficulty in distinguishing relevant questions while navigating sexual history taking. Ethics, patient rights, and encouraging patient agency also seem to play a role in sexual health discussions with her patients.

I feel like you’re walking the fine line between what is and is not your business. I feel like, depending on what the patient describes, you can ask questions and explain why from a medical perspective it’s important to know, and a patient always has the right not to answer. I try to tell people that as well.

Finally, Dr. Nassau*, an attending physician, described a feeling of clinical responsibility to act upon the information that patients give her. She also explained that her patients often offer specific information, which she believes is based on a level of rapport. However, she acknowledged that often this proffered information is irrelevant to her clinical decision-making, and mentioned examples of health issues that she feels she can assist patients with.

Sometimes people just wanna tell me stuff just to tell me, and that’s fine. As the doctor hat, I feel like I’m supposed to do something with a lotta this information. Depends on my relationship with the patient, whether—I know they’re telling me because we have a relationship, and that’s what it means. Or they’re like, “I’m having”—it’s a female. “I’m
having sex with a male. I don’t wanna get pregnant. What’re my options?” That’s a great thing to bring up to me. “I’m having vaginal discharge. What could be going on?” “I have these bumps down on my penis. What is it?” “I got raped yesterday. I’m here for help.”

**Challenging Topics**

For providers, there are various challenges with taking sexual histories and having sexual health discussions, including determining the appropriate timing and questions, as described in the previous sections. Additionally, as shown in previous literature, specific topics can be difficult for providers to broach with patients. Here, we coded what these providers named as complicated and demanding health issues to address during medical encounters as *Challenging Topics* under *Navigating Sexual History Taking*.

Nurse Delancey*, a nurse practitioner, explained that she feels rather conflicted and almost inadequate if a patient were to mention they were suffering from trauma.

Trauma. If someone’s experienced trauma, I always find that really, really hard. ‘Cause nothing you can say is—you, no matter what you say, you always feel like it’s not the right thing. Right? Then, it’s just a matter of you don’t say anything. You want to know that you're supporting them. Trauma’s a tough one.

For Dr. Eldridge*, a fellow, a previous conversation with a patient about a new HIV diagnosis was particularly difficult. She mentioned that diagnosing patients with other STIs is much less stressful, and that she perceives an HIV diagnosis as having much more impact.

I know I got this one scare, when this patient came back with a positive HIV result, but it was—they had to do the secondary testing, and they hadn’t done it yet, but then I still had to let her know, “By the way, this is positive.” That was a very difficult conversation. Like, “Oh, you may have HIV, but we don’t really know, so we’re … The testing are coming through, we’re just gonna let you know …” That was extremely uncomfortable… I was just like— “I have to tell somebody that they have HIV!” I’m so like—chlamydia, gonorrhea, syphilis, whatever, I’m just like, “Okay, whatever, we’ve got treatments for that.” HIV, it’s still—it’s one of those things that’s really hard to have that conversation, like yeah, this is kind of a permanent thing.
Dr. Fulton*, an attending physician, mentioned difficulty around asking patients whether they engage in transactional sex. She also wondered about which patients she should be asking and at what point during the encounter.

I say where I feel a little bit less comfortable is maybe eliciting history of, trading sex for money or drugs. I still don’t have a great way to ask about that and I do feel like sometimes people are like, “Why would you ask me that?” Like once I’m in the discussion, it’s not that challenging, it’s more like, do I have that discussion with everybody? Do I have it with just some people? How in depth do I go? Do I just forget to ask about it?

Similarly, Nurse Gresham*, a nurse practitioner, talked about her own challenges with the transactional sex question, as well as asking patients about non-consensual sex. She explained that she finds it less difficult to ask younger patients, but that often the patients themselves are very uncomfortable with those topics and that influences the conversation.

I know that we use our personal judgment on when to ask about, well, having sex for money, which is such a dignity thing for people. For me to even ask, depending on the— it’s like, ohhh. Then, additionally, I find it challenging to ask if—I do it much more, is ask about coercive sexual situations. Certainly, I feel more comfortable asking those types of questions to, actually, adolescents. I don’t know why. I guess maybe they’re more likely to be manipulated by partners at that age. We see a lotta that. It’s uncomfortable; you feel— cuz they may not wanna talk about it if it has, and you can sometimes just see them like, “Oh, I don’t really wanna talk about it. Yes, but can we change the subject?” Kind of a discomfort in the person.

Another attending physician, Dr. Nassau*, explained that, for her, difficult topics are ones that she may not be able or have time to medically help a patient with.

Things where I don’t necessarily have an answer or thing I can do. I guess if we talk IPV, or interpersonal violence, or coercion, I can be empathetic. I can ask ‘em if they’re safe. I can talk about a safety plan maybe. I can say, “Do you wanna see our counselor?” but I can’t do a lot but be a sympathetic ear. Also, a lotta topics, it’s just not time to go there.

Finally, Dr. Pinehurst*, an attending physician, wondered if she was alone in thinking that herpes is stressful to talk about with patients. She also explained, like the previous provider, that limited time often further complicates these discussions.
I find herpes so hard to discuss with people. Are other people saying that too? [Laughter]. I find that really hard. I think it’s because of what precedes the conversation which is like society and the way that they’ve handled herpes. So, for me it’s really, it’s a lot of quelling anxiety and there are no great answers for people who view it a certain way, like as a stigma. You can hear—of course I talk about stigma with them but it doesn’t really, it doesn’t seem to work very well. It’s just a long conversation, that’s all, and our stupid 15 minutes visits you’re [checking off best practice advisory alerts in their chart] and stuff that’s not conducive to those kind of conversations. I mean I don’t mind having the conversation at all, it’s just I know it’s usually a longer one with a lot of anxiety. I don’t know if people feel good leaving.

CONCLUSIONS

In the interviews, we heard the various ways providers learned how to conduct sexual histories, and they explained intricacies around timing during medical encounters. Both patients and providers described similarities in navigating sexual history taking, but there were important differences. Specifically, providers mentioned several topics, such as IPV, transactional sex, and certain STI diagnoses, that are difficult for them to broach with patients, while patients said that most topics were acceptable to discuss.

Consistent with previous literature, female patients want to talk about sexual health matters with their medical providers regardless of topic. Furthermore, patients described an almost ethical responsibility to be honest and open during medical encounters so that providers can receive information they need to receive to diagnose and treat properly. For providers, forthrightness on the part of the patient is appreciated, but some acknowledged that disclosing certain details, such as type of sexual activity, may not be clinically relevant; a few providers wondered how much they were contributing to oversharing by asking sexual history questions that may not be applicable to every patient. These insights into how patients and providers navigate sexual health discussions indicate common experiences from which nursing, medical and patient education could benefit from. Based on what we learned from the provider interviews, there exists a need for additional training for providers around how to discuss difficult or uncomfortable sexual health topics with
their patients. Results from the patient interviews indicate that increased educational opportunities for patients regarding sexual health issues may help patients to more accurately describe their previous health issues and symptoms during sexual history taking (i.e. become “better” historians).

In the next section, **Chapter 5**, common barriers and facilitators to sexual history taking and sexual health discussions will be explored, and in **Chapter 6**, suggestions from patients and providers for improving these discussions are summarized.
Table 7. Navigating sexual history taking: Preliminary themes, sub-themes and descriptions

<table>
<thead>
<tr>
<th>Theme/Sub-Theme</th>
<th>Description</th>
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<tbody>
<tr>
<td><strong>Navigating Sexual History Taking</strong></td>
<td>Experiences of and feelings around taking/giving a sexual history and discussing sexual issues within medical encounters; for providers, can include tips, tricks, issues, etc. regarding ways in which sexual history taking is conducted</td>
</tr>
<tr>
<td><strong>Patients</strong></td>
<td></td>
</tr>
<tr>
<td>Questions Asked and Conversation During Encounter</td>
<td>Specific sexual health questions recalled, named as important, or were prioritized by patient, including: sexually active (timing – past year); # of partners; prior STI diagnoses; birth control; about pregnancies (miscarriages/abortions); also includes topics of discussion that were recalled</td>
</tr>
<tr>
<td>Uncomfortable Topics</td>
<td>Specific sexual health topics that are described as uncomfortable for patient; questioned why questions are asked; speculated that topics are possibly irrelevant to them</td>
</tr>
<tr>
<td>Honesty and Openness</td>
<td>Description of behavior during disclosure of sexual history and sexual issues; being honest and open with provider; that the patient almost had an ethical responsibility to do so otherwise the provider won’t be able to treat properly or they won’t know everything they need to know</td>
</tr>
<tr>
<td>Trust</td>
<td>Described as the key to being able to disclose sexual history and sexual issues honestly and openly; trust had to be established with provider in order for true disclosure to occur; trust did not occur if patient felt stigmatized or judged by provider</td>
</tr>
<tr>
<td>Shame and Stigma</td>
<td>Feelings of shame around elements of sexual history; related to social desirability; particularly if provider shows disapproval or slightly judges/shames patient about behavior, symptom, or sexual encounter; real or perceived stigmatization related to disclosure of sexual history</td>
</tr>
<tr>
<td><strong>Providers</strong></td>
<td></td>
</tr>
<tr>
<td>Personal Style and Journey</td>
<td>Description of how provider learned how to take a sexual history; tips and tricks learned along the way</td>
</tr>
<tr>
<td>Timing of History Taking During Encounter</td>
<td>Which questions should I ask, and when? If “wrong questions” are asked or questions are asked at “inappropriate time”, particularly regarding sexual history or sexual health; related to patient expectations -- impacts overall patient satisfaction with encounter</td>
</tr>
<tr>
<td>“What is and isn’t your business”</td>
<td>Weighing which (sexual history) questions are relevant and what info do I need in order to make a diagnosis? Why am I asking?; patients may not understand why questions are asked, implications of answers; what is and isn't your business; walking a fine line</td>
</tr>
<tr>
<td>Challenging Topics</td>
<td>Specifically related to IPV, sexual dysfunction, etc; if patient is asked, what do I do with that info?; described as having no support/resources for providers and patients</td>
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CHAPTER 5 - Barriers and Facilitators to Sexual History Taking and Discussions During Gynecological Care Encounters

One of the main goals of this study was to explore barriers and facilitators to sexual history taking and sexual health discussions from the perspectives of patients and providers. While some literature exists on what impedes or aides in these discussions during medical encounters\textsuperscript{32,73-76,78-82}, only two studies have been conducted with both patients and providers to examine similarities and differences between their responses.\textsuperscript{131,132} In this study, patients and providers were asked to describe sexual history taking processes they have experienced or conducted in the past, as well as conversations about sexual health in previous medical encounters. From those responses, we coded actual difficulties and successes that patients and providers experienced at a recent visit or past visits (at this and other medical facilities). In this chapter, patient and provider perspectives are categorized by barriers and facilitators that were mentioned during their interviews. In each section, patient responses are presented before those of the provider interviewees. By illuminating similarities and differences among patients and providers, improvements can be suggested to the history taking process and patient-provider communication about sexual health.

BARRIERS

As mentioned in Chapter 1, previous studies suggest a number of barriers to patient-provider communication during sexual history taking, including: gender, age, religion, race/ethnicity, and patient socioeconomic status.\textsuperscript{73,74,88,99} In this study, we were interested in the barriers patients and providers have experienced previously (described in this chapter), and what suggestions they had to improve those conversations in the future (presented in Chapter 6). Patients were asked about the sexual history taking process and sexual health discussions during their visit and how it compared to previous conversations they have had during medical encounters (e.g. \textit{How did you feel during the discussion?}; \textit{Have you discussed your sexual health with}
healthcare providers in the past?; How was this discussion similar or different?). Questions were also posed to patients about any possible omissions during their visit that day (Were there any sexual health topics not brought up that you wished had been? Why do you think they didn’t come up?), and around their comfort with sexual health discussions (Did you find it easy or difficult to discuss sexual health matters with [the provider]? Why do you think that is?). Providers were also asked about the sexual history taking process and sexual health discussion during a recent encounter. Similar to the patient interviewees, questions were posed to providers regarding their comfort with sexual health discussions (Personally, what sexual health topics do you find difficult to discuss with patients, if any? Why do you think that is?). Furthermore, detailed questions were also asked about the providers’ own sexual history taking process (e.g. In your experience, what is an effective way to gather sexual history information from patients?; How do your patients respond to this method of history taking?). The thematic findings from these questions during interviews with patients and providers are discussed below and are outlined in Table 8.

Patient Perceptions of Barriers

In previous studies with patient interviews, focus groups or surveys, provider gender, patient and/or provider age, and discussions about specific sexual health topics were named as barriers. Here, we heard similar experiences from patient interviewees, in addition to other reasons for difficulties with patient-provider communication during sexual history taking. In their interviews, fewer patients talked about barriers than facilitators; however, those patients frequently referenced those barriers to communication throughout their interviews, and thus those experiences were significant to the interviewee. Five sub-themes emerged about barriers to sexual history taking and discussions under the larger theme of Patient Perceptions of Barriers, which we coded as: 1) Gender of Provider; 2) Judgment, Shame and Stigma; 3) Social Desirability; 4)
Not Asking or Trying and, 5) Time (see Table 8). Next, these themes will be described and exemplar quotes will be presented.

Gender of Provider

Several patients talked about the gender of their provider as being a key barrier (or facilitator, as described later in this chapter) to communication, but also as influencing their overall satisfaction with the visit that day. Interestingly, a few interviewees described, in detail, their shock and dismay in finding out that they had an appointment with a male provider that day. Particularly for gynecological care, most patients felt that female providers (matched with their own gender) were understanding, empathetic, and easier to communicate with. We coded descriptions and feelings as Gender of Provider within Patient Perceptions of Barriers. While this is not a new finding, the occurrence of the theme in this study underscores the findings in other studies, as well as the influence of provider gender upon sexual history taking and sexual health discussions during gynecological care encounters.

For one patient, Ines*, aged 35-44, having a male provider during her visit that day was quite unexpected, and she reiterated this feeling of shock throughout her interview. She went on to explain that, from her perspective, the gender of her provider made it more difficult to discuss her health concerns, particularly any gynecological and sexual health issues.

It didn’t click to me that it was a guy doctor, so I felt kind of nervous and a little uneasy, but I have to do what I have to do. It was just like uhh. I mean, it was okay. I just felt just a little nervous, but talking to the doctor about physical stuff like getting [a] test for my shoulder and all that other stuff was fine, but when talking about Pap smears and anything else that happens with young ladies, it felt kind of awkward.

Likewise, Tasha*, aged 35-44, was taken aback when she realized that she had a male provider during her visit that day. She did describe some initial discomfort, but explained that,
since she views her health as important, she did not allow provider gender to be too much of an impediment to communication during her visit.

I was actually really surprised, I never ever had a male doctor. I was a little uncomfortable at first. I said it's my health, just whatever. Everything went well... He was really nice, and then he also had a female come when he was doing the examination. I was fine.

Tania*, aged 18-24, described her relief that her provider that day was female, after a series of recent visits with male providers to be tested and treated for an STI. The fact that she saw a female provider during her current visit made her question the frequency in which she was scheduled with male providers previously. She went on to explain her opinion of communication difficulties with male providers about gynecological and sexual health issues.

I was glad for the fact that she was a female doctor. Previously, I've been seeing male doctors, which is, I actually wanted to question that. Because I've been seeing males and males and males, and I'm trying not to—I'm trying to understand, like, why... I felt like with a male, they don't have the same parts as us. It's, like, it's automatically, like, oh, why are you checking my insides? You don't have—you don't know what I'm feeling. You never experienced it before.

Conversely, two patients mentioned that they believed having a male provider was a facilitator of patient-provider communication during gynecological care encounters. Alisha*, aged 25-34, explained that she feels male providers are more compassionate towards their female patients because they have not experienced the same physical sensations and health concerns.

It’s weird. I like male doctors, honestly. I feel like—I don’t know if it’s just me. I feel like they’re more sympathetic to the female patient. I think it’s because they don’t really know exactly how it feels, so they’re a little bit more sympathetic, whereas I feel like a female doctor’s just like girl, been there, done that. [Laughter] You’ll be fine.

Judgment, Shame and Stigma

A handful of patients described judgmental sexual health discussions with providers (at other medical institutions), and how these experiences evoked shame and perceived stigma for them around certain sexual health concerns or issues. Patients explained that these feelings prevent
them from broaching those subjects with subsequent medical providers for fear of further judgment. However, a few patients mentioned attempting to overcome those fears because they view their health as more important. We coded these experiences and perceptions as Judgment, Shame and Stigma under Patient Perceptions of Barriers.

Kristen*, aged 18-24, described the perception and anticipation of judgment as being a barrier to sexual health discussions during medical encounters. She mentioned provider age as a factor in experiencing actual or perceived judgment from providers during those conversations. Since she views her health as important, she explained that she tries to dispel her fear of judgment so as to not further impede patient-provider communication during medical encounters.

I think it can be difficult, especially when [the provider is] older and you think they might not relate to you as much, or are they gonna judge me because I've had X number of sexual partners, or done this, or something like that, or had an abortion, or whatever it may be, but I try and put my own health above those fears and just hope that they don't.

Lourdes*, aged 25-34, illustrated her experience of actual judgment from providers regarding the age in which she contracted HPV. She went on to explain that she believes providers should make an effort to be open-minded and unbiased during discussions of a patient’s sexual history.

A judgmental [conversation]. The HPV thing, the first time I went to that doctor, he was like, “You're 16!” He was freaking out. Actually, this doctor, like I was, “Oh yeah, I was 16…” She [the doctor] tried to not make a big deal of it, but it was all over her face. Yeah, just kind of try to be nonjudgmental. Maybe a judgmental one [conversation] wouldn’t be good.

For Ines*, aged 35-44, perception and fear of judgment during medical encounters are barriers to sexual health discussions. She offered an interesting take on disclosure and how much patients may feel comfortable telling providers particularly if patients fear some kind of recourse based on the provider’s assessment. She finished by explaining that discussions with family and
friends, and even strangers, are different in her opinion, but that a patient’s relationship with their provider can be deeply affected by the perception and fear of judgment.

To come in—you see a doctor as a, not an officer, but some form of official that you're like, oh man, am I going to get in trouble for saying this, or if I ask this question would it cause me a ACS case? You always have that negative thought behind your head like, if I say too much, are you going to call ACS, are you going to get me arrested, or are you going to red flag my chart? They are mandated reporters, so it's like, how much can you tell them before you’re reported or you feel comfortable enough to be like, I don’t think that’s bad. It's like a two-faced kind of thing or a flip of a coin. What can you tell a doctor or what can you not tell the doctor? You can tell your friends and family and strangers everything. You could tell a stranger anything and they're not going to see you again, but to tell your doctor who you got to come back and see if they judge you, there's a lot of judging. That’s what people are afraid of, to be judged.

Social Desirability

A few patients explained their apprehension and discomfort with a certain question (number of sexual partners) during the sexual history taking process. Related to the previous theme of Judgment, Shame and Stigma, interviewees described this discomfort as stemming from a fear of judgment from the provider based on the patient’s actual answer to the question. Two other studies have suggested similar results regarding that particular sexual history taking question\textsuperscript{38,79}; here, the interviewees described a tension between social desirability and honesty with their answers, and so, we coded these descriptions as Social Desirability within Patient Perceptions of Barriers.

Ines*, aged 35-44, talked about her discomfort around a particular question during sexual history taking. She explained that fear of judgment from the provider drives this apprehension to give an honest answer. She also mentioned a fear of disclosure by the provider to others, particularly if the answer is atypical.

If they ask you, “How many partners you have?” Now, am I going to lie and say I had zero partners, when deep down I know I had like 150 of them, you know? That’s what it is. That’s what makes the patient uncomfortable, sometimes being honest and stuff because
you don’t know how they're [the provider] going to look at you afterwards or if they are going to go and say, “Listen, I had this patient...”

Likewise, Renee*, aged 25-34, mentioned that social desirability, particularly around the same sexual history taking question (number of sexual partners), may impede sexual health discussions during medical encounters.

Everybody’s not gonna be cool with answering the question correctly. Some people might just be like, “Yeah, I’ve had one partner over the three years,” and stuff like that when they know that they freaking everybody.

Not Asking or Trying

Several patients mentioned that lack of provider engagement can impede sexual history taking and sexual health discussions. Interviewees specifically cited technology (e.g. computers, EHR) as negatively affecting whether the provider addressed their current health concerns and made an effort to connect with them. Much like provider gender, lack of provider engagement (or perception of) due to technology present in the exam room is not a new finding with regard to barriers to patient-provider communication. However, the intensity at which this theme was discussed within patient interviews is notable, and, thus, we coded these descriptions as Not Asking or Trying under Patient Perceptions of Barriers.

Kassandra*, aged 18-24, talked about providers she has experienced that are more focused on the EHR than speaking to her and discussing her concerns. She gave a rich analogy to how she felt during those encounters, equating her feelings to being served by a rude barista.

Oh, the doctor's that be typing, and they be like, "Oh, how many partners you have? Five? Okay, five." I feel like that's—that—it's not even customer service. I don't know how to say it, but if I was going to buy a frappe, and the worker's just making the stuff, and not giving me a moment to speak to her, it's like—I don’t feel like it's real respectful.

Similarly, Ines*, aged 35-44, described an encounter where the provider failed to address her concerns, and was primarily engaged with typing notes into the EHR. During this encounter,
the provider also suggested that she should make an additional appointment with her PCP to get her concerns addressed.

When they just come in, would turn on the computer, “Okay, what do you want?” and not follow up with you on stuff or not give you eye contact and they just keep typing away or they just say, “Oh, well I'm not your doctor so why don’t you just set up another appointment with your other doctor and then follow up with them?”

Alisha*, aged 25-34, named multiple barriers to communication that she has experienced during medical encounters, including providers failing to engage with her. Despite limited time during visits, she explained that she makes the effort to be at the appointment and get health concerns addressed, and so, providers should make a similar effort to communicate effectively with patients.

No suggestions, not really listening to me, like if I’m saying I’m having questions about this and they’re answering about something else, it’s just like clearly you’re not listening to me. Making me feel rushed during the appointment. No eye contact. Just simple things… Definitely making me feel rushed ‘cause I do understand that everything is timed, but I wanna feel like I have your undivided attention while I’m here ‘cause I’m only here maybe once a year, so I need to get all my questions answered.

**Time**

A few patients talked about lack of provider time as a major barrier to patient-provider communication during sexual history taking and sexual health discussions. In their descriptions, interviewees richly illustrated how limited time impacted conversations, as well as receiving appropriate diagnoses and treatments during prior medical encounters. Again, this is not a novel finding, but lack of provider time was an important barrier mentioned by patient interviewees, which we coded as **Time**.

Kristen*, aged 18-24, explained how the perception of lack of provider time hinders patient-provider communication during gynecological care encounters. She mentioned that she and others close to her have frequently experienced this barrier. She went on to illustrate what
occurred with her mother during pregnancy, and how she believes that provider time played a role in her mother’s delayed diagnosis of ovarian cancer.

In-out, out the door, just, "Here's your prescription," or whatever, answering only the exact problem you came in there for, which if it's, "Oh, I need a birth control prescription." "Okay, done." I think that's what I've experienced a lot, and a lot of women I know experienced. Even my mom had ovarian cancer, and that probably could have been—and she was pregnant with me when she had ovarian cancer. [The healthcare providers] were all in [her body], and no one ever [explored] outside of the little scope of [the pregnancy]. I think, again, it happens cuz doctors are overbooked, and they're too busy, and so maybe it's the nurse that comes in and checks your vitals is asking those questions, who also tends to be female as well, or the student doctor that I had coming in and taking that time. It all just, I think, boils down to time.

Monique*, aged 35-44, also described the lack of provider time as a barrier to communication, but also to seeking and receiving appropriate medical care. Like the previous patient, Monique* explained that this barrier is experienced frequently and can negatively affect healthcare-seeking behaviors of patients, particularly if the patient perceives time spent with the provider as an indication of provider concern and compassion (as described in Chapter 6).

A lot of the times when you do go to clinics I feel like, because sometimes they’re short staffed, you do feel rushed when you get into the visiting area--the actual doctor’s office, so sometimes you don’t say everything that you could say because you feel like they’re on a time schedule… For me, I have a lot of friends, a lot of the time they say that’s why they don’t like going to the doctor, because they feel as if the doctor doesn’t care. It’s like they’re just here getting a check or they’re prescribing you with things, but they’re not asking you what’s going on with you.

Provider Perceptions of Barriers

Several studies have named barriers to sexual history taking and sexual health discussions from the perspectives of providers, including encounter length, multiple health concerns to be addressed, and patient age and socio-economic status. In our provider interviews, we heard a variety of reasons for difficulties with patient-provider communication during sexual history taking, but only a few were mentioned in previous studies. Unlike our patients, providers talked more in depth about barriers than facilitators, indicating that those experiences were significant to
the interviewee. Six sub-themes emerged about barriers to sexual history taking and discussions under the larger theme of *Provider Perceptions of Barriers*, which we coded as: 1) Discomfort; 2) Judgment or Presumptions; 3) Generational Differences, 4) “There’s Physically No Time”. 5) Multitasking During Encounter and, 6) Differing Definitions of Sex (see Table 8). These themes will be described subsequently and exemplar quotes will be presented.

**Discomfort**

Similar to the patient interviewees, several providers mentioned discomfort around specific sexual health topics that are discussed during medical encounters. Interviewees talked about this unease as either stemming from themselves or from their patients. If the discomfort was on behalf of the provider, the interviewee explained the reasoning behind those feelings. Other studies have cited provider discomfort with sexual history taking\textsuperscript{38,81,109-116}, and so the results presented here, which were coded as Discomfort, supplement those previous findings.

Nurse Wheeler*, a nurse practitioner, described her unease with detailed descriptions of patients’ sexual activity. She jokingly added that those descriptions are a result of the comfort felt by her patients in the encounter (which is named as a facilitator later in Chapter 5), and went on to emphasize her discomfort with those conversations.

I don’t have any problem initiating sexual questions or anything, but sometimes when patients are a little bit too descriptive, it, I guess, can make me a little uncomfortable. Sometimes maybe patients feel a little too comfortable with me [laughing], and so they tell me more than what I really need to know. Maybe sometimes it’s uncomfortable when people are being a little bit too elaborate with whatever sex that they were having a couple days ago or whatever. Sometimes that can be uncomfortable.

For Nurse Gresham*, another nurse practitioner, there is often discomfort felt by her patients during conversations about sexual dysfunction, particularly for older male patients. She explained that this discomfort negatively affects the discussion about sexual health during those
visits, and she attempts to lessen those effects by adapting her questions and responses to the comfort level of the patient.

I guess sometimes older males often, I find, are probably the least successful conversations, because they’re really visibly uncomfortable until I talk about it [sexual health]. I certainly will tailor the conversation to what their level of comfort is, and so, especially if they have a complaint of something in the erectile dysfunction realm…

Dr. Fulton*, an attending physician, talked about her discomfort around a particular sexual history taking question due to adverse reactions to the question from patients in the past. She acknowledged that her feelings and lack of skill with the question perpetuate the discomfort felt by patients and herself during those conversations.

I say where I feel a little bit less comfortable is maybe eliciting history of, trading sex for money or drugs. I still don’t have a great way to ask about that and I do feel like sometimes people are like, “Why would you ask me that?” That I feel a little bit more shaky on, and those conversations have been awkward sometimes because I’m awkward about it, so then the patient’s awkward about it.

Dr. Pinehurst*, another attending physician, described instances during sexual history taking and discussions where a few of her patients have reacted in an adverse way, which was a barrier to patient-provider communication. She hypothesized about the reasons behind their reactions, and reflected on how she handled those conversations with patients in the past.

I’d say most people are fine with that questioning and then there’s a very small handful where you’re surprised that they are reacting a different way. You feel like maybe there’s something else going on. I feel like some of it is mistrust for—you know, I didn’t realize it, but when I walk in the door, there’s like a mistrust for the system in a way. They’re seeking help but it’s like very, very sensitive. In those situations I wished that I had maybe gone a lot more, given a lot more space around the person and kinda just said sure here’s, and not dug around deeper, maybe waited for rapport to kind of firm up, and then maybe next time kind of asked about those questions.

Judgment or Presumptions

During their interviews, a majority of providers talked about judgment or presumptions that they have made about patients in the past, or that they have heard about from patients as
barriers to sexual history taking and discussions during gynecological care encounters. This barrier was also named by our patient interviewees. The fact that this theme was named by patients and providers in this study underscores its significance to the sexual history taking process. Providers gave detailed examples about the impact that assumptions and judgment have upon patients, particularly during conversations about sensitive matters, such as sexual and reproductive health. We coded these descriptions as Judgment or Presumptions within Provider Perceptions of Barriers.

Dr. Eldridge*, a fellow, explained how her initial assumption about patient knowledge around contraception choices underscored the importance of asking questions and having a discussion with her patients. She mentioned that assumptions made by providers can impact patient-provider communication, and ultimately the care a patient receives.

Well, in the beginning, it was people really don’t understand the difference between the IUD and the Nexplanon, when I talk about contraception options. They’re just like, “Oh, I want the IUD in the arm,” and I’m just like, “Oh, you mean, the Nexplanon?” I feel like everyone makes that mistake now, so I just ask. I don’t assume, because I’m just like, “What would you like, in terms options?” to make sure that we’re all on the same page, to see what they want.

Dr. Fulton*, an attending physician, gave an example of judgmental sexual health conversations that her patients have experienced at other medical institutions. She went on to explain that provider beliefs, attitudes and biases can negatively affect patient-provider communication, particularly about sexual and reproductive health. During her own encounters, she described her nonjudgmental attitude as facilitating sexual history taking and sexual health discussions with her patients.

People bring their own biases to the table in this [sexual and reproductive healthcare], like maybe more so than other facets of medicine. You definitely have heard stories from patients about, “Oh, well it’s such a pleasure to have this conversation. The last doctor I asked for birth control called me a slut.” You know? Things you would not think you’d hear in this city in the 21st century. I think there's a broad range of how much physicians
feel this is or isn’t their job, and bringing their own moral beliefs or whatever, into it and with varying degrees of it.

Nurse Wheeler*, a nurse practitioner, explained her experiences with patients who perceive they are being judged during sexual history taking and sexual health discussions. She mentioned that a perception of judgment and resulting defensive attitude impedes conversations about sexual health with those patients. She specifically mentioned the question about number of sexual partners which was also named by patient interviewees as a barrier to patient-provider communication during sexual history taking.

Sometimes people are defensive when you ask them [sexual health] questions. It happens more, you know, like they feel like they’re being judged, so they don’t wanna tell you or they are defensive about how many, like, “Why do you need to know how many?” Or “What’s that have to do with anything?” That’s not helpful at all, ‘cause then it just puts up that barrier, and then you don’t wanna go any deeper, ‘cause the patient doesn’t want to share with you. To me, that’s not a good—the defensive tone.

Generational Differences

Like the patient interviewees, many providers also described patient age (compared to their own) as a potential barrier to sexual health discussions during medical encounters. Providers explained that these generational differences affect their comfort level, as well as the patient’s, with raising and talking about certain sexual health topics. Any references to difficulties with sexual history taking due to a patient’s age was coded as Generational Differences under Provider Perceptions of Barriers.

Nurse Gresham*, a nurse practitioner, talked about her discomfort in asking older patients specific sexual history taking questions. She explained that her comfort level is higher during visits with younger patients, and she is able to ask those questions more frequently due to those patients’ risk profile.

I find it challenging to ask if—I do it much more, is ask about coercive sexual situations. Certainly, I feel more comfortable asking those types of questions to, actually, adolescents.
I don’t know why. I guess maybe they’re more likely to be manipulated by partners at that age. We see a lotta that.

For Dr. Odell*, an attending physician, sexual health discussions with older patients are impeded by her age. She went on to say that her age is a facilitator with younger patients, and that they perceive her as more of an equal than her older patients.

I guess I would say some of my older female patients brush aside the topic of sexual history… I think also, because I’m younger and so I think a lot of people, especially young women, I feel like they talk to me like some combo of a doctor and a peer. Which makes a lot of sense.

“There’s Physically No Time”

Several of the providers mentioned that lack of provider time is a barrier to patient-provider communication about sexual health. Interviewees gave rich examples of how limited time has impacted previous medical encounters, and how they weigh their desire to do more for their patients with the reality of what can be accomplished during brief medical visits. We coded these explanations by providers as “There’s Physically No Time”, under Provider Perceptions of Barriers.

Nurse Delancey*, a nurse practitioner, described how limited time often prevents her from addressing health issues that the EHR prompts her to ask patients about. She expressed her desire to discuss these issues with patients, but detailed the challenges she is presented with during brief medical encounters.

It really depends on the patient. Ideally, you wanna do [best practice advisories] every time. Then, sometimes it’s like okay, well I ask, but then I don’t do anything about it. I’m like, “Let's talk. Your BMI’s elevated,” but there's physically no time, or, to discuss diet and exercise. It’s not fair to just be like, “Oh, stop.” I like to actually tell them why I’m doing it and educate… You pray that they’ve seen a dentist, ‘cause then it’s a whole other can of worms.

For Dr. Nassau*, an attending physician, limited time negatively affects the depth of sexual health discussions she is able to have with her patients. She described time as a luxury that patients
and providers are not afforded during medical encounters, and thus, it may take multiple visits to address sexual health concerns of patients.

Pragmatically, as I tell patients about that [sexual health], I wish I had an hour to spend with every patient, but if we have time constraints, we can’t cover everything well. If we have to do a lot, we can’t do anything really well, but we can hit a bunch of topics… What practically can we do is a lot more limited, or we can do pieces of it over time but not in one visit. We don’t have that luxury.

Lastly, Dr. Eldridge*, a fellow, described limited time as negatively affecting sexual history taking during medical encounters. She explained that, due to limited time, she is not regularly assessing female patients for a history of trauma. This omission often leads to negative patient experiences during pelvic exams.

Some women are still—I think it’s just the discomfort. They respond differently to [a pelvic exam]. Some worse than others. We don’t necessarily go over their history, like if there’s been any trauma, necessarily, before I do a pelvic exam. Sometimes, I feel like maybe I should do a little bit more of that, but I don’t, due to time constraints, unfortunately. That’s just how it is, in real life.

Multitasking During Encounter

Related to the previous theme, “There’s Physically No Time”, providers explained challenges around limited time during medical encounters and the need to assess, diagnose and treat multiple health conditions. Previous studies have cited similar findings, and indicate that physician gender and visit reason (annual examination vs. acute illness) also play an important role in how many health issues are addressed and the delivery of preventative health services.245-247 Here, interviewees felt that it was unrealistic and impossible to address best practice advisory prompts in the EHR and other health concerns mentioned by patients (particularly those who are new, and not established), in addition to the primary reason for a patient’s visit. Relatedly, prior research regarding decision-making tools in EHRs indicate mismatches between language used in the prompts and the health and fundamental literacy level of patients, which present barriers to
patient-provider communication. In this study, we coded the feelings and frustrations expressed by providers as Multitasking During Encounter.

Nurse Delancey*, a nurse practitioner, described the conflict between addressing multiple health conditions with new patients (specifically those with walk-in appointments). She explained that the reason for the patient’s visit may seem mismatched (from the patient’s perspective) with questions about common health issues that the EHR prompts her to ask during every visit. This perceived mismatch by the patient can impede discussions about and care provided for those health issues during these encounters.

As a walk-in provider, it’s hard to address them [best practice advisories] at every visit. Especially when you don’t know the patient and they come in, for example, for vaginal discharge. They’ve never met me, so by the time they warm up to me and then I start asking about dentists, they get confused, and they’re like, “I’m not here for that.”

Dr. Eldridge*, a fellow, experienced a similar situation during encounters with new patients. She mentioned her difficulties in trying to address the patient’s current medical complaint and any other concerns, and eventually ignoring EHR question prompts for other health conditions due to limited time.

For most walk-ins, I don’t do [best practice advisories], cuz they’re not normally my patients, and it’s hard to really get a grasp, and establish your rapport, and get through all those things, on top of everything else that they want, for that walk-in visit.

Dr. Nassau*, an attending physician, described the tension between a patient’s current health concerns, and provider ability to treat and diagnose within a limited timeframe. She mentioned that she teaches medical residents to focus on specific health issues because multitasking during encounters is not entirely feasible.

While we’re family doctors, we also have to realize we have a lotta patients to see... Here’s the language as age-appropriate as STI testing, cervical cancer screening, HPV vaccination is needed and keeping it in that purview, because we can go down the rabbit hole of your migraines and your belly pain and all that. As I do in the [resident] training, this is not what we’re here for today. We’re here to help you find the birth control that’s best for you.
Differing Definitions of Sex

Lastly, providers talked about a barrier that is not frequently cited in other studies of sexual history taking and sexual health discussions. Interviewees explained difficulties with patient-provider communication when providers and patients define sexual health topics differently. Similar to the findings presented in Chapter 3, where framing of sexual health and behavior varied among patients and providers, specific jargon and definitions of sex used by one participant may not be understood by the other during medical encounters. As mentioned in Chapter 1, mismatches in health literacy levels have been described as a major barrier to patient-provider communication.\textsuperscript{164,206} When providers mentioned these mismatches and difficulties, we coded them as Differing Definitions of Sex. The following quotes detail examples of those differences.

Nurse Delancey*, a nurse practitioner, illustrated how differing definitions of sexual behavior can impede patient-provider communication during sexual history taking. She mentioned that, particularly for younger patients, the question around current sexual activity can elicit a response that may not be accurate. Their seemingly inaccurate responses may be due to variations in understanding the term “sexual activity”, which are often dissimilar to the provider definition.

I mean, you ask if they're having sex, or are sexually active. Although people don’t really understand what that means. The adolescents, if they didn’t have sex in the morning, they're not sexually active. They're like, “That’s yesterday.” \textit{[Laughter]}

Dr. Fulton*, an attending physician, described how her personal ideas and beliefs about sexual activity often pose a challenge during sexual health discussions with patients. She explained her difficulty with addressing a possible sexual health issue if she and the patient view sexual activity and sexual pleasure differently.

I struggle sometimes, with what my expectations for sexual activity, not ought to be, that’s not—but if I have a patients whose like, “Well, you know he doesn’t want it often and it’s over quick.” I’m like, “Well that sounds awful.” She’s like, “No, it’s fine.” I’m like, “Well, do I just leave it there, or do I try to empower her to be more of an agent in her sexual
health and sexual activity?” If she’s saying it’s fine, is it fine? Am I just imposing my sex positivity, whatever, on her and she doesn’t give a shit? I don’t know.

Dr. Thayer*, another attending physician, talked about the actual language used by patients and providers to describe sexual health issues. She mentioned that providers should attempt to understand the various words and definitions used by patients in order to reduce barriers during conversations about sexual health.

People have different words for different body parts and different sexual positions and different practices, and I think it’s really helpful to know what those are, so that people can feel comfortable speaking in whatever language is most comfortable for them around those topics.

FACILITATORS

In addition to barriers, other studies have named a variety of facilitators to patient-provider communication during sexual history taking, such as: concordance with gender, age, religion, and race/ethnicity (see Chapter 1).33,73,74,78,99 Here, we explored actual and perceived facilitators that patients and providers have experienced during past medical encounters. As detailed in the Barriers section, patients were asked a series of questions about the sexual history taking process and sexual health discussions during their recent visit and previous medical encounters. Questions were also posed to providers about history taking and conversations during a recent encounter, as well as their comfort around those discussions. The thematic findings from these questions are described below and are outlined in Table 8.

Patient Perceptions of Facilitators

Prior research has indicated that gender and encounter length positively influence patient-provider communication.73,74,99,249 Our patient interviewees mentioned that they have experienced those facilitators during medical visits, in addition to other enablers to sexual history taking and sexual health discussions. Interestingly, during their interviews, patients gave more examples of
facilitators than impediments to these conversations. Four sub-themes emerged about facilitators to sexual history taking and discussions under the larger theme of Patient Perceptions of Facilitators, which we coded as: 1) Provider Approach; 2) Gender of Provider; 3) Building Relationships, and, 4) “Not Feeling Rushed” (see Table 8). These themes will be described subsequently and exemplar quotes will be presented.

Provider Approach

Provider demeanor and approach to communication was mentioned by a majority of patients as a facilitator to sexual history taking and sexual health discussions during medical encounters. Interviewees explained that the perception of a calm, professional, and respectful attitude from their provider generates feelings of comfort on behalf of the patient. These feelings (described in more detail in Chapter 6) can impact disclosure during sexual history taking, as well as health-seeking behaviors of patients. Due to this positive impact, we coded references to provider demeanor as Provider Approach under Patient Perceptions of Facilitators.

Erika*, aged 25-34, described the demeanor of the provider she had that day and how that particular quality created a sense of comfort for her. She explained that provider approach is essential to her experience as a patient in that it facilitates (or hinders) patient-provider communication.

It's just the aura he [the provider] gave off. I believe that's pretty important. The professionalism was good, as well. It's just how he approached the -- like approached the situation, like some doctors, they would give off an aura where you feel like I don't think I want to tell him about that, but he was okay. Yeah. I felt real comfortable.

Similarly, Kassandra*, aged 18-24, mentioned that the attitude and disposition of one’s provider can affect patient-provider communication, and ultimately health outcomes. She went on to explain that provider approach can motivate a patient to pay attention to their health and seek medical care regularly.
I think it's the communication with the doctors. The way they are, and the way they carry themselves, and how polite they are, that makes the whole visit way better. It makes the visit—they make you feel like you want to come to the doctor regularly, and take care of your health because you have a doctor who cares for you, as well.

Carmen*, aged 25-34, also mentioned provider approach as being crucial to patient-provider communication. She gave the example of an intense or forceful demeanor as being a barrier to patient comfort and disclosure. After prompting, she described an ideal provider approach as compassionate and open-minded.

*Interviewee: To me it depends on the approach—because you can—a person can pretty much talk about anything, but it’s the way that they [the providers] approach the patients. If you come on too strong, it’s going to make the person feel uncomfortable.

*Interviewer: Mm-hmm. Sure. The approach would be… you said, non-judgmental before…

*Interviewee: Empathetic…

Lastly, Renee*, aged 25-34, echoed similar sentiments to the other patients by explaining that provider approach and demeanor can lead either to a successful medical encounter or to a complete breakdown in patient-provider communication.

They gotta feel like—your provider is not your friend but is friendly. You know what I mean? ‘Cuz that’s always a big thing. It’s a big deal with me. If I don’t like my provider, I will not talk to them. I won’t even get anything from them. I’ll be like, “Yo, I’ll come back another day,” and wait ‘till another provider comes.

**Gender of Provider**

While provider gender was described as a barrier, several patients also mentioned the gender of their provider as a facilitator to sexual health discussions during their recent visit. This is consistent with other studies that cite gender as both impeding and aiding in conversations about sexual and reproductive health. Here, patient interviewees talked about their preferences for either
gender-concordant or -discordant medical encounters and reasons behind those preferences. These explanations were coded as Gender of Provider within Patient Perceptions of Facilitators.

Ines*, aged 35-44, was emphatic about her discomfort with a male provider, and explained why she always visits a female provider for gynecological care. She even mentioned that she is guiding her children to adopt similar healthcare-seeking behavior.

I guess ever since I was younger, I always had a female doctor, and I'm raising my kids to always have—that’s what they like. I feel like females understand more about what another female is going through. It just feels weird having a guy look at you, even though you're here because you've had intercourse and everything like that, but to have another guy look at your private area, it's kind of weird, you know?

Similarly, Brittany*, aged 18-24, richly described her reasoning behind visiting a female provider for gynecological care. She explained that the shared understanding between patients and providers that are of the same gender facilitates patient-provider communication during medical encounters, as well as building relationships and trust over time.

I guess as a female [patient], I would feel awkward asking a male doctor about these things because I just overall, my gut instinct says a female would understand more especially if it’s like a female doctor and a female patient because you know, not you know, but how do I explain it? I guess it's just like the emotion. You know you get that relationship you have with the patient and doctor is very important, but sometimes you talk to a male doctor and you feel like maybe they won't understand me completely 'cause what they know is from the books and from what other people have told them. But when you talk to doctor that can probably personally connect with you, it feels more trusting and easygoing to really have the patient-doctor relationship and meet the goal of how do I treat this patient today satisfactory?

Like the previous patients, Tania*, aged 18-24, stated her preference for female providers, particularly for gynecological care. However, she did mention that she has had medical visits with male providers in the past. With female providers, she explained that she often experiences a higher comfort level and feelings of connectedness, which facilitates patient-provider communication during those visits.
I think I find it more easy with a female [provider], to discuss [sexual health]. With a male, I really don't care. I care more about my health than anything. It's, like, if I have to tell you, yeah, I have chlamydia—okay, yeah, I had it. Okay, so more forward. Let's see. You know? I would definitely feel more comfortable talking with a female, talking over the symptoms and the things that I'm feeling and things like that. As I said, she can relate to the things that are going on. With the males, you're a different species. [Laughter]

Of the patients that described gender as a facilitator (or a barrier), most stated that they preferred female providers. As mentioned earlier in this chapter, a few patients did talk about feeling more comfortable visiting a male provider for gynecological care. Alisha*, aged 25-34, was one of those patients. Here, she succinctly explained her reasoning for preferring medical care from male providers.

That’s just my feeling from male doctors. I feel like they’re just more sympathetic than the female doctors… My last doctor, she was a female doctor and she was really, really good. She made me feel really, really comfortable, so I’ve had males and females, but for me, I just feel like males—I don’t know. My preference.

Building Relationships

Several patients mentioned the importance of building a relationship with their provider and how that facilitates conversations about sensitive topics, like sexual health. Interviewees talked about feelings of comfort that were a product of the open, inviting environment created by their provider. These feelings, which were perpetuated during that encounter and/or subsequent visits, helped the patient to build a relationship with that particular provider. We coded these descriptions of comfort, trust, and honest discussions as Building Relationships.

Janelle*, aged 25-34, gave the example of her first gynecological care experience and the fear she felt about having a pelvic exam. However, she went on to say that her fear was eventually dissipated by the comfort she felt during the visit, and, during subsequent visits, she was able to openly discuss issues and concerns with that provider.

Like the first time I went to the OB/GYN I was scared. It was like, you don't really want some random person to examine you like that, but after the first time and I got comfortable
with my OB/GYN—then you start opening up and telling 'em everything. As long as you're comfortable with that person, I think that's how it should be.

Monique*, aged 35-44, described how the non-judgmental attitude of her provider that day allowed her to answer his questions honestly and without hesitation. She explained that a feeling on comfort (on behalf of the patient) is key to facilitating patient-provider communication and building relationships during medical encounters.

To me, that’s where you have to build that relationship with your doctor. For me, because he had a calm spirit, I didn’t get that [judgment] from him. When he asked me questions, I just was like, “Oh, this is what’s going on.” I do feel like you have to make your patient comfortable in order for them to want to open up to you.

Similar to the previous patients, Ines*, aged 35-44, explained that building a relationship with a provider can facilitate discussions between patients and providers. She gave a hypothetical example of a patient with ongoing medical issues being able to receive the care they need based on the rapport built between the patient and provider over time.

You want to be able to have that relationship with your doctor where you can say, “Hey Doc, today I woke up and this was happening down here and I need you to check it out for me,” and the doctor be like, “Okay, no problem. I understand you’ve been having problems before,” so that goes back to making sure that everything is updated, that you go back in the person's chart and realize okay, she's been here for A, B, and C a couple of times a month, so if she comes back, she might repeat this.

“Not Feeling Rushed”

Much like Gender of Provider, time was mentioned as both a barrier and facilitator to patient-provider communication about sexual health. A few patients explained that, during their visit that day, they felt their provider spent sufficient time addressing their health concerns. Interviewees favorably described the provider and the encounter itself during these explanations. Patients went on to talk about how that extra time increased their comfort level, which we coded as “Not Feeling Rushed”.
For Monique*, aged 35-44, sufficient time with her provider was an important facilitator of patient-provider communication during her visit that day. She also mentioned that an unhurried and relaxed medical environment can help patients feel more comfortable, which also aids in discussions between patients and providers.

I feel like some doctors can’t always worry about a time. I think you really do need to get to know your patients. I feel like that was the difference today. Because I was his new patient, [the provider] took his time. I feel like, in order for someone to feel comfortable with you, they can’t feel rushed.

Kristen*, aged 18-24, contrasted the sexual history taking process that she participated in during her visit that day with ones she has experienced in the past. She explained that adequate time with her provider was a factor in making her feel understood, in addition to receiving the medical care she needed.

Similar in the sense of the same [sexual health] questions always, but different in the sense they [the provider] took the time, it felt like, instead of just making it a process. I would say that's this whole building, that every floor I've been in has been very much like that, to take the time to answer any questions and go slowly and stuff…. Here, they take the time to understand and asking you every question. I had an HIV test last week, "Do you want another one this week?" Just taking the extra step. It was really nice… Giving time, not feeling rushed, like, "I need this room again."

Likewise, Marissa*, aged 18-24, favorably described the sexual health discussion she had with her provider that day. She explained that the considerable time that was spent by the provider during the conversation evoked a sense of caring and consideration that Marissa* appreciated as a patient.

For the doctors to even care so much, she even had the conversation with me where I was like if she clocks in and don’t see no patients and clocks out she’s still gonna get paid for it. It’s not like—she’s like, “You see how I came here and sat down and actually had a conversation. We could come here for an hour or two if we wanted.” That’s what I liked about this experience.
Similar to the barriers that providers discussed, we heard about several facilitators to patient-provider communication during sexual history taking from our provider interviewees, but some have rarely been mentioned in previous studies. Interviewees gave thoughtful responses to what they believed as aiding these discussions and encouraging patient disclosure. Four sub-themes emerged regarding facilitators to sexual health discussions under the larger theme of Provider Perceptions of Facilitators, which we coded as: 1) Relevant, Tailored Questions; 2) “Not a Guy with a Tie”; 3) Open Environment and Nonjudgmental Questions, and 4) Patient Preparation. (see Table 8). Next, these themes will be described and exemplar quotes will be presented.

Relevant, Tailored Questions

When talking about how they conduct sexual histories, a majority of providers mentioned tailoring questions to a patient’s attitude, health behaviors, or health issues. They stressed the importance of making the questions and conversations seem relevant to the patient and their current health concerns. By doing so, interviewees explained that patients are more receptive to sexual health discussions and willing to disclose information about their sexual history. We coded these scenarios as Relevant, Tailored Questions within Provider Perceptions of Facilitators.

Nurse Wheeler*, a nurse practitioner, described her individualized sexual history taking process, and how she believes that it facilitates sexual health discussions with patients. She stressed the importance of adapting the questions and conversation to specific health concerns that the patient is experiencing, and providing education germane to those health issues.

Sometimes I’ll ask if the patients have any questions first, and just tell them about—I know with women I always talk about birth control and giving them—make sure that they know that if they’re on birth control pills, be sure that you take it every day. I gear it towards whatever is relevant to the patient. Be sure that they know that just ’cause they had an IUD,
that doesn’t protect you from STDs. Just tailor it to the patient. Even if it’s stuff that you may assume that they know, they may not know. Always just adding in the things that you know are important to their care.

Dr. Nassau*, an attending physician, explained how specific and tailored questions to patient characteristics and health issues help her to diagnose and treat her patients appropriately. Earlier in the interview, she mentioned that each medical encounter is different, and she believes there is not a singular method to gathering a sexual history, particularly with the limited time that providers are given with patients.

Interviewee: I guess in an age-appropriate way. Where are they [the patient] developmentally? I saw a couple of teenagers in the office the other day, and I would talk to them differently than I talk to my—my, actually, 60-some year-old who I did the vulvar biopsy on the other day and who I’ve known for a long time and is having a lot of sexual health issues, totally different conversation with those patients. A lot of it I try to do is be nonjudgmental and just leave it open, in a way…

Interviewer: Yeah. It sounds like you tailor it to each—

Interviewee: The situation.

Another nurse practitioner, Nurse Delancey*, described how she initiates the sexual history taking process with patients who may not be presenting with a gynecological issue. She explained her attempts to make the process and questions seem relevant to these patients, which she feels facilitates patient-provider communication. She also mentioned the differences in receptiveness to sexual history taking that she has observed with her younger and older patients.

I do try to, if it’s not—so, say they're not in for a vaginal or a sexual complaint. It’s just a physical. Then, it comes to the repro section. You do like to just preface it by saying, “This is something we ask everybody. This is a part of your overall well-being,” so they're not totally shocked. I think that helps, if a patient is more reserved or—that’s not really a good way to put it. That’s not their complaint, right? If it’s not necessarily expected to be addressed. Or, when that BPA does pop up—although the kids are so used to it. They're like, “You ask me every time, this.” You say, “This is a new question that we’re discussing.” Yeah. Then, I feel like people are more receptive.
“Not a Guy with a Tie”

Several providers talked about their usage of simple, clear language during sexual health discussions with patients. As mentioned earlier in this chapter with the sub-theme, Differing Definitions of Sex, matches (and mismatches) in health and fundamental literacy levels among patients and providers can influence communication and understanding during medical encounters. During our interviews, providers explained how attempting to match patients’ literacy levels by using layman’s terms, conveying relevant information clearly and concisely, and encouraging question-asking facilitates patient understanding and conversations about sexual health issues as opposed to strictly utilizing medical terminology. Using one of the participant’s phrases, we coded the providers’ descriptions of casual, informal conversations with their patients as “Not a Guy with a Tie.”

Dr. Thayer*, an attending physician, detailed how she discusses sexual health topics with patients, and what she believes improves patient-provider communication during medical encounters. She stated the importance of using layman’s terms during these discussions, and laughingly mentioned that she often remembers the simple terminology better than medical terminology.

I tend to use pretty simple language, to the point where sometimes I forget medical terms, but I try to do stuff in really simple lay terminology as much as possible. I check in pretty frequently during those discussions, like, “Does that make sense to you? Do you know what this means? Am I explaining this correctly?” and stuff like that.

For Nurse Gresham*, a nurse practitioner, having an informal manner and colloquial way of speaking facilitates patient-provider communication about sexual health. She described the opposite scenario as a buttoned-up, formal delivery of health information. She explained that, in her experience, using plain language helps her patients to better digest information they are given during medical encounters.
I’m just very conversational about [sexual health]. I think I probably take pride in being slightly less formal than maybe the average kind of—what people are expecting, like “the guy in a tie”. I just try to really—economy of words, just slow it down. It’s a learning process, cuz you’ll be shocked when the patient is just like, “Wait, I do what?” You’re like, “Ughh. I just explained that for ten minutes.” Then you’re like, okay; you learn not to do that, cuz they can’t—no one can stay tuned in for that long, so you just slow it down and use fewer words, and simple, simple, simple words.

Dr. Nassau*, an attending physician, gave a rich analogy about how she discusses sexual health topics with patients. Similar to the previous providers, she talked about using layman’s terms during conversations with her patients, and how she believes it facilitates patient-provider communication.

All the time with medical terms, I joke. I’m like, “You know we have this whole other language of things. Let me…”—I translate. I just think of medical terminology as just another language, and so—I speak another language in addition to English. Often, I see patients in whatever other language, but I have to document in English. I’m translating all the time. It’s the same brain, I think, when I think of medical terms versus laypeople language.

Lastly, Nurse Wheeler*, a nurse practitioner, explained that, while she uses plain language during sexual health discussions, she also makes sure to define medical terms for her patients. She felt that providing these explanations improves patient knowledge and facilitates patient-provider communication.

Throughout my entire medical life, I’ve been taught how to explain the things in layman’s terms. It comes pretty natural to me over the years. Just making sure that you’re using words—like if you say, “Oh, that just looks like candida vaginitis,” they’re gonna be like, “What?” If you say “A yeast infection” or “It looks like you have some infection on your vagina or some inflammation here,” and then that helps not using broad medical terms. If they want to know, sometimes I’ll say, “You’ll see here on your visit summary or whatever, it says vaginitis. That just means inflammation or infection of the vagina. It’s because of the yeast infection.” I don’t treat them like they don’t need to know what those words mean, but I try to explain what those words mean if I do use those words.

Open Environment and Nonjudgmental Questions

All provider interviewees mentioned that creating a sense of open-mindedness and a receptive environment within medical encounters facilitates patient-provider communication
during sexual history taking. When describing a recent encounter involving a pelvic exam, providers underscored the importance of fostering an open, honest relationship with patients and using nonjudgmental phrasing of questions and responses during discussions about sensitive topics, such as sexual and reproductive healthcare. We coded these descriptions as Open Environment and Nonjudgmental Questions.

For Dr. Pinehurst*, an attending physician, creating an open and nonjudgmental environment during her medical encounters also fosters trust between herself and her patients. She described empathizing with patients during discussions about sexual health, and counseling them about safer behaviors.

You have to create sort of a trusting environment where the person is trusting that you’re not judging them and you’re just trying to be helpful, and that you know what you’re doing. I think it’s helpful to kind of understand where the person’s coming from, which again has to do with trust, but I also think it has to do with the questions you’re asking, right? It’s sort of like these are very personal things and people don’t quite even know themselves what they want yet, so you’re trying to help them to figure it out and move them in a direction where they’re trying to move toward to safeness versus riskiness.

Nurse Wheeler*, a nurse practitioner, gave specific examples of how she conveys a nonjudgmental attitude during sexual health discussions. In her examples, she gave the reasons why she needed the information from her patients, which she explained later, facilitates patient-provider communication during sexual history taking.

Just telling them, you know, “I’m not judging you. I just need to—if you’re not using condoms, if you are using condoms, it just lets me know if you’re at a higher risk of having an STD.” Or “If you’re having this pain when you’re having sex, it would trigger me to know if you are at risk for other things, like pelvic inflammatory disease or other things like that. I’m not judging you in any way. It’s okay.”

Dr. Nassau*, an attending physician, described her approach to teaching medical students how to conduct sexual histories and discuss sexual health issues with patients. She explained that she instructs the students to personally gain comfort with sexual health topics, which she feels will
help students normalize questions and impart a sense of open-mindedness during conversations about sex and sexuality with patients.

Probably it’s nonjudgmental and just—’cuz when I work with med students, I’m like, “Just routinize. Just start feeling comfortable saying even this thing that’s totally unsatisfactory, ‘Men, women, both?’ or ‘Trying to prevent pregnancy or get pregnant?’” Just totally normalizing it as a routine part of care, at least things we can, like I said, do something about in a limited time that we have today.

Likewise, Nurse Gresham*, a nurse practitioner, explained that routinizing sexual history questions and having a nonjudgmental attitude during discussions of sex and sexuality facilitates patient-provider communication. She provided examples of sexual behaviors that may not be commonly discussed, and suggested that providers frequently ask about the types of sexual activity patients are engaged in to assess a patient’s potential risk, similar to patient recommendations coded under “Just Ask” in Chapter 6.

Just being really nonjudgmental. Make it really routine, and ask about types of sex, because people, and especially in certain subsets of the population—group sex, sex on drugs, party sex is much more like—I don’t know. I don’t know what it was back in the day. I’m not sure. I mean, gay male adults go and do these parties, so do the super-young heterosexual couples? Certain ones are very adventurous, and so I feel like if you see that somebody is kind of—just ask. Just ask, and they’ll sometimes just tell you.

Patient Preparation

A few providers mentioned the importance of patient preparation for their visit, particularly regarding sexual and reproductive healthcare. They described preparation as a journey to improve patient understanding and comfort around medical encounters, with the ultimate goal of providing necessary testing and treatment. Specific examples were given about the conversations, trust and time needed to successfully conduct a pelvic examination and screen patients for cervical cancer. We coded this journey as Patient Preparation under Provider Perceptions of Facilitators.

Dr. Eldridge*, a fellow, talked about patient expectations around the reason for their visit, and how those expectations can cloud a patient’s understanding and acceptance of seemingly
impromptu exams or testing. She explained that patients often opt to receive testing at a later date, which can ultimately affect health outcomes. Dr. Eldridge* went on to illustrate the information and support she gives unprepared patients to prepare them for a future visit.

Here, most the times, well, if it’s a patient coming in for the vaginal complaint, they already anticipate an exam, but sometimes, if it’s a patient coming in, let’s say, for an annual visit, and then I may talk about, you know, “Oh, are you up to date on your Paps?” They don’t necessarily know that it’s coming, and so they’re surprised, and caught off guard. They’re like, “Wait, really? I need one?” They’re like, “I’m not ready,” and I’m just like, “Okay … We don’t have to do it today, but just know that you are due for one, so we can schedule a follow up.”

Dr. Odell*, an attending physician, gave a specific example of a patient who needed extensive preparation prior to her visit involving a pelvic exam. When she reflected on the visit later in the interview, Dr. Odell* expressed that the visit was not entirely successful in her opinion (she sensed the patient was unsatisfied), despite the extensive and thoughtful conversations with the patient before the visit. However, she mentioned that, because of that preparation, the patient was able to receive the sexual healthcare she needed at that point in time. So, for that reason, she believed that provider time spent preparing patients is important for developing patient-provider relationships and rapport, and ultimately improving health outcomes.

She was long, long, long overdue for a Pap smear, and so, she was someone where we started to prep for the visit about a month ahead of time, and had a lot of conversations about it. We had a lot of conversations before hand and then there were, I think, a lot of e-mails, patient e-mails about the exam. Then she came in for the exam and talked about it again for quite a bit of time. Then the actual exam itself, once again, was relatively fast…

**CONCLUSIONS**

During their interviews, patients and providers described a number of barriers and facilitators to patient-provider communication about sexual health. Patients described fewer barriers than facilitators. The greatest impediments were gender of the provider, and provider disengagement. Interestingly, our interviewees primarily mentioned barriers to sexual history
taking and discussions as originating from providers, rather than from patients. With respect to provider interviewees, frequently-named barriers were discomfort with certain sexual history taking questions, generational differences between patients and providers, and balancing what assessments, examinations and testing can be accomplished during medical encounters.

Patient interviewees perceived that the gender of provider, provider demeanor and approach, and the process of building a relationship with a provider facilitated sexual history taking and discussions. In the case of providers, facilitators included tailoring conversations to patient situations, using layman’s terms, and preparing patients for sexual health discussions and reproductive healthcare. A few similarities existed between patients and providers with respect to what is perceived as barriers and facilitators to sexual history taking, such as encounter length and creating an open, non-judgmental environment during medical encounters. Future research should explore the additional barriers and facilitators named in this study, as well as the similarities and differences among patients and providers with regard to what aids and impedes sexual history taking and sexual health discussions. Suggestions for improvements from interviewees will be described in the next chapter (Chapter 6), and the implications of these barriers and facilitators will be discussed in Chapter 7.
Table 8. Barriers and facilitators to sexual history taking and discussions during gynecological care encounters: Preliminary themes, sub-themes and descriptions

<table>
<thead>
<tr>
<th>Theme/Sub-Theme</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td><strong>Barriers</strong></td>
<td>Impediments to communication between patients and providers during medical encounters (actually experienced by patients or providers); described as “making or breaking” the experience of medical care; it all depends on… whether these barriers occur/are experienced/are perceived during encounter</td>
</tr>
<tr>
<td><strong>Patients</strong></td>
<td></td>
</tr>
<tr>
<td>Gender of Provider</td>
<td>Description of perceived difference between male and female providers; how provider gender impedes medical encounters from the perspective of the patient.</td>
</tr>
<tr>
<td>Judgment, Shame and Stigma</td>
<td>Perceived judgment (by provider) of sexual health and behavior; tone or questions/answers; also feelings (on behalf of patient) of shame and perception of stigma related to sexual health and behavior; also influenced by early experiences with family and friends, religion, etc.</td>
</tr>
<tr>
<td>Social Desirability</td>
<td>Patient’s description of struggles with listing “appropriate” number of partners, sexual behaviors, etc.; e.g. how many is too many? what is acceptable/appropriate in providers’ opinion?</td>
</tr>
<tr>
<td>Not Asking or Trying</td>
<td>Perception (on behalf of patient) that provider is not interested or not trying to understand medical issue or patient by not asking questions/gathering information; described as a barrier</td>
</tr>
<tr>
<td>Time</td>
<td>Description of lack of time (on behalf of provider) or perception of rushing impedes communication during medical encounter</td>
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<tr>
<td><strong>Providers</strong></td>
<td></td>
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<tr>
<td>Discomfort</td>
<td>Description of discomfort felt (by provider) during sexual history taking and with any topics raised; can also refer to specific questions that are difficult for provider to ask patients; can also refer to patient discomfort during visit/exam in general</td>
</tr>
<tr>
<td>Judgment or Presumptions</td>
<td>Description of how judgement or presumptions (on behalf of provider) of patient sexual health and behavior can impede the medical encounter; tone or questions/answers</td>
</tr>
<tr>
<td>Generational Differences</td>
<td>Description of how age/generational differences between patient and providers can impede the medical encounter; perception of provider</td>
</tr>
<tr>
<td>“There’s Physically No Time”</td>
<td>Description of time influencing patient-provider communication, the visit itself, and health concerns addressed during visit</td>
</tr>
<tr>
<td>Multitasking During Encounters</td>
<td>Description of juggling reason for visit with other health concerns and EHR prompts</td>
</tr>
<tr>
<td>Differing Definitions of Sex</td>
<td>Discordant (between patient and provider) definitions of sexual health and behavior; mentioned as difficult to reconcile/harmonize during medical encounter</td>
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<td>Theme/Sub-Theme</td>
<td>Description</td>
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<tr>
<td><strong>Facilitators</strong></td>
<td>Enablers or catalysts to communication between patients and providers during medical encounters (actually experienced by patients or providers); described as “making or breaking” the experience of medical care; it all depends on… whether these facilitators occur/are experienced/are perceived during encounter</td>
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<tr>
<td><strong>Patients</strong></td>
<td></td>
</tr>
<tr>
<td><em>Provider Approach</em></td>
<td>Description of a provider’s demeanor/aura, positivity, empathy, comfort, nonjudgment as facilitating communication</td>
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<tr>
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CHAPTER 6 – Suggestions by Patients and Providers for Improvements in Communication

Oftentimes, changes are made to processes without the consultation or consideration of all parties involved. However, with the advent of patient-centered medicine and patient-oriented research, there has been increased attention placed on patient preferences and values, in addition to patient goals, within the medical environment. Derived from the biopsychosocial approach to medicine, this focus also considers the patient’s economic resources which can impact their ability to fully participate in their care. Patient-centered medicine honors patient autonomy, shared decision-making with providers, and supports patients in making informed decisions. Patient-oriented research focuses on unexpected findings and variations within study data, rather than emphasizing similarities and comparisons.

With that in mind, this study explored what suggestions patients and providers had to improve the sexual history taking process and sexual health discussions during medical encounters. Firstly, participants were asked about which questions should be included during the sexual history taking process (With regard to sexual health topics, what questions, if any, should providers ask patients?). The aim was to gauge acceptability of the questions that are normally asked and see if there were any new questions that arose that were felt to be important but were not typically asked or included in history taking guides and clinical practice guidelines. Secondly, participants were asked if there were any sexual health topics that were off-limits, in their opinion (What topics, if any, should providers stay away from? Is there anything that patients shouldn’t tell providers?). Again, this was to gauge acceptability of the typical questions and topics that may be addressed during sexual history taking and subsequent discussions. Thirdly, participants were asked if there were any sexual health issues that should be brought up (In your opinion, what are the kinds of things patients should tell providers about? What questions, if any, should patients ask
providers?). These questions were meant to elucidate the comfort of patients and their providers with sexual health discussions within the medical environment.

Additionally, I included two questions for patients regarding information and knowledge. One question was meant to assess what knowledge patients perceived they needed to possess in order to satisfactorily participate in sexual health discussions, and to be able to ask questions of their providers (In your opinion, what information do patients need, if any, in order to ask questions?). The second question aimed to elicit preferences for receiving information from providers during these discussions (What would be the most comfortable way for you, personally, to get sexual information?). Lastly, all participants were asked to provide any ideas and recommendations regarding modifications that patients and medical staff (providers and nurses) can make to their communication style during sexual health discussions and the sexual history taking process (In your opinion, what are some ways patients can improve sexual health discussions? What are some ways doctors and nurses could improve how they ask about sexual health issues? How could providers improve giving sexual health information to patients?). In response to the questions cited above, participants described a variety of improvements based on their prior experiences which we coded under Suggestions for Improvements in Communication (see Table 9).

PATIENTS

Although they were asked towards the end of the interview, almost all patients became more animated when asked if they had any suggestions of how to improve conversations about sexual health with providers. Even patients who were more reserved during their interview provided detailed ideas and recommendations based on their experiences, observations, and conversations with friends and family members. Seven themes emerged for patients under
Suggestions for Improvements, including: 1) Acceptable Questions; 2) Patient Responsibility; 3) Patient Preparation; 4) “Just Ask”; 5) Perceptions of Caring and Provider Empathy; 6) Reminders and Reassurance; and, 7) Resources, Support and Education (see Table 9). Next, these themes will be described and exemplar quotes will be presented.

Acceptable Questions

Most patients were able to specifically explain which questions they felt should be included in the sexual history taking process. However, a few patients found it difficult to generalize their opinions to what other patients may feel. Apart from those difficulties, the explanations that patients gave during their interviews offered insight into the acceptability of certain sexual history questions, in addition to reasons why they felt those questions were important to ask during medical encounters. For that reason, we coded these descriptions as Acceptable Questions, under Suggestions for Improvements.

Tania*, aged 18-24, suggested that providers should be more detailed in how they ask patients about sexual activity, explaining that there are various ways of having sex. She placed emphasis on asking the patient if they are having oral sex because she sensed that that information may not be offered up by all patients unless specifically asked.

I guess the doctor asking, first thing asking the patient if they were sexually active. Oh, you can be sexually active orally, too, so ask them, like, are you having oral sex? Are you giving head? Because that's something that's some—a natural person—a regular person probably wouldn't say, "Oh, yeah, I give my boyfriend this" other than, "Oh, yeah, I'm just having sex with them," because there's different ways of having sex.

Another patient, Cheryl*, aged 35-44, offered a similar suggestion and added that she thought that the frequency or amount of sexual activity that a patient is engaged in is also important for the provider to ask about and understand. She explained that the frequency of sexual activity is important for information-giving purposes.
What types of sex they have, whether it be anal, or—'course they can tell, but they should ask them, so that they know what to look for, and can be more abrupt about gathering information so they can help them. I think that’s important. What else? It’s important to know the amount of—I think it’s important to know the range, the average amount that that client would have. I think it’s…Yes, so they can confer with them, and be able to give them information as far as that.

Despite some patients feeling discomfort, others described acceptability around providers asking about number of sexual partners and types of protection they use, in keeping with their view of sexual health and behavior through a risk-based or protection framework (see Chapter 3). Erika*, aged 25-34, also mentioned that providers should ask if there are any additional issues or concerns that the patient has. “I think they should ask how many sexual partners have you had in a certain amount -- a certain period of time. Are you protecting yourself? If anything is bothering you that you have concerns about? You know.”

Likewise, another patient, Ines*, aged 35-44, thought that questions around sexual partners and protection were appropriate to ask, but only in a specific context. She mentioned that her comfort with those discussions depended on perceived relevancy to the medical visit and current medical concerns.

How many partners you've had, how long you've been with them, if you do use condoms, you don’t, and that it… If you're just here for just a plain physical, they don’t need to ask that, but if you're here for a Pap smear or something else, I feel that they should ask just so that they have an idea and they can get the information from you because you can just say, okay, I'm here for a Pap smear and that’s it… That’s when I think the sexual questions should appear, not if you're doing a regular follow up or a checkup or something like that… I think they don’t really need to ask unless you bring something up about abdominal pain or stuff like that, then that’s when the questions that I've noticed pop up, like “okay, does it hurt when you have intercourse?” If you came to the doctor, your shoulder hurt, then they shouldn't ask a question about sex or stuff like that.

Kelsey*, aged 18-24, also brought up number of partners and types of protection, but pondered whether the questions that she subsequently mentions were relevant. It was revealed later in the interview that she viewed disclosure and questions about sexual trauma as potentially
irrelevant (depending on the patient), and that the topic may be better handled by a mental health professional. In this section of the interview, Kelsey* also described acceptability around questions about previous medical tests, current medical concerns, and resources or information that the patient may need.

I don’t know how relevant these things are, but asking ‘how sexually active have you been in the last six months?’ ‘How many partners have you had?’ ‘What kind of protection have you been using?’ ‘When was your last test? Were the results abnormal?’ ‘Do you have any concerns about your sexual health currently? Is there anything I can answer? Any resources I can provide?’ Those sorts of things…

Another patient, Marissa*, aged 18-24, echoed other patients regarding acceptability around questions about sexual activity and protection, but added the topics of contraception and pregnancy intention.

I guess the first thing you would have to ask is if they’re sexually active at the time and if you’re using protection, if you’re on birth control, or are you trying to get pregnant for yourself or you’re not. The doctor should ask how you feel in a way unless you already have something to say or if you’re not feeling well, if you’re here for a certain reason.

Lastly, throughout her interview, Carmen*, aged 25-34, mentioned discomfort with a question she has been asked previously around contraception. She believed that the contraception question does not allow a patient space to declare an intention or desire to become pregnant. She thought that the phrasing of the question automatically assumes that a patient does not intend to do so, and for a patient who may have fertility issues (which she explained she was struggling with), the question gives the impression of being insensitive to that issue. She suggested a different set of questions for that reason.

For me they can ask me, “Are you trying to get pregnant?” versus, “Are you on birth control?” Straight away that question the way it’s asked is kind of like it’s geared towards no kids. Maybe just asking, “Is the person trying to conceive? Is the person trying to avoid pregnancy?” Like that. Don’t just bluntly say, “Are you on birth control pills?”
“Put your walls down a little bit”: Patient Responsibility

When asked about suggestions for improvements during sexual health discussions, several patients believed there was a responsibility on behalf of the patient to be open and honest with providers. They described that this is almost an inherent attribute that patients must adopt in order to receive quality medical care. Patients also gave reasons why dishonesty or providing limited information impacts the provider’s ability to diagnose and treat appropriately. We coded these suggestions as Patient Responsibility.

Janelle*, aged 25-34, empathized with fellow patients about being frightened about a certain health concern or issue, in addition to worries regarding confidentiality of discussions within the medical encounter. However, she felt that patients should be open with their provider despite those fears.

Just be open. If there's something goin' on that you're like scared or anything like that, you shouldn't have to hold back or feel like, oh, maybe they'll and go tell somebody else or they'll talk amongst their colleagues and everybody's gonna know my business.

Another patient, Cheryl*, aged 35-44, echoed the previous patient, but offered additional advice to fellow patients. She explained that being frank and truthful during medical encounters invokes feelings of comfort and relief, as well as the ability to gain further knowledge from the provider’s responses.

Being truthful, and abrupt, and being honest. It always works. You ask a question straight out, I’m sure the doctor, he’s experienced to give you the answer. That way you’re relieved of everything, and you’re comfortable… It’s like a chip off your shoulder, knowing that you can ask, and you’ll get an efficient of a reply.

Similarly, information gathering was a focus of Ines**, aged 35-44, response. Like others, her belief was that the responsibility lies with the patient within the encounter. She also went on to say there was only so much the provider could do with patients who were unwilling to be honest
and open. Her advice to fellow patients was more tempered in that she said to open oneself, but only enough to get the information that one needs.

That’s hard because it all depends on the patient and how open they're willing to be. If they don’t want to be open then it's like pulling teeth… I mean, the doctor could be the most amazing doctor in the world, but it all depends on the patient and shutting down and being an open book or just being that person to say, you know, I’m going to put my pride to the side and this is what happened one day, and I'm here now. It all depends on the patient… Put your walls down a little bit. You don’t have to put it all the way down, but just put them down a little bit enough so you can get that information.

Another patient, Brittany*, aged 18-24, placed the onus directly upon the patient with regard to appropriate medical care for health concerns. She explained the importance of making your health concern(s) interesting and worrying to providers. Similar to a previous patient, she mentioned that fear of judgment or loss of confidentiality from disclosure should not impede patients from being open and honest, particularly around sexual health concerns, where she explained that risk assessments are important.

I honestly believe whatever the doctor can't help you with it’s because you haven't made it their concern or you haven’t, like I said, behaviorally or historically shown that it should be of concern… Because it doesn’t matter how freaky you get or how maybe vanilla your life might seem. It’s important to let your doctor know that what activities could lead you to certain illnesses or risk factors.

Lastly, Lourdes*, aged 25-34, went further in explaining that patients’ fear of judgment or loss of confidentiality from disclosure stems from cultural taboos. She also described a lack of health literacy around sex and sexuality among patients, in general, which can lead to a lack of understanding how bodily systems are interconnected. To combat this, she suggested that fellow patients should be open and honest during medical encounters to ensure that as much information as possible is shared with providers regardless of whether the patient believes it is relevant to their current medical condition or not.

Cuz, sex is such a taboo and not everyone is going to be educated enough about being open-minded. Just I think being open is a big responsibility of the patient. Yeah, I mean
most people who aren’t open and aren’t telling you everything do that because of taboos, I don’t know, insecurity. They’re not thinking of how helpful it could be if they brought it up. They’re not thinking in a more holistic way. Realizing that yeah, there are a lot of things that could be interconnected, underlying and connected…. Just openness. I think that’s the key word. Being open.

*Patient Preparation*

In addition to a patient’s responsibility to disclose, several patients talked about a responsibility to be prepared prior to medical visits, and how that would improve patient-provider communication. Patient preparation was described in a few different ways, such as knowing how to ask appropriate questions and writing down your questions beforehand (much like existing patient-provider communication tools, such as Question Builder and Questions are the Answer), as well as being more proactive regarding their own sexual health. We coded these suggestions as *Patient Preparation*. While these ideas are not novel, the fact that the patients mentioned that they believed these methods could improve communication with their provider, and thus, health outcomes, was noteworthy to include in this section.

When asked about what patients can do to improve sexual health discussions, Kristen*, aged 18-24, offered the suggestion that patients should take the time to prepare despite their hectic schedules. She felt that, while some patients may view medical visits as another task to get finished during their day, thinking about questions or concerns prior to their visit would be advantageous.

I think it's taking the time to prepare before you go into your doctor's office. We're so busy in our lives, it's like “doctor's offices” - checking off a box in their [patient’s] to-do list, but it's not, and you should take the 5, 10, 15 minutes or whatever to know, “These are the things I would like to discuss with my doctor, and if there's time, is there an extra thing that I would like to discuss with my doctor,” and stuff like that, so preparing for it.

During her interview, Renee*, aged 25-34, described how her provider conveyed information about changes in vaginal pH after sex that was new to her that day. She explained throughout the interview that she was knowledgeable about sexual health topics because she
attended specific trainings as a teenager, and so, she was surprised about this new information. Her experience during her medical visit may have influenced her suggestion that patients should ask questions about topics that they are interested in, so they can learn new information. She went on to also suggest that patients should learn how to ask clear and detailed questions, so that providers can address patient concerns appropriately.

**Interviewer:** Are there any questions do you think the patient should ask of providers with regard to sexual health?

**Interviewee:** Well, yeah. Anything that you want to know. That means anything. Anything that they want to know. Then, even the stuff that they want to know but they know that there’s really no answer, they should ask that, too, because there might be an answer [laughter]… It’s like, okay, you have to ask. If you don’t ask, then you don’t know.

**Interviewer:** What are some things, in your opinion, that patients can do to improve discussions about sexual health with providers? Besides being honest, because I know you’ve mentioned that…

**Interviewee:** I can’t think of anything else besides them just being honest. They [patients] have to learn how to ask the question, I guess, so that it makes sense. They can’t be like, “Well, there was this thing and this time when I did this thing, but you know I don’t like the things.” I’m like, “What the hell are you talking about?” You know what I mean? You have to learn how to ask the questions. I think that’s pretty much it.

Erika*, aged 25-34, reasoned that preparing and asking questions during medical visits saves time and effort. She went on to explain that being prepared and proactive is better, in her opinion, than forgetting and remembering the questions when patients are finished with the visit.

I mean, they [patients] should -- if it's about that time, they should ask for an HIV test. They should ask about -- if it's about like when exactly should they have a mammogram done or prostate exam done. They should -- like anything pertaining to your sexual health that you should ask questions about… Because then you'll get all the way home and then you'll be like, “Dang, I forgot to ask about that”. And you'll be beating yourself up when you could have asked when you was there.
“Just Ask”

A majority of patients suggested that providers should broach the subject of sexual health with their patients during medical visits. Interviewees mentioned a few different reasons for placing the responsibility upon the provider to ask questions about sexual health, including: jogging a patient’s memory, the general importance of sexual health to overall health, and discomfort on the part of the patient. We coded these particular recommendations from patients and the reasons for them as “Just Ask”.

During her interview, Lourdes*, aged 25-34, mentioned twice that she felt providers should ask questions a few times during medical visits. She explained that patients may forget about certain symptoms or health issues, and prompting from the provider may help trigger a memory or encourage the patient to disclose more details. “Maybe asking about history and other concerns more than once so that you think—like searching the back of your head, ‘What else?’”

Ines*, aged 35-44, explained that some patients may be reticent to disclose certain details about their sexual histories during medical visits. She went on to say that, from a patient perspective, when a provider reviews testing that was done or health issues that were discovered during previous visits, it may help begin the conversation about sexual health. She also suggested that the provider offer repeat testing and/or reexamination, which she felt conveys a sense of caring about the patient.

I guess like just having a doctor start of the conversation, look at the chart like, “Hey I know that you had this test done, or I know that this happened a while ago. Do you want an update or checkup or do whatever?” It’s easier for the patient to hear from the doctor and having the doctor offer than you’re just sitting there twiddling your thumbs, and you’re like, “Okay, I’m not going to tell him that I had 20 partners two days ago.” You know? Just stuff to update the information, like, “Hey, this test came back negative or this test came back positive. Do you want to redo the test just to make sure?” That lets the patient know, okay, this doctor really does care. Let’s redo this. Let’s do it again.
Similar to the previous patient, Kelsey*, aged 18-24, indicated that patients may have difficulty around disclosing sexual health information during medical visits. She added that she believes providers should ask specific, tailored questions, particularly if they have not yet received verbal information from the patient that is necessary to aid them in ordering appropriate diagnostic testing and/or making an accurate diagnosis.

If they don’t hear the information that they would’ve gotten from a question—then definitely any questions that would be relevant and helpful to my health. Definitely, I think they need to ask… Just questioning. You know? So someone doesn’t have to offer information, just asking really targeted questions—that will help them get a background.

Kristen*, aged 18-24, also emphasized that providers should be asking questions about patients’ sexual health during medical visits, as opposed to the expectation that patients may volunteer the information. She reasoned that sexual health is part of overall health and well-being, and that she feels the topic is of importance. Furthermore, she still believed, even though she views herself as particularly knowledgeable about sexual health issues, that providers should be prompting patients for information, and also questioning whether patients have any questions about sexual health themselves.

Just in terms of how sex can affect your psychology, and your physiology, and how—I mean, I don't even think I know, and I'm pretty well educated about when you can actually get pregnant on your cycle and those things. They should be prompting those questions from people, and just asking if they even have any questions, like, "Do you have questions about your sexual health?" I think it is important.

“We’re Human, We Forget”: Reminders and Reassurance

Several patients also suggested that healthcare providers offer reminders and reassurance to their patients with regard to their sexual health. While this could be viewed as a sub-theme to “Just Ask”, we decided to code these suggestions directly under Suggestions for Improvements, as many of the examples given by interviewees were broader than a provider’s responsibility to initiate the conversation about sexual health. Specifically, patients recommended that providers
offer advice around protection and testing, ease worry and fear about particular sexual health concerns, and support patient decision-making around treatment and/or medication options.

Tania*, aged 18-24, described particular guidance around HIV/STI testing that she feels providers should give patients. Later, she mentioned that she wished she had received the same advice during previous medical visits. She explained that she would have listened to the guidance (if given) and it may have prevented her from experiencing recurrent STIs.

The doctors, they could also tell the person to make sure that you get tested before you do anything, like, without a condom. If you are choosing to go raw, like at least make sure that you and your partner got tested before you all do anything. Because that could avoid a whole bunch of problems, instead of, for example, like if it was my partner, if I would have listened and got these tests done before, and he says that before, we wouldn't be in the predicament [reinfection with chlamydia] we were in now. Yeah, people make mistakes. I feel like people—we're human, we forget. Sometimes we're in the moment. Even though you're in the moment, you have to, yeah, still be, like—You have to stop, you have to self—what is it? I forgot the word. Self-control. You have to have self-control.

Relatedly, Brittany*, aged 18-24, talked about reminders from providers serving to assure and comfort patients about sexual health issues that patients may be worried or concerned with. She gave the example of needing to be reassured periodically by her providers that her IUD placement was satisfactory. She also recommended that, to provide adequate comfort and assurance, providers should ask patients tailored questions about symptoms to identify any additional fears or concerns, much like the suggestions coded under “Just Ask”.

I definitely think that they could help with probably like reminding. I think reminders are helpful. I tend to forget things sometimes, so sometimes I need a little reassurance. Like again the ParaGard [IUD] I have seems to jump around a lot and they always tell me that it moves. They would check each time. They would feel around it and they’re like, “It’s where it should be. You’re not experiencing any pain or spotting or discomfort.” I don’t have any symptoms of anything wrong. I definitely feel like reassurance, maybe asking the patient something that the patient wouldn’t have thought of, which really takes a lot of thinking, you know.

Alisha*, aged 25-34, richly described a different type of reminder for patients during medical encounters. She explained that patients may not be aware of the various treatment and/or
medication options available to them, particularly if there are recent advances in medicine or updated clinical guidance. With a personal example of hormonal contraception options, she illustrated the tension between patient autonomy and shared decision-making, and explained that her limited knowledge may have guided her choices in the past more than necessary. For that reason, she suggested that providers should relay up-to-date information to patients during visits when treatments and/or medications are discussed.

I think providing the patient with all the options and then letting the patient decide based on the options is the best way to go because say, for instance, if I only know one type of contraceptive and you ask me what is it that I want, I’m only gonna tell you what I know because I don’t know the other options that are out there, so if I was provided with all the options and I could say “Oh, I know this one, but maybe I’m willing to try this one”. The only thing with medicine and technology, there’s always something coming out that’s new, so for instance, my last doctor’s appointment was two years ago, maybe there’s a new contraceptive out. I wasn’t informed of the new stuff, so that’s probably the only thing.

“It was just about me”: Perceptions of Caring and Provider Empathy

A majority of interviewees stated that providers should convey interest and concern, and show compassion for their patients in order to improve conversations between patients and providers about sexual health. Patients mentioned a few reasons why perceptions of caring and empathy were important, including facilitating patient honesty and open dialogue, and building relationships between patients and providers. We coded these particular recommendations from patients and the reasons for them as Perceptions of Caring and Provider Empathy.

For Marissa*, aged 18-24, provider demeanor seemed to be a particularly crucial element to effective patient-provider communication during medical encounters. She gave a number of rich examples to illustrate how patients may view providers who may not convey concern or show compassion.

By just being more, I don’t know, don’t come in with attitude and stuff, looking like a doctor. No. I’m joking. I don’t know. Just be more happy. Be more like a people’s person. Being a doctor you should definitely be a people’s person like I’m here all screwed up and
have discombobulated and you’re here coming with the attitude like, “What’s wrong with you today?” “I have a knife stuck in me here.” Come in and be like, “Oh my God.” Have some type of emotion. “Are you feeling okay?” Someone could some just come in and see you half banged up and be like okay, start getting to work. Do you really care about me if you don’t have some type of emotion? You wouldn’t care if they made a mistake on the surgery bed and I died?

Renee*, aged 25-34, also mentioned provider demeanor as improving patient-provider communication. However, she added that specific attention and focus paid to individual patients suggests concern and interest on the part of the provider, which is perceived positively by patients. She provided an example from her visit that day where she felt like particular attention was paid to her by her provider, despite the number of other patients the provider had on their schedule.

I think just stay friendly. Say you focus on them. Make them feel like they’re the only ones. Because, like I said, my provider had 17 other people and she still came and she made me feel like—and even though she made me mad because she had me waiting forever, but whenever she came in the room, it was just about me.

Likewise, Ines*, aged 35-44, suggested that providers should pay attention to patients (by briefly reviewing their chart) before even entering the exam room. She also mentioned that conveying a sense of caring and compassion can help improve sexual health discussions during medical encounters. She explained that patients will perceive involvement and interest on behalf of the provider which facilitates open conversations and relationship building.

Just go back, don’t wait until you sit with the patient and open their chart and say, okay, what are you here for? Maybe review the chart before—leave the patient there for five minutes, review the chart. Hey, such and such, I reviewed your chart and I noticed that you didn’t do this test a couple of years ago, but I was looking at your chart. It all depends on how the doctor is. If they really care—not that they care, but if they're really involved and they want to get to know their patient and have that open relationship with the patient where the patient feels very comfortable to talk with them. Know about your patient, not just the number. It can be number five, four, whatever, whatever, but you know, “Oh, that’s my patient. That patient is a constant patient with me.” Every month and every couple of weeks, whatever the case may be, just know your patient. It all depends on how the doctor approaches you and makes you feel.
Resources, Support and Education

In all of the patient interviews, ideas and suggestions coded under the theme of Resources, Support and Education were the most richly described and in striking detail. It was obvious that patients were visibly engaged and eager to share their thoughts about what would improve patient-provider communication during sexual history taking and sexual health discussions. While not all examples of suggestions are included below, most included recommendations about feedback, explanations and support from providers around sexual health, various resources for sexual health information, and sexual health education opportunities during medical visits, at the clinics, and in the communities the clinics served.

Marissa*, aged 18-24, specifically explained that patients should be told reasons for why testing, examinations and medications are being conducted/dispensed, which she thought would improve conversations between patients and providers. She contrasted the example of Pap smears, which she was unsure if she had been told about during previous medical visits, with the example of x-rays, which she remembered, as a patient, being informed about the reason for having the test performed.

"We’re looking for the feedback. We’re looking for the most greatest explanations that you guys have. We’re not here just to hear “Okay, we’re gonna do this, we’re gonna do that.” We wanna know what is it being done for. Why am I being treated for? What is it? I had to do a Pap smear. I never heard of—I’ve done a Pap smear before but I don’t know what the hell I’m doing. I’m in my early 20’s. I probably had one before when I just turned 21. I don’t know if this was my first one. I’m not even sure. She [the provider] told me about it. You know when you go in for an x-ray they tell you what you’re going for an x-ray for. “Okay, this is broken. We’re going to get an x-ray of your elbow to see what’s up.” You know exactly what you’re down for, you’re going in for.

Similarly, Kristen*, aged 18-24, suggested that providers should explain the reasoning behind the questions that are being asked during medical exams. She explained that knowing why
the questions are being asked would assist patients in being engaged in sexual health discussions, and increase patient knowledge around sexual health.

I think making it less formal, and just saying, "Let's have a conversation here about your sexual health," instead of me checking out the boxes, what I just said. I think that form should lead to a discussion. Sometimes, it just feels like, "Oh, you did this, you did this," but you don't know why they're asking these questions, either. I think tying it back to, "Okay, why are you asking about the Pap smear I had this year?" "Why does it matter that I've never had a breast exam?" Explaining the why behind things, I think, versus just, "Well, you haven't done that. You need to go do that," that would be super-helpful.

Tania*, aged 18-24, recommended support for patients around how to describe symptoms during medical encounters. She explained that she had difficulty articulating her current symptoms to her provider during the visit that day, and offered a suggestion (visual aides) to alleviate miscommunication in future visits.

I feel like maybe if they gave me a chart of, like, symptoms I guess, or different discharges so that you can know, oh yeah, I'm experiencing this type of discharge. I really don't know. Most of the time, I read online, things like, oh, like, what type of discharge. What are the symptoms for this? Blah blah blah, you know? Because I didn't know. I really didn't know what to say… Like, “Oh, you have a light discharge? Yeah, but it's a little bit?” I really did not know. Like, yeah, it was confusing for me. Then they kept repeating the question. I'm, like, “I just told you.” I don't know if you would switch the answer, but…

Several patients suggested that providers and medical practices should offer and prominently display paper-based health information materials for patients, which was considered beneficial to patient-provider communication about sexual health. Janelle*, aged 25-34, explained that handing a patient printed material may be a method of introducing difficult topics, and increasing the comfort level of the patient during discussions about those topics.

Maybe like flyers or just like—'cause if you give somebody a flyer and they read it, they're more like, oh. They can ask questions. I feel like that's the opening to them being really comfortable and being able to talk about it. Yeah, just like information about different types of things like rape or STDs. Anything like that.

Alisha*, aged 25-34, recalled the effectiveness of pamphlets (both personally and for others) that were present in medical settings when she was younger. She described her reasoning
behind requesting paper-based materials, such as poor recall of verbal information during medical visits, and distinct learning styles (visual vs. auditory) of patients.

I feel like those pamphlets when I was a kid, those worked. I don’t see them anymore. I don’t see them. I feel like the only information you get is when you actually come into the office and speak with your doctor. There’s no pamphlets for you to read on your way back home or for you to take and share with other people. Yeah, there’s just no—There’s no paper. There’s nothing. It’s just everything—you get all your answers and you just have to memorize them. There’s no paper. There’s no visual. People learn at different—they remember things differently. Not everybody has a good memory, so I feel like yeah, with pamphlets and stuff. That would really, really help.

Similarly, Paola*, aged 35-44, explained that paper-based educational materials, particularly with images rather than text, would aid patients in understanding health information that providers are trying to convey during medical encounters. She gave the example of the encounter summary that she was given during her visit that day, and mentioned that, oftentimes, she does not review it due to her busy schedule.

I think so they can improve a lot because we have too many peoples, they not read—so they have to see the pictures, and that’s all really. Because if you give me this paper [points to encounter summary], I mean, personally, sometimes I not read. Later, cuz I don’t have time. When you see the picture, you’re, “What?” “What happening?” “What’s this?”

A few patients also mentioned that technology could improve patient-provider communication about sexual health. Ines*, aged 35-44, talked about disseminating important and up-to-date health information through electronic means, particularly about sexual health. She explained that, for some patients, printed materials about certain topics may make them uncomfortable and self-conscious, as they may feel the content would be negatively perceived by others.

Everybody’s on technology now. Everybody can get their chart on their phone, so why not have a memo of breaking news or whatever and what came out. You know? I think that, especially with young girls who are now on social media and everything, it will be something for them to understand and need and not be embarrassed to have your flyer—like oh my god, I have a flyer about STD and people are going to think that I have an STD because I’m reading on it. Stuff like that. Maybe electronical information would be best.
Kristen*, aged 18-24, also mentioned that electronic communication and/or information can increase patient comfort with difficult topics. She explained that the perception of anonymity when asking a sensitive question via technology rather than face-to-face can help facilitate patient-provider communication about sexual health.

I think using technology to improve those discussions, like I said, where you can log in online and ask them a question. Also, people love the anonymous screen, where even if it is—they're still a doctor and they know you, but it still puts a screen in front of you. People, I think, become more comfortable, so if there's a way that you can scale, to make that available for people everywhere, I think that would probably be the most beneficial.

A small number of patients recommended educational opportunities for a broader audience than patients who have medical appointments at the clinic sites. These ideas were described in great detail and with enthusiasm. Kassandra*, aged 18-24, suggested impromptu, individual-level educational sessions and conversations with clinic staff for patients as they are waiting during their visit. She also pointed out that the clinic sites have workshops about other health topics, and wondered if they could also have educational sessions about sexual health topics available to the neighborhood and community.

They should have people coming around, and women social worker that come around, and when you come to the doctor, he just comes, stop by, or she come walk—stop by, say hello, and just talk to you about sex, or any updates in the world, and then—and I think they should do more of that...They should have little—they should do things for the community, like little meeting sometimes, like how to teach us about—like right behind you when it says—sign says, "Fun, food, and facts." Then they have meetings about healthy foods, and where to be healthy, and why can’t they have meetings about having safe sex, and maybe kids will come and talk about it, and learn something, you know?

Ines*, aged 35-44, also mentioned educational sessions for the community for the purpose of informing parents of how to discuss sexual health with their children. She explained, in detail, the need for tailored educational sessions (based on culture and language) for the community and individual patients in which the clinic sites serve. She felt that the workshops would improve
parent-child and patient-provider communication about sexual health, in addition to sexual health outcomes, such as reducing unintended pregnancies and sexually-transmitted infections among children in the community.

Have a workshop, you know at the clinic here. The thing is with the community and the way that we are here and the minority that are here, you have to give stuff away for free, so if a parent is having problems with the child and you can't really explain to them, “Listen, sex is this, this, and this”, but they're with you and they're having a workshop where they're going to give you pizza or whatever the case may be, but that’s how you're going to get the word out. That’s how you going to get the flyers out. That’s how you going to get parents to communicate better with their children so you don’t have all these young pregnancies and all these young kids getting all these diseases because they don’t know and parents are scared to talk to them about it because they feel embarrassed.

And, have workshops in many languages because we have a community here, it's not only Hispanics, but it’s a lot of different religions, a lot of different languages, and people don’t understand how to tell their kids. If they open it up and they branch out and say, “Today, we're having for the Spanish-speaking community, this workshop. We're having for the Arabic’s, we having it for whatever it is”, then that’s going to make the people say, “Hey, let me go because I wasn’t really sure how to bring this conversation up or didn’t know about it, so it'll help me help my child or help me help somebody else because you never know”. It's all through the word of mouth.

**PROVIDERS**

Similar to the patient interviewees, towards the end of their interviews, providers were asked if they had any suggestions of how to improve conversations about sexual health with patients. Providers were extremely thoughtful when describing their ideas and suggestions, and reflective upon clinical experiences they have had in the past. Five themes emerged for providers under *Suggestions for Improvements*, including: 1) *Relevant Questions*, 2) “*I Could Ask More*”, 3) *Patient Preparation and Engagement*, and 4) *Training, Education and Guidelines* (see Table 9). These themes will be described subsequently and exemplar quotes will be presented.

*Relevant Questions*

One of the secondary goals of this study was to explore the acceptability (for both patients and providers) of questions asked during sexual history taking. We heard in the provider interviews
that acceptability is less of an issue than the clinical relevancy and suitability of the questions. In other words, providers were more concerned that some of the common questions asked during sexual history taking may not help them gather the information needed to assess a patient’s health status as well as they would like. Furthermore, the way the questions are commonly phrased may be incongruous with a patient’s relationship status, age, or life experiences. So, when a provider mentioned questions that may not be clinically relevant or suitable during sexual history taking, we coded the desire and suggestions for different questions or assessment tools under Relevant Questions.

Dr. Fulton*, an attending physician, reflected on questions that she asks about sexual activity during sexual history taking. She explained that she often places the emphasis on a patient’s risk (as was described in Chapter 3), but that she wished there were better methods for assessing issues other than risk for HIV/STIs and pregnancy, such as sexual pleasure, safety during sex, and consensual relationships. She went on to say that she feels the questions she currently uses may be inadequate, particularly for her older patients, to assess whether her patients are in a safe relationship and are experiencing pleasure during sexual activity.

I think we focus a lot on risk, but not so much on empowering people to have pleasurable sexual experiences, to make sure that they're engaging in sexual activity that’s safe, sane, consensual, all that stuff. I don’t know that I have great tools at my disposal to help assess that. I kind of have some vague questions that I’ll probably ask teens more often, than older — I usually see women, older folks. You know, like, “How’s that relationship?” “You feel safe in that relationship?” “Fine.” I’m sure some of my patients are having sex that they feel like are being coerced into, or they're not enjoying, or whatever.

For Dr. Nassau*, another attending physician, a common sexual history taking question seemed to be particularly inadequate for some of her patients. She richly described a recent encounter with a patient where she tried to ask them about their sexual preferences, and the patient was unsure of how to answer. Dr. Nassau* mentioned she has been searching for a different
question to ask (and has yet to find one), and went on to ask the interviewer if they had any ideas about question phrasing.

I don’t even like the question, and I’m still looking for—“Are you sexually active with men, women or both?” I have a patient. She’s a she, and her partner used to be a she, then was gender-non-binary, now is a he. I saw her, and I was like, “Oh, my God. I have a completely unsatisfactory question to ask you. Men, women or both?” She’s like, “I don’t know. I used to be a lesbian. Am I still a lesbian?” I was like, “I agree. I don’t know what to say here.” Do you know?

Likewise, Dr. Pinehurst*, an attending physician, was searching for ways to bring trauma informed care into her sexual history taking practices, particularly for a “handful” of patients who (she said earlier in her interview) may have a mistrust of the medical system due to trauma experienced at some point in their lives. She mentioned a desire for better training and tools to assess whether she currently asks questions in a trauma-informed manner. She offered the suggestion of a lengthy, more indirect style of questioning to improve sexual history taking and discussions with patients who may have experienced trauma. However, the suggestion was stated as a question, so she may have been uncertain as to whether that method of communication would help.

I’m always interested in sort of the kind of questions that you might… how are my, the way I ask questions versus there are ways of asking questions in trauma informed care. How is it similar or different? That kind of thing… Maybe wanting more of a circuitous route of questioning? And, waiting for the person to say what they want.

“I Could Ask More”

While there were some sexual history questions that providers felt were inadequate, many of the providers talked about how they could ask the questions more often to improve sexual health discussions with patients. These providers described specific examples in which they could have asked certain questions, and they sounded almost disappointed in themselves or that they fell short
in their opinion. We coded these examples and the recommendation to ask sexual history taking questions more frequently during medical encounters as “I Could Ask More”.

For Nurse Delancey*, a nurse practitioner, safety and consent in sexual relationships were issues she felt she could ask more about during sexual history taking and sexual health discussions with patients. She emphasized that IPV is a reality and the reason why she feels asking those questions are important.

I wish, and this is something I’m trying to do with everybody, I wish I asked if she felt safe. I didn’t, so that’s something that, yeah, I really try to ask everybody. “Do you feel safe? Did you voluntarily engage in this?” Because it’s [intimate partner violence] real.

Dr. Eldridge*, a fellow, echoed the previous provider in that she felt that she could ask her patients more often about safety in their sexual relationships.

Something I feel like we should ask, but I feel like I don’t ask enough is if they are in a relationship, are they in a safe relationship, or do they have any concerns about their relationship. That should be part of it [sexual history taking].

Dr. Fulton*, an attending physician, thought it was important to ask patients more frequently about a different sexual health topic. She explained that she rarely asks her patients about their sexual desire and drive, and wondered about the extent to which she was overlooking that particular sexual health issue among her patients. While she does not currently do this, she talked about an intention and a desire to improve her ability to routinely screen and apply primary and secondary prevention methods (rather than strictly tertiary) with patients to promptly identify and treat issues with sexual desire and drive.

I know how often I talk to my patients about that, which is almost never, so I’m sure that I’m missing it. That I think, I would like to be better skilled at. I think when women come in to me with like, or men for that matter, have come in and been like, “Hey, I’m having problems with libido, I don’t have interest or desire.” I can have that conversation but I have it in a very reactive way instead of a proactive way. I’m not screening all people for, “Are you happy with your sexual health? Your sexual activity?”
Dr. Pinehurst*, an attending physician, mentioned challenges with a specific sexual history taking question about sexual enjoyment and pleasure. She explained her conundrum with thinking that the question was valuable and beneficial to sexual health outcomes, but that patients’ answers to the question and possible medical solutions are far more complex, and therefore difficult for her to address appropriately within a primary care appointment.

It’s a harder question to ask, I feel, “Are you enjoying sex and feeling like you are able to orgasm and have a healthy sex life?” I feel like that’s harder sometimes because I think we could be asking that more, I don’t tend to ask that because people, I don’t know, I feel like it’s a good question, right? But, I think it’s a more complicated one where depression, sleep, stress, your emotional thought, there’s a lot more there that I can’t really help you with. I can maybe help and chip away at or help you recognize or something.

Patient Preparation and Engagement

In addition to recommending more clinically-relevant questions for their sexual history taking “toolkit” and asking sexual history taking questions more frequently, a majority of providers suggested they could help and support patients to arrive at medical visits more prepared, curious and engaged. Those providers felt this added assistance would improve patient-provider communication during sexual history taking and sexual health discussions. We coded these suggestions as Patient Preparation and Engagement.

Dr. Fulton*, an attending physician, gave the example of asking her patients about their sexual preferences, and she went on to explain that many patients (particularly male patients) have an adverse reaction to that specific question. She mentioned her desire to encourage her patients during future medical visits to feel comfortable discussing their sexual health, as well as any concerns they may have or health issues they may be experiencing.

I think in general as a society, we’re very uncomfortable talking about sex. I feel often patients aren’t that comfortable talking about it, or very taken aback that I ask—typically in my experience, men have been very, “Ugh, why would you ask me that?” If I’m asking if they’re having sex with men, women or both? They’re just like, “Mmmrrghhh [recoiling].” The women are typically like, “Whatever”. I feel like men who identify as
heterosexual are very much like “What is this?” I think a lot of people just don’t bring—I think I would like to help empower patients bring up these concerns. Because again, I think, like I feel comfortable addressing them when I know about them, but I probably am not pulling them out as much as I could.

Similar to what the patient interviewees suggested, Dr. Odell*, an attending physician, recommended that patients arrive at their medical appointments prepared with questions or concerns that they may want to discuss with the provider. She explained that providers can assist their patients with this preparation by motivating and encouraging them. She mentioned that she often advises her patients to note down any questions or concerns after their visit, so that she can address them at a future date.

Reflecting ahead of time on what kinds of questions or things have been on their mind, cause not everyone can talk about things with friends or family or their doctors. I think if people felt like it [sexual health] was a much more normal thing to talk about, which it is, then people wouldn’t be as scared to approach it… I would just encourage them to write down—I encourage my patients all the time, like, if there’s anything that we talked about that you later on realized that didn’t quite sink in, or you still have questions about it or something new comes up, just write it down and let me know and then we’ll talk about it. I feel like that’s 90 percent of what we do is just try to figure out what’s going on and then hopefully answer questions that better address their concerns.

Nurse Delancey*, a nurse practitioner, also mentioned that patient preparation would improve patient-provider communication during sexual history taking and sexual health discussions. However, she suggested that additional education about sexual health would assist patients in that preparation before medical examinations. Interestingly, she used the example of flyers at the clinic site as a source of education material (which patient interviewees also mentioned as suggestion). At the very end of her response, she came to the conclusion that providers should be a primary source of sexual health education for patients.

You hope your patients have some education, right? They know what questions to ask, or how to come prepped. It’s really, it’s hard. I think that would be a way. We do, sometimes, have pamphlets in the front. “Oh, I saw this and I wanna get tested.” Right? I think that’s helpful to become more educated. That comes from us, right?
Some providers described the need and/or desire for additional training, education and updates regarding current clinical guidelines with regard to sexual health topics. They mentioned that further instruction on questions, terminology and evidence-based recommendations to use during sexual history taking would help improve patient-provider communication, and so we coded these descriptions as Training, Education and Guidelines under Suggestions for Improvements.

Dr. Fulton*, an attending physician, observed that, in sexual healthcare, there is often a lack of (or the perception of less) clinical guidance for providers. She mentioned that, as a preceptor of medical residents, she has seen personal experiences and opinions used with patients in the absence of clinical data/or recommendations, and illustrated a few examples. She felt this was an area for improvement, and went on to say that clear evidence-based guidelines for sexual healthcare would help differentiate what advice should be given to patients by medical students and residents.

I think if we treat it like any other part of health and stick with the evidence and not give our own—and I feel like this comes in to play with our residents a lot too, just helping them, our learners, understand the difference between your own experience, versus what actual medical care is. This is one of those topics, it’s like well-baby care, where if you’re a parent, or you babysat or something.

You tell your patient what worked for your kid, or kids you’ve seen in the past. That’s not actually maybe, necessarily evidence-based. I think it’s similar for sexual health. There's a lot of things that people are like, “Oh, try that.” Or, “This is what my girlfriend told me when I had this question.” We don’t go to the literature and see if there's any data on it. A lot of times there's no data on it and that’s also tough, is that you’re like, “Wow, this seems like a reasonable answer to this question that’s not really medical, per say, like a disease, but it’s relevant to this person’s health and well-being.”

Similarly, Dr. Eldridge*, a fellow, described (in response to a previous question) difficulties that medical students (whom she has precepted) have had with knowing which sexual
history taking questions to ask and how to tailor the questions to each patient. The interviewer prompted her to describe what she thought would aid those students, as well as other providers, in asking questions during the sexual history taking process. She responded that she felt more frequent training opportunities regarding new or updated clinical guidelines would be helpful to improve communication between patients and providers about sexual health.

*Interviewer:* What would help yourself, or other providers, in order to ask those questions, I guess, or to know which questions to ask?

*Interviewee:* I know that there’s always like—the CDC’s always updating the CDC guidelines, so maybe a webinar on that would be nice, every now, and then, to reinforce, oh, yes, these are treatments, and whatnot – how to manage things. That’s always a good indicator, at least for those outside, already practicing.

Nurse Delancy*, a nurse practitioner, mentioned that additional training and education regarding trauma informed care would be helpful to her. While she said that she does not often see patients who have experienced trauma, she would like to be equipped to provide appropriate care when the need arises.

I wanna do more trainings, or attend workshops on something like how to deal specifically with trauma, people that have experienced trauma when it comes to sexual health. Or, talking about contraceptives, or contraceptions. Or, even, yeah, doing a pelvic on someone. The people here, also, when they were teaching me how to do IUDs and whatnot, just little tips… I’d like to learn more. Then, I mean, with, the more you see, the more comfortable you are. I mean, I hope I don’t see lots of trauma patients, but I think that’s another thing too. I don’t, or at least I don't know— I don’t do it every day. That’s always a tough part.

Lastly, Dr. Thayer*, an attending physician, admitted that she needed training or education regarding sexual health jargon used by some of her younger patients. “I’m getting older, and sometimes I don’t know all the latest terminology that the kids are using, so sometimes training around language is really helpful.”
CONCLUSIONS

During their interviews, interviewees made a number of suggestions and recommendations for improving patient-provider communication about sexual health. For the majority of patients, the most salient suggestions were those regarding resources, support and education about sexual health during medical visits, as well as patient responsibility to be prepared, honest and open, and the opinion that providers should broach the topic of sexual health with patients. For providers, frequently asking questions about a patient’s sexual health, and the need for relevant sexual history questions were key recommendations, as well as guidance around how to ask the right questions for particular patients. A few of the suggestions from patients and providers overlapped, such as preparing and empowering patients prior to their medical visits, and provider responsibility to initiate conversations about sexual health. In future studies, these similarities and differences among suggestions made by patients and providers should be explored in greater depth to determine the impact they may have upon patient-provider communication during sexual history taking and sexual health discussions.
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<td>Suggestions for how patients and providers can improve communication during medical encounters, specifically around sexual history taking and sexual health discussions</td>
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<td><em>Patients</em></td>
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<td><strong>Acceptable Questions</strong></td>
<td>Specific questions that patients listed and felt are acceptable to ask during sexual history taking; for example: who, what, when?</td>
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<td><strong>Patient Responsibility</strong></td>
<td>Suggestion of how patients should be during medical exams; what they should tell medical providers, i.e. a responsibility to ask questions, be prepared, be honest, open, describe symptoms, etc.</td>
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<tr>
<td><strong>Patient Preparation</strong></td>
<td>Suggestion that provider could prepare the patient before and during the medical encounter; for example: preparing for pelvic exams, empowering them to ask questions, etc.</td>
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<td><strong>“Just ask”</strong></td>
<td>Suggestion that providers should “just ask” patients questions about their sexual health, which should facilitate/improve communication</td>
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<td><strong>Perceptions of Caring and Provider Empathy</strong></td>
<td>Suggestion that provider should be “perceived as caring” about the patient and that this would improve communication, and references to empathy; example: chart review prior to entering room</td>
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<td><strong>Reminders and Reassurance</strong></td>
<td>Suggestion that providers could provide reminders (i.e. tips, educational tidbits, reminders about testing intervals) and reassurance (what is normal?) during medical encounters for patients</td>
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<td><strong>Resources, Support and Education</strong></td>
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<td><em>Providers</em></td>
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<td><strong>Relevant Questions</strong></td>
<td>A desire for more relevant/resonant questions for sexual history taking that would improve patient-provider communication</td>
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<td><strong>“I could ask more”</strong></td>
<td>Suggestion that providers should probably ask more questions and more frequently in medical encounters (a feeling of responsibility to do so)</td>
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<td>Perception that prepared, curious and engaged patients improve communication during medical encounters; suggestion that providers should empower patients to come prepared to visit; also involves advocacy</td>
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<td>Desire for additional guidance, training or education about sexual health topics for patients and providers</td>
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SECTION III: DISCUSSION AND CONCLUSIONS

The purpose of this dissertation was to gain insight into how female patients and family medicine providers define sexual health, as well as how they navigate sexual history taking and sexual health discussions during gynecological care encounters. In Chapters 3-6, thematic findings from patient and provider interviews were presented. In Chapter 7, I will discuss various interpersonal, institutional, and structural factors which may have influenced framing of sexual health and behaviors, and the experience of gynecological care for both patients and provider interviewees. In Chapter 8, I will give an overview of the study, and describe the strengths and limitations, as well as implications for clinical practice, policy and future research.
CHAPTER 7 - Discussion

From the social-ecological perspective of health and health behavior, an individual is affected by all levels of their physical and sociocultural environments.\textsuperscript{194,255} As previously described in Chapter 2, this perspective, in addition to other theories, guided the conceptual framework used in developing this study (see Figure 3). Firstly, there are individual characteristics that influence health, such as gender, age, race/ethnicity, native language, education, and socioeconomic status. Secondly, there exists a reciprocal relationship between an individual’s health behaviors and interactions with other people. For example, social support, social networks, and cultural expressions influence an individuals’ perceptions, feelings, and health behavior. Thirdly, an individual’s healthcare-seeking behaviors can be affected by organizational or institutional factors, like clinic policies, rules and regulations of insurance plans, and standards and atmosphere of medical care. Lastly, structural factors such as social norms, local, state and federal government policies around healthcare access, and clinical practice guidelines developed by professional organizations can impact an individual’s experience of medical care.

As described in Chapter 1, prior research has mainly focused on the effect of intrapersonal factors (e.g. gender, age, provider specialty, etc.) upon patient-provider communication during sexual history taking and sexual health discussions, and so, I will not revisit those results in this discussion section. The focus of this section is to explore interpersonal factors, as well as higher level influences such as institutional and structural factors. From what was revealed in the patient and provider interviews in this study, I will subsequently discuss a few of those factors that may be influencing sexual history taking and sexual health discussions during gynecological care encounters.
INTERPERSONAL FACTORS

Within medical encounters, interactions between patients and providers can deeply influence patients’ health behaviors and health outcomes. In this study, interviewees described a few effects upon sexual health discussions and their framing of sexual health and behavior which were interpersonal in nature. Specifically, patients mentioned messages about sex and sexuality from their close family members that were eventually internalized by the patient. They also talked about perceptions of judgement, shame and stigma during sexual health discussions with providers, as well as the perception of provider compassion and empathy during medical encounters. In their interviews, providers talked about their perceptions when a patient displays honesty and openness during sexual history taking. Next, I will discuss each of these interpersonal factors and how they may influence sexual health discussions and the experience of gynecological care for patients and providers.

Influence of Social Networks upon Conceptualization of Sexual Health and Development of Internalized Messages

When asked about their conceptualization of sexual health and behavior, we learned that some patients have been deeply affected by sexual health messaging from family members or from personal experiences. Interestingly, friends and media sources were mentioned as less impactful sources of messaging. Sadly, messages from family members were predominately described as negative in content. The repetition of those messages, as well as the relationship that the patient had with the bearer of the messages, appeared to increase the impact of those external ideas, thoughts and opinions upon the patient. A few patients even talked about how negative messaging has pervaded their own thoughts and emotions during sexual activity.
Most of the research regarding the influence of social networks upon an individual’s beliefs and attitudes about sex and sexuality have explored this phenomenon with adolescents.\textsuperscript{234,235} This study included the perspectives of younger patients (aged 18-24), and so it would be understandable that messaging from parents and grandparents would still be quite salient in those participants’ minds. Yet, we heard descriptions of internalized messages from our older participants, as well. On the surface, repetition and delivery of health promotion messages by family members who are loved and respected may appear to be beneficial due to the lasting nature of the messaging within an individual’s psyche. However, for sex and sexuality (inherent human behaviors), negative messaging has mixed results and may enforce the risk-based or consequences-based framing of sexual health that we heard from interview participants. Recent studies have explored sex positive messaging with young adults, and some have found the acceptability and resonance of positive messaging to be superior to negative messages.\textsuperscript{256,257} Later in Chapter 7, I will discuss the influence of patient education and support around sexual and reproductive health, which includes a discussion about conversations between parents and their children, as well as education provided in the school setting. Maintaining existing educational resources and creating new opportunities for sexual health education for parents and their children could also positively influence the delivery of health promotion messaging by family members.

\textit{Perceptions of Judgment, Shame and Stigma during Sexual Health Discussions}

In addition to negative messaging from family members, interpersonal factors, such as perceived stigma and moral judgment around sexual health and behavior from providers, can impact the experience of gynecological care for patients. In their interviews, a few patients described how their perceptions of and experiences of actual provider judgment (not at the clinics where the study was conducted) evoked feelings of shame and stigma during discussions of sexual
health. While not necessarily from the same patients, perceived (or anticipated) judgment from providers prevented some patients from honestly answering sexual history taking questions, for fear that their answer will be met with shock or disdain. The impact of these judgments upon patients has been described as potentially devastating. While none of our interviewees talked about it in that manner, they did describe perceived stigma and judgment as influencing their responses during sexual history taking and sexual health discussions.

Effect of Provider Approach and Demeanor upon Trust and Relationship Building within Medical Encounters

We also learned from patient interviewees that the perception of a calm, professional, and respectful attitude from their provider can facilitate trust and relationship building during medical encounters. Relatedly, patients described that a perception of provider compassion and empathy also influences disclosure during sexual history taking, as well as healthcare-seeking behaviors of patients. All patient interviewees talked about comfort (or discomfort) during gynecological care encounters, and that feelings of ease seemed to encompass or lead to other reactions and emotions, such as confidence and trust in a provider’s ability to assess, diagnose and treat health concerns appropriately. This pathway to establishing trust and building relationships with providers was explained as beginning with patient perceptions of provider approach and demeanor, and can lead either to a successful medical encounter or to a complete breakdown in patient-provider communication.

Understandably, if patients are not sensing care and compassion from an individual who is supposed to be concerned about their well-being, their perceptions of and communication with that provider, as well as the situation that they are in, would be influenced. There is an ample body of literature regarding patient perceptions and the efforts by providers to convey those emotions,
particularly in acute care settings and at the end-of-life. Recently, the humanistic approach to medicine has provided a framework for those providers who wish to hone their empathetic and relationship-building skills. In studies evaluating provider empathy level (humanistic approach), higher levels of perceived provider empathy improved patient health outcomes. While there are few studies regarding humanism or provider empathy and sexual and reproductive healthcare, the findings from this pilot study suggest that, like other areas of medicine, sexual history taking and sexual health discussions benefit from perceived provider empathy.

*Balancing Patient Honesty and Openness with Gathering Necessary Information During Sexual History Taking*

One interesting interpersonal factor mentioned by providers was the balancing act between appreciating patient honesty during sexual history taking and questioning the utility of collecting copious amounts of personal information for the purposes of risk assessment and diagnosis. To my knowledge, this has yet to be cited by other studies of sexual and reproductive healthcare. During patient interviews, honesty and openness was described as one of the most important facilitators of patient-provider communication during sexual health discussions. Provider interviewees also mentioned that patient honesty and openness indicates that a level of rapport has been reached, which is vital to communication during medical encounters.

While it was not mentioned by our interviewees during explanations of this phenomenon, this tension reminded me of descriptions of “poor historians” in reference to patients. An appraisal of a patient’s narrative skills is always subjective; the patient is describing what is most salient and important to them in that moment. Literature about “poor historians” is scarce, but a few articles mentioned provider perceptions of patient oversharing during history taking, and tactics to overcome those feelings, including effective listening and empathy. From what was learned
in this study, the struggle to gather relevant information while still maintaining a relationship with their patients is an area for further research, and possibly additional training for providers.

INSTITUTIONAL FACTORS

In addition to interpersonal factors, influences upon an individual’s healthcare-seeking behaviors can occur at the organizational or institutional level. In this study, interviewees described two important aspects of medical care at the institutional level that they felt affected sexual history taking and sexual health discussions. Namely, patient interviewees talked about the tension between their actual answer to a sexual history taking question and adhering to social norms. Both patients and providers described issues with encounter length and feeling rushed during medical encounters. Below is a discussion of these institutional factors and how they may affect patient-provider communication during sexual history taking and sexual health discussions.

Social Desirability during Sexual Health Discussions

Interpersonal factors, such as stigma and moral judgment around sexual health and behavior, can also permeate attitudes and beliefs at the institutional level which can influence a larger portion of the patient population. In this study, some of the patient interviewees described tempering their responses to a certain sexual history taking question (How many sexual partners have you had in recent months and/or the past year?) due to anticipated judgment about their actual answer from providers. It was interesting, from the patient standpoint, that this particular question evoked a need to be socially desirable, which has been cited in other studies. In contrast, provider interviewees talked about that question as not necessarily clinically relevant, and often wondered why they were asking patients for a specific number.

Clearly, there are social conventions in effect around how many sexual partners is “too many”. Particularly for women, social conversations about number of sexual partners are different
compared to men and can be negatively-charged, with the use of words like “slut” and “ho”. With these higher-level forces at work, is it clinically necessary to ask such an emotionally laden question during medical encounters? Given that other studies have similar findings, future research should examine if alternate phrasing for that question would garner more clinically-relevant information, and reduce the negativity that patients experience. Likewise, future sexual history taking guidance should consider modifications to that particular question.

The Enduring Issue of Time During Medical Encounters

Limited time during medical visits is a problem that every provider and patient has experienced. In this study, our interviewees were no exception to that rule. Several patient and providers explained that the lack of provider time is a major barrier to patient-provider communication about sexual health. Providers mentioned an added impediment of addressing various best practice advisories with patients who may have primary health concerns that are seemingly unrelated to alerts from the EHR. Interviewees described time as the major factor for being unable to address those additional health topics with patients. Conversely, patients talked about sufficient time with their provider during a recent medical visit as a facilitator to sexual health discussions.

Encounter length is ultimately a function of institutional-level policies and regulations. First and foremost, fee-for-service models of provider reimbursement (used by health insurance companies and Medicare) emphasize quantity of encounters over the quality of healthcare provided during those encounters. Additionally, the total amount of patients needing healthcare in the US compared to the number of providers puts pressure upon the healthcare system, and perpetuates issues with (and perceptions of) limited provider time. Also, it is likely that the work environment or culture of a particular healthcare setting (i.e. emergency rooms, private practice,
urgent care, non-profit community health centers, etc.) can influence expectations around encounter length for both patients and providers. Various suggestions have been put forth to address the issue of limited time during medical visits, such as provider salaries (rather than fee-based) and value-based payments for health services.282

With respect to gynecological care encounters, our interviewees clearly stated that time was an issue, but interestingly, no suggestions were offered to address the problem. During encounters where they did not feel rushed, patients mentioned feeling surprised and appreciative of the extra time spent with their provider. Perhaps, they felt that being rushed is an inevitable aspect of their experience of medical care, and sufficient time is merely a bonus? In any case, the findings presented in this study indicate that encounter length is an important factor in patient-provider communication during sexual history taking and sexual health discussions.

STRUCTURAL FACTORS

For patients and providers, the influence of structural factors may be less obvious, but these factors are no less important than intrapersonal, interpersonal and institutional ones. In our interviews, patients and providers only mentioned education, resources and training as affecting sexual history taking and sexual health discussions. However, I also felt a discussion of the environment (both socially and politically) in which the study was conducted, as well as cultural and sexual scripts that may have influenced patient and provider framing of sexual health and behavior, were important to include here. Next, I will discuss each of these structural factors and how they may influence patient-provider communication about sexual health and the experience of gynecological care for patients and providers.
**Social and Political Environment During Study Period**

The study took place in NYC, where residents are diverse in age, race/ethnicity, incomes, nationality, and educational backgrounds. The demographics of the patient population at the clinic sites were generally representative of the neighborhoods in which the clinics were located, but proportionally different from the county as a whole. The degree of income inequality between the top 1% of NYC residents and the rest of the city’s population is particularly striking, and the gap has been widening since 2013. Incomes relative to the cost-of-living, as well as eligibility for health insurance benefits (including Medicare and/or Medicaid), can impact how and when patients access health care.

While the study was conceived in the months prior, the study participants were recruited and interviews were conducted at a time of political change in the United States. It is possible that those changes may have impacted study results, and so I feel a responsibility to briefly discuss them here. Beginning in January 2017 and lasting until January 2019, a new presidential administration and Republican control of the 115th Congress impacted federal funding for Title X and other social service programs related to sexual and reproductive health, and threatened costs-sharing for contraceptive methods. Faced with these threats, public participation in advocacy around women’s rights increased during this period starting with the inaugural Women’s March on January 21, 2017.

Prior to this, persistent efforts to restrict sexual and reproductive health rights and access were ongoing, but this two-year period seemed particularly chaotic for advocates, providers and patients. Of immediate concern were federal changes to contraceptive coverage requirements, which had been part of the 2010 Patient Protection and Affordable Care Act (PPACA). Those requirements to cover contraceptive options without any costs to the patient fundamentally
changed contraceptive access for women in 22 states that lacked legislation around contraceptive coverage, and prompted advances in the remaining states’ laws.\textsuperscript{286,287} Additionally, under the new administration, there were changes made to Title X in 2017\textsuperscript{288} and then again in 2018\textsuperscript{289}. The most recent rule change prohibited healthcare locations that offer family planning services funded by Title X from also providing abortion services.

Another restrictive measure was to propose block grants for Medicaid, such as in Iowa and Ohio, which had previously expanded Medicaid family planning coverage, and now voted to restrict funding for agencies affiliated with abortion providers.\textsuperscript{286} 12 states passed measures to ban and/or restrict abortions under certain circumstances.\textsuperscript{286,287} For patients and providers in New York City (where this study was conducted), funding restrictions may have had less of an impact than for some in other states and locales, due to some important interventions by the state and city governments.

In addition to threats to federal and state funding and the PPACA, implementation of immigration policy in harsh and uncompromising ways by the new administration impacted the health and well-being of immigrants who had lived in the US for many years, and those newly seeking asylum from unsafe living conditions in their home countries.\textsuperscript{290} During this time, immigrant women may not have sought sexual and reproductive healthcare with the same frequency as previous years, due to fear of deportation by US Immigration and Customs Enforcement (ICE).

Of further note, during the study period, conversations around sexual harassment, assault and abuse increased. In October 2017, personal experiences of sexual violence began trending on Twitter, which led to world-wide exposure and discussion of the issue for women, men and transgendered individuals. Often referred to as the \#MeToo movement,\textsuperscript{291} the campaign led to a
number of accusations, resignations and convictions of high-profile individuals. While much of the discussion centered around sexual harassment and violence in workplace, as the movement continued, conversations broadened to include places of worship, the role of pornography, and social norms.

Although control of the 116th Congress shifted slightly in January 2019 (the end of the study period), threats to *Roe v. Wade*, Title X and other social service programs related to reproductive and sexual health still remain at the federal and state levels. In March 2019, changes to the Title X program as a final ruling deeply impacted federal-funded family planning services in the United States (84 FR 7714). For that reason, New York State enacted the Reproductive Health Act of 2019 (N.Y.S. S240) to protect New Yorkers’ rights to safe, legal abortion care.

It is likely that provider interviewees may have been more aware of the legislative changes happening during this time, and how they were impacting their ability to provide comprehensive sexual and reproductive healthcare to their patients. However, patient interviewees would have likely heard about changes to and the ramifications of the PPACA contraceptive coverage, as well as various restrictions to abortion services, immigration enforcement, and may have participated in conversations about sexual harassment, assault and abuse via social media or with family and friends. This unpredictable environment was different than previous years, and certainly increased the dialogue regarding sexual health and healthcare online, in movies, and in the media.

The lasting impacts of the social and political environment during the study period are unknown; none of the patients or providers in the study mentioned the social or political climate outright during the interviews, but I also did not specifically ask about it. This study was meant to gather perceptions of the sexual history taking process and sexual health discussions. While cultural scripts and norms impact those perceptions, I do not have a clear answer for how the social
and political environment may have impacted this study’s results. However, there is anecdotal evidence which suggested that more women were seeking long-acting reversible contraceptives (LARCs) at that time to ensure that they had contraception during the presidential term when policy around insurance coverage for contraception may be changed.

Influence of Cultural and Sexual Scripts upon Framing of Sexual Health and Behavior

In this study, we learned how patients and providers frame sexual health during gynecological care. Relatedly, we also learned that a barrier to sexual history taking, from the provider perspective, is that specific jargon and definitions of sex used by either patients or providers may not be understood by the other within medical encounters. Despite that, providers described mirroring patients with respect to risk- or consequences-based framing, which reflects the messaging that individuals in the US have heard repeatedly after the discovery of HIV/AIDS in the 1980s.\textsuperscript{239,240} This messaging has primarily framed sexual behavior in terms of its costs by highlighting the consequences of having sex (HIV/AIDS, STIs, and pregnancy), and how to be protected from those consequences (condoms, contraception, and abstinence). However, this framing is in contrast to current definitions of sexual health from public health organizations, the medical community, and those definitions offered by providers in this study when discussing sexual health in a personal context.

Here, patients rarely expressed the holistic view of sexual health. Patient interviewees were asked about their conceptualization of sexual health after a medical encounter, which could have influenced their risk-based responses. Specifically, in the US, “health” is still conceptualized within the biomedical model of illness and disease.\textsuperscript{241,242} If I had asked patients and providers about other terms related to sexual health, like “sexual well-being”, it is possible that I would have gotten different responses. However, a recent study in Scotland (not conducted in a medical
environment) found similar results that women did not conceptualize sexual health in a holistic manner\textsuperscript{294}, but rather within a risk-based/prevention framework as was found in this dissertation. Interestingly, a few male participants of the Scotland study described sexual health within a holistic framework.

The World Health Organization (WHO) and numerous other organizations have definitions of sexual health that incorporate a holistic view.\textsuperscript{295,296} When the WHO was established, they formulated a different view of health (a state of complete physical, mental and social well-being) that was in contrast to the conventional medical model (the absence of disease).\textsuperscript{297} Drawing from their broader health definition, the current working definition of sexual health from the WHO describes the concept as:

a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.\textsuperscript{298}

The American Sexual Health Association (ASHA) takes a similar, but more concise approach, “Sexual health is the ability to embrace and enjoy our sexuality throughout our lives. It is an important part of our physical and emotional health.”\textsuperscript{299} However, a note from an ASHA board member on the same webpage details the difficulties with generating definitions of sexual health. Similar to WHO and ASHA, the CDC developed their own definition in 2012: “Sexual health is a state of well-being in relation to sexuality across the life span that involves physical, emotional, mental, social, and spiritual dimensions.”\textsuperscript{300} Interestingly, that definition is not currently cited on the CDC’s Sexual Health website; instead, the WHO description is displayed.\textsuperscript{301}

Throughout these definitions, painstakingly crafted by experts in the field of sexual and reproductive health, there is consensus, but also subtle differences. Hence, maybe that is why we,
as a society and within the field of public health, are still struggling with what the concept means. This discordance offers insight into how patients and providers can work towards a common understanding of sexual health and how the public health and medical communities can improve messaging around sexual and reproductive health. We know that negative messaging around sex has become part of cultural and social scripts in the US, but what impact would positive messaging have?

**Educational Resources and Support for Patients Regarding Sexual and Reproductive Health**

While many patients described a desire for printed materials and verbal education during medical encounters, a few patients mentioned increased need for educational opportunities around sexual and reproductive health at the community- and national-levels through workshops and school-based curricula. In the United States, vast differences exist in the content (and quality) of sexual health education offered in schools, due to the fact that curriculum decisions are often left up to the city, county or state school boards. While the debate about a national sexual and reproductive health curriculum continues, some patients and providers in this study desired comprehensive and accurate education for the younger generations. In their interviews, they mentioned the impact that improved educational opportunities for patients and their families would have upon their understanding and communication during medical encounters. Until it can be implemented on a national level, the suggestions by patients to have increased educational opportunities at the community level would aid in this endeavor.

**Clinical Practice Guidelines, Training and Education for Providers Regarding Sexual and Reproductive Health**

Like the patient interviewees, providers expressed a desire for training and education around sexual history taking. Much has been written on medical school curricula for teaching sexual history taking and how to have difficult discussions with patients. I mentioned some of the
research in Chapter 1, and so, I will not revisit those previous findings. However, I will mention that the need for specific guidance around sexual history taking and discussions, as well as relevant, tailored questions, is significant and deserves further research and attention.

CONCLUSIONS

In this study, various interpersonal, institutional, and structural factors that influence sexual history taking and sexual health discussions were revealed during patient and provider interviews. While I did not discuss all of them, the most important interpersonal factors mentioned by patients were: 1) the influence of social networks upon their conceptualization of sex and sexuality, 2) their perceptions of provider judgment, shame and stigma, and 3) their perceptions of provider compassion and empathy. Providers described their perceptions regarding patient honesty and openness. With respect to institutional factors, patients and providers discussed: 1) social desirability, and 2) encounter length. Structural factors are less noticeable; however, patients and providers did mention increased/improved education, resources and training which can be considered structural in nature. I also felt that it was important to include a discussion about: 1) the social and political environment in which the study was conducted, and 2) cultural and sexual scripts around sexual health and behaviors.
CHAPTER 8 – Conclusions

In this concluding chapter, I will give an overview of the study, including the aims and methodology. Then, I will review the findings from Chapters 3-6, and discuss significant themes present for both patients and providers. I will also summarize key intrapersonal, interpersonal, institutional, and structural factors from Chapter 7 that may influence sexual history taking and gynecological care encounters. Lastly, I will describe the strengths and limitations of the study, as well as implications for clinical practice, policy and future research.

OVERVIEW

In the United States (US), women face a number of serious issues concerning sexual health, including HIV/STIs, sexual anxiety, sexual dysfunction, and intimate partner violence (IPV). For those reasons, current clinical practice guidelines (CPGs) take a broad and integrated approach to sexual healthcare. Healthcare providers are urged to document a patient’s sexual history and conduct risk assessments at regular intervals to determine if testing and treatment for sexual health issues should occur. However, previous studies have shown that the frequency of sexual history taking and documentation of sexual histories vary widely during medical exams. Similar to what has occurred with other health issues, there appears to be a disconnect between published recommendations and real-world implementation of CPGs around sexual history taking during medical encounters.

Building upon prior research, this study has identified numerous barriers and facilitators to sexual history taking and sexual health discussions from the perspectives of female patients and family medicine providers, as well as other factors (interpersonal, institutional and structural) that may be influencing those discussions. The quality and extent of patient-provider communication during those discussions can impact the care the patient receives, as well as sexual health
outcomes. Ultimately, this dissertation research described differences between published recommendations and real-world implementation of CPGs around sexual history taking during medical encounters, which addresses a gap in knowledge regarding patient-provider communication during sexual health discussions.

Specifically, this pilot study sought to explore the framing of sexual health and behavior by family medicine providers and female patients, as well as their perceptions of sexual history taking and sexual health discussions during gynecological care encounters. This study was developed to better understand how clinical practice guidelines around sexual history taking are implemented by learning more about the barriers and facilitators experienced by family medicine providers and their female patients during those discussions. I was also interested in gauging patient and provider acceptability of sexual history taking questions, in addition to their suggestions to improve the well-documented issues with sexual history taking during gynecological care encounters.

This research was guided by the following theoretical frameworks: framing theory, sexual scripting theory, phenomenological psychology (specifically, autobiographical theory), and feminist theory. Individual, in-depth interviews were conducted with 18 female patients (aged 18-44 years) and 9 family medicine providers (also female, and a mixture of nurse practitioners and physicians) at two clinic sites in an academic family medical setting in New York City. In this dissertation, data from portions of their interviews were analyzed, and similarities and differences among patients and providers were discussed. By comparing and contrasting patient and provider experiences, this study offers insights into areas of consensus that can be used to improve implementation of sexual history taking guidance and future gynecological care encounters for both patients and providers.
The specific aims of this study were:

**Aim 1:** To examine the framing of sexual health by female patients and family medicine providers, and describe any similarities and differences

**Aim 2:** To examine the sexual history taking process and sexual health discussions from the perspectives of female patients and family medicine providers, and describe any similarities and differences

**Aim 3:** To describe common facilitators and barriers to sexual history taking during gynecological care encounters

**Aim 4:** To describe suggestions for improvements to the sexual history taking process and sexual health discussions from the perspectives of female patients and family medicine providers

**KEY FINDINGS**

In their interviews, patients and providers described numerous ways in which they navigate sexual history taking and sexual health discussions during medical encounters, and many of the findings have been described in previous studies using patient or provider surveys, focus groups or interviews. However, there were a few salient results from this study that I will subsequently describe.

In **Chapter 3**, the framing of sexual health and behavior by female patients and family medicine providers was explored. For patient interviewees, sexual health was primarily conceptualized within risk-based/protection framework. They described sexual health as protection (e.g. condoms, testing, birth control, etc.) from HIV, STIs and pregnancy, as well as an individual’s risk of acquiring STIs and/or becoming pregnant. Provider interviewees mirrored this protective view of sexual health during discussions with their patients. However, providers
revealed a broader, holistic view of sexual health when asked what sexual health meant to them personally during their interviews. A few patients also framed sexual health and behavior using this broader definition. This particular phenomenon has been rarely cited in the literature, and so these findings add to that body of research.

**Chapter 4** examined how patients and providers navigate sexual history taking and sexual health discussions during gynecological care encounters. In this chapter, many of the findings around difficult topics to discuss during medical encounters (i.e. IPV, transactional sex and certain STI diagnoses), as well as patient attitudes about those topics and questions, were consistent with results in previous studies. Additionally, the perspectives of patients and providers regarding sexual history taking and sexual health discussions were similarly aligned; there were many thematic parallels found in these two groups, rather than differences. However, one area of difference was that patients described a profound responsibility to be honest and open during conversations with providers about sexual health. While providers mentioned appreciating honesty during these discussions, they questioned the utility of collecting copious amounts of personal information for the purposes of risk assessment and diagnosis, particularly during time-limited medical encounters. This indicates a tension between honesty and openness on behalf of the patient and a perception of oversharining on behalf of the provider during sexual history taking, which has yet to be cited, to my knowledge, in past studies.

**Chapter 5** explored actual barriers and facilitators to sexual history taking and sexual health discussions that were experienced by patient and provider interviewees. Like the previous chapter, most of thematic findings were similar among patients and providers, and some of the themes (e.g. provider gender, encounter length, and provider discomfort with certain sexual history questions) have been reported in previous studies. Here, patients and providers also named
encounter length and provider gender as both aiding and impeding sexual history taking and sexual health discussions during gynecological care encounters.

We also heard about some additional barriers and facilitators that have not been frequently mentioned in the literature. Providers described differing definitions of sexual health and behavior that are difficult to reconcile or harmonize with patients during medical encounters. Patients mentioned disengagement on behalf of providers as a major barrier to patient-provider communication during sexual health discussions. Furthermore, patient and provider interviewees primarily discussed barriers to sexual history taking and sexual health discussions as originating from or the onus being on the provider, as opposed to the patients. Regarding facilitators, providers explained the importance of creating an open, receptive environment when discussing sensitive topics, such as a patient’s sexual history, during medical encounters. A positive and respectful provider approach and demeanor was described by patient interviewees as facilitating patient-provider communication during sexual health discussions.

In addition to barriers and facilitators, in Chapter 6, we heard about several suggestions to improve sexual health discussions and the implementation of sexual history taking guidance from patients and providers. Namely, patients described numerous ways in which providers and clinic sites could offer additional resources, support and education around sexual health, including printed informational materials, educational workshops, visual aids to help patients describe symptoms, thus increasing their health literacy. Providers discussed their desire for clinically-relevant and suitable sexual history taking questions, as many of the current questions may not help providers gather the information needed to assess, diagnose and treat patients to the best of their ability. Provider interviewees also suggested that healthcare providers should ask their
patients sexual history taking questions more often, and described a feeling of responsibility to do so during future encounters.

**Chapter 7** described various interpersonal, institutional, and structural factors that influence sexual history taking and sexual health discussions. For patient interviewees, the most important interpersonal factors were the influence of social networks upon their conceptualization of sex and sexuality, their perceptions of judgement, shame and stigma, and perceptions of provider compassion and empathy; provider interviewees described their perceptions regarding patient honesty and openness. Several institutional factors were mentioned, including: 1) social desirability, and 2) encounter length. Regarding structural factors, the social and political environment in which the study was conducted, and cultural and sexual scripts around sexual health and behaviors were important to discuss with respect to patient-provider communication. Patient and provider interviewees also mentioned their desire for increased/improved education, resources and training which they believed would positively influence sexual history taking and sexual health discussions.

**LIMITATIONS**

There are several limitations to this study. First, due to the small sample size, study findings may be only generalizable to gynecological care provided in New York City at enrolled sites. Second, selection bias may be present, as there are likely differences in providers and patients who choose to participate versus those who did not. It is highly possible that patients who had an above-average awareness of sexual health and a belief that it was important were more apt to participate in the study. Also, while we recruited both new and established patients, there are cited differences in levels of satisfaction between patients who have an established relationship with their provider and those who do not.302 None of the patients expressed complete dissatisfaction with their visit;
however, a shorter time period to build rapport may have influenced the new patients’ answers regarding barriers and facilitators to sexual health discussions. Third, no male providers chose to participate in this study, and, as a result, I did not collect any data with male perspectives. While it is not fully understood why we were unable to successfully recruit male providers, my hypothesis is that the subject matter (sexual health) and the fact that the RA and myself are female may have played a role in our failure to recruit them for this study. Ethnographically-speaking, as a recruiter and interviewer for the study, I also must acknowledge that I may have (sub)conscious biases that could have unintentionally affected my personal approach to recruitment, and thus, discouraged male providers from participating. In addition to interviewer gender and biases, there may have been error or variance introduced due to other interviewer characteristics. Many of the patient interviewees identified as African-American or Latina, whereas the interviewer (myself) identifies as White, Caucasian or European American. Race/ethnicity of the interviewer has been cited as affecting interviewee responses.303

Fourth, using a pelvic exam as a proxy for gynecological care may have biased the results, as pelvic exams are conducted for specific reasons. While I felt that there was the greatest likelihood of sexual history taking occurring during visits with pelvic exams (and thus, aiding with recruitment), sexual history taking is not exclusive to those encounters. Therefore, I did not collect data from patients who may have had a reproductive health visit without a pelvic exam, such as those patients seeking hormonal contraceptives (pill, patch, or vaginal ring). Fifth, for a few patients, the timing of interviews for may have affected recall of specific details from their recent medical encounter. Most (16 out of 18) interviews were conducted directly after their visit, but in the two interviews where more time had elapsed, there was likely recall bias with their answers about the recent encounter. Lastly, while a level of saturation was achieved with a few thematic
findings, most results from this pilot study are preliminary findings, and, thus, further research is needed to assess the generalizability of the conclusions presented here.

**STRENGTHS**

This study has many strengths. First, this study interviewed patients and providers from the same clinic sites, which, consequently, enabled me to make comparisons between interviewee responses. Only two other studies have simultaneously examined patient and provider perspectives regarding sexual history taking,\textsuperscript{131,132} and so the findings presented here add to our knowledge about similarities and differences among patients and providers. Second, while I did not set out to exclusively collect female perspectives in the interviews, ultimately that is what was collected, and what is described in this dissertation. Too few female narratives regarding taking/giving a sexual history and providing/receiving gynecological care have been collected and represented in the literature. Thus, the findings presented here help add to that body of research. Third, this study includes perspectives of African-American and Latina women which few studies about sexual history taking have done. Fourth, analyses of the interview data were guided by the interviewees’ perspectives on sexual history taking and sexual health discussions, and the themes were generated from the words, experiences and perspectives of the patients and providers. Furthermore, notes from our coding meetings and drafts of the codebooks increase the confirmability and dependability of the data and subsequent findings by providing a review of any changes and decisions made during the course of data analysis. Lastly, the representation from different provider types and patient age groups are a strength.

**IMPLICATIONS FOR CLINICAL PRACTICE AND POLICY**

This pilot study represented a distinct opportunity to learn about female patient and family medicine provider experiences, perspectives and needs during gynecological care, with the overall
goal of improving patient-provider communication and positively impacting health outcomes. During their interviews, patients and providers described what can realistically be accomplished during gynecological care encounters and what cannot. Providers reiterated their specific goals (risk assessment, provision of contraception and identification of certain sexual health issues) during these time-limited encounters, which are narrower in scope than what is called for by current clinical practice guidelines that approach sexual healthcare in a holistic way, such as those published by ACOG⁵⁸. Patients and providers also described the need for additional education and training materials to improve patient knowledge and understanding, and to help providers navigate these oftentimes difficult discussions. Collectively, these results can be used to propose modifications to history giving/taking guidance that incorporates these real-world experiences, perspectives and needs. Additionally, these findings identify areas where existing interventions and/or tools may be leveraged and adapted to work in various gynecological care settings with patients and healthcare providers.

**IMPLICATIONS FOR FUTURE RESEARCH**

The results of this pilot study suggest many avenues for further research regarding the implementation of clinical practice guidelines around sexual history taking. First, a study similar to this one could be conducted in a comparable family medicine setting with a larger sample size, and with the inclusion of male provider perspectives. Second, conducting a study with other age groups, such as adolescent or older female patients, would add to the existing literature about patient perspectives regarding sexual history taking during gynecological care encounters. Third, another approach would be to conduct a similar study in various practice environments, such as private practices, government-owned STD clinics, non-profit clinics, emergency rooms, and urgent care centers, to compare and contrast the experiences and perspectives of female patients
and their providers. Lastly, future research can build upon the findings from this study regarding framing of sexual health and behavior by female patients and family medicine providers by exploring definitions from other patients and providers. Medical education, sexual health educators and researchers, professional organizations and clinic environments would collectively benefit from a better understanding of how sexual health is conceptualized within medical encounters.
PATIENT SEMI-STRUCTURED INTERVIEW GUIDE

First, let’s talk about your visit to the clinic today...

1. When you first arrived at the clinic, what did you experience?
   a. Possible probes: What is it like in the waiting room? What is it like to wait?

2. Describe to me what it was like before you saw [the provider], when someone first took you into an exam room to ask you questions and take your blood pressure...

3. Did they ask you about your sexual health?
   a. Follow-up questions: [If yes:] Tell me about the questions they asked... What do you think they wanted to know when they asked about [topics from the questions the patient mentions]? How did you feel when they asked you those questions? Why do you think they ask those questions about sexual health before you see the doctor?

4. So, I just mentioned it, but what does it mean to you when someone talks about “sexual health”?

Next, let’s talk about your visit with [the provider]...

5. Before going to the clinic, what did you expect to happen during the visit?

6. Tell me about how the visit with [the provider] actually went...
   a. Possible probes: What went well? What could have gone differently? Did anything surprise you? How did you bring up any issues or concerns during the exam, if you had any? How did you feel overall about the experience?

7. Did [the provider] ask questions about your health? What did they ask about?
   a. Follow-up questions: Did you and [the provider] discuss your sexual health? Who started the conversation? What did you discuss?

8. When you and [the provider] discussed [topics from question 7a above], were things explained in a way that made sense? Was anything confusing? Tell me about that...
   a. Follow-up questions: What pieces of information did you think were important to tell [the provider]? How do you think the information you provided affected (positively or negatively) the care you received? Did you ask the provider any questions? What information did you need, if any, in order to ask those questions?

9. Were there any sexual health topics not brought up that you wished had been? Why do you think they didn’t come up?

10. How did you feel during the discussion?
    a. Possible probes: Have you discussed your sexual health with healthcare providers in the past? How was this discussion similar or different? Do you find it easy or difficult to discuss sexual health matters with [the provider]? Why do you think that is?

11. Do you think it’s [the provider’s] job to ask questions about your sexual health? Why or why not?

12. In your opinion, what are the kinds of sexual health concerns healthcare providers can help patients with? Are there any sexual health concerns that, maybe, a provider may not be able to help with?

13. In your opinion, what would make discussions with [the provider] about sexual health matters better?

Next, I’d like to discuss some of your life experiences that may help me better understand sexual health and behavior from your perspective...

14. Tell me about where have you learned about sexual health over the years...
    b. TV? Magazines? Internet? Other media?
    c. Pediatrician? Other medical professionals?
    d. Follow-up question: What specifically did you learn from [each source]?

15. How do you think that information shaped your thoughts and feelings about sexual health and behavior?
16. Besides medical professionals, who have you talked to about your sexual health?
   a. Possible probes: Partners? Friends? Family?
17. How are your conversations about sexual health outside the clinic similar to your conversations with medical professionals? How are they different?

Finally, let’s discuss future visits with medical professionals...

18. Can you describe what would be an ideal conversation about sexual health between a patient and their provider, in your opinion? What would a bad conversation look like?
   a. Follow-up questions: With regard to sexual health topics, what questions, if any, should providers ask patients? What topics, if any, should providers stay away from? What are the kinds of things patients should tell providers about? Is there anything patients shouldn’t tell providers? What questions, if any, should patients ask providers? In your opinion, what information do patients need, if any, in order to ask questions?
19. In your opinion, what are some ways patients can improve sexual health discussions during medical visits? What are some ways doctors and nurses could improve how they ask about sexual health issues? How could providers improve giving sexual health information to patients?
   a. Follow-up question: What would be the most comfortable way for you, personally, to get sexual health information?

We’re almost done, but before we finish...

20. We’ve talked a lot in detail about “sexual health”, but do you have any further thoughts about what it means to you?
   a. Possible probe: How would you describe “sexual health” to a friend?
21. Do you have anything else to add?
22. Do you have any feedback about the interview?
Provider Semi-Structured Interview Guide

First, let’s talk the clinic environment and what an average day looks like for you…

1. When you first arrive at the clinic, what do you experience?
   a. **Possible probes:** What is it like before each session? During huddle?

2. Briefly describe an average day for you at the clinic...
   a. **Possible probes:** How many hours do you spend charting? On Best Practice Advisories or other required sections?

Now, I’d like you to think about a recent patient encounter during which you did a pelvic exam...

3. Before going into the exam room, what did you expect to happen during the visit?
   a. **Follow-up question:** Were you planning on doing a pelvic exam?

4. Tell me about how the visit actually went...
   a. **Possible probes:** What went well? What could have gone differently? How did you respond to the patient’s issues or concerns? How did you feel overall about the experience?

5. Did you talk about sexual health? Tell me about what was discussed and how...
   a. **Possible probes:** Did you initiate the discussion about sexual health or did the patient? Did the EPIC module assist you with this?

6. How did you feel during the discussion?
   a. **Possible probes:** Have you discussed sexual health topics with this patient in the past? How was this time similar or different?

7. What were you hoping to elicit from the discussion about sexual health?
   a. **Follow-up questions:** Did you receive the information that you were trying to get? Why do you think that was? Did anything surprise you? How do you think the information the patient gave affected the care you provided?

8. Were there any sexual health topics not brought up that you wished had been? Why do you think they didn’t come up?

Now let’s talk about sexual history taking, in general...

9. When do you think a provider should ask questions about the patient’s sexual health?

10. What sexual health topics do you find difficult to discuss with patients, if any?
    a. **Follow-up questions:** Why do you think that is? What would need to change in order for it to be easier?

11. In the past, from which sources, if any, have you received guidance about how to discuss sexual health with patients?
    a. **Follow-up questions:** How do you think that guidance impacted your sexual history taking “style”? Where did you first learn how to take a sexual history? What was your experience?

12. In your experience, what is an effective way to gather sexual history information from patients?
    a. **Possible probes:** How do your patients respond to this method of history taking? How do you navigate/explain complex medical terminology during discussions with your patients?

13. In your opinion, how could providers improve discussions of sexual health issues (e.g. sexual partners, STDs, contraception use, sexual anxiety/dysfunction, domestic violence) during medical visits?
Next, I’d like to discuss some of your life experiences that may help me better understand sexual health and behavior from your perspective...

14. Tell me about where have you learned about sexual health over the years...
   a. School? Family? Friends?
   b. TV? Magazines? Internet? Other media?
   c. Pediatrician? Other doctors? Medical journals?

15. How do you think that information shaped your thoughts and feelings about sexual health and behavior?

16. How do you discuss sexual health topics with your own medical provider?
   a. **Possible probes:** Are there any topics difficult for you to raise? Which ones are easy? Why do you think that is?

17. How are your conversations about sexual health with your own medical provider similar conversations with your patients, if at all? How are they different?

18. Besides medical professionals, who have you talked to about your own sexual health?
   a. **Possible probes:** Friends? Family? Partner?

19. How are your conversations about sexual health outside the clinic different from conversations with your patients, if at all? How are they similar?

We’re almost done, but before we finish...

20. We’ve talked a lot about “sexual health”, but what does it mean to you?

21. Do you have anything else to add?

22. What did you think about the interview?

**Thanks so much! Before you leave, I’d like to ask you a few demographic questions...**

1. How old are you? ______ YEARS

2. Which of the following best describes you? **Select all that apply.**
   a. African-American or Black
   b. American Indian or Alaska Native
   c. Arab or Middle Eastern
   d. Asian or Asian-American
   e. Caribbean or West Indian
   f. Hispanic or Latina/Latino
   g. Native Hawaiian or Pacific Islander
   h. White, Caucasian or European American
   i. Other, please describe: ___________

3. During your residency, what area of medicine did you specialize in? _________

4. If you completed a fellowship, what was the focus? ______________

5. Do you have any additional training in:
   a. Gynecology?
   b. Reproductive health?
   c. Sexual health and/or sexuality?
   d. Obstetrics?
   e. Other? Please describe:____________

6. How long have you been practicing? _____ YEARS _____ MONTHS

7. How many hours do you work per week, on average? ______ HOURS
8. How many patients do you see per week, on average? _____ PATIENTS

9. During an average week, approximately how many pelvic exams do you perform?
   a. 1-5 exams
   b. 6-10 exams
   c. 11-15 exams
   d. More than 15 exams
Approval Notice
Initial Application

04/06/2017

Ashley Chastain, BS, MPH
The Graduate School & University Center

RE: IRB File #2017-0343
Patient and provider perspectives on sexual history taking during gynecological care encounters

Dear Ashley Chastain,

Your Initial Application was reviewed and approved on 04/06/2017. You may begin this research.

Please note the following information about your approved research protocol:

Protocol Approval Period: 04/06/2017 - 04/05/2018
Expedited Category(ies): (6) Collection of data from voice, video, digital, or image recordings made for research purposes.; (7) Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies. (NOTE: Some research in this category may be exempt from the HHS regulations for the protection of human subjects. 45 CFR 46.101(b)(2) and (b)(3). This listing refers only to research that is not exempt.);

Documents / Materials:

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Please remember to:

- Use **the IRB file number** 2017-0343 on all documents or correspondence with the IRB concerning your research protocol.

- Review and comply with CUNY Human Research Protection Program policies and procedures.

The IRB has the authority to ask additional questions, request further information, require additional revisions, and monitor the conduct of your research and the consent process.
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