Exploring Sexual History Taking in One Health Center: A Focused Ethnography

Timothy J. Sowicz, PhD, CRNP\(^1,2\); Christine K. Bradway, PhD, CRNP, FAAN\(^2\)

\(^1\)VA Pittsburgh Healthcare System; \(^2\)University of Pennsylvania School of Nursing

**Introduction**

- Sexual history taking (SHT) – collecting information about sexual health
- Rates of SHT documentation vary
- SHT literature limited to content of sexual histories, barriers to SHT, and interventions to improve documentation
- Few qualitative studies of SHT

**Purpose & Initial Research Question**

- Understand the SHT practices of health care providers (HCPs) as they occur within the context of various health care encounters
- How do HCPs collect, evaluate, and use sexual history data during health care encounters with patients?
- **Focused ethnography** of one federally qualified health center ("LHC")
- **Theoretical perspectives**: Symbolic interactionism; the Theory of Culture Care Diversity and Universality
- **Informants**: Physicians, PA-C, NP, SWs, MA, peer advocate, case manager, RNs, certified application counselor
- **Data collection**: Passive observations, situational conversations, semi-structured interviews, field notes
- **Analysis**: Leininger’s Phases of Ethnonursing Data Analysis Enabler for Qualitative Data
- **Rigor**: Prolonged engagement in the field; producing a thick description; triangulation of data; peer debriefing

**Findings**

- **No sexual history data collected during 79 observed encounters**: 1 wellness visit; 84% for acute/chronic concerns, establish care, review labs; 16% for medication-assisted treatment for opioid use disorder
- Additional research questions emerge:
  - Why was SHT not observed?
  - What was happening during patient-provider interactions in this setting?

- "Sometimes patients have other needs that come first like mental health, or housing, or food, or whatever they need, or addiction, um, whatever they need at the moment. So we try to balance primary care with, and, medical care with other forms of care" (HCP)

- **Study Contributions**:
  - Informants comfortable dealing with vulnerable patients
  - Identification of new factors affecting communication
  - Encounters conducted differently than traditionally-structured encounters
  - Reportable quality measures unrelated to sexuality
  - Higher rates of documentation in previous studies
  - First ethnographic study of sexual history taking

- **Boundaries**:
  - One setting
  - Few observed wellness encounters
  - EHR data excluded
  - Patients not interviewed

- **Implications**:
  - Expose trainees to SHT
  - Realities of daily practice require adaptation
  - Continuing education for HCPs
  - Further development of operational definition of SHT
  - Need to include EHR data

**Persons served by the LHC**

- Patients vs. "our regular people"
- Ideas about how patients perceive LHC
- Patients’ immediate needs supersede HCPs’ goals

**Persons served by the LHC**

- Communication between patients and health care providers
  - Can be handled differently
  - Patients perceived as “mean”
  - Difficult to contact patients
  - Language differences
  - Reluctance to disclose reason for visits
  - HCPs perceived as intimidating

- Patients’ immediate needs in the context of organizational mandates
  - Mental health, housing, food, substance use
  - Experienced trauma
  - Absence of preventive care
  - Mandatory reporting to funders
  - Limited sexual history section in electronic health record (EHR)
  - Providers’ skills/training
  - Scheduling

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