LET’S TALK ABOUT SEX…OR NOT…: DOCTOR-PATIENT COMMUNICATION ABOUT SEXUAL HEALTH

by

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Let’s Talk about Sex…or Not…: Doctor-Patient Communication about Sexual Health

Abstract

by

CASEY MICHELLE SCHROEDER

Rates of sexually transmitted infections (STIs) are rising (CDC, 2014). Because primary care physicians interact with a majority of patients (Ashton et al., 2001; Rabin, 1998), it is important that primary care physicians feel comfortable approaching the subject of sexual health, especially STI prevention. This research employs an ethnomethodological design, putting research participants’ perceptions at the forefront. Seventeen semi-structured interviews with currently practicing family doctors or internists were conducted. Respondents’ beliefs about prestige, influence and success (cultural capital) in medicine are assessed. Their views about the appropriateness and effectiveness of discussing sexual health, specifically STI prevention, are evaluated. Interviews were transcribed and the discourse was analyzed for recurring themes. While respondents feel it is appropriate to discuss sexual health, there are many reasons why they do not: the belief that STI prevention conversations are not effective and the concern that they will make patients uncomfortable. Respondents feel that sexual health is often not relevant to a patient’s visit. Tensions between cultural capital with patients and cultural capital with other physicians also influence how respondents approach their patients. Primary care physicians need to become more comfortable discussing sexual health with their patients. Sexual health needs to be considered an essential part of patients’ health and can be modeled by attending physicians for resident physicians. Sexual health questions can also be added to standard patient information forms.
Chapter 1: Introduction

Statement of purpose (specific aims)

This research will examine specific aspects of doctor-patient communication, including:

1. Physician beliefs about specific tasks involved in patient-centered care and their importance

2. Physician beliefs about cultural capital, including perceptions of competition in the medical field as well as their definitions of success, prestige and influence in the medical field. Cultural capital is also assessed by eliciting physicians’ views on how the practice of medicine and U.S. society influence each other as well as how the healthcare system within which they practice affects the care they provide

3. Physician beliefs about the appropriateness and effectiveness of conversations with patients about sexual health and sexually transmitted infection (STI) prevention

4. Physician comfort levels with discussing sexual health topics with patients

Statement of problem

According to the Centers for Disease Control and Prevention (2014), rates of sexually transmitted infections are rising. Black people, American Indians/Alaska Natives and Hispanics are more likely to contract chlamydia and gonorrhea as well as primary and secondary syphilis. Black people are most significantly affected. The United States Preventive Services Task Force (USPSTF) urges health care providers to be aware that black and Hispanic women and men are an increased risk of chlamydia, gonorrhea and syphilis (Meyers, Wolff, & Gregory, 2008). According to the CDC (2014), black
women face higher rates of chlamydia than any other group, while the highest rates of gonorrhea are among black men. Overall, women experience higher rates of gonorrhea and chlamydia, while men who have sex with men experience the highest rates of syphilis. The USPSTF recommends that all sexually active women under the age of 25 be screened for chlamydia and gonorrhea, as they are at increased risk (Meyers et al., 2008).

There are serious long-term health effects of undetected or untreated STIs (CDC, 2006, 2010). According to the CDC (2010), untreated STIs can have serious health consequences, particularly for women. Pelvic inflammatory disease (PID) can occur in between 10% and 20% of untreated gonorrhea and chlamydia infections in women. PID can cause chronic pelvic pain, ectopic pregnancy and infertility. Untreated gonorrhea and chlamydia infections in men can cause epididymitis, which is a painful infection in the tissue surrounding the testicles. Untreated males can also develop urethritis, which can cause pain and fever. Untreated syphilis infections can result in brain, cardiovascular, and organ damage and even death (CDC, 2010). Further, Fleming and Wasserheit (1999) determine that having a syphilis, chlamydia or gonorrhea infection can increase the risk of HIV transmission. This research indicates that the increased risk comes from “shedding in the genital tract, which probably promotes HIV infectiousness…by recruiting HIV susceptible inflammatory cells to the genital tract, and by disrupting mucosal barriers to infection” (p. 4). STIs are also a costly burden to the United States health care system. According to Owusu-Edusei Jr et al. (2013), the cost of STIs to the U.S. health care system is estimated to be as much as $16 billion annually.

Because primary care physicians interact with a majority of STI patients (Ashton et al., 2001), it is important that these physicians know how to approach the subject of
sexual health, including STI prevention and that they feel comfortable doing so. According to Rabin (1998), primary care physicians account for about 60% of all physician encounters in the United States. In other words, people are more likely to see a primary care doctor than any other type of doctor. Further, members of U.S. society consider health care professionals to be legitimate sources of health information, including information about sexual health (Foucault, 1978). As a result, the doctor-patient encounter can provide a significant opportunity for physicians to counsel their patients about sexual health topics such as safer sex (Browne, Minichiello, & Plummer, 2002; Lewis & Freeman, 1987). However, primary care physicians avoid talking to their patients about sex (Porter & Ku, 2000; Tao, Irwin, & Kassler, 2000; Kingsberg, 2006). This lack of sexual health discussion may be for a variety of reasons, including a lack of patient knowledge about STI prevention and sexual health (Al Mohajer, Lyons, King, Pratt, & Fichtenbaum, 2012; Dehlendorf, Levy, Ruskin, & Steinhauer, 2010; Jain et al., 2006; Parisi et al., 2012). Physician gender also influences whether or not a physician will engage in patient-centered care (Ben-Sira, 1980; Bensing & Dronkers, 1992; Burnard, 1996; Fiscella & Epstein, 2008; Silverman, 1987) and preventive care (Bertakis, 2009; Millstein, Igra, & Gans, 1996). Further, patients tend to feel most comfortable with medical encounters in which their gender is the same as their physician’s gender (gender concordant visits) (Bertakis, 2009; Sandhu et al., 2009). During gender concordant visits, patients are more likely to experience “healthcare that is respectful and responsive of their needs, values and preferences and encourages shared clinical decision making,” (Bertakis, 2009, p. 326).
A patient’s gender, race, ethnicity, socioeconomic status or sexual orientation may influence the way a patient is treated by a physician as well as the way the patient approaches the physician (Bertakis, Franks, & Epstein, 2009; Dahan, Feldman, & Hermoni, 2008; Dardick & Grady, 1980; Grant & Ragsdale, 2008; Nusbaum, Frasier, Rojas, Trotter, & Tudor, 2008; O’Hanlan, Cabaj, Schatz, Lock, & Nemrow, 1997; Petroll & Mosack, 2011; Polek, Hardie, & Crowley, 2008; Politti, Clark, Armstrong, McGarry, & Sciamanna, 2009; Tanfer, Cubbins, & Billy, 2009; Street, Gordon, & Haidet, 2007; van Ryn, 2002; van Ryn & Burke, 2000; Watzkin, 1984). In turn, a patient’s demographic characteristics and sexual orientation may influence the likelihood that a conversation between doctor and patient about sex will occur. Women are less likely to seek STI treatment or preventive treatment than men. However, according to research conducted by Tanfer et al. (1995), women and black respondents are more than three times as likely to report an STI as men and white respondents. Therefore, while women are more likely than men to report an STI, they are less likely to seek treatment or preventive care. Tanfer et al. (1995) hypothesize that women’s reluctance to seek treatment may be because STI treatment can be more stigmatizing for women than for men.

Stewart, Napoles-Springer, Gregorich, and Santoyo-Olsson (2007) and Stewart et al. (1999) connect status as a racial or ethnic minority with communication difficulties during medical encounters, which can be detrimental when the patient is seeking information about STI prevention or when a physician is attempting to impart such information. Street et al. (2007), van Ryn (2002), and van Ryn and Burke (2002) identify that racial/ethnic minority patients experience negative stereotypes by physicians. Such
negative stereotypes may affect physicians’ expectations of patients and whether a patient is more or less deserving of treatment (van Ryn, 2002). Studies conducted by van Ryn and Burke (2000) and Street et al. (2007) determined that physicians tended to perceive African American patients more negatively than white patients on characteristics such as personality, education, intelligence, communicativeness, and likelihood of adherence to treatment regimens as well as likelihood of engaging in risk behaviors. Ultimately, these types of misperceptions based on race can result in a lower quality of care of racial/ethnic minority patients (Street et al., 2007).

Like race and ethnicity, a patient’s social class can be a structural barrier because it can influence how much time a patient spends with the doctor as well as the quality of explanations a doctor will provide. According to Waitzkin (1984), lower class patients tend to experience less time with their physicians and receive less thorough explanations. In addition, lower class patients tend to ask few questions during their doctor’s visits (Willems, DeMaesschalck, Deveugele, Derese, & Maesneer, 2005), which suggest an unequal power dynamic in the doctor-patient relationship (Waitzkin, 1984). Patients from lower social classes also give less information, give their opinions less, are less expressive, and show less preference for shared decision making. Furthermore, patients from lower social classes are further disadvantaged because the physician may misperceive their communication style to mean that they do not want information (Willems et al., 2005). van Ryn and Burke (2000) also find that patient socioeconomic status influenced physician’s perceptions of patient’s personality, abilities and behavioral tendencies and that physicians tended to perceive members of low and middle socioeconomic groups more negatively on the aforementioned qualities.
A patient’s sexual orientation is often ignored by primary care physicians; and when it is considered, it often has negative consequences, such as a lower quality of health care (Dahan et al., 2008; Dardick and Grady, 1980; Nusbaum et al., 2008; O’Hanlan et al., 1997; Petroll and Mosack, 2011; Polek et al., 2008; Politti et al., 2009). Many patients’ primary care providers do not know or ask about their patients’ sexual orientation; some physicians even make false assumptions of patients’ heterosexuality (Allen, Glicken, Beach, and Naylor, 1998; Bonvicini and Perlin, 2003; Politti et al., 2009). According to Clark, Bonacore, Wright, Armstrong & Rakowski (2003), communication about sexual history can impact a patient’s willingness to disclose other relevant health information as well as the patient’s overall satisfaction with a provider. In a study conducted by Petroll and Mosack (2011), 29% of the sample (homosexual men) reported that their primary care provider did not know their sexual orientation. 44.4% of physicians surveyed by Dahan et al. (2008) did not know any gay, lesbian or bisexual patients. Patients are reluctant to bring up their sexual orientation for a variety of reasons, including self-stigmatization, lack of self-esteem, living or working in an environment that stigmatizes alternative lifestyles as well as perceived negative attitudes of health care provider (Polek et al., 2008). In addition, patients may also be reluctant to bring up their sexual orientation due to prior negative experiences when disclosing their sexual orientation or the perception that clinicians were not informed about relevant issues (Dahan et al., 2008; Politti et al., 2009).

In addition, lack of patient knowledge or inaccurate knowledge about how STIs are transmitted may partially explain these rising STI rates (Ashton et al., 2002; Crosby, Newman, Kamb, Zenilman, Douglas, & Iatesta, 2000; Tolani & Yen, 2009; Voisin, Tan,
Salazar, Crosby, & DiClemente, 2012). Patients also have many misconceptions about how to prevent STIs (Crosby et al, 2000; Weinstein, Walsh, & Ward, 2008). Further, women of color are less likely to use contraception and more likely to have negative attitudes (misconceptions) about contraception (Dehlendorf et al., 2010; Rocca & Harper, 2012). Considering that women, people of color and gay men are more likely to contract certain STIs, cultural competence will be explored as an avenue through which more sensitive and inclusive sexual health conversations can be initiated.

**Theoretical background**

The examination of these specific aspects of doctor-patient communication will be guided by postmodernism and constructivist structuralism. Specifically, J.H Turner’s (2003) postmodernist criticism of modern medicine being considered a neutral science and medicine’s resultant prestige will be considered. In addition, B.S. Turner’s (1996) examination of the history of medicine and its ability to morally advise people as well as Foucault’s (1978) work on modern and historical sexual repression further support the notion that medicine is not neutral are part of the postmodern perspective. Foucault’s theories (1978) will also be used to explore reasons why sex health is such a stigmatized topic in the field of medicine. Link and Phelan’s (1995) as well as Waitzkin’s (1989) positions that medicine ignores structural barriers to health behaviors are an essential part of the postmodern component in that postmodernism is critical of medicine’s privileged status.

Bourdieu’s structuralist constructivism considers the fluidity of social situations (such as medical encounters) in that it posits that social structures shape and guide
individuals but can be shaped and interpreted by individuals (Bourdieu & Wacquant, 1992). Therefore, structuralist constructivism considers the role of the individual physician as well as the institution of medicine’s (in U.S. society) role in maintaining this esteemed status. Further, Bourdieu considers not only how the field of medicine influences physicians but how physicians influence the field of medicine. Thus, the medical habitus (the culture of medicine) and the medical field (the hierarchy within the medical profession) will be examined. This perspective also provides more insight into the doctor-patient relationship by examining the ways in which physicians and patients compete for the resource of knowledge (Waitzkin, 1989; J.H. Turner, 2003) and the way physicians compete with each other for cultural capital, or prestige in the field of medicine (H. Luke, 2003).

Sample and methods

Semi-structured interviews with currently practicing family physicians or internists were conducted. A snowball sampling strategy was employed. This process involves one respondent who fulfills the theoretical criteria (being a currently practicing primary care resident or physician); then that person helps to locate others through his or her social networks (Biernacki and Waldorf, 1981). Initial interviews were conducted with physicians with whom I have worked in an academic setting. At the conclusion of the interview, respondents had the option of referring me to other physicians who may have been interested in being interviewed. Offices of (primary care) physicians from a major health care system in the Cleveland metropolitan area were emailed to request interviews.
According to Bertaux (1981), Bernard (1995), Creswell (1998), Kuzel (1992) and Morse (1994), at least 15 interviews are needed to reach theoretical saturation. Schutt (2006) describes the saturation point of sampling as the point at which interviews yield little to no new information. I conducted a total of 17 interviews. Each interview was thematically analyzed. There were multiple coding iterations, including open coding (no preconceived notions of what codes should be), axial coding (matching codes to research questions) and focused coding (using frequently appearing codes to sort data) (Blumer, 1969; Charmaz, 2002; Corbin & Strauss, 1990; Glaser & Strauss, 1967). Based on recommendations from Guest, Bunce & Johnson (2006), I recorded the proportion of individual interviews to which a code was applied as well as the sequence of interviews in which a code appeared. These codes highlight meanings physicians associate with cultural capital, patient-centered care, appropriateness and effectiveness of discussing sexual health topics with patients as well as comfort levels discussing sexual health topics with patients.

**Sociological significance**

These findings will contribute to the discipline of sociology by employing Bourdieu’s theory of structuralist constructivism to consider the influences of individual physician and patient attributes on the institution of medicine as well as the ways that the institution of medicine affects physicians and patients. Furthermore, this research will analyze how physicians respond to taboo subjects such as sexual health. It will contribute to the specialty of medical sociology by considering why sex is a taboo subject in medicine and why sexually transmitted infections are stigmatized. This research will also reconsider how cultural capital in the medical habitus affects patient-centered care more
generally and practitioner comfort levels with the discussion of taboo subjects (such as sex) more specifically.

In-depth interviews will provide rich data regarding exactly what cultural capital means to physicians. Further this research will examine the potential conflict between an endorsement of patient-centered care and a concern with cultural capital. Examining sexual health as an essential part of patient-centered conversations is also unique to this research. This research will analyze how structures of medical institutions as well as the patient populations they serve influence when and why practitioners discuss sex. Finally, a sociological exploration of how individuals and structure influence problematic STI rates could bridge the gap between social sciences and epidemiological sciences.
Chapter 2: A postmodern examination of medicine

This chapter considers the application of both postmodernism and Bourdieu’s (1977, 1991, 1993) structuralist constructivism to the culture of medicine. Postmodernism allows for a critical analysis of modern ideas about objectivity, including its association with science, particularly the science of medicine. This chapter also outlines a brief history of medicine, focusing on factors that contributed to medicine’s rise to power and prestige, as well as medicine’s relationship to modern sexual repression. Postmodernism calls into question the prestige given to the field of medicine. The vast amount of influence culture and society have on medicine challenges its claim of objectivity. Bourdieu’s structuralist constructivism allows for reflexive analysis of medicine. This theory are used to consider the influence physicians have on the culture of medicine and the way the culture of medicine influences physicians.

Along with postmodernism, structuralist constructivism enables a close examination of the medical habitus, which is the culture of medicine as acted out by physicians. Specifically, this chapter examines the field, capital and the habitus. The field is where the competition for cultural capital takes place. Cultural capital is knowing how to properly act as a physician. Habitus is the way that physicians learn, internalize and subsequently act like physicians. Learning how to act like a physician may entail learning about the importance (or lack of) patient-centered care, being involved in professional medical associations or considering patient barriers to preventive care. This learning involves power dynamics of senior physicians (attendings) influencing more junior physicians (medical students, clerks and residents). Furthermore, these theoretical perspectives consider that part of becoming a physician is informally learning and
internalizing that sex is an embarrassing topic. In addition, postmodernism and structuralist constructivism are utilized to consider that physician concern with patient-centered care may be at odds with cultural capital.

**What is postmodernism?**

*The idea of a correct interpretation presupposes a number of conditions that are unrealizable, namely, that a text or an event is objective and determinate because it refers to an objective reality or has a determinate meaning or the author or actor had determinate intentions that can be objectively discovered.*

Hollinger, 1994; p. 101

Postmodernism is critical of modern ways of understanding society. Such modern ways of understanding society consist of the notions that there are universal truths, that humans have extensive levels of free will and agency and that reason and logic should and do dominate social interactions as well social structure. In addition, a modern perspective would posit that humankind’s existence is good, extremely powerful, and should be extremely powerful. However, postmodernism considers that humans are not always as good and as powerful as they think they are. Rather, these attitudes have often resulted in racism, sexism, classism, homophobia and ethnocentrism (Hollinger, 1994).

Furthermore, postmodernism posits that the stability resulting from consensus about norms that can exist in society may not be purposeful. In other words, society does not exist in its current form because humankind intended it to be that way. Social order is a result of social interactions. It may be stable because of the interactions between its structures and its actors; however, these interactions may not have the intent of stabilizing. Instead, stability may be a latent consequence of these interactions (Hollinger,
The challenge of society’s source of stability calls into question the power of humankind.

Further, such modern interpretations of humankind’s superiority infer that human agency utilizing logic and reason are the correct way for societies to function. Postmodernism suggests that the (modern) notion of an absolute truth (logic and reason are superior) or one correct conclusion (humans have extensive levels of free will/agency) is harmful to the sciences. These modern notions of absolutism are problematic, because they narrow the focus of inquiry with the assumption that there is a linear relationship between cause and effect. However, postmodernism posits that there is not always a linear relationship between cause and effect. Often, these relationships are circular (Hollinger, 1994). In other words, various elements of society affect each other; certain elements of society do not necessary exert greater influence than others (Hollinger, 1994). People affect society, and society affects people. Essentially, postmodernism introduces the idea that there may be multiple truths and multiple acceptable conclusions. This notion that there may be multiple truths leads postmodernism to posit that elements of society, such as interactions and social structures should be interpreted like texts. Thus, elements of society are contextual and may have different meanings at different times. Society’s elements can be studied and understood; however, they can neither be understood absolutely nor objectively (Hollinger, 1994). While there are no absolute or objective truths, there are conclusions that are better or relatively more appropriate than others (Hollinger, 1994). Conclusions that consider their subject matter to be contextual are more likely to be considered “better.”
**What can postmodernism teach medicine?**

At present, medicine’s association with objectivity is part of what makes it so prestigious (Starr, 1982). “Medicine has constructed its history as one of a steady progress towards greater objectivity, understanding, and precision, a pursuit of the truth of illness and disease” (Smart, 1985, p.29). During the 19th century, medicine increased its focus on specialized knowledge and specialized training. Physicians began to band together to increase their power and were relatively effective at curing disease. The late 19th century saw an increased emphasis on public health and hospital expansion. These structural factors combined with modern individualist culture led to a large amount of prestige and power wielded by physicians (Starr, 1982).

However, according to Foucault, medicine isn’t actually objective and is critical of its prestigious status. Instead, the individual becomes the object and subject of knowledge; this makes people feel more important and powerful because they are being studied and also controlling how they are studied. “…the doctor defines not the mode of knowledge, but the world of objects to be known” (1973, preface, x.) Instead, the discipline of medicine owes its prestige to its focus on the health and well-being of people. Therefore, it contributes to the modern idea that people are highly important (Foucault, 1973). Due (in part) to medical personnel utilizing surveillance and judgment (Smart, 1985), medical knowledge is viewed as autonomous and as “the original” human science or “sciences of man” (Smart, 1985). “Modern medicine is one of those extraordinary works of reason: an elaborate system of specialized knowledge, technical procedures, and rules of behavior” (Smart, 1982, p.3).
In addition to medicine’s ability to reify the importance of humanity, it uses its own, very specific discourse about bodies and disease to further enhance its power (Foucault, 1973). This specific discourse increases the power of medicine by determining who possesses medical knowledge and who lacks it. Furthermore, this medicine’s discourse and power determines which descriptions of ailments are considered accurate and which are considered incorrect, as well as what are considered correct and incorrect ways to reach a diagnosis (Foucault, 1973). According to Foucault, changes in medicine were simply one facet of a wider cognitive revolution: certainly diseases were fabricated by medicine, but so were the bodies that contained the diseases; and this production of bodies was common to a range of techniques deployed through schools, prisons, workshops, barracks and hospitals (Armstrong, 1994). The result is that medicine has the power to tell us how to regulate our bodies and our lives. Specifically, medicine has recommended prudence and economy in the use of sexual pleasures since “the first century of our era.” (Foucault, 1973, p. 16).

Waitzkin (1989) also posits that medical encounters are not neutral or objective; instead they convey dominant cultural ideologies. When physicians ignore issues of access and resources and focus on individual behaviors (Link & Phelan, 1995), as is common in western culture, they assume that all individuals have the same ability to practice safer sex. Physicians may reinforce broader social structures (such as inequality by class) by ignoring that they factor into disease (Waitzkin, 1989). For example, physicians may not consider socioeconomic inequality when advising a patient to practice safer sex. If and when a physician discusses condom use with a patient, the physician may not ask if a patient can afford condoms or if that patient can easily get to a
store to purchase condoms. That is, the physician may not question or criticize the structural barriers of either socioeconomic status or location and transportation access, which may prevent the patient from obtaining and using condoms. Location may be a problem because not everyone lives near a business that sells condoms. Many people may also not have the expendable income to use on purchasing condoms.

Another structural barrier physicians may not consider is gender (Waitzkin, 1989). Gender may present access issues because there may be an (incorrect) assumption based on traditional gender norms that a male in a heterosexual relationship may be responsible for purchasing condoms. Women may fear being viewed as too assertive by asking their partner to wear a condom or untrusting of her partner by asking him to wear a condom. According to Waitzkin (1989), this lack of consideration actually contributes to medicine’s impact by making people think that the cause of their problems is of a psychological or individual nature, not a social one.

**Structuralist constructivism**

Structuralist constructivism posits that “there exists, within the social world itself and not only within symbolic systems (language, myth, etc.), objective structures independent of the consciousness and will of agents, which are capable of guiding and constraining their practices or their representations” (Bourdieu, 1989, p.14). Bourdieu explains that these structures constrain individual decisions but are also influenced by individual decisions. Thus, structuralist constructivism considers both the objective (social structure) and the subjective (individual agents and their definitions of situations) and the reciprocal relationship between the two, which makes it reflexive (Bourdieu & Wacquant, 1992). Unlike more traditional forms of structuralism, structuralist
constructivism considers the fluidity of social situations in that it posits that social structures shape and guide individuals but can also be shaped and interpreted by individuals.

Bourdieu’s structuralist constructivism results from a criticism of interactionism and phenomenology as well as a criticism of structuralism. Interactionism focuses on smaller, individual interactions and considers them astructural. Structuralism focuses on larger societal institutions working together to make a cohesive society. According to Bourdieu (Bourdieu, 1977; Bourdieu & Wacquant, 1992), interactionism’s weakness is that it does not consider the power of social structure. Interactionism treats the social world as purely subjective (J.H. Turner, 2003). However, Bourdieu asserts that interactions always occur within a particular context; they are embedded in structure (Bourdieu, 1977; Bourdieu & Wacquant, 1992). People’s definitions of the situations aren’t neutral; usually they are influenced by class-based interests and their desire to legitimate such interests (J.H. Turner, 2003). Essentially, interactionism gives people too much power to control situations and interpretations by their own free will (Bourdieu, 1977). On the other hand, structuralism gives too much power to social structure and not enough power to individual agency. Structuralism posits that the social world is objective. Bourdieu’s position is that structuralism treats people as “mechanical, rule-following and role-playing robots in standard contexts,” (J.H. Turner, 2003, p. 492-493). However, Bourdieu’s position is that people often adapt to situations by thinking and acting outside of structural constraints. Thus, it is important to acknowledge the power of both structure and individuals; but too much emphasis should not be placed on one or the other.
Structuralist constructivism’s application can be demonstrated through Gouanvic’s (2002) work on text translation. This researcher posits that structuralist constructivism involves people who are subject to symbolic power also having their own symbolic power. What makes this type of constructivism unique is that human action can also be influenced by unconscious components of the human psyche. For example, people are influenced by and can influence micro level interactions with one another; they can also influence and are influenced by social institutions and structures. Translators demonstrate the habitus by choosing which texts to translate and determining to which literary genre the translated text belongs (the subjective). These choices are determined by aesthetic taste, an essential component of the habitus. However, these choices and determinations are affected by structural conditions of education and literature as a sociocultural institutions (the objective). Gouanvic (2002) argues that translators exercise their power through the struggle among themselves to obtain the texts for translation and to have exclusive contracts signed by foreign authors and agents. Thus, this power is relational in nature and is acted out in the field. It is what makes the field.

The reflexive tendency of structuralist constructivism can also be seen in this research’s consideration of the institution and culture of medicine and physicians’ behaviors and concerns within medicine. A significant cultural bias that exists in medicine is caused by modern sexual repression. According to Foucault (1978, 1985, 1986), the idea that sex is a sensitive or even controversial topic exists in doctor-patient encounters. This is problematic because this idea may contribute to physicians being less likely to discuss STIs with their patients (Kingsberg, 2006; MacDowall et al., 2010; Porter & Ku, 2000; Tao et al., 2000). Physicians have helped reinforce the notion that
sexually transmitted infections (STIs) are an embarrassing subject (by not discussing them). Therefore, because medicine is influenced by culture, its attempt to explain the world around us (or attempt to prevent STIs in this case) may be distorted. Self-interest or professional interest may influence what scientists or physicians accept as valid explanations. Further, a physician’s concern with cultural capital (being a successful physician) may shape what that physician accepts as valid or true. For example, if the culture of medicine informally teaches physicians that they should not discuss sex with their patients unless their patient brings it up, physicians will accept this practice as valid, whether it actually has positive effects on STI prevention rates or not.

The medical habitus

Many researchers have indicated that primary care physicians do not talk to their patients about sexual health very often (Cant, 2005; Foucault, 1978; Friedman & Bloodgood, 2010; Kingsberg, 2006; Lewis & Freeman, 1987; Macdowall et al., 2010; Porter & Ku, 2000; Schwartz et al., 1991; Tao et al., 2000) and even avoid offering HIV tests (Al Mojajer et al., 2012). Further, many physicians lack or have incorrect knowledge about sex-related topics (including STI transmission and screening practices) as well as about contraception (Al Mohajer et al., 2012; Dehlendorf et al., 2010; Jain et al., 2006; Parisi et al., 2012). Bourdieu’s concepts of cultural capital, field, and habitus provide an analytical tool for (a lack of) doctor-patient communication. H. Luke (2003) posits that capital is power or prestige; the field is where struggles for power take place; the habitus is the process by which actions and behaviors are thought out. Therefore, when considering doctor-patient communication about sexual health, specifically STI prevention, it is important to acknowledge that physicians are competing for prestige
among colleagues (cultural capital). And according to A. Luke (1990), cultural capital is likely to develop as a result of assimilation of skills and practices over time. This competition takes place in the field (medical practice) and is influenced by the collective mindset of physicians’ colleagues (habitus). Therefore, an examination of these processes may illuminate how physicians determine interactional styles with patients as well as how they decide which clinical knowledge is more important.

**Habitus**

Simply put, the habitus is “a sense of one’s place and a sense of the other’s place,” (Bourdieu, 1990, p. 131). Bourdieu (1984) notes that the habitus is the mediating process between class or group perceptions, choices and behavior. It is the collective unconscious of those in similar positions (such as physicians). “The habitus is necessity internalized and converted into a disposition that generates meaningful practices and meaning-giving perceptions” (p. 166). By providing cognitive and emotional guidelines, the habitus allows physicians as individuals to represent the world in common ways and to classify, choose, evaluate and act in a particular manner. The habitus is embodied in perception, appreciation and action. The habitus is neither strictly individual nor fully determinative of conduct (Bourdieu & Wacquant, 1992, p. 18). However, other socializing institutions (such as the family, education and religion) influence an agent’s actions, even within the field (Bourdieu, 1991).

The habitus is the culture of medicine as acted out by physicians; it is an internalization of the rules of the field and an interaction between the individual agent and the field (Bourdieu & Wacquant, 1992). According to H. Luke (2003), different
forms of capital (i.e., social and cultural) are utilized in the habitus. In Latin, habitus means habitual or typical condition, state or appearance, particularly in reference to the body (H. Luke, 2003). The internalization of external rules as well as the direct interaction of people in institutions are involved in the habitus, or culture of that particular institution. The habitus predisposes people towards certain desirable behaviors and is thus useful in reproducing culture. However, agents also influence the structure of the habitus (Bourdieu & Wacquant, 1992, p.13, 16). Therefore, agents influence and are influenced by the habitus. When rules are internalized, they are not done so passively and can be altered by the agents (Bourdieu & Wacquant, 1992, p. 121). The overall effect is that these skills and attributes, though intrinsically social and relational in their origin, are perceived to be individual in their accumulation and expression (Shim, 2010).

H. Luke (2003) applies the concept of habitus to medical institutions and posits that the habitus is part of the social course of medical school and residency. It is in the habitus that medical students and residents gain a sense of collective and individual social identities as physicians. Specifically, they are socialized into particular habits of thoughts, tastes and dispositions. They learn and subsequently internalize these dispositions from medical school faculty, fellow medical students, more senior medical students, residents as well as attending physicians with whom they practice. Specifically, H. Luke (2003) indicates that “residents through workplace practices begin to adopt particular habitual practices while being socialized into certain forms of desired medical practice and structures” (p. 67). Further, H. Luke (2003) indicates that the habitus manipulates the field and these varying (aforementioned) power dynamics. Interestingly, even the least
powerful medical students want to participate in these power dynamics, as they will eventually become clerks, residents and attending physicians with more power.

According to Atkinson (1996) and Fox (1992), medical student clerkships and resident rotations in hospitals are where the power dynamics of the medical field are demonstrated. Fox (1992) posits that hospitals are the places where medical students and residents are socialized and where medical knowledge is reproduced. This is where attendings can display their medical expertise for clerks and residents (Atkinson, 1996). More senior physicians (attendings) engage in a discourse of medical ‘truth’ (or knowledge) and often convince clerks and residents (junior physicians) to those so-called truths (Fox, 1992). H. Luke (2003) adds an example to these power dynamics by describing medical students and clerks learning to appear interested in their particular rotations, as this demonstration of interest will earn them favor with the more senior physician (attending) in charge of their rotation. Favor of an attending physician is valuable, as attending physicians provide reports on students and clerks, which can lead to prestige in the form of access to a fellowship program.

Field

The habitus interacts with the field to influence the individual perceptions of agents in the field (Bourdieu, 1991, p. 14). The field is where the habitus is acted out (Bourdieu & Wacquant, 1992; Lahire, 2015). Because of agents’ differential positioning within the field, habitus is acted out in a variety of ways (Fiske, 1992). The field is where competition for power takes place; more specifically, it is where competition for specific forms of capital (dependent upon the priorities of the field itself) takes place (Lahire,
The field is the structure through which agents (people) with different levels of power (or capital) operate. In this case, the field takes place within the institution of medicine. Within the institution of medicine, there are historical relations between positions, such as junior physicians deferring to senior physicians (H. Luke, 2003). Because capital is unequally distributed in the field, some agents who are part of the field are dominant while others are dominated. This unequal distribution determines the structure of the field.

Bourdieu and Wacquant (1992) and Lahire (2015) indicate that within a field, tasks and rules are quite specific, as are power relations. For example, within medicine, senior physicians (attendings) train and evaluate junior physicians (residents). As a consequence, attendings are likely to impose their perceptions about patient compliance or patient sexual practices as well as beliefs about the relative importance of certain clinical knowledge (for example, taking a comprehensive sexual history) on residents. Because attendings are very clearly in charge of residents (based on seniority, which is based on number of years practicing medicine), it is in the residents’ best interest to conform to the attendings’ perceptions and beliefs. “Agents have points of view on this objective space which depend on their position within it and in which their will to transform or conserve it is often expressed” (Bourdieu, 1984, p. 165).

Furthermore, the field and the habitus are relational (Bourdieu & Wacquant, 1992, p. 19), in that one cannot exist without the other. The field is where components of the habitus (namely power in the form of capital) are acted out. To each field, there corresponds a habitus (a system of internalized dispositions) specific to the field. Only those who have incorporated the habitus specific to the field are able to play the game.
and to believe in the importance of the game (Bourdieu & Wacquant, 1992; Lahire, 2015). And the longer an individual or agent is part of a particular field, the more that agent internalizes desirable characteristics and/or alters what is perceived as desirable (Bourdieu & Wacquant, 1992, p. 13). This is precisely the reason attendings have more influence than residents on the field of medicine: they have been part of the field longer; therefore, they are more invested in it.

**Capital**

Within the field of medicine, there are different forms of capital, which influence the amount of power and prestige a person has (Bourdieu, 1986). According to Bourdieu (1986), capital is the use of symbols to legitimate the possession of varying levels and configurations of economic, social and cultural capital. These forms of capital are interrelated. The distribution of the aforementioned types of capital determines the class structure of a social system. Economic capital is money and other material goods used to produce goods and services (J.H. Turner, 2003). Social capital is networks and norms of reciprocity (Putnam, 2002). Cultural capital is informal interpersonal skills, habits, manners, linguistic styles, educational credentials, tastes, lifestyles. Symbolic capital is the uses of symbols to legitimate the possession of varying levels and configurations of the other three types of capital. For example, a physician’s white coat symbolizes a certain level of prestige and power (cultural capital) (J.H. Turner, 2003).

In general, physicians possess relatively high levels of all forms of capital. Compared to most other professions in U.S. society, physicians have a high salary (economic capital) as well as a great deal of prestige (cultural capital). Physicians also would seem to have high levels of social capital due to their affiliations with other
physicians, who form a powerful group, the American Medical Association (Starr, 1982). Finally, as mentioned previously, symbolic capital such as the white coat or the title of “Dr.” serve to legitimate the power and prestige of the profession of medicine. Theories concerning cultural and social capital (Bourdieu, 1986, 1991; Coleman, 1988; Putnam, 2002) may inform the dynamic of the inequalities in doctor-patient communication. Given the focus on the prestige of the medical profession as well as the power of physicians as a group, more in depth analyses of social capital and cultural capital are warranted. However, competition for social and cultural capital can create a dilemma for physicians, as social capital involves gaining power through a group of which an individual is a part; cultural capital is gaining prestige as an individual within a group. In other words, attainment of social capital does not guarantee attainment of cultural capital. This sort of conflict could play out if a physician is part of a healthcare practice (social capital) and is trying to gain prestige (cultural capital) within that practice. A conflict could exist if the healthcare practice focuses on patient-centered care but the physician has been socialized to be neutral with patients.

**Social capital**

Putnam (2002) defines social capital as networks and the norms of reciprocity associated with them. In other words, having social capital is like having a reliable social support system. Social capital can come in the form of membership to a professional organization (formal social capital) or living in a friendly neighborhood (informal social capital). In their research on an executive MBA course, Van Buren III and Hood (2011) outline the application of social capital in the context of business organizations. These authors indicate the individual level ‘soft skills’ can increase a person’s social capital by
enhancing interpersonal business relationships. These relationships make resources available through social networks, which can provide advice and emotional support for business decisions. Citing Putnam (1995), social capital can also include various features from a social organization or business, such as norms, trust and networks.

Gil de Zúñiga, Jung & Valenzuela (2012) focus on ways that social media use affects informal social capital, while Haughton-McNeill, Kreuter and Subramanian (2006) focus on ways that informal social capital influences individual health behaviors. Regarding informal social capital, Gil de Zúñiga et al. (2012) surveyed 475 people in the U.S. about their motivations for social media (i.e., Facebook, TakingITGlobal.org, YouthNoise.org) use and examined relationships between that use and social capital. To measure individual level social capital, Gil de Zúñiga et al. (2012) asked six questions assessing feelings of intimacy in the community, sharing community values, talking about community problems, feeling connected, helping to resolve community problems and watching out for community members. These researchers found that the extent to which respondents used social network sites to keep up with political news, public issues and information about their community was positively related to social capital. Citing multiple studies (McLeod, Scheufele & Moy, 1999; Norris, 2000; Prior, 2007; Shah, 1998; Wellman, Haase, Witte & Hampton, 2001; Zhang & Chia, 2006) on media use and social capital, Gil de Zúñiga et al. (2012) point out that using media for observation and information gathering is positively associated with individual level social capital. Alternately, using media for private entertainment and distraction has a negative effect on individual level social capital.
According to Haughton-McNeill et al. (2006) consider the influence of informal social capital and health. They found that communities with high levels of social capital may be better able to reinforce positive social norms for health behaviors. However, Mansyur, Amick, Harrist, and Franzini (2008) point out that high levels of social capital do not always have positive effects. An individual who is not socially engaged but lives in a community with high social capital may not benefit from the connections and resources that are available. Further, some members of the community may be excluded; group members may have their individual freedoms restricted (Coleman, 1988). In addition, Mansyur et al. (2008) point out that even in communities with high levels of social capital that may influence healthy behaviors, the positive outcomes are not the same for all members of the community. An example related to this research would be if a community has high levels of social capital and its members also engage in unhealthy behaviors, such as unprotected sex, the reinforcement of this behavior is not likely to benefit the community.

When considering formal social capital and medicine, physicians can be influenced by the healthcare system in which they practice. If the physician is part of a network (i.e., a healthcare practice) that does not consider preventive care a priority, that practitioner may not consider STI prevention pertinent to their role as a health care provider. If a physician internalizes to the idea that preventive care is not a priority, she or he would enhance her or his cultural capital in the medical habitus. For example, Waitzkin (1984) found that physicians tended to underestimate a patient’s desire for information, which may enhance preventive capabilities. If a physician assumes that a patient does not want information, that physician may not engage in preventive care with
that patient. Social capital can also influence how much a patient trusts a physician (Ahern & Hendryx, 2003) in that if a patient does not have many other established trustworthy relationships, that patient may be less likely to trust his or her physician. If a patient trusts a physician, that patient is more likely to follow his or her advice (Perloff, Bonder, Ray, Ray, & Siminoff, 2006).

**Cultural capital**

Cultural capital it can be noticed (in a particular social field) in differences in talk, ritual, deference or demeanor (Bourdieu, 1986), which are acted out as the habitus. Based on Bourdieu’s theories, cultural capital is defined as informal interpersonal skills, habits, manners, linguistic styles, educational credentials, tastes, and lifestyles (Bourdieu, 1986). Often cultural capital is determined by one’s leisurely activities (Jaeger, 2011; Lewicka, 2013). While the outcomes Jaeger (2011) and Lewicka (2013) are studying are different, their definitions of cultural capital overlap. Both researchers focus on cultural tastes and resultant cultural activities, such as music preference and concert attendance, library attendance and number of books, as well as museum preference and attendance. This type of capital is significant because it gives those who possess it more prestige and power within a particular group. For example, individuals with classic cultural tastes (preference classical music and historical museums) would have more cultural capital among those with advanced levels of education (Lewicka, 2013).

Differences in such preferences, attributes and behaviors can also be noticed in interactions among individuals with different resources. Conversations among people who are not equal (in terms of individual resources and power) are more likely to be impersonal, highly routinized and short term (Collins, 1975). For example, Perloff, et al.
(2006) found that physicians were more likely to interrupt patients who have a lower socioeconomic status. In the field of medicine, physicians compete for cultural capital because more cultural capital results in more prestige, possibly power as well as other forms of capital. These physicians may not be concerned with prestige among poorer patients. Physicians with higher levels of cultural (or other forms of) capital have the ability to exert greater influence on the medical habitus (H. Luke, 2003). In the field of medicine, a patient who is not a physician’s equal may not feel comfortable discussing such taboo issues as sex and STI prevention because of the difference in power. Physicians, in their positions of power, may convey certain cultural messages (specific to their medical habitus) during discussions related to STIs, such as the notion that abstinence is the preferable way to prevent STIs, which overlooks a patient’s social circumstances, resources or power (Waitzkin, 1989).

As individuals within the field compete for control of institutions and resources, they attempt to gather social capital through the formation of groups and networks, but a group’s ability to form such networks depends on how much economic, symbolic and cultural capital they possess (J.H. Turner, 2003). As Bourdieu posits (1986), different forms of capital are interrelated. Structuralist constructivism is pertinent to this conflict between social capital and cultural capital, as the individual can influence the groups of which they are a part, but the groups of which they are a part influence their actions and behaviors (habitus). In a medical encounter, the struggle for different forms of capital and other resources may be between the physician and the patient. One of the resources being struggled over is medical knowledge about how to prevent and/or treat symptoms or disease. Patients’ social capital may affect how adequately they will be able to access
preventive health care due to their geographic proximity to sexual health clinics or other health clinics. Economic capital may also affect how likely a patient is to follow through on recommendations given by a physician or if that patient is even able to be seen by a physician. It also affects the quality of care the patient receives because their health insurance may restrict their choice of physician. In the medical field, cultural capital should be understood as knowing how to act appropriately, in ways that will promote success and career advancement. The competition for cultural capital may be between or among physicians. The desire to attain high levels of cultural capital may influence how physicians deal with patients in that certain ways of interacting with patients are more highly valued than others (H. Luke, 2003). According to Marx, conflict of interest among groups becomes more intense when resource distribution becomes more disparate (J.H. Turner, 2003). In the field of medicine, the distribution of knowledge between senior physicians (attendings) and junior physicians (clerks and residents) is quite disparate (H. Luke, 2003). According to Quinn (1987) and H. Luke (2003), attending physicians (physicians supervising the care of patients by interns, residents, and medical students) (mediLexicon.com) play a major role in resident physicians’ educations, and their practice behavior (directly observed by residents) may greatly influence the behavior of their residents.

During a medical encounter, the distribution of knowledge between physician and patient is often disparate. In Quinn’s (1987) research, physicians are more likely than individuals outside of the medical profession (including patients) to have the social and cultural capital of ‘information’ about STI prevention. This does not necessarily mean that physicians have correct information, just that they are viewed as experts (Foucault,
According to H. Luke (2003), the institution of medicine may benefit from physicians reinforcing their status as experts. Therefore, medicine does not and would not act in ways that would undermine its authority base relating to medical knowledge. As a result, physicians must assert their authority and expertise during interactions with patients, even if they are not experts. Therefore, rather than admitting that they do not have the communication skills or technical expertise to discuss STI prevention with a patient, they may revert to dominant cultural ideology about sex being an embarrassing topic or a topic only to be discussed in certain clinic situations with certain people (Foucault, 1978). This way, the authority of the physician is not undermined in a situation where they may be less knowledgeable, because the physician is still behaving in an authoritative way.

Doctors learning to act like doctors

Within the medical field, cultural capital differs among physicians. Those with similar levels of cultural capital (i.e., senior physicians) often share certain modes of classification, appreciation, judgment, perception, and behavior (habitus). Cultural capital is situational, which means that attributes that are valued in medicine may not be valued in educational fields (Shim, 2010). Furthermore, cultural capital in the medical habitus may differ in importance to physicians, depending on their place in the hierarchy (H. Luke, 2003). Cultural capital can often seem as though it is a natural part of a particular field because it is so subtly reproduced by agents and through their interactions within the medical field and in medical culture (the habitus) (Bourdieu, 1993, p. 177). Junior physicians learn what behavior is appropriate by observing and communicating with senior physicians, not by being directly told what will make them successful (H. Luke,
Thus, it may seem as though individuals or agents who have a propensity for technical knowledge and lack communication skills for sensitive topics are drawn to the field of medicine, but it may also be that these actions and perceptions are encouraged and reinforced in the medical habitus.

In the medical field, physicians are taught certain ways to evaluate and react to patients as well as what types of communication are most effective or appropriate (H. Luke, 2003). H. Luke (2003) examines other ways that physicians learn to act like physicians in the medical field. They learn what topics of discussion are appropriate with patients; they learn how to treat patients. Physicians also learn about the importance and status of their white coats. They learn that they are considered health experts. They learn about their prestigious status as well as these interactions and behaviors by observing the habitus and interacting with others in the habitus until they become a part of the habitus.

For example, a physician may judge a patient’s non-compliance as a character flaw, when it may be due to structural barriers (Waitzkin, 1989). Another example is that if junior physicians (residents and clerks) see more senior physicians (attendings) approaching their patients with neutrality, they informally learn and internalize that being neutral with patients is a desired characteristic in the field of medicine. Research conducted by Becker, Geer, Hughes, and Strauss (1961), H. Luke (2003), Haas and Shaffir (1987), and Sinclair (1997), demonstrate some of the qualities that are valued in the culture of medicine. An exaggerated presentation of competence is highly important, as are cynicism toward the medical system and the patients as well as confidence (Becker et al., 1961; H. Luke, 2003; Haas & Shaffir, 1987; and Sinclair, 1997). Furthermore, a sense of detachment, or neutrality from the patients, authoritateness in dealing with
patients, establishing patients’ trust, and a sense of responsibility for the patients are valued (Becker et al., 1961; H. Luke, 2003; Haas & Shaffir, 1987; Sinclair, 1997). A physician who possesses many of these qualities would possess high levels of cultural capital. In other words, a physician is more likely to be successful in terms of prestige and authority with medical peers if that physician possesses certain valued characteristics.

According to Singh-Manoux and Marmot (2005), socialization that occurs in the field and becomes the habitus has a major influence on individual perception and results in a reproduction of beliefs and behaviors. Cultural capital contributes to the accumulation and exercise of power and the maintenance of inequality (Shim, 2010). In a particular habitus and field, stratification based on types of capital is reproduced (Edmonson, 2003). In other words, those with more cultural capital maintain their status by exercising the ability to manipulate reality in accordance with their self-interests. As a result, if senior physicians (who typically have more cultural capital) perceive patient sexual activity as something that is private, largely based on individual agency and something in which physicians should not be involved, this perception is likely to be passed along to junior physicians (who have less cultural capital and ability to define reality), rather than questioned. It is in the best interest of the junior physicians to adhere to similar beliefs and behaviors of the senior physicians as this modeling behavior will enable their success in the medical field (H. Luke, 2003). Eventually, those junior physicians will become senior physicians and reinforce the same habitus and inequality in the field as was informally taught to them.

Research conducted by Perloff et al. (2006) and Stokes, Dixon-Woods, and Williams (2006) demonstrates how much influence physicians have on the medical
encounter. Stokes et al. (2006) examine doctor-patient interaction and doctor-patient
differences in understanding the “rules” of the medical encounter. Perloff et al. (2006)
focus on communication between physicians and patients who are racial/ethnic minorities
or patients who have low socioeconomic status. In both studies, based on the typical
physician’s possession of a higher level of cultural capital, the physician’s actions dictate
what results will come from the medical encounter. Patients in Perloff et al.’s (2006)
study were more likely to be interrupted, which resulted in an inability to introduce
additional concerns. In Stokes et al.’s (2006) study, patients were removed from their
general physician’s list, meaning that they were no longer able to see that physician.
These researchers found that patients removed from the list were unaware of the “rules”
of the medical encounter as the general physicians understand them.

Stokes et al. (2006) point out that most of the rules of the medical encounter are
unspoken and are only recognized when they are broken. Patients who were removed
from their physician’s list and unable to continue seeing that physician did not possess
the cultural capital that would have enabled them to act appropriately (follow the rules) in
that situation. Following the rules means that the general physician should be the
dominant actor in the encounter. As in Stokes et al.’s (2006) study, physicians in Perloff
et al.’s (2006) study still expected to be the dominant actor in the medical encounter,
even though they limited information patients could provide (by interrupting them). Thus
the physicians still had the power to decide what is wrong with the patient and what to do
about the problem, even though they did not have sufficient information. As a result,
proper treatment may not always be prescribed. Further, this power can affect how
comfortable a patient is bringing up sexual health topics. If the physician (as the
dominant actor) does not bring up sex-related topics or conveys embarrassment about such topics, the patient is likely to get the message that sex is an inappropriate topic to discuss with their physician.

**Can we talk about sex?**

Furthering the consideration of sex as a controversial topic, Foucault (1978) distinguishes modern sexual repression from historical sexual repression in *The History of Sexuality: an Introduction*. According to Foucault (1978), in the past, matters of sex and sexuality were rarely discussed. In modern times, it is only a powerful few (i.e., physicians, psychiatrists, psychologists) who are considered authorities on such matters, and in a highly regulated way. These powerful few are considered legitimate sources of knowledge on sex. However, they too treat sex as secretive and taboo (Cant, 2005; Foucault, 1978; Lewis & Freeman, 1987; Porter & Ku, 2000; Tao, et al., 2000). In addition, these authority figures establish discourse about sex, ways to regulate and monitor it, and determine what is considered natural and what is considered unnatural (Smart, 1985). Thus, Foucault questions whether we are really sexually liberated; he says we are not and that we are repressed, albeit in a different way. The repression stems from the highly regulated way that only a powerful few are deemed appropriate moderators of discussing sex-related topics. This modern sexual repression may be a reason that it is difficult for physicians to discuss matters of sex, especially with people who are not in culturally approved relationships, such as those not involved in a heterosexual marriage.

On a more general level, societal attitudes toward the prevention of STIs imply that while there are medical treatments for such diseases, monogamy and celibacy are the most effective ways to prevent them (B.S. Turner 1996, 1997). And while this may be
true, there is certainly a moralistic overtone, one which ignores reality, which is that people are going to have sex and probably have multiple partners (Mosher, Chandra, & Jones, 2002). Specifically, Foucault (1978) argues that the institution of medicine is uncomfortable discussing sexual topics, which is problematic considering that medicine is considered one of the institutions that has the power to regulate sex-related topics (Lupton, 1997). Although it often claims to be a neutral science, medicine is not neutral in matters of sex. Medicine, like other institutions, is influenced by heteronormative cultural attitudes and taboos on the discussion of sex with anyone other than physicians, psychiatrists and psychologists (B.S. Turner, 1997; Foucault, 1978). As a result, discussion of sexual matters is only acceptable when it is being discussed within the context of a medical encounter. Therefore, it is only appropriate to discuss sex in a heteronormative way; patients have either stated that they are heterosexual or the physician assumes that they are heterosexual.

Because medicine is a powerful sociocultural institution, it can define normality in terms of mental health or sexuality. However, medicine is also influenced by modern dominant cultural ideology that sexual is a sensitive or controversial topic for discussion. It is only acceptable to discuss sex with appropriate experts such as physicians, psychiatrists and psychologists (Foucault, 1978). Furthermore, medicine and appropriate sex experts are also influenced by dominant cultural ideas of heteronormativity and preferential treatment of monogamous sexual relationships.

Social structure influences the doctor-patient encounter by enforcing the dominant cultural ideology (Foucault, 1978) that sex is a sensitive or even controversial topic. Because the discussion of sex is influenced by culture, the way it has changed over time
should be considered (Smart, 1985). Historically, Foucault notes that there has been an association of evil with sexual activity. Also, more recent dominant cultural ideology dictated that heterosexual couples should be monogamous and only engage in sexual activity when they are married and for procreative purposes (Foucault, 1973). The heterosexual, monogamous couple was thought to be the only legitimate type of couple worthy of considering sexual activity (Foucault, 1973; Smart, 1985). Foucault also acknowledges the dominant cultural ideology was that homosexuality is abnormal and inappropriate (Foucault, 1973). Pervasive attitudes existed that homosexuality involves women acting like men and men acting like women and that this is unnatural (Foucault, 1973). More recent research conducted by Inglehart and Baker (2000) indicates that the United States is unique among Western democracies in that its citizens have retained traditional values of sexuality and gender roles. Sherkat, Powell-Williams, Maddox, and Mattias de Vries (2011) demonstrates that while the percentage of United States residents who support same-sex marriage has more than tripled (from 12% in 1988 to 39% in 2008), less than half of the population supports this right.

Another idea resulting from modern sexual repression is that abstinence is the best way to prevent STIs (Foucault, 1986; B.S. Turner 1996, 1997). Foucault notes the idea that sexual abstention can have positive effects on one’s life (Foucault, 1986). These positive effects result from control of bodies and desires and are especially applicable to men (Foucault, 1973). In addition, it is believed that there is a relationship between sexual abstinence and access to the truth (Foucault, 1986, p. 120). Interestingly, Foucault notes that many of these ideas have stemmed from Christianity and made their way into the science of medicine (Foucault, 1973).
More recent research conducted by Shindel and Parish (2013) find that even sexuality education in North American medical schools is limited. Sexuality education tends to focus on prevention of unwanted pregnancy and STIs. Information on sexual function and dysfunction, female sexuality, abortion and sexual minority groups is hard to come by or completely absent. Friedman & Goodblood (2010) indicate that currently practicing physicians still avoid the topic of sexuality altogether. Or when they do discuss sex-related topics, they seem extremely uncomfortable and embarrassed (Browne et al., 2002; Cant, 2005; Lewis & Freeman, 1987; Shaleh, Operario, Smith, Arnold, & Kegeles, 2011). Therefore, in addition to reinforcing the notion that sex is an embarrassing topic, physicians also reinforce the idea that sex is only okay for people in certain types of relationships (i.e., heterosexual marriage) by only asking married couples about sex (Foucault, 1987). By ignoring or avoiding the sexual concerns of unmarried couples, physicians send the message that these relationships are not as legitimate as those of married couples.

**Conclusion**

There are many sociocultural influences on the field of medicine in general and on doctor-patient interactions specifically. Therefore, medicine is not neutral and may not be deserving of its prestigious status. The theoretical perspectives of postmodernism and structuralist constructivism have determined that concern with cultural capital and competition in the field of medicine have an impact on physicians and their interactions with patients. They are socialized to behave in certain ways (habitus) that will be most advantageous for them as individuals as well as their profession of medicine (H. Luke, 2003). Examining the history of medicine and structural factors that contributed to its
power and prestige as well as its association with neutrality is helpful in determining the ways in which it influences and is influenced by society and culture. Furthermore, modern sexual repression that exists in our culture influences doctor-patient interactions in that sex is interpreted as an embarrassing topic that is not discussed. Additionally, physicians impact the culture of medicine, especially those with higher levels of cultural capital. Finally, competition for cultural capital influences how likely a physician is to discuss sex-related topics with their patients. These theoretical perspectives of sociocultural influences on medicine provide insights into doctor-patient communication and guide research aiming to discover additional influences on health care with the ultimate goal of improving doctor-patient communication.
CHAPTER 3: DOCTOR-PATIENT COMMUNICATION THROUGH A MEDICAL SOCIOLOGY LENS

Introduction

Physicians don’t talk to their patients about sex very often and for a variety of reasons (Cant, 2005; Foucault, 1978; Friedman & Bloodgood, 2010; Kingsberg, 2006; Lewis & Freeman, 1987; Macdowall et al., 2010; Porter & Ku, 2000; Schwartz et al., 1991; Tao et al., 2000). Because sexually transmitted infections are on the rise (CDC, 2014) and primary care physicians are in a unique position to provide preventive care (Ashton et al., 2001; Rabin, 1998), they should talk to their patients about sex more.

Framed by postmodernism, which considers both individual and societal attributes that affect doctor-patient communication, this research will focus on physician, patient as well structural characteristics of the United States healthcare system. Physician comfort levels with discussion of sex-related topics as well as physician beliefs about the appropriateness and effectiveness of sex-related discussion will be explored. According to Foucault (1978), modern sexual repression still affects United States culture in that even those deemed experts qualified to discuss the sensitive topic of sex continue to treat the topic as taboo. This may also influence physicians’ lack of or incorrect knowledge about many sex-related topics including STI transmission and screening practices and contraception (Al- Mohajer, Lyons, King, Pratt, & Fichtenbaum, 2012; Del, Levy, Ruskin, & Steinhauer, 2010; Jain et al., 2006; Parisi et al., 2012).

Structural constraints of the United States health care system such as length of office visit, number of clinical items to cover in a visit, practice setting and health
department mandates influence the frequency of sex-related discussions between physicians and patients (Abbo, Zhang, Zelder, & Huang, 2008; Chorba, Scholes, Bluespruce, Operskalski, & Irwin, 2004; Fiscella & Epstein, 2008; Mechanic, Alpine, & Rosenthal, 2001; Tai-Seale, McGuire, & Zhang, 2007). Furthermore, physician endorsement of patient-centered care and concern with attaining high levels of cultural capital in the medical habitus (success in terms of prestige and authority in the field of medicine) affect physician beliefs about discussing sex-related topics. Physician and patient characteristics as well as concern with cultural capital influence physician endorsement of patient-centered care. Physician characteristics such as gender (Ben-Sira, 1980; Bensing & Dronkers, 1992; Burnard, 1996; Fiscella & Epstein, 2008; Silverman, 1987; Street et al., 2007; Ventres & Gordon, 1991), social class background (Waitzkin, 1984) and knowledge of sex-related topics (Fayers, Crowley, Jenkins, & Cahill, 2003; Frank, Coughlin, & Elon, 2008) also affect the frequency of doctor-patient communication about sex-related topics.

Other structural constraints of United States culture present barriers to many patients trying to practice safer sex. Some community norms and social networks may present ideas against using condoms or other types of contraception (Maynard, Carballo-Dieguez, Ventuneac, Exner, & Mayer, 2009; Latkin, Forman, Knowlton, & Sherman, 2003; Warren et al., 2008). Other potential barriers include socioeconomic status and access to contraception (Culwell & Feinglass, 2007; Dehlendorf et al., 2010). Patients also lack knowledge or have incorrect knowledge of STI transmission and contraceptive side effects (Crosby et al., 2000; Dehlendorf et al., 2010; Gilliam, Warden, Goldstein, & Tapia, 2004; Guendelmari, Denny, Mauldon, & Chetkovich, 2000; Rocca & Harper,
Thus, when discussing safer sex options with patients, physicians (as health experts) have the opportunity to correct such misinformation and address potential barriers to access during their visits with patients. The utilization of culturally sensitive patient care, which acknowledges community, ethnic and cultural norms, will be explored as an avenue through which these goals can be achieved.

**Doctor-patient communication**

Physician race, gender, socioeconomic status of origin can influence not only how that physician communicates with patients but also how that physician is assessed by the patient (Iezzoni, Rao, DesRoches, Vogeli, & Campbell 2012; Johnson -Thornton, Powe, Roter, & Cooper, 2011; Ventres & Gordon, 1990; Waitzkin, 1984, 1989, 1990). Such influences demonstrate structural constructivism’s position that social situations are never objective or neutral and are affected by social structure as well as self-interest (Bourdieu, 1977; Turner, 2003). For example, Waitzkin (1984) finds that physicians who grow up in an upper class or upper middle class families tend to be better communicators. Specifically, they give their patients more information, clearer information and spend more time doing so when compared to physicians who grow up in lower middle class or lower class families.

Waitzkin (1984, 1989, 1990) finds that physicians tended to underestimate patients’ desire for information (not lower class patients specifically) and overestimate the actual amount of time they spent giving information. A potential source of physicians underestimating their patients’ desire for information may be a belief they informally learned and internalized during their medical training. H. Luke (2003) indicates that
“residents through workplace practices begin to adopt particular habitual practices while being socialized into certain forms of desired medical practice and structures” (p. 67). This overestimation of information giving and underestimation of patient desire could be highly valued cultural capital in the medical field. Physicians may understand that senior physicians assume that a patient does not need much information and that those senior physicians also assume they spend more time with patients than they actually do (H. Luke, 2003). If it is only important (in regards to cultural capital) to convey limited information to patients, physicians may not concern themselves with providing useful and relevant information.

In addition to physicians overestimating time they spend with patients and underestimating their patient’s desires for information, another barrier to effective doctor-patient communication is a lack of physician honesty. Based on data from a 2009 survey of 1,891 physicians, Iezzoni et al. (2012) find that almost 33% of physicians in their sample did not completely agree that physicians should disclose serious medical errors to patients. Furthermore, almost 20% of this physician sample do not completely agree with that statement, “Physicians should never tell a patient something untrue”. It is possible that complete honesty with patients may not be valued (as cultural capital) in the medical field. Finally, almost 10% of these physicians had told a patient something untrue in the past year. As a result, physicians who don’t value honesty in their communication with patients may not be concerned with providing accurate information to their patients. This could result in a lower quality of care, as patients will be less able to make fully informed decisions about their sexual health or otherwise.
Considering social concordance, Ventres and Gordon (1990) determine that a mismatch in patient social class and physician social class can influence the amount of information a patient receives at a visit. These researchers find that lower class patients tend to ask less questions, and physicians misperceive this as the patients not wanting information. These unequal power dynamics negatively affect doctor-patient communication in that patients of lower social status do not get adequate information from their providers. Johnson-Thornton et al. (2011) find that mismatched characteristics between physician and patient (race, gender, social class or education level) can actually result in cumulative negative effects on patient satisfaction. If patients’ social characteristics don’t match up very well with their physicians’, patients tend to have less positive perceptions of care and lower positive patient affect. These researchers find that lower levels of social concordance (similarities in race, gender, age, education, or other social or cultural commonalities) in the doctor-patient relationship almost always reflect higher levels of patient vulnerability.

**Patient-centered care**

At the core of this research is the concept of patient-centered care, which has the potential to improve doctor-patient communication. Considering research undertaken by Ben-Sira (1980), Bensing and Dronkers (1992), Burnard (1996), Fiscella and Epstein (2008), Silverman (1987) and Slatore et al. (2012), patient-centered care usually involves empathy, a consideration of patients’ rights and feelings, getting to know patients on a personal level and accepting them, confirming patients’ understanding and providing emotional support. Epstein and Street (2007) provide an operational definition of patient-centered care, which includes fostering healing relationships, exchanging information,
responding to emotions, managing uncertainty, making decisions and enabling patient self-management. Street et al. (2007) posit that patient-centered care can best be enacted by treating patients as equals, asking for patients’ opinions and thoughts and providing recommendations and explanations that are clear and easy to understand. If physicians focus on patient emotions and treating patients as equals, they may be able to better approach a (potentially sensitive or taboo) discussion of sex-related topics with patients, because they would potentially consider barriers to safer sex practices.

Physician empathy and other demonstrations of patient-centered care are important considering that according to Del Canale et al. (2012), physician empathy is associated with a higher level of patient compliance. Thus, if physicians are empathetic with their patients, their patients may be more likely to follow their recommendations for safer sex practices or other positive health behaviors. Furthermore, Slatore et al. (2012) find that high quality patient-centered communication can lead to increased patient satisfaction, decreased patient anxiety and pain as well as improved decision making. Street, Makoul, Arora, and Epstein (2009) assess current research on the influence of doctor-patient communication on patient health and found seven ways communication can lead to better health. They are increased access to care, greater patient knowledge and shared understanding, higher quality medical decisions, enhanced therapeutic alliances, increased social support, patient agency and empowerment and better management of emotions. Thus, patient-centered care has benefits for the patient. However, patient-centered care may be at odds with cultural capital in the medical field. That is, it may not be in a physician’s best interest to provide emotional support to patients. If more senior
physicians do not seem to find emotionally supporting patients important, neither will junior physicians (H. Luke, 2003).

While most of the aforementioned research on patient-centered care focuses on empathy, treating patients as equals and confirming patient understanding, Slatore et al. (2012) add a unique component to patient-centered care: provider as person. This concept involves the health care provider being aware of the limits of medical knowledge as well as the foresight to involve other providers, such as social workers, when necessary. In this concept, structuralist constructivism’s acknowledgment of the intersection of the intersection of the individual (the physician) and social structure (resources) is clear, as social workers often connect people with resources they are lacking. This concept can also be illuminated by Waitzkin (1989) pointing out that physicians often do not consider structural barriers patients have when attempting to obtain health care or adhere to a treatment regimen. Medical knowledge does little good if patients can’t act upon it.

**The influence of physician gender on patient care**

When considering how gender shapes doctor-patient care, particular attention should be paid to how physician gender influences the amount of concern a physician has with prestige or attaining high levels of cultural capital in the medical field. Because patient-centered care maybe not be an attribute of cultural capital, gender may influence how likely a physician is to endorse patient-centered care in that women are more likely to engage in it. Patient-centered care focuses on open-ended communication, empathy and being accepting (Ben-Sira, 1980; Bensing & Dronkers, 1992; Burnard, 1996; Fiscella & Epstein, 2008; Silverman, 1987). The ability to discuss and be comfortable with sex-related topics may also relate to patient-centered care, as patient-centered care involves
treating a patient on a more personal level. According to Macdowall et al. (2010), male practitioners are reportedly less likely to discuss sex-related topics with their patients and often referred patients to female colleagues to discuss such topics. Finally, it seems that attaining high levels of cultural capital may be at odds with patient-centered care, because patient-centered care (by definition) encourages the physician to focus on the patient, while cultural capital involves seeking prestige among colleagues (Bourdieu, 1986).

Martin, Arnold, and Parker (1988) suggest that while medical socialization determines most aspects of a physician’s practice style, a physician’s gender can have a significant influence as well. Bertakis (2009) and Millstein et al. (1996) find that preventive service delivery is associated with gender, as female physicians are more likely to provide higher levels of preventive care. In addition, Millstein et al. (1996) find that male and female physicians have similar diagnostic and therapeutic skills, but their communication skills are dissimilar. According to Sandhu, Adams, Singleton, Clark-Carter, and Kidd (2009), male physicians are more likely to direct visits, use medical jargon and focus on medical conditions. They are also more likely to spend time on medical history taking and physical examination. Female physicians are more likely to engage in patient-centered care, which indicates that they engage in a visit dynamic that involves more patient feedback and patient participation (Sandhu et al., 2009). Overall, female physicians score higher on measures of exploring both the disease and illness experience; male physicians score higher on understanding the whole person (Bertakis et al., 2009).

Further, according to research conducted by Sandhu et al. (2009) and Bertakis et al. (2009), both physicians and patients are most comfortable during gender concordant
visits. Patient-centered care is the most likely to occur when a female physician sees a female patient and there is more of a focus on psychosocial issues (Sandhu et al., 2009). In male physician/male patient dyads, there is also a higher likelihood that the visit will focus on the patient’s social agenda. Interestingly, however, the visits during which patients and physicians feel the least comfortable are those with female physician/male patient dyads. Sandhu et al. (2009) suggest that this high level of discomfort may be caused by gender role conflict. That is, male patients may feel uncomfortable with women being in a position of power as the physician.

Physician gender may also influence patients’ perceptions in other ways. Interestingly, physicians as well as patients perceive women to be more humanistic (Sandhu et al., 2009). Overall, patients of female physicians tend to be more satisfied with their care (Bertakis et al., 2009). Specifically, Martin et al. (1988) find that female medical students as well as female physicians are more understanding about issues of sex discrimination, contraception, abortion and other healthcare-related issues for women. Therefore, they may also be more sensitive about STI prevention and treatment. Unlike gender differences in interpersonal, psychosocial and preventive aspects of the physician’s role, differences in sensitivity to women’s issues persisted from medical school and into practice (Martin et al., 1988).

**Cultural sensitivity and patient-centered care**

Another concept that is crucial to mindful doctor-patient communication is cultural sensitivity, which is conceptually similar to patient-centered care in that it focuses on health care meeting patient needs (Mirsu-Paun, Tucker, and Hardt, 2012; Saha, Beach, and Cooper, 2008). Tucker, Moradi, Wall, and Nghiem (2014) links
provider cultural sensitivity to patient satisfaction with provider care, identifying trust as an essential component of this relationship. These researchers identify provider impartiality as the most important reason a patient would trust a provider. According to Resincow et al. (1999), cultural sensitivity involves consideration of how a patient’s culture may influence their communication, attitudes, practices and health-related beliefs. Further, Mirsu-Paun et al.’s (2012) concept focuses on modifiable provider behaviors and attitudes that racially and ethnically diverse patients identify as indicative of respect as well as encourage comfort and trust of the provider. Mirsu-Paun et al. (2012) posit that their perspective is unique, as it considers patients (not provider) as experts on what constitutes cultural sensitivity.

In addition to cultural sensitivity, increasing attention has been paid to cultural competence (Boone, Mayberry, Betancourt, Coggins, and Yancey, 2006; Coggins and Yancey, 2000; Resincow, Baranowski, Ahluwalia, and Braithwaite, 1999). Cultural sensitivity encourages physicians to consider cultural, social, historical, environmental and psychological forces and ideas that influence health behaviors (Resincow et al., 1999). Similarly, proponents of patient-centered care encourage physicians to be empathetic with patients, to consider patients’ rights and feelings, getting to know their patients on a personal level and accepting patients for who they are (Ben-Sira, 1980; Bensing & Dronkers, 1992; Burnard, 1996; Fiscella & Epstein, 2008; Silverman, 1987; Slatore et al., 2012). According to Boone et al., (2006), Coggins and Yancey (2000) take cultural sensitivity a step further and encourage cultural competence, which is appropriate behavior with respect to considerations of cultural sensitivity. Therefore, physicians need
to do more than just be aware of cultural differences; they need to demonstrate respect for them in their interactions with patients.

In addition to cultural sensitivity and cultural competence is the concept of cultural humility (Tervalon & Murray-Garcia, 1998), which contains all of the components of cultural sensitivity and competence, but encourages self-evaluation and critique among those employing methods of cultural sensitivity and competence. Cultural competence, sensitivity and humility are important, (Boone et al., 2006) because they may serve to enable more comfortable communication between minority patients and physicians. Furthermore, cultural competence can serve to enhance physicians’ understanding of what Boone et al. (2006) call cultural dynamics of disease transmission, which is similar to what Link and Phelan (1996) consider social conditions as fundamental causes of disease or what Waitzkin (1990) would call social structural barriers. Beliefs could be considered barriers to safer sex practices, because they are socioculturally formed, often by religious and family ties. Cultural competence could enable physicians to address the rapidly rising STI rates among racial and ethnic minority populations by enabling awareness of inaccurate beliefs about contraception or STI transmission, which may be specific to these populations (Boone et al., 2006; CDC, 2006).

Sexual health and patient-centered care

Sex as a cultural taboo

Regardless of how much attention is paid to patient-centered care, the problem with most patient encounters is that they do not involve discussion about sexual health, particularly STI prevention (Friedman & Bloodgood, 2010; Kingsberg, 2006;
In 1991, Schwarz et al. report findings from their national survey that only 40% of internists ask patients about sexual behaviors.

According to Foucault (1978), sex is still considered sensitive or even controversial by the few professions deemed acceptable to discuss such topics, including the profession of medicine, a problem he calls modern sexual repression. This may help explain the lack of doctor-patient communication about sexual health. In her research exploring reasons why taking a sexual history is important, Kingsberg (2006) cites a survey conducted by Pfizer in 2002 (A Global Study of Sexual Attitudes and Behaviors) which find that only 14% of Americans between the ages of 40 and 80 report a physician asking about sexual concerns in the past 3 years. Another survey of primary care physicians finds that only 21% reported that they routinely screened patients (who had not previously been screened) for HIV (CDC, 2014). This low rate of screening occurred despite the CDC issuing guidelines in 2006 recommending that all adolescents and adults get tested for HIV at least once as a part of routine medical care.

A study conducted by Porter and Ku (2000) examines reasons for discussion of STIs during a healthcare visit. This study consists of a nationally representative sample of 15-19 year old males and finds that 71% of them had a physical in the past year, but only 39% of them received any reproductive health services. This study discusses what factors made a reproductive health discussion more or less likely; these factors are having symptoms of an STI or engaging in sexual activity with more than one woman. They also find that young men living in the Midwest had reduced odds of having a discussion about reproductive health. Petroll and Mosack (2011) also identify factors that relate to sexual health conversations. They find that patients from rural areas are less likely to disclose
their sexual orientation to their healthcare provider. In a survey of 271 men who have sex with men (MSM), these researchers also find that men who are black or have an income of less than $15,000 per year are less likely to disclose their sexual orientation to their primary care provider. In this research, 27% of primary care providers do not know their patients’ sexual orientations. Thus, patient sexual orientation is not discussed as frequently as it should be, which is concerning because when patient’s don’t disclose their sexual orientation to their health care provider, it decreases the likelihood that appropriate health services will be recommended.

Tao et al. (2000) also propose that discussions of STIs have generally been inhibited and reported findings similar to those of Porter and Ku’s (2000) and Petroll and Mosack’s (2011) studies. Only 28% of Tao et al.’s (2000) respondents report being asked about STIs during their last routine checkup. Similarly, Friedman and Bloodgood (2010) find that 28% of their respondents (125 females in metropolitan areas aged 15-25 years) had never discussed STIs with a healthcare provider. In addition, Tao et al. (2000) find that being under the age of 45, male, single, and having a household income below the federal poverty level were positively associated with conversations about STI prevention. Also, respondents who were insured by a health maintenance organization or public coverage as well as those with no plan were more likely to be asked about STIs than were respondents who had a fee-for-service agreement. Interestingly, Tao et al.’s (2000) respondents are more likely to be asked about smoking, physical exercise, alcohol, diet, contraceptives (for respondents under 50 years old), and illegal drug use.

In their research, Macdowall et al. (2010) find that many primary health care providers have difficulties discussing sex-related topics with their patients due to
embarrassment as well as a lack of confidence and a lack of expertise. These researchers find other obstacles to be concerns about attitudes and values of patients as well as religious and ethnic differences. When there are concerns about patient values and attitudes including religious and ethnic differences, culturally competent patient-centered care may help physicians properly address patients’ sexual health in appropriate ways (Boone et al., 2006; Coggins & Yancey, 2000; Resincow et al., 1999). Villaamil (2013) also finds physician reluctance to discuss safer sex concerns, even with patients who already have an STI. This researcher conducted interviews with 14 physicians (working in HIV consultations) and 30 patients in HIV treatment. In this study, physicians indicate that preventing further spread of HIV is important but is often not brought up when seeing HIV patients. Many of these physicians feel that what is more important is keeping their patient with HIV in an acceptable health condition. These safer sex concerns are often only addressed at initial encounters, immediately after diagnosis. After initial encounters, safer sex concerns are only discussed if the patient initiates the discussion, because physicians often feel uncomfortable dealing with issues regarding patients’ intimate lives.

Physicians’ (poor) knowledge of sexual health topics

Modern sexual repression not only influences the lack of doctor-patient communication about sex-related topics, but it may also influence medical students’ as well as practicing physicians’ overall poor knowledge of these topics. Among medical school students, knowledge about condom failure rates, abortion rates and chlamydia rates is poor (Fayers et al., 2003). As seems to be a common gender-related finding (Frank et al., 2000; Jain et al., 2006), female medical students know more about
contraceptive pills than male medical students (Fayers et al., 2003). Bartz, Tang, Maurer, and Janiak (2013) surveys 106 students from seven different United States medical schools and assesses their intrauterine device (IUD) knowledge (regarding discontinuation rates, use for emergency contraception and return to fertility following discontinuation) before and after their obstetrics and gynecology rotations. Students score 54% mean percent correct on the 10 IUD knowledge items prior to the rotations and 72% mean percent correct on the 10 IUD knowledge items after their rotations. Thus, it seems that obstetrics and gynecology rotations increase students’ knowledge of IUDs; however, their knowledge is still lacking.

Increased years of medical training only has a small effect on accuracy of sexual health knowledge. Frank et al. (2008) survey 2316 medical students and almost half of them believe that counseling their patients about safe sex will not be highly relevant to their practice. Only 41% of respondents report receiving extensive training in discussing sex-related topics with their patients and only 57% of respondents feel highly confident about discussing sex-related topics. Frank et al. (2008) also find that female and African American medical students are most likely to believe that safe sex counseling would be highly relevant to their practices. Tamas, Miller, Martin, and Greenberg (2010) outline some of the problems related to addressing sexual orientation and other sex-related topics in undergraduate medical education curriculum. The most commonly cited problems are lack of instructional time, lack of relevance to course content and lack of professional development on sexual orientation topics.

According to Al Mohajer et al. (2012), this lack of knowledge about sex-related topics continues into medical practice. Researchers such as H. Luke (2003) indicate that
“residents through workplace practices begin to adopt particular habitual practices while being socialized into certain forms of desired medical practice and structures” (p. 67). Thus, medical students and residents learn from attending physicians that sexual health is not an important topic to discuss with patients. Al Mohajer et al. (2012) determine that most internists and emergency medicine physicians (in their sample of 232 physicians) are not aware of current CDC recommendations of HIV screenings. Only 30.9% of their sample are aware of the current recommendations. Further, emergency medicine physicians (60.7%) are more likely to routinely offer HIV testing than internists (27.8%). Al Mohajer et al. (2012) also find that when conducting an HIV screening, the physicians in their sample are more comfortable asking about a variety of other sensitive topics (history of injection drug use, having unprotected sex, previous STIs) than asking about their patients’ sexual orientation. Physician discomfort with certain aspects of the HIV screening may contribute the less screenings being conducted, which means that less preventive care is offered.

Other knowledge deficiencies were found in a studies conducted by Jain et al. (2006) and by the CDC (2014). With a nationally representative sample of 368 family physicians, Jain et al. (2006) find poor physician knowledge of HPV infections. They found that fewer than 50% of their sample are aware that HPV infections may clear up spontaneously. Further, only 57% have ever used HPV tests. Among 1006 primary care physicians, the CDC (2014) finds that poor knowledge of CDC HIV screening recommendations or a lack of awareness of the actual HIV transmission risk of their patient population made a physician less likely to provide routine HIV screening for their patients.
However, Jain et al. (2006) find that gender is related to physician knowledge of STD screening. These researchers find that female family physicians are more likely to have accurate knowledge about HPV infections and are more likely to screen patients for HPV. Female family physicians are also more likely to engage in preventive service delivery in general (Bertakis et al., 2009; Millstein et al., 1996; Sandu et al., 2009). Number of years practicing medicine also influences how likely a physician is to have accurate knowledge about HPV infections. Jain et al. (2006) found that physicians practicing medicine for less than 15 years are also more likely to have accurate knowledge about HPV infections. Similarly, the CDC (2014) finds that physicians who had been practicing for 20 years or more we less likely to provide routine HIV screening for their patients.

St. Lawrence et al. (2002) also find problematic screening practices among physicians. Based on their research, less than one third of 4,226 physicians (specializing in obstetrics/gynecology, internal medicine, family practice, emergency medicine, or pediatrics) routinely screen patients for STIs. Sobecki, Curlin, Rasinski, and Tessler-Lindau (2012) found that while a majority (63%) of United States of obstetrics/gynecology physicians report routinely asking patients about their sexual activities, other areas of patients’ sexual health are not routinely discussed. Only 28.5% routinely ask about sexual satisfaction; 13.8% routinely ask about pleasure with sexual activity; 27.7% routinely ask about sexual orientation/identity. This omission could convey to patients that other aspects of their sexual health are not important.

Additionally, Parisi et al. (2012) and Dehlendorf et al. (2010) determine that primary care providers lack knowledge about contraception. Parisi et al. (2012) find that
primary care providers (particularly males) underestimate contraceptive and intrauterine
device failure rates. Dehlendorf et al. (2010) also find that male physicians are more
likely to have incorrect knowledge about intrauterine contraceptives. These researchers
also found that older physicians are more likely to have this type of incorrect knowledge.
Specifically, 23% of their sample (of 524 obstetrics/gynecology and family medicine
providers) answer incorrectly about the risk of infertility with intrauterine contraception;
38% answer incorrectly about the risk of pelvic inflammatory disease with intrauterine
contraception. These researchers also found that 29% of their physician sample answer
incorrectly about the appropriate time frame for the use of Plan B. Clearly, this lack of
knowledge has the potential to negatively affect the quality of contraceptive care these
physicians give their patients. Physicians will either not bring up contraception because
they don’t know about contraception or they will give incorrect information about
contraception, because they don’t have accurate information (MacDowall et al., 2010).

**Structural constraints of medicine**

Bourdieu’s theory of structuralist constructivism considers that individual
behaviors and actions are influenced by structure but also influence structure (Bourdieu,
1989; Bourdieu & Wacquant, 1992; J.H. Turner, 2003). Thus, the structure of medicine
(time of medical office visits and insurance companies’ billing practices) must be
considered when examining physicians’ attitudes and behaviors about sexual health. In
addition to physician attributes, constraints within a physician’s practice setting may
influence the likelihood that they will engage in patient-centered care, including a
discussion of sex-related topics. According to Tai-Seale et al. (2007) as well as Mechanic
et al. (2001), the average office visit in the United States lasts about 16 minutes. Research
conducted by Fiscella and Epstein (2008) concludes that this amount of time is inadequate for physicians to engage in patient-centered care, which includes forming partnerships with patients and their families and possibly initiating conversations about more sensitive topics, such as sexual health.

In more recent analyses of non-hospital based adult primary care visits, both Abbo et al. (2008) and Tsai, Abbo, and Ogden (2011) utilize data from the National Ambulatory Medical Care Survey on non-hospital based adult primary care visits. Abbo et al. (2005) consider visits from 1997 to 2005, and Tsai et al. (2011) consider visits from 2005 to 2006. Abbo et al. (2008) find that average visit duration actually increased from 18.0 minutes to 20.9 minutes; Tsai et al. (2011) also find that the average office visit time length has increased to 21.77 minutes. However, the number of clinical items addressed per visit also increased from 5.4 items to 7.1 items. As a result, there is less available time (a 13.6% reduction) to address individual clinical items. Chorba et al. (2004) and Macdowell et al. (2010) also determined that time constraints are a major barrier to patient-centered care and discussion about STI prevention. In research conducted by Al Mohajer et al. (2012), emergency medicine physicians and internists cite time constraints as a reason for not conducting more HIV screenings with patients. Fiscella and Epstein (2008, p. 1844) point out that patient-centered care, such as “asking patients about their own beliefs, engaging patients in collaborative decision making, identifying adherence barriers, and confirming patients’ understanding…” take more time (p. 1844). And it seems that physicians do not have as much time as they need with patients.

Fiscella and Epstein (2008) consider insurance companies to be another structural barrier to doctor-patient communication about sexual health. They suggest that insurance
companies make it more difficult for patients to have longer visits because insurance companies are billed based on chart documentation, not on patients’ needs. In other words, insurance companies typically do not reimburse physicians for spending more time with patients or engaging in preventive care or patient-centered care. As a result, physicians often do not have enough time for or are discouraged from using their time to engage in meaningful conversation with their patients (Liddicoat et al., 2004), much less approach a sensitive subject like sex (Chuang et al., 2012; Kingsberg, 2006). Researchers also cite competing priorities, lack of organizational structures/structured testing systems and differing mandates of health departments and managed care organizations as barriers to STI prevention with patients (Liddicoat et al., 2004; Chorba et al., 2004). Essentially, this lack of structural support for STI prevention results in health care providers only providing services to patients whom they consider high risk (Montaño, Phillips, Kasprzyk, and Greek, 2008). Furthermore, a discussion about STIs may not be a highly valued skill in the field of medicine. In other words, STI prevention may not be highly valued cultural capital in the medical field.

Patient influences

In addition to physician attributes, cultural stigma and structural constraints of the medical field, patient attributes influence doctor-patient communication. A patients’ race, ethnicity, gender, socioeconomic status, sexual orientation or education level may influence the way she or he is treated by her or his physician as well as the way he or she approaches his or her physician (Bertakis et al., 2009; Dahan et al., 2008; Dardick & Grady, 1980; Grant & Ragsdale, 2008, 2009; Nusbaum et al., 2008; O’Hanlan et al., 1997; Petroll & Mosack, 2011; Polek et al., 2008; Politti et al., 2009; Tanfer et al., 2009;
Street et al., 2007; van Ryn, 2002; van Ryn & Burke, 2000; Watzkin, 1984). As explained by postmodernism, because of the self-important beliefs of modern people, individuals often treat each other in biased ways (Hollinger, 1994). Such biases may affect how comfortable a physician is bringing up the sensitive topic of sex. Many of these patient characteristics influence how likely a patient is to view their physician as trustworthy; this assessment could, in turn, affect how comfortable a patient is discussing sex-related topics with their physician (The Commonwealth Fund, 2002; Cooper et al., 2003; Cooper, Beach, Johnson, & Inui, 2006; Maynard, 1991; Shim, 2010; Stewart et al., 1999; Stewart et al., 2007).

**Patient attributes**

Shim (2010) considers ways that patient health literacy and feelings of self-efficacy affect doctor-patient communication, by using a concept called patient cultural health capital. A patient’s education level and socioeconomic status contribute to health literacy and feelings of self-efficacy. For example, Perloff et al. (2006) find that physicians are more likely to interrupt patients with a lower socioeconomic status. Further, Maynard (1991) finds that physicians still focus on a biological model of disease, ignoring patient access to resources. If a patient has low health literacy and a physician is focusing on purely biological explanations, a patient is likely to feel intimidated and potentially have low feelings of self-efficacy. According to Link and Phelan (1995), physicians should consider access to resources and other contextual factors, as these are the fundamental causes of disease. If a physician ignores these factors, a patient feel uncomfortable asking questions (especially about sexual health) (Maynard, 1991).
Stewart et al. (1999) and Stewart et al. (2007) find that racial and ethnic minorities also experience lower quality healthcare. Specifically, Stewart et al. (2007) find that black people reported experiencing the most discrimination by health care providers, followed by English-speaking Latinos. A study done by the Commonwealth Fund (2002) determined that Asian Americans, Hispanic people and black people are more likely than white people to experience difficulty communicating with their physician, to feel that they are treated with disrespect when receiving health care, to experience barriers to access to care such as lack of insurance or not having a regular doctor, and to feel they would receive better care if they were of a different race or ethnicity.

Race, gender and social networks may also influence patients’ access to health care, access to accurate information as well as their likelihood of engaging in risky sexual behaviors (such as having unprotected sex) and contracting STIs (Cooper, Hill, & Powe, 2002; Cooper & Roter (2002); Jemmott, Jemmott, & O’Leary, 2007; Latkin et al., 2003; Sutton et al., 2009; Tanfer et al., 1995). Cooper and Roter (2002) as well as Cooper at al. (2002) find that racial and ethnic disparities in health care exist even when insurance status, income, age, and severity of conditions are comparable. Specifically, Jemmott et al. (2007) and Sutton et al. (2009) find that black people have a higher risk than any other racial or ethnic group in the United States of contracting gonorrhea, syphilis and HIV/AIDS. Cooper and Roter (2002) as well as Cooper at al. (2002) posit that such differences should be considered in the context of historic discrimination and economic inequalities that continue to affect racial and ethnic minorities today. Physicians employing culturally sensitive practices with patients who are racial and ethnic minorities
may be able to better address some of these heightened risks, as cultural sensitivity involves consideration of how a patient’s culture may influence their communication, attitudes, practices and health-related beliefs (Resincow et al., 1999).

Tanfer et al. (1995) also find that black respondents in their study are more than three times as likely as white respondents to report an STI. Further, Tanfer et al. (1995) find that women are much more likely than men to report an STI. These researchers also determine that SES increases the likelihood that a person will have multiple sexual partners, which is significant because the likelihood of reporting an STI dramatically increases with the lifetime number of sex partners reported. Latkin et al. (2003) examined the relationship between social network characteristics and condom norms (including condom use). This sample consisted of 1051 economically impoverished individuals at risk for acquiring and transmitting HIV (mostly due to drug use). This study found that if peers talked about using condoms and encouraged condom use, individuals with those peers were more likely to use condoms themselves. Interestingly, although lower SES can be a barrier to safer sex practices due to financial constraints (Latkin et al., 2003), peer promotion of safer sex practices may be a more positive influence in promoting safer sex practices.

Regarding sexual orientation, many primary care providers do not know or ask about their patients’ sexual orientation; some physicians even make false assumptions of patients’ heterosexuality (Allen et al., 1998; Bonvicini & Perlin, 2003; Politti et al., 2009). Patients are reluctant to bring up their sexual orientation for a variety of reasons, including perceived negative attitudes of health care provider, self-stigmatization, lack of self-esteem, and living or working in an environment that stigmatizes alternative
lifestyles (Polek at al., 2008). Unfortunately, this fear of a negative interaction or physician judgment has resulted in lesbian, gay and bisexual patients avoiding routine health care (Charlton et al., 2011; Dahan et al., 2008). This avoidance results in physicians’ missed opportunities for STI prevention.

**Lack of accurate patient information**

It is important for physicians to provide patients with accurate information about safe sex and STI transmission because many patients lack accurate information about sex-related topics (Crosby et al., 2000). Such misinformation exists in the general U.S. population as well as specifically among young adult college undergraduates. For example, Crosby et al. (2000) find that 16.3% of respondents believe that washing genitals after sex protects from STIs; 38.7% of respondents believe that urinating after sex protects from STIs; 45.7% of respondents believe that douching protects from STIs, and 19.9% of respondents believe that the use of oral contraceptives can prevent STIs. They find that those continuing to have misconceptions are more likely to be under the age of 24 and African American. Similarly, Voisin, et al. (2012) assess a sample of 715 African American young women (aged 15-21 years) from three public health clinics in Atlanta and also find misinformation regarding STI transmission. Slightly more than 33% of the sample do not know that females are more susceptible to STIs than males and that having an STI increases the risk of contracting HIV. Almost 50% of the sample do not know that if a man has an STI, he will not have noticeable symptoms and that most people who have AIDS look healthy.

Another study conducted by Tolani and Yen (2009) also find that young adults in college also have misconceptions about STI transmission. Within this respondent
population from a Northern Californian private college, 21% do not know what STI testing involved; 15% stated that they do not know where to get tested, and 51% of sexually active respondents had never been tested for STIs. Furthermore, 88% of respondents never use condoms during oral sex, and only 34% of those students who have ever had anal sex always use condoms; 45% of those students who have had anal sex never use condoms. Finally, there are also misconceptions about women’s preventive health care. Of the respondents, 46% of women in this sample incorrectly state that pap smears are recommended at age 18, while 38% of women in this sample answer (to the question of when pap smears are recommended)“as soon as they are sexually active.”

Research conducted by Weinstein et al. (2008) assesses 347 undergraduates who participated in a study of sexual health knowledge in exchange for course credit by administering a sexual knowledge questionnaire. Overall, women are more knowledgeable than men. This knowledge is positively correlated with greater sexual assertiveness as well as confidence with condoms among women. However, a majority of these undergraduates demonstrate poor sexual health knowledge by only answering 64.2% of the questions correctly on the knowledge of sexual health measure ($M = 35.31$ of 55). Sexually active individuals’ poor knowledge of preventive sexual care contributes to the rising number of STI’s in the United States; structural barriers hindering access to preventive care (such as socioeconomic status and racial/ethnic minority status) exacerbates this public health problem, as individuals who have a lower socioeconomic status or are racial or ethnic minorities have difficulty accessing quality preventive healthcare (Cooper & Rotter, 2002; Cooper et al., 2002; Jemmont et al., 2007).
Other researchers also find misconceptions about and lower rates of contraception use. Dehlendorf et al. (2010) find evidence indicating that minority and low SES women are less likely to use contraception overall, use different contraceptive methods and have higher rates of contraceptive failure than white and higher SES women. In their assessment of 602 unmarried women aged 18-29 who participated in the 2009 National Survey of Reproductive and Contraceptive Knowledge, Rocca, and Harper (2012) find that black and Latina women are more likely than white women to have a variety of misconceptions about contraception. For example, black and Latina women are more likely to believe that the government encourages contraceptive use to limit minority populations. Latina women in Rocca and Harper’s (2012) sample are more likely to believe that the timing of pregnancy is a matter of fate as well as more likely to have more favorable attitudes than white women about pregnancy, meaning that they are more likely to feel positive about an unplanned pregnancy. More positive attitudes toward the prospect of pregnancy have been shown to be associated, at least to some extent, with less effective and consistent use of contraceptives. Contraceptive safety concerns, as well as apprehension about side effects seem to be more prevalent in minority communities (Gilliam et al., 2004; Guendelmari et al., 2000), which may explain why there is a lower level of use among racial and ethnic minorities. It is possible that if patients are educated about family planning and contraceptive use, they may be more likely to use it effectively.

**Risky patient sexual behaviors**

The USPSTF defines high-risk sexual behavior as having multiple current partners, having a new partner, using condoms inconsistently, having sex while under the
influence of alcohol or drugs, or having sex in exchange for money or drugs (Meyers et al., 2008). While discussion about all sexual intercourse is considered taboo (Foucault, 1978), there are certain sexual behaviors that are considered even more taboo, such as anal intercourse (Maynard et al., 2009). Cultural taboos surrounding anal intercourse include its association with homosexuality and the notion that it is unhygienic (Maynard et al., 2009). According to Maynard et al. (2009), women who engage in unprotected anal sex with their male partners claim that they did not use condoms, because they are familiar with their partner and that condom use makes anal sex less pleasurable. Studies conducted by Hasse et al. (2010) and Kennedy et al. (2010) also find that a high level of commitment to a sexual partner increase the likelihood of unprotected sex. Maynard et al. (2009) also point out that knowledge of HIV and STI risks from unprotected anal sex does not seem to encourage condom use among the women in their sample. Clearly, the belief that condom use limits pleasure or intimacy puts some people at an increased risk for acquiring STIs. Other factors determined to influence the likelihood of having unprotected sex include physical violence in the relationship, attitudes about condoms, perceived riskiness of partners HIV (Sheeran, Abraham, & Orbell, 1999; Hader, Smith, Moore, & Holmberg, 2001; Snelling et al., 2007) and alcohol use (Hasse et al., 2010; Kennedy et al., 2010; Kiene, Barta, Tennen, & Armeli, 2009).

Mansyur et al. (2008) consider the potential negative impact social capital can have on health behaviors. A study conducted by Latkin et al. (2003) finds that social networks can influence the likelihood that someone will have unprotected sex. For example, social networks can enforce the notion that risky sexual behavior is normal. Furthermore, a lack of communication about HIV and condom use among social network
members has been shown to result in ignorance about protective behaviors and subsequent engagement in risky sex (Latkin et al., 2003). Warren et al. (2008) examine racial and ethnic group differences in reasons for having unprotected sex. These researchers find that being in a long term relationship, having been kicked out of the home for being homosexual and a younger age at initiation of sexual behavior are associated with an increased likelihood of having unprotected sex for African American youth. These researchers find that, for Hispanic youth, an increased likelihood of having unprotected sex is associated with higher ethnic identification and an older age at initiation of sexual behavior. Regarding ethnic identification, Warren et al. (2008) cite attitudes that include a sense of invincibility and a need for dominance. Furthermore, such ethnic attitudes are deemed fatalistic and include the belief that HIV infection is inevitable and is in “God’s hands.” Thus, there doesn’t seem to be a compelling reason for people with these attitudes to have protected sex.

Rocca and Harper (2012) also find that black women and Latina women used less effective contraceptive methods than white women. When analyzing the 2002 National Survey of Family Growth, Mosher, Martinez, Chandra, Abma, and Willson (2004) find that of women at risk for unintended pregnancy, 9% of white women, 12% of Hispanic women and 15% of black women did not use contraception at all. These researchers also find that 12% of women earning less than 150% of the federal poverty level re not using contraception compared with 9% of women earning more than 300% of the federal poverty level. A lack of health insurance coverage can also affect rates of contraceptive use, as Culwell and Feinglass (2007) find that women with no insurance coverage are 30% less likely to use prescription contraception. Awareness of such cultural attitudes in
certain ethnic groups or other social networks as well as health insurance barriers can be essential to the success of doctor-patient communication concerning STI prevention.

**Structural barriers**

Greater attention must be paid to basic social conditions and how they influence health. “Individually-based risk factors must be contextualized, by examining what puts people at risk of risks, if we are to craft effective interventions and improve the nation's health” (Link & Phelan, 1995). Link and Phelan (1995) posit that social factors are likely “fundamental causes” of disease because they signify access to essential resources and ultimately affect disease outcomes. Fundamental causes involve resources such as money, knowledge, power, social connections and prestige. Further, such causes are mediated through more proximate biological, behavioral and other risk factors that contribute to ill health (Link and Phelan, 1995). Watzkin (1984) points out that social structural barriers can include characteristics of patients, such as gender, education, level of urbanization and social class. These characteristics are structural because they have meanings that are part of a social and medical system that provides fewer opportunities to women, the less well educated and people in lower socioeconomic classes.

Primary care physicians encompass a large proportion of patient encounters and within those encounters, individuals within certain groups (such as young adults or racial/ethnic minorities) have a high STI risk (Ashton et al., 2001). Rabin (1998) argues that it is a major responsibility of primary care physicians to give accurate information to patients about STIs and suggests that there are more effective ways to discuss issues such as STI prevention with patients. However, physicians need to consider patients’ barriers
to STI prevention. They need to do more than just tell their patients to practice safe sex by using condoms; they need to ask about their sexual activities and consider what may be preventing their patients from practicing safer sex. Other barriers such as geographic location or relationship dynamics access may influence a patient’s ability to practice safer sex (Hader et al., 2001; Petroll & Mosack, 2011; Sheeran et al., 1999; Snelling et al., 2007). As suggested by Bourdieu’s structuralist constructivism, both individual and structure need to be considered to get an adequate depiction of a situation.

According to Waitzkin (1989) and Shim (2010), physicians usually do not address the structural barriers that would impede their patients from practicing safer sex and instead focus on individual behaviors. For instance, telling a patient to use condoms, a diaphragm or birth control will only be effective if the physician also asks that patient if she or he has the resources necessary to obtain them and provide information about where to obtain contraceptives. Jemmott et al. (2007) point out that simply providing information is not enough to induce change in sexual behavior. Providers must consider patient context and instill particular behavioral skills such as condom negotiation skills. For example, Chuang et al. (2012) conduct interviews with primary care physicians in rural Pennsylvania and find that these physicians believe that contraceptives are widely accessible to patients in their communities but that there is a lack of patient interest in family planning. These physicians perceive rural community norms of unintended pregnancies, large families and indifference toward career and educational goals for young women as the biggest barriers to both contraceptive and preconception care. However, these physicians do not attempt to challenge these beliefs; so they don’t bring up family planning.
Conclusion

There are many influences on doctor-patient communication: patient and physician attributes as well as structural components of medicine and cultural factors. As outlined by Bourdieu’s structuralist constructivism in this research, it is essential to consider individual as well as structural components of social phenomena to obtain a more complete assessment (Bourdieu, 1977, 1991, 1993). Physician attributes such as gender and social class of origin influence their interactions with patients in that female physicians are more likely to engage in preventive service delivery (Bertakis, 2009; Millstein et al., 1996) as well as engage in patient-centered care (Sandhu et al., 2009). Further, physicians who grow up in an upper class or upper middle class families are better communicators with patients (Waitzkin, 1984). Patient attributes can also influence doctor-patient interactions. According to Johnson et al. (2011), social concordance (on age, race, gender or educational background) can positively influence doctor-patient interactions. Community norms and social networks can influence individual patient beliefs about contraception and decisions about whether or not to engage in other safe sex practices (Maynard et al., 2009; Latkin et al., 2003; Warren et al., 2008).

Other sociocultural factors influence doctor-patient interactions. For example, Foucault (1978) determined that sex is still considered sensitive or even controversial by the few professions deemed acceptable to discuss such topics, including the profession of medicine. Another barrier to sex-related discussion between physicians and patients is that many physicians are embarrassed by and lacking confidence in talking about sex with their patients due to a lack of expertise. This lack of knowledge starts in medical school and extends all the way through residency into medical practice. (Al Mohajer et
al., 2012; Dehlendorf et al., 2010; Jain et al., 2006; Macdowall et al., 2010; Parisi et al., 2012). As H. Luke (2003) indicates, this type of socialization starts in medical school and gets reinforced by more senior clinicians. Finally, structural constraints of medicine including time of office visit, competing clinical priorities, and insurance company billing practices discourage STI preventive care (Abbo et al., 2008; Chorba et al., 2004; Fiscella & Epstein, 2008). However, it is still important for physicians to provide patients with accurate information about safe sex and STI transmission because many patients lack accurate information about sex-related topics (Crosby et al., 2000; Dehlendorf et al., 2010; Gilliam et al., 2004; Guendelmari et al., 2000; Rocca and Harper, 2012; Tolani & Yen, 2009; Voisin et al., 2012; Weinstein et al., 2008). Therefore, attention to ways of eradicating some of the aforementioned barriers should be explored in order to decrease STI rates.
Chapter 4: Researching doctor-patient communication about sexual health

Overview

The goal of this research was to understand what influences whether or not primary care physicians discuss sexual health topics with their patients and how comfortable they are with such discussions. While many STIs are on the rise (CDC, 2014), research demonstrates that most primary care physicians do not discuss STI prevention and other sexual health topics with their patients (Porter & Ku, 2000; Tao et al., 2000; Kingsberg, 2006). To uncover the many possible influences on doctor-patient communication about sexual health, I conducted 17 original, in-depth, semi-structured interviews. Interview questions covered ideas about cultural capital (which are discussed in terms of prestige, influence and success), endorsement of patient-centered care, beliefs about appropriateness and effectiveness of sexual health conversations (especially STI prevention conversations) and comfort levels having sexual health conversations. Purposive sampling was used to recruit currently practicing family doctors and internists. Interviews were recorded and subsequently transcribed. The discourse analysis of these interviews involves an ethnomethodological focus on physician concern with cultural capital, endorsement of patient-centered care and how those concerns and endorsements affect doctor-patient communication about sexual health.
Qualitative study design

Ethnomethodology

This research employs an ethnomethodological or social constructionist view, which acknowledges that research participants actively construct social reality and influence it (Berger & Luckmann, 1967; Garfinkel, 1967; Stake, 2008). Maynard and Clayman (1991) also posit that ethnomethodology is an excellent resource for explaining what is necessary to understand details involved in setting-specific tasks, such as bringing up sexual health topics with patients during a medical visit. This research method also demonstrates how tasks fit into a larger institutional structure. These researchers further explain that ethnomethodology is useful in providing a sociological understanding of statistics.

For example, as a researcher, I know that physicians do not talk to their patients very often about sexual health topics (Porter & Ku, 2000; Tao et al., 2000; Kingsberg, 2006), but I do not know why. Using an ethnomethodological approach, I can uncover reasons these discussions do not happen. In addition, much of what physicians do in their everyday practice of medicine is taken for granted; they don’t even think about it. For example, many of the respondents seemed confused when they were asked if there were ways in which they learned how to act like doctors. Many of them required an explanation that this question was about behavioral or relational ways they learned how to act like a doctor, rather than clinical ways. Further, physicians influence the reality they experience as healthcare providers as well as the reality their patients experience. Their beliefs about which sexual health topics are appropriate to discuss with patients as
well as how comfortable they are bringing up such topics influence their patients’ medical encounters. Many respondents also indicated that they believed it was the patient’s responsibility to bring up sexual health topics; this would influence the reality physicians experience as healthcare providers, because depending on how little or how often a patient brings up sexual health, these conversations may or may not be included in their medical encounters.

Ethnomethodology is concerned with how people construct meaning or definitions of the situation (a version of symbolic interaction). Part of this construction involves actors (physicians) recognizing the circumstances in which meanings are constructed (Maynard & Clayman, 1991; Stake, 2008). It is for this reason that the respondents were asked about their definitions of essential concepts (i.e., patient-centered care, prestige, influence) involved in the practice of medicine. According to Warren (2002), interview participants construct meaning. In other words, during an interview, the questions asked are open to interpretation by the interviewee. Many of the respondents asked for clarification of some of the concepts about which I asked. For example, when I asked what it takes to be prestigious in the medical field, many respondents asked if I meant prestige with patients or other physicians. My response was that it meant whatever they thought it meant. In addition, Holstein and Gubrium (1995) as well as Stake (2008) suggest that the interview is not neutral; it is a site for knowledge production. This means that although I tried not to influence the physicians’ responses, I still affected the interview. Finally, according to Warren (2002), only interpretations can be derived during interviews, not facts. In other words, my findings are based on what my respondents understand about prestige, patient-centered care and discussion of sex-related topics in
the culture of medicine. This may not even be how everyone in the culture of medicine understands these concepts, but it is how these respondents understand these concepts.

Respondents would also express concern over not giving me the correct answer or make statements like, “I’m not sure if this is what you want.” In postmodern interviewing, Fontana (2002) points out (as did I) that there is no right answer or universal truth. According to Charmaz (2002), there is not one universal truth; the interviewer should record truth as told by the interviewee. The truth is whatever the interviewee says. Also, Fontana (2002) encourages researchers to deconstruct the more traditional ideology of detached interviewers and interviewees. Further, interviewers need to acknowledge their roles in constructing knowledge and in influencing interview outcomes. Interviewers should instead deconstruct the privilege of their own agency and strive to promote a communicative partnership with the interviewee. Holstein and Gubrium (1995) echo this tenant of postmodernism by indicating that an active interview should be a collaborative construction.

**Reflexivity**

Finlay (2008) and Malterud (2001) urge qualitative researchers to engage in the practice of reflexivity: considering how the researcher affects the research. This is done by acknowledging how a researcher’s background and personal experiences affect their choice of problem to investigate, the theoretical perspectives they employ, the research methods they use as well as the findings they consider the most important. I chose to study doctor-patient communication about sexual health (specifically STI prevention), because I have had (and some of my friends have told me about) unpleasant experiences with physicians when discussing STIs specifically or sexual health in general. Further, as
a person with a chronic illness since age 15, I see physicians at least three times per year. Thus, I have had a great deal of personal experience with health care providers, much of which left me feeling stifled or judged.

Postmodern theoretical deconstruction of social institutions appeals to my intellectual curiosity because it resonates with many of my own experiences. A postmodern approach is an invaluable to understanding social interactions and structures. Medical sociology courses encouraged students to be critical of the institution of medicine as well as the actors within the institution. My current occupation as a standardized patient trainer/coordinator allows me to see how much medical students struggle with discussing sexual health concerns with patients. As a result, I approached this research with the preconception that doctors have the power to determine the tone of a patient visit and that they may not be particularly adept at discussing sensitive topics like sex or STI diagnosis. With this awareness, I attempted to consider structural components of medicine as well as the role patients play in doctor-patient communication. However, because of my preconception that doctors are more powerful than patients and have a responsibility to make their patients feel comfortable, I focused more heavily on themes related to physician socialization and physician beliefs.

**Sample selection and justification**

**Sample description**

Primary care providers were chosen as my sample because according to Rabin (1998), primary care physicians account for 60% of all physician encounters in the United States. Considering that STI rates are rising (CDC, 2014), primary care physicians are in a significant position to educate patients about safer sex practices. Primary care
physicians specifically and physicians generally, are considered legitimate sources of (sexual) health information (Foucault, 1978). Thus, it is crucial to determine which sexual health topics primary physicians feel comfortable discussing, with which patients and during which visits they are more likely to address sexual health and whether or not such discussions are encouraged in their field of medicine.

According to Guest et al. (2006), my interview sample is purposive, as my participants have been selected based on predetermined criteria: they are currently practicing family physicians located in the metropolitan area in which the researchers are conducting their research. The researchers contacted primary care physicians (family physicians and internists, including residents) with whom they have worked in an academic setting to be interviewed. Those physicians were given the option to refer me (the interviewer) to other primary care physicians who were interested in participating in the study. Only three attending physicians and one resident physician referred me to other physicians. This method is known as chain referral sampling (Biernacki & Waldorf, 1981). Additionally, I identified attending and resident family physicians and internists from a local hospital system through internet searches, and contacted those physicians via email (with a two and four week follow up) to request an interview. Charmaz (2002) labels this type of sampling as theoretical. It is sampling to develop a researcher’s theory, not to represent a population. She points out that this type of sampling endows grounded theory with analytic power. It helps grounded theorists gain rich data, fill out theoretical categories, discover variation within theoretical categories (by comparing respondents’ transcripts) and define gaps within and between categories.
Interview strategy

A snowball sampling strategy was employed. This process involves one respondent who fulfills the theoretical criteria (being a currently practicing primary care resident or physician); then that person helps to locate others through his or her social networks (Biernacki & Waldorf, 1981). Atkinson and Flint (2001) and Browne (2005) posit that this strategy can be utilized to reach populations that are more difficult to access, such as physicians. Problematic aspects of snowball sampling are selection bias and a lack of representativeness (Atkinson & Flint, 2001). In snowball sampling, respondents are not randomly selected. Further, the selection of later respondents is dependent upon the recommendations of earlier respondents. This means that in addition to the results not being generalizable, they are also likely to be biased towards the inclusion of people who already know each other. As a result, there may be an increased emphasis on cohesiveness in the findings. Further, Brown (2005) finds that snowball sampling excludes certain individuals who are not part of particular social networks. In this research specifically, primary care physicians may seem more similar than they actually are because much of the sample contains physicians that know each other. In addition, they might also be more likely to be comfortable discussing sexual health with their patients since they agreed to participate in the research knowing that it would be about discussing sexual health with patients.

Interview procedure

Once a potential respondent agreed to participate in an interview, I would schedule a date, time and place for the interview that was most convenient to the respondent. The day before the interview was scheduled, I sent a reminder/confirmation
email to the respondent. Before starting the interview, I would go over the informed consent document and highlight certain parts. For example, I reminded the respondent that the purpose of the interview is to discuss their conversations with patients about sexual health. I also reminded them that they did not have to answer any questions that made them uncomfortable and that the interview would be recorded on my netbook. Finally, I mentioned that I would not use their name in the interview and that if they used their name, anyone else’s name, their medical offices or health care system’s name, that information would be left out of the interview transcription. Once the interview was over, I would stop the recording, save the audio file of the interview and thank the respondent for their time and responses. I also sent a thank you email to my respondents after I completed their interview.

**Semi-structured interviews**

A semi-structured interview consisting of 32 questions was constructed to extract age, race, and gender information from practitioners. In addition, the questionnaire obtained information about where and when the physicians completed medical school and residency. During the interview, physicians were also asked to demographically describe their patients, including disadvantaged groups or groups with low health literacy. The interview assessed cultural capital of physicians (defined in terms of success, prestige and influence) in the medical field (using information from Haas and Shaffir, 1987; H. Luke, 2003; Sinclair 1997), physician comfort levels when discussing sexual health (using information from Ashton et al., 2001; Waite et al., 2007), beliefs about the physician’s role in STI prevention (using information from Ashton et al., 2001; Waite et al., 2007), and practitioners’ beliefs about the importance of patient-centered
care (using information from Ben-Sira, 1980; Bensing & Dronkers, 1992; Burnard, 1996; Silverman 1987). Finally, physicians were asked open-ended questions assessing their comfort levels discussing sexual health (especially STI prevention) with patients as well as their beliefs regarding the appropriateness and effectiveness of STI prevention discussions.

Measures

Derived from research done by Ben-Sira (1980), Bensing and Dronkers (1992), Burnard (1996), Fiscella and Epstein (2008), and Silverman (1987), interview questions were constructed to assess how important practitioners consider patient-centered care. These are behaviors intended to make the patient feel more comfortable and to more actively participate in his or her healthcare. Based on the aforementioned research, in the medical habitus, patient-centered care usually involves empathy, a consideration of patients’ rights and feelings, getting to know the patients on a personal level and being accepting of them, confirming patients’ understanding, and providing emotional support. If physicians focus on patient emotions and treating patients as equals, they may be able to better approach a (potentially sensitive or taboo) discussion of sex-related topics with patients, because they would potentially consider barriers to safer sex practices.

Based on research by Becker et al. (1961), H. Luke (2003), Haas and Shaffir (1987), and Sinclair (1997), I created interview assessing qualities or characteristics that are valued in the culture of medicine. These are characteristics that should enable a practitioner to be successful in the field of medicine. An exaggerated presentation of competence and confidence are highly important, as are cynicism toward the medical
system and patients. Further, a sense of detachment, or neutrality from the patients, authoritativeness in dealing with patients, establishing patients’ trust and a sense of responsibility for the patients are valued. Considering physicians’ concepts of cultural capital is important, because it can shed light on physicians’ priorities during medical visits with patients (and whether or not discussing sexual health is among those priorities).

Research by Ashton et al. (2001) intends to measure physicians’ attitudes regarding the effectiveness and appropriateness of having conversations about sexual health (especially STI prevention). Questions regarding importance, appropriate context and barriers to sexual health conversations will be asked. Discussion of such questions may shed light on whether or not such beliefs influence whether or not physicians initiate conversations about sexual health with their patients. Other questionnaire items have been derived from the National Social Life, Health and Aging Project (NSHAP) (Waite et al., 2007). These researchers developed questionnaire items to assess personal relationships and how they are related to the health of older adults. Respondents’ history of sexual and intimate partnerships is assessed along with physician-patient communication. NSHAP researchers asked individuals what types of questions their medical practitioner asks them. For the purposes of this research, the questions originally asked by the NSHAP researchers were modified to assess practitioner comfort levels in discussing such issues with patients.

**Interview sample description**

In total, 17 physicians were interviewed from a local hospital-based healthcare system. About half of the respondents practice medicine at a family medicine office at the
system’s main campus. The others practice medicine at suburban or rural satellite family or internal medicine offices. Respondents were interviewed wherever was convenient to them. Interviewing physicians in their medical practices wasn’t necessary to determine what influences whether or not they will bring up sex-related topics during patient visits. According to Warren (2002), qualitative interviews are acceptable when a researcher’s topics of interest are patterns between particular types of respondents, not a particular setting.

**Table 1: Physician demographics**

<table>
<thead>
<tr>
<th>N=17</th>
<th></th>
<th></th>
<th></th>
<th>Physician family member</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>Age</td>
<td>Race/Ethnicity</td>
<td>SES of origin</td>
<td>have a family member who practices medicine</td>
</tr>
<tr>
<td>59% female</td>
<td>53% over 40</td>
<td>76% Caucasian</td>
<td>53% middle class</td>
<td>41%</td>
</tr>
</tbody>
</table>

There are a total of 17 respondents. Ten of the respondents are female; seven are male. 13 of the respondents identify as Caucasian or white. Two respondents identify as Asian; one respondent identifies as Asian Indian. One respondent identifies as African American. The respondents ranged in age from 30 years old to late 70s (one respondent did not answer the age question). A little less than half of the respondents are in their 30s. About half of the respondents identified middle class as their class of origin. Five respondents identified upper middle class as their class of origin; three respondents identified lower middle class as their class of origin. One respondent identified poor as their class of origin, and one respondent identified “high” as their class of origin. Over half of the respondents have at least one parent with an advanced degree. Almost half of
the respondents have family members who are physicians; three of the respondents’ fathers were physicians. Three of the respondents are married to physicians. Six of the respondents have extended family members who are physicians.

Table 2: Physician education and specialty

<table>
<thead>
<tr>
<th>N=17</th>
<th>Medical school graduation year</th>
<th>Medical school location</th>
<th>Resident or attending?</th>
<th>Specialty</th>
</tr>
</thead>
<tbody>
<tr>
<td>82% graduated after 1980</td>
<td>76% U.S. medical school graduates</td>
<td>82% attending physicians</td>
<td>88% family doctors</td>
<td></td>
</tr>
</tbody>
</table>

Years of medical school graduation ranged from 1963 to 2012. Years of residency completion ranged from approximately 1966 (one respondent did not answer this question) to 2016. Four of the respondents are foreign medical school graduates; the other 12 attended medical school in the northeast or Midwest United States. One of the respondents completed their residency in Canada; the rest of the respondents completed their residency in the northeast, southeast, Midwest, Great Lakes region or west coast of the United States. 14 of the physicians are attending, and three are resident physicians. One of the respondents is a DO; the other 16 respondents are MDs. 15 of the respondents are family physicians; two of the respondents are internists.

A majority of the interviews took place at the physicians’ medical or academic office. A few interviews took place at restaurants or coffee shops; one interview took place in a library. The interviews ranged in time from 19 minutes to 146 minutes. A majority of the interviews lasted between 35 and 45 minutes. Only six of my respondents
were recruited using the snowball sampling method. The other 11 respondents were recruited via email.

Interview analyses and data management

**Grounded theory**

According to Bowen (2008) and Charmaz (2002), implementing grounded theory involves analyzing data during the data collection process. This means that researchers should engage in discourse analysis while coding interviews and before reaching theoretical saturation. Further, utilizing grounded theory encourages researchers to integrate newly discovered codes or themes into their writing, including theoretical perspectives. It was originally developed by Glaser and Strauss in 1964. Essentially, grounded theory allows for a more flexible discourse analysis, because it doesn’t confine the researcher to the parameters of a particular theoretical framework. Therefore while a theoretical framework is a significant part of research (and the creation of interview questions), it should not be limiting. Finally, Strauss and Corbin (1990) posit that grounded theory research can provide a better understanding of a phenomenon about which little is known.

At its core, grounded theory is constructionist (Charmaz, 2002) in that it considers the social construction of reality. Employing a constructivist strategy, I wanted to study how physicians construct meanings of cultural capital and patient-centered care and actions regarding initiating discussions about sex-related topics with patients within the culture of medicine. And while I utilized postmodern theories to form my concepts and interview questions, it did not restrict my initial coding process. According to Charmaz
constructionist grounded theory views data collection and data analyses as tools that help researchers produce tentative explanations about the social construction of reality. A constructionist grounded theory places emphasis on how data and data analysis are actually products of social interaction. Constructivists also view data analysis as a construction that not only locates the data in time, place, culture and context but also reflects the researcher’s thinking. For example, many physicians mentioned electronic medical record implementation as a hindrance to providing quality care to patients. Some respondents mentioned the implementation of the Affordable Care Act or “Obamacare” as having a positive effect on primary care providers because it encourages preventive care. This is indicative of a specific modern political climate. Although my questions were about larger, abstract concepts, my thinking is reflected in which concepts I chose to ask about.

Discourse analysis

Discourse analysis was used to examine the interview data. According to Hammersley (2002), “The term discourse is interpreted here as referring to detailed analysis of language-in-use, whether this takes the form of speech or text. In practice, it is almost always text that is analyzed; since speech is usually transcribed from audio or video recordings for analysis (p. 2).” In particular, this examination utilizes critical discourse analysis. This type of analysis rejects the applicability of the types of quantitative measurements associated with scientific positivism (Flowerdew, 1999). It is not possible nor desirable to be objective in data analysis. Instead, this type of analysis embraces postmodernism and structuralist constructivism; it is reflexive (Flowerdew, 1999; Hammersley, 1997). In other words, critical discourse analysis considers the
influence ideology and methods have on the research and analysis itself. This type of analysis asks the researcher to consider the influence they have on the research process. It encourages researchers to abandon restraint when evaluating texts and contexts, which is similar to open coding (Esterberg, 2002). Charmaz (2002) and Glaser and Strauss (1967) refer to this process as utilizing grounded theory. Blumer (1969) proposes an idea similar to grounded theory called coding for sensitizing concepts, which encourages researchers to examine texts for themes without any preconceived notions of what those themes should be.

Another influence on interviews are the social structures within which they occur (Fairclough, 1985). All of the research interviews took place within the institution of medicine, in which there are certain norms and valued behaviors (e.g., cultural capital). For example, physicians are accustomed to being treated as experts in the field of medicine as well as in U.S. society (Starr, 1982). In the field of medicine, physicians’ advice and treatment are sought by patients. In the context of these research interviews, the respondents are not being asked to demonstrate their clinical competence, which is what they are used to in the field of medicine. They are not used to being asked philosophical, open-ended questions about their profession. Therefore, they often seemed uncomfortable with the open-ended questions or the reality that there wasn’t necessarily a correct answer to interview questions.

Further in the spirit of critical discourse analysis, Schegloff (1997) comments that most analyses ignore the concerns of the research participants in exchange for the privileged status of the researchers’ concerns. Instead, most analyses characterize respondents/research participants in ways that are decided entirely by the researcher. In
other words, the researcher has all of the power, and critical discourse analysis takes issue with that. In this data collection process, two types of power dynamics were at play: the first is that researchers have a powerful status as evaluators. As such, the physicians were concerned about getting the right answer or answering the way that they thought I wanted them to. However, in U.S. society, physicians have higher social status than sociology PhD. candidates. Overall, the power dynamic that pervaded the interviews was the first. When the second dynamic presented itself, the interview tended to be shorter. It is possible that this was due to J.H. Turner’s (2003) description of conversations among people who are not equal (in terms of individual resources and power): he describes such conversations as impersonal, highly routinized and short term.

**Theoretical saturation**

Schutt (2006) describes the saturation point of sampling as the point at which interviews yield little to no new information. According to Bernard (1995), Bertaux (1981), Creswell, (1998), Kuzel (1992), and Morse (1994) at least 15 interviews and generally no more than 20 to 30 interviews are needed to reach theoretical saturation. Guest et al. (2006) posit that saturation usually occurs within the first 12 interviews. In total, I interviewed 17 primary care physicians. After my 12th interview, I felt confident that I was approaching theoretical saturation, because as I was transcribing interviews and beginning initial coding, I did not notice any new themes. At my 15th interview, I was certain that I had met the criteria, as I had not discovered any new codes after my 13th interview transcription. However, Bowen (2008) warns against focusing on sample size when determining theoretical saturation. Other researchers urge a consideration of
information richness, variety of respondent experiences and how well respondents represent the research topic (Kuzel, 1992; Mason, 2010; Morse, 1995).

Guest et al. (2006) suggest a systematic documentation of theme or code identification to demonstrate theoretical saturation. Specifically, these researchers recommend recording the proportion of individual interviews to which a code is applied as well as the sequence of interviews in which a code appears. Bowen (2008) encourages researchers to utilize the constant comparative method when analyzing interviews, considering theoretical saturation and creating codes. This method involves the following: comparing incidents applicable to each theme that emerges from the data; integrating themes applicable to each theme that emerges from the data; delimiting the theory; writing the theory. During this process, previously coded text is checked to see whether newly created codes are relevant for developing and refining theoretical categories or central concepts.

**Thematic analysis (coding)**

I started thematic analysis while I was still interviewing respondents, as recommended by Bowen (2008) and Corbin and Strauss (1990). While most of the interview questions are intended to explore physician’s concepts of cultural capital, endorsement of patient-centered care, comfort levels discussing sexual health topics (especially STI prevention) as well as beliefs regarding the appropriateness and effectiveness of sexual health topic discussion, the thematic analysis was guided by grounded theory (Glasner, 1967). Thus, there were no preconceived notions of what the physicians’ conceptions of the aforementioned topics would be. Instead, these
conceptions emerged during an analysis of the interviews. Bowen (2008) suggests that thematic analysis be done at three levels: open, axial and selective.

For the interview analysis, Blumer (1969), Bowen (2008), and Glaser and Strauss (1967) suggest taking an initial look at data to systematically discover themes without any preconceived notions of what the themes should be. Esterberg (2002) refers to this process as open coding and suggests being open to whatever you see in the data, even if you notice something that seems irrelevant to your research. In open coding, there are no pre-established codes. Bowen further suggests that open coding can make data more manageable and that it can also be used as labels for interview transcripts. Blumer (1969) calls this technique coding for sensitizing concepts. A sensitizing concept is basically a working tool for analysis, which means that it can be revised to fit the nuances of a research topic. During initial coding, the goal is to explore the data (transcribed interviews) for meaningful categories or themes. Glaser and Strauss (1967) also recommend discovering theory or codes from the data rather than applying them before data collection has begun; they argue that grounded theory prevents research from using theories opportunistically, as does Berg (2004).

When finishing initial coding and before beginning focused coding, Charmaz (2002) recommends that researchers ask themselves where initial codes apply in the data and where the concepts will take the analysis. She argues that researchers can then determine how useful a focused code will be. According to Corbin and Strauss (1990), this process is called axial coding; it requires researchers to match themes to specific research questions and relating subcategories to categories. Bowen (2008) indicates that axial codes are actually more abstract than open codes and can be determined by frequent
use of key terms in interviews. The final part of the analysis is selective or focused coding. Charmaz notes, “In selective or focused coding, the researcher adopts frequently reappearing initial codes in sorting and synthesizing large amounts of data. Focused codes are more abstract, general, and, simultaneously, more incisive than the initial codes…” (2002: 686). Bowen (2008) explains selective coding as connecting and consolidating axial codes. Further, Bowen (2008) and Glaser and Strauss (1967) suggest that selective codes can be analyzed to identify themes that cut across the data to create a core category.

**Documentation of code identification**

As previously mentioned, Guest et al. (2006) suggest a systematic documentation of theme or code identification to demonstrate theoretical saturation. Specifically, these researchers recommend recording the proportion of individual interviews to which a code is applied as well as the sequence of interviews in which a code appears. Based on these recommendations, I created a table to track each of the themes identified in initial coding. The tabular format used for tracking is listed below:

<table>
<thead>
<tr>
<th>Code</th>
<th>Number of interviews in which code appeared</th>
<th>Sequence of interviews in which code appeared</th>
</tr>
</thead>
<tbody>
<tr>
<td>Code 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Code 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Code 3</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Two tables were created for each code identified in each interview question: one for initial coding and one for revised coding. During revised coding, initial codes that showed up in a smaller number of interviews were combined with other similar codes that showed up in a smaller number of interviews.

**Summary and conclusion**

Utilizing ethnomethodology, grounded theory and critical discourse analysis, I attempted to uncover reasons why primary care physicians do or do not discuss sexual health topics with their patients and how comfortable they are with such discussions. Thus, the analysis was conducted with a framework that research participants (physicians) actively construct social reality (medical encounters with patients) and influence it (Berger & Luckmann, 1967; Garfinkel, 1967; Stake, 2008). And while postmodern theories are used, using grounded theory (Charmaz, 2002) encouraged me to broaden my codes to include concepts outside of postmodernism. In other words, when coding my interviews, codes were not restricted to the postmodern concepts outlined in earlier chapters (cultural capital, habitus and field). I widened the scope of my analysis to include sociological concepts from any theoretical background. Finally, referencing critical discourse analysis, I considered ways that I influenced on the research process by acknowledging power dynamics at work during the interviews. For example, as a researcher, I made some of the physicians who participated in this research uncomfortable as the subject of social science research. Further, many respondents felt unsure answering some of the interview questions to which there is not a right or wrong answer.
Chapter 5: Acting like a doctor

Introduction

This chapter examines ways that physicians learned to act like physicians and how that learning influenced the way they practice medicine now. The postmodern theoretical concepts of habitus and cultural capital (Bourdieu, 1990; Bourdieu & Wacquant, 1992) are employed to frame respondents’ statements about what influences their interactional styles with patients. Luke (2003) posits that capital is power or prestige; the habitus is the process by which actions and behaviors are thought out. Social capital will also be examined, as it influences the ways physicians interact with each other as well as with patients. Social capital is networks and norms of reciprocity (Putnam, 2002). Habitus will be utilized to determine the most significant influences on physicians’ approaches to patients. Components of cultural capital such as a focus on academic research and publications, as well as cynicism toward the healthcare system in which they work and patients are most commonly considered by respondents. Physician concern with cultural capital and its overlap with patient-centered care will also be considered. Physicians’ (who participated in this study) distinctions between cultural capital with patients (defined by the term success) and cultural capital with other physicians (defined in terms of prestige and influence) will be examined, especially as it relates to primary care physicians being less respected by their colleagues who practice in other fields of medicine.

Further, increased regulation by external sources such as hospital system administration and United States federal government has led to less physician control over patient encounters. In addition, increased patient empowerment via increased access
to medical information has created an entitled and demanding patient population. These factors have led to a decline in physician prestige; these factors have also led to physicians being more cynical about their profession. However, physicians still maintain a fairly high level of social capital and address certain aspects of social capital in some of their responses to this research’s questions.

**Habitus**

Simply put, the habitus is “a sense of one’s place and a sense of the other’s place” (Bourdieu, 1990, p. 131). By providing cognitive and emotional guidelines, the habitus allows physicians as individuals to represent the world in common ways and to classify, choose, evaluate and act in a particular manner (Bourdieu, 1984). The habitus is the culture of medicine as acted out by physicians. H. Luke (2003) applies the concept of habitus to medical institutions and posits that the habitus is part of the social course of medical school and residency. In other words, it is in the habitus (through informal learning) that medical students and residents gain a sense of collective and individual social identities as physicians. They learn and subsequently internalize these dispositions from medical school faculty, fellow medical students, more senior medical students, residents as well as attending physicians with whom they practice. Specifically, H. Luke (2003) indicates that “residents through workplace practices begin to adopt particular habitual practices while being socialized into certain forms of desired medical practice and structures” (p. 67). Acting in desirable ways should enable physicians to obtain and maintain cultural capital. To assess the habitus of primary care physicians, respondents were asked about ways that they learned to act like a doctor.
Learning how to act like a doctor

While most of this research’s theoretical framework focuses on medical school learning and informal learning during residency, a more open-ended inquiry was utilized regarding influences on these respondents’ interactional style with patients. When asked, “Are there ways in which you learned how to act like a doctor?” most of the respondents were confused. Typically, this prompted me to explain that I was referring to interactional or relational styles with patients rather than clinical aspects of medicine. Once this was explained, respondents overwhelmingly indicated that residency was most influential in teaching them how to act like doctors. Through observation of attending physicians, feedback from attending physicians, feedback from other health care professionals and feedback from patients, respondents learned interpersonal skills they utilize as physicians.

According to Quinn (1987) and H. Luke (2003), attending physicians (physicians supervising the care of patients by interns, residents, and medical students, mediLexicon.com) play a major role in resident physicians’ educations, and their practice behavior (directly observed by residents) may greatly influence the behavior of their residents. Specifically, interns, residents and medical students are socialized into particular habits of thoughts, tastes and dispositions. Luke (2003) indicates that “residents through workplace practices begin to adopt particular habitual practices while being socialized into certain forms of desired medical practice and structures” (p. 67).

Many respondents say that (when they were in residency) they looked to attending physicians for guidance in establishing comfortable relationships with patients. Multiple respondents also mention observing attending physicians’ favorable behaviors that
influenced their current manners of dealing with patients. Some physicians mention observing attending physicians being informal and friendly with patients. Others mention observing an attending physician remembering details about a patient’s life and using those details to put a medical issue (the patient is having) in perspective. According to A. Luke (1990), cultural capital is likely to develop as a result of assimilation of skills and practices over time. Therefore, if physicians notice particular ways that more senior physicians approach physicians and mimic that behavior, they may be more likely to accumulate cultural capital. To illustrate particular themes quotations from respondents are used. Pseudonyms, rather than actual respondent names, are used when quoting respondents.

I think I’m also very informal, and I struggle with that with my patients. Because I find that there still has to be some disconnect or some kind of hierarchical level is not the right thing, but basically there has to be some disconnect where you can be friendly but you are still that professional person in the room. And I’ve done that by watching some of my attendings, some of my younger attendings, who are very colloquial with their patients and joke a lot. I watch them to see how they do that but still manage to keep that gap, that separation. That’s pretty much how I learned to act like a doctor, because I struggled with that.-

Dr. J. (resident), female, age 30

Well I’m sure there are. How I learned to do this? Obviously in residency I watched other doctors. As you practice you both make conscious and unconscious decisions how you want to appear to your patients and how you want to appear to different kinds of patients. I mean, I was in Psychology and Anthropology as an undergraduate; so I know some about it. I think about those things.-

Dr. H. (attending), male, age 67

Dr. L. also mentions noticing attendings’ behaviors she disapproved of (interrupting patients and not giving patients an opportunity to ask questions) and learning what not to do with patients.
Well, I observed some things that were good and not so good. I observed doctors interrupting patients and then leaving the room. They would tell them what was going on and leave before they (patients) had a chance to ask questions. That is something I observed and learned not to do. I observed some physicians’ conversation styles that I really liked. I noticed some of them in labor and delivery…sort of jovial or more relaxed. I liked that some of the physicians would remember details about a patient’s life and use that to put something that was going on currently in perspective.

Dr. L. (attending), female, age 43

Drs. B., G. and R. mention professional socialization and medical school learning as methods of learning how to interact with patients. Because Dr. B. began her practice of medicine in a rural area, she did not have as many colleagues from whom she could seek advice.

They sent me out to a rural, small town practice. And so there, I really saw people being respected for being family doctors. And yet, I still had to invent a way of acting like a doctor there… I don’t know if that has to do with professional socialization…”

Dr. B. (attending), female, age 61

Dr. G. identifies medical school as having a significant impact on how she interacts with patients. She also points out that some people are inherently better at interacting with other people because of their personalities.

I do think the practice that you are provided in medical school does help with your patient bedside manner and your interaction. I do think some of it is inherent; I think it is your personality. So I think it’s a little bit of both. But I do think that you over time feel comfortable kind of letting your guard down with patients once you’re very comfortable with them. –

Dr. G. (attending), female, age 40
Dr. R., a quiet person, needed to work a bit harder to attain an appropriate level of relatability with patients. His residency was especially helpful in this regard.

Um, well, number one, I’m really a quiet person by nature. And so in residency, my residency directors kind of taught me that I had to act like a doctor, meaning I had to be more outgoing, social, not be all uptight and straight to the point, and kind of be a person. So that I would come across as a person, not so much as a stuffed shirt. Yes, in medical school we had simulated patients. In residency, they would film us at least once a year with a patient that agreed, and then we would review it, and they would give us tips. And then they had days in residency where they would follow us and also give us tips. –

Dr. R. (attending), male, age 35

Starting in medical school and continuing into residency, students gain a sense of collective and individual social identities as physicians. Specifically, they are socialized into particular habits of thoughts, tastes and dispositions. One of the ways they are socialized is learning how to approach patients. Further, they learn which topics of conversation important are important to discuss with patients. Approaching patients in ways that are similar to that of other physicians could enhance a physician’s cultural capital not only with other physicians but also with patients. Determining what influences a physician’s interactional style (with patients) lays the framework for exploring more detailed questions about which topics physicians believe are appropriate and which topics physicians feel more or less comfortable with.

Cultural capital

Based on Bourdieu’s theories, cultural capital is defined as informal interpersonal skills, habits, manners, linguistic styles, educational credentials, tastes, and lifestyles (Bourdieu, 1986). Cultural capital is knowing how to behave appropriately. In the medical field, physicians are taught certain ways to evaluate and react to patients as well
as what types of communication are most effective or appropriate (Luke, 2003). Physicians learn what topics of discussion are appropriate with patients; they learn how to treat patients. Further, cultural capital is likely to develop as a result of assimilation of skills and practices over time. This competition for cultural capital takes place in the field (medical practice) and is influenced by the collective mindset of physicians’ colleagues (habitus). Throughout interview transcription and coding what emerged are two distinct forms of cultural capital for physicians: cultural capital with patients and cultural capital with physicians. Cultural capital with patients is highlighted when physicians are asked about what it takes to be a successful physician, whereas cultural capital with other physicians emerges when physicians are asked about their definitions of prestige and what it takes to be influential in their field (of medicine).

Research conducted by Becker et al. (1961), H. Luke (2003), Haas and Shaffir (1987), and Sinclair (1997) identify some qualities that are valued in the culture of medicine or qualities that cultivate a physician’s cultural capital: a sense of detachment, or neutrality from patients, authoritativeness in dealing with patients, establishing patients’ trust, and a sense of responsibility for the patients (Becker et al., 1961; H. Luke, 2003; Haas & Shaffir, 1987; Sinclair, 1997). Further, a physician is more likely to be successful in terms of prestige and authority (have cultural capital) with medical peers if that physician possesses other valued characteristics, such as cynicism toward the medical system, confidence and an exaggerated presentation of competence (Becker et al., 1961; H. Luke, 2003; Haas & Shaffir, 1987; and Sinclair, 1997). As a result, I asked respondents what it means to be successful, prestigious and influential in their fields.

**Being a successful primary care physician**
To assess physicians’ views of cultural capital, I asked them about what it takes to be a successful primary care physician, as researchers indicate that success, prestige and authority are part of cultural capital in the medical field (Becker et al., 1961; H. Luke, 2003; Haas & Shaffir, 1987; and Sinclair, 1997). Further, I wanted to know if success is defined differently in specialty fields. Respondents unanimously indicate that being a successful physician is defined by how well they treat their patients. In other words, these physicians view their treatment of patients as an essential component of their cultural capital with patients. Characteristics involved in patient-centered care are similar to those described by physicians as success or cultural capital. Therefore, it seems that endorsing patient-centered care and having cultural capital with patients (being a successful physician) are synonymous. More specifically, respondents believe patients will be happier with their care if their physicians are empathetic, approachable and if their physicians treat them as a whole person.

Um, abiding relationships with their patients is probably the first thing. The satisfaction of taking care of whole people. I think those are the two main things actually. –

Dr. K. (attending), male, age 56

Strong communication skills and the ability to relate to the patient, I think this applies in all fields of medicine.-

Dr. L. (attending), female, age 43

Compassion, number one and the most important. Taking time, not rushing. Understanding that the patient is a human being and not a machine and not a computer and needs to be talked to…a lot of psychological problems are usually in the background of any kind of medical problems.-

Dr. T. (attending), male, age 38

While some respondents indicate that characteristics that make successful primary care physicians are similar to those that make successful specialists, others indicate that there
are differences. The biggest difference mentioned is that with specialists there is more of
a focus on technical skill, making approachability (as a physician) and continuity of care
less important.

There are differences, because with primary care, you’re establishing a continuity
of care. As sick as I am of hearing that, those three words. It is vitally important to
our field that our families, our patients’ families, that they continue to follow up
with their primary care physicians. For example, if you’re a surgeon, you get in,
you get a nip/tuck. You have your appendix taken out. That’s the end of the story.
You never go back. I’d say the same thing for all surgeons. Unless if you’re a
plastic surgeon. If you’re a Barbie doll then you’re going to be continually seeing
that person. I think the internists, albeit primary practitioners, be it internal
medicine or family medicine, be it pediatric internists, be it ob/gyns, there’s some
extent of continuity of care in those fields. But in surgical fields, it’s more
consult, surgery, done. –

Dr. W. (resident), male, age 37

I do think patients expect a closer relationship with their primary care doctor
versus a specialist…you know most patients expect their primary care doctor to
be very easy to talk to, get along with. I think patients do sometimes tolerate it if
they don’t get that from their specialist. They’re kind of more…maybe abrasive,
not as talkative, not as informative, not as…you know, answering questions. But I
think patients are expecting more now. So it’s changing, whereas maybe 10 years
ago, if you were a specialist, patients didn’t expect to have more time with
you…not necessarily that warm and fuzzy feeling but feel comfortable. –

Dr. G. (attending), female, age 40

Dr. W. points out that patients expect more of a relationship with their primary care
provider; patients do not expect this long-term relationship with a specialist. Dr. G.
echoes this sentiment by indicating that patients expect primary care providers to be
approachable. Thus, cultivating relationships with patients by being approachable would
seem to be a part of what defines success for primary care providers.

When asked specifically about how discussing sexual health with patients would
affect a physician’s status, many respondents indicate that having a conversation about
sexual health with a patient would make a physician seem more approachable to patients.
Yeah, and with patients, yes it affects your status in if you bring it up, people know that they can talk about anything. And so if you happen to uncover something they were too shy to bring up that’s important to them, then they’re really grateful. If you ask them a bunch of questions, and they’re like, no, no that’s not really relevant for me. No, really. Everything’s fine, doc. It’s okay. Everything’s fine. And so they know if everything’s not fine that they can bring it up. So I think that helps.-

Dr. K. (attending), male, age 56

Dr. R. indicates bringing up sexual health may make physicians more approachable to certain patients, but bringing up sexual health also has the potential to offend patients.

Um, honestly I don’t think it does, at least not with other physicians. Maybe in small groups of doctors in the society it does, like small, little cliques. But I think in general, outside the office all anyone really talks about is oh my doctor is very good about bringing this up. I don’t think that’s something patients usually talk about. I think it’s more that they are more appalled when you do bring it up than actually going out and saying, oh my doctor talked to me…I think it’s more (gasps), can you believe the doctor talked to me? I never want to talk to him again! –

Dr. R. (attending), male, age 35

A few respondents indicate that it wouldn’t affect a physician’s status one way or the other, because physicians don’t usually discuss patients with each other unless something clinically interesting happens during a visit.

So do I think you’re a better doc or less of a doc if you talk about it? I don’t think so. I think it’s a non-issue, I guess because I think docs try not to talk about medicine to each other unless they have an interesting case. And then I think with an interesting case, it comes around to say, did you talk about that? You know what I mean? It’s not like you’re sitting around going, what’s your average well child discussion like? So I’m thinking like, if I were to have a discussion, and they were like well let’s talk about that. I mean, that’s how I learned…I had another discussion, and I was like, I asked this question and I learned about this. I was talking with other docs, but it was a different case. But it was a case by case.
But I think that’s how you learn. It’s not like a point of conversation, but I am sure sexual health histories come up when you have interesting cases. –

Dr. I. (attending), female, age 41

Patient-centered care

As previously mentioned, many of this research’s respondents indicated that patient satisfaction is what makes a primary care physician successful. In other words, patient satisfaction is the cultural capital for which primary care physicians compete in the primary care medical field. Focus on patient-centered care is part of primary care physicians’ habitus. However, when considering cultural capital for primary care physicians with physicians as a whole, more traditional definitions come into play, such as publications and research.

As previously mentioned, patient-centered care has been defined as including empathy, a consideration of patients’ rights and feelings, getting to know patients on a personal level and accepting them, confirming patients’ understanding and providing emotional support (Ben-Sira, 1980; Bensing & Dronkers, 1992; Burnard, 1996; Fiscella & Epstein, 2008; Silverman, 1987; Slatore et al., 2012). Epstein and Street (2000) provide an operational definition of patient-centered care, which includes fostering healing relationships, exchanging information, responding to emotions, managing uncertainty, making decisions and enabling patient self-management. Street et al. (2007) posit that patient-centered care can best be enacted by treating patients as equals, asking for patients’ opinions and thoughts and providing recommendations and explanations that are clear and easy to understand.
While they may resent the concept itself (because they perceive it to be administratively imposed), most respondents indicated that engaging in what they define as patient-centered care is cultural capital among other primary care providers. The cynicism towards the concept of patient-centered care comes from resentment towards external regulations of medical care. Many respondents indicated that physicians have always engaged in patient-centered care and don’t need a bureaucratic label for it, as demonstrated by Dr. C.

I have no idea what they mean or how that’s different from what we’ve always done. I mean, you should always do your best to take care of patients. It sounds like a statement made by some person in…some administrator.-

Dr. C. (attending), male, age approximately late 70s

According to respondents, patient-centered care involves caring for the whole patient and considering patient context, such as considering a patient’s socioeconomic status and whether or not they can afford their medication(s). Considering patient context may also encompass making connections to social services. Patient-centered care also involves making health behavior change and treatments attainable by tailoring them to the individual patient, which may consist of providing the patient with additional information about or justification for their treatment.

So I think patient centered care is trying to meet the patient where he or she is. And then, engage them in a partnership towards their health. I always tell my patients, they have the hard job. Because I am here as a resource and I will offer them information, and I will be a sounding board if that’s needed. But really, they have to go home and do the work. I also want them to understand why I am recommending what I’m recommending, because in general that makes them understand when they go home and something changes that they didn’t expect.-

Dr. Z. (attending), female, age 37
Short of that, probably any time you allow your time to be sucked up with trying to see where the patient lands next…so just the sense of that the patient in your office isn’t in and of itself the meaning for their existence. They came to you from somewhere by some sort of mode of transportation, and they’re going back to some other health environment… I think I’m more sympathetic to financial factors like, oh wow, I’m filling out HEAP forms; so this guy probably may not be getting his right medicine…HEAP forms are where you get the free electric and heating… and so I prescribe the generics when I can. I prescribe the cheap stuff when I can. You don’t go out on a limb and come up with the most complicated plan first, especially now that everyone has co-pays and giant deductibles. So, I sort of start there.

Dr. M. (attending), male, age 38

When asked about specific ways they engage in patient-centered care, respondents indicate that they engage in patient-centered care by respecting the patient. Specifically, they listen to the patient, avoid pre-diagnosis, involve the patient in decision-making, know a patient’s limitations and simplify treatment plans.

I mean, generally, I sit there, and I listen to the patient. I listen to what they’re actually saying without trying to…before they even start talking, thinking about what’s wrong with them, listening to what they’re saying, listening to what their family’s saying. You also have to take the family into how that affects the patient, and how their job and their upbringing affects their thoughts and how their perceptions… and how that affects their health.

Dr. R. (attending), male, age 35

There is overlap between researchers’ definitions of patient-centered care and physicians’ (who are involved in this research) definitions of patient-centered care. For example, respondents state that considering a patient’s background is an important
component of patient-centered care, which is similar to getting to know patients on a personal level (Ben-Sira, 1980; Bensing & Dronkers, 1992; Burnard, 1996; Fiscella & Epstein, 2008); Silverman, 1987; Slatore et al., 2012). Other respondents focus on additional patient education when prescribing a particular treatment or recommending a specific health behavior change, which is similar to information exchange, managing uncertainty and enabling patient self-management (Epstein & Street, 2000). Engaging in patient-centered care is important to the primary care physicians involved in this study, because it is part of what it means to be a successful physician. In other words, it is a component of their cultural capital.

**Influence and prestige**

To further assess physicians’ views about cultural capital in medicine, I asked about what it takes to be influential and prestigious. As previously mentioned, when asked about success in medicine, respondents almost always took success to mean success with patients. However, when discussing prestige and influence, respondents define influence and prestige as involving peer recognition and respect as well as having published research. Thus, influence and prestige are synonymous with cultural capital with other physicians, whereas success is synonymous with cultural capital with patients. Many respondents include patient satisfaction in their definitions of influence and prestige, but almost all of them consider having the respect of colleagues and published research as being more important for prestige and influence but not for success. Specifically, respondents mention participation in academic institutions by having faculty appointments at universities or publications in medical journals. Other physicians who participated in this research mention location of practice and hospital system as affecting
their levels of prestige or cultural capital with other physicians, in that physicians who practice in community health care systems instead of private health care systems seem less prestigious.

Well I guess there’s two different kinds of prestige, at least that I can think of. There’s prestige among your colleagues and the other is prestige with patients. People who are looking for prestige either don’t come to family doctors at all or they don’t often stay. I mean there are some family doctors who are fairly prestigious; so in that sense I do have to compete, because I can think offhand of some family doctors who get some carriage class patients and I have gotten some of those, and they don’t stay very long, because I’m not prestigious enough. And I don’t try to be.

Dr. H. (attending), male, age 67

I would say one is if you are in academia, it’s the journal articles, the grants, the research and the accolades that come with that. I’m obviously not in academia, but I think that for other people who just do more clinical medicine, it’s having the confidence that family and friends want to refer to you. Your practice is growing and that specialists use us and that when people don’t have a primary care provider, specialists send people to us. I think it’s your colleagues thinking that you’re a good physician. That is pretty important. That at least gives me some self-esteem that I’m at least decent at what I do.

Dr. G. (attending), female, age 40

Respondents indicate that influence and prestige with peers or patients is related to physician demographics and personality traits as well as the hospital system within which a physician practices. Dr. J. notices that because she is a white, native English speaker, she has less problems relating to her patients, which improves her chances of having prestige with patients.

I think that one I have noticed in my practice that being a Caucasian, English speaker, I have no issues talking to most of my patients. We have some, a Nepali population, and I have a hard time; I’ve only had 2 patients using a translator, and it can be kind of complicated…I know that there are not very many in Family Medicine but in Internal Medicine residents, some of the residents are non-English speakers as their first language. They’re from India or China. Those are
the ones I’ve seen the most. One of my residents has a similar issue; she’s from Pakistan. She’s having a hard time kind of connecting. They just have different expectations of what is normal.-

Dr. J. (resident), female, age 30

Dr. T. has experienced more difficulties gaining influence and prestige, because she is not a U.S. medical school graduate.

Well I know for sure…it’s not a fact, but I know U.S. medical graduates are more...are usually more influential, because they have connections. And connections are very important in any field. So when you are a U.S. graduate, you have connections with people from colleges and universities. You just have more of that, which is usually not available for people who come from international graduate schools. That’s something I would say.-

Dr. T. (attending), female, age 38

Drs. K. and Z. believe that location of practice and whether or not a practice is academically affiliated will affect how influential a physician is.

There is a physician who was the Ohio family physician of the year a while ago who told me that one of her patients mentioned something about her not being a good doctor. And she said, why would you say that? And the patient said, if you were a good doctor, why would you be practicing here [being at a community health center]? And she’s a very good doctor; she does that because she’s mission-driven. So you know being in the poor part of town versus being at a practice that has moniker of delivering world class health care and has waterfalls in the lobbies, you certainly can borrow prestige from that. And that’s certainly commonly done. And we certainly see that done a lot with marketing physicians. It used to be that people could hang up their shingle and if they were around and were well-known to their patients and well-thought of by their colleagues, they would be prestigious. And now I think people borrow a lot of their prestige from their system. –

Dr. K. (attending), male, age 56

Sure. Like when I was practicing [at an academic institution], I would have been way more influential than I would be here [where she currently practices medicine], because I was just around many more physicians on a daily basis. And you have the opportunity there, without as much expenditure of energy, to influence and discuss things. When you’re out in the boonies you don’t interact with other movers and shakers very often, which has perks sometimes but does make you less influential. I mean I can have all kinds of weird opinions out in [rural area] and no one will know. So, I think if you live in an area where you are
around more physicians more easily and you work in a big practice or something like that, you’re much more likely to have your opinions heard. –

Dr. Z. (attending), female, age 37

**Competing for respect (in the field of medicine)**

Based on these physicians’ responses, it seems that there are two kinds of cultural capital: cultural capital with colleagues (influence and prestige) and cultural capital with patients (success). This theme continues when asking respondents about competing for respect or cultural capital in the medical field. The field is where competition for power or prestige takes place; more specifically, it is where competition for specific forms of capital (dependent upon the priorities of the field itself) take place (Lahire, 2015). The field is the structure through which agents (people) with different levels of power (or capital) operate. In this case, the field takes place within in the institution of medicine. Or more specifically, the field takes place where physicians practice medicine: in their hospital system. Most physicians describe having to compete with other physicians for respect (cultural capital) from fellow physicians, but a few respondents also mentioned having to compete with other physicians for respect (cultural capital) from patients. Criteria for cultural capital with other physicians includes medical specialty, status as a resident or attending physician, physician demographics and amount of time in medical practice. Therefore, it seems that respect is mainly determined by cultural capital with other physicians, not by patients.
However, Dr. R. has a colleague who is extremely well-respected by a particular subculture; however Dr. R. does not explain if his colleague had a particular patient approach to gain such respect or cultural capital.

Um, somewhat. I mean I practice where one of my partners is literally considered god to the Amish. So I have to kind of compete somewhat to get some respect. Although once you get it with the Amish, generally they’re pretty good. It just disseminates out. I don’t ever expect to have the same prestige that he does but maybe just enough so that they want to see me. –

Dr. R. (attending), male, age 35

Other respondents focused on cultural capital gained through respect from other physicians. Specifically, Drs. C. and F. indicate that among physicians, primary care providers are not as respected (have less cultural capital with other physicians) as specialists.

In my field? No. In other fields? Yes. Here, everybody is subspecialty oriented. And we’re generalists; I mean, we do everything. In our previous life, we delivered babies, took care of kids…did the whole thing. Went to the hospital. That’s not the culture here; that’s not necessarily purposeful. That’s just the way it is. I haven’t seen anyone in years that says I want to go into internal medicine. They all say cardiology, GI, hem/onc. And family medicine is a wonderful department here, but the number of students going in is very small. It’s not considered as academically rigorous or as substantial. People trash it. Oh you’re too smart to do that. –

Dr. C. (attending), male, age approximately late 70’s

I don’t think it’s a competition. It’s just kind of a fact. I think a lot of family physicians don’t have the same respect as maybe a cardiologist or some other specialist, at least in our culture. It’s really weird…-

Dr. F. (resident), male, age 31

Dr. J. states that resident physicians are not as respected (have less cultural capital with other physicians) as attending physicians.
I know some of my co-workers feel like because they are residents that their patients don’t respect them as much.-

Dr. J. (resident), female, age 30

Dr. D.’s statement about influences on how much she is respected highlights some respondents’ feeling that demographics (age, race, and gender) may affect how much respect (cultural capital) from other physicians they have.

For me personally, (a) being a female and (b) being African American. Actually I should reverse those. Then, being in primary care. So I think I just have a triple…you know, whatever adjective that I want to put here…that sort of automatically places me differently in the eyes of my colleagues who are not in primary care. –

Dr. D. (attending), female, age 53

Dr. I. indicates that age and amount of time in medical practice can result in a physician being more respected.

But definitely between years one and five and year ten and up…so how long you’ve been in practice...-

Dr. I. (attending), female, age 41

Further, while respondents may not be fond of the hierarchies that exist within medicine, they accept and participate in them. They may be critical of the criteria for and results of competition of cultural capital with patients and other physicians, but they are invested in the field of medicine (where this competition takes place). In other words, they have a sense of their place and a sense of the others’ place; this is what Bourdieu calls the habitus (Bourdieu, 1990). Physicians who participated in this research understand that some of the criteria for cultural capital with patients or with other physicians may be based on criteria beyond their control, such as physician demographics. Other criteria seem to be merit-based, such as experience or medical specialty.
Cynicism toward the medical system

According to Haas and Shaffir (1987), another aspect of cultural capital (with other physicians) in medicine is cynicism toward the medical system. Cynicism toward the medical system can be determined by disillusionment with the institution of medicine or decreased idealism about the field of medicine. Cultural capital can be noticed (in a particular social field) in differences in talk, ritual, deference or demeanor (Bourdieu, 1986), which are acted out as the habitus. If physicians notice other physicians expressing frustration with the medical system within which they practice, they may learn that it is acceptable or even encouraged to criticize the medical system within which they practice. Plantz (2011) describes cynicism in the medical profession as, “feel[ing] like we are wasting our time and resources…We don’t know our patients’ names or life stories, just their complaints and diagnoses… Also, our impact on our patients and their behavior is very minimal. Sometimes it is hard to believe that we really make a difference, no matter what we do…All of these factors… would cause anyone to get a little distrustful, pessimistic, and even bitter” (p. 13). This cynicism would be part of the medical habitus; in other words, physicians learn this cynicism by participating in medicine. And if physicians feel like what they do doesn’t make a difference, they would not see a purpose in having conversations with their patients about sexual health, particularly STI prevention. For the purposes of this research, medical system is defined as the United States healthcare system or the hospital system within which a physician practices medicine.

To determine whether or not these physicians were cynical toward the medical system, they were asked the following questions: How does the healthcare system within
which you work hinder you? How does the healthcare system within which you work help you? Overall, respondents feel dissatisfied with administratively imposed regulations such as billing practices and productivity pressures. When asked about hindrances to practicing medicine effectively, respondents emphatically mention their newly implemented Electronic Medical Record (EMR) system. An EMR is a digital version of a paper chart in a clinician’s office. It contains the medical and treatment history of the patients in one practice (healthcareitnews.com). Physicians who participated in this research seem to feel that the EMR is simply another hurdle imposed by healthcare administrators. They feel that the EMR is less efficient than utilizing paper charts for patient information.

The electronic health record they chose, especially for here, is not optimal. You might have heard that from a couple of people. Someone at another university said that [system at another healthcare institution] worked pretty well. This one is a problem. They didn’t do it to cause us problems. I think for most everybody, transitioning to the electronic health record is harder.-

Dr. C. (attending), male, age approximately late 70s

Like right now the biggest assault to the happiness in my job is the new EMR that we have. It is the worst system I’ve ever encountered. It erodes my desire to go to work, because I don’t want to touch it. And I was surprised at that. I’m not afraid of computers. I’ve been live on other EMRs. I knew it would be a challenge, but I had no idea how bad this was going to be. And I’m not super hopeful that this is going to get a lot better within the next couple years. Now, five years from now they might have worked most of the bugs out.-

Dr. Z. (attending), female, age 37

Other hospital system features such as billing practices and productivity pressures were also mentioned as hindrances to these physicians’ abilities to practice medicine effectively. Dr. K. believes that productivity pressures (seeing a predetermined number of patients per day) are to harmful to providing patients with the best care.
Sure. So we don’t…particularly in primary care…we don’t actually know how to measure those things that are important. So we don’t measure quality of care based on abiding relationships with patients, or we don’t measure quality based on care of the whole person. In fact, our quality measures are really about things we tend to do to people, one disease at a time. So, in some ways how we measure quality is the opposite of what I just defined that makes a good primary care physician. So, that actually can get in the way. We’re being differently paid. We’re being hired and fired on the basis of that. I guess the other big thing that everyone will probably mention in productivity pressures. Productivity defines just how many people you can crank through in an hour. So, that definitely gets in the way of things. So, we’re actually paid on a piece work basis versus trying to do things to help people be healthier. –

Dr. K. (attending), male, age 56

Considering Bourdieu’s concept of habitus (1990) as it applies to medicine, physicians learn to and are perhaps even encouraged to be resentful of administrative procedures. Fiscella and Epstein (2008) also consider billing practices (by way of insurance companies) to be another structural barrier to doctor-patient communication. Dr. W.’s statement highlights this point.

I think that primary care physicians aren’t given the credit they should be. They’re not reimbursed as much as other specialties, for which reason a lot of people tend to sway away from it. Plus I think…so if reimbursements are not as high, you’re seeing a higher patient volume to maintain an adequate practice… I’m not saying I’m against Obamcare. I’m not saying I’m for it, but I do believe everybody should have affordable insurance…-

Dr. W. (resident), male, age 35
Based on respondents’ answers to questions about medical system hindrances to providing adequate health care, cynicism towards the healthcare system within which they practice as well as cynicism towards the United States healthcare system exists. Such cynicism has been determined to be a component of cultural capital with other physicians (Haas & Shaffir, 1987). Mainly, physicians who participated in this research indicate frustration with administratively imposed medical record keeping in the form of the EMR as well as administratively imposed productivity pressure and billing practices. Others resent regulations by the federal government and feel that they take power away from physicians and lower the quality of healthcare provided to patients.

Declining prestige

Throughout many of the interviews, respondents mention that physicians’ prestige is declining; due to increased hospital system administrative regulation as well as government regulation, physicians have less power. There is a lot of cynicism among physicians who participated in this research about this sort of regulation. Respondents resent the involvement of the federal government and other external regulatory bodies (such as the Drug Enforcement Agency or the Food and Drug Administration). Specifically, respondents feel that government involvement is limiting physicians’ abilities to engage in patient-centered care and thus hinders physicians’ abilities to provide the best care possible for their patients.

We really don’t like how the government is intruding on our patient-physician relationship and our ability to make patient-centered choices and patient-centered care, and you know, all of these choices…and all of these efforts from the insurance companies and the pharmaceutical companies and to the Medicare and Medicaid to the DEA and FDA and all of these regulatory bodies that essentially tell us what to do when it’s our business. You know, we’ve carved this niche out, and we’ve fought pretty hard for it. We really know best. And the way we know
best is by having this confidential relationship that they can rely on called the physician-patient relationship. And if we don’t have that, it’s bad for everybody.

Dr. M. (attending), male, age 38

I won’t ever state whether I’m an opponent or proponent to Obamacare or whatever, but it’s a starting point of something. So I do think we need to make a change; I don’t think the change should have been formatted by the government. I only say that because of my concern that if you set a rule for the country you should be able to adopt it yourself. To me, if we need to take this on as a national component, whatever we develop for the nation should be accepted as the best standard for the people who designed it… And unfortunately, I think healthcare is becoming too political, and it can’t.

Dr. I. (attending), female, age 41

Dr. K. laments problematic productivity pressures but is more upset about the external influence of the federal government.

It hinders me with the…well a couple of things, it’s the time constraint we have with patients. We are expected to be productive. You have to find a balance between spending enough time with patients but also being productive where you’re able to pay your overhead and make a salary for yourself, something you’re comfortable with. I think that we’re basically forced to go into electronic medical record and e-prescribing. And I don’t blame [healthcare system in which she practices medicine]; the whole country has to do that. It makes doctors less efficient by…because the government has imposed all of these meaningful use criteria that really we have to do to make sure that our reimbursement is there, but it doesn’t benefit the patient. So, we have to document every visit, the medical status of a first degree relative. Well, when you have a cold, I don’t really care what your parents’ medical conditions are. It’s a waste of time. And I understand that it’s important, and I always document their family history. But I don’t feel like I have to document it every time and make sure, because it’s already in the chart.

Dr. G. (attending), female, age 40
Starr (1982) considers an alternate cause of the declining prestige of physicians: escalation of medical costs. Due to this escalation of medical costs, in the 1970’s, stricter regulation of medicine became popular in public opinion. This took some control out of physicians’ hands. Drs. K. and C. also believe that physicians aren’t as prestigious as they used to be; as a result, physicians have less control over the health care they provide and how much trust patients have in them.

Um, until recently, it’s almost been a taboo to criticize doctors. It’s just amazing how much unearned prestige doctors get. I think that’s changing. So I think that it can make doctors arrogant in how they approach things.-

Dr. K. (attending), male, age 56

Well I mean I don’t think that physicians are looked upon the same as they were back in the olden days. I think the practice of medicine had a more paternalistic approach…you know, whatever the doctor said, that was the bible. That was it. And I believe back in those days, it was probably safe for it to be like that. I mean, now I can’t honestly say that all of my colleagues have patients’ best interests in mind. Because, again, at the end of the day, this is a job, people want to get paid. Now who wants to work longer and harder than they have to? Who wants to deal with barriers? Who wants to deal with insurance companies? Who wants to deal with non-compliant patients?... So, I know that medicine has taken a drastic approach from the paternalistic approach to now patients are like…uh uh, let me go Google this and see you know…let me see what Dr. Oz says about this.-

Dr. D. (attending), female, age 53

**Entitled patients**

Not only do researchers identify cynicism toward the healthcare system as being part of cultural capital with other physicians, they also identify cynicism towards patients as part of cultural capital with other physicians (Becker et al., 1961; H. Luke, 2003; Haas & Shaffir, 1987; and Sinclair, 1997). When asked about the influence U.S. society has on medicine, many physicians stated that patients feel entitled as a result of an individualistic society, which makes them excessively demanding and have unrealistic expectations. Drs. J. and E. specifically mention that patients are very demanding. Dr. J.
Dr. E. then considers people having access to and being influenced by inaccurate information.

Americans have a very individualized feeling, and they seem entitled to everything. So, they basically come into my room, the clinic room and will say, “I’m here for my Percocet.” And I’m like, “I’ve never met you. Who are you? What are you here for?” And I think that basically the American idea that they should get what they want because they want it is really affecting medicine because we’re having problems seeing as many patients as we supposed to see in a day without being like, oh fine, here’s your prescription go away. I need to get on with the rest of my day. So, I think that people are writing too many prescriptions because there is that assumption that you’re going to the doctor, you’re going to get a prescription for something.-

Dr. J. (resident), female, age 30

Um, well, I think people demand certain things or…like the vaccination thing. Like people won’t get their children vaccinated, and I think it’s ridiculous, especially when there are studies that show time after time that things they were originally worried about autism and ADD, and it’s not related. So anyway, that kind of stuff bothers me.-

Dr. E. (attending), female, age 63

Further, Dr. Z. expresses that there is a delicate balance between empowering patients through education and respecting the authority and knowledge of physicians.

I spend a lot of my day having to basically sell my rationale for what I’m doing, which is time consuming and frustrating at times. There’s been somewhat of a backlash from the medicine that was practiced up until I was born…so probably in the mid 70’s…medicine took a huge shift and was very paternalistic where cancer patients weren’t even told they had cancer, because then they would be depressed and not try to fight to now the cancer patients are almost expected to see multiple oncologists and shop around…and that they are somehow qualified to decide who is offering them the best treatment.-

Dr. Z. (attending), female, age 37
Further, while many respondents appreciate that patients have more access to health information, they lament that much of the information is not accurate. Specifically, some respondents blame “quacks” such as Dr. Oz, who is a cardiothoracic surgeon, author, and television personality. Research conducted by Korownyk, Kolber, McCormack, Lam, Overbo, Cotton, et al. (2014) finds that Dr. Oz’s television show (which provides dietary and other health advice), *The Doctor Oz Show*, was ranked in the top five talk shows in the United States. However, these researchers find that evidence supported only 46% of this show’s recommendations, contradicted 15% of the show’s recommendations and was not found for 39% of the show’s recommendations. As a result, Korownyk et al. (2014) urge the general public to be skeptical of recommendations made on *The Doctor Oz Show* or other medical talk shows.

“Quacks” create a misinformed general population. This often leads patients to believe that they know more about their health than their physicians. Direct-to-consumer advertising has influenced patients and made them feel that they have sufficient information to request a prescription drug or particular test. I think society has placed physicians in a place where we have to really be on our p’s and q’s. Because patients are more educated, they are armed with, “why do I have to do this?” why do you want me to take this? And sometimes that gets on your nerves, but I like it, because at the end of the day, patients should know about that. In the old days, you didn’t ask why, you just did. Sometimes the misinformation is just how they interpret it….My all-time favorite Dr. Oz story is an 18 year old patient of mine who came in and insisted that she needed a colonoscopy, because Dr. Oz said she needed to be screened for colon cancer. And no matter how much I went back and forth her about unless you have a strong family history for colon cancer, you do not start screening until you are 50. And she was not hearing that. And that the end of the day…she actually left me, because I wouldn’t order it. And I said, honey, I bet you that you went to the bathroom and was texting or was on the phone…you missed the key point when he said that screening starts at 50. Because I know Dr. Oz didn’t…there’s nothing he said that made you run in here at age 18 and say that you needed a
colonoscopy. I said, I know...this is after going through...she did not have a strong family history...no other reasons to do it. I said, you have to have missed something he said...

Dr. D. (attending), age 53

I think it is...there’s a lot of different pieces. On a patient perspective, there’s an enormous media influence. Patients now often come in and basically want something, like, let’s just make it simple. They want an antibiotic. I have to almost have to defend myself as to why I don’t think they need one. And we’ve created a very demanding population and we’ve created a very misinformed population. There are so many outlets out there...the number of times in one day that I hear the words “Dr. Oz....” is amusing to say the least...or Readers’ Digest...neither of whom I consider to be great medical resources. But anyhow, there’s a lot of information out there. It’s not all necessarily scientific or helpful. And so many people think they’re better informed consumers than they are.-

Dr. Z. (attending), female, age 37

**Maintaining social capital**

As previously indicated by respondents, Starr (1982) and Jenkins (2014), physicians are becoming less powerful as a group. However, they still have a significant amount of social capital, or networks and the norms of reciprocity associated with them (Putnam, 2002). Other physicians with whom physicians practice medicine are part of their social network, through which they can gain social capital. Thus, social capital is like having a reliable social support system. Putnam (1995) posits that social capital can also include various features from a social organization or business, such as norms, trust and networks. In this study, respondents consider their colleagues (within the hospital system they practice) to be assets and may contribute to their social capital as a group of physicians who are part of a particular hospital system.
So, they have, the doctors come down here to meet you, the surgeons and different things. And they want us to refer to them, but they do it in a proper way, and they follow through on what they will say. The chief of surgery gave me his cell phone number, and I’ve called him up a few times and say, “Hey I have this patient, which doctor should he see?” And he says, “I’ll take care of it.” And we get the patient admitted and things like that. It’s amazing. I’ve never seen anything like that anywhere. The doctors and the medical care are fantastic. –

Dr. E. (attending), female, age 63

I’ve got great peers. I’ve got great colleagues to refer to. I can make as much complaint about them giving me a bad EMR system, but I didn’t have to do any work as far as picking it out, because the stats out there are that even if you do a good job vetting a program, it’s still a piece of crap. And you end up being like I just wasted every evening for the past six months on this thing, and it’s still crummy. So this way, if you’re going to wallow in this lump of crap you may as well have your evenings free.-

Dr. M. (attending), male, age 38

Other respondents find the lack of administrative/business responsibilities or concerns as the most advantageous feature of their hospital system.

They help because I’m able to practice medicine with some security and some freedom from running a practice, like setting up contracts and doing…working out billing…not that they’re doing that well. So, they’re hindering that. And I have flexibility in my schedule; so I can do different things, which I do. I purposely don’t fill up my schedule all week, because I never wanted to do medicine all week.-

Dr. P. (attending), female, age 57

In terms of the way they help, I don’t have to deal with a lot of insurance companies. I don’t have to be on the phone with them. My malpractice is taken care of. We have access to a legal team if we have any questions, or god forbid a case came up.-

Dr. G. (attending), female, age 40

Increased regulation by hospital system administration as well as the federal government along with increasingly entitled patients have led to decreased levels of prestige among physicians. Because of productivity pressures, inefficient billing practice and the politicization of health care, these respondents feel that there is too much external
influence on how they practice medicine. In addition, increased patient access to information (which sometimes lacks validity) has made patients excessively demanding and have unrealistic expectations from physicians. Such patient behavior makes physicians feel defensive. However, maintaining the social capital they still have remains important among physicians who participated in this research, as there are certain aspects of practicing in their particular healthcare system they appreciate, such as a low level of administrative responsibilities and highly competent peers.

**Conclusion**

Many of the physicians who participated in this research learned how to interact with patients by observing more senior physicians, attendings. Regarding prestige in the medical field, respondents tend to distinguish between cultural capital with patients (success), which is the same as patient-centered care and cultural capital with colleagues (influence and prestige), which is more traditional and exists in the form of published research. Interestingly, most respondents don’t see cultural capital with colleagues leading to cultural capital with patients or vice versa. Further, because primary care providers are not as respected as other types of physicians, they tend to care more about cultural capital with patients.

Respondents are cynical about elements of the hospital system in which they practice medicine, as they also affect their interactions with patients. Specifically, implementation of a new EMR system makes health care visits less efficient. Additionally, productivity pressures of most hospital systems make the number of patients a physician sees more important than the quality of care that physician actually provides. These system-level elements along with increasingly entitled patients with
greater access to information that isn’t always accurate make it especially challenging for physicians to bring up an important issue like sexual health, especially STI prevention.
Chapter 6: Why bother having conversations about sexual health?

Introduction

This research is intended to uncover influences on physicians’ interactional styles with patients. As previously, physicians don’t talk to their patients about sexual health very often (Cant, 2005; Foucault, 1978; Friedman & Bloodgood, 2010; Kingsberg, 2006; Lewis & Freeman, 1987; Macdowall et al., 2010; Porter & Ku, 2000; Schwartz et al., 1991; Tao et al., 2000), and they should, because sexually transmitted infections are on the rise (CDC, 2014). This chapter explores why physicians don’t talk to their patients about sexual health and will discuss what modern sexual repression looks like in doctor-patient communication about sexual health. A major theme that emerged during interviews with physicians is a lack of physician-initiated conversations about sexual health. Many physicians discussed that they don’t believe STI prevention conversations to be very effective. This belief that STI prevention conversations are not very effective emerged as a novel form of cultural capital with other physicians, as it seems to be an extension of cynicism towards the medical system.

Further, physicians seemed more concerned with patients’ comfort levels than with preventing sexually transmitted infections (STIs). Physicians also considered their own comfort levels as well as structural barriers to sexual health conversations in the hospital systems in which they practice. Patient gender and age was brought up by many physicians as another influence on whether or not they initiate conversations about sexual health. In addition, physicians discussed when and why it is appropriate for primary care
providers to talk about sexual health with patients. They also divulged which sexual health topics they believe are appropriate to discuss with patients.

**Modern sexual repression**

Although every physician participating in this study indicated that it is appropriate for primary care physicians to discuss sexual health with their patients, in practice, they are quite selective about when they actually have such conversations. They also don’t believe that STI prevention conversations are effective. Medicine, like other institutions, is influenced by cultural taboos on the discussion of sex with anyone other than physicians, psychiatrists and psychologists (B.S. Turner, 1997; Foucault, 1978). Foucault (1978) calls this modern sexual repression. The repression stems from the highly regulated way that only a powerful few are deemed appropriate moderators of discussing sex-related topics. This modern sexual repression may be a reason that it is difficult for physicians to discuss matters of sex.

**(Lack of) physician-initiated conversations**

When first asking physicians who participated in this study about the appropriateness of primary care physicians discussing sexual health with their patients, they were emphatic that it is completely appropriate. These physicians unanimously agreed that it is appropriate for primary care physicians to discuss sexual health with their patients, mainly because sexual health is part of overall health.
Well sex is part of health and a part of unhealth as well…I have the entire sex ed conversation…I mean, I try to talk about this because otherwise people tend to do things wrong, because there’s not a lot of good information out there, I think the percentage of good sexual information versus all that’s available is probably even less than the [good] nutrition information that’s out there. –

Dr. Z. (attending), female, age 37

Yes, because it’s one of the things health care can do to keep people from being sick and can make people healthier if they are.-

Dr. K. (attending), male, age 56

Because they tell us everything. We’re the ones who are privy to their inner most thoughts. So if they’re having affairs or adultery…we’re their vault of secrets essentially. And we’re the ones responsible for their care. So, sex, intercourse…even the mind…the whole intellectual or emotional part of sex is very much related to their other health, I think, and their well-being, and exercise. All of it is interconnected. So if we’re not addressing it, we’re…it’s a huge component of our lives.-

Dr. J. (resident), female, age 30

Drs. J., K. and Z. agree that sexual health is a component of all other aspects of health. However, Dr. Z. focuses more on the educational role of primary care providers, while Dr. J. considers primary care providers to have a role similar to a counselor. Dr. K. considers the role primary care providers play in disease prevention.

Other reasons given for having sexual health conversations with patients are to engage in education and prevention regarding sexually transmitted infections (STIs) and to engage in education and prevention regarding pregnancy. However, when asked about how comfortable they are bringing up sexual health and how often they actually discuss it, many respondents indicate they only bring up sexual health if a patient has a symptom that could be attributed to an STI.
Yes, because we’re covering almost everybody from babies to adults. There are women that just delivered a baby or going into prenatal care, we have to ask them about their sexual habits, because we are worried about STDs or their regular sexual health I guess. A lot of the young teenagers I have to ask their parents to leave the room, because they’re already starting to have sex. So I ask the parents to leave. So I do think it’s an important part of our visit, especially for the younger kids, because when you’re trying to prevent diseases or promote good health behavior, like sexual health is a huge component of that, especially with those young age groups.

Dr. F. (resident), male, age 31

It’s important to discuss with patients about prevention of STDs, prevention of early pregnancy, especially with the significant increase in the number of herpes cases.

Dr. G. (attending), female, age 40

While Dr. F. still has a prevention focus, he tends to narrow the prevention efforts to younger age groups. Dr. G. also has a prevention focus, but has incorrect knowledge about which STIs are actually on the rise in the U.S. population. Dr. G. is the only physician who mentions any specific STI by name (herpes), and it is not increasing (CDC, 2014) on a national level. Dr. G. does not indicate whether he believes herpes cases are on the rise for his practice, however. It is difficult to determine if herpes is on the rise locally, as that information is not included in the Cleveland Department of Public Health’s 2012 STD report.

Researchers find that physicians lack proper knowledge about STI prevention (CDC, 2014; Jain et al., 2006). The CDC (2014) finds that primary care physicians have poor knowledge of the CDC’s HIV screening recommendations as well as of actual HIV transmission risk of their patient population. Jain et al. (2006) find that less than half of their sample of family physicians had proper knowledge that HPV infections can clear up spontaneously.
Physicians lacking knowledge was not mentioned by any respondents. This may be because according to H. Luke (2003), physicians benefit from reinforcing their status as experts. If they admit that they do not have adequate medical knowledge about a particular condition, their cultural capital may diminish. Some physicians did mention that some sexual health topics are more challenging, because they are not as easy to resolve. Therefore, the same concern with cultural capital (with patients) may influence why physicians are reluctant to bring up sexual health: they can’t fix the problem. And if they can’t fix the problem, they don’t seem like experts.

Oh actually the other thing would be whether or not you actually have something you can do for what you uncover. If someone has an unsatisfying sex life, what are you going to do about that? We don’t get much training in counseling people about that. So people don’t want to open up something they don’t have a good response to. So your ability to respond or people you can refer to for that…I think that’s fairly limited. It’s easier just not to deal with it. –

Dr. K. (attending), male, age 56

You don’t really want to open up the can of worms about the women’s libido, because you can’t do anything about it anyway. Doctors can't fix things; they can help people manage. Doctors aren't shamans.-

Dr. L. (attending), female, age 43

Both physicians indicate that they don’t want to discuss problems they can’t correct. While Dr. K. mentions that it is easier not to deal with patients’ sexual problems, it may also be because he doesn’t want his patients to lose faith in his ability as a physician (to provide a remedy to his patients’ sexual problems).

While the aforementioned physicians mentioned that they don’t always bring up sexual health with their patients, because they are concerned that they won’t be able to fix that type of (complex) problem, only one of the 17 respondents admitted to being somewhat uncomfortable discussing sexual health simply because of the subject matter.
However, respondents’ answers to other questions about comfort levels with sexual health discussions indicated that there are many caveats (mostly related to the patient’s reason for the doctor’s visit) to when sexual health is actually discussed. Macdowall et al. (2010) find that many primary health care providers have difficulties discussing sex-related topics with their patients due to embarrassment as well as a lack of confidence and a lack of expertise.

It is kind of hard for me, but it depends on what we’re talking about. I mean, I’m not a sex therapist. So if it’s for something like that, I’ll refer them. Or sometimes it’s depression or something else. So if you treat that, it will get better. And sometimes it’s medication and sexual dysfunction…

Dr. E. (attending), female, age 53

Dr. E. echoes the sentiments of Drs. K. and L. regarding the discomfort with the potential for an unresolved complaint but adds that she is just generally uncomfortable discussing sex with people. As will be outlined throughout this chapter, many of the physicians’ chief complaint-related caveats may actually be due to their own discomfort with talking about sex. But only Dr. E. is candid about such discomfort.

Overall, there seems to be a lack of prevention conversations, with more of a focus on complaints related to reproductive organs or the urinary system.

I mean, when they’re having an emergent issue, it’s probably not the time to bring it up. But when you’re first meeting a patient, it’s good just to get a baseline. When they see…when there’s certain issues that when they come in, you go, okay that’s a perfect time to talk to them. And then there are other times, and if they’re here for a sinus infection, it might not be the best time. When they’re in for a physical, it’s definitely a good time to go into that with all of them. Sometimes with women when they come in complaining of bladder infections or anything that involves belly pain or anything that could involve female organs; it’s definitely a good time to talk about safe sex, um…things such as that.

Dr. R. (attending), male, age 35
It is more appropriate to bring up sex during well-care visits, UTI concerns or abdominal pain concerns.

Dr. L. (attending), female, age 43

While many physicians do mention bringing up sexual health during well-care visits, more respondents seem to focus on situations during which a patient has a chief complaint that could be caused by an STI, making STI prevention conversations less likely.

**Why don’t doctors talk to their patients about sex?**

Liddicoat et al. (2004) determine that physicians often do not have enough time for or are discouraged from using their time to engage in meaningful conversation with their patients, much less approach a sensitive subject like sex (Chuang et al., 2012; Kingsberg, 2006). Tsai et al. (2011) find that the average office visit time length has increased to 21.77 minutes. However, the number of clinical items addressed per visit also increased from 5.4 items to 7.1 items. As a result, there is less available time (a 13.6% reduction) to address individual clinical items. Chorba et al. (2004) and Macdowell et al. (2010) also determined that time constraints are a major barrier to patient-centered care and discussion about STI prevention. When asked what prevents physicians from initiating more sexual health conversations, a majority of respondents mentioned time constraints. They also mentioned that sex is a complex topic that takes extra time, that they are uncomfortable with the topic of sex, that patients are uncomfortable with the topic of sex and that sexual health is a low priority. Dr. C. mentions having too many issues to cover during visits; however he (incorrectly) believes that the amount of time all physicians have with patients has also gone down.
I think the amount of time’s gone down. Everybody’s under much more pressure to see patients faster. You just don’t have the time. My wife is a family doctor. She’ll have 16 or 17 patients in an afternoon, and they all want pap smears and they all want this, and they all want that, and some of want a physical. So, what can you do? You can only do so much. So I think it’s opposite. Time’s gone down. Everybody’s pressed. So I think that’s probably it as much as anything. If you’re pressed, you’re only going to do what you have to. –

Dr. C. (attending), male, age approximately late 70s

When asked what prevents more physicians from bringing up sexual health conversations with their patients, Drs. H., I., T. and W. focus on inhibitions. Drs. T., W. and H. also mention time constraints. It seems that like Dr. C., what Dr. H. means by time constraints is really an increased number of clinical items to address in one visit, whereas Dr. T. and Dr. W. focus on the reason for the patient visit or chief complaint.

Their own inhibitions, number one. Number two-the inhibitions of their patients. And number three-time. There are millions of things you need to go through with your patients. And especially the U.S. public health service saying there’s no reason to do physicals. They’re questioning annual physicals. But, that’s the one time you get more time and can do more preventive care. On the other hand, there are so many things you’re trying to cram in often that there still is not enough time. I book a half an hour for a physical and it winds up…especially with an older person or a multi-problem person… taking me forty five minutes, especially with the amount of time the electronic medical record takes. It takes me fifteen minutes to document a physical. So there’s always the pressure of time. There’s always the pressure of everybody’s inhibitions. There’s always the pressure of expectations. We already mentioned the patient expects you to already know it by osmosis and to communicate it without embarrassing them. It’s a difficult negotiation. –

Dr. H. (attending), male, age 67

Their own comfort level, and I don’t think they get it. There’s a generational component. Most of them can’t discuss sex, because they have no idea that they’re…I don’t know what they’re called…but the parties where they go around and swap oral sex partners that you hear about…but I hear about…they know not to have vaginal intercourse, so they have oral sex. And yeah, they’re like it can’t get me pregnant. And that is the thing in high school now. I can’t even imagine telling my dad about this…he used to be a family doctor.-

Dr. I. (attending), female, age 41
Well they probably don’t have time. That’s number one. Comfort level, if a patient comes for elevated blood pressure, you probably don’t even think about sexual life or…those would be the main things.-

Dr. T. (attending), female, age 38

Many reasons-one: primary care physicians are very busy. Two: that’s not the center of the focus of the appointment a significant number of times.-

Dr. W. (resident), male, age 35

Dr. L., like Dr. H. and Dr. C., mentions time constraints, but also seems to mean that physicians have a large number of clinical items to address in one visit, which makes it seem like there is less time. When considering physician reluctance to bring up sexual health with patients, Dr. L. (like Dr. H.) indicates that some physicians may not be comfortable with sexual health as a topic. Further, Dr. L. refers to physicians’ medical school and residency experiences as possible explanations for their reticence to initiate sexual health conversations.

Time, you know, feeling like you’ve got to go through and do the cholesterol and the diabetes screening… There are reservations there, because there is such a long list. If you have the benefit of all of this time you’d probably also have a conversation about exercise and health and a healthy sex life and all of these kinds of things. So if people come to me with that, we can do there, but some of it’s time. I’m sure some people are squeamish about it or maybe they didn’t have it modeled for them.-

Dr. L. (attending), female, age 43

Researchers also cite competing priorities, time pressures, lack of organizational structures/structured testing systems and differing mandates of health departments and managed care organizations as barriers to STI prevention with patients (Liddicoat et al., 2004; Chorba et al., 2004). According to Liddicoat et al. (2014), physicians have a limited amount of time with patients; as a result, they must prioritize clinical items that
can be addressed during the short time they have with patients. Therefore, STI testing is a low priority in terms of clinical items to be addressed during most healthcare visits.

Liddicoat et al. (2004) point out that clinics other than those focused on STIs generally do not remind their physicians to test patients for STIs. These reminders (when present) are often in a patient’s chart or electronic medical record. If physicians don’t receive these reminders, it is more difficult for them to remember to discuss sexual health with their patients. Further, Chorba et al. (2004) find that managed care organization physicians may not offer STI testing to patients if they believe the patient’s insurance will not cover STI testing. Regarding the differing mandates of health departments and managed care organizations, managed care organizations have financial responsibilities to their sponsors to limit expenditures (i.e., preventive care) while health departments are supposed to serve communities and engage in disease control (including STI control).

However, none of this research’s respondents mentioned lack of organizational structures, a lack of testing systems or differing mandates of health departments and managed care organizations as barriers to STI prevention conversations. Dr. J. indicates that sexual health conversations are a low priority to many of her colleagues. She also echoes sentiments similar to those of Drs. T. and H. that some physicians are not comfortable discussing sexual health topics with patients at all.

Probably because they’re uncomfortable talking about sex related things. Also they probably have less time and don’t think it’s as important, whereas I think it’s very important. So yeah, the comfort level…I’m trying to think of my other co-workers who don’t ask about it and why they don’t ask about it. It’s not something that matters to them. -

Dr. J. (resident), female, age 30
Essentially, this lack of clinical time results in health care providers only providing services to patients whom they consider high risk (Montañó et al. et al., 2008). Tao et al. (2000) find that being under the age of 45, male, single, and having a household income below the federal poverty level were positively associated with conversations about STI prevention. According to the CDC (2014), young men and women of color as well as men who have sex with men have the greatest risk of contracting an STI. Respondents mentioned teenagers, young, black men, homosexual people and people who engage in other risky behaviors as being high risk groups. Drs. K. and T. speak more vaguely about with which type of patients they would discuss sexual health.

The other is if there’s something that comes up that would make you concerned or the patient’s brought it up and it makes you concerned. Or the patient brought it up and it’s a cause for possible concern or just based on their demographic group that they’re at risk. –

Dr. K. (attending), male, age 56

Well, if there are several episodes of sexually transmitted diseases, I might find that maybe this the time to ask questions about what they’re not doing correctly.-

Dr. T. (attending), female, age 38

Drs. H., G. and Z. identify specific groups with whom they are more likely to have a sexual health conversation: teenagers, black men, people who are gay or lesbian and people with substance abuse issues.
Well, the standard is that a lot of young, black men will come in and say, I just want a check-up, which seems to be code for I want to check for STDs. I immediately think of that. And the question is, is that what you’re really asking for. And again, patients have this almost magical thing. If they get a check-up well, they’re going to be checked for everything, which is going to mean STDs… I don’t explicitly, routinely ask about STDs… Obviously a genitourinary complaint, um… a women who has had an abnormal pap, um… somebody who tells me they’re gay… uh… somebody who tells me they’re sexually active and not using any birth control… any protection.

Dr. H. (attending), male, age 67

People who have a lot of substance abuse issues, I go there, because again, they may be trading sex for drugs. They just may be engaging in risky sexual behaviors that I would prefer to intervene on ahead of time. I even often bring it up if I have a patient that always seems to be coming in with a new tattoo, because we have a ton of Hepatitis C, and it’s growing. And I have had a few patients that have had Hep C from their tattoos, because they get it done by their friends. So I always just ask, oh I’ve noticed that you’ve been getting new tattoos. Are you getting them at a licensed parlor by someone who has their livelihood on the line if they don’t follow the rules? And do you watch and do you know what to watch for? And if they say any no’s, we’re going to do a Hepatitis C screen with their permission and also a sexual history, because if I think this patient is at risk for Hep C or HIV, then I need to make sure they are not exposing anybody.

Dr. Z. (attending), female, age 37

I think there’s always a good point to bring up at your physicals for your adolescents… if they’re coming in with symptoms.

Dr. G. (attending), female, age 40

Physicians who participated in this study cite competing priorities and time constraints as organizational or structural reasons why they do not discuss sexual health with their patients more often. As previously mentioned, Liddicoat et al. (2014) find that physicians have a limited amount of time with patients; as a result, they must prioritize clinical items that can be addressed during the short time they have with patients. Therefore, STI testing is a low priority in terms of clinical items to be addressed during most health care visits. Essentially, this lack of clinical time results in health care providers only providing services to patients whom they consider high risk (Montaño et
al et al., 2008). Only three respondents indicate that they determine when to bring up sexual health by a patient’s demographics or other risky behaviors.

### (In)effectiveness of STI prevention conversations

Another potential explanation for a lack of sexual health conversations is that physicians do not believe they are very effective. Frank et al. (2008) find that even in medical school, many students do not believe safe sex counseling will be relevant to their practice of medicine. Similarly, many physicians participating in this research indicated that physician-initiated conversations about STI prevention are not very effective; fewer indicated that such conversations are only moderately effective.

It seems that this belief that STI prevention conversations are ineffective is a novel form of cultural capital. It may be an extension of cynicism toward the medical system and burnout. Physicians may informally learn from other physicians that initiating conversations about STI prevention does little good; as a result, they may be disinclined to initiate such conversations. Especially since most of these physicians indicated that sexual health is an uncomfortable topic anyway.

I would like to think it’s effective, but I honestly don’t think it’s that effective.-
Dr. F. (resident), male, age 31

Probably not very-because the education has come from someplace else already. It’s such a public…I think the knowledge is public enough, but I may be wrong. I think there was a big push for it for a while, and then I’m not sure it’s as topical all of the time. When AIDS was raging, I think everyone knew about STD prevention, but AIDS isn’t in the news anymore.-
Dr. P. (attending), female, age 57

Once again, a respondent, Dr. P., demonstrates a misunderstanding of STI rates by stating that HIV/AIDS is no longer a major public health concern. According to the CDC (2014),
HIV is still a public health concern. Further, Dr. P. references public knowledge. However, respondents express concern over the quality of the public knowledge patients can access about their health.

Others stated that the effectiveness of STI prevention conversations depends upon the physician’s relationship with their patient, more specifically, it depends upon gender concordance between the physician and their patient, the patient’s age or the patient’s gender.

I think it’s probably more effective if you have a relationship with the patient, because then they can keep coming back. You can keep revisiting it. I don’t know what other people do, but with teenagers, and even people in their early 20s, I give the whole spiel…And usually the parents are like avidly interested, because they don’t know that. And that’s why I like doing it with mom and dad in the room, because then hopefully they will go home and discuss it if I make it funny. Then they have a way to discuss it in a third person way… And if the parents seem uncomfortable, I call them on it in front of their kid, because I say to them…it’s not uncommon. A lot of parents don’t know how. But again, that’s normal. There’s issues for everybody. I want parents to have accurate information. So I’m educating the parents; so if the kids ask…and I also want the parents to be in the room understanding this is part of your job as a parent, to assess this and talk about this and be a part of this communication…-

Dr. Z. (attending), female, age 37

I think it is important. I never realized that a lot of younger patients…female patients or male patients…they don’t know anything about STDs. I never really thought that in our society so many people are so uneducated about anything, because my kids are getting education about that when they are in 7th grade. So I thought all of them did go through. But some kids don’t pay attention to those things or maybe their parents never talk to them about that. So I think it’s very, very important. –

Dr. T. (attending), female, age 38

Regarding effectiveness of STI prevention conversations, like Drs. Z. and T., many respondents focus on STI prevention with younger people. Both of the aforementioned physicians indicate that parents play a crucial role in educating their children about safer
sex practices. Physicians who participated in this research are quite discerning about with whom and when they initiate sexual health conversations, and perhaps that is at least partially because they don’t feel that the conversations are worth the awkwardness that may ensue. In other words, why bring up sexual health with a patient if it isn’t going to make a difference anyway?

**Gender and age**

Another factor that affects whether or not physicians initiate sexual health conversations is physician gender. According to Macdowall et al. (2010), male practitioners are reportedly less likely to discuss sex-related topics with their patients and often referred patients to female colleagues to discuss such topics. Further, according to research conducted by Sandhu et al. (2009) and Bertakis et al. (2009), both physicians and patients are most comfortable during gender concordant visits. Drs. P. and Z. specifically mentioned that potential for harassment from male patients: both felt comfortable talking to their patients about sexual health unless their patients were viewing them as sexual objects. They said that this has become less of an issue as they get older.

Sometimes, as I get older, it’s easier to ask men about sexual function. When I was younger it was harder, because I was still an object. I’m not an object anymore.-

Dr. P. (attending), female, age 57
The only time I’m not comfortable is if I feel like there is a patient…in residency we took care of the jail population, and it was hard with some of the guys who were in prison for sexual assault who would look at you, when the whole topic came up, especially then, because I was in my late 20s, I was feeling much more insecure. Now I’m older and I have grey hair, and I’m not as worried about it. But at the time, I felt like that was the only time I didn’t feel comfortable…like I may become the victim…if the guy has made inappropriate comments towards me, then I feel uncomfortable bringing up sexual health. Then I will usually just then refer that person to a different provider. Because if I’m not comfortable managing their needs, then they need another provider. There’s really only been one that I truly had to do that with. There was another that I was a little uncomfortable with. And again, I was in residency. I was much younger, much less practiced, and just much younger. So I think you feel more victimized and more…I don’t think too many of my patients are hitting on me anymore, which is okay. It’s a perk. You know, some of those patients…it’s not the issue that it used to be. But, that’s the only time is when I feel unsafe.

Dr. Z. (attending), female, age 37

More often however, respondents would mention that they feel more comfortable discussing sexual health with patients who are the same gender as they are.

I am, mostly with females. Males, you know, they try to be more shy; they want to talk to the male doctor. And it’s normal and understandable. But with female patients, I do talk to them about everything.

Dr. T. (attending), female, age 38

With males, not a problem. Females, I get a little more uncomfortable with it, and I tend to be much more…I mean certain topics, pregnancy avoidance, avoidance of sexually transmitted diseases, I’m pretty comfortable with that. If we start talking about sexuality, I’m not quite as comfortable with females. Males, it’s like…again…it’s the gender concordance.

Dr. R. (attending), male, age 35
And because we are both out there, I will sometimes notice that a male patient who is in their 50’s or 60’s who usually sees me will suddenly be on doctor’s [in the practice] schedule. And I’m like, oh, somebody’s having erectile dysfunction. And that’s okay. And a lot of his patients when they have female sexual concerns, they will come see me. He has even started referring most of his pap smears to me. I have…I do colposcopies. I have more women’s health training, but I mean, I have somewhat of a specialty within the women’s health thing. So I think he just feels like that is more of my expertise. But I think a lot of his patients do open up more on the female side with me. And I don’t confront them about that. If they feel more comfortable with him, that’s fine. There’s nothing wrong with this being addressed. –

Dr. Z. (attending), female, age 37

Drs. T. and R. indicate that they and their patients feel more comfortable when conversations about sexual health are gender concordant, whereas Dr. Z. focuses more on what makes her patients more comfortable.

Another demographic factor commonly brought up by respondents is patient age. While physicians mentioned that they often bring up sexual health topics with their teenage patients, there are other complicating factors. There is an assumption that teenagers can’t or won’t discuss sexual health topics in front of their parents.

…it’s not always…I can’t really describe it. I’m trying to think of a situation where I’ve not asked the parents to leave. But I feel uncomfortable, because a lot times the moms are like, oh we know everything about each other. We know that she’s on this birth control; she’s having sex with this guy. Or they all come into their visit together, and I feel uncomfortable. I still sometimes ask the parent to leave, or like when I first started, I wouldn’t even talk about it.

Dr. F. (resident), male, age 31

If they’re a teenager, sometimes you don’t know where to start. And usually the mother is there; so that’s always a sensitive thing.-

Dr. C. (attending), male, age approximately late 70s

Further, many respondents indicated that they do not believe they need to have sexual health conversations with older people, even though STIs among the elderly are on
the rise (CDC, 2010). Similar to Dr. G. believing that herpes cases are on the rise, Drs. B., T. and Z. incorrectly that STI prevention conversations are less relevant to older people.

The old people are less comfortable talking about it, and so I am too, probably. And I guess I’m not very comfortable talking to my own colleagues about it if I happen to be in a medical situation or my own kid. Well, I mean, I talked to them when they were children, but not when they are adults, unless they ask.

Dr. B. (attending), female, age 61

Elderly patients you probably don’t talk to too much about that, just because their sexual life is not as active, maybe…you never know. So unless they bring up something…we definitely ask just general questions, but I wouldn’t really go into details with a 65 year old about their sex life, unless she has some questions for me. -

Dr. T. (attending), female, age 38

I try to talk to almost everybody. I don’t always bring it up if I have a widowed elderly person who lives by him or herself and isn’t involved and isn’t complaining about anything. I don’t always go there…I don’t always just open it up with an 85 year old man. You know, like hey, how are those nocturnal erections these days? Because, he might pass out, but if it seems appropriate or a problem, then I do. -

Dr. Z. (attending), female, age 37

**Patient comfort level**

There seems to be more of a concern with politeness or not making the patients uncomfortable than there is with making sure patients are safer (from STIs) and healthier (sexually). So, if a patient seems uncomfortable discussing sexual health, a physician won’t bring it up or will stop asking questions about sexual health. This seems to echo Foucault’s (1978) notion of modern sexual repression, as conversations about sex are still avoided or even taboo in medical encounters. Research conducted by Villaamil (2013) indicates that after initial encounters, safer sex concerns are only discussed if the patient
initiates the discussion, because physicians often feel uncomfortable dealing with issues regarding patients’ intimate lives.

You don’t want to leave it out if it’s germane, and you don’t want to bring it up if it’s going to upset people. That’s probably the trickiest.-

Dr. C. (attending), male, age approximately late 70s

I won’t push it if someone seems uncomfortable. I think most of the time I bring it up, if it’s a young person, depending on what they’re there for. If it’s just a routine visit or if they come in for like a headache, then I might not go into it completely. But if they’re there for health maintenance or to establish a PCP, then I’ll go into it.-

Dr. F. (resident), male, age 31

Further, Drs. W. and J. indicate that it is a patient’s responsibility to initiate conversations about sexual health.

… So a lot of time, that’s actually at the discretion of the patient. They don’t feel comfortable bringing it up until they finally realize this is my last chance to quickly say something and maybe get…and a lot of the times when they say it, it’s too late in the sense that you’ve already got three patients roomed, waiting for you. You’ve already billed them for this appointment. So irrespective of if you’re going to open up their note or if they’re going to maybe have to get a new ticket made. Or you just don’t have time. So a lot of the times it’s the patient themselves. A lot of the times the physician just doesn’t have time. Because you’re a primary care physician, you’re not just dealing with one problem… Sex is um…it’s a very personal thing, and a lot of people don’t feel comfortable talking about it. They really don’t. So, they’ll hide those little secrets. People coming in with vaginal discharge for the last two years. Really? Now you’re deciding to tell me?-

Dr. W. (resident), male, age 35

Also, I don’t think a lot of patients will ask about a lot of things. And I don’t think a lot people will discuss it. They won’t ask the patient about it. And if the patient is uncomfortable or just shy or whatever, they aren’t going to bring it up.-

Dr. J. (resident), female, age 30

Dr. W. states that patients don’t feel very comfortable talking about sex, because it is a very personal matter. So, if they do bring it up, they bring it up at the end of the visit,
when there is little to no time left to discuss sexual health matters. He also mentions that physicians don’t have time to discuss sexual health, because they are dealing with a multitude of other, more pressing patient concerns. Dr. J. states that not only are patients uncomfortable, but physicians are also uncomfortable. And as a result, physicians won’t initiate conversations about sexual health.

When considering patient comfort level, some physicians mentioned that they are uncomfortable asking their patients about their sexual orientation, because the patients get offended.

I’ve tried asking do you have sex with men, women or both, and I’ve had a really bad response to that. Patients don’t like being asked that question, at least in my population. They’re just like…the women are like, “obviously men.” And the men are like, “obviously women.” And I’m like, oh I ask everyone. It’s no big deal. I don’t care. -

Dr. J. (resident), female, age 31

The one thing that I initially had difficulty doing, because I didn’t want patients to think I was judging them was…I’m very conscientious of asking, especially my younger patients, you know…do you have a boyfriend? Do you have a girlfriend? Initially, I was like, well I don’t want them to think that I think that they are, not that that’s a bad thing, but I don’t want them to perceive any negative connotation, I guess. So I try to make it a point with my adolescent patients to ask about both genders, and a lot of times they laugh, and they’re like, “No.” And I’m like, well I just have to ask. And then other…once in a while, I’ll get the yes to the same gender, and then we direct the conversation that way without a blink of an eye. You read about a lot of kids who are suppressing their sexuality because of a fear of retribution. I think that opens doors that way, that it’s okay and that there’s nothing to be scared of. Some of them will come out and tell me and other people kind of assume that I know. You know, I don’t know. So you know, I don’t assume things. So that’s my area of discomfort and that’s about it. -

Dr. G. (attending), female, age 40

One physician mentioned that physicians haven’t always asked their patients about their sexual orientation.
In my number of years, the issue with guys that’s gone from how many girls have you been with to are you sexually active with men, women or both. That’s not new for the people that are being trained now, but it’s new for someone who’s been practicing for twenty years. So that’s different.

Dr. C. (attending), male, age approximately late 70s

Because of perceived patient discomfort with discussing sexual orientation, physicians either don’t ask patients about it or are extremely careful when they do ask patients about sexual orientation. Dr. C. (an older physician) mentions that he had to adjust to asking patients about their sexual orientation, indicating that this topic makes him uncomfortable as well.

**When is it appropriate to talk about sex?**

A majority of respondents indicated that whether or not they initiate sexual health conversations depends on their patient’s chief complaint, or the reason for their visit. For example, if a patient has an acute complaint, such as a sinus infection, respondents indicated that they would be less inclined to inquire about a patient’s sexual health. Specifically, if a patient has a complaint related to their abdomen, genitals or urinary tract, it could indicate pregnancy or an STI. As before, there is a theme of reaction (to STI-related symptoms) rather than prevention of STIs.

Yes, because it’s all situationally based. So, if you’re in for a sore throat, it is not appropriate. If you’re in for a general physical or you’re evaluating for a broken bone or bruises, you know, if you’re suspecting abuse or an STD or you know…then there’s highly appropriate ways.

Dr. M. (attending), male, age 38

So, not for an acute complaint, unless it’s for PIV [pelvic inflammatory disease] or something…sometimes we ask the parent or the husband to leave the room…well if they have any symptoms of pregnancy or of STDs, I’ll bring it up. I’ll also try to bring it up during physicals.

Dr. E. (female), attending, age 63
Further, a physician would bring up sexual health if their patient is seeing them for a well-care visit or yearly physical exam.

If it’s the first time you’re meeting a patient, they might not have anything they want to talk about or they might not even be sexually active, but at least you’ve opened the door for it.-

Dr. J. (resident), female, age 30

Certainly during a well care visit, when you’re just running the litany of things…so there are two times. One is just during a well care visit. Sex is part of health, and sexual things affect other aspects of health. So you would do that there.-

Dr. K. (attending), male, age 56

Some respondents mentioned that interpersonal dynamics affect whether or not they will initiate a conversation about sexual health.

I mean, it could be less appropriate if I’ve got the husband and the wife sitting in the room, and they’re both my patients. And it’s the wife’s doctor appointment, and I’m getting ready to tell her that her chlamydia test was positive. I don’t know if she wants her husband to know that, but she invited him into the room. So, there’s situations where I think it’s not appropriate to discuss it then. But I don’t think there’s ever a situation…I think it can always be discussed. You just have to find the appropriate time to do it. It might not be in the office; it might be over the phone.-

Dr. D. (attending), female, age 53

It is less appropriate if it is someone who is with their kid who can understand everything that they are talking about. It’s the parent’s visit. Then I ask, wouldn’t you like your daughter to step out in the waiting room for a while while we talk about this? Oh no. She’s my daughter. She can listen. And I’m not very comfortable with a 10 year old there, listening…Or the other day I had a couple, and the 5 year old was there, and I was just diagnosing her with a pregnancy that she didn’t intend. And so I wanted to talk about her options. And I was talking to her about her options, and I was talking with her partner too, because she refused to have him leave. And I thought, what is a 5 year old going to get out of this? Could they get the wrong idea somehow? And I asked if there was any way that I could have my assistant take care of the kid or something while we talked. And she said, oh no. Let him listen. –

Dr. B. (attending), female, age 61
Drs. D. and B. indicate that discussing an STI diagnosis may not be appropriate if there is anyone else in the room with a patient. However, Dr. D. seems more concerned about complicating relationship dynamics with an STI diagnosis, whereas Dr. B. is concerned about children not understanding their parents’ sexual health counseling. Dr. F. addresses complicating relationship dynamics when providing an STI diagnosis.

I think a lot of times when I talk to women especially about it, I tell them, look…especially if it’s a sexually transmitted disease and they think they got it from their partner. And they’ve only been with one partner. And I say, look, I don’t know who your partner is, but just make sure…you are my patient right now, and you are the person I’m focusing on. So just make that you’re safe, and whoever the other person is, just make sure that they’re using condoms…or they’re treated or whatever…something like that. I mean, I’m not pointing fingers…just make sure your partner is treated also. I ask them, are you with only one partner? If they say yes, then I ask them if they’re sure their partner is with only one partner. And that’s how I usually ask it. And usually people are pretty open.-

Dr. F. (resident), male, age 31

**Appropriate sexual health topics**

Sobecki et al. (2012) find that while a majority (63%) of United States of obstetrics/gynecology physicians report routinely asking patients about their sexual activities, other areas of patients’ sexual health are not routinely discussed. Only 28.5% routinely ask about sexual satisfaction; 13.8% routinely ask about pleasure with sexual activity; 27.7% routinely ask about sexual orientation/identity. Similarly, physicians in this research most commonly mentioned STI prevention and safe sex, contraception and sexual dysfunction (such as vaginal dryness or erectile dysfunction).
Under what circumstances? I raise protection with every teenager. I don’t with every adult. I probably should. I do whenever we’re talking about birth control. I do whenever we’re talking about STDs. But I don’t routinely at a physical…or do I? Yeah I guess I do with young, sexually active, not married or partnered people. I do say what are you doing about birth control? Do I do it with guys as much as I should? Probably not. I tend to do it more with women.-

Dr. H. (attending), male, age 67

Oh and menopause is something a lot of my patients go through…and men, with their erectile dysfunction. So, sexual issues of later life…-

Dr. B. (attending), female, age 61

Dr. H. suggests many caveats to his conversations about safer sex with patients: age, relationship status and gender. He discusses sexual health with women more often than he discusses sexual health with men. If a patient is younger and single, Dr. H. is more likely to discuss safer sex. Interestingly, this is different from what Foucault (1978) describes as modern sexual repression, as Foucault theorizes that physicians would be more comfortable discussing sexual health with married couples. And while Dr. B. specifically mentions older people, she is only focused on sexual dysfunction in later life, not on safer sex, which is problematic considering that STIs among the elderly are on the rise (CDC, 2010). It seems that this may be another alternate form of modern sexual repression: physicians feeling more or less comfortable depending on a patient’s age.

Conclusion

While all respondents indicated that they believe it is appropriate for primary care providers to discuss sexual health topics with their patients, there are many caveats. Due to their own discomfort with the topic of sexual health (but not wanting to admit such discomfort), physicians find excuses to avoid these conversations. Many respondents seem more concerned about politeness than prevention. In other words, they will not
bring up sexual health if a patient seems uncomfortable or will stop asking sexual health questions if a patient becomes uncomfortable. As a result, many respondents put the onus of discussing sexual health on the patient. Thus, modern sexual repression still exists, but among physicians who participated in this research, modern sexual repression is different than the way Foucault (1978) describes it. Instead of only having safer sex or sexual health conversations with married couples, (Foucault, 1978) physicians avoid having sexual health conversations with older patients or other patients who they do not consider high-risk. Until such caveats are addressed, it will be difficult to increase STI prevention.
Chapter 7: What else is there to say about sex?

Reflection on the research

The main reason I wanted to write my dissertation on doctor-patient communication about sexual health is that I have had (and many friends have told me about) bad experiences with physicians when discussing STIs specifically or sexual health in general ranging from awkward to stigmatizing. I wanted to use my knowledge as a medical sociologist and my affinity for postmodern theory to uncover and frame reasons why such a common occurrence (STIs) are so stigmatized. As I began to conduct research on STIs, it became abundantly clear that whatever we as a society are trying to do to prevent STIs, we are doing it wrong. According to the CDC (2014), STIs are still on the rise. Then, when I began to conduct research on doctor-patient communication, I discovered that primary care physicians (family physicians and internists) see a majority of patients. Further, I learned that physicians don’t talk to their patients about STIs and that when they do, they are not very good at it. So, that part was (relatively) easy. I decided to survey primary care physicians about a variety of influences (based on an extensive literature review) on their conversations with patients (particularly about sexual health).

However, physicians are notoriously reluctant to respond to surveys. Because I had a poor response rate, I had to take another route: in-person interviews. I have to admit attempting in-person interviews with a group of people that couldn’t even be bothered to fill out a survey felt daunting. But slowly, I conducted enough interviews to reach theoretical saturation. What I uncovered seemed contradictory at first though. All of these
physicians were saying they think it is appropriate and important to discuss sexual health with patients, but they all also have a variety of reasons why they don’t discuss sexual health more often. This is where a different form of Foucault’s modern sexual repression emerged: physicians do not limit their conversations about sexual health to married couples at all; instead, most of them limit their conversations to well-care visits. Only a few physicians mentioned trying to initiate conversations about sexual health with high-risk groups (such as young, black men or men who have sex with men). I was actually surprised that more physicians didn’t mention high risk groups.

The most interesting finding was the discrepancy between how many respondents said discussing sexual health with patients is appropriate and important and how few of them actually have this discussion as often as they know they should. This is also an extension of Foucault’s modern sexual repression, albeit in a different form. Physicians are still highly routinized in how and when they discuss sexual health with patients, and they worry about making patients uncomfortable. Transcribing interviews and coding them in various stages (initial, axial and focused) uncovered just how complex doctor-patient communication is, particularly about a sensitive topic like sex. So, while I feel that I uncovered a substantial amount of new information about doctor-patient communication about sexual health, there is still a good bit more to find out, namely: what are manageable changes physicians can make to their practices that would allow them to have brief STI prevention conversations? The research I have done was a lot of work, and what I have found is that there is still a lot more work to do.
Why Are Sexual Health Conversations Important?

An aim of this research was to examine physician beliefs about cultural capital, including perceptions of competition in the medical field as well as their definitions of success, prestige and influence in the medical field. Cultural capital was assessed by eliciting physicians’ views on how the practice of medicine and U.S. society influence each other as well as how the healthcare system within which physicians practice affects the care they provide. Further, this research studied physician beliefs about specific tasks involved in patient-centered care and their importance. In addition, this research aimed to uncover physician beliefs about the appropriateness and effectiveness of conversations with patients about sexual health generally and sexually transmitted infection (STI) prevention specifically. Finally, this research ascertained physician comfort levels with discussing sexual health topics with patients. Examining these particular aspects of doctor-patient communication is significant because according to the Centers for Disease Control and Prevention (2014), rates of STIs are rising; racial and ethnic minorities are most significantly affected (CDC, 2014). There are serious long-term health effects of undetected or untreated STIs (CDC, 2006, 2010), such as pelvic inflammatory disease (PID) and epididymitis (painful infection in the tissue surrounding the testicles). Untreated syphilis infections can result in brain, cardiovascular, and organ damage and even death (CDC, 2010). STIs are also a costly burden to the United States health care system. According to Owusu-Edusei Jr et al. (2013), the cost of STIs to the U.S. health care system is estimated to be as much as $16 billion annually.

Because primary care physicians interact with a majority of STI patients (Ashton et al., 2001), it is important that these physicians know how to approach the subject of
sexual health, including STI prevention and that they feel comfortable doing so. Further, members of U.S. society consider health care professionals to be legitimate sources of health information, including information about sexual health (Foucault, 1978). As a result, the doctor-patient encounter can provide a significant opportunity for physicians to counsel their patients about sexual issues such as safer sex (Browne et al., 2002; Lewis & Freeman, 1987). However, primary care physicians avoid talking to their patients about sex (Porter & Ku, 2000; Tao et al., 2000; Kingsberg, 2006). Thus, an attempt to discover what makes a physician more or less likely to discuss sexual health is essential to preventing more STIs.

Based on this study of family physicians and internists, sexual health is still not considered a priority during most medical encounters. Physicians are reluctant to bring up sexual health for many reasons, such as perceived patient discomfort, perceived lack of relevance and time constraints. Most physicians in this study also feel that having STI prevention conversations makes little difference with patients. However, many respondents indicated that they will discuss sexual health if a patient brings it up. But, patients usually do not initiate conversations about sexual health unless they’re already having an STI symptom or other sexual health concerns. Ideally, sexual health conversations would take place before STI symptoms occur, as to prevent such symptoms. Using postmodern theories to frame findings, this conclusion chapter highlights influences on physician approaches to patients, reflect on academic implications as well as implications for physicians and patients, and consider limitations as well as future research.
Impact on physicians

Foucault’s (1978) notion of modern sexual repression was present in all of the interviews, although slightly varied. According to Foucault (1978, 1985, 1986), the idea that sex is a sensitive or even controversial topic exists in doctor-patient encounters. An extension of this should be considered as a reason that it is difficult for physicians to discuss matters of sex, especially with people who are not in culturally approved relationships, such as those not involved in a heterosexual marriage. However, no physicians in this study indicated that they feel more comfortable discussing sexual health with married couples (or any other couples). In fact, one physician mentioned feeling less comfortable discussing STI concerns with couples, because such a discussion may imply infidelity.

I mean, it could be less appropriate if I’ve got the husband and the wife sitting in the room, and they’re both my patients. And it’s the wife’s doctor appointment, and I’m getting ready to tell her that her chlamydia test was positive. I don’t know if she wants her husband to know that, but she invited him into the room. So, there’s situations where I think it’s not appropriate to discuss it then. But I don’t think there’s ever a situation...I think it can always be discussed. You just have to find the appropriate time to do it. It might not be in the office; it might be over the phone.

Dr. D. (attending), female, age 53

Instead, modern sexual repression emerges in other types of conversation restrictions. For example, many respondents indicate that they do not usually bring up sexual health with elderly patients. However, according to the CDC (2010) and the Benjamin Rose Institute on Aging (2014), STIs among the elderly are on the rise. As a result, physicians need to get more comfortable discussing sexual health (especially STI prevention) with older patients. Instead, respondents mentioned feeling more comfortable discussing sexual
health with patients who are the same gender as they are and patients who are younger. While only one of the physicians interviewed for this research indicated that sexual health conversations are uncomfortable, all of the others cited a variety of reasons for not discussing sexual health during patient visits: perceived patient discomfort, lack of time (productivity pressures) or perceived lack of relevance to the patient visit.

It seems that overall, physicians still aren’t comfortable initiating conversations with their patients about sexual health. One of the biggest reasons cited by respondents is fear of offending a patient. Thus, it seems that politeness is more important than prevention.

You don’t want to leave it out if it’s germane and, you don’t want to bring it up if it’s going to upset people. That’s probably the trickiest.-

Dr. C. (attending), male, age approximately late 70s

I won’t push it if someone seems uncomfortable. I think most of the time I bring it up, if it’s a young person, depending on what they’re there for. If it’s just a routine visit or if they come in for like a headache, then I might not go into it completely. But if they’re there for health maintenance or to establish a PCP, then I’ll go into it.-

Dr. F. (resident), male, age 31

Physicians need to become more comfortable discussing sexual health with their patients, because STIs are still on the rise (CDC, 2014). Physicians still hold the power in the medical encounter, despite the declining prestige of medicine. According to Quinn (1987) and Foucault (1978), physicians are considered to be the experts in a medical encounter. Therefore, they need to take responsibility for patients’ sexual health. In Quinn’s (1987) research, physicians are more likely than individuals outside of the medical profession (including patients) to have the social and cultural capital of ‘information’ about STI prevention. However, physicians may be more concerned with
having cultural capital with patients (patient satisfaction), than with having (difficult) conversations about sensitive topics (such as sexual health).

Further, what attending physicians learn informally and formally during their residencies heavily influences the care they provide to patients. According to Luke (2003), junior physicians (residents and medical students) typically defer to more senior physicians (attendings) regarding patient approaches and clinical knowledge. Even if medical students gain extensive knowledge about prevention of and testing for STIs (which isn’t the case according to Shindel & Parish, 2013), they may utilize very little of this information if when they are in residency, their attendings do not consider sexual health important. Therefore, until more senior physicians consider lifestyle (including sexual health) to be an essential component of patients’ health and prioritize it accordingly, practicing physicians will find reasons not to discuss it. This may be encouraged through Continuing Medical Education (CME) courses or through new patient questionnaires or even electronic medical records (EMRs).

**Impact on patients**

Based on the responses of physicians who participated in this research, patients need to be encouraged to feel more comfortable bringing up sexual health topics during a medical encounter, especially since many of the respondents put the onus of bringing up sexual health topics on the patient. What is encouraging is that most of the respondents value patient-centered care, which according to Ben-Sira (1980), Bensing and Dronkers (1992), Burnard (1996), Fiscella and Epstein (2008), Silverman (1987) and Slatore et al. (2012), involves empathy, a consideration of patients’ rights and feelings, getting to know patients on a personal level and accepting them, confirming patients’ understanding
and providing emotional support. Introducing the idea that encouraging patients to feel more comfortable bringing up sexual health concerns as an extension of patient-centered care may hold some promise. In other words, because most physicians who participated in this study care about knowing the whole patient, and most of them also believe that sexual health is part of knowing the whole patient, it seems reasonable that a few sexual health questions could be added to most physicians’ medical encounters.

With the limited number of sexual health conversations that are happening, most of which are during a well-care visit or yearly physical exam, patients who do not have a regular source of healthcare may not obtain essential STI prevention information. An argument for why physicians need to ask patients about sexual health even when physicians don’t believe it is pertinent to the visit is that many patients only see a healthcare provider when they are sick. According to Anyanian, Weissman, Schneider, Ginsburg, and Zaslavsky (2000), uninsured adults are much less likely to have had a routine checkup in the last two years. Woolhandler and Himmelstein (1988) indicate that reverse targeting of preventive care occurs with people without health insurance; further, they argue that this withholding of preventive care happens to those who need it most: the uninsured. Therefore, prevention needs to happen in more visits than just well-care visits, yearly physicals and those involving an STI symptom. Prevention should start before patients come in with STI symptoms so that they don’t come in with STI symptoms to begin with.

While no respondents specifically mentioned patients having inaccurate STI prevention information as a problem, previous research indicates that inaccurate information can be a barrier to safer sex practices. Crosby et al. (2000), Dehlendorf et al.
(2010), Rocca, and Harper (2012), Tolani and Yen (2009) Voisin, et al. (2012), Weinstein et al. (2008) find inaccurate STI information in a variety of communities: college undergraduates, public health clinic patients, as well as minority and low SES women. According to Rocca and Harper (2012), some misconceptions can come from cultural beliefs. Therefore, physicians should to engage in cultural sensitivity, which is the consideration of how a patient’s culture may influence their communication, attitudes, practices and health-related beliefs (Resincow et al., 1999). Further, increased efforts need to be made via public health information campaigns to get more accurate information to patients. However, many respondents mentioned more generally that while patients have access to more medical information than ever, that information is not always sound. This could also be addressed by public health information campaigns.

A patient’s gender, race, ethnicity, socioeconomic status or sexual orientation may influence the way a patient is treated by a physician as well as the way the patient approaches the physician (Bertakis et al., 2009; Dahan et al., 2008; Dardick & Grady, 1980; Grant & Ragsdale, 2008; Nusbaum et al., 2008; O’Hanlan et al., 1997; Petroll & Mosack, 2011; Polek et al., 2008; Politti et al., 2009; Street et al., 2007; Stewart et al., 2007; Tanfer et al., 2009; van Ryn, 2002; van Ryn & Burke, 2000; Watzkin, 1984). Many respondents in this research indicated that they are less comfortable discussing sexual health with a patient who is not the same gender as they are. Further, Stewart et al. (2007) find that black people reported experiencing the most discrimination by health care providers, followed by English-speaking Latinos. For example, Perloff et al. (2006) find that physicians are more likely to interrupt patients with a lower socioeconomic status.
In turn, a patient’s demographic characteristics and sexual orientation may influence the likelihood that a conversation between doctor and patient about sex will occur. However, only one physician who participated in this research mentioned those characteristics as influencing whether or not they discuss sexual health with patients. Specifically, this physician mentioned race and sexual orientation.

Well, the standard is that a lot of young, black men will come in and say, I just want a check-up, which seems to be code for I want to check for STDs. I immediately think of that. And the question is, is that what you’re really asking for. And again, patients have this almost magical thing. If they get a check-up well, they’re going to be checked for everything, which is going to mean STDs… I don’t explicitly, routinely ask about STDs… Obviously a genitourinary complaint, um…a women who has had an abnormal pap, um…somebody who tells me they’re gay…uh…somebody who tells me they’re sexually active and not using any birth control…any protection. -

Dr. H. (attending), male, age 67

According to the CDC (2014), “gay, bisexual, and other men who have sex with men (MSM) are more severely affected by HIV than any other group in the United States.” Therefore, based on CDC recommendations, it would make sense that Dr. H. is more likely to bring up sexual health with patients who are gay. Racial and ethnic minorities are more likely to contract chlamydia and gonorrhea as well as primary and secondary syphilis (CDC, 2014). Thus, Dr. H. is targeting a few high-risk groups. However, it is unfortunate that more respondents didn’t mention doing the same, as this could aid in more STI prevention.

**Sociological significance**

This research makes an original contribution to the discipline of sociology by employing Bourdieu’s theory of structuralist constructivism (Bourdieu, 1989) to consider the influences of individual physician and patient attributes on the institution of medicine.
as well as the ways that the institution of medicine affects physicians and patients. Further, this researchExplore how physicians respond to taboo subjects such as sexual health. The most common responses are for physicians to deprioritize sexual health and use a patient’s age or gender to determine whether or not they discuss sexual health. Overall, physicians who participated in this research tended to put the onus for discussion on the patient. Even physicians who seemed more inclined to discuss sexual health with their patients mentioned that they would not initiate a sexual health conversation if a patient seemed uncomfortable. If more STIs are going to be prevented, this needs to change, either by physicians or patients feeling more comfortable discussing sexual health topics.

The in-depth interviews I conducted provide rich information regarding exactly what cultural capital means to physicians. Until now, cultural capital in medicine has only been explored as it relates to patients (Shim, 2010). This research considers cultural capital as it relates to physicians. It goes a step further and distinguishes between different forms of cultural capital for physicians. There are two main types of cultural capital for physicians: cultural capital with patients and cultural capital with other physicians. These interviews were particularly enlightening regarding this distinction, as I originally hypothesized that cultural capital with other physicians would be more important to respondents. Cultural capital with patients seems equally if not more important than cultural capital with other physicians; this may be because primary care physicians are not as well respected in the hierarchy of physician specialties. Further, patient-centered care, while not a popular label for patient approaches, is endorsed by
almost all of the respondents as a significant part of patient satisfaction, or cultural capital with patients.

Examining sexual health as an essential part of patient-centered conversations is unique to this research. This research analyzes how structures of medical institutions (billing practices and productivity pressures) as well as the patient populations they serve (teenagers, elderly people, people of color) influence when and why physicians discuss sex. Further, this research considers how physicians’ declining prestige influences their interactions with patients, as it seems that patients are becoming much more demanding. And if (as previously mentioned), patients don’t bring up sexual health, it won’t get discussed. Respondents view national healthcare policy (especially the Affordable Health Care Act) as an infringement on their relationships with patients.

Finally, a sociological exploration of how individuals and structure influence problematic STI rates could bridge the gap between social sciences and epidemiological sciences. Physicians influence problematic STI rates by putting the onus of sexual health conversations on patients and by not prioritizing such conversations. Patients contribute to problematic STI rates by not asking their physicians about sexual health concerns. The structure of medicine influences problematic STI rates by enforcing productivity pressures that force physicians to see a certain number of patients in a certain amount of time during their practice hours (Abbo et al. 2008; Tsai et al., 2011). This does not leave time for the physician to address concerns other than the patient’s chief complaint (Fiscella and Epstein, 2008). Further, insurance company billing practices make it difficult for physicians to justify spending their time having prevention conversations (Chuang et al., 2012; Kingsberg, 2006; Liddicoat et al., 2004). When making
recommendations for best practices, organizations such as the American Medical Association (AMA) or the American Academy of Family Physicians (AAFP) need to consider structural barriers to having important conversations.

Policy implications

Considering the annual cost of STI treatment to the U.S. health care system ($16 billion) (Owusu-Edusei Jr., et al, 2013), the U.S. government should focus more on preventing illnesses and infections (such as STIs) rather than on productivity pressures (seeing a predetermined number of patients per day). Many physicians who participated in this research mention feeling frustrated by productivity pressures imposed by the U.S. government as well as by the health care systems in which they practice. They indicate feeling that the U.S. government and their system administrators should not be intruding on their relationships with their patients. However, it seems that such administrative and government regulations are becoming more common. Therefore, if these regulations are going to take place and continue to frustrate physicians, it would be more beneficial to enforce regulations that work to decrease the spread of STIs and actually save the U.S. healthcare system money.

Limitations

While rich in information, the physicians I interviewed in this study may not be representative of physicians in the United States. According to the U.S. Department of Health and Human Services (2008), 31% of primary care providers are female; however, my sample is 59% female. Further, Macdowall et al. (2010), male practitioners are less likely to discuss sex-related topics with their patients. Therefore, if the sample was more
representative of U.S. primary care providers, more (male) respondents may have expressed more reluctance to discuss sexual health with their patients. The physicians and the patients they see may vary demographically, but they are all part of one hospital system in northeast Ohio. Therefore, their responses may be more similar than if I had interviewed physicians from more than one hospital system. Further, physicians who participated in this research may have been more comfortable discussing sexual health to begin with given that they were willing to be interviewed about their conversations with patients about sexual health. In addition, the respondents may have said they talked to their patients about sexual health more than they actually do since that was the topic of the interview.

**Future Directions**

Based on physicians’ responses to interview questions, we now have more insight into what influences a physician’s clinical priorities. It is clear that physicians in this study know it is appropriate for primary care physicians to discuss sexual health (especially STI prevention) with patients; however many of them don’t feel that it is appropriate to discuss sexual health in visits other than well-care visits or yearly physical exams, nor do they feel that they have adequate time to discuss sexual health. Therefore, more research is needed to determine ways to encourage physicians and patients to bring up sexual health more often. Further, many respondents put the onus of bringing up sexual health on the patient, which encourages research on the patient perspective of doctor-patient communication about sexual health. It is important to elicit the patients’ perspectives on communicating with physicians about sexual health, as this study focused solely on physicians’ perspectives. As previously mentioned, in medical encounters,
physicians have more power (Quinn, 1987; Waitzkin, 1989). However, as many physicians in this study mentioned, if patients bring up sexual health topics, physicians may be more likely to discuss them. Therefore, it is essential to find out what influences whether or not a patient brings up sexual health during a medical encounter.

Now that richer, more complex information has been discovered about physicians’ cultural capital in medicine, a larger, more generalizable study about the varying importance of the two main types of cultural capital (cultural capital with patients and cultural capital with other physicians) should be conducted. This may provide more insight into physicians’ clinical priorities and narrow down what may motivate them to discuss sexual health with patients. In addition, it may be useful to determine smaller changes to patient approaches that could be made to encourage physicians to bring up sexual health with more of their patients, including those with acute chief complaints unrelated to sexual health. As previously mentioned, people without health insurance usually only go to the doctor once they have a problem. Therefore, more efforts need to be made to engage patients in sexual health conversations in visits other than well-care. Surveying or interviewing physicians may provide some insight into how these changes might occur.
Appendix A: Interview guide

Demographic questions

What is your age?

What is your gender?

With which racial and ethnic group(s) do you most closely identify?

What year did you graduate from medical school?

Where did you attend medical school?

What year did you or will you complete your residency?

Where did you complete your residency?

What was your SES growing up?

What are your parents’ education levels?

Is anyone else in your family a physician?

How would you demographically describe your patients?

Are there any disadvantaged groups for whom you provide care? Which ones?

How many of your patients have low health literacy?

Cultural capital

Do you feel that there are ways in which you learned to act like a doctor? What are they?

What advice would you give to a physician just starting to practice?
Do you feel like you have to compete (for respect) with other physicians in your field? What do you feel helps or hinders your competition?

What characteristics does a successful primary care physician possess? What about in other specialties of medicine? Are there barriers to being a successful physician?

How would you define prestige (as a physician)? What does it take to be prestigious in your field? Is being prestigious important to you?

How do you think the practice of medicine is influenced by U.S. society? How do you think medicine influences U.S. society?

What does it take to be influential in your field? Are certain individuals more influential than others? Are there certain personality traits, demographics, locations of practice that make physicians more influential than others?

How does the health care system within which you work hinder you? How does it help you?

**Patient-centered care**

What do you think is involved in patient centered care? Do you believe that you engage in patient centered care? What are specific ways you engage in patient-centered care?

Do you think patient centered care is important? Why?

**Appropriateness/effectiveness of STI prevention discussion**

Is it appropriate for family practice physicians to talk to their patients about sex-related topics? Why? Are there times that it is more or less appropriate? How do you decide when it is appropriate to discuss sex-related topics with patients?
How effective do you think physician-initiated STI prevention discussions are?

What types of sex related topics should primary care physicians discuss with their patients?

Comfort level with STI prevention discussion

How comfortable are you discussing sex-related topics with your patients?

Do you feel more comfortable discussing sex-related topics with certain patients?

What influences whether or not you discuss sex-related topics with your patients?

What types of sex related topics do you discuss with your patients?

What prevents more physicians from discussing sex-related topics with their patients?

Does discussing sex-related topics affect a physician’s status in the medical field? If so, why and how?
Appendix B: Recruitment materials/email recruitment

Subject: Interview on doctor-patient communication?

Dr. [insert doctor’s last name],

I am writing to ask you to participate in my study concerning doctor-patient communication about STI prevention and other sex-related topics. I am a PhD. student in the sociology department at Case Western Reserve University. This study has been approved by the Institutional Review Board of Case Western Reserve University (IRB-2012-308). This study evaluates the factors influencing whether or not and why doctors discuss sex-related topics with their patients. Your participation is voluntary.

Participation in this study would only require between 30 minutes and one hour of your time, during which you would discuss patient care and the medical environment in which you work with a researcher during a confidential, recorded interview. A possible (and secondary) benefit of participating in this study is the potential for improving doctor/patient communication such that doctors are more comfortable discussing sex-related topics with patients. Patients may also benefit from your participation in this study because of the potential improvement in your communication about sex-related topics. However, these secondary benefits are not guaranteed. If you are interested in participating in this study or want more information about this study, please contact Casey Schroeder, MA at 216-368-0834 or casey.schroeder@case.edu.

Thank you,

Casey Schroeder
Appendix C: Difficulties with access

Data collection challenges

Originally, a 73-item questionnaire was constructed to extract age, race, and gender information from physicians. In addition, the questionnaire obtained information about where and when the physicians completed medical school and residency. It also assessed cultural capital of physicians in the medical field (using information from Haas and Shaffir, 1987; H. Luke, 2003; Sinclair 1997), practitioner views about gender roles (via a modified version of the Bem Sex Role Inventory [Bem, 1974]), comfort levels of the practitioners when discussing matters of sex (using information from Ashton et al., 2001; Waite et al., 2007), beliefs about the role of the practitioner in STI prevention (using information from Ashton et al., 2001; Waite et al., 2007), and practitioners’ beliefs about the importance of patient-centered care (using information from Ben-Sira, 1980; Bensing & Dronkers, 1992; Burnard, 1996; Silverman 1987). The survey also contained questions about the practitioners’ perceptions of patient characteristics as they relate to comfort levels in discussing STI prevention (such as socioeconomic status and sexual orientation).

A randomly selected list of 3000 members of the American Academy of Family Physicians (AAFP) was obtained from Infocus Marketing. From this list, recruitment letters were mailed to 500 randomly selected members of the original list. Only currently practicing family doctors were included in the sample. A total of 500 questionnaires were mailed; 26 surveys were returned. 5 primary care physicians responded directly to the researchers indicating that they are no longer involved in direct patient care. Thus, it
would have been inappropriate for them to complete the survey. Therefore 474 questionnaires were considered when calculating the response rate. 35 questionnaires were completed, making the response rate 7%. Due to the low response rate to the questionnaire recruitment, in-depth interviews were also conducted.

**Physicians as elite members of society**

According to Odenahl and Shaw (2002), elite members of society may be more difficult to access as research participants. These researchers define elite members of society as those with more knowledge, money and status than others in the population. Physicians have more knowledge and status that most of the United States population (Starr, 1982). A key reason why physicians may be even more difficult to access is gatekeepers. For the purposes of this research, gatekeepers would include office managers (Adler & Adler, 2003) and health care systems’ Institutional Review Boards (IRBs).

The Case Western Reserve University IRB requires researchers to have documented approval from any healthcare systems from which they want to recruit physicians. They do not necessarily require an IRB approval from each healthcare system from which researchers wish to recruit physicians, only documentation of institutional cooperation or permission. Thus, I reached out to three of Cleveland’s major healthcare systems in October 2012. One of the three major systems provided me with a letter of cooperation within one month of initial contact. Another system did not communicate with me beyond an initial response after multiple attempts to continue communication. The third major healthcare system required that I go through their IRB, even though that is not required by CWRU. Communication with this third system began in October 2012;
it took until February 2013 to be directed to the proper department within this institution. According to Adler and Alder’s (2003) discussion of the reluctant respondent, organizations and corporations are powerful groups in society that sometimes try to prevent social researchers from accessing them. This particular healthcare system would be considered one of those organizations.

Staff of this institution were unsure about whether or not I would be considered a visiting researcher, based on their definitions (which were never disclosed). The first part of their process was to fill out a Visiting Researcher Form as well as to provide a curriculum vitae. It took until May 2013 for the institution to approve my Visiting Researcher Form; I was told that it had been “pushed down the priority list due to several federal grants being submitted at the same time.” By June 2013, the research protocol submitted (based on this institution’s template) had been returned due to this institution’s Protocol Review Committee’s concerns, including: concerns that I would not be able to recruit enough physicians for my study, the proposed time of one hour for the interview being too lengthy, concerns with the chain referential sampling method biasing my results and concerns that my institutional physician mentor (required) was not experienced with qualitative research methods. At this point, the physician who was working with me at this institution discontinued his role as mentor. Because I already had a letter of cooperation from one of Cleveland’s three major health care systems, I submitted my application to CWRU’s IRB. IRB approval was granted July 2013. Subject recruitment began July 2013 and ended in July 2014.
Appendix D: Code tracking

CULTURAL CAPITAL THEMES

What advice would you give to a physician just starting to practice?

<table>
<thead>
<tr>
<th>Code</th>
<th>Number of interviews in which code appeared</th>
<th>Sequence of interviews in which code appeared</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-care (outside of the medical profession)</td>
<td>6</td>
<td>3, 5, 6, 8, 9, 16</td>
</tr>
<tr>
<td>Self-advocacy</td>
<td>6</td>
<td>8, 9, 10, 14, 15, 17</td>
</tr>
<tr>
<td>Patience</td>
<td>4</td>
<td>7, 10, 12, 13</td>
</tr>
<tr>
<td>“Don’t go in it for the money.”</td>
<td>4</td>
<td>9, 11, 12, 13</td>
</tr>
<tr>
<td>Patient approaches</td>
<td>4</td>
<td>1, 2, 6, 12</td>
</tr>
<tr>
<td>Decisiveness</td>
<td>3</td>
<td>9, 11, 14</td>
</tr>
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</table>
Are there ways that you learned to act like a doctor?

<table>
<thead>
<tr>
<th>Code</th>
<th>Number of interviews in which code appeared</th>
<th>Sequence of interviews in which code appeared</th>
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<tbody>
<tr>
<td>Family of origin</td>
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<td>7, 10</td>
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<tr>
<td>Undergraduate education</td>
<td>2</td>
<td>3, 9</td>
</tr>
<tr>
<td>Medical school</td>
<td>6</td>
<td>3, 7, 9, 12, 13, 15</td>
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<tr>
<td>Residency</td>
<td>9</td>
<td>1, 3, 4, 5, 6, 8, 9, 13, 16, 17</td>
</tr>
<tr>
<td>Learning by doing/professional socialization</td>
<td>8</td>
<td>4, 6, 8, 9, 12, 14, 15, 17</td>
</tr>
<tr>
<td>Personality</td>
<td>5</td>
<td>2, 4, 9, 11, 12</td>
</tr>
</tbody>
</table>
Do you feel like you have to compete (for respect) with other physicians in your field*? What do you feel helps or hinders your competition?

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<thead>
<tr>
<th>Code</th>
<th>Number of interviews in which code appeared</th>
<th>Sequence of interviews in which code appeared</th>
</tr>
</thead>
<tbody>
<tr>
<td>No competition within practice/discipline</td>
<td>8</td>
<td>1, 2, 3, 7, 8, 10, 12, 15</td>
</tr>
<tr>
<td>Primary care providers not respected as much as specialists</td>
<td>4</td>
<td>4, 6, 11, 13</td>
</tr>
<tr>
<td>Residents not respected as much</td>
<td>2</td>
<td>1, 14</td>
</tr>
<tr>
<td>Influence of gender</td>
<td>1</td>
<td>11</td>
</tr>
<tr>
<td>Influence of race</td>
<td>1</td>
<td>11</td>
</tr>
<tr>
<td>Influence of age</td>
<td>1</td>
<td>17</td>
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### What characteristics does a successful family doctor/internist possess?

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<tbody>
<tr>
<td>Treating the whole patient</td>
<td>7</td>
<td>3, 8, 10, 11, 13, 15, 17</td>
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<tr>
<td>Empathy</td>
<td>7</td>
<td>2, 8, 9, 10, 13, 14, 17</td>
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<tr>
<td>Competence</td>
<td>5</td>
<td>4, 6, 9, 12, 13</td>
</tr>
<tr>
<td>Approachability</td>
<td>4</td>
<td>1, 9, 12, 16</td>
</tr>
<tr>
<td>Relatability</td>
<td>2</td>
<td>4, 5</td>
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</table>

### What characteristics do successful specialists possess?

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<th>Code</th>
<th>Number of interviews in which code appeared</th>
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</thead>
<tbody>
<tr>
<td>Same as primary care: communication skills, empathy, competence</td>
<td>7</td>
<td>2, 5, 6, 8, 10, 13, 15</td>
</tr>
<tr>
<td>Different: Technical skill</td>
<td>5</td>
<td>1, 7, 12, 13, 16</td>
</tr>
<tr>
<td>Different: Not as personable</td>
<td>2</td>
<td>12, 17</td>
</tr>
<tr>
<td>Different: No continuity of care</td>
<td>2</td>
<td>7, 14</td>
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</table>
Are there barriers to being a successful physician?

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<tbody>
<tr>
<td>Media</td>
<td>5</td>
<td>4, 9, 15, 16, 17</td>
</tr>
<tr>
<td>Electronic medical record implementation</td>
<td>4</td>
<td>2, 10, 13, 14</td>
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<tr>
<td>Productivity pressures</td>
<td>4</td>
<td>3, 7, 9, 17</td>
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<tr>
<td>Time</td>
<td>2</td>
<td>2, 10</td>
</tr>
<tr>
<td>Quality measures</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Less respect for primary care providers</td>
<td>3</td>
<td>1, 7, 15</td>
</tr>
<tr>
<td>Lower salary of primary care providers</td>
<td>3</td>
<td>9, 15, 16</td>
</tr>
<tr>
<td>Insurance coverage</td>
<td>5</td>
<td>7, 13, 17</td>
</tr>
<tr>
<td>U.S. healthcare system (inequality)</td>
<td>2</td>
<td>7, 8</td>
</tr>
<tr>
<td>Government regulation</td>
<td>2</td>
<td>10, 13</td>
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</table>
How would you define prestige as a physician?

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<th>Code</th>
<th>Number of interviews in which code appeared</th>
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<tbody>
<tr>
<td>Patient satisfaction</td>
<td>9</td>
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</tr>
<tr>
<td>Patient referral</td>
<td>3</td>
<td>9, 11, 12</td>
</tr>
<tr>
<td>Peer respect</td>
<td>6</td>
<td>2, 4, 8, 14, 15, 16</td>
</tr>
<tr>
<td>Research</td>
<td>3</td>
<td>1, 5, 12</td>
</tr>
<tr>
<td>Publications</td>
<td>2</td>
<td>1, 12</td>
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</tbody>
</table>

Is being prestigious important to you?

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<tr>
<th>Code</th>
<th>Number of interviews in which code appeared</th>
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<tbody>
<tr>
<td>Not important</td>
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<td>1, 3, 13, 15, 17</td>
</tr>
<tr>
<td>Value continuity of care more</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Value patient relationships more</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Yes</td>
<td>9</td>
<td>2, 4, 6, 7, 8, 9, 10, 12, 16</td>
</tr>
<tr>
<td>Being well-thought of</td>
<td>2</td>
<td>6, 16</td>
</tr>
<tr>
<td>Patient satisfaction</td>
<td>3</td>
<td>7, 9, 10</td>
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</table>
Does discussing sex-related topics affect a physician’s status in the medical field?

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<th>Code</th>
<th>Number of interviews in which code appeared</th>
<th>Sequence of interviews in which code appeared</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes: Approachability</td>
<td>4</td>
<td>3, 6, 8, 15</td>
</tr>
<tr>
<td>Yes: With certain populations</td>
<td>2</td>
<td>13, 16</td>
</tr>
<tr>
<td>No: Physicians don't discuss their patients with each other unless something very clinically interesting happens</td>
<td>3</td>
<td>4, 9, 17</td>
</tr>
</tbody>
</table>
What does it take to be influential in your field?

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<th>Code</th>
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<th>Sequence of interviews in which code appeared</th>
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<tbody>
<tr>
<td>Empathy (with patients)</td>
<td>5</td>
<td>3, 12, 14, 15, 17</td>
</tr>
<tr>
<td>Outspokenness (with colleagues)</td>
<td>3</td>
<td>2, 10, 12</td>
</tr>
<tr>
<td>Prestige with colleagues</td>
<td>2</td>
<td>14, 16</td>
</tr>
<tr>
<td>Titles (with colleagues)</td>
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<td>3, 11, 12</td>
</tr>
<tr>
<td>Publications (with colleagues)</td>
<td>3</td>
<td>6, 11, 13</td>
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Are there certain personality traits, demographics or locations of practice that make some physicians more influential than others?

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<th>Code</th>
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<tbody>
<tr>
<td>Health care system: location of practice</td>
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<td>3, 9, 12, 14, 16</td>
</tr>
<tr>
<td>Health care system: community vs. private</td>
<td>2</td>
<td>3, 6</td>
</tr>
<tr>
<td>Health care system: academic vs. non-academic</td>
<td>4</td>
<td>5, 6, 9, 13</td>
</tr>
<tr>
<td>Demographics: being a Caucasian physician</td>
<td>3</td>
<td>1, 5, 11</td>
</tr>
<tr>
<td>Demographics: Being a male physician</td>
<td>2</td>
<td>5, 16</td>
</tr>
<tr>
<td>Demographics: native English speaker</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Demographics: U.S. born</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Demographics: U.S. medical graduates</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>Personality: charisma</td>
<td>3</td>
<td>13, 15, 16</td>
</tr>
<tr>
<td>Personality: born leaders</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>Patient approaches: disadvantaged patients (they are more likely to appreciate what you are doing for them)</td>
<td>2</td>
<td>7, 14</td>
</tr>
<tr>
<td>Patient approaches: cultural competence</td>
<td>2</td>
<td>1, 11</td>
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</table>
How does the healthcare system within which you work hinder you?

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<thead>
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<tr>
<td>EMR</td>
<td>9</td>
<td>3, 5, 6, 8, 9, 10, 12, 13, 16</td>
</tr>
<tr>
<td>Billing</td>
<td>4</td>
<td>1, 2, 5, 15</td>
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<tr>
<td>Reimbursements</td>
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<td>3, 7, 12</td>
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<tr>
<td>Coding</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Productivity pressures/time constraint</td>
<td>4</td>
<td>3, 11, 12, 15</td>
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</tbody>
</table>
How does the healthcare system within which you work help you?

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<tr>
<th>Code</th>
<th>Number of interviews in which code appeared</th>
<th>Sequence of interviews in which code appeared</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colleagues</td>
<td>5</td>
<td>5, 6, 13, 15, 16</td>
</tr>
<tr>
<td>No administrative/business concerns</td>
<td>4</td>
<td>2, 9, 12, 13</td>
</tr>
</tbody>
</table>
How do you think the practice of medicine is influenced by U.S. society?

<table>
<thead>
<tr>
<th>Code</th>
<th>Number of interviews in which code appeared</th>
<th>Sequence of interviews in which code appeared</th>
</tr>
</thead>
<tbody>
<tr>
<td>High (patient) expectations</td>
<td>7</td>
<td>2, 4, 6, 11, 12, 15, 16</td>
</tr>
<tr>
<td>Entitled patients</td>
<td>4</td>
<td>1, 2, 9, 12</td>
</tr>
<tr>
<td>Quick fix expectations</td>
<td>3</td>
<td>1, 11, 12</td>
</tr>
<tr>
<td>Direct to consumer advertising</td>
<td>4</td>
<td>2, 9, 11, 12</td>
</tr>
<tr>
<td>“Quacks” (i.e., Dr. Oz)</td>
<td>4</td>
<td>4, 9, 11, 12</td>
</tr>
<tr>
<td>Misinformed patients</td>
<td>3</td>
<td>9, 11, 15</td>
</tr>
<tr>
<td>Increased patient education</td>
<td>3</td>
<td>9, 11, 12</td>
</tr>
<tr>
<td>Less physician prestige/paternalism</td>
<td>5</td>
<td>8, 7, 9, 11, 12</td>
</tr>
</tbody>
</table>
How do you think medicine influences U.S. society?

<table>
<thead>
<tr>
<th>Code</th>
<th>Number of interviews in which code appeared</th>
<th>Sequence of interviews in which code appeared</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improved patient education with technological advances</td>
<td>3</td>
<td>7, 9, 10</td>
</tr>
<tr>
<td>Increased health consciousness/public health</td>
<td>3</td>
<td>9, 10, 13</td>
</tr>
<tr>
<td>(Lack of) access to medicine</td>
<td>2</td>
<td>1, 17</td>
</tr>
<tr>
<td>Inefficiency of health care system</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>
PATIENT-CENTERD CARE THEMES

What do you think is involved in patient centered care?

<table>
<thead>
<tr>
<th>Code</th>
<th>Number of interviews in which code appeared</th>
<th>Sequence of interviews in which code appeared</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consideration of patient context</td>
<td>7</td>
<td>3, 4, 5, 8, 9, 13, 15</td>
</tr>
<tr>
<td>Caring for the whole patient</td>
<td>6</td>
<td>2, 4, 7, 12, 13, 14</td>
</tr>
<tr>
<td>Attainable health behavior changes/treatments</td>
<td>3</td>
<td>1, 3, 5</td>
</tr>
<tr>
<td>Tailoring treatment/health behavior change to individual patient</td>
<td>5</td>
<td>1, 4, 5, 15, 16</td>
</tr>
<tr>
<td>Access to social services/reducing barriers</td>
<td>4</td>
<td>1, 10, 11, 17</td>
</tr>
<tr>
<td>Patient involvement in the decision-making process</td>
<td>5</td>
<td>1, 5, 7, 8, 9</td>
</tr>
</tbody>
</table>
Do you believe that you engage in patient centered care?

<table>
<thead>
<tr>
<th>Code</th>
<th>Number of interviews in which code appeared</th>
<th>Sequence of interviews in which code appeared</th>
</tr>
</thead>
<tbody>
<tr>
<td>This is what I’ve always done.</td>
<td>4</td>
<td>6, 11, 13, 16</td>
</tr>
</tbody>
</table>

What are specific ways you engage in patient-centered care?

<table>
<thead>
<tr>
<th>Code</th>
<th>Number of interviews in which code appeared</th>
<th>Sequence of interviews in which code appeared</th>
</tr>
</thead>
<tbody>
<tr>
<td>Listening to what the patient is actually saying</td>
<td>1</td>
<td>16</td>
</tr>
<tr>
<td>Avoiding pre-diagnosis</td>
<td>1</td>
<td>16</td>
</tr>
<tr>
<td>Respecting patients</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Making the patient feel like they have a choice.</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Knowing patients’ limitations</td>
<td>1</td>
<td>11</td>
</tr>
<tr>
<td>Simplifying treatment plans</td>
<td>1</td>
<td>15</td>
</tr>
</tbody>
</table>
Do you think patient centered care is important? Why?

<table>
<thead>
<tr>
<th>Code</th>
<th>Number of interviews in which code appeared</th>
<th>Sequence of interviews in which code appeared</th>
</tr>
</thead>
<tbody>
<tr>
<td>Better for patients’ health</td>
<td>4</td>
<td>2, 5, 10, 16</td>
</tr>
<tr>
<td>Best practice for health behavior change</td>
<td>2</td>
<td>1, 15</td>
</tr>
<tr>
<td>Patient satisfaction</td>
<td>3</td>
<td>8, 12, 14</td>
</tr>
</tbody>
</table>
SEXUAL HEALTH COMMUNICATION THEMES

Is it appropriate for family doctors or internists to talk to their patients about sexual health? Why?

<table>
<thead>
<tr>
<th>Code</th>
<th>Number of interviews in which code appeared</th>
<th>Sequence of interviews in which code appeared</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex is part of overall health.</td>
<td>13</td>
<td>1, 2, 3, 4, 5, 8, 9, 10, 11, 13, 14, 15, 16</td>
</tr>
<tr>
<td>STD prevention</td>
<td>3</td>
<td>3, 12, 14</td>
</tr>
<tr>
<td>Patient education</td>
<td>3</td>
<td>7, 9, 17</td>
</tr>
<tr>
<td>Pregnancy prevention</td>
<td>1</td>
<td>12</td>
</tr>
</tbody>
</table>

Are there times that it (discussing sexual health with patients) is more or less appropriate?

<table>
<thead>
<tr>
<th>Code</th>
<th>Number of interviews in which code appeared</th>
<th>Sequence of interviews in which code appeared</th>
</tr>
</thead>
<tbody>
<tr>
<td>Related to chief complaint</td>
<td>8</td>
<td>1, 2, 5, 6, 9, 13, 15, 16</td>
</tr>
<tr>
<td>More appropriate:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>UTI concerns</td>
<td>7</td>
<td>2, 5, 6, 10, 12, 13, 16</td>
</tr>
<tr>
<td>Abdominal pain</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Erectile dysfunction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>STI complaint</td>
<td></td>
<td></td>
</tr>
<tr>
<td>More appropriate with preventive visits/well care visits</td>
<td>6</td>
<td>1, 2, 5, 12, 15, 16</td>
</tr>
<tr>
<td>Interpersonal dynamics</td>
<td>4</td>
<td>8, 11, 14, 17</td>
</tr>
</tbody>
</table>
How do you decide when it is appropriate to discuss sexual health topics with patients?

<table>
<thead>
<tr>
<th>Code</th>
<th>Number of interviews in which code appeared</th>
<th>Sequence of interviews in which code appeared</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well care visit</td>
<td>5</td>
<td>1, 3, 12, 14, 15</td>
</tr>
<tr>
<td>An STI/pregnancy symptom or worry visit</td>
<td>5</td>
<td>1, 2, 4, 13, 15</td>
</tr>
<tr>
<td>Specific groups (teenagers, young black men, multiple partners)</td>
<td>2</td>
<td>3, 4</td>
</tr>
<tr>
<td>Well care visit, STI/pregnancy concern visit, and specific “high risk” groups</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

How effective do you think physician-initiated STI prevention discussions are?

<table>
<thead>
<tr>
<th>Code</th>
<th>Number of interviews in which code appeared</th>
<th>Sequence of interviews in which code appeared</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not very effective</td>
<td>6</td>
<td>2, 3, 4, 7, 8, 14</td>
</tr>
<tr>
<td>Moderately effective</td>
<td>5</td>
<td>5, 7, 10, 11, 16</td>
</tr>
</tbody>
</table>
What types of sexual health topics should primary care physicians discuss with their patients?

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>STIs and safer sex practices</td>
<td>14</td>
<td>1, 2, 3, 4, 5, 7, 8, 9, 10, 12, 14, 15, 16, 17</td>
</tr>
<tr>
<td>Contraception</td>
<td>8</td>
<td>1, 2, 4, 8, 14, 15, 16, 17</td>
</tr>
<tr>
<td>Sexual dysfunction (vaginal dryness, erectile dysfunction)</td>
<td>7</td>
<td>1, 2, 8, 9, 11, 12, 13</td>
</tr>
<tr>
<td>Sexual orientation</td>
<td>5</td>
<td>1, 5, 6, 8, 16</td>
</tr>
</tbody>
</table>

How comfortable are you discussing sexual health topics with your patients?

<table>
<thead>
<tr>
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<th>Number of interviews in which code appeared</th>
<th>Sequence of interviews in which code appeared</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completely/very/normally (without explanation)</td>
<td>8</td>
<td>1, 3, 5, 6, 7, 11, 12, 17</td>
</tr>
<tr>
<td>Comfort level increases with experience</td>
<td>4</td>
<td>4, 9, 13, 14</td>
</tr>
<tr>
<td>Based on patient gender (gender concordance)</td>
<td>3</td>
<td>8, 10, 16</td>
</tr>
</tbody>
</table>
Do you feel more comfortable discussing sexual health topics with certain patients?

<table>
<thead>
<tr>
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<th>Number of interviews in which code appeared</th>
<th>Sequence of interviews in which code appeared</th>
</tr>
</thead>
<tbody>
<tr>
<td>Based on patient comfort level</td>
<td>5</td>
<td>3, 4, 5, 6, 7</td>
</tr>
<tr>
<td>Gender concordance makes it easier</td>
<td>4</td>
<td>1, 8, 15, 16</td>
</tr>
<tr>
<td>Age related:</td>
<td>4</td>
<td>1, 4, 8, 10</td>
</tr>
<tr>
<td>Teenagers/young adults are easy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less comfortable with elderly patients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less comfortable if you know the person outside of your practice</td>
<td>3</td>
<td>8, 8, 15</td>
</tr>
</tbody>
</table>

What influences whether or not you discuss sexual health topics with your patients?

<table>
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<th>Sequence of interviews in which code appeared</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief complaint (acute vs. well care)</td>
<td>4</td>
<td>1, 5, 9, 14</td>
</tr>
<tr>
<td>Patient comfort level</td>
<td>4</td>
<td>6, 9, 10, 16</td>
</tr>
</tbody>
</table>
What prevents more physicians from discussing sexual health topics with their patients?

<table>
<thead>
<tr>
<th>Code</th>
<th>Number of interviews in which code appeared</th>
<th>Sequence of interviews in which code appeared</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time constraints (sex is a complicated topic)</td>
<td>11</td>
<td>1, 3, 4, 5, 6, 7, 8, 9, 10, 13, 16</td>
</tr>
<tr>
<td>Physician discomfort with the topic</td>
<td>9</td>
<td>1, 2, 3, 4, 10, 12, 14, 15, 16, 17</td>
</tr>
<tr>
<td>Multiple clinical items to cover/low priority</td>
<td>8</td>
<td>1, 2, 4, 5, 6, 7, 10, 16</td>
</tr>
<tr>
<td>Patient discomfort/patients don’t bring it up</td>
<td>6</td>
<td>1, 4, 7, 9, 11, 16</td>
</tr>
</tbody>
</table>
References


