

EVALUATION

Sexual History Taking: Perspectives on Doctor-Patient Interactions During Routine Consultations in Rural Primary Care in South Africa



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ABSTRACT

Background: Sexual history taking for risk behavior contributes to improving health outcomes in primary care. Giving the high numbers of people living with AIDS, every patient in South Africa should be offered an HIV test, which implies that a comprehensive sexual history must be taken.

Aim: To describe the optimal consultation process, as well as associated factors and skills required to improve disclosure of sexual health issues during a clinical encounter with a doctor in primary health care settings in North West province, South Africa.

Methods: This qualitative study, based on grounded theory, involved the video-recording of 151 consultations of adult patients living primarily with hypertension and diabetes. This article reports on the 5 consultations where some form of sexual history taking was observed. Patient consultations were analyzed thematically, which entailed open coding, followed by focused and verbatim coding using MaxQDA 2018 software. Confirmability was ensured by 2 generalist doctors, a public health specialist and the study supervisors.

Main Outcome Measure: Sexual history was not taken and patients living with sexual dysfunction were missed. If patients understand how disease and medication contribute to their sexual wellbeing, this may change their perceptions of the illness and adherence patterns.

Results: Sexual history was taken in 5 (3%) out of 151 consultations. Three themes emerged from these 5 consultations. In the patient-doctor relationship theme, patients experienced paternalism and a lack of warmth and respect. The consultation context theme included the seating arrangements, ineffective use of time, and privacy challenges due to interruptions and translators. Theme 3, consultation content, dealt with poor coverage of the components of the sexual health history.

Conclusion: Overall, sexual dysfunction in patients was totally overlooked and risk for HIV was not explored, which had a negative effect on patients' quality of life and long-term health outcomes. The study provided detailed information on the complexity of sexual history taking during a routine consultation and is relevant to primary health care in a rural setting. **D Pretorius, I Couper, M Mlambo. Sexual History Taking: Perspectives on Doctor-Patient Interactions During Routine Consultations in Rural Primary Care in South Africa. Sex Med 2021;XX:XXXXXX.**

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Key Words: Sexual History Taking; Sexual Dysfunction; Patient Centeredness; Communication; Sexual Risk Screening; HIV Screening; Privacy; Consultation; Routine Consultation

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INTRODUCTION

Sexual history taking for patients with chronic illness, such as diabetes and hypertension, remains a neglected area in primary care settings. Research suggests that between 10% and 58% of doctors globally conduct routine sexual history taking.^{1,2} In both the UK and USA, researchers found that the human immunodeficiency virus (HIV) testing in primary care did not only offer health benefits but was also cost effective.^{3,4} In light of the overall estimated HIV prevalence in South Africa (13.5%),⁵ routine

HIV risk screening is both important and aligned with the Government Health Strategy to improve health outcomes in South Africa.⁶ The South African national guidelines for management of HIV prescribe that every patient must be offered an HIV test or be informed of self-screening for HIV.^{7,8} Through regular HIV screening and testing, clinical management can reduce AIDS-related events and death substantially.⁹ It is therefore important to assess the frequency and nature of sexual history taking.

Screening for HIV infection varied between countries. For example, 2% of men living in Niger were screened for HIV, whereas 45% of Ukrainian women were tested, and still other countries have no screening data.¹⁰ Tillman¹¹ suggested that despite older people being more receptive to sexual history taking, asymptomatic screening for HIV and sexually transmitted infections (STI) was low. If provider-initiated screening was conducted during the routine consultation, it could provide an opportunity for sexual history taking. This opportunity for sexual history taking was then also the result of provider-initiated HIV testing that improved the uptake of screening and treatment in Nigeria.¹² A qualitative meta-analysis of HIV literature found that rapid testing in routine primary care settings enhanced screening opportunities.¹⁰ The assumption is that to screen for HIV, a sexual history must be taken in order to do HIV pretest counselling.¹³

A sexual history usually covers sexual practices, partners, previous STI, prevention of STI and pregnancy, and other factors such as sexual wellbeing, trauma, gender identity, sexual orientation, and other sexual concerns.^{14,15} In the literature, there is an emphasis on a culturally sensitive and respectful sexual history taking, where good communication and an inclusive attitude are important.¹⁶ When taking a sexual history, lay terminology makes it easier for doctors and patients, not only in terms of concepts, but also to ease the discussion or patient-doctor interaction.¹⁷ The lack of open-ended questions to facilitate the patient's story, as well as prejudice of the health care worker tends to limit opportunities to explore sexual challenges.¹⁸ Sexual history taking is, however, inhibited by personal, professional, educational, and normative barriers, which may impact on the frequency of sexual history taking.^{19–23} Expert opinion is that sexual history seldom happens in primary care, despite best intentions.²⁴ The absence of sexual history taking was also reported in an observational study of homeless people in the USA.²² However, a cross-sectional study in the USA on documentation of sexual history taking in primary care found partial sexual history taking in 34%, and none in the other 65% of the primary care consultations.¹⁵

A South African study found that the prevalence of non-communicable disease and HIV infection is high, and that community-based screening must be expanded.²⁵ This prompted the researcher's interest in understanding what the nature of sexual history taking entails in a rural primary care setting in South Africa. Coverdale et al²⁶ published a systematic review of English

publications globally on teaching sexual history-taking skills and found only one study involving community-based physicians. In South Africa, research on sexual dysfunction is lacking, as only 17 articles were published in peer-reviewed journals between 1970 and 2013.²⁷ Video-recorded research is scarce globally. To the best of our knowledge, in South Africa, there is no record of a study that involved video recording of real-time consultations to observe and describe sexual history taking and thus a lack of evidence of the nature and content of sexual history taking in primary care. Observation of real-time sexual history taking with patients can contribute to better training during undergraduate years and continuous education for practicing doctors.

MATERIALS AND METHODS

Aim of the Study

This study observed and described sexual history taking, as well as doctor-patient interaction regarding sexual history taking, during routine consultations in primary care settings in Dr Kenneth Kaunda Health District, North West Province, South Africa.

Method

This qualitative study formed part of the broader grounded theory PhD study using observed video-recorded consultations of adult patients (>18 years of age), who were at risk of sexual dysfunction due to their diagnosis of hypertension and/or diabetes, and/or the medication they used.²⁸

Dr Kenneth Kaunda Health District, in North West Province, South Africa, is considered a rural area. It has a population of 807,252, living in an area of 14,767 km². Government-provided primary care services are rendered to approximately 80% of the population.²⁹ These patients do not have the financial resources to access any other health care services.

Twenty-one doctors gave written consent to participate. The adult patients living with diabetes and hypertension, and thus at risk of sexual dysfunction, were purposefully selected. Of them, 151 were consecutively sampled and gave written consent. The number of patients was based on the number of consultations that must be observed to have enough examples of sexual history taking. The midpoint of the disclosure rate of sexual dysfunction, which varies between 14% and 20%^{19,30–31} was used to calculate the sample as described in another article.³² Only the video consultations where sexual history taking took place constituted the final sample for this article. Consultations where the focus was routine health maintenance without any further sexual health education, sexual risk screening, or any attempt of sexual history taking were excluded.

Written consent was obtained from patients and doctors for both video recording of the consultation and the completion of the questionnaires following the consultation. Participants were informed that the content of the consultation will be analyzed,

without referring to sexual history taking. Following the recording, the patient consented to complete globally used questionnaires, namely, the Female Sexual Function Index (FSFI)³³ or International Index of Erectile Function (IIEF),³⁴ to determine if the patients experienced sexual dysfunction symptoms.

Data Analysis

The videos were transcribed verbatim and analyzed using MaxQDA 2018 software. For analysis, open coding was done initially to systematically identify similar behavior and interactions, as well as consultation content. Consultations where there was no reference to any form of sexual health by the patient or any form of screening or discussion of sexual health by the doctor, were excluded from further analysis. Axial coding of the 5 remaining consultations was guided by what issues were addressed during the sexual history taking, who was involved, the nature of the interaction, if the issue was addressed or not, how, when and why it was addressed and if there was a reason for it, and lastly, if there were any methods or strategy to address the issue.³⁵ Using descriptive and in vivo coding, data codes with similar characteristics were grouped into categories representing observations, behaviors, or interaction. The observations and coding scheme were reviewed by a family physician, general practitioner, public health specialist, and the study supervisors to ensure trustworthiness and credibility. To establish the trustworthiness of the study, multiple data sources were used, including video recording of the consultations, questionnaires, and field notes.

Ethical Considerations

The study was approved by the Human Research Ethics Committee (Medical) of the University of Witwatersrand (M160557). Clinics were referred to only as site numbers to ensure confidentiality of both the setting and healthcare workers. The Directorate: Policy, Planning, Research, Monitoring and Evaluation of the Department of Health, North West Province, South Africa, granted permission for the research to proceed. Permission was granted to use the sexual dysfunction questionnaires by the publishers.

RESULTS

Patient, Doctor, and Consultation Characteristics

Sexual history taking was observed in 5 consultations out of 151 patient consultations (Table 1). All 5 of the consultations offered the opportunity for both screening for HIV infection and exploring sexual dysfunction. The 4 doctors were between the ages of 25 and 47 years, and the 5 patients varied between 33 and 63 years. Active interaction with patients varied between 2 and 8 minutes in consultations that lasted between 8 and 23 minutes (Table 1). Time was lost in the consultation on administrative tasks, as well as searching for information and laboratory results. Although all 5 patients experienced sexual dysfunction

symptoms, such as erectile or orgasmic challenges, pain or desire and arousal challenges (Table 1), only 1 patient did not meet the criteria for overall sexual dysfunction.

Sexual History During the Consultation

The excerpts of the consultations are summarized in Table 2.

Consultation 1 presented a 63-year-old man consulting for a follow-up for stomach pain. He was asked if he has HIV, and despite the patient not knowing, he was not offered an HIV test.

Consultation 2 was a 46-year-old woman who presented with pain after intercourse and was informed on vaginal hygiene practices.

Consultation 3 included a warning about HIV given to a 33-year-old man presenting with a STI.

Consultation 4 presented a 63-year-old man that had a prostatectomy in the previous year and was asked if, “*All good and working after the operation?*”

Consultation 5 deals with a 47-year-old woman who said she felt sick, and the doctor wanted to know her HIV status.

Thematic Analysis

Three themes emerged from the study, namely the patient-doctor relationship, the consultation context, and content (Tables 3–5).

Theme 1 centered around the patient-doctor relationship, which comprised of 3 subcategories, namely patient-centeredness, professionalism, and communication. Doctors were paternalistic, with little evidence of professionalism and no evidence of patient-centeredness (Table 3).

Theme 2 focused on the consultation context (Table 4). Time dedicated to the patient interaction was less than a third of the consultation time. Privacy was a challenge with either the nurse acting as translator or other staff members entering the consultation room to collect equipment. There was no evidence of sexual history taking, as no risk screening and management were observed (Table 4).

Theme 3 involved the consultation content (Table 5). It dealt with the content of the consultation and the scope of sexual history taking. Health education was conducted in 2 consultations. No screening for sexual risk or dysfunction was conducted (Table 5).

DISCUSSION

This study set out to observe and describe patient-doctor interactions related to sexual history taking during routine consultations in primary care settings. This study found only 5 examples of any attempt at sexual history taking, out of 151 consultations recorded. Three themes emerged that described the

Table 1. Patient, doctor, and consultation characteristics

Consultation	Doctor	Presenting complaint	Time of interaction	FSFI/IEF results
<i>Consultation 1</i> Patient 25: A 63-year-old Setswana man, living with diabetes, hypertension and cholesterol. The patient completed primary school.	Dr 07: 47-year-old male doctor	Painful stomach. BP 127/88.	11.50 min Time paging in file: 47 s. Time writing in file: 3.06 min Examination: 1.02 min. Writing referral note: 1.32 min. Interaction with patient using a Translator: 5.36 min	IEEF: Patient 25 had severe orgasmic dysfunction, mild to moderate sexual desire challenges and no intercourse satisfaction. Overall, he had severe sexual dysfunction
<i>Consultation 2</i> Patient 37: 46-year-old Setswana woman The patient completed secondary school.	Dr 09: 31-year-old female doctor	Diabetes, asthma, depression, and HIV. Presenting complaint on file: Pain after intercourse, and on recording renewal of script and scratchy eye was added. BP 144/108.	Total consultation: 22.50 min Time paging in file: 1.16 min Time writing in file: 8.15 min Examination: 2.58 min Writing referral note: 1.25 min Dispensing medication: 1.20 min Interaction with patient: 8.16 min The consultation was done in English	FSFI: Patient 37 had overall sexual dysfunction being affected in all the domains, namely desire, arousal, lubrication, orgasm, satisfaction, and pain.
<i>Consultation 3</i> Patient 49: A 33-year-old Xhosa man. The patient completed secondary school.	Dr 11: A 28-year-old male doctor	Hypertension. Presenting complaint: STI written on file. The patient never mentioned it to the doctor. BP 145/81.	Total consultation: 7.55 min Time paging in file: 2.45 min Time writing in file: 3.1 min Examination: 1.01 min Dispensing medication: 0.55 s Interaction with patient: 1.56 min Consultation was done in Setswana	IEEF: Patient 49 lived with overall sexual dysfunction. He experienced moderate erectile dysfunction, severe orgasmic and desire challenges and had moderate intercourse satisfaction.
<i>Consultation 4</i> Patient 95: A 63-year-old Xhosa man The patient completed secondary school.	Dr 17: 25-year-old male doctor	Diabetes and hypertension. Presenting complaint: Not documented on file (On video repeat of chronic script and pain in shoulders indicating left shoulder) BP 136/96.	Total consultation: 9.56 min Time paging in file: 1.73 min Time writing in file: 3.06 min Examination: 1.37 min Interaction with patient: 2.07 min Consultation was done in English. Nurse Translator in the room.	IEEF results The patient had mild erectile dysfunction, severe orgasmic challenges, moderate desire, and moderate intercourse satisfaction. Overall, he did not meet the criteria for sexual dysfunction
<i>Consultation 5</i> Patient 98: A 47-year-old Xhosa woman living with The patient completed secondary school.	Dr 17: 25-year-old male South African graduate	Hypertension. Presenting complaint: Not documented on file (On video repeat of chronic script and she feels sick). BP 140/91.	Total consultation: 8.09 min Time paging in file: 2.04 min Time writing in file: 3.08 min Examination: 30 s Writing referral for blood: 39 s Interaction with patient: 2.28 min Consultation was done in English	FSFI The patient had overall sexual dysfunction. All the domains namely desire, arousal, lubrication, orgasm, and satisfaction were affected except pain

Table 2. A qualitative summary of sexual history taking excerpts as observed during the consultations (n = 5)

Consultation 1 Male patient (63 years), male doctor (47 years)	Consultation 2 Female patient (46 years), female doctor (31 years)
Prelude to sexual history taking: The patient was at the clinic the weekend prior to this consultation and got medicine for his stomach with the instruction to return. Sexual history excerpt: Dr 07: Did you finish your treatment? Pt 25: Yes, I have. Dr 07: Do you have HIV? Pt 25: I do not know. Dr 07: Please go on the bed. Pt 25: On the bed? Dr 07: Yes. Doctor examined the patient on the couch. Dr 07: Is your stomach getting bigger Pt 25: No. Dr 07: So, everything is fine. I just want to do a test in your stomach to see if your stomach and pancreas is okay. . . Doctor started writing the referral and the nurse explained to the patient where to go.	Prelude to sexual history taking: This was a routine consultation to renew the script, covering all her chronic conditions. The doctor followed up on the blood pressure. The patients attended a relative's funeral the day before and doctor decided to follow up on blood pressure at the next visit. Sexual history excerpt: Dr 09: You did blood tests. . . (reading) August last year. Let me see the results. (Dr accessed laboratory results on her phone). Okay, the viral load looks good. We used to look at the CD4, but we do not do it anymore. The viral load is now the one that tells us how good you are and if you use your medicine. Pt 37: Oh (nodding) Dr 09: Anything else? Pt 37: When. . . when I have sex neh, I have pain. . . but after. Dr 09: Painful? Pt 37: Nodding and indicating suprapubic area. Dr 09: At the bottom? Pt 37: (Nodding yes). Dr 09: How many children do you have... Pt 37: . . . interrupts: Three Dr 09: . . . and were they born normal or caesarean section? (Indicating 3 fingers) Pt 37: Yes. Dr 09: It is because . . . because of the stitches. It can happen they grow in there. As long as it does not cause discomfort during intercourse. Pt 37: And sometimes itchiness (whispering). Dr 09: What do you use to wash? Pt 37: "Brand name" soap. Dr 09: It is too strong for the vagina. "Brand name soap" is too strong. You can use aqueous cream and water but must not put soap there. Pt 37: Laughs (looking embarrassed) Dr 09: When was the last time you had a PAP smear? Pt 37: Shaking her head indicating no or never. (The doctor wrote in the file). Dr 09: I am going to refer you. . . Please undress – I am going to examine your bottom and your eye. (Patient gets up and doctor continued writing). The doctor examined the patient. While examining: Do you still see your period? Pt 37: No answer on the recording, so the researcher assumed the patient nodded. Dr 09: Okay, but it will come and go till it stops. (Doctor returned to desk and made notes. The patient dressed and returned). Dr 09: You had a dry eye and the vagina is dry. You must go to the eye clinic. (doctor writes and she and patient make small talk). When was the last time your husband tested? Pt 37: (Patient shrugs). Dr 09: It is important that he also test regularly. If his viral load is also low then you will stay healthy. (Patient nodded). (Doctor wrote in the file and then wrote a referral note. She gave the referral note to the patient). They will sort your eye for you at the eye clinic. They made small talk and greeted, and patient departed.
Consultation 3 Male patient (33 years), male doctor (28 years)	Consultation 4 Male patient (63 years), male doctor (25 years)
Prelude to sexual history taking: The patient entered, and the doctor asked him to close the door properly. The patient greeted. The doctor was already paging in the file and failed to greet. Sexual history excerpt: Dr 11: (Paging through file and sigh.) Again? Pt 49: (embarrassed) Yeh (remove the cap from his head) Dr 11: Next time it is HIV neh? How long? Pt 49: Two weeks Dr 11: Color? Pt 49: Yellow Dr 11: You can prevent this. Abstain, be faithful and use a condom. Pt 49: Yeh, I know Dr 11: Get on (the) couch. (Dr examined the patient). Dr 11: I will give you medication, but you must abstain, be faithful and use a condom. Pt 49: Yeh, I will Dr 11: (Try and find medicine in the cupboard in the consultation room, failed to find it and wrote a script and gave to patient. Patient left).	Prelude to sexual history taking: The consultation started with the doctor asking if she understood English, and proceeds with: Dr 17: How old are you and do you need something today? Pt 98: 47. I need medicine and I feel sick. Dr 17: Do you sleep and eat nicely? Pt 98: Yes. Dr 17: (Doctor does a mental health check). Your blood was done a year ago, I am going to send you for bloods to check sugar, kidneys and other organs. (The doctor goes to the chair she is sitting in and listens to her lung sounds, and check for edema on lower limbs). No swelling, that is good. (He makes notes in her file and renewed her script). Dr 17: BP is not bad, but you say you are sick? Pt 98: Yes Dr 17: Have you tested for HIV? Pt 98: No Dr 17: You must go to the counselor. You must be tested. Okay? (not waiting for a reply). I will hear if they are here. (Doctor leaves consultation room and returns later). Yes, they are here. You can go. Video recording terminated. *When patient presented for the questionnaire, she spontaneously informed us she tested HIV positive.
Consultation 5 Female patient (47 years), male doctor (25 years)	Consultation 6 Male patient (63 years), male doctor (25 years)
Prelude to sexual history taking: The patient entered, and doctor asked the patient to close the door. Patient 95: Good morning Doctor. How are you? Dr 17: Good (Paging through file and not looking at the patient). What is wrong today? Pt 95: My shoulders pain. The doctor explored the attributes of the shoulder pain. Dr 17: I am going to check your blood results that was done last year. . . . (checking laboratory results on his phone). . . July. . . It is good. (Filed notes: A year ago). Dr 17: I want to examine your shoulder. Doctor examined the patient. I will prescribe something for the shoulder. Dr 17: (Writing in file) BP is still a bit high but good for your age. Pt 95: Yes. Dr 17: I see you had prostate surgery a year ago? Pt 95: Yes Dr 17: All good and working after the operation? Pt 95: Yes Dr 17: Good. You must keep drinking your pills. Pt 95: Yes Dr 17 You can make an appointment for next visit. Pt 95. Yes Consultation ended.	Prelude to sexual history taking: The patient entered, and doctor asked the patient to close the door. Patient 95: Good morning Doctor. How are you? Dr 17: Good (Paging through file and not looking at the patient). What is wrong today? Pt 95: My shoulders pain. The doctor explored the attributes of the shoulder pain. Dr 17: I am going to check your blood results that was done last year. . . . (checking laboratory results on his phone). . . July. . . It is good. (Filed notes: A year ago). Dr 17: I want to examine your shoulder. Doctor examined the patient. I will prescribe something for the shoulder. Dr 17: (Writing in file) BP is still a bit high but good for your age. Pt 95: Yes. Dr 17: I see you had prostate surgery a year ago? Pt 95: Yes Dr 17: All good and working after the operation? Pt 95: Yes Dr 17: Good. You must keep drinking your pills. Pt 95: Yes Dr 17 You can make an appointment for next visit. Pt 95. Yes Consultation ended.

Table 3. Summary of observations supporting Theme 1

Relationship 1: The patient-doctor relationship

		Consultations					
Categories and codes	Category or code description	1 Pt 25	2 Pt 37	3 Pt 49	4 Pt 95	5 Pt 98	Key: ✓ – done or present; X – not done, absent; O – partly done
Category: Patient-centeredness							
• Participation	Respectful and warm patient approach to understand the unique context, preferences, needs and values of the patient. For the patient to become actively involved in the consultation	X	✓	X	X	X	
• Paternalism	Doctor limits the patient’s autonomy to make decisions or participate in decision making	✓	✓	✓	✓	✓	“Please undress – I am going to examine your bottom and your eye” “I will give you medication, but you must abstain, be faithful and use a condom”. “You must go to the counsellor. You must be tested. Okay?”
• Partnership	Doctor and patient take co-responsibility for the consultation process and outcome	X	X	X	X	X	
Category: Professionalism							
• Doctor greeted when consultation commenced.	Welcome the patient politely as determined by culture or custom.	X X	✓ ✓	X X	O X	X X	Greeting observed in one consultation. “Good morning Doctor. How are you?” “Good” (Paging through file and not looking at the patient).
• Greeting when consultation ended							
• Introduced him/herself	The doctor introduced him/herself and confirm the patient’s name	X	✓	X	X	X	Observation
• Examined the patient	Standardized clinical structured way to assess what is wrong with a patient after history taking.	✓	✓	✓	O	✓	Observations: Consultation 2 & 3 examined patient on the couch and 3 others were examined patient on the chair. Consultation 4: The doctor did a shoulder exam with a seated patient wearing a thick jersey.
• Used gloves	The use of surgical gloves for examination	✓	✓	✓	X	X	Observed
• Washed hands	Washing of hands before or after examination or after gloving.	X	✓	✓	X	X	Field notes: All 5 consultation rooms had basins and running water and gloves.
Communication skills							
	The verbal (includes sign language), nonverbal or written exchange of information or ideas between one or more individuals. It also conveys emotion.						
• Rapport building	A way to make the patient feel comfortable, safe and free to share feelings and ideas. It can be verbal or nonverbal.	X	✓	X	X	X	“I think I know you; you have been here before?” Observation: Doctor smiled and looked friendly.
• Medical jargon	The use of medical terminology unfamiliar to the patient.	✓	X	X	✓	X	“I just want to do a test in your stomach to see if your stomach and pancreas is okay. . .”. Observed over simplification: “. . .bottom”.
• Explain disease or process to the patient	To explain to the patient your findings or reason for doing or asking things.	X	✓	X	X	O	“It is because . . .because of the stitches. It can happen they grow in there. As long as it does not cause discomfort during intercourse”. “It is too strong for the vagina. “Brand name soap” is too strong. You can use aqueous cream and water but must not put soap there”. “Your blood was done a year ago, I am going to send you for bloods to

(continued)

Table 3. Continued

Relationship 1: The patient-doctor relationship

• Questioning	Purposive and systematic way to ask few questions to elicit deep experiences and optimal information in an official context.	X	X	X	X	X	check sugar, kidneys and other organs." (The doctor checks for edema on lower limbs). "No swelling, that is good."
• Clarification / Reflection	Technique to verify if the doctor understood information, feelings and ideas correctly to avoid misunderstandings / to paraphrase information, feelings and ideas with added meaning that the patient can "hear" their own thoughts or to elicit underlying messages.	X	X	X	X	✓	Positively phrased, leading, closed ended and double barrel questions. "Do you sleep and eat nicely?" "All good and working after the operation?" "Painful?" "Again?"
• Following up on questions	Non-optimal questions and answers must be followed up to discover or explore meaningful information that can enrich the assessment process.	X	X	X	X	X	Observation: No meaningful follow up. "BP is not bad, but you say you are sick?" "Yes" "Have you tested for HIV?" "How many children do you have..." Patient interrupts: "Three". "...and were they born normal or caesarean section?" "Yes".
• Listening	To hear and interpret what the patient is saying — it usually leads to appreciation, empathy, comprehension or critical thinking actively and effectively.	X	O	X	O	O	
• Eye contact	Face to face or eye to eye contact (inference listening or paying attention).	X	✓	O	O	O	Observation: Varied between no eye contact to good eye contact, to intermittent eye contact.

patient-doctor relationship, the consultation setting, and the content of the consultation, which could explain the omission of sexual history taking in primary care.

There was no patient-centeredness as described in literature observed in any of the 5 consultations.^{36–38} Unlike the other consultations, Doctor 9 (Consultation 2) partially succeeded in involving the patient in the conversation but did not demonstrate other aspects of patient-centeredness. Unfortunately, all the consultations had evidence of paternalism and a lack of partnership. Despite being difficult to quantify patient-centeredness, it is well described that the presence of its components lead to better patient outcomes.^{39,40} Cohen and Alfonso⁴¹ believe that the scope of the biopsychosocial approach, which includes medical, psychological, intrapsychic, interpersonal, sociocultural, and ethnic variables, facilitates sexual history taking.

Professionalism is an important component of the patient-doctor relationship that was lacking in these consultations. Greeting, politeness, and using a person's name are not only expressions of professionalism, but also signal respect in most African cultures.⁴¹ The Setswana people describe a person

who greets as having "botho" which means they have humanity, good relations and care for others.⁴² The perception of politeness is supported by rapport building, where upholding social practices and communicating accordingly connects people. For example, not greeting an older African person can lead to the individual feeling disrespected and can compromise the patient-doctor relationship.⁴¹ This was observed in Consultation 4: the older, friendly patient greeted the young doctor and even inquired about his wellbeing: (*Patient 95: "Good morning Doctor. How are you?"*) The doctor failed to greet the patient in return, and the patient consequently responded with sullen-sounding, one-syllable answers for the remainder of the consultation. If the doctor had observed and reflected on this behavior change in the patient, the interaction could have been normalized. Consultation 2 differed from the other consultations, in greeting and introduction, as well as acknowledging the patient's name, which improved the doctor-patient relationship and resulted in the patient disclosing intimate information. Rapport between the patient and doctor relieves anxiety and promotes dialogue.⁴³

Table 4. Summary of observations supporting Theme 2

Theme 2: Consultation context

Categories and codes	Category or code description	Consultations					Key: ✓ – done or present; X – not done, absent; O – partly done
		1 Pt 25	2 Pt 37	3 Pt 49	4 Pt 95	5 Pt 98	
<i>Setting</i>	The environment in which the consultation takes place						
1. Seating	Optimal seating arrangements that allows movement and observation and put patient and doctor on equal footing.	X	✓	X	X	X	Consultation 2: The patient was seated next to the desk while the doctor turned away from the desk that she and the patient sat in a semi-L-shape. Consultation 1 & 49: Sat opposite each other with desk between them. For Consultation 4 and 98: The patient was seated next to the washing basin with about 1 m between him and doctor. Doctor was seated behind a desk and the nurse was sitting opposite the doctor on the examination couch with files next to her.
2. Timing	Moments in the consultation measured in time.	X	✓	X	X	X	Time was lost with paging in file for information or finding the correct page, writing notes, and obtaining laboratory results on the cell phone. Examination varied between 2 minutes and 3 minutes. Active patient and doctor in interaction varied between <2 min (21% of consultation time) and 8 minutes (36% of consultation time) – both without Translators. The translation consultations had longer interaction with the patient, but it did not change the involvement of the patient in the consultation.
<i>Privacy</i>	Situation where doctor and patient are not interrupted or overheard by other people. It includes an area where the patient can be examined without the risk of being seen by another person.						
• Door closed	The door of the consultation room must be closed.	✓	✓	✓	✓	✓	
• Curtaining at the examination couch	Curtains that can close off the examination couch.	X	✓	X	X	X	Field notes: No curtains at examination couches except Consult 2.
• Window	Windows in the consultation room covered to prevent the patient to be seen.	✓	✓	X	✓	✓	Field notes: Windows with blinds or curtains. Consultation 3 – only a sheet covering two thirds of the window looking out on a service area.
• Translator	A person translating from English to one of the other African languages.	✓	X	X	✓	✓	Field notes & observations: Two consultations made use of the nurses to translate. The doctors did interact either with the nurse translator or kept making notes during the translation process. Consultation 3 – the nurse (translator not utilized) yawned loudly while patient was examined and had private social discussions on community events with the patient while the doctor made his notes.
• Interruptions	An act or utterance that interfere or break the continuity of the consultation.	✓	✓	✓	✓	X	Observation: Interruptions caused by translator or other staff members entering looking for forms or needles etc. and then leaving. Only one consultation did not have an interruption.

Table 5. Summary of observations supporting Theme 3

Theme 3: Consultation content

Categories and codes	Category or code description	Consultations					Key: ✓ – done or present; X – not done, absent; O – partly done
		1 Pt 25	2 Pt 37	3 Pt 49	4 Pt 95	5 Pt 98	
<i>Consultation content</i>	The components of the consultation namely medical history, examination, and discussion of care and treatment – all of which are grounded in evidence-based criteria or standards.						
• Management of presenting complaint	The complaint the patient presents with as primary focus of the consultation.	✓	✓	✓	✓	✓	Observation: All presenting complaints addressed to some degree or other.
• Management of chronic condition	Discussion of one or more diseases that needed ongoing monitoring and management.	X	✓	X	X	X	Observation: Consultation 2 had a detailed systematic overview of chronic conditions, whilst Consultation 3 and Consultation 4 had one comment on blood pressure.
• Health education	Information or teaching of ways to promote and maintain personal health.	X	✓	✓	X	X	“Okay, the viral load looks good. We used to look at the CD4, but we do not do it anymore. The viral load is now the one that tells us how good you are and if you use your medicine”. “You can prevent this. Abstain, be faithful and use a condom”
• Opportunistic health screening	To identify an asymptomatic or healthy person who at risk of a disease or condition. It includes recent travel and domestic violence.	O	✓	X	X	✓	“Do you have HIV? Patient: “I do not know.” “When was the last time you had a PAP smear?”
• Refer appropriately	Sending a patient for an appropriate review or further action to another professional.	X	O	X	X	O	Consultation 2 – Eye clinic, but no referral pain complaint or PAP smear. Consultation 5 – No justification for referral to do HIV testing.
• Sexual history – risk screening and management	Any assessment of recent sexual history, sexual orientation, type of sexual activity, the possibility of pregnancy (women), use of contraceptives including condoms, recent antibiotic history.	X	X	X	X	X	Not observed
• Sexual history – sexual dysfunction screening and management (DSM 5)	Any diagnostic criteria of sexual dysfunction.	X	X	X	X	X	Not observed

Communication skills, including the verbal and non-verbal exchange of information and ideas between individuals, are core to the doctor-patient relationship. Poor eye contact and poor listening were the 2 factors most prominent in these consultations. Gorawara-Bhat and Cook⁴⁴ connected eye contact and listening as 2 crucial components of patient-centeredness. Eye contact is often sensitive in Africa, as some people claim that in certain

cultures, adults do not to tolerate younger people making direct eye contact. Nonetheless, a study conducted in rural KwaZulu Natal, in an optometry setting, found that an introduction between the professional and patient and maintaining eye contact ensured that 75.6% of the participants considered the professional as more reliable.⁴⁴ Doctor 9 in Consultation 2 demonstrated good eye contact with the patient during the entire

consultation, compared to the other consultations in which there was intermittent or no eye contact.

Listening did not manifest very well in these consultations. Lang et al⁴⁵ developed a clue taxonomy for doctors to improve communication, specifically listening. Listening in this taxonomy refers to the awareness of how the patient verbalizes the symptom, how they articulate feelings or concerns, speech clues that underscore the concern, the patient's illness story and behaviors indicative of unanswered needs. Doctor 9 satisfied symptom expression and the patient's illness story to an extent, but missed the speech cues in the hesitation between words when the patient expressed her concern (Patient 37: "*When... when I have sex neh, I have pain... but after...* "). If the doctor had just reflected this hesitation, the patient may have believed that she was heard and could potentially facilitate disclosure of the sexual dysfunction. In Consultation 3, Doctor 11 missed the opportunity to modify behavior. The patient presented repetitively with STI (Doctor 11: "*Again?*" [*Patient bowed his head*] Patient 49: "*Yeh*" [*removed the cap from his head and looked embarrassed*]). The doctor could have used the repetitive presentation and embarrassment factor to motivate behavior change. In Consultations 4 and 5, Doctor 17 had the opportunity to allow both patients to share their illness stories, but this did not happen, as there was no receptiveness, or interest in hearing their stories. None of the patients were asked about their illnesses, or how these influenced their daily lives or the lives of their partners and families.

One can hypothesize that concerns about the appropriateness of a sexual history when it is not the presenting complaint may be a barrier, but Peltola et al⁴⁶ suggested that the healthcare worker-patient relationship and the willingness to engage bridge this concern and are conducive to self-management in chronic disease. Unfortunately, people in rural areas generally have lower socioeconomic status and lower education levels, and with these there is often the perception, on the part of doctors, that the patient has less to tell them.⁴⁷ In this study, the relationship never reached a point of reciprocation and could be summed up as a doctor taking on an administrative duty to write a prescription or administer medication while the patient had to accept blindly whatever the doctor thought relevant. The observed relationships lacked warmth and empathy, which correlates with the findings of other research that rural or high deprivation areas experienced a lack of warmth and empathy.⁴⁷

The quality or components of the sexual history did not change when the consultation was in the patient's home language. Consultations in this study were concluded in less than 11 minutes, except for Consultation 2. Stirling et al⁴⁸ postulated that if the duration of the consultation was extended from 9 to 13 minutes, this would result in a 32% increase in disclosure rates of personal or sensitive information. The brief consultations in this study caused the doctors to focus only on the presenting complaint, thus forsaking a comprehensive consultation and illness story.

Another structural aspect was that of privacy. The perception of privacy in sexual history taking goes further than a covered window, closed door, interruptions, or the presence of a translator.⁴⁹ Privacy can improve the opportunity to discuss sensitive matters, but one cannot underestimate the role of control and power in the translator relationship.⁵⁰ In this study, the doctor often engaged only with the translator and not the patient (Consultations 1 and 4), which deprived the patient of the chance to set the agenda. Eye contact with the patient, as well as questions directed to the patient while maintaining eye contact, is a more patient-friendly way to interact with the patient, and the patient remains the primary concern of the doctor. The nurse translator's familiarity with Patient 49's social environment and activities in Consultation 3, which was observed when she asked him about it while the doctor was writing notes, could also have inhibited the doctor from exploring more sensitive matters. For this same reason, it was unlikely that the patient would disclose sexual matters, even if the doctor created the opportunity. This brings us to the sexual history itself.

The way in which the sexual history questions were phrased were not tactful or patient-centered. Behavior that could increase the HIV risk was not discussed. As it was not possible to record the return of Patient 98 in Consultation 5 after the HIV diagnosis, we cannot conclude on the patient-doctor engagement after the test. However, considering the random HIV question and lack of justification for the test, it is unlikely there was meaningful interaction post-HIV testing. In Consultation 2, Doctor 9 applied the principle of family medicine regarding health education and prevention of disease. The patient received good advice on personal hygiene practices and was offered a PAP smear, but the advice may not be effective as the cause of these symptoms was not optimally explored. The health protection advice Doctor 11 gave the young man with the STI (Consultation 3) was generic and not person-centered. The doctor's judgmental "again" attitude blocked any meaningful engagement with the patient when the repetitive presentation of STI necessitates further exploration. With the high unemployment and poverty rate in the country, more men enter the commercial sex arena.^{51,52} If that was the situation and he was HIV negative (which was not elicited or tested), the doctor could have offered pre-exposure prophylaxis,⁷ also something could have been done to reduce future risks.

The scope and content of sexual history taking was unacceptable. None of the doctors did screening for sexual risks or sexual dysfunction. This could be due to a lack of knowledge regarding the prevalence or importance of sexual dysfunction in patients with hypertension and diabetes, the lack of skill, or the consultation structure where a lot of time was lost by doctors paging through the file, checking for laboratory results on their phones, and making notes. The planned electronic recordkeeping process could improve this, if it is rolled out.⁵³ Different resources should also be linked so that time can be saved looking for results and referral forms.

The study provided detailed information on the complexity of sexual history taking during a routine consultation and is relevant to primary health care in a rural setting. The video recording in this research might have elicitation bias for doctors but can also be a true reflection of practice.⁵⁴ The role of the patient in this consultation, help-seeking behavior and health literacy of the patient could also play a role, but this was not assessed.

CONCLUSION

Nusbaum and Hamilton⁵⁵ suggested that sexual health care is compromised due to a lack of a proactive and preventative approach in the primary care setting. To be proactive, the doctor needs to know what they are dealing with; in other words, to take a comprehensive history. Research also suggests that evidence-based diagnosis and management, a good patient-doctor relationship and collaboration in the management approach can change sexual history taking.^{56,57} Again, a comprehensive history could elicit sexual dysfunction or, at a minimum, an idea that the patient was not living a full life, but this is unlikely to occur if there is a poor doctor-patient relationship. Collaboration is possible if there is respect for the patient living with the illness and a willingness to connect and engage with a patient. Unfortunately, a willingness to engage, or receptiveness to the patient, appeared to be absent in the observed consultations. Althof et al.⁵⁶ stated that sexual history taking must happen within a culturally sensitive context, incorporating the person's health literacy, lifestyle, unique background and relationship status; these were not observed in this study. Sexual history taking failed because the observed interaction between doctor and patient was superficial and, from the doctor's perspective, appeared to be focused on getting the patient out of the door.

Training is the key to upskilling doctors in terms of the clinical approach to a patient, consultation content and time management, but more importantly, an attitude shift around the importance of sexual wellbeing must happen. Doctors need to reflect on their practice and ask themselves if they are there to chase patient numbers or to render a comprehensive service. Dealing with patients with diabetes and hypertension must be a red flag regarding quality of life, which includes sexual wellbeing. The health system can support the doctor better with technology to prevent valuable consultation time being lost due to poor administration of files and laboratory results. Such changes are important, but these will be insufficient if doctors themselves do not change. This requires an attitude change on the part of the doctors involved, which will also involve having to deal with their personal perceptions of professionalism and their relationships with their patients.

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REFERENCES

1. Wimberly YH, Hogben M, Moore-Ruffin J, et al. Sexual history-taking among primary care physicians. *J Natl Med Assoc* 2006;98:1924–1929.
2. Ribeiro S, Alarcão V, Simões R, et al. General practitioners' procedures for sexual history taking and treating sexual dysfunction in primary care. *J Sex Med* 2014;11:386–393. doi: [10.1111/jsm.12395](https://doi.org/10.1111/jsm.12395).
3. Baggaley RF, Irvine MA, Leber W, et al. Cost-effectiveness of screening for HIV in primary care: a health economics modelling analysis. *Lancet HIV* 2017;4:465–474. doi: [10.1016/S2352-3018\(17\)30123-6](https://doi.org/10.1016/S2352-3018(17)30123-6).
4. Bozzette SA. Routine screening for HIV infection—Timely and cost-effective. *N Engl J Med* 2005;352:620–621. doi: [10.1056/NEJMe048347](https://doi.org/10.1056/NEJMe048347).
5. Statistics South Africa. Statistical Release P0302 Mid-year population estimates 2019. Available at <https://www.statssa.gov.za/publications/P0302/P03022019.pdf> Accessed February 19, 2021.
6. South Africa, Department of Health. Strategic plan: Department of Health, 2014/15 - 2018/19. Republic of South Africa: Dept. of Health; 2014. Available at: <http://pmg-assets.s3-website-eu-west-1.amazonaws.com/140715strategicplan.pdf>. Accessed June 29, 2021.
7. South Africa, Department of Health. Sexually Transmitted Infections Management Guidelines 2018: Adapted from Standard Treatment Guidelines and Essential Medicine List PHC.. Republic of South Africa: Dept. of Health; 2018. Available at: [https://sahivsoc.org/Files/STI%20Guidelines%2027%2008%2019%20\(1\)Final.pdf](https://sahivsoc.org/Files/STI%20Guidelines%2027%2008%2019%20(1)Final.pdf). Accessed April 10, 2020.

- [8]. South Africa, Department of Health. National HIV Self screening Guidelines. Republic of South Africa: Dept. of Health; 2018. Available at: <https://sahivsoc.org/Files/Final%20HIVSS%20guidelines%20May%202018.pdf>. Accessed June 29, 2021.
9. US Preventive Services Task Force. Screening for HIV infection: US Preventive Services Task Force Recommendation Statement. *JAMA* 2019;321:2326–2336. doi: [10.1001/jama.2019.6587](https://doi.org/10.1001/jama.2019.6587).
10. Leblanc NM, Flores DD, Barroso J. Facilitators and barriers to HIV screening: a qualitative meta-synthesis. *Qual Health Res* 2016;26:294–306. doi: [10.1177/1049732315616624](https://doi.org/10.1177/1049732315616624).
11. Tillman JL, Mark HD. HIV and STI testing in older adults: an integrative review. *J Clin Nurs* 2015;24:2074–2095. doi: [10.1111/jocn.12797](https://doi.org/10.1111/jocn.12797).
12. Ogbo FA, Mogaji A, Ogeleka P, et al. Assessment of provider-initiated HIV screening in Nigeria with sub-Saharan African comparison. *BMC Health Serv Res* 2017;17:188. doi: [10.1186/s12913-017-2132-4](https://doi.org/10.1186/s12913-017-2132-4).
13. Fonner VA, Denison J, Kennedy CE, et al. Voluntary counseling and testing (VCT) for changing HIV-related risk behavior in developing countries. *Cochrane Database Syst Rev* 2012;12:CD001224.
14. Rubin ES, Rullo J, Tsai P, et al. Best practices in North American pre-clinical medical education in sexual history taking: consensus from the summits in medical education in sexual health. *J Sex Med* 2018;15:1414–1425. doi: [10.1016/j.jsxm.2018.08.008](https://doi.org/10.1016/j.jsxm.2018.08.008).
15. Palaiodimos L, Herman HS, Wood E, et al. Practices and barriers in sexual history taking: a cross-sectional study in a public adult primary care clinic. *J Sex Med* 2020;17:1509–1519. doi: [10.1016/j.jsxm.2020.05.004](https://doi.org/10.1016/j.jsxm.2020.05.004).
16. Frasca K, Castillo-Mancilla J, McNulty MC, et al. A mixed methods evaluation of an inclusive sexual history taking and HIV prevention curriculum for trainees. *J Gen Intern Med* 2019;34:1279–1288. doi: [10.1007/s11606-019-04958-z](https://doi.org/10.1007/s11606-019-04958-z).
17. Ross MW, Newstrom N, Coleman E. Teaching sexual history taking in health care using online technology: a PLISSIT-Plus zoom approach during the coronavirus disease 2019 Shutdown. *Sex Med*. 2021;9:100290. doi: [10.1016/j.esxm.2020.100290](https://doi.org/10.1016/j.esxm.2020.100290).
18. Lloyd M. Sexual health assessments in primary care. *Cultura Del Cuidado* 2018;15:80–92. doi: [10.18041/1794-5232/cul-trua.2018v15n2.5113](https://doi.org/10.18041/1794-5232/cul-trua.2018v15n2.5113).
19. Gott M, Hinchliff S. Barriers to seeking treatment for sexual problems in primary care: a qualitative study with older people. *Fam Pract* 2003;20:690–695. doi: [10.1093/fampra/cmg612](https://doi.org/10.1093/fampra/cmg612).
20. Sarkadi A, Rosenqvist U. Contradictions in the medical encounter: female sexual dysfunction in primary care contacts. *Fam Pract* 2001;18:161–166. doi: [10.1093/fampra/18.2.161](https://doi.org/10.1093/fampra/18.2.161).
21. Abdolmanafi A, Nobre P, Winter S, et al. Culture and sexuality: cognitive–emotional determinants of sexual dissatisfaction among Iranian and New Zealand women. *J Sex Med* 2018;15:687–697. doi: [10.1016/j.jsxm.2018.03.007](https://doi.org/10.1016/j.jsxm.2018.03.007).
22. Sowicz TJ, Bradway CK. Factors affecting sexual history taking in a health center serving homeless persons. *Qual Health Res* 2018;28:1395–1405. doi: [10.1177/1049732318765442](https://doi.org/10.1177/1049732318765442).
23. Kingsberg S. Just ask! Talking to patients about sexual function. *Sex Reprod Menopause* 2004;2:199–203. doi: [10.1016/j.sram.2004.11.007](https://doi.org/10.1016/j.sram.2004.11.007).
24. Michal LS. Expert opinion on “practices and barriers in sexual history taking: a cross-sectional study in a public adult primary care clinic. *J Sex Med* 2020;17:1415. doi: [10.1016/j.jsxm.2020.05.015](https://doi.org/10.1016/j.jsxm.2020.05.015).
25. van Heerden A, Barnabas RV, Norris SA, et al. High prevalence of HIV and non-communicable disease (NCD) risk factors in rural KwaZulu-Natal, South Africa. *J Int AIDS Soc* 2017;20:e25012. doi: [10.1002/jia2.25012](https://doi.org/10.1002/jia2.25012).
26. Coverdale JH, Balon R, Roberts LW. Teaching sexual history-taking: a systematic review of educational programs. *Acad Med* 2011;86:1590–1595. doi: [10.1097/ACM.0-b013e318234ea41](https://doi.org/10.1097/ACM.0-b013e318234ea41).
27. Campbell MM, Stein DJ. Sexual dysfunction: a systematic review of South African research. *S Afr Med J* 2014;104:440–444. doi: [10.7196/samj.7827](https://doi.org/10.7196/samj.7827).
28. Lewis RW, Fugl-Meyer KS, Bosch R, et al. Epidemiology/risk factors of sexual dysfunction. *J Sex Med* 2004;1:35–39. doi: [10.1111/j.1743-6109.2004.10106.x](https://doi.org/10.1111/j.1743-6109.2004.10106.x).
29. Health Systems Trust. North West Kenneth Kaunda District Profile. Republic of South Africa: Health Systems Trust; 2012. Available at: <https://www.hst.org.za/publications/NonHST%20Publications/North%20West%20-%2020KK%20Kaunda%20District.pdf>. Accessed March 7, 2020.
30. Bartlik BD, Rosenfeld S, Beaton C. Assessment of sexual functioning: sexual history taking for health care practitioners. *Epilepsy Behav* 2005;7:15–21.
31. Meystre-Agustoni G, Jeannin A, de Heller K, et al. Talking about sexuality with the physician: Are patients receiving what they wish? *Swiss Med Wkly* 2011;141 w13178. doi: [10.4414/smw.2011.13178](https://doi.org/10.4414/smw.2011.13178).
32. Pretorius D, Couper I, Mlambo M. Patient-doctor interaction inhibits sexual history taking in routine primary care consultations in North West Province South Africa. Forthcoming 2021.
33. Rosen R, Brown C, Heiman J, et al. The Female Sexual Function Index (FSFI): a multidimensional self-report instrument for the assessment of female sexual function. *J Sex Marital Ther* 2000;26:191–208. doi: [10.1080/009262300278597](https://doi.org/10.1080/009262300278597).
34. Rosen R, Riley A, Wagner G, et al. The International Index of Erectile Function (IIEF): a multidimensional scale for assessment of erectile dysfunction. *Urology* 1997;49:822–830. doi: [10.1016/s0090-4295\(97\)00238-0](https://doi.org/10.1016/s0090-4295(97)00238-0).
35. Böhm A. Theoretical coding: text analysis in grounded theory. In: Flick U, Kardoff E, Steinke I, editors. *A companion to qualitative research*. London: SAGE Publications; 2004. p. 270–275.

36. Grau Canét-Wittkamp C, Eijkelboom C, Mol S, et al. Fostering patient-centredness by following patients outside the clinical setting: an interview study. *BMC Med Educ* 2020;20:16. doi: [10.1186/s12909-020-1928-9](https://doi.org/10.1186/s12909-020-1928-9).
37. Michie S, Miles J, Weinman J. Patient-centredness in chronic illness: What is it and does it matter? *Patient Educ Couns* 2003;51:197–206. doi: [10.1016/s0738-3991\(02\)00194-5](https://doi.org/10.1016/s0738-3991(02)00194-5).
38. Little P, Everitt H, Williamson I, et al. Observational study of effect of patient centredness and positive approach on outcomes of general practice consultations. *BMJ* 2001;323:908–911. doi: [10.1136/bmj.323.7318.908](https://doi.org/10.1136/bmj.323.7318.908).
39. Louw JM, Marcus TS, Hugo J. How to measure person-centred practice – An analysis of reviews of the literature. *Afr J Prim Health Care Fam Med* 2020;12:a2170. doi: [10.4102/phcfm.v12i1.2170](https://doi.org/10.4102/phcfm.v12i1.2170).
40. Mead N, Bower P, Hann M. The impact of general practitioners' patient-centredness on patients' post-consultation satisfaction and enablement. *Soc Sci Med* 2002;55:283–299. doi: [10.1016/s0277-9536\(01\)00171-x](https://doi.org/10.1016/s0277-9536(01)00171-x).
41. Fawole AA. Communication strategies of english-speaking foreign medical doctors in the Limpopo Province [doctorate's thesis on the Internet]. Polokwane: University of Limpopo; 2014. Available at: <https://ulspace.ul.ac.za/handle/10386/1283>. Accessed February 5, 2020.
42. Bagwasi MM. The effect of gender and age in Setswana greetings. *SALALS* 2012;30:93–100. doi: [10.2989/16073614.2012.693717](https://doi.org/10.2989/16073614.2012.693717).
43. Dang BN, Westbrook RA, Njue SM, et al. Building trust and rapport early in the new doctor-patient relationship: a longitudinal qualitative study. *BMC Med Educ* 2017;17:32. doi: [10.1186/s12909-017-0868-5](https://doi.org/10.1186/s12909-017-0868-5).
44. Madadi C, Perumal T, Sibiyi CH, et al. What do patients expect of health care providers? Patient perceptions and expectations of professionalism in optometry practice in Kwa-Zulu-Natal, South Africa. *Glob J Health Sci* 2019;11:135–145. doi: [10.5539/gjhs.v11n13p135](https://doi.org/10.5539/gjhs.v11n13p135).
45. Lang F, Floyd MR, Beine KL. Clues to patients' explanations and concerns about their illnesses. A call for active listening. *Arch Fam Med* 2000;9:222–227. doi: [10.1001/archfami.9.3.222](https://doi.org/10.1001/archfami.9.3.222).
46. Peltola M, Isotalus P, Åstedt-Kurki P. Patients' interpersonal communication experiences in the context of type 2 diabetes care. *Qual Health Res* 2018;28:1267–1282. doi: [10.1177/1049732318759934](https://doi.org/10.1177/1049732318759934).
47. Mercer SW, Higgins M, Bikker AM, et al. General practitioners' empathy and health outcomes: a prospective observational study of consultations in areas of high and low deprivation. *Ann Fam Med* 2016;14:117–124. doi: [10.1370/afm.1910](https://doi.org/10.1370/afm.1910).
48. Stirling AM, Wilson P, McConnachie A. Deprivation, psychological distress, and consultation length in general practice. *Br J Gen Pract* 2001;51:456–460 Available at: <https://bjgp.org/content/51/467/456>. Accessed June 29, 2021.
49. Nichols WL. Deception versus privacy management in discussions of sexual history. *Atl J Commun* 2012;20:101–115. doi: [10.1080/15456870.2012.665346](https://doi.org/10.1080/15456870.2012.665346).
50. Brisset C, Leanza Y, Laforest K. Working with interpreters in health care: a systematic review and meta-ethnography of qualitative studies. *Patient Educ Couns* 2013;91:131–140. doi: [10.1016/j.pec.2012.11.008](https://doi.org/10.1016/j.pec.2012.11.008).
51. Peters SM, Kessi S, Boonzaier F. Narrative identity: the construction of dignified masculinities in Black male sex workers' narratives. *Soc Dyn* 2019;45:425–441. doi: [10.1080/02533952.2019.1668622](https://doi.org/10.1080/02533952.2019.1668622).
52. Sebogodi MR, Huma M, Mokgatle MM, et al. Casual sex, sex work and unprotected sex among men who have sex with men in the human papilloma virus (HPV) clinical trial—North-West Region of Tshwane, South Africa. *WJA*. 2019;9:167–182. doi: [10.4236/wja.2019.94013](https://doi.org/10.4236/wja.2019.94013).
53. Leslie HH, Laos D, Cárcamo C, et al. Health care provider time in public primary care facilities in Lima, Peru: a cross-sectional time motion study. *BMC Health Serv Res* 2021;21:123. doi: [10.1186/s12913-021-06117-9](https://doi.org/10.1186/s12913-021-06117-9).
54. Henry SG, Feters MD. Video elicitation interviews: a qualitative research method for investigating physician-patient interactions. *Ann Fam Med* 2012;10:118–125. doi: [10.1370/afm.1339](https://doi.org/10.1370/afm.1339).
55. Nusbaum MRH, Hamilton CD. The proactive sexual health history. *Am Fam Phys* 2002;66:1705–1713 Available at: <https://www.aafp.org/afp/2002/1101/p1705.html>. Accessed June 29, 2021.
56. Althof SE, Rosen RC, Perelman MA, et al. Standard operating procedures for taking a sexual history. *J Sex Med* 2013;10:26–35. doi: [10.1111/j.1743-6109.2012.02823.x](https://doi.org/10.1111/j.1743-6109.2012.02823.x).
57. Hatzichristou D, Rosen RC, Broderick G, et al. Clinical evaluation and management strategy for sexual dysfunction in men and women. *J Sex Med* 2004;1:49–57. doi: [10.1111/j.1743-6109.2004.10108.x](https://doi.org/10.1111/j.1743-6109.2004.10108.x).