**Clinical Chats Official Podcast Transcript**

**Title:** Conducting an HIV Risk Assessment in Family Planning Settings

**Speaker:** Dr. Brandon Mizroch

**Duration:** 00:45:24

**Katherine Atcheson (**[**00:05**](https://www.rev.com/transcript-editor/shared/OPgt2jhD4d5tcuTWkJABMZ4_mUxtpTAU3nRCFIE2IDUqESU_8cuUY-to-llkcNaLiyY4JWPfsbi69vnnnMlCksbRB-8?loadFrom=DocumentDeeplink&ts=5.31)**):**

Hello, and welcome to Clinical Chats, a podcast for sexual and reproductive health professionals. Clinical Chats, formerly known as The Family Planning Files, is a program from the Clinical Center for Sexual Reproductive Health, or CTCSRH, formerly known as the National Clinical Training Center for Family Planning, or NCTCFP, and is funded by the Office of Population Affairs in order to enhance the knowledge of Title X clinicians and other staff.

**Katherine Atcheson (**[**00:32**](https://www.rev.com/transcript-editor/shared/PEneaouakdP7tze6ilRHwIhFBIFZ0xMUenEYC_CElXdzHoLzcV0ypjw045YVpWSzdqMpZtBi1B78hvyO_KaXldaHFq4?loadFrom=DocumentDeeplink&ts=32.67)**):**

In today's podcast, we'll be discussing how to conduct an HIV risk assessment in family planning settings. Our guest today is Brandon Mizroch, MD, MBBS. Dr. Mizroch is the Public Health Detailing project manager at the AIDS Education Training Center at the University of Utah Hospital where he works with clinicians throughout the state to increase access to services across the HIV Care Continuum. Dr. Mizroch received his medical education at the University of Queensland in Australia and has previously worked for the Louisiana Department of Health. Welcome to the podcast, Dr. Mizroch. We're so excited to speak with you today.

**Dr. Brandon Mizroch (**[**01:13**](https://www.rev.com/transcript-editor/shared/2niUzw3Zj_l5s8xaYutjoeiV5jFyOKOSg5C_XJ_lw7ZG6LuGiruZSZZe12yd3BjbEfcW3ZejJnGz7ItXFpQhwLVHtOw?loadFrom=DocumentDeeplink&ts=73.41)**):**

Me too. Thank you so, so much for having me. I'm so excited to be able to talk to you all about this today.

**Katherine Atcheson (**[**01:19**](https://www.rev.com/transcript-editor/shared/qK7WX549tXVjNs_nvRdtpfcR9vmeNXIALzR-clHZLYyEDzk45huETYtFrrSoctQh56Y_5JjHqHEXpMbh_T_Kz-GHctA?loadFrom=DocumentDeeplink&ts=79.92)**):**

Just to start us off, can you tell us what an HIV risk assessment is versus HIV testing itself? And why is it important for clinicians to know how to conduct an HIV risk assessment?

**Dr. Brandon Mizroch (**[**01:34**](https://www.rev.com/transcript-editor/shared/qFNCqqBc9l0f0g0r4Vt0q14VFFU60gS5oaprSWjsG-ISiyjj83VYYzrRwu5N1c0_YnoiFtkFuqELyc5AKKGwIwBXgiE?loadFrom=DocumentDeeplink&ts=94.38)**):**

First and foremost, I always like to tell clinicians that that word risk has become so charged in today's world, when we're talking about the risk of something happening to somebody, obviously that makes sense, but when we're talking about something that is the inherent identity of a person being classified as a risk factor, it can really derail conversations that we're trying to have with our patients. I always like to think of instead of an HIV risk assessment for a patient, what we're assessing for are their opportunities for exposure. We're trying to see in which capacities a patient might've been exposed to the HIV. And then from there, we can determine how often we would like to perform the normal testing that we do for HIV. Obviously, the test itself is typically a blood test. Typically, you can either have it done through a blood draw, or just even a finger prick can give you a very good idea about someone's HIV status. But essentially when we're trying to ascertain a person's, quote, unquote, "risk," we're trying to see how many opportunities they would've had for exposure to HIV.

**Katherine Atcheson (**[**02:43**](https://www.rev.com/transcript-editor/shared/go3a6dz98pMLuuOq2MuIMZLAW7x5fm9vdZnFXP1cFTlllONmOorNKURmVN9wFudM49ATOTIKNn4UH1SryQmRnA52MQU?loadFrom=DocumentDeeplink&ts=163.29)**):**

And how often should patients be assessed for this exposure opportunities for HIV? To use your phrase. How often should that happen?

**Dr. Brandon Mizroch (**[**02:53**](https://www.rev.com/transcript-editor/shared/Io5AMIKJ2SmskRJwnWCwBxssk_LqvNaxgVVb0ONkVoZCyvEs6vqpoU8B9I-ud0wcHptLbSFnRhUGF_N-Mf9JpBp2WjI?loadFrom=DocumentDeeplink&ts=173.61)**):**

Thank you. It's a great question. When the CDC puts out the guidelines that we all tend to follow, we all try to follow as clinicians across the country, and they have essentially a stratified approach to how often a person should be tested for HIV. First and foremost, we do have a general recommendation for everyone in the country age 13 to 65 to have at least one HIV screening done on them. This can be done at an annual physical; this can be done when you have a new patient coming into your practice. Really just making sure that you have something on the box where it says HIV status for this patient, doing the test on them.

**Dr. Brandon Mizroch (**[**03:34**](https://www.rev.com/transcript-editor/shared/fcInYUew1gSsO6lt7m5ilPg3GgM-1xKh1bWedqo42n66QQWpSDwoNDir2jvSwQz3s_ZHL498nsjxW24PBiOVc0a4Shc?loadFrom=DocumentDeeplink&ts=214.23)**):**

Now, we increase the frequency of that testing if they have more opportunities to have been exposed to the virus. One of the most fascinating things when it comes to HIV work is how important geography actually is. If you look at a map of the country seeing where we had the most cases of HIV, you can see a distribution that is not even, meaning that if you are in an area of the country where HIV cases are much higher, the CDC recommends that you do test patients more frequently, even if they don't necessarily have an overall increased chance to be exposed to the virus. If you do live in what the CDC classifies as a high incidence area, many states, especially in the southeastern United States, fit that sort of parameter, then that lifetime testing recommendation increases to an annual testing recommendation. When I worked in Louisiana, that was something that I always told any doctor that I worked with. Louisiana is classified as a high incidence area, so make sure that when you have your annual physicals for your patients, you're including an HIV test and hopefully some other STI testing at the same time is that.

**Dr. Brandon Mizroch (**[**04:43**](https://www.rev.com/transcript-editor/shared/gnLLPzaSie1X-FYmJLsIgeT6LGWKdBBdquYE53s0rWJqkqxGwsusEVk-sRnCs36yTHS_yyZaIQEcHufnYluNpQNdN4g?loadFrom=DocumentDeeplink&ts=283.29)**):**

Now, if you are an individual who has a higher chance of exposure to the virus, say you are a gay or bisexual man, especially the receptive partner in that you frequently have condomless sex with individuals, if you have been or are currently using injection drugs or your partners are using injection drugs, those are all incidences when the recommendation would now increase to a quarterly testing. For any patients that are on PrEP, that's one of the things that we recommend is quarterly testing for pretty much all STIs. And the same sort of pattern would follow for an individual who would be at a higher likelihood of being exposed to the virus.

**Dr. Brandon Mizroch (**[**05:24**](https://www.rev.com/transcript-editor/shared/OWIwNh1SbjYa48hV6tU12Dee3epQDv54DZHLPQ4xb9Ce_Q8OzVYKsQEoDjrdkq0u5GHadaUggp5K3poufKRAoEAX_tw?loadFrom=DocumentDeeplink&ts=324.39)**):**

To break that all down, at least a lifetime risk for anyone with no apparent, quote, unquote, "risk factors." Increase that to annually if a person is living in an area that has a higher incidence of it, and then quarterly for a patient who may be engaging in practices which could potentially expose them to the virus.

**Katherine Atcheson (**[**05:44**](https://www.rev.com/transcript-editor/shared/Yl8HGBClO3eYqFvQ9F3zyhvjTXU0iBbuw-eeJDawINXb4KqulG_5n2t3a0-miDz_5G4ge8WdqGJ7H_vBzUibhFkzkyU?loadFrom=DocumentDeeplink&ts=344.4)**):**

That leads us really well into our next couple questions. But what sexual history questions should be included in this HIV exposure assessment? You mentioned a couple of them, but obviously that doesn't apply to everyone, and you said everyone should get that kind of screening assessment.

**Dr. Brandon Mizroch (**[**06:05**](https://www.rev.com/transcript-editor/shared/AaDoyG3vv6-pk8R-WQNm0cQPu057ssLXDFx5jkvYaQGEBFC5TOlbbDP4h_nz37EgDMoC3BGnotW5YR_rLpvTHOvOE08?loadFrom=DocumentDeeplink&ts=365.61)**):**

Absolutely, absolutely. Actually, I love this question because there are so many fun ways to potentially address it. The CDC has their own guidelines called the five Ps. Those are really easy to follow. Honestly, any Google search can tell you exactly what they have. And they even have examples of the sort of questions that you as a clinician would ask; how to phrase it in a way that's really trying to get at the information that we would like to ascertain from a patient there.

**Dr. Brandon Mizroch (**[**06:32**](https://www.rev.com/transcript-editor/shared/2YRjHq3viB8rpZt2xrWkvh7JEJAsq1I88N64R2wWVOatSZfFQua2n1YINF8ybzXjQnu-0ZILPMOYVEPcQlAhRIoBieI?loadFrom=DocumentDeeplink&ts=392.73)**):**

I personally like to use a slightly modified version of that that is a mnemonic that is P-R-E-P, or spells pref. The first P in that one is for partners. Essentially the question you want to ask is what are the genders of your sexual partners? And how many partners have you had in the last six months? That question right there can give you a lot of information as a clinician to the potential that this person in front of you has had to have been exposed to the virus. Obviously, we see higher rates of HIV in our gay, bisexual and other men who have sex with men populations, so knowing that if you, say, have a male patient and the gender of their partners is male, that puts someone at a somewhat likelier exposure potential.

**Dr. Brandon Mizroch (**[**07:18**](https://www.rev.com/transcript-editor/shared/kcgjY09tnKyE9bULlLXIpa_2NPSvqOCalfw5vzdE-IJSzEywAzLB_iNEv-n1aGnQ7RyXyGpHQX_zS9WuYL9tfXL_Ef4?loadFrom=DocumentDeeplink&ts=438.18)**):**

Moving on, the R is for receptive or insertive. Essentially when we're talking to especially a gay patient, the easiest way to phrase that is are you a bottom or a top? The vast majority of people in today's world really know what that means. To break it down, a top is the insertive partner in a sexual act and a bottom is the receptive partner in a sexual act. There is a slight difference in the potential chance of acquiring HIV if you are the receptive partner or the insertive partner, so knowing essentially where your patient falls can give you a little bit more information on do they want that extra level of protection? Is there something that I should be actively counseling them on doing to make sure that they're staying safe?

**Dr. Brandon Mizroch (**[**08:04**](https://www.rev.com/transcript-editor/shared/zkVbLo2mpwlbj7J0OPpnfJY2ePXImegS0I9XVLdRuZoLfHC63eP06NdKjFXu_E60bJuRjPzKSgrBCMUNPBPGCckJ8w4?loadFrom=DocumentDeeplink&ts=484.32)**):**

The next question that we have is E for ever had an STD? The E in that one is really important because STDs are such an important factor in someone's risk for HIV acquisition. Let me break that down a little bit further. Statistically speaking, obviously STIs and HIV are transmitted through the same pathways, essentially. The exposure to one of these sort of pathogens could be the same exposure to another one. But more than that, having a bacterial STI can increase one's likelihood for acquiring HIV. STIs, even if there are no symptoms associated with it, can cause inflammation, they can cause leaky capillaries. They also cause recruitment of the blood cells that HIV likes to infect to that area of the body, meaning that it's more likely that the actual transmission HIV can occur in there, so knowing if a patient has ever had a bacterial STI and when that was can give you a lot of information about someone's overall potential for acquiring the virus.

**Dr. Brandon Mizroch (**[**09:07**](https://www.rev.com/transcript-editor/shared/38JYzSqP1wtho4nAZiUw1r0h4wrPKC7WOG1hc1rJ44fbSMIX16oZ-sypnCj_GcND12LCSwNByK0JWEKulwzLWERAakQ?loadFrom=DocumentDeeplink&ts=547.56)**):**

Again, it's important to really phrase these questions in non-judgmental way. Again, just looking at it objectively, "Have you ever had an STI?" The vast majority of STIs are completely curable, so it's not necessarily some sort of scarlet letter that a patient has to carry, but certain things like that can really help you as a clinician determine whether your patient should be counseled about other modalities, they can use to protect themselves and their partners.

**Dr. Brandon Mizroch (**[**09:36**](https://www.rev.com/transcript-editor/shared/iAmTRoWZQ92wKVTO1BNtE2HdT7p4ATKautvEQibYibEVKHmcYrw6euG17Ng1UlDcRSOD2m5erO0Ud1vrgQtiYWNnrXQ?loadFrom=DocumentDeeplink&ts=576.24)**):**

And the final one for this little mnemonic that I'm creating here is P for protection. Protection. The easiest way to start this conversation is how often do you use condoms? Or what percentage of the time do you use condoms when you're with your partners? That is a great way to overall determine someone's potential there. Condoms are overwhelmingly effective at preventing HIV. It's not the most effective strategy we have, but they are very good at preventing that particular STI in what we're trying to do.

**Dr. Brandon Mizroch (**[**10:09**](https://www.rev.com/transcript-editor/shared/Q_2rypBqzEOD6bNb_muj4Nb7PWUR0RsBkOruD2iyDrH3y5GxP_516T2vdYOV8nJoXVqUvHzhl5rtV0wAsGVOyTdnmC0?loadFrom=DocumentDeeplink&ts=609.39)**):**

Unfortunately, the overall rate of condom usage across the world has dramatically fallen. I believe I was just reading a statistic that said from 2010 to now, we've seen condom usage drop another 20% overall just in the background way. Again, it's just really to get a patient thinking about that sort of question. Again, ask it in an open-ended sort of way, not, "Do you use condoms?" Because you're not necessarily going to get the answer that is the most honest one from your patient on that. But saying, "How often do you use condoms?" Can be a great idea of the protection strategies that a patient is currently using.

**Dr. Brandon Mizroch (**[**10:48**](https://www.rev.com/transcript-editor/shared/6pnXbLZPCpyhOi57n5ZCzLU-rCAQcUwx7-cNcAKjN_SwXLlXxyN8_fSwmO9Su7jjMDDmacKwV-pmeav1f0u0u7VbhLc?loadFrom=DocumentDeeplink&ts=648.78)**):**

And I like to finalize it with a separate little P on that being for PrEP. Any sort of conversation that you have about protection should always include some sort of discussion about do you know what PrEP is? Did you know that there is a pill that you can take to prevent HIV? That sort of a thing can really help get the wheels turning so to speak for your patients and letting them think about if this is something that they would like to do to improve their sexual wellness.

**Katherine Atcheson (**[**11:17**](https://www.rev.com/transcript-editor/shared/rVsrbgwzgVpHv_zikDv9uHrJ1z2oB9__Ej8UP3LJPwmEHf_A9544iN4oeQIUMr0_gpR1AMDyMJSvoUK9d7NO5j4O_6I?loadFrom=DocumentDeeplink&ts=677.49)**):**

And also, to include in the HIV exposure opportunity assessment, what substance use history questions should be included in that?

**Dr. Brandon Mizroch (**[**11:28**](https://www.rev.com/transcript-editor/shared/4cuUFyA56y8GiP8pCyTZvaQNJ3FD7eNOgrDhaQBLzhs189tjIUDrS5tohRC4q1zIptuEfuA-V2xuyIhcomTyiHux58U?loadFrom=DocumentDeeplink&ts=688.74)**):**

Great question. It's an often-overlooked capacity for HIV acquisition, that we're seeing sporadic outbreaks in our country from injection drug use. IV drug use is a direct method by which someone can transmit the virus from one person to another. Unfortunately, enough in anything that can be transmitted through blood can also be transmitted through sex, and HIV very much follows that sort of pattern that we see. We're seeing a lot of cases that would revolve coming from an epicenter of people sharing drug equipment.

**Dr. Brandon Mizroch (**[**12:02**](https://www.rev.com/transcript-editor/shared/lXnDF7WOtCwXRwW6WJKxZ2sSZHhYBowbWYx9WRy_0oMQZt3fUjFQXC0A3lO-rg4mW7_AIcS5WRe2HdIwqcDWGYeUGWs?loadFrom=DocumentDeeplink&ts=722.67)**):**

Now, to break that down a little bit further, it's important that if you're having this conversation with your patients that they know it's not just the needles themselves that are a potential risk for spreading the virus, it's all of the associated accoutrement that goes along with it. Terms like cookers, the syringe itself, if patients are mixing certain drugs in certain devices, those are all potential contamination risks. Letting your patients know if they do use injection drugs, if their partners use injection drugs, that they want to make sure that they're using sterile equipment for everyone. And that includes everyone having their own cooker, their own syringe, their own what have you and the potential for exposure to that.

**Dr. Brandon Mizroch (**[**12:46**](https://www.rev.com/transcript-editor/shared/CKwZdq957ziR8Dga_mGZZwJUokNX4mZuDF2VNUiiV86bpZN4eAswOixunMDrZSOX4g5y7A3DCZ9r6RInLwvWFtTRm98?loadFrom=DocumentDeeplink&ts=766.44)**):**

In addition, I think it's also important to talk about the impact that substances can have on a person's potential to be unknowingly exposed. I think a great question to ask your patients that can help open up a conversation that you can see is, "Do you ever have sex while using drugs or drinking alcohol to the point where you can no longer give consent?" I think that's a great way to phrase it in terms of you're not in that moment judging a person for using substances, but you're asking, "Does it ever get too far to the point where you may not necessarily fully remember everything that happened to you, that you may not have realized that there was a potential exposure that happened?" And it's a good way to ascertain the type of relationship that a patient has with sex and the sorts of practices that they're really engaging in.

**Dr. Brandon Mizroch (**[**13:37**](https://www.rev.com/transcript-editor/shared/uOreKMYp7dRXLuVll4nsb1SVwoaG0fE9lw8Vt0ovHYzBOFxb0-14c2lkNVOeYRHlj0LljWjTnX8trlJbfDf_T3rmZBg?loadFrom=DocumentDeeplink&ts=817.95)**):**

Absolutely asking about drug use is really important when it comes to determining a person's ability to be exposed to HIV, and especially the sharing of equipment. And again, just asking in a matter-of-fact way, "Have you or your partners ever used injection drugs?" I think is a great way to typify that point and ask if that is something that should be considered when doing this.

**Dr. Brandon Mizroch (**[**14:05**](https://www.rev.com/transcript-editor/shared/7fzJtvXEMitQyjyOlMoNw6_ZJz3FJ6XOTmBPAgDyJEbwasnq18aBbzV89SVsV4lgOMg3Hmg_rDGBnFQOD29j0RVFXHc?loadFrom=DocumentDeeplink&ts=845.52)**):**

I also love to emphasize at this point that about a year and a half ago, two years ago, CDC did officially put its stamp for the use of PrEP for individuals whose sole exposure risk for HIV is injection drug use. It is in and of itself an indication for the medication. If you do have a patient who says that they in the past have used injection drugs, they're currently using injection drugs, talking to them about PrEP for that reason can be very, very monumental in what we're trying to achieve.

**Katherine Atcheson (**[**14:39**](https://www.rev.com/transcript-editor/shared/vmc66gpmYQ_r3tAZxDk5MvMpvZ6POV0xsDiR_ENosPp0u-PJl1fQXncKk1yVOs83dYzj_1mfq0ah8G2czEciOyJCqbk?loadFrom=DocumentDeeplink&ts=879.03)**):**

Are there other health history or sexual history questions that should be included in an HIV assessment? And what sort of questions would those be?

**Dr. Brandon Mizroch (**[**14:49**](https://www.rev.com/transcript-editor/shared/rtkmRCjFh7PcpxYnrL3osV3a3dhZJnuKLjrKZPWwypfVudoQmaFfI7-mUQgJw076SUNRMruZjHDbe_dMM__wHio1UZw?loadFrom=DocumentDeeplink&ts=889.65)**):**

Yes, great question. In all honesty, I have to give credit here to a colleague of mine, Dr. Erika Sullivan. She does a lot, a lot of great work when it comes to educating clinicians about these sort of questions. She has taken the CDC's five Ps on the same sort of questions that I mentioned before and expanded it into what she calls the 10 Ps that cover a wider range of the sort of questions that we would all, as clinicians, like to know about how a patient's sexual life and wellness is overall functioning for them.

**Dr. Brandon Mizroch (**[**15:20**](https://www.rev.com/transcript-editor/shared/bckUiNGcHCWWtY6U8WiUgXTOWFi-wW7sknydkn__iMB2b5WmEpsEtXNaV_DUJ5dVNWbgDmKaa-LBfr7o6Tvydg0a7Z8?loadFrom=DocumentDeeplink&ts=920.46)**):**

I won't go through the full list now because this podcast would take forever, but one of the most important questions that I think should absolutely be added to the conversation are these notions of pleasure and then partner violence are very important. The first one, pleasure. Let me start with that. We really want to make sure that people understand that sexuality is a normal part of our lives, is a normal part of our interpersonal communications. It's a very essential part of what it means to be a person in today's world, so helping to empower them to understand are you having pleasurable sex? Is there something that's wrong? Is there something that I can help with? Extending that olive branch to let your patients know that you want to help them not only have a reproductively successful sex life but also a pleasurable one I think can go a very long way into creating that rapport, creating that bridge between the doctor and the patient and helping to facilitate those sorts of conversations. I think that, again, is very important to it. Allows patients to tell you what they think is the most important part of that notion is their sex life satisfying?

**Dr. Brandon Mizroch (**[**16:37**](https://www.rev.com/transcript-editor/shared/PLM45TUi81UKarRmjqq66r_sSmq95w7UCkKolEya80kvTkFoLDexptXz7ManFPzqveJgRaM4DTHn6AuyeYIwfgu-2T8?loadFrom=DocumentDeeplink&ts=997.83)**):**

The other question, the partner violence one I think is very important because when we look at statistics, people who are involved in domestic violence partnership, patients who have experienced violence or unwanted sexual experiences have a higher rate of acquiring HIV. I think there's a lot of different socioeconomic factors and a lot of different societal factors that go into that, but knowing that a patient either has a current or past history of interpersonal violence of issues with that can give you a little bit more of a window into their potential to be exposed to the virus, to be able to say no in situations that they don't feel comfortable in. Overall, I think it helps remind them that they are in control of their interpersonal relationships, that there is something they can do, that you, as a clinician, can help them find the help that they need as well as that there is something to be done in a situation if a patient feels uncomfortable or abused or afraid. And those sorts of conversations, while they can be uncomfortable on the surface, I think they're so worth it because letting anybody that there's someone there that can help them, that there are options, that there is something that can be done I think really, truly builds that trust and rapport and really makes a patient want to open up with you more about what's going on in their life.

**Katherine Atcheson (**[**18:05**](https://www.rev.com/transcript-editor/shared/8wB9NDfnKtiaPEd4_fS2sSYQF1qR-Kc9Y8J_pIsbANNrO64gaemw9myqBDeShddVRP-VOGk9x_iJppC6M6iY0iuhmeM?loadFrom=DocumentDeeplink&ts=1085.25)**):**

And a final question about the assessment questions itself. What questions should clinicians ask about patients' partner or partners? Mentioned them a little bit throughout, but if you could give us an idea there.

**Dr. Brandon Mizroch (**[**18:19**](https://www.rev.com/transcript-editor/shared/ope-tQrF_VzBKaZQSzR7WR9wthqdnesjVfabhmR3_xSBQmmli3s0rNPuThdoByspeTSnjZi6nwvIVx4oCvKkwReukq4?loadFrom=DocumentDeeplink&ts=1099.86)**):**

Fantastic question. It really boils down to what we've been talking about before with exposure risk. When we're talking about any sort of communicable disease, we're really talking about links in a chain of transmission, so asking your patient these sort of questions about, "What are the genders of your partners?" Things along those lines can help you understand that person's potential for exposure. When it comes to their partners, you really just want to ask the same questions: "Are you and your partner monogamous?" If the answer is yes, that can tell you a lot about what you need to know. If the answer is no, then you want to essentially ask them the same questions for their partners: "What are the genders of your partner's partners?" Again, there's a lot of different things that can happen, especially in today's world when it comes to relationships not necessarily being completely monogamous with each other.

**Dr. Brandon Mizroch (**[**19:08**](https://www.rev.com/transcript-editor/shared/5SxN-R_pxjgmPhBIJPG6yBkMAGkl9yurdpfba_sSxpBWHLhYbf7An8084-Qkfqy8yi-hiukBAMUaaCF8VFdqZM_lXUE?loadFrom=DocumentDeeplink&ts=1148.04)**):**

"What types of sex do you have with your partners?" I think is also an important question to ask. And it's something that I haven't touched on too much throughout this conversation, but in today's world, people are having much higher rates of both oral and anal sex along with vaginal sex, so we want to make sure that we're asking our patients, "Do you have oral sex? Do you have anal sex? In those instances, are you the receptive or the insertive partner?" Those questions, again, are just very helpful to know if a person potentially has an STI and what the need is for three site testing.

**Dr. Brandon Mizroch (**[**19:44**](https://www.rev.com/transcript-editor/shared/w4zVllQ4LX9gOh2ShxFt2Kh3VCipmVvnZ-suqg9PlDovPQ0bZN3M1ZTvpoM9RGiKEIicFQbeUYcCacwXoAWCWjOyq-A?loadFrom=DocumentDeeplink&ts=1184.55)**):**

Personally, I feel like we should be testing... Anytime you do an STI test on a patient, you should always do three site testing because, quite frankly, you'd be hard-pressed in today's world to find someone who only has sex with their urethral organs. Quite frankly, it's very common, overwhelmingly so, patients to also engage in other types of sex practices. And unfortunately enough, when located outside of the urethra, bacterial STIs tend to have no symptoms. And if they do have symptoms, they typically only last for a day or so and then regress even though the infection is going there. Again, asking the specific types of sex that a patient is having can let you know what anatomical sites on their body you should be swabbing for STIs.

**Dr. Brandon Mizroch (**[**20:27**](https://www.rev.com/transcript-editor/shared/Eli4VNnKGyW6cMHAescAJW9XkvFK2ZsUgcGV8L_Fc1Yi_TYuWSbLiBwVfokKBLCsX--op5V3IHy1XISUEE1i2HYmqgk?loadFrom=DocumentDeeplink&ts=1227.78)**):**

I mentioned this before, but asking if a person is it an open or closed relationship. That's a terminology that I think many, many people use these days versus monogamous and non-monogamous relationships. Those terms don't exactly roll off a tongue. But an open relationship is one where both partners have agreed to not necessarily be exclusive sexual partners with each other. A closed relationship is where you do have a monogamous relationship with one person.

**Dr. Brandon Mizroch (**[**20:55**](https://www.rev.com/transcript-editor/shared/7QPVVNgUtV44gqjnIhBWEAV9h1s44W3tTTs2RiUcCtEZdAzuV2bLX38oXpFvSyFLWoK9w5Nc1ubVfi9RHGHbalDAUO0?loadFrom=DocumentDeeplink&ts=1255.23)**):**

All of that being said, again, it's not to judge someone's choices on that matter, but really just to see who could have been exposed to an STI or HIV during that time period. Is that something that would potentially increase someone's risk for exposure and then therefore, should I take a little bit extra caution, or should I counsel them on a particular topic? Again, these are just all sorts of important questions that you'd want to know when trying to build a picture of a potential exposure risk for a patient.

**Katherine Atcheson (**[**21:25**](https://www.rev.com/transcript-editor/shared/kG0OJ49ciPbqsE7Q0oFy9LV9F8jeW235HlMWx7zXs_IPMZ5_LPPQUAwTTV7WVqEFeku5ehRSusYegoXN5MwVdrLIavc?loadFrom=DocumentDeeplink&ts=1285.32)**):**

And because doing thorough exposure assessments does require asking some questions that can be uncomfortable or difficult to phrase, what is some good guidance or some good techniques that you found to make this easier for clinicians who may not be as comfortable or may be new to doing this work?

**Dr. Brandon Mizroch (**[**21:51**](https://www.rev.com/transcript-editor/shared/VhKjYyw5tqC2j_5l9YjH3_gC_sMStDxd2MrBK3cdx6MSUtqjp-HduN-AP-bCxhN81fDEWElFN7IGvbbaxUGWeOtKiL8?loadFrom=DocumentDeeplink&ts=1311.57)**):**

Absolutely. That's a great question. I like to say in these sort of conversations, the sexual health, the social history tends to come after some of our more general questions. But I do like to have a specific preface before I get into it all, really just introducing the topic for your patients. You would say something along the lines of, "Hello. My name is Dr. Mizroch. I'd like to ask you a few questions about your sexual history." Just, again, set the conversation, very simple introduction to that. Then make sure that they know that you're not targeting them, that you're not specifically coming after them. Something that I like to say is, "I ask these questions at least once a year of all my patients because I want to make sure I'm giving you the best medical advice about your sexual and reproductive health." Again, letting them know that this is normal, this is what we ask everyone. This is what we're trying to do. I think it really helps set the stage for the conversation.

**Dr. Brandon Mizroch (**[**22:49**](https://www.rev.com/transcript-editor/shared/UGZFXxvsndI4rDNgV9aDKniH9LYnzBj-2o10vNhHSdvcRXAiNrtAxhG0Gp-fOHZEki8WxIarB51Cn_Vg6hGmtKv3ftk?loadFrom=DocumentDeeplink&ts=1369.41)**):**

And then you always want to give them agency as well, so following up what I just said with something along the lines of, "You don't have to answer any questions that make you feel uncomfortable. I just want to get a full picture of what is going on in your life so that I can recommend what I believe would be the best course of action for you to protect your sexual wellness." Again, allowing patients, if they feel uncomfortable, to say no is very important, and really just making sure and putting that up front. Again, you can do this in a very conversational way. What I was just saying, it would take maybe 10 seconds of explanation. And as tight as clinic meetings are, I think we could all have an extra 10 seconds to maybe throw a preface in before we start something like this. Again, just set the stage for them to know that.

**Dr. Brandon Mizroch (**[**23:39**](https://www.rev.com/transcript-editor/shared/dK8NigVoCgfZ5MkPbHjtTPVkU6X6z1ybZwWm6jz2QmS42X5VzYdbkq-rN9mODVB7phiaPC7u3NJufpk7eTeVMxGzdt8?loadFrom=DocumentDeeplink&ts=1419.57)**):**

I don't mention this specifically, but one of the things that I find so fascinating about this topic is a lot of clinicians are afraid that they're going to offend their patients, that they're going to ask them a question about their sex life or about drug use or whatnot that's going to personally offend the patient and make them get mad at someone. But in my experience and in the literature, it really is reflected in this, the opposite is true. Asking these personal, in-depth questions demonstrates that you care about a patient. To them, it feels like, oh, they're asking these questions because they genuinely want to help me. And they're not trying to judge me about the choices that I make, the types of things that I do, they really just want to make sure what that list is so that they can recommend the best treatments for it.

**Dr. Brandon Mizroch (**[**24:27**](https://www.rev.com/transcript-editor/shared/048uJTQ6z0S2QCiVhixXOxGJOcgKaCZVRqeykKSreKk1VSqaK2NfKGRo1beOHqH-OSF15NDIqWaSPaQ1ZX_AQpTbIbU?loadFrom=DocumentDeeplink&ts=1467.24)**):**

It goes along with something I believe is called the Benjamin Franklin effect. It's this idea that if by doing someone a favor, you implicitly start trusting them more. In the context of what we're trying to do here, it's this notion that if I ask a person a personal, in-depth question and they answer it, they feel like they're being more cared for by their clinician. It does improve the overall relationship that we're trying to foster, which would be open and honest communication between the two of you.

**Dr. Brandon Mizroch (**[**24:56**](https://www.rev.com/transcript-editor/shared/a82EbjZNqtaGU5we9JAt8SvqTAud22K8UoND0VuxNgn-rgs-iclITWZd9BeCmqYs6BxJCZgToGobstB6rQf3858zzjw?loadFrom=DocumentDeeplink&ts=1496.67)**):**

Or another way to think about this is just the process of motivational interviewing. If they're willing to answer one small, rudimentary question, they become more likely to answer maybe a question that is more personal when it comes to topics that'd be difficult to discuss sometimes. Again, it's really just about framing the conversation, letting them know that they can stop at any time they want. But more often than not, they appreciate it and actually start to like you more for asking questions that may feel very personal for someone to answer.

**Katherine Atcheson (**[**25:29**](https://www.rev.com/transcript-editor/shared/sh9k0pU5tSyNimm0CThOn5kQKIApDDY8s7JyjzOfPbE8OAibXIvoyfWUgR61E5NeNg4jyrxudKrv8fD5EYOCvg2XAPM?loadFrom=DocumentDeeplink&ts=1529.49)**):**

And because most of our listeners for this podcast are Title X clinicians and other staff and the overwhelming majority of patients in Title X settings identify as women, I do want to ask are there any particular considerations that clinicians should keep in mind when conducting an HIV exposure opportunity assessment for patients who may be pregnant, maybe come pregnant, or are trying to become pregnant?

**Dr. Brandon Mizroch (**[**25:58**](https://www.rev.com/transcript-editor/shared/DLk8hL6pPY7NNaHGBa0unEg5HcWhJJlEoOmqVfY5g8SaEkbSGfPSLBeeGst7VqiWTL2Iu7N6xvh_guXLaXHFq_GC94Q?loadFrom=DocumentDeeplink&ts=1558.26)**):**

Absolutely. It's a very interesting question because on the surface, I almost want to say no. I almost want to say that HIV is distinct and different from somebody's pregnancy concerns, questions, desires. But in today's world, there are absolutely things that can overlap with it. First and foremost, every single person has a role to play in ending the HIV epidemic. Whether you are positive or negative, there's absolutely things that we can do. Any patient who is wanting to get pregnant, has the potential to get pregnant, I always think it's important to let them know that PrEP is an option for them. For so, so long, if you ask a normal person on the street if they heard of PrEP, the most likely answer that they will give you is, "Oh, that gay medicine." And that's absolutely not the case. We want to make sure that there is a version of PrEP for every single person on the planet, and that includes people who want to get pregnant or who are currently pregnant.

**Dr. Brandon Mizroch (**[**26:57**](https://www.rev.com/transcript-editor/shared/Ruf9XdoojGYW7rnr--TXWbU7dYq6eBhZP0s8AWuWooHsAyF35_29d5_pRHFlov7GTaMV_gU8sPJwyfLAw7_47YCGHS0?loadFrom=DocumentDeeplink&ts=1617.36)**):**

If a patient does have the potential to be exposed to the virus, even though they are, say, undergoing any attempt to become pregnant, let them know that PrEP is an option for them. Let them know that they can protect themselves with it. PrEP is unbelievably effective at what it does. Over 99% effective at preventing HIV and over 80% effective at preventing HIV through intravenous routes. Again, we're talking about a very significant, very large reduction that a person can have. If HIV is, quote, unquote a "possibility" for the patient in question, letting them know that PrEP is an option for them is absolutely something that would be indicated. PrEP should not have any sort of negative impact on a person's ability to get pregnant. It should not factor into that equation other than it can provide a lot of anxiety relief as well as protection from the virus itself.

**Dr. Brandon Mizroch (**[**27:52**](https://www.rev.com/transcript-editor/shared/WkzrTeVqY8q6qVrBWaOyy62aoKyUM_RpSGz5geH3patuSSMxymVZmP-S72CxlWoIV3mlCxYQUMiWYM8w5GB2HSfWatY?loadFrom=DocumentDeeplink&ts=1672.8)**):**

PrEP is also effective and safe during pregnancy. If you have a patient who has ongoing risk factors during the course of their pregnancy, PrEP is also absolutely an option that they can use. Many, many people have taken PrEP throughout their pregnancies. Quite frankly, PrEP in and of itself is just a combination of antiretroviral drugs, so the drugs that we use during pregnancy for a person who is HIV positive are essentially the same drugs that we'd use for prevention when it comes down to it.

**Dr. Brandon Mizroch (**[**28:21**](https://www.rev.com/transcript-editor/shared/STOaIbe_ihwT7rUuhpUMBIL2ft_0EwlKB4nBk_nvwKr4-uw9ILaZOqKjXhvkKtpk4-s0kaV7A54mosHF6ziSATtro0Y?loadFrom=DocumentDeeplink&ts=1701.6)**):**

The other thing to think about is the potential for chest feeding/breastfeeding can occur after delivery. If we do have an HIV positive patient, there's very, very, very little risk that they would transmit the virus to their unborn child through what we call vertical transmission if they are on an effective treatment for HIV and their viral load is suppressed. Again, that is the goal of all HIV treatment is to get your viral load suppressed to an undetectable level. And we've gotten very good at being able to do that, especially during the course of pregnancy. Afterwards, there is a still a slight chance of transmission of the virus through a patient's breast milk. I believe the CDC classifies that as a less than 1% risk that this would occur if a patient is on effective HIV therapy. But at the same time, that is a conversation that you would have to have with your patient on whether they would want to take that risk or not.

**Dr. Brandon Mizroch (**[**29:19**](https://www.rev.com/transcript-editor/shared/z5wjkUJXU5rd4ce4dvP7XNAxtOUmjCsThGPhxU-3aK5rJFdgnMjUPQrDRtScpXi57Ipz4UIGRpmPrCpcXYyX56y2z5A?loadFrom=DocumentDeeplink&ts=1759.5)**):**

At the end of the day, I really just like to say that when dealing with patients who want to get pregnant, who are pregnant, the same sort of questions apply that we typically do for any exposure risk potential for our patients and letting them know that if there are risk factors present, if there is something that could potentially lead to exposure of the virus, letting them know there's several different modalities to protect themselves. I'm talking about condoms, I'm talking about working with their partners to have conversations about this, I'm talking about making sure that they have safe injection equipment if that is something that is going on during the course of their pregnancy or leading up to it. Again, just essentially treating it the same way that you would have for a patient who is not pregnant or who does not wish to be pregnant and that you would approach it. But again, just a message that I can scream from the rooftops is PrEP is for everyone. PrEP is not just for one select group of people, and it very much includes individuals who can or are pregnant.

**Katherine Atcheson (**[**30:20**](https://www.rev.com/transcript-editor/shared/zqcZiVocNMKCnXRcxtL6mSLksm-GoCXhsW8A9zqw-ycEaGXOkkYdgmSK9hkZESmrZq4n0mgQI6l1dVBnWl49MzLuuk4?loadFrom=DocumentDeeplink&ts=1820.94)**):**

And are there special considerations that clinicians should keep in mind when doing HIV exposure assessments for adolescent patients?

**Dr. Brandon Mizroch (**[**30:31**](https://www.rev.com/transcript-editor/shared/2OZuOe1OV-_1lspXH0nta4K4EKqtmCI8b0Nk3qHy6nS8Ekc5uRGr3FGV5zDGBJNvjJkkcDHF-uaIVfqIG358cNIMFiw?loadFrom=DocumentDeeplink&ts=1831.47)**):**

Yes, yes, great question. Unfortunately, we're seeing a very large increase in the rates of HIV amongst people aged 14 to 24. It always just breaks my heart because there's a very good chance that our younger patients didn't know what they didn't know about the topic. They didn't know about HIV and the potential risk that it poses. They didn't know about the prevention strategies that we can use. They didn't know that there's even after the fact prevention strategies that we can use. Education becomes the cornerstone to having conversations with your adolescent patients when it comes to HIV and STIs, making sure that they know about PrEP, making sure that they know about PEP for post-exposure prophylaxis if they've had any sort of potential exposure that they're worried about. There is an after the fact medication. Think of it as a morning after pill, so to speak, for HIV acquisition.

**Dr. Brandon Mizroch (**[**31:28**](https://www.rev.com/transcript-editor/shared/MusTw4INC8RulBtouQHakH9wigg4s9KpzhjZRaSECzw5pEUySZTUvRPNRDO83hbfE40MZYm9iNelzd0pNJZjOMfPVP8?loadFrom=DocumentDeeplink&ts=1888.56)**):**

Also making sure that they know that the most important thing that they can do for protecting themselves against HIV is knowing their status and making sure that partners know their status. Again, I like to really phrase this when we're talking about this status neutral approach to ending the HIV epidemic is whether a person is positive or negative, everyone has a role to play. If you are HIV positive, we want to get you on effective therapy and make your viral load undetectable. Once a person's viral load is undetectable, they're no longer able to transmit the virus to another person. In and of itself, we're talking about ending that chain of transmissions from that person. If you are an HIV negative person, there are many different ways that you can protect yourself against becoming positive. The most effective strategy is either this U equals U thing that I just mentioned or PrEP. Those are actually more effective than condoms are when it comes to preventing HIV. Condoms, again, important thing to talk about in this process, letting people know what their options are when it comes to this sort of a thing, I think is so important.

**Dr. Brandon Mizroch (**[**32:37**](https://www.rev.com/transcript-editor/shared/_HsTh7i4M4MITWthg6O9nftcp_NF21kNuzlGe_2Vzs1bC6j3pqYin9sh2lR1KpYwfQzU2X2OBdf-iNXpONjN5bVY4ak?loadFrom=DocumentDeeplink&ts=1957.8)**):**

Specifically, when we're talking about the testing algorithms that we would have for our adolescent patients, the CDC and essentially all of the experts in the field agree that education is the most important, making sure that people know how the virus can transmit, and the potential for that is. As well as if you have patients who have a higher risk for exposure, we want to test them more frequently. The CDC recommends for any sexually active youth to have annual testing done. If we're talking about a sexually active adolescent patient, they should have annual testing done. If we're talking about a patient with a more potential for risk exposure, that would be a quarterly, just like you would if you were, say, taking PrEP. It's when I say more exposure risk, the CDC specifically classifies it as male youth reporting male sexual contact, active injection drug users, transgender youth, youth having a sexual partners who are HIV infected of any gender, or injection drug users. Those patients should have testing done more frequently, but everyone should have testing done annually to make sure that they have the highest level of protection they have from the virus.

**Katherine Atcheson (**[**33:53**](https://www.rev.com/transcript-editor/shared/Gvngp4e9vML53G2O1wxNAkUsD3NBsLiyBOkNLswbfa6rgG1T9stB5d5U_widKLn-PFvfkzx8kZCNC4Vg4uu7YfBUNTM?loadFrom=DocumentDeeplink&ts=2033.22)**):**

And after taking an HIV risk assessment, clinicians may choose to, as you've said, test for HIV or prescribe or refer for PrEP services, but what other interventions, services, referrals might a clinician want to keep in mind when doing HIV exposure opportunity assessments? How can information from an assessment inform decisions around, for example, providing referrals to a substance use treatment program or an STI risk assessment and testing?

**Dr. Brandon Mizroch (**[**34:29**](https://www.rev.com/transcript-editor/shared/pynxJXTBbqABqFZBtc1sjb-c1LM4sRURVIgGPqZnYwxw_Q5xRwvu6eQcBEVxopFn70TiuO4wHwY7dY4U0AKXwdHp40M?loadFrom=DocumentDeeplink&ts=2069.22)**):**

I guess the first thing that I mentioned before is the importance of three site testing. The CDC estimates that we're missing 2/3rds of our STI infections by only looking at a urine sample when it comes to that. Again, we also want to make sure that we're swabbing the oropharynx and the rectum to do that GC chlamydia test that we typically do that is part and parcel of any STI testing.

**Dr. Brandon Mizroch (**[**34:52**](https://www.rev.com/transcript-editor/shared/7I-ox90VkskUtdT1luzfEpsyb-V9r4A6NSEm9W2ffsvs-rs8aDy9-IK1h10hTh8Ksi9zmvcaOqQDK3hQ86ihAJkUUVs?loadFrom=DocumentDeeplink&ts=2092.26)**):**

I think another important fact to look at, it's not necessarily directly related but very highly correlated would be hepatitis C testing. Hepatitis C is a very fascinating virus in that its prevalence is so much higher than anyone would really expect. Hepatitis C affects about 1% to 2% of the world's population. Typically, when we're talking about diseases, we talk about incidences per 100,000 people in the population, but when talking about hepatitis C, we can talk about it per one in 100 members of the population. That is how common this virus is, so making sure that your patients have been tested for that, that you have a screening on file for them is very important. I always like to say if you look at the chart and you don't see an HCV test on a patient, add it onto the bill, so to speak. Add it onto what sort of blood testing you would normally be doing because it can give you a lot of information.

**Dr. Brandon Mizroch (**[**35:47**](https://www.rev.com/transcript-editor/shared/OYsfG39IPgdQMVWQpQPaYBdl-UpKKPYnRIhmTy7wWxY0aq5uZj18-VKPqMQZde3oDs00kP9XE56s1TS8IkNYR_LPhyA?loadFrom=DocumentDeeplink&ts=2147.22)**):**

HCV is typically transmitted through shared injection drug use equipment. That is by far the most common means of potential for that virus to spread. But it's also commonly transmitted through percutaneous exposure, so homemade tattoos, homemade piercings, things that may have not been done in the most sterile environment as well as sexual contact can also transmit this virus. Again, it's not an STI, but hepatitis C, they're like cousins, I like to say, for STIs and something that you can check for. And again, we have revolutionary, remarkable curative therapies for HCV now. Taking a pill a day for 12 weeks is often all it takes to cure somebody of hepatitis C completely. It's important to ask the questions for that and then know that there's something that we can do to fix it if we do discover it.

**Dr. Brandon Mizroch (**[**36:38**](https://www.rev.com/transcript-editor/shared/CuGmUkj7RaNHca5GThY7Ig1axLG6bMQ01b6Ff9PTV-_k5DYxKU9Jcu6YQnBDDj0s63YoWGPCurA4rXZkbWjIMwzs5WU?loadFrom=DocumentDeeplink&ts=2198.22)**):**

I also think it's important to normalize the lab testing that we do for STIs, making it part and parcel of either an annual exam for a person with very little potential to be exposed to HIV or other STIs or upwards of quarterly. Again, for patients taking PrEP, the schedule that we typically like to follow is a full STI panel testing done every three months for your patients. That really gives you an idea of not only what's going on in their system, I think it also helps keep these concepts in the forefront of people's minds. The idea that, oh, I'm going to be tested. Oh, that's right, STIs exist, and maybe I should be doing more to protect myself against them.

**Dr. Brandon Mizroch (**[**37:18**](https://www.rev.com/transcript-editor/shared/SkudkK0TUmah5Uef38gydnEgHRPYVxZtEhjhPeSZRXAaX0qPZxgtcAr3q1qnGnoYhoUEBze6JODLXIvef_-MhRY41EA?loadFrom=DocumentDeeplink&ts=2238.39)**):**

In addition to that, when we diagnose and find an STI case early, we have prevented the transmission moving forward. That's actually how you lower the infection pool in a community. That's actually how you start to get the numbers of STIs to rescind on themselves and go in the direction that we want. Again, it's really important to just normalize this behavior and making it a standard protocol for everyone involved. Those would really be my ideas about what to do after the conversation. What to do once you've had a conversation about HIV and PrEP with your patients is actually sort of following it up with the testing that goes along with it.

**Katherine Atcheson (**[**37:57**](https://www.rev.com/transcript-editor/shared/WOWkT7OX67DPW7F1mdn1Rtp9MN-FNKhw4HpHs4310dZQ0laCxpPs_S5iO_l1hAp_sCwbThM1oZIOnezaTpcKBvCLqiA?loadFrom=DocumentDeeplink&ts=2277.45)**):**

And where can clinicians go to learn more about discussing HIV exposure opportunities with their patients and how to incorporate these questions from the assessment into their counseling and also to provide that follow up? Once you've done the assessment, what do you do with that information? Where are some good resources for clinicians?

**Dr. Brandon Mizroch (**[**38:21**](https://www.rev.com/transcript-editor/shared/fHITyvvl_wt-ZXbKI86Ac2siya1XIWCte6xCy4MJRCmaBy2WLK6NWuob93j05jG-fcNUgLB3P0Qb35cPYKy-tPFPXqI?loadFrom=DocumentDeeplink&ts=2301.09)**):**

Absolutely. The CDC has really great resources on this topic. I often encourage people to either go to their website. You can also download all of the new recommendations for the treatment of STIs. They have big posters that you can put on the wall of your clinic. They have little pocket cards that you can use. In the last couple of years, we've changed some of the antibiotic regimens that we recommend for the treatment of STIs, and that can make it very helpful for just keeping that all in the forefront of your mind as a clinician.

**Dr. Brandon Mizroch (**[**38:50**](https://www.rev.com/transcript-editor/shared/1BEoecXyodyTmAAJyvY1zfpOQe1p_DQPIR_ijAxuzKL3KRG7oujCRuoQZWHcIIt6xZfgHTsokD1RLLaKf1I5ySE67i8?loadFrom=DocumentDeeplink&ts=2330.16)**):**

In addition to that, I also absolutely want to do a plug for a really fantastic resource out there that is somehow, I'm not 100% sure, affiliated with my organization, the AIDS Education Training Center. I'm talking about the National STD Curriculum. That is std.uw.edu. It's a fantastic website. It has essentially everything that you, as a clinician, would need to know about all of the different pathogens that cause STDs as well as how to have conversations with your patients about them, how to treat them, what potential interactions can they have down the road. It has really everything broken down for you as a clinician. It's a completely free website hosted by the University of Washington who does excellent work on these large compendium curriculums that a clinician would want. And it really talks about everything that you, as a clinician, would want to know about these sorts of diseases: how to prevent them, how to treat them, and everything associated with it. Again, that website is std.uw.edu. That's a great resource that I cannot recommend enough.

**Katherine Atcheson (**[**40:01**](https://www.rev.com/transcript-editor/shared/w8kpT6sBxa6pyp0kchRWYmcf-OEK6R8vudTjEKblryTr6ylFqDlOr4A6u2XPaw9tywvtZG5a-DxXIbMJVrHA4VinHz4?loadFrom=DocumentDeeplink&ts=2401.71)**):**

And this has been a fantastic conversation, but we do have to say goodbye at some point. But before you go, I always like to ask my guests what their one takeaway... If there is just one thing you want our clinician listeners to remember from this podcast and take forward with them as they return to their practices, what would that be?

**Dr. Brandon Mizroch (**[**40:24**](https://www.rev.com/transcript-editor/shared/O_a9fs89PtN9LPleAF8FkxU1TmhiRltnM23i3KMh2U9zUDxa9IFwOKjA9jJPDGIfU-47tCZ-NGBxFfRUhvU5Fltoud8?loadFrom=DocumentDeeplink&ts=2424.99)**):**

Absolutely. That's a great question. Honestly, I would have to say don't be afraid to have these conversations. I promise you they will go better than you think they will. Patients really do value being asked these sort of questions, especially questions that they're not asked frequently because it gives them a chance to express their true feelings on something.

**Dr. Brandon Mizroch (**[**40:46**](https://www.rev.com/transcript-editor/shared/3XfWVd3gPku17sI1oYLUTvcfZZJK5_LuBxbikujfmFeLwghuPJ7gezAtI2fUxcPdXAtd2ykx7RzdGTuObEAXDqVnp2M?loadFrom=DocumentDeeplink&ts=2446.77)**):**

As a millennial doctor, I was a big fan of ER back in the day, if you've ever watched that show. And one of the biggest takeaways that I have from that is they throw around pretty frequently, but you set the tone is one of the most famous lines from that show. I think it's so important that we remember that, as clinicians, we are in the position of authority when it comes to the patient-doctor interaction, and being able to have a frank, open conversation with our patients is really going to facilitate the information that we need to gather as well as how we can best help them and protect themselves and to have the most fulfilling sexual life that they have.

**Dr. Brandon Mizroch (**[**41:26**](https://www.rev.com/transcript-editor/shared/D1hFobVWnct4rPmU8uOuxq-i-fopGlj-otmBInAhxM_WndTVK_gWVZenciUucEV4Pv-lrAaz-Z0FSaIE99EH9ZC1vZU?loadFrom=DocumentDeeplink&ts=2486.7)**):**

Easy ways to do that are, first, try to be as relaxed as possible when starting the conversation. And then once you start talking with your patient, mirror back the language that they use. If they use words like top or bottom as opposed to insertive or receptive, use the terms top and bottom. If they are using a particular slang term that you don't know, ask them. Again, patients really do like to be asked those sort of things.

**Dr. Brandon Mizroch (**[**41:51**](https://www.rev.com/transcript-editor/shared/O7DmpKwvSHbpnx9_2b3wXyUcEUtsm7SLsmTKS9ubVRBrZt68PsVbg18WSTMJnN8pdwWyw3ygUMVBKy6RqLzY1S0xe1o?loadFrom=DocumentDeeplink&ts=2511.69)**):**

And going along with that, very much try to limit being judgmental, being on any way accusatory or condemning a choice that a patient makes because at the end of the day, harm reduction is really what we're trying to do. Harm reduction is medicine. If a patient is not willing right now to talk about their substance use, maybe talking to them about adding PrEP so that they can help be protected against HIV if they are using recreational drugs is a fantastic place to start, because then that will lead to them maybe down the road being more interested in what you have to say about rehab programs or different modalities to help with addiction symptoms and other healthier choices that they can make when it comes to dealing with the situations that facilitated their drug use to begin with. Again, it's all about starting the conversation and allowing them to come to you with these sort of things. And I think that's so important in setting the tone for an effective communication between the doctor and the patient.

**Katherine Atcheson (**[**42:53**](https://www.rev.com/transcript-editor/shared/461wUxPijLq3qKf8ncBQbFpkOxI7WnZXcgJsAyL_r8ILxNY--ABaeSz6OPSBy1IAieUBeSz-JEmGRQpcup5aFKtv3PY?loadFrom=DocumentDeeplink&ts=2573.13)**):**

Well, thank you so much for joining us today, Dr. Mizroch, And for sharing your time and expertise with our listeners.

**Dr. Brandon Mizroch (**[**43:00**](https://www.rev.com/transcript-editor/shared/uNe1pY9dHXQarBOWQgxI2tCMRU6-pj-isoxIMgSt9EJ886VxzcjTAeygA2hUrgWOJGjCeuZpTqX3Mx5V7QKZpsooRh8?loadFrom=DocumentDeeplink&ts=2580.66)**):**

Thank you so much. It's been a pleasure.

**Katherine Atcheson (**[**43:02**](https://www.rev.com/transcript-editor/shared/LGN8rR-5XtOk98GGR9paUZIJkC3msQkC3pu-voBlWJgGdnV7HDTfHqGnSeeAF_KDp8OY5f-5UlTZ6jXPvWvHnqutrP4?loadFrom=DocumentDeeplink&ts=2582.76)**):**

If you'd like to hear more from Dr. Mizroch, he's one of our speakers at the CTC SRH's 2024 National Reproductive Health Conference taking place this year in Philadelphia, Pennsylvania from September 10th through September 13th. Registration is currently open and available through the CTC SRH website.

**Katherine Atcheson (**[**43:24**](https://www.rev.com/transcript-editor/shared/-TgimKU6g1I6zaxApfwFJX6vg5cidXXm16cr_OWl1LulC6Qjrixt8KZQV1ma8b4MHMsGCUJGwXKeoA_r4Zhpo5qyXCw?loadFrom=DocumentDeeplink&ts=2604.42)**):**

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**Katherine Atcheson (**[**44:22**](https://www.rev.com/transcript-editor/shared/AGPXlQu8eecr3PZJ1_udwJvMc4KMK15bcpRHq7TAyHjtOqXMx1U9a3wEggeCYcd_sdOHjk5XNW0pejC5qhINvHMPGrg?loadFrom=DocumentDeeplink&ts=2662.89)**):**

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**Katherine Atcheson (**[**44:55**](https://www.rev.com/transcript-editor/shared/MH-XLrtbUvXj8i-HKFB2wrL41iYxpGrzoQ7bcdTXagSaXZjnUPCYP48ejM0y6KeXzgKHZKLxpElWZqiXEmNZXQbHa5g?loadFrom=DocumentDeeplink&ts=2695.77)**):**

Theme music written by Dan Jones and performed by Dan Jones and the Squids. Other production support provided by the Collaborative to Advance Health Services at the University of Missouri, Kansas City School of Nursing and Health Studies. And finally, thank you to our listeners for tuning in today. We hope that you'll join us next time for another episode of Clinical Chats.