

ORIGINAL ARTICLE

Prescribing as affective clinical practice: Transformations in sexual health consultations through HIV pre-exposure prophylaxis

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Abstract

New medicines can transform routines and priorities in clinical practice, but how do clinicians think and feel about these changes, and how does it affect their work? In Australia, the HIV prevention regimen pre-exposure prophylaxis (PrEP) has been rapidly rolled out, transforming the sexual cultures and practices of users, but less attention has been given to the ways PrEP has reconfigured clinical practice. This paper draws on 28 qualitative semi-structured interviews conducted between 2019 and 2020 with PrEP-providing doctors and nurses in Australia to consider how they have affectively engaged with PrEP and put it into practice. Through a reflexive thematic analysis, we explore how clinicians adapted to PrEP, how the field of HIV prevention has been transformed, and how these developments have changed how clinicians approach patients. While the introduction of PrEP was initially received with uncertainty and shock, clinicians described PrEP as enjoyable to prescribe, and better aligned with the moral duties of sexual health consultations than existing HIV prevention strategies like condoms. Through

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approaching clinical work as an ‘affective practice’, we argue for attending not only to how new interventions change expectations and practices, but also how these changes are felt and valued by clinicians.

KEYWORDS

Australia, condoms, gay men, health care provider, HIV prevention, moral work, qualitative

INTRODUCTION

HIV pre-exposure prophylaxis (PrEP) involves HIV-negative people taking combination antiretroviral drugs on a regular or episodic basis to prevent the acquisition of HIV. It is highly effective, if taken as directed (Grulich et al., 2021). Social science research has documented how PrEP can rapidly and radically transform sexual practices and cultures (Groves et al., 2021), but how has PrEP reshaped HIV prevention for clinicians? In this article we consider how PrEP – a relatively new medicine in Australia – has transformed clinical practice in the field of HIV prevention, including changing how clinicians feel about their work and engaging patients in sexual health consultations.

New medicines and routines

Clinical practices are often ‘routinised’, comprised through the rules and rituals, knowledge practices, medical frameworks, and approaches to care that make up everyday clinical work (Ledderer, 2011). New technologies, medicines, and other clinical interventions can transform or disrupt these routines, producing new and unintended consequences, solving or compounding existing problems, and importantly, constituting new practices (Timmermans & Berg, 2003). The introduction of new drugs is typically accompanied by uncertainty, either because the drugs must be put into practice outside of controlled trial conditions, or because they are unfamiliar to clinicians and patients (Prosser & Walley, 2006; Timmermans & Angell, 2001). Professional guidelines provide recommendations for prescribing, but clinicians are more likely to integrate new drugs into their prescribing routines if they are recommended by their colleagues, or through developing confidence and familiarity through practice-relevant knowledge and firsthand application of the medicine (Prosser & Walley, 2006; Wadmann & Bang, 2015). The introduction of new technologies in clinical practice inevitably produces new social dynamics between adopters and non-adopters of the technology, and clinical interventions are therefore opportunities to enact and contest professional identities (Korica & Molloy, 2010). New medicines can change the routines, expectations, and dynamics of clinical practice, but it is less clear how these changes are felt and experienced by practitioners.

Affective clinical practice

Clinical work – especially doctoring – is sometimes presented as a practice which is ideally conducted in a state of ‘medical objectivity’, free from the compromising impacts of emotions,

and overriding cultural instincts and values (Cook, 2014; Lupton, 2012; Scott, 2000; Whyte et al., 2002). However, in some medical specialities, emotions are a more obvious feature of clinical work, and clinicians are expected to reflexively manage and communicate emotions, such as supporting patients and their families with death and dying (Olson et al., 2020). Beyond managing emotions for effective communication and supporting patients, affect and emotion are arguably ubiquitous features of clinical practice (Scott, 2000). For example, Swallow and Hillman (2019) argue that affect is entangled with assessment and diagnostic practices in the work of memory clinics, in which clinicians attempt to manage or control how patients and families respond to diagnoses with multiple uncertainties. Uncertainty has been a central concept in medical sociology, involving the technical work of interpreting and applying 'evidence' through the 'art' of medical practice (Timmermans & Angell, 2001). However, the communication and management of clinical uncertainty is also affective: it involves caring, valuing, and feeling in clinical practice (Scott, 2000; Swallow & Hillman, 2019).

As a primary analytical approach for considering how PrEP has transformed clinical practice, we draw on the concept of affective practices (Wetherell, 2012). We regard affective clinical practices as encompassing how individual and collective feelings are embedded in everyday clinical care and routines, in both ordinary and novel events, and the range of contested, contradictory, vague, and subtle feelings they elicit. The analysis of affective practice follows what these feelings 'do' in everyday life, and how affect is embedded in and reinscribed through repeated practices and memories of the past (Wetherell, 2012). We argue that clinical work and care – as routinised, adaptive, and value-laden practices that implicate health, wellbeing, suffering and the discussion of intimate embodied processes – can fruitfully be considered as affective practices.

In relation to PrEP, affective clinical practices encompass the collective ways that clinicians report thinking and feeling about PrEP, including how they anticipate and put PrEP into practice with patients, and how they make sense of PrEP through past HIV prevention strategies and experiences of clinical care. Through affect, we are also interested in the underlying values and moral duties that underpin clinical practice (Cook, 2014; Lupton, 2012; Scott, 2000), and the wider field in which HIV prevention is practiced.

The sexual health consultation

Sexual health consultations offer an evocative site to consider matters of affect and clinical practice. In the context of Australia, these clinical encounters most often take place in primary care settings, particularly sexual health and general practice clinics. Sexual health consultations involve patients sharing (or 'confessing') the intimate details of their sexual history, and medical examinations of the body may also be conducted (Pryce, 2000, 2001). Within sexual health settings, clinicians often strive to enact a non-judgemental ethos (Cook, 2014). However, in valuing this ethos, there is a tendency to describe clinician perspectives as 'moral' only when negative attitudes are expressed, which serves to obscure the routine 'moral work' of most sexual health encounters (Cook, 2014). For Cook, this moral work includes how clinicians unintentionally act as moral educators, providing guidance about normative sexual practices and health through the process of eliciting a sexual history and negotiating the social meaning of a sexually transmissible infection (STI) diagnosis. However, given the pervasive orientation towards medical objectivity or neutrality, clinicians are unlikely to think of themselves or their work as constituting moral education (Cook, 2014; Lupton, 2012).

Transformations in HIV medicine

Despite a focus on ‘biomedical’ solutions, HIV medicine is unreservedly social, and the ambitions, passions, interests, and practices of scientists and clinicians are culturally mediated and deserving of attention (Bernays et al., 2021, p. 16). Many clinicians working in sexual health and HIV care in Australia are drawn to it by a particular sense of justice for marginalised communities, especially those living with and affected by HIV (Newman et al., 2013). Some clinicians share a sense of personal connection and belonging to HIV-affected communities, while others become personally invested through working with patients.

Clinicians working in HIV medicine have experienced enormous transformations in the field, particularly through the introduction of combination antiretroviral therapy (ART) in the mid-1990s. Marking a paradigmatic shift, ART transformed HIV care in many settings from the management of a life-threatening condition to chronic disease management, and enabled clinicians to express hope for the future health of patients they worked with (Newman et al., 2013; Westburg & Guindon, 2004). While ART controlled viral replication, allowing immune system reconstitution and prevention of progression to AIDS for many people living with HIV, the side effects produced by early ART drugs and the potential for antiretroviral resistance meant that clinicians expressed uncertainty about early combination treatments (Rosengarten et al., 2004). The feelings of optimism and excitement that clinicians initially reported through witnessing patients no longer dying from AIDS-related conditions was gradually replaced by the contingencies and practicalities of providing everyday clinical care to a chronic health condition, including adjusting to long term clinical relationships and managing comorbidities related to ageing. This example demonstrates how new medicines can transform clinical practice (Newman et al., 2016), but also how feelings such as hope and uncertainty are entangled in routine care (Rosengarten et al., 2004). The use of ART as PrEP marks another important transformation in HIV medicine.

HIV prevention and PrEP prescribing

In Australia, PrEP was initially introduced in 2015, and made publicly available in 2018, available via prescription from a doctor or nurse practitioner (Smith, Haire, et al., 2021). Rapid scale-up of PrEP in New South Wales, Australia demonstrated that PrEP can be successful in preventing HIV transmissions (Grulich et al., 2021). While condoms were the primary recommended form of HIV prevention in Australia for decades, in 2019 PrEP use became the most commonly used form of prevention by gay and bisexual men (Holt et al., 2021).

As an object, technology and process, PrEP has generated a range of affects which are visible in scientific and popular discourse (Smith, Newman, et al., 2021). Earlier in the roll out of PrEP, Auerbach and Hoppe (2015) argued that PrEP was framed as ‘hold[ing] the promise to ending the HIV pandemic’, but also as ‘an insidious strategy that will exacerbate HIV epidemics and attendant social ills’ (p. 2). Reflecting on the role of social scientists in the Canadian HIV response, Gaspar et al. (2021) expressed ambivalence towards PrEP and the ‘biomedical triumphalism’ that accompanied it, which appeared to have resurfaced longstanding tensions in the politics of HIV research. Early PrEP implementation studies sparked concerns and debate about its consequences for sexual cultures, prioritisation of resources in the HIV response, and impacts on other aspects of sexual health, including the prevention of STIs (Auerbach & Hoppe, 2015; Holt et al., 2019). In the U.S. there has been a particular focus on how moralising views about PrEP might hinder prescribing (Calabrese et al., 2019).

Beyond public debates about the relationship between PrEP and sexual behaviour, some researchers have started to consider how PrEP has transformed clinical practice for the clinicians who provide it. Nicholls and Rosengarten (2020) have suggested that PrEP can alter the clinical encounter, enabling 'more open discussion' with patients and the possibility of 'a different style of clinical practice' (p. 1336). The promotion of PrEP prescribing by general practitioners (GPs) and family physicians has led some to argue that PrEP could be a 'gateway' for younger, healthy patients to engage in a holistic primary care relationship that they might not otherwise have (Marcus et al., 2018). However, this potential is limited by the challenge of encouraging generalist clinicians to prescribe PrEP (Zhang et al., 2019), as well as overcoming discomfort and a lack of confidence in addressing sex and sexual health in medical consultations (Calabrese et al., 2019; Smith et al., 2020).

While the ways in which PrEP has reconfigured the sexual behaviour and practices of gay and bisexual men is increasingly well documented (Groves et al., 2021; Haire et al., 2021), we know far less about how PrEP has shaped clinical practices, and how clinicians feel about the pace of cultural change precipitated by PrEP. Sexual health consultations can be emotionally and morally loaded clinical encounters, and understanding clinician investments and engagements with prescribing a new regimen like PrEP provides an opportunity to understand aspects of clinical practice neglected in implementation research, but which may be important to effective clinical provision. Drawing on interviews with PrEP providers in Australia, this study considers how PrEP has transformed the affective clinical practices of sexual health consultations.

METHODS

The material presented here was collected as part of a doctoral study, PrEP in Practice: Clinician Perspectives on Prescribing PrEP in Australia. One of the aims of the study was to understand clinician experiences of providing PrEP. The study design is discussed in more detail elsewhere (Smith, Holt, et al., 2021). The study received ethics approval from relevant institutions (see acknowledgements).

We conducted qualitative semi-structured interviews with Australian PrEP providers working in different locations and settings, with varying levels of experience. We advertised through newsletters and emails circulated to clinicians, directing potential participants to the study website. To be eligible, participants had to work in New South Wales or Western Australia, be aged 18 years or older, and have prescribed or dispensed PrEP at least once. Participants were offered compensation of \$125 AUD for their time, although some were unable to accept compensation. All participants provided written or verbal consent prior to interviews.

Interviews were conducted by A.S. between October 2019 and July 2020 by telephone, video-conferencing, or in person, based on participant preference and location. Participants were asked about their clinical role, experiences, challenges, and opportunities of providing PrEP, and whether PrEP had changed the way they approached HIV prevention (see interview guide; Smith, Holt, et al., 2021). On average, interviews lasted 1 h, ranging from 35 to 100 min. Interviews were audio-recorded, professionally transcribed, checked for accuracy and de-identified.

We interviewed 28 participants, with 26 interviews conducted by phone, one face-to-face and one through video conferencing. The sample (Table 1) primarily included clinicians working in inner city, metropolitan and suburban contexts, and mainly in sexual health-focussed clinics, whether publicly funded or private general practice clinics. Most of the sample was very experienced with PrEP, sexual health, and HIV prevention, and included high proportions of

TABLE 1 Participant characteristics

	n
Profession	
General practitioner	12
Sexual health nurse	9
Sexual health physician	7
Jurisdiction	
New South Wales	18
Western Australia	10
Clinical location	
Inner city	14
Metropolitan or suburban	10
Regional or rural	4
Clinical setting	
Publicly funded sexual health clinic	14
General practice	10
Community based clinic	4
Years working in sexual health/HIV prevention	
Average (mean)	10 years
Range	2–27 years
Highest qualification	
Undergraduate degree	8
Postgraduate certificate or diploma	9
Masters	11
Gender	
Woman	20
Man	8
Sexual orientation	
Straight/heterosexual	15
Gay	5
Queer	2
Fluid	1
'I don't know'	1
Not answered	1
Cultural identities (not mutually exclusive)	
Australian	15
White/Caucasian/Anglo	16
English-speaking overseas heritage	5
Non-English speaking overseas heritage	9
Total	28

women, heterosexual and White participants. Doctors were assigned a primary speciality as either a general practitioner or sexual health physician. 'Sexual health nurse' included registered nurse, clinical nurse consultant, clinical nurse specialist, and nurse practitioner. While most nurses (except nurse practitioners) cannot prescribe PrEP in Australia, we included nurses in our study as some were permitted to dispense PrEP during trials, and many continued to educate and assess patients for PrEP alongside prescribing clinicians (see Smith, Haire, et al., 2021). To ensure confidentiality when quoting participants, only their profession is reported, that is, [P01 – Sexual Health Nurse].

Transcripts were analysed using reflexive thematic analysis (Braun & Clarke, 2019), in which themes were developed through a combination of our theoretical approaches, research questions, understanding of the literature, and the interview material. Interviews were listened to and transcripts read multiple times, and A.S. wrote summaries of each interview and shared these with the study team. A coding frame was developed from research questions and interview summaries, and refined with new codes through several rounds of inductive coding. Data were manually organised into codes using QSR NVivo (12.6.0). While we had not initially intended to analyse affective practices, we identified affect as an important dimension in our data, and so we focussed further rounds of coding on the description of emotions, feelings, memories, reflections, experiences of change or transformation, anticipations, and clinical or moral values related to PrEP prescribing. Collectively, as we developed the analysis and writing, we aimed to ensure that our analysis attended to the divergent and multiple tensions in clinical practice, but also the feelings which might seem mundane but were indicative of affective practices (Wetherell, 2012). As the themes were iteratively generated and the manuscript draughted, interview transcripts were read again to ensure that the analysis reflected participants' accounts.

FINDINGS

From uncertainty to excitement: Anticipating and experiencing the practice of PrEP

This theme explores participants' collective adjustments to PrEP's introduction in Australia, which was characterised as a period marked by uncertainty, optimism, and caution. Participants in our study offered reflections about how they first felt anticipating and then providing PrEP, including their present-day experiences of prescribing. P24 [Sexual Health Nurse] recalled,

When something new comes along, you have a level of anxiety and concern about it. So initially it was a little bit of, 'What's all this about?' Interested curiosity, I'd say. Part of me was very optimistic – is this something that's going to prevent HIV? A really good thing. But how is it all going to work, and how on Earth is it going to look in terms of implementing it into our clinic with the staff [numbers] that we've got?

Rather than a mix of optimism, curiosity, and concern, others characterised the anticipation of PrEP as entirely fraught. P12 [Sexual Health Physician] described feeling a sense of 'unease', and explained the uncertainties that drove this concern: "What are we doing here? Are we doing the right thing?" And, "What's it going to do to STIs? What's it going to do to drug resistance?" These accounts of caution were carried into the early stages of PrEP provision, in which clinicians reflected on being vigilant:

We were worried about the potential to do harm in a population of people who were otherwise fit and well. We had initial studies that showed PrEP was efficacious, but kind of 86% effective, were the sort of figures. And there were concerns about long-term side effects and the kind of PrEP-syndrome when people feel unwell when they first start it, and a lot of monitoring of LFTs [liver function tests] and renal function. We were just being really cautious about it because it was new, and we didn't want to do harm.

(P22 – Sexual Health Physician)

While the drugs used in PrEP were familiar for clinicians involved in prescribing HIV treatment, the shift to prescribing these medications as a prophylactic treatment was a new approach, and participants reflected concerns about a range of potentially problematic consequences. Initially, only those categorised as being at 'high risk' of acquiring HIV were eligible for PrEP in demonstration studies (Grulich et al., 2021). This early period was therefore characterised by a clinical duty to ensure that PrEP prescribing was carefully scrutinised, particularly because there was unease about prescribing a potentially harmful drug to people who were otherwise believed to be healthy. However, many of these concerns did not eventuate in practice:

The toxicities of [PrEP] in young men, it's not really coming up as an issue. Like it's not like all these guys are dropping their kidney function down the track. So that's been reassuring. I think it's just the real world of prescribing and actually doing it and you're seeing that it's not posing any problems.

(P12 - Sexual Health Physician)

While initially a cause of worry, side effects were described as both rare and easy to manage once participants gained experience prescribing. P22 observed that 'we've become more relaxed in prescribing it, it's just become normal.' This sense of being 'relaxed' was reflected in prescribing attitudes. While eligibility for PrEP was initially restricted to people at 'high risk' of acquiring HIV, some participants shared stories of colleagues taking an increasingly flexible approach to determining eligibility (using clinical discretion), or subtly supporting patients to suggest that they had a higher risk of acquiring HIV than was accurate for patients to access PrEP. The prescribing criterion were later 'relaxed' in Australian PrEP guidelines, although participants often remained invested in identifying a discernible HIV risk before prescribing (see Smith, Holt, et al., 2021).

As increasing evidence emerged of high effectiveness in the Australian context, and PrEP became nationally funded through Australia's Pharmaceutical Benefits Scheme (PBS; see Smith, Haire, et al., 2021), participants reflected on becoming highly confident with prescribing:

The most compelling thing was the data that people were not seroconverting [acquiring HIV] on PrEP. That was really reassuring. And you get comfort from when it's on the PBS – it's all been legitimised now. That's how confident they are that it's working.

(P12 – Sexual Health Physician)

In contrast to the earlier periods of uncertainty, most participants expressed enthusiasm in interviews about their current experiences of providing PrEP. P08 [Sexual Health Nurse] effused, 'It's been really exciting to be involved with PrEP. I think it's fantastic and I hope it's available to

everyone who needs it.' And P13 [GP] remarked, 'I look forward to patients who come and say, "Can I have PrEP?"' The sexual health consultations in which PrEP was discussed and prescribed were presented as sites of energy and enthusiasm.

While present-day experiences of PrEP prescribing were generally characterised positively, some also contrasted these with a pragmatic disposition towards HIV prevention: 'PrEP is another tool. I don't think it's a be-all and end-all, but I think it's an extremely important tool.' [P06 – GP]. Others tempered their excitement about PrEP by pointing out that not all people who might need PrEP were equally supported in accessing it: 'PrEP is excellent. But I certainly think there's priority groups that aren't being targeted as well as they could be.' [P14 [Sexual Health Physician].

Although most participants expressed enthusiasm or pragmatism, a few reported conflicted feelings about PrEP. For one participant, the early implementation phase was described as demanding:

PrEP clinics were fun. [pause] Actually, it was stressful, it was really stressful. There were nervous breakdowns because there was a lot of pressure for us to roll PrEP out as soon as we possibly could. It was an impossible task that we were given. And it's not that we didn't want to be able to provide PrEP, it was that we felt the pressure immensely in the clinic.

(P25 – Sexual Health Nurse)

For P25 and colleagues, ensuring the success of PrEP was a duty which required significant labour. Sexual health services had been rapidly reshaped to meet the demands of PrEP in demonstration studies, although this stress on services seemed to be limited to the initial rollout period. However, the changes to service delivery lasted beyond the studies (see (Smith, Haire, et al., 2021), which another participant described as a less than welcome outcome:

PrEP has created a rather sort of boring landscape for sexual health clinicians, in many ways. Our time is taken up testing people and having the same conversations. And that is a problem because the time that we spend dishing out PrEP is time that we don't get to do other things.

(P09 – Sexual Health Physician)

This complaint was an unusual outlier, as the clinical work of sexual health prior to PrEP could also involve repetitive consultations. However, P09's frustration seemed to be grounded in the experience of PrEP changing the types of conversations that made up the mainstay of their clinical work, and an observation that some sexual health issues were now deprioritised. While the practice of providing PrEP was most often experienced as exciting and hopeful, a sense of unease carried through into some participants' accounts of clinical practice, as we explore in the next two themes.

PrEP is a 'game changer': Witnessing the transformation of HIV prevention

Adjusting to PrEP was not just a matter of integrating new prescribing practices into the clinic, but also required a deliberate investment by participants to make sense of how PrEP (re)shaped their clinical practice and the field of HIV prevention more broadly. This theme considers how PrEP transformed the field of HIV prevention, how clinicians reported adjusting their thinking and values in response, and what they considered to be the implications for clinical practice.

Participants frequently reflected on the past as a way of making sense of how PrEP had reconfigured consultations, such as this doctor who offered the following vignette:

It happened this week, actually. I was reviewing an old file and I found some notes of mine. So, 10 years ago? And I was seeing this chap who's coming in sort of regularly for screening, and each time I was talking about the fact that he was having a lot of condomless sex and he was at risk of HIV. I was recommending condom use and counselling, poor man. A few years later he acquired HIV. I was just looking back and thinking: that's all we had, really. There was serosorting and people being on treatment who were [HIV] positive, and there were condoms, and I don't know what else - abstinence I suppose - and that was kind of all we had on offer. And I thought, 'Gosh.' Now, I'd be like, 'Okay, here's PrEP. There's different ways you can take it.' And I haven't thought about this before, but I feel a bit less useless now 'cause I've got more to offer the patients that I see in terms of preventing HIV infection. [...] PrEP is not for everyone, but it's revolutionised HIV prevention for a huge number of the patients that I see.

(P22 - Sexual Health Physician)

In framing the HIV prevention strategies of the past as insufficient and inadequate for many patients, P22 articulated PrEP as not only powerful in preventing HIV, but also transformative for their sense of professional satisfaction, enabling them to feel like they made a difference in patients' lives. Participants collectively articulated a shifting mood; the stakes of HIV prevention had changed. This transformation was particularly visible for a nurse who had worked in another field for half a decade:

I came back to a field that I could barely recognise. And I was like, 'Whoa! What happened?' I knew about PrEP, theoretically, but I just didn't know how massive it was and the demand for it, and what a game changer it was in terms of HIV.

(P10 - Sexual Health Nurse)

Participants working throughout the roll-out of PrEP recalled a gradual process of adjusting to the logic of PrEP, including relinquishing the longstanding attachment to physical barrier methods like condoms for preventing HIV transmission. This typically required challenging stereotypes about who PrEP was for, and confronting values about sexual practice, condomless sex, and relying on medication for HIV prevention. One participant reflected:

It's been a bit of a journey in terms of peoples' attitudes, especially medical professionals' attitudes. I remember thinking to myself after hearing about the PrEP trial the general feeling was, 'Oh God, I don't think I would ever take that myself,' or, 'It just feels quite shocking to me.' And I think it was one of my friends when I started PrEP, they said, 'I can't believe you're choosing that lifestyle for yourself.' And that seems so backward now.

(P20 - Sexual Health Physician)

While participants were not asked whether they used PrEP themselves, two participants disclosed PrEP use during interviews, including P20, who described PrEP as 'life-changing for lots of my patients and for myself.' First hearing about the concept of PrEP was 'quite shocking' for P20, and other participants shared similar reflections. P08 [Sexual Health Nurse] recalled 'I

remember when they first started talking about PrEP. I must admit I was a bit like [pause] *you know*, because condoms were available, and we spent so much energy encouraging condom use.' PrEP was a challenging new concept because it seemed to threaten the symbolic centrality of condoms as a focus of prevention, despite levels of condom use gradually declining for many years before (Hess et al., 2017).

Although an infrequent experience, a few participants reported that the introduction of PrEP created a schism between those who were enthusiastic and those reluctant to encourage PrEP uptake. P11 [Sexual Health Nurse] observed, 'Some of the older nurses that I've worked with over the years have mixed views on PrEP. And some of them say, "I think we should be really encouraging people to use condoms."' P08 explained that this sense of resistance to change could have an impact on prescribing opportunities:

With the nurses who wouldn't get on board [with PrEP], it was problematic when a new person would come in as they might not be offered PrEP. Or they sort of say that PrEP is available, but 'there could be some side effects' and 'Do you really want to take a pill every day?'

P08 reported a suspicion that some colleagues who overemphasised the burden of side effects and pill taking were doing so because of a reluctance to abandon the familiar approach of using condoms. This reluctance may be reflective of a broader resistance and stigma towards prescribing PrEP (Calabrese et al., 2019), but also emphasises how new technologies shape professional divisions between adopters and non-adopters (Korica & Molloy, 2010).

Beyond the fidelity to condoms as primary HIV prevention strategy, the threat of increased STIs from a reduction in condom use also made PrEP a concerning paradigm shift for many participants:

We were worried about STIs, and now suddenly we're telling people, 'You can take these pills,' and, 'Yes, use condoms,' but you know everyone's not going to use condoms now that they're on PrEP. That took a bit of shifting.

(P12 – Sexual Health Physician)

While condoms and PrEP can be used together, most participants expressed a belief that PrEP users would not routinely use condoms (Smith, Newman, et al., 2021). A few participants were alarmed about this development:

PrEP has been introduced without thought to the risk adjustment STI effect that we see. [...] So everyone's sort of thrown condoms away for whatever reason, and the rise of syphilis, infectious syphilis, is quite disturbing.

(P09 – Sexual Health Physician)

Despite concerted efforts to monitor PrEP's implementation in Australia, the introduction of PrEP was presented by P09 as though it was a reckless development, because of potential consequences for other infectious diseases like syphilis. Whether PrEP directly contributes to an increase in STIs has been a source of contention amongst experts working in HIV prevention (Holt et al., 2019). Most participants in our interviews expressed ambivalence about the public health problem of STIs in relation to PrEP, explaining that PrEP worked to prevent HIV, and that responding to STIs would require other solutions, including regular testing and care.

These participants focussed on their role in supporting individual patients: 'If someone's coming continually with an STI, I say to them like, 'You should think about condoms.' But I don't care [about STIs], I'd be out of business if people didn't get STIs. (Laughter)' [P01 – Sexual Health Nurse]. This joke signalled P01's perception that STIs were manageable, and that beyond a gentle suggestion of condom use, controlling whether those infections happened in the first place was not their primary duty. Participants collectively shared a process of readjusting their values about STIs, and they modified the way they discussed STI prevention with patients, acknowledging the positive experiences generated by PrEP. P17 [Sexual Health Nurse] reflected:

Condom use certainly has its place and that's always a conversation I have around bacterial STIs. But at the end of the day, as long as we're seeing these clients, we have this rapport with them, they are consistently quite adherent to their PrEP – they might have a bacterial STI here and there – I'm very much in favour of PrEP, even more so than condoms.

PrEP transformed values in HIV prevention, particularly in the way that condoms and STIs were attended to and prioritised in clinical practice. Amidst these changes, PrEP required participants to anticipate and respond to patients in new ways, as we explore next.

An easier sexual health consultation? Towards different styles of clinical practice

This theme explores how PrEP enabled participants to establish different or improved clinical relationships with patients, particularly through attending to important but often neglected goals in sexual health such as the acknowledgement and pursuit of pleasure (Marcus et al., 2021).

The experience of prescribing PrEP was often contrasted with that of promoting condoms. P20 [Sexual Health Physician] explained, 'We've always had condoms, but they just didn't work. People don't use them. So now we've got something that people actually do use and it works. It's changed everything.' There was a collective sense that promoting condoms had often felt like an unrealistic strategy to advocate:

You feel like you're nagging them about using condoms. [...] In the heat of the moment, I doubt they're going to think about what their GP told them. They're gonna do what they feel like doing. So you'd always talk to people about using condoms but there was a sense of futility about how effective that messaging actually was.

(P02 – GP)

While some participants maintained that they felt a responsibility to promote condom use (particularly to prevent STIs), P02 imagined that their discussions with patients had little impact on patients using condoms. In contrast, PrEP was an intervention which large numbers of people were requesting at clinics, and clinicians reported that consultations were 'a little bit more patient led.' [P02], supporting conversations with patients that were more 'honest':

We've been trying to tell people to use condoms for decades, and that doesn't work, and people don't use them. And now we've got something else that we can say to people, 'Look, it's okay if you're having lots of condomless sex. We're happy that

you're honest with us. And if you're not gonna be using them going forward, there's all these things you can do.'

(P11 – Sexual Health Nurse)

Here, P11 presents an imagined patient who needs to be encouraged to be 'honest' about condomless sex, which in the era of PrEP is a sexual practice which clinicians are permitted to enthusiastically respond to, an intervention which co-exists more easily with the practice of condomless sex. Consequently, participants reported feeling more effective, useful, and relevant when providing PrEP, as there was a shared goal of PrEP between patient and provider, enabling reciprocal trust.

Participants in our study also recognised how PrEP enabled patients to feel less anxious about testing for or acquiring HIV, sometimes known as 'HIV anxiety' (Smith, Holt, et al., 2021). This reduction in anxiety about HIV for patients who took PrEP meant that consultations were described as more relaxing and less stressful for clinicians. P01 [Sexual Health Nurse] explained:

A lot of the conversations I used to have I don't have as much anymore. It's funny, like we have created a very different world in sexual health now with PrEP because we're not doing as much pre-counsel around so many things because clients are on PrEP ... it has changed the way that I practice. [...] like, they're taking their PrEP. They're taking it all the time. The consult goes for 5 minutes because you're like, 'Any concerns? Any issues? You know what you're doing, off you go.'

The effectiveness of PrEP meant that pre-test counselling about a potential HIV-positive result was no longer necessary and suggested patients and clinicians were more relaxed when testing for HIV. As P03 [GP] explained '[testing] is a little bit more light-hearted and they kind of know what the result will be', while prior to PrEP, 'people would be worried. They'd ring the clinic before the results were available and they'd just ring every couple of hours, and we were like, 'we're waiting for the results!' It's a lot less frantic now.' However, the shift away from pre-test discussions and exploring motivations for engaging in condomless sex troubled one participant:

So it's easier because you know if they take PrEP they're not going to get HIV. But I do worry about the psychosocial stuff that we miss out on. Like I feel like it's all medicalised, which is all well and good – and the numbers certainly show that [HIV notifications] seem to be decreasing – but I do worry that we might be missing out on something, like discussions around psychosocial aspects of why people take the risk that they take or why people have as many partners they do [...] I wonder if we are missing [diagnoses of] anxiety and depression.

(P12 – Sexual Health Physician)

While other participants framed PrEP as liberating consultations from a preoccupation with HIV risk and attendant anxieties, P12 framed discussions of risk as important occasions for unmasking complexities in people's lives, including experiences of mood, motivation and relationality that can become entangled with particular sexual practices. They suggested a moral duty to consider broader aspects of patient's lives, including assessing mental health and sex lives. P26 [GP] suggested a counter perspective on the connections between PrEP, consultations, and mental health:

I often find that when people are on PrEP and they see you for a while, you get the opportunity to talk about how they feel about their sexuality and their relationships with other people, their family, and their friends. That allows you to explore those a little further and work out whether they need linking in with other people, like psychologists, etc., to work through some of that stuff. But that's not what they've come to see you about. The PrEP's what they've come for and it's over time that you develop that relationship.

Here, P26 suggests that providing PrEP is not just a medicalised process of writing a script, but also an opportunity to build trust and rapport over successive consultations, representing the model of PrEP as a 'gateway' to primary care (Marcus et al., 2018). These are two contrasting clinical gazes (Pryce, 2000), although both might achieve similar outcomes; for P12, the ritual of a pre-test discussion might reveal or incite the patient to confess a risk or clinical problem, and for P26, through the building of a therapeutic relationship the patient might trust the clinician and discuss other relevant practices. However, the former approach seemed fragile in the current era because the success of PrEP reduced the need for consultations to focus on discussions of HIV risk.

Overall, participants reflected that pre-PrEP sexual health consultations with gay men were marked by feelings of futility over 'nagging' about condom usage, and heightened anxiety about patients acquiring HIV. In contrast, PrEP enabled a style of clinical practice that was felt to be more honest, relaxed, less focused on discussing sexual risk, and which participants believed better met the expectations of patients. Collectively, participants expressed less worries about their patients' HIV risk, producing sexual health consultations which were enjoyable and easier. This transformation suggests shifts in participants' perceived moral duties in sexual health consultations.

DISCUSSION

In this qualitative study of PrEP providers, we considered how individual and collective feelings are embedded in clinical care and generated in the experience of prescribing a new drug regimen. Specifically, our analysis revealed how clinicians reported thinking and feeling about their work and transformations of the sexual health consultation. Collectively, clinicians in our study characterised PrEP as an easy and enjoyable intervention to prescribe. Most clinicians indicated that providing PrEP enabled them to more easily achieve HIV prevention in ways that better aligned with patients, although some indicated tensions with perceived duties to promote condom use and discuss sexual histories and risk. Our study offers insight into how a new medicine can transform a field of practice and the affective, intimate, and moral work of clinical practice.

Clinicians in our study reflected on a gradual process of adjusting to PrEP, including grappling with initial uncertainties about managing side effects. Through personal experiences of prescribing and population level evidence that it worked, participants suggested that PrEP became a routinised part of clinical work, as has occurred with other new medicines (Prosser & Walley, 2006; Timmermans & Berg, 2003; Wadmann & Bang, 2015). PrEP has been characterised as both a 'simple' and 'complex' medicine to provide – simple in terms of technical knowledge required to deliver PrEP, but complex in implicating discussions of sexuality, sexual practice, and HIV risk (Calabrese et al., 2019; Smith et al., 2020). Many clinicians avoid these intimate domains of sexual health medicine because they feel uncomfortable about them. Building on the recognition of these dynamics, we show how integrating PrEP was also complex because it required clinicians to manage feelings and values related to the moral 'shock' of its introduction and to

relinquish a focus on barrier HIV prevention methods like condoms. This was a significant shift in medical practice, requiring frontline clinicians to rapidly adjust to rolling out a new intervention which conflicted with longstanding beliefs and practices about how to stay 'safe' to prevent HIV. Understanding professionals' accounts is valuable not only because their approaches to HIV prevention were challenged, but they were then charged with the duty of engaging with patients to (re)negotiate HIV prevention, for whom meanings related to 'safe sex' amongst gay and bisexual men have also been rapidly transformed through PrEP (Groves et al., 2021; Haire et al., 2021).

Clinicians have specific emotional investments, priorities, and responsibilities in sexual health consultations that PrEP has both challenged and reinforced. Participants wanted to feel capable, useful, and trusted, but they also felt obliged to recommend prevention methods that are socially acceptable, are supported by evidence, and have an effective risk/benefit profile. They also seemed to enjoy and value how PrEP produced more 'patient-centred' consultations characterised by reduced worry and concern about HIV status for both patient and provider. A few expressed unease at what they felt as the deprioritisation of other sexual health issues, including STIs and discussions of mental health that might be elicited in the context of discussing sexual risk and practice. This suggested that PrEP might diminish the capacity for clinicians to elicit a full investigation of patients' clinical needs. Transformations in medicine can produce new affective clinical practices, but frustration and ambivalence about new approaches, and fidelity to and nostalgia about known and familiar ways of working can remain (Korica & Molloy, 2010). PrEP generated change for what constitutes appropriate care in the sexual health consultation and the obligations of clinicians in discussing sexual histories and risk. Beyond establishing an initial rationale for prescribing PrEP (see also (Smith, Haire, et al., 2021), most clinicians described a shift away from needing to know about the patients' sexual practices, suggesting a diminished clinical gaze towards PrEP users, at least in terms of how risk is surveilled in sexual health consultations (Pryce, 2000).

This study builds on Auerbach and Hoppe's (2015) argument that getting PrEP to work is more than just 'getting drugs into bodies' by suggesting that it also entails engaging the technical, moral, and affective experiences of clinicians as part of the process of prescribing. Reflecting on prescribing and what prescription achieves in the clinical encounter is a rich site for sociologists to consider the underlying moral values that are at play in patient-provider relationships (Whyte et al., 2002, p. 117). For example, in the context of ongoing debates amongst HIV sector professionals about PrEP's impact on condom use and rates of STIs (Calabrese et al., 2019; Holt et al., 2019), clinicians in our study took a pragmatic view that PrEP is effective at preventing HIV, and that it is an intervention that most of their (gay male) patients wanted (Smith, Newman, et al., 2021). While still often concerned and unnerved about rates of STIs – which condoms could help to prevent – clinicians typically valued PrEP more because it was clinically effective at preventing HIV, more consistent with patients' sexual practices and harmonised the patient-provider relationship. In contrast, some participants reflected that promoting condoms had felt like a futile obligation by putting them in potential conflict with patients' sexual desires. This aligned with Nicholls and Rosengarten's (2020) observation that 'PrEP enabled practitioners to depart from what some otherwise saw as a demand on them to moralise about the need for condoms despite what was felt to be the futility of doing so.' (p. 1333).

Our analysis builds on sociological insights about how new knowledge and technologies shape clinical practice. Sociologists have argued that new interventions require clinicians to reckon with uncertainty and negotiate contested ideas about 'applying' evidence in the real world (Prosser & Walley, 2006; Timmermans & Angell, 2001). We add to these insights by considering prescribing as an 'affective clinical practice', in which clinical work and care is approached as routinised, adaptive, and value-laden practices involving emotions (Wetherell, 2012) and moral work (Cook, 2014;

Scott, 2000). This approach enabled us to attend to how new drug prescribing required clinicians to care, value, and feel in different ways about their work, and to reconsider affective and moral engagements with patients, colleagues, and the wider field of medicine in which they work. Further, although sociologists have given considerable attention to affect and emotions in clinical practice, we argue that affect and emotions are not simply problems to be 'managed' but characteristics that are always present in and shape clinical practice (Swallow & Hillman, 2019). How clinicians come to think, feel, and value their work, including how they negotiate and enact moral duties, is important because it is a critical component of how they practice effectively. We believe that attending to affective clinical practices enriches the sociology of health by broadening the range of sociocultural aspects that shape the delivery of medicine (Lupton, 2012).

There are several limitations to this study. Given that we conducted qualitative interviews, we only had insight into participants' reflections on prescribing and clinical practice, and did not observe what clinicians actually did or said in practice. While participants provided rich reflections on clinical practice and prescribing that were amenable for analysing affect, we did not initially set out to explore and probe for accounts of affect and emotions. Further, most participants in this study were highly experienced with PrEP prescribing, and their perspectives on sexual health consultations may differ to clinicians with less experience. Future studies could aim to explore affective clinical practice from the initial design stage, or employ other methods such as video reflexive ethnography, the observation of consultations, or analyse the affective aspects of prescribing consultations for PrEP users.

New drug prescribing can be a source of uncertainty, but also caution, excitement, shock, discomfort, and unease, and sociologists should pay attention to the range of affects generated when implementing new medical technologies. This study demonstrates the importance of attending not only to how new interventions change expectations and practices (Korica & Molloy, 2010; Prosser & Walley, 2006; Timmermans & Berg, 2003; Wadmann & Bang, 2015), but also how these changes are felt and valued by clinicians (Cook, 2014; Lupton, 2012; Scott, 2000; Swallow & Hillman, 2019). Considering affective clinical practices can reveal divergent priorities in clinical care and work, is useful for understanding how new interventions transform everyday work, and can identify the emotional investments that clinicians make and value in their areas of expertise. Beyond a focus on PrEP and new drug prescribing, we believe the concept of affective clinical practice could be useful to analyse other interventions, relations of care and modes of health service delivery.

AUTHOR CONTRIBUTIONS

Anthony K J Smith: Conceptualisation; Equal, Data curation; Lead, Formal analysis; Lead, Funding acquisition; Equal, Investigation; Lead, Methodology; Equal, Project administration; Lead, Writing - original draft; Lead. **Christy E Newman:** Conceptualisation; Equal, Funding acquisition; Equal, Methodology; Equal, Supervision; Equal, Validation; Supporting, Writing - review & editing; Supporting. **Bridget Haire:** Conceptualisation; Equal, Funding acquisition; Equal, Methodology; Equal, Supervision; Equal, Validation; Supporting, Writing - review & editing; Supporting. **Martin Holt:** Conceptualisation; Equal, Funding acquisition; Equal, Methodology; Equal, Supervision; Equal, Validation; Supporting, Writing - review & editing; Lead.

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Research data are not shared.

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