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GPs' views on their management of sexual dysfunction

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Background. Sexual dysfunction is an important aspect of sexual heath that is prevalent in the population but frequently goes undetected.

Objective. The aim of this study was to investigate the role of the GP in the management of problems of sexual dysfuntion.

Methods. A postal questionnaire was sent to the 218 GPs on the Camden and Islington Health Authority List. The questionnaire collected demographic information on the GPs, their clinical interests, experience, postgraduate qualifications and their view of the clinical importance of sexual dysfunction. Their clinical management of the most recent patient encounter in the previous month was explored using a critical incident technique and they were asked to list their views on barriers to the management of sexual dysfunction and to provide a list of suggestions for tackling these barriers.

Results. A total of 133 GPs responded to the questionnaire. Although only eight had a special interest in sexual health, 41 and 50 reported a special interest in mental and women's health, respectively. Forty-six had received postgraduate training in taking a sexual history, 45 in the diagnosis of a sexual problem, 49 in the management of sexual dysfunction, 39 in psychosexual counselling and 24 had training in all four areas. Most GPs (87) categorized sexual dysfunction as medium priority, 25 as high priority and 18 as low priority; three GPs did not respond to this query. Several barriers to the management of sexual dysfunction in general practice were identified. Most doctors identified more than one barrier.

Conclusions. The participating GPs offered specific suggestions that focused on the need for more professional and patient education, consultation time, psychosexual counsellors and relevant secondary care service.

Keywords. GPs, management, sexual dysfunction.

Introduction

Sexual dysfunction is an important aspect of sexual heath that is prevalent (43% of women and 31% men)[1] in the population but frequently goes undetected.[2] Most patients think it appropriate to discuss their sexual problems with their GP.[2,3] Little, however, is known, about the role of the GP in their management.

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Method

A postal questionnaire with a covering letter and a stamped addressed return envelope was sent to the 218 GPs on the Camden and Islington Health Authority List, in June 1999. The questionnaire collected demographic information on the GPs, their clinical interests, experience, postgraduate qualifications and their view of the clinical importance of sexual dysfunction (using a Likert scale). Their clinical management of the most recent patient encounter in the previous month was explored using a critical incident technique. Lastly, using two-open ended questions, we asked them to list their views on barriers to the management of sexual dysfunction and also to provide a list of suggestions for tackling these barriers.

Results

After two reminders, 133 (61%) GPs responded, 78 (59%) of whom were male. Their average age was 44 years (SD 9.6), 101 (76%) were full-time, 120 (90%) were principals, and the average time in their current post was 11 years (SD 8.3). One hundred and fifteen (86%) had at least one postgraduate qualification. Although only eight (6%) had a special interest in sexual health, 41 (30%) and 50 (47%) reported a special interest in mental and women's health, respectively. Forty-six (33%) had received postgraduate training in taking a sexual history, 45 (33%) in the diagnosis of a sexual problem, 49 (36%) in the management of sexual dysfunction, 39 (29%) in psychosexual counselling and 24 (17%) had training in all four areas. On a scale of 1–5 (1 = very low priority and 5 = very high priority), most GPs, 87 (65.4%) categorized sexual dysfunction as medium priority, 25 (18.8%) as high priority and 18 (13.6%) as low priority; three (2.2%) did not respond to this query.

Data from critical incidents suggest that the GP encounters on average 2.6 patients/month (SD 1.8). Eighty-five (62%) of these recent consultations were for erectile dysfunction. One hundred and twelve (84%) GPs followed up the patients themselves, while 33 (25%) referred them to secondary care, in particular Urology out-patients 12 (9%). Lastly, 45 (34%) prescribed Sildenafil to the most recent patient seen the preceding month.

Several barriers to the management of sexual dysfunction in general practice were identified. Most doctors identified more than one barrier. These are listed in Table 1. We independently analysed all items listed by the doctors to develop principal themes. Further analysis of these themes identified four main categories. These were the doctor, the patient, the doctor–patient interaction and the contextual barriers. Data on suggestions around tackling barriers were also analysed (Table 1).

Discussion

This is the first study in the UK that assesses the management of sexual dysfunction in general practice from the GPs' perspective. Our GPs were representative of those in Camden and Islington, a health authority that is representative of other London health authorities.[4] The average age of the GPs in Camden and Islington at the time of the study was 48 years, and 56% of the doctors were male (based on data obtained from the Health Authority). Patients with sexual dysfunction were

TABLE 1 *Barriers to and suggested solutions for the management of sexual dysfunction in general practice*

Barriers	Total no. of barriers identified	Suggestion on tackling the barriers	Total no. of suggestions made
Doctor barrier	**96 (22.1%)**	**Doctor solutions**	**64 (32.2%)**
1. Lack of training/education/knowledge	59 (61.5%)	1. More education/training/improved skills	47 (73.4%)
2. GP embarrassment/attitude/lack of sensitivity	8 (8.3%)	2. More awareness/more proactive	12 (18.7%)
3. Lack of experience especially taking sexual history	10 (10.4%)	3. Better knowledge of secondary services	4 (6.3%)
4. Not asking about the issue/fear of opening flood gates/ doctors' awareness	19 (19.8%)	4. More clinical freedom	1 (1.6%)
Doctor–patient interaction	**56 (12.9%)**	**Doctor–patient interaction**	**3 (1.5%)**
1. Sensitive subject	7 (12.5%)	1. Patients' choice of gender of doctor	3 (1.5%)
2. Different genders	34 (60.7%)		
3. Different cultures	7 (12.5%)		
4. Different ages	2 (3.6%)		
5. Embarrassed patient/doctor	6 (10.7%)		
Patient barriers	**93 (21.4%)**	**Patients' solutions**	**31 (15.6%)**
1. Patients' reluctance/reticence/embarrassment	68 (73.1%)	1. Patient education (leaflet/workshop)	22 (71%)
2. Difficult area to discuss	4 (4.3%)	2. Empower patients to seek help	2 (6.4%)
3. Patient thinks it is 'normal'/lack of knowledge and awareness	14 (15%)	3. Improve availability of interpreting services	1 (3.2%)
4. Do not want to waste doctors' time	2 (2.2%)	4. Increased patients' awareness of what help and treatments are available	6 (19.4%)
5. Indirect presentation (hidden by other symptoms)	5 (5.4%)		
Contextual/structural barriers	**189 (43.6%)**	**Contextual/structural solutions**	**101 (50.7%)**
1. Lack of time	99 (52.4%)	1. Increase consultation time (smaller list size/more GPs)	30 (29.7%)
2. Lack of NHS treatments, lack of choice/availability of secondary psychosexual services	45 (23.8%)	2. Cheaper drugs/less restriction on prescribing	20 (19.8%)
		3. Increase counsellors and secondary services	44 (43.6%)
3. Lack of freedom to prescribe	39 (20.6%)	4. Media awareness	2 (2.0%)
4. Stigma/society's attitudes to sex	6 (3.2%)	5. Less stigma/review society's attitude	5 (4.9%)
Total no. of barriers	**434 (100%)**	**Total solutions suggested**	**199 (100%)**

Percentage figures in bold are based on totals, and the rest are calculated for each subgroup.

encountered commonly in general practice, and at least a third of GPs had some training in this area. External barriers around contextual/structural issues were mentioned most commonly, particularly the lack of time and limited availability of secondary care referral services (especially psychosexual services). Other important barriers centred on poor knowledge, training and skills together with the patients' reluctance to discuss these issues in general practice. The suggestion for possible solutions focused mainly on increased education of doctors and patients on sexual problems, more general practice consultation time to deal with these issues and a need for more specialists in this field.

The study was limited by the use of a questionnaire for data collection. Although we used open questions, some of the ideas listed by the GPs could not be explored as would have been possible using in-depth interviews. For example, when the GPs mentioned inadequate knowledge or lack of training in the area of psychosexual medicine, they did not offer more details. Specific aspects, however, have been listed by some GPs. These include lack of experience in taking a sexual history; not asking about the issue; GPs attitude and embarassment; and lack of sensitivity (Table 1).

Medical treatments of sexual dysfunction will result in increasing numbers of patients seeking help from their GP.[5] Both doctors and patients, however, remain poorly informed about these issues and specialist care cannot be accessed easily. The participating GPs, however, offered specific suggestions that focused on the need for more professional and patient education, consultation time, psychosexual counsellors and relevant secondary care service (Table 1).

The future of management of sexual dysfunction in general practice was described most clearly in some of the comments made by the participating doctors. These are

> "It is an important topic that needs more research and investigation. I feel there is a lot of misery waiting to be discovered and treated."
>
> But "This is not a priority area, not a healthier nation target and there is no reimbursement for extra work."
>
> But yet "At the time when one is with a distressed patient, the priority seems high for the individual."

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