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To cite this article: Audun Vik & Mette Brekke (2017): Do patients consult their GP for sexual concerns? A cross sectional explorative study, Scandinavian Journal of Primary Health Care

To link to this article: <http://dx.doi.org/10.1080/02813432.2017.1398934>



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Published online: 06 Nov 2017.



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Do patients consult their GP for sexual concerns? A cross sectional explorative study

Audun Vik^a and Mette Brekke^b

^aFaculty of Medicine, University of Oslo, Oslo, Norway; ^bDepartment of General Practice, Institute of Health and Society, University of Oslo, Oslo, Norway

ABSTRACT

Objective: To explore how often general practitioners (GPs) deal with patients' sexual concerns, what kind of concerns are brought up and how the GPs deal with them.

Design: Cross sectional observational study.

Setting/subjects: 22 GPs in Southern Norway.

Main outcome measures: The percentage of consultations dealing with sexual concerns during three consecutive working days, as registered by the GPs on a questionnaire.

Results: Out of 1 117 consultations, 47 (4.2%) dealt with sexual concerns, varying from 1.6 to 10.9% of consultations. The concerns brought up varied widely, with erectile dysfunction and pain related to sexual activity in females as the largest groups. Concerns regarding sexual orientation, preferences or behavior were also dealt with, as were problems due to sexual assaults or rape. In 36 (76.6%) of the consultations, discussion of the problem and/or advice was the only action. Medication was prescribed in one third of the consultations. Patients' mean age was 46.7 years, with a span from 17 up to 75 years and 60% were female. We found no associations between GP characteristics and how frequently they dealt with sexual concerns.

Conclusions: In around 4% of consultations, the GPs dealt with a wide variety of sexual concerns.

ARTICLE HISTORY

Received 28 June 2017

Accepted 23 October 2017

KEYWORDS

Sexual problems; general practice

Introduction


A satisfying sex life is an important part of quality of life [1]. Correspondingly, sexual concerns, dysfunctions, discrimination or abuse are associated with impaired quality of life and health [1–3].

Sexual dysfunctions, difficulties and concerns are common, but prevalence estimates are highly sensitive to the definitions used. In a Danish population based study among sexually active persons aged 16–95 years, 11% of men as well as women reported at least one sexual dysfunction in the last year, defined as a frequent sexual difficulty perceived as a problem. Another 68–69% experience infrequent or mild sexual difficulties at least once in a while [3]. In a British study, one third of men and more than half of women who had been sexually active in the previous year reported a sexual problem lasting at least one month during this period [4]. The most common problems among men were low sexual interest, premature ejaculation and performance anxiety; and among women,

inability to experience orgasm and painful intercourse. Persistent sexual problems, lasting at least six months in the previous year, were less prevalent among men (6%) than among women (16%).

Out of all who reported a problem in the British study, only about 10% of men and 20% of women had sought help, the figures being around 20 and 30% among those with persistent problems [4]. The most common help-seeking was to consult a GP, as this was the choice for around two thirds of the men and 75% of the women. In a study carried out among 40–80 year olds in eight European countries, Nicolosi et al. [5] found that out of the 23% of men and 32% of women who reported sexual dysfunction, one fourth had consulted a physician, with considerable between-country differences.

Sexual dysfunction may have organic or psychological causes and may be linked to common diseases or to medication [6]. The general practice setting thus should be highly suitable for the evaluation and

CONTACT Mette Brekke  mette.brekke@medisin.uio.no  Department of General Practice, Institute of Health and Society, University of Oslo, Oslo, Norway

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management of sexual dysfunction, because the GP usually handles patients' chronic diseases and medications over time and acquires knowledge about their personal and family situation [7]. But patients, as well as doctors, may be reluctant to address sexual concerns in the consultations [8]. Patients may feel shame or embarrassment. They may believe that their problem is an inevitable part of ageing or illness and be unaware that treatment is available. And they may be sensitive to the doctor's reluctance to talk to them about sexual difficulties. General practitioners (GPs) on their side report lack of time, little knowledge about certain sexual matters and worry about offending the patient as reasons not to deal with sexual concerns [5–8].

Remarkably little is known about how frequently sexual concerns in fact are brought up in GP consultations, about the type of problems and how they are handled. A systematic literature search carried out by the first author in January 2017 and limited to English language and to the time period 2002–2017 yielded a handful of studies, none of them from Scandinavia [2,4–7,9–12]. The main aim of this study is to shed some light upon how frequently and how Norwegian GPs deal with concerns related to sexuality among their patients.

Materials and methods

Twenty-two list holding GPs working in the South-Eastern part of Norway participated in the study. During three consecutive working days in January/February 2017 the GPs filled in a questionnaire at the end of each day. The questionnaire was designed by the authors and collected the following information: The GPs' age, gender and specialist status, total number of consultations and whether questions or problems regarding sexuality or sexual health had been brought up in any consultation. If so, the following information was registered for each patient: gender, birth year, what kind of concern was brought up (open question), who brought it up, was the sexual concern the only issue in the consultation, what did the GP do about the question/problem (advice, investigations, prescription, referral). Further: did the patient say or show that he/she was embarrassed or uncomfortable by bringing up the sexual concern? And last: did the GP feel comfortable in the consultation?

The questionnaire was piloted by one GP during three working days previous to the study. We asked the participants not to include consultations regarding contraception when this was the sole topic. The recruitment of the GPs was done pragmatically by

Table 1. Characteristics of GPs participating in the study ($n = 22$).

Gender (n)	male: $n = 9$ female: $n = 13$
Age (year)	min: 29 year max: 67 year mean: 48.1 year
Specialist status (n)	GP specialist: $n = 16$ In specialization: $n = 6$
County (n)	Oslo: $n = 6$ Vestfold: $n = 6$ Oppland: $n = 5$ Akershus: $n = 4$ Aust-Agder: $n = 1$
Consultations/day (n)	min: $n = 8$ max: $n = 28$ mean: $n = 16.9$
Consultations/3 d (n)	min: $n = 28$ max: $n = 71$ mean: $n = 50.8$

e-mailing a one-page information letter and a request to participate to contacts of the authors. We hoped to cover around 1000 consultations, and thus needed around 20 GPs to register their consultations over 3 d. Out of the 30 GPs asked to participate, eight declined or did not return the questionnaire (27%). Characteristics of the 22 participating GPs are shown in Table 1.

Statistics and ethics

The data from the questionnaires were plotted into IBM SPSS Statistics version 24 (IBM SPSS Statistics, Armonk, NY).

Simple bivariate analyses were carried out (chi square test, Fisher exact test) to analyze the results against the GPs' age, gender, specialist status and number of consultations.

The study was presented to the Regional Committee for Medical and Health Research Ethics (ref.nr. 2016/2128 C, 30 November 2016). As the study focused on health services only and did not involve individual patients, the committee saw no need to further evaluate the study.

Results

Total number of consultations carried out by the 22 GPs during 3 d was 1117. Out of these, 47 consultations (4.2%) concerned sexual health. Each GP had between one and six such consultations (mean 2.14). For each GP, consultations regarding sexuality out of total number of consultations varied from 1.6 to 10.9% (mean 4.2%).

Out of the 47 patients discussing a sexual concern, 28 (59.6%) were female and 19 (40.4%) were male.

Table 2. Categories* of sexual concerns brought up in 47 consultations.

Problem	Male patients (n = 19)	Female patients (n = 28)
Erectile dysfunction	n = 13	
Lack of sexual desire	n = 3	n = 5
Sexual side effects of medication	n = 4	n = 2
Sexual orientation, preferences or behavior	n = 2	n = 2
Pain related to sexual activity		n = 8
Sexually transmitted diseases	n = 2	n = 4
Assault/rape		n = 4
Sexual problems related to physical illness	n = 2	n = 4
Sexual problems related to mental illness	n = 1	n = 3
Vaginal dryness		n = 3
Worries regarding external genitals		n = 3

*Some concerns involved more than one category.

Patients' mean age was 46.7 years, with a span from 17 up to 75 years.

The concerns brought up and reported in text by the GPs varied widely and were categorized by the authors under 11 labels (Table 2). In 20 of the consultations the problems involved more than one category. For example: erectile dysfunction and lack of desire in the same patient.

In 35 (74.5%) out of the 47 consultations, the patient was the one who brought up the concern or problem. In 11 consultations the GP brought it up, and in one consultation it was the patient's caregiver. In nine out of the 11 consultations where the GP initiated to deal with the sexual problem, the patient was female.

In 16 (34.0%) out of the 47 consultations the sexual concern was the only topic brought up – in the remaining 31 (66.0%) consultations other issues were also dealt with. When the patient brought up questions or problems related to sexual orientation, preferences or behavior, this was more frequently the sole focus of the consultation, compared to other types of concerns ($p = .004$, Fisher exact test).

In 43 out of the 47 consultations, the GP reported to feel at ease. In the four consultations where the GP felt uncomfortable, the GP was young and undergoing specialization, and in three of these consultations the patient was an elderly man. In all these four consultations, however, the patient was reported to feel at ease.

In eight (17.4%) out of the 47 consultations, the GP noted that the patient signaled verbally or non-verbally not to feel comfortable. Sexual assault or sexual preferences and behavior were in focus in five such consultations, but also in three consultations concerning erectile dysfunction, the patient appeared to feel embarrassed by bringing up the problem.

In the 47 consultations, a total of 63 actions were initiated. In 36 (76.6%) of consultations the discussion

of the problem and/or advice was the only action. In 16 (34.0%) consultations, medication was prescribed – mainly to patients with erectile dysfunction or vaginal dryness. In five consultations further investigations were initiated, and four patients were referred to a specialist.

We found no associations between GP characteristics (age, gender, specialization) or their number of consultations and how frequently they dealt with sexual concerns.

Discussion

This study is probably the first in Scandinavia to explore how frequently sexual concerns are brought up in consultations in general practice. We were able to investigate 1117 consultations carried out over three consecutive days by 22 GPs. Our main finding was that 47 consultations (4.2%) dealt with a wide variety of concerns regarding sexual health.

A study comprising 1512 patients in 13 general practices in London found that 3–4% of patients had an entry on sexual problems in their notes in the two years previous to the survey [10]. In this study patients also completed a comprehensive questionnaire on sexual function. Sexual difficulties were common and as many as 22% of men and 40% of women could be given an ICD-10 diagnosis of sexual dysfunction. Out of those, 30% reported having sought sexual advice from their GP, even though considerably fewer turned out to have such documentation in their files.

In a German study, investigating male patients' sexual problems and their expectations of help from their GPs around half of the patients considered it important to talk with their physicians about sexual concerns [7]. In this sample, 12% of the patients had consulted their GP on a sexual problem, and most were satisfied with the response. Most would prefer that their physician initiated any discussions about sexuality. However, the majority of the physicians did so only seldom. This corresponds to a study from Greece revealing that physicians seem to engage in taking the sexual health history less than their patients would wish [12]. This study comprised doctors in different specialties including GPs, looking at factors predicting how the doctors addressed sexual health issues. Previous training in communication skills was found to be the strongest predictor for sexual history taking. Physicians who regularly addressed patients' psychosocial concerns were found to be more likely to also ask about sexual health problems and to consider their management as less difficult [12].

In our rather small sample of GPs we were not able to find any doctor characteristics influencing their dealing with sexual concerns, such as age, gender, specialist status or number of daily consultations. A high number of daily consultations could indicate shortness of time, and some studies emphasize lack of time as a barrier [7,11,13]. In a Portuguese study, residents in several specialties including general practice, reported on barriers to evaluate patients' sexuality and on attitudes toward sexual education [13]. Participants in general reported a lack of formal education on sexual health. Although the residents perceived their patients' sexuality as important, they failed to inquire about sexual health regularly, especially with patients from non-Western cultures and lack of time was given as an important obstacle.

The patients in our study varied in age from 17 to 75 years with a mean age of 46.7 years.

In general, sexual problems tend to increase with increasing age [2–4]. However, in the study by Christensen et al. [3] in Denmark, the highest prevalence of sexual difficulties in women appeared in those under 30 or above 49 years [3]. A recent study from UK investigating young people's sexual health found that among sexually active 16–21-year-olds, 9% of men and 13% of women reported a distressing sexual problem lasting 3 months or more in the last year [14]. Only a minority of them had consulted a GP, sexual health professional or psychiatrist. Sex education for young people generally focuses on contraception and 'safe sex'. Probably many young patients could profit from a possibility to discuss a broader focus of sexuality with their GP.

In our study, the sexual concern was the only issue in one third of consultations. In the remaining two thirds, it was brought up together with other requests. This corresponds with how GPs' consultations work: a recent Norwegian study found that mean number of problems brought up in non-acute consultations was 3.3 and that in more than one fourth of consultations a mental health issue was presented [15]. The same study found that the patient was the one who brought up the problem in 91% of cases, mirroring the 'patient centered' way GPs' consultations are usually carried out [16]. In this study, the doctor was the one who brought up the question on sexuality in as many as one fourth of the consultations. Participation in the study might have made the GPs more aware of doing so.

The main aim of our study was to provide an estimate of how frequently patients bring up sexual concerns in Norwegian general practice. The strength of the study was that we were able to register more than

1100 consultations over a short time span, and we think this gave us a rather reliable estimate on our main research question. Though our respondents were recruited pragmatically – the authors e-mailing a request to participate to 30 of their contacts – it is not likely that this in any way has induced bias in how respondents deal with sexuality in consultations. The 22 responding doctors vary substantially: they work in five different counties. Their age varies from 29 up to 67 years with a mean of 48 years, corresponding to the present mean age of Norwegian GPs. Our respondent sample comprised 60% females, versus 45% of all Norwegian GPs. Seventy percent were specialists, compared to around 55% of GPs in Norway. As the GPs were asked to fill in the questionnaire at the end of a working day, recall bias might be a problem. Anyhow, all GPs use computerized records, and mean number of consultations each day was 16.9, so recall bias was hardly a major limitation. The registration if patients felt at ease or not was done indirectly by the GPs, which is a limitation. Out of 30 GPs asked to participate, eight declined. It is possible that these GPs are less interested in sexual health than those who responded. In spite of the large total number of consultations, the study generated only 47 consultations focusing on sexual concerns, which is obviously a too low number for more than rough analyses of patient characteristics, type of concerns and actions taken.

Our explorative study showed that Norwegian GPs do deal with sexual issues in consultations. The GP setting should be highly suitable for the task, because of the long-lasting doctor–patient relationship and the GP's knowledge of the patient's medical as well as social situation. Several studies indicate that patients expect and wish that the doctor focuses on sexual issues, it be related to their specific medical problems or to their sexual orientation or preferences [4,7,12,17,18].

A study including 2800 patients <55 year with myocardial infarction in US and Spain found that 30% of women and 20% of men reported sexual problems one year after [17]. Having talked with a GP or a cardiologist correlated with less sexual problems, but only 20% of women and 30% of men had talked with a doctor about sex. Such counseling was a significant indicator of time to resumption of sexual activity after recovery from the myocardial infarction.

A Norwegian study explored lesbian women's expectations toward health care [18]. The study concluded that to obtain quality care for lesbian women, healthcare professionals need a persistent awareness that not all patients are heterosexual, an open attitude toward a lesbian orientation and specific knowledge of

lesbian health issues. A recent 'Personal view' in BMJ claims that GPs fail to help people with gender dysphoria and that such discrimination in primary care is unacceptable [19].

The dimensions of awareness, attitude and knowledge are interconnected, and a positive direction on all three dimensions appears to be a necessary prerequisite for GPs to better meet their patients' expectations and needs regarding sexual concerns [17,18]. A Portuguese study aimed to investigate GPs' knowledge, attitudes and beliefs concerning sexual dysfunction, perceived competence in discussing sexual matters and need for training [11]. Lack of academic training and lack of experience were considered important barriers for dealing adequately with these issues. The GPs expressed a high need for continuous education in this area and more than half considered that their degree was not an adequate source of training. Another Portuguese study among residents concluded that implementation of a formal curriculum will signal to residents that patients' sexuality is an important topic to address [13]. In Aschka's study [7] among German GPs the physicians were afraid of intrusion and inadequacy when addressing issues of an intimate and private nature, such as sexuality. A Swiss study showed that only 8% of GPs considered their competence in discussing sexual dysfunction as very good and none of the 25 participating GPs considered their competence in treating sexual dysfunction as very good [20]. Correspondingly, a majority expressed a need for further education. To overcome problems, such as lack of knowledge or feelings of shame and inadequacy, it is probably necessary to give the topic of sexuality and sexual problems a higher status in basic medical education, as well as in continuous medical education.

Acknowledgments

We hereby express our gratitude to the 22 GPs who participated in the study.

Disclosure statement

No potential conflict of interest was reported by the authors.

Funding

No specific funding was received for this study.

Notes on contributors

Audun Vik is a last year medical student at the University of Oslo.

Mette Brekke is professor in general practice and also works as a list holding GP.

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