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Addressing Sexual Problems in German Primary Care: A Qualitative Study

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Abstract

Although general practitioners (GPs) are often the first contact for patients' sexual issues, little is known about how German GPs approach, diagnose, and treat sexual problems and disorders. Therefore, the present qualitative study explores approaches and management of sexual health issues used by GPs. The sample included 16 GPs from Kiel and surroundings and Sachsen-Anhalt. The in-depth, semi-structured interviews were coded according to the qualitative content analysis by Mayring using MAXQDA. The results revealed 5 main themes, 2 of which are explored in more detail in relation to the study objective (2 and 4): (1) sexual issues that arise in general practice, (2) addressing sexuality, (3) influencing factors in doctor-patient communication about sexuality, (4) diagnosing and treating sexual dysfunctions, and (5) changes in the approach to sexuality over time. Most GPs did not routinely ask their patients about sexual problems. Common barriers included lack of time, suspected embarrassment on both sides, and fear of offending patients. Almost all GPs tended to diagnose sexual problems individually adapted to patients' issues, not following a standardized approach. Medication was offered as the main treatment for sexual problems. For complex disorders, most GPs lack sexual medicine knowledge, and they requested a better range of training courses in sexual medicine.

Keywords

sexuality, sexual problems, primary care

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Introduction

Regarding sexual health primary care, general practitioners (GPs) are the "natural" first point of contact for sexual problems and disorders. However, little is known about how they approach sexuality in practice.[1] Routinely addressing the patient's sexual health is an important medical intervention necessary for medical and psychosocial reasons, allowing not only the detection of sexual dysfunction but also the early detection of other medical conditions, such as coronary heart disease.[2] Previous research has found that while some patients are embarrassed to initiate sexual health discussions with GPs, this patient group wants to be asked about their sexual health needs and concerns by the GP. Nevertheless, in practice, the initiative usually comes from the patients.[3-5]

To date, mainly international studies exist on the conversation about sexual health in general practice. From the GP's perspective, the most common reasons for addressing sexual problems are certain diseases that serve as "topic-openers," such as diabetes mellitus, hypertension, prostate adenoma, hormonal disorders, or psychosomatic issues. Other common topics are family planning or HIV. In addition, GPs with sexual medicine training are more likely to talk openly with their patients about sexuality than GPs without training.[3,6] Previous studies show that GPs prefer an open conversation about patient's sexual history rather than a structured approach (eg, according to ICD-10).[3,7] Younger GPs addressed sexual problems in practice more often by themselves than their older colleagues.[7]

The most common obstacles from the GPs perspective included lack of time, lack of expertise, and "not thinking about a sexual issue." Furthermore, the age and gender

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discordance between GP and patient, complexity of patient comorbidities, and patient—doctor relationships make it difficult for the GPs to address their patients.[5]

"Embarrassment," "problems in expression," and "lack of confidence" were barriers from the patient's perspective.[3] Furthermore, they tend to consider the "problem as non-medical," the "problem as normal part of aging," and "hope that the problem will solve itself." Across all age groups, women were more likely to be approached by GPs than men.[4]

Considering the frequency of sexual problems and disorders in Germany, little is known about how GPs approach and treat sexual problems.[8,9] The few qualitative research available has suggested that a conversation about sexual health rarely takes place in GPs' offices because often neither the doctor nor the patient brings up the subject.[10] A German study in 2010 interviewed GPs about addressing sexual health in the office.[11] Ninety percent of 110 respondents reported rarely being approached by their patients about sexual problems. Of all GPs asked, 68% "address" their patients about sexual health, 29% "partially do not address," and 4% "do not address at all" sexual disorders. Those of the same gender (GP and patient) were more likely to bring up sexual problems. The main reasons for not addressing the issue were, in addition to suspected embarrassment on part of the patient, lack of time, insufficient expertise, and the gender difference. Another qualitative German study explored GPs' perspectives on HIV pre-exposure prophylaxis (PrEP) among HIV providers and GPs.[12] Many GPs lacked knowledge about PrEP, and some of them did not support the idea of PrEP as a prophylactic option. Perceived problems included stigma and lack of privacy for PrEP care in rural areas. A questionnaire-based survey of lesbian women's care in German general practice showed that only 40% of patients shared their sexual orientation with their GP. Some even experienced discrimination regarding their sexuality. Patients recommend improvements regarding gender-neutral language, GP training, and flyers about homosexuality in waiting areas.[13]

The few existing studies on sexual conversation in general practice are either quantitative studies or explore very specific aspects (eg, only barriers in addressing sexual health, homosexuality, or HIV PrEP). Although GPs are the main gatekeepers for the majority of patients with medical and psychosocial problems, there is still a lack of empirical knowledge in the complete handling of sexual problems in German primary care. Therefore, the aim of the present study was to assess how GPs address, diagnose, and treat sexual problems.

Materials and Methods

The study used qualitative content analysis to obtain an in-depth understanding of the GPs' perspective in managing sexual problems.[14] Qualitative content analysis according to Mayring is a structured, qualitative method for evaluating text-based data. The evaluation process is characterized by a rule-guided, fixed procedure.[14] Data collection was exploratory using guideline-based interviews. After interviewing 16 participants, "theoretical saturation" was reached. "Theoretical saturation" is assumed when further cases and analyses no longer provide any new insights.[15] The interviews conducted ranged in length from 16 to 64 min, were transcribed verbatim, and analyzed using MAXQDA qualitative data analysis software (VERBI Software, MAXQDA Plus, Berlin, Germany).

Subject Recruitment

To capture the broadest possible spectrum of attitudes, experiences, and approaches, GPs of different ages and genders from rural and urban areas were included in the study. Recruitment occurred via letters sent to 27 GPs who partially are involved in medical education. GPs were offered to participate in the study after receiving a comprehensive explanation of the study's purpose. The interview situation was designed to create the greatest possible trust: the study objectives were explained in writing and verbally, anonymity was assured, and the interviews took place as personal individual interviews in the practices of the interviewees. Compensation for completing the interview was 50€. Sixteen practicing GPs from 2 areas of Germany with different structure participated. Eight came from Kiel (a medium-sized city with ~220 000 inhabitants) and its surroundings. The other 8 participants were located in rural areas in the federal state of Sachsen-Anhalt. There were 7 female and 9 male GPs, from an overall range between 42 and 65 years at the time of the interview.

Interview Guide

The data was collected using in-depth, semi-structured interviews. An interview guide was formulated based on a review of the related literature. The interview guide included several top-level questions and respective sub-questions, which could be used in case the top-level questions did not generate enough information. An overview of the top-level questions is shown in Table 1. The interview guide was developed based on the research objectives, so the top-level questions relate primarily to the approach (including facilitating factors and barriers from the GP's perspective), the diagnosis and therapy of sexual problems.[5,7,9] Furthermore, it is asked which sexual problems and dysfunctions frequently occur from GPs perspectives and whether problems such as paraphilias or sexual abuse are also addressed.[8,11] In addition, training of GPs in the field of sex medicine is explored. Subsequently, more exploratory questions were asked to address gender-specific differences in approaching

Table 1. Top-Level Interview Questions Posed to GPs for the Qualitative Analysis*.

1. When patients raise sexual issues on their own, what issues do they bring up?
2. When patients raise sexual issues: How do you then proceed?
3. How do the patients accept the treatment offers?
4. How successful are, in your experience, the treatments?
5. Where are still difficulties in treatment for your part? On which pathologies is the consultation more difficult?
6. For which sexual problems do you feel confident to offer counseling?
7. Are there situations in which you approach your patients about sexual problems by default? Can you describe these situations to me?
8. Are there patient groups for whom it is difficult to talk about sexual problems?
9. Are there patients in whom you suspect sexual problems, but where the topic is not brought up—either by you or by the patient?
10. In your view, is there a need for action in terms of promoting doctor-patient conversations about sexual problems? Further training, seminars. . ..
11. What did you learn in your studies about sexual problems, diagnostics, and therapy?

*The interviews were conducted in German and the questions were translated into English only for the purpose of publication.

sexual problems, specific medication, sexual problems in specific clinical pictures, and potential differences in the doctor-patient relationship regarding urban and rural areas.[7,11,16,17] The interviewer encouraged the GPs to narrate their experiences in their own words.

Procedure

The Ethics Committee of the Medical Faculty of the University of Kiel approved the study (No. D450/15). Shortly before each interview, the aims and procedures of the study were explained to the interviewee again and everyone had the opportunity to ask questions. Furthermore, each GP signed the consent form before the interview and was handed a form for the expense allowance. Ten of the 16 GPs took advantage of the expense allowance. The GPs were informed that the interview would be recorded using a voice recorder, later transcribed verbatim, anonymized, and scientifically analyzed. In addition, each GP was asked about age, length of time in private practice, and any additional training. Immediately after each interview, additional impressions of the interview were recorded by the interviewer in writing: the interview atmosphere, special features, and a personal conclusion. Interviews were conducted in German and lasted between 16 and 64 min.

Coding and Data Analysis

The recorded interviews were transcribed verbatim and coded according to the qualitative content analysis by Mayring with a combination of deductive and inductive data driven process coding and theme creation using MAXQDA qualitative data analysis software.[14,18] In a first step, deductive categories were identified from the interview guide by one of the researchers. Secondarily, the researcher inductively identified "residual categories" from the interview data material. This included the data material that could not be assigned to any of the deductively created categories. By reducing the material from the residual category to the central statements (in the sense of summarizing content analysis), new categories and subcategories were inductively formed. The entire category system was then interpreted in relation to the research question and the theory included. The interviews were reviewed multiple times. To ensure analysis quality, 4 of the interviews were additionally coded by a second, independent researcher. After coding 10 interviews, no new categories emerged, so that after 16 interviews, data saturation can be assumed.

Results

A total of 16 GPs in private practice participated in the interviews. Eight GPs came from Sachsen-Anhalt (5 women and 3 men) and 8 from Schleswig-Holstein (2 women and 6 men). The average age over all participants was 53.8 years (SD = 7.2). The average interview duration was 31 min (SD = 13). Table 2 summarizes the characteristics of the interviewees as well as the interview length.

The qualitative analysis of the interviews resulted in 5 main themes, which have some overlap and interdependency:

(1) Sexual issues that arise in general practice.
(2) Addressing sexuality.
(3) Influencing factors in doctor-patient communication about sexuality.
(4) Diagnosing and treating sexual dysfunctions.
(5) Changes in the approach to sexuality over time.

For a comprehensive understanding of the qualitative content analysis, a brief overview of the most important findings will be given followed by a more detailed exploration of themes 2 and 4 as these are in the center of the present research question about how GPs address, diagnose and

Table 2. Overview of the Characteristics of the GPs and the Interviews.

Number	Gender	Age (years)	Occupational title[a]	Origin	Branch since	Interview length (min)
1	Male	53	General practitioner	SA	1993	34
2	Female	42	Internist	SA	2013	19
3	Female	50	General practitioner	SA	1997	21
4	Male	43	General practitioner	SA	2001	29
5	Male	44	General practitioner	SA	2000	17
6	Male	65	Internist	SH	<1985	18
7	Male	56	Specialist for surgery; general practitioner	SH	2006	29
8	MALE	58	Internist	SH	1993	36
9	Female	60	General practitioner	SA	1990	16
10	Female	58	General practitioner	SA	1990	20
11	Male	53	General practitioner	SH	1995	64
12	Male	49	Internist	SH	2005	40
13	Male	54	Internist; general practitioner; anesthesiologist	SH	2000	44
14	Female	63	General practitioner	SH	1984	34
15	Female	50	General practitioner	SH	2008	43
16	Female	63	General practitioner	SA	1984	27

Abbreviations: SA, Sachsen-Anhalt; SH, Schleswig-Holstein.
[a]Regardless of the occupational title all interviewees worked as GPs.

treat sexual problems. We focused on these 2 themes as we are most interested in the concrete approach and management of sexual health issues.

According to the GPs, there is a wide range of sexual topics in primary care, yet sexual problems are not often addressed. All GPs named erectile dysfunction as the most frequently addressed sexual disorder. Loss of libido, dyspareunia, or ejaculatio praecox were mentioned secondarily, often in connection with partnership conflicts. GPs were barely asked by patients about sexually transmitted diseases, infertility, sex reassignment surgery, or sexual abuse (theme 1). The initiative for conversation about sexuality is predominantly taken by patients and not by GPs (theme 2). According to the participants, the biggest obstacles in doctor-patient communication about sexuality are lack of time, fear of offending patients, and the own sense of embarrassment (theme 3). The diagnostic procedure of GPs appears to be individualized and does not follow a standardized approach. Most GPs feel confident in treating organically caused sexual dysfunction, especially with prescribing erection-enhancing drugs (theme 4). Sexuality could be addressed more openly in the course of time as therapy methods improve (especially for organically caused sexual disorders). Certain sexual topics have become less taboo, and different sexual orientations are accepted (theme 5).

Addressing Sexuality

GPs indicated that they do not regularly ask their patients directly about sexual functioning or problems. Rather, sexual issues are raised by patients. Depending on the situation, pre-existing conditions, knowledge about the patient, and current complaints, potential sexual disorders are addressed in the office visits. GPs often mentioned that sexual health is frequently addressed in combination with certain diseases and medication prescriptions, for example, when prescribing beta blockers or complaints such as urinary incontinence, polyneuropathies, diseases of the prostate, hypertension, diabetes mellitus, mental disorders, or various oncological diseases. For some GPs, check-ups provided additional opportunities to ask about sexual functioning. To lower the inhibition threshold when approaching sexual issues, 3 GPs placed flyers about sexual problems in the waiting area. Most respondents, however, did not use flyers and brochures to approach the topic of sexual health and sexual problems.

> "(. . .) Starting beta-blockers, e.g., for severe hypertension, heart disease, severe diabetes or in men on vascular damage. That's (. . .) where I ask the patient [about sexual problems]." (I13)

Limited resources such as workload, time constraints, lack of payment for long patient talks, lack of privacy, and gender differences between GP and patient were among the most common external barriers in talking about sexual functioning (overlap to theme 3). In general, very few GPs report approaching female patients about sexual problems. Some GPs suspected that female patients were more likely to bring up their sexual problems with a gynaecologist than with a GP.

"Lack of time is one thing. The other is the issue that, depending on the practice routine, the nurses come into your room in between (. . .). When you immediately notice that the patient is uncomfortable, I must interrupt the conversation and restart again." (I4)

"Being a man, it is easier for me to talk about sexual problems with male patients. And I would certainly have difficulties with a young woman to talk seriously about sexual problems, because I might think that I can't quite empathize with their problems." (I4)

"(. . .) I do not do gynaecological cancer screening for women as I think that these problems would be addressed more often by the gynaecologist." (I11)

The most common internal barriers were suspected embarrassment on both sides, fear of offending patients and the fear of not being able to meet patient expectations.

"I can't deal with it at all. I have a hard time with it, but only I know that." (I16)

"Well, this is a topic that patients are often embarrassed about (. . .) and therefore, I possibly behave insecurely, because I notice this embarrassment." (I12)

"I always see difficulties when I cannot fulfil high expectations because there are organic causes behind it, and nothing can be done (. . .)." (I13)

According to the interviewees, addressing sexual problems by patients can be broadly divided into 2 different types: straight and uninhibited versus restrained However, a gender-specific difference in addressing sexual problems cannot be identified among all the GPs surveyed; rather, it depends on personal communication strategies of the patients.

" (. . .) there are two main groups: first, there are younger men who maybe have high blood pressure or diabetes and thereby an erectile dysfunction. And then there are older men who (. . .) have greater difficulties talking about it. Because it is often a problem for them to be 75 or 80 years old and still tell me that they find it [sexually] unsatisfying (. . .) but there are also many patients who like to talk about it." (I15)

"I think there are always difficulties (. . .) that the patient is willing up to open and address issues, fears, worries, needs, and also an erectile dysfunction or loss of libido (. . .)." (I7)

The fact that general media increasingly address treatment options and medications for sexual problems is also a positive factor for open conversation about sexual functioning on patients' side.

"(. . .) that the tabloid press also offers opportunities for what could be done. So that it is altogether increasingly a social topic, which is addressed also publicly in the normal press and not only in the specialized press. And as a result, patients are probably more willing to take the plunge." (I3)

Diagnosing and Treating Sexual Dysfunction

The majority of GPs indicated that most patients who brought up sexual problems were men and that their main complaint was impotence. In contrast, very few female patients raised sexual issues with their GPs. The major complaint among women was diminished or loss of libido.

"Interviewer: When patients bring up sexual problems on their own, what is it usually?

I9: Mostly erectile dysfunction in men. Women very rarely."

"Other topics are of course also (. . .) that women sometimes mention that their sexual desire decreases, which of course often has psychosocial causes, because of partnership conflicts or overall, also family conflicts." (I1)

First diagnostic steps. Depending on the type of sexual disorder, GPs initiate various diagnostic steps. Most GPs perform an individualized, non-standardized anamnesis to determine whether, and if so, organic or psychological conditions cause the problem. After taking a detailed medical history, they either decide to refer the patient directly to specialists (preferably gynecologists and urologists) or they start diagnostics and treatment on their own. Depending on the GP's preference, hormone testing (such as thyroid hormones, PSA, estrogens, or testosterone) may be performed in a second step.

"In men, I would look at the external genitals and see if there are any anatomical-physiological problems due to deformations, tumours or swellings that need to be clarified. Depending on the findings, and depending on the patient's age, I would also perform a digital rectal exam to rule out prostate disease. And then, also depending on the patient's age, I recommend a blood test for testosterone, (. . .) and the PSA value to make a diagnosis of exclusion regarding androgen deficiency, testosterone deficiency, and question of substitution. In case of abnormal findings, I would have to involve the urologist as well. (. . .) In women, I reduce my procedure to anamnesis, perhaps a clinical examination. If the hypothesis is cystitis, I would look at the bladder with ultrasound, perhaps would test the inguinal lymph nodes and then of course (. . .) I would refer her to the gynaecologist." (I4)

Referrals to specialists. GPs with expertise in specific problems (eg, erectile dysfunction) tend to treat patients directly with medication. For organic or complex psychological disorders, referrals are directed to urologists, gynecologists, andrologists, psychotherapists, or sexual medicine specialists. All GPs who referred to colleagues complained about the poor availability of appointments with psychotherapists,

which is why some try to help with supportive discussions themselves, even if they feel insufficiently trained.

Use of standardized questionnaires. Three GPs indicated using questionnaires as diagnostic tools for testosterone deficiency. The remaining respondents did not use questionnaires in their diagnostics, mostly due to lack of time for evaluation and because of the assumption that sexuality cannot be explored in a standardized way.

> "Interviewer: Do you use questionnaires in anamnesis, e.g., when it comes to testosterone deficiency or similar?
>
> I8: I have a pre-built questionnaire, we keep paper files, which is a bit dinosaur-like now, but well. And there is an insert sheet for the medical history. And when I think it is important, I ask for it."

> "Using very strict questionnaires in everyday consultation is still a bit difficult. The time required to go through a complete questionnaire. I rather memorize these questionnaires, in order to ask specifically what is still missing, because the patient already gives me partial information. (. . .) But regardless of the clinical picture, I don't use standardized questionnaires for this." (I13)

Therapy. Depending on the cause of disease (organic, psychological, or multifactorial), the physicians offer a range of treatments, whereby most of them feel more confident in treating simple organically caused sexual symptoms than complex organic or psychological causes. In case of organic disorders, for example, erectile dysfunction, ejaculatio praecox, circulation problems, or vaginal dryness due to estrogen deficiency, they use a variety of pharmacological agents, such as PDE-5 inhibitors for erectile dysfunction, dapoxetine or lidocaine gel for ejaculatio praecox or estrogen-containing creams for vaginal dryness. If beta blockers are taken permanently, all GPs consider a change in antihypertensive therapy. After ruling out contraindications (eg, taking nitrates), drug therapy is often indicated. In patients with loss of appetence due to estrogen deficiency or dyspareunia, all GPs recommend a gynecological evaluation.

> "Yes, so if it is erectile dysfunction, then I treat it with phosphodiesterase inhibitors, which are great. (. . .) If I have female patients with gynaecological problems, then of course I do not treat them." (I12)

> "(. . .) And in case of ejaculatio praecox there is a selective serotonin reuptake inhibitor (. . .). I recommend also local applications, like Lidocain gel, Xylocain gel, which you can apply on the glans, in order to delay the climax (. . .). (I4)

In difficult organic diseases (eg, prostate cancer), most GPs did not feel responsible and confident in establishing the diagnosis and initial treatment. All GPs agreed that the constellation of GP-patient relationship, personal attitude, professional experience, previous illnesses of patients, patient gender, and age as well as individual environmental/lifestyle preconditions are relevant for dealing with sexual problems.

> "I would first look at the overall situation and would definitely discuss the fact that perhaps smoking or massive obesity could also cause vascular problems." (I8)

> "I think that's a maturation process that you have to go through. (. . .) You develop individual patterns for individual patients and their individual diseases." (I5)

Most GPs estimated the proportion of psychological, psychosomatic, or psychosocial components in sexual problems as high, especially in young and female patients. They tried to help either through supportive discussions, medication, or referrals.

> "In women I see a high percentage of psychological causes. At least over 90%. And in men, however, I also see a high mental-psychological percentage, which I assume about 80%, 70-80%. And in daily practice we treat 60%, 70%, sometimes 80% a day, basically also psychosomatic disorders." (I7)

> "As far as psychosocial causes or psychosomatic disorders are concerned, it is problematic that we must do a lot on our own, here in the country (. . .). But the patients [do not] get any appointments with psychologists, specialists for neurology/psychiatry or similar. And that is of course a thing that you try to do yourself, but you're certainly not qualified enough to do so." (I1)

GPs were also asked where they obtained information on treating sexual problems and disorders. Most of them acquired their knowledge mainly through self-study and their years of professional experience in primary care. They developed personal standards in dealing with certain illnesses. Ten of the respondents could not recall sexual health coursework in medical school. Disorders such as erectile dysfunction were only partially addressed in the context of other clinical pictures. Overall, 15 of 16 respondents felt that sexual health teaching during the studies was inadequate and wished for more training opportunities. Main topics were advanced trainings on sexual problems in women, especially concerning loss of appetence and vaginism, procedures for gender reassignment, and advanced training on dealing with psychologically induced sexual problems (eg, partnership conflicts with sexual aversion).

> "Interviewer: Do you remember if you learned anything about sexual problems of patients in your studies? That it was talked about?
>
> I6: I can't remember that."

> "I would also be interested in these surgical procedures for sex reassignment, there is no further training at all (. . .). We would also be interested to learn how the colleagues do it." (I10)

> "Special trainings over the last ten years actually concerned male issues. And not problems of women. Vaginismus or any other stories, that has never been further educated to me." (I13)

Most GPs reported never having attended any special gynecological or urological trainings, whereas some visited at least 1 urological or gynecological training course, for example, on benign prostatic hyperplasia or urinary incontinence with sexual problems also being presented. As a negative connotation, most of the continuing education courses were sponsored by pharmaceutical companies and therefore lacked the independence to evaluate treatment options.

> "(. . .) the preparations - often pharmaceutical training courses - are unfortunately sponsored by pharmaceutical companies, so that the companies currently have no interest in making larger training courses in this area. And pharma-independent training courses in this subject area are not specifically known to me." (I4)

Discussion

The aim of the present study was to examine the perspectives of German GPs on approaching, diagnosing, and treating sexual problems in general practice. The overall goal was to broaden the understanding of the German primary care system for sexual problems and disorders. The study found that the participants do not routinely address sexual issues by themselves, mostly due to work overload, lack of time, and internal barriers such as embarrassment and fear of offending the patients. Sexual problems and dysfunctions are predominantly raised by patients. Most participants reported taking an individualized approach to sexual problems and dysfunctions, which does not follow diagnostic or therapeutic standards. According to the interviewees, erectile dysfunction is the most common topic, but numerous multifactorial problems are also addressed. They treat sexual problems mostly by medication (eg, PDE-5 inhibitors) or supportive conversation. For complex sexual disorders, most GPs lacked expertise.

Nearly all GPs stated that sexuality of the patients is not a topic on daily basis in primary care, but nevertheless seems to be relevant for the overall wellbeing. Most GPs did not initiate discourse on sexual functioning and discussed sexual problems secondarily in the context of higher-level disorders. These reports are supported by previous studies in which GPs preferred to discuss sexual problems or dysfunctions mainly in combination with risk factors such as diabetes, coronary heart disease and hypertension.[11,17] Most respondents did not use flyers and brochures to approach sexual issues and problems. Since many patients could benefit from flyers and brochures, it would be a recommendation to GPs to display flyers on sexual health in the waiting room. This could make it easier for those affected to address sexual issues and signal openness and objectivity.

In line with other studies, main difficulties in approaching sexuality on GP's side were both external and internal factors like lack of time or embarrassment.[17,19] Empirical studies on patients indeed show that embarrassment and nervousness play a major role on the patient side, however, most patients also indicated that GPs should ask all patients about sexual concerns and that the medical history forms should include a question about sexual problems. In fact, most patients agree that GPs should not wait for patients to raise these concerns.[20] Gender differentiation was mentioned significantly more often by male respondents and cited as a difficulty in the doctor-patient consultation than by female respondents. In contrast, another study shows that the GP's gender did not make it more difficult for patients in primary care to talk about sexuality.[20]

From the patient's perspective, GPs suspected that men are more likely to address functional problems, while women focus on psychosocial motives. The inhibition threshold for patients addressing erectile dysfunction in men had dropped significantly, due to the improved affordability of sexual enhancers and the increased presence of erection-enhancing drugs. Additionally, "being asked by doctor first" as well as "doctor of same gender" facilitate the conversation, especially for young female patients.[17,20]

When sexuality is mentioned in practice, most GPs tend to make a diagnosis that focuses on physiologically treatable aspects by discussing symptoms, prevalence, medication, and other side effects. Most feel more confident making an individualized diagnosis and providing a satisfactory solution when the sexual issue fits their expertise, that is, primarily drug therapy. Questionnaires are not used at all. Some GPs also refer directly to other specialists, especially gynecologists, urologists, or psychiatrists and psychotherapists. Psychologically influenced sexual disorders are sometimes addressed by GPs themselves, as the capacities of psychotherapists are usually insufficient. They often feel left alone to treat psychologically related problems—not only in sexual health. This contrasts with the high prevalence of psychological comorbidities in sexual dysfunction. Depression, anxiety, pain, hypertension, diabetes, and psychotropic medication use are significantly associated with sexual dysfunction for men and women.[21]

The proposed therapeutic approach includes drug therapy (eg, with PDE-5 inhibitors for erectile dysfunction) or referrals to more advanced specialists. Particularly on erectile dysfunction, GPs mostly demonstrated sound knowledge of current pharmacological therapy. Most respondents felt very confident in dealing with simple organically caused sexual disorders. The GPs have personally created

their own "guidelines" for prescribing potency drugs after excluding contraindications. This therapeutic procedure is consistent with previous findings.[17] According to an international survey of 12 563 people only 7% of those who reported erectile dysfunction used medication, but 74% claimed that they would like to receive medical treatment.[22] There seems to be a considerable public preference for medical treatment.[20] In rare cases, GPs themselves attempt psychoeducational and counseling discussions to alleviate sexual symptomatology. Long waiting times of psychotherapists and psychiatrists are cited as the predominant reason.

Due to the wide range of diagnostic and therapeutic steps reported in primary care, it seems appropriate to clarify even more precisely which diagnostics should be used for specific sexual disorder patterns. At least for the frequently reported problems of erectile dysfunction, ejaculatio praecox, dyspareunia, vaginal dryness and loss of appetence, there should be standardized recommendations, if not guidelines, for diagnosis and therapy to reduce uncertainties. Only when GPs have concrete guidelines for diagnosis and treatment of specific sexual problems and disorders, they can develop a routine and competent way of dealing with sexual health in primary care.

Nearly all GPs reported feeling inadequately prepared, if at all, by medical studies and/or further trainings to deal with sexual health and sexual problems. Here, GPs would like to participate in more continuing education offerings, for example, on psychological problems, appetence loss or vaginismus, and gender reassignment. This information is consistent with numerous studies showing that many GPs feel only moderately confident (53%) or even insecure or very insecure (13%) in dealing with sexual disorders, and 87% of respondents reported that they did not receive adequate information about sexual medical disorders in their studies.[11,23]

Both the present and previous studies point out that GPs are aware of the prevalence and relevance of sexual problems for overall wellbeing, but most of them feel insecure dealing with a range of more complex sexual medicine topics because of knowledge and skill gaps. It highlights the need for improvements of education and trainings as well as an integration of sexual medical contents into medical studies and/or extra occupational advanced and further training opportunities. Thus, an interdisciplinary lecture of gynecology, urology, and primary care on the topic of sexual disorders in men and women could fill the knowledge gap at an early stage.

Limitations

The study was designed to obtain narrative data from GPs dealing with sexual problems. A major study limitation includes the geographical constraint to only individuals residing in the northern areas of Western and Eastern Germany, so that the results may not reflect the opinions of GPs from other areas of Germany, such as Southern Germany. Nevertheless, the sample of GPs from very different societies and social milieus (East and West Germany) with rural versus urban backgrounds can be considered a strength of the study. In addition, it can be assumed that GPs connected to the university are more likely to participate in research projects and thus the selection of the GPs from Kiel was subject to a certain selection. However, no significant difference was found between the 2 differently selected groups of GPs (except for a lower experience with migrants in Sachsen-Anhalt). No information was requested from GPs that might influence how they address, diagnose, and treat sexual problems (eg, sexual orientation, religion, and culture). Additionally, this was a retrospective study in which participants had to recall previous experiences and therapies with patients rather than describe them in real time. Further research on a larger sample of German GPs is required to further examine a relevant primary care sector of sexual problems and disorders. This may help to develop better sexual medicine trainings for GPs.

Conclusion and Further Recommendation

The present study can contribute to the improvement of GP's approach to the subject of sexual functioning. GPs rarely address sexual problems and when they do, it is in the context of higher-level disorders. The interviews emphasize several obstacles that prevent GPs and/or their patients from addressing sexual problems but also highlights facilitators of discussing sexuality. The main obstacles seem to be embarrassment on both sides to talk about sexuality, high workload, and lack of time. Displaying informational materials about sexual problems could reduce the inhibition threshold for patients to talk about certain issues. An initiation of the conversation by GPs and sufficient skills in dealing with specific disorders can help to facilitate the management of sexual problems in primary care. It is recommended to ask the patient's permission to talk about sexual health as part of the general medical history, for example: "Are you experiencing any difficulties with sexual functioning?" or "People taking this medication sometimes report problems with sexual function; is that something you are familiar with?"[17]

Diagnostics and therapy are mostly unstandardized and individually adapted to the patient. Simple organic sexual problems are mainly treated with medication. It would be a recommendation to develop superordinate action guidelines for the diagnosis and further handling of sexual problems and sexual disorders in primary care. Furthermore, there

seems to be a lack of sexual health training opportunities. Further qualitative research on sexual functioning in German GP practices could help to identify knowledge gaps on specific sexual disorders and based on this, develop a better range of academic training opportunities for GPs.

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Informed Consent Statement

Informed consent was obtained from all subjects involved in the study.

Institutional Review Board Statement

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Data Availability Statement

To protect the anonymity of participants, the qualitative data used in this research cannot be made publicly available.

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