

# Erectile Dysfunction in Brazilian Primary Health Care: Dealing with Medicalization

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Antônio Augusto Dall'Agnol Modesto, MD, PhD<sup>1</sup>  
and Marcia Thereza Couto, PhD<sup>1</sup>

## Abstract

Erectile dysfunction (ED) is a common sexual problem and has been attracting growing interest from the field of medicine. The pharmaceutical industry works together with medical associations to popularize the theme, emphasizing individual enhancement and medication, besides reinforcing an idea of a male sexuality defined by the ability to have an erection and penetrate. Patients worried about erection problems search for general practitioners (GPs), frequently without a clear complaint, and a comprehensive primary health care (PHC) must be capable of dealing with these issues considering medicalization and disease mongering. This article discusses how PHC physicians take (and might take) care of men with erection problems, and how users perceive it and search for help in two cities in the State of São Paulo, Brazil. The qualitative research, performed in five PHC services, included semistructured interviews with 16 GPs and 15 adult male users. The adult male users were invited by their doctors during consultations where questions about prostate, ED, or other sexual problems arose. Interviews were transcribed and submitted for content analysis. In addition, the five participating services were observed with help of a specific script. Results indicate that ED is frequently a hidden agenda and that doctors have trouble approaching the problem, usually focusing on the biological aspects. Based on empirical data and literature, this work indicates some measures to qualify the care of men with ED in PHC which includes contemplating users' questions, respecting their autonomy, avoiding an antidrug stance, and considering drug and nondrug approaches as a *continuum* of resources.

## Keywords

men's health clinics, masculinity, erectile dysfunction, primary health care

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“En Médecine comme en amour, ni jamais, ni toujours”

(Old proverb)

Erectile dysfunction (ED) is one of the most common complaints in male sexuality and has been attracting growing interest from the field of medicine (Hatzimouratidis & Hatzichristou, 2005; Hatzimouratidis, Amar, Eardley, Giuliano, Hatzichristou, Montorsi, Vardi, & Wespes, 2010). Brazilian surveys indicate that almost 46% of men older than 18 years are affected. According to men's ability to obtain and maintain a satisfactory erection for sexual intercourse, ED is classified as mild or occasional (68% of cases), moderate (27%), and complete (only 5% of cases) (Moreira Jr, Abdo, Torres, Lobo, & Fittipaldi, 2001; Abdo, Oliveira Jr, Scanavino, & Martins, 2006). Studies describe increasing incidence throughout life with the highest

prevalence among the elderly. Other risk factors include low scholarship, unemployment, cardiovascular disease (especially diabetes and hypertension), depression, and benign prostatic hyperplasia (Abdo et al., 2006; Hatzimouratidis & Hatzichristou, 2005; Hatzimouratidis et al., 2010; Moreira Jr et al., 2001; Moreira Jr, Lobo, Diament, Nicolosi, & Glasser, 2003). Erection problems affect men's quality of life, self-esteem, and personal relationships (Abdo et al., 2006) mainly because the ability to

<sup>1</sup>Department of Preventive Medicine, School of Medicine, University of São Paulo, São Paulo, SP, Brazil

## Corresponding Author:

Antônio Augusto Dall'Agnol Modesto, Departamento de Medicina Preventiva, Faculdade de Medicina da Universidade de São Paulo, Av. Dr. Arnaldo, 455, 2o andar, 01246-903, São Paulo, SP, Brasil.  
Email: filomedlit@yahoo.com.br



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have an erection and penetrate is a physical demonstration of a hegemonic masculinity, identified as an active and impulsive sexuality usually restricted to penetration (Gomes, 2008; Wentzell & Salmerón, 2009; Pinheiro, Couto, & Silva, 2011).

Despite pharmaceutical industry and medical associations' efforts to popularize the theme (Rosenfeld & Faircloth, 2006; Rohden, 2012), ED is still a problem hard to talk about in consultations. In interviews with 500 men attending a urology clinic for problems other than ED, 44% indicated that they also had erection problems. Reasons for not seeking help for ED included shame (74%), thinking the problem is a normal part of aging (12%), not knowing the urologist could help (9%), and not giving importance to the problem (5%). Moreover, 78% of those men who had not spoken to the urologist had also not spoken with their general practitioners (GPs) and 82% of these men said they would like their GPs to start this discussion in usual consultations (Baldwin, Ginsberg, & Harkawayet, 2003).

Many Brazilian authors identified this male silence about ED, besides the professional inability to deal with the subject and its nonrecognition as a medical need. When it occurs, the approach to erectile dysfunction has a strong biomedical bias that overestimates the biological aspects and associated diseases (such as hypercholesterolemia, diabetes mellitus, hypertension) and reinforces an idea of a male sexuality defined by the ability to have an erection and penetrate. Those characteristics are related to the pharmaceutical industry's efforts to call attention to the disorder, emphasizing individual enhancement and medication use (Gomes, 2008; Pinheiro, Couto, & Silva, 2011; Rohden, 2012).

Male sexuality has been identified as a target of medicalization in the Brazilian (Pinheiro, Couto, & Silva, 2011; Rohden, 2012) and foreign (Rosenfeld & Faircloth, 2006) contexts. *To medicalize* is to bring to the medical scope problems originally belonging to other scopes. More than just treating something with medication, it means understanding problems through the explanatory schemas of hegemonic medicine, as well as legitimizing medicine as an authority on the subject and promoter of effective responses (Illich, 1976; Moynihan, Heath, & Henry, 2002; Norman & Tesser, 2009; Rosenfeld & Faircloth, 2006; Tesser, 2012).

Although erection problems have been a concern for men for centuries in Western culture, it has always been understood as an inconvenient experience, a troublesome behavior, or a personal disorder. Medicalization of impotence was initially in the scope of sexology, psychology, psychiatry, and couple treatments until recently. The change of the concept from *impotence* to *erectile dysfunction* has been largely promoted by the pharmaceutical industry and represents the allocation of the

problem to a field where it is almost exclusively targeted for drug treatment and where characteristics of hegemonic masculinity are reinforced (Wiencke, 2006). In Brazil, in the beginning of the 20th century, male sexuality was treated in the context of sexually transmitted diseases on behalf of public health and collective outcomes. Differently, in the beginning of the 21st century, the emphasis is on the ability to have an erection and perform penetrative sex mainly through the use of medication, with an interest on individual enhancing. Besides, groups of doctors have been trying to use sex life (understood in terms of erection and penetration) as a gateway to men's health (Rohden, 2012).

Brazil, Australia, and Ireland were the first countries to develop a public policy aiming to men's health. Discussing those international experiences, Couto and Gomes (2012) indicated advances in considering men as persons of rights and as a population with specific vulnerabilities, but also observed signs of the medicalization of men's health. Analyzing the Brazilian National Policy for Integral Attention to Men's Health launched in 2009 by the Ministry of Health (Brazil, 2009), Carrara, Russo, and Faro (2009) demonstrated how the discourse of urologists combined with the discourse of social movements to medicalize the masculine body. It implies an idea of a masculinity that is essentially unhealthy and, differing from policies aiming at women and other minorities, results in the disempowerment of its targeted population.

Despite the potentially beneficial relationship between media and public health (Bernardini-Zambrini, 2013; McCaffery, Jansen, Scherer, Thornton, Hersch, Carter, Barratt, Sheridan, Moynihan, Waller, Brodersen, Pickles, & Edwards, 2016), the information disclosed is never neutral—as the science that produces it is not neutral (Costa, 2006; Castiel & Diaz, 2007). The media often generates demands in a damaging way (Tesser, 2012; Ruiz-Cantero & Cambronero-Saiz, 2011). It is important to understand how the pharmaceutical industry, together with physicians and patient groups, uses the media to create illnesses and patients in a form of medicalization called “disease mongering.”

According to Moynihan, Heath, and Henry (2002), there are five strategies involved in this phenomenon: “turning ordinary ailments into medical problems, seeing mild symptoms as serious, treating personal problems as medical, seeing risks as diseases, and framing prevalence estimates to maximise potential markets”.

Viagra® (sildenafil citrate), manufactured by Pfizer, was approved as the first drug treatment for erectile dysfunction by the US Food and Drug Administration (FDA) in 1998. In a few weeks of selling, more than one million American men had received a prescription and it ceased to be the exclusive focus of specialists (such as urologists

and psychiatrists) and gained space among generalists (Ghofrani, Osterloh, & Grimminger, 2006). To ensure this success, Pfizer has used several of the disease-monitoring strategies.

Referring to prevalence and incidence studies financed by the company itself, in which worked company members from Brazil and other countries in the Americas (Moreira Jr et al., 2001; Moreira Jr et al., 2003; Morillo, Díaz, Estevez, Costa, Méndez, Dávila, Medero, Rodriguez, Chaves, Vinueza, Ortiz, & Glasser, 2002), Pfizer endeavored to popularize the discussion on the subject, publicizing the disease and including virtually any man in the public that could be treated (Lexchin, 2006). Based on Moreira Jr et al. (2001), for example, the manufacturer can claim that 46% of men have erectile dysfunction, not mentioning that in almost 95% it is a mild or moderate, even temporary, problem. In addition, the possibility of drug treatment was positively influenced by an antideclinal discourse according to which no man should lose the ability to have a satisfactory erection at any time (Potts, Grace, Vares, & Gavey, 2006), triggering and reinforcing demonstrations of masculinity through sex and constituting a “Viagra Man” (Loe, 2006). Promotion of Viagra’s concurrents highlighted technological advances such as the rapid onset of action of Levitra® (vardenafil) (Bayer HealthCare Pharmaceuticals Inc., 2014) and the long duration of Cialis® (tadalafil) (Eli Lilly and Company, 2017). Additionally, they promised improvements in “natural” sex which symbolically appeals to hegemonic masculinity and promotes a nonmedical “lifestyle” use of the drugs—expanding their use even among young, healthy men (Wiencke, 2006).

Looking forward to a comprehensive primary health care (PHC), family physicians must be capable of working up with patients worried about erection problems who search them, frequently without a clear complaint (Baldwin, Ginsberg, & Harkawayet, 2003; Jackson, 2005; Modesto, 2016; Starfield, 1998). Likewise, one of the objectives of the Brazilian National Policy for Integral Attention to Men’s Health (PNAISH) is “to stimulate, implement and qualify personnel for attention to male sexual dysfunctions” (Brazil, Ministry of Health, 2009).

On one hand, a common problem that affects the self-esteem and interpersonal relationships of many men; on the other hand, the movement of the pharmaceutical industry, striving to attract more and more customers.

The objective of the current article is to discuss how family physicians take (and might take) care of men with erection problems, considering medicalization and the resistance to it. Based on findings from qualitative research performed in five primary health-care services in two cities in the state of São Paulo, some measures to achieve a less-medicalizing, realistic approach to erectile dysfunction are indicated. This may be useful not only for general practitioners, but also for urologists, psychiatrists,

psychologists, and other professionals who take care of men with this problem. In the same way, much of the considerations presented are applicable to other male sexual issues (like premature ejaculation) as well in other PHC contexts in Brazil or abroad.

## Methodological Aspects

This work is part of a larger qualitative research that studied the search for prostate evaluation, erectile dysfunction, and men’s hidden agenda in PHC in three PHC services in São Paulo, capital of the homonymous state, and two in Mauá, a suburban town adjacent to the capital (Modesto, 2016). All services were public-funded. Though it offers universal coverage, the Brazilian public health system is mostly used by poor people (Paim, Travassos, Almeida, Bahia, & Macinko, 2011).

Qualitative research is very useful to access perceptions of individuals and to extract meanings from their speeches and behaviors (Bourdieu, 1999; Denzin & Lincoln, 2011; Geertz, 1973; Poupart, Deslauriers, Groulx, Laperrière, Mayer, & Pires, 1997). In-depth interviews and field observations are typical techniques and the methodology is particularly suitable for studying delicate subjects such as violence and sexuality. The research in which this article is based looked forward to understand issues like men’s and doctors’ perceptions about erectile dysfunction, the search for prostate cancer screening, the rapport between men and primary health-care services, and so on.

The research was approved by the Research Ethics Committee of the School of Medicine of University of São Paulo (protocol number 372/14) and the Health Secretaries of São Paulo and Mauá. All interviewees read (or chose to hear from the interviewer) and signed a term of informed consent. Research materials related to this article (e.g., recorded and transcribed interviews, analysis tables, signed terms of informed consent) are stored by the first author. Personal access by other researchers may be arranged via email to the first author.

## Participants and Recruitment

Sixteen general practitioners (7 male, 9 female) and 15 adult male users were interviewed during the first semester of 2015. After a presentation of the research at their workplace, doctors were invited to the interview and were asked to invite male users—men older than 18 years in whose consultations arose questions about prostate, erectile dysfunction, or other sexual problems. This criterion would allow exploration not only of men’s perceptions of prostate matters and sexual issues, but also possible relations between the two. If the male user agreed to participate, he was called to hear more about the research and have an interview scheduled.

Practitioners had more than 2 years of work in PHC and 3 months with their current team. Medical residents were not included. Cuban missionary doctors were not included because of the possible cultural differences from Brazilian doctors.

Besides sociodemographic data and aspects that can influence practices and speeches, the questions for the interviews with practitioners were grouped in the following topics: "masculinities and health," "search for evaluation of prostate and erectile dysfunction," and "masculinities and use of health services." In interviews with users, the topics were: "perceptions about health and self-care," "masculinities, health and use of services," "the medical consultation in which he was invited," and "prostate and erectile dysfunction." The practitioner's script had more interest in medical issues including perception about patients' agendas while the users' script focused on more general perceptions and practical experience.

The criteria of saturation were used to define the numbers of interviewed practitioners and male users. It meant interrupting the inclusion of new participants when not only the speeches but also the senses they translate started to be repetitive, offering no more new data (Fontanella, Ricas, Turato, 2008).

It is worth mentioning that when qualitative research investigates more deeply a short sample, combining different techniques (like semistructured interviews and field observation), specifying its context and understanding its limits (such as geographic and cultural ones), it allows the advent of unexpected findings that not only give better understanding of the matter, but also may call for new research.

### Data Collection

Interviews with practitioners were done in their workplaces (in a consultation room or other free room). Only one practitioner chose to be interviewed at home. Interviews with users were done at the health services office (in any free room) or at home. All participants from both groups were interviewed alone, except for one male user in São Paulo who was interviewed at home accompanied by his wife.

The recordings of the analyzed interviews totaled 17 hr (practitioners) and 11.5 hr (male users)—in medium, almost 64 min of interview with each doctor and 46 min with each male user. All the interviews were done by the first author. No practitioners in the five participant services refused to be interviewed yet two other services on the suburbs were excluded because of trouble reaching or interviewing the practitioners.

Three services (two in the capital and one in the suburbs) selected 22 men for the authors to call. During the first semester of 2015, nine men in the capital and eight in

the suburbs were interviewed. One man from each city was eventually excluded, one wrongly selected and other with mental health issues that compromised the interview. Three users were unavailable, one refused to be interviewed by the researcher (and not his doctor, as he expected), and the last was excluded after saturation. No participant from either group abandoned the interview before its end.

The five participating services were observed with the help of a specific script and with recordings in a field diary. Each service was visited at least two entire periods (morning, since before service opens and afternoon, till after service closes) plus many visits for presenting the research and conducting interviews. All observations were made by the first author. Besides watching the ambience and relations between users and doctors (with each other and themselves), it was possible to talk to users in general and different professionals, not only doctors. This provided much information about the services and contributed to the interviews and their interpretation.

### Analysis

The interviews were transcribed and the transcriptions were checked for fidelity and subjected to content analysis (Bardin, 1996). The main steps of content analysis were:

1. Exhaustive reading of empirical data from interviews and observations, separately;
2. Shaping of empiric analysis categories, considering the themes we expected to explore and those which arose from the data produced;
3. First synthesis of each group of data;
4. Analysis of this synthesis based on the theoretical references (gender and the construction of masculinities as well as the notions of comprehensiveness and medicalization) and on other studies about ED; and
5. Final synthesis articulating the empirical material (interviews with users and practitioners and field observation) and literature regarding the themes and theoretical references.

In this article, fragments of interviews will be identified by "Male Doc," "Female Doc," and "User" respectively to male or female doctors or male users, followed by city ("SP" meaning "São Paulo") and age.

### Results and Discussion

The most important characteristics of the participants are reported in Tables 1 and 2.

All doctors earned more than R\$ 10,000 a month (almost US\$ 3,250 in April 2017, taxes discounted). All users lived with a female partner except "User SP 57"

**Table 1.** Characteristics of Interviewed Doctors.

|                  | Sex | Age | Year of graduation | Family medicine residence <sup>a</sup> | PHC specialization <sup>b</sup> | Years on PHC <sup>c</sup> | Years on current practice |
|------------------|-----|-----|--------------------|--|---------------------------------|---------------------------|---------------------------|
| <b>São Paulo</b> | F   | 26  | 2011               | 2014                                   | No                              | 2                         | 2                         |
|                  | F   | 27  | 2011               | 2014                                   | No                              | 3                         | 0                         |
|                  | F   | 29  | 2010               | 2013                                   | No                              | 4                         | 0                         |
|                  | F   | 30  | 2008               | 2012                                   | No                              | 4                         | 2                         |
|                  | M   | 27  | 2010               | 2013                                   | No                              | 3                         | 1                         |
|                  | M   | 30  | 2009               | 2013                                   | No                              | 5                         | 1                         |
|                  | M   | 35a | 2004               | 2010                                   | No                              | 10                        | 4                         |
|                  | M   | 35b | 2004               | 2011                                   | 2009                            | 10                        | 3                         |
| <b>Mauá</b>      | F   | 31  | 2007               | No                                     | 2011                            | 7                         | 4                         |
|                  | F   | 34  | 2008               | No                                     | No                              | 3                         | 3                         |
|                  | F   | 52  | 1991               | No                                     | 2000                            | 17                        | 10                        |
|                  | F   | 61  | 1983               | No                                     | No                              | 10                        | 2                         |
|                  | F   | 62  | 1979               | No                                     | 2013                            | 10                        | 1                         |
|                  | M   | 36  | 2005               | No                                     | No                              | 9                         | 9                         |
|                  | M   | 65  | 1980               | No                                     | 2005                            | 7                         | 6                         |
|                  | M   | 67  | 1981               | No                                     | No                              | 15                        | 2                         |

Note. F = female; M = male. PHC = primary health care.

<sup>a</sup>Year of conclusion. <sup>b</sup>PHC specialization refers to shorter formations, different than residence. <sup>c</sup>Zero indicates 3 to 12 months. Experience on PHC refers to Family Health Strategy model (for more, see Paim et al.); some doctors in Mauá had also experience in older models of primary care.

**Table 2.** Characteristics of Interviewed Users.

|                  | Age | Demand on consultation <sup>a</sup>             | ED/PE | Occupation <sup>b</sup>                               |
|------------------|-----|---|-------|---|
| <b>Mauá</b>      | 52  | Erectile dysfunction told by wife               | Yes   | Licensed from work (bricklayer)                       |
|                  | 53a | Diabetes and erectile dysfunction               | Yes   | Residential building gatekeeper                       |
|                  | 53b | PSA follow-up                                   | No    | Unemployed (gas station worker and vigilant)          |
|                  | 58  | PSA follow-up, BPH followed by urologist        | Yes   | Mechanic  |
|                  | 65  | Diabetes and erectile dysfunction               | Yes   | Licensed from work (cleaner)                          |
|                  | 69  | Prostate problems                               | Yes   | Retired (mechanic)                                    |
|                  | 70  | Prostate cancer followed by urologist           | Yes   | Licensed from work (structural iron and steel worker) |
| <b>São Paulo</b> | 30  | Premature ejaculation                           | Yes   | Delivery boy and pizza cooker                         |
|                  | 43  | Chest pain and routine exams including prostate | No    | Gas station worker                                    |
|                  | 61a | Prostate preventive exams                       | No    | Retired (vigilant)                                    |
|                  | 61b | Re-evaluation of cough and erectile dysfunction | Yes   | Gardener  |
|                  | 38  | Premature ejaculation and anxiety               | Yes   | Seller  |
|                  | 47  | Routine exams including prostate                | Yes   | Driver  |
|                  | 57  | Prostate examination                            | Yes   | Joiner  |
|                  | 76  | Erectile dysfunction                            | Yes   | Retired (textile worker)                              |

Note. ED = erectile dysfunction; PE = premature ejaculation; BPH = benign prostatic hyperplasia; PSA = prostatic specific antigen.

<sup>a</sup>How the matter of interest of the research arose on consultation, according to the doctors who invited the patient. <sup>b</sup>Last job(s) in parenthesis.

who was single. All mentioned only heterosexual practices. The highest education level was high school (two men in each city) and none was illiterate. Users earned R\$ 905 to R\$ 3,500 a month (equivalent to US\$ 293 and US\$ 1,133 in April 2017), and had been living in the neighborhood from 13 to 63 years.

According to professionals in both cities, erectile dysfunction is an uncommon complaint in consultations, rarely made spontaneously or clearly by men. It

usually appears by the professional’s active questioning, is brought by a female partner (on men’s or her own consultation), or in the physicians’ own words, *trans-vestited, camouflaged, masked*—it means as a hidden agenda (Modesto & Couto, 2016). Men searching for prostate evaluation, check-up in general, or prescription of vitamins as well as those complaining about weakness, for instance, may hide a sexual issue, especially erectile dysfunction.

[A man] came demanding routine exams, eh... to perform the famous check-up... And then I did an anamnesis with him, and so, examined, checked it was everything alright, and said "I'm going to ask only the exams adequate for your age range", and then he asked if there was any exam which could see the issue of potency, of erectile dysfunction. And then I said no and started asking what was his problem ... So he finally really opened himself, he was having erection problems, having trouble, he'd got libido but he hadn't a complete erection, soon it was over and there wasn't another, he hadn't [an erection], it was short in duration, wasn't effective... (Male Doc SP 35b)

This quote exemplifies the variety of ways a man can describe an erection problem, seen also in users' interviews.

Professionals in general referred to limitations in the approach to ED. Reasons included inexperience (related, in part, to hidden agendas) and valorization of the focal specialist. Few cited the prescription of phosphodiesterase-5 inhibitors and many used to promptly refer patients to a urologist or psychologist. Factors as anxiety, life context, or marriage troubles were pointed as influencing ED but biological factors prevailed in the speeches, especially in Mauá, with aging being the most important factor cited. Factors like age, diabetes, hypertension, smoking, alcohol abuse, and use of multiple medications seemed more than risk factors—they were practically determinants of bad erections and thus, a poor sexual life.

*He was a senior in his sixty years, sixty-four, with diabetes, using insulin, hypertensive, using all classes [of drugs] that cause impotence (...), in a word, a disgrace; it was his wife who came to complain he didn't stop [looking for having sex] [laughs], "there wasn't no problem with his erection", who had problems was her, because she had a lack of lubrication, well, I had to help her. For you to see how it can vary from person to person, right? It's unusual, it's not common, once you're a smoker, you've got a certain age, and you use alcohol, let's say, only alcohol, and you're diabetic and hypertensive, and use this drugs, ACE [angiotensin converter enzyme] inhibitors, methyl dopa, for instance, and thiazides, right... There's a natural impotence, right? But in his case, no. (Female Doc Mauá 62)*

Field observations and interviews suggested that bio-centric perceptions of ED among doctors in Mauá may result from a selection of the served population that might be called a *programming bias*. If men with diabetes have rather facilitated access and follow-up (due to specific scheduling, for instance), complaints from this population arise more frequently in consultations—including those non-necessarily caused by the diseases of interest. This may lead to an invisibility of erectile dysfunction in other populations and explain the generalized perception of almost causation between some

diseases and ED—extrapolating the concept of risk factors and gaining top-priority before other aspects, understandings, or possibilities of managing ED.

*Most of the [erection] problems are like this, the husband comes, he is an alcoholic, drinks, comes drunk... Eh, then I explain to him the consequences of alcohol... Patients who are hypertensive, that doesn't take care of themselves, right... Diabetics that doesn't take care of themselves, come with that high blood sugar, so I explain, too... Sometimes the patient is a joker, I say like this, "do you know this can make you fail?" [laughs] Right, so they stay like this, they just got concerned (Female Doc Mauá 52)*

Potts et al. (2006) argue that biomedical pressure for diagnosing and treating ED and restoring erection and penetration neglects alternative forms of sexual intercourse experienced by some men and identified by them as "normal" and "satisfactory" for themselves and their partners, as well as devalue the understanding of these changes as positive consequences of aging. In fact, none of the practitioners interviewed here apparently spoke with men about other forms of sexual intercourse that do not involve penetration—losing opportunities to problematize penetration itself, masculinity, and sexual pleasure.

Interviews with male users indicated that *erectile dysfunction* is known better as *impotence*, but this name, besides meaning trouble obtaining or maintaining a satisfactory erection, may also mean loss of libido and "weak" or premature ejaculations. They established very strong relations between problems of erection, aging, and comorbidities, especially diabetes, sometimes citing medical counseling that reinforced this relationship. There was also a perception that problems of sexuality (especially erectile dysfunction) are just one of various manifestations of illness and limitations related to aging. This indicates that the discourse of decline is not only present in the individual speeches of the two groups interviewed, but also reproduced in the therapeutic relationships experienced.

Previously to the onset of Viagra®, medical and lay literature on erectile dysfunction (or impotence) reproduced two main discourses: *Narratives of decline*, according to which male sexuality decreases with age, being a negative and inevitable consequence of getting older; and *narratives of progress*, which perceives positive changes related to age and experience. The texts of the post-Viagra era, on the other hand, transmit *antideclinal narratives* that pathologize ED and affirm that it is possible to restore sexual function "from before" and *revised narratives of progress*—defined in terms of the ability to have sexual performance similar to that of the young man or even better (Potts et al., 2006). Despite the existence of counterstories about sexuality and aging that question the biomedical privilege of erections and value discoveries

of satisfactory sexual experiences related to aging, those discourses certainly influence men and professionals—including our interviewees.

Users' statements also reaffirmed that physicians had difficulty managing the available treatments and resisted using medications in the presence of underlying disease, claiming great expectation on glycemic and blood pressure controls.

The importance of hypertension and diabetes on professional practice and clinic organization was clear, contributing to the strong relationship between those two conditions and ED in the view of professionals and users. In between, there seems to take place a negotiation about the causality of ED with practitioners favoring a biological approach while men expected other answers—a kind of disencounter known to occur in primary health care (Machado, Venturini, Manzan, & Silva, 2015; Rodondi, Maillefer, Suardi, Rodondi, Cornuz, & Vannotti, 2009). The current research has demonstrated the findings of other authors (Pinheiro, Couto, & Silva, 2011; Figueiredo, 2008) that the needs regarding male sexuality are seldom posed as something to be problematized or taken care of and are usually approached from a biomedical perspective. Both users and professionals seem disinterested (or unprepared) in investing the subject. Thus, both the opportunities to approach sexuality in a broader perspective and to legitimize the users as a welcoming and resolute resource are lost (Teixeira, 2003).

Only one user mentioned having resorted to sexual practices that did not involve penetration to bypass the premature ejaculation he was suffering—specifically a vibrator, thrown away when he started successful treatment with an antidepressant. While this reaffirms the task of the service in stimulating other forms of sexual intercourse that do not involve penetration with a view to a broader experience of sexuality and avoiding medicalization, it has become clear that penetration is, in fact, the most important way of sexual pleasure for many men—and, some have argued, many women.

*Impotency? It's the person who... I believe that... the person who... speaking more grossly, the person who doesn't work. (...) for example, if he goes... Eh, try to have a relation with a woman, he's not going to satisfy the woman, and in this case he's not going to have, in this case, a satisfactory erection or even any (User Mauá 53b)*

Those counter stories on sexuality and aging apparently led Potts et al. (2006) to their positive view of experiencing erectile dysfunction, as it would allow new discoveries and experiences of sexuality with sexual relations more focused on the couple and not only on the man. It is important not only to consider these experiences but also to avoid disqualifying ED complaints—even because many men may already experience a more

comprehensive and creative sexuality, not reduced to penetration and attentive to the partner's wishes, but still resent their problems of erection.

Similarly, criticism of medicalization of male sexuality should not lead to an antidrug stance regarding ED. First, even with the best counseling, erection and penetration will remain important for many men and women. Second, medicalization of erectile dysfunction is an advanced process with social actors as influent as medical societies and the pharmaceutical industry. Third, even though it's forbidden to advertise PD5-inhibitors directly to the lay public in Brazil (differently from the United States), knowledge of and access to medication is easy, so men will probably use it with or without a doctor's counseling. Finally yet importantly, non-pharmacological approaches to the problem (as psychotherapy) may be time-consuming, require specific training, have limited efficacy (as any therapy), and are rarely available in the Brazilian public health system.

In other words, between the medicalized erection and the resigned sagging, medicine keeps telling people how they should live their sexuality. Contemplating users' questions and autonomy and avoiding reductionism can lead to a better medical response to the medicalization of male sexuality which may recognize the benefits of sildenafil, tadalafil, and vardenafil and make rational use of these resources.

Limited clinical management of ED in PHC may result in two negative consequences for men. First, the resolution of this level is impaired regarding a prevalent health issue which a family physician could easily approach (Modesto, 2016; Starfield, 1998). Besides, consultation with a urologist is always an opportunity for the controversial prostate cancer screening (Ilic, Neuberger, Djulbegovic, & Dahm, 2013; Moyer, 2012).

In order to include men and their sexual issues in primary health care in a holistic, person-centered, comprehensive and ethical way, it seems necessary to fulfill three tasks: identifying problems among other complaints, sparing men from unnecessary and unhelpful interventions; identifying candidates to medical intervention while avoiding overdiagnosis and overmedicalization, and assuring access to different alternatives of primary and secondary care; and third, managing the available treatments while avoiding overestimation of chronic diseases and false expectations about its control or the use of medication.

Based on empirical data and all literature discussed above, some measures may be indicated to qualify the care of men with ED in the face of medicalization and disease mongering, looking forward to a prudent use of medication. First, it is important to keep in mind the medicalization of male sexuality and the pharmaceutical industry's movement on the subject when constructing an

approach (Lexchin, 2006; Pinheiro, Couto, & Silva, 2011; Rohden, 2012; Rosenfeld & Faircloth, 2006; Wentzell & Salmerón, 2009). It includes being careful with diagnostic questionnaires (like the one from Rosen, Riley, Wagner, Osterloh, Kirkpatrick, & Mishra, 1997) usually sponsored by industry and tending to facilitate diagnosis and enlarge the consumer market, as well as with pharmaceutical representatives' visits (Brax, Fadlallah, Al-Khaled, Kahale, Nas, El-Jardali, & Akl, 2017; Workneh, Gebrehiwot, Bayo, Gidey, Belay, Tesfaye, & Kassa, 2016).

Offering empathic listening, which addresses ideas about sexuality and living and relationship conditions, is an opportunity to discuss and encourage other forms of sexual intercourse that do not involve penetration and problematize the readiness to penetrate as a demonstration of hegemonic masculinity (Moura, 2015). The partner should be included at some point of the conversation when possible and acceptable. A good listening may also identify hidden agendas, helping to spare men from unnecessary procedures (Modesto & Couto, 2016).

The medical evaluation of people with erectile dysfunction must include a careful assessment of the severity and impacts of the problem, differentiating it from others (such as premature ejaculation) and diagnosing and treating diseases that can contribute to the condition (Hatzimouratidis et al., 2010), yet avoiding excessive biologization (Rohden, 2012). It also comprises clarifying risks, benefits, and limitations of medical treatment, referring for psychological support when necessary and available, and sharing decisions with the patient.

Treatment of ED should include both drug and non-drug interventions (Hatzimouratidis & Hatzichristou, 2005; Hatzimouratidis et al., 2010; Leusink, De Boer, Vliet Vlieland, Rambharose, Sprengers, Mogendorff, & Van Rijn-Van Korten Hof, 2008; Melnik, Soares, & Nasello, 2007; Moura, 2015) and it is important to recognize phosphodiesterase-5 inhibitors as an effective resource for many men with ED, including those with associated organic problems (Hatzimouratidis & Hatzichristou, 2005; Hatzimouratidis et al., 2010).

As for other sexual or mental health issues, watchful waiting and reassessments are useful to a better understanding of the disorder and may be ways of delaying a prescription (Norman & Tesser, 2009; Tesser, 2012)—but not to secretly deny it.

## Conclusions

In the midst of the growing, mostly medicalized, interest in ED, we discussed some ways to enlighten men's sexuality and gender issues affecting their health as well as to protect this very same health from unnecessary interventions or precipitated pharmacological treatment. They

include, to name a few, being aware of medicalization and pharmaceutical industry strategies, performing an embracing and comprehensive evaluation that contemplates psychosocial as well as biological factors concerning sexuality issues, identifying hidden agendas, and watchful waiting.

The authors hope this work may be useful not only for general practitioners but also for every health professional concerned with men's health and sexual issues, especially those working in primary health care. Particularly for U.S. physicians, this work may be of interest for three reasons. First, by criticizing overmedicalization and discussing a reasonable use of medication, it can help in reducing iatrogenia—estimated to be the third leading death cause in the United States (Makary & Daniel, 2016). Second, the cross-cultural perspective may improve cultural competence of primary health care (Starfield, 1998). Even considering that the 352,879 Brazilian people living in the United States in 2015 corresponds to only 0.8% of its foreign-born population at the time (López & Radford, 2017), they certainly belong to a broader cultural web shared with other Latin American people. Lastly, 8 of the 15 world's biggest drug and biotechnology companies in 2016 are headquartered in the United States—one of them, Pfizer, is the world's second largest (Journey, 2016). This certainly places North American physicians in a privileged position for questioning medicalization in general, and medicalization of male sexuality in particular.

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