

## EDUCATION

## Predictors for Low Frequencies of Patient-Physician Conversations Concerning Sexual Health at an Austrian University Hospital



Nikola Komlenac, PhD, and Margarethe Hochleitner, MD

### ABSTRACT

**Introduction:** Studies concerning barriers to patient-physician conversations about sexual health or, specifically, sexual functioning fail to go beyond descriptive analyses of such barriers.

**Aim:** To identify barriers that predict the frequency of patient-physician conversations concerning sexual health or sexual functioning.

**Methods:** An online survey among physicians was conducted at an Austrian university hospital. Self-constructed questionnaires assessed physicians' sociodemographic information, frequency of holding a discussion on sexual health or sexual dysfunctions with their patients, and self-perceived barriers to asking patients about sexual health. Stepwise logistic regression models determined barriers that predicted the frequency of patient-physician conversations concerning sexual health or sexual dysfunctions in everyday clinical practice.

**Main Outcome Measure:** The outcome variables in the structural equation models were frequency of patient-physician conversations concerning sexual health or sexual dysfunctions in everyday clinical practice.

**Results:** One hundred two physicians (53.9% women, 46.1% men; mean age = 41.3 years; SD = 10.6) provided full responses. Of these physicians, 61.8% reported having a discussion on sexual health or sexual dysfunctions with their patients at least rarely in their everyday clinical practice. The barriers most influencing the frequency of such patient-physician conversations were not feeling responsible for this health issue and expecting the patient to initiate such a conversation. Fear of offending the patient and the physician's own feelings of shame and discomfort were additional factors influencing the frequency of these patient-physician conversations.

**Clinical Implications:** Future physician training should address physicians' responsibilities that include sexual health. Future physician training should also help physicians in overcoming fears of offending a patient, and one's own feelings of shame and discomfort when addressing patients' sexual health.

**Strengths & Limitations:** This study included physicians across a range of disciplines, who may encounter patients with sexual problems and with their treatments influence a patient's sexual health and sexual functioning. However, the low response rate and the limited number of participants prevented generalization of findings.

**Conclusions:** At an Austrian university hospital, patient-physician conversations concerning sexual health are seldom part of a physician's everyday clinical practice. Future training for physicians should focus on demonstrating the relevance of sexual health in the physician's medical discipline and should tackle a physician's feelings of shame or how to handle patients' negative reactions during patient-physician conversations concerning sexual health. **Komlenac N, Hochleitner M. Predictors for Low Frequencies of Patient-Physician Conversations Concerning Sexual Health at an Austrian University Hospital. Sex Med 2019; 8:100–106.**

Copyright © 2019, The Authors. Published by Elsevier Inc. on behalf of the International Society for Sexual Medicine. This is an open access article under the CC BY-NC-ND license (<http://creativecommons.org/licenses/by-nc-nd/4.0/>).

**Key Words:** Patient-Physician Conversations; Sexual Health; Sexual Dysfunctions; Physician; Hospital; Barriers to Patient-Physician Conversations

Received May 27, 2019. Accepted September 29, 2019.

Gender Medicine Unit, Medical University of Innsbruck, Innsbruck, Austria

Copyright © 2019, The Authors. Published by Elsevier Inc. on behalf of the International Society for Sexual Medicine. This is an open access article under the CC BY-NC-ND license (<http://creativecommons.org/licenses/by-nc-nd/4.0/>).

<https://doi.org/10.1016/j.esxm.2019.09.006>

### INTRODUCTION

Many medical disciplines can become involved in issues with a patient's sexual health, specifically sexual functioning<sup>1</sup>; for example, internal medicine physicians may frequently see patients with sexual dysfunctions. Many cardiovascular diseases<sup>2,3</sup>

and urological diseases are associated with sexual dysfunctions.<sup>4</sup> Physicians in surgical disciplines, neurology, psychiatry, gynecology, pediatric medicine, dermatology, nuclear medicine, or otolaryngology should be particularly concerned about their patients' sexual health, because many physical diseases seen in these disciplines are associated with sexual health.<sup>5,6</sup> Thus, patient-physician conversations concerning sexual health are important and should be part of a patient's treatment in all relevant medical disciplines.<sup>7</sup>

Physicians, however, rarely initiate conversations about their patients' sexual health during patient-physician conversations. Most often, physicians mention time constraints as preventing them from asking patients about their sexual health.<sup>8,9</sup> Next to time constraints, a lack of knowledge and a lack of experience are other often mentioned barriers to including questions about sexual health in physician-patient conversations.<sup>10–12</sup> Also, many physicians do not consider it to be their responsibility to talk about a patient's sexual health or sexual functioning.<sup>8,13</sup> Further barriers to patient-physician conversations about sexual health or sexual functioning include a fear of causing offense, advanced age of the patient, assuming it to not be relevant, being uncomfortable raising the issue, or being ashamed to bring it up. Many physicians assume that the patient should or would initiate such a conversation if it were relevant to the patient.<sup>8,14</sup>

The aim of the current study was to evaluate the extent to which physicians at an Austrian university hospital address sexual health with their patients. This study included physicians across a range of disciplines who may encounter patients with sexual problems and who, due to their treatments, can influence a patient's sexual health.<sup>1</sup> Previous studies have revealed valuable information concerning barriers to patient-physician conversations about sexual health or sexual functioning. Most of those studies relied on descriptive analyses of barriers to such conversations, leaving unexplored how barriers to these conversations and the actual frequency of patient-physician conversations concerning sexual health or sexual functioning are related. In order to more efficiently address barriers to patient-physician conversations concerning sexual health and, more specifically, sexual functioning, the current study focused on identifying those barriers that affect the frequency of such patient-physician conversations and therefore most need to be overcome in clinical practice.

## METHODS

### Measures

#### Sociodemographic Variables

Participants self-reported their gender, age, and nationality. Participating physicians were asked to report how many years they had worked as a physician (1–7 years, 7–15 years, 15–20 years, 20–30 years, or longer than 30 years) and the department in which they worked at the university hospital.

### Frequency of Discussing Sexual Health

Physicians were asked how many of their patients they discussed any aspect of sexual health with in their everyday practice. We did not further define sexual health for the participants in order to be less restrictive and to assess any discussion about sexual health that physicians recalled.<sup>13</sup> Additionally, we asked physicians to indicate how many of their patients they had discussions with about one topic of sexual health—namely, sexual dysfunctions such as erectile problems or low sexual desire—in their everyday practice.<sup>13</sup> Physicians were asked to estimate how many of their patients in general initiate discussions about sexual dysfunctions. Even though responses to these 3 variables were to be given on a 5-point Likert scale (never/almost never; with less than 50% of patients; with 50% of patients; with more than 50% of patients; with nearly every patient), most of the participants used only the first 2 response options. Thus, these 3 variables were dichotomized. For each variable, one category was formed for the response never/almost never and the other category indicated at least less than 50% of their patients.

### Barriers to Asking Patients About Sexual Health

Physicians were presented with a list of potential barriers to asking patients about sexual health (Table 1). The authors selected in consensus the barriers most frequently reported in other questionnaire studies,<sup>13,15,16</sup> qualitative studies,<sup>17</sup> and a review<sup>8</sup> for inclusion in the list of potential barriers. The authors were not able to include an exhaustive list of all reported barriers because of the risk that the questions might feel too repetitive to the participants and thereby risk participants' withdrawal from the study. Physicians were asked to indicate on a 4-point Likert scale the extent to which each of the barriers applied to them (1 = not at all; 4 = yes).

**Table 1.** Physicians' barriers to asking patients about sexual health issues (N = 102)

Barrier	Mean response (SD)*		
	All	Men	Women
No reason to talk about sexual health issues	2.7 (1.0)	2.8 (1.0)	2.7 (1.1)
Patient does not start conversation about sexual health issues	2.7 (1.0)	2.6 (1.0)	2.7 (0.9)
Not being responsible	2.4 (1.1)	2.6 (0.9)	2.2 (1.1)
Not enough training	2.3 (0.9)	2.2 (0.8)	2.4 (1.0)
Patient is "too ill"	2.2 (1.0)	2.2 (0.9)	2.2 (1.0)
Not enough time	2.1 (1.0)	2.0 (1.0)	2.2 (0.9)
Patient is "too old"	1.9 (0.9)	2.0 (0.8)	1.9 (0.9)
Patient may be offended	1.8 (0.8)	1.9 (0.9)	1.7 (0.7)
Being ashamed to bring up sexual health issues	1.7 (0.8)	1.6 (0.7)	1.7 (0.8)
Patient has a different gender	1.4 (0.6)	1.5 (0.7)	1.3 (0.6)

\*Means and SDs of responses regarding barriers to asking patients about sexual health issues (1 = strongly disagree; 4 = strongly agree).

**Table 2.** Correlations among age, years in medical practice, barriers to asking patients about sexual health, and the frequency of patient-physician conversations concerning sexual health or sexual dysfunctions (N = 102)

Variable	Variable, correlation															
	2.	3.	4.	5.	6.	7.	8.	9.	10.	11.	12.	13.	14.	15.	16.	17.
1. Gender <sup>†</sup>	-.31**	-.28**	.22*	.11	.13	-.17	.00	-.02	-.07	.12	-.04	-.11	.03	.05	.16	.24*
2. Age	—	.95**	.10	-.21*	-.27**	-.08	.11	.10	-.01	-.11	-.11	.13	.02	.08	.01	.03
3. Years in practice	—	—	.10	-.14	-.28**	-.14	.14	.04	-.06	-.13	-.17	.10	-.05	.06	.04	.02
4. Comfort	—	—	—	-.06	-.23*	-.11	.05	-.02	-.04	-.10	-.08	.05	-.13	.19	.27**	.21*
5. B: Not enough time	—	—	—	—	.32**	.05	.29**	.20*	.06	.14	-.17	.04	.27**	-.01	-.01	-.01
6. B: No training	—	—	—	—	—	.28**	.06	.25*	.29**	.26**	.08	.07	.23*	-.18	-.04	-.25*
7. B: Not own responsibility	—	—	—	—	—	—	.17	.22*	.18	.07	.41**	.12	.10	-.34**	-.46**	-.42**
8. B: Patient is “too ill”	—	—	—	—	—	—	—	.51**	.13	0.15	.07	.20*	-.01	-.06	-.10	-.04
9. B: Patient’s age	—	—	—	—	—	—	—	—	.31**	.23*	.17	.33**	.08	.03	-.05	.02
10. B: Fear of offending the patient	—	—	—	—	—	—	—	—	—	.67**	-.04	.40**	.09	-.07	.03	-.20*
11. B: Own shame	—	—	—	—	—	—	—	—	—	—	-.11	.33**	.16	-.05	-.04	-.19
12. B: Having no reason	—	—	—	—	—	—	—	—	—	—	—	-.16	.19	-.31**	-.34**	-.24*
13. B: Patient has a different gender	—	—	—	—	—	—	—	—	—	—	—	—	-.05	-.02	.00	-.09
14. B: Patient does not start	—	—	—	—	—	—	—	—	—	—	—	—	—	-.06	-.02	-.02
15. Patient initiated	—	—	—	—	—	—	—	—	—	—	—	—	—	—	.41**	.53**
16. F: Sexual health	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	.50**
17. F: Sexual dysfunctions	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—

B = barrier; F = frequency of discussing sexual health or sexual dysfunctions.

\* $P \leq .050$ .

\*\* $P \leq .010$ .

<sup>†</sup>The baseline was men = 1 (women = 2).

**Table 3.** Four logistic regression models (M1–M4) showing the strongest associations between barriers to patient-physician conversations concerning sexual health or sexual functioning and the frequency of such patient-physician conversations in everyday clinical practice (N = 102)

Variable	M1. Frequency of talking about sexual health, male physicians	M2. Frequency of talking about sexual health, female physicians	M3. Frequency of talking about sexual dysfunctions, male physicians	M4. Frequency of talking about sexual dysfunctions, female physicians
Model	$\chi^2(6) = 35.4^{***}$	$\chi^2(5) = 22.9^{***}$	$\chi^2(4) = 18.5^{***}$	$\chi^2(5) = 35.7^{***}$
Nagelkerke $R^2$	.71	.48	.43	.68
	Logistic regression model, standardized beta (SD)			
Years in medical practice	−0.7 (0.5)	0.1 (0.4)	−0.3 (0.3)	0.2 (0.4)
Comfort Barrier <sup>†</sup>	− <sup>‡</sup>	1.9 (0.8)*	− <sup>‡</sup>	− <sup>‡</sup>
Responsibility	−1.8 (0.8)*	−1.1 (0.4)**	− <sup>‡</sup>	−1.4 (0.5)**
Age	0.8 (0.7)	−0.8 (0.5)	1.0 (0.5)	− <sup>‡</sup>
Shame	−1.9 (1.0)*	− <sup>‡</sup>	−1.3 (0.6)*	−1.2 (0.7)
Reason	−0.7 (1.2)	− <sup>‡</sup>	− <sup>‡</sup>	− <sup>‡</sup>
Fear of offending patient	− <sup>‡</sup>	1.8 (0.8)*	− <sup>‡</sup>	− <sup>‡</sup>
Patient initiated	3.5 (1.2)**	− <sup>‡</sup>	2.2 (0.8)**	2.8 (1.0)**

\* $P \leq .050$ .\*\* $P \leq .010$ .\*\*\* $P \leq .001$ .

<sup>†</sup>Initially, all barriers were included in the logistic regression analyses; however, during the stepwise backward procedure barriers that did not significantly contribute to the model were conditionally removed from the model. The removed barriers are not shown in the table.

<sup>‡</sup>Barrier was not in the logistic regression model because of the stepwise backward procedure and the non-significant contribution to the model.

To assess how comfortable physicians felt about asking their patients about their sexual health, the question was asked: “How comfortable do/would you feel when asking a patient about his or her sexual health?” Physicians indicated their comfort on a 4-point Likert scale (1 = not at all; 4 = comfortable).<sup>18</sup>

## Procedure

The study was conducted at an Austrian university hospital. The data were collected online on the survey platform SoSci (der onlineFragebogen; <http://soscisurvey.de/>) from the end of November 2018 to the end of February 2019. A medical university e-mail distribution list that included all practicing physicians at this university hospital was used to reach potential participants. The invitation e-mail included information on the goal of the study, participation conditions, and a link to access the survey. Participation was voluntary, anonymous, and not associated with any compensation. No data are available on participants who chose not to participate. An online informed consent form was included at the beginning of the survey. Only persons who granted informed consent were able to access the online questionnaire. According to the Universities Act<sup>19</sup> and Hospitals and Health Resorts Act,<sup>20</sup> the current study did not require review by the medical university’s ethics committee. In total, the e-mail distribution list contained 568 e-mail addresses; of these, 143 persons

accepted the invitation and participated in the online study (estimated response rate, 25.2%).

## Statistical Analysis

Descriptive statistics of participants’ answers included the percentages and means of given responses. The correlations among age, years in medical practice, barriers to asking patients about sexual health, and the frequency of patient-physician conversations concerning sexual health or sexual functioning were calculated. Further gender differences were detected with  $\chi^2$  tests for categorical variables. Separate stepwise backward logistic regression models were calculated for female and male physicians.<sup>21</sup> The first 2 logistic regression models determined predictors for having had patient-physician conversations concerning sexual health. The third and fourth logistic regression models determined predictors for having had patient-physician conversations concerning, specifically, sexual dysfunctions. Each regression model was comprised of 4 steps. In the first step, years of being a physician were entered. In the following 3 steps, variables were entered into the model and conditionally removed from the model if they failed to significantly contribute to the model.<sup>21</sup> In the second step, each physician’s comfort estimate was entered and only retained in the model if it significantly contributed to the model. In the third step, all of the barriers to asking patients about sexual health were entered. Barriers that did

not significantly contribute to the model were conditionally removed from the model. Finally, in the same manner, the variable for patient initiation of a conversation concerning sexual dysfunctions was considered. The level of significance for all analyses was  $\alpha = .05$ . All statistical analyses were performed with SPSS 25.0 for Windows (IBM Corp; Armonk, NY).

## RESULTS

### Participants

In total, 143 physicians participated in the online study. Of these physicians, 27 were excluded from the analysis because they reported working in specialties that are unlikely to be concerned with patients' sexual health,<sup>1</sup> such as radiology, dentistry, ophthalmology, or other unspecified field of medicine. Another 14 participants did not respond to one or more variables that were included in the logistic regression analyses. After exclusions, the final sample included 102 full responses (53.9% women, 46.1% men). Male physicians were older (mean, 44.7 years; SD = 10.8) than female physicians (mean, 38.3 years; SD = 9.6) (Table 2). Men indicated having worked as a physician for a longer time (mean, 2.9 years [indicating 15–20 years of practice]; SD = 1.4) than did women (mean, 2.2 years [indicating 7–15 years of practice]; SD = 1.2) (Table 2). Physicians reported holding Austrian nationality (72.3%), German nationality (14.9%), Italian nationality (8.9%), or "other nationality" (4.0%). Many physicians belonged to the surgical department (41.2%). The other participants belonged to the departments of internal medicine (14.7%), neurology (13.7%), psychiatry (7.8%), gynecology (5.9%), pediatric medicine (5.9%), dermatology (4.9%), nuclear medicine (3.9%), and otolaryngology (2.0%).

### Frequency of Patient-Physician Conversations Concerning Sexual Health

Of the male physicians, 53.2% talked about sexual health with their patients in everyday practice. A similar percentage of female physicians (69.1%;  $\chi^2(1) = 2.7$ ;  $P = .100$ ) reported the same. More female physicians talked about sexual dysfunctions in their everyday clinical practice (71.9%) than did male physicians (51.1%;  $\chi^2(1) = 4.2$ ;  $P = .040$ ). As many female physicians (56.4%) as male physicians (51.1%;  $\chi^2(1) = 0.3$ ;  $P = .592$ ) reported that at least some of their patients had initiated a conversation about sexual health in the past.

### Barriers Associated with Patient-Physician Conversations Concerning Sexual Health

Physicians' barriers to asking patients about sexual health are listed in Table 1. The most common barrier was having no reason to talk about sexual health or the patient not initiating such a conversation. Furthermore, many physicians did not feel responsible for this aspect of their patients' health. On average, physicians did not think that feeling ashamed or the patient having a different gender than themselves was a barrier

to having a patient-physician conversation about sexual health (Table 1).

Correlations among age, years in medical practice, barriers to asking patients about sexual health, and the frequency of patient-physician conversations concerning sexual health or sexual dysfunctions are shown in Table 2. Older physicians were less likely than younger physicians to name time constraints and lack of training as barriers for not talking about sexual health with their patients. Furthermore, the longer a physician practiced medicine the less likely he or she was to indicate a lack of training as reason for not including the topic of sexual health during patient-physician conversations. Female physicians did not differ from male physicians in their indications of barriers to such conversations; however, female physicians reported feeling less comfortable asking their patients about sexual health than did male physicians. Nevertheless, they more frequently talked about sexual dysfunctions with their patients than did male physicians (Table 2).

Logistic regression models revealed that male physicians who agreed about shame being a barrier were not likely to have had conversations about sexual health in general or about sexual dysfunctions in their everyday clinical practice (Table 3). Additionally, feeling that talking about sexual health was not their responsibility reduced the likelihood of male physicians having had conversations about sexual health in their everyday clinical practice. The strongest predictor for having had patient-physician conversations about sexual health or sexual dysfunctions was initiation of this topic by the patient (Table 3). The other variables did not significantly contribute to the logistic regression models concerning male physicians.

For female physicians, the strongest predictor of not having had conversations about sexual health or sexual dysfunctions in everyday practice was the physician's standpoint that she was not responsible for this health issue (Table 3). A positive predictor of female physicians having had patient-physician conversations about sexual dysfunctions was initiation of this topic by the patient. Female physicians who felt comfortable talking about sexual health were more likely to have had patient-physician conversations concerning sexual health than were female physicians who felt uncomfortable during such conversations. Fear of offending the patient was a positive predictor for having patient-physician conversations about sexual health (Table 3). No other variables significantly contributed to the logistic regression models concerning female physicians.

## DISCUSSION

Sexual health and, specifically, sexual functioning are medical health topics that many medical disciplines should address because of the association that many physical and mental health problems and diseases have with sexual health and sexual functioning.<sup>1,5,6,22</sup> In the current study, physicians at an Austrian medical university hospital across a range of medical disciplines were asked whether they addressed patients' sexual health or

specifically sexual dysfunctions in everyday practice. The focus of the study was to determine which barriers to patient-physician conversations concerning sexual health could predict the frequency of patient-physician conversations about sexual health or sexual dysfunctions.

Previous studies showed that patients prefer their physicians to initiate the topic of sexual health and they would like their physicians to actively ask questions about sexual health.<sup>3,23–26</sup> However, the current study and previous studies<sup>13,27,28</sup> revealed that physicians rarely include topics of sexual health or sexual functioning in patient-physician conversations, which is probably due to not feeling responsible, being afraid of offending patients, or feelings of shame. In line with previous studies, in the current study patient-physician conversations concerning sexual health or sexual functioning were likely to take place only at the patient's initiative.<sup>15,29</sup> In contrast to other studies,<sup>30–33</sup> in the current study the lack of time was not a prominent barrier to patient-physician conversations concerning sexual health or sexual functioning.

These results demonstrate that there should be clearer agreement and training in responsibilities,<sup>14</sup> because in all the medical disciplines that were included in the study sexual health or sexual functioning may be affected by a physical difficulty or illness specific to the respective discipline.<sup>1,5,6</sup> It is important that physicians recognize the interconnectedness of sexual health and other medical conditions that they often encounter in their respective medical disciplines<sup>22</sup> and as a result feel more responsible for sexual health. During continued training or during supervision, physicians should additionally learn how to overcome feelings of shame or how to handle patients' negative reactions during patient-physician conversations concerning sexual health. This may help physicians who have experienced such negative reactions toward the discussion of sexual health in their practice to better cope with such reactions and prevent them from being afraid to offer future patient-physician conversations concerning sexual health.

One of the study's limitations is the relatively low response rate. It may be that most of the physicians who participated in the study were interested in sexual health. This may have led to an overestimation of the frequency of patient-physician conversations concerning sexual health; therefore, the sample is not representative of all physicians at this university hospital, and results should not be overgeneralized. In connection with the low response rate, it was not possible to analyze physicians' responses on the basis of the different medical departments in which they worked. Such an analysis may have shed insights on whether physicians in different departments perceive similar barriers or whether some departments cover patients' sexual health to a greater extent than others. Even though the list of barriers included in the questionnaires was based on previous studies,<sup>8,13,15–17</sup> the list was not exhaustive. Therefore, in future studies, additional open-ended questions should be included in order to assess additional (currently missed) barriers. Finally, as is the case with many questionnaire studies, the physician self-reports may have been

biased; for example, the physicians may not have correctly remembered all occasions of patient-physician conversations concerning sexual health or may not have recollected such events. Additionally, social desirability (ie, the wish to withhold or tell certain information in order to present oneself in a certain socially desirable way) may have biased the results of the current study.<sup>34</sup>

## CONCLUSION

The current study shows that patient-physician conversations concerning sexual health are seldom part of everyday clinical practice for university hospital physicians from a range of medical disciplines. The main reason for not initiating such conversations seems to be the physician's uncertainty about who is responsible for initiating the conversation. Most often the responsibility was passed to the patients. Fear of offending a patient and one's own feelings of shame and discomfort were factors influencing the frequency of patient-physician conversations concerning sexual health. Future physician training should focus on these aspects and help physicians overcome the barriers to patient-physician conversations concerning sexual health.

**Corresponding author:** Nikola Komlenac, PhD, Gender Medicine Unit, Medical University of Innsbruck, Fritz-Pregl-Straße 3, 6020 Innsbruck, Austria. Tel: +43 512 9003-71859; Fax: +43 512 9003-74859; E-mail: [nikola.komlenac@i-med.ac.at](mailto:nikola.komlenac@i-med.ac.at)

*Conflict of Interest:* None.

*Funding:* None.

## STATEMENT OF AUTHORSHIP

### Category 1

- (a) **Conception and Design**  
Nikola Komlenac; Margarethe Hochleitner
- (b) **Acquisition of Data**  
Nikola Komlenac
- (c) **Analysis and Interpretation of Data**  
Nikola Komlenac

### Category 2

- (a) **Drafting the Article**  
Nikola Komlenac
- (b) **Revising It for Intellectual Content**  
Nikola Komlenac; Margarethe Hochleitner

### Category 3

- (a) **Final Approval of the Completed Article**  
Nikola Komlenac; Margarethe Hochleitner

## REFERENCES

1. Rösing D, Klebingat K-J, Berberich HJ, et al. Sexualstörungen des Mannes Diagnostik und Therapie aus sexualmedizinisch-interdisziplinärer Sicht. *Dtsch Arztebl* 2009;106:821-828.
2. Polland AR, Davis M, Zeymo A, et al. Association between comorbidities and female sexual dysfunction: findings from

- the third National Survey of Sexual Attitudes and Lifestyles (Natsal-3). *Int Urogynecol J* 2019;30:377-383.
3. Dias R, Alarcão V, da Mata S, et al. Erectile dysfunction in primary care: sexual health inquiry and cardiovascular risk factors among patients with no previous cardiovascular events. *Rev Port Saú Públ* 2016;34:250-258.
  4. McCabe MP, Sharlip ID, Lewis R, et al. Risk factors for sexual dysfunction among women and men: a consensus statement from the fourth International Consultation on Sexual Medicine 2015. *J Sex Med* 2016;13:153-167.
  5. Kandeel FR, Koussa VKT, Swerdloff RS. Male sexual function and its disorders: physiology, pathophysiology, clinical investigation, and treatment. *Endocr Rev* 2001;22:342-388.
  6. Khajehei M, Doherty M, Tilley PJM. An update on sexual function and dysfunction in women. *Arch Womens Ment Health* 2015;18:423-433.
  7. Althof SE, Rosen RC, Perelman MA, et al. Standard operating procedures for taking a sexual history. *J Sex Med* 2013;10:26-35.
  8. Dyer K, das Nair R. Why don't healthcare professionals talk about sex? A systematic review of recent qualitative studies conducted in the United Kingdom. *J Sex Med* 2013;10:2658-2670.
  9. Ribeiro S, Alarcao V, Simoes R, et al. General practitioners' procedures for sexual history taking and treating sexual dysfunction in primary care. *J Sex Med* 2014;11:386-393.
  10. Humphery S, Nazareth I. GPs' views on their management of sexual dysfunction. *Fam Pract* 2001;18:516-518.
  11. Ussher JM, Perz J, Gilbert E, et al. Talking about sex after cancer: a discourse analytic study of health care professional accounts of sexual communication with patients. *Psychol Health* 2013;28:1370-1390.
  12. Korse NS, Nicolai MPJ, Both S, et al. Discussing sexual health in spinal care. *Eur Spine J* 2016;25:766-773.
  13. Nicolai MPJ, Both S, Liem SS, et al. Discussing sexual function in the cardiology practice. *Clin Res Cardiol* 2013;102:329-336.
  14. van Hees PJM, van der Plas AA, van Ek GF, et al. Discussing sexuality with patients with Parkinson's disease: a survey among Dutch neurologists. *J Neural Transm* 2017;124:361-368.
  15. Cedzich DA, Bosinski HA. Sexualmedizin in der hausärztlichen Praxis: Gewachsenes Problembewusstsein bei nach wie vor unzureichenden Kenntnissen. *Sexuologie* 2010;17:135-147.
  16. Byrne M, Doherty S, Murphy AW, et al. Communicating about sexual concerns within cardiac health services: do service providers and service users agree? *Patient Educ Couns* 2013;92:398-403.
  17. Frederick NN, Campbell K, Kenney LB, et al. Barriers and facilitators to sexual and reproductive health communication between pediatric oncology clinicians and adolescent and young adult patients: the clinician perspective. *Pediatr Blood Cancer* 2018;65:27087.
  18. White W, Brenman S, Paradis E, et al. Lesbian, gay, bisexual, and transgender patient care: medical students' preparedness and comfort. *Teach Learn Med* 2015;27:254-263.
  19. Federal Act on the Organisation of Universities and their Studies (Universitätsgesetz 2002—UG). Federal Law Gazette | No. 120/2002, amended by Federal Law Gazette | No. 11/2017 2002/amended; 2017.
  20. Hospitals and Health Resorts Act (Bundesgesetz über Krankenanstalten und Kuranstalten—KAKuG). Federal Law Gazette | No. 1/1957, amended by Federal Law Gazette | No. 3/2016 1957/amended; 2016.
  21. Field A. *Discovering statistics using SPSS*. 3rd edition. London: Sage Publications; 2009.
  22. Satcher D. The Surgeon General's call to action to promote sexual health and responsible sexual behavior. *Am J Health Educ* 2001;32:356-368.
  23. Wittenberg A, Gerber J. Recommendations for improving sexual health curricula in medical schools: results from a two-arm study collecting data from patients and medical students. *J Sex Med* 2009;6:362-368.
  24. Komlenac N, Siller H, Bliem HR, et al. Associations between gender role conflict, sexual dysfunctions, and male patients' wish for physician—patient conversations about sexual health. *Psychol Men Masc* 2019;20:337-346.
  25. Hartmann U, Nicolosi A, Glasser DB, et al. Sexualität in der Arzt-Patient-Kommunikation. Ergebnisse der "Globalen Studie zu sexuellen Einstellungen u. Verhaltensweisen." *Sexuologie* 2002;9:50-60.
  26. Meystre-Agustoni G, Jeannin A, de Heller K, et al. Talking about sexuality with the physician: are patients receiving what they wish? *Swiss Med Wkly* 2011;141:7.
  27. van Ek GF, Krouwel EM, Nicolai MP, et al. Discussing sexual dysfunction with chronic kidney disease patients: practice patterns in the office of the nephrologist. *J Sex Med* 2015;12:2350-2363.
  28. Kottmel A, Ruether-Wolf KV, Bitzer J. Do gynecologists talk about sexual dysfunction with their patients? *J Sex Med* 2014;11:2048-2054.
  29. Gilbert E, Perz J, Ussher JM. Talking about sex with health professionals: the experience of people with cancer and their partners. *Eur J Cancer Care* 2016;25:280-293.
  30. Gott M, Galena E, Hinchliff S, et al. "Opening a can of worms": GP and practice nurse barriers to talking about sexual health in primary care. *Fam Pr* 2004;21:528-536.
  31. Schloegl I, Köhn FM, Dinkel A, et al. Education in sexual medicine: a nationwide study among German urologists/andrologists and urology residents. *Andrologia* 2017;49:e12611.
  32. Alarcao V, Ribeiro S, Miranda FL, et al. General practitioners' knowledge, attitudes, beliefs, and practices in the management of sexual dysfunction: results of the Portuguese SEXOS study. *J Sex Med* 2012;9:2508-2515.
  33. Rashidian M, Minichiello V, Knutsen SF, et al. Barriers to sexual health care: a survey of Iranian-American physicians in California, USA. *BMC Health Serv Res* 2016;16:263.
  34. Choi BCK, Pak AWP. A catalog of biases in questionnaires. *Prev Chronic Dis* 2005;2:A13.