

ORIGINAL RESEARCH—EDUCATION

Frequency and Focus of Sexual History Taking in Male Patients—A Pilot Study Conducted among Swiss General Practitioners and Urologists

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ABSTRACT

Introduction. General practitioners (GPs) and urologists are the first medical contacts for men with sexual dysfunction. Previous studies have shown that many GPs hesitate to address sexual issues and little is known about the sexological skills of urologists.

Aim. To analyze sexual history taking (SHT) by Swiss GPs and urologists, in terms of active exploration, focus, and competence in discussing and treating sexual dysfunction.

Methods. A semi-structured interview was developed and used in face-to-face encounters with 25 GPs and 25 urologists.

Main Outcome Measures. Content and frequency of interview responses.

Results. Urologists reported a significantly higher frequency of actively asking male patients about sexual dysfunction (22.80% vs. 10.42%, $P = 0.01$). GPs and urologists avoided actively asking certain patient groups about sexual dysfunction (e.g., “immigrants,” “macho men”). GPs reported a significantly lower percentage of male patients who spontaneously address sexual problems (6.35% vs. 18.40%, $P < 0.001$). Both physician groups emphasized erectile dysfunction in SHT. Eight percent of GPs and 28% of urologists considered their competence in discussing sexual dysfunction as very good. No GP and 20% of urologists considered their competence in treating sexual dysfunction as very good. Urologists reported having significantly greater competence in discussing ($P = 0.02$) and treating ($P < 0.001$) sexual dysfunction than the GPs. Competence in discussing correlated positively with competence in treating sexual dysfunction for GPs ($P = 0.01$) and urologists ($P < 0.001$). The majority of GPs (92%) and urologists (76%) reported a need for continuing education in sexual issues.

Conclusions. Our results justify establishing guidelines for SHT in Switzerland to better meet the sexual health needs of male patients. Physicians should be encouraged to routinely inquire about sexual issues, overcome their discomfort with the subject, and regard male sexuality as more than erectile function. A clear need exists for relevant continuing education for Swiss GPs and urologists. **Platano G, Margraf J, Alder J, and Bitzer J. Frequency and focus of sexual history taking in male patients—A pilot study conducted among Swiss general practitioners and urologists. J Sex Med 2008;5:47–59.**

Key Words. Sexual History Taking; General Practitioners; Urologists; Active Exploration; Focus; Sense of Competence

Introduction

Much is known about the prevalence of male sexual dysfunction. Average prevalence rates indicate that 20–30% of adult men have at least one

manifest sexual dysfunction [1–3]. The Pfizer Global Study of Sexual Attitudes and Behaviors found that an average of 42% of men aged 40–80 years reported sexual difficulties lasting two or more months within the preceding 12 months [4].

These prevalences can vary by region and severity of the condition [5]. Detailed results from a decade of research on the prevalence of sexual dysfunction have been reported by Simons and Carey [6].

Studies that focus on how general practitioners (GPs) deal with male sexual dysfunction report that many hesitate to address sexual issues, although patients would appreciate their doctor initiating such a discussion [4,7–10]. GPs are normally considered the first medical contacts for men with sexual dysfunction because they usually know about the personal and family situation of their patients [11,12]. Many of them refer their patients with sexual problems to urologists [8], especially in cases where the effect of specific medication such as phosphodiesterase type 5 (PDE5) inhibitors is limited. Although urologists are often confronted with sexual dysfunction in men, little is known about their sexological skills or what approach they take with patients for whom psychosocial factors are identified as the main cause of the sexual dysfunction [10,13–15].

This pilot study examines the possible effects of the introduction of PDE5 inhibitors on how physicians address sexual problems with their male patients. For the purpose of the study, we developed a two-part semi-structured interview to be used in face-to-face encounters with GPs in the greater Basel area and with urologists in six of the main urban areas in German-speaking Switzerland. We examined three hypotheses: (i) the introduction of PDE5 inhibitors has led GPs and urologists in our region to regularly ask their male patients about sexual problems; (ii) the introduction of PDE5 inhibitors has contributed to a strong focus on erectile dysfunction by GPs and urologists, and (iii) the introduction of PDE5 inhibitors has increased the feeling of competence in dealing with sexual issues for a majority of GPs and urologists. Part I of the semi-structured interview aimed to determine how actively these physicians explore male sexual dysfunction, what they focus on, and how competent they feel in talking about and in treating male sexual dysfunction. In part II, we explored the detailed characteristics of sexual history taking (SHT) and therapeutic decision making. The results of part II will be reported separately.

Methods

Sample

To detect a significant difference between GPs and urologists, we estimated that a sample consisting of 25 GPs and 25 urologists was necessary.

Using <http://www.medindex.ch/>, we generated a list of 217 male and female GPs in the greater Basel area. These 217 GPs were grouped as follows: male GPs, female GPs, GPs practicing in the city of Basel, and GPs practicing in the metropolitan area around Basel. From these subgroups, 105 GPs were randomly contacted by mail and were asked to participate. Twenty-five GPs responded positively (10 male and 3 female GPs from the city, and 10 male and 2 female GPs from the metropolitan area).

The sample of urologists was also recruited using <http://www.medindex.ch/>. A total of 69 board-certified urologists was identified in six of the main urban areas of German-speaking Switzerland. To ensure a sample drawn from across this entire pool, no randomization was applied. A total of 52 candidates had to be contacted in order to obtain 25 urologists willing to participate. The sample consisted of 12 urologists who were heads of urology departments and 13 urologists in private practice.

In all of Switzerland, there are 144 male and only 3 female urologists. Therefore, we decided to allow an all-male sample of urologists. Because five female GPs were willing to participate in the study, we decided to include them, which resulted in the gender distribution reported for the GPs.

Material

The Appendix shows part I of the English translation of our semi-structured interview. It contains five elements: (i) standard demographic questions, (ii) eight questions referring to active exploration of male sexual dysfunction in SHT, (iii) seven questions referring to male sexual dysfunction caused by a primary organic, endocrine, mental, or substance-induced disease, (iv) three questions referring to active initiation of discussion about male sexual dysfunction by patients, and (v) three questions referring to the self-reported sense of competence in discussing and treating male sexual dysfunction and the need for continuing education in this area. The questions for part I were formulated based upon the recommendations and guidelines on men's sexual dysfunction published in the inaugural issue of the *Journal of Sexual Medicine* [16] and the recommendations on the diagnosis and therapy of sexual dysfunction published by the German Academy of Sexual Medicine [17], and in the literature dealing with the etiology of male sexual dysfunctions. We included open and closed questions. The entire semi-structured interview was validated by elaborating a final version in a continuous personal exchange with two of the

main experts on sexuality issues in Switzerland (face validation), one of whom is a head physician at the University Hospital Basel and the other an acknowledged expert on sex therapy in German-speaking Switzerland. The final version was pilot tested for content validity with a physician at the University Hospital Basel who formerly worked as a GP.

Outcome Measures

Outcome measures for *active exploration* in SHT were based on questions 1, 6, and 16 of the semi-structured interview (see Appendix).

Outcome measures for *focus* in SHT were based on questions 9, 10, and 11 of the semi-structured interview (see Appendix).

Outcome measures for the self-reported *sense of competence* in SHT were based on questions 51, 52, and 53 of the semi-structured interview (see Appendix).

Procedure

The interviews were conducted by the first author and took place from January 2005 to November 2006. The interviewer visited each participating physician at his or her practice and noted the answers concurrently on the response sheet. Each interview was audio recorded on tape for documentation purposes and to ensure accuracy and completeness. Informed consent was not required.

Statistical Analysis

For all tests performed, the alpha level was set at 0.05. Kolmogorov–Smirnov tests were performed to assess the data's distribution. SPSS 12.0 for Windows (SPSS Inc, Chicago, IL, USA) was used to analyze the data.

Active Exploration

Nonparametric tests (Mann–Whitney, chi-square) were performed to determine any significant differences between the GPs and urologists.

Focus

For each interviewee the total number of sexual dysfunctions reported per disease category was set in relation to the total number of diseases reported per category. These ratios were then used as variables in a nonparametric test (Mann–Whitney) to identify any significant differences between GPs and urologists.

Sense of Competence

Descriptive statistics on ordinal variables, nonparametric tests (Mann–Whitney, chi-square), and

Table 1 Sociodemographic details

	GPs (N = 25)	Urologists (N = 25)
Sex		
Male	20 (80.0)	25 (100.0)
Female	5 (20.0)	—
Marital status		
Single	2 (8.0)	1 (4.0)
Married	19 (76.0)	20 (80.0)
Divorced	3 (12.0)	4 (16.0)
Widowed	1 (4.0)	—
Mean age (SD) (years)	51.76 (8.07)	50.16 (9.15)
Mean experience in field (SD) (years)	15.90 (8.67)	14.40 (8.04)
Mean duration of interview (SD) (minutes)	49.20 (15.05)	58.60 (21.14)

Figures in parentheses = %, unless noted otherwise.
GP = general practitioner; SD = standard deviation.

a correlation (Spearman's rho) were applied to assess any significant differences between the GPs and urologists.

Results

The main demographic details of the sample are reported in Table 1.

Active Exploration

The first hypothesis, which stated that the introduction of PDE5 inhibitors has led GPs and urologists in our region to regularly ask their male patients about sexual problems, was not confirmed. The frequencies reported by both physician groups with which they actively ask about sexual dysfunction were below the prevalence rates normally reported for sexual dysfunction. The sample as a whole reported asking 16.61% (standard deviation [SD] = 20.49, median (*Mdn*) = 10.0) of their male patients actively about sexual dysfunction. GPs asked 10.42% (SD = 16.14, *Mdn* = 5.0), and urologists asked 22.80% (SD = 22.74, *Mdn* = 15.0) of their male patients actively about sexual problems, which represents a significant difference between the two physician groups (Mann–Whitney $U = 170.0$, $P = 0.01$). Furthermore, 12 GPs (48%) and 14 urologists (56%) reported situations in which they actively avoided asking male patients about sexual dysfunction. Here, a chi-square test showed no significant difference between the two groups ($X^2 [1, N = 50] = 0.32$, $P = 0.57$).

The frequencies reported by the physicians in both groups with which they were actively addressed about sexual problems by their male patients were below the prevalence rates normally

Table 2 Which sexual problems do you ask about in connection with the diseases you mentioned?

	Organic diseases*		Endocrine diseases†		Mental health problems‡	
	GPs (N = 25)	Urologists (N = 25)	GPs (N = 25)	Urologists (N = 25)	GPs (N = 25)	Urologists (N = 25)
None	—	1 (1.0)	1 (2.1)	—	—	—
Hypoactive sexual desire disorder	20 (20.6)	11 (10.6)	10 (20.8)	13 (25.5)	38 (40.4)	7 (24.1)
Male erectile disorder	54 (55.7)	57 (54.8)	28 (58.3)	27 (52.9)	33 (35.1)	14 (48.3)
Male orgasmic disorder	3 (3.1)	11 (10.6)	2 (4.2)	5 (9.8)	4 (4.3)	2 (6.9)
Premature ejaculation	14 (14.4)	17 (16.3)	6 (12.5)	6 (11.8)	15 (16.0)	6 (20.7)
Dyspareunia	5 (5.2)	6 (5.8)	1 (2.1)	—	2 (2.1)	—
Sexual aversion disorder	—	—	—	—	—	—
Substance-induced sexual disorder	1 (1.0)	—	—	—	1 (1.1)	—
Others	—	1 (1.0)	—	—	1 (1.1)	—
Total responses	97 (100.0)	104 (100.0)	48 (100.0)	51 (100.0)	94 (100.0)	29 (100.0)

Number of times the sexual problem was mentioned by interviewees; figures in parentheses = %.

*Includes urological, cardiovascular, neurological, and other somatic (infectious, rheumatoid, etc.) diseases.

†Includes diabetes, hypogonadismus, hypothyrosis, and hyperthyrosis.

‡Includes depression, anxiety disorders, and substance-related disorders.

GP = general practitioner.

reported. The sample as a whole reported that 12.37% (SD = 15.67, *Mdn* = 10.0) of male patients actively addressed a sexual problem during consultation. GPs indicated that 6.35% (SD = 6.65, *Mdn* = 5.0) of their male patients actively addressed a sexual problem during consultation, while urologists reported a figure of 18.40% (SD = 19.53, *Mdn* = 15.0). This difference was found to be significant (Mann–Whitney $U = 120.50$, $P < 0.001$).

Focus

The second hypothesis, which stated that the introduction of PDE5 inhibitors has contributed to a strong focus on erectile dysfunction by GPs and urologists, was confirmed. Table 2 shows the sexual dysfunctions named by interviewees about which they asked their male patients, classified by physician group and disease category. In the context of organic diseases, erectile dysfunction was the main sexual dysfunction asked about: 55.7% of the GPs' answers and 54.8% of the urologists' answers referred to erectile dysfunction. In the context of endocrine diseases, erectile

dysfunction was also the main sexual dysfunction asked about: 58.3% of the GPs' answers and 52.9% of the urologists' answers referred to erectile dysfunction. In the context of mental health problems, the sexual dysfunction asked about most frequently by GPs was hypoactive sexual desire disorder (40.4%), followed by erectile dysfunction (35.1%), while urologists asked primarily about erectile dysfunction (48.3%).

Table 3 shows the ratios between the number of sexual dysfunctions asked about and the number of diseases indicated in the corresponding disease category. In the context of organic diseases, the mean number of sexual dysfunctions asked about was 1.54 (SD = 0.78) by GPs and 1.71 (SD = 0.89) by urologists, which represents a nonsignificant difference (Mann–Whitney $U = 239.50$, $P = 0.30$). In the context of endocrine diseases, the mean number of sexual dysfunctions asked about was 1.47 (SD = 0.91) by GPs and 1.69 (SD = 0.88) by urologists, which likewise represents a nonsignificant difference (Mann–Whitney $U = 166.0$, $P = 0.16$). In the context of mental health problems, the mean number of sexual dysfunctions

Table 3 Mean number of sexual dysfunctions asked about by disease category, expressed as the ratio of the total number of sexual dysfunctions indicated in a disease category vs. the total number of diseases indicated in that category

	GPs (N = 25)			Urologists (N = 25)			<i>P</i>
	Ratio	SD	Range	Ratio	SD	Range	
Organic diseases*	1.54	0.78	0.67–3.50	1.71	0.89	1.00–4.00	0.30
Endocrine diseases†	1.47	0.91	0.67–4.50	1.69	0.88	1.00–4.00	0.16
Mental health problems‡	2.13	0.85	1.00–4.75	2.09	0.54	1.00–3.00	0.64

*Includes urological, cardiovascular, neurological, and other somatic (infectious, rheumatoid, etc.) diseases.

†Includes diabetes, hypogonadismus, hypothyrosis, and hyperthyrosis.

‡Includes depression, anxiety disorders, and substance-related disorders.

GP, general practitioner; SD = standard deviation.

asked about was 2.13 (SD = 0.85) by GPs and 2.09 (SD = 0.54) by urologists, which also represents a nonsignificant difference (Mann–Whitney $U = 123.50$, $P = 0.64$).

Sense of Competence

The third hypothesis, which stated that the introduction of PDE5 inhibitors has increased the feeling of competence in a majority of GPs and urologists when dealing with sexual issues, was not confirmed. Table 4 shows how competent GPs and urologists felt in talking about and treating sexual dysfunction. Two GPs (8%) and 7 urologists (28%) rated their competence in *discussing* sexual dysfunction as very good, 12 GPs (48%) and 13 urologists (52%) as good, and 11 GPs (44%) and 5 urologists (20%) as moderate, sufficient, or insufficient. Hence, urologists felt significantly more competent in this respect than GPs (Mann–Whitney $U = 198.50$, $P = 0.02$). Furthermore, in terms of competence in *treating* sexual dysfunction, no GP (0%) and 5 urologists (20%) rated themselves as very good, 10 GPs (40%) and 15 urologists (60%) as good, and 15 GPs (60%) and 5 urologists (20%) as moderate, sufficient, or insufficient. Here, too, the urologists felt significantly more competent than the GPs (Mann–Whitney $U = 132.50$, $P < 0.001$). Self-reported competence in discussing sexual dysfunction correlated positively with self-reported competence in treating sexual dysfunction for both the GPs ($r[25] = 0.55$, $P = 0.01$) and the urologists ($r[25] = 0.74$, $P < 0.001$).

Twenty-three GPs (92%) and 19 urologists (76%) indicated a need for continuing education on sexual issues. A chi-square test showed no significant relationship between the perceived need for continuing education and the type of physician ($X^2 [1, N = 50] = 2.38$, $P = 0.12$).

Discussion

The results presented earlier are discussed here with respect to the content of the three hypotheses underlying the study.

Active Exploration

Our findings do not support the hypothesis that the introduction of PDE5 inhibitors has led Swiss GPs and urologists to ask their male patients more frequently about sexual problems. The frequency with which the sample as a whole (16.61%) and particularly the GPs (10.42%) reported that they actively ask about sexual dysfunction was below the prevalence rates of 20–30% for sexual dysfunction [1–6]. Fifty percent of the GPs even reported a frequency of only 5% or less ($Mdn = 5$). Similarly, although the average frequency reported by the urologists (22.80%) was in the overall prevalence range of 20–30%, here too, a high proportion of the respondents (50%) reported low frequencies of only 15% or less ($Mdn = 15$). It should be remembered that many male patients with sexual problems are sent to urologists by GPs. The urologist consequently already knows about the patient's sexual problem, which makes exploration in these cases easier. Our findings suggest that urologists are more accurate in exploring a sexual problem when the patient is referred by a GP than they are when routinely asking actively about sexual problems. In addition, many urological patients have had surgical interventions (e.g., prostatectomy) or are on medication that impact on sexual functioning. Given these considerations, urologists could be expected to report frequencies exceeding the usual prevalence rates. The Pfizer Global Study of Sexual Attitudes and Behaviors [4] has concluded that worldwide, only 9% of men and women report having been asked by their physician about sexual difficulties within the last 3

Table 4 How do you assess your competence in discussing and treating the sexual problems of your male patients?

	Self-reported competence in discussing			Self-reported competence in treating		
	GPs (N = 25)	Urologists (N = 25)	P^*	GPs (N = 25)	Urologists (N = 25)	P^*
Insufficient	1 (4.0)	—	—	3 (12.0)	—	—
Sufficient	3 (12.0)	—	—	9 (36.0)	—	—
Moderate	7 (28.0)	5 (20.0)	—	3 (12.0)	5 (20.0)	—
Good	12 (48.0)	13 (52.0)	—	10 (40.0)	15 (60.0)	—
Very good	2 (8.0)	7 (28.0)	—	—	5 (20.0)	—
	—	—	0.02	—	—	<0.001

Figures in parentheses = %, unless noted otherwise.

*Mann–Whitney test: GPs vs. urologists.

GP = general practitioner.

years. Our findings suggest that Swiss GPs and urologists feel rather uncomfortable addressing this issue. This is supported by the fact that the average frequency reported by our sample of GPs (10.42%) is consistent with the outcome of the Pfizer study. The average frequency reported by our sample of urologists (22.8%) may also be regarded as consistent with the outcome of the Pfizer study, given that the corresponding median is only 15%. Furthermore, the Pfizer study also found there were differences from country to country in the rates men and women reported being asked by their physician about sexual problems, for example, 25% in Thailand, 17% in Brazil, 14% in the United States, and 11% in Germany. Looking at the average result for our sample of GPs and the medians for both the GPs and urologists in our study, Switzerland would seem to be at the low end of the scale by national comparison. It may be argued that if attitudes among Swiss GPs and urologists about exploring sexual problems with their male patients could predominantly be characterized as “comfortable” and “routine,” our findings should be much closer to the overall prevalence rates or even exceed them. That many GPs and urologists feel uncomfortable inquiring about sexual problems is also supported by our finding that almost half of our interviewees reported that with certain patient groups, they *avoid* actively asking about sexual dysfunction. The most frequently cited groups were immigrants (insecurity about cultural values) and what physicians described as “macho men” (patients who might regard being asked about sexual problems as an offense to their self-image). This is consistent with previous research [9–11,18] showing that in many patient–physician settings, sexual health is still not discussed routinely. In addition, the physicians in our sample reported a rather low percentage of male patients who themselves actively address a sexual problem during consultation (GPs 6.35%, urologists 18.40%), in view of which the median values for GPs (5%) and urologists (15%) stated earlier need to be viewed in an even more critical light. It may thus be concluded that Swiss GPs and urologists need to overcome their discomfort in discussing sexual health issues with their male patients so they can appropriately address these patients’ sexual health concerns.

Focus

The study confirmed the hypothesis that the introduction of PDE5 inhibitors has contributed to a

strong focus on erectile dysfunction by GPs and urologists. For several reasons, an overly strong focus on erectile dysfunction during SHT may be detrimental. First, male sexuality encompasses much more than erectile function, which is underscored by World Health Organization definitions of sexual health and definitions of sexuality not exclusively concentrating on organic or physiological aspects [19]. Current concepts of sexuality, sexual health, and sexual dysfunction are based on a biopsychosocial model considering the possible interactions of biological, psychological, and social dimensions when dealing with these issues [16,19,20]. Even if the main reason behind sexual dysfunction is organic in many cases, sexual dysfunction will have psychological and/or social impacts [13]. In addition, many chronic diseases, surgical interventions, and medical therapies including medication have a direct impact not only on erectile function but also on desire and ejaculation. Studies reporting substantial prevalence rates for hypoactive sexual desire disorder and ejaculation disorder suggest that these disorders should receive due attention in SHT [8,16,21,22]. In our sample, urologists seem to focus especially strongly on erectile dysfunction—a condition for which medication such as PDE5 inhibitors is available. Not asking routinely about possible disorders of desire and ejaculation may be an expression of diagnostic and therapeutic helplessness among both GPs and urologists alike. In fact, many physicians in our sample consider patients with these latter conditions to be very time-consuming and often choose to refer them to a psychologist/psychiatrist.

Sense of Competence

The third hypothesis, stating that the introduction of PDE5 inhibitors has had a positive effect on GPs’ and urologists’ feelings of competence in discussing and treating male sexual problems, was not confirmed. Our findings suggest that especially GPs do not feel sufficiently competent in dealing with male sexual dysfunction, which is in line with corresponding research [7,8,11,12,15,18]. This is additionally supported by the fact that many GPs refer male patients with sexual dysfunction to urologists. Although a majority of urologists rated their competence in discussing and treating sexual problems as good, this judgment may be biased by the generally strong focus on erectile dysfunction and the fact that sexual problems that have already been reported via the referral process are easier to explore more accurately. Furthermore, our data

show a positive correlation between self-reported competence in discussing and treating sexual problems. This emphasizes how increased competence in one skill has positive effects on the other. We therefore conclude that increasing physicians' competence in discussing patients' sexual problems would lead to more frequent and accurate exploration and better treatment of sexual problems. The need to increase competence in both areas is additionally reflected by the fact that a majority in our sample expressed a desire for further education in sexual medicine.

Some limitations in our study should be noted. No direct pre-/post measurement could be performed, because for the variables examined, there is no data available for the time before PDE5 inhibitors were introduced. Results can only be partly generalized because of the size of the sample and its limited representativeness. We had to choose a regionally defined sample of physicians and, because of the decision to perform a 1-hour face-to-face interview, we had to limit the size of the sample. We contacted 48% of the GPs in the greater Basel area and 75% of the urologists in six of the main urban areas of German-speaking Switzerland. The rate of willingness to participate among GPs was 11% and among urologists 36%. The representativeness of our group of urologists can be considered satisfactory—but for the group of GPs, it is only just satisfactory. Furthermore, this pilot study is the first of its kind in Switzerland. Strictly speaking, the study should be repeated to confirm our conclusions. Another limitation of the study is that the physicians reported subjectively on their practices in dealing with this issue and were not directly observable. A truly reliable measure would entail exact recording of the reported measures in files over a given period or even some form of direct observation. Finally, the impact of social desirability on the physicians interviewed was not controlled for, so it is legitimate to question whether all interviewees were completely open in expressing and admitting their feelings of discomfort and insufficient competence in the face-to-face interview. Finally, the participating physicians were predominantly males (see Methods). The results may therefore reflect mainly a male perspective. Although female physicians conceivably may be more at ease with psychosocial history taking in general, we assume that the barriers for female physicians asking male patients about their sexuality are just as high or higher than for male physicians, which would be

consistent with the first author's experiences interviewing the female GPs for the study.

Despite these limitations, various indications are present that the main results of our pilot study reflect clinical reality. First, the physicians participating in the interviews probably represent the group with the greatest interest in sexual issues. This reduces the risk that our results may overestimate the detected deficiencies. Second, the results indicate a narrowed approach to male sexual health, which is important because of the implications with respect to physicians' education and training. Third, the observation that the sexual dimension of medical conditions is frequently overlooked offers a further important insight into current primary care and medical practice. The results of this pilot study would seem to justify establishing a set of guidelines for SHT for Swiss physicians and developing training resources focused on the needs of the physicians.

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Appendix

Overview of Part I

1. Demographic data
2. Active exploration of sexual problems by physician Items 1–8
3. Primary disease responsible for sexual dysfunction
 - Organic disease → sexual dysfunction? Item 9
 - Endocrine disease → sexual dysfunction? Item 10
 - Mental health problems → sexual dysfunction? Item 11
 - Pharmaceuticals, alcohol, drugs → sexual dysfunction? Items 12–15
4. Active addressing of sexual problem by patient Items 16–18
5. Competence/need for further education
 - Competence in discussing/treating sexual dysfunctions Items 51–52
 - Need for further education Item 53

Part I of Semi-Structured Interview for General Practitioners (GPs) and Urologists

Date of interview _____

Demographic Data

Code (anonymization)
 Third letter of family name _____
 First letter of first name _____
 First digit of street number of practice _____
 Last letter of first name of mother _____

Sex Male Female
 Age _____ years
 Marital status Unmarried Married
 Divorced Widowed
 Number of children _____

Board-certified in General or internal medicine / Urology

In practice since _____

Practice located in _____ City
Metropolitan area or countryside

Type of physician

GP

Urologist

In the following interview, the term “patient” refers to the males you see in your practice for any type of medical treatment.

Active Exploration of Sexual Problems

1. Please estimate:
What percentage of your patients do you *actively* ask about sexual problems?
Estimate in %: _____

2. In which cases do you think you should *actively* ask patients about sexual problems?

3. Do you ask your patients how important sexuality is for them?
Yes No

4. When you *actively* ask about sexual problems, do you take any special approach?

5. Do you rely on any typical initial questions?

6. Are there any cases in which you avoid *actively* asking your patients about sexual problems?

7. Does your *actively* asking about sexual problems depend on the age of the patient?
Yes No

If yes—with which age group do you actively ask about sexual problems, and with which age group do you not?

8. How easy is it for you to *actively* ask your patients about sexual problems?
Please rate yourself somewhere between 0 (absolutely no problem for me) and 100 (this is a big problem for me)
Rating: _____

Organic Disease → Sexual Dysfunction?

9. Which organic diseases prompt you to *actively* ask about sexual problems?

→ Specify for each disease

Organic disease 1: _____

How often do you ask about sexual problems in connection with organic disease 1?

- Always
- Mostly
- Sometimes
- Rarely

Which sexual problems do you ask about in connection with organic disease 1?

- Hypoactive sexual desire disorder
- Hypersexual desire disorder
- Sexual aversion disorder
- Erectile dysfunction
- Male orgasmic disorder (delayed/absent ejaculation)
- Premature ejaculation
- Dyspareunia
- Sexual dysfunction due to a general medical condition
- Substance-induced sexual dysfunction

Organic disease 2: _____

How often do you ask about sexual problems in connection with organic disease 2?

- Always
- Mostly
- Sometimes
- Rarely

Which sexual problems do you ask about in connection with organic disease 2?

- Hypoactive sexual desire disorder
- Hypersexual desire disorder
- Sexual aversion disorder
- Erectile dysfunction
- Male orgasmic disorder (delayed/absent ejaculation)
- Premature ejaculation
- Dyspareunia
- Sexual dysfunction due to a general medical condition
- Substance-induced sexual dysfunction

Organic disease 3: _____

How often do you ask about sexual problems in connection with organic disease 3?

- Always
- Mostly
- Sometimes
- Rarely

Which sexual problems do you ask about in connection with organic disease 3?

- Hypoactive sexual desire disorder
- Hypersexual desire disorder
- Sexual aversion disorder
- Erectile dysfunction
- Male orgasmic disorder (delayed/absent ejaculation)
- Premature ejaculation
- Dyspareunia
- Sexual dysfunction due to a general medical condition
- Substance-induced sexual dysfunction

Organic disease 4: _____

How often do you ask about sexual problems in connection with organic disease 4?

- Always
- Mostly
- Sometimes
- Rarely

Which sexual problems do you ask about in connection with organic disease 4?

- Hypoactive sexual desire disorder
- Hypersexual desire disorder
- Sexual aversion disorder
- Erectile dysfunction

Male orgasmic disorder (delayed/absent ejaculation)

- Premature ejaculation
- Dyspareunia
- Sexual dysfunction due to a general medical condition
- Substance-induced sexual dysfunction

Endocrine Disease → Sexual Dysfunction?

10. Which endocrine diseases prompt you to *actively* ask about sexual problems?

→ Specify for each disease

Endocrine disease 1: _____

How often do you ask about sexual problems in connection with endocrine disease 1?

- Always
- Mostly
- Sometimes
- Rarely

Which sexual problems do you ask about in connection with endocrine disease 1?

- Hypoactive sexual desire disorder
- Hypersexual desire disorder
- Sexual aversion disorder
- Erectile dysfunction
- Male orgasmic disorder (delayed/absent ejaculation)
- Premature ejaculation
- Dyspareunia
- Sexual dysfunction due to a general medical condition
- Substance-induced sexual dysfunction

Endocrine disease 2: _____

How often do you ask about sexual problems in connection with endocrine disease 2?

- Always
- Mostly
- Sometimes
- Rarely

Which sexual problems do you ask about in connection with endocrine disease 2?

- Hypoactive sexual desire disorder
- Hypersexual desire disorder
- Sexual aversion disorder
- Erectile dysfunction

Male orgasmic disorder (delayed/absent ejaculation)
 Premature ejaculation
 Dyspareunia
 Sexual dysfunction due to a general medical condition
 Substance-induced sexual dysfunction

Endocrine disease 3: _____

How often do you ask about sexual problems in connection with endocrine disease 3?

- Always
- Mostly
- Sometimes
- Rarely

Which sexual problems do you ask about in connection with endocrine disease 3?

Hypoactive sexual desire disorder
 Hypersexual desire disorder
 Sexual aversion disorder
 Erectile dysfunction
 Male orgasmic disorder (delayed/absent ejaculation)
 Premature ejaculation
 Dyspareunia
 Sexual dysfunction due to a general medical condition
 Substance-induced sexual dysfunction

Endocrine disease 4: _____

How often do you ask about sexual problems in connection with endocrine disease 4?

- Always
- Mostly
- Sometimes
- Rarely

Which sexual problems do you ask about in connection with endocrine disease 4?

Hypoactive sexual desire disorder
 Hypersexual desire disorder
 Sexual aversion disorder
 Erectile dysfunction
 Male orgasmic disorder (delayed/absent ejaculation)
 Premature ejaculation
 Dyspareunia
 Sexual dysfunction due to a general medical condition
 Substance-induced sexual dysfunction

Mental Health Problems → Sexual Dysfunction?

11. Which mental health problems prompt you to *actively* ask about sexual problems?

→ Specify for each disease

Mental health problem 1: _____

How often do you ask about sexual problems in connection with mental health problem 1?

- Always
- Mostly
- Sometimes
- Rarely

Which sexual problems do you ask about in connection with mental health problem 1?

Hypoactive sexual desire disorder
 Hypersexual desire disorder
 Sexual aversion disorder
 Erectile dysfunction
 Male orgasmic disorder (delayed/absent ejaculation)
 Premature ejaculation
 Dyspareunia
 Sexual dysfunction due to a general medical condition
 Substance-induced sexual dysfunction

Mental health problem 2: _____

How often do you ask about sexual problems in connection with mental health problem 2?

- Always
- Mostly
- Sometimes
- Rarely

Which sexual problems do you ask about in connection with mental health problem 2?

Hypoactive sexual desire disorder
 Hypersexual desire disorder
 Sexual aversion disorder
 Erectile dysfunction
 Male orgasmic disorder (delayed/absent ejaculation)
 Premature ejaculation
 Dyspareunia
 Sexual dysfunction due to a general medical condition
 Substance-induced sexual dysfunction

Mental health problem 3: _____

How often do you ask about sexual problems in connection with mental health problem 3?

- Always
- Mostly
- Sometimes
- Rarely

Which sexual problems do you ask about in connection with mental health problem 3?

- Hypoactive sexual desire disorder
- Hypersexual desire disorder
- Sexual aversion disorder
- Erectile dysfunction
- Male orgasmic disorder (delayed/absent ejaculation)
- Premature ejaculation
- Dyspareunia
- Sexual dysfunction due to a general medical condition
- Substance-induced sexual dysfunction

Mental health problem 4: _____

How often do you ask about sexual problems in connection with mental health problem 4?

- Always
- Mostly
- Sometimes
- Rarely

Which sexual problems do you ask about in connection with mental health problem 4?

- Hypoactive sexual desire disorder
- Hypersexual desire disorder
- Sexual aversion disorder
- Erectile dysfunction
- Male orgasmic disorder (delayed/absent ejaculation)
- Premature ejaculation
- Dyspareunia
- Sexual dysfunction due to a general medical condition
- Substance-induced sexual dysfunction

Pharmaceuticals, Alcohol, Drugs →
Sexual Dysfunction?

12. Which pharmaceuticals do you think have side effects on sexuality?
- Antihypertensives/diuretics
 - Antiarrhythmics
 - Psychotropics
 - Anticholesterics
 - Cortisone

- Antidiabetics
- Agents against prostate diseases
- Antiandrogens
- Steroids

I don't know of any

13. If you prescribe pharmaceuticals to your patient, do you *actively* ask about possible side effects on sexuality?

- Always
- Mostly
- Never

14. If you know or assume your patient has an alcohol addiction, do you ask about sexual problems?

- Always
- Mostly
- Never

15. If you know or assume your patient has a drug addiction, do you ask about sexual problems?

- Always
- Mostly
- Never

Active Addressing of Sexual Problem by Patient

16. Please estimate:

What percentage of your patients *actively* address a sexual problem during consultation?
Estimate in %: _____

17. Which sexual problems do your patients *actively* address?

- Hypoactive sexual desire disorder
- Hypersexual desire disorder
- Sexual aversion disorder
- Erectile dysfunction
- Male orgasmic disorder (delayed/absent ejaculation)
- Premature ejaculation
- Dyspareunia
- Sexual dysfunction due to a general medical condition
- Substance-induced sexual dysfunction

18. How easy is it for you to discuss sexual problems if your patient addresses this issue?

Please rate yourself somewhere between 0 (absolutely no problem for me) and 100 (this is a big problem for me)
Rating: _____

Competence

51. How do you rate your competence in *discussing* sexual problems with your male patients?

- Very good
- Good
- Moderate
- Sufficient
- Insufficient

52. How do you rate your competence in *treating* male sexual problems?

- Very good
- Good
- Moderate
- Sufficient
- Insufficient

Further Education

53. Do you have a need for continuing education regarding sexuality issues?

- Yes
- No

If yes—what should this education consist of?

If no—by whom and how is this education already covered?

Thank you very much for your participation!