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ORIGINAL ARTICLE

What are the barriers faced by doctors in the management of erectile dysfunction in general practice?

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Abstract

Aim: This study was conducted in Singapore and aimed to determine the barriers perceived by general practitioners (GPs) in the management of their patients with erectile dysfunction (ED).

Methods: This was a qualitative analysis of a sample of 22 GPs using focus group discussions. Data were analyzed using content analysis techniques.

Results: Erectile dysfunction as a problem was often hidden in the agenda during GP–patient consultations. GPs perceived that older patients accepted ED as part of the ageing process but that for younger patients, GPs attributed fatigue as the etiology of ED. GPs felt that most patients preferred using widely publicized medications for ED, as a quick solution for their problem, rather than undergoing a thorough evaluation of the problem. Costs of medication for ED was constantly highlighted by GPs as a barrier to effective management, although some regarded it as a deterrent to social and moral degradation. Side-effects and improper administration of the medication were problems raised by GPs. Barriers included: the GP's gender; competence; perception of ED as less critical compared to the patient's comorbidities; and a passive approach to the problem. Relevant training and a good doctor–patient relationship were considered as likely to improve the management of ED.

Conclusions: Interplay of doctor, patient and drug factors needs to be addressed to enhance the management of ED. Understanding of this interaction will enable GPs to be proactive in their approach, diagnosis and treatment of ED.

Key words: barrier, erectile dysfunction, general practitioners, Singapore

Introduction

In Singapore over the past three decades, vast socio-economic improvement has had a significant impact on the lifespan and lifestyle of its citizens. The ageing population contributes to the rising prevalence of chronic ailments such as hypertension and diabetes mellitus. Both these chronic diseases and age can adversely affect sexual function. Sexual matters such as erectile dysfunction (ED) used to be a taboo subject. With the advent of the information revolution, media publicity and the availability of effective oral medication for erectile dysfunction, general practitioners (GPs) recognized that the subject was being raised more with their male patients. The subject is not unique to any race and religion in multiracial Singapore. Similar findings were detected in a study[1] in neighboring Malaysia, where the population consists of a similar mix of Asians including Malays, Chinese, Indians and Eurasians.

Nonetheless, the management of ED is hindered by a complex interplay of doctor, patient, medication and socio-cultural factors. Another Malaysian study[2] has highlighted problems faced by GPs in ED treatment but there has not been a similar report from Singapore. This study aims to identify and explore the various factors that impede effective ED management in general practice in Singapore.

Methods

The study population included GPs practicing in both private clinics and government-aided primary care centers in Singapore. Participants were purposively recruited, based on the inclusion criterion that they had managed patients with ED and had instituted treatment for ED. The

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GPs were invited through personal contact, introduction letter via the post or email, which clearly stated the objectives of the study.

This study utilized focus group discussions to obtain in-depth information. Focus groups are an accepted way to explore knowledge and experiences, and examine not only what people think, but how and why they think in a particular way.[3] However, it does not provide quantitative data that can be generalized to the wider population.

The focus groups were carried out at a local clubhouse and a clinic, and were facilitated by the first two authors (Tan and Ng) based on a structured discussion guideline. The guideline covered the following topics:

- GPs' attitudes and perceptions toward ED and its treatments;
- managing ED in their practice;
- prescribing habits and assessment of new ED treatments.

Written consent was obtained from each participant, who also provided basic socio-demographic data in a questionnaire. Each focus group session was audio-taped and lasted approximately 90 minutes. Detailed notes of each session were taken. The study was terminated with saturation of ideas after four such sessions. The tape-recorded interviews were transcribed in their entirety into text files.

This qualitative data were analyzed using standard content analysis technique, which allowed valid inference to be made from the text by extracting patterns of themes in the data.[4] All transcripts were read and checked several times to ensure consistencies and were coded according to potential conceptual and content-related themes, using a qualitative data analysis software NUD*IST Version 6.0™.[5] The quotes were typical views expressed by the GPs to exemplify emergent themes.

Results

Socio-demographic background of participants

The participants comprised 22 GPs, aged from 26 years to 56 years with a mean age of 34.8 years (SD = 5.6 years). The participants generally treated an average of four ED patients per month. Half of them had attended workshops or seminars related to sexuality. The profiles of the GPs are listed in **Table 1**.

Table 1 Socio-demographic background and practice profile of participating GPs in Singapore

Variable	Frequency N = 22	Percentage	Mean (SD)
Age			
< 35	11	50.0	34.8 (5.6)
35–55	10	45.5	
> 55	1	4.5	
Ethnic group			
Chinese	22	100.0	
Sex			
Male	18	81.8	
Female	4	18.2	
Religion			
Buddhist	2	9.1	
Christianity	14	63.6	
Others	6	27.3	
Marital status			
Single	2	9.1	
Married	20	90.9	
Classification of practice			
Government	5	22.7	
Private	17	77.3	
Types of private practice *(n = 17)*			
Single doctor	9	47.1	
Group	8	52.9	
Number of years practicing medicine			
< 10	10	45.5	9.8 (5.5)
= 10	12	54.5	
Number of patients treated for ED (per month)			
< 1	2	9.1	4.0 (9.1)
1–4	16	72.7	
> 4	4	18.2	
Number of years prescribing anti-impotent oral treatment			
≤ 3	20	90.0	2.2 (1.3)
> 3	2	10.0	
Attended workshop on sexuality			
Yes	11	50.0	
No	11	50.0	

Factors influencing the management of ED are presented in themes from various perspectives, namely factors related to patient, doctors and drugs (**Table 2**).

Table 2 Themes emerged from the focus groups

Factors	Themes
Patient	GP perceived that patients often hid their ED and were often not straightforward in their presentation.

	GP encountered patient's reluctance to full assessment of ED. Cost of anti-ED medication was widely regarded as a deterrent.
Medication	Improper administration and side-effects could deter the patient from using the drug. GP's gender, perceived competence and passive approach to the problem were perceived as barriers in ED management.
Doctor	Relevant training and good rapport with patient could overcome the barriers. GP perceived older men's acceptance of ED as an ageing process and attributed fatigue as a predominant cause of ED in younger men.

Patient factor

GPs felt that the majority of patients were silent sufferers of ED. Most of these men did not volunteer that this was a problem, or had difficulty bringing up the subject to their GPs. Obtaining a history of ED was often not straightforward and required GPs to dig out such 'secrets'. Decoding this secret was a test of the skills of the GPs as patients presented the problem in myriad ways. GPs frequently discovered that the ED history was 'hidden' in the main agenda of the consultation. Others used a second party to bring up the topic.

An ED information pamphlet in the clinic is another tool that subjects utilize to bring their GP's attention to their problem.

Patients would make use of their medications to bring up the topic and commonly queried if ED is the consequence of side-effect of their regular long-term medications. One GP claimed he detected a case of ED from a patient with failure to consummate a marriage.

The surge in emotion from their patients during the consultation could pose a problem for the GPs if they were ill-prepared to handle it: '…they start talking …sometimes can be quite emotional, very trapped in that sense… being very frustrated; the wife can become quite, rather dissatisfied; …anytime, when they are about to do it, and you cannot get it to stand, the wife …vow, the expression is there…they felt that they are quite inadequate.'

A lag time was common before the problem finally surfaced to the GPs. During the interim period, GPs perceived that self-medication with traditional herbs was characteristic of help-seeking behavior of local men.

However, this traditional barrier was viewed by the GPs as disintegrating with increased media coverage and publicity of the problem and its pharmaceutical treatment. 'I agree with what (GP) had said, generally they (men in general) are now more frank, their erectile dysfunction …now that this medicine is available, I don't think that any of them are shy about it.'

In fact, the trend was perceived to move to the other extreme. Increasing numbers of men would directly ask their GPs to prescribe the anti-ED drug as a quick fix treatment rather than solve the problem.

As such patients preferred this short-circuit approach to the problem, GPs encountered difficulty in getting them to undergo a full assessment, as indicated by the Singapore Urological Association guidelines for ED management. From the patient's perspective, they would prefer to simply take the medication without further evaluation and possibly avoid additional cost from the investigations. 'The difficulty will be to convince the people who are seeking treatment to undergo the full assessment …who …among our patients are willing to succumb themselves to all these tests?'

The GPs also encountered men seeking medication for ED from another physician rather than from their regular GP, to avoid embarrassment and to hide their ED problem. 'I have a lot of husbands who come and see me because they don't want to go to their regular family doctor for their Viagra …they feel that …the regular doctor will not keep their secret for them or they felt a bit "pai seh" (embarrassed) about it.'

Medication factor

The availability of an oral form of anti-ED medication was a step forward in ED management. Despite a more acceptable form of therapy for men in comparison to hitherto parenteral and inflatable devices, drugs for ED have their own set of potential problems.

The cost of the medication was repeatedly highlighted in all the focus group sessions as a prime consideration among GPs in the management of ED. The GPs felt it could deter those from the lower socio-economic strata of society. The high cost might possibly prompt users to seek them at cheaper prices in the 'black market' but at the risk of acquiring adulterated medication of unknown quality and without proper instruction for its administration.

However, one GP argued that the cost of the drug was a matter of relativity. It depended on the perceived personal values and attitude of the patient. If sexual function constitutes a vital part of a person's life, cost of treatment will be secondary. 'Cost is not a problem …it reflects the importance of this aspect of life. I felt that it's very important, in fact, sex is very important. So they don't mind spending.' In contrast, several GPs considered the price of drug treatment acted as a deterrent to social and moral decadence. In fact the drug has opened up a new horizon for men with ED that the pendulum has now swung to the other end, with people using it as a recreation drug.

Some GPs were at odds with themselves as they felt they had an obligation to safeguard the men's spouses and ultimately the morality of society. GPs gave examples of family relationship breakdowns in the advent of the medication for ED.

According to the GPs, press reports of death associated with sildenafil (Viagra) dealt a blow to the confidence of potential users, although the direct link was not fully established. This was one reason for men

with ED to try out their familiar herbs and traditional medications, which were of variable and often not proven efficacy, instead of consulting their GP for ED management.

The 'failure' of sildenafil to treat ED due to improper administration such as immediate ingestion just prior to coitus also had an adverse impact on the user.

The myth that sildenafil was used as an aphrodisiac could result in failure to resolve the ED problem.

Certain patients might also shun the drug as they experienced the side-effects from the therapy, though most were self-limiting and not life-threatening. 'The difficulty is the side-effects. Sometimes they do get a bit of side-effects like giddiness or headaches or nasal congestion.'

Physician factor

The GPs also felt that elderly men were more concerned about comorbidities and regarded ED as part of their ageing process.

In contrast, several GPs felt that the younger patients' poor sexual performance could be related mainly to factors such as fatigue rather than ED itself.

Failure of the GPs to consider ED as a disease in either group of men would deter detailed exploration of the problem.

The gender of the GP seemed to influence the decision of men to raise the topic of their ED. The GPs perceived that the presence of male doctors was advantageous, as men tend to highlight the problem to male more than female doctors. Female GPs were also less likely to bring up the subject for fear of distorting their 'lady' image and misconceived ideas by the male ED sufferers.

More patients tend to open up if they perceived that their GPs were confident of treating such problems or more proactive in their approach to managing ED. A good patient–doctor rapport is another key factor to bring out the problem.

The GPs seldom raised the problem routinely. They would deal with ED only after the patients brought up the topic themselves or after adequate rapport was established after a series of consultations. They were concerned and apprehensive to initiate the discussion of sexual dysfunction themselves, lest they triggered an unpleasant reaction from their patients.

GPs were more willing to query the effect of ED for male patients with chronic illnesses and medications associated with ED, such as diabetes mellitus and hypertension. They were unlikely to raise the subject for patients who came for acute ailments such as flu and diarrhea, to avoid perceived ridicule by their patients.

However, GPs occasionally faced restraint in their attempt to switch certain blood pressure lowering medications with known deleterious effect on erectile function. Patients ultimately would be the decision maker. 'If they are very comfortable with atenolol, they don't want to change …there is only this much you can do … sometimes they would rather go ahead with their (usual) medication …(patient says) don't have any side-effect from the high blood pressure or diabetes. Just give me another medicine to help me with my ED.'

Most GPs considered themselves as 'passive prescribers' of anti-ED medication on a case-encounter basis. They would be more willing to prescribe if they detected actual cases of ED.

In contrast, a few GPs did not prescribe medication for ED as they lacked confidence. Another GP sent patients to the urologist for the initial workup and would then continue the ED medication if the urologist commenced such therapy.

In general, GPs would adopt a reactionary approach, as and when patients presented the problem to them. This was especially so with new patients when rapport was yet to be established.

Training and confidence go hand-in-hand in the management of ED in primary care. The study showed that GPs with training in relevant fields, such as andrology, were more proactive in dealing with ED.

With background training in andrology, one GP considered 'ED as a barometer of cardiovascular health' as 'artherosclerosis would definitely affect the penis'. He would actively pose the question: 'How's your sexual health?' to all his patients, especially those above 40 years and with comorbidities such as diabetes mellitus and hypertension. However, another GP in the same setting retorted that: 'ED is a barometer of vascular disease… don't you think it's a late-stage event!' It perhaps reflected GPs' variable perceptions of ED in terms of urgency and importance as a disease.

Several GPs had prescribed drug treatment for ED and then discovered that the patients were using them in extra-marital relationships. One GP felt strongly that he should not be promoting promiscuity. However, the general sentiments were that GPs should not be judgemental, though a few tried hard to reconcile their roles as both a physician and a stakeholder of social and moral responsibility.

The GPs felt that if a patient came with a fixed mindset to obtain treatment for ED and nothing else, they would usually comply after ruling out any contraindications. They were well aware that these patients would obtain drugs elsewhere if they did not prescribe.

Ultimately the GPs felt that the onus to take the medication for ED remained with the patients themselves.

Discussion

The study showed an interplay of factors that potentially could have an impact in ED management in general practice. Most GPs in the study felt that social stigma was still a hindrance to the presentation of ED, leading to inadequate exposure of the problem in general practice. Common barriers included men wanting to avoid revealing their inadequacy and avoid embarrassing both their sexual partner and their GP. GPs were aware of patients' different, and often subtle, presentations of ED but they needed to take the initiative to raise the problem during the consultation and to handle the occasional vehement emotions from their patients. Their perception that older men's acceptance of ED as an ageing process and attributing fatigue as the predominant cause of ED in younger men, would hinder detailed exploration of the

problem.

However, GPs also noted the evolving pattern of ED presentation with gradual dissolution of such inhibition among the affected patients. The gradual opening up of this inhibition may not necessarily translate into more effective ED treatment. The authors felt that the walk-in system of primary care in Singapore allowed patients to doctor-hop and seek treatment and medication in different clinics. This fragmented care would hamper the overall ED management as the 'new' GPs were disadvantaged by their possible lack of familiarity with the patients' other medical conditions and family background.

The pay-for-service system in the local context is regarded as another hurdle. Cost of medication is added to the service at the GP clinics, which also coupled as a dispensary, unlike in the West where drugs are dispensed at the pharmacy. Patients pay full cost for the medication or devices for treating ED. It added on to the overall cost of treatment of their chronic diseases.

Cost of medication was perceived by the GPs to have contradictory effects. For men who needed the drug for their ED, the cost could be forbidding for those from the lower socio-economic class. On the other hand, GPs regarded cost to be a deterrent to rampant abuse. Failure to adhere to proper administration of the current drug for ED, side-effects and tainted reports of adverse reactions in the media, were other factors which hindered the pharmacological management of ED.

It was also not surprising that GPs encountered patients' reluctance to undergo full investigations for ED, perhaps as a cost-saving measure. It eroded the confidence of the GPs in managing these patients, not only for safety reasons, but also because of medico-legal considerations.

Read *et al.*[6] noted that many men considered sexual issues to be an appropriate subject for the GP to discuss. Despite this, only 2% of the GPs' notes showed records of sexual problems.[6] A study of healthcare needs in the general population had indicated that only a small proportion of patients wanting professional help for sexual problems actually receive it.[7] In fact, many preferred doctors to initiate discussion on sexual issues related to their medical condition.[1] For those who seek treatment, there was a delay of about one year between the onset of the problem and presentation of the complaint of ED to the GPs by patients.

The study revealed that GPs' lack of proactive approach to ask about ED in their patients could be one possible answer. The fact that ED did not manifest proportionate to its prevalence was partially attributed to GPs' attitudes, passive approach, competence and confidence in dealing with the problem. The GPs' passive approach might be shaped by their attitude that regarded ED as less critical to treat than other comorbidities. They also feared that their image could be tarnished if they were perceived to be promoting medication for ED.

Many GPs in the study regarded the treatment of the chronic diseases to take precedence over the management for sexual function, which was lower down in their priorities. The treatment of a perceived 'non-urgent' condition could adversely influence the GPs' decision to initiate ED discussion with their patients.

Although physicians are the most frequently consulted professionals for sexual problems, it has been suggested that they are often ill-prepared to handle these problems.[8,9] This was illustrated by the two GPs in this study who tended not to prescribe drugs for ED because they were 'not confident'.

The results were comparable to that of Low's study[2] where the constraints identified by GPs in dealing with sexual problems included:

- lack of training and knowledge on sexual problems;
- being the opposite sex to their patients; and
- the fear of offending patients.

However, time constraint was not mentioned as a factor in this study.

In addition, the GPs' prescribing behavior was influenced by the patients' pattern of presentation and request for medication.[10] They struggled to reconcile their dual roles as a 'healer' of their patient's ED problem and a guardian against moral and social decadence resulting from prescription of anti-ED medication. The issue of diagnosis and treatment of ED, like many other chronic diseases, involved a complex interplay of factors.[11]

Training in sexual health for relevant disciplines could perhaps inject confidence in the prescribing of medication for ED as exemplified by the andrology-trained GP. In addition, experience and the traditional skills of GPs in establishing good rapport with their patients are catalysts toward holistic management of their patients with ED.

Conclusion

The study showed that patient, medication and doctor factors could adversely affect the management of ED. These issues need to be addressed and a better understanding of how these factors interact is important in order for ED to be adequately treated in general practice.

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