

BARRIERS TO BULGARIAN PRIMARY CARE PHYSICIANS TO ADDRESS AND DISCUSS THE ERECTILE DYSFUNCTION PROBLEM WITH THEIR PATIENTS

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Abstract: Introduction: Several factors play the role of barriers to GP-s and most of them avoid discussing the erectile dysfunction (ED) problem with their patients, even though a part of the patients hope the doctor would initiate such a discussion. Taking into account the relationship of ED with a number of socially significant diseases, these barriers impede the diagnostic process. **Objective:** To identify possible barriers to Bulgarian primary care physicians to address and discuss the ED problem with their patients. **Materials and methods:** The opinions of 12 GP-s from the town of Plovdiv, randomly selected, were studied using qualitative research methods, interview with standard open-ended questions, asked by the research investigator. An audio recording was made and transcribed by the interviewer and by two other research investigators. The obtained data are the result of a consensus. **Results:** Even though the majority of participants point out that doctors do not avoid and should not avoid commenting on problems, related to the sex life of their patients, only one participant declared to always raise this issue before them. Constraining factors (barriers), pointed out by the colleagues, are lack of training in this aspect of health, also lack of training in asking intimate questions, the perception that sex problems of patients are not among "essential" diseases, associated with "survival", refusal of the patient, lack of time, waiting for the patient to raise this issue first and "personal taboos" of the doctor himself. The respondents point that doctors share the same inhibitions as their patients, as they are a part of the same society and are influenced by various cultural factors. Other factors, that play role of a barrier, are patient – physician gender discordance, lack of confidence and lack of experience with the patients with ED, physician personal sexual experience, when doctors do not apply holistic approach and when physicians do not perceive ED as a disease. **Conclusion:** This survey is the first of its kind in Bulgaria. The results of the survey show that a variety of factors, including factors, related to doctor's personality, acts as barriers that impede doctors from proactively asking about and discussing sexuality issues and ED in particular. The overcoming of these barriers would present an opportunity to improve the therapeutic result.

Keywords: barriers, erectile dysfunction, general practitioners.

INTRODUCTION

Epidemiological studies [15,17] show that male sexual dysfunction (SD) and ED in particular are common medical conditions, yet as little as 10-16% of all ED patients seek and receive treatment [8,12,27]. The following definition is provided in the national consensus about the diagnosis and treatment of this problem [4]: "ED affects the physical and psychosocial health of men and has a deep impact on their quality of life and that of their sex partners [31] and family". All this determines the significance of this problem for each family member and society as a whole. Unfortunately doctors rarely take sexual history [21] and miss a chance for opportunistic prophylaxis [5]. Good skills in history taking is the first step to making a correct diagnosis of SD[29], of ED [4,33] in particular, as well as any other disease. Research has demonstrated that the majority of primary care physicians avoid [21,27] or reluctantly discuss the ED problem of their patients, even though a part of the patients hope the doctor would initiate such a discussion [3,10,13,26,34]. Additionally, the surveys show that a variety of factors act as barriers [14,27] to raising and discussing the SD issue and ED in particular. These barriers impede the patient [27], as well as the doctor [28].

Objective: To identify barriers to Bulgarian primary care physicians to address and discuss the SD problem, ED in particular, with their patients.

MATERIALS AND METHODS

The study was conducted among 12 primary care physicians from the town of Plovdiv, Bulgaria, selected at random. Each of the GPs interviewed was invited to participate in the qualitative study. After confirming agreement, each participant was given to read standardized information on the purpose, objectives and nature of the survey and informed consent was obtained to record the conversation. The interviews were conducted in an informal setting, the interviewer asked standard questions, following the same protocol for all participants, and additional questions were asked, where needed. The conversations were recorded using the "Voice Recorder" function on a mobile phone. They were eventually transcribed by the interviewer and by two other research investigators and thematic analysis was made. The obtained data are the result of a consensus. The interviews were conducted up to a point of achieving saturation of data, defined as non-emergence of fundamentally new ideas and answers to the questions, given by the last interviewed participants, their answers duplicating the answers, already given by the previous participants.

A total of 12 general practitioners took part in the survey. Of them eight (66,7 %) were female and four (33,3 %) were male. Average age 47.42 ± 8.051 years. Average professional experience 21.42 ± 7.845 years. Average number of patients, listed in the practice - 2034 ± 795 . Ten of them (83,3%) are practice owners and two (16,7%) are locum or second doctors, hired by the owner, eleven (91,7%) work in individual (solo) practices and one (8,3%) in a group practice with 11 co-workers. Nine of them (75%) are GP (Family medicine) specialists, two (16,7%) are GP post-graduate students, four (33,3%) are internal diseases specialists and one is a pediatrician, other specialty – 3 (25%). In addition, two (16,7%) of them are PhD in the field of general practice and two (16,7%) have acquired some other qualification.

The statistical analysis was made using descriptive statistics, transcribed interviews of the participants in the survey with numbered lines, SPSS 17.0, Microsoft Word 2010 and Microsoft Excel 2010.

RESULTS

The analysis of the transcribed interviews consensually outlined six themes, forming barriers to general practitioners to initiate a discussion on eventual sexual dysfunctions and ED in particular.

1. Training: More than half of all participants identified the lack of training in this area as the main barrier. *"...my definite opinion is that our training did not put, emphasis would be a strong word, but in a way it was not said [about sexual history, author's note], that it is a part of the whole," "...generally this topic is never discussed here, it is even avoided, probably doctors do not feel prepared well enough" and "...we have not been trained, in my opinion, to seek this problem. In several western countries sexual health is a part of patient's medical history".* The respondents outlined training aspects both in terms of communication skills, as well as having specific knowledge on sexuality and the related aspects of health, in particular.

"...the personal skills per se, including doctor's communication skills"

"...we, being doctors, are not trained how to predispose the patient"

"...how to approach the patient with intimate questions", "...how to seek the answers"

"...how to ask the question, so that a person would not feel offended, or humiliated or somehow in a situation that would make him feel uncomfortable".

It could be summarized that doctors are generally aware of the barrier due to insufficient knowledge and skills, which impedes initiating a consultation on these issues.

"...we have to ask such questions in the right manner, because the problem we discuss now is not only a psychological problem, but also an early symptom of many somatic diseases".

2. The patient: Another significant barrier is doctor expecting the patient to report the problem first, which is also cited in the interviews of more than half of all respondents. *"I discuss openly with them, as long as they start first," "...nothing stops me, as long as the patient starts a discussion on whether he has an erectile problem," "...more often we adopt a wait-and-see position,"; They do not share! Communication is difficult, indeed, if he does not come up and say: I have this problem."*

The doctor sometimes tries to approach the problem indirectly: *"If a problem is formulated, concerning the relations within the family, then one is more likely to bring up the question of the dimensions or the manifestations of this problem. Or its relation with the sexual contact," "I try any possible way to find, somehow, the right approach to him and to resolve the problem, because I believe that whoever has such problem, it is good to discuss."*

3. Lack of time: Lack of time is reported as a very common restraining factor to initiating a discussion on ED, with the clear understanding that such type of consultation requires peace of mind and patience. *"The main reason, in my opinion, is the lack of time," "Mainly the lack of time, but not unwillingness," "...not the lack of time in the literal sense, but because the patient usually presents some problem and is impatient to have this problem resolved and even the doctor does not suspect that there is something else that underlies this problem, something suppressed"*

and unnamed, and this requires more time for discussion and predisposing the patient, the patient himself does not provide such an opportunity."

4. Significance of the SD/ED problem: Part of interviewed doctors identify as a barrier the general attitude that patients' sexual problems are not directly related to health, considered merely as survival: *"In my opinion there is a general feeling in our country that disease or important illnesses are only those, related to survival and human life, such as cardiovascular diseases or diabetes." Very little attention is paid to the fact that quality of life is no less important, it is also very important, for the patient not only to be alive, but to live well and in full enjoyment of life."*

Underestimation of the problem and common misconception that patients' sexual problems are not among the "important" diseases are also noted from the perspective of the medical community. *"... most physicians do not realize the relationship of these problems with the rest of, let's say, patient's mental and functional health;" "...it is not considered necessary to help the patient with these problems exactly"; "We, as doctors, do not ask about such a thing, because we are preoccupied, as we believe, with more considerable and more important problems, such as patient's general condition, his cardiovascular system, his tests and other things."*

5. Public attitudes: A theme which restrains doctors from consulting on sexuality issues, lies with certain elements of the public attitudes. Undoubtedly, first comes the feeling of personal embarrassment, which could originate both from the patient and the doctor: *"...certain people, when asked a question or two, I can see they are embarrassed and not willing to discuss this issue;" "...the patient refuses to discuss this issue, he feels uncomfortable, awkward;" Even when attention is actively focused, they would rather deny, or broadly refer to some family problems." When you encounter a few patients, who frown so emphatically, you just feel demotivated to initiate a discussion about this..." "...if the patient would not lift the curtain, one feels uncomfortable to lift it himself."*

Formulated from sociocultural perspective by one of the participants: *"Some other cultures consider sexual health an integral point, while our society still does not put it this way."*

On the other hand two participants cited as a possible barrier the belief that it is outside of doctor's professional role: *"I do not think it is supposed to be our function." I have talked to students, young people, modern people and they say - well, this is not our business."*

The following statements can be assumed to summarize the point:

"We, doctors, belong to the same society, meaning that we suffer the same inhibitions, for us also this issue is not the easiest to discuss"

"We have not been trained to seek such help, we have not been trained to provide it."

6. Factors, relating to doctor's personality – age, gender, experience: Age differences between doctor and patient (younger doctor) was identified as a barrier by two of the interviewed: *"...age- and generation-related. For a young doctor it is rather difficult, indeed, to open such a discussion, to talk about this issue with a patient, who could be at the age of his father or even older. This always poses a barrier."*

Opposite gender doctor-patient interaction has also been identified as a possible obstacle to starting a consultation on ED: *"For a female doctor it is more difficult to discuss such problems with a male patient, especially if he is her senior or at the age of being her father, for instance."*

Professional experience, or rather the lack of experience, could also restrict the doctor in the discussion, according to one general practitioner, included in the survey: *"...this lack of self-confidence, which is...the doctor should be just helped somehow to be able to refer the respective patient ... onto an urologist, neurologist, psychologist."* One participant draws the attention to the medical specialists lacking holistic approach, which could be referred to more than one theme. Training comes on the first place, because the medical specialties principle still dominates in our country. We could also consider the lack of holistic approach also with respect to significance of the SD/ED problem, when the diseases, originating from certain body systems, are prioritized. Finally, this is also reflected in the public attitudes, shaping the perception of sexuality.

"There is no global approach, only the specific problem is considered..."

"...we rarely consider the patient as a whole organism."

In the context of the themes identified above, inhibiting the start of discussion, the participants make some general provisions. Doctors wishfully assert that "there should not be any problem", while one participant asserted to ask all patients a question on sexual history.

Discussion: The choice of a qualitative study aims to gain an in-depth understanding of the problem, to identify all possible barriers and to collect a number of different points of view. In a similar survey, conducted in Australia [21], the colleagues have chosen, unlike us, a focus-groups method.

Our results identify a wide range of barriers impeding doctors to discuss problems, related to SD and ED in particular, which confirms previous findings in this field and in similar areas[21], which also identify as barriers lack of time[18,21], fear of invasion of privacy, age and gender of the patient and the doctor[21,23], fear of

incompetence, defensive behaviour on behalf of the patient[21], cultural differences[21,23] and the presence of a third party in the examination room[21].

Among the constraining factors (barriers), the lack of training in this aspect of health was put on the first place. This results in under-diagnosing both SD and ED and the diseases, associated with them. This is important, especially taking into account that ED of vascular origin shares the same risk factors as the cardiovascular diseases[1,2,4,6,7,11] and the fact that ED has been recognized as a risk factor (RF) for cardiovascular diseases (CVD)[22,25,30] and significant co-morbidity has been found between ED and other socially-significant diseases, such as diabetes, depression, etc.[4,18,24,32,33].

Our results are consistent with the previous findings, bringing first the feeling of insufficient training in this aspect of health and insufficient training in the skill of asking intimate questions in particular. It is highlighted accordingly, that training is need in this, as a tool to overcome these barriers, which coincides with the recommendations, given by other authors [21]. Similar results are also presented by Humphrey and Nazareth [28] with respect to the factors - lack of sufficient training, education, knowledge; doctors feeling embarrassed or having no sensitivity in this field; not being trained to ask intimate questions and take sexual history, as well as the observed trend doctors not to ask first and perhaps even be afraid to initiate a discussion on this issue first.

Research has demonstrated that the majority of primary care physicians avoid or reluctantly discuss the ED problem of their patients, even though a part of the patients hope the doctor would initiate such a discussion[3,10,13,26,34]. On the other hand, our results show that doctors expect the patient to start the discussion first. It is obvious that the two sides have a communication problems in this field, which is believed to be attributable to the lack of training [20,23].

Our results also support part of the factors, reported by Burd, ID et al. [9], causing discomfort for the doctor, such as age and gender differences between doctor and patient and they define them as a barrier. Other factors, such as primary level of education and marital status - single or divorced [9], are not found in our results. In addition, we identify the existence of more barriers, such as age and gender differences between doctor and patient, doctor's own sexual experience and other features of doctor's own personality, as well as the lack of holistic approach, which are not mentioned in the cited survey [28].

Our results coincide largely with the findings of Dyer K. and das Nair, P. [16] in a systematic review of the qualitative studies, conducted in the United Kingdom over a 10-year period. In contrast to our study, which was conducted only among general practitioners, the aforementioned review covered studies, conducted among doctors, nurses and other professionals, involved in the provision of health services. Nevertheless, our results are consistent with the following indicators:

- The expectation the patient to raise this issue first;
- Concerns about not having knowledge and skills to tackle the ED problem; Lack of experience, lack of training,
- Lack of time and resources;
- Concerns about patient's reaction and fear of opening "Pandora's box" as an allegory to broaching a complex subject, requiring vast resources.

Interestingly, 1/3 of the factors playing the role of a barrier are associated with the personality of the doctor. This brings to mind the notion of Michael Balint's "drug doctor", i.e. doctor's personality as a medication, having its positive and negative effects [19].

The present study also has some limitations. It is possible that some questions may have presented a hypothetical situation to some participants, as they may have never experienced such a situation.

Another possible limitation is the relatively small number of interviewed, but taking into account that the aim of the study was to identify as many barriers and motivating factors as possible, and that the survey was conducted up to a point of saturation (defined as non-emergence of new ideas and themes in the answers of the last participants), we believe that these goals have been reached.

CONCLUSION

This survey is the first of its kind in Bulgaria. The results clearly identify the barriers preventing doctors from discussing proactively the existence of SD and ED problems in particular with their patients. These barriers impede or even render impossible the diagnostic and therapeutic process. Overcoming part of these barriers would present an opportunity to improve the therapeutic care.

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