

The role of general practitioners in the management of erectile dysfunction—a qualitative study

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The objective of this study was to explore the roles and perceptions of general practitioners (GPs) in the management of erectile dysfunction (ED). This qualitative study used focus group discussions and in-depth interviews. This study was conducted based on 28 GPs from an urban area in Malaysia who had managed patients with ED and prescribed anti-ED drugs. Main outcome measures included the roles of GPs in managing patients with ED (active or passive), perceptions regarding ED and the treatment, and factors influencing their decision to prescribe. Majority of the GPs assumed a passive role when managing patients with ED. This was partly due to their perception of the disease being nonserious. Some also perceived ED as mainly psychological in nature. The anti-ED drugs were often viewed as a lifestyle drug with potentially serious side effects. The fear of being perceived by patients as ‘pushing’ for the drug and being blamed if the patients were to develop serious side effects also hampered the management of this disease. GPs who participated in this study remained passive in identifying and treating patients with ED and this was attributed to their perception of the disease, drug treatment and patient’s background.
International Journal of Impotence Research (2004) 16, 60–63. doi:10.1038/sj.ijir.3901141

Keywords: role; erectile dysfunction; general practitioners; Malaysia

Introduction

Erectile dysfunction (ED) is a men’s health issue that is receiving overwhelming attention in the recent years. Although studies have shown that up to 52% of the male population aged 40–70 y had some degree of ED,¹ data from the National Health and Social Life Survey had found that only about 1 in 10 men with ED between 18 and 59 y of age actually went to a physician for consultation regarding their sexual dysfunction.² There are many reasons why these men were not seeking treatment.³ Some men may not be bothered that they have ED, while others may be apprehensive about the available treatment options as a result of inaccurate media attention, or shame. The attending physicians have an important part to play too. The results of a US survey of 500 adults aged 25 y and above showed that up to 71% ‘thought their doctors would dismiss any concerns about sexual problems they might bring up’.⁴ The physicians may not be well equipped with the necessary skills to deal with these problems. Even those who

are knowledgeable regarding ED, their attitudes and perceptions of the disease and therapy may influence their ability to carry out an effective consultation. This would in turn influence the detection and management of patients presenting with ED.⁵

With the aging population and increasing incidence of atherosclerotic conditions such as diabetes mellitus, doctors, especially general practitioners (GPs), would be expected to manage more patients with ED in their daily practice. Therefore, it is important for us to examine the role of GPs when they manage patients with ED, and to understand the factors influencing their decisions.

Methods

This qualitative study used focus group discussions (FGD) and in-depth interviews (IDI) to gather verbatim comments from the GPs. This study was conducted based on 28 GPs practising in Klang Valley, an urban area in Malaysia. Participants were recruited via convenient sampling on a voluntary basis. The inclusion criterion for participants was that they had managed patients with ED and had prescribed some forms of anti-ED drug before. The GPs were selected from a list of private clinics and a hospital-based outpatient clinic within Klang Valley. They were invited through invitation letters followed by tele-

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 Received 16 June 2003; revised 28 July 2003; accepted 29 September 2003

phone calls to confirm their participation. An attempt was made to include GPs from different ethnicity, government and private sectors, and practices from both upper and lower socioeconomic strata.

Seven FGD and two IDI were conducted in English by the researchers CJN and WYL, at the University Malaya Medical Centre, a teaching hospital in Malaysia. The objectives of the session were explained to the participants and confidentiality of their identities was ensured. A consent form was signed by each participant and their sociodemographic information was obtained. The interview guideline included the GP's general attitude towards ED and its management, and the factors influencing their perception. All sessions were audiotaped, and detailed notes were taken by a note-taker. Each FGD lasted about one and a half hour.

The tape-recorded interviews were transcribed in full and the analysis was based on these typed transcripts. The transcripts were checked and analysed independently by CJN and WYL to ensure reliability. The data were analysed using NUD*IST Version 6.0™, a qualitative data management software.

Results

Participants' profile

The mean age of the participants was 45.7 y (s.d. 10.2) and majority were male (71.4%). The participants comprised Chinese (46.4%), followed by Indians (42.9%), Malays (3.6%) and others (7.1%). Most of them were married (85.7%) while 10.7% were single and 3.6% divorced. Average number of years of medical practice was 18.4 y (s.d. 9.3) and majority saw three cases of ED per month. Two-thirds of the GPs were in private practice. Most GPs had prescribed an oral anti-ED drug for an average of 3.3 y. Most GPs (67.9%) had attended workshops or seminars on sexual health.

Roles of GPs in the management of ED

Passive role. Majority of the GPs assumed a passive role when it comes to diagnosing and managing ED. They would only discuss if patients brought up the topic voluntarily.

"The indirect way I bring up is, I put posters in the waiting area, in the consultation room, so I allow them to bring it up." (A)

"So, basically it's the patient who already decided that they really need it. And as long as the medicine is safe, as doctors, we just go ahead and prescribe." (B)

Some would ask indirect questions (such as side effects of medicine), hoping that the patients

would volunteer the information about their sexual problem.

"No, I generally don't mention specifically whether you have ED. Sometimes, I may just ask patients about medication. I ask general questions like: do you have any problems with your medication, because if I start asking: do you have ED, do you have this, do you have that? ... Then, they'll say 'yes, yes, yes...' I don't like to put too many ideas in their heads..." (A)

Active role. A few GPs would discuss freely with their patients whom they had been seeing for some time.

"Usually like ... for diabetic patients, high blood patients, I usually ask, come up at the end of the session, 'how's your sex life?'. Sometimes, they will voluntarily ask. Otherwise, I just leave it like that." (C)

"I only talk to those patients who had been with me for years. If, let's say, those patients who came for the first time, I tried not to touch on that." (D)

Some would ask routinely during the patient's medical check-up:

"So when they come in and we are going through things about their health, I'll bring it up." (E)

Ultimately, some GPs would like to see themselves as facilitators and to help the patients to improve their quality of life.

"So probably as a facilitator and a prescriber and telling them the pros and cons, contraindications of the medication." (F)

"I think for me, we are not just treating organic diseases, we would like to improve his mental health." (A)

Factors affecting their roles

Non-life-threatening disease. Part of the reason why GPs were rather passive about prescribing an anti-ED drug was that they perceived ED as a non-life-threatening condition compared to chronic illnesses such as diabetes mellitus and hypertension.

"My personal feeling is that this is not a very serious problem. So, I do brush patients aside ... said, 'this condition is not so important.'" (G)

"...it is not as important as a lot of other more serious diseases like diabetes, or hypertension." (A)

"Let's say, their blood pressure is not under control, I would say, 'Why don't you go and take care of this problem first rather than spending your money on this (anti-ED drug)?' I think priority... I think if all things being equal, then I will let the patient choose, but if the priority is obviously wrong, ...like the morbidity and mortality of other priorities are higher, then we will advise them accordingly and I think most of them will accept that." (H)

Psychological cause. Some GPs also attributed ED to a psychological cause and did not feel that prescribing anti-ED drugs would help.

“All in the mind, it is all in the mind! The mind controls the body. It is a fact. The mind has a big role to play.” (I)

“Sometimes, most of the patients are because of the stress, tension, overworked, overload, or so and I give them some placebo, that’s all.” (J)

Lifestyle drugs. Some GPs considered anti-ED medications as a lifestyle drug and worried that they might be misused. They also felt a sense of moral obligation to discourage promiscuity.

“Anyway, this is not a curative drug, it’s a lifestyle drug. Only certain people would want to take it.” (K)

“It gave the feeling that it is encouraging the males to have extramarital affairs or have funs or whatever.” (L)

Drug ‘pusher’. Some GPs were hesitant in prescribing anti-ED drugs to avoid being perceived as ‘pushing’ the drug for profits.

“I am open if they bring it up, but normally I don’t say do you have ED. Not directly because I find that more like too much marketing, too pushy already...” (A)

“But I don’t go in and ask them. Sometimes, we have to be very careful. They think you are doing business with them.” (C)

However, others perceived it as giving an option for the patients:

“What I’m trying to say is we are not actually promoting this particular sale. We are giving options to the patients.” (M)

Fear of being blamed. Some GPs would exercise caution when prescribing anti-ED drugs due to the side effects. Although they were fully aware of the indications and contraindications, some would still prefer to play safe.

“...they may blame me for giving this drug when the actual medical problem is the one that is causing (the angina). So I don’t want to be responsible...” (N)

“We don’t want to create something in the patients. We want to be more cautious in using the drug.” (O)

Specialist’s role. There were GPs who still felt that patients with ED should be managed by the specialists, rather than at the general practice.

“ED is a pathological condition which should be managed, I think, personally, by a consultant with a very, very detail, a very thorough investigation.” (I)

“I found that he got problem that I would refer to the urologist, let them settle the problem. If they come back with a definite diagnosis, prescribed with Viagra, then I will deal with it.” (K)

Patient’s background. Moreover, the socioeconomic status of the patients also influenced the GP’s prescribing pattern. The GPs would tend to prioritise the treatment according to their comorbidities. ED would be considered at a lower priority.

“The place where I practise has poorer patients. So other things are more of priority. The richer ones, we sometimes talk to them about this problem... the poorer one usually... unless they open up, I don’t want to...” (L)

Some GPs also had a negative view of bachelors who sought treatment for ED, as they felt that the bachelors in the first place should not be engaged in sexual activities.

“But they are bachelors, they shouldn’t engage in sex. You know why I mentioned this because the doctor is a party to it. We are involved in dispensing it.” (J)

“He can afford to pay. But the way you talk to him, he looks like he may misuse it. So, whether you want to give it to him.” (K)

Discussion

The Process of Care Model for ED outlined a goal-oriented approach for the diagnosis and treatment of ED.⁶ This excludes specialised diagnostic testing in most patients and instead focuses on the identification of a suitable treatment. This approach, together with the availability of effective new oral anti-ED drugs, has shifted the treatment of ED from the specialists to general practice.⁷ GPs who were previously unfamiliar with the management of the disease were forced to acquire new knowledge and skills about ED. This has resulted in the GPs assuming different roles when treating ED. It is hence not surprising that most of the GPs in this study were rather passive when confronted with patients with ED.

One of the main factors that influenced their passivity in managing ED was their perception of the disease. Most GPs would consider medical illnesses such as diabetes mellitus and hypertension as diseases with serious complications, while sexual and psychological problems were felt to be of less priority. This attitude could be due to the common belief among the GPs that physical illnesses are more serious compared to psychological or sexual disorders. However, this may not coincide with the expectation of the patients when they seek treatment⁸ and, as a result, patients remain untreated. This may cause poor patients’ satisfaction and affect their quality of life.⁹

Sildenafil, although proven to be effective in the treatment of ED of most aetiology,¹⁰ was still regarded by GPs as a lifestyle drug. This might be due to their

perception of ED being a 'non-disease'. The fear that the users might potentially abuse the drug caused anxiety among the prescribers. This could be partly due to the difficulty in making an objective diagnosis in ED, which relied mainly on the patient's history rather than by an objective test. Another reason could be that the doctors were assuming a social responsibility, especially when they knew that the patients were taking the anti-ED drugs for extramarital affairs or with multiple partners.

Another reason why the GPs were hesitant in actively asking patients for ED problem was the fear of being perceived as 'pushing' for the drug. The wide publicity of the new anti-ED treatment had resulted in an increasing number of patients seeking treatment at the general practice. However, majority of them were expecting the doctors to initiate the topic, rather than volunteering their sexual problems. Metz observed that although the majority of men reported some sexual concerns, only 19% actually discussed these issues with their physicians.⁸ They preferred the physician to broach the topic first. It is interesting to note that the GPs were worried about how the patients might perceive their prescribing pattern. This perception could be due to the fee-for-service practice in Malaysia, where the GPs charge for their consultations as well as drugs dispensed from their clinics.

The fear of being blamed for the side effects of the drugs was another consideration. Some GPs were still apprehensive to prescribe sildenafil due to its potentially serious cardiovascular side effects. Studies have shown that sildenafil can be safely prescribed to patients with coronary artery disease who are not taking nitrates.¹¹ This reluctance to prescribe sildenafil might not be necessarily due to lack of knowledge, as majority of them were aware of the safety of the anti-ED drugs and had attended courses regarding ED. Possible reasons include a lack of self-confidence and unpleasant past experience.⁵ This might result in patients not receiving appropriate treatment and unnecessary referral to the specialists.

GPs tend to adopt a more proactive attitude towards patients whom they have managed for a long time. Patients suffering from diabetes mellitus or hypertension were considered to be of higher risk of developing ED. Hence, GPs were more likely to discuss with them regarding sexual problems. This observation was consistent with the results of studies conducted by Pertutula¹² and Rutchik *et al*,⁷ who found that family physicians inquired about ED if the patients fall into appropriate age categories or if medical risk factors could be identified. However, this does not translate into prescribing appropriate ED treatment because ED was considered by most GPs as a non-serious condition compared to other chronic medical diseases. Some held back the prescription of anti-ED drugs to avoid poly-pharmacy. They were also

hesitant to prescribe anti-ED drugs to patients from lower socioeconomic strata to avoid incurring additional cost to them.

In conclusion, GPs who participated in this study remained passive in identifying and treating patients with ED and this was attributed to their perception of the disease, drug treatment and patient's background. This observation has major implication in terms of meeting patient's expectation and providing quality of care to the patients. The GPs should always consider patient's priorities and discuss openly the options of ED treatment with them before a clinical decision is made. They should also assume a more proactive role to improve the detection and treatment of patients with ED presenting to general practice.

Acknowledgements

This study was supported in part by educational grants from the Asia Pacific Society for Impotence Research (APSIR), and by GlaxoSmithKline Pharmaceutical and Bayer Healthcare.

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