Results of a national needs assessment for continuing medical education of family physicians related to erectile dysfunction and/or male sexual dysfunction

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BACKGROUND: Family physicians are the first point of contact for men who are experiencing erectile dysfunction (ED) and andropause. At the same time, most patients with ED are not identified or treated by health care professionals. This can result in under-recognition and inadequate management of sexual health pathology.

OBJECTIVES: The present study undertook to identify Canadian primary care physicians' demographics, learning needs and preferences for continuing medical education in relation to ED. The results would aid in the development of educational programs in the area of male sexual dysfunction.

METHODS: Surveys were distributed to a stratified, proportionate, random sample of 5000 Canadian physicians. The survey asked about screening practices, comfort with sexual history taking, preferred educational format, perceived difficulty and incidence of common male sexual problems, barriers to treatment and demographic information.

RESULTS: Almost 40% of physicians reported being nonscreeners. Those who reported asking all male patients about their sexual health (global screeners) reported statistically higher comfort levels than those who only screened selectively (selective screeners) or not at all (nonscreeners). The most common and most difficult condition to treat was found to be sexual problems in couples. The greatest challenge in managing ED was reported to be treating couples by nonscreeners, treatment failures by selective screeners and time required to treat for global screeners. A 1 h overview course was the most preferred educational format.

CONCLUSION: The results suggest that any educational intervention that increases comfort with sexual history taking will also increase screening among family physicians. However, educators need to consider the specific learning needs for each group of screeners.

Key Words: *Continuing medical education; Male sexual dysfunction; Needs assessments; Screening*

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Résultats d'une évaluation nationale des besoins en matière de formation médicale continue, effectuée auprès des omnipraticiens en ce qui concerne le dysfonctionnement érectile ou sexuel mâle

CONTEXTE : Les omnipraticiens sont les premières ressources que consultent les hommes souffrant de dysérection ou d'andropause. En même temps, la plupart des patients qui présentent de la dysérection ne sont pas dépistés ou traités par des professionnels de la santé, d'où sous-reconnaissance et traitement inadéquat possibles de ces troubles sexuels.

OBJECTIF : La présente étude avait pour objectif de relever les données démographiques des médecins de premier recours au Canada, leurs besoins d'apprentissage et leurs préférences en matière de formation médicale continue relativement à la dysérection. Les renseignements ainsi recueillis faciliteraient l'élaboration de programmes de formation en ce qui concerne les troubles sexuels mâles.

MÉTHODE : Un sondage a été envoyé à un échantillon aléatoire proportionnel stratifié de 5000 médecins. Les questions portaient sur les pratiques de dépistage, l'aisance à relever les antécédents sexuels, la formule préférée de cours, la difficulté perçue d'aborder les problèmes sexuels mâles courants et leur fréquence, les obstacles au traitement ainsi que des données démographiques.

RÉSULTATS : Presque 40 % des médecins ont déclaré ne pas faire de dépistage. Ceux qui disaient poser des questions à tous les hommes sur leur santé sexuelle (dépisteurs systématiques) ont fait état d'un degré d'aisance statistiquement plus élevé que ceux qui ne faisaient que du dépistage sélectif (dépisteurs sélectifs) ou qui n'en faisaient pas du tout (non-dépisteurs). Le problème le plus fréquent et le plus difficile à traiter était les troubles sexuels au sein des couples. Les difficultés les plus grandes dans le traitement de la dysérection se sont avérées le fait de traiter des couples par les non-dépisteurs, les échecs de traitement par les dépisteurs sélectifs et le temps nécessaire au traitement pour les dépisteurs systématiques. La formule de cours qui a recueilli le plus large consensus a été le tour d'horizon d'une heure.

CONCLUSION : Les résultats donnent à penser que toute intervention éducative facilitant la prise des antécédents sexuels aura pour effet d'accroître le dépistage des troubles par les omnipraticiens. Toutefois, les éducateurs doivent tenir compte des besoins d'apprentissage propres à chacun des groupes de dépisteurs.

Since the advent of more 'patient-friendly' medications for the treatment of erectile dysfunction (ED) and andropause, family physicians have become the first point of contact for most men who complain of sexual problems (1). As the role of the family physician has grown, so has the number of educational opportunities available for non-specialists to learn about the management of male sexual heath problems.

It has been long recognized that health care professionals have not identified most patients with ED. Despite extensive public education, as many as 85% of patients with ED have not been identified or treated. While there may be many reasons for this, it has been shown that patients expect that physicians will routinely ask about their sexual health. If physicians do not routinely screen patients for sexual problems, there will be an under-recognition and inadequate management of sexual health pathology.

In the present study, primary care physicians were divided into three hypothetical groups according to their screening behaviours. One group of physicians (global screeners) asked most or all of their patients screening questions about sexual health. A second group selectively screened patients at high risk for sexual problems – for example, diabetic patients. A third group, nonscreeners, did not initiate any screening questions, but may have responded by investigating sexual health complaints that their patients initiated.

TABLE 1
Number of questionnaire responses in each screening group

Level of screening	French-speaking Quebec (%)	Rest of Canada (%)	Total (%)
Nonscreeners	56 (49.5)	291 (38.2)	351 (39.7)
Selective screeners	35 (31.0)	295 (38.7)	334 (37.7)
Global screeners	22 (19.5)	177 (23.2)	200 (22.6)

There are no published data that define the characteristics, learning needs or preferences of each group.

The University of Calgary, Alberta, in conjunction with the Fédération des Médecins omnipraticiens du Québec, undertook a survey of the demographics, learning needs and preferences of primary care physicians from across Canada in anticipation of developing educational programs for family physicians in the area of male sexual health.

DATA AND METHODS

A computer-scored survey was sent out to 5000 randomly selected family physicians across Canada. The survey was distributed to each region in numbers that reflected the proportion of family physicians in each province. Family physician demographics included primarily those who were in primary care and in full-time practice.

The questionnaire (Appendix 1) asked about usual screening practices, comfort level with sexual history taking, preferred educational format, perceived difficulty and incidence of common male sexual problems, barriers to treating ED and demographic information.

RESULTS

Of the 5000 surveys distributed (3800 to English-speaking physicians in Canada and 1200 to French-speaking physicians in Canada), 69 surveys were returned unanswered and 905 surveys were returned completed – 122 (10%) from Quebec and 783 (21%) from the rest of Canada, giving an overall response rate of 18%. Sixty-five per cent of respondents were men and 35% were women.

Screening approaches

The number of responses in each screening group is reported in Table 1. Almost 40% of family physicians reported

TABLE 2
Number of questionnaire responses by region of Canada

Region	Nonscreeners (%)	Selective screeners (%)	Global screeners (%)
Atlantic Canada	20 (28.2)	40 (56.3)	11 (15.5)
Quebec	67 (47.2)	44 (31.0)	31 (21.8)
Ontario	123 (39.4)	108 (34.7)	81 (25.9)
Prairies	57 (32.8)	71 (40.8)	46 (26.4)
British Columbia	69 (42.1)	66 (40.2)	29 (17.7)

TABLE 3
Mean of commonality and degree of difficulty of clinical situations, along with the sum of these scores

Clinical situation	Mean score for commonality	Mean score for difficulty (ranking)	Sum of the means (ranking)
Sexual problems in couples	3.39	3.43 (5)	6.82 (1)
Patients with low desire	3.21	3.35 (6)	6.56 (2)
Issues of infidelity	2.85	3.46 (4)	6.31 (3)
Patients with painful intercourse	2.60	3.32 (7)	5.92 (4)
Patients with erectile dysfunction	3.21	2.63 (8)	5.84 (5)
Patients with rapid ejaculation	2.27	3.50 (3)	5.77 (6)
Patients with delayed ejaculation	1.88	3.73 (2)	5.61 (7)
Patients with retrograde ejaculation	1.66	3.90 (1)	5.56 (8)
Patients with low testosterone	2.27	2.60 (9)	4.86 (9)

being nonscreeners. There were no significant differences in sex distribution among the screening groups.

There appeared to be differences in screening rates across the country. For the ease of analysis, responses were divided into five regions: Atlantic Canada, Quebec, Ontario, the prairies and British Columbia. The results displayed in Table 2 demonstrate that the highest rates of self-reported screening (selective screening plus global screening) occurred in Atlantic Canada (71.8%) and the prairies (67.2%). The lowest screening rates were in Quebec (51.8%) and British Columbia (57.9%).

There were significantly fewer (P=0.008) rural family physicians who were global screeners (42 of 260) compared with urban family physicians (153 of 605).

Comfort levels with sexual history taking

Participants were asked to rate their comfort level with sexual history taking (1 = very uncomfortable; 5 = very comfortable). Comfort levels of global screeners (mean 4.09) were significantly higher than those of selective screeners (mean 3.84) and nonscreeners (mean 3.37).

Comfort level of sexual history taking was greater in English-speaking physicians (mean 3.73) than in French-speaking physicians (mean 3.58), although this did not reach statistical significance.

Commonality and difficulty of various sexual problems

Participants were asked how common certain sexual dysfunctions were in practice (1 = very uncommon; 5 = very common) and how difficult these conditions were to treat (1 = not at all difficult; 5 = very difficult). It was proposed that by summing these two results, higher values would provide a strong indication of areas of high perceived need for educational programming (ie, situations that were both common and difficult to treat).

Table 3 reports the mean of commonality and the degree of difficulty of each clinical problem, along with the sum of these scores. Rankings are shown in brackets.

Challenges to the management of ED

The greatest challenges to the management of ED are reported in Table 4. Respondents were asked to rate each factor according to how much of a barrier it presented to the management of ED (1 = not at all challenging; 5 = highly challenging). Scores are presented in descending order of most challenging, based on the nonscreening group. The rank order of the other screening groups is shown in parentheses. Clinical significance (P<0.05) between the groups in denoted by an asterisk.

Preferred educational formats

Physicians were asked what type of continuing medical education (CME) event on male sexual dysfunction they would prefer to attend: a 1 h overview course, a 3 or 4 h MAINPRO-C course, a full-day MAINPRO-C course, or a short, 30 to 40 min drug company lunch. Respondents were asked to indicate if it was 'very likely', 'perhaps likely' or 'not at all likely' that they would attend a CME event on male sexual dysfunction. The results are shown in Table 5.

There were differences in the preferred learning formats between the screening groups. These differences are detailed in Table 6. Nonscreeners were less likely to attend programs on male sexual health and preferred shorter educational programs, while those who were more active in

TABLE 4
Mean scores of the greatest challenges to the management of erectile dysfunction

Challenge to treatment	Nonscreeners (ranking)	Selective screeners (ranking)	Global screeners (ranking)	Group results (ranking)
Treating couples*	3.63 (1)	2.76 (6)	2.64 (6)	3.48 (1)
Treatment failures*	3.53 (2)	3.45 (1)	3.32 (2)	3.45 (2)
Availability of resources	3.42 (3)	3.45 (1)	3.30 (3)	3.40 (3)
Time required to treat	3.39 (4)	3.23 (3)	3.32 (1)	3.32 (4)
Laboratory evaluation	3.38 (5)	3.21 (4)	3.30 (3)	3.30 (5)
Nonlaboratory evaluation*	3.32 (6)	3.03 (5)	2.97 (5)	3.13 (6)
Knowing who to treat*	3.01 (7)	2.76 (6)	2.64 (6)	2.83 (7)
Comfort with screening*	3.00 (8)	2.58 (8)	1.96 (9)	2.61 (8)
Cardiac risk*	2.54 (9)	2.34 (9)	2.26 (8)	2.40 (9)

**Statistically significant difference between screening groups, P<0.05*

TABLE 5
Respondents' likelihood of attending a continuing medical education event on male sexual dysfunction

Type of event	Not very likely (%)	Perhaps likely (%)	Very likely (%)
1 h overview course	88 (10.3)	279 (32.8)	484 (56.9)
3 or 4 h MAINPRO-C course	137 (16.1)	311 (36.5)	403 (47.5)
Full-day MAINPRO-C course	427 (52.7)	270 (33.3)	113 (14.0)
30 to 40 min drug company lunch	206 (24.8)	278 (33.5)	345 (41.6)

TABLE 6
Preferred learning formats of respondents

Format of program	Nonscreeners who may attend (%)	Selective screeners who may attend (%)	Global screeners who may attend (%)
1 h overview course	87.4	92.0	89.1
3 or 4 h MAINPRO-C course	78.6	85.9	89.4
Full-day MAINPRO-C course	43.8	45.7	54.6
Short, 30 to 40 min drug company lunch	72.5	75.8	72.3

TABLE 7
Respondents' levels of intervention for the management of erectile dysfunction

Management of erectile problems	Non-screeners (%)	Selective screeners (%)	Global screeners (%)
Do not see this problem	5.2	1.2	1.0
Refer with a minimum of inquiry	21.8	5.2	3.6
Refer after obtaining ancillary information	32.8	25.9	23.3
Attempt to fully assess and treat	40.1	67.6	72.0

screening patients for sexual problems preferred to attend longer programs.

Level of intervention in the management of ED

The level of intervention was examined among the screening groups. Four options were presented with respect to the management of ED – 'do not see this problem', 'refer with a minimum of inquiry', 'refer after obtaining ancillary information', and 'attempt to fully assess and treat'. The results are shown in Table 7.

DISCUSSION

The level of global screening for male sexual health problems was disappointingly low. Only 22% of respondents indicated that they routinely asked most of their male patients about their sexual health.

It appears that the comfort level with sexual history taking correlates strongly with screening for sexual dysfunction. The more comfortable physicians are with taking sexual histories, the more likely they are to screen their patients for sexual problems. This suggests that any educational intervention that increases comfort in sexual history taking will also increase the level of screening among family physicians.

There is evidence that increasing physicians' comfort levels with sexual history taking through a structured educational activity will increase physicians' comfort levels with sexual history taking and, thus, their levels of intervention. This suggests that the best way to encourage nonscreeners to become more active in asking their male patients about their sexual health is to increase their comfort levels with sexual history taking.

In general, couples' sexual problems were reported to be common and difficult to treat. Associated couple-based problems (low desire, infidelity and ED) were also reported to be common and difficult problems to treat.

Rapid ejaculation, which is felt by experts to be a very common male sexual health problem, was considered to be uncommon based on the questionnaire responses. This learning gap should be addressed by an educational activity.

Overall, there was a lower 'challenge' score for global and selective screeners (2.9 and 3.1, respectively) compared with nonscreeners (3.3). This was statistically significant ($P<0.05$), and may indicate a higher level of self-efficacy for screeners.

It is interesting that nonscreeners listed 'treating couples', 'treatment failures' and the 'availability of resources' as the greatest barriers to management. If nonscreeners do not ask their patients about ED or sexual problems, how can 'treating couples' or 'treatment failures' be barriers? It may suggest that these are the greatest presumed barriers, rather than actual barriers. It is interesting to note that those who do screen their patients see 'treating couples' as a lesser challenge.

'Time required to manage' was reported to be the greatest challenge to global screeners. However, this group also reported the highest comfort level with sexual history taking and the highest intervention level of managing patients with ED.

CONCLUSIONS

The findings of the present study suggest that educators should develop a variety of educational programs that target the specific needs of each group. To encourage greater screening for sexual problems in men, CME should promote the skill of sexual history taking.

APPENDIX 1
National needs assessment for erectile dysfunction (ED) and/or male sexual dysfunction

1. What is your usual approach to male patients and screening for sexual problems?

( ) I do not routinely ask about their issues. If a patient brings up a concern of this nature, I refer the patient.
( ) I do not routinely ask about male sexuality. If a patient brings up a concern of this nature, I will attempt to investigate and treat.
( ) I will ask patients who are at risk for ED if they have any problems with sexual function.
( ) I ask all, or virtually all, of my male patients about their sexual health.

2. What is your comfort level in taking a complete sexual history of your male patients?

Very uncomfortable doing a sexual history				Very comfortable doing a sexual history
1	2	3	4	5

3. If a continuing medical education event on male sexual problems addressed your learning needs, how likely would you be to attend the following?

	Very likely	Perhaps	Not at all likely
1 h overview course	( )	( )	( )
3 to 4 h MAINPRO-C course	( )	( )	( )
Full-day MAINPRO-C course	( )	( )	( )
A short, 30 to 40 min drug company lunch	( )	( )	( )

4. For each of the following clinical situations, how common is this in your practice and how difficult is this for you to manage with regard to your male patients?

	How common is this in your practice?					How difficult do you find it to treat?				
	Very uncommon				Very common	Not at all difficult				Very difficult
Patients with ED	1	2	3	4	5	1	2	3	4	5
Patients with rapid (premature) ejaculation	1	2	3	4	5	1	2	3	4	5
Patients with delayed or inhibited ejaculation	1	2	3	4	5	1	2	3	4	5
Patients with retrograde ejaculation	1	2	3	4	5	1	2	3	4	5
Patients with low desire	1	2	3	4	5	1	2	3	4	5
Sexual problems in couples	1	2	3	4	5	1	2	3	4	5
Issues of infidelity	1	2	3	4	5	1	2	3	4	5
Patients with painful intercourse	1	2	3	4	5	1	2	3	4	5
Patients with low testosterone	1	2	3	4	5	1	2	3	4	5

continued on next page

APPENDIX 1 (continued)
National needs assessment for erectile dysfunction (ED) and/or male sexual dysfunction

5. Consider your treatment of men with ED. How challenging are each of the following with respect to good management?

	Not at all challenging				Highly challenging
Time required	1	2	3	4	5
Comfort with screening	1	2	3	4	5
Cardiac risk assessment with treatment	1	2	3	4	5
Treatment failure	1	2	3	4	5
Knowing who to treat	1	2	3	4	5
Treating couples	1	2	3	4	5
Availability of referral sources	1	2	3	4	5
Laboratory evaluation of ED	1	2	3	4	5
Nonlaboratory evaluation of ED	1	2	3	4	5

6. Are you ( ) Male ( ) Female

7. Year of graduation from medical school: _____

8. Medical school of graduation: ( ) Canadian or American ( ) International

9. Certification status: ( ) CFPC ( ) FRCPC ( ) GP Other (specify): _____

10. In what province do you practise?

( ) Newfoundland
( ) Prince Edward Island
( ) Nova Scotia
( ) New Brunswick
( ) Quebec
( ) Ontario
( ) Manitoba
( ) Saskatchewan
( ) Alberta
( ) British Columbia
( ) Northwest Territories
( ) Nunavut

11. Practice location: ( ) Rural ( ) Urban

12. How many clinical hours, per week, do you practise?

( ) 20 hours or less per week ( ) more than 20 hours per week

13. Approximately what percentage of patients in your practice is male?
( ) <20%
( ) 20%–40%
( ) >40%

Approximately what percentage of your male patients is older than 40 years of age?
( ) <20%
( ) 20%–40%
( ) >40%

14. What would best describe your management of erection problems in your practice?

( ) I do not see this problem.
( ) When I see this problem, I refer with a minimum of inquiry and assessment.
( ) I will obtain ancillary information (ie, complete history; medical, sexual, psychiatric and physical examinations; and laboratory investigations, if necessary) and then refer.
( ) I will attempt to fully assess and treat this patient. I will refer only if my strategies are not helpful.

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