

# An exploratory study to assess primary care physicians' attitudes toward talking about sexual health with older patients in Trinidad and Tobago

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## ABSTRACT

**Background:** A good quality sex life and interest in sex are positively associated with health in middle-aged and later life. For effective diagnosis of sexual health problems, an appropriate discussion about sexual health issues including a sexual history is advised. The sexual health care delivery and management during consultations by primary care physicians is relatively unexplored, especially for older patients. This paper aims to explore primary health care physicians' (PCPs) attitudes to sexual health care and management of middle-aged and older patients in Trinidad and Tobago. **Methods:** In-depth, semi-structured interviews were conducted with 35 PCPs in Trinidad and Tobago. Topics examined included physician-patient relations, sexual health care management challenges, communication and sexual history taking practices, and training needs of PCPs. The framework analysis method was adopted for analysis. **Results:** Most doctors stated that they were not comfortable with conducting a sexual history with their older patients, and they rarely discussed or initiated talking about sexual health with them. Barriers included time constraints, inappropriate environmental conditions for privacy, inadequate professional referral services, insufficient medical training in sexual function in middle and old age, reluctant patient behavior, conflicting personal beliefs on sexuality, and socio-cultural factors. **Conclusion:** PCPs may be reluctant to raise sexual health-related issues with their older patients, and these older patients may not initiate this discussion because of discomfort and embarrassment. Consequently, physicians' inability to effectively communicate with these patients could result in missed opportunities for interventions and patients' concerns may remain unheard and their sexual problems untreated.

**Keywords:** Middle-aged, old aged, primary care, sexual health, sexual history taking, sexuality

## Introduction

In primary care, sexuality in later life is often neglected.<sup>[1]</sup> This is contradictory to the fact that everyone aspires to grow old, the second largest population on earth is over 45 years and older (owing to increased longevity), and people in this age group are still sexually active.<sup>[2]</sup> As a result, the same attention

that is given to improve their daily life filled with comorbidities from chronic diseases, improving their sexual health-related quality of life should also be considered. However, health care professionals, researchers, government policies, and even globally agreed sustainable development goals have been known to overlook sexuality, sexual health care, and sexual views of older people.<sup>[3]</sup> For sexual health of the middle-aged and beyond to be put on the agenda, the first hurdle to overcome is for people regardless of age to be able to openly talk about sex. Talking about sex is difficult for most, even in

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the medical setting including between physicians and patients of middle and old age.<sup>[4]</sup>

Middle-aged and older patients frequent the primary care setting for their general health concerns, which may include sexual health care.<sup>[5]</sup> There are very important clinical reasons for addressing sexual health issues during the medical visit such as identifying sexual dysfunction.<sup>[6]</sup> In fact, sexual dysfunction should possibly be considered a core sexual health concern particularly with the middle-aged and beyond because of its high prevalence - most often undiagnosed and untreated.<sup>[7]</sup> Studies indicate that older adults value sexuality and engage in sexual activity such as the National Social Life, Health, and Aging Project study in the US that indicates more than half of people aged 57–85 and about a third of those aged 75–85 are sexually active.<sup>[8]</sup> It is possible that sexual concerns are common among patients; however, there is evidence to suggest that these concerns are not appropriately investigated by clinicians.<sup>[9]</sup>

Although patients may want to attain sexual health care, they are rarely forthcoming with expressing their sexual health concerns to their doctors. A review by McAuliffe *et al.* and other population based studies, identified some reasons for these patients' communication barriers with their health care professionals.<sup>[10,11]</sup> The study also included the apparent lack of expression of sexuality to their partners indicating that communicating issues regarding sexuality is difficult in general.<sup>[10,12,13]</sup> These included attitudinal barriers such as myths around sexuality and aging; physiological barriers such as sexual dysfunction; or physical barriers (loss of partner or lack of privacy or during a medical consultation where a relative or friend may be present, or situations where some patients have developed relationships while residing in nursing homes).<sup>[10,14]</sup> Sexual health provision for middle-aged and older patients within primary care appears to be inconsistent and dependent on the attitudes and training of PCPs (some of whom may be too embarrassed to discuss sex).<sup>[15,16]</sup>

### Diagnosing sexual health concerns

Despite its importance, many health care professionals feel concerned about their ability to take an appropriate sexual history, regardless of how skilled and confident they may be taking a standard medical history.<sup>[17]</sup> Research suggests that general practitioners (GPs) do not proactively discuss sexual health with their middle-aged and older patients. Unsurprisingly, as we noted that sexuality in the media and sexual health in our existing care policies and surveillance systems for sexually transmitted infections (STIs) is equated with younger people, the same is true within primary care.<sup>[17]</sup> Studies indicate that physicians in primary care (including general practice) appear to have limited knowledge about sexuality in older patients. Specifically, female physicians have less knowledge and had more negative attitudes toward sexuality in this age group. Communication barriers between patients and physicians (among others) have been suggested as one of the main reasons for a low report

rate of sexual dysfunction.<sup>[18]</sup> It should be noted that sexual dysfunction such as erectile dysfunction (ED) is indicative of other underlying medical conditions such as diabetes, pituitary tumors, cardiovascular conditions such as atherosclerosis and depression, and hence, should not be ignored.<sup>[19-21]</sup>

This paper aims to explore the attitudes of primary health care physicians' (PCPs) in Trinidad and Tobago when discussing sexual health and its care with their middle-aged and older patients.

## Methods

A qualitative methodology using in-depth semi-structured interviews was employed. This method allowed the researcher to further explore primary care physicians' perspectives on sexual health care for middle-aged and older adults and their attitudes to discuss sex with these patients.

### Sampling

In-depth, semi-structured interviews were conducted with a purposive sample of GPs/PCPs in Trinidad and Tobago. A provisional target of 40 interviews was set with the intention that no new data would arise using the sampling to redundancy or theoretical saturation approach. The researcher narrowed the sampling frame to include PCPs based in two out of five health authority districts nationwide. Trinidad and Tobago is a twin island state, thus, one district in each island was selected. As there is only one in Tobago – the Tobago Regional Health Authority was selected, and the largest of the four Regional Health Authorities (RHAs) in Trinidad namely the North West Regional Health Authority was chosen for Trinidad. The participant criteria were mainly depending on physician gender, years of experience, and whether they worked in the private or public sector. Secondary criteria determined if they were working with rural or urban communities and whether the PCPs had any experience managing special clinics such as sexual health, chronic disease, or gerontology.

### Recruitment of PCPs and GPs

The lists of PCPs currently employed and available (not on vacation) were provided by the County Medical Officer of Health for that district enabling the researcher to confirm sample and recruitment. PCPs were mapped using the aforementioned sample criteria as a guide and contacted and offered a participation request. The final list of study participants were recruited according to their response to availability and willingness to participate. GPs were recruited through purposive sampling that met the same sample criteria.

### Data collection and analysis

The interviews conducted were part of a wider mixed-methods study that aims to assess PCPs overall knowledge, attitudes, and practices with regard to sexual history taking, communication and management of sexual health care for

middle-aged and older patients. The topic guide employed was not only informed by supporting literature but also according to the questions derived from *a priori* hypotheses being tested in the wider study. The aim of the interview phase was to determine physician's general perception of the sexual healthcare status of patients aged 45 years and older and physicians' views about taking a sexual history and communicating with these patients about sexual health. The topics explored included the physician-patient relationship; sexual health in later life; sexual health care priorities; clinical experience on managing sexual health in older adults, delivery, and challenges in primary care; factors facilitating and hindering effective communication of sexual health including taking a sexual history; and physicians' training needs in sexual health care of older adults.

After getting the consent from the participants, the interviews were conducted in consultation rooms within the health centers where participants worked. Interviews were digitally recorded and transcribed verbatim by the primary investigator. The complete data set was analyzed using framework analysis, a content analysis method that uses a thematic approach to classify and interpret summaries of the qualitative research data.<sup>[22]</sup> The backbone of the framework was created using the core themes identified in the literature and *a priori* themes. Using deductive methods, the interview data were coded and classified under these headings and frames in MS Excel. Inductive methods followed to further analyze the emerging themes that arose from the data summaries. The framework coding and analysis were done by the primary researcher, and a sample of transcripts was double coded and others reviewed by the research supervisor.

### Ethical considerations

Ethical approvals were attained from the ethics committees of the London School of Hygiene and Tropical Medicine and the Ministry of Health of Trinidad and Tobago. All linkable or identifying details were replaced with a code to identify gender and practice type, e.g., MPV (Male, Private) or FPB (Female, Public) followed by a 2-digit code to protect the participants and maintain confidentiality.

## Results

In-depth, semi-structured interviews were conducted with 35 PCPs from private ( $n = 19$ ) and public healthcare practices ( $n = 16$ ) in Trinidad and Tobago. A provisional target of 40 interviews was set, however, it was observed that no new data arose using the sampling to redundancy or saturation approach,<sup>[23]</sup> by the 35<sup>th</sup> interview, as many participants provided repetitive verbatim or similar perspectives on the same questions. During purposive sampling, the researcher aimed to ensure that the range of characteristics and experiences of the PCPs interviewed met the sampling criteria closely. Non-responders,  $n = 3$ , were because of the unavailability to participate. The PCPs

collective experiences (attitudes and subsequent actions) during sexual health consultations with patients of middle and old age and the socio-cultural factors that may have shaped these behaviors are presented below.

### Communication barriers in sexual health consultations with older patients

PCPs described various obstacles responsible for the ineffective communication that ensued during discussions regarding sexual health concerns of middle-aged and older patients. Categorized broadly, these barriers include socio-cultural factors, workplace setting limitations, and the status of the physician-patient relationship. Influenced by PCPs personal beliefs about sexuality, factors such as age, gender, ethnicity, religiosity, education level, socio-economic or professional status, and community locale (rural or urban) impact on the outcome of sexual health discussion.

### Socio-cultural factors

#### *PCPs personal beliefs about discussing sex*

Discussing sex in the medical setting appeared to be taboo for most physicians in this study. When PCPs were asked to describe how they felt when talking about sexual health with their middle-aged and older patients, the words "reluctant," "reserved," or "uncomfortable" were most common. Notably, during the interviews with the researcher, some PCPs even in their past accounts about older patients, they avoided use of words or phrases with "sex" or "sexual" in them and never mentioned the sexual reproductive organs by name, although these are all appropriate medical sexual jargon.

"Some of the patients complain that they don't feel to... (*PCP whispers*) you know? to go and do... (*PCP nods at researcher to assume understanding of the words omitted*) so I explain that this happens at menopause" FPB01

"What's happening is a normal thing (*PCP refers to menopause*) and they shouldn't stop, you know...? (*PCP looks assumingly at the researcher*). I let them know that they could still have the best..." (*nods his head expectantly at researcher to assume understanding of the words omitted*) MPB03.

Some PCPs even avoided the term "sexual history" and referred to it as "those" questions. Other PCPs were able to articulate the words but felt uneasy about taking a sexual history and that the sexual history itself appeared to be a barrier.

"When you are asking 'those' questions, they start to look away, show signs of anxiety and being uncomfortable. There are some boundaries, you know, (*nods in agreement at researcher*) I do feel uncomfortable" FPB07.

### Gender preferences

PCPs reported that when it comes to discussing sexual concerns, their middle-aged and older patients preferred speaking to physicians of their same gender. PCPs shared that they too were more comfortable as they recalled better rapport with the patients in those consultations.

“Most women would prefer to see a female doctor” [Male PCP]

“I have had a couple male patients who were open talking about sex, and I did find it a little bit uncomfortable.” [Female PCP]

“Most women even with a female PCP don’t want to disclose sensitive sexual health info at a clinic where they know the people who work there” [MPV02].

PCPs recommended for future, it should be optional for patient’s not to register their health concern with the other attending health care personnel that they visit prior to consultation with PCP.

### Age

PCPs identified “age gap” as a barrier. In their accounts of their sexual health consultations with older patients, “discomfort,” “embarrassment,” and “fear” were common themes resulting from ageist views on who is eligible to ask or talk about sex. PCPs reported that as their patients get older, if they are still sexually active they perceive their own sexuality as something to hide, otherwise they expect it is to be non-existent.

“Personally, it’s a difficult topic (sexual health) to broach especially when you’re dealing with people who could be the age of your parents who might think that this is not something to be discussed” FPB07.

Some PCPs reported a profound anxiety to talk about sexual concerns with a patient with whom there was a vast age difference between them. For instance, PCPs have stated that patients who perceive them as “very young” are more likely to be reluctant to discuss sexual concerns with them regardless of who raised the topic. The PCPs themselves found it difficult to discuss sexual health with older patients because they recognize the patients as elders to whom respect must be shown and discussing sex – the topic or asking an elder about their private experiences, was perceived by some PCPs as invasive, too personal or disrespectful.

“A woman of 70 years is not going to start talking about her sexual health because it might sound disrespectful. Regardless, only if she brings it up, no problem, I will talk about it, but I would not bring it up” MPB08.

### Community (Locale)

PCPs reported that in small rural communities they have noticed communal social norms and practices to socialize together and to share about each other’s chronic illnesses except for sexual health matters. PCPs found older patients to be more shy or outright reticent on this topic in such closed societies. PCPs also discovered that some of their older patients preferred to pursue alternative medical routes especially for sexual concerns because they felt it was too taboo to discuss in a formal clinical setting.

“A lot of them will go to the herbalist and buy these things rather than seek professional help. They come to us only after these alternative methods did not work or made their circumstances worse” FPV04.

### Religion and ethnicity

PCPs voiced that it is more noticeable that both physician and patient are inhibited from effectively discussing sexual health-related issues (regardless of who raises it), if the patient is of a staunch religion or of a different ethnicity.

“I ask more of the Afro-Trinidadian men. If they are Muslim I wouldn’t dare go there, they are too religious. Very religious people won’t want to discuss this, they don’t want to go there.” [PCP’s ethnicity: Afro-Trinidadian]

“You get more openness from Afro-Trinidadian women than you do from Indo-Trinidadians – to me... African women are far freer with talking casually about these things. Indian women are a lot more cagey...” [PCP’s ethnicity: Mixed Trinidadian]

In most cases, PCPs were more comfortable with speaking with a patient who was of a similar ethnicity as they assumed having possibly more similar cultural stance on sexuality and less likely to offend the patient.

### PCPs sexual health training

Almost all PCPs admitted that they did not have sufficient exposure to information about sexual health in general and even less or not all pertaining to middle-aged and older adults during their medical training. They felt this may have disadvantaged them in terms of their level of competence around communication of such sensitive topics and having adequate knowledge to offer appropriate care.

“In med school we did not have much exposure to sexual health; it is not fully integrated into the curriculum as much as what would be needed to make us competent at practicing” FPB06.

PCPs have also admitted that they are just not familiar with prevalent sexual health concerns in middle and old age other than erectile dysfunction, menopause, and sexually transmitted infections (STIs).

### Diagnostic sexual history taking skills

PCPs reported that if they do take a sexual history with this age group, it is not done routinely and only because a patient presenting a complaint (mostly STI-related), or as in majority of the cases if the patient initiates the discussion. It was unanimous among PCPs that taking a sexual history with these patients is indeed important; however, not prioritizing it is more common practice

“From my personal experiences I haven’t done a lot of it unless they brought it up” MPB02.

In a sexual history, asking about one’s sexual orientation is the most avoided question, and because of the discomfort, all 35 PCPs interviewed stated that, they had never asked their older patients this question.

“I” would be very uncomfortable, I actually never asked a patient that (referring to sexual orientation) but maybe it is something that we need to consider. Sometimes on their physical appearance you may wonder that, sometimes a lot

of patients become offended if you ask any questions like that, especially in our culture. We do not see asking sexual orientation as a normal question, so I have never considered that to be honest” FPB05.

Few PCPs shared their experiences in consultation with homosexual patients, however, none of these PCPs shared experiences treating a transgendered middle or old aged patient up to the time this data were collected.

### *Patient's lack of education*

Some PCPs described how it was difficult to engage with older patients when they held entrenched beliefs about sex, making it difficult to offer advice such as “being a condom user infers that you have an infection,” “having sex with a virgin can cure HIV,” and “sexual dysfunction means not being able to have sex five and six times a day”

“In terms of an older audience, you cannot teach old dog new tricks it’s a little more difficult to change their mind about some things MPB06.

PCPs admitted that they really feel turned away to discuss sexual health with a patient who is ill informed and difficult to accept their counsel. PCPs suggested that there is need for population wide health promotion in sexual health education tailored for patients in middle and old age about the sexual health concerns as they are more likely to face at this point in their lives.

“I think once the public is sensitized that doctors will be asking these questions from time to time they will be more aware and won’t think you are minding their business” FPB03.

### *Workplace limitations*

PCPs described that the clinics are oversubscribed by mostly middle and old aged patients of a lower socio-economic status. Although PCPs are encouraged to focus on chronic disease management for this age group, namely diabetes, hypertension, and other cardiovascular diseases, they have recognized that sexual health care is linked to some of these chronic diseases.

“We work in a system that is tremendously overloaded with patients and understaffed with doctors. You try to focus more on the problem they came for than address issues that they have with sexuality” MPB02.

### *Lack of appropriate preventative care and referral services*

PCPs acknowledged that there is no focus on sexual health care of middle-aged and older adults; the current PC system they work in does not foster supportive systems such as genitourinary medicine (GUM) services for sexual dysfunction in women and men in middle and old age and far less for psychosexual therapy. Men rarely attend the health center; they have denial issues when it comes to having health problems, especially impotency. For these patients to be accurately diagnosed, PCPs

refer their patients for secondary care at the nearest hospital for a gynaecologist or a urologist consultant in private health care (if the patient can afford it).

“We need to have the support systems for appropriate referrals and we also need to be competent to investigate.... A lot of times we are not, and we cannot inform patients” MPB05.

### *Resource poor setting*

PCPs explained that they work in resource poor settings with a limited manpower, time, and treatment options, which hamper their ability to be more exploratory during their consultations.

“doctors in the community will reiterate that we wish we had more time to actually provide optimal primary healthcare” MPB03.

Even when PCPs do attempt to address sexual health issues they concur that the environment in most public health centers is not conducive in making the patient feel comfortable and, in some cases, there are concerns about maintaining confidentiality.

“Public health centres don’t offer privacy for patients, so the patients will be in one room and they will not be a real door, there is just like a curtain and you can come in at any time” FPB04.

Necessary infrastructural changes to the consultation rooms in some primary buildings are needed so that they can install doors or use sealed off rooms for more privacy. In addition, all patients could be given an optional brief sexual health care assessment questionnaire to complete and give directly to their PCP. This technique is successful 3-fold as it offers the opportunity for the patient (i) to identify sexual health issues and keep this confidential to themselves by passing registering this with other health care personnel; if completed it triggers the PCP to initiate a sexual health discussion/take a sexual history and (ii) the patient and PCP can address this concern during the consultation more comfortably as the patient will be expecting the discussion.

### *Professional barrier*

There appeared to be collective beliefs about roles in primary care regarding the expected physician-patient relationship. PCPs reported that older patients view them as a person in authority and part of the elite in society who they should treat with respect (regardless of their age).

“When people come to the clinic or hospital they’re expectant, they’re needy and they come from a position where they feel you are high up and they’re down there” MPB05

“There is a professional barrier; doctor vs. patients, they don’t see the doctor as being an equal; they see the doctor as being this person of authority, so they are very cautious about what they say to you” FPB06.

The reality is that hierarchy creates a professional barrier between physician and patient. Patients revere the PCP inculcating professional boundaries and the physicians offer

paternal focused care mostly because of the resource limitations and sometimes because of the patient's education level or lack of compliance to treatment regime or they prefer it.

### Physician-patient rapport

PCPs reported that they try to foster better rapport by keeping their questions brief, while letting patients know that sexual health is important and that their issues are common in the attempt to facilitate the discussion and make the patient less uncomfortable (as well as themselves). However, despite the obstacles expressed by most interviewed doctors some of the more experienced PCPs used communicative techniques to empathize and inspire the patient's trust to facilitate a sexual health discussion or even to take a history.

“It has to do with empathy. First, try to calm their fears, convince them that you have their best interests in mind. Educate them, let them know that there's a privacy clause that cannot be broken at all; now they'll open and talk to you. When they start, whenever they come to the clinic, they look for you.” MPB03

## Discussion

PCPs acknowledged that they have limited medical training in sexual health of older adults and communication skills in sexual health. PCPs also spoke about their “reluctant” patients' behavior that made it difficult to broach or continue a discussion on the topic, as well as how their own beliefs and the above-named socio-cultural influences affect impact on their sexual health care and delivery. All interviews were conducted in primary healthcare settings, some at times when it was extremely busy and this could have been a limitation as interviews had to take place during a space between patient consultations or on the physician's lunch break. Some physicians may have provided socially acceptable answers that may be false because they felt that their position or office could be under examination as the study was permitted by the Ministry of Health.

The PCPs overall attitudes when talking about sex in primary care were discomfort, disinclination to treat sexual health issues of middle-aged and older as a priority, and insecurity with regard to how much they knew about sexual health of this age group. These findings have much similarity with other findings in the literature. For example, Gott *et al.* found that GPs in the UK do not address sexual health proactively with older people and that, within primary care, sexual health is equated with younger people and not seen as a valid topic for discussion with the older age group.<sup>[17]</sup> Low level of awareness of later life sexual health issues among GP participants and significant barriers to initiate discussion relating to sexuality in consultations with older patients were similarly identified. The authors also acknowledged the need for continued professional education in sexual health of older adults for physicians.<sup>[17]</sup> The reservation among older patients and their healthcare providers regarding the discussion of sexual health, frequently constitutes the main barrier to open and effective

communication. A study conducted by Politi *et al.* concluded that the older patients felt that health care providers should ask about sexual health issues only if questions relate to an associated health problem (e.g., STIs) and in ways that can be answered by all regardless of partner status and follow questions with non-judgmental discussions. If the physician can initiate such a discussion and a good screening sexual history is routinely elicited, much useful information will be obtained.<sup>[24]</sup> Furthermore, the patient may become informed to a number of issues of which he or she might not have been aware.<sup>[25]</sup> Perhaps a door has been opened so that if concerns or problems about sexual functioning arise in the future, the patient will feel more comfortable discussing them with the doctor.<sup>[25]</sup>

Many physicians feel concerned about their ability to take an appropriate sexual history, regardless of how skilled and confident they may be taking a medical history. Similarly, in our study, PCPs voiced their lack of confidence regarding their professional competencies in sexual health care and communication with older adults. These findings may also exist in other countries whose medical school curricula is being taught with a similar socio-cultural influence. Regardless of the uncomfortable situation, or patient's age or gender, a sexual history is very important, and there are core components of a sexual history that every practitioner should ask and discuss.<sup>[25]</sup> With reference to the middle-aged and older age group of this study, identifying sexual dysfunction should possibly be considered a core component because of the high prevalence of sexual dysfunction in this general population - most often undiagnosed and untreated.<sup>[26]</sup> It should also be identified as a marker of organic or psychiatric disease, e.g., ED, as a risk marker for cardiovascular disease, and as an iatrogenic side-effect of medication or surgery.<sup>[26]</sup>

Regarding the professional barriers that exist in the physician-older patient relationship this may be more specific to Trinidad and Tobago and possibly other countries that still promote the paternalistic model of care, specifically because of the resource constraints, lack of sexual healthcare policies on the national level, and strong socio-cultural influences. However, patients have an inbuilt respect for professional roles/office. This society is taught to have respect for people in authority.

This interaction with the PCP embracing a more paternal role is reinforced because most middle-aged and older patients do not have many alternatives (besides unaffordable private care) to seek sexual health care elsewhere. This is because it is unlikely for them to attend family planning clinics as they do not meet the criteria (or interested in contraception or fertility, and seeking antenatal or postnatal care). There are sexual health clinics (GUM services), but a referral is usually required from a health (primary care) center, and these services focus primarily on medicalized sexual health care – HIV and other STIs rather than sexual health-related quality of life and sexual functioning and well-being, which may be more pertinent to this age group. Middle-aged and older patients are more likely

to seek doctors in the primary care setting or the GP (private), both at which they seem to have difficulty acquiring care for their sexual health needs.<sup>[25]</sup>

Unfortunately, sexual problems are frequent among older adults, but these problems are infrequently discussed with physicians.<sup>[12]</sup> The physicians agree it is their responsibility to initiate discussions about sexual health (putting aside their personal discomfort talking about sex with an older patient), however, because of their resource poor settings and time constraints, some feel it should be a shared responsibility, especially if it is a concern of the patient. This causes controversy over the societal norm of paternalistic care. Although the physicians want to be in control of the consultation (particularly with regard to treatment options), they do not want to exhibit this control when talking about sex with the patient. The patient also does not want to broach the topic as they are also uncomfortable thinking that they will disrespect the physician. Contrary to these needs, if the reverse situation occurs where sexual health is not a primary complaint, and the physician initiates the discussion the patient is even more uncomfortable and feels disrespected.

Existing evidence suggests that discussing later life sexual health issues within medical consultations is problematic both for patients and for professionals. Because of these dilemmas, the suggested way forward will include the promotion of appropriate health education for all, further research and policy development in sexual health and provision of appropriate resources to improve sexual health care for middle-aged and older adults. There is urgent need for up-to-date sexual health education for medical students, present day physicians, and patients. There must be implementation of sexual health policies that include care for the middle-aged and beyond; medical education policies that ensure mandatory continuing medical education in sexual health, sexual history taking, and sexuality of older adults for practicing physicians.<sup>[27]</sup> With regard to further research, there is need to determine the middle-aged and older patients' perspective of barriers and facilitators when communicating with physicians, their sexual health needs, and services they require and to compare with the views expressed by physicians.

## Conclusions

Primary care physicians may be reluctant to raise sexual health-related issues with their older patients. Their patients' may not initiate this discussion because of discomfort and embarrassment. Consequently, physicians' inability to effectively communicate with these patients result in missed opportunities for health care prevention and intervention, and patients' concerns may remain unheard and their problems untreated. As a result, there is an urgent need to address sexual health care among this vastly increasing middle-aged and older population in our health system with regard to care and treatment, health education, and training policies with our medical physicians in primary care.

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## Conflicts of interest

There are no conflicts of interest.

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