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# Breaking the Ice of Erectile Dysfunction Taboo: A Focus on Clinician–Patient Communication

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**Abstract**

Erectile dysfunction is a common yet complex problem facing men and their partners worldwide. It continues to be an under reported issue despites its high prevalence and negative impact as well as the availability of successful treatment. One of the main reasons for such a problem is the stigma surrounding it as a complaint and the deep-seated fear to discuss it. This paper aims to highlight the reasons behind the taboo and dilemma behind erectile dysfunction reporting and discusses means to overcome this stigma focusing on clinician–patient communication.

**Keywords**

erectile dysfunction, under reporting, taboo, clinician–patient communication

## Introduction

Erectile dysfunction (ED) is defined as a consistent or recurrent inability to attain and/or maintain penile erection sufficient for sexual performance, in which a 3-month duration of ED is required to meet the criteria of consistency (1,2). It is a complex condition that involves biological and psychosocial factors. In keeping with the International Society of Impotence Research, ED can be classified into 3 subtypes (1,3):

1. organic (iatrogenic, neurogenic, vasculogenic, and hormonal),
2. psychogenic,
3. mixed erectile dysfunction.

The above classification mandates a careful assessment in order to avoid misdiagnosis.

From a historical point of view, the prevalence of ED has been hard to estimate since it is not life-threatening, patients often do not seek treatment, and literature terminology for the condition has been confusing (4). Perhaps the most often cited study is The Massachusetts Male Aging Study (MMAS) that was conducted in 1994 revealing the prevalence of ED to be 52% in non-institutionalized men aged 40 to 70 years, in the Boston area; 17.2%, 25.2%, and 9.6% for minimal, moderate, and complete ED, respectively (5). In addition, the prevalence of ED in the general population according to the Cologne Male Survey of 4889 men showed an age-related increase in ED. Regular sexual activity was reported by 96.0% (youngest age group) to 71.3% (oldest group). It revealed that 31.5% to 44% of responders were dissatisfied with their current sex life. The prevalence of ED was 19.2%, with a steep age-related increase (2.3%-53.4%) and a high co-morbidity of ED with hypertension, diabetes, pelvic surgery, and "lower urinary tract symptoms" (6).

### *Why Is Sex Important?*

For the majority of people, some form of sexual expression is an integral part of a full and healthy life (7). World authorities have declared that sex is a basic human right and an important part of life. A survey involved over 26 000 persons in 28 countries found that, at least in the group aged 40 to 80 years, about 83% of men and 63% of women describe sex as "extremely," "very," or "moderately" important (8). ED is known to carry a negative psychological impact on patients. Patients with ED suffer from a multitude of

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psychological problems such as depression, liability to loss of self-esteem, feeling of worthlessness, losing workplace attention, and experiencing loss of concentration (9).

In a large cohort of patients with type 2 DM (n = 1460), ED was associated with higher levels of diabetes-specific health distress and worse psychological adaptation to diabetes, which were, in turn, related to worse metabolic control (10). A Cross-National Survey on Male Health Issues surveyed men aged 20 to 75 years in 6 countries about ED. Men in all countries agreed that ED was a source of great sadness for themselves and their partners (11). The psychological impact is not limited to patients with ED since it also involves their partners. They can feel guilty, unwanted, or not attractive anymore. Shame and worrisome can happen leading to the partners being distant from each other. Eventually, the crisis in the relationship would be the result.

Despite all these issues, the condition remains under reported. It is estimated that greater than 70% of ED patients remain undiagnosed because many men are still reluctant to discuss it despite being a major public health problem worldwide (1).

## ED Taboo and Dilemma

When discussing the taboo and dilemma of ED, 2 major factors stand out as barriers facing this condition. The first is patient-related factors outlined in Table 1 (12,13).

The second is the physician-related factors. Many physicians still avoid talking about sex/ED with their patients. Reasons are outlined in Table 2 (14–16).

In a study by Baldwin and colleagues, 500 consecutive men over the age of 30 years visiting their urologist's office for problems unrelated to ED were asked, whether or not they had any difficulty with their potency. Those who gave a positive response were then asked to complete a written questionnaire to assess their reasons for underreporting and whether they had any previous discussions with their primary-care physicians regarding their sexual function. Of the 500, 218 (44%) reported experiencing some degree of ED. Of the 218 men, 161 (74%) were embarrassed; 27(12%) felt that ED was a natural part of aging; 20 (9%) were unaware that urologists dealt with ED; and 10 (5%) did not consider the problem worthy of attention. Of the 170 patients who did not report having such discussions, 140 (82%) reported that they would have liked their primary-care physician to have initiated a discussion of ED during their routine visits (17). In another study, a postal questionnaire was sent to 218 GPs to investigate their role in the management of problems of sexual dysfunction. GPs were asked to list their views on barriers to the management of sexual dysfunction. The participating GPs offered specific suggestions that focused on the need for more professional and patient education, consultation time, psychosexual counselors, and relevant secondary care service (18). Furthermore, a study was aiming to test the knowledge, attitude, and practice (KAP) of physicians (including urologists) towards ED in the Eastern province of Saudi Arabia by means of a 34-item questionnaire. The mean total KAP score for the group was below the expected standard of 60% (19). Solursh et al (20) examined the human sexuality education of physicians in North American medical schools. A prospective cohort study was carried out to assess how well 125 schools of medicine in the United States and 16 in Canada prepare physicians to diagnose and treat sexual problems. They found that less than a third of the respondent medical schools offer a required course on human sexuality and fewer teach medical students how to take a detailed sexual history and concluded that expansion of human sexuality education in medical schools may be necessary to meet the public demand of an informed health provider.

**Table 1.** Patient-Related Factors as Barriers in ED Taboo and Dilemma (12,13).

| Patient-related factors as barriers in ED taboo and dilemma |
|---|
| • Embarrassment/stigma about own sexual life |
| • Being inherently private and sensitive issue to men |
| • Misconception of the condition being a normal process of aging and thus no treatment is warranted |
| • Loss of self-esteem and depression leading to avoidance |
| • Belief that the condition is psychological |
| • Belief that the condition is transient and would be short-lived |
| • Perception of no medical treatment exists to address it |
| • Lack of routine screening in the society |

## Breaking the Ice of ED Taboo and Dilemma

The successful management of ED starts by recognizing the issues then dissolving the ice of this culturally sensitive matter. In order to do so, physicians should remember some rules of thumb. These rules would act as a good start to screen the patients as outlined in Table 3 (21).

**Table 2.** Physician-Related Factors as Barriers in ED Taboo and Dilemma (14–16).

| Physician-related factors as barriers in ED taboo and dilemma |
|---|
| • Feeling constrained by tightly scheduled appointments not paying attention to such as issue |
| • Not considering ED a serious priority when compared with other conditions associated with high morbidity or mortality |
| • Consideration of ED as quality of life (QoL) matter not a medical issue |
| • Not being comfortable talking about sex or sex-related issues with their patients |
| • Misconception or feeling that questions related to sexual satisfaction may be intrusive or embarrassing |
| • Lacking knowledge about sexual health and its management |
| • Lack of expertise |
| • Female physicians may not be comfortable to discuss male sexual dysfunction that could be reflected by the physician cultural or religious background |

**Table 3.** Rules of Thumb to Break the Ice of ED Taboo and Dilemma (21).

| Rules of thumb to break the ice of ED taboo and dilemma |
|---|
| • Understand the patient's ongoing psychological issues |
| • Make sure to establish good patient rapport |
| • Be flexible and cognizant of the deeply seated values and beliefs of each patient including cultural and religious beliefs |
| • Carry out the initial meeting in a quiet environment without any interruptions or a sense of haste |
| • Avoid carrying out a moral role |
| • Realize that similar values and experiences between the patient and the physician are not essential for a successful interview |
| • Listen carefully to the patient in a nonjudgmental manner |
| • Try to be at ease with the vocabulary used |
| • Describe sexual terminology and wording in layman's jargon without sounding condescending or degrading |
| • Consider interviewing the partner with the patient's consent |

## *Other Strategies to Break the Ice of ED Taboo*

Some strategies have been suggested to have to the physician–patient dialogue taking place before the face-to-face interview. In a study describing an Italian situation through a 20-year experience of Rome's Clinical Sexology Institute in training doctors and psychologists interested in acquiring the specific competencies required to work in the sexology field. The authors analyzed calls received during a 3-year period (n = 944) and concluded that telephone counseling is an important and effective resource to elicit requests that otherwise might remain hidden. It can be a useful link between the healthcare system and callers (22). Physicians can use a variety of techniques to introduce the topic of sexual functioning and satisfaction before the formal meeting for history taking begins. Such techniques include using patient-friendly displays and brochures in the waiting and examining rooms, using novelties (eg, lapel buttons), and discussion with the staff in an informal and comfortable atmosphere (23).

The use of a standardized questionnaire on ED can introduce the patient to a personal unexplored topic by asking questions that may be hard to answer initially on a one-to-one basis. The questionnaire can be mailed, emailed, or left in the waiting room. This is now further aided by the vast availability of social media resources and applications. When a large group of physicians was asked to hand out a short patient questionnaire to all male patients over 30 years, a high level of acceptance was observed and 54% of discussions of sexual health were prompted by it. The authors concluded that addressing a patient's sexual health as part of a physician's everyday routine is feasible in terms of duration and content; and that a short patient questionnaire is an excellent aid for patients and physicians for initiating communication on the topic (14).

## *The Importance of Communication Skills*

Improving the communication skills of the physicians dealing with patients with ED can help at easing the atmosphere around the topic which would place patients at more comfort to open up. For patients who have no obvious risk factors for ED, use open-ended or general questions, such as "how is sex going for you lately?" or "are you having sex with your partner?" Answers to these basic questions and queries can help set the stage for further discussions if needed (21,23).

For men with known risk factors, such as diabetes, the physician can get important information by asking "permission-giving questions." Example of such questions: "several of my male patients with diabetes or high blood pressure have difficulty with erections. What about you?" or "Many men (of your age/with your condition) have revealed sexual difficulties. If you have any difficulties, I am happy to discuss them" or "I can help you, if you are having issues. This can make the patient with diabetes feel more comfortable, rather than singled out or being different." If the patient replies that he does have a problem with erections, the physician will not seem shocked or surprised (21,23).

Other facilitation techniques during the face-to-face interview include nodding in agreement, showing interest and reinforce it, and repeating or rephrasing the patient's response to further get his attention. For example, if a patient says, "well, doctor, I'm having some issues with sex lately," the physician could reply with, "Oh, so you're having some issues with sex? Go ahead tell me a little bit more about it," or you may like elaborate about it (23).

Physicians should make effort to ask the right questions at the right time. Although some patients may well initiate discussions about any sexual difficulties, nevertheless physicians are likely to practice their communication skills to introduce and talk about the subject. Sadovsky et al (24) introduced some questions aiming at reviewing the phases of the male sexual cycle and focus specifically on issues of desire, arousal/erection, orgasm/ejaculation, and sexual pain. As such, determining the exact nature of the sexual problem will then assess in guiding subsequent evaluation and treatment approaches.

## *Role of Education*

Coverdale et al,(25) showed that physicians who were mailed educational materials about sexual history taking and received an unannounced instructor visit performed better in risk assessment and counseling than others. Shabsigh et al,(26) performed a randomized, blinded, multicenter, controlled study to examine the impact of a multiyear continuing medical education (CME) initiative on physician knowledge and behavior in the treatment of ED. They concluded that disease-specific CME initiatives are important in that they positively impact the knowledge and therefore the behavior of participating physicians, potentially conferring clinical benefits toward patient outcomes. Training courses on ED management, utilizing a combination of tutorial and interactive sessions, constitute an effective way of providing

**Table 4.** Indications for a Specialist Referral (29,30).

| Indications for a specialist referral |
|---|
| • Level of physician training/experience is not adequate |
| • Patient requested for a referral |
| • Patients for whom initial, minimally invasive treatment has failed |
| • Patients for whom certain minimally invasive treatments are contraindicated |
| • Patients with significant penile deformities |
| • Patients with histories of significant penile or pelvic trauma |
| • Complex problems including cardiovascular/neurological/endocrine |
| • Patients with obvious relationship problems or crisis |
| • Patients who lack known risk factors for ED or are young (< 30 years), suggesting a psychogenic pathology |
| • Patients who present with ED accompanied by severe depression |

knowledge, enhancing physicians' communication skills with ED patients, and positively influencing attitudes toward patient-centeredness in sexual issues (27). In addition, previous training in communication skills was found as the strongest predictor for sexual history taking and the management of sexual problems, as it improves their level of comfort in dealing with these issues. At the same time, exposure to sexual medicine courses, psychosocial orientation, and physicians' personal sexual attitudes, is also important factors affecting their involvement in sexual medicine (28).

### *Specialist Referral. When to Refer?*

Managing ED is not always the function of a specialist. Many ED patients are being managed at the beginning by first-line physicians such as primary health care workers or general urologists. However, physicians, in general, should know when to refer for a specialist with special interest or training in sexual medicine. A list of circumstances that necessitate referral is outlined in Table 4 (29,30).

## Conclusion

ED is common yet under-reported due to the stigma surrounding it. It has negative psychological outcomes for men and their partners. The silence of ED is governed by both patient and physician factors. Strategies and techniques are available and should be practiced to engage the patients. Physicians should continue to improve their communication skills. Continued education is a key to overcome ED under-reporting and stigma which will eventually aid to break the ice of its taboo and dilemma.

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### References

1. Impotence: NIH Consensus Development Panel on Impotence. JAMA. 1993;270(1):83-90.
2. Montague DK, Barada JH, Belker AM, Levine LA, Nadig PW, Roehrborn CG, et al. Clinical guidelines panel on erectile dysfunction: summary report on the treatment of organic erectile dysfunction. The American Urological Association. J Urol. 1996;156(6):2007-2011.
3. Lizza EF, Rosen RC. Definition and classification of erectile dysfunction: report of the Nomenclature Committee of the International Society of Impotence Research. Int J Impot Res. 1999;11(3):141-143.
4. Safarinejad MR, Hosseini S. Erectile dysfunction: clinical guidelines (1). Urol J. 2004;1(3):133-147.
5. Feldman HA, Goldstein I, Hatzichristou DG, Krane RJ, McKinlay JB. Impotence and its medical and psychosocial correlates: results of the Massachusetts Male Aging Study. J Urol. 1994;151(1):54-61.
6. Braun M, Wassmer G, Klotz T, Reifenrath B, Mathers M, Engelmann U. Epidemiology of erectile dysfunction: results of the 'Cologne Male Survey'. Int J Impot Res. 2000; 12(6):305-311.
7. Satcher D. Office of the Surgeon G, Office of Population A. Publications and Reports of the Surgeon General. The Surgeon General's Call to Action to Promote Sexual Health and Responsible Sexual Behavior. Rockville (MD): Office of the Surgeon General (US); 2001.
8. Nicolosi A, Buvat J, Glasser DB, Hartmann U, Laumann EO, Gingell C. Sexual behaviour, sexual dysfunctions and related help seeking patterns in middle-aged and elderly Europeans: the global study of sexual attitudes and behaviors. World J Urol. 2006;24(4):423-428.
9. McCulloch DK, Campbell IW, Wu FC, Prescott RJ, Clarke BF. The prevalence of diabetic impotence. Diabetologia. 1980;18-(4):279-283.
10. De Berardis G, Franciosi M, Belfiglio M, Di Nardo B, Greenfield S, Kaplan SH, et al. Erectile dysfunction and quality of life in type 2 diabetic patients: a serious problem too often overlooked. Diabetes Care. 2002;25(2):284-291.
11. Perelman M, Shabsigh R, Seftel A, Althof S, Lockhart D. Attitudes of men with erectile dysfunction: a cross-national survey. The J Sexual Med. 2005;2(3):397-406.
12. DiMeo PJ. Psychosocial and relationship issues in men with erectile dysfunction. Urologic Nursing. 2006;26(6):442-6. 53; quiz 7.
13. Sand MS, Fisher W, Rosen R, Heiman J, Eardley I. Erectile dysfunction and constructs of masculinity and quality of life in the multinational Men's Attitudes to Life Events and Sexuality (MALES) study. J Sexual Med. 2008;5(3):583-94.
14. Hartmann U, Burkart M. Erectile dysfunctions in patient-physician communication: optimized strategies for addressing sexual issues and the benefit of using a patient questionnaire. J Sexual Med 2007;4(1):38-46.
15. Shabsigh R, Stone B. Understanding the needs and objectives of erectile dysfunction patients. World J Urol. 2006; 24(6):618-622.

16. William A, Fisher SM, Sand M, Brandenburg U, Buvat J, Mendive J, Sandra Scott A. Communication about erectile dysfunction among men with ED, partners of men with ED, and physicians: The strike up a conversation study (Part 1). J Mens Health Gend. 2005;2(1):64-78.
17. Baldwin K, Ginsberg P, Harkaway RC. Under-reporting of erectile dysfunction among men with unrelated urologic conditions. Int J Impot Res. 2003;15(2):87-89.
18. Humphery S, Nazareth I. GPs' views on their management of sexual dysfunction. Family Practice. 2001;18(5): 516-518.
19. Abdulmohsen MF, Abdulrahman IS, Al-Khadra AH, Bahnassy AA, Taha SA, Kamal BA, et al. Physicians' knowledge, attitude and practice towards erectile dysfunction in Saudi Arabia. Eastern Mediterranean health journal = La revue de sante de la Mediterranee orientale = al-Majallah al-sihhiyah li-sharq al-mutawassit. 2004;10-(4-5):648-654.
20. Solursh DS, Ernst JL, Lewis RW, Prisant LM, Mills TM, Solursh LP, et al. The human sexuality education of physicians in North American medical schools. Int J Impot Res. 2003;15(Suppl 5):S41-S45.
21. Chun J, Carson CC. 3rd. Physician-patient dialogue and clinical evaluation of erectile dysfunction. Urologic Clinics of North America. 2001;28(2):249-258, viii.
22. Simonelli CFA, Rossi R, Silvaggi C, Tripodi F, Michetti PM. Clinical sexology: An integrated approach between the psychosomatic and the somatopsychic. Sexologies. 2010; 19(1):3-7.
23. Sadovsky R. Integrating erectile dysfunction treatment into primary care practice. Am J Med. 2000;109(Suppl 9A): 22S-28S; discussion 9S-30S.
24. Sadovsky R, Dunn M, Grobe BM. Erectile dysfunction: the primary care practitioner's view. Am J Managed Care. 1999; 5(3):333-341; quiz 42-3.
25. Coverdale JH, Balon R, Roberts LW. Teaching sexual history-taking: a systematic review of educational programs. Academic Medicine: Journal of the Association of American Medical Colleges. 2011;86(12):1590-1595.
26. Shabsigh R, Sadovsky R, Rosen RC, Carson CC, 3rd, Seftel AD, Noursalehi M. Impact of an educational initiative on applied knowledge and attitudes of physicians who treat sexual dysfunction. Int J Impot Res. 2009;21(1):74-81.
27. Athanasiadis L, Papaharitou S, Salpiggidis G, Tsimtsiou Z, Nakopoulou E, Kirana PS, et al. Educating physicians to treat erectile dysfunction patients: development and evaluation of a course on communication and management strategies. J Sexual Med. 2006;3(1):47-55.
28. Tsimtsiou Z, Hatzimouratidis K, Nakopoulou E, Kyrana E, Salpigidis G, Hatzichristou D. Predictors of physicians' involvement in addressing sexual health issues. J Sexual Med. 2006;3(4):583-588.
29. Droupy S, Ponsot Y, Giuliano F. How, why and when should urologists evaluate male sexual function? Nat Clin Pract Urol. 2006;3(2):84-94.
30. I.D.S. When to refer the patient with erectile dysfunction to a specialist. In: B GA (eds) Oral pharmacotherapy for male sexual dysfunction current clinical urology. Humana Press; 2005.