

Original article

Attitudes and practice patterns of Finnish obstetrician-gynecologists regarding patients' sexual problems

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ABSTRACT

Objective: Female sexual problems are common but are not routinely assessed in obstetrician-gynecologist appointments. Therefore, we evaluated obstetrician-gynecologists' attitudes and practice patterns regarding their patients' sexual problems.

Study design: A web-based questionnaire was used to collect information from each respondent on gender, age, education, occupational status, and the total number of patients treated per day and sexual issues dealt with per day.

Main outcome measures: This study covered three fields of interest: 1) attitudes toward sexual problems, 2) practice patterns in sexual history-taking, and 3) practice patterns in the treatment of sexual problems.

Results: Of the 328 respondents, 299 provided eligible responses (specialists, 83 %, $n = 249$; residents, 17 %, $n = 50$). Almost all obstetrician-gynecologists (95 %) considered treating sexual problems as an important health care practice, but only 45 % and 53 % asked about sexual problems and sexual life satisfaction during general medical history-taking, respectively. Most obstetrician-gynecologists (86 %) used open conversation to assess sexual history. Half (52 %) of them reported that diagnosing female sexual problems is difficult, with the female obstetrician-gynecologists (54 %) more likely to report difficulty than the male obstetrician-gynecologists (29 %). Of the obstetrician-gynecologists, 15 % prescribed medications, whereas 58 % prescribed other treatments. A third (34 %) received distinct instructions from their organization for referring patients to continued care.

Conclusions: Although almost all obstetrician-gynecologists reported that treating sexual problems is an important health care issue, fewer than half routinely inquired about sexual problems. The practice patterns regarding sexual problems were disorganized. Our results show a need for additional clinical practice guidelines and education in sexual medicine.

1. Introduction

Sexuality is an important aspect of quality of life [1,2]. However, sexual problems are common, with the prevalence of female sexual dysfunction (FSD) ranging from 40 % to 50 %, irrespective of age [3]. Many different health care professionals—for instance, certified nurses, sexuality educators, sexuality counselors, and sexuality therapists, as well as physicians in various fields—take part in the management of

sexual problems. Obstetrician-gynecologists (OB/GYNs) are some of the key health care professionals who diagnose and treat female sexual problems, but previous studies have reported that OB/GYNs underestimate the occurrence of FSD in their patient populations [4,5].

Many patients wish that health care professionals would initiate discussions about sexual health issues. In a Norwegian study, 87 % of women reported agreeing to OB/GYNs asking about their sexual function [6]. In a Latvian study, only one-third of women reported that they

Abbreviations: FSD, female sexual dysfunction; OB/GYN, obstetrician-gynecologist; aOR, adjusted odds ratio; CI, confidence interval; vs., versus.

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had ever been asked about their sexual life by a gynecologist, but most declared that they would like to be asked [7]. Furthermore, in surveys of patients with sexual problems, only a third reported seeking medical care for sexual symptoms [8,9]. According to a US study among women who sought help for a sexual problem, 42 %, 24 %, and 12 % consulted a gynecologist, a general practitioner, and a psychiatrist, respectively [10].

The frequency of bringing up sexual issues by OB/GYNs has widely varied due to differences in study methods and terminologies, ranging from sexuality in general to actual FSD diagnosis [4,5,11–14]. Only 8 % of Swiss gynecologists [11] and 21 % of German OB/GYNs [12] routinely brought up sexual function, whereas 63 % of US OB/GYNs assessed patients' sexual activities and 40 % routinely asked about sexual problems [13], and 50 % of British urogynecologists [5] and 77 % of US urogynecologists [4] regularly screened for FSD. Although OB/GYNs unanimously agree that screening for FSD is important [4,5,11], several barriers hinder them from bringing up the issue, including lack of time [4,5,12,15], education [4,12,15], and experience [15].

Practice patterns in sexual health screening indicate that both open-ended questions and specific questionnaires can both be used. To ease patient management, models such as “Permission, Limited Information, Specific Suggestions, and Intensive Therapy (PLISSIT)” [16,17] and “Bring up, Explain, Tell, Time, Educate, Record (BETTER)” [18] have also been suggested. In these models, all health care professionals should utilize the first two steps of each model. Most previous studies have focused on screening for sexual problems, but studies of other practice patterns are sparse [11,12]. Furthermore, patterns of referral to continued care have varied greatly [11,12], presumably because the health care systems vary largely between different countries and continents. In a German study, half of OB/GYNs treated 50 % or more of their patients who presented with sexual problems. The most common approaches included psychosocial counseling, medical treatments, education, and recommendations [12].

Previous studies have shown gender-related differences in attitudes and practice patterns in sexual medicine. Some studies found female OB/GYNs to be more active in assessing sexual health issues [12–14], but other studies [4,5] showed no such difference. In a review of 97

studies on gender differences in OB/GYNs' practice patterns, males more often prescribed medications (5/7 studies) and females more often made referrals (5/7 studies) [19]. Furthermore, some previous studies have shown that younger OB/GYNs are more active in sexual history-taking [12,13]. Over time, a more open mood about sexuality might especially ease younger physicians in bringing up sexual issues. However, not all previous studies have confirmed any age differences [4,5,14].

The aim of our study was to assess practicing OB/GYNs' attitudes and self-reported practice patterns regarding sexual problems, with special regard to gender and age. We hypothesized that OB/GYNs bring up sexual problems infrequently, which may lead to insufficient management of FSD. The information provided by this study can be used to improve OB/GYNs' sexual medicine education.

2. Methods

2.1. Study population

This study was a part of the Finnish Sexual Medicine Education (SexMEdu) study, in which we evaluated the practice patterns and the level of sexual medicine education in Finland. Data collection methods have been described in our previous article [15]. The participants were recruited through an email link to an online questionnaire. The link was sent to the members of The Finnish Society of Obstetrics and Gynecology, which consists of OB/GYN specialists and residents. The original link and two reminders were sent between January 2019 and February 2020. An additional reminder email was sent to the chief OB/GYNs in Finnish hospitals.

The survey was completed by 328 respondents. Eight respondents were excluded because they did not work as clinicians. In addition, due to identical background information, 21 possibly duplicate questionnaires were excluded. Thus, the completed questionnaires from 299 respondents were eligible for analysis. The number of respondents represented one-third (34 %) of all Finnish OB/GYN specialists [20]. Of all respondents, 93 % were female, corresponding to the gender distribution of Finnish OB/GYN specialists (87 % female) [20].

The participants' basic characteristics (Table 1) included gender

Table 1
Basic characteristics ($N = 299$).

	%	<i>n</i>
Gender		
Female	93	278
Male	7	21
Other	0	0
Age (years)		
Young (28–39)	27	82
Middle-aged (40–49)	36	107
Late middle-aged (50–74) ^a	37	110
Education		
Specialist	83	249
Resident	17	50
Occupational status ^b		
Hospital	72	214
Private sector	56	166
Primary health care	5	14
Researcher	14	41
Clinical teacher	5	16
Patients treated per day		
1–10	39	116
≥11	61	183
Patients dealt with sexual issues per day		
0	14	41
1–5	74	221
≥6	12	37

^a Many retired Finnish physicians still continue part-time working mainly in the private sector.

^b More than one occupational option could be chosen. Includes also OB/GYNs, who also reported to be retired, students, on maternal leave or sick leave.

(female/male/other), age (years), education (OB/GYN specialist/resident), and occupational status (hospital/private sector/primary healthcare/researcher/clinical teacher/retired/other [maternal leave/leave of absence/sick leave/not currently working]/student). The respondents' mean (standard deviation) age was 47.1 (11.0) years (range, 28–74 years) overall, 46.5 (10.5) years (range, 28–74 years) for the females, and 55.0 (14.0) years (range 30–74 years) for the males. In statistical analysis, the respondents were divided into three age groups: young, <40 years; middle-aged, 40–49 years; and late middle-aged, ≥50 years. The respondents' sexual medicine education was assessed as follows: 10 % ($n = 29$) had additional education in sexual medicine (sexuality educator/counselor/therapist or clinical sexologist training [authorized]) and 2 % ($n = 7$) had other therapy training. For occupational status, more than one option could be chosen, as Finland permits working in different sectors at the same time (e.g., in a hospital during office hours and in the private sector after office hours). Our data indicated that 72 % ($n = 214$) of the respondents worked in a hospital, including 44 % in the private sector and 3 % in primary healthcare. In addition to their hospital work, 19 % and 7 % worked as researchers and clinical teachers, respectively. Moreover, 19 % reported working only in the private sector. Furthermore, 12 retired OB/GYNs reported still working in the private sector, which is allowed in Finland. Because a large number of patients per day can lead a physician to be hasty and overlook sexual problems, the number of patients the OB/GYNs treated per day was assessed and analyzed according to two groups: 1–10 and ≥ 11 patients. If OB/GYNs are accustomed to managing sexual problems, this probably echoes in their attitudes and practice patterns. That is why we included in the analyses the number of patients who dealt with sexual issues per day, which was analyzed according to three groups: none, 1–5 patients, and ≥ 6 patients.

2.2. Questionnaire

The study questionnaire was adapted from the Portuguese SEXOS study questionnaire [21,22]. Permission to use the questionnaire was obtained from the researchers.

The study contained the following fields (Table 2):

- A) Attitudes toward sexual problems (five questions)
- B) Practice patterns in sexual history-taking (two questions)

Table 2
Study questionnaire.

A) Attitudes toward sexual problems

Each item is rated on a 5-point scale defined as follows:

1 = “totally disagree,” 2 = “...,” 3 = “...,” 4 = “totally agree,” and 5 = “cannot say”

- Treating sexual problems is an important health care practice.
- Diagnosing female sexual problems is difficult.
- Sexual problems are often side effects of medications for other pathologies.
- The treatments I have prescribed for sexual problems are often effective.
- Sexual problems can be treated with lifestyle changes.

B) Practice patterns in sexual history-taking

1. When taking the patient's sexual history, do you ask how satisfied the patient is with their sexual life?
“Always”/“Usually”/“Seldom”/“Never”
2. How do you usually conduct sexual history-taking? (You can choose more than one option.)
“Open conversation”/“Structured interview”/“A questionnaire”/“I do not take a sexual history”

C) Practice patterns in the treatment of sexual problems

Each item is rated on a 5-point scale defined as follows:

1 = “totally disagree,” 2 = “...,” 3 = “...,” 4 = “totally agree,” and 5 = “cannot say”

- I often inquire about sexual problems during general medical history-taking.
- I often order further tests when diagnosing sexual problems.
- I often prescribe medications for sexual problems.
- I often prescribe treatments other than medications for sexual problems.
- I change the patient's medication if it causes sexual problems as a side effect.
- I ask the patient to consult a specialist for the underlying medical condition to change the medication if it causes sexual problems as a side effect.
- I often refer patients with sexual problems to a sexual medicine specialist.
- My organization has specific instructions where to refer patients with sexual problems for continued care.

- C) Practice patterns in the treatment of sexual problems (eight questions).

Each questionnaire was returned with complete responses, as it was programmed not to proceed if answers were missing.

2.3. Statistical analyses

The data are described using frequencies (percentages). In the analyses, each question in fields A and C was dichotomized (“totally agree” or “agree” versus “totally disagree” or “disagree”). The “cannot say” responses in fields A and C were omitted from the analyses. Question 1 in field B was dichotomized as “always” or “usually,” as opposed to “never” or “seldom.” Question 2 in field B was a multiple-choice question with several options. In the three fields of interest (A–C), multivariable binary logistic regression was performed with adjustment for the OB/GYNs' gender (female/male), age (young/middle-aged/late middle-aged), daily number of patients (1–10/≥11), and daily number of patients with sexual issues (0/1–5/≥6). In each field of interest, each question was examined separately. The results are presented as adjusted odds ratios (aORs) with 95 % confidence intervals (CIs). For significance, p -values <0.05 were considered statistically significant. Statistical analyses were performed using the SAS System for Windows, version 9.4 (SAS Institute Inc., Cary, NC, US).

2.4. Ethical approval

The SexMEdu study respects the Declaration of Helsinki in terms of ensuring the participants' anonymity and obtaining their informed consent. The study protocol was reviewed and approved by the ethics committee of Turku University (44/2017). Replying to the questionnaire implied consent, which was made clear to the respondents in the questionnaire itself.

3. Results

3.1. Attitudes toward sexual problems

The findings on attitudes toward sexual problems are shown in Fig. 1 and Table 3. Most OB/GYNs agreed that treating sexual problems is an

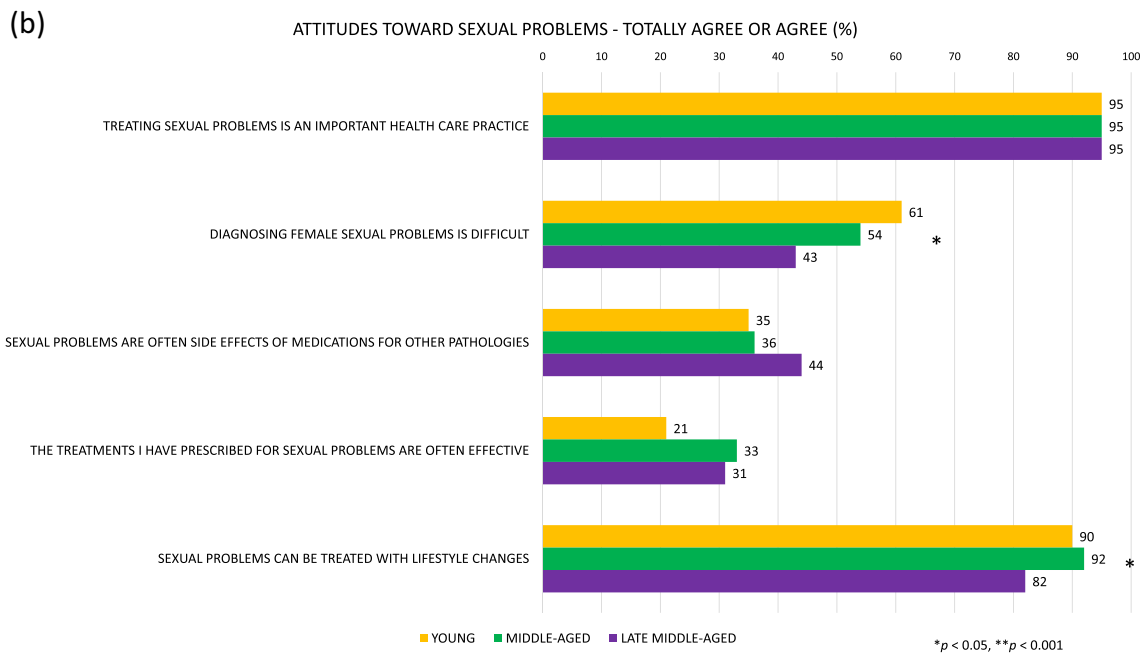
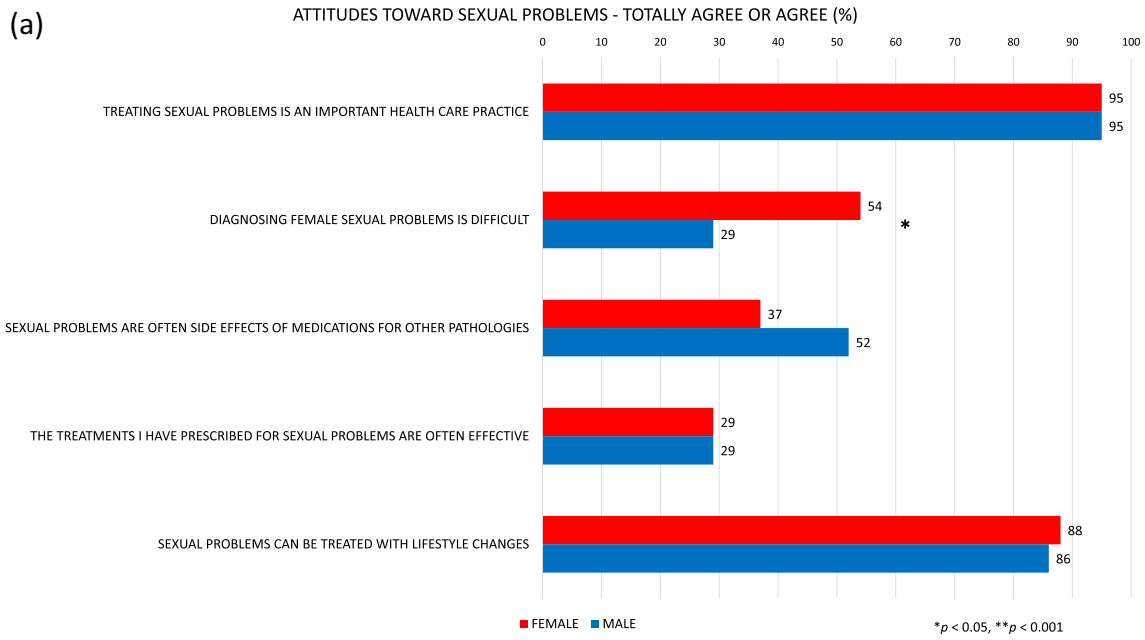


Fig. 1. a. Attitudes toward sexual problems (gender).
 b. Attitudes toward sexual problems (age).

important health care practice. Compared with the OB/GYNs who attended to 1–5 patients with sexual issues per day, those who did not have such patients (group 0 patients per day) were less likely to report that treating sexual problems is important (97 %, 214/221 vs. 88 %, 36/41).

Half of the OB/GYNs considered that diagnosing female sexual problems as difficult. Compared with the male OB/GYNs (29 %, 6/21), the female OB/GYNs (54 %, 149/278) were more likely to report difficulty. Compared with the young OB/GYNs (61 %, 50/82), the late middle-aged OB/GYNs (43 %, 47/110) were less likely to report difficulty.

More than one-third of the OB/GYNs considered sexual problems to be side effects of medications for other pathologies. A third responded that the treatments they used for sexual problems were effective.

Compared with the OB/GYNs who attended to ≥ 6 patients with sexual issues per day (54 %, 20/37), those who attended to 1–5 patients per day (26 %, 58/221) were less likely to consider their treatments effective. Most OB/GYNs reported that sexual problems can be treated with lifestyle changes. Compared with the middle-aged OB/GYNs (92 %, 98/107), the late middle-aged OB/GYNs (82 %, 90/110) were less likely to report that lifestyle changes could be a treatment.

3.2. Practice patterns in sexual history-taking

When taking a patient’s sexual history, half (53 %, 158/299) of the OB/GYNs reported always or usually asking about sexual life satisfaction. No differences between genders were found. However, age was an important factor: compared with the younger OB/GYNs, the late middle-

Table 3
Attitudes toward sexual problems (N = 299).

Entire group	Treating sexual problems is an important health care practice		Diagnosing female sexual problems is difficult		Sexual problems are often side effects of medications for other pathologies		The treatments I have prescribed for sexual problems are often effective		Sexual problems can be treated with lifestyle changes	
	Totally agree or agree		Totally agree or agree		Totally agree or agree		Totally agree or agree		Totally agree or agree	
	95 % (285/297)		52 % (155/283)		38 % (115/260)		29 % (86/161)		88 % (262/279)	
	aOR	95 % CI	aOR	95 % CI	aOR	95 % CI	aOR	95 % CI	aOR	95 % CI
Gender	<i>p</i> = 0.874		<i>p</i> = 0.034		<i>p</i> = 0.350		<i>p</i> = 0.947		<i>p</i> = 0.417	
Female versus male	0.83	0.09–7.79	2.99	1.09–8.22	0.63	0.24–1.67	0.96	0.26–3.56	1.81	0.43–7.63
Age	<i>p</i> = 0.553		<i>p</i> = 0.030		<i>p</i> = 0.626		<i>p</i> = 0.831		<i>p</i> = 0.014	
40–49 versus 28–39	0.39	0.07–2.27	0.69	0.37–1.30	0.83	0.43–1.58	1.30	0.56–3.02	1.46	0.20–10.81
50–74 versus 28–39	0.42	0.07–2.44	0.44	0.24–0.82	1.10	0.58–2.08	1.16	0.49–2.75	0.21	0.04–0.99
50–74 versus 40–49	1.07	0.28–4.02	0.63	0.36–1.11	1.33	0.74–2.38	0.90	0.43–1.86	0.14	0.03–0.67
Patients treated per day	<i>p</i> = 0.072		<i>p</i> = 0.735		<i>p</i> = 0.412		<i>p</i> = 0.723		<i>p</i> = 0.120	
1–10 versus ≥11	0.30	0.08–1.11	1.09	0.66–1.81	0.80	0.48–1.35	0.89	0.46–1.72	0.42	0.14–1.25
Patients dealt with sexual issues per day	<i>p</i> = 0.024		<i>p</i> = 0.601		<i>p</i> = 0.620		<i>p</i> = 0.071		<i>p</i> = 0.255	
0 versus 1–5	0.16	0.04–0.61	0.92	0.44–1.94	1.42	0.64–3.14	1.48	0.45–4.84	0.93	0.18–4.71
0 versus ≥6	0.52	0.08–3.34	1.35	0.51–3.63	1.14	0.41–3.16	0.50	0.12–2.14	2.80	0.40–19.58
1–5 versus ≥6	3.30	0.57–19.05	1.46	0.70–3.08	0.81	0.39–1.68	0.34	0.13–0.87	3.03	0.81–11.34

The ‘cannot say’ responses were omitted from the analyses. In each question the number of analyzed responses/total number of questionnaires are shown in the upper column.

p-Values are over the group values.

aOR higher than 1 indicates that the respondents in the comparison group were more likely to report ‘agree’ with the question compared to the reference group.

aOR lower than 1 indicates that the respondents in the comparison group were less likely to report ‘agree’ with the question compared to the reference group.

aOR = adjusted odds ratio; multivariable logistic regression; CI = confidence interval.

The multivariable binary logistic regression was carried out with adjustment of OB/GYNs’ gender (female/male), age (28–39/40–49/50–74 years), the number of patients treated per day (1–10/≥11) and the number of patients dealt with sexual issues per day (0/1–5/≥6).

aged OB/GYNs (69 %, 76/110) were more likely to ask about sexual life satisfaction (the late middle-aged vs. the young: aOR 2.87, 95 % CI 1.53–5.41, *p* = 0.001; the late middle-aged vs. the middle-aged: aOR 3.15; 95 % CI 1.74–5.75, *p* < 0.001). In addition, the OB/GYNs with fewer patients with sexual issues per day were less likely to ask about sexual life satisfaction (0 patients per day vs. ≥6 patients: aOR 0.06, 95 % CI 0.01–0.23, *p* < 0.0001; 1–5 vs. ≥6: aOR 0.08, 95 % CI 0.02–0.28, *p* < 0.0001).

As a sexual history-taking method, open conversation was used by 86 % (258/299) of the OB/GYNs, structured interviews by 3 % (10/299), and questionnaires by 6 % (19/299). Of all OB/GYNs, 12 % (37/299) did not perform sexual history-taking. No significant differences between gender, age, or daily number of patients were found (data not shown).

3.3. Practice patterns in the treatment of sexual problems

The findings on the practice patterns in the treatment of sexual problems are shown in Fig. 2 and Table 4. Almost half of the OB/GYNs asked about sexual problems during general medical history-taking. When diagnosing sexual problems, a minority reported ordering further examinations. Compared with the male OB/GYNs (29 %, 6/21), the female OB/GYNs (12 %, 34/278) were less likely to order further examinations. The OB/GYNs who dealt with patients with sexual issues less frequently per day were less likely to order further examinations (0 patients per day, 7 %, 3/41; 1–5 patients, 12 %, 26/221; ≥6 patients, 30 %, 11/37).

A few OB/GYNs prescribed medications for sexual problems, and more than half prescribed treatments other than medications. The OB/GYNs who dealt with patients with sexual issues less frequently per day were less likely to prescribe treatments other than medications (0 patients per day, 44 %, 18/41; 1–5 patients, 56 %, 124/221; ≥6 patients, 81 %, 30/37).

When the OB/GYNs considered sexual problems to be side effects of the medications for other pathologies, a quarter reported changing the medication themselves, while most asked the patient to consult a specialist for the underlying medical condition. The female OB/GYNs

were less likely than the male OB/GYNs to report changing the medication themselves (24 %, 68/278 vs. 48 %, 10/21). More than half of the OB/GYNs reported often referring patients with sexual problems to a sexual medicine specialist. A third reported that their organization has specific instructions concerning patient referral to continued care.

4. Discussion

This is one of the few studies to assess OB/GYNs’ attitudes and practice patterns regarding patients’ sexual problems. The aim of our study was to assess OB/GYNs’ attitudes and practice patterns regarding sexual problems with a special regard to gender and age. Although almost all OB/GYNs considered the treatment of sexual problems as an important health care practice, fewer than half asked about sexual problems during general medical history-taking, and only half asked about sexual life satisfaction. Furthermore, only a few OB/GYNs ordered examinations or prescribed medications for sexual problems. Our results suggest that despite the OB/GYNs’ awareness of the importance of the subject, routine practice patterns in assessing sexual problems are insufficient, which may lead to the underdiagnosis and undertreatment of FSD.

In caring for patients with sexual problems, three steps are crucial: first, bringing up the issue; second, making a reliable diagnosis; and third, taking action. Sexual problems are typically intimate, and embarrassment can hinder patients from initiating the discussion themselves [9]. According to previous studies, 8 % to 77 % (45 % in this study) of OB/GYNs brought up patients’ sexual problems during general medical history-taking [4,5,11,12]. Since sexual problems can be multifactorial, the risk of not bringing up the issue might be due to a lack of time. In this regard, also other health care professionals, such as nurses, would also be essential, since they often have more time to engage in discussions with patients. Therefore, further education and training for them would be warranted.

In our study, only half of the OB/GYNs reported assessing sexual life satisfaction, but this number is higher than that reported previously (29 %) [13]. This finding is not surprising, as for some OB/GYNs, the question can be considered ‘opening Pandora’s box’: sexual life

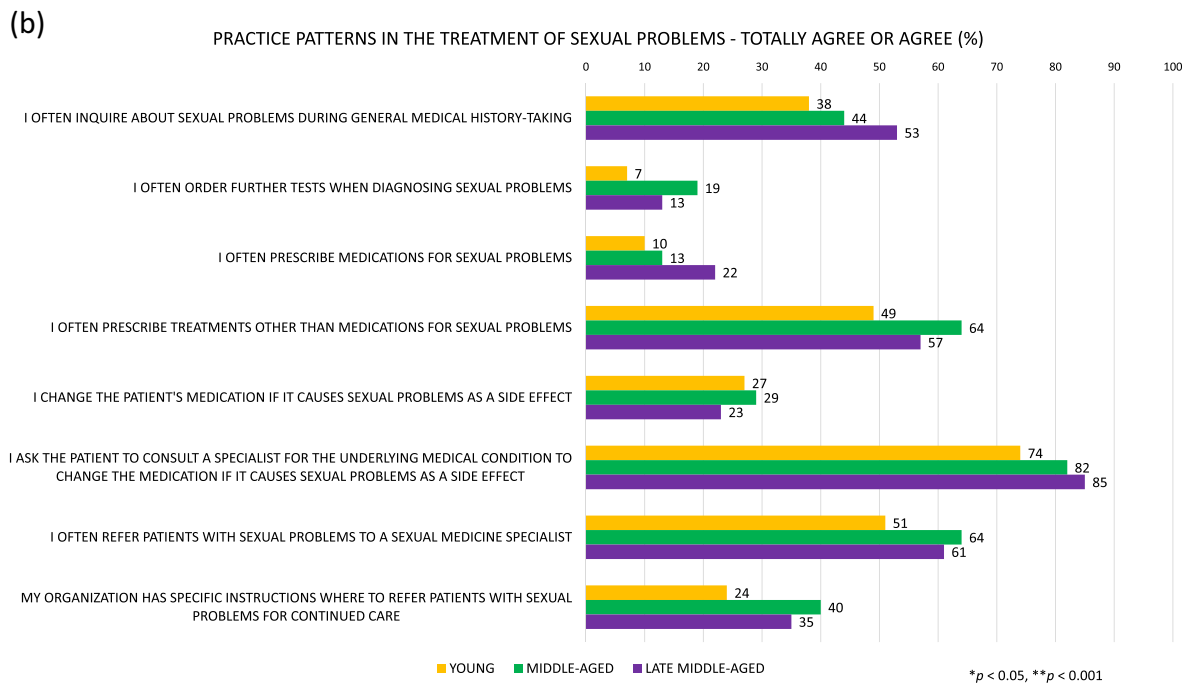
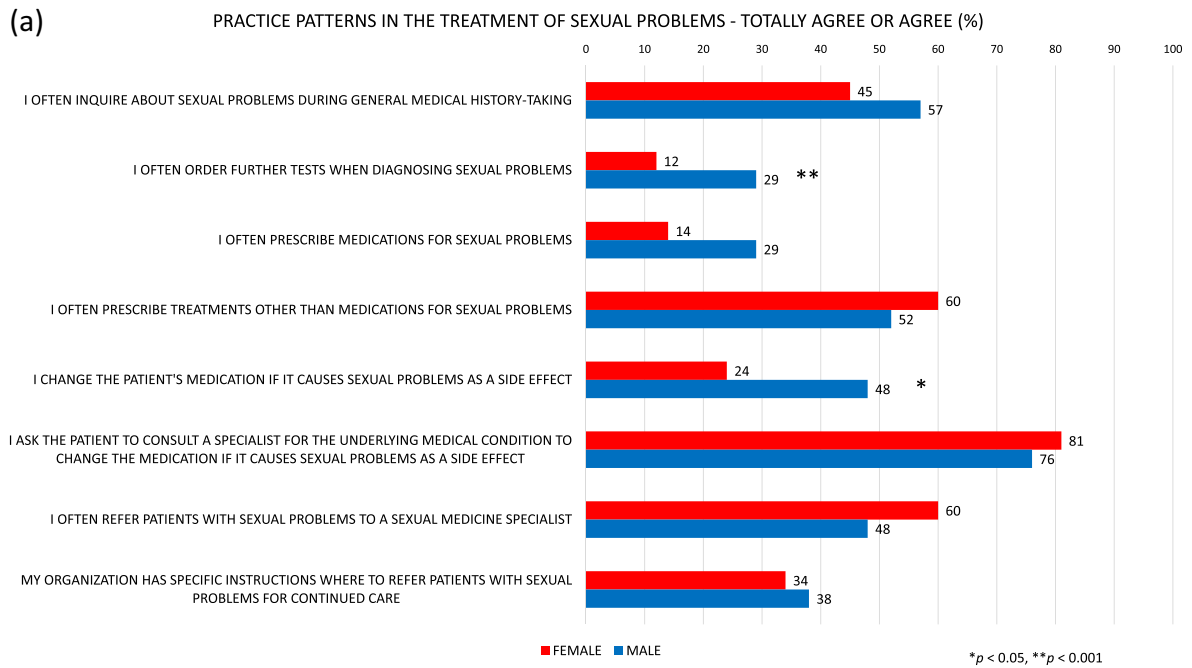


Fig. 2. a. Practice patterns in the treatment of sexual problems (gender).
 b. Practice patterns in the treatment of sexual problems (age).

Table 4
Practice patterns in the treatment of sexual problems (N = 299).

Entire group	I often inquire about sexual problems during general medical history-taking		I often order further tests when diagnosing sexual problems		I often prescribe medications for sexual problems		I often prescribe treatments other than medications for sexual problems		I change the patient's medication if it causes sexual problems as a side effect		I ask the patient to consult a specialist for the underlying medical condition to change the medication if it causes sexual problems as a side effect		I often refer patients with sexual problems to a sexual medicine specialist		My organization has specific instructions where to refer patients with sexual problems for continued care	
	Totally agree or agree		Totally agree or agree		Totally agree or agree		Totally agree or agree		Totally agree or agree		Totally agree or agree		Totally agree or agree		Totally agree or agree	
	45 % (136/298)		13 % (40/293)		15 % (46/295)		58 % (172/284)		26 % (78/255)		81 % (242/273)		59 % (177/294)		34 % (102/278)	
	aOR	95 % CI	aOR	95 % CI	aOR	95 % CI	aOR	95 % CI	aOR	95 % CI	aOR	95 % CI	aOR	95 % CI	aOR	95 % CI
Gender	<i>p</i> = 0.134		<i>p</i> = 0.006		<i>p</i> = 0.142		<i>p</i> = 0.852		<i>p</i> = 0.024		<i>p</i> = 0.264		<i>p</i> = 0.345		<i>p</i> = 0.722	
Female versus male	0.48	0.18–1.26	0.20	0.07–0.63	0.45	0.15–1.31	1.09	0.43–2.77	0.32	0.12–0.86	1.99	0.59–6.70	1.57	0.62–4.00	0.84	0.32–2.20
Age	<i>p</i> = 0.385		<i>p</i> = 0.056		<i>p</i> = 0.131		<i>p</i> = 0.213		<i>p</i> = 0.259		<i>p</i> = 0.949		<i>p</i> = 0.217		<i>p</i> = 0.074	
40–49 versus 28–39	1.16	0.62–2.17	3.00	1.10–8.17	1.36	0.53–3.47	1.66	0.88–3.13	1.04	0.52–2.09	1.15	0.42–3.13	1.62	0.89–2.94	2.11	1.10–4.04
50–74 versus 28–39	1.52	0.82–2.83	1.45	0.51–4.11	2.29	0.96–5.48	1.06	0.57–1.96	0.62	0.31–1.28	1.01	0.39–2.65	1.58	0.87–2.89	1.80	0.93–3.47
50–74 versus 40–49	1.32	0.74–2.34	0.48	0.21–1.09	1.68	0.80–3.55	0.64	0.35–1.15	0.60	0.31–1.16	0.88	0.36–2.16	0.98	0.56–1.73	0.85	0.48–1.51
Patients treated per day	<i>p</i> = 0.926		<i>p</i> = 0.844		<i>p</i> = 0.628		<i>p</i> = 0.220		<i>p</i> = 0.827		<i>p</i> = 0.209		<i>p</i> = 0.518		<i>p</i> = 0.378	
1–10 versus ≥11	1.02	0.62–1.69	0.93	0.44–1.95	1.18	0.61–2.29	1.38	0.83–2.30	1.07	0.60–1.88	0.61	0.28–1.32	0.85	0.52–1.39	0.79	0.47–1.33
Patients dealt with sexual issues per day	<i>p</i> < 0.0001		<i>p</i> = 0.007		<i>p</i> = 0.608		<i>p</i> = 0.004		<i>p</i> = 0.279		<i>p</i> = 0.611		<i>p</i> = 0.552		<i>p</i> = 0.887	
0 versus 1–5	0.41	0.19–0.89	0.50	0.13–1.89	0.57	0.18–1.75	0.60	0.30–1.21	1.91	0.86–4.22	0.76	0.26–2.22	0.76	0.38–1.53	1.20	0.57–2.53
0 versus ≥6	0.06	0.02–0.19	0.14	0.03–0.64	0.56	0.14–2.30	0.14	0.04–0.44	1.84	0.63–5.44	1.26	0.31–5.16	1.05	0.41–2.68	1.15	0.42–3.17
1–5 versus ≥6	0.14	0.06–0.36	0.29	0.12–0.68	0.99	0.37–2.62	0.23	0.08–0.61	0.41	0.41–2.27	1.66	0.56–4.90	1.38	0.67–2.84	0.96	0.44–2.09

The 'cannot say' responses were omitted from the analyses. In each question the number of analyzed responses/total number of questionnaires are shown in the upper column.

p-Values are over the group values.

aOR higher than 1 indicates that the respondents in the comparison group were more likely to report 'agree' with the question compared to the reference group.

aOR lower than 1 indicates that the respondents in the comparison group were less likely to report 'agree' with the question compared to the reference group.

aOR = adjusted odds ratio; multivariable logistic regression; CI = confidence interval.

The multivariable binary logistic regression was carried out with adjustment of OB/GYNs' gender (female/male), age (28–39/40–49/50–74 years), the number of patients treated per day (1–10/≥11) and the number of patients dealt with sexual issues per day (0/1–5/≥6).

satisfaction covers diverse aspects and problems that may be beyond the OB/GYN's field of expertise. To assess and diagnose sexual problems, the use of structured questionnaires has been recommended [23]. However, in our study, only a few OB/GYNs used questionnaires during sexual history-taking, compared with those in British [5] and US studies [4]. Furthermore, only a minority ordered further examinations to confirm the diagnosis. As for guidelines for referring patients to continued care, only a few reported receiving specific instructions from their organization. Nevertheless, more than half referred patients to a sexual medicine specialist. According to previous studies, practice patterns for referrals differ widely internationally. According to a Swiss study [11], 85 % of OB/GYNs proposed referrals to specialized colleagues, whereas in a German study [12], the referral rate was generally low (15 %). This discrepancy raised the need for international clinical practice guidelines. Thus, in 2019, the International Society for the Study of Women's Sexual Health created a process of care for clinicians that outlines recommendations for the identification and management of female sexual problems [24]. These recommendations are made for clinicians at any level of competence in sexual medicine. The continuity of care should be ensured, and it would be a cost-efficient and cost-beneficial way to manage patients' sexual problems.

The Finnish Institute of Health and Welfare has declared a Sexual and Reproductive Health Action Plan providing guidance for the implementation of sexual and reproductive health into health care services (https://www.julkari.fi/bitstream/handle/10024/116162/THL_OPAS33_VERKKO9.3.2016.pdf?sequence=3&isAllowed=y), but more detailed mandatory instructions and uniform health care service structures are lacking in Finland. The treatment of sexual problems is covered by the public health care. However, in practice, the queues for sexual counseling can be long, so patients may seek help from the private sector. Therefore, encouraging gynecologists to address the issue would be important so that minor sexual-health-related questions could be solved and treated during the appointment, especially in actual, financially tight societal situations.

As for treating sexual problems, our results showed that OB/GYNs preferred nonpharmacological treatments over medications, consistent with a Swiss study [11]. Our findings could indicate the limited selection of medications for FSD and also limited knowledge about available medications; and therefore, nonpharmacological treatments might be underlined in replies. For instance, medications, such as flibanserin or brexatone, which are in use in some countries, are not available in Finland. Psychosocial factors and their treatments are risk factors for sexual dysfunction; thus, patients with FSD should be offered psychosocial evaluation and treatment, in addition to possible medication [25]. Furthermore, low physical activity, smoking, and alcohol consumption are risk factors for sexual dysfunction, whereas participation in physical activity and a healthy diet are associated with a lower risk of FSD [26].

Sexual problems are more prevalent among patients with chronic diseases [27]. Whether sexual problems are caused by the actual disease, or by its medication, or by both is often uncertain and controversial. The use of medication [28], especially antidepressant drugs [29], is known to cause sexual dysfunction. In our study, fewer than half of the OB/GYNs considered sexual problems to be common side effects of other medications. Nonetheless, those who considered sexual problems to be side effects of other medications mainly hesitated to change the medication by themselves and asked patients to consult other specialists for the medication change. This finding indicates good cooperation between different specialties and the importance of sexual medicine education in all specialties.

Previous studies have shown contradictory results regarding gender-related differences in attitudes and practice patterns in sexual medicine. Some studies found female OB/GYNs to be more active in sexual history-taking, one from Germany (female 61 %, male 39 %; $N = 235$) [12], one from the US (female 47 %, male 53 %; $N = 1147$) [13], and another from the US (female 49 %, male 51 %; $N = 416$) [14]. Similar to our study, a British (female 37 %, male 60 %; $N = 95$) [5] and an US study (female

36 %, male 64 %; $N = 471$) [4] have shown no differences in FSD screening activity between genders. In a review of 97 studies, including studies from both the North and South Americas as well as the Europe, on gender differences in OB/GYNs' practice patterns, male OB/GYNs prescribed medications more often (5/7 studies) and female OB/GYNs more often made referrals (5/7 studies) [19]. This was not the case in our study. However, we found that the female OB/GYNs showed less active practice patterns in treating sexual problems, such as referrals to a sexual medicine specialist and changes of the patient's medication for the underlying medical condition, and were more likely to report difficulty in diagnosing female sexual problems. Female OB/GYNs typically provide lower self-ratings than male OB/GYNs in a number of areas [19], which concurs with our finding, that the female OB/GYNs were more likely to report the difficulty in diagnosing female sexual problems.

Previous German [12] and US [13] studies have found that younger OB/GYNs were more active in sexual history-taking. Over recent decades, the atmosphere around sexuality has become more open, and therefore the younger generations may have more practical skills to deal with sexual issues. However, in our study, OB/GYNs' ages were not notably associated with practice patterns, parallel to some previous studies [4,5,14], with two crucial exceptions: the older OB/GYNs were more likely to ask about sexual life satisfaction, and the late middle-aged OB/GYNs were less likely to report difficulty in diagnosing female sexual problems, suggesting that diagnostic experience might come also with age, and thus, presumably, also with experience.

Though similar studies have been published earlier, our study is the first one conducted in the Nordic countries. One major strength of this study was the representativeness of our population, which consisted of one-third of the specialists in obstetrics-gynecology in Finland [20]. The online questionnaire used in this study allowed for completing it at the most suitable and convenient time. Furthermore, since it was programmed not to proceed if any response was missing, all respondents returned complete questionnaires. This might have lowered the response rate, but provided comprehensive data from those who responded.

Our study has limitations. No information about non-respondents was available for comparison, as we did not have access to the actual Finnish Society of Obstetrics and Gynecology registry. The proportion of male OB/GYNs was small; therefore, the results should be interpreted with caution. However, the gender ratio corresponded to that of the OB/GYNs in Finland [20]. Our results on practice patterns were based on self-reporting, and thus might vary from reality. Furthermore, our study included only Finnish OB/GYNs, so, our results might not be directly applicable to OB/GYNs in other countries. However, our respondents formed a consistent study group since Finland is a racially and culturally homogenous country.

5. Conclusion

Sexual problems are considered important health issues, but routine assessment of these problems by OB/GYNs is yet to be implemented. The practice patterns are disorganized, which presumably leads to underdiagnoses and undertreatment of FSD. The clinical pathways of patients with sexual problems should be improved. International clinical practice guidelines and screening tools for the identification and care of women with sexual problems should be applied to routine clinical practice.

Contributors

Anna Aromaa was the principal investigator and main writer of this paper.

Päivi Polo-Kantola was a leader of the Sexual Medicine Education (SexMEdu) study and was a coinvestigator and cowriter.

Sanna-Mari Manninen was a coinvestigator and cowriter.

Jarna Grönlund was a coinvestigator and cowriter.

Markus Riskumäki was a statisticians for this study.

Tero Vahlberg was a statisticians for this study.

Katja Kero was a leader of the Sexual Medicine Education (SexMEdu) study and was a coinvestigator and cowriter.

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Ethical approval

The study received approval from the ethics committee of the University of Turku (44/2017).

Provenance and peer review

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Research data (data sharing and collaboration)

There are no linked research data sets for this paper. Data will be made available on request.

Declaration of competing interest

The authors declare that they have no competing interest.

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