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CENTRO UNIVERSITÁRIO DE LISBOA

MESTRADO TRANSDISCIPLINAR EM SEXOLOGIA

ESCOLA DE PSICOLOGIA E CIÊNCIAS DA VIDA

EMPOWERING CARE: NAVIGATING THE ROLE OF PORTUGUESE FAMILY DOCTORS IN SEXUAL MEDICINE

Dissertação de Mestrado apresentada a provas públicas para a obtenção do Grau de Mestre em Medicina Sexual, orientada por Prof.ª Doutora Patrícia Pascoal e Prof. Doutor Nuno Tomada.

Ana Margarida Mendes Guilherme Rodrigues

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VERSÃO FINAL

Dissertação defendida em provas públicas na Universidade Lusófona, Centro Universitário de Lisboa no dia 11/ 04/ 2024, perante o júri, nomeado pelo Despacho de Nomeação n.o: 630/2024, de 30 de janeiro, com a seguinte composição:
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Este trabalho também foi orientado por Prof. Doutor Nuno Tomada.

ANA MARGARIDA MENDES GUILHERME RODRIGUES

2024

One of the essential qualities of the clinician is his interest in humanity, for the secret of the care of the patient is in caring for the patient.

Dr. Francis W. Peabody

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Resumo

A saúde sexual (SS) é fundamental à qualidade de vida, sendo foco da intervenção da Medicina Sexual (MS). Dentro do Serviço Nacional de Saúde, os Médicos de Família (MF) garantem cuidados abrangentes numa ação biopsicossocial.

O objetivo deste estudo exploratório foi investigar perceções dos MF acerca do seu papel na MS e como otimizá-lo. Utilizou-se um design qualitativo on-line transversal, recolhendo-se uma amostra de 73 MF. Analisaram-se os dados através de análise sumativa de conteúdos.

Estabeleceram-se três categorias sobre como os MF percecionam o seu papel na MS: "Protagonista", "Antagonista" e "Circunstancial". Identificaram-se duas categorias sobre como este poderia ser otimizado: "Legitimar a Saúde Sexual" e "Aumentar o Desenvolvimento Profissional".

Os MF reconhecem-se como gestores institucionais e cuidadores abrangentes, recorrendo a tarefas familiares para exercer num contexto condicionado. Melhorar o seu papel significaria investir em formação, expedir recursos, criar diretrizes detalhadas e sensibilizar profissionais e utentes para lá da perspetiva biomédica.

Os resultados salientam a necessidade de ação institucional para reforçar o papel crucial dos MF na MS, garantindo uma utilização eficaz dos recursos e uma resposta holística e consistente em SS, melhorando o cuidado geral aos utentes e sinalizando a SS como uma prioridade nos cuidados de saúde primários.

Abstract

Sexual health is fundamental for overall well-being and quality of life, and the focus of intervention of Sexual Medicine (SM). Within the National Health Service, Primary Care Physicians (PCPs) guarantee comprehensive care, in a biopsychosocial action.

The aim of this exploratory study was to investigate PCPs' perceptions about their role in SM and how to improve it.

A cross-sectional online qualitative design was used and a sample of 73 Portuguese PCPs was collected. Data was analyzed employing a summative content analysis.

Three categories were established regarding how PCPs perceive their role in SM: "Protagonist", "Antagonist" and "Circumstantial". Concerning how PCPs' practice could be improved, two categories were identified: "Legitimizing Sexual Health" and "Enhancing Professional Development".

PCPs recognize themselves as institutional gatekeepers and comprehensive caregivers, resorting to familiar tasks to practice in a conditioned framework. To improve their role, PCPs highlighted education investment, resource expedition, detailed guidelines creation, and raising provider and patient awareness beyond the biomedical scope.

The results stress the need for an institutional effort to uphold PCPs' crucial role in SM to ensure effective resource use and consistent comprehensive sexual healthcare provision, enhancing overall patient care and placing sexual health as an important field in primary care.

Abbreviations and Acronyms

cf. - to compare

EU - European Union

HR - Health Region

i.e. - that is

IP - internet protocol

IRB - Institutional Review Board

LGBTQIA+ - lesbian, gay, bisexual, trans, queer/questioning, intersex, asexual, and other minoritized sexual orientations and identities

M - mean

n - number

NHS - National Health Service

PCP - Primary Care Physician

PHC - Primary Health Care

SD - standard deviation

SM - Sexual Medicine

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Introduction

Relevant research emphasizes the importance of sexual health for overall well-being and quality of life (1), although healthcare access to sexual and reproductive health services is still a major issue (2–4). Within the National Health Service (NHS), responsible for ensuring universal and equitable access to healthcare, Primary Health Care (PHC) is, in most countries, at the forefront of the health system (5,6). Among the professionals who cover PHC, Primary Care Physicians (PCPs), also known as Family Doctors, are trained healthcare providers who deliver essential services to individuals and communities. Their mission is to promote health, prevent disease, and provide curative, accompanying, or palliative care, depending on the community's health needs and resources (7). PCPs guarantee extensive and continuous care, regardless of age, gender, or condition, in a biopsychosocial action. This involves making accurate diagnoses, guiding effective treatment strategies, serving as a supportive ally, facilitating referrals to specialized care, and empowering patients by being a permanent agent of health education (7).When analyzing the impact of “primary care orientation” (receiving tailored care from a trained PCP) on health outcomes and healthcare costs, comparative studies of industrialized nations show that people in countries with greater levels of "primary care orientation" have better health outcomes and pay less for healthcare than populations in countries with lower levels (8,9).

Specifically regarding sexual health, PCPs acknowledge that sexuality is essential to a person's well-being and identity throughout their lifespan (10–12). As PCPs oversee healthcare, managing sexual health has become a significant part of their role; that is, the role of the PCP has been highlighted as a gateway for sexual complaints in healthcare, the first resource people find and use. However research shows that most patients who receive PHC are worried about accessing sexual and reproductive health services that are not available in primary care settings (13).

While the European Union (EU) is committed to promoting sexual health and access to sexual healthcare (14), recent studies highlight the persisting gaps in guaranteeing the right to sexual and reproductive health across various member countries (15). Research has shown multiple unmet needs and perceived barriers amongst patients and PHC professionals alike concerning the provision of adequate sexual healthcare, particularly in specific populations, such as LGBTQIA+ (lesbian, gay, bisexual, trans, queer/questioning, intersex, asexual, and

other minoritized sexual orientations and identities) people, migrants, oncologic patients, chronic disease bearers, peripartum status, among others (16–21).

In the context of the evolution of the discourse on sexual health in the EU, Portugal's path reflects broader medical and social transformations developed after the restoration of democracy in April 1974. During this period of evolution, clinical sexology consultations were established in key hospitals, namely in Coimbra, Lisbon, and Porto (22). An integral factor contributing to the success of the integration of sex-related consultations in Portugal was the presence of a Beveridgian-inspired healthcare system, trying to ensure comprehensive healthcare access for all residents (5), which is coherent with overall policies and specific laws aimed to protect sexual rights (15). However, an aspect to consider is the limited representation of PCPs in sexual healthcare. Data from Alarcão et al. (2016) indicated that, out of a sample of 91 Portuguese individuals working in sexology, only one was a PCP (23).

Consequently, although there is research pointing to the need to emphasize the role of the PCP (16,22,24,25), the role and practice of PCPs in sexual health remain relatively uncharted, not only in Portugal but also within the larger European context, unlike what happens with other specialties (26,27).

The Present Study

Given the significant role that political and ideological perspectives can play in shaping healthcare legislation and the potential impact on patient care, it is crucial to investigate the representation and perspectives of Portuguese PCPs in sexual health, which could provide valuable insights for the scientific community and policymakers in other European countries that face similar constraints (lack of representativeness of PCPs in the delivery of sexual healthcare).

We intend to contribute by pointing out PCPs' perceived duties, challenges, and difficulties, systematizing them, and indicating which solutions and paths are most anticipated by these healthcare providers.

This study uses a cross-sectional qualitative design to explore PCPs' perceptions about their role in Sexual Medicine (SM) and how to improve it, to identify barriers, and to disclose results in the hope of an institutional effort to overcome them.

Given the insufficient qualitative research on this theme, we employed an inductive approach (28,29). Therefore, as conventional methods for exploratory qualitative research

suggest, we did not have a prior hypothesis and instead provided two ample study questions (30) - 'How do PCPs perceive their role in the context of sexual healthcare in primary care and, how do they propose to improve it?'. This approach allowed us to deliver insights into possible processes and pathways for guiding policy and patient-serving program activities (31).

Methods and Participants

- Research Design

This study aimed to investigate PCPs' perceptions about their role in SM and how to improve it. For this purpose, an anonymous cross-sectional and exploratory study was developed. The survey was elaborated as a result of thoughtful interest and discussion between the board members of 'Sociedade Portuguesa de Sexologia Clínica' during 2018-2022, who acknowledged the need to explore how PCPs saw their roles and their needs in the SM field. The last author invited the second author, representing the 'European Society for Sexual Medicine', and the current President of 'Sociedade Portuguesa de Andrologia, Medicina Sexual e Reprodução', to collaboratively design the study, continuously reviewing the survey until a consensual final version was reached, and to establish the means of advertising. The first author, along with three other PCP experts, developed concise, relevant questions for the study. They also agreed on the amount and content of sociodemographic data to be collected to maintain anonymity. The study was then submitted for IRB review and set up on a secure online server (QUALTRICS). The survey protocol was reviewed for adequacy, relevance, and length by the research team and the PCPs who had been involved in the study content.

The final version was shared online through mailing lists belonging to professional associations, creating a snowball effect. The online data was collected from a non-probabilistic convenience sample between March and May of 2023.

The inclusion criteria comprised: (a) understanding of the Portuguese language, (b) being a PCP (resident or specialist) with clinical autonomy recognized by the Portuguese Medical Association, and (c) practicing in Portugal.

The study had three parts: 1) informed consent, 2) non-identifying sociodemographic data collection and 3) two open questions to answer the main research questions, namely: (1) *How do you perceive the role of General and Family Medicine professionals in Clinical Sexology/Sexual Medicine?*; (2) *How could the agency of General and Family Medicine professionals in the field of Clinical Sexology/Sexual Medicine be optimized?*. The questions

were not randomized, so every participant answered exactly to the same set of questions presented in the same order.

The compliance rate cannot be established because the advertisement method used does not allow the determination of how many professionals were reached.

- Ethical Consideration

The project was ethically approved by the Ethics and Deontology Committee for Scientific Research of the School of Psychology and Life Sciences of Lusófona University of Humanities and Technologies, and followed Helsinki Declaration principles and the European Textbook on Ethics and Research (32,33). Informed consent was obtained, and data was protected in an archived digital database. No IP or geolocation information was saved.

- Participants

From 141 responses, a sample of 73 Portuguese PCP were included: 9 men, 63 women and 1 non-binary person, aged between 25 to 63 years (M = 32.36; SD = 8.13). The participants were 68.5% residents (n = 50), evenly distributed between the four years of the specialty internship. The specialists (n = 23) had an average practicing time of 10.19 (SD = 8.79) years. Of the established seven Portuguese Health Regions (HR), all but Algarve HR were represented, including both archipelago regions; the Centre HR was the most representative (n = 23), followed by Lisboa e Vale do Tejo HR (n = 19) and North HR (n = 18). Out of the respondents, only one PCP was practicing SM for the past 10 years, while 6 residents and 2 specialists had or were currently pursuing post-graduate education in SM.

- Data Analysis

The data analysis followed the summative content analysis explored by Zhang and Wildemuth (2009), a broadly employed qualitative research methodology within the health and social sciences research domain (32).

Parallel and independent coding was performed by two researchers (M.G.R. and A.A.M.), following the ensuing procedure: (1) repeated transcript reading to gain an initial familiarity with the content; (2) defining the unit of analysis for the transcriptions; (3) defining the coding scheme by examining the transcriptions; (4) testing the coding scheme for consistency and clarity on a transcriptions' sample, with the level of coding consistency as high; (5) coding and categorizing all the transcriptions; and (6) rechecking the coding consistency to ensure continued reliability.

The codes were refined through analysis and consensus reached between the two coders and verified by a senior author (P.M.P.). The results were reported with frequency data in narrative form.

The categories were generated based on the study material through an inductive method (28,29) not confined to the restrictions imposed by structured methodologies since this is an exploratory qualitative study conducted in an uncharted setting.

No software was used to manage the qualitative data. Quantitative data was managed using Excel. Citations and references were organized according to the Vancouver referencing style.

Results

The responses from participants varied between brief (a couple of words, for example, "very important") to medium (two or three sentences); adverbial examples are shown below. Regarding response length, the first question elicited longer answers, dwelling in more than one issue. It was also noted that some responses to the first research question anticipated and included information linked to the second research question, which also justifies lengthier comments to question number one.

After scrutinizing the answers, we observed no trend when considering the participants' gender, professional experience, region where healthcare is delivered and/or training in SM.

The resultant categories were interconnected within each question since answers from one participant informed more than one category. The presentation of the results corresponds to the sequence in which the questions were delivered.

- *"How do you perceive the role of General and Family Medicine professionals in Clinical Sexology/Sexual Medicine?"*

Three categories were established from the identification of the codes and ensuing subcategories associated with how PCPs perceive their standing in SM, namely 'Protagonist' (n = 104), 'Antagonist' (n = 13) and 'Circumstantial' (n = 31) (the full breakdown of how codes and subcategories were included into the main categories is shown in Table 1).

In the category ‘Protagonist’, PCPs recognize their role as essential in three specific aspects: institutionally, as a specialist doctor, with certain values, tasks, and assignments, and as a humanized caregiver, sensible and dependable to the patients’ eyes. Regarding the ‘Antagonist’ category, some of our sample’s PCPs acknowledge that their involvement is not ideal, mostly when devaluing and/or negating sexual health, not considering it relevant enough or abstaining from the theme altogether. The final category, ‘Circumstantial’, was found as PCPs describe their position dependent on multiple decisive factors, either intrinsic or extrinsic, being just as limited as adapting.

- *“How could the agency of General and Family Medicine professionals in the field of Clinical Sexology/Sexual Medicine be optimized?”*

By determining the codes and subsequent subcategories on how PCPs’ role could be improved, two categories were identified that is, ‘Legitimizing Sexual Health’ (n = 36) and ‘Enhancing Professional Development’ (n = 62) (the full breakdown of how codes and subcategories were included into the main categories is shown in Table 2).

Concerning the first category, ‘Legitimizing Sexual Health’, PCPs enunciated practical, structural, day-to-day strategies pertaining a different outlook on type of appointment, consultation techniques, and resources expedition. At the same time, our participants expressed a concern about addressing attitudes by raising awareness. Regarding the second category, ‘Enhancing Professional Development’, our sample’s PCPs focused primarily on education, highlighting the timing of said education, at whom it should be aimed, the financial aspect of it and what themes should be explored.

Table 1 - Response categories, subcategories, and codes for the question on how the PCP perceives their role in SM.

Categories	Subcategories	Codes	Examples
PROTAGONIST	Institutional	1st contact with the NHS *n* = 13	"we are the 1st point of contact for users with the NHS" "PHC being the gateway to the NHS"
		Only contact with the NHS *n* = 2	"we are the […] only contact with health care that people have" "we are the […] doctor they turn to and, sometimes, the only one"
		Accessible *n* = 4	"[we have] a privileged position [...] with ease of accessibility" "[PCP] may be the most easily accessible figure with whom patients can explore aspects of sexuality."
		Plan B *n* = 2	"people are unable to seek private sexology consultation […] or they don't know that there are specialists who can help them" "[seeing the PCP] does not have the stigma associated with going to a "psychiatry/psychologist consultation""
	Specialist Doctor	Doctor of the Family *n* = 8	"[role] valued for the possible knowledge of the different perspectives of the couple's members (partners' version)" "we accompany […] often the whole family, which makes it easier to understand certain phenomena that may occur in the area of sexuality"
		Comprehensive Approach *n* = 21	"it is the family doctor who accompanies the patient in all [...] areas of his health, including sexual health" "General and Family Medicine addresses health problems in any sphere and system, which is why it also has its role in Clinical Sexology"
		Continued Care *n* = 12	"it is comprehensive enough to involve the user throughout their entire life cycle" "the longitudinal relationship with users allows for a holistic initial assessment and reassessment of the impact of interventions"
		Early detection *n* = 1	"we can early identify changes in quality of life related to sexuality"
		Interventionist *n* = 5	"we can […] intervene to provide greater sexual satisfaction" "we have the possibility to […] act quickly and early when we are asked for help"

		Advisor *n* = 6	"fundamental role either in counseling or in guiding these situations" "specialty [that] is able to respond, support, advise"
		Mediator *n* = 7	"globally we have to know how to forward [to secondary care]" "[our role] enables the identification of problems requiring referral"
		Preventing disease *n* = 3	"the role of the PCP is primarily prevention" "we have the opportunity to address this issue before any dysfunction"
		Promoting health *n* = 3	"we have the opportunity to address this issue […] in order to promote a satisfying and safe sex life" "key specialty in health promotion"
	Humanized Caregiver	Trustworthy Caregiver *n* = 17	"due to the close relationship that is established with PHC users, there is an opportunity for them to open up about the matter and [for us] to treat them" "in the context of a doctor-patient relationship of trust and openness, allowing the user to express their complaints and doubts in this sphere, which is fundamental to human life but highly stigmatized and surrounded by taboos"
		Thoughtful approach *n* = 10	"more than anyone else, a PCP, or a healthcare professional, must have an approach and communication without judgments or taboos" "our openness, our ease […] in the area of sexuality are very important"
ANTAGONIST	Devaluing Sexual Health	Insensitive doctors *n* = 5	"many doctors still downplay the importance of sexual health" "taking into account the scope of care provided, we often leave issues related to sexuality in the background"
	Negating Sexual Health	Avoidant doctors *n* = 8	"sometimes it is a taboo topic, not addressed by us" "and we [physicians] do not approach it [theme of sexuality], sometimes, because we do not want to ask questions about something that is intimate"
CIRCUMSTANCIAL	Limited	Conditioned by gender *n* = 1	"in some patients it is noticeable that the trouble is that the health professional is not the same gender as the patient"
		Lacking education *n* = 13	"we have no training to address them" "family doctors are not trained enough to deal with sexology"

		Lacking communication skills *n* = 1	"it is notable [...] the difficulty in addressing topics in the sphere of sexuality with patients [...] due to [our] limitations in communication skills"
		Non-interventionist *n* = 6	"PCPs should [...] have a more interventionist role regarding the sexual health of their patients" "limited [role]"
	Adapting	Ascending role *n* = 4	"[role] growing, with progressive attention from younger doctors" "it is a matter that we work with, which is of interest to patients and is currently more sought after"
		A frequent issue *n* = 6	"it is very common for patients to address sexual issues in the context of a consultation" "sexual dysfunctions being a frequent problem and gender dysphoria also a growing situation or, at least, addressed with increasing frequency"

One participant can occur in multiple response categories.

Table 2 - Response categories, subcategories, and codes for the question on how the PCP's agency in SM could be optimized.

Categories	Subcategories	Codes	Examples
LEGITIMIZING SEXUAL HEALTH	A New Type of Consultation	The PCP as a SM specialist *n* = 10	"the PCP's schedule would have to comprise this type of consultation differently" "encourage the creation, at national and regional level, of consultations dedicated to this area, providing the opportunity for direct referrals between PCP colleagues"
		Multidisciplinary teams *n* = 2	"facilitating a multidisciplinary approach with clinical psychologist, psychiatrist, urologist, gynecologist" "integrating doctors/professionals with training in the field in the health units' teams"
	New Techniques	Opportunistic approach *n* = 2	"opportunistic approach in the scheduled consultation" "systematization of this assessment whenever clinically relevant"
		Consultation tools *n* = 4	"to add a warning/notification to address this topic in our consultation's informatic program" "existence of a standardized questionnaire to be applied in family planning consultations or whenever a related health issue arose"
	Expediting Resources	Identifying resources *n* = 2	"broadcasting of existing resources in the community and finding out if there is hospital care that can be referred to, and what the criteria are" "provide PCPs with the necessary training to […] understand referral criteria for other specialties"
		Creating support materials *n* = 3	"dissemination of guidelines, action protocols and sharing of knowledge in the form of books, leaflets, posters, among others" "quick and easy application questionnaires, with management charts according to scores, covering types of therapy, medication, reassessment"
		Enabling connection *n* = 2	"meet colleagues with skills in sexual medicine to share doubts and guidance" "creating a consulting service so that doctors' doubts about how to act and approach problems in this area can be discussed"

		Training dissemination *n* = 2	"greater dissemination of existing postgraduate training" "more publicity [of training]"
	Raising Awareness	Sensitize the PCP *n* = 3	"normalize the subject and its approach in the consultation" "demystify the taboo, encourage professionals [...] to address the subject"
		Patient's literacy *n* = 6	"greater literacy of the population in this subject so that the patients themselves seek PHC when they need follow-up on issues within the scope of sexology and take the initiative to address these issues in the consultation" "raise awareness of the population on this matter, informing them that the PCP is a professional capable of addressing this issue"
ENHANCING PROFESSIONAL DEVELOPMENT	Professional Education	Postgraduate *n* = 9	"more training, […] postgraduate" "more postgraduate training"
		Internship *n* = 13	"just as we have obligatory training in our internship on smoking, ethics or nutrition, we should have on sexual medicine" "completion of courses, mandatory or optional, within the scope of the medical internship"
		Congresses *n* = 4	"at congresses aimed at PCP" "there should be [...] specific conferences on the subject for the PCP"
	College Education	Undergraduate *n* = 12	"training, awareness-raising actions and more classes on the topic during the Medicine course" "early integration of the topic into pre-graduate medical training"
	Health Team Intervention	Educating all professionals *n* = 3	"adequate training for all [health] professionals" "training in this subject, not only for medical but also nursing teams"
	Gratuity	Free education *n* = 3	providing free training" "provide more training to professionals, namely free of charge
	Broad Subjects	Communication *n* = 5	"communication skills that facilitate approaching them during the consultation in a natural way" "including information about attitudes or phrases that we should not reproduce, teaching how to approach this subject"
		Practical education *n* = 6	"field training"

				"training, in the style of workshops in which there is roll-play […] if we train our skills in practical situations we can optimize our performance in real life"
		Beyond the biomedical	*n* = 2	"it is important for professionals to inform themselves about the topic, whether through articles, newspapers, social networks, etc., not only from a clinical perspective, but also from a social perspective. In other words, not only knowing which contraceptive methods are available, or the most common STIs, but also whether the user has a satisfactory sexual life, whether they explore their body, whether they live a healthy dynamic with their partner, etc." "provide PCPs with the necessary training to better monitor users [...] especially in the non-pathological aspect"
	Specific Subjects	Elder sexuality	*n* = 1	"[training for professionals in] sexuality in old age"
		Teenage sexuality	*n* = 1	"[training for professionals in] sexuality in teenagers"
		Medications' adverse effects on sexuality	*n* = 1	"highlight therapeutic alternatives, in cases of medication with sexual side effects"
		Menopause and sexuality	*n* = 1	"[training for professionals in] sexuality and menopause"
		Gender identity	*n* = 1	"[training for professionals in] gender identity":

One participant can occur in multiple response categories.

Discussion

To better understand PCPs' perspectives on their agency in SM and how to advance it, this study used an online exploratory cross-sectional qualitative design to provide insights on an underexplored scientific field and spur potential procedures and avenues for directing legislation.

The first question *"How do you perceive the role of General and Family Medicine professionals in Clinical Sexology/Sexual Medicine?"* elicited longer answers, dwelling in more than one issue. This illustrates the engagement that PCPs' have with this topic, giving deep thought to the matter under discussion. While this may be explained by a self-selection bias (the respondents were already highly motivated by this specific theme), these answers were rich in latent content, revealing significant interest in this subject, which created extensive and prolific content. The resulting categories included: 'Protagonist', 'Antagonist' and 'Circumstantial'.

Regarding the 'Protagonist' category, our findings reflect the clear institutional role PCPs recognize in themselves, as often they are the *only contact* or the most *accessible* within the NHS. Being responsible for gatekeeping means that the medical role is often transcended by a cost managing one, which highlights the need for coordinating and overseeing a patient's overall healthcare journey within the NHS (9). But just as they are the *1st contact*, PCPs also regard themselves as patients' *plan B*. According to our sample, this is justified due to public unawareness regarding the services available on PHC and how public referral functions, and due to the existing stigma about sexuality affairs (cf. Code *Plan B*). PCPs are often considered the cheapest backup option, leading to delayed care-seeking behavior (37). This highlights the importance of educating people about the role and capabilities of PHC providers.

PCPs appear to conclude that their role in SM is just the same as in any other matter, meaning that the significance and character of a PCP / Family Doctor, acting as a medical specialist, implies specific duties, goals, attitudes, which remain independently of the patient's issues (cf. Subcategory *Specialist Doctor*). The PCP then emerges as an *interventionist*, a *detector*, and a *mediator*, which may inform the hot topic of medicalizing sexuality, as in increasing the dominance of medicine over how we understand and experience sex (33,34). Though medicalization has increased treatment options, it remains problematic for promoting a narrow, biological view of sexuality and applying a "disease model" to typical experiences. Yet, as a comprehensive practitioner by definition, PCPs stand in a unique position to act in a

culturally-sensitive manner, acknowledging the social determinants of sexual health (35), striving to address underlying factors contributing to health disparities, and potentially changing long term practices. This concern is visible when looking at the code "*Beyond the biomedical*", found on the answers to how PCPs role could be optimized. It becomes evident from our participants' responses that PCPs hold a special position within the NHS to intervene in sexual health matters (cf. Subcategory *Specialist Doctor*).

Simultaneously, our study uncovered the importance PCPs give to the patient-doctor relationship, even instrumentalizing it, i.e. putting it to use to attain specific goals (36,37), as they recognize the benefits of continued and close care when it comes to addressing sexuality (cf. Subcategory *Humanized Caregiver*). By building trust and rapport, PCPs foster a strong patient-doctor relationship, leading to open and honest communication, as patients feel more comfortable discussing their concerns, which contributes to better overall care and outcomes (38).

Concurrently, our data reveals that within the profession there are factors that can make the best provision of care unfeasible, notably considering sexuality a taboo topic and relegating it to a secondary matter (cf. Category *Antagonist*). Long waiting lists, high out-of-pocket expenses, workforce shortages, time constraints and stress on staff (24,37,39,40) may add to PCPs not being the best stakeholders for their patient's sexual health at times. Which is why, in their view, structural changes are needed to improve PCPs agency (cf. Subcategories *A New Type of Consultation* and *New Techniques*). The "Antagonist" category arises as a remarkable reflexive exercise. While some evidence suggests PCPs occasionally struggle with reflexivity, other studies indicate that physicians aim to reflect on their practice and adapt their behavior to circumstances in a balanced, ethical manner (41,42). Encouraging reflexivity may be one non-formal way to improve PCPs' performance in SM.

These perspectives develop in a conditioned environment. PCPs see their position as dependent on multiple factors and just as patients' sexual complaints become more frequent, their *ascending role* as potential protagonists is hindered by multiple limitations, many already described (12,19,43) but, according to our sample, the most impactful one being their lack of formal training (cf. Subcategory *Limited*), just as previously discussed by Alarcão (2012) (24).

The theme of academic or professional education was overwhelmingly present in the participants' answers to our second question *"How could the agency of General and Family Medicine professionals in the field of Clinical Sexology/Sexual Medicine be optimized?"*, which

resulted in two categories: 'Legitimizing Sexual Health' and 'Enhancing Professional Development'.

The findings regarding professional training substantiate the existing literature (10,24,44,45). Our samples' PCPs focused on undergraduate education as an early and impactful intervention, and on internship adjustments (in Portugal, a Family Doctor undergoes an extra 4-year internship under the guidance of an experienced specialist), revealing uncertainty on whether the training should be compulsory or not. This hesitation may derive from the perception of investing in themes PCPs individually find more compelling, and it's also visible in answers like *"possibility of more postgraduate training for those who are more interested and comfortable in the subject"*.

Furthermore, according to PCPs' views, the easiness when dealing with sexuality matters is essential (cf. Code *Thoughtful approach*). Thus, enhancing professional development in PCPs involves investing also in communication skills (cf. Subcategory *Broad Subjects*). Although they often handle sensitive issues like delivering bad news, managing relationships, among others, and it would seem plausible to recruit strategies from one situation to another, literature reveals insufficient training in soft skills may inhibit their proficiency and overall confidence (10,20,46).

Additionally, to address the gaps in the healthcare system, it is crucial to improve resource management. The Portuguese NHS has implemented sexology-related services as a component of comprehensive healthcare (23), but our participants revealed that there is still room for improvement. Specifically, clear identification of resources and referral pathways, along with national/international guidelines, would help standardize practices and improve consistency in patient care (cf. Subcategory *Expediting Resources*). These improvements would give PCPs tools and knowledge to use resources effectively, standardize practices, ensure consistency, and improve patient care.

To improve sexual health and give PCPs more agency, raising awareness among providers and patients is key (cf. Subcategory *Raising Awareness*). Educating PCPs about sexual health and empowering patients with accurate information can motivate them to prioritize their well-being. This statement is valuable for various stakeholders, government, civil society, and PCPs themselves, as they recognize themselves as health education agents (cf. Subcategory *Specialist Doctor*).

The current study adds to existing knowledge by reinforcing PCPs' self-perceived shortcomings in a concise manner, namely on specific training, but also concerning structural

frailties that need to be addressed institutionally. Moreover, this study brings novelty by demonstrating PCPs' recognition and willingness in having an active role in SM, giving clear clues on what subjects most matter and could be included in training and guidelines, both national and international. Likewise, this study highlights PCPs need for facilitated communication with specialized care to optimize patient management. It may be of interest to investigate secondary care professionals' perspectives on what PCPs do and/or should be doing regarding SM and better understand mutual expectations. Finally, the reflexive prowess shown by the professionals of this sample may be shared across the medical class, which may incite further qualitative research in medicine.

Although the online survey provided valuable answers, it had limitations including the focus on a specific country and system of healthcare and the inability to explore or solve ambiguities in the participant's discourse. Nonetheless, it allowed to reach a multi-located sample and specify needs and recommendations that may preliminarily inform future programs and policies.

Conclusion

This study showed that PCPs acknowledge their crucial role in SM, and, therefore, in sexual healthcare, but their insecurities about their abilities and structural limitations may lead to inadequate delivery. Solutions to improve their role seem to include investment in education, organizational interventions, resources' expedition, guidelines' creation, and raising both provider and patient awareness beyond the biomedical scope.

An institutional and legislative effort is necessary to empower PCPs in SM, with international standards for professional training and practice guidelines, to which this study contributes by describing possible subjects and methods. Our results provide significant national coverage, but further investigation is needed for a better global understanding, as only locally developed research can provide what is country specific or adequate for each health system, and what is crosswise and could be included in multinational directives. This would endorse effective resource use and consistent healthcare provision, placing sexual health as an important field in primary care, and ultimately enhance overall patient care.

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