manager's instructions anyway. Colour blindness is equally important, but can cause difficulties, especially for goalkeepers, who may miss a ball coming from the side, particularly when playing under floodlights. (Many football fans think that most referees are myopic, though I have never had this particular explanation offered before.)

INJURED PLAYERS

All injured players are seen at least once a week to observe their progress but their day-to-day treatment is left to the club physiotherapist, who is a full-time employee of the club. Because he is with them every day players tend to seek his opinion on all other problems, including coughs and colds. In many football clubs the club doctor is also general practitioner to the player and his family but in London clubs this is not feasible as most of the players live in the outer suburbs, often as far as 20 miles or more from the ground. At the start of each season I write to each player's own doctor informing him that the club provides a medical service for the players and asking if he would be agreeable to my seeing his patient when necessary.

Sometimes a player will not accept our medical advice and will seek another opinion from someone recommended to him by one of his friends. They may even seek the opinion of one of the fringe practitioners—an acupuncturist, an osteopath, or even faith healer—but it is my experience that they always come back to orthodox medicine.

THE WHOLE PICTURE

Almost all the productive work of a professional footballer is

Clinical curio: sugaring the pill

While awaiting my train at Hammersmith station I was witness to a sad illustration of the problems of the weight-watcher. A very overweight young lady sat down beside me and, after a brief perusal of *The Times* crossword, suddenly reached into her bag and extracted a blister pack of Temate Doan from which she pressed out a single tablet. She then took the tablet and with a grimace of distaste washed it down with a bottle of Lucozade.

I have heard of sugaring the pill but this seems to be taking the concept to extremes.—A N RAMJI, MRCGP, Middlesex Hospital, London.

Practising the art

I was an assistant in a mining practice near Edinburgh in 1952, having just completed my house jobs and service in the RAMC. I was keen to do well and very "up to date." There was an old retired miner who I visited every few weeks as he had quite had osteoarthritis. During my last few visits he had complained repeatedly of his "sweaty feet." I advised him to change his socks daily, but this did not help. I told him to wash his feet with spirit and use a foot powder but to no avail. I tried antihistamine tablets, which were fairly new at this time; these helped him to sleep but did not relieve the perspiring feet. I prescribed alum soaks and antiperspirant. I excluded thyrotoxicosis. Nothing helped.

A few weeks later he called to me as I was passing. He looked very happy and was running his socks. I asked him how were the sweaty feet. He told me that the old doctor had been in to see him and had said, "Well, how is that young assistant of mine looking after you?" "Oh, he is quite good, doctor, but he can't cure my sweaty feet." "Ah," said the old doctor, "you see that arthritis in your knees—well, that sweat is the poison from there getting out of your body. Let me know if it stops—then we'll have cause to worry!" The old miner was delighted. Ever after he welcomed me with a happy

smile—"They're still sweating, doctor, and I think that my arthritis is improving."

I suppose that it was my first lesson in the real art of general practice. Two minutes of chat with the patient had resulted in a promise that all my advice and up-to-date prescribing had failed to help.—HARLEY NOBLE, general practitioner, Sherrinstree, Kent

Searching for a practice

Dr Dickinson's vignettes of general practice in the 'sixties remind us that abuse of junior partners was in those days almost a normal event. I can remember one practice in which the junior partner was expected as a matter of course to do all the other partners' on-duty nights when they were on holiday. It followed that, with the exception of his one half-day a week, he was on duty every night during July and August. In the same practice the wives received an allowance in recognition of their telephone duties, which was divided out to them in proportion to their husband's partnership share. The junior partner, however, lost again, because this allowance appeared in the accounts and was taxed as if it had been divided out to the wives equal. When several years he evened up, the practice partner it was partly less 1%, which meant that there was still a difference of £350 between the shares of the senior and junior partners.

There must be a number of senior partners in general practice who can remember inequities of this kind, and some might even be tempted to "get their own back." New entrants into general practice should therefore be constantly on their guard. Thank goodness this rarely happens now, and exploitation of young doctors is very much a thing of the past.—G NIGOL, general practitioner, Stratford-upon-Avon

We shall be pleased to consider for publication other interesting stories from general practice.—Ed, BMJ

Sex Problems in Practice

Homosexuality

Misconceptions and problems

RICHARD BATH, JOHN SKETCHLEY

In the past 20 years there has been a revolution in attitudes to sexuality, and perhaps one of the most important changes has been concerned with male and female homosexuality. In modern times and in Western culture homosexuality has been considered an illness—one of the sexual deviations—that requires treatment. Techniques such as aversion therapy, drugs, psychotherapy, or the advice received by a number of homosexual men—merely "to marry or find and take to bed a pretty girl"—were considered to be both acceptable and to hold out hope of a "cure."

Homosexuality has now been taken off the official register of psychiatric illnesses in the United States. Gradually the general view in Britain has begun to endorse this decision, and several medical publications now present homosexuality in accordance with informed opinion.¹⁻⁴ The increasing use of the term "gay," while not pleasing to everyone and being idiosyncratic and arbitrary, helps to distance the subject from such medical categorisation.

Homosexuality is slowly becoming recognised and accepted as part of human sexuality. Kinsey's study,⁵ conducted in the 1940s, found a 4% incidence of exclusive male homosexuality, which if true for Britain would indicate a population of one million exclusively homosexual males. Kinsey found a continuous spectrum of sexual preference and behaviour between exclusive heterosexuality and exclusive homosexuality and that "37% of the total male population has at least some overt homosexual experience to the point of orgasm between adolescence and old age." This accounts for nearly two males out of every five that one may meet.⁶ In Britain Schofield⁷ undertook a much smaller study but arrived at similar conclusions.

Despite changing attitudes, however, problems for homosexuals remain formidable, and we think that these are mainly the result of society's hostility to homosexuals. In this first of two articles we attempt to outline some of these problems.

The law

Before 1967 the law stated that all male homosexual acts were illegal. Following changing opinions, as reflected in the *Wolfenden Report* published in 1957,⁸ the 1967 Sexual Offences Act made male homosexual behaviour between consenting adults over 21 years of age in private no longer illegal. Its narrow definition of privacy means, however, that male homosexual acts are still strictly illegal—say, in a hotel bedroom, or if

another person is in another room of the same house, or, as in a recent court case, in a car in the middle of a field. Homosexual activity is still illegal in the armed forces, the Merchant Navy, and in Northern Ireland, for all ages. The law in Scotland is being reformed to bring it in line with England.

One question concerns the older teenager who, being at an age when sexual drive may be at its highest, transgresses the law, running the risk of penalties. In practice, unlikely policy seems to be against prosecution unless one partner is over 21, when he is liable to imprisonment depending on the circumstances. Attempts are being made to make the age of consent the same as that for heterosexuals. The Policy Advisory Committee on Sexual Offences is making recommendations to Parliament and taking submissions from the public. By contrast, women's private sexual behaviour has never been similarly restricted. No laws exist relating to lesbianism. The reason for this is obscure and open to conjecture.

Misconceptions about homosexuals

There are many misconceptions about homosexuals—who exist in all walks of life: on the factory floor, in management, in government, the arts, the professions; indeed, everywhere. The men are not especially "artistic," and the women not especially "masculine." They cannot be recognised by their dress or mannerisms. Thus the concept of the cigar-smoking, tie-and-mustache lecher, or the mannered and effeminate male homosexual is inaccurate. There are no stereotypes, just as one cannot identify a heterosexual stereotype.

There is no evidence that homosexuals have an increased incidence of psychiatric illness.¹⁻³ Some are married with children. Some are in long-standing paired relationships, whereas others live alone. Some have a number of sexual partners, and some choose sexual abstinence. A few have feelings of regret because they cannot become parents, perhaps women especially, yet this sentiment is by no means widespread.

Specific sexual activity between woman and man or man and man is variable. We were surprised at the general level of ignorance in the medical profession that was revealed when one venerable gynaecologist at a seminar asked what female homosexuals did together in bed. Preferences include oral and anal contact, or mutual masturbation, associated with a variable degree of talking, fondling, and affectionate behaviour, as with heterosexual relations. For some homosexuals, as for some heterosexuals, sexual activity is not at all important.

Problems that homosexuals face

Loneliness is frequently a major problem. A homosexual living in a village or small town may imagine him or herself "the only one" and be compelled to suppress instinctive needs

by conforming to small-town patterns of behaviour. It is not always, as we have seen, that homosexuals live with their aging parents or alone these communities. But doctors in rural practices may observe the dutiful son, or daughter, who rarely goes out, has few personal friends, and who may be sexually inexperienced too. In this predicament there are several options, depending on the personality: reticence imposed by an environment that tends to be centred on the family unit and where sexual mores are more conservative; a double life; suppression; and escape to the city. Many do move to the cities, where they are able to lead a less concealed lifestyle. Loneliness exists in the cities, too, but for different reasons, and such loneliness is not confined to homosexuals, whether in rural or in urban communities.

A person may have similar feelings of isolation at work. Added to this, if detected, he or she may lose the job or be discriminated against when promotion is due. Teachers and those working with the young seem especially vulnerable, despite the equal possibility of sexual pressure upon young persons by heterosexuals.

Most churches condemn homosexual activity, so that the religious aspects of morality and the consequent values have sometimes to be resolved, and this of course may apply to those with vestigial religious convictions or to those with a secular morality.

Women have special problems because of their historically and socially imposed role of housewife, mother, and financially dependent partner. Despite changes in attitudes they still tend to be reared with these expectations in a ball game. Knowing the political tensions within a club can be very helpful and some players are under stress at home, particularly if their wives are worried about what might happen when they travel abroad.

During the last year or two there has been a lot of publicity about the abuse of certain drugs by athletes. The list of banned drugs includes stimulants such as the amphetamines and also anabolic steroids. Any doctor who is treating a professional footballer, or for that matter any athlete participating in international sports, should remember that included in this list is epinephrine, even when it is used for asthma.

Men undergo conditioning processes too, and it may be quite late in adulthood before they recognise or acknowledge their homosexuality. They likewise may have drifted into marriage, or into a profession where being unmarried is not considered unusual—and this applies equally to women.

Homosexuality cannot usually be repressed indefinitely, and the loyalties to family and sexual needs will cause conflicts. Some remarkable marriages seem able to withstand the wife or husband having relationships outside. During the successful marriage of Harold Nicholson and Vita Savkville-West both had homosexual affairs. The one between Vita and Virginia Woolf has been much written about in recent years. We both know of marriages with or without children that exist more or less securely with one partner being homosexual. A remarkable degree of trust, adroitness, and understanding is required for the marriage to continue, and indeed all marriages have to adapt in varying degrees to the idiosyncrasies of the partners.

For others, separation and divorce are the right, if painful, choice.

The middle aged and elderly find themselves in an especially difficult position, having grown up in a less tolerant age. Until recently homosexual encounters were often associated with secret and fear of blackmail. Many older people are still obsessed with this legacy of the years before 1967 and perhaps will never attain a sense of ease and security about their homosexuality. And because the recent changes have in the main taken place through the younger generation and are associated with youthful activities, for a number of older people the sense of alienation and exclusion is reinforced. On the other hand, some elderly people thrive on this freedom.

Disabled people and those living in community homes carry an added burden. They are more isolated, have less privacy, and if physically handicapped are dependent on others who may be unsympathetic, even hostile. A lesbian woman, known to one of us, was severely disabled and lived in a Cheshire Home, unable

to talk to staff or fellow patients and incapable without help of getting out to meet friends with whom she could just be herself. Another, a man, in a nursing home, who was completely disabled after a car accident, relies upon a typewriter to write sexual fantasies which he sends to a sympathetic correspondent, but he cannot depend upon being understood in his room by nursing staff at any time.

Similar stress and inability to communicate may afflict those homosexual couples whose relationship disintegrates. The habitual secrecy may prevent them from seeking outside help. In the event of bereavement, the secret mourning of a loved person may lead to intolerable stress if the survivor feels unable to talk to others.

This is a brief survey of some of the difficulties facing homosexuals. In our opinion those homosexual men and women who come to terms with their sexuality face no more problems than heterosexuals. Both groups face comparable problems in life, such as first companionship, experiencing love, establishing a career, finding a home, and facing loneliness, illness, and death. The only difference appears to be social approval, and, sometimes, self-acceptance.

The next article discusses how general practitioners might help homosexuals to self-acceptance.

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ONE HUNDRED YEARS AGO The Rev Joseph Cook, a well-known American pulp-orator, has come over to this benighted country to convert the heathen, Michael Foster, to the Christian faith. The plea for this special mission appears to be that, having attained to an accurate knowledge of scientific research, he is competent to expose the fallacies of science. Judging, however, from some extraordinary statements which this lecturer is reported to have made with reference to the action of alcohol on the living brain, our modern scientific inquirers may take heart of grace, and rest in peace a little longer. Mr Cook, in sight of large audiences in the North, poured alcohol on white of egg. After stirring this for a few minutes, he held the mass up to the representative moderate drinker's brain. After a longer interval, the mass, having become hardened, was exhibited as a fair illustration of a drunkard's brain. With lamentable ignorance of the fallacies of science, he professed to follow the secure procedure, state, as a fact, that alcohol hardened the living human brain, leaving indelible scars on the cerebrum. The elementary fact that, while alcohol hardened dead brain substance, in life it induces softening of the brain, is, it must charitably be assumed, unknown to him. Before public dogmatic statements on physiological questions are made, it is desirable that lecturers, in the case of this country, should, for their own reputation, and for the truth's sake, ascertain the elementary facts, either by personal research or by consulting some competent physiologist. In the case of science, as in the case of religion, a good cause, which most members of our profession have, are we convinced, deeply at heart, and can only dispense sensible hearers. (*British Medical Journal*, 1881.)

Unemployment in My Practice

Whitehead, Carrickfergus

JOHN WILSON

For the past 24 years I have practised in a rural area with a radius of 10 miles from the village of Belfast. When I started practising unemployment was not a problem because there was a large engineering concern and the port of Larne looking after employment on the eastern side of my practice and three man-made fibre industries looking after employment on the northern and western sides. Before that most of the patients from my practice travelled to Belfast for their work. Then these new industries arrived from England. Our practice list increased from 5600 patients to 7300 in five years. We had two new housing estates in our small town and small catchment areas of 50 houses pocketed throughout the rural areas. The bus services were good, but the public service then faded with the workers' prosperity as the motorcar became a family possession. The whole practice had a sense of progression, and there was a feeling of prosperity. Three years ago two of the fibre works announced redundancies, and the engineering industry in Larne was contracting. The patients then began to get apprehensive, the workers were less likely to ask for medical sickness statements, and simple illnesses presented as major complaints.

Dealing with an increased work load

In the past year unemployment has become a real problem. Most of the redundancy payments have been spent on a change of car or a holiday abroad, and the problems are now increasing. Consultations have increased in number, and there has been a change in the reason for them. Wives are consulting more frequently with no obvious reason to financial problems, and the fact that the husband is around the house for too long each day causes marital disharmony—even to the stage of wife venturing, almost daily, into the practice three years ago. Healthy middle-aged men arrive with complaints—with minimal pathology—but insist on full check-ups because they now have more time, with the result that the fears of serious illness are greater.

Twelve years ago I entered a health centre and the home visits were reduced to one-third. We were then more available for consultations, and patients came to the health centre by public transport, their own car, or their neighbour's car. We now have a noticeable increase in requests for home visits because public transport is not available, the neighbour's car can no longer be requested, and the patients' cars are not taxed or insured. We have had an increase in the number of requests for immunisation for emigration to South Africa or Australia, which means spending more time giving full medicals and immunising whole families.

Five years ago there was an average of 10 houses for sale at any time, today there are 82. Several of the English families from the

mainland have been leaving for England to join up with their respective companies in new areas. They all have to have a final check-up and referral letters to their new general practitioners. The number of requests for references is greater because the smaller firms, when they have a few vacancies, have become more selective and insist on references. I had almost given up writing these. It is sometimes soul-destroying when you know that you are writing references for six men, all of whom are after the same job.

Consultations take longer because the wife is accompanied by the husband, or the husband brings along the children when he has very little knowledge of the child's details—and even less of the child's complaints. Recently I had a young epileptic wife whose husband had lost his job nine months before. She had been a capable worker in an instrument department before her marriage. The finances of the family got to the level that she had to look for employment and she managed to get a job as a home-help. She presented with headaches, loss of concentration, and she had been taking hours over her housework. It was only in the second consultation that her problem became clear—her rejection of her job as a home-help was depressing her so much that she could not cope with her own housework. She needed reassurance and someone to understand her problems. A young man presented with chest pain at the afternoon he got his redundancy letter and a request for a reference, which were negative. Unfortunately, his life insurance search report was requested after the history of chest pain. He now has a 10% levy on his premium. One month later he was successful in getting an interview for a new occupation, and his pain cleared and has not returned.

To compensate for the greater number and length of consultations I have had to reduce the number of necessary follow-up consultations for patients with chronic illnesses, such as hypertension, from four to six weeks or six to eight weeks, etc. The practice has had to add five extra surgeries a week to cope with the demand. Nearly 20% of our patients are elderly, and many of these were receiving review calls every six weeks, so some of the alternate visits have been taken over by the district nurse or health visitor. But there has been an increase in referrals by staff, which has taken up my available time for the new call list.

My fear is for the youth of the practice. They are now showing signs of vandalism, drunkenness, rowdiness, and general loss of morale. I am a forensic medical officer, and when I interview these youths after they are detained in custody they need extra time to discuss their problems. It also means referral to a social worker, or even a welfare officer from the police. They need help, even if it is only helping someone agree that they have a problem because their problems will only end when employment comes back to our practice.

I have no doubt that I have had to increase my working hours because of the acute unemployment, but I have managed to compensate for this in part by adding surgeries and by reducing visits and follow-up consultations for the patients with chronic illness. The patients in turn are losing out, but I think that they have accepted this as a part of our general recession and also of our local problems in Northern Ireland.

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