Mechanics of Negotiation

In an effort to relate professional income to the earnings within the community during an inflationary period negotiation becomes extremely complex. Indices of living costs, wages and salaries, gross national product, and disposable income are quite unfamiliar to us. Governments have a massive bureaucracy at their disposal that thrives on such esoterica. The Canadian Medical Association has found it very necessary to develop a department of research and development which supplies its 10 provincial divisions with all the information necessary, including an independent look at the construction of any government statistical data. This is expensive but very worthwhile.

While the associations are backed by their own statisticians, economists, and lawyers it is still better that respected physicians be the actual negotiators. Lawyers negotiating on our behalf encourage the government to employ other lawyers, who then proceed to exchange expensive letters between themselves. It is better to have doctors in eye-to-eye confrontation with politicians. They make the final decisions. The setting up of review bodies, commissions, and other political phantasmagoria is merely a device for procrastination and those of us who have served on such bodies are very aware that there is no such thing as their independence.

It is very important that a time interval be set between negotiations—"Don't phone me, I'll phone you" is a favourite political device. It results in delay, so that finally the profession has to ask for a massive percentage increase which embarrasses the doctors and which the politicians find it politically easy to deny. The device of referendum to the membership to confirm a settlement is still experimental in Canada. We have learned the

referendum has to be simple. Yet this simplicity precludes a discussion on paper of the complexities of the issues. In a small province it is probably better to have a specially attended general meeting where all can hear the arguments, but in the larger provinces we are still experimenting with these referenda.

Professional Independence

The ultimate strength of the professional case must depend on public opinion. This demands that we give good service and that we be reasonable. The public, our patients, have to be prepared to pay the cost of our services one way or another. Government insurance mechanisms merely allow them to do it collectively. The final freedom of the profession to return to a direct financial relationship with their patients is a freedom that most Canadian doctors do not wish to utilize. Nevertheless our freedom to do this is the key to professional independence, and professional independence is essential to our patients as well as to us. Once we lose it we are incapable of protecting our patients against any lowering of standards caused by governments trying to cut costs.

During my training in London I never heard one of my teachers mention fees—let alone their negotiation. Those surviving, beloved in the kindly perspectives of memory, will shake their heads and say economics has nothing to do with good medicine. Abernethy and Paget were not concerned with rewards. With ingrained respect, I suggest they are wrong. A profession that feels itself unfairly rewarded does not function at its highest levels of performance. Delusions of scientific altruism will not keep the doctor warm while unscrupulous politicians remove his shirt.

Aspects of Sexual Medicine

Some of the Commoner Sexual Disorders

II. Problems Mainly Affecting the Woman

R. W. TAYLOR

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Expectation

Gynaecologists have in the past been made aware of a woman's sexual problems only if they produced symptoms and in particular if they gave rise to pain. There is a wealth of literature dealing with vaginismus and dyspareunia, for example.¹⁻⁴ Increasingly today's practitioners are being confronted by frigidity and the marital problems it sometimes brings in its train. A consideration of a woman's sexual problems must therefore be concerned with the question of her expectation of sexual enjoyment and the degree to which it is fulfilled, as well as dealing with those problems which have either a physical basis or a clear physical manifestation.

Orgasmic Failure

By the nature of her biological responsibilities a woman's reproductive function can be separated from her enjoyment of intercourse. Nature can be served whether or not she achieves any satisfaction; even her consent is unnecessary. Though there is obviously a paramount physical element to sexual satisfaction, and a rhythm of response associated with the ovarian hormone cycle can sometimes be found, psychological factors are also very important in the majority of women. Circumstances can therefore determine the woman's response in a way they do not in the man. Psychological factors may certainly influence his reaction, particularly if he is inexperienced or has a low sexual drive, but in general orgasm is determined by the degree of physical stimulation. Add to these things the fact that the physical response in woman is usually much slower to develop than that in man, and many of the elements which might contribute to a woman's dissatisfaction with intercourse are plain to see.

Failure to achieve orgasm can be primary or secondary. When it is primary in the sense of always having been present it will

St. Thomas's Hospital, London S.E.1

R. W. TAYLOR, M.D., M.R.C.O.G., Professor of Obstetrics and Gynaecology

often be found that the woman is ill at ease with the whole concept of sex. This may be because of faulty education, traumatic early experiences, fear of being hurt, fear of pregnancy, or an unwillingness to do something which she believes amounts to a surrender of part of her personality. This latter is characteristic of women who are poor at making personal relationships and would perhaps be seen more commonly if this was not in itself often a barrier to marriage.

Faulty education may include the imperceptible absorption of ideas from friends and relatives as well as from parents. Religious taboos are occasionally important, but great care should be taken before accepting such an explanation at face value. In most cases careful examination of the patient's personality will show that the taboo has been gratefully taken up because it corresponds to a basic feeling, it supports an attitude that has an earlier origin. In these cases the logical examination of the taboo will not in itself do anything to help bring about a change in attitude. The source of the faulty attitude must be traced in order to do this. Similarly, one sometimes finds a woman whose problem appears to stem from the way in which the biological facts of reproduction were learned. Sex education in school may be blamed. Once again it is imperative that the underlying personality problem should be sought. Only the vulnerable child suffers from group sex education, however bad it might be.

MAN'S UNDERSTANDING

The attitude of the man is important sometimes in the aetiology of orgasmic failure and always vital to therapy. Unless he understands the nature of a woman's response in general, and appreciates the particular things that his individual woman finds stimulating, he cannot hope to elicit an orgasmic response. Further, he must appreciate the difference in the time scale of the response. His reaction could be complete within a minute and in consequence he could be a snoring log when his wife first enters the excitement stage. Her frustration in consequence may build up to produce a frank neurosis. Certainly she cannot hope to achieve orgasm.

Occasionally the problem can be laid even more squarely with the man. Premature ejaculation will certainly preclude satisfaction in the wife, and in practice any male dysfunction results ultimately in loss of the masculine image and impairs the woman's enjoyment.

In summary a woman can generally hope to obtain a satisfying sexual response only in the context of a secure and loving relationship. She must be a stable personality with a healthy view of the sexual relationship. She must be free from fear of the consequences of intercourse and have a considerate and knowledgeable consort. Finally she should be in good general health and not unduly fatigued.

Secondary loss of orgasmic function can usually be attributed to some specific traumatic episode and change in the background to marriage. I have seen loss of orgasmic function follow rape and difficult childbirth. I have seen it occur because of advancing age, because of ill health, and on one occasion because the couple had to share accommodation with parents and were given an ancient, creaking bed to sleep in. Usually the cause of the trouble is not far to seek and any possible solution is obvious.

Vaginismus

By vaginismus we mean the partly voluntary, partly spontaneous contraction of the pelvic muscles which occurs when intercourse is attempted and which may make intercourse painful or prevent it completely. Almost always the cause is psychological. Rarely there is a painful lesion at the vulva—a painful scar or an infection—which causes involuntary spasm as a protective reflex, but usually physical examination discloses nothing but a reluctance to be examined. In these circumstances a reluctant

attitude to sex, based generally upon poor education, will usually be found. Occasionally a traumatic early experience is responsible, an attempted rape, or less obviously the forced attention of a boy friend in circumstances of anxiety. Grave personality defects including latent homosexuality are fortunately rare, for the results of treatment are poor.

The gynaecologist has an enormous advantage over the psychiatrist when dealing with vaginismus. The patient attending the gynaecological outpatient clinic expects a pelvic examination, whereas the woman attending a psychiatric clinic would reasonably look askance at such a suggestion. In practice the vaginal examination is useful both diagnostically and therapeutically.

CONFIDENCE

Diagnostically, the few organic lesions causing vaginismus are detected. More important, the remaining patients can be divided into two groups. More than 95% of patients fall into the first group of what may be termed mild to moderate vaginismus. When vaginal examination is attempted, as they are lying on their back, the levator ani muscles go into spasm and the examination is resisted. By gentle perseverance, talking, holding the eyes of the patient, and thus encouraging relaxation, the examination, be it only with one finger, can be achieved. It may take 10-15 minutes to complete this examination, but it is well worthwhile. Besides excluding organic disease it reassures that patient about the capacity of the vagina and convinces her that relaxation is possible. In some circumstances this reassurance can be supported by examination under anaesthesia, gentle dilatation of the introitus, and the placing of a glass or perspex dilator into the vagina. This is left in situ for the patient to remove herself. She is taught to reinsert it and perhaps encouraged to graduate to larger dilators. The object is not of course the dilatation but the instillation of confidence in the possibility of painless penetration.

All of this must go hand in hand with an analysis of both partners' attitude to sex. The breakdown of unhelpful attitudes and the instillation of the idea that intercourse is good, healthy, and helpful to the development of personality are more important than the breakdown of any apparent physical bar to penetration. It is reasonable to expect the cure of every patient who falls into this group. Careful therapy will in addition ensure that intercourse subsequently becomes a pleasure rather than a chore.

A small proportion of patients fall into a separate group of severe cases of vaginismus. Approach to these patients is met by contraction of the levator ani muscles, apposition of the thighs, and arching of the back. All of this occurs even before the vulva is touched. In these cases there is usually some serious personality defect. Latent homosexuality is the commonest. My own very limited experience of only five such cases seems to indicate a very poor prognosis whether they are dealt with by gynaecologist or psychiatrist. One certain thing is that a surgical approach to treatment will fail. Even the removal of the perineal musculature simply substitutes a painful scar for what the patient has in her own mind regarded as a congenital tightness at the introitus.

Dyspareunia

Literally the term dyspareunia covers all cases of difficult intercourse. In practice it has come to include only cases in which intercourse is painful. The pain may vary in severity and it may be felt superficially at the vulva or deep in the pelvis.

SUPERFICIAL DYSpareunia

Vaginismus would certainly be a cause of superficial dyspareunia if the attempts at intercourse were pursued. Generally, patients

with the temperament to suffer from vaginismus are found to have married men who demand comparatively little. Organic causes of pain include a large or thick hymen, even occasionally an almost imperforate vagina; but generally an unruptured hymen is a consequence, not a cause, of superficial dyspareunia. Occasionally superficial dyspareunia develops because of a local infection or the presence of a painful scar, but these things present no problem either in diagnosis or in treatment.

DEEP DYSPAREUNIA

Pain deep in the pelvis, felt either at the time of intercourse or soon afterwards, usually has a demonstrable pathology. A retroverted uterus even when mobile may be associated with deep dyspareunia, because the ovaries can be trapped in the pouch of Douglas and pressed against the sacrum at intercourse. In these circumstances the dyspareunia may be intermittent, since it depends on the ovaries being trapped. In most cases the difficulty is relieved by coitus in the left lateral position. The therapeutic use of a Hodge pessary to antevert the uterus does not really advance the diagnosis, because intercourse may be incomplete with the pessary in situ. Permanent cure will usually be obtained by one of the operations to ventrosuspend the uterus.

Lesions in the pelvis such as endometriosis or sepsis may result in pain on intercourse, which can be reproduced on pelvic examination. Appropriate treatment usually brings relief. Finally, back lesions such as prolapsing discs or sacroiliac strains can give rise to pain after intercourse, which may be referred round into the abdomen. Characteristically this pain lasts for a day or more after the intercourse.

Pelvic Congestion

Many of woman's problems have been attributed to pelvic congestion associated with sexual frustration. It is difficult to know how much weight to attribute to such a factor when sexual frustration is so often symptomatic of a poor relationship and a more general discontent. Masters and Johnson⁵ were able to show a gradually developing but eventually intense pelvic vasocongestion, with enlargement of the uterus, in a woman subject to repeated pelvic examination and coital stimulation over a period of six hours. The congestion was relieved rapidly by orgasm.

It would not be surprising if such congestion, repeatedly induced by sexual stimulation but never relieved by a satisfactory climax, did ultimately produce physical problems such as low-grade pain and menstrual abnormalities, but it is impossible to indicate how common such things are. In any event, good counselling of both partners will usually produce an improvement in general health and mental outlook that it will render comparatively minor physical disorders tolerable if it does not actually relieve them.

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Medical Education

Approach to Rapid Problem Solving in Clinical Medicine

B. J. ESSEX

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Summary

Problem-orientated flow charts have been developed to teach paramedical workers the skills of making diagnoses in outpatient clinics in Tanzania. The charts give high levels of repeatability, accuracy, and rapidity and their use may lead to improved standards of medical care.

Introduction

Most medical care in developing countries is provided in outpatient clinics, where large numbers of patients are seen in a short time. Most of this work is done by paramedical staff who undergo a three-year training programme which is almost exclusively hospital based. They are taught the skills of history taking and examination on patients admitted to health centres

or hospitals. Conventional methods of teaching these skills are important but time consuming. Moreover, after such teaching students often find that they are unable to diagnose the problems of all 150 to 200 patients seen each morning, which leads to frustration and cynicism about the use of much of their training and results in the symptomatic treatment of most illnesses with little attempt at differential diagnosis. A new technique has therefore been developed to teach the special diagnostic skills needed to practise effective outpatient medicine.

Objectives and Method

A project was undertaken to develop, test, and evaluate a method of diagnosis which would (a) be problem orientated; (b) have an acceptable level of accuracy; (c) be based on history taking and clinical examination alone; (d) enable a diagnosis to be reached in under three minutes; (e) be suitable for teaching paramedical and medical students; and (f) have a high level of repeatability. It should also lead to a standardized pattern of referral to health centre or hospital. The technique was developed in the following four stages.

Identification of Symptoms.—A simple classification was developed to record the frequency of symptoms in children aged up to 4 years and 5 to 15 years and adults. This was used to record all symptoms in all patients attending the dispensary and health centre clinics

Medical Faculty, University of Dar es Salaam, Tanzania

B. J. ESSEX, M.Sc., M.R.C.P., Senior Lecturer in Community Medicine (Now Consultant to the African Medical and Research Foundation, Nairobi)