LETTERS

Sexual health

Consider people, not gender

EDITOR,—I was disappointed by Christopher Bignell's provocative editorial on men's sexual attitudes and behaviour and their relevance to improving sexual health.[1] I fear that his views have been influenced by the sample of men he sees as a consultant in genitourinary medicine. This sample's sexual attitudes and behaviour may well be widely divergent from those of the remainder of the general population of men.

Bignell makes many categorical statements regarding male sexuality and, perhaps, confuses universal characteristics with more occasional features of masculinity. Many would dispute the existence of universal characteristics. With regard to occasional features, some men are indeed aggressive, dominant, competitive, and unable to articulate feelings and emotions. Generalising this to every man, however, obscures considerable variability within the gender. All of the features he mentions are evident in some women. For most of the features, variance within a sex is likely to exceed that between the sexes.

I agree that the narrow view of sexual health, measured by impersonal statistics such as the incidence or prevalence of new partners, diseases, and unwanted pregnancy, is flawed. These statistics emphasise mechanics at the expense of intimacy and the collective at the expense of the individual person and his or her particular needs. I fail to see, however, how the sexual health of the nation can be improved by stereotyping men as pleasure seeking, aggressive, and inarticulate. Is this really a "more realistic male role model"? It certainly seems a less desirable model than the "new man" beloved of women's magazines, which Bignell dismisses as "a fantasy image that denies integral facets of masculinity." What is needed is emphasis on the person rather than membership of a particular sex. That, allied with research on the fundamentals of differences in sexual attitudes between the sexes, should move forward the debate on the sexual health of the nation.

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1 Bignell C. Improving the sexual health of the nation. *BMJ* 1993;307:145-6. (17 July.)

Medical training must acknowledge sexuality

EDITOR,—As a medical student I share Christopher Bignell's concern at the shroud of silence surrounding male sexuality,[1] but I remain pessimistic while the basic medical curriculum continues to deal with sexuality by denial. As specialties vie with each other for teaching time there is less and less space for considering the fundamental emotional, psychological, and sexual issues so important to both illness and health. It is easy to understand why the public criticises doctors for their lack of understanding and compassion since the long and arduous training process engenders technical and theoretical competence but ignores the basics of human nature.

An appreciation of sexuality requires more than a brief placement in a sexually transmitted diseases clinic. The complexity of sexuality can be explored only by the type of open discussion that Bignell suggests. Small seminars and workshops would be a welcome change from didactic and factual lectures and tutorials. Role play is a stimulating and rewarding technique in medical education and raises students' awareness of the emotional needs of patients.[2] It would be an ideal way of examining the dynamics of personal interaction, sexual identity and behaviour, and sexuality in mental and physical illness and handicap.

Sexual tension inevitably exists between doctors and patients, particularly in the relationship between male gynaecologists and their female patients. Karpf notes that "the medical profession mostly deals with this by denying it, as if their right to examine patients physically and enquire into intimate areas of their life is offset by a professional ability to remain detached. It would surely be better for medical training instead to acknowledge these awkward feelings and teach doctors how to manage them."[3] It is time to follow such advice and put sexuality firmly on the medical agenda.

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1 Bignell C. Improving the sexual health of the nation. *BMJ* 1993;307:145-6. (17 July.)
2 Coonar AS, Dooley M, Daniels M, Taylor RW. The use of role-play in teaching medical students obstetrics and gynaecology. *Medical Teacher* 1991;13:49-53.
3 Karpf A. Trust me . . . I'm a gynaecologist. *Guardian* 1992 Dec 2:9.

Advice to authors

Priority will be given to letters that are less than 400 words long and are typed with double spacing. All authors should sign the letter. Please enclose a stamped addressed envelope for acknowledgment.

Male stereotyping is unhelpful

EDITOR,—We were surprised, after reading the title of Christopher Bignell's editorial—"Improving the sexual health of the nation"—to discover that it concerns the sexual health of less than half the nation.[1] The problems of women and homosexual men have been omitted. There are also subgroups such as disabled people who may have special needs with regard to sexual health. We were not aware of an "impregnable silence" surrounding men and sex but rather of too much inappropriate and unhelpful noise.

Much of the editorial's content is based on anecdote rather than science. We doubt whether the comments made refer to all men. Those men who exhibit the behaviour described may be the least likely to seek or accept treatment. Characteristics such as "aggression, dominance, status seeking, physical strength, and competitiveness" are human rather than exclusively male (as are faked orgasms and an initial lack of sexual knowledge). The media models of sexual behaviour described are unhelpful to women as well as men; in addition, women may find them offensive, threatening, and abusive.

The objectives in *The Health of the Nation* recognise for the first time in a government health strategy the importance of sexual health.[2] The chosen indicators (teenage pregnancy, incidence of gonorrhoea) are markers of sexual "disease." Bignell is to be congratulated on advocating the promotion of sexual health and not merely the prevention of sexual disease but proposes no suitable indicators or specific service developments that would effect change.

Some of the comments in the editorial are debatable. Would a man's knowledge of "how he compares with previous partners" always enhance sexual contentment?

Finally, who said that "new man" is not masculine? Although hampered in our assessment by the lack of any scientific definition or models of good practice, we understand that new men spend a lot of time bonding under car bonnets and banging tom toms in the woods.[3]

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1 Bignell C. Improving the sexual health of the nation. *BMJ* 1993;307:145-6. (17 July.)
2 Department of Health. *The health of the nation. Key area handbook on HIV/AIDS and sexual health.* London: DoH, 1993.
3 Bly R. *Iron John.* New York: Elements, 1993.

Serum screening for Down's syndrome

Informed consent is vital . . .

EDITOR,—One of the most disturbing features of Helen Statham and Josephine Green's survey of 20 women with positive results of serum screening for Down's syndrome[1] is the apparent failure of medical staff to obtain the informed consent of women who have the test. Medical staff who administer this test have the ethical duty to ensure that women are informed fully before testing of the nature and purpose of the test, possible results, and the options that arise from the results.[2] This enables the women to make an informed choice whether to have the test, and it may reduce anxiety. Sadly, this ethical duty seems to have been neglected, particularly for the women who had the test as part of routine screening. Some of these women "had not known that [the test] screened for Down's syndrome." It is a matter for concern that women are being entered into a screening programme, the outcome of which may be a termination of pregnancy, without their prior knowledge or informed consent.

As Statham and Green admit, the 20 women in their survey are not a representative sample. To be included in the survey they needed to know about the organisation Support After Termination For Abnormality and have the means and inclination to avail themselves of its services. This does not mean necessarily that they were more anxious than other women who received positive results of tests. Other women may have expressed their distress through other agencies, their general practitioners, or their families or suffered in silence.

Statham and Green ask, but do not answer, the most fundamental question about serum screening for Down's syndrome: "Is serum screening a good enough test?" This question was conspicuously absent from a list of controversies in Michael Connor's editorial on the same subject.[3] If the test is not good enough even the best counselling before and after the test will fail to prevent unnecessary

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