lesion. Despite these differences, there is no obvious explanation for the discrepancy.

We had few eligibility criteria that would limit the external validity of the study. GPs particularly interested in skin lesions may have been more likely to participate, but the ratios that we observed were similar to that found in an analysis of all excisions sent to a pathology service in Victoria.[5] GPs in Australia practise on a fee for service basis, and excisions of malignant skin lesions attract a higher payment than excisions of benign skin lesions.

In conclusion, our results do not show that photography of pigmented skin lesions in general practice in Australia decreases the number of benign lesions excised without compromising sensitivity of the diagnosis of melanoma.

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Competing interests: None declared.

Ethical approval: The Human Research Ethics Committees of the Royal Australian College of General Practitioners and the University of Western Australia approved the study protocol. No consent was sought from patients, whose names were not sought.

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Corrections and clarifications

England is in a sexual health crisis, MPs say
In this news article by Zosia Kmietowicz, we wrongly suggested that Dr Helen Lacey worked in Manchester (14 June, p 1281). In fact she is a consultant in the departments of genitourinary medicine in Rochdale and Bury.

New South Wales cracks down on commercial scanning
In the full version (which appears on bmj.com only) of this news article by Christopher Zinn (21 June), we inadvertently misspelt the name of Dr Paul Condoleon.

A paper that changed my practice

Asking the right question

Ten years ago I was feeling overwhelmed by the plethora of scientific papers at the annual Australasian STD Congress when I noticed a paper to be presented in one of the smaller lecture theatres. It looked as if it might be relevant to my work in a city sexual health clinic: *Should the question "Have you been sexually abused?" be asked routinely when taking a sexual health history?*[1]

Of 407 patients asked this question in September 1992 at the Auckland Sexual Health Centre, 90% had never been asked this before by a health professional, 31% disclosed past abuse, and for 26% this was their first disclosure. Given the context of the study, such high levels were not unexpected, but it was the final statistic that changed my life: only two patients were unhappy about being asked the question.

The authors acknowledged that patients from high risk behaviour groups—such as street kids, sex workers, substance misusers, and those with unsafe sexual practices—comprised a higher proportion of their case load than was so for an average family practice. Previous studies of non-clinical populations have shown that a history of child abuse significantly increases the risk of such behaviour, and many psychosomatic and psychosexual complaints may indicate previous abuse as well as the more familiar sexually related consequences of sexually transmitted disease, HIV infection, unwanted pregnancy, and genital neoplasia.

Some years later, while researching a talk on the effects of sexual abuse on pregnancy, I became aware of other issues I had previously failed to consider sufficiently. For example, a history of an eating disorder (typically bulimia), patients who refuse a smear or pelvic examination, patients who will see only a woman doctor, women with chronic pelvic pain or symptoms that seem to be psychosomatic, and so called difficult patients. All these could be linked with a history of early sexual abuse or assault, and we can recognise these behaviours as being an attempt to regain control after a frightening or degrading experience.

Should we, I asked myself, be re-evaluating some of our more challenging patients, whether male or female? Since then I have followed the practice of asking about sexual abuse much more often, especially with patients such as these. All doctors are now expected to be able to ask important questions with tact and understanding, so it has also been useful to alert medical students in several countries to this valuable question while training them in communication skills.

Many patients remain reluctant to disclose a history of sexual assault unless given the opportunity by a safe and sensitive inquiry. The healing process begins with validation combined with appropriate counselling.

Incidentally, this relatively short and simple paper was awarded the prize for the best paper of the congress. I suspect many other delegates who heard it also took its message to heart and changed their practice.

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