

apologists for what the public, politicians, and the press deem unacceptable. There is a strong feeling that the medical profession has got above itself. Lord Justice Otton, on the matter of "accepted medical practice" as a defence in law writes, "It has been extended well beyond diagnosis and treatment, thereby substantially enlarging the role of the doctor as arbiter of social progress."⁷ Can we really expect that doctors will any longer be given a free hand in end of life decisions, the ethics of organ retention, or monitoring surgical outcomes?

The consultants' prime function within the organisation is as provider of medical and surgical care. Entitlement to special status solely because consultants are senior members of the medical profession is what is being challenged and has largely been lost. Let us consider car parking. It is a limited resource where demand outstrips supply. Management might reasonably seek to allocate parking according to explicit criteria centred on the best interests of the hospital's business, which is the delivery of health care. Priority should therefore be given to staff who must move between hospital sites to do key work during the day. This would favour the pathologist doing frozen sections, the cancer nurse attending multidisciplinary team meetings, and the computer engineer. Then there are the special needs of individuals. Female staff on shift work have to leave the hospital in the dark and their safety must be considered. Let us not forget patients with limited mobility and their elderly and infirm relatives. The lowest priority should be given to fit individuals with regular daytime duties who can make their routine journeys to work in other ways. The thinly veiled agenda of the surgeon who wants to be able to nip into a private hospital before, after, and between NHS commitments should not trump all other considerations.

Car parking is only an allegory so let it not fill the editor's mail box. The point is that arguments based on entitlement rather than the needs of the hospital will have less and less impact. This realisation reduces the status of the doctor and may well contribute to unhappiness.¹

So how does all this tie in with leadership? Leadership may be mistaken for "being in charge." One approach suggested at the workshop was "to make a bloody nuisance of yourself until you get what you want." In many cases better care of patients may have been gained by the force of an individual, but the words were ill chosen in a discussion with senior managers. A consultant who uses his clout to bully and browbeat,

and to undermine managers and colleagues, may get his way to a point, but what sort of environment does it create? A teacher who uses his platform to whinge and berate the system is unlikely to inspire. The individual who wastes time, talent, and energy on unwinnable issues is not a leader in the sense that the NHS Confederation's workshop wants it defined. We have all seen colleagues who use their influence to obstruct progress and subvert change. The health service grew up in the tradition of autonomous consultants who could refer to "my patients, my registrar, my houseman, and my beds." In that sense the consultant was leader. But the "my" must be replaced by our service, our team, and our role in the care network, and within that some will lead and some follow but all will participate.

West, addressing Smith's question "Why are doctors so unhappy?" argues that the calibre of people recruited to medicine is too high for the job.⁸ This assumes a single dimension on which we estimate a person's worth. A more insightful understanding of individuals' competences is needed in appraising consultants. We must be competent in our primary clinical roles, of course, but we each bring one or more other skill. These might be talents in teaching, research, data analysis, lateral thinking, completing tasks that others initiated, computing, communication, statesmanship, or indeed diplomacy. Twenty summers ago Ian Botham, the hero of Headingly, played a major part in defeating the Australians at cricket. He was the best at batting and bowling, but he was not the captain.⁹ We admire him none the less, and his contribution was as great. Managing consultants in the health service must feel like trying to manage a team of Bothams in a game where the concept of team captain has not yet been thought out.

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Managing intersex

Most vaginal surgery in childhood should be deferred

For over 40 years doctors have been in the impossible situation of making momentous decisions for intersex children, without well founded scientific principles and with little more to guide them than a personal hunch that they were doing the "right thing for the child." Despite rapid advances in understanding sexual differentiation and increased accuracy of diagnosis, the clinical management of intersex has changed little. Recently the medical

profession has been confronted by the powerfully critical voices of intersex consumer groups (www.cah.org.uk/; www.isna.org/; www.medhelp.org/www/ais). With a serious deficiency of any evidence base, emotive debates on ethics, and clinical concerns over the long term consequences of interventions, it is time to stand back and rethink every aspect of this management.¹⁻⁴

Intersex conditions consist of a blending or mix of the internal and external physical features usually

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classified as male or female—for example, an infant with ambiguous genitalia or a woman with XY chromosomes. Actual prevalence figures are unknown, with population estimates of 0.1% to 2%, though figures can be distorted by varying definitions of intersex.⁵ When intersex is recognised in infancy, doctors decide if the child with an intersex condition is to be raised as a boy or a girl and they recommend surgical and hormonal treatment to reinforce the sex of rearing. Core to this process is a belief in a societal binary two gender system. In the 1950s-70s, John Money gained widespread acclaim for work analysing differentiation of gender identity with intersex subjects.⁶ He stated that to achieve a stable gender identity a child must have unambiguous genitalia and unequivocal parental assurance of the chosen gender. Extrapolated into clinical management, the accepted keys to successful outcome were believed to be an active policy of withholding any details of their condition from the child and early genital surgery, before 18 months of age.⁷ Hence the current intervention of genital surgery has focused on early cosmetic appearance of the genitals rather than later sexual function.

A paternalistic policy of withholding the diagnosis is still practised by some clinicians. No objective work has analysed the widespread effects of such non-disclosure, but the impact on individual patients has been eloquently described.¹⁻⁸ There are more than just medicolegal reasons for abandoning non-disclosure. Most patients eventually become aware of their diagnosis through a variety of ways—from mortgage applications to television and magazine articles on intersex. Some articulate feelings of anger, distrust, and betrayal directed towards their doctors and families.⁹ Surely if a patient is going to learn the truth whatever happens, it would be more appropriate if they learnt it from their doctor and were given accurate information and appropriate psychological input. Policies of non-disclosure also prohibit access to genetic screening and the important option of peer support groups for shared learning and experiences. Once we accept that there is no place now for non-disclosure we can devote more research to appropriate ways of educating both the family and the patient, and how to tailor psychological support accordingly.

Genital surgery is one of the most controversial interventions in current intersex management. A large proportion of infants with ambiguous genitalia are raised as girls, and surgically feminising the genitalia usually involves a clitoral reduction and a vaginoplasty. In the absence of clinical trials and with minimal objective cohort studies providing data on outcomes on cosmetic, gender, social, or sexual function after this surgery, along with anecdotal evidence of dissatisfaction of adult patients with childhood surgery, both clinicians and parents face huge dilemmas. Current theories of gender development say that both prenatal factors (for example, testosterone) and postnatal factors, including the social environment, are important, and that genital appearance is less relevant.¹⁰ Clinicians, however, remain uneasy about gender development if the genitals remain uncorrected and are concerned over the possible psychological distress from bullying over different genital appearance. Recent work has shown that most children undergoing vaginoplasty will require another operation to permit

use of tampons and sexual intercourse.³⁻⁴ The vagina is non-essential and not even visible in childhood, and most vaginal surgery should be deferred.

Conversely the clitoris is visible in childhood. An erotically important sensory organ, both the clitoris and the clitoral hood are densely innervated.¹¹ Most cosmetic clitoral surgery removes the paired clitoral corpora. The physiology of female orgasm, however, is poorly understood. It is only logical to consider that any surgery to the clitoris, which risks vascular, anatomical, or neurological compromise, could potentially alter sexual response. To date, published studies on outcomes of intersex clitoral surgery contain observer bias and non-objective assessment. None provides evidence for the assertion that adult clitoral sensation and sexual function remain undamaged by clitoral surgery.¹² Indeed it would be expected that people with intersex conditions might suffer an increased incidence of sexual dysfunction owing to the nature of their condition and the many psychological factors that impact on sexual function. Unravelling the complex interplay between surgery and psychology to understand their impact on adult sexual function remains the unconquered challenge. In the meantime, any decision regarding clitoral surgery must be taken with the knowledge of potential damage.

We need to rethink our approach to the management of intersex conditions. We must abandon policies of non-disclosure and manage patients within a multidisciplinary team. Long term follow up studies of adults with intersex conditions are crucial. However, such studies can be done only with the equal involvement of people with these conditions and of peer support groups and the cooperation of all clinicians managing intersex. It is time to create a major intersex research partnership to begin tackling these questions and move forwards towards enlightened and patient empowered care.

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