their approach despite their caution to screen for diabetes mellitus. They referred to it as a "clinical disaster area."

The reasons for this conclusion seem to be that Masters and Johnson overlooked important factors —somatic, pharmacological, and psychological. Roger S Kirby draws attention to the main somatic factors contributing to erectile dysfunction, including the better recognition of a basis in vascular disease.[2] Of the pharmacological factors, the main omission from the list is cimetidine.[3]

The other main factor, overlooked by Masters and Johnson and not considered by Kirby, is depression. "Depression" covers a multitude of concepts, including the low self esteem and demoralisation that may result from sexual dysfunction. The biogenic form of the mood disorder, which may be expected to improve with prescription of antidepressants, is characterised by a lowering of hedonic tone, the loss of pleasure and interest pervading every aspect of a person's life, including sexual arousal. Lack of recognition of the mood disorder may lead to focus on the sexual dysfunction, and it may be this that leads to a request for advice and treatment. Consideration of both psychotherapy and physical treatments must be deferred until the mood state has resolved. A simple self assessment mood disorder scale, the hospital anxiety and depression scale,[4] is readily completed in clinic waiting areas or at the time of the consultation; the depression subscale focuses on the loss of pleasure response—that is, the biogenic form of the mood disorder. The scale is provided with clear indications for interpreting the scores and chart to assess progress. The scale should be used routinely in sexual dysfunction clinics; it is available from NFER-Nelson, Darville House, 2 Oxford Road East, Windsor, Berkshire SL4 1DF.

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## Training in psychosexual medicine

EDITOR,—As a founder member of the Institute of Psychosexual Medicine who began my own psychosexual training briefly with Balint and then with Tom Main, I read with interest the account of the institute's current method of training and of its valiant attempt to assess it, a notoriously difficult exercise.[1] I was, however, surprised to learn that the institute adheres rigidly to some of the rules laid down in those early days and has not moved to a more eclectic approach as I and most other therapists in this country and around the world have done.

In particular, I was astonished to read that it still does not encourage partners to attend. One of the essential skills in this kind of work is the ability to improve communication between partners. Changing the attitude of one partner, who may be quite unable to impart these new insights to the other, is liable to be more destructive than therapeutic to the total relationship. I have always encouraged the presenting patient to persuade his or her partner to join in therapy.

Training in seminars is, however, valuable. Meeting regularly in a small group helps the therapist to share the anxieties we all feel when beginning to work with patients, and blind spots are soon exposed by colleagues.

Seminars have been used as part of training both in the course I began in Manchester in 1980 and in most of the training schemes now running in centres throughout the country under the auspices of the British Association of Sexual and Marital Therapists.[2] These courses are all multidisciplinary, and I have learnt a great deal from colleagues in other disciplines, whose collaboration I have valued both in training and in therapy. I think that the institute has suffered in restricting its training to medical practitioners.

Seminars are a good way of introducing doctors to the techniques of counselling, which are still not taught well in most medical schools. They can also increase doctors' skills in treating patients who present with sexual problems in their surgery or family planning clinic. If, however, these doctors wish to be accredited for work in psychosexual clinics the institute should adopt broader, more eclectic, and ideally multidisciplinary training methods.

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## Teaching medical students about disability

EDITOR,—Alleyna Claxton rightly emphasises that medical education on the special needs of disabled people should start with undergraduates.[1] But we need to decide what undergraduates need to know and how that knowledge should be imparted. Furthermore, because students learn much in medical schools that is instantly forgotten once the exams are over we need to show that doctors have a positive role in their work with disabled people, so that at least some of what is learnt is likely to be retained.

The most important message to impart is that the traditional model of diagnosis—treatment—cure is mostly inappropriate when dealing with disabled people. A cure (for the disability) is almost never likely, but that does not mean that doctors have no role. Take visual impairment as a model: less than a quarter of people who have severe visual impairment over the age of 60 are registered as either partially sighted or blind.[2] This is a failure by doctors in the community to identify patients and also by medical staff in hospitals to register patients attending eye clinics. According to the prevailing medical and lay view, this hardly matters for registration is seen as a negative act of dubious benefit, resulting only in labelling and stigmatism. Nothing could be further from the truth, for the Royal National Institute for the Blind has shown that registration is the trigger for multidisciplinary support,[2] recently exhorted by the Department of Health.[3] By not appreciating the importance of registration doctors are unwittingly, yet significantly, limiting patients' quality of life.

Further examples from other types of disability would have a similar message: the doctor is the key to identification and subsequently to unlocking a range of facilities and services, many perhaps outside the NHS, that can help to improve the quality of life of individual disabled people.

Disability medicine is indeed "whole person medicine" and requires good communication skills. Even today communication skills are far from ideal: many parents of children with visual impairment want to talk to but cannot find someone who is knowledgeable about the condition, and 80% want better communication and more information, particularly on medical matters.[4] Understanding the functional aspects of impairment is complex. According to one blind man, "my ophthalmologist tells me what I can see, but it doesn't bear much relation to what I can do." Simulation helps. Although only a limited range of disabilities can be simulated, perhaps the most valuable lesson for students is how the attitude of ordinary people towards them changes when they are placed in wheelchairs or given white sticks.

How best to impart the requisite knowledge and the appropriate attitudes can be argued about indefinitely. Probably no single method is appropriate for all medical schools as local families and traditions vary widely. We welcome the publication of *Medical Education on Disability*[5] as a starting point offering ideas on both content and method—as Claxton says, just the stuff of the core medical curriculum.

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## Sexual revolution and sperm count

EDITOR,—Together with other discoveries, the findings of Carlsen *et al* that the quality of semen has been declining over the past 50 years[1] have led to disturbing speculation about the world's environment. I think, however, that the relation of their findings to such speculation is scientifically untenable.

Given the criteria for semen quality used by Carlsen *et al*, the findings suggest merely a general dilution of semen caused by more frequent ejaculation of men today compared with 50 years ago. But their conclusion—that "such remarkable changes in semen quality . . . over a relatively short period is more probably due to environmental rather than genetic factors"—is not so trivial.

They justify this conclusion with two statements that, on closer inspection, are unscientific. Firstly, ". . . to our knowledge there are no data to indicate a change in masturbation or coital frequency since the 1930s." There are no reliable data on masturbation or coital frequency whatsoever, neither for the 1930s nor for the 1990s. It is not justified to conclude from this lack of knowledge that there has been no change.

Secondly, ". . . 32 papers contain information on the prescribed length of abstinence, which was at least three days, as generally recommended by andrologists throughout the past 50 years." This means that in the 29 other papers reviewed the period of abstinence was not mentioned. This is understandable: it is naive for an investigator to expect that perfectly healthy men (one of the inclusion criteria for this review) will refrain from sexual activity for at least three days to perform a

test whose results are of no interest to them. It is definitely naive to expect so nowadays, but it may not have been naive 50 years ago, and this uncertainty means that Carlsen *et al* "have no case."

My objections are logically sufficient to invalidate the conclusions of Carlsen *et al*, but I also think that an alternative explanation applies. Their table lists the studies they reviewed and includes the numbers of men in each. Of the total of 14947 men, 11225 or 75%, lived in west European countries (including Sweden and Finland) and the United States. In the past 50 years in all of these countries there has been a major cultural development—the so-called sexual revolution. Sexual freedom has become an important part of personal emancipation in Western societies, and the taboo on masturbation has almost completely been lifted. Carlsen *et al* have not found an alarming biological phenomenon, but they have found a remarkable cultural phenomenon.

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## How to build a better manager

### Consider audit

EDITOR,—There is a delicious irony about the letter from Anthony Walker, a management consultant, implying that loss of clinical freedom will be the deserved consequence of the arrogance and failings of a minority of physicians.[1] I suggest that another shibboleth—"management prerogative"—is a more appropriate target for criticism in the current climate. Has Walker audited the results of his profession's activities on the welfare of people working in organisations? Does he "arrogantly" base his practice on the premises of the functionalist paradigm alone,[2] or has he yet incorporated the insights derived from critical theory[3]? My point is that even the simplicities of management are open to radically differing views on what constitutes acceptable practice.

Should Walker wish to know the damaging effects of organisational change on the morale and commitment of working people then enlightenment is available.[4] Given that the exercise of managerial prerogative has a greater potential for harm than the exercise of clinical freedom, what structural mechanisms are in place to weed out unreflective management consultants? If Walker can conceive a viable model the clinicians may gratefully use it.

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### Consider training

EDITOR,—The senior managers of the National Association of Health Authorities and Trusts call for more training for general practitioners.[1] But what of managers? Do they need more training as well? Don't the multimillion pound disasters in Wessex and West Midlands imply an urgent need for more training, or at least for some training?

It might be illuminating to learn how many NHS managers have any formal training and qualifications in management. How many hold the diploma in management studies or have a degree in management: an MBA (master in business administration) or an MSc (master of science) in management?

The National Association of Health Authorities and Trusts calls for principals in general practice to have their training increased to five years—which, with the five year undergraduate course, means 10 years in all—with the obligatory higher degree of MRCGP. What would the association regard as the first and postgraduate qualification and training as the minimum for the chief executive of an NHS trust or a health authority?

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## Genesis of apoptosis

EDITOR,—John Goldman's review of the BBC2 *Horizon* programme "Death Wish" salutes Andrew Wyllie and Alastair Currie for the discovery of apoptosis or programmed cell death but makes no mention of John Kerr of Brisbane.[1] The original article on apoptosis, published in the *British Journal of Cancer* in 1972, was written by Kerr and Wyllie and Currie.[2] Kerr had initially described this process of cell death and called it shrinkage necrosis on morphological grounds.[3,4] He appreciated that it could be initiated by a range of noxious agents as well as occurring in both pathological and physiological processes. The 1972 paper builds on his earlier work.

Alastair Currie met John Kerr in Brisbane while Currie was at the University of Queensland as a visiting professor. He became interested in Kerr's observations and invited him to spend a sabbatical period with him in Aberdeen. Back in Aberdeen, Currie also invited Andrew Wyllie, his PhD student, to join him and Kerr in carrying out further studies on what they eventually called apoptosis. The term "apoptosis" was suggested by Professor James Cormack, of the Department of Greek in the University of Aberdeen, for this unique pattern of cell death.

I write this in the interests of historical accuracy and so that recognition is given to John Kerr for his seminal observations.

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## BPA's response to Clothier inquiry

EDITOR,—It is now 10 months since the two paediatricians in Grantham, Drs Nelson Porter and Charith Nanayakkara, were made redundant after the conviction of Beverly Allitt for the murder of four children under their care. Both are appealing to the secretary of state for health under paragraph 190 of the terms and conditions of service for hospital and dental staff. The British Paediatric Association is concerned to ensure that its views are known.

Soon after the suspension of Drs Porter and Nanayakkara a small committee was established at the request of the British Paediatric Association's council to produce a submission to the Clothier inquiry. This group included a paediatrician, who is Trent's regional representative on the council; another member of the council, who is a paediatrician working in a unit comparable in size and staffing to Grantham; and me. The British Paediatric Association's submission to the Clothier inquiry included the following paragraph: "From the information presently available it appears that the Grantham paediatricians' standard of clinical practice was comparable with that of paediatricians elsewhere. This was also the conclusion of the regional adviser in paediatrics and of the Trent region's own internal inquiry. It is probable that many paediatricians would have had similar difficulty in recognising the criminal acts which occurred in Grantham."

Unfortunately, the report of the Clothier inquiry made no reference to this submission.[1] As soon as the Clothier inquiry was published the British Paediatric Association produced a response, dated 16 February 1994, which was sent to the secretary of state for health and is generally available. In our response we emphasised that the Grantham incident was recognised and addressed within three months and a conviction followed, where the two reported similar incidents from North America took much longer to detect, resulted in many more deaths, and did not lead to a conviction for murder. We also pointed out that the Clothier inquiry did not have advice from a paediatrician working in a unit of similar size or with similar staffing constraints to those in Grantham. We went on to refer to the joint letter from Drs Porter and Nanayakkara (1 October 1990) to the regional medical officer and district managers pleading for additional medical staff to provide a safety net, in which they warned prophetically, "we do not think it is advisable to wait until a disaster strikes." Our response to the Allitt inquiry concluded that "in the view of the BPA the report's criticisms of the nurses and doctors working with the children in this environment were unjustly harsh."

The matter of Drs Porter and Nanayakkara's redundancy is a contractual issue for which the British Medical Association is responsible; it is clear that it will fight the principle hard, fearing that a precedent may otherwise be set. The British Paediatric Association does not think that either doctors should be without a job, on the basis of the Clothier inquiry's findings and the views of those paediatricians who have detailed knowledge of the events.

Copies of the British Paediatric Asssociation's response to the Allitt inquiry are available from the association's office.

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1 Dyer C. Inquiry into serial killer criticises hospital's response. *BMJ* 1994;308:491. (19 February.)

## Out of hours consultations

EDITOR,—In her paper on out of hours consultations with general practitioners Lesley Hallam laments the lack of data.[1] With regard to the demand for out of hours consultations she states that "studies are generally restricted to individual practices or small areas." We wish to summarise our data on this issue, which were not available in time for her study.[2-4]

We combined three surveys of satisfaction, which were all done with the same instrument between November 1991 and August 1992 in large areas (sample sizes and response rates in paren-