

## 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.<sup>1</sup> 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,<sup>1</sup> 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

## Advice to authors

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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.<sup>2</sup> 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."<sup>3</sup> It is time to follow such advice and put sexuality firmly on the medical agenda.

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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.

## 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.<sup>1</sup> 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.<sup>2</sup> 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.<sup>3</sup>

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2 Department of Health. *The health of the nation. Key area handbook on HIV/AIDS and sexual health*. London: DoH, 1993.

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## 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<sup>1</sup> 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.<sup>2</sup> 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.<sup>3</sup> If the test is not good enough even the best counselling before and after the test will fail to prevent unnecessary

distress. This test, with a positive predictive value of less than 3%,<sup>4</sup> will generate many false positive results. Women who receive a positive result from a screening test are entitled to much greater support than they now receive. The costs of such a service would, however, outweigh the benefits of routine screening. Districts now considering the introduction of such a programme should bear in mind the maxim quoted by Marteau: "first do no harm."<sup>5</sup>

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- 4 Wald NJ, Kennard A, Densem JW, Cuckle HS, Chard T, Butler L. Antenatal maternal serum screening for Down's syndrome. *BMJ* 1992;305:391-4.
- 5 Marteau TM. Psychological consequences of screening for Down's syndrome. *BMJ* 1993;307:146-7. (17 July.)

### ... but time consuming and expensive

EDITOR.—Like Michael Connor, I welcome biochemical screening for Down's syndrome and look forward to newer tests with higher detection rates.<sup>1</sup> I agree that the NHS should fund and provide screening. My concerns are what constitutes informed consent for people who undergo screening tests, especially tests with low detection rates; the extra work needed to counsel people to gain their full informed consent; and the threat that this extra work poses to other educational tasks in the antenatal consultation.

As a general practitioner, I have had to visit distraught families who have been informed of a positive result of a screening test and who—despite knowing vaguely what the test was—really knew nothing. In counselling a woman who is to have a screening test for Down's syndrome a doctor must explain what Down's syndrome is and how it varies, how it is detected by the test, and what probability is and what the positive predictive value of a positive result is, and must discuss what options exist if the result is positive. It can take more than 45 minutes to explain the test properly. Anything less than an understanding of these issues does not enable the woman to give informed consent and leads to unnecessary anxiety in the event of a positive result. The alternative to a full explanation is to give limited information, hope that the woman does not inquire too closely, and hope too that her result is negative. Is that the kind of informed consent we would want for ourselves?

Cost-benefit analysis of biochemical screening programmes usually compares the savings from the care of affected children with the tertiary costs of the screening programme but does not estimate the effect on workload.<sup>2</sup>

If counselling is not resourced adequately other tasks in antenatal care must be neglected in order to include it. Either informed consent is not gained—which lowers compliance, detection rates, and the success of the new screening programme—or assertive middle class patients, who rightly wish to know exactly what such tests do and mean, are counselled at the expense of unassertive single young mothers (an example of the inverse care law). Alternatively, all women are counselled at the expense of other activities in the consultation. Thus the true costs of offering the test may include less advice about smoking or less time to discuss breast feeding. Such prioritisation will undermine other aspects of health education, with expensive sequelae, such as increased rates of premature delivery, which are not considered in the simple cost-benefit analyses described above.

Resources are scarce—so we are told—and must be used efficiently and wisely. There is no room for new services if they are resourced inadequately and stop us from providing the old ones with no professional or public debate about which is the more economically, quantitatively, and qualitatively valuable.

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### Private screening is problematic

EDITOR.—In his editorial on biochemical screening for Down's syndrome Michael Connor says that NHS screening is preferable to private screening because of the inequality of access inherent in private medicine.<sup>1</sup> Although this is a major socio-political consideration, there are more serious concerns about the provision of screening tests for Down's syndrome.

Screening for Down's syndrome is relatively new and uses the concept of risk.<sup>2</sup> Interpreting risk is difficult and highly personal—for example, people may be prepared to risk money in a transaction that has a 95% chance of making a profit but would be unlikely to risk flying if there was a 5% chance of crashing. It is therefore important that the obstetric services to which a woman who has been tested privately presents herself know what the estimate of the risk of Down's syndrome means and are able to perform any further investigations that are required.

If screening is organised locally clinics can be reorganised so that results suggesting a high risk are not given out at the end of a week—as recommended by the Royal College of Obstetricians and Gynaecologists working party on Down's syndrome screening.<sup>3</sup> This may not be possible if the result of a test performed privately is returned direct to the patient. Further problems may arise when a patient has both NHS and private tests: what procedure should be followed if the results are discordant?

The gestational age is crucial to the accurate determination of risk.<sup>4</sup> It is easier for the laboratory in a local NHS programme to contact the antenatal clinic to confirm the gestational age when results are unusual than for a remote private laboratory to do so. It is also easier for the antenatal clinic to contact a local laboratory if the gestational age is revised and the risk must be recalculated.

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### Widening the programme would be costly

EDITOR.—Michael Connor rightly calls on the Department of Health to coordinate screening for Down's syndrome within the NHS<sup>1</sup> as the resource implications of offering serum screening for this condition to all expectant mothers extend beyond the cost of the biochemical reagents.

The aim of the screening programme is to find affected fetuses and offer abortion. A recent study

showed that a substantial proportion of parents refuse the screening test, decline definitive investigations if the result of the test is positive, and refuse abortion if the fetus is cytogenetically abnormal.<sup>2</sup> While these ethical decisions must be respected, they raise the question of whether current methods of pretest counselling are adequate.<sup>3</sup>

In my district an analysis of the costs and benefits of changing from a selective policy (based on age) to a screening programme for all expectant mothers showed that an adequate counselling service would be the greatest single cost (followed by the increased resources needed for accurate gestational dating). The marginal opportunity costs of such a change would be greater than suggested,<sup>2</sup> and as all districts already offer age related screening,<sup>4</sup> careful consideration must be given to the efficient use of resources when only marginal benefits can be expected.<sup>5</sup>

Providing a service with inequality of access need not be an issue as it is a duty of all who work in the NHS to ensure that resources are used effectively. In this instance the biochemical screening tests that are used currently are more sensitive in older mothers.<sup>2</sup>

The identification of biochemical markers as risk factors for Down's syndrome has been a major development in obstetric care, but their place in antenatal diagnosis needs to be established in the context of advances in the availability and techniques of ultrasound scanning. We now need to consider how to combine these screening tools efficiently without denying resources inappropriately to other NHS users.

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### Existing tests not good enough

EDITOR.—Michael Connor suggests that the NHS should provide biochemical screening for Down's syndrome and describes the controversies surrounding the issue.<sup>1</sup> But he reaches his conclusion only by ignoring some of the crucial problems, although these have been documented in extensive correspondence in the *BMJ* and elsewhere.<sup>2,5</sup>

In particular, Connor trivialises the psychological and emotional costs, making only a passing reference to the difficulties with counselling experienced by all districts and health boards. Counselling is essential: "failure to obtain informed consent for a screening procedure is not only ethically unacceptable but also exposes the health authority to the risk of litigation." It is necessary to inform patients, before blood is taken, of the false positive rate (about 65 false positive results for every true positive result, or about one pregnancy in 20), the false negative rate (around 40%), the necessity for amniocentesis to make diagnoses, and the ultimate aim of termination. The practical difficulties of doing this have disrupted antenatal services. If counselling is done properly most women reject the offer of biochemical screening.<sup>5</sup> If counselling is not done properly many women reject the offer of amniocentesis.<sup>5</sup> In this case patients' autonomy leads to results not desired by the advocates of screening; we suggest that the values of the patients should have priority.

These values may reasonably be shared by