encouraging, and nurturing potential researchers and assessing the quality of their output. There is no better way to do this than by permitting a wide range of people to sample the world of research and test their product by submitting it to supervisors and peer reviewed journals.

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1 Altman DG. The scandal of poor medical research. *BMJ* 1994;308:283-4. (29 January.)

2 Correspondence. The scandal of poor medical research. *BMJ* 1994;308:591-3. (26 February.)

Definition of the sudden infant death syndrome

EDITOR,—The definition of the sudden infant death syndrome was called into question at the second international conference on the syndrome, in February 1992. As no consensus could be reached it was decided to keep the 1969 Beckwith definition: "the death of an infant or young child, which is unexpected by history and in whom a thorough necropsy examination fails to reveal an adequate cause of death."

The issue is what constitutes an "adequate cause of death." To base the definition of the sudden infant death syndrome on a diagnosis of exclusion is questionable. There is no current consensus on the minimum postmortem investigations that are needed to ensure that every cause of death has been excluded. There is also no consensus among pathologists on what is an adequate cause of death. The problem is not related to the identification of lesions, as every careful paediatric pathologist reports similar findings,¹ usually noted as "insignificant lesions." This interpretation is the core of the problem and is not shared by French pathologists. They believe that the pathological findings can be considered to be an adequate cause of death in three quarters of the cases diagnosed as the sudden infant death syndrome in many countries.^{2,3}

The main difference between the French and other approaches to sudden infant death is the systematic protocol that involves many specialists at the time of death.⁴ Any infant who dies suddenly is brought to the emergency room and dealt with in the same way as an acutely ill child would be. Biological and microbiological samples are collected within 10 hours of the last sighting of the infant alive in 90% of cases. Paediatricians direct the sampling process and collect the paediatric and obstetric data, and microbiologists play a part well before the necropsy protocol starts. The extensive necropsy protocol is always performed by a paediatric pathologist with a major interest in the sudden infant death syndrome.⁴ All findings are reviewed at a multidisciplinary conference, and the decision concerning the cause of death is made there. This approach is very different from many investigations into sudden infant death that have been reported in the United States, for example.⁵

The definition of the sudden infant death syndrome is crucial as many epidemiological data will be derived from infants labelled as having died of the syndrome by a bureaucratic, sometimes ill equipped system. These so called epidemiological data may misdirect researchers toward irrelevant protocols. It has been reassuring for parents to be given something that they consider to be a diagnosis (that is, the sudden infant death syndrome), and such a positive impact must be taken into consideration. Therefore, we suggest a modification of the definition of the syndrome. The sudden infant death syndrome should be diagnosed in every case of cot death fulfilling the classical clinical criteria

for the syndrome (a 1 month to 1 year old infant, clinically well before the death or with only minor illness, is put to sleep and found dead), with a subsequent classification according to the main postmortem findings (for example, the sudden infant death syndrome with myocarditis). This systematic indication in every report of the main two or three findings, as a minimum requirement, may give more substance and medical usefulness to the term sudden infant death syndrome.

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Doctors and homosexuality

Homosexuals deserve better from doctors

EDITOR,—The correspondence¹ concerning Lynn Rose's paper on homophobia² was a major topic of the discussion at a recent monthly meeting of the Lesbian and Gay Health Workers Association. Members of the association represent a wide range of health workers, and we believe that we can offer a consolidated opinion for all homosexuals working in health care.

We believe that it is essential to identify the key facts in the debate. Homophobia may be the wrong word for the attitude of malice towards homosexual people, but nothing can disguise the fact such an attitude can be found throughout the health service in a scattering of staff. Fortunately, an equal number of heterosexuals will support and defend the right of equality. Homosexuals who are struggling to cope with their sexuality perceive a bigger problem than really exists, but doctors are driven to contemplate suicide by trying to resolve their feelings in what they believe is a hostile profession. We have never heard of homophobic doctors considering the same.

The criticism of Rose's methods is valid, but homophobia is extremely difficult to prove or quantify. Homophobia is indicated by attitudes more commonly than it is by actual actions. Isolating a patient in a side room because "the other patients wouldn't want a shirt-lifter on the ward" is homophobic, but allowing a patient to have a side room so that he and his partner can show affection like every other couple is compassionate.

Homophobes who claim that homosexuality will affect someone's ability to work in the health service imply that they consider their heterosexual attractions to be essential to correct professional behaviour, which is ludicrous. But if sexuality is

irrelevant to the practice of medicine the reason for our association might be questioned. Sexuality should not be the overriding component of anyone's life, but it does affect our social life. Health staff talk socially about their partners. We would like to be able to do the same without fear of affecting our job prospects. Being gay is not like smoking, drinking, or riding motorbikes, for those are acts of choice; unlike colour or gender, being gay is not immediately identifiable to others. It often takes time for us to identify what we are. It is always difficult, and sometimes almost impossible, to explain, but a life of secrecy is an intolerable strain. We accept that some people cannot approve, but we resent the active discrimination in parts of the profession and call on those who abhor such attitudes to challenge them whenever they occur. Gays and lesbians deserve better from their doctors, and those of us who have not yet come out are sick of living a lie.

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1 Correspondence. Doctors and homosexuality. *BMJ* 1994;308:854-5. (26 March.)

2 Rose L. Homophobia among doctors. *BMJ* 1994;308:586-7. (26 February.)

Doctors could make life easier

EDITOR,—I wish to respond to the correspondence on my paper on homophobia among doctors.¹ The paper is an extrapolation from a paper for a masters degree of 21 000 words entitled "Doctors divide? Doctors and sexuality in the era of HIV and AIDS." A copy of this is at South Bank University's library.

The questions regarding sample size and selection, subjectivity and objectivity, lifestyle effects on medical treatment, the reasons for my involvement in the type of research, ethics, and so on are all clarified in the original document, as is a definition of homophobia, which seems to be a fairly new word in English dictionaries. The statement "blatantly homophobic" was a direct quotation from one of the respondents.

The article was an attempt to show that the medical profession could make life easier for their colleagues, themselves, and patients with HIV infection and AIDS. Further research is certainly needed, and is also requested in the document.

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1 Correspondence. Doctors and homosexuality. *BMJ* 1994;308:854-5. (26 March.)

Depression and impotence

EDITOR,—For a long period erectile dysfunction (impotence) was assumed to have primarily a psychological basis. Except in cases of severe neurological impairment and endocrinopathies, the management of the disorder was handed to psychotherapists, marriage counsellors, or whoever else might be found to offer guidance. In the 1960s Masters and Johnson set out a view of the nature of sexually dysfunctional disorders together with a plan of treatment that was persuasive and partially successful¹; they provided a model for clinics treating sexual dysfunction, which increased in numbers. Yet Masters and Johnson admitted that, of all the sexual dysfunctions, erectile dysfunction was the most resistant to

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 stigmatisation. 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,³ recently exhorted by the Department of Health.⁴ 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 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