

Letter from Mumbai

NURSES AND ETHICS

You will recall the earlier account in this column of a senior staff member at the S.N.D.T. College of Nursing in Mumbai who is carrying out a research project on ethics in nursing. To the best of my knowledge, this remains the only example in India of such a study being carried out by any medical person towards obtaining the PhD degree.

Nurses in Mumbai have now added another feather in their caps. On 15 February 2004, they organized a day-long seminar on ethical values in healthcare. Matrons at the Jaslok Hospital and Bombay Hospital joined hands in this effort. In addition to local experts, they invited senior nursing and intensive care consultants from Sweden and Poland, who added considerably to the importance of the proceedings.

Equally praiseworthy was their decision to invite a young plastic surgeon practising on his own in one of Mumbai's suburbs to deliver the keynote address. Dr Arun Sheth fully lived up to the expectations of the organizers and provided a clear, 'no-holds barred' overview of the present state of healthcare in the state, our deficiencies and what steps could be taken to improve matters. As he put it, loss of morality is our national malaise. This can only be tackled by instilling moral values in our children so that they will grow up to be honest adults. In his 'adolescent practice of five years' he has not seen any improvement in the thinking or practice of his colleagues. Money matters first and money matters last! The welfare of patients gets a low priority. He also feels that herd mentality ensures that the average doctor will not antagonize the medical establishment or colleagues by independent, principled thinking and ethical behaviour. Dr Sheth's frankness and constructive attitude earned him well-deserved applause.

I have space here for just one more of the several other interesting presentations.

When Dr Laura Wolowicka, Professor Emeritus in a Polish university, was called to the lectern, she endeared herself to the audience with her opening sentence. 'I am in the unenviable position of having to deliver my talk when it is already past the time when I should end it!' This gentle dig at previous speakers who had continued their presentations well past their allotted time was followed by a succinct account of her experiences with patients dying in intensive care units. Her wisdom and experience were reflected in her observations and suggestions. The need to respect the dignity of the patient and of relatives at all times was emphasized. The greatest care is called for when death approaches. Unfortunately, many healthcare workers tend to flee the scene precisely then 'as there is nothing more we can do for the patient'. In fact, this is the time when the patient and family need all the support that can be offered. Dr Wolowicka finds the patient greatly comforted when she invites the relatives to the patient's bedside at this time so that they can spend the last few minutes together. Her intensive care unit has set aside an area where this can be done without hindrance to the care of other seriously ill persons.

At the end of her talk, a young nurse, now working in a semi-rural setting in Maharashtra, asked about the care of the corpse. She told of her own experiences while training in a large hospital in Mumbai. The body was wrapped up like a sack of potatoes, heaved onto a dirty, uncovered, rattling trolley and trundled down

the corridor in full view of other patients and relatives. Dr Wolowicka and Dr Elsy Athlin (Associate Professor, Karlstad University, Sweden) explained the practice in their hospitals. The body was treated with the same care and respect as the living patient. Relatives were asked if they would like to participate in the preparation of the body. Many welcome this chance to do something even at the very end for their loved one. After withdrawal of tubes, catheters and cleansing of the body, it is covered in fresh clothes provided by the relatives. The body is placed on a trolley similar to that for live patients, a pillow inserted under the head and a clean cover used as a drape. The trolley is brought to the morgue by a special elevator, which bypasses the hospital corridors.

I recall learning of a further refinement in Japan. From the intensive care unit, the body is taken to a small shrine in the basement of the hospital. The senior resident doctor and nurse accompany the relatives. Having placed the body in the shrine, the doctor and nurse take leave of the relatives in the traditional manner, bowing to each of them. The relatives complete their ritual or religious practices before taking the body away.

THE CHOICE OF POOR PATIENTS

In a recent paper entitled 'Health care under neo-colonization', Dr C. Sathyamala (of Swasthya Panchayat Lokayan and the Medico-Friends Circle) points out that the 'minimum essential clinical package' proposed by the World Bank and under consideration by our government bears little relationship to the illnesses suffered by the poor. It will prove inadequate to meet the healthcare needs of this segment of our population. When the package is coupled with the introduction and progressive increase in fee for services rendered by public sector hospitals, the poor will be left with no means of dealing with their illnesses. This is especially tragic as public hospitals—particularly those in Mumbai—were founded for the express purpose of catering to poor patients.

It is of interest that many poor families prefer medical care from the private sector. I see several poor patients at the private hospital where I now work. They have followed me from my earlier public sector hospital. Those needing admission and surgery are directed to that hospital. I offer to speak to my erstwhile colleagues there and ensure prompt admission. I reassure my patients that the equipment and expertise there are of high order. And, of course, I emphasize that the costs in that hospital will be a fraction of the cost in the private hospital. Despite 15 minutes or more of discussion, most opt for treatment at my current hospital. They do the rounds of charitable trusts and other such funding agencies to meet costs.

When queried, several explanations are offered by the relatives. Attendance at a hospital such as the King Edward Memorial Hospital or Sir Jamsetjee Jejeebhoy Hospital in Mumbai necessitates spending the entire day or days before a diagnosis is offered and treatment prescribed. This means loss of daily wages in addition to the expenses of travelling to and from and payment of hospital charges. The patient is made to run from department to department with long queues at each stop. Arrogance, indifference and a total lack of concern are encountered everywhere, especially from the clerical and other non-medical staff. Senior doctors are often not approachable. The younger, inexperienced doctors offer

little by way of explanations or choices, issuing orders and ultimatums instead.

If we wish to make our public hospitals a refuge for poor patients—as they are intended to serve—it is essential that they stay true to the traditions set by their founding fathers. Poverty necessitates greater concern for these patients. Illiteracy cannot be the excuse for not offering explanations or choices. Many of these patients are more intelligent than their literate fellow-citizens. They have to be to survive despite their many handicaps.

ON AWARDS

A few days ago, *The Times of India*, Mumbai, featured a large advertisement. Students and admirers of a senior consultant cardiologist in the city announced a meeting to felicitate him on the Padma Shri title conferred by the government. The advertisement referred to him as being the father of coronary angioplasty in India. On reading the advertisement, a wag in the hospital exclaimed: ‘Where’s Mummy?’

I am sure the consultant must have been deeply embarrassed by this advertisement.

On 28 February 2004, BBC telecast a programme on Dr Richard Feynman in its series entitled ‘Genius’. In it, Dr Feynman responded to a query on what it felt to be awarded the Nobel Prize in Physics. He replied that he did not understand the fuss made over such awards. ‘I had already received my prize in the pleasure I got in discovering what I did and from the fact that others used my work...’

Chuck Doswell of the American Meteorological Society, elaborating on Feynman’s comment, expressed similar sentiments. ‘Being a scientist, being allowed to do the work that we love so much ... in my view, this is the primary reward that we scientists get. Obviously, it’s very nice that our employers pay us as well! I can remember my first check that I received as a meteorologist ... it felt like stealing, this being paid to do something that was so much fun! ... The idea that I should expect more from this profession than the very generous things I’ve received strikes me as the height of greed. It misses the point of what science is all about...’

Money has never been a motivator for me ... the opportunity to do the work is what motivates me. I have difficulty understanding those for whom money has such allure...

‘As for recognition ... the most sincere and meaningful recognition that a scientist gets is that the work one does is used by one’s peers. When your scientific results are cited by your peers, when that work stimulates your peers to do other, related work (even if that work is motivated by the desire to show that your work was wrong!) ... this form of recognition from the scientific community is not just flattery or some sort of accident. There can be no more meaningful recognition than when your peers have understood what you have been trying to share and have found it useful or stimulating in what they are trying to do. Anything else—any other form of recognition—is, at most, frosting on the cake.’

I wonder what the students and admirers of our senior consultant cardiologist would make of this!

A TIP FROM A VETERAN TEACHER

In closing, I offer you one of the many tips that Dr O. P. Kapoor provided the audience at a meeting of the Bombay Medical Congress on 29 February 2004. Dr Kapoor is famed for his marathon classes at the Birla Matushri Sabhagar each year where he expounds over several weekends on various aspects of medicine to an audience of over 1500 persons.

He talked of the 70 and odd *hathiyars* (weapons) that each doctor must use for successful private practice. First among these is the fly swatter. As Dr Kapoor pointed out, history taking is often the most important part of the examination of a patient. The history provides the diagnosis in 90% of cases. A fly buzzing around the patient and you impedes proper history taking. The successful doctor must be an expert in fly swatting and must, without missing a beat, swat the pest as it makes its first appearance on the scene.

But how does one develop such expertise?

Simple, says Dr Kapoor. When you start practice, you will have no patients. All you will do as you wait for them is swat flies!

SUNIL PANDYA

Letter from Croatia

TEACHING SCIENTIFIC METHODOLOGY AT A MEDICAL SCHOOL: EXPERIENCE FROM SPLIT, CROATIA

Background

The University of Split School of Medicine was founded in 1997 following its 19 years of existence as a branch college of the Zagreb Medical School. Becoming an independent school has enabled the development of a new 6-year curriculum,^{1,2} which includes more teaching hours for scientific methodology in the second year.

The course was modelled after the course from the Zagreb Medical School, entitled ‘Principles of Scientific Research in Medicine’ in 1995–96.^{3,4} The Zagreb course included 20 hours of teaching the basics of scientific reasoning, data analysis, retrieving information and writing a paper. We used the same model but

adjusted it for 50 students per academic year in Split, compared to 250 students in Zagreb. In an effort to enhance scientific productivity in a relatively small medical community, the school decided to expand this course to 60 teaching hours, which included a ‘hands-on’ approach. Students conduct a study, prepare a manuscript and present the data at the end of the course. This approach was an important innovation, with some effects already becoming apparent in the past 6 years.

THE COURSE STRUCTURE AND ITS CONDUCT

The course is composed of 5 major teaching units (Table I). Each unit, except the last one, included lectures, medium- or small-sized discussion groups, and small groups at practical work and/or in a computer classroom. At the beginning of the course

TABLE I. Overview of the 'Principles of Scientific Research in Medicine' course at the Split University Medical School

Unit	Content	Description
Scientific reasoning (study planning) 14 hours	Scientific way of thinking Types of studies in medicine Planning a study	Lectures Examples of all types of studies Medium-sized group discussions Designing students' studies
Conducting a study (data collection) 20 hours	Study conduct, experiments, data collection, importing data into computer (MS Excel), worksheet editing, descriptive statistics, exporting data (Statistica 6.0), extensive statistical analysis	Lectures Teamwork in small groups (5–6 students) Each student is a leader of one of the segments of data manipulation
Retrieving information 10 hours	Information in medicine Types of publications <i>Index Medicus, Science Citation Index, Current Contents</i> Search strategies (PubMed, OVID) Downloading full-text PDF files Creating reference lists	Lectures Medium-sized and small group discussions Literature retrieval in the library On-line literature retrieval in computer classroom Learning procedures and applying it to their own ongoing studies
Writing a paper 14 hours	Publishing medical research How to write a paper IMRAD structure Creating graphical presentation of their own data Writing a paper according to ICMJE* guidelines Submitting a paper Revision of papers	Lectures Small group discussions in computer classroom On their own (computer classroom or elsewhere) Papers reviewed by the teachers Each student responsible for his/her part (Abstract, Introduction, Methods, Results, Discussion) Revision prior to presentation
Presenting data 2 hours	Oral presentation Poster presentation Local meeting at the medical school	PowerPoint presentation (10 min talk followed by 5 min discussion) Poster session (1–2 presenters from each group may gain 4 additional credits)

* International Committee of Medical Journal Editors

students were provided detailed information about all parts of the course. They were divided into small groups of 5–6 students and a mentor was appointed who helped them through the last 4 units of the course. Student groups were offered 8 topics, covering different areas of research and types of studies. These included a survey, a retrospective cross-sectional study using hospital records, performing physiological measurements on themselves or hospital patients, and conducting case-control studies.

Thus students worked in a team environment conducting their own studies from the beginning to the end. This was integrated in the course. The regular lectures and discussion groups, as well as the laboratory or computer classroom work, were used to learn about the principles of scientific methodology and apply the newly acquired knowledge in their own research.

Following completion of the study, student groups submitted their papers, prepared in accordance with the guidelines of the International Committee of Medical Journal Editors,⁵ 3 days prior to the end of the course. The papers were then reviewed by the teachers and course leader, and returned to the students the next day for revision. Thus, they experienced the essence of the typical process of publishing articles in scientific journals and the peer review process.

On the final day, besides submitting the final (revised) version of the manuscript, there was a small meeting with the data being presented by 1–2 students from each of the 8 groups. A poster or oral presentation was made, in tune with the rules at scientific meetings and following all the standards for good presentations.⁶

Each student was given a credit for each course unit (maximum of 40) and the presenters were able to earn 4 extra credits. The final score was based on earned credits and the score in the written test,

which consisted of 30 multiple choice questions (maximum of 60 credits) that took place 3–5 days after the course.

Effects

The effects of this course were tested during a study performed at the University of Split which assessed the students' attitudes towards science at the three different schools—School of Economics and Business, School of Electrical Engineering and School of Medicine.⁷ The students of all three schools exhibited the same attitude towards science at the beginning of their curricula, but there was a significantly higher positive attitude toward science of the medical students in the final year compared with the other two schools.

Taken together, these data and our positive experience from the past 6 years suggest that including a longer course on the 'Principles of Scientific Research in Medicine' early in the medical school curriculum (during the second year) may enhance the students' knowledge, as well as their attitude toward the sciences.^{4,8} Hopefully, in the long run, this will be reflected by greater productivity of our small medical scientific community⁹ and stimulate our students, young doctors and their older peers.

The future

We plan to integrate this basic course into a larger one named Scientific Methodology, in which medical informatics and medical statistics will also be taught. The elementary knowledge acquired in these two courses will be used for students' research methods in the present course. This integration, we believe, should be the next step in the objective to bring our medical students to a level at which they will improve their critical appraisal skills and increase their ability to conduct scientific research, as well as write better.

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Letter from Australia

INTENSIVE CARE IN AUSTRALIA AND NEW ZEALAND: PAST, PRESENT AND FUTURE

The ascent of intensive care medicine from a subspecialty to a discipline in its own right in just over 25 years represents a marvellous achievement. Although the events resulting from the polio epidemic in Scandinavia in the 1950s are the original forerunners of modern-day intensive care, Australia and New Zealand were among the first countries to recognize the importance of developing it as a specialty.¹ These two countries now also have one of the best developed systems for training in and practising intensive care medicine. The establishment of a common medical faculty to oversee specialist training programmes in both countries has fostered a similar style of intensive care practice in the two nations. This review examines the development of intensive care as a specialty in Australia and New Zealand and discusses some exciting changes taking place with regard to training and research.

Development of the training programme

The origins of the early intensive care units (ICUs) in Australia date back to the 1960s. To begin with, the ICUs were concentrated in the larger metropolitan cities. The early 'intensivists' came from a background of anaesthesia or internal medicine or both.

Prior to 2001, two streams of training in intensive care medicine were available in Australia and New Zealand.² The Faculty of Anaesthetists of the Royal Australasian College of Surgeons (RACS) commenced a training programme in intensive care in 1976. Successful diplomates were awarded the FFARACS (Fellowship of the Faculty of Anaesthetists, Royal Australasian College of Surgeons), endorsed in intensive care. The formation of the Australian and New Zealand College of Anaesthetists (ANZCA) in 1992³ and establishment of the Faculty of Intensive Care in 1993 by College Council led to a change in the diploma awarded from FFARACS to FFICANZCA (Fellow of the Faculty of Intensive Care, ANZCA). A diploma in paediatric intensive care was set up in 1997.

The Royal Australasian College of Physicians also established

an independent training programme in intensive care. This involved 3 years of basic physician training, the written and clinical examinations in internal medicine, and 3 years of advanced training, comprising 2 core years in intensive care and 1 elective year.

Australian and New Zealand Intensive Care Society (ANZICS)

The ANZICS was formed in 1975.⁴ The Society's aims are to represent the professional interests of the specialty, encourage training and research in intensive care, and develop standards of professional practice. It also provides expert advice to governmental and other bodies on matters pertaining to intensive care and maintains liaison with the nursing profession, and other organizations and international bodies involved in intensive care. The Society achieves these aims through a number of standing committees. The ANZICS has also been holding an Annual Scientific Meeting since 1976. In 2001, the World Congress of Intensive Care was held under the auspices of the ANZICS in Sydney. It is affiliated with the World Federation of Societies of Intensive and Critical Care Medicine.

Australasian Academy of Critical Care Medicine (AACCM)

The AACCM is an incorporated body established for the advancement of education and research in Australasian Critical Care Medicine.⁵ The Academy runs two courses in intensive care annually, one each in Adelaide and Brisbane. The Academy also publishes a quarterly scientific journal *Critical Care and Resuscitation*, which is now listed in the National Library of Medicine, Australia.

Clinical intensive care

There are nearly 200 ICUs across Australia and New Zealand treating approximately 100 000 patients each year. The majority of units contribute to a central database called the ANZICS Adult Patient Database.⁶ The database has recently compiled the statistics for Australia and New Zealand. The mean APACHE II score

is 15.1 and the mean length of stay in the ICU is 43 hours. The overall unadjusted mortality is 13.9%. For further information on the demographics, distribution of ICUs and workforce issues, the reader is referred to the database.⁶

Australia and New Zealand are also unique in their set-up of intensive care services across the country. The majority of the population lives in the major metropolitan cities. Much of the inland area is sparsely populated. While limited intensive care services are available in rural and remote regions, there is a well-established aeromedical retrieval system allowing transfer of these patients to the major metropolitan cities.

Research in intensive care

Funded research jobs in intensive care are few and far between. Nevertheless, an increasing number of well-conducted basic and clinical research trials in intensive care originating from Australia and New Zealand are being published. This is largely due to the enthusiasm of clinicians who devote a substantial part of their own time to research. In the past 5 years, 2 organizations have contributed immensely to the successful conduct of clinical research.

ANZICS Clinical Trials Group (CTG). The CTG was formed at the ANZICS Annual Scientific Meeting in Sydney in 1994.⁷ The Group's stated objectives are to conduct high-quality, large-scale randomized controlled trials (RCTs) in intensive care, and provide a discussion forum that allows members to present research ideas and obtain feedback from others interested in clinical research. It also encourages smaller ICUs to join in research efforts.

The CTG has been highly successful, attracting funding and generating publications in high impact journals.⁸⁻¹⁰ The Group's most ambitious project to date—The SAFE Study—a 7000 patient RCT comparing albumin and saline for intravascular volume resuscitation has recently been completed. The results are eagerly awaited.

ANZIC Foundation. The Foundation was set up with the primary aims of raising funds for and promoting research in 3 key areas: lung injury, brain injury and sepsis.⁴ The Foundation has been highly successful as a fund-raiser and, to date, has been able to fund a number of clinical and basic science trials in these target areas.

Critical care education

In 1996, a Joint Specialist Advisory Committee for Intensive Care (JSAC-IC) was formed following considerable discussion between the Faculty of Intensive Care and the Royal Australasian College of Physicians. The aim of the JSAC-IC was to develop a single training programme for the specialty. This came to fruition in 2001, with the formation of the Joint Faculty of Intensive Care Medicine (JFICM).

The JFICM performs a number of important roles: it oversees intensive care training, conducts and administers the examination, performs accreditation of ICUs, publishes policy documents and training manuals, and organizes the intensive care component of the Annual Scientific Meeting of the ANZCA.

Current training programme

The training programme in intensive care has recently been

revised. The total duration of training is 6 years, of which the first 3 years represent basic training and the latter three advanced training. The 6 years are divided into 1 year each of general hospital appointments, general medicine and anaesthesia, 2 years of intensive care and a 1 year elective period spent in intensive care or anaesthesia or medicine or research.

To be eligible for admission to the Fellowship of the JFICM, trainees must pass or be exempt from the ANZCA Primary Examination, pass the Faculty Fellowship Examination, complete a formal project and supervised training. Further details on the training programme are available on the College website.³

The future

Australia has recently been plagued by a number of crises hitting the medical community in general and those in intensive care in particular. These include disheartened doctors suffering from heavy workloads, bed shortages and medical indemnity woes. Despite this, the overall balance sheet looks favourable in terms of progress in training, clinical practice and research. We look forward to the future with hope, anticipation and confidence.

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Letter from Glasgow

SEXUAL HEALTH

Sex arouses such strong reactions among people, governments, religions and the media that very often the importance of sexual health is ignored and not discussed and debated openly. Even if we ignore it, the ubiquitous nature of sex and sexual health means that we ignore it at our peril. The problems of sexual health cannot be suppressed because they merely re-surface as more pressing or acute problems for society.

Currently, sexual health is a problem high on the agenda in Scotland. Why is this? It is clear to those interested in public health in Scotland that sexual health remains a major and, in some respects, a growing problem. This is evidenced by the teenage pregnancy rates in Scotland (which are among the highest in western Europe), increasing numbers of people with sexually transmitted diseases including syphilis, genital *Chlamydia* and gonorrhoea, and the abuse and violence (psychological and physical) associated with gender such as rape, or sexual orientation such as homophobia. I hasten to add that Scotland is by no means alone in the sexual ill-health it has. But being honest and transparent about its problems is an important step forward and sends a positive message to all concerned that these problems need to be dealt with and not swept under the carpet.

How is Scotland being honest and transparent? The Scottish draft sexual health strategy¹ has recently finished its consultation phase. In the draft document, the Chair of the expert Reference Group that produced the draft, Professor Phil Hanlon states, 'Sex is a positive and fulfilling part of the lives of most people, irrespective of age, culture or faith.' The draft document is known more correctly as the Scottish sexual health and relationships strategy 'Enhancing sexual wellbeing in Scotland'. Readers who are interested in the draft document can access it at the following website: <http://www.scotland.gov.uk/library5/health/esws-00.asp>

The Reference Group had a remit to develop a national sexual health and relationships strategy for Scotland, with particular emphasis on:

- reducing unintended pregnancies and sexually transmitted infections;
- enhancing the provision of sexual health services; and
- promoting a broad understanding of sexual health and sexual relationships that encompasses emotions, attitudes and social context.

For those interested in definitions, *Stedman's concise medical dictionary* includes a definition of sex as 'the physiologic and psychological processes within an individual which prompt behaviour related to procreation or erotic pleasure'. In fact, the Reference Group used the WHO definition of sexual health which, rightly, takes a broad and holistic approach to sexual health: 'A state of physical, emotional, mental and social wellbeing related to sexuality...sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be

respected, protected and fulfilled.' (http://www.who.int/reproductive-health/gender/sexual_health.html)

I should add that as a public health physician, as well as a citizen, it is evident that Scotland has an ambivalent attitude towards sexual health. All the evidence points to young people becoming sexually active and exploring their sexual orientation at a relatively young age. The popular approach to these issues is to ignore them or not talk openly about them. The official response has never quite been 'just say no', i.e. an abstinence approach to sex for young people, but it has been confused. Part of this may be the culture of Scotland of not talking openly about emotional or difficult issues. But I believe it is more than this culture—it is also about Scotland not learning from the evidence from the Netherlands and elsewhere of what works about sexual health policy and practice.

It is important to accept that people do have differing and, sometimes, divergent views on sex, sexuality and sexual health. But the need for policy-makers and practitioners is, while acknowledging these differing viewpoints, to develop an approach that meets the needs of the people of Scotland; in particular, the needs of young people. As the Reference Group stated, such a response incorporates the following values:

- self-respect and respect for others;
- equality of opportunity and access to lifelong learning; and
- a commitment to promote and reinforce the rights of people to have mutually respectful, happy, healthy and fulfilled sexual relationships free from abuse, violence or coercion.

The Reference Group recommended 5 ways of meeting its vision of a society that accepts sex as a normal and healthy aspect of life, people valuing their sexual health, having respect for others, and having access to appropriate health services. The 5 ways are through the provision of national leadership, through the provision of local leadership, setting clear national and local targets and goals, using existing mechanisms for consistent and comprehensive delivery, and monitoring progress through public reports.

It will be interesting to see the responses to the draft strategy. I believe the Reference Group has produced a balanced document that takes account of the differing perspectives on sexual health in Scotland. Importantly, the Reference Group had representatives from the Church of Scotland, Catholic Church and Scottish Jewish community who all agreed to the draft strategy. The document also provides a genuinely broad, evidence-based approach to sexual health and well-being. Producing the document was the easy bit (difficult enough though that was) and the much harder test of making a difference in practice is yet to come. It is a test which Scotland dare not flunk.

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