

never experienced it, but it is thoroughly familiar to most workforces—including that of the BMA. Appraisal provides an opportunity to give individuals feedback on their performance, chart their continuing progress, and discuss training and career development. It's also an opportunity, although the report doesn't make this clear, for employees to feed back on their boss's performance and how their job conditions could be improved. Once you've experienced appraisal you wonder how you did without it. The report also says that the NHS executive is to develop a policy for addressing the needs of sick doctors. This is long overdue. Every employer has an obligation to help sick employees, and the NHS has so far done a dismal job. Resources will be needed but are not mentioned.

Elaborate mechanisms to deal with poor performance are no use if those who are performing poorly cannot be identified. The report seems to hope that appraisal will be the main mechanism but also proposes a review of many methods that are used in other countries, including credentialling; use of simulators; regional, national, and international audits; and primary care detection schemes. More work is needed here.

Some of the main difficulties in implementing the report may come from the proposal to replace current disciplinary procedures, including the current right of consultants to appeal to the Secretary of State. The report proposes the creation of "assessment and support centres" which would "provide both impartial support to the local employer by advising on the action to be taken and an environment supportive to the doctor undergoing assessment." The action to be taken might range from a return to work without supervision through to referral to the GMC. The centres would cover all doctors, including general practitioners, and would have "a medical director and a board of governors with a lay chairman." The report intends "that referral [to a centre] would not carry any public stigma." Surely, a huge cultural change will be needed before that could ever be the case.

These proposals are unlikely to be greeted with enthusiasm. They may be seen as boiling down to "less freedom, more management"—but management is essential in increasingly complex systems. The chief

medical officer's proposals are impressively coherent and surely hold the possibility of making progress with this intractable but important problem. Many doctors will be wondering how NICE (the National Institute for Clinical Excellence), CHI, clinical governance, audit, appraisal, revalidation, and assessment and support centres are all intended to fit together, and the report explains the overall pattern well. Nevertheless, there must be an anxiety that a plethora of new mechanisms may not work any better than the old mechanisms, many of which were ignored. Presumably the government hopes that the various big sticks that are included in the package will be enough to command the attention of doctors—but what is needed most is a culture change. We need a culture that allows doctors to express fears, doubts, and vulnerabilities; identifies and helps those in difficulties; refuses to condone inappropriate delegation; values teamwork and continuous learning and improvement; and genuinely puts the interests of patients first. The "Newcastle mafia" of Donaldson, Donald Irvine (president of the GMC), and George Alberti (president of the Royal College of Physicians of London) are all promoting cultural change. So perhaps something will happen.

Richard Smith *editor, BMJ*

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Sexual and reproductive health: what about boys and men?

Education and service provision are the keys to increasing involvement

Boys and men have been left out in our efforts to improve sexual and reproductive health. A national survey of family planning clinics by the Family Planning Association showed that young men are much less likely than women to access sexual health services.¹ The United Kingdom government is currently assessing the feasibility of a screening programme for *Chlamydia trachomatis*. Its two pilot studies are focusing on women, but some argue that this "calls into question our ability and commitment adequately to address the sexual health needs of heterosexual men."² Why should we turn our attention to men? And how can we foster

men's responsibility towards sexual and reproductive health? These questions were considered recently at the fifth seminar of the European Society of Contraception in Amsterdam and several proposals made.

Objections were raised to focusing on men's needs, including the concern that this may jeopardise reproductive health services for women and that men already have too much power over decisions affecting women's fertility and sexual health. Nevertheless, increasing evidence exists that ignoring the sex education and sexual health needs of young men has important and wider social and health consequences.

There is widespread research and media interest in the idea of male adolescence as a negative and chaotic experience and a poor preparation for adulthood. Yet the few services provided for boys seem not to help. Boys consulted by the Sex Education Forum said that their formal sex education is “too little, too late, too biological” and that it fails to prepare them to deal with sexual relationships, contraception, abortion, and their sexual identity.³ Similarly, a qualitative study among 39 boys aged 11-21 in the Norwich region showed them united in denying the utility of their sex education.⁴

One result is a failure among young men to use contraception or engage in safe sex. A survey of 1919 college students showed that only 10% used condoms consistently.⁵ Boys have been overlooked in tackling high teenage pregnancy rates, as recognised in the recent report from the UK government’s social exclusion unit.⁶ Data from annual behavioural surveys and from the sexually transmitted disease surveillance programme in the United States show an increase in unsafe sex among men who have sex with men.⁷ Few studies have addressed young men’s involvement in decisions about termination of pregnancy, though one qualitative study of the attitudes of teenage boys showed a desire to be involved and to receive emotional and social support.⁸ Little research has been done into the possible emotional sequelae of termination decisions for men.

Three broad approaches exist to improving men’s participation in activities concerning sexual health, though there is a frustrating lack of evidence to show that these initiatives will have social or clinical impact. Firstly, experts in sex education argue that we should start with what boys want, rather than what adults think they need.³ This means that boys should participate in developing education programmes, influencing the content, delivery, and setting of their sex education. This approach was used by the Sex Education Forum³ and the Family Planning Association⁹ in developing practical guides to working with young men.

Secondly, we should be more honest to young men about the barriers to using condoms and practising safe sex, including embarrassment, fear of failure, and

loss of sensitivity. A basic concept is to understand the anxieties of young men starting their sexual “careers.” Initial difficulty in using a condom may influence a young man’s attitudes to condoms forever (A Kubba, personal communication). Practising condom use during masturbation may alleviate anxiety, and one author has argued that healthcare systems should pay for condoms for such practice.¹⁰ In discussions with young men about sex, we should include notions of pleasure and not just prevention, for many pleasurable activities are also safe ones. Increasing the range of contraceptive choices for men will be empowering for both men and women, and a recent international survey found that most men would consider taking a “male pill.”¹¹

Finally, we need to make sexual health services more accessible to boys and men. We should consult them locally to assess their needs, advertise services in an informal and attractive way, broaden the settings of service provision, and provide for specific groups such as young gay men and men from ethnic minorities. Motivating men to take a more active interest in sexual and reproductive health could be rewarding for us all.

Gavin Yamey *editorial registrar, BMJ*

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The future of clinical forensic medicine

Quality issues need to be addressed before the service is privatised

In 1993 the Royal Commission on Criminal Justice considered the role of police surgeons in the criminal justice system. While acknowledging that they performed much valuable work, the commission voiced concerns about a lack of central coordination and quality control of this work.¹ The commission recommended that a multidisciplinary Home Office working group should be set up to consider, among other things, the need for establishing centres of excellence at universities and appropriate training and standards for doctors providing clinical forensic services to the police. In 1997 the working group produced a draft report with several recommendations for improving the service, such as the establishment of a national forum to develop accreditation and monitor its effectiveness. No final report has been published,

however, and there has been no government backing for the proposals. Despite the unfinished business of addressing the quality of the service, some police forces have contracted out their clinical forensic medical services.² This is a trend that seems likely to increase.

Traditionally police forces have retained several police surgeons, who have usually been general practitioners working part time and paid through item of service fees. Inherent difficulties in managing the budget for forensic medical services, which is essentially open ended and demand led, caused the Audit Commission to suggest that police forces might consider purchasing services under a single, or several large, block or cost and volume contracts.³ Possible providers were envisaged as being NHS trusts, universities, primary care organisations, or consortiums set

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