support of the European Union’s Daphne initiative. It provides health professionals with information and recommendations for detecting female victims of domestic violence and providing follow up for them (www.civic.org).

In addition, a European surveillance network of primary care practices (the Vigil network) now brings together health professionals (general practitioners, staff of emergency services, gynaecologists) and associations that help female victims of domestic violence in eight European countries. For each case recognised the volunteer doctors are questioned about how the violence was detected, their intervention, and the difficulties encountered. The female victims are also questioned about their contacts with health professionals (or why there were none) and the proposals that were made.

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Screening can be made acceptable to women

Editor—We wish to highlight outcomes of the Queensland health domestic violence initiative, which incorporated screening for domestic violence into routine history taking protocols as a component of core domestic violence into routine history the Queensland health domestic violence (77% by Bradley et al and 80% by 97% of those surveyed supporting it. This is for domestic violence was a good idea, with help. positive on screening, about 10% accepted lence, with roughly 6.5% disclosing that doctor had asked about domestic violence. In a screening process. Only 12% of women report questionnaire, but many had never


Sexual behaviour and its medicalisation

Many (especially economic) forces promote medicalisation

Editor—The subject of the medicalisation of sexual behaviour requires an even larger perspective than that offered by Hart and Wellings,1 one specifically identifying socioeconomic trends and agents. For example, the addition of sexual dysfunctions to the American psychiatric nomenclature in 1980 came at a time when psychiatry needed to become more biological and quantitative to participate in new American insurance reimbursement plans. The Masters and Johnson list of disorders, focusing on dissatisfaction with genital arousal and orgasm but omitting “soft” problems of pleasure or intimacy, fitted these quantitative and biological needs but popularised standards for sexual satisfaction that are overly genital and performance oriented.2

The involvement of urologists in male sexual problems in the 1980s came about because of specialists’ needs for new topics and patients, the encouragement of newly interested industries, and shifts in relations between academics and these industries.3 It was widely promoted in the press, creating heightened expectations about medical sexual expertise.

When Hart and Wellings cite epidemiological statistics for sexual problems they inadvertently contribute to the problems of medicalisation by citing weak research and failing to discuss how definitions of a problem play a part in market-driven medicalisation. American studies of the prevalence of sexual problems use overinclusive definitions—not surprising given the extent of drug company involvement in the research.4

A discussion of medicalisation needs to examine the fit between models of sexuality and the medical model. Hart and Wellings conclude that the problems of medicalisation are really those of overmedicalisation, but I believe that that is superficial. Sexuality is a social construction, and medicalisation is the new social construction. Excessive medicalisation may be malpractice, but we must question the fundamental model of sexual ity as a biological rather than a sociocultural and political entity. Hart and Wellings’s final sentence (“The last century saw a considerable increase in acceptance of diversity of sexual expression—it would be a shame if this century saw diversity replaced by uniform expectations of performance and desire”) is their strongest, but their analysis needs to be more comprehensive. I would direct readers to a new feminist campaign that has emerged to resist the for-profit medicalisation of women’s sexual problems (www.fsdlert.org).

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HIV/AIDS prevention efforts deserved greater mention

Editor—In their account of the medicalisation of sexual behaviour Hart and Wellings do not pay sufficient attention to the HIV/AIDS prevention efforts that were undertaken during the mid-1980s. They can be considered to be the most important