Domestic Violence- screening can be made acceptable to women

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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.sivic.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 clinical practice.[1] The provider asks the client two or three additional questions relating to domestic violence during the history taking procedure. This small change has improved diagnosis and the provision of health services and information to women who experience domestic violence.

Respondents in the studies by Richardson et al[2] and Bradley et al[3] completed a self report questionnaire, but many had never been asked directly about domestic violence in a screening process. Only 12% of women in Bradley et al's study reported that their doctor had asked about domestic violence. In our study 83% of women presenting to the antenatal or gynaecology outpatient services were screened for domestic violence, with roughly 6.5% disclosing that some form of domestic violence had occurred. Of those women who were positive on screening, about 10% accepted help.

Clients thought that screening women for domestic violence was a good idea, with 97% of those surveyed supporting it. This is higher than the figures reported in the *BMJ* (77% by Bradley et al and 80% by Richardson et al). Richardson et al report that at least 20% of women objected to screening. To determine the extent of acceptability more accurate conclusions can be drawn from research that reports on the views of women who have experienced personalised screening.

Richardson et al report that 42% of women would find it easier to discuss issues concerning domestic violence with a female doctor. Issues of gender, power, and interpersonal sensitivity must be considered when assessing people for domestic violence. Neither Richardson et al nor Bradley et al identified whether certain contexts were described in the questionnaire when investigating women's attitudes to screening. For example, a woman's attitude to screening about domestic violence might alter if the questions were asked in private with no family member present, if they were asked by a female health professional, if the woman perceived the health professional to be genuinely concerned about her, and if the woman was offered access to information and referral. Such issues need to be considered when investigating attitudes of service users.

The papers also report on the low rate of documentation of domestic violence—for example, only 17% of cases were documented in Richardson et al's paper. Our work identified that quick, simple, routine screening can be effective, with documented compliance of around 88% and 97% acceptability to women.

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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.[5] 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 sexuality 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.fsd-alert.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.[1] They can be considered to be the most important