

Unrealistic Sexual Expectations

When Myths, Comparisons and Performance Pressure Begin to Affect Sexual Confidence, Intimacy and Relationships

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Introduction

In my clinical practice, I regularly meet patients who believe something is seriously wrong with their sexual health even though the problem is not always a disease of the sexual organs.

A young man may tell me:

“Doctor, I can have intercourse for only a few minutes. I think I am weak.”

Another says:

“My penis does not look as large as what I have seen online. Will I be able to satisfy my wife?”

A newly married man may say:

“Doctor, on the first night I could not maintain an erection. Does this mean I am impotent?”

A woman may tell me:

“I don't reach orgasm every time. Is something wrong with me?”

A couple may say:

“We thought married couples should have sex every day. We are worried because we don't.”

And sometimes a patient says:



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“My partner does not respond the way people do in videos. Does that mean there is no attraction?”

These concerns are very real to the patient.

But frequently, the problem is not simply the body.

The problem is the **expectation placed upon the body**.

This is what I describe clinically as **unrealistic sexual expectations**.

Unrealistic sexual expectations are beliefs about sexual appearance, desire, erection, intercourse, ejaculation, orgasm, frequency, pleasure or partner behaviour that do not adequately reflect the normal variation of human sexuality.

It is important to understand that **“unrealistic sexual expectations” is not itself a formal medical diagnosis**. Rather, it is a clinically useful description of thoughts and beliefs that can contribute to sexual anxiety, dissatisfaction, relationship conflict and sometimes genuine sexual dysfunction.

Modern sexual medicine strongly supports a biopsychosocial approach. The 2025 recommendations from the Fifth International Consultation on Sexual Medicine emphasize that sexual difficulties should be understood through biological, psychological, interpersonal and relationship factors rather than through physical symptoms alone.

The World Health Organization similarly describes sexual health as physical, emotional, mental and social well-being in relation to sexuality—not simply the absence of sexual disease. Healthy sexuality should involve respect, safety, communication and the possibility of pleasurable sexual experiences without coercion.

This is why I often tell patients:

Good sexual health is not a performance competition.

What Are Unrealistic Sexual Expectations?

An expectation becomes problematic when a person believes that a particular sexual outcome **must always happen**, even though normal human sexual functioning is naturally variable.

Examples include believing:

- a man must get an erection immediately;
- an erection must remain completely rigid throughout every sexual encounter;
- intercourse must continue for a very long time;



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- ejaculation within a few minutes always means disease;
- a larger penis automatically produces greater satisfaction;
- both partners must become sexually aroused at exactly the same time;
- both partners must always orgasm;
- both partners should orgasm simultaneously;
- women should become instantly lubricated;
- men should always desire sex;
- women should never initiate sex;
- newly married couples must successfully complete intercourse on the first night;
- couples should have sex a specific number of times every week;
- pregnancy should occur immediately after marriage;
- a sexually healthy man should be ready for intercourse whenever his partner wants;
- a sexually healthy woman should automatically desire intercourse whenever her husband does;
- pornography accurately represents normal sexual behaviour;
- every erection fluctuation means erectile dysfunction;
- every early ejaculation means premature ejaculation;
- every reduction in sexual desire means hormonal disease;
- sexual satisfaction depends mainly upon penis size.

None of these statements can be universally applied.

Human sexual response changes with:

- age;
- health;
- sleep;
- stress;
- emotional state;
- relationship quality;



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- medications;
- hormones;
- privacy;
- fatigue;
- pregnancy;
- childbirth;
- menopause;
- anxiety;
- cultural expectations;
- previous experiences.

Healthy sexuality therefore requires flexibility.

Where Do Unrealistic Expectations Come From?

Patients sometimes ask me:

“Doctor, why did I start thinking like this?”

Usually there is no single cause.

Unrealistic sexual expectations can develop from several sources.

These include:

- pornography;
- social media;
- films and television;
- exaggerated online advertisements;
- friends and peer conversations;
- incomplete sex education;
- cultural myths;
- misinformation about masculinity;
- misinformation about femininity;
- fear before marriage;



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- comparison with other people;
- commercial marketing of sexual products;
- previous sexual experiences;
- shame surrounding sexual discussion;
- body-image insecurity.

When accurate sexual education is absent, myths easily fill the gap.

UNESCO's international sexuality-education guidance specifically warns that sexually explicit media can create unrealistic ideas about sexual behaviour, sexual responses and body appearance.

Pornography and Sexual Expectations

One of the most common influences today is pornography.

Pornography is entertainment created to produce sexual stimulation.

It should not be treated as a medical textbook.

The people, scenes and sexual activities presented may involve:

- selected performers;
- unusual physical characteristics;
- camera angles;
- editing;
- repeated takes;
- pauses not visible to the viewer;
- scripted reactions;
- prolonged sexual scenes;
- selective portrayal of bodies.

When someone repeatedly compares ordinary sexuality with pornography, several expectations may develop:

“My erection should remain perfect continuously.”

“My penis should look like that.”

“Intercourse should last that long.”



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“My partner should behave that way.”

“She should orgasm from penetration alone.”

“I should be able to repeat intercourse immediately.”

Those expectations may create anxiety rather than pleasure.

A recent meta-analysis involving 41 studies and more than 70,000 participants found a small overall negative association between pornography use and sexual satisfaction, although the relationship was complex and differed across studies and populations. It therefore cannot be reduced to a simple claim that pornography always causes sexual dissatisfaction.

My clinical message is simpler:

Do not compare private, real-life intimacy with professionally produced sexual media.

Social Media and Comparison Culture

Pornography is not the only influence.

Social media can create distorted expectations regarding:

- body shape;
- penis size;
- breast appearance;
- fitness;
- attractiveness;
- romantic relationships;
- sexual confidence.

People generally post selected moments.

They do not post:

- sexual anxiety;
- failed erections;
- disagreements;
- tiredness;



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- low desire;
- infertility stress;
- awkward sexual experiences.

A person may therefore compare their complete private life with somebody else's carefully selected public image.

That is not a fair comparison.

Unrealistic Expectations About Penis Size

Penis-size anxiety is one of the most common concerns I see among men.

A patient may say:

“Doctor, mine is not big enough.”

I then ask:

“Compared with what?”

Frequently the answer is:

“Compared with what I saw online.”

This is where accurate information becomes therapeutic.

A 2025 systematic review and meta-analysis covering 33 studies and 36,883 men reported an average erect penile length of approximately **13.8 cm** and an average erect circumference of approximately **11.9 cm**, while also finding geographic variation across populations. These values describe population averages, not a required or “ideal” sexual size.

Earlier clinician-measured research similarly found an average erect length around 13 cm.

Most importantly, research has **not established a simple relationship in which a larger penis automatically means greater partner satisfaction**. Available studies on penis size and partner satisfaction remain limited and methodologically imperfect.

A 2025 review of genital body image also notes that dissatisfaction with genital size or appearance can itself affect sexual and psychological well-being. Media ideals and comments from peers or partners may contribute to these concerns.

Therefore, the problem may sometimes be:

not penile size,



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but **penile-size anxiety**.

When Body Anxiety Enters the Bedroom

Sex becomes difficult when a person is mentally standing outside their own body and evaluating themselves.

During intimacy, the man begins thinking:

“Is my penis large enough?”

“Is my erection hard enough?”

“Does my stomach look bad?”

“Is she comparing me with somebody?”

The woman may think:

“Do my breasts look normal?”

“Does my stomach look unattractive?”

“Are my genitals normal?”

“Will my partner notice my stretch marks?”

Now the brain is occupied with evaluation instead of erotic experience.

This kind of cognitive distraction is clinically important.

A recent study among patients with anxiety disorders found that greater cognitive distraction and negative expectations regarding sexuality were associated with more sexual dysfunction, greater sexual distress and lower sexual satisfaction.

Unrealistic Expectations About Erections

Many men believe:

“A healthy man should get a perfect erection every time.”

This is incorrect.

Erection is influenced by:

- blood circulation;
- nervous-system function;
- hormones;



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- sexual stimulation;
- relaxation;
- anxiety;
- fatigue;
- sleep;
- medication;
- alcohol;
- relationship circumstances.

Even a healthy man may occasionally experience a weaker erection because he is:

- tired;
- distracted;
- worried;
- stressed;
- under pressure;
- uncomfortable;
- not sufficiently aroused.

One unsuccessful sexual encounter does not automatically equal erectile dysfunction.

The 2026 European Association of Urology guidance defines ED as a **persistent inability** to achieve or maintain an erection sufficient for satisfactory sexual performance and recognizes vascular, hormonal, neurological, medication-related and psychological causes. The guidelines specifically identify performance-related and partner-related difficulties among psychological contributors.

The Performance-Anxiety Cycle

Unrealistic expectations can actually create the sexual problem the person fears.

Consider this sequence.

A man thinks:

“I absolutely must get a perfect erection.”

He begins intercourse.



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Instead of experiencing pleasure, he monitors his penis.

“Am I fully hard?”

His erection reduces slightly.

He becomes frightened.

“I am losing it.”

His anxiety increases.

The erection decreases further.

He now thinks:

“I have erectile dysfunction.”

The next sexual encounter begins with the memory of failure.

He thinks:

“What if it happens again?”

It happens again.

A temporary erection difficulty has now become a self-reinforcing cycle.

The body may be capable of erection.

The pressure has become the obstacle.

This is why modern EAU guidance recommends assessing dysfunctional thinking styles and expectations about sexuality in men with erection problems, alongside relationship and medical factors.

“I Must Perform Every Time”

Sexuality is not a machine.

A healthy person does not respond identically every time.

Erection may be stronger on one occasion and weaker on another.

Desire may be high one day and low the next.

Orgasm may occur quickly on one occasion and take longer another time.

Human physiology changes.

The expectation of perfect consistency creates unnecessary pressure.

I often tell patients:



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Sexual health means having the capacity for satisfying intimacy—not performing like a machine.

Unrealistic Expectations About Intercourse Duration

Another extremely common myth concerns duration.

Men frequently ask:

“Doctor, how many minutes should I continue?”

The question itself shows how easily sex becomes a stopwatch examination.

Premature ejaculation is not diagnosed merely because intercourse did not last as long as someone expected.

Contemporary sexual-medicine guidance evaluates several factors, including:

- ejaculation latency;
- perceived control;
- distress;
- interpersonal difficulty.

Importantly, the EAU recognizes **subjective premature ejaculation**, in which a man believes that ejaculation is abnormally early even though his ejaculation time may actually be within the normal range or even longer. Such cases should not automatically be considered true medical pathology.

This is a perfect example of how expectations can become a sexual-health concern.

Stop Comparing Sexual Duration With Videos

Pornographic content may give the impression that intercourse normally continues without interruption for an unusually long time.

This ignores:

- editing;
- pauses;
- scene changes;
- selective performers;
- production techniques.



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Real intimacy is not measured by camera time.

Longer intercourse is also not automatically better.

Comfort and satisfaction matter more than achieving an arbitrary number.

Sexual Satisfaction Is Not a Stopwatch

A satisfying sexual encounter may involve:

- affection;
- kissing;
- touching;
- conversation;
- foreplay;
- intercourse;
- other mutually desired forms of sexual activity.

If a man believes that only penetration counts as “real sex,” he may place enormous pressure upon himself to maintain penetration for an artificially long period.

Sexual counselling often involves expanding the understanding of intimacy beyond penetration alone.

Unrealistic Expectations About Orgasm

Orgasm is another area where performance pressure develops.

Some couples believe:

“Both partners must orgasm every time.”

Others believe:

“They must orgasm at exactly the same moment.”

Neither is a universal requirement for healthy sexuality.

Orgasm is affected by:

- stimulation;
- arousal;
- psychological state;



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- relationship context;
- medication;
- hormones;
- pain;
- anxiety;
- distraction;
- familiarity with one's sexual responses.

Women in particular vary considerably in the type and amount of stimulation that produces orgasm.

Population studies consistently demonstrate differences in orgasm frequency between men and women during partnered heterosexual activity. For example, a large 2024 analysis involving 24,752 adults found that reported orgasm rates were lower among women than men across age groups.

This should **not** be interpreted as meaning female pleasure is unimportant.

Rather, it tells us that human sexual response is more complex than:

“Intercourse occurred, therefore orgasm must automatically occur.”

The “Orgasm Imperative”

Even the goal of pleasure can become unhealthy if it is converted into compulsory performance.

A woman may start thinking:

“I have to orgasm, otherwise something is wrong.”

Her partner thinks:

“If she does not orgasm, I have failed.”

Now both people are watching for the outcome.

The pressure itself may make orgasm more difficult.

A 2024 scholarly review specifically discussed the potential problems created by an “orgasm imperative”—the assumption that orgasm must be the central measure of successful sex.

The appropriate goal is:



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pleasure without pressure.

Female Desire Does Not Always Begin Before Intimacy

Another misunderstanding concerns sexual desire.

People often assume:

“First desire appears, then sexual activity begins.”

That is one pattern.

But it is not the only pattern.

Some people experience **responsive desire**, where desire increases after affectionate or erotic interaction has already begun.

Research continues to examine responsive sexual desire, particularly among women, and demonstrates that desire and genital arousal interact with relationship context in complex ways.

Therefore:

“My wife did not spontaneously ask for sex today”

does not automatically mean:

“She has no attraction toward me.”

Likewise, nobody should be pressured into sexual activity in the hope that desire will appear.

Consent remains necessary.

Unrealistic Expectations About Sexual Frequency

Patients frequently ask:

“How many times per week should a married couple have sex?”

There is no medically compulsory number that applies to every couple.

Sexual frequency may vary according to:

- age;
- relationship duration;
- workload;



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- pregnancy;
- childbirth;
- children;
- illness;
- privacy;
- stress;
- desire;
- religious or cultural circumstances.

Recent couple research confirms that sexual frequency and relationship satisfaction interact in complex ways rather than through one universal numerical rule. A 2025 study of more than 2,000 couples identified several patterns of sexual frequency and relationship satisfaction, with relationship factors such as conflict, commitment and self-disclosure also playing important roles.

The useful question is not:

“Are we achieving somebody else's number?”

It is:

“Are both partners reasonably satisfied with our intimacy?”

Desire Mismatch Is Common

One partner may want sexual contact more frequently than the other.

That does not automatically mean:

- rejection;
- infidelity;
- hormonal disease;
- loss of love.

Differences in desire are common in relationships and can become distressing if couples cannot negotiate them effectively.

The answer is communication—not coercion.



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“If My Partner Loves Me, They Should Always Want Sex”

This belief can damage relationships.

Love and sexual desire overlap, but they are not identical.

A loving partner may temporarily have little sexual desire because of:

- fatigue;
- work stress;
- illness;
- pregnancy;
- postpartum changes;
- medication;
- depression;
- hormonal changes;
- relationship conflict.

Low desire should be assessed when persistent and distressing, but it should not automatically be interpreted as absence of love.

Sexual Communication Matters

Many couples know very little about what their partner actually enjoys.

Instead, they assume.

The husband assumes:

“My wife should automatically understand what I want.”

The wife assumes:

“If he really loves me, he should know what I need.”

Neither partner speaks.

Both become dissatisfied.

Research strongly supports communication.

A meta-analysis of 93 studies representing more than 38,000 people found that better sexual communication was positively associated with both sexual satisfaction and relationship satisfaction, with the **quality** of communication particularly important.



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Therefore, healthy sexual communication is not evidence that a relationship is weak. It is one of the skills that can make intimacy stronger.

Unrealistic Expectations About the First Night of Marriage

This is particularly important in South Asian and other culturally conservative settings.

Many newly married men arrive with enormous expectations.

They believe:

“Tonight I have to prove that I am a man.”

The wife may simultaneously think:

“Intercourse must happen tonight even if I am frightened.”

Both partners may have limited sexual education.

Both may be nervous.

Then:

The husband develops erection difficulty.

The wife becomes tense.

Lubrication decreases.

Pelvic-floor muscles may tighten.

Penetration becomes uncomfortable.

They become frightened.

Now they believe the marriage has failed sexually.

It has not.

A 2026 review of erectile dysfunction in newly married men identifies sexual-performance anxiety, inadequate sex education, sociocultural pressure, misleading information and relationship factors among important contributors to unconsummated marriage. It recommends individualized management combining education, psychological intervention, improvement in marital intimacy and medical treatment where necessary.

The First Sexual Encounter Is Not an Examination



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I often tell newly married couples:

The purpose of the first night is not to demonstrate sexual expertise.

The couple has an entire relationship in which to understand one another.

Healthy early intimacy may involve:

- conversation;
- affection;
- comfort;
- touching;
- gradually developing trust.

Penetration does not need to be forced simply because the wedding has occurred.

Unrealistic Expectations About Masculinity

Some men are taught:

“A real man always wants sex.”

“A real man never loses an erection.”

“A real man can continue for a long time.”

“A real man must have a large penis.”

“A real man should satisfy his partner every single time.”

These beliefs can become psychologically exhausting.

Masculinity should not be measured by erectile rigidity or intercourse duration.

Sexual functioning is part of health—not a test of personal worth.

Unrealistic Expectations About Femininity

Women can experience their own damaging expectations:

“A good wife should never refuse.”

“A woman should not express sexual desire.”

“A woman should automatically enjoy penetration.”

“A woman should orgasm only through intercourse.”



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“A woman with low desire is abnormal.”

These beliefs can prevent women from communicating:

- pain;
- fear;
- desire;
- boundaries;
- preferred stimulation.

Sexual health requires mutual respect.

Consent Is More Important Than Expectation

Marriage does not eliminate the importance of consent.

Sexual expectations become harmful when one partner pressures the other.

Statements such as:

“You are my spouse, therefore you must agree”

or:

“If you loved me, you would do this”

do not create healthy intimacy.

WHO's sexual-health framework explicitly emphasizes safe and pleasurable sexual experiences that are free from coercion and violence.

Healthy sexual relationships include the freedom to say:

“Yes.”

“No.”

“Not tonight.”

“Slower.”

“I am uncomfortable.”

“I would prefer something else.”

Unrealistic Expectations and Erectile Dysfunction



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Expectations can contribute to ED through:

- performance pressure;
- self-monitoring;
- catastrophizing;
- fear of partner judgment;
- fear of failure.

But I always emphasize another important point:

Do not automatically assume that ED is psychological.

Medical causes include:

- diabetes;
- hypertension;
- vascular disease;
- obesity;
- endocrine disorders;
- neurological conditions;
- medication effects;
- smoking;
- sleep disorders.

The 2026 EAU guidelines therefore recommend comprehensive medical and sexual history, appropriate examination and assessment of psychological and relationship factors.

Unrealistic Expectations and Premature Ejaculation

A man may have normal variation in ejaculation time yet believe:

“I am too fast.”

If he continuously compares himself with videos or exaggerated claims, he becomes anxious.

That anxiety may then make ejaculation control more difficult.



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Modern EAU guidance specifically recognizes performance anxiety and relationship difficulties among factors associated with acquired premature ejaculation and distinguishes true PE from normal variable and subjective forms.

Unrealistic Expectations and Delayed Ejaculation

The opposite can also occur.

A man expects himself to ejaculate simply because intercourse has lasted for a particular time.

When orgasm does not occur, he panics.

Delayed ejaculation may have multiple contributors, including:

- medication;
- diabetes;
- neurological illness;
- psychological factors;
- particular masturbation patterns.

It requires assessment rather than self-diagnosis.

Unrealistic Expectations and Low Sexual Desire

People sometimes believe that desire should remain unchanged throughout life.

In reality, desire fluctuates.

Possible influences include:

- age;
- stress;
- sleep;
- relationship quality;
- depression;
- anxiety;
- medications;
- hormones;



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- chronic illness.

The clinical question is not:

“Is my desire identical to five years ago?”

It is:

“Has there been a persistent, distressing change, and why?”

Unrealistic Expectations and Female Sexual Difficulties

Women may experience pressure regarding:

- arousal;
- lubrication;
- orgasm;
- penetration;
- sexual frequency.

Anxiety can contribute to:

- reduced arousal;
- pelvic-floor tightening;
- difficulty reaching orgasm;
- avoidance of sex.

However, these symptoms should not automatically be labelled psychological.

Physical possibilities include:

- infection;
- menopause;
- vulvodynia;
- endometriosis;
- pelvic-floor dysfunction;
- hormonal changes;
- medication effects.



The Fifth International Consultation on Sexual Medicine emphasizes individualized biopsychosocial assessment and recognizes roles for psychoeducation, CBT, mindfulness and couple-based interventions where appropriate.

Unrealistic Expectations About Pregnancy

Another problem I see is the belief:

“We have been married for two months and there is no pregnancy. Something must be wrong.”

Human reproduction is not guaranteed with every episode of intercourse.

Conception depends upon several factors:

- ovulation;
- female age;
- tubal health;
- uterine factors;
- ovarian function;
- sperm concentration;
- sperm motility;
- intercourse timing.

Fertility should be assessed according to appropriate clinical criteria rather than through panic after a few unsuccessful cycles.

Fertility Pressure Can Damage Intimacy

When couples are trying to conceive, sex can gradually change from intimacy into a fertility procedure.

The husband thinks:

“Today is ovulation day. I must get an erection.”

The wife thinks:

“If we miss today, we have lost the month.”

Pressure increases.



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Sexual spontaneity decreases.

Some men then develop situational erection difficulties.

This is why infertility treatment should consider both reproductive and sexual health.

Unrealistic Expectations Created by Sexual Medicine Advertising

Another source of misinformation is commercial advertising.

Patients may see claims such as:

“Perform for one hour.”

“Increase penis size permanently.”

“Become powerful overnight.”

“Guarantee pregnancy.”

“100% permanent sexual cure.”

Such claims can themselves create a disease-like feeling.

A man who was previously reasonably satisfied begins thinking:

“Maybe I am inadequate.”

Sexual-health treatment should correct misinformation rather than exploit insecurity.

Sexual Perfectionism

Some patients are not satisfied with “good enough.”

Sex must be perfect.

The erection must be perfect.

The orgasm must be perfect.

The body must be perfect.

The partner must respond perfectly.

This is sometimes described as **sexual perfectionism**.

A systematic review found that certain forms of sexual perfectionism—particularly expectations perceived as being imposed by partners or society—were associated with greater sexual anxiety and poorer aspects of sexual functioning, although the evidence base remains limited.



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Healthy sexuality requires flexibility, not perfection.

Signs That Unrealistic Expectations May Be Affecting You

Consider professional assessment when you repeatedly experience several of the following:

- constant worry about penis size;
- repeatedly measuring the penis;
- constant monitoring of erection hardness;
- checking intercourse time with a clock;
- believing you have PE despite normal sexual function;
- fear before every sexual encounter;
- comparing your partner with pornography;
- believing every encounter must end in orgasm;
- avoiding intimacy because you may “fail”;
- taking sexual medicines without proper diagnosis;
- pressuring a partner to perform particular acts;
- becoming distressed when your partner has lower desire;
- believing your marriage is unsuccessful because sex is not frequent enough;
- assuming infertility after a very short period of trying;
- repeated reassurance seeking;
- severe body-image anxiety;
- relationship arguments caused by sexual comparisons.

These signs do not automatically establish a psychiatric disorder.

They suggest that a proper sexual-health assessment may be helpful.

How I Evaluate Unrealistic Sexual Expectations

When a patient comes to me saying:

“Doctor, my sex life is not normal,”



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my first question is:

“What does normal mean to you?”

That question often reveals the entire problem.

The patient may answer:

“I should last 30 minutes.”

“My erection should never decrease.”

“My penis should be seven inches.”

“My wife should orgasm every time.”

Now I understand that part of the treatment may involve correcting expectations.

Step One: Detailed Sexual History

I ask about:

- sexual desire;
- erection;
- ejaculation;
- orgasm;
- intercourse;
- pain;
- masturbation;
- pornography;
- relationship circumstances;
- fertility concerns.

Step Two: Understand the Patient's Expectations

I ask:

Where did you learn what sex should look like?

Pornography?

Friends?



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Social media?

Previous partners?

Advertisements?

The answer helps identify the source of the belief.

Step Three: Rule Out Genuine Sexual Dysfunction

Education should never be used to dismiss real symptoms.

A patient with persistent erection difficulty needs ED assessment.

A patient with genuine PE needs PE assessment.

A woman with painful sex requires investigation.

A couple experiencing infertility needs appropriate reproductive assessment.

The objective is to distinguish:

unrealistic expectation

from

genuine medical disorder

and recognize that both may sometimes coexist.

Step Four: Assess Physical Health

Depending upon symptoms, evaluation may involve:

- blood pressure;
 - diabetes screening;
 - thyroid assessment;
 - hormonal evaluation;
 - medication review;
 - urological evaluation;
 - gynecological evaluation.
-

Step Five: Assess Psychological Factors



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We consider:

- anxiety;
- depression;
- performance fear;
- body-image insecurity;
- shame;
- obsessive thinking;
- previous trauma;
- perfectionism.

Step Six: Assess Relationship Factors

I ask:

Can the couple discuss sexuality?

Is there trust?

Is there resentment?

Does either partner feel pressured?

Is there desire mismatch?

Do they understand one another's preferences?

Relationship context matters because sexual health occurs between people, not merely between organs.

Treatment: Can Unrealistic Sexual Expectations Improve?

Yes.

In many patients, considerable improvement occurs once they understand how normal human sexuality actually functions.

Treatment may include:

- sexual education;
- reassurance;
- cognitive restructuring;



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- CBT;
- psychosexual counselling;
- mindfulness;
- couple therapy;
- treatment of genuine sexual dysfunction;
- lifestyle management;
- appropriate Unani support;
- referral when required.

1. Accurate Sexual Education

Knowledge itself can be therapeutic.

A patient who believes:

“I must maintain intercourse for 30 minutes”

may experience substantial relief when he understands that sexual satisfaction cannot be reduced to an arbitrary duration.

A patient who believes:

“I have a very small penis”

may benefit from objective clinical assessment rather than internet comparison.

2. Correct Catastrophic Thinking

A single failed erection becomes:

“I am impotent.”

One quick ejaculation becomes:

“I have permanent PE.”

One occasion without orgasm becomes:

“Our sexual relationship is broken.”

Counselling helps replace these thoughts with:

“One experience does not define my sexual health.”



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3. Stop Spectatoring

During intimacy, some patients become observers.

They mentally watch themselves:

“How is my erection?”

“How long has it been?”

“What is my partner thinking?”

The therapeutic goal is to return attention toward:

- touch;
 - sensation;
 - affection;
 - breathing;
 - emotional connection.
-

4. Reduce Performance Pressure

I often tell couples:

The goal of intimacy should not initially be proving sexual performance.

The first objective may simply be:

comfort.

Then:

connection.

Then:

pleasure.

Performance usually functions better when it is no longer being continuously tested.

5. Cognitive Behavioural Therapy

CBT may help patients challenge thoughts such as:

“If I lose my erection once, I am impotent.”

“If my wife doesn't orgasm, I have failed.”

“If I don't have sex several times each week, my marriage is abnormal.”

“If I ejaculate quickly once, I have PE.”

The objective is not false reassurance.

It is replacing distorted beliefs with evidence-based, realistic ones.

6. Couple Communication

Partners should learn to discuss:

- desire;
- preferred touch;
- frequency;
- comfort;
- boundaries;
- concerns;
- sexual expectations.

Good sexual communication has a substantial positive association with sexual satisfaction.

7. Sensate-Focus and Psychosexual Approaches

In appropriate patients, structured psychosexual techniques can reduce the focus on erection, penetration and orgasm and gradually redirect attention toward non-demand physical intimacy.

Modern sexual-medicine recommendations include psychosexual education, CBT, couple interventions, mindfulness and sensate-focus approaches depending on the individual problem.

These interventions should be used carefully when trauma or relationship safety concerns exist.

8. Treat Genuine Sexual Disorders Properly

Correcting expectations does not mean ignoring disease.



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If a patient actually has:

- ED;
- PE;
- delayed ejaculation;
- low desire;
- vaginismus;
- sexual pain;
- infertility,

that condition should be investigated and managed according to its cause.

How the Unani System of Medicine Can Contribute

The Unani system has traditionally viewed health through a broad framework involving physical habits, mental state, sleep, activity, diet and general constitutional balance.

Official Ministry of AYUSH descriptions of Unani medicine emphasize the **Asbab-e-Sitta Zarooriya**, or six essential factors:

- air;
- food and drink;
- bodily movement and rest;
- mental activity and peace;
- sleep and wakefulness;
- retention and evacuation.

The same official material also recognizes psychological approaches such as **Nafsiyati Tadbeer** within traditional Unani health care.

This holistic perspective can be useful when unrealistic sexual expectations occur alongside:

- anxiety;
- disturbed sleep;
- excessive stress;
- fatigue;



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- poor lifestyle;
- associated sexual complaints.

However, an important scientific distinction is necessary:

There is no specific Unani herbal medicine that has been established through high-quality evidence as a stand-alone cure for unrealistic sexual expectations.

This is primarily an educational, psychological and relationship problem unless an associated medical sexual disorder is present.

Therefore, I believe responsible Unani care should complement—not replace—appropriate counselling, psychotherapy or modern sexual-medicine treatment.

Harakat-o-Sukoon Nafsani: Mental Activity and Peace

Unani medicine traditionally considers mental activity and emotional balance among the essential factors influencing health.

This has practical relevance.

A patient with constant sexual worry may:

sleep poorly.

Poor sleep creates fatigue.

Fatigue affects desire.

Reduced sexual response creates more worry.

The circle continues.

An integrative approach tries to interrupt this cycle.

Nawm-o-Yaqza: Sleep and Wakefulness

Sleep is particularly important for general health and sexual well-being.

Chronic sleep deprivation can worsen:

- fatigue;
- irritability;
- anxiety;
- general health.



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At Saira Health Care, I therefore ask about sleep when patients present with sexual complaints.

A sexual problem should not be separated from the rest of the patient's health.

Harakat-o-Sukoon Badani: Activity and Rest

Appropriate physical activity supports:

- cardiovascular health;
- metabolic health;
- mood;
- sleep;
- body confidence.

The Ministry of AYUSH's Unani healthy-living guidance describes balance between bodily activity and rest as one of the essential factors for maintaining health.

This may be particularly useful in men with obesity, metabolic disease or cardiovascular risk alongside sexual complaints.

Ilaj bil Ghiza – Dietary Support

Diet cannot directly remove a distorted sexual belief.

However, nutrition contributes to overall:

- metabolic health;
- energy;
- vascular health;
- reproductive well-being.

When sexual complaints coexist with obesity, diabetes or other lifestyle-related disorders, dietary management may therefore form part of comprehensive care.

What About Unani Medicines?

Unani herbal medicines should not be prescribed simply because somebody feels sexually inadequate.



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A medicine cannot correct the belief:

“My penis must be larger.”

A medicine cannot teach communication.

A medicine cannot remove pornography-created expectations.

A medicine cannot make two partners understand one another.

But when a properly diagnosed associated medical or sexual condition exists, individualized Unani treatment may be considered within the practitioner's appropriate clinical scope.

The principle is:

Do not give every anxious patient an aphrodisiac. First determine why the patient is anxious.

My Approach at Saira Health Care

At Saira Health Care, when a patient comes to me saying:

“Doctor, I am sexually weak,”

I do not immediately prescribe medicine.

First, I ask:

What does “weak” mean?

Does he mean:

poor erection?

early ejaculation?

low desire?

infertility?

small penis anxiety?

performance fear?

fatigue?

or simply that he cannot meet an unrealistic expectation?

These are entirely different problems.



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Step One at Saira Health Care: Confidential Consultation

Sexual concerns are deeply personal.

Patients may be embarrassed to discuss:

- pornography;
- masturbation;
- penis size;
- erection;
- ejaculation;
- orgasm;
- marital intimacy;
- infertility.

A confidential and respectful consultation makes accurate assessment possible.

Step Two: Separate Myth From Disease

This is one of the most important steps.

Some patients need medical treatment.

Others primarily need accurate education.

Others need both.

My role is to determine the difference.

Step Three: Physical and Sexual Assessment

If symptoms suggest a genuine disorder, evaluation may include:

- blood glucose;
- blood pressure;
- thyroid function;
- hormone testing when appropriate;
- medication review;
- urological examination;



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- reproductive investigations.
-

Step Four: Psychological Assessment

I evaluate whether the problem involves:

- performance anxiety;
 - excessive comparison;
 - sexual perfectionism;
 - fear of failure;
 - body dysmorphia;
 - depression;
 - relationship conflict.
-

Step Five: Correct Sexual Misinformation

Sometimes this is the most powerful intervention.

Patients need to understand:

Erection naturally fluctuates.

Orgasm does not occur automatically every time.

Partners may have different desire levels.

Intercourse duration alone does not determine satisfaction.

Penis size is not equivalent to masculinity.

The first night of marriage is not an examination.

Pregnancy is not guaranteed immediately.

Step Six: Treat Associated Sexual Dysfunction

When an actual sexual disorder exists, it must be treated separately.

For example:

A patient may simultaneously have:

unrealistic expectations + genuine erectile dysfunction.



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Treating only his thoughts would be incomplete.

Likewise:

ED medicine without correcting severe performance anxiety may also be incomplete.

Step Seven: Couple-Based Education

Sometimes I prefer both partners to understand the problem.

When only one partner changes their expectations while the other continues applying pressure, improvement may be difficult.

Couple education can help establish more realistic expectations.

Step Eight: Unani Support Where Appropriate

Depending upon the individual patient, Unani principles may support:

- sleep regulation;
- healthy dietary habits;
- activity and rest;
- stress management;
- general health;
- associated sexual-health conditions.

The treatment remains individualized.

Step Nine: Appropriate Referral

A responsible sexual-health clinician should know when another professional is required.

I may recommend appropriate referral when the patient needs:

- clinical psychology;
- psychiatric evaluation;
- specialist sex therapy;
- couple therapy;



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- gynecological assessment;
- urological evaluation;
- pelvic-floor physiotherapy.

Modern sexual medicine increasingly emphasizes exactly this type of individualized biopsychosocial care.

Dr. Nizamuddin Qasmi's Clinical Focus

My professional focus at Saira Health Care is the assessment and management of sexual disorders and infertility.

My qualifications and training include:

BUMS – Hamdard University, Delhi

MD

CGO

Certificate in Infertility – MGBIMS, Delhi

Certificate in Urology – London, UK

Masters in Male Infertility – MasterHealthPro (HealthPro)

Integrated Sexual and Reproductive Health – ISRH, UNFPA

My clinical interest includes the interaction between:

- sexual function;
- male reproductive health;
- infertility;
- urological concerns;
- psychological factors;
- relationship health.

For me, a patient with a sexual problem should not be reduced to one organ or one laboratory value.

Saira Health Care's Contribution to Sexual Disorders & Infertility

One of our priorities at Saira Health Care is to make accurate sexual-health education available in language that ordinary patients can understand.



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Many people live with unnecessary anxiety because sexual health remains difficult to discuss openly.

Some believe they are sexually weak when they are healthy.

Some purchase medicine repeatedly without diagnosis.

Some compare themselves with pornography.

Some are frightened by misleading internet advertisements.

Some experience genuine sexual dysfunction but assume that it is simply “weakness.”

Our approach therefore emphasizes:

- confidential consultation;
- accurate sexual education;
- individualized assessment;
- differentiation between myth and disease;
- medical evaluation when necessary;
- responsible Unani integration;
- infertility assessment when indicated;
- couple communication;
- psychological referral where necessary.

My principle is:

Sexual medicine should reduce unnecessary fear—not create it.

Common Myths About Sexual Performance

Myth 1: A Healthy Man Must Always Have a Perfect Erection

Reality: Occasional erection variation can occur even in healthy men. Persistent difficulties should be assessed.

Myth 2: Good Sex Must Last a Very Long Time

Reality: There is no universal duration defining a satisfying sexual encounter. PE is assessed using control, latency, distress and relationship impact—not an arbitrary internet number.



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Myth 3: A Bigger Penis Always Gives Greater Satisfaction

Reality: Current evidence does not establish a simple direct relationship between penis size and partner sexual satisfaction.

Myth 4: Both Partners Must Orgasm Every Time

Reality: Orgasm frequency varies between people and situations. Satisfaction should not be reduced to a compulsory orgasm target.

Myth 5: Couples Must Have Sex a Certain Number of Times Each Week

Reality: Healthy sexual frequency varies greatly among couples.

Myth 6: Men Always Want Sex

Reality: Male desire also changes with physical health, psychological state, stress, relationships, hormones and medications.

Myth 7: Women Should Always Be Ready for Intercourse

Reality: Female desire and arousal vary considerably. Pressure is not treatment.

Myth 8: Failure on the Wedding Night Means Impotence

Reality: Performance anxiety and lack of sexual education can cause temporary erectile difficulties in newly married men.

Myth 9: Pornography Shows Normal Sex

Reality: Pornography is produced sexual media and may create unrealistic expectations regarding bodies, behaviour and sexual responses.

Myth 10: A Sexual Medicine Can Fix Every Problem

Reality: Some concerns require education, counselling, relationship work or psychological treatment rather than medication.



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Frequently Asked Questions

Is unrealistic sexual expectation a mental illness?

No. The term itself is not a psychiatric diagnosis.

However, unrealistic expectations may occur alongside anxiety, depression, body dysmorphic concerns, OCD-related thinking, sexual dysfunction or relationship problems.

Can unrealistic expectations actually cause erectile problems?

They can contribute.

Performance anxiety, cognitive distraction and fear of failure can interfere with sexual arousal. Medical causes of ED must still be evaluated.

How long should intercourse normally last?

There is no universal ideal duration that guarantees satisfaction.

Diagnosis of premature ejaculation involves more than time alone and includes control, distress and relationship impact.

What is the average penis size?

A recent large meta-analysis reported an average erect length around 13.8 cm and erect circumference around 11.9 cm, with variation across populations. These averages should not be treated as targets or standards of masculinity.

Does penis size decide whether a partner will be satisfied?

Current evidence is insufficient to support such a simple conclusion. Partner satisfaction depends upon many sexual, emotional and relationship factors.

Should my wife orgasm every time?

Not necessarily.

Female orgasm varies substantially between individuals and sexual situations.



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The appropriate focus is communication, pleasure and mutual satisfaction rather than compulsory performance.

Why does my wife sometimes not feel desire before sex?

Some individuals experience more responsive desire, in which sexual interest develops after affectionate or erotic engagement begins. This does not mean consent should be assumed or that low desire should never be evaluated.

How often should married couples have sex?

There is no universal medically required frequency.

The frequency that works for a couple depends upon both partners' health, desire, circumstances and satisfaction.

I lost my erection once. Do I have ED?

Not necessarily.

ED generally involves a persistent difficulty rather than one isolated episode. Recurrent difficulties should be medically assessed.

Can pornography affect my expectations?

Yes.

Sexually explicit media can create unrealistic ideas about body appearance, sexual responses and sexual behaviour.

Can counselling help?

Yes.

Depending upon the individual case, psychoeducation, CBT, mindfulness, psychosexual counselling and couple therapy can help address psychological and interpersonal contributors to sexual difficulties.

Can Unani medicine help?

The Unani system can contribute a supportive holistic approach through attention to diet, sleep, physical activity, rest, mental well-being and associated medical conditions.

However, unrealistic sexual expectations themselves usually require accurate sexual education and psychological or relationship interventions rather than relying upon herbal medicine alone.

Can the problem be completely corrected?

In many patients, expectations and associated anxiety improve significantly once misinformation is corrected and underlying sexual or relationship problems are appropriately treated.

The outcome depends upon the individual cause.

When Professional Help Is Recommended

Seek professional assessment when sexual expectations:

- produce severe anxiety;
- repeatedly cause erection problems;
- cause persistent ejaculation concerns;
- result in avoidance of intimacy;
- produce significant marital conflict;
- lead to repeated unnecessary medication;
- create obsessive penis-size concerns;
- result in pressure or coercion toward a partner;
- cause persistent sexual dissatisfaction;
- interfere with fertility-related intercourse;
- contribute to depression;
- become associated with severe body-image distress.

If severe depression, self-harm thoughts or ongoing abuse are present, appropriate mental-health or safety support should be sought promptly.

A Message From Dr. Nizamuddin Qasmi



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When a patient tells me:

“Doctor, I am not sexually normal,”

I do not immediately ask:

“Which medicine do you want?”

I ask:

“Why do you believe you are abnormal?”

Sometimes there is genuine erectile dysfunction.

Sometimes premature ejaculation.

Sometimes infertility.

Sometimes hormonal disease.

But sometimes the patient is physically healthy and is suffering because somebody taught him an unrealistic definition of masculinity.

A man may be measuring himself against pornography.

A woman may be comparing herself with an unrealistic beauty standard.

A newly married couple may think they must become sexually perfect on their first night.

Another couple may believe that both partners must want sex at exactly the same time.

These expectations can turn intimacy into examination.

When sexuality becomes an examination, anxiety increases.

When anxiety increases, natural sexual response can become more difficult.

This is why sexual medicine must treat more than the sexual organ.

We need to understand:

the patient's body,

the patient's mind,

the patient's relationship,

the patient's expectations,

and the information that shaped those expectations.

Final Perspective



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Unrealistic sexual expectations represent an important but frequently overlooked sexual-health concern.

They are not a standalone disease.

But they can produce very real consequences.

They may contribute to:

- anxiety;
- reduced confidence;
- erectile difficulty;
- subjective premature ejaculation;
- orgasm pressure;
- relationship dissatisfaction;
- avoidance of intimacy;
- marital conflict.

Modern sexual medicine increasingly emphasizes the importance of psychological expectations, cognitive distraction, relationship factors and patient beliefs alongside medical assessment.

WHO's broader concept of sexual health reminds us that sexual well-being involves physical, emotional, mental and social dimensions as well as respectful and safe relationships.

The Unani system can add a valuable supportive perspective through its traditional emphasis on:

- mental balance;
- sleep;
- diet;
- exercise;
- rest;
- overall health.

Official Unani guidance recognizes these lifestyle and psychological dimensions within the Asbab-e-Sitta Zarooriya framework.

At Saira Health Care, my approach is therefore:



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First understand the patient.

Then identify whether the problem is expectation, anxiety, relationship difficulty, physical disease—or a combination of these factors.

Then treat the actual cause.

My message to patients is simple:

Sex is not an examination.

You do not need a perfect body.

You do not need a perfect erection every second.

You do not need an artificial duration.

You do not need both partners to orgasm simultaneously.

You do not need to copy pornography.

What you need is accurate knowledge, mutual respect, communication, appropriate medical care when required, and the freedom to experience intimacy without constantly judging your performance.

When unrealistic expectations are replaced with accurate understanding, many patients discover that the sexual “weakness” they feared was not weakness at all.

It was pressure.

And pressure can be addressed.

Selected Scientific References

World Health Organization – Sexual Health. WHO describes sexual health as physical, emotional, mental and social well-being and emphasizes respectful, safe and pleasurable sexual relationships free from coercion.

Fifth International Consultation on Sexual Medicine, 2024/2025. Current recommendations emphasize biopsychosocial assessment, including psychological health, relationship conflict, cognitive factors, psychoeducation, CBT, mindfulness and couple therapy.

European Association of Urology Sexual and Reproductive Health Guidelines, 2026. Current guidance recognizes medical, psychological and relationship causes of sexual dysfunction and specifically recommends assessment of performance-related cognitive factors and patient expectations.



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EAU Guidance on Premature Ejaculation. Diagnosis requires consideration of ejaculation time, perceived control, distress and interpersonal impact. The guidance also distinguishes subjective PE from true pathological PE.

UNESCO International Technical Guidance on Sexuality Education. The guidance explicitly recognizes that sexually explicit media can create unrealistic expectations concerning sexual behaviour, sexual response and body appearance.

Penile Size Meta-analysis, 2025. Analysis of 33 studies and 36,883 men reported pooled penile measurements and demonstrated natural population variation.

Genital Body Image Review, 2025. Current evidence links negative genital self-image with poorer sexual and psychological well-being and identifies sociocultural influences including media representations.

Sexual Communication Meta-analysis. Analysis of 93 studies involving more than 38,000 individuals found positive relationships between sexual communication and sexual and relationship satisfaction.

Ministry of AYUSH / CCRUM – Unani Medicine. Official Unani literature describes the Asbab-e-Sitta Zarooriya and recognizes diet, activity and rest, sleep and wakefulness, and mental activity and peace as important components of the traditional health framework.

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Certificate in Urology – London, UK

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Medical Disclaimer



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This article is intended for patient education and general health information.

“Unrealistic sexual expectations” is not itself a formal medical diagnosis. Sexual concerns may involve physical, psychological, relationship, social or reproductive factors and should be assessed individually.

Erectile dysfunction, premature ejaculation, delayed ejaculation, low sexual desire, painful intercourse, orgasm difficulties and infertility may have medical causes and should not automatically be attributed to anxiety or expectations.

The Unani system may provide supportive lifestyle and general-health care where clinically appropriate, but there is no established Unani herbal medicine that by itself cures unrealistic sexual expectations. Psychological or relationship difficulties may require qualified counselling, psychotherapy, psychosexual therapy or other specialist care.

This article does not replace individual medical consultation, diagnosis or treatment.



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