Individuals in this situation need help and support to plan how and to whom they will disclose their status, and to find strategies for protecting others from infection. With a spouse or long term partner, suddenly refusing to have sex or requiring the use of condoms without explanation is unlikely to be effective, but disclosure of HIV status may lead to rejection, physical violence, and financial destitution. If word gets out into the community, perhaps through a sexual partner, individuals with HIV risk being ostracised, with their families taunted and their employment and entire existence under threat. Health professionals can advise and assist, but their patients, if fearful of prosecution, may be unwilling even to tell them if they are having difficulties avoiding unprotected sex.⁴

An estimated 20 000 people in the United Kingdom have HIV infection that is still undiagnosed.⁵ There is a clear disincentive to testing when prosecution relies on defendants knowing they are infected. Meanwhile, those who do take the test may not agree to their partners being notified for fear of legal repercussions, thereby jeopardising essential public health control efforts. In addition, the threat to the confidentiality of data posed by criminal investigations may deter participation (or honesty) in the sexual behaviour research which provides an essential evidence base for HIV prevention.

Doctors need guidance on whether the potential for criminal prosecutions changes their legal and ethical duty of confidentiality, and how to advise their HIV positive patients, who may become "victims" or "defendants" if a prosecution occurs. A briefing paper to inform clinicians is in preparation, a draft of which can be obtained from the British HIV Association.⁶

Research evidence on the public health impact of criminal prosecutions for reckless transmission of HIV is limited,⁷ and there is an urgent need for further research. Rates of uptake of HIV testing in groups at highest risk should be monitored to see whether criminalisation may be leading to reductions.

In the short term, there is the opportunity to respond to the Crown Prosecution Service consultation. The draft guidance includes advice on how to

apply the Code for Crown Prosecutors, which states that a prosecution will usually take place "unless there are public interest factors tending against prosecution which clearly outweigh those tending in favour." Putting aside the difficulties in attributing who infected whom, we would argue that, in the case of criminal prosecution for reckless transmission of HIV, the public interest is not best served by pursuing justice against the few at the expense of the health of the many.

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- 1 Crown Prosecution Service. *DRAFT policy for prosecuting cases involving sexual transmission of infections which cause grievous bodily harm*. London: Crown Prosecution Service, 2006. (Consultation closing date: 3 November 2006.) www.cps.gov.uk/news/consultations/sti_policy.html (accessed 11 Sep 2006).
- 2 Department of Health. *Better prevention, better services, better sexual health—The national strategy for sexual health and HIV*. London: DoH, 2001. www.dh.gov.uk/assetRoot/04/05/89/45/04058945.pdf (accessed 11 Sep 2006).
- 3 Donaldson L. *Health check on the state of public health: Annual report of the chief medical officer 2003*. London: Department of Health, 2004. <http://www.dh.gov.uk/assetRoot/04/08/68/11/04086811.pdf> (accessed 11 Sep 2006).
- 4 UK Coalition of People Living with HIV & AIDS. *Criminalisation of HIV transmission: Results of online and postal questionnaire survey*. London: UK Coalition of People Living with HIV & AIDS, 2005. www.ukcoalition.org/law/Criminalisation%20report.pdf (accessed 11 Sep 2006).
- 5 The UK Collaborative Group for HIV and STI Surveillance. *Mapping the issues. HIV and other sexually transmitted infections in the United Kingdom: 2005*. London: Health Protection Agency, 2005. www.hpa.org.uk/publications/2005/hiv_sti_2005/contents.htm (accessed 13 September 2006).
- 6 Anderson J, Chalmers J, Nelson M, Poulton M, Power L, Pozniak A, et al. *HIV transmission, the law and the work of the clinical team. A briefing paper*. Draft for consultation. British HIV Association, 2006. Available from www.bhiva.org (accessed 11 Sep 2006).
- 7 Dodds C, Weatherburn P, Hickson F, Keogh P, Nutland W. *Grievous harm? Use of the Offences Against the Person Act 1861 for sexual transmission of HIV*. London: Sigma Research, 2005. www.sigmaresearch.org.uk/downloads/report05b.pdf (accessed 11 Sep 2006).

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Commissioning health education in primary care

Primary care trusts must give all patients timely access to relevant, high quality health information

In the United Kingdom most people acknowledge personal responsibility for their own health,¹ and 87% say they have to be "really ill" to visit the doctor.² Yet most general practitioners who responded to a study in *Family Practice* said that they are often consulted about illnesses or symptoms that they consider to be minor.³ Meanwhile, people with chronic conditions that are treatable continue to present late to their general practitioners.⁴ How can we explain these apparent contradictions? Most general practitioners regularly provide education and information to patients, but the message and style of this information is often not optimal. A *Reader's Digest* survey in

2005 found that more than four fifths of the population rely on information from their general practitioners and over half use health leaflets from their surgery or pharmacy. Even so, market research conducted for the policy group Developing Patient Partnerships found that nearly three quarters of respondents would be less likely to visit their general practitioner if they had more information about managing common ailments.

A recent international study that compared data from Australia, Canada, New Zealand, United States, and Germany with the four UK nations, showed that British patients are the least likely to receive advice

from doctors on disease prevention and lifestyle changes.⁵ Oral advice alone may be inadequate. Reinforcing advice from general practitioners with written information can have a positive impact on patients' understanding and education.⁶ Furthermore, evidence supports the value of patient information delivered by computer, in print, or by video as long as both the design and content are evidence based, but a recent review found that the access to such communication tools varied greatly.⁷

Since 2004 health policy in the UK has encouraged people to understand the part they should play in looking after their own and others' health, as an important way to make efficient use of local services and improve self care and wellbeing. The English white paper *Our health, our care, our say* published in January this year is expected to result in more personalised care, with health professionals informing patients and enabling them to make choices about their health and care.

In a telephone survey of more than 300 primary care staff for Developing Patient Partnerships, four fifths of responders agreed that several initiatives and bodies will increase the need to give patients information about their health; these include the quality and outcomes framework (a UK-wide system linked to improved health outcomes that financially rewards general practices for treating patients effectively), practice based commissioning (by which general practitioners in England manage the NHS budget and commission local health services for their patient populations), and guidelines from the National Institute for Health and Clinical Excellence (NICE) (which provides national guidance for the NHS on the promotion of good health and the prevention and treatment of ill health). Who can best unite policy and practice on this issue? Can newly configured primary care trusts and practices meet the challenge to ensure that the public can make informed choices about their health and health care? Primary care trusts and practices need cost effective, well designed, and unbiased resources that give consistent messages, support central strategies, meet local needs, and are properly tested and evaluated. These resources must also overcome inequalities in access to information and meet the needs of people with low literacy who may speak little or no English, and who often do not make the most effective use of health care.

It is inefficient to expect individual practices to design and produce such resources and bear the cost, and this would raise many questions. Are workers in primary care competent to apply the evidence base concerning design and content of information for patients? Will they need their primary care trusts to produce or commission information resources on their behalf? And who would take on such a role in the restructured primary care trusts? Who will represent patients' perspectives and commission information on access to services as well as on health protection and wellbeing?

Primary care trusts and practices could meet these challenges by commissioning advice and resources, dependant on local need, from independent third party organisations that specialise in providing health information, and then by evaluating the impact of this on the public's health literacy and health behaviour. Indeed, 88% of health professionals surveyed for

Developing Patient Partnerships said they would welcome a single source of high quality, unbiased health information for their patients. An evaluation by the University of Keele of the usefulness to patients of a self care booklet *Better health at home and at work*, produced by Developing Patient Partnerships (www.dpp.org.uk) showed that most respondents found it helped them to recognise and treat common ailments and encouraged them to exercise more or to improve their diet. More than four fifths had used the booklet at least once and a similar proportion said they intended to keep it for future reference.

Some patients such as school age children and workers, especially working men who are often low users of health services, may be reached more easily outside the NHS. One such initiative is *Best Treatments* from the BMJ Publishing Group (www.besttreatments.co.uk). Making Sense of Health, a website funded by the Department of Health that aims to help school children take control of their health (www.makingsenseofhealth.org.uk) has had positive results.⁸ Similarly, Health at Work—a work based health education initiative from Developing Patient Partnerships (www.dpphealthatwork.org.uk)—has been welcomed by workers who said it encouraged them to improve their diet and lifestyle.

Will primary care organisations use this opportunity to commission the information that is needed or will the information be spontaneously produced, inefficient, incomplete, and unmonitored data provided by individual healthcare professionals and patients? If the second situation proves to be the case, the gaps in provision of information will probably affect those people who most need good information and know least about health, thus accentuating inequalities in their health status.

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- 1 Kings Fund. *Public attitudes to public health policy*. London: King's Fund, 2004. www.kingsfund.org.uk/resources/publications/public_attitudes.html (last accessed 29 Aug 2006).
- 2 Proprietary Association of Great Britain (PAGB)/Reader's Digest Report. *A picture of health*. 2005. www.pagb.co.uk/pagb/primarysections/marketinformation/otconsumerresearch.htm (last accessed 5 Sep 2006).
- 3 Morris CJ, Cantrill JA, Weiss MC. GPs' attitudes to minor ailments. *Fam Pract* 2001;18:581–5.
- 4 Department of Health. *Supporting people with long term conditions: an NHS health and social care model to support local innovation and integration*. London: DoH, 2005.
- 5 Coulter A. *Engaging patients in their healthcare—how is the UK doing relative to other countries?* Boston: Picker Institute, 2006.
- 6 McDonald VM, Gibson PG. Asthma self-management education. *Chronic Respir Dis* 2006;3:29–37.
- 7 Trevena LJ, Davey HM, Barratt A, Butow P, Caldwell PJ. A systematic review on communicating with patients about evidence. *Eval Clin Pract* 2006;12:13–23.
- 8 Murphy P. *Making sense of health at key stage 4: key findings and recommendations*. UK: Centre for Research in Education and Educational Technology, 2006. http://makingsenseofhealth.org.uk/default.asp?section=Default&chapter=news&chapsection=NEWS_004 (last accessed 5 Sep 2006).

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