Rethinking sexual health clinics

Trainees need integrated training programme

EDITOR,—Yvonne Stedman and Max Elstein are right to suggest that sexual health clinics should be provided under one roof.¹ Patients would get a better and distinctive service by an experienced, well trained, trusted doctor as opposed to the current situation in which services are provided by different professionals at various times, sometimes even leading to a conflict of information regarding sexual health matters. Providing sexual health care under one roof would enable the *Health of the Nation's* targets to be achieved with minimum cost to the government.

Studies have shown that, among female patients attending genitourinary medicine clinics, 37 of 356 were at risk of an unwanted pregnancy,² only 33 of 71 adolescent females used oral contraceptives,³ and 78 of 159 aged under 16 were not using any contraception.⁴ These figures clearly indicate the need for family planning and sexual health and genitourinary medicine services to be under one roof. In Australia and New Zealand all fellows of the Australasian College of Venereologists are trained in family planning. They provide an efficient and comprehensive sexual health and family planning service under the same roof.⁵

In my specialist practice in genitourinary medicine I offer contraceptive advice to my patients who require it, but do not prescribe as facilities are not readily available, except for emergency contraception. When I work as a part time family planning clinician elsewhere I refer patients to myself to be seen in the genitourinary medicine clinics when they have an acute genitourinary infection. The unwanted delay in treatment leads to avoidable morbidity.

It is now time to look more critically at this issue and effect relevant changes; an extensive service could be offered by the providers. It would be ideal if the Joint Committee on Higher Medical Training of the Royal College of Physicians integrated with the education and training committee of the Faculty of Family Planning and Reproductive Healthcare of the Royal College of Obstetricians and Gynaecologists to formulate a structured training programme in family planning and reproductive health care, to be made available to trainee specialists in genitourinary medicine. If this could be implemented a comprehensive sexual health service would be available in the NHS, ensuring better care.

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Advice to authors

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Family planning doctors should refer patients with sexually transmitted diseases to specialists

EDITOR,—Yvonne Stedman and Max Elstein's main argument for stating that sexual health clinics should be under one roof is that patients who present with genital infections to family planning clinics are not managed as well as they would be if they attended genitourinary clinics.¹ Consequently Stedman and Elstein believe that the two specialties of family planning and genitourinary medicine should come together, with medical and nursing staff being shared.

It is a pity the authors did not sound out genitourinary specialists before putting pen to paper. Their argument would be unacceptable to many genitourinary physicians, as it is to me (I work in the same hospital as Elstein). Most doctors working in family planning clinics do so on a sessional basis and frequently have no higher (college) medical qualification, while genitourinary physicians have a structured training programme of accreditation in the specialty and possess such a qualification. There would be little advantage in genitourinary physicians offering a service already provided by family planning clinics and general practitioners.

My advice to family planning doctors who find themselves with patients who they suspect might have a sexually transmitted disease is to refer them to the appropriate specialists rather than try to manage such patients themselves: they have little experience, few resources for microbiological investigations, no access to a health adviser to notify the patient's partner, and little skill.

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Primary and secondary sexual health services need a consistent philosophy

EDITOR,—Sexual health care integrates the promotion of sexual health with the provision of services for its maintenance. Thus it combines education on reducing risks and promoting health seeking behaviour with clinical care for contraception, abortion, sexually transmissible diseases, and the wide range of associated problems in one service. The need for integrated or holistic sexual health care is not a sudden, recent development but one that has been obvious to a minority of concerned doctors for at least a generation.

Having quoted a concise definition of sexual health,¹ Yvonne Stedman and Max Elstein elabo-

rate on the advantages of integrated care but slightly misconstrue my reference to suggest that it is "unlikely to be achievable for most health authorities."² Our local service innovations were entirely designed and led by providers,³ with education of purchasers proving an uphill struggle. Elsewhere these developments are likely to meet entrenched resistance from provider clinicians constrained either by their training background, time, and financial pressure or by competition between trusts. A consistent philosophy or clinical management between collaborating primary and secondary sexual health services seems to be the best option: a consensus should therefore be sought to accommodate the interests of those without the broad base of clinical training required for this work, without detriment to the care offered to patients.

In striking a balance between concentrating specialised care under one roof and improving access, we cannot ignore the widely differing transport logistics of large conurbations versus rural settings and the specific effect that this has on attendances by teenagers. In provincial towns, hospitals are becoming least accessible to those most in need. Convenient satellite sites in town centres, shared with existing contraception clinics, might help those sexually transmitted disease services that are based in hospitals that are hard to get to.

While the benefits for individual patients might seem obvious, the most important objection to expanded sexual health services is the fear that overall control of care for sexually transmitted diseases will suffer in the same way that quality of contraceptive care has diminished with increasing provision in general practice.⁴ New services must be audited carefully and run only by those with thorough training in both contraception and sexually transmitted diseases and with optimal diagnostic back up.

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Clinics may miss those in greatest need

EDITOR,—We agree with the main thrust of Yvonne Stedman and Max Elstein's editorial advocating more cohesive provision of sexual health services.¹ But have the authors taken too narrow a view of where and when patients present? There is no mention of the work of accident and emergency departments in this field.

Males who present to accident and emergency departments with problems of a sexual nature can usually be managed with either reassurance or referral for investigation in the relevant clinic, often at the triage stage. Women present a more difficult problem in two areas.

Firstly, our department receives a considerable number of requests for postcoital contraception. Other local departments do not provide this service; provision by family planning clinics and general practitioners is patchy and usually limited to working hours. During January this year 45 women were registered in our department for postcoital contraception. Levonorgestrel-ethinyl-oestradiol was prescribed to 43 of them after evaluation and discussion. The range of ages was 13 to 41 years (mode 16 (n=8), median 19, mean 21 (SD 6.4)). Of the 45, 19 attended on a Saturday, 12 on a Sunday, and five on a Bank Holiday Monday. Thus only nine presented in the working week.

It is of concern that five patients were under 16. None was accompanied by a parent, but all were adjudged sufficiently mature to be treated without parental consent and prescribed levonorgestrel-ethinyl-oestradiol. It is even more worrying to speculate how many of this group fail to attend their general practitioner or a family planning clinic for a follow up pregnancy test, contraceptive advice, and wider counselling. Critics of this approach should ask themselves what alternatives there are: dealing with a situation with a 30% chance of an unplanned teenage pregnancy surely comes into the category of emergency medicine.

Secondly, young adult women not uncommonly present to the accident and emergency department with abdominal pain. Urinary tract infections, pelvic inflammatory disease, normal or ectopic pregnancy, and even labour manifest in this way.

Our point is this: by sitting in their purpose built clinic and waiting for people to come to them are the sexual health specialists in danger of seeing those women most in need pass them by? Providing emergency treatment should be within the remit and capability of any accident and emergency department, and this should apply equally to matters of sexual health. But can the specialists reach out to these women whose attendance is definitely unplanned?

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Australia and New Zealand have taken the lead

EDITOR,—Yvonne Stedman and Max Elstein's editorial touches on an issue in which Australia and New Zealand have perhaps taken the lead—the development of broad based sexual health services.¹ Indeed, as well as providing services for sexually transmitted diseases and basic family planning under one roof—a common practice for state funded sexually transmitted disease clinics for over 20 years—the clinical staff increasingly receive training in such diverse topics as sexual and relationship counselling, sexual assault, sexual dysfunction, and promotion of sexual health.² As a minimum this promotes the identification of problems and efficient referral. Specialist counsellors on site can manage most of these broader problems, particularly if they give rise to a risk of sexually transmitted diseases or HIV infection. There has been no rivalry with our federally funded (and therefore separately located) family planning services, which have enthusiastically provided many of their clients' needs with regard to sexually transmitted diseases and other sexual health problems for the past decade. Cross referral is confined to problems requiring specialist assessment.

In recent years almost all of Australia's sexually transmitted disease clinics have changed to the title

"sexual health" clinics. This change reflects a population based approach to health. It also gives patients and staff permission to address a wider range of concerns regarding sexual health. A request for "morning after" contraception may be a more reliable indicator of risk of a sexually transmitted disease or HIV infection than a vaginal discharge. Helping a young gay man through the process of "coming out" provides an opportunity to ensure that his sexual career will be safe. Whatever patients' presentation, the prime objective is that they leave the service with the knowledge and means to reduce morbidity from sexually transmitted diseases and HIV infection within their sexual milieu. All patients are screened for bacterial sexually transmitted diseases, hepatitis B status, contraceptive cover, genital neoplasia, drug use, and other personal or cultural risk factors for acquiring sexually transmitted diseases or HIV infection, and most are counselled and tested for antibodies to HIV.² When appropriate the model has included full primary medical care for populations with particular need—for example, gay men, aboriginal people, drug injecting "street kids,"^{3,4} and sex workers.^{2,4,5} General practitioners ensure that they are an essential component of the network by managing most people with symptomatic sexually transmitted diseases or early HIV infection and by addressing the bulk of the population's contraceptive needs.

Australasian sexual health services see their roles as addressing gaps in services; providing specialist support; and functioning as a focus for training, research, and surveillance. Some services also provide clinical services and health promotion on an outreach basis.^{4,5}

The training of Australasian venereologists places less emphasis on training in internal medicine than that of their British counterparts. Australasian venereologists tend to focus on ambulatory care and leave most inpatient care of patients with HIV infection to immunologists and infectious disease physicians when they are available.

Though the model is still evolving, we believe that there is merit in reducing the fragmentation of individual patients' sexual health needs. Discussion has even begun on the notion of partially blending medical training and career structures through an integrated body of sexual health physicians while maintaining subspecialist skill.

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Most genitourinary physicians are trained in family planning

EDITOR,—Yvonne Stedman and Max Elstein seem not to appreciate that an integrated model of care for sexual health already exists.¹ One example is our department of sexual health in Bolton, where we have an integrated and comprehensive range

of care. This includes a genitourinary medicine service; family planning; a sexual dysfunction clinic; primary, secondary, and tertiary intervention in screening for cervical cancer; a specialised vulval clinic; and a full range of HIV services. This allows quick cross reference within the department when necessary, and all patients attending have full access to the department's facilities, which avoids duplication of services.

The authors rightly point out that much overlap exists between many medical specialties, including family planning, genitourinary medicine, and gynaecology. Colposcopy services are another area of sexual health that may be included. Many genitourinary physicians have had formal training in family planning, and many are members of the Royal College of Obstetricians and Gynaecologists. In a telephone survey of 60 trainees in genitourinary medicine in Britain 47 had had training in family planning that was recognised by the Faculty of Family Planning. Of the 34 senior registrars and 26 registrars questioned, 30 (88%) and 17 (65%) respectively had had training. This trend is encouraging, with nearly all physicians having had training by the time they became senior registrars.

We agree that the future lies in a more comprehensive sexual health service for patients, and much can be learnt from countries with such a service.² The specialty of genitourinary medicine is ideally placed in terms of flexibility, availability, and trained medical staff to provide this. From our experience, this model of care is highly efficient and comprehensive and provides an excellent service for patients in a seamless way.

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Patients prefer clinics to have non-descriptive titles

EDITOR,—Yvonne Stedman and Max Elstein suggest that genitourinary medicine and family planning services should work closely together in an attempt to provide a comprehensive sexual health service for patients.¹ Many genitourinary medicine clinics have for some time appreciated the need for sexual health care and provide skill in colposcopy, psychosocial medicine, and genital dermatology in addition to prescribing or offering advice on contraception. Although the days of the old style "venereal disease clinic" are gone, the associated stigma remains. The change of name from venereology to genitourinary medicine has helped to emphasise the wider remit of the specialty, which in turn will aid the process of reducing the stigmatisation. The use of the term sexual health clinic might, however, reverse this trend.

To establish which title is preferred by people attending clinics, 150 patients were asked to complete an anonymous questionnaire asking what name they would like to see on signs in the hospital that lead to our clinic. Eight titles were proposed, including our current name (clinic 1A—genito-medical clinic), and more than one title could be chosen. Clinic 1A was chosen by 98 subjects, a "name" (for example, Lydia clinic) by 35, department of GU medicine by 23, department of genitourinary medicine by 20, department of sexual health by 20, GU medicine clinic by 17, sexual health clinic by 17, and genitomedical clinic by 12.

Our patients seem to prefer a non-descriptive