which a patient can reasonably be thought to have a continued interest."[5] The level of treament will depend on the result of clinical assessment by the physician and discussion with the patient's family or other decision makers. The place of high technology treatments (mechanical ventilation, dialysis, cardiopulmonary resuscitation) and routine drugs (such as antibiotics) or other treatments such as supplementary oxygen can be determined only in the context of the individual case.[2,3]

The BMA has recommended that "if it is apparent at the end of a twelve month period of insentience due to persistent vegetative state that the patient's condition is irreversible doctors will consider whether it is in the patient's best interest to continue with treatment to prolong life."[7] The findings of the American Multi-Society Task Force challenge these recommendations by suggesting that a persistent vegetative state is almost always permanent at three months if the cause was a non-traumatic cerebral insult. Although the evidence is strong, experience (particularly in the subgroups) is not yet still adequate to recommend a change in the British recommendations—but these are currently under review by a working party established by the royal colleges.

Both the medical and the legal authorities have advised that in some circumstances when the patient's condition is irreversible withdrawal of life sustaining treatment, including tube feeding, may be legitimate and ethically acceptable.[12] Such a decision requires independent evaluation of the diagnosis and prognosis, the likely benefits or burdens of treatment, the patient's views if known, and the views of the people close to the patient. In Britain the decision to withdraw artificial nutrition from a patient in a persistent vegetative state requires consultation with the courts.

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Rethinking sexual health clinics

Providing them under one roof would be an improvement

HIV, AIDS, and sexual health make up one of five key areas identified in the *Health of the Nation*.[1] The objectives for this area are to reduce the incidence of HIV infection and other sexually transmitted diseases and the number of unwanted pregnancies. Sexual health has been defined by Greenhouse as, "the enjoyment of sexual activity of one's choice without suffering or causing physical or mental harm."[2]

In Britain, as in many other countries, the provision of sexual health care has often been fragmented and isolated and has sometimes been incomplete, being split among family planning, general practice, genitourinary medicine, and gynaecology. The cause of this fragmentation is that sexual health covers many different areas, including contraception, sexually transmitted diseases, infertility, termination of pregnancy, menopausal symptoms, and psychosexual difficulties. Consequently men and women present to many different specialties according to their problem. A woman presenting to her family planning doctor or general practitioner with a vaginal discharge may be screened for vaginal infections but not always for cervical infections if facilities are limited. If a sexually transmitted infection such as genital warts is detected, and treatment given, facilities may not exist to screen for other sexually transmitted infections, and family planning clinics and general practices are unlikely to have the resources for tracing contacts.

Patients with sexual health problems are most likely to present to doctors in family planning and genitourinary medicine. These two specialties provide contraception and diagnose and treat sexually transmitted diseases. Family planning and genitourinary medicine were started separately and have continued to develop independently. The staff in the two specialties, therefore, have different training, skills, and career structures. This difference in the evolution of and emphasis in the provision of services may result in incomplete investigation and treatment of patients. For example, a study of women attending family planning clinics in the north west of England found that only 60% of clinics could screen for chlamydia, 35% for gonorrhoea, and 4% for herpes simplex virus. Fewer than one in 10 clinics could prescribe treatments. Although 78% of respondents believed that trichomoniasis was a sexually transmitted infection, only half of these respondents would refer patients with this disease to a genitourinary medicine clinic.[3] A comprehensive service is needed to provide non-judgmental and sensitive management for patients with sexual health problems. As well as treating the patients' presenting problem, such management may involve discussion of their sexual history and follow up of their partners, which should be an integral part of all sexual health care.

The specialties of family planning and genitourinary medicine are both concerned with preventing adverse consequences of sexual intercourse—specifically, unintended pregnancies and genital infections. Unfortunately, the most effective methods of contraception offer little, if any, protection against sexually transmitted diseases, and some contraceptive methods may even increase the risk that a sexually transmitted disease will be acquired from an infected partner. Conversely, the contraceptive methods that are most effective at preventing the spread of sexually transmitted diseases are less effective as contraceptives. Cates *et al* discuss the similarities and differences between genitourinary

medicine and family planning and the impact of sexually transmitted diseases on the provision of contraceptives in the specialties.[4,5] Until recently family planning clinics focused on providing a service that enabled men and women to prevent or to plan pregnancies. The problem of genital infections was seen as secondary. In genitourinary medicine, however, the emphasis has been on diagnosing and treating sexually transmitted diseases in both the patient and his or her partners; contraception has been regarded only as a means of preventing sexually transmitted diseases.

More recently the emergence of HIV has sharply focused attention on the need for an effective contraceptive method that protects against both infection and pregnancy. Although the public has been made increasingly aware of sexually transmitted diseases and their prevention, there is concern that a move to a barrier method is a move to a less reliable contraceptive. The "double Dutch" method—using a condom and an oral contraceptive—is the only effective protection against both pregnancy and sexually transmitted diseases.[6] If a barrier method is used alone men and women must be made aware of postcoital contraception.

Sexually active women and men need to be given straightforward, factual information about the risks of sexual activity and the opportunity to discuss such matters in an appropriate environment. This process should start in schools as part of the personal, social, and health education curriculum. Professionals working in reproductive health care should participate in such programmes.

Although providing all sexual health services under one roof may be the ideal, it is unlikely to be achievable for most health authorities.[2] Collaboration by those who deliver sexual health care may be another way of providing people with appropriate care and treatment. A coordinated sexual health service in both family planning and genitourinary medicine is urgently needed—especially as those at most risk of genital infection and unintended pregnancy are aged under 25.

Collaboration between these two specialties could be achieved without undue cost and organisational complexity. The sharing of nursing and medical staff ensures that staff disseminate their knowledge and training. All family planning clinics should have facilities to screen for vaginal and cervical infections and an agreed protocol for referring patients to genitourinary medicine. Feedback, including to the general practitioner when confidentiality allows, would ensure continuing collaboration. Similarly, family planning services should be made available to people attending genitourinary medicine clinics. Continuing medical education for all staff, with combined meetings, would ensure a coordinated approach to the sexual health care of patients seen in the two departments. Patients would then be referred to a service in which nursing and medical staff had knowledge of, and confidence in, both settings.

Such a model of coordinated and integrated health care seems a sensible target for other specialties that deal with sexual health problems. All doctors and nurses faced with patients with sexual health problems should know their limitations and refer patients when necessary.

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Learning medicine in the community

Learners should be where the patients are

See pp 369, 407

"Medical Education is a reflection of medical practice; it is not the education that will change the practitioners, but reformed practice that will redesign medical education."[1] George Silver, professor of epidemiology and public health at Yale, wrote in 1983, reflecting on repeated and ineffective attempts over the years to improve medical care through education. We are now undergoing just such a reformation in the delivery of health care. Patients in hospital are likely to be very sick indeed or admitted briefly for minimally invasive surgery or investigation. Much of the natural course of those chronic disorders that put the greatest burden on our society can now be best observed outside hospital. Students based in the community can follow up patients over longer periods than before and, by accompanying these patients when they go into hospital, can see secondary care in an appropriate context.

The General Medical Council recently recommended that medical students should gain more experience in outpatient clinics, general practice, and community health services.[2] Pioneering steps have already been taken by King's medical firm in the community,[3] the Cambridge community based clinical course,[4] and the preregistration house officer rotation in general practice organised by Lisson Grove Health Centre and St Mary's Hospital in London.[5] This week's journal contains accounts of how the Cambridge approach provided Mandy Wharton with "a rich environment in which to anchor . . . teaching of disease, health, and clinical skills" (p 407)[4] and how house officers in general practice gain insight into primary care services and receive substantially more teaching and clinical time than hospital colleagues (p 369).[6] If these initiatives are so satisfactory why is the move to community based learning of medicine so slow? This problem and suggested solutions are explored in *Widening the Horizons of Medical Education*, recently published by the King's Fund.[3]

In the report researchers from King's College, London, explore the implications of transferring a substantial amount of undergraduate medical education into the community. They advocate managing educational change by consultation, and describe how they carried out this consultation in and around King's College Hospital. They report the views of patients, general practitioners, students, and other interested parties. Patients and carers wanted to participate in the teaching of medical students; and general practitioners were also enthusiastic but saw the need for protected time, training, and support; students were initially anxious about potential