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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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 elaborate 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.