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-ethinyloestradiol 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-ethinyloestradiol. 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?

M Q CHOYCE
Senior registrar
A K MAITRA
Consultant in charge

Accident and Emergency department,
Royal Victoria Infirmary,
Newcastle upon Tyne NE1 4LP

1 Stedman Y, Elstein M. Rethinking sexual health clinics. *BMJ* 1995;310:342-3. (11 February.)

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[2]—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.[3] 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,"[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.

BASIL DONOVAN
Director
GRAHAM NEILSEN
Staff specialist
ADRIAN MINDEL
Professor

Sydney Sexual Health Centre and
Academic Unit of Sexual Health Medicine,
Sydney Hospital,
Sydney,
Australia

1 Stedman Y, Elstein M. Rethinking sexual health clinics. *BMJ* 1995;310:342-3. (11 February.)
2 Stirland A. Family planning up a GUM tree. The integration of family planning and genitourinary medicine services in Australia and New Zealand. *Br J Fam Plann* 1995;20:132-6.
3 Mulhall BP, Anderson B, Venables S, Donovan B. STDs in Australia—a decade of change. Part 2. The development of a broader sexual health model. *Ann Acad Med Singapore* (in press).
4 Van Beek I. A health service for sex workers. In: Perkins R, Prestage G, Sharp R, Lovejoy F, eds. *Sex work and sex workers in Australia*. Sydney: UNSW Press, 1994:279-91.
5 Brockett L, Murray A. Thai workers in Sydney. In: Perkins R, Prestage G, Sharp R, Lovejoy F, eds. *Sex work and sex workers in Australia*. Sydney: UNSW Press, 1994:191-202.

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.

DAVID NUNNS
Lecturer
D MANDAL
Consultant in genitourinary medicine

Department of Genitourinary Medicine,
Bolton Hospitals NHS Trust,
Bolton BL4 0JR

1 Stedman Y, Elstein M. Rethinking sexual health clinics. *BMJ* 1995;310:342-3. (11 February.)
2 Stirland A. Family planning up a GUM tree. The integration of family planning and genitourinary services in Australia and New Zealand. *Br J Fam Plann* 1995;20:132-6.

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, psychosexual 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—genitomedical 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