All letters are subject to editing and may be shortened. Letters should be sent to the *BJGP* office by e-mail in the first instance, addressed to **journal@rcgp.org.uk** (please include your postal address). Alternatively, they may be sent by post (please use double spacing and, if possible, include a MS Word or plain text version on an IBM PC-formatted disk). We regret that we cannot notify authors regarding publication.

Eliciting patients' concerns

McLean and Armstrong conclude that eliciting patient concerns in the consultation resulted in longer consultations.[1] The results section did not include these results in detail but states 'Intervention consultations were on average 1 minute longer than controls, that is 11.0 minutes versus 10.0 minutes, although this difference did not reach statistical significance'.

Why bother to test for statistical significance if it is ignored in this way? Surely the correct conclusion is that there was no difference between the groups in the length of consultations, and that the benefits described came at no extra cost.

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1. McLean M, Armstrong D. Eliciting patients' concerns: a randomised controlled trial of different approaches by the doctor. *Br J Gen Pract* 2004, **54:** 663-666.

My experience of the patient-centred approach has led me to conclude that it is of the most importance at the beginning of consultations, although it should be embedded in the whole consultation process. Therefore, I find it strange to read of a method that involves switching some patients to a patient-centred approach in the second half of the consultation.[1] I believe this was also the method used by Savage and Armstrong in 1990.[2] Did the patients find it a strange experience to have this apparent change in the second half of the consultation and were the participating GPs normally doctor-centred in style? The authors do not comment on whether this was apparent on the videotapes from the 14 consultations that were made for validation purposes.

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1. McLean M, Armstrong D. Eliciting patients' concerns: a randomised controlled trial of different approaches by the doctor. *Br J Gen Pract* 2004, **54:** 663-666.
2. Savage R, Armstrong D. Effect of general practitioner's consultation style on patients' satisfaction: a controlled study. *BMJ* 1990; **301:** 968-970.

I read this paper by Maclean and Armstrong[1] with keen interest. Indeed, my Registrar Day Release Group chose this paper for further study this week. This original work raised important issues, questioning the place of patient-centredness on our agenda as educators in general practice. What if our concern to know our patients' concern is indeed misplaced? Has all the time I have spent over these past 15 years eliciting patient concerns been vain hope and glory?

The authors recognise the limitations of their work, and specifically question the sample size and the possibility that further benefits may be proven by a larger study. However, they assert that the 'increased cost in terms of consulting time seems intuitively right'. It is this assertion that is at odds with the results of the study itself wherein they conclude that there was, in fact, no statistically significant difference between consultation times in the two arms of this trial. How can the authors proceed to question the importance of patient-centredness based on this false premise?

Freeman *et al*, rightly reflects the shortcomings of this paper in his editorial, although he does gives credit to the authors for having helped prove the importance of seeking patients' concerns in terms of patient satisfaction.[2] I trust this paper stimulates healthy debate, but we would do well to question our intuition — especially when the facts question our misconceptions.

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1. McLean M, Armstrong D. Eliciting patients' concerns: a randomised controlled trial of different approaches by the doctor. *Br J Gen Pract* 2004, **54:** 663-666.
2. Freeman G, Car J, Hill A. The journey towards patient-centredness. *Br J Gen Pract* 2004; **54:** 651-652

Authors' response

We apologise for any lack of clarity in our implication that the extra minute, on average, taken to elicit patients' concerns was statistically significant. For reasons that we described, the study did not recruit sufficient patients to provide clear answers to all our questions. Even so, the regression analysis showed that the extra time contributed almost as much as elicitation to the already small effect on satisfaction with professional care. We then conflated these observations into the claim that elicitation takes time — for which we have, admittedly, only suggestive results.

We still, however, think it feels intuitively right that enquiring after patients' views in a consultation for a self-limiting condition will add to consultation length. If elicitation does not take extra time, then we concede that

the small gain in satisfaction with professional care could be worthwhile; if it does lengthen consultation, however, then that cost must be set against the limited gains. We were unable to explore this trade-off further given the problems with statistical power, but these are surely important questions, namely: does eliciting the patient's concerns lengthen the consultation and, if so, is this cost worth the benefit in terms of patient satisfaction?

The use of the prompt as the intervention in this study was not an invitation to switch from one style to another. In consultations designated as controls, the doctors were instructed to 'continue as usual' in whichever style he/she chose. In those randomised to the intervention, it is true that it is possible that the doctor may have been behaving in a very doctor-centred way other than when using the prompt, and this would have seemed incongruous. Our validation process was not designed to examine this possibility and it would have required a much more complex study design to explore properly.

Despite these weaknesses, we still think that a debate about elicitation activity (which, in fact, we both practice and teach) would not go amiss. There is conflicting evidence of the benefits of a patient-centred approach and, where its prevalence has been measured, active elicitation of patients' concerns is fairly infrequent. Have we been somewhat premature to promote it to the extent that it has become a criterion of merit standard in the MRCGP video examination?

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GPs and education for sexual health

We were interested to read Damian Conway's letter in October's issue of the *BJGP*.[1] We believe he goes straight to the heart of the problem: that until primary care is fully involved in sexual health care, this particular health crisis will not be solved. He also points out that adding together the DRCOG, DFFP, and Dip GUM does not total a complete education for practising sexual health in the primary care context. However, we would like to reassure him that all in the UK is not as bleak as it seems.

In Birmingham we now have a long track record in GP and practice nurse education in sexual health. The long-established Sexual Health in Practice (SHIP) scheme links primary care-centred education with resources (including condoms and pregnancy testing kits) for participating practices. The full range of SHIP training covers 'minimum-level' knowledge in sexually transmitted infections (STIs), sexual-history taking, HIV, confidentiality, and young people. It is shortly to add a contraception unit for nurses.

Currently 132 practices in Birmingham (60% of all Birmingham practices) are part of the SHIP scheme. Of the SHIP practices, 93% have completed the entry-level training; 7% have joined the scheme too recently to have achieved this. We have evidence that, 3 months after SHIP training, practice nurses express greater confidence in their ability to take a sexual history compared with confidence levels measured prior to training. They are also less likely to believe that there is insufficient time to take sexual histories. Lab audits indicate that SHIP practices appear to be increasing their chlamydia testing rates faster than other practices, and appeared (in the days of chlamydia culture) to have a better isolation rate.

As a result of the experience gained in education in this field, the West Midlands Deanery commissioned a Post Graduate Award in Sexual Health in Primary Care for GPs and practice nurses. This Warwick University accredited course encompasses STIs, cervical screening (to NHS cervical screening programme standards), sexual history-taking, and contraception. It also includes a 'foundation' unit, which gives an overview of policy, epidemiological, ethical, and legal aspects of sexual health as they relate to primary care.

The course strives to 're-integrate' the topic of sexual health, using an approach that encourages practitioners to always seek to consider the different aspects of sexual health. More information can be found at www.warwick.ac.uk/go/pgasexualhealth.

We have also had experience with a 6-month GP registrar extension post that encompassed a practice with extensive experience of sexual health care, a Brook clinic for young people, and a genitourinary medicine (GUM) clinic. However, there has been considerable pressure on funding in GP postgraduate education and we have not been able to expand this as we wished.

We have found — as Dr Conway suspects — that practices are prepared to change their approach to sexual health if the education they have is highly relevant, stimulating, and enabling. We hope we might lure him back to the UK to join us!

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1. Conway D. Train GPs to provide good sexual health care. *Br J Gen Pract* 2004; **54:** 784.

Antibiotic prescribing in primary care

I read the recent work of Graffelman *et al*[1] and a letter by Damoiseaux[2] with great interest. They discuss community antibiotic use, with options for reducing prescribing safely.

Are primary care clinicians susceptible to altered prescribing because of attitudes on certain days of the week? This consideration emerged