

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 pri-

mary 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 post-graduate 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 Damoiseaux² 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