

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?

MALCOLM MCLEAN

General Practitioner
Henfield Medical Centre, Deer Park,
Henfield BN5 9JQ. E-mail: malcolm.
mclean@gp-h82060.nhs.uk

DAVID ARMSTRONG

Reader in Sociology as applied to
Medicine, King's College London.

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!

PHILIPPA MATTHEWS

Former Programme Director for Sexual Health, West Midlands Deanery GP Unit, Edgbaston.
E-mail: philippa.matthews@pmde.org

JUDITH MULLINEUX

SHIP Coordinator
Sexual Health Promotion, Heart of Birmingham Teaching Primary Care Trust, Edgbaston.

ALYSON QUINN

Academic Director PGA Sexual Health in Primary Care, University of Warwick.

STEPHEN KELLY

Director of Post Graduate General Practice Education
West Midlands Deanery, Edgbaston.

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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

after discussion with colleagues; the conclusion being Friday afternoons would be the period for low-threshold prescribing. Reasons behind this include the fact that patients seen on Fridays have the weekend to potentially become even more unwell;³ making it appropriate to prescribe before the weekend. There is also the idea that some physicians prescribe on Fridays so their patients will not make use of other doctors or walk-in centres over the weekend.⁴

Another reason given interested me greatly: would doctors give less thought and prescribe more simply because it was Friday? After all, not giving antibiotics involves a greater investment of physician time.⁵ The temptation is there: even as a pre-registration house officer, I have felt frustration when patients arrive late at the end of a week. Would this and the fact that it's Friday affect our prescribing?

During my time at Selsdon Park Medical Practice (a five-partner surgery in South London) Egton Medical Information Systems (EMIS) searches that were performed achieved numbers of patients seen per day, then detected how many of these were prescribed antibiotics.

From 4 January–24 April 2004, the practice saw 12 144 patients with 20 342 total entries. Thus, on average, a patient has 1.675 complaints. Antibiotic prescriptions totalled 1533. Averaged results for prescribing rates of each day are:

Day	Mean (%)	<i>n</i>	SD (%)
Mon	15.06	15	2.65
Tue	10.84	16	3.29
Wed	12.52	16	2.63
Thu	10.98	16	2.86
Fri	12.31	15	1.95

Total mean for all days of the week: 12.0%; ANOVA between groups: *P*-value 0.0003 (<0.001).

Of note, is that Friday results show no difference compared with those from Tuesdays, Wednesdays, or Thursdays. Analysing the variance between average rates for individual days over this period shows a significant difference (*P* = 0.0003) between each group of averaged days, with Monday being significantly higher.

An explanation for this is perhaps that patients have brewed illnesses over the weekend — due to the comparative decrease in doctors over this time, plus the concept of 'waiting to see how I feel', resulting in a potential worsening of symptoms.

The interest lies in the fact that Friday prescribing rates are no different to the remaining days of the week. Does that mean we do not let 'Friday afternoon moods' affect us, even though we are aware of them?

YESTIN CHONG

Senior House Officer,
GP Vocational Training Scheme,
Kingston and Roehampton.
E-mail: yestin@blueyonder.co.uk

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RCGP's position on the Assisted Dying Bill

I was rather taken aback to be asked why the RCGP had dropped its opposition to the Assisted Dying Bill, and had to admit that I didn't even realise this decision had been taken, let alone why. Were members consulted? I certainly wasn't, and don't recall any discussion of the issue in the *BJGP*.

Scanning the internet revealed much interesting correspondence, including an excellent submission by the National Council for Hospice and Specialist Palliative Care Services,¹ which I would recommend to anyone with an interest in the debate.

The RCGP's press release² — intended to 'clarify the RCGP's position' explains that a neutral position should not be interpreted as support for the Bill. I would argue that if you are not

against it, you therefore must be for it. What if the College suddenly decided to take a neutral stance on smoking in public places? No longer being against it, you would by default now be for it.

The press release also suggests that it is not the College's role to 'support or oppose' the Bill: 'This decision is a matter for society as a whole and its law makers.' If that is the view of the College on a very serious ethical (not to mention practical) dilemma for its members, it certainly has no business getting involved in a public health issue, such as smoking in public, which has no direct bearing on its members' working lives.

I believe it is precisely the role of the College to take up a strong position on this matter and advise the government accordingly. Failure to do so is a shocking act of moral cowardice and an abject betrayal of its members.

DR DOMINIC HORNE

Locality Clinical Lead
Huntly Health Centre, Bleachfield
Street, Huntly AB54 8EX.
E-mail: dominic.horne@huntly.grampian.scot.nhs.uk

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Editor's note

Following discussion at the meeting of UK Council on 13 November, it's clear that this is a matter of individual conscience, however, after thorough audit of the draft Bill the RCGP confirmed that it has NOT changed its position of deliberate neutrality. This matter will be further debated at the February Council Meeting.

Flexibility for special clinical and non-clinical interests

We need flexible training and career development schemes in order to be flexible in our work. It's better to get people into the right job, balancing their careers with other aspects of their lives