Letters

All letters are subject to editing and may be shortened. General letters can be sent to **bjgpdisc@rcgp.org.uk** (please include your postal address for publication), and letters responding directly to *BJGP* articles can be submitted online via **eLetters**. We regret we cannot notify authors regarding publication.
For submission instructions visit: **bjgp.org/letters**

Safer chemsex: consideration of *Shigella*

We would like to follow up the recent editorial entitled 'Safer "chemsex"' by Ma and Perera[1] by including sexually transmissible enteric infections (STEI) among the pathogens whose transmission may be associated with chemsex. *Shigella*, which causes a range of gastrointestinal symptoms in humans,[2] is the primary example here, although verocytotoxin-producing *Escherichia coli* has also been described.[3] Until recently, *Shigella* infections in England were primarily associated with travel to endemic areas. However, in the past decade, a *Shigella* epidemic has been documented in men who have not travelled, thought due to faecal–oral transmission during sex, in men who have sex with men (MSM).[4] Chemsex may influence willingness to engage in sexual practices that increase the risk of faecal–oral transmission.[5]

Gilbart and colleagues[5] reported an investigation into a *Shigella* case series in adult males between 2012 and 2013. Of 42 patients interviewed, 34 were MSM, many of whom were HIV positive, and who reported multi-partner condomless sex at sex parties and chemsex. Importantly, more than half first presented to their GP, emphasising the importance of increasing understanding about this epidemic both within and outside of specialised sexual health clinics.

In the event of a diagnosis of *Shigella* and no recent travel to an endemic area, we recommend sensitively ascertaining a sexual history from men, particularly in London, Brighton, and Manchester, where we know *Shigella* transmission is high among MSM. If a patient with *Shigella* reports same-sex partners, this should prompt discussion of referral to sexual health services as these patients are likely to be at risk of STIs and HIV co-infection. Providing information on avoidance of sex until a week after symptom cessation, on condom use, and on reducing risk of exposure through oral–anal contact is also important.[6] If the patient presents with infectious bloody diarrhoea there is a duty to notify the health protection team.[7]

Manpreet Bains,

GP Trainee & National Medical Director's Clinical Fellow, Public Health England. E-mail: manpreet.bains@phe.gov.uk

Paul Crook,

Consultant Field Epidemiologist, Field Epidemiology London.

Nigel Field,

Consultant Clinical Epidemiologist, Department of HIV and STIs, National Infection Service, Public Health England.

Gwenda Hughes,

Consultant Scientist (Epidemiology) and Head of STI Section, Department of HIV and STIs, National Infection Service, Public Health England.

REFERENCES

1. Ma R, Perera S. Safer 'chemsex': GPs' role in harm reduction for emerging forms of recreational drug use. *Br J Gen Pract* 2016, DOI: 10.3399/bjgp16X683029. http://bjgp.org/content/66/642/4.
2. Public Health England. Shigella: guidance, data and analysis. 2013. https://www.gov.uk/government/collections/shigella-guidance-data-and-analysis (accessed 2 Feb 2016).
3. Simms I, Gilbart VL, Byrne L, *et al.* Identification of verocytotoxin-producing *Escherichia coli* 0117:H7 in men who have sex with men, England, November 2013 to August 2014. *Euro Surveill* 2014; **19(43). pii:** 20946.
4. Simms I, Field N, Jenkins C, *et al.* Intensified shigellosis epidemic associated with sexual transmission in men who have sex with men — Shigella flexneri and S. sonnei in England, 2004 to end of February 2015. *Euro Surveill* 2015; **20(15). pii:** 21097.
5. Gilbart VL, Simms I, Jenkins C, *et al.* Sex, drugs and smart phone applications: findings from semistructured interviews with men who have sex with men diagnosed with *Shigella flexneri* 3a in England and Wales. *Sex Transm Infect* 2015; **91(8):** 598–602.
6. Public Health England. Shigella leaflet and poster. 2013. https://www.gov.uk/government/publications/shigella-leaflet-and-poster (accessed 2 Feb 2016).
7. Public Health England. Notifiable diseases and causative organisms: how to report. 2010. https://www.gov.uk/guidance/notifiable-diseases-and-causative-organisms-how-to-report#laboratories-report-notifiable-organisms-causative-agents (accessed 2 Feb 2016).

DOI: 10.3399/bjgp16X683929

Rhetoric and reality in person-centred care: introducing the House of Care framework

Many GPs have read NHS England transformation plans and met the 'primary care home' model. The recent article on the House of Care[1] promotes the model from a different perspective and suggests benefits from enhancing patient-centred care (PCC), professional exchange, and reducing care inequity. The irony of the imperative to revolutionise and address perceived deficiencies in delivering PCC in the name of patients' opportunity to take control is however awe-inspiring. By the authors' admission the PCC construct is immature and it 'probably leads to only small improvements in some indicators of physical health'. By contrast traditional GP care has high patient satisfaction and given the opportunity patients choose technical quality of care and relationship continuity over PCC.[2]

In an austere environment in which scant primary care resources are dwindling, attracting staff is becoming impossible, the demand for performativity (being seen to do rather than really do) escalating, and morale at a nadir, GPs are pragmatism experts. Inevitably, resilience in primary care is essential and at its core lies a moral compass.[3] My compass asserts that, although as a pragmatist I accept healthcare delivery must change, the process by which it is being done is paternalistic, inherently dishonest, and disempowers patients.

This economist-driven enterprise may coincidently improve professional exchange, care coordination, and variability in areas of high population density, but will have a devastating impact on our profession through placing structure and function ahead of people and values. Our local plan fails to define the key attributes of GPs, 50 years to define and 50 months to defile. On the ground, the gap between the expressed cooperative ideology and the rapid deconstruction of valued, effective resources is demoralising. All this and little evidence that patients have been consulted, empowered to contribute, or given alternatives to consider.