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Safer chemsex: consideration of *Shigella*

We would like to follow up the recent editorial entitled 'Safer "chemsex"' by Ma and Perera¹ 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 colleagues⁵ 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

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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 Care¹ 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 coincidentally 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.

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Substance misuse: institutionalised neglect in general practice

The suite of articles in the recent edition of the *BJGP* is well received and reminds us of the changing landscape of drug misuse.¹ Implicit in the descriptions and suggestions is the expectation that we, as medical generalists, should be aware of these medical problems and be in a position to offer help, guidance, and referral when necessary.

It should not need to be said that the majority of the problems that present to the NHS are related to opiates, particularly injecting opiates, and that the rising number of deaths are from overdose of opiates.

The other changing landscape is driven by the 2012 Health and Social Care Act in England and Wales, and by parallel changes in Scotland. These changes are unravelling the carefully constructed shared care between primary and secondary care by commissioning third-sector agencies at the expense of statutory NHS provision and, in a contracting economy, spending a larger proportion of available budgets on non-medical interventions. The spectre of outbreaks of blood-borne viruses or bacterial infections should remind us of the dangers of trivialising drug taking in the medical sector.

At a critical turning point in funding and policy we should be careful to recognise the importance of primary care and that this role needs to be integrated into policy and funding arrangements. It seems extraordinary that drug treatment is not a core responsibility and that, as an Enhanced Service contractual arrangement, it can be included or excluded from our day-to-day work. General Medical Council guidance advises and reminds us of our responsibility to all patients to, 'provide effective treatments based on the best available evidence'. National guidelines both from National Institute for Health and Care Excellence and the Departments of Health point to the essential place that GPs have in managing drug users.

It is unacceptable that management of drug users and their problems, prescribing methadone, buprenorphine, or other appropriate medication, and cooperating closely with secondary care and the third sector should not be a core service requirement. Any other group of patients would have spotted and alerted us to this institutional neglect, which is hard to understand, but must be based on prejudice, maybe ignorance and fear, and sadly a systematic reorganisation, which apparently doesn't care.

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Novel psychoactive substances

Gilani does well to highlight the increasing and concerning use of novel psychoactive substances (NPS) in the UK.¹ We have seen the damaging and unpredictable effects of synthetic cannabinoids in prisons and substance misuse services over the last 3 years.

The number of deaths attributable to NPS is increasing year on year and

prisoners are transferred to hospitals with tachyarrhythmia, dangerous hypertension, impaired consciousness, and seizures on an almost daily basis from some prisons. A number of deaths have been reported due to NPS abuse.

Worryingly, vulnerable prisoners are targeted and, anecdotally, individuals are bullied into smoking 'Spice' (as NPS are colloquially known) while bets are taken on how much can be smoked before the victim collapses.

It is to be hoped that the legislature can make suitable arrangements to criminalise the production, supply, and possession of these dangerous substances. But enforcement will have to be improved if such measures are to prove effective in reducing the harm created by NPS.

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