DEBATE

Debate

STI services in the United Kingdom: a way forward

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The crisis in our sexual health services has recently received wide publicity, firstly, with the publication of the National Strategy for Sexual Health and HIV¹ and, subsequently, with the report of the House of Commons Health Select Committee.²

The issue of how to cope with a seemingly impossible workload faces many clinics. Anecdotally, the solutions employed are many and varied (ranging from the use of a security guard to keep out the crowds to changes leading to a wide variety in clinical practice³). Some of the ideas raised by Bradbeer and Mears will already have been adopted by a number of clinics (including my own). Some are most certainly controversial. There is little hard evidence to inform this debate. The views that I express are based on over 20 years' experience of working full time in genitourinary medicine (GUM) clinics, both teaching and non-teaching, in and outside of London.

PRINCIPLES

Two main principles should allow us to decide which ideas to adopt for our own practice. Firstly, nothing that we alter should harm the health of individuals. Secondly, nothing that we alter should harm the public health. One important element underlying both of these principles is that in order to serve their function with respect to control of sexually transmitted infections (STIs), the public must regard clinics as places they are prepared to attend, which, in turn, requires that they provide a high quality of clinical care and high levels of patient satisfaction. Surveillance systems need to be amended, in the context of the new patterns of service delivery, to accurately record the incidence of STIs.

DIVERTING INAPPROPRIATE ATTENDERS

The work of GUM/sexual health clinics is, of course, much more varied than the sexually transmitted infections in the title of this debate. The workload measure (KC60 codes) showed that attendances for non-sexually transmitted problems at GUM clinics in the United Kingdom in 2000 included 65 398 women with vaginal candidosis and 59 835 women with bacterial vaginosis, 106 217 people with "other conditions requiring treatment," and 218 217 with "other conditions not requiring treatment." In total, this represented 39.5% of "all diagnoses and workload."⁴ A number of such patients do not need to attend a specialist hospital department. In addition, many patients with uncomplicated STIs could be managed in the community.

The National Strategy for Sexual Health and HIV has delineated three future levels of service delivery: level one—primary care; level two—intermediate; and level three—specialist practitioner.¹ Further gradations will be introduced by the development of various levels of "enhanced services" in primary care.

Any proposals to reform STI services must take account of the fact that self referring patients will sometimes be better advised to self treat or seek help elsewhere. Patients need to be advised as to what choices are available. This advice will be best given by telephone triage conducted by an experienced GUM nurse in association with a computer booking service that covers level two services in the vicinity. Many clinics already operate such triage but, as yet, lack the ability to book appointments for other services. The key requirement is clearly that some or all of the patients have to have appointments. This does not exclude holding "walk-in" sessions for patients who prefer not to make appointments. Offered the choice of walking in to wait in excess of 3 hours or being seen reasonably close to an appointment time, many patients will opt for the latter.

Workload will decrease for the clinic as patients are variously reassured, directed to self treatment, or directed to other services, and thus freeing level three to do a higher proportion of specialist work. A key requirement in setting up such alternative services is that less specialised services should be less expensive to run except where they offer particular advantages in accessibility to vulnerable patients. There is, however, a real danger that "enhanced services" located in general practice will provide a lower quality service—for example, no microscopy, less training, etc—at a higher cost than the GUM clinic. Nor is it acceptable to react to the lack of resources by compromising on quality and disguising this under the cloak of "modernisation."

THE ASYMPTOMATIC PATIENT

The history

Each of us is, I believe, aiming to produce the highest quality service while avoiding wasteful practices. With limited resources for health care our attitude is to produce the greatest good for the greatest number. Compromises are necessary and clinicians will have varied opinions on these. One thing which must not be compromised is the doctor–patient or nurse–patient relationship. The possibility of having a STI is fraught with stresses. Clinicians must, in a short space of time, build a relationship with patients based on trust. Only in such an atmosphere can

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Debate

unpalatable test results be discussed to best effect. The psychological impact is significant. It is mistaken to believe that the right trusting relationship can be built in the absence of full sexual history taking.

The examination

Similarly, what trust can an asymptomatic patient, presenting for a screen for STIs, place in a clinician who fails to conduct an examination for genital warts, allowing their patient's clinical condition to worsen, and perhaps to be passed on, with all the emotional and relationship consequences that may ensue? If medicolegal action followed, the clinician could presumably be deemed negligent. Failure to observe such basic elements of a clinician's practice is counterproductive to ensuring the emotional, physical, and mental wellbeing that goes to make up sexual health.

The tests

Details of which aspects of microscopy and other tests should or should not be routine must, I believe, become more closely defined in the clinical effectiveness guidelines⁵ of the British Association of Sexual Health and HIV, and by its special interest groups. The Bacterial Special Interest Group is currently holding a consultation process on this subject. Although some interclinic variation in practice may be dictated by local circumstances, it is inappropriate for each clinic to try to define for itself what best practice should be. If there are valid questions these need to be addressed by research or by nationally convened groups of experts feeding into the clinical effectiveness guidelines.

Microscopy

A small snapshot of practice in the Cambridge clinic provides an illustration (though not hard evidence) of how Mears and Bradbeer's proposal to stop microscopy in "asymptomatic" patients may be misguided. A nurse specialist's recent lists of self declared asymptomatic patients revealed, on microscopy, 33 with candida of whom 24 (72%) then revealed their symptoms and were treated, and 18 with bacterial vaginosis of whom 12 (66%) then revealed their symptoms and were treated (D Stiles, personal communication).

HIV tests

The test discussion can, in many cases, be dispensed with altogether in favour of a brief information sheet at the bottom of which the patient indicates whether or not they wish a test or whether they wish to have a discussion. The clinician must then ascertain whether the patient is at high risk. Anxious patients and most high risk patients should have a verbal discussion and be encouraged to attend in person for the result. Others will usually telephone.

Testing for syphilis

Epidemiologists will address this question with greater authority. However, I note that the diagnosis of the apparently asymptomatic index case in the Cambridgeshire outbreak of heterosexual syphilis was initially missed in the GUM

clinic because the patient declined testing.⁶ The same paper describes heterosexual syphilis mistaken initially for herpes. It is, I believe, unwise to restrict syphilis screening to "high risk groups." In 2000, 174 cases of early latent syphilis were diagnosed in heterosexuals in GUM clinics in the United Kingdom. To have missed these would inevitably have led to further onward transmission and higher rates of syphilis in pregnancy. Far better to maintain clinical standards and avoid a crisis a few years on.

THE SYMPTOMATIC PATIENT

The comments above on the importance of taking a sexual history and performing a relevant examination apply also to the symptomatic patient. One of the specialty specific standards for physicians in GUM is that "The physician shall ensure that a sexual history is obtained and documented in all persons presenting to a genitourinary medicine service with a new clinical problem."⁷

The details of tests should and, I believe, will be defined nationally by a consensus of expert opinion.

REDUCING THE NUMBER OF PATIENT VISITS

There might be scope for a reduction in follow up visits for some conditions—for example, 41% of clinics routinely ask patients treated for *Chlamydia trachomatis* infection to return for a follow up check³ despite the UK and European guidelines agreeing that microbiological follow up is not strictly necessary after treatment with doxycycline and azithromycin.^{8,9} However, both guidelines acknowledge the potential uses of follow up for health education, follow up of partner notification, and reassurance. It would seem sensible to reach a national consensus on the issue of follow up. In this case either 41% or 59% of us are presumably doing it wrong! The British Co-operative Clinical Group also found that 25% of clinics routinely performed two tests of cure for gonorrhoea, which may be judged unnecessary and expensive.^{3,10}

Bradbeer and Mears propose that patients who self treat their genital warts need not return if they are better. Twenty nine per cent of clinics already have this policy.³ Such discrepancies between national guidelines and practice indicate either a lack of knowledge of the guidelines¹¹ or a need for wider debate of the issues, or both.

GETTING THE WORKLOAD DONE BY SOMEONE ELSE

I fully support Bradbeer and Mears's suggestions on how each post can be used to the full. There should also be scope in the clinic to train general practitioners (GPs) for the various enhanced levels of primary care and for level two services. The latter, in particular, should continue to do some sessions at level three, this being the easiest way to ensure that a practitioner's practice remains of high quality and up to date. This system should also help to ensure that the same protocols are employed throughout the district, with appropriate referral between levels,

and good communication between clinicians ensuring that patients get optimal care.

The above recommendations concerning the importance of history and examination apply to levels one and two. However, it seems likely that reliable microscopy will not be available at level one. This will inevitably mean some loss of quality is sacrificed in favour of accessibility and patient choice. Provided molecular techniques are employed for detection of *C trachomatis* and gonorrhoea, this loss will be markedly outweighed by the increased proportion of STIs detected and treated. In the future, new developments in near patient testing based on molecular techniques may allow rapid diagnosis to take place in a community setting, even to the extent of predicting gonococcal sensitivity patterns.

Level two services should ideally be staffed by doctors who have trained in GUM to an agreed level of competency and supported by GUM nurses of suitable seniority. Reliable microscopy can then be provided ensuring a high quality service for both men and women. Both the doctor and the nurses would spend an appropriate proportion of their time at level three ensuring that they see sufficient pathology to maintain their skills. None of the above removes the necessity for more GUM trained staff.

CONCLUSION

The future of our clinical service should be based on traditional values of good communication, careful examination, and appropriate tests. An excellent review of possible ways to modernise GUM services has emerged from a working group on this issue.¹² Any changes that occur should not damage the good reputation of GUM clinics, which is vital to conquering the current epidemic of STIs. Change is needed in the traditional roles of doctors and nurses in GUM

clinics making full use of the potential of all clinicians working in the hospital or in the community. As far as possible any changes in practice need to be evidence based or, at the very least, properly evaluated following their introduction. While aiming for greater efficiency we must be careful not to compromise on quality. Guidelines on best practice should be decided nationally rather than by individual clinics.

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Debate

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