

FROM OUR CONSUMER CORRESPONDENT

Sexual health services

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Background

How do women view British National Health Service (NHS) sexual health services [e.g. general practitioner (GP) services, family planning clinics (FPCs), special clinics]? For this issue, I have collected feedback on what works and what doesn't. Not to look at the statistics, but to give a personal viewpoint backed by the views of 22 women from all over Britain. So, are we universally 'A grade' students? Or do we need to 'try harder'?

Doing well

I'm not alone in thinking this. My interviews revealed overwhelmingly strong support from all the women I spoke to. Phrases like "perfectly well satisfied ... going the right way ... women are being helped wonderfully well ... impressed by the professionalism I received!" And there were specific mentions of good practice: "My current doctor is a gem ... the family planning clinic offers a really warm, personal service".

In particular, some women compared the sexual health provision of today with the way things were 20 or more years ago – and noted a vast improvement. "Stinking of disinfectant with rows of school-type plastic chairs filled with internalised women (mostly), focusing on their feet ... I felt much as I imagine those coming to the end of a sentence on death row might feel – convinced I was infected with everything under the sun and going to die a slow, lingering death – irrational with hindsight but unbelievably terrifying at the time ... very different today".

Let's delve deeper, however. When we move from the general to the specific, how are we measuring up?

Time, place, money

First, the timing. Unsurprisingly, women complain about the appointments system and how difficult it is to get one: "I'm having to steel my nerves for the psychological battle needed to book my next smear test". There is particular concern about the time delay on investigations and procedures linked to more worrying conditions such as cervical and breast cancer. One woman reported having a lump in her breast and, after the GP had advised a mammogram, being sent an appointment in 6 months' time because services were so overstretched. Many women also commented on the lack of specialist clinics, particularly those linked with life stages such as menstruation and the menopause.

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Second, the place. Women don't seem too concerned about the setting in which sexual health services are delivered – though some did draw negative comparisons with the private sector when it comes to decor, facilities and, in particular, the "out-of-date magazines in surgery offices".

Third, the cost – and here, of course, the NHS scores. "I love the fact that I don't ever have to worry about being able to afford health care, as women do in other countries – it's great that I get my birth control for free."

However, not all women were as positive about the impact on facilities that this low-cost option involves. "I suffered from very low libido ... and was offered a block of six counselling sessions. At first I thought it seemed a lot, but before I knew it the sessions were finished and they could not offer me any more. Plus, the practice was only offering this service on a trial basis and that has now ceased. This type of service needs to be far more readily available."

Plus the very element of a 'free service' is a double-edged sword. While women are very grateful that the NHS is free, it nevertheless makes them see it as a low-value service. I have to admit that some women's eulogies of the NHS ended with statements suggesting that when things got tough, they switched tracks and used their parallel private insurance to get their needs met. The woman mentioned above eventually went privately for her mammogram and "had the investigations the following week". The woman with low libido is also considering a shift to the private sector. The bottom line is that whilst what the NHS offers may be top quality, it fails badly in terms of timing and quantity.

Diagnosis, exploration, treatment

The vast majority of women knew they had received accurate and effective health care. But there is also an underlying feeling that women don't quite trust health providers. First, they don't trust us to be honest about what is or is not a reasonable risk – quite a few women commented on the recent hormone replacement therapy breast cancer health scare and said that GPs themselves seemed unwilling to give advice. In addition, there is a lack of trust about professionals' tendency to run a 'cut and slash' policy. "There are too many Caesareans taking place, too many mastectomies, too many hysterectomies. One could perhaps be forgiven for thinking that the male attitude to the medical treatment of women is, when in doubt, cut it out."

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Also there are just a few horror stories about complete loss of trust. Perhaps because of misdiagnosis – complaints of abdominal pain being treated lightly until further investigation revealed a misinserted coil. Perhaps because of misinformation – the woman who learned only when pregnant that she would have to have a Caesarean because treatment for cervical abnormality had so scarred her cervix. Perhaps because of ignorance – the GP who responded to a woman's plea for an AIDS test following a split condom by saying that "No, a nice, young, white, middle-class girl like you won't be at risk of anything like that ...".

Finally, as regards treatment, many women talked about the unwillingness of medical practitioners to consider natural alternatives. Of course from the professional point of view wariness is understandable, but from the lay

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perspective it can seem overprofessionalised. "Our health services need to become more holistic ... doctors don't offer lifestyle alternatives such as diet and exercise, they just go straight for medication ... it would have been nice if she could have told me about the natural alternatives."

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Information

Many women commented that they wanted more written information. In particular, they requested introductory leaflets for cervical smears, family planning services, and as a calming and permission-giving introduction to sexually transmitted infection (STI) clinics. "A leaflet outlining not only where to go for the tests and also what will happen to you and how you receive the results would have been a great help to me."

Conversely, the face-to-face information services were often criticised as being too reliant on written information: "they ... tend to refer you to leaflets ... perhaps a bit more knowledge and less passing of the buck would be a good idea". That said, most practitioners were seen as excellent when it came to information giving. "One of my sons recently asked me whether you can get HIV/AIDS from oral sex? As I was not sure, I called my local practice – the nurse practitioner called me back within 2 hours of my call, explained everything and said I could pop in and pick up a leaflet and/or call her anytime. Fab."

Mr or Ms?

Attitudes of staff to patients were mentioned more frequently than any other aspect. Generally, we are seen as "non-shaming ... highly confidential ... caring ... sympathetic ... I can talk about any topic ...". But, of course, there are caveats.

To begin with, the overwhelming preference women have is to see female rather than male staff. Why? Of course because of the embarrassment factor, a natural dislike of showing 'private' parts in public places. But also because "I believe no man, however medically proficient he is, can know – or perhaps I should say feel – what it's like to have PMT, go through the menopause or give birth". Also because often men seem to be less gentle in diagnosis and examination. "Male consultants do tend to be ham-fisted ... I was on the ceiling with pain."

Plus, sadly, there is a fear of abuse. "I still find it very strange that any man would choose to work in women's sexual health and for some reason feel very suspicious of them." Worryingly, there were several stories of male doctors who deserved such suspicion because, shall we say, they acted without due care and attention. Stories of "an unnecessary breast examination by a male doctor", "the GP who stroked my clitoris without warning in order, apparently, to check for infection" and the smear test biopsy taken in full view of "five male students who couldn't have been much older than me ... I cried most of the way home on the bus".

They were also in favour of the chaperone system. "I was much more comfortable with a nurse there, even though in fact she didn't take part in the examination and merely stood to one side."

Personally speaking

Women want basic social competence. They love eye contact rather than compulsive concentration on notes. They prefer staff to ask permission to use a first name rather than just assuming familiarity. They want a service attitude – rather than "front office personnel who act as if they are doing you

a favour by giving you an appointment" or "consultants who are pompous, supercilious and patronising".

Plus, patients would like an awareness of the embarrassment factor. Women themselves may feel embarrassed and ashamed and health professionals need to be ultra-aware of this – and ultra-relaxed, accepting and permission giving. Many women talked of being too embarrassed to talk about sexual problems, and so disguising such problems with, for example, a presenting condition of depression. They need the health professional to pick up on their wariness and ask the right question at the right time.

The problem is, however, that some health professionals may be just as embarrassed as their patients. They therefore may not want to enquire – they may not even want to mention sexual issues in the first place. There is woefully little psychological training for medical professionals – and even less emotional support for them as they cope with day after day of distress from patients. Hence, understandably, as one woman put it: "Doctors seem to have a real fear of opening the emotional flood gates with their patients – in case they get drowned".

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Judgement and blame

One step on from sheer embarrassment is judgement. Happily, almost all women said that they had received non-judgemental treatment – and only one or two hinted that they had been directly blamed for their pregnancy, menopausal symptom or STI.

But I did note worrying reports of a tendency in health professionals to minimise patient problems or to invalidate patient experience. For example, there were several reports of doctors – never nurses, interestingly enough – telling women that they were not suffering symptoms of such severity as they thought. "My doctor cheerfully told me that women always overestimate the amount of blood they lose ... I really didn't need to hear this after a nightmare evening during which I'd spent half an hour in the loo of a London theatre because every time I put a tampon in, it came straight out again in a rush of blood." "I had ovarian cysts ... no attention was paid to my obvious pain even though [when they operated, it turned out that] my cysts were as big as oranges."

And here I have to pose a challenging question. To what extent does such provider reaction – embarrassment, distaste or underestimation of symptoms – reflect an albeit unconscious judgement on the part of health professionals? Could it be that for some health professionals there is lurking underneath a subtle sense of righteousness, a theme of "Well, if she will have a sex life, what can she expect?"

I wouldn't be surprised if there were this bias. Britain today still holds double standards, still runs Madonna-whore scripts, and still secretly feels that a woman who has a sexually linked condition has only herself to blame for being not only a woman but also a sexual one.

That said, in general, most women – particularly the older ones in my survey – had developed strong and positive relationships with their sexual health providers, particularly where there was ongoing contact and a chance for trust to build. And where that trust had built, even problems could be overcome – there were many comments about taking concerns to a GP or nurse, and being allowed the possibility to go back and rethink treatment or even diagnosis. "My GP suggested a new pill that stops periods as well – this did not work for me and she changed the medication immediately. I had no problems after that."

Good enough?

Of course women have a wish list – and it's a very good sign that they do. They want better facilities. Easier appointments. The same low cost but more for the money. A willingness to consider alternatives – and an unwillingness to rush in with the knife. But above all, women want their sexual health professionals to create good relationships – respectful, open, non-judgemental and supportive. All that said, largely, women feel that the British health service is 'good enough'.

And where we are good enough, wondrous things can happen. Women told me that where they have found a good provider, their lives have been changed. In the wake of a positive smear they have found the confidence to stop

smoking. After a contraceptive consultation, they have found the courage to insist on condoms. They have been given the information and the emotional resources to sort their contraceptive needs, to get treatment for their STIs or to have the babies they desperately need and want. That kind of feedback can only make us both proud and motivated to keep on working.

So our school report is not 100% positive. We still need to try harder. But in general, we are 'B++ and rising'.

Editor's Note

On 17 June 2004 Susan's book, *Staying Together*, written in connection with Relate (£9.99 Vermilion), was reviewed in *The Times* as "the only relationship book you'll ever need".

VIEW FROM PRIMARY CARE**Sexual health entering primary care: is prevention better than cure?**

Dr Sue Donym, GP from *Spread Thinly*, UK

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Apparently the new General Medical Services (GMS) contract provides a number of opportunities to further implement the *National Strategy for Sexual Health and HIV*. How? As a Trojan horse, a stealth bomber? It also provides a mechanism through which primary care organisations can secure the provision of Level 1 sexual health services in general practice. Oh, that's clear then. It's strong-arm tactics since, to put it another way, general practitioners (GPs) are not keen to have this on their plate so here's how to make sure it happens.

Why is it that whenever someone is praising the idea of primary care providing more choice and opportunity for patients with regards to any wonderful new initiative, they invariably add "I'm not a GP but ..."? I've not yet met a GP who is enthusiastic about additional workload. Primary care has just gone through possibly the most significant change in its history with the introduction of the new GP contract, and practices around the country are frantically trying to learn the rules and play the game. It's a game where not even the creators are clear how it should be played. For instance, should Level 1 sexual health services be an essential or an enhanced service? It looks like the answer to that important question will be provided by the lawyers who will fight over definitions of illness whilst filling their pockets. Those representing GPs will of course argue it is an enhanced service to ensure GPs get paid for providing it. Those representing the paymasters will argue against this so that costs can be contained.

The major problems of introducing wider sexual health services into primary care at the present time are clearly acknowledged. A lack of resources, a lack of time, the issues around contact tracing and partner notification, and let's not forget the patients. According to a report from the London Assembly Health Committee published earlier this year, most HIV patients would rather go to a genitourinary medicine (GUM) clinic than to their GP. People like the anonymity of a GUM clinic. It's difficult for many patients to even talk about sexual dysfunction issues with their GP whom they've known since childhood, let alone be quizzed and examined for sexually transmitted diseases.

The latest trend is for everything to be done under one roof – the 'one-stop shop'. This really is a tremendous idea. Most patients love it because it means fewer visits and is more convenient. So why when you have a GUM clinic that provides this one-stop service would anyone want to

start fragmenting sexual health services? Unless primary care provides all the services of a GUM clinic then some, if not many, patients are going to need to visit somewhere else for the rest of what they need. Yes, you've guessed it, the GUM clinic. 'Slip through the net' is a phrase that comes to mind, a problem that is likely to occur more often when any service becomes piecemeal.

The drive to establish more sexual health services in primary care may have been marketed as better patient choice but that's just the public face of it. Behind it, is there something more? Surely this is about trying to throw a lifeline to struggling GUM services. It's all about stars these days and it only takes one service failing to score to let the whole side down. If Trusts don't achieve their performance targets, at the end of the day it's the government in power who looks bad. Pass the buck to primary care, however, and problem solved. If primary care makes a success of it, the powers that be are heroes and will be seen congratulating themselves for suggesting the idea. If primary care fails then, hey, it's the GPs' fault as usual.

When the *National Strategy for Sexual Health and HIV* was first published, it looked like it might be a goer. A few issues needed to be sorted out if things were to run smoothly but in essence it seemed possible. Maybe it was a case of bad timing, but with the new GP contract and all it brings to the doorstep of primary care, now doesn't seem the right time to dish up another 'exciting challenge for primary care'.

Perhaps it's time to follow the mantra of sexual health and practise safer sex. For the time being let's slip a condom over the *National Strategy* and prevent sexual health services from escaping into the community where, at the moment, they may cause untold harm. In time, when it has regained some stability and has acquired the knowledge it needs to provide these services appropriately, primary care will be ready to welcome a new member into their family. But in the meantime, it may be better to leave sexual health services where they are: just do up the huts so they don't look like places for dossers, open them for longer, pack in the kindest staff, and send them bags of bullion so that they can see the punters promptly.

Editor's Note

Dr Rob Hicks is having a sabbatical. During this time the Journal will invite a number of different authors to contribute to this column.