Australasian Medical Journal 2009, 1, 4, 1-8

Comparative Healthcare Series no. 2.

Abstract

This month two general practitioners (GPs) describe their approach to sexual health consultations. The issue of a sexually active adolescent demonstrates some differences in legislation pertaining to the requirement to involve the authorities, although in essence the young person can expect the same response from these practitioners in two different health care systems. On the other hand a patient at risk of sexually transmitted infections is more likely to be referred to a specialist Genitourinary clinic in the UK although the protocols for screening and education are largely similar. Equally patients who are HIV positive can expect to receive the bulk of their care from specialist clinics in both countries.

Midwives are the main stay of antenatal services in Australia and the UK with general practitioners minimally involved in routine cases. Also home births are a negigible proportion of all deliveries in either country. When patients opt for a home birth our authors expressed the view that GPs generally do not have the skills or experience to be the main health professional in attendance. Therefore such births are primarily managed by midwives as the key health care professional. The focus of General practitioners is primarily to ensure that the patient is making an informed decision about delivering her baby at home. The GP is therefore still in an influential position to assist the woman in making a decision about where to give birth. As a point of difference in Australia a home birth would result in out of pocket expences for the mother.

The views expressed below are those of the authors and do not necessarily reflect health policy or practice elsewhere in their countries. However we believe they offer an interesting perspective on their health care systems and commend the article to our readers.

Please cite this paper as: Boyce C and Cottrell E. Comparative healthcare: Sexual Health. AMJ. 2009 , 1, 4, 1-8 Doi 10.4066/AMJ.2009. 63

Australasian Medical Journal 2009, 1, 4, 1-8

Sexual Health

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Your next patient is a 15 years old girl. She admits to have become sexually active with her 18 year old boyfriend in the last 6 months and last had unprotected sexual intercourse two weeks ago. How do you manage the issue of sexual activity among minors in your practice?

Confidentiality needs to be established and a pregnancy test performed. At fifteen the girl is entitled to her own 'Medicare' card and can therefore consult a general practitioner without her parents having to accompany her. Sexual intercourse between a fifteen year old and an 18 year old is technically illegal in Tasmania. The age of consent is seventeen (sixteen in most other states). However, under Tasmanian law there is provision for a legal defence, based on an age gap of less than five years between the sexual partners. (In most other states, this gap is only three years). These aspects would need to sensitively managed.

As the law relating to these matters is complex and, confusingly, varies from state to state, this is a challenging area for GPs. In most cases, a notification to Police in the above scenario would not be necessary. The government Child Protection agency would need to receive a notification but would be unlikely to take any action in the absence of true risk to the minor. Pregnancy diagnosis, Sexually Transmitted Infection (STI) screening, and discussion around contraception would all require attention.

In my practice management would depend on whether the girl was reporting non-consensual sexual intercourse. In England, the age of consent is sixteen, thus making such sexual activity in the above case, whether consensual or not, illegal. However the General Medical Council (GMC) recommends that information is disclosed to agencies (e.g. police, social services) if the child is under the age of 13 years, the sexual activity is abusive or "seriously harmful" and/or the individual involved is "vulnerable". With regard to the ages of the sexual partners the GMC recommends that information should be shared if the age difference is "big". If in doubt, all doctors are also encouraged to discuss with colleagues whether a breach of confidentiality is warranted. They may also consult their medical indemnity provider for advice.

This girl is at risk of pregnancy and sexually transmitted diseases. She needs education, investigation and treatment focused on contraception, pregnancy and/or abortion and sexually transmitted diseases. Again the GMC provides guidance on providing such advice and treatment in patients under the age of 16 years in the absence of a parent or guardian. First you should try and persuade the girl to involve her parents, however if she refuses, according to published guide lines, this does

not preclude providing the necessary treatment if the patient can provide informed consent. The GMC acknowledges the concept of minimizing harms by recommending the provision of contraception to patients under 16 years if you believe they are “very likely” to undertake sexual activity whether you provide contraception or not.

A 25 year old man and has been visiting male sex workers when he travels abroad. He admits that he has not been using condoms and is concerned about a urethral discharge and mild dysuria. How would you advise him at your practice?

This man would require information and pre- screening counselling regarding testing for STIs and Blood Borne Diseases. Investigations offered would include; Serology for HIV1/2, Hep B sAg, cAB, sAB (if previously vaccinated), Hep C AB, TPHA and RPR (VDRL). Urethral, anal, and throat swabs if indicated would be taken , for gonococcus and Chlamydia . Confidentiality would be ensured by offering de identified testing for HIV and other tests if indicated .Vaccination would be offered if seronegative for Hep B , which is not subsidised under Australia’s Medicare system and for which the patient would be charged a fee. (Off label) HPV vaccination would be considered. He would be informed about state based legislation on notifiable diseases (HIV / Hep B / Hep C / Gonorrhoea / Chlamydia / Syphilis) and the fact that this notification occurs directly from the testing laboratory to the public health department. Referral to a specialized sexual health clinic in our area would be offered, and this may afford more (or less) confidentiality. Treatment, if necessary, would be organized by either GP or sexual health physician. Information would be offered and reinforced regarding barrier methods and future screening requirements, as well as enquiry and advice regarding relevant general areas such as drug and alcohol use, smoking, and psychological health.

The prime concern here is the significant risk of a sexually transmitted infection (STI) resulting in urethritis, but also other STIs including HIV. The primary step it to take a full history including the types of sexual practices. He requires a full examination and laboratory investigations. GPs are advised by National Health Service guidelines to refer to Genitourinary Medicine (GUM) service whenever possible for counseling, contact tracing and sensitivity testing. However, this may not always be possible or acceptable to the patient, in which case the GP should consider arranging for urine microscopy, culture and sensitivity for non-sexually transmitted urinary tract infection, urinary nucleic acid amplification test (NAAT) to detect Chlamydia and swabs and/or urine NAAT for gonococcus. He should also receive counseling and blood testing for syphilis, hepatitis and HIV. Repeat testing may be needed in some cases in view of a risk of false negative tests. This can be

offered in the GP practice or alternatively he may be referred to a GUM clinic. GUM clinics are separate from any other healthcare provider, holding separate medical records and do not routinely contact the patient's GP, thus affording greater confidentiality.

The findings on examination as well as the details obtained in the history will direct treatment towards the most likely organism. Each area in England will usually have its own antibiotic guidelines for infections based on local sensitivities and patterns of resistance. Therefore, although national guidelines and literature may be consulted, for example Clinical Knowledge Summaries or the British National Formulary (BNF), many GPs will routinely consult their local microbiologist for the recommended antibiotic regimes.

The patient must also be educated about his sexual behaviors, long term risks to himself and his sexual partners and safe guards to reduce risks where appropriate. This would include suggestions to exercise abstinence until diagnosis and treatment.

A 27 year old married lady presents to you with a flu-like illness. She has had multiple sexual partners in the past three years and a HIV test is reported as positive. What support is available to this patient in your practice?

Within our practice, I would be this woman's main support. She could access information, advice, testing and referral, also psychological support. My first step would be to establish that this is not a false positive and refer the woman to an Infectious Diseases physician either in the private or public system, who would collaborate with a Sexual Health specialist in the public sector clinic. These services would then provide ongoing specialized care and support, with access to counselling services.

The GP role would focus on advocacy, support, debrief, health care systems navigation, general and preventative care and opportunistic care, immunization, and screening for psychological morbidity. With a small number of HIV positive people in Tasmania (110 in 2007, 12 of whom were women, 4 of whom had AIDS), she might find some of her supports (eg "Positive Women Victoria") outside of Tasmania- this also in view of her need for confidentiality.

GPs in England are increasingly encouraged to test for HIV when appropriate, as missed opportunities for diagnosis are recognised as contributing to HIV-related morbidity and mortality in the UK. It is even suggested that HIV testing is offered to all new patients registering at practices in

areas where 2 out of every 1000 patients is HIV positive. However, as in Tasmania, the care of patients who are found to be HIV positive is secondary care led in specialist HIV Clinics. Assessment by specialist HIV clinics should occur within a fortnight of the diagnosis. Such clinics may be led by consultants in Infectious Diseases and/or Genitourinary Medicine but also provide access to counsellors, social workers, dieticians, and pharmacists. Such clinics should be able to organise contact tracing of the appropriate sexual partners. British Guidelines for HIV care recommend that HIV services should include provision for assessment and routine monitoring, initiation and monitoring of Highly Active Anti-retroviral Therapy (HAART), acces to peer support, sexual health screening, contraception and pre-conception care, mental health support and 24-hour advice.

GPs are responsible for coordinating non-HIV related conditions that may co-exist, long-term complications of HIV which are more familiar to GPs (e.g. cardiovascular disease, depression and substance misuse) and acute and opportunistic infections, such as in this case. Therefore, it is crucial that GPs consider the more unusual pathogens that may be underlying “flu-like” illnesses in patients with HIV and the speed with which these may progress. Guidelines also emphasise the importance of GPs knowing to liaise with HIV specialist services, or at least exercise caution, whenever they are prescribing due to the multiple interactions that exist with HAART.

Your next patient is 10 weeks pregnant. What protocols govern the management of her pregnancy in your practice?

Our practice is supported by GP South, a federally funded GP organization that provides information, education, clinical and administrative support to GPs and practices. Most GPs use the GP South resource for Antenatal Shared Care to guide practice in this area. This is a product of ongoing work shared by a group of local obstetricians and interested GPs. This is available electronically from the GP South website, or in hard copy.

The protocols advise re screening bloods, which in Australia include TPHA/Hep B and strongly recommend HIV serology, also first or second trimester screening for chromosomal abnormality, referral of high risk pregnancies to the ante natal clinic, and provide a trimester by trimester guide for the GP providing “shared care”.

To be eligible to provide services to women under this shared care model, GPs need to maintain a basic level of postgraduate education in the area of antenatal care. At our practice, approximately half of the eight GPs maintain this registration. The woman sees the obstetrician for an initial “booking in” visit at 12-14 weeks and the not again until 36 weeks, if all goes well. High risk pregnancies are not eligible for the shared care model. This system works well and is very popular with women.

In England Obstetrician involvement is not indicated for uncomplicated pregnancies. Therefore the National Institute for Health and Clincal Excellence (NICE) recommends a midwife- and GP-led shared care model. Therefore GP practices generally have midwives visit the practice on a weekly basis to perform 'booking' appointments and antenatal checks. Some surgeries hold these on a drop-in basis others on an appointment basis. The NICE guidelines on antenatal care, recommends enquiries and education about and management of co-morbid conditions, medication, blood pressure, smoking, diet, alcohol, illicit drug use and folic acid supplementation. Patients are then referred to the local midwife clinic.

Depending on when the woman presents, up to two appointments may be arranged in the first trimester. The lady may see her midwife monthly thoughout the pregnancy but with increasing frequency nearer the end, NICE suggests nulliparus woman have up to 10 antenatal appointments throughout their pregnancy and multiparus mothers have seven appointments. At these appointments the woman will be offered screening blood tests (e.g. sickle cell disease, HIV test, hepatitis B, rubella, syphyllis, anaemia, blood type), foetal monitoring and screening (combined test/triple or quadruple test) and a regular blood pressure measurement . The midwife will also assess foetal presentation and lie from 36 weeks onwards. Even in shared care models, there are times when midwifes are off work due to annual leave and/or sickness and their work may not be covered by another midwife. Therefore GPs must keep themselves up to date with the skills of antenatal examination and the checks required at these visits. However frequently the midwife and patient arrange appointments NICE guidance suggests that specific antenatal information should be given at a booking appointment which should occur by 10 week, again bt 36 weeks and at 38 weeks. Pregnant women will be offered ultrasound scans between 10 weeks and 14 weeks to determine gestational age and presence of multiple pregnancies and between 18 weeks and 21weeks to detect foetal anomalies.

A 35 year old lady requests a home delivery. She is now 28 weeks pregnant. How would such a request be managed in your practice?

At a consultation with her GP, there would be a frank discussion about the pros and cons of a home birth based on the woman's obstetric and medical history and the reasons for her request. (A midwife care scheme at one of the local hospitals, or a "shared care" model with the GP may, in fact , satisfy her requirements to see largely the same professionals throughout the remainder of the

pregnancy.) There are no GP obstetricians in our practice, and one in the southern region, who does not do home births. The woman would be informed that there is a small group (4-5) of midwives who assist in home births, whom she could then approach. Due to the small size of the community, these midwifes may have closer relationships with the hospital obstetric system than in larger centres. The pregnancy and birth would be managed by the midwife, and individual GPs could make decisions about what part of antenatal care they could deliver e.g. screening blood tests. The woman would be encouraged to "book in "at the local public maternity service, which would then be aware of her presence if there were complications. In Tasmania, she could expect to pay about $2700 for her midwife care.

Homebirths account for a very small number of births in Australia. In 2005, homebirth accounted for 0.22 per cent of all births in Australia, compared with 2.7 per cent in England and Wales, 2.5 per cent in New Zealand, and 0.6 per cent in the United States. The situation regarding home births is poised to change pending implementation of the Maternity Services Review commissioned by the federal government in 2009. The impact of a proposed compulsory registration scheme in 2010, with self funded mandatory insurance for midwives, may see decreased availability of home birth midwifery services.

Home births account for around 2% of all births and the Royal College of Midwives and the Royal College of Obstetricians and Gynaecologists advocate them for uncomplicated pregnancies. National guidance therefore suggests that women without pre-existing medical conditions and without a previous complicated birth, should be offered an opportunity to birth at home. However GPs must inform woman of the pros and cons of a home birth. In particular, women must be warned that it may take time to be transferred to the obstetric units should complications arise during the birth. The women should also be advised of the increased risk of an adverse outcome should there be an unexpected complication during a home birth.

GPs generally do not have the skills or experience to assist with home deliveries. Therefore such births are usually midwife led so, as above, patients should be encouraged to discuss this matter early with their midwife in order to make necessary arrangements.