

more than 72 hours had elapsed since risk of pregnancy. A pregnancy test if the client's next period is late or abnormal would be advised. This client would be offered a sexual health screen, performed by a doctor and nurse together, including testing for gonorrhoea at both cervical and urethral sites, thus increasing the chance of detection, in addition to tests for trichomoniasis and chlamydia. If the client had genital symptoms, microscopy for gonococci might allow same-day diagnosis of gonorrhoea as well as bacterial vaginosis or candidiasis. The client would be offered a blood test for syphilis and HIV testing after appropriate counselling and advised to ensure that all current and new sexual partners are screened for STIs. At present, the GUM clinic in question would not be able to provide ongoing hormonal contraception although this may be possible within the next year.

#### *The community pharmacist*

The community pharmacist reported working to strict protocols that include checking the time since unprotected intercourse, appropriate information on failure rates, and follow-up and referral to local family planning and GUM services for discussion of contraception and STI. She did not routinely discuss additional health promotion issues such as smoking cessation.

#### *The GP*

The GP suggested that this client's electronic patient record would contain a recent health check with the practice nurse covering weight, blood pressure, smoking and alcohol use. In addition her 'Fraser competence' would have been assessed by both the GP and practice nurse at previous visits for contraception. This GP would prescribe oral EC if within 72 hours of risk of pregnancy and provide written information on both methods in case, on reflection, the client wants an IUD fitted. He would advise that an IUD is more effective but would warn that it would involve an intimate examination and is a (usually) painful procedure for a nullipara. STI screening done by the GP (with a chaperone) or his practice nurse would be offered, or alternatively referral to the local FPC or GUM department for more accurate urine-based chlamydia testing. The GP predicted that this client would return 1 week later having had a negative STI screen with her partner at the local GUM department. She would request an IUD fitting having premedicated with ibuprofen as advised. The IUD would be fitted by

the GP and his practice nurse together and follow-up at the end of the client's next period to discuss contraception would be arranged. The practice nurse would reinforce the importance of stopping smoking, the need to return to the clinic, and provide the fpa (Family Planning Association) leaflet on the range of contraceptive methods available. The GP would provide a repeat prescription for the client's usual asthma inhalers and book her in for her annual asthma check, which is overdue.

#### *The agony aunt*

The agony aunt for teenage magazines felt that in the first scenario too little is being done for the client – 'she should definitely be given practical suggestions for lifestyle change and effective contraception use. But the second scenario may well alienate her and make her less likely to ask for contraceptive advice in the future. The key in both cases is the approach; a punitive or judgmental attitude in either scenario will do more harm than good. After dealing with the emergency situation the main aim should be to create sufficient rapport and confidence in the client so that she's happy both to follow advice and return for further consultations.'

#### **Discussion**

Presented above, then, are four different examples of good practice, the views of a professional adviser to young people, and the opinion of a young person.

The consultation plans described raise issues about the number of additional health promotion services that should be offered to young clients presenting for EC and the extent of the personal, social and medical history that is appropriate before questions become intrusive.

Both the young person and the agony aunt suggest that a comprehensive approach to this consultation risks alienating young people – but a less comprehensive one risks missing important health promotion opportunities.

We would value comments on these issues, and suggestions for developing consensus between different service providers and between service providers and their patients.

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## **ERRATA**

### **FFPRHC Guidance on First Prescription of Combined Oral Contraception (October 2003),**

*J Fam Plann Reprod Health Care* 2003; **29**(4): 209–223

The Clinical Effectiveness Unit (CEU) wish to apologise for an error that appeared in the abovementioned Guidance document. On page 219, in Table 5 (second column), the oestrogen dose stated for Yasmin® should have been 30 µg ethinyl oestradiol (EE) and not 35 µg EE.

In the same Guidance document, on page 222, in the list of Expert Group members, Linda Hayes' name was misspelled and appeared in print as Lynda Hayes. The CEU and the Journal wish to apologise to Ms Hayes for any inconvenience or embarrassment caused by this error.