Canadian study reviewed the success of a pilot programme for providing EC via a pharmacy without a prescription.[4] Almost 7000 prescriptions were obtained and 21% of women stated that if they had not obtained EC in this manner, they would not have obtained it elsewhere. The Canadian health minister recently introduced a bill to remove EC from its current 'prescription-requiring status' making it available 'over the counter', thereby further removing barriers to access by women of all ages. According to the UK guidelines, the cost of licensed EC products available at pharmacies range from £5.50 with a prescription to £24.00 for an over-the-counter (OTC) product. To make matters worse, OTC products are limited to patients over 16 years of age. Imposing these restrictions on EC severely limits access to the products in the population least likely to see a physician and most likely to benefit from their use.

The medical eligibility criteria for EC are quite broad. According to the WHO guidelines[5,6] there are no absolute contraindications to EC use, which supports the safety of providing EC as an OTC product. If a prescription is required, advanced issue of a prescription for EC does not cause an increase in the use of EC (i.e. patients do not abuse EC as a form of regular contraception). Indeed, they are more likely to use EC when needed and are also more likely to use standard contraception properly.[7]

Hormonal EC needs to be made accessible to all women, but especially to adolescents. This is most likely to occur in an environment where they can access EC at a convenient time, in a convenient location, at a convenient price (preferably free of charge). Only then might we start to see the financial and social benefits of primary prevention of unwanted pregnancies in this age group.

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Reply

Madam

As mentioned in my original article there is only one paper[1] that shows a direct correlation between intercourse treatment interval and effectiveness of emergency hormonal contraception (EHC). Neither the subsequent World Health Organization (WHO) paper in 2002[2] nor another large study[3] have shown this correlation.

The 1998 WHO paper quoted by the correspondent was carried out in women within 72 hours of intercourse and only four women used EHC>72 hours. In the 2002 paper the authors clearly state: "There was no evidence of an interaction between regimens and timing of treatment within 72 hours or after 72 hours. For the three regimens combined, women who were treated after 72 hours had a higher pregnancy rate than those treated within 72 hours but the difference was not significant". Another study looking at the Yuzpe regimen between 72 and 120 hours[3] also had small numbers and, therefore, wide confidence intervals so it is difficult to know the true efficacy.

The 2002 paper shows that the 1.5 mg levonorgestrel stat dose regimen is as safe and effective as a split dose; it therefore seems logical that the simpler dosing should be the one of choice. I agree that EHC should be ideally used as soon as possible and that this may be best achieved by ensuring that any woman who may, at sometime in her life, be at risk, has some easily available. After all, don't most people have simple painkillers at home and sometimes in their handbags in case they should get a headache? This is despite both aspirin and paracetamol (acetaminophen in North America) having a considerably greater list of contraindications and side effects than levonorgestrel.

My mention of the intrauterine device (IUD) was precisely to remind clinicians that they should not be constrained by myths. Fitting an IUD in a nulliparous woman is a common occurrence in our service and acceptance, as with all methods, is related more to the adequacy of counselling and practical expertise of the fitter than with the parity or age of the woman.

Contraception in the UK is free when on a National Health Service prescription. When bought from a pharmacy without prescription, the cost of EHC is indeed high. I agree that the age restriction has no medical basis. I was delighted to hear that Canadians now have access to EHC without prescription. I hope it is at an affordable price. It was very disappointing that the USA Food and Drug Administration (FDA) did not feel able to make an equally enlightened decision despite the advice they received.

EHC is safe and should be broadly and affordably available to all who need it. However it is not the answer to unwanted pregnancies[5] and must be part of a much wider effort to increase knowledge, accessibility, affordability and usability of all methods of contraception and prevention against sexually transmitted infections.

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Service standards: chaperones and record keeping

Madam

We are grateful for the responses from McVicker, Murray and Robinson[1,2] but without wishing to over-prolong this debate we would like to clarify the problems a little more.

(1) If the offer of a chaperone is essential for doctors, guidance is also needed for nurses. The Association for Genito-Urinary Medicine (AGUM) guidelines for intimate examinations in genitourinary clinics[3] point out that there is a problem, both with the nature of sexual health work (which makes it difficult for relatives and friends to chaperone) and with nurses performing examinations, but they do not offer any immediate solution. With the increasing role of nurses in reproductive health and general practice[4] this is a real issue. Will we all have to be able to provide two nurses to do every smear test, and will they not be seen as supporting each other rather than the patient?

We have both noticed an increasing reluctance among general practitioners (GPs) to perform intimate examinations, and a tendency to send women to our services for them. GPs may lose very little under the new contract if they give up cytology and contraception[5] but the burden will fall on community clinics. If extra nurses therefore have to be employed as chaperones they must be specifically funded, otherwise our services will increasingly have to limit the number of clients they can see per session so that nurses are freed up to do this very unrewarding task. This may ensure that we are protected against false accusations of improper conduct during a routine intrauterine device check, but that the distraught teenager needing urgent advice who turns up at the last minute is turned away. Is this what we really want?

Unless professional bodies and the General Medical Council (GMC) support clinicians who are working under pressure, the result will be a decrease in the availability of clinical services, with the burden falling chiefly on the most vulnerable patients.

(2) We are grateful for guidance on record keeping, but are concerned that 'good record keeping' is often confused with 'extensive record keeping'. No-one would support careless, inaccurate records, and there are situations where notes written for medico-legal purposes are obviously needed, but densely written, defensive notes can be dangerous. First, because they may mean the clinician is not listening to the patient but is concentrating on writing. Second, because they make it difficult for the next clinician to spot the clinically important points therein. Red ink to highlight important points is not allowed as it does not photocopy well, and stickers and stamps can still be surrounded by lines or even pages of writing.

We call on the Faculty of Family Planning and Reproductive Health Care to review the implementation of the GMC, Royal College of Obstetricians and Gynaecologists (RCOG) and AGUM guidance on intimate examinations in community and primary care situations. We also ask for explicit support in future service standards for clear, concise notes that are written out of a desire to communicate well rather than out of fear of lawyers.

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Editor's Note

This letter has been forwarded to the Chair of the Clinical Standards Committee.