The conduct of colleagues

Gill Wakley

Introduction

Sometimes colleagues do things that you feel are unprofessional, thoughtless or even hazardous. You may disapprove of their actions, but should you do more and share your concerns with the colleague concerned or with others?

Clinical scenario

Mrs X attends the clinic for removal of her intrauterine device (IUD). She explains that she had it inserted as emergency contraception and now wants it removed with this period. While on the couch, she confides that her general practitioner (GP), a close friend, had fitted the IUD in his own home to avoid anyone in the village knowing about her need. She had been away to a conference for 5 days and had unprotected sex with another delegate. Her husband had had a vasectomy, so she was unused to having to think about contraception. On her return home, she realised that she had had intercourse several times around the middle of her cycle and pleaded with her GP friend to do something. The clinic doctor realises from Mrs X's story that the GP had fitted the IUD 8 days after mid-cycle and intercourse. Since then, Mrs X had spent some time finding out where a family planning clinic was situated so that she could have the IUD removed in anonymity, while avoiding intercourse with her husband. What should the clinic doctor do or say?

The panel

Four professionals (detailed in Box 1) were invited to discuss what they would have done.

Box 1: Invited discussants for the clinical scenario

- Ethicist
- Family planning clinic doctor
- General practitioner
- Barrister

Ethicist

On first appearances, it seems the GP has behaved in a morally dubious way. He has treated a close friend in his own home apparently without generating a written record. Additionally, he has inserted a postcoital IUD after the earliest possible date of implantation: this would be outside the terms of the 1967 Abortion Act and therefore illegal. It would appear then, that there is some cause for concern on the part of the clinic doctor about the GP's behaviour.

However, if we look at the wording in the General Medical Council (GMC)'s *Good Medical Practice*, we are advised to voice concerns about colleagues if: "You have grounds to believe that a doctor … may be putting patients at risk". Has the GP put the patient at risk? He almost certainly hasn't followed GMC guidelines about keeping clear, accurate and contemporaneous patient records but surely this is not a serious enough breech of guidelines to instigate 'whistle blowing'. The GP could argue he has acted in the patient's best interests. Confidentiality is crucial here and cannot be guaranteed in the local surgery of a small village, so he has fitted the IUD in the privacy of his own home. Under the circumstances, the GP might claim he has made the care of the patient his first concern, which is, after all, the first 'duty of a doctor'.

This leaves us with the matter of the timing of the IUD insertion that may contravene professional guidelines and the law. The patient has not suffered any harm; on the contrary, she is not pregnant. An IUD is likely to work postcoitally even if inserted right up to the next period – the reason we don't do this in practice is because of the law on abortion. Perhaps the GP knew this and fitted the IUD anyway because the patient was a friend. Or perhaps he was ignorant of the legal implications. Whatever the explanation, the question remains about what course of action, if any, the clinic doctor should take. Perhaps if the clinic doctor had other concerns about this GP's fitness to practise then this incident could be used as the catalyst for an investigation. If this were a one-off incident, however, I feel 'whistle blowing' would be a rather harsh course of action.

Family planning clinic doctor

This is a common problem in some respects. It is difficult to be certain in any menstrual cycle when ovulation will occur unless the woman always has a 28-day cycle, which is uncommon. In a 38-day cycle, for example, mid-cycle would be the 19th day. The timing of the IUD fitting would only have been mid-cycle and 8 days in a regular 28-day cycle. My advice would be to remove the IUD as requested and offer a chlamydia swab in view of the new partner. Explain the need for sexually transmitted infection (STI) testing but give no advice about her husband and the risk of transmission of infection; that is her problem. Develop deafness and not hear anything about the GP and his home and make no records of the details as to how or where or why. Record that the IUD was removed as requested but give no reason for its presence. Ask if it was a good conference.

General practitioner

The care of the patient is paramount and I would use the communication skills guidance for breaking bad news, as it is possible that what follows may come as a shock to her.

I would explain that IUDs are only used for emergency contraception up to 5 days after unprotected intercourse and there was a possibility that she might have conceived prior to insertion. She must be certain that her vaginal bleeding is indeed a menstrual period and not a complication of early pregnancy. I would offer an immediate pregnancy test. In addition, as she has had unprotected intercourse with a new sexual partner, she is at risk of having contracted a STI including HIV. I would offer appropriate testing in a sensitive manner.

If her pregnancy test is negative, I would be happy to remove her IUD as she requests. I would discuss her contraception choices for the future should she have an extramarital sexual partner again.

Finally, I would consider what action I ought to take regarding my colleague. I believe it is important to acknowledge my disquiet about having to deal with this part. I would seek further advice from the local medical committee or my medical defence organisation. I hope that

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Staffordshire University, Stafford and Abergavenny, UK
Gill Wakley, MD, MFFP, *Visiting Professor in Primary Care Development and Freelance GP, Writer and Lecturer*

Correspondence to: Dr Gill Wakley. E-mail: gillwak@aol.com

the situation can be dealt with in a caring and understanding, but appropriate, manner.

Barrister

For ease of language, all doctors are 'he' in this response. The issues for the clinic doctor can be divided into two.

First, in respect of the patient, Mrs X:

1. Although, at present, this may appear as an isolated incident, advice should be given as to her contraceptive options for similar circumstances in the future.
2. Care will need to be taken in dealing with what the clinic doctor believes to be errors on the part of the GP. However, the clinic doctor is the specialist and the patient should be given the benefit of the specialist's opinion. It is noteworthy that she has not chosen to return to her friend the GP to have the IUD removed. If the clinic doctor believes that serious errors were made, his duty to the patient must require him to give advice which reflects his opinion of those errors, thereby allowing the patient to make a more fully informed decision in the future.

Second, in respect of the GP:

1. On balance, the clinic doctor should not report the matter to the GP's professional body. That judgement takes into account the following factors:
   - Although potentially serious in its way, the error on the part of the GP was not life threatening. In any event, the patient has not suffered long-term damage in this case.
   - The evidence of an error on the part of the GP comes entirely from the account given by the patient. The patient has shown no interest in having the error exposed to a wider audience. From the conduct of the patient to date, it would be safe to assume she has no interest in this matter being referred on for further investigation. Moreover, reporting the matter would conflict with the clinic doctor's duty of confidentiality to the patient.
2. Further, the clinic doctor should not raise the matter with the GP directly. The considerations above apply here too. In addition, the nature of the patient's relationship with the GP (and the circumstances in which the IUD came to be fitted) makes this course particularly difficult and inappropriate.

Discussion

The differences of opinion expressed indicate that no 'right answer' applies. It is clear that if you felt that action should be taken, you would need further information about the circumstances around the insertion of the IUD, and the consent of the patient to proceed. You may agree that, in view of the lack of harm caused, no action should be taken, but does this condone inadequate practice that might be repeated? What if the woman had developed a pelvic infection or had collapsed in the GP's home during the IUD fitting? What would you have done faced with this situation? The Journal invites your comments.

Acknowledgement

The author would like to thank the panel members for their input. A listing of the individual panel members who have contributed to the Clinical Conundrum section of the Journal is published annually.

Journal Review

Effect of mefenamic acid on controlling irregular uterine bleeding in DMPA users. Tantiwattanakul P, Taneepanichskul S. *Contraception* 2004; **70**: 277–279

This is a double-blind, placebo-controlled study to evaluate the effect of mefenamic acid and placebo on controlling uterine bleeding in Depo-Provera® users. The design of the study was good but the numbers were very small. Fifty-four women were recruited and six were dropped from the study. This left 23 in the mefenamic acid group and 25 in the placebo group. Mefenamic acid reduced the bleeding in the short term but the effect could not be shown with long-term use.

Mefenamic acid might be of use for those women who cannot use oestrogen preparations. If it can produce an effect in the short term it might encourage a woman to continue with the method, especially after the first injection when there can be more bleeding irregularities than following later injections.

Reviewed by **Judy Murty**, DRCOG, MFFP
SCMO Contraceptive and Sexual Health Services, Leeds, UK

Contraceptive efficacy and safety of DMPA-SC. Jain J, Jakimiuk AJ, Bode FR, Ross D, Kaunitz AM. *Contraception* 2004; **70**: 269–275

This is a report on Phase III trials for the new subcutaneous version of depot medroxy-progesterone acetate (DMPA-SC). There were two arms to the trial, an American population and a European/Asian population. It is interesting to note that only the European/Asian population had exclusions for risk of osteoporosis and enzyme-inducing drugs. The drug was administered every 3 months for 1 year with the interval between injections being 91 ± 7 days.

Several of the results support what we already know in practice from the intramuscular version. Ovulation is suppressed in all women no matter what their weight. The body mass index of the study groups ranged from 14.7 to 57.7 and there were no pregnancies. There was no indication that DMPA-SC increases weight excessively. In the European group, the median weight gain was 1.0 (mean, 1.4 ± 3.6) kg and was not reported as a reason for stopping the method. The high incidence of amenorrhoea was confirmed at 55% after 1 year. This study suggests that the weight gain during the use of DMPA-SC may be less than that seen with the intramuscular version.

Reviewed by **Judy Murty**, DRCOG, MFFP
SCMO Contraceptive and Sexual Health Services, Leeds, UK

Direct access to emergency contraception through pharmacies and effect on unintended pregnancy and STIs. Raine TR, Harper CC, Rocca CH, Fischer R, Padian N, Klausner JD, *et al*. *JAMA* 2005; **293**: 54–62.

In an effort to increase availability, some states in the USA have introduced legislation to allow pharmacies to issue emergency contraception (EC). This randomised trial attempted to compare pregnancy rates and abortions, as well as sexually transmitted infection (STI) rates in women attending family planning clinics in the San Francisco Bay area. The women were allocated to one of three groups:

- Pharmacy access to EC
- Advance provision of three packs of levonorgestrel EC
- Clinic access as usual as a control group.

Unfortunately for the randomisation, local legislation was changed during the course of the study and the clinic access-only group would have been disadvantaged by being restricted to clinic access only. The control group had to be eliminated in the last half of the study, so that they could obtain EC from pharmacies if they wished. However, the study was powered to detect significant differences between the control group, clinic access and either of the two treatment groups. There was a low loss to follow-up of only 8% with almost equal losses from all three arms of the study. The women were young, mainly uninsured with low incomes, representing a high-risk group for unprotected sexual activity. The three groups reported similar rates of unprotected intercourse at 37.5%. Overall, only half (46.7%) of the women who had unprotected intercourse used EC, but a higher proportion of those who were in the 'advanced provision' group used EC (54.9%). Sexual risk factors, such as number of partners and frequency of intercourse, were similar across the three groups.

Proposals to widen access to EC have prompted worries that it might increase sexual risk-taking, both of STIs and of pregnancy (by abandoning regular contraception). There was no evidence in this study that women abandoned their regular contraception, or that there was any increase in STIs. There was no difference in pregnancy rates in the three groups, perhaps because the (low) use of EC was so similar in all the study groups with fairly high rates of unprotected intercourse. The increased use of EC in the advanced provision group suggests that having to make an effort to obtain EC (via a pharmacy or clinic) adds a barrier to use. However, the main barriers to use seem to be the women's lack of appreciation of their risk of pregnancy from acts of unprotected intercourse or their inability to take control of their fertility (leaving it to fate!). The study concluded that there should be no restriction of the provision of EC by pharmacies, in that it causes no harm. The study was unable to demonstrate that increasing availability of EC reduced pregnancy rates, because of the lack of use in around half the episodes of unprotected intercourse.

Reviewed by **Gill Wakley,** MD, MFFP
Visiting Professor in Primary Care Development, Staffordshire University and Freelance GP, Writer and Lecturer, Abergavenny, UK