experience at IV administration. Perhaps we are unusual in that so many of our nurses do so many procedures.

Do any readers know of anyone else who is struggling with this issue? I have talked to one or two colleagues who were totally unaware of this guidance but I thought some of the Journal's readers might be.

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3 Royal College of Nursing (RCN) Statement.

Nurse training and the need for IUD fitters to have expertise in resuscitation

I felt I had to put fingers to keyboard after reading the thoughtful Personal View by Shelley Mehigan and her colleagues[1] along with the subsequent correspondence in the April 2010 issue of the Journal.

Nurse training in our specialty needs a nationally recognised and standardised educational pathway[2] producing health care professionals who are 'fit for purpose'. This training must be theoretically and practically robust, be based on sound evidence and the accreditation must not be overly expensive. Our services may still be 'doctor-led' in many parts of the UK, but clinics would come to a grinding halt if nurses are restricted in their practice and become 'handmaidens' once more. The letter written by Dr Barbara Hollingworth[3] clearly illustrates this point.

We have also had local community nurse-based clinics fitting intrauterine contraceptives in general practice premises suspended because 'doctor cover' by the general practitioners [who can administer intravenous (IV) drugs] has been withdrawn. Faculty guidance in Service Standards for Resuscitation[4] and Intrauterine Contraception[5] does not clearly state that a health care professional proficient in giving IV drugs is available on site but this is implied by having atropine (0.6 mg/ml) available for IV use. Clinical Leads should check with their local Ambulance Trusts as many suggest that adrenaline is the only drug that needs to be available within community clinics.

I have recently asked over 70 health care professionals who fit intrauterine contraceptives about their use of atropine and no one has administered it. I have on one occasion in the last 22 years when a woman was very keen to keep an intrauterine device (IUD) in situ as she felt it was her only contraceptive option. On all other occasions when faced with vasovagal attacks or persistent bradycardias women have recovered by applying basic life support measures including the removal of the IUD device where necessary.

Perhaps when both these documents[4,5] are reviewed this issue will be clarified.

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5 Faculty of Sexual and Reproductive Health Care Clinical Guidance. Clinical Effectiveness Unit. *Intrauterine Contraception.* November 2007. http://www.ffprhc.org.uk/admin/uploads/CEUGuidanceIntrauterineContraceptionNov07.pdf [Accessed 9 May 2010].

Reply

I would like to thank Drs Hollingworth and Mansour for their letters about nurse training and the need for intrauterine device (IUD) fitters to have expertise in resuscitation.[1,2] This is a question that I am being increasingly asked by clinicians around the country as they become aware of the implications of recent guidance on this topic. Not only is it unrealistic to expect all the clinicians involved to undertake the extra training and regular practice to comply with the guidance – looking at the British Resuscitation Council guidelines,[3] doing what is advised would need advanced life support (ALS)-level training with regular practice of the techniques – it also has implications for how services can be delivered not just by nurses but by doctors too. Many services will feel it is unworkable. Those that have tried, like Dr Hollingworth, to ask the Royal College of Nurses (RCN), have been referred to the Faculty guidance,[4] and the Faculty rightly feel that they were following advice from the RCN.

As I understand it, the original guidance from the RCN,[5] which was directed at nurses fitting devices rather than assisting other clinicians and was based on discussions with the RCN legal team, advised that nurses should make a local risk assessment based on how often they felt a problem might arise? Would we insist on the same restrictions for doctors fitting an IUD/implant?

Why might we treat nurses differently? Issues to consider include:

- Should the nurse fit an IUD very late in the evening?
- If the woman has had a difficult fitting in the past?
- Is there a need to have another registered practitioner (nurse or doctor) in clinic?
- If a woman had rushed in and had not eaten for hours, and so on?

Perhaps the way forward would be for one or more groups at the Faculty to produce guidance for use by all clinicians to follow in such scenarios. This would reflect the multidisciplinary aspect of the work and recognise that this could apply to either doctors or nurses, both groups having highlighted that this is an area where few currently feel able to undertake the actions suggested in the current guidance. If this guidance could be produced following discussion with experts in the field of resuscitation it would then hopefully be realistic, as well as being practical, and would reflect current evidence-based best practice.

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5 Royal College of Nursing (RCN) Statement.

Safe sex during pregnancy

As a consultant in genitourinary medicine, I wish to comment on Box 1 entitled 'Is it safe to have sex? in Susan Quilliam's Consumer Correspondent article[1] in the April issue of the Journal.

The second point made is that "if either partner has a sexually transmitted infection (STI), they should use protection ...". If one of a couple has an STI then is it generally recommended that for a treatable infection a couple desist completely from having any penetrative sex until treatment of both partners is complete. Condoms do not provide 100% protection against any STI and any untreated infections in pregnancy can carry serious consequences.

I am uncertain why protected anal sex should be "avoided altogether". If the couple exercises good hygiene practice is there any other concern about such a practice in regard to pregnancy? I could not find anything in the article to explain this advice.

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Reference
1 Quilliam S. Sex during pregnancy: *Yes, Yes, Yes! J Fam Plann Reprod Health Care* 2010; **36**: 97–98.

Reply

First, I wish to thank Dr Young for reading my article[1] so carefully and responding to it so thoughtfully in her letter.[2]

Dr Young is, of course, correct that if either partner in a couple has a sexually transmitted infection (STI) they should ideally not have sex at all until after treatment. However, in practice this advice is frequently ignored – particularly during pregnancy when partners want to reinforce their bond and reflect their closeness – so I was being pragmatic in advising protection.

Similarly, Dr Young is correct in saying that in ideal circumstances, anal sex is safe. But in the 'real life' situations that I hear about, hygiene practices around anal sex are often far from perfect and so, again pragmatically, during pregnancy in particular I generally advise avoidance.

Finally, the aim of my article, and the substance of the main body of my text, was to promote sex in pregnancy and ask professionals to encourage it. I didn't aim to give detailed information about risks – such information is covered fully in many other sources. Hence the guidance provided in the summary boxes gives headlines only rather than explaining in full the medical background.

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1 Quilliam S. Sex during pregnancy: *Yes, Yes, Yes! J Fam Plann Reprod Health Care* 2010; **36**: 97–98.
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e-SRH e-Learning

As an Instructing Doctor for the Faculty of Sexual and Reproductive Health Care (FSRH), I have enjoyed completing this online training[1] at www.e-lfh.org.uk.

This is an excellent course, and the animations, including the physiology of the