Towards consensus on good practice in the prescription of emergency contraception for young people

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Introduction

Key elements of quality in medical practice are consistent, evidence-based care – and shared clinical decision-making between doctors and patients. But where evidence is limited, providing quality care may be difficult; even more so when patients and doctors hold different views on appropriate treatment. This is the first in a series of articles that compare the perspectives of health professionals and patients on controversial aspects of clinical care. The series will draw views from different disciplines and aims to generate discussion and to develop consensus.

Clinical scenario

This article considers the case of two 15-year-old girls who attend different health professionals, requesting emergency contraception (EC).

One health professional takes a brief, relevant history and provides a clear explanation of how to take EC. She backs this up with written information. She prescribes a suitable preparation with advice to return for follow-up if there is no normal period within 3 weeks.

The second health professional provides all of the above services but also takes a sexual history, contraceptive history and relevant medical history (to exclude contraindications to the common contraceptive methods). She advises screening for sexually transmitted infections (STIs) and takes cervical swabs for this purpose. She suggests an intrauterine device (IUD) for EC, as it is the most effective method of postcoital contraception, and fits an IUD when the client chooses this method. She discusses ongoing contraception and prescribes the combined oral contraceptive pill (COC) to start on the first day of the client's next period. She advises the client to use condoms in addition to the COC for protection against STIs, advises the client to stop smoking, and suggests that her new partner visits his local genitourinary medicine (GUM) clinic for a sexual health screen, provides information about local GUM services and arranges a follow-up visit for IUD removal.

The debate here relates to:

1. Whether doctor or patient should take responsibility for raising relevant but additional health promotion and disease prevention aspects of the consultation.
2. The implications of these decisions on the length of the consultation and the extent to which it is intrusive.

Discussants

To facilitate discussion the six individuals listed in Box 1 were asked how they felt this scenario should be managed.

Box 1: Invited discussants for the clinical scenario

- A 15-year-old girl
- An agony aunt for young people's magazines
- A general practitioner (GP)
- A consultant in GUM
- A family planning doctor
- A community pharmacist who prescribes EC

The teenager

Claire, aged 15 years, responded 'the first scenario would suit me better because it is easy ... the second scenario does give you an insight into your sexual health but it would be more stressful'. She felt that using condoms and pills would be 'too much to ask' and she had already discussed risk of infection with her partner reporting that 'he's always been careful'. She felt that her age had 'nothing to do with the professional ... age doesn't matter. Many young people I know have had sex, often before sixteen and usually in a loving relationship'. She felt well informed on sexual health issues after a school sex education programme delivered by the school nurse. 'Teenagers know more than you think.'

The family planning doctor

The family planning doctor felt that her management would fall somewhere between the two scenarios. Having prescribed the EC pill with an explanation of how to take it and information on the failure rate and benefits of follow-up, she would discuss other aspects of sexual health, 'confirming whether intercourse was consenting or not and with a casual or regular partner'. She would then discuss future contraception, providing information on all methods and prescribing if appropriate or providing condoms for the interim. Finally, she would ask about STI including the risks associated with increasing numbers of sexual partners and failure to use barrier methods in addition to hormonal contraception. She would not take tests requiring a pelvic examination at the first visit but offer to do so at subsequent visits. 'This 15-year-old has taken responsibility for her actions by attending. The family planning clinic (FPC) has a role in providing information on fertility control and STI prevention that she can use responsibly.'

The GUM consultant

The GUM consultant outlined his approach, starting with a health adviser consultation. This would include an introduction to the clinic, discussion of the client's sexual experiences to date and contraception, a demonstration of condom use and a description of the STI tests available. The subsequent clinical consultation would include a sexual history, contraceptive history, menstrual history, relevant medical history and drug history. Both doctor and the health adviser would assess 'Fraser competence' and encourage the involvement of a parent or relative. Oral EC, with information on failure rates, would be offered, as would referral for an IUD if

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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),
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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.

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