Evidence-based medicine and guidelines

Mead

I feel it necessary to join the discussion about evidence-based medicine (EBM) and its applications. I am dismayed by the constant negative attitude towards new contraceptives that are being marketed. I do not believe (serious safety issues aside) that contraceptives should be viewed in entirely the same light as drugs used for a medicinal purpose; in the latter some minor adverse side effects are tolerated provided the overall risk/benefit balance is acceptable for the condition being treated. With contraception, both efficacy and minor side effects are equally important. Indeed, for some women, the balance is reversed with a poorer efficacy being tolerated in favour of lesser or more acceptable side effects.

The proponents of EBM have lost sight of the fact that most of what we do in family planning is not based on a high level of evidence, but what would now be considered good evidence, and that it is reasonable to make certain assumptions. Last year the Clinical Effectiveness Unit’s Product Review of Cerazette® stated: “an evidence-based recommendation cannot be made that the desogestrel pill is different from other POPs in terms of efficacy ...”, while the Drug and Therapeutics Bulletin® went further: “...there is insufficient evidence on whether it is a more effective contraceptive than other POPs and ... we believe the company’s claim that Cerazette has the ‘efficacy of a combined pill’ is unsubstantiated and should be withdrawn.” Less than a year later, the product licence for Cerazette has been officially altered to allow a 12-hour pill-taking interval – the same as for the combined pill. To most of us, this had been obvious from the start: while acknowledging a lack of good evidence, why could those writing the product reviews not have been less scathing, more willing to use a little common sense? Similar attacks have been made on both Evra® and Yasmin®, which should be welcomed as providing alternatives for women who may not have found a method that suits them.

Choice is extremely important: a woman may wish to use a product simply because her friend is happy with it. This may not be evidence-based, but if it will improve her compliance then it may be less expensive than paying for her termination of pregnancy. Most modern contraceptives are very good: should we only promote those that are invariably effective (e.g. a theoretical risk of intestinal perforation, which can result from a small fragment of an intrauterine device remaining in the uterus)? Finally, the development of letters of competence or similar certification for nurses in family planning services is essential. There ought to be nationally agreed PGDs for all contraceptive methods and drugs used for treatment of sexually transmitted infections, which would save the enormous amount of time and effort which is expended in producing individual PGDs for each Trust or service in the country. This would mean that a nurse who has in-house training to use PGDs in one service could then take this competence with her to any other employer.

Role of nurses

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The Nursing Focus article by Pam Campbell in the July issue of the Journal raised the important issue of the enhanced nurse role, which is not being fully utilised. Many areas of the United Kingdom have barriers to implementing this role for nurses who are not limited to lack of ‘commitment and support from doctors and managers’. With the development of the world, certain recurrent obstacles have been present in my experience in three different family planning services.

First, it is extremely difficult to find extra nurses to cover sessions while others are training. Even when a nurse takes annual leave there is often a gap in the service, so sending nurses on a 6-month rotation in another department would be highly detrimental to service provision. Even if a nurse were sent from the other department as a ‘swap’, extra staff would be needed to train and supervise the visiting nurse’s practice. An alternative would be to pay the nurse to attend sessions elsewhere at a time other than their normal work session; however, as pointed out in the article, many family planning nurses have full-time jobs in other departments and this could prove difficult.

Second, family planning services tend to be run on a ‘shoestring’ budget with little leeway for the expense involved in achieving adequate nurse training and the extra expense for enhanced remuneration following said training. Third, there are some nurses who refuse to take on an enhanced role even when training is offered, hiding behind the Nursing and Midwifery Council’s (NMC) requirement to recognise their own ‘scope of practice’ and to work only within their area of competence, which they decline to expand. This can lead to resentment in the workplace as they receive the same pay as nurses who have developed themselves and appear to be working harder.

Fourth, a nurse who has been developed in the workplace by a particular service may find it difficult to transfer these skills if she gets a family planning job in another service, and the new employer is obliged to provide repeat ‘in-house’ training and assessment because the nurse does not have a nationally recognised qualification. This can be difficult and confusing for nurses who work simultaneously for two or more different family planning services in their area, because Patient Group Directions (PGDs) are independently produced by each service with varying levels of freedoms for nurse supply and administration of drugs. It is not common practice for nurses to issue prescriptions to clients in family planning clinics, as supplies are normally available to give out or administer on site.

These problems cannot be solved by doctors and managers alone; there needs to be a national plan for the introduction of modernised nurse training standards and practice, ideally driven by liaison between the NMC, the Faculty of Family Planning and Reproductive Health Care and the British Association for Sexual Health and HIV, to ensure that basic training for family planning nurses covers all aspects of care included in Level 1 of the national sexual health strategy. The syllabus should include the understanding and use of PGDs and the practical sessions should result in the nurse being able to work to PGDs. There should also be time devoted to attendance at genitourinary, pregnancy termination and colposcopy clinics as standard.

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Missing IUD fragment

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The case report of Nadir et al.1 recommends that if a small fragment of an intrauterine contraceptive device (IUD) is found to be missing and cannot be retrieved by hysteroscopy or laparoscopy then laparotomy is necessary. This advice is neither pragmatic nor evidence based. The chances of finding a small portion of an IUD at laparotomy are remote and would require an extensive midline incision. The subsequent morbidity (adhesion formation, subacute obstruction, etc.) considerably outweighs a theoretical risk of intestinal perforation, which even in the unlikely event of it occurring, is not likely to cause a major degree of peritonitis.