Evidence-based medicine and guidelines

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On both Evra® and Yasmin®, which should be common sense? Similar attacks have been made

Barbara Hollingworth, ZHOGG, MPH

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Consultant and Lead Clinician, Redbridge and Havering PCTs, Surrey, UK. E-mail: bhal@zoc.org.uk

Role of nurses

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The Nursing Focus article1 by Pam Campbell in the

Barbara Hollingworth, ZHOGG, MPH

Consultant and Lead Clinician, Redbridge and Havering PCTs, Surrey, UK. E-mail: bhal@zoc.org.uk

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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 three 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.2 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 terminations and colposcopy clinics as standard.

There ought to be nationally agreed PGDs for all contraceptive methods and drugs used for treatment of sexually transmitted infections, which would save the immense 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 carry this competence with her to any other employer.

Finally, the development of letters of competence or similar certification for nurses in skills such as swab taking, smear taking, implant insertion, implant removal, intrauterine device (IUD) insertion and IUD removal would allow nurses to gradually develop a skill base that is transferable and nationally recognised.

Linking these evidence-based skills to remuneration can now be enabled by the Agenda for Change.3 Graded remuneration may encourage nurses to take up family planning as a career rather than a job to tide one over the side, leading to greater job satisfaction. Nurses spending more time practising their skills will feel more confident and competent, which is beneficial to both them and their clients. Managers can help by this respect by redesigning their services to provide evening and weekend sessions (e.g. 11am-6pm or 12–7pm) rather than the traditional 2-hour sessions, allowing for more effective use of clinical time, greater client choice of attendance time, and less time wasted on setting up and clearing away clinic trolleys and equipment. Staff will feel they have more ownership of the service, and it is easier to offer full-time jobs with more prospect of career progression.

Lynia Kingsley, MB CRN, MFPH

Director of Family Planning and Reproductive Health Care, St Helen’s PCT, Cowler Hill Lane, St Helen’s WA12 1AP, UK

References


Missing IUD fragment

Madam

The case report of Nadir & 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 intrauterine perforation, which even in the unlikely event of it occurring, is not likely to cause a major degree of peritonitis.

Peter Bowes-Simpkins, FRCOG

Consultant Gynaecologist, Singleton Hospital, Sketty Lane, Sketty, Swansea SA2 8QA, UK

References