Letters to the Editor

Teen magazines

It's great to see such a comprehensive and considered piece[1] that talks to a range of people, particularly teenagers themselves, whose views are often left out of the debate. Young people will always find a way to read teen magazines – if they're not allowed them at home they'll probably go round to a friend's house!

Melissa Dear
Communications Manager, fpa, London, UK. E-mail: melissad@fpa.org.uk

Reference
1 Quilliam S. 'Teen mags': helpful or harmful? *J Fam Plann Reprod Health Care* 2005; **31**: 77–79.

Cerazette® licence extension

I welcome the extension to the Cerazette® 'missed pill' licence up to 12 hours[1] as it facilitates concordance by offering a longer therapeutic window and minimises confusion in pill taking as the rule is similar to that of the combined oral contraceptive pill (COC). The extension of the missed pill licence for Cerazette offers better adherence as well as inhibition of ovulation,[2] and increases the contraceptive choices available to youngsters who cannot take the COC on account of medical risks or who cannot accept the invasiveness of long-term implants. Young girls worry that their mothers may suspect a pregnancy if they have amenorrhoea or gain weight on implants. Cerazette may also be used when clients are unable to provide their family medical history. I give below an account of a client who changed my prescribing habit.

It was at the end of a busy clinic when I saw this young 16-year-old girl, and the underlying message is undeniably imprinted in my memory. She accessed the clinic for emergency contraception and it is my usual practice to talk about future contraception. Her father had suffered from pulmonary embolism. She informed me that he was under 45 years old and gave no risk factors for venous thromboembolism (VTE).

I was impressed by the amount of medical information this young girl could give me and wondered whether my children of similar age would remember details of their parents' medical histories. I offered the patient a thrombophilia screen and with her consent gave her a letter requesting detailed medical information from her general practitioner. She was disappointed that I could not prescribe her pills with a longer therapeutic window similar to the ones her friends were taking. Progestogen-only contraceptive implants were unacceptable because of amenorrhoea and the progestogen-only pill was not acceptable because of concordance and efficacy issues. At the time I was accused of being overcautious and the general consensus was that I should have prescribed a COC.

A few months later I learnt that this girl had developed femoral vein thrombosis and was being treated at the local hospital with anticoagulants. This young client was so determined to get the COC that she went to another clinic, concealed the family history of VTE, and was prescribed COC. Surprisingly, she saw the same nurse, a very competent senior family planning nurse, who is very thorough and meticulous with history taking and other details and would not have missed out any relevant family history of clotting disorders. This girl deliberately concealed the facts in order to get a prescription of the COC.

I see many adolescents who are in care, or have been adopted, and hence cannot provide the medical history of their families. I am always reminded of this girl when I prescribe COC for the first time.

I acknowledge the lack of evidence on the safety profile of Cerazette to prescribe it routinely as the first-line pill or as a replacement pill for the COC, which regulates periods and mimics the natural cycle. Nonetheless, it is possible that as with progestogen-only emergency contraception, we may have enough evidence in future to change the prescribing habits of health professionals offering contraceptives to youngsters.

Anjana Oswal, MRCOG, MFFP
Associate Specialist, Family Planning and Reproductive Health Services, Luton PCT, Luton LU1 3BJ, UK. E-mail: Oswal52@aol.com

Ratna Chatterjee, MRCOG, MFFP
Clinical Lecturer in Reproductive Medicine, Department of Reproductive Medicine, University College Hospital, London, UK

References
1 Cerazette (UK SMC 03 Cera v1.3). *Electronic Medicines Compendium*, 8 July 2004. http://emc.medicines.org.uk/emc.
2 Korver T, Klipping C, Heger-Mahn D, Duijkers I, van Osta G, Dieben T. Maintenance of consistent ovulation inhibition with the 75-mug desogestrel-only contraceptive pill (Cerazette®) after scheduled 12-h delays in tablet intake. *Contraception* 2005; **71**: 8–13.

FPC prescribing

One of the issues raised at the Faculty's Current Choices Conference in November 2004 has become more pertinent in view of the changes to general practitioner (GP) out-of-hours work. It seems most family planning clinic (FPC) doctors are not able to prescribe on FP10s, and hence not able to complete patient care effectively. Does any one else find this a problem?

Take the following scenario. It's a Friday evening clinic, which is running late. A lady attends in whom you fitted an intrauterine device (IUD) 2 weeks ago. You diagnose a pelvic infection secondary to her IUD fitting. You write a letter to the GP, and she has to find time and energy to attend the out-of-hours clinic. Then she has to wait for a doctor's consultation and prescription. If the chemist is not local she may well have to wait till morning.

This scenario causes extra journeys for patients, and will involve extra cost. As a result, advice is not taken and antibiotics are not sought in a timely fashion. The out-of-hours doctor may be busy, and is unlikely to be the patient's own GP. Keeping a selection of drugs on the FPC premises may mean wastage, as some will inevitably go out of date.

Most of us working in FPCs are actually employed by the local Primary Care Trust. By prescribing we can ensure a patient's care is effective, efficient and has continuity – this is surely in everyone's interests. Why duplicate work? Surely it makes sense to allow prescriptions to be written within a FPC setting.

In Swindon we can prescribe on FP10s, to which we add the patient's GP code. We don't use it often and we have agreed within our department which drugs we will be happy to prescribe. I do believe this enhances patient care.

Laura Patterson, MRCGP, DFFP
GP and Associate Specialist in Family Planning, Carfax Street Health Centre, Carfax Street, Swindon SN1 1ED, UK

Range of qualitative research

I was glad to see your journal publish a series on qualitative research, and commend the authors for their concise summary of qualitative methodology in family planning and reproductive health care.[1–3]

I wish to make a few additional points, particularly with respect to the range of qualitative research methods. Qualitative research generates data with no inherent numeric value (images, sounds, words, etc.) and typically takes the form of text. Most definitions of qualitative research, however, fail to distinguish between the data themselves and the analyses performed on them.[4] The authors of your series discuss some of the more frequently used qualitative data collection methods – observation, in-depth interviews and focus groups – as well as some of the more common qualitative approaches to data analysis. Like many others in the field, however, they miss an ever-growing suite of quantitatively-oriented analytical methods that can be employed with qualitative data.

Qualitative data can be, and often are, quantified. Text or themes can be numerically coded and put into matrices, for example, and various data reduction techniques and statistical methods used. Content analysis, in which words or verbatim phrases are counted, also relies on statistical analyses. Likewise, observations can be quantified, and measured, for example, the number of behaviours, or the number of individuals engaged in an activity, in a specified time period. Advances in software permit efficient analyses of all of these types of data.

Sampling strategies beyond the typical purposive samples are also used in qualitative research. Sampling of an entire population (e.g. all decision-makers in a Ministry of Health) or simple random samples comprise two such examples. Appropriate sampling techniques and analytical methods permit qualitative inquiry to go beyond the formative or exploratory. With proper design and adequate datasets, qualitative research can be used to test hypotheses and data can be generalisable beyond individuals within a sample.

The authors of the series did a good job of covering the basics of qualitative research, but it would be remiss to leave your readers with the impression that this is indeed the full range of qualitative inquiry. It is an expanding and exciting field, much broader than typically portrayed in health science journals. I encourage interested readers to have a look at some of the forums for innovation in this field, such as *Field Methods Journal* or the Cochrane Qualitative Methods Network (http://www.iphrp.salford.ac.uk/cochrane/homepage.htm).

Greg Guest, PhD
Senior Research Associate, Behavioral and Social Sciences, Family Health International, PO Box 13950, Research Triangle Park, NC 27709, USA

References
1 van Teijlingen E, Forrest K. The range of qualitative research methods in family planning and reproductive health care. *J Fam Plann Reprod Health Care* 2004; **30**: 171–173.
2 Forrest Keenan K, van Teijlingen E. The quality of qualitative research in family planning and reproductive health. *J Fam Plann Reprod Health Care* 2004; **30**: 257–259.
3 Forrest Keenan K, van Teijlingen E, Pitchforth E. The analysis of qualitative research data in family planning and reproductive health care. *J Fam Plann Reprod Health Care* 2005; **31**: 40–43.
4 Bernard HR. Qualitative data, quantitative analysis. *Cultural Anthropology Methods Journal* 1996; **8**: 9–11.

Reply

We are glad to read that Dr Guest has valued our series of articles on qualitative methods in family planning and reproductive health and agree that it is an expanding and exciting field. We do appreciate that there is an increasing use 'of quantitatively-oriented analytical methods that can be employed with qualitative data'. Dr Guest will, of course, appreciate that our articles are meant to be (a) aimed at a broad audience and (b) merely an introduction to qualitative methods. This said, we have outlined one of these quantitative approaches in the qualitative methods paper appearing in this issue of the Journal (pp. 132–135).[1] Under the heading