Letters to the Editor

Teen magazines

It’s great to see such a comprehensive and considered piece1 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 to have them at home they’ll probably go round to a friend’s house!

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

Reference

Cerazette® licence extension

I was impressed by the amount of medical information a 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 to which she consented and gave her a letter requesting detailed medical information from her general practitioner (GP) out-of-hours work. It seems most family planning clinics (FPC) doctors are not able to prescribe on FP10s, and hence not able to complete patient care effectively. Does anyone else find this a problem?

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

References

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) contraindications. This girl and would not have missed out any relevant medical advice. This girl and most family planning clinics (FPC) doctors are not able to prescribe on FP10s, and hence not able to complete patient care effectively. Does anyone 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 time to find 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 can cause 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 less likely 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 Keeping a selection of drugs on the FPC premises may mean wastage, as some will inevitably go out of date.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, MBACP, DFFP
GP and Associate Specialist in Family Planning, Curfax Street Health Centre, Curfax 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

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, distinguish between the data themselves and the analyses performed on them. The authors of your series discuss some of the more frequently used qualitative data collection strategies in the form of 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. Quantitative data can often be, and are, quantified. Text or themes can be numerically coded and put into matrices, for example, and visualized in health science journals. I encourage methods used. Content analysis, in which words or verb-adjunct phrases are counted, also relies on statistical analyses. Likewise, observations can be quantified. Number of behaviors, 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 sample are also useful to 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. Appropriately sampling 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 generalizable 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.jbpm.salford.ac.uk/cochrane/homepage.html) by Steven Field (2003). Qualitative research in family planning and reproductive health and agree that 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.

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

References

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). Under the heading...
LETTERS/NEWS ROUNDUP

Emma Pritchford, BSc, PhD
Department of Health Sciences, University of Leicester, Leicester, UK

Maureen Porter, ABS, MBBS
Department of Obstetrics and Gynaecology, University of Aberdeen, Aberdeen, UK

Karen Forrest Keenan, MA, MPhil
Public Health and Department of Medical Genetics, University of Aberdeen, Aberdeen, UK

References


News Roundup

Mobile phone technology to the rescue?

The youth of today spend large amounts of time texting each other on their mobile phones. Brook have utilised the fashion and the technology to give young people access to information about sexual health. The new service gives young people instant access to information on a range of topics, including sexually transmitted infections, contraception, and other sexual health issues. As well as details of their nearest Brook Centre or young people’s clinic, all via their mobile phones. Brook introduced the service to compensate for the postcode lottery that affects the amount of information that young people can access. By texting BROOK HELP to 81222, users will receive a menu of options, giving them access to automated information on key sexual health topics or details of their nearest young people’s sexual health service. This is in addition to their comprehensive website at http://www.brook.org.uk.

Depo-Provera and bone density again

Just in case anyone didn’t see the information from the Committee for Safety of Medicines,1 their current advice on Depo-Provera2 is as follows:

- In adolescents, Depo-Provera may be used as first-line contraception but only after other methods have been discussed with the patient and considered to be unsuitable or unacceptable.
- In women of all ages, careful re-evaluation of the risks and benefits of treatment should be carried out in those who wish to continue use for more than 2 years.
- In women with significant lifestyle and/or medical risk factors for osteoporosis, other methods of contraception should be considered.
- It has gradually become clear that, for some women, bone loss occurs during the time they are using Depo-Provera and recovers by a variable amount after stopping the method. This is particularly unacceptable in adolescents who have not yet attained their peak bone mass. The highest risk for low bone mass is in those (young) women who smoke, eat a poor diet and do not exercise.

Bandoletti examines compliance with medication in an interesting article that includes looking at compliance with contraception. An analysis of perfect and imperfect use of a patch and oral combined contraception had pregnancy as an outcome.3 Perfect use was defined as 21 consecutive days of either the patch or taking the oral contraceptive. Information was obtained from diary cards on an ongoing basis. It was amazed at the number of ‘perfect’ cycles – but then this was a clinical trial, not real life. Imperfect use increased the pregnancy rate by between five and ten times, although the total number of pregnancies was small in each group. This reminds us that contraception which is not dependent on human activity or memory works better every time.

References


Keep taking the medicine

Bandolier examines compliance with medication in an interesting article that includes looking at compliance with contraception. An analysis of perfect and imperfect use of a patch and oral combined contraception had pregnancy as an outcome.3 Perfect use was defined as 21 consecutive days of either the patch or taking the oral contraceptive. Information was obtained from diary cards on an ongoing basis. It was amazed at the number of ‘perfect’ cycles – but then this was a clinical trial, not real life. Imperfect use increased the pregnancy rate by between five and ten times, although the total number of pregnancies was small in each group. This reminds us that contraception which is not dependent on human activity or memory works better every time.

References


Ideological constraints on women’s health

A National Protocol for Sexual Assault Medical Forensic Examinations1 was published in September 2004 by the US Department of Justice, Office on Violence Against Women. No mention of emergency contraception is made in the document. Detailed and extensive advice on the identification and prevention of sexually transmitted infections (STIs) is included. The only mention of the pregnancy risk is the following:

“Recommendations at a glance for health care providers to evaluate and treat pregnancy:

- Discuss the probability of pregnancy with female patients.
- Administer a pregnancy test for all patients with reproductive capability.
- Discuss treatment options with patients, including reproductive health services.”

It is feared that the document has been influenced by the desire to avoid controversy with the anti-abortion groups in the USA who believe that life begins at conception and that the prevention of implantation (which might be produced by emergency contraception) is murder. Other instances of the difficulties produced by the anti-abortion pressure groups and the support given to them by President Bush are well documented.2 The Emergency Plan for AIDS Relief provided by the USA exists in parallel with the Global Fund to fight AIDS, Tuberculosis and Malaria from the United Nations. The president’s programme has been criticised as diverting funds from the Global Fund, and organisations that receive funds from the programme are usually required to agree not to be involved in abortion provision or counselling. This is difficult in countries where women may only have access to one clinic that provides all health care for them whether that is contraception, abortion or treatment for AIDS. The expected changes in the composition of the Supreme Court will help to push forward a review of abortion legislation. Social policies emphasise fundamentalist views on sexuality, including the promotion of abstinence as the only means of preventing pregnancy.3 It is feared that women’s health will suffer and unwanted pregnancies will increase.4

References

2 http://www.ippe.ru/publications/personealex_s.asp.

Collated and reported by Gill Wakley, MD, MFFP, Visiting Professor in Primary Care Developments, Staffordshire University and Freelance GP, Writer and Lecturer, Abergavenny, UK