Letters to the editor

Table 1 Duration of intrauterine device/intrauterine system (IUD/IUS) use (in months)

<table>
<thead>
<tr>
<th>Parameter</th>
<th>IUD/IUS</th>
<th>TSafe 380 ®</th>
<th>Mirena ®</th>
<th>NovaT ®</th>
<th>Multiload ®</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>88(49.7)</td>
<td>65(37.1)</td>
<td>11(6.3)</td>
<td>4(2.8)</td>
<td></td>
</tr>
<tr>
<td>Duration</td>
<td>0.5–108</td>
<td>1–84</td>
<td>5–132</td>
<td>0.75–26</td>
<td></td>
</tr>
<tr>
<td>Average</td>
<td>14.56</td>
<td>21.60</td>
<td>58.64</td>
<td>14.9</td>
<td></td>
</tr>
<tr>
<td>Number</td>
<td>16</td>
<td>16</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Duration</td>
<td>0.5–54</td>
<td>18–84</td>
<td>36–132</td>
<td>0.75–26</td>
<td></td>
</tr>
<tr>
<td>Average</td>
<td>14.4</td>
<td>44.68</td>
<td>74.16</td>
<td>13.37</td>
<td></td>
</tr>
</tbody>
</table>

Table 2 Shows the year of removal. Eleven (27.5%) were removed in the first year of use, of which nine were TSafe 380 ® IUDs. Three of these had expired and four were removed for bleeding. Eight (20%) were removed in the second year, of which three TSafe 380 ® IUDs were removed to facilitate pregnancy. More than 50% of the IUS were after 5 years. There were no IUS/IUD-related pregnancies.

Training GPs to fit IUDs/IUS

We were delighted to read the article on training general practitioners (GPs) to fit intrauterine devices/intrauterine systems (IUDs/IUSs) by Deborah J Lee in the July 2007 issue of the Journal.1 Dr Lee has been very proactive in developing alternatives to the traditional format for this specialised training. Having heard about her work I too have been developing a ‘peripatetic’ system for training clinicians, based mainly on Dr Lee’s ideas. There are exciting times ahead; it is possible that practice-based commissioning will lead to a renaissance in the provision of services in the community by primary care. I have some comments:

Training GPs to fit IUDs/IUS

1. I have been training both doctors and nurses – particularly with Implanon ® insertion and removal. I have survived reversible contraception (LARC) provision by suitably trained nurses should be available for all women.

2. There is a cohort of older GPs who have great skill and many years experience in IUD fitting who do not have any certificates or Letters of Competence (LoC). The National Enhanced Service Contract for primary care accepts their experience under ‘Grandfather’ rules. I have worked with Dr Mohammed Edris to develop a system of revalidation, which involves visiting the practice and observing the clinician fit at least three devices. This visit is also used as an updating and teaching session, reviewing issues such as sterilisation of equipment and current issues. My visits have been welcomed by my GP colleagues, who often work in isolated settings. The learning is mutual! I suggest that PCTs should consider incorporating some sort of a system for all providers with whom they place contracts for IUS/IUD/Implanons services.

3. By training practitioners who are in established practice, I know that they will develop their services because they are responding to the needs of their locality. This is different to doctors in training completing another LoC because it will look good on their CV.

4. I also do a regular session in a community family planning clinic, and find that the pressure on appointments for LARC makes unhurried training difficult. There is increasing demand for these services when as we know there is little financial investment in community sexual health services at present.

5. My colleagues in training have been supported by drug company financial support. Of course Organon has a motive to ensure that practitioners who fit and remove its implants are suitably trained, as this should reduce litigation. I see this as mutually beneficial. Primary Care Trusts (PCTs) have become very wary of involving drug companies in any form of sponsorship. There is no money specifically available for training in general practice as this is included in the ‘Global Sum’. I am concerned that nurses in particular could lose the opportunity to train, as their GP employers may not see cost benefits. I now simply charge practitioners for IUD fitted – this sum is slightly lower than the amount the PCT pays per fit. By training and accrediting, the practice is greatly enhancing its earning potential, with only trainees to the Faculty LoC standard and encourage revalidation.

6. My only concern is the issue of indemnity, which was not discussed by Dr Lee. As a visiting clinician undertaking a procedure on a patient registered with another doctor, I assume my liability follows me wherever I go, but my insurance company may need to consider any new risks.

References


Training for the LoC IUT

Is it time to alter the criteria for this qualification?

At the moment the training requirement for the Faculty of Family Planning and Reproductive Health Care Letter of Competence in Intrauterine Techniques (LoC IUT) is that the trainee should fit at least two different currently available devices. I have recently had one of my trainees refused her certification because she had only fitted Mirenas. In my family planning clinic, and find that the periods lighter and less painful, it is not a contraceptive service. Along with the LARC guidelines, I conclude there will be no women seeking IUS/IUDs/implants.

The vision of a locally accessible service provided by well-trained clinicians will need lots more training in a variety of settings. There are more and more trainers to set up ‘provider’ services that will train and accredited, and which could be profitable.

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Blackwell Publishing

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