experience at IV administration. Perhaps we are unusual in that so many of our nurses do so many procedures.

Do any ... including the physiology of the

Barbara Hollingworth, FFSRH, DRCOG
Consultant in Family Planning and Sexual Health, Barking, Havering and Redbridge University Hospitals NHS Trust, UK.
E-mail: bab@lapins.plus.com

References

Nurse training and the need for IUD fitters to have expertise in resuscitation

I would like to put fingers to keyboard after reading the thoughtful Personal View by Shelley Mehigan and her colleagues along with the subsequent correspondence in the April 2010 issue of the Journal.

Nurse training in our specialty needs a nationally recognised and standardised educational pathway producing health care professionals who are ‘fit for purpose’. This training must be theoretically and practically robust, be based on sound evidence and the accreditation must not be overly expensive. Our services may still be ‘doctor-led’ in many parts of the UK, but clinics would come to a grinding halt if nurses are restricted in their practice and become ‘handmaids’ once more. The letter written by Dr Barbara Hollingworth clearly illustrates this point.

We have also had local community nurse-based clinics fitting intrauterine contraceptives in general practice premises suspended because ‘doctor cover’ by the general practitioners [who can administer intravenous (IV) drugs] has been withdrawn. Faculty guidance in Service Standards for and Intrauterine Contraception does not clearly state that a health care professional proficient in giving IV drugs is available on site but this is implied by having an IV bag and ‘IV drug’ medications available for IV. Clinical Leads should check with their local Ambulance Trusts as many suggest that adrenaline is the only drug that needs to be available within community clinics.

I have recently asked over 70 health care professionals who fit intrauterine contraceptives about their use of atropine and no one has administered it. I have on one occasion in the last 22 years when a woman was very keen to keep an intrauterine device (IUD) fitter to have expertise in resuscitation,1,2 This is a question that I am being increasingly asked by clinicians around the country as they become aware of the implications of recent guidance on this topic. Not only is it unrealistic to expect all the clinicians involved to undertake the extra training and regular practice to comply with the guidance – looking at the British Resuscitation Council guidelines,3 doing what is advised would need advanced life support (ALS)-level training with regular practice of the techniques – it also has implications for how services can be delivered not just by nurses but by doctors too. Many services will feel it is unworkable. Those that have tried, like Dr Hollingworth, to ask the Royal College of Nursing (RCN) to produce further guidance based on the Faculty of Sexual and Reproductive Health Care’s and the Faculty of Sexual and Reproductive Health Care’s ‘real life’ situations that I hear about, hygiene practices around anal sex are often far from perfect and so, again pragmatically, during pregnancy in particular I generally advise avoidance.

Finally, the aim of my article, and the substance of the main body of my text, was to promote sex in pregnancy and ask professionals to encourage it. I didn’t aim to give detailed information about risks – such information is covered fully in many other sources. Hence the guidance provided in the summary boxes gives headlines only rather than explaining in full the medical background.

Shelley Mehigan, RGN
Nurse Specialist (Contraception), Berkshire East Community Health Services, Sexual Health, Upton Hospital, Slough, UK.
E-mail: shelley.mehigan@berkshire.nhs.uk

References

Safe sex during pregnancy

As an instructing Doctor for the Faculty of Sexual and Reproductive Health Care (FSRH), I have enjoyed completing this online training2 at www.e-iff.org.uk.

This is an excellent course, and the animations, including the physiology of the