I would be grateful for the authors’ thoughts on this matter.

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Reference

Reply
Dr Qureshi’s interest in our article is most welcome. The results of the audit from Dr Qureshi’s unit suggest that the introduction of a standardised proforma might be expected to improve compliance with RCOG guideline recommendations.

As regards to whether the procedure is called ‘laparoscopic tubal occlusion’ or ‘laparoscopic sterilisation’, whilst the former may be more precise, the latter is likely to be more easily recognised as an identifiable procedure by most of our patients. Preoperative counselling is an exercise in communication and we should strive to use the terminology that is most easily understood by our patients.

The publication of the consent advice from the website in our audit, so quoting a risk of dying from the procedure was not included as an audible standard. Whilst there should be no difficulty in explaining that the procedure must be considered an operation, I agree that to then discuss the availability and results of sterilisation reversal seems contradictory. This latter dilemma is not an issue locally since our Health Board do not permit us to perform sterilisation reversal procedures.

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Pelvic examination for detecting ovarian cancer

I was very disappointed to read Gill Wakley’s website review in the last issue of the Journal.1 Have we finally abandoned clinical common sense on the altar of guidelines and evidence-based practice? Nobody with any sense would advise a pelvic examination as a means of detection of ovarian cancer. The main reason for performing a bimanual examination prior to taking a cervical smear is to ensure a digital vaginal examination fails the criteria for a screening test.2 For example, it does not identify reliably, at an early stage, conditions that can be treated to prevent progression. It may do harm by identifying conditions that are not significant and expose the patient to unnecessary further investigations. It may do harm by giving false reassurance of normality.

As a preliminary investigation of a patient with symptoms, it can be useful, but is not accurate enough to preclude further investigation of symptoms by other means such as ultrasound or laparoscopy.3,4 A large number of questions and answers now appear in the women’s health section of this NELM service,1 many of which health professionals will find instructive and useful, as they are based on real clinical problems.

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References

Copying clinical letters to patients

I read with interest Anna Glasier’s contribution to Personal View in the April edition of the Journal.1 Whilst not wishing to find it difficult to draw precise conclusions from her small project, I should like to add our own findings from a more general patient population to support her impressions.

We conducted an audit into the system for ‘Copying Letters to Patients’, which had been set up at Barnsley Hospital NHS Foundation Trust in response to the Department of Health Initiative first noted in the NHS Plan.2 Our findings mirrored those of Anna Glasier in that patients were enthusiastic about the initiative but that medical, nursing and administrative staff were much less so.

Eighty-five case notes were reviewed as an unselected sample of patients attending a first outpatient appointment in General Medicine, Orthopaedics, Rheumatology or General Surgery. Confirmation of a wish to receive a copy letter was present in 40 cases and all of these patients were asked to complete a questionnaire by post on their satisfaction or otherwise after receiving the copy letter. Some 130 clinical and administrative staff were asked to complete a similar questionnaire. Both patients and staff were also allowed the opportunity in the questionnaire to comment by means of free text.

Staff were generally critical, regarding the initiative as time consuming, bureaucratic and a duplication of time and effort, potentially leading to increased work from telephone calls from patients who had not understood some of the medical terms used in the letter. Patients were correspondingly enthusiastic, with the majority of patients who had received a copy letter helped them to understand their condition or illness and what would happen to them next, as well as being a reminder of what was said during their consultation. Only one patient said that they had noticed a factual error in the letter and all remarked that they could understand the medical terminology used.

The outcomes are so similar to Anna Glasier’s findings that I would conclude that the nature of the information being sent to the patient has little bearing on their satisfaction at having received it. The highly personal nature detailing a sexual health consultation appears to be no more or less inhibitory to its formal documentation than a history taken that does not require such intimate detail to be recorded.

Equally striking was the suspicion and uncertainty with which staff approached this issue. Our personal view is that in terms of this initiative staff appear to have a common hesitancy approach but that patients are more likely to be receptive in their wish to understand their own personal health information than their health worker carers give them credit for.

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Invisible contraception?

I thought others might be interested to hear a comment passed on to me in my family planning clinic today. My client noticed her friend’s Implanon® rod glowing under UV lighting while they were in a nightclub. It didn’t put her off having one fitted herself, but maybe we should warn people that their ‘invisible’ contraceptive method may be seen in these circumstances.

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