# Prescribing combined oral contraceptive pills: enhancing shared decision making and women's choice.

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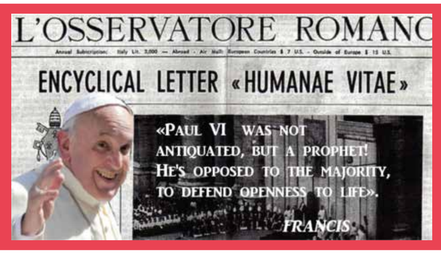
## BACKGROUND

It was a landmark moment for women's reproductive rights when the COCP was invented in the 1950s. There is no doubt that the advent of hormonal contraception changed the lives of women across the globe and paved the way for sexual emancipation. From the offset it faced opposition from the Catholic Church, and other conservative outlets, claiming that it was an affront to nature. One of its co-creators Dr John Rock campaigned for the Catholic Church to approve the COCP, arguing that it mimicked natural hormones and replicated a natural menstrual cycle with a 7 day break. The church still forbade it.

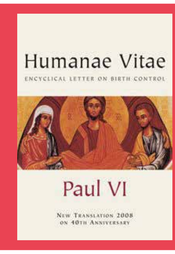
This was 60 years ago.

The 7 day break causes most of the COCP's significant side effects: headaches; mood changes; heavy and painful withdrawal bleeds. It also significantly increases the risk of ovulation and decreases the efficacy of the pill. The levels of hormones in the COCP has steadily decreased throughout the years, making the 7 day break even more unnecessary. Irrespective of the controversy surrounding the original justification for the 7 day break, the true scandal is that this has continued largely unchecked for 60 years. It is a concerning indictment of the medical profession's attitude to women's reproductive health and sexual freedoms.

The new FSRH guidelines have the potential to increase quality of life for women on the COCP; they decrease the side effects and reduce the risk of an unwanted pregnancy. Importantly, the new guidelines open a dialogue between patient and doctor about reproductive choices, enhancing shared decision making and empowering women to make informed decisions about their reproductive choices. It is vital that they are communicated effectively and routinely to women. To not do this is to continue a shameful legacy of denying women bodily autonomy. In a global context of a rollback of women's reproductive rights and real threats to the advances made in gender equality, this is all the more disturbing.





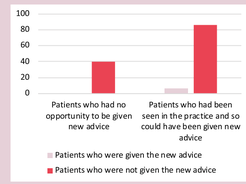

## METHODOLOGY

- We ran a search through the practice's record system of all registered patients. We searched for all those who had been prescribed a 'standard strength, oral CHC' on or after 1st November 2018, either as a new or repeat prescription. This yielded a data set of 236 patients.
- We decided what our cut-off date would be for when the practice should have been delivering the new advice of the FSRH guideline. Since the new guideline was published on 16th January 2019, and the press release given on 21st January, we selected 1st February as this cut-off date, to allow for the delay in knowledge dissemination.
- We went through the list of 236 patients and underlined all those with a prescription on or after 1st February.
- Of our underlined patients, we checked whether they had had a consultation since 1st February. If they had not, we marked them as 'no opportunity' for new advice to be given.
- If they had been seen, we checked the notes as to whether they had been given any of the new advice or not.
- We then divided up our population sample and counted those in each category for statistical analysis later. The patients were divided as follows:

  a) Patients with a prescription given on or after 1st February who had no opportunity to be given new advice.

  b) Patients with a prescription given on or after 1st February who had been seen in the practice and so could have been given new advice.

  i. Those who were given the new advice.
  ii. Those who were not given the new advice.




| | Category of Patients | No. of Patients |
|---|---|---|
| | Total number of patients who had received a prescription on or after 1st February 2019 | 132 |
| a | Patients who had no opportunity to be given new advice | 40 |
| b | Patients who had been seen in the practice and so could have been given new advice | 92 |
| b.i | Patients who were given the new advice | 6 |
| b.ii | Patients who were not given the new advice | 86 |

Only 6.5% of patients were informed about the opportunities for new, tailored CHC regimens, falling pitifully short of the FSRH's expected target of 97%

> "Traditionally women have then either had seven pill-free days or taken seven placebo tablets; during this HFI, most women will have a withdrawal bleed... It should be made clear to women that this bleed ... has no health benefit (The Faculty of Sexual and Reproductive Health, Combined Hormonal Contraception, January 2019; 6.1.1)"


## RECOMMENDATIONS

- **1. Raising awareness of the new guidelines in the practice:** we plan to present a talk about the new FSRH guidelines to staff members to accelerate their dissemination.
- **2. New CHC protocol:** we recommend writing a new protocol on CHC prescribing in accordance with the new guidelines, ideally presented in a flowchart format that could perhaps be on the walls in the surgery for quick reference.
- Finally, the delay in the dissemination of these new guidelines exposes the gap between the information being given by medical faculties and that being received by healthcare professionals. This hinders positive changes to patient care, and thus must be addressed in order to deliver a cohesive health care system:
- **3. Ongoing healthcare education of staff:** for future changes to any guideline, we would suggest that automatic prompts could be built into the new computer system when they are updated. In addition, the practice could appoint one healthcare professional to be responsible for reviewing and updating a specific guideline within their area of interest or expertise.