GYNAECOLOGY

Changing Services for Changing Needs

Edited by
SUE JOLLEY

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Contents

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Julie Golding has worked in the Gynaecology Department at Queen's Medical Centre, Nottingham, for the whole of her career. She was a ward sister from 1986 until 2002 when she became an Oncology Nurse Specialist within the same unit. In 2003 she took on the additional role of Risk Management Coordinator for the Gynaecology Unit. She is also currently acting Head Nurse/Matron for Gynaecology on a job-share basis.

Sue Griffiths
Sue Griffiths's basic nursing skills were gained in Renal Medicine before she moved to Gynaecology in 1987. After many years working as a senior gynaecology staff nurse, she was appointed as a Nurse Adviser in the Gynaecology Outpatients Department at City Hospital, Nottingham. In 2002 she moved to Primary Care, working alongside the Community Gynaecologist in Contraception and Sexual Health to set up a Medical Termination Service. She now works 'cross-boundary' in both primary and secondary care.

Sue Jolley
Sue Jolley was a mature entrant into nursing, previously working as a primary school teacher. She has been a Gynaecology Nurse for 15 years and has developed a special interest in teenage sexual health. She currently has dual responsibility for promoting research and managing the Gynaecology Pre-operative Assessment Unit. She has had several articles published on issues relating to women's health.

Sarah Kordula
With dual qualifications in both general nursing and midwifery, Sarah Kordula has worked in women's health since 1989. She has undertaken specialist training in continence, family planning, menopause and bone densitometry (operation and safety). She is currently studying for the postgraduate certificate in Osteoporosis and Falls Management at Derby University. She provides probably the only DXA service within a gynaecology/menopause clinic in the UK.

Judith Lee
Judith began her working career as a physiotherapist at the Radcliffe Infirmary, Oxford. After moving to Nottinghamshire, she became interested in the

management of incontinence in the elderly and also began conducting antenatal parentcraft classes at a local Health Centre. Since then she has worked in the specialty of obstetrics and gynaecology. For the past 16 years she has held senior positions at King's Mill Hospital, Mansfield, and Queen's Medical Centre, Nottingham, where she is now the Clinical Specialist Women's Health Physiotherapist. She is an active member of the Association of Chartered Physiotherapists in Women's Health and has a specialist interest in the promotion of continence.

Joan Meyerowitz
Joan Meyerowitz has been a qualified nurse for 30 years, spending the last 15 years in women's health both in Oxford and Nottingham. She has specialised in colposcopy, family planning and the menopause. Her interest in the menopause started 10 years ago and in 1999 she initiated a nurse-led implant service in Nottingham. Since then she has provided this service along with menopause advice in the gynaecology menopause clinic. She is an active member of the British Menopause Society and responsible for teaching about the menopause on local gynaecology and sexual health study courses and practice nurse study days.

Sian Schmidt
Sian Schmidt qualified as a Radiographer in 1994 and subsequently qualified in Medical Ultrasound from St Martins University College, Lancaster. She has worked in several ultrasound departments throughout the UK and her positions have included a superintendent post. She currently works at Queen's Medical Centre, Nottingham, and specialises in obstetrics, gynaecology, and abdominal and vascular ultrasound.

Liz Towell
Liz Towell started her career as a gynaecology nurse at the City Hospital in Nottingham. She subsequently trained as a midwife but later returned to gynaecology nursing, eventually working at Queen's Medical Centre, where she became a ward manager. After transferring to the Gynaecology Outpatients Department, she was involved in setting up the Gynaecology Urodynamics Service in the early 1980s. Initially a research venture, this later became part of the gynaecology service. Liz widened her scope of practice by undertaking courses in both urodynamics and continence. She regularly teaches different groups of staff about urodynamics and female continence, and is particularly involved in teaching medical staff who are attached to the gynaecology unit. She is now Divisional Nurse for Gynaecology.

Anne Walton
Anne Walton works as a Gynaecology Nurse Practitioner at Queen's Medical Centre, Nottingham. She set up and manages the Early Pregnancy Assessment

Centre. Anne qualified as a state registered nurse and then as a midwife in Birmingham and has worked as a ward manager on gynaecology wards. She has qualifications in Family Planning and Clinical Developments in Nursing Care. Anne has recently been appointed as a Trustee for the Miscarriage Association.

Helen White
Helen White chose to work in gynaecology when she qualified in 1987. She has worked on three different gynaecology wards and became a ward manager in 1993 at Queen's Medical Centre, Nottingham. After 10 years in the post, she looked for a new challenge in women's health, which involved more individual patient contact. She was subsequently appointed to a Specialist Nurse role in the Medical Termination of pregnancy. This involves work in gynaecology outpatient clinics, community clinics and also inpatient care.

Cindy Wilson
Cindy Wilson trained at University College Hospital, London, and moved to take up a post on a gynaecology ward at Queen's Medical Centre, Nottingham, in 1985. She has worked in women's health since then, gaining a Diploma in Professional Studies. Her current role is as a Gynaecology Liaison Nurse in the Early Pregnancy Assessment Centre, where she has worked for five years and developed her expertise in supporting women with problems in early pregnancy.

Sally Wright
Starting her career as a gynaecology staff nurse, Sally Wright went on to train and work as a midwife. She later returned to gynaecology and became a ward sister in 1990. As a ward sister she became very interested in oncology and was subsequently seconded to do a specialist Oncology Course (ENB 237). Following this Sally was appointed as Oncology Nurse Specialist and has developed the Gynaecology Oncology Service at the Queen's Medical Centre, Nottingham. This also involves working with the oncologists at Nottingham City Hospital. She has since trained as a Nurse Colposcopist and is currently acting Head Nurse/Matron for Gynaecology on a job-share basis.

Jill Yates
Jill Yates has had a very varied career. After training at Gloucester Royal Hospital, she worked as a staff nurse in medicine, surgery and research in Southport. She became a sister in the Endoscopy Unit in Greenock, Scotland, before moving to Nottingham and a post in Endoscopy at Queen's Medical Centre. She worked as a Fertility Sister for 10 years and obtained a Diploma in Sexual Health. She currently works as a Practice Development Nurse in Gynaecology.

Preface

Gynaecology in the twenty-first century is much more than just a surgical speciality. The range of services and associated care has expanded rapidly in recent years, reflecting the changing health needs of women. Many exciting developments have been initiated by nurses and professionals allied to medicine (PAMs).

The chapters in this book each focus on a main area of gynaecological care, providing a general overview of the issues involved as well as specific examples of how nurses and PAMs are making a difference. All of the contributors have used their interest and expertise in a specific field to develop a gynaecology service for women. They are all keen to promote gynaecology by sharing best practice.

The book will have a special appeal for all nurses and PAMs already working in gynaecology. Hopefully it will motivate and encourage them to look at new ways of delivering care. However, anyone interested in women's health in general would gain a useful overview of gynaecological problems and modern service provision.

Sue Jolley

Introduction

This book discusses a wide range of topical gynaecological issues. The areas chosen reflect the changes that are taking place in gynaecology services, with an emphasis on how nurses and PAMs can make a difference to the delivery of care, either through nurse-led clinics or the development of roles within the multidisciplinary team. This exemplifies the action advocated in recent government reports (*Making a Difference*, Department of Health 1999 and *The NHS Plan*, Department of Health 2000*)*.

The book may be read as a whole in order to gain an overview of recent developments in gynaecology, but as each chapter stands on its own it would be useful for those professionals, or students, with an interest in one particular field. The first chapter gives an overview of nurse-led assessment in gynaecology and is a natural introduction to the work covered by the following chapters. Topics are arranged roughly in the order they may be experienced as a woman matures, starting with sexual health problems, frequently associated with teenagers, and ending with the menopause and gynaecological oncology. However, there is considerable overlap with, for example, more mature women now contracting sexually transmitted infections and an increase in gynaecological cancers among younger women.

Common to each of the chapters is an outline of the challenges resulting from the needs of women with particular gynaecological problems and how services are developing to meet those challenges. A helpful summary of this is included in box form at the start of each chapter. Otherwise the chapters are all written differently, reflecting the style and interests of each of the contributors. They all deliver gynaecology services at Queen's Medical Centre, Nottingham, so many examples of good practice are drawn from that hospital. However, these examples are chosen not only to demonstrate what is possible but also to illustrate similar changes that are taking place at many different centres across the UK.

Each chapter is evidence-based and fully referenced. Useful help lines and websites are included. At the back of the book is a glossary, which explains the different gynaecology terms used in the book.

1 Nurse-led Assessment in Gynaecology

SUE JOLLEY

Assessment refers to a continuous process of collecting and organising both subjective and objective data about a patient's health status. This is an implicit part of all ongoing nursing work as nurses continually assess the patients in their care in order to offer the appropriate interventions. Indeed, for many years student nurses have learned about assessment as an integral part of the nursing process, included in most nursing models (Aggleton & Chalmers 2000; Pearson *et al.* 1996; Roper *et al.* 2001). *Nurse-led assessment* is a much more specific and directed activity, carried out to help with either diagnosis or treatment. It has become important as new nursing roles have developed. This chapter discusses the implications of nurse-led assessment and describes how it is used within gynaecology.

Challenges	Service developments
• The need to improve waiting list management in response to government targets • The reduction in junior doctors' hours • Improving patient access and optimising flow • Constant pressure on hospital beds • Inappropriate emergency admissions to gynaecology wards	• Nurse-led clinics to fast-track admissions for suitable cases, e.g. sterilisation service • Nurse-led Pre-operative Assessment Units • Guidelines and protocols to support extended roles • Nurse-led Gynaecology GP Emergency Admission Units

WHY ARE NEW NURSING ROLES DEVELOPING?

The expansion of nursing roles and development of nurse-led clinics has undoubtedly been driven by the need to reduce doctors' hours, reduce costs and improve waiting list and bed management. The *New Deal* for junior

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doctors, introduced in 1991, limits the working week to 56 hours on average (NHS Management Executive 1991). The *European Working Time Directive* (93/104/EC) should reduce doctors' working hours even further, to 48 hours a week by 2009 (British Medical Association 2004; Department of Health 2005). Progress towards meeting these targets has been very slow and figures suggest that almost half of junior doctors in the UK work more than 56 hours a week (British Medical Association 2004). *The NHS Plan* (Department of Health 2000a) promised patients a modern, flexible service with reduced waiting times. The target waiting times were three months for an outpatient appointment and six months for inpatients. These have been superseded by even more optimistic promises, culminating in the government pledge that 'no patient will wait more than eighteen weeks for hospital treatment from GP referral to admission' (*The Times* 2005).

This has created both a challenge and an opportunity for the NHS to modernise its services and look at different ways of working. There has been pressure for nurses to improve their professional status (Department of Health 1999) and the nature of nursing has changed in response to demands for more flexible and relevant healthcare services (Department of Health 2000b). One of the central features of health policy is to introduce innovative services that use the specialist skills of nurses (Knape 1999). Nurses now share a wide range of clinical work with medical colleagues in primary care, accident and emergency departments, specialist clinics and maternity services (Savage *et al.* 2000). This has also led to an increase in nurses' autonomy as they run clinics, perform minor surgery, admit and discharge patients and request tests and investigations (Collins 1999; Magennis *et al.* 1999; Royal College of Nursing 1997).

ISSUES AROUND NEW NURSING ROLES

The emergence of new roles such as nurse consultant, liaison nurse, specialist nurse and nurse practitioner has sometimes been controversial. Partly this is because nurses and midwives are adopting a variety of titles without any clear consensus as to what they all mean and what qualifications are required. There is no agreed definition for a nurse practitioner in the UK (Hicks & Hennessy 1999; Wadsworth *et al.* 2002). There is some degree of uniformity in the work of nursing and midwifery consultants but, as yet, no regulation of their training. All the new titles sound important and imply that the bearer possesses some higher knowledge that will lead to better care for patients. However, without appropriate regulation patients could be put at risk (Carroll 2002). Trusts use a wide range of methods to decide which staff should be given advanced positions. Sometimes prior experience is enough, but sometimes extra training is also required. This can vary from a few days on a course to a doctorate requiring several years' study. There are now moves by the Nursing

and Midwifery Council (NMC) to address this problem. Hopefully new standards and competencies will make the situation clearer, and setting up a part of the register specifically for nurses and midwives in advanced practice could protect certain titles.

There is also concern about the over-medicalisation of nursing. If nurses are asked to expand their roles for reasons other than their own professional development, there is a danger that they may be exploited (Magennis *et al.* 1999). There is sometimes resentment when expanded roles do not necessarily attract appropriate remuneration (Collins 1999; Rose *et al.* 1998). Being expected to perform mundane medical tasks may compromise the quality of nursing (Edwards 1995), and Cahill (1998) argued that many nurse practitioners are pretending to be doctors. The legal position for nurses in expanded roles may also be unclear and nurses do have some concerns about their perceived increased vulnerability to litigation (Magennis *et al.* 1999). Under *The Scope of Professional Practice* (United Kingdom Central Council 1992) nurses are accountable for their own practice, but how practitioners determine their own competence is sometimes unclear. This is important because vicarious liability refers to the employer being responsible for their employees' actions providing they are working within their remit and agreed protocols.

There are fears that the continued pressure for nurses to expand their roles will be done at the expense of essential nursing care and that nursing should be valued in its own right (Kitson 1999). However, this argument forgets that nurses have always informally guided junior doctors and some nurses want to expand their role (Collins 1999; Magennis *et al.* 1999). If the development of new specialist roles are led by nurses for the benefit of the patients and not dictated by the needs of trusts, there are considerable advantages. Castledine (1995) argued that advancing the boundaries of nursing practice could be used to the profession's advantage, and Rounds (1997) highlighted the benefits of nursing input because nurses can 'offer a unique blend and broader scope of healthcare but physicians can offer only medicine'.

Clearly without appropriate education and training to support new roles, health workers may be placed under stress and the quality of patient care could be compromised. However, evidence suggests that many nurses lack the appropriate skills and preparation for such roles. Read *et al.* (1999) found that 93 % of 618 practitioners in innovative roles felt that they needed further education and training. Educational requirements should be formalised by professional bodies and the Nursing and Midwifery Council (Carroll 2002) and there have been calls for major investment in educational programmes, both at pre- and post-registration levels, to give nurses the skills they need (Hicks & Hennessy 1999; Magennis *et al.* 1999).

A key component of any nurse-led service is the ability to carry out a thorough, accurate and relevant assessment. For this there are both general and specific training requirements. General issues include different interview techniques and communication strategies (Shaw 1997) and the ability to conduct

sensitive patient interviews using high-level consultation skills (Price 2004; Redsell *et al.* 2004). More specific training depends on the area of practice and, in gynaecology, would include learning how to take a sexual history. Unfortunately, the evidence suggests that most gynaecology nurses do not receive specific training in this area (Jolley 2002). Assessment does not involve asking questions about everything – this would be both intrusive and irrelevant. Selectivity should be based on a sound knowledge of the problem being assessed.

Relevant guidelines and protocols are also needed. Protocols offer an explicit framework for healthcare professionals 'to guide their clinical activities and promote quality patient care' (Handy 2002). Local protocols also usually include guidelines to assist the practitioner in making decisions about appropriate care. Some consider that these may restrict nursing practice rather than develop it because protocols should not be used as rigid tools of assessment, but nurses may be unwilling to compromise because of fears of litigation (Garrett 1999; Handy 2002). However, they are needed to set standards and support practice. This in turn protects both the practitioner and the patient.

ASSESSMENT IN GYNAECOLOGY

The female genito-urinary system includes the urinary tract and the reproductive organs and structures. Disorders of this system can have wide-ranging effects on general health. For example, ovarian dysfunction can alter the endocrine balance, and menstrual disorders can cause problems with bladder and bowel function and cause anaemia and pain. More women seek healthcare for reproductive disorders than anything else (Shaw 1997). Assessing problems in this area can be difficult because not only is the reproductive system very complex but its functions also have far-reaching psychosocial implications. It is sometimes difficult to differentiate signs and symptoms because the urinary and reproductive organs are so close to each other.

There are many areas within gynaecology where nurses are not only performing work traditionally undertaken by doctors but also setting up new and innovative services. These are listed in Table 1.1. Some are described more generally in other chapters but three contrasting areas have been chosen for discussion in this chapter because they illustrate the importance of nursing assessment and how it can be implemented in practice.

1. GP EMERGENCY ADMISSION UNITS FOR GYNAECOLOGY

Gynaecology departments have to deal with women who present as 'emergencies' with acute gynaecological symptoms. There are five main categories of symptoms:

- vaginal bleeding
- pelvic pain
- pelvic mass
- vulvovaginal symptoms
- problems in early pregnancy (not related to bleeding or pain).

Table 1.1. Specialist nursing roles in gynaecology

Services	Related skills
Early pregnancy assessment	Ordering investigations ultrasound scans recurrent miscarriage investigations Bereavement counselling
Fertility clinics	Ordering investigations Speculum examinations
Unwanted pregnancies	Promotion of sexual health Medical termination of pregnancy nurse prescribing
Family planning	Speculum examinations taking smears Contraceptive implants (etonogestrel) nurse prescribing
Advisory clinic for women undergoing pelvic radiotherapy (White 2004)	Counselling
Menopause advice	Hormone replacement therapy (HRT) implants
Postmenopausal bleed clinics	Hysteroscopy
Sterilisation clinics	Sexual history taking Counselling
Menstrual disorder clinics	Hysteroscopy Insertion of mirena coils
Oncology nursing service for gynaecology	Colposcopy taking a biopsy carrying out treatments Palliative care and support
Nurse-led diagnosis and advice in Genitourinary Medicine (GUM) Clinics	Collecting and examining swabs Treatments in GUM Clinics cryocautery to genital warts
Osteoporosis advice	Bone densitometry
Continence advice Urodynamics	Bladder pressure cystometry
Emergency Admission Units	Triage Ordering investigations ultrasound scans Referrals
Pre-operative assessment	Medical and sexual history taking Auscultation of chests Counselling
Post-operative hysterectomy follow-up (Walsgrove 1999)	Speculum examinations (to check vault) Health promotion

Table 1.2. Causes of vaginal bleeding

Pregnancy	Miscarriage threatened incomplete inevitable missed Ectopic pregnancy
Atrophic vaginitis Coital trauma	
Cervicitis Cervical polyp Cervical ectropian Cervical cancer	
Endometrial polyp Endometrial cancer Fibroids Intrauterine contraceptive device Dysfunctional uterine bleeding Hormone therapy	
Post-surgery	Secondary infection Vault haematoma Bleeding from vaginal granulation tissue Retained products (following evacuation of retained products of conception (ERPOC) or termination)
Postpartum haemorrhage	

Abnormal vaginal bleeding is the most common symptom, and women usually seek help if the bleeding requires immediate investigation or is heavy, prolonged or unusually painful. Bleeding during pregnancy, following a recent delivery or after surgery gives rise to concern and needs immediate investigation. Unexpected bleeding can also be intermenstrual, postcoital or postmenopausal, but usually these would not necessitate an emergency admission unless the bleeding was particularly heavy. Acute menorrhagia, or heavy vaginal bleeding, can be very severe, distressing for the patient and requires prompt emergency management. The causes of abnormal vaginal bleeding in women are listed in Table 1.2.

Acute pelvic pain can also be associated with problems during pregnancy, such as miscarriage or an ectopic pregnancy, which may be about to rupture. Other causes may be related to the menstrual cycle such as the passage of blood clots or a ruptured corpus luteum cyst. Pain can also be caused by ovarian problems such as cysts, which can be severely painful if they tort or twist, and ovarian hyperstimulation syndrome. Sometimes post-surgical complications can be painful. Pelvic inflammatory disease, usually associated with

pelvic infections, can cause severe pain. Pain is often an exacerbation of symptoms associated with cancer or may not actually be related to the reproductive system but caused by urinary retention, constipation or acute bowel disease.

Women may present with a sudden swelling or mass. Unusually this may be an unsuspected pregnancy, sometimes seen in teenage girls or women approaching the menopause. More common reasons include fibroids, ovarian tumour, hydrosalpinx and urinary retention. Occasionally young girls present with a non-tender mass in the pelvis and are diagnosed with haematocolpos arising from an intact vaginal membrane. After surgery patients sometimes develop a haematoma or an abscess. Acute vulvovaginal symptoms are usually associated with trauma (accident, self-mutilation, assault), inflammation or discharge (bacterial vaginosis, ectropian, vulvitis, sexually transmitted infections) or swelling (Bartholin's abscess, polyp, prolapse). Some women have problems during an ongoing pregnancy, which are not related to bleeding or pain. The most obvious example is hyperemesis, when a woman can become extremely dehydrated.

Gynaecological emergency admissions usually arrive at hospitals in two ways. Either the patient is referred to hospital having seen her GP or she goes straight to a general emergency department. The important difference is that the GP referrals forewarn the hospital that the patient's problem is likely to be gynaecological. Although these patients are still sometimes sent to a general accident and emergency (A and E) department, increasingly they are being sent directly to a gynaecology unit in order to relieve some of the pressure on A and E.

The majority (approximately 75 %) of gynaecological emergencies involve women who have pregnancy-related bleeding or pain (MacKenzie 2005). During the past 10 years the management of these problems has changed dramatically with the introduction of Early Pregnancy Assessment Units or Centres (EPAU or EPAC), led either by a gynaecologist or specialist nurse. This work mainly relates to threatened or actual miscarriages and is described in Chapter 4. However, similar and often more urgent attention is needed for other gynaecological emergencies. Traditionally these patients have been admitted to a gynaecology ward for assessment. Some of these patients stay in hospital for medical management or observation and some need surgery, which is usually performed on an emergency list, often out of hours when an operating theatre is available. However, following assessment, some patients do not need to stay in at all. In effect the admission is unnecessary. Clearly this is neither cost-effective nor desirable for the patient. In order to improve management of this situation, many hospitals are now setting up outpatient GP emergency admission units in gynaecology departments. Frequently these are led by suitably qualified and experienced nurses.

When a patient arrives at the emergency admission unit, the nurse's role is to carry out an initial quick assessment to see if the patient is in any immedi-

ate danger. This would include a set of observations (blood pressure, pulse and temperature) and assessment of any blood loss. A pregnancy test is always carried out on any woman who could possibly be pregnant, because the result significantly influences the management of any presenting symptoms. Clearly conditions such as severe haemorrhaging causing shock or a likely ectopic pregnancy would require prompt action, intravenous access and medical assistance.

Fortunately most patients are fairly stable and the nurse can then proceed to carry out a more thorough assessment and order relevant clinical investigations (blood tests, urinalysis, ultrasound scan). This follows an agreed protocol with supporting guidelines. Following this the nurse can contact a doctor with details of the case history, arrange for abdominal and vaginal examination if necessary and then a decision can be made about whether the patient should be admitted. A negative result to a pregnancy test often avoids the need for admission. Sometimes patients are admitted to a different department, e.g. a general surgical ward or an obstetric ward if the patient is more than 16–20 weeks pregnant (depending on local practice). Patients who are discharged may need an appropriate follow-up appointment in a gynaecology clinic or EPAU. Some may need a prescription, usually for antibiotics and analgesia.

Nurses working in emergency admission units need to use assessment skills at different levels including basic observations, understanding non-verbal signs and taking and interpreting a logical patient history. Since the patient is likely to be very anxious, good communication skills and a calm reassuring manner are clearly important. Table 1.3 is a breakdown of emergencies seen during

Table 1.3. Referrals to a gynaecology emergency admission unit over 12 months

Indications for referral	Number
Bleeding and/or pain during pregnancy	216
Pain (not associated with pregnancy)	164
Vaginal bleeding (not associated with pregnancy)	77
Possible ectopic pregnancy	62
Post-operative problems, including haematomas, wound problems, vaginal bleeding, retained products	60
Bartholin's abscess	30
Hyperemesis	30
Postpartum problems	6
Miscellaneous general gynaecological problems, including lost coils, vaginal laceration, vulval swelling, sexually transmitted infections, procidentia, hyperstimulation of ovaries, dysfunctional bleeding	169
Not recorded	20
Other symptoms, not gynaecological, including appendicitis, constipation	12
Total	846

Local figures supplied by Libby Millett, Lead Sister for the Gynaecology Emergency Admissions Unit at Queen's Medical Centre, Nottingham.

the first 12 months on a newly established gynaecology emergency unit at Queen's Medical Centre (QMC), Nottingham. The range of problems demonstrates why a broad experience of gynaecology nursing and a thorough understanding of acute gynaecological problems are essential. Since this work is usually supported by clear protocols and the availability of a designated doctor for advice, extra training requirements are minimal and most senior gynaecology nurses could easily cope. However, maintaining relevant emergency care skills via courses such as *ALERT* (Smith 2003) is highly recommended.

The main advantage of a nurse-led service for patients is that it is more efficient and consistent. Patients can be seen promptly, especially those who are deemed less urgent and might therefore wait a long time to see a doctor busy with other priorities. Most importantly there are less unnecessary admissions. Figures collected on the emergency gynaecology unit at QMC, Nottingham, show that out of 846 patients seen in a year, only 431 were admitted. This represents a huge saving and more than justifies the new service. Owing to staffing problems, the unit is only open from Monday to Friday, during the daytime, but the figures support the need for a continuous service. It is important to point out that the number of women being seen with problems during pregnancy is only a fraction of the total because the vast majority go directly to the EPAU. During the same period of time 2931 women were referred to EPAU and together this represents 79 % of the overall emergency admission work, a similar proportion to that reported by MacKenzie (2005) for another large teaching hospital. In fact some hospitals, like St Thomas's, London, now have the GP emergency admission unit and EPAU in one department. It is also interesting to note that out of the 62 women sent in to the emergency unit with a possible ectopic pregnancy, over half ($n = 35$) did not have an ectopic pregnancy and 21 of these were not even pregnant.

2. NURSE-LED STERILISATION CLINICS

Sterilisation has become the most popular method of contraception worldwide. Approximately 190 million women and 50 million men have chosen to be sterilised (Glasier & Scott 2005; Royal College of Obstetricians and Gynaecologists 2003). In 2001, 10 % of women aged 16–49 in Great Britain had been sterilised (Royal College of Obstetricians and Gynaecologists 2003).

Female sterilisation involves blocking or excising both fallopian tubes. This prevents the ovum from being fertilised by sperm in the fallopian tube. The procedure is usually performed under a general anaesthesia by laparoscopic techniques, but sometimes a mini laparotomy is required. The most common method of occluding the fallopian tube is by applying a Filshie clip (see Figure 1.1). Less common methods include a Falope ring, which is applied around a loop of tube; diathermy, which makes reversal impossible and carries risks of causing damage to other organs; and salpingectomy, which involves cutting and removing the tubes.