Assessment three and a half years later has confirmed a structural as well as a functional benefit from the treatment, although a substantial group of children had severely impaired vision despite adequate cryotherapy.[15] Earlier treatment with cryotherapy than that given in the American study has been advocated by some authors,[16 17] and this might further improve the results.

Although cryotherapy is usually not associated with any problems, complications such as bradycardia, apnoea, chemosis, periorbital oedema, scarring, and late onset retinal detachment may occur. Another treatment of advanced retinopathy is laser treatment, which has recently been reported to be at least as effective as cryotherapy and may give rise to fewer systemic and ocular complications.[18] Finally, some cases, despite cryotherapy or laser treatment, progress to retinal traction and detachment and will need surgery with scleral buckling or vitrectomy. Although this form of surgery may produce good anatomical results, the functional results are still poor.[19 20]

As cryotherapy substantially reduces the visual handicap of premature children, paediatric ophthalmologists should be responsible for identifying those who would benefit from it. Studies on the natural course and epidemiology of the condition have resulted in screening programmes that should be in use in every neonatal unit.[4 21 22]

GERD HOLMSTRÖM
Consultant in paediatric ophthalmology

Department of Ophthalmology,
Huddinge University Hospital,
Stockholm, Sweden

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Deregulating emergency contraception

Justified on current information

The statistics on unintended pregnancy in Britain make worrying reading. Almost half of all conceptions are unplanned.[1] Over 170 000 pregnancies are terminated every year, and soon a quarter of 25 year olds will have had an abortion.[2] Unwanted pregnancy affects mainly (though by no means exclusively) people under 30. In London and Oxford abortion rates are highest in 20-24 year olds, [3] but elsewhere the peak rate is among 19 year olds.[4]

Little is done to help young people avoid pregnancy. They are given the impression that it is normal to be sexually active, but contraception is marketed inadequately to the public.[5] Nevertheless, about half of unwanted pregnancies result from contraceptive failure rather than a lack of use of contraception.[6-8] The methods most used by younger couples —oral contraception and condoms—have failure rates of at least 1% even among experienced users, and failure rates are higher among young and less well educated people.[6]

About 70% of unwanted pregnancies are predictable because the woman realises that she is at risk after unplanned intercourse or an accident with a condom.[6 8] In such cases emergency contraception offers a 98% chance of preventing pregnancy. The most effective method—insertion of an intrauterine device—is not ideal for young women, but hormonal postcoital contraception is suitable. (As it can be used 72 hours after intercourse the term "morning after pill" has been abandoned.[9]) Its failure rate, probably around 2% per cycle,[10] is much higher than that of standard contraceptive methods, and postcoital contraception is therefore unsuitable for repeated use.[11]

Surveys of women with unwanted pregnancies have shown that 70% knew about emergency contraception but only 3% tried to use it.[6 8] The woman may deny to herself that she is really at risk. She may not know where to obtain postcoital contraception, particularly if (as often happens) unprotected intercourse has occurred at a weekend or away from home. Another obstacle is that access to emergency contraception is controlled by doctors.

Family planning is now part of general practice, but a woman who is ashamed or embarrassed may prefer to accept what she hopes is a small risk rather than explain to a receptionist why she wants an emergency appointment with her general practitioner. Young people may prefer the relative anonymity of family planning clinics, few of which are open seven days a week. Emergency contraception may be available in accident and emergency departments, but these are not the best places for counselling about sexual behaviour.

An editorial in the *British Journal of Obstetrics and Gynaecology* has suggested that emergency contraception should be available without prescription from pharmacists.[2] This would be safe. The "Yuzpe" regimen (the only one currently approved by the Committee on Safety of Medicines[13]) was introduced in 1972 and has been licensed in Britain since 1984. There are no published reports of death or serious illness after its use and it does not affect clotting factors.[14] It should not be given to a woman who is already pregnant (so the woman should also buy a pregnancy test), but 17% of British family planning clinics say that no other contraindications exist and 41% regard thromboembolism as the only other contraindication.[15] Even if the woman is already pregnant the risks are only theoretical,

and no evidence exists that the "Yuzpe" regimen can damage a pregnancy.

Would some women repeatedly resort to postcoital contraception and fail to use more effective contraception? If postcoital contraception was available over the counter the opportunity for a doctor to counsel such women would be lost. Nevertheless, misuse is possible at present, and the expense of over the counter postcoital contraception, as well as its inconvenience and higher failure rate, should deter most women from using it routinely. Would public opinion be against such a change? People are increasingly aware of the problem of unwanted pregnancy, and the open sale of condoms causes no comment nowadays.

The call to deregulate postcoital contraception may be overtaken by calls for oral contraceptives themselves to be sold over the counter. In the United States an expert group has decided that modern oral contraceptives are safe enough for this.[16] In this context, allowing pharmacists to provide postcoital contraception seems a sensibly cautious step. By itself, however, deregulation will not reduce abortion rates, and a programme of public education is needed. Publicity about deregulation would be useful, as would advertising at the point of sale.

The best way to obtain emergency contraception will still be from a doctor experienced in family planning or from a specialist "sex education and health promotion nurse."[17] Deregulating postcoital contraception should not be a cheap substitute for other initiatives to improve family planning services.

JAMES OWEN DRIFE
Professor of obstetrics and gynaecology

Clarendon Wing,
General Infirmary,
Leeds LS2 9NS

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Educating general practitioners

The new demands of general practice require substantial educational change

The need to change the structure of education for general practice is becoming ever more apparent. Currently university departments provide undergraduate teaching; regional postgraduate organisations organise vocational training; and clinical and general practice tutors loosely coordinate continuing education. But with the increasing demands for the maintenance of standards and new knowledge and skills the adequacy of these arrangements is being questioned.[1,2]

General practitioners in the NHS are painfully metamorphosing from gatekeepers to hospital care into the main providers of comprehensive health care in the community.[3] Although not all the implications of this development have been worked out, one thing is clear: society must recognise that the new responsibilities it seeks for general practice will require practitioners who are not only technically very competent[4] but also more broadly educated.

Practitioners need an approach to health care that combines sound ethical principles, a deep understanding of people, and the confidence and mature judgment to enable them to know not only when to seek help but also how best to protect their patients from the excesses of specialisation. Tomorrow's general practitioners will therefore need greater clinical and interpersonal skills, epidemiological skills for assessing the health of their practice populations, the ability to play an effective part in practice management, and skill in operating practice based quality assurance systems.[5]

Here, then, is the challenge to the educational establishment in general practice. While the primary focus is on general practitioners, there are important secondary objectives. Thus academic general practice now has the chance to influence basic medical education, including general clinical training[6,7] and early specialist training, especially if the concept of general professional training is revived.[8] Furthermore, since team working is essential in modern health care, general practice must play its full part in promoting multidisciplinary learning.

A start has been made. Payment for course organisers has been settled, and agreement is in sight on similar arrangements for general practice tutors, paving the way for the integration of these two groups. Teachers in general practice at all levels are talking to each other with a new sense of purpose about how best to work together. On p 719 Allen *et al* go further, urging the integration of regional advisers, course organisers, and trainers in unified departments of general practice.[9] Yet others argue for retaining the present structure; they point to the opportunities that some postgraduate deans are creating for developing interspecialty cooperation and a critical mass of skill in medical education in regional postgraduate institutes and departments of medical education.

Beyond these conventional structural options, each with its advantages and disadvantages, there is scope for some lateral thinking and imaginative experimenting with the purchaser-provider split. For instance, general practice could become the biggest single customer for senior house officer posts. Now that postgraduate deans act as purchasers for training posts those responsible for general practice training could exert the sort of influence on the quality of training for senior house officers that fundholders now exert on hospital services. Similarly, regional advisers in general practice could focus on the educational needs and expectations of individual practitioners and groups of practitioners, placing contracts for teaching services with competing providers—of which departments of general practice could be one. Contracting, especially if used in combination with networking, opens up