The continuation rates and satisfaction among the women suggest that our counselling was adequate, although there is no room for complacency: despite having been counselled separately, none of the 100 women thought that they had had too much information and 18 thought that they had not had enough. The main things that they thought they were uninformed about were irregular bleeding and discomfort over the site of the implant. The lack of problems with removal vindicates the insistence on adequate training. No method of contraception is completely free of problems, but correct, complete, understandable information and, in this case, appropriate training for insertion and removal are essential so as not to restrict women's choices unnecessarily.

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Use is declining and may peak again around 1999

EDITOR,—David R Bromham bemoans the fact that "trial by media" has had an adverse effect on the use of levonorgestrel implant capsules for contraception.[1] The Prescription Pricing Authority has examined the trends in the use of contraceptive products in general practice in England over the six months from September 1995 to February 1996.[2] The trends in use of oral contraceptives and the changes from third generation to second generation pills have already been reported.[3] Overall the use of the three main depot products—medroxyprogesterone acetate injections, levonorgestrel implants, and levonorgestrel intrauterine systems—did not change much during the six months. An average of 200 000 months' treatment was prescribed each month (if the duration of treatment is taken as three months per dose for medroxyprogesterone acetate, 60 months per dose for levonorgestrel implants, and 36 months per dose for levonorgestrel intrauterine systems). Use of the intrauterine system remained fairly constant at about 25% of the total, but use of the implant fell from 17% of the total to under 5%, with use of medroxyprogesterone acetate injection increasing to compensate (fig 1).

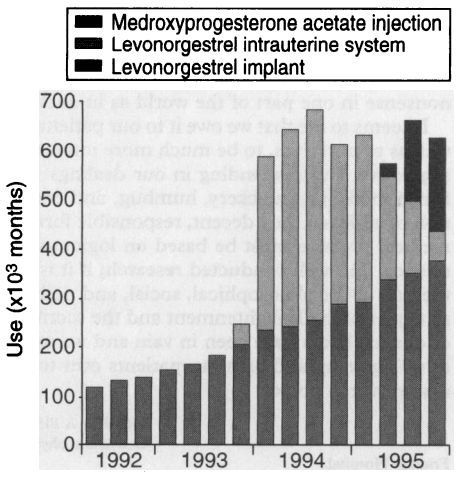

Fig 1—*National trends in use of depot contraceptives, England, 1992-5*

Bromham suggests that there is a finite therapeutic target population for the implant. The implant is expected to last for up to five years, and thus uptake would be expected to fall once the target population had been fitted with an implant. How much of the observed decrease in use is due to saturation of the target population and how much is due to adverse publicity is uncertain. The statistics need to be looked at in a few years' time, when those women who currently have an implant need to have another one fitted. Examination of the trends in use of contraceptives over a longer period indicates, however, that use of the implant peaked in 1994—the first full year in which it was available—and then fell (fig 1). Thus our figures suggest that the demand from the target population was largely met in the first year for which the implant was available and that it might peak again around 1999.

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Pharmaceutical representatives

Guidelines exist on making effective use of time spent with representatives

EDITOR,—Allen F Shaughnessy and David C Slawson give an American view of how to get the best from a medical representative.[1] This is something that the Association of the British Pharmaceutical Industry would encourage all doctors to do. The association recognises that a doctor's time is valuable and has many demands on it; therefore it is important that it is not wasted.

Doctors make a prescribing decision on the basis of a firm knowledge of the patient or the disease process being treated. Also important in this decision is an understanding of the medicine being prescribed. There are many ways of acquiring this information, but the medical representative provides a direct link between the manufacturer and the prescriber.

Medical representatives have been specifically and thoroughly trained to provide information to doctors about the products available from their company and, early in their career, have had to pass an examination set by the Association of the British Pharmaceutical Industry. The information on the products will have been generated by the average of 12 years' research that goes into developing a new medicine and will include known and potential adverse reactions as well as the benefits of the medicine and its cost.

If a representative is unable to answer a specific question from a doctor then the problem will usually be referred to the company's medical information department for a response and more detailed evaluation. All representatives have direct access to the company's medical staff, particularly for reporting adverse drug reactions.

Guidelines have been issued on how doctors can make the most effective use of the time they give to seeing representatives.[2] This can be done by allocating time for the interview by providing an appointment or by setting aside a specific time each week, as is done in many general practices. Doctors are advised to consider keeping records of representatives, particularly to help them decide whether to give a representative a future interview. It is wise to have an objective for the interview—for example, learning about new products or passing back information on the use of the medicine. One of the essential features of the guidelines is the recommendation that a doctor's staff should know the arrangements for seeing representatives. Doctors should remember that the association's code of practice lays down strict requirements for pharmaceutical representatives.

Finally, I strongly support the authors' statement that "the primary goal of drug representatives is to promote a product, but an active approach by doctors can transform them into a useful and accurate source of information."

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Doctors should decline to see them

EDITOR,—Allen F Shaughnessy and David C Slawson say that pharmaceutical representatives "can be a valuable source of new information for a busy doctor."[1] The information will help in rational decisions on prescribing only if it is unbiased. The BMA's on line Medline service warns that amateurs may find only 15% of relevant references. Given this scope for bias, we should be circumspect. After all, the incomes of the representatives and the companies they represent depend on sales of drugs.

The best way to avoid "'stealth' attacks" by drug representatives is much easier than the authors suppose: simply decline to see them. Those who lunch with a representative must have a long spoon.

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Regulating complementary medicine

Researchers into complementary therapy do not have to "sacrifice their therapeutic integrity"

EDITOR,—Julie Stone's editorial cautioning against the statutory regulation of complementary treatments rests on a common but misplaced argument about the nature of medicine and science.[1] Regulation is said to depend on a treatment resting on solid foundations in science, having examinable knowledge and skills, and being demonstrably effective by "objective standards." This is described as the need for validation "within a scientific paradigm."[1] Stone then claims that, to meet such criteria, complementary practitioners would have to "sacrifice their therapeutic integrity," thereby creating a "'medicalised version of the therapy, denying its philosophical underpinnings." Stone presents no argument, however, to justify this claim. She merely asserts that science cannot investigate unconventional treatments without changing their nature.