scenarios such as those being experienced by the Iraqi doctors.

The Al-Jazeera incident seems to indicate that ethics were lost in the battle on 28 March 2003. However, they should not be lost in the war.

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1 Article 13 of the 1949 Geneva Convention relative to the Treatment of Prisoners of War.

Emergency contraception

Even easier to prescribe, but users still need a holistic sexual health service

A trial by the World Health Organization published in 1998 established "levonorgestrel only" as the gold standard in hormonal emergency contraception.[1] Over 80 countries have now approved dedicated emergency contraception products containing progestogen only, that are often available directly from pharmacies. Innovative strategies to improve access are also proliferating, expanding the ranks of those who can supply to nurses and other health workers, and offering supplies to women in advance. More recently, a further WHO trial has encouraged new flexibility in offering emergency contraception.[2] Emergency contraception with levonorgestrel can now be given as "one stat" dose. However, women who need emergency contraception also have other needs, and a holistic sexual health service is essential.

The trial compared the effectiveness of the standard two dose regimen of 0.75 mg levonorgestrel repeated after 12 hours with the effectiveness of a double dose (1.5 mg levonorgestrel) taken all at once.[2] Women in a third group took low dose (10 mg) mifepristone. Women could participate if they were able to start taking emergency contraception within 120 hours of unprotected intercourse, rather than just the traditional 72 hours. Over 4000 women in 10 countries participated.

Although it was adequately powered, the study detected no difference in effectiveness between the three regimens. Pregnancy rates were slightly higher among women who started treatment more than 72 hours after unprotected intercourse, but the difference was not significant. The dramatic upward trend in failure rates with time elapsed before starting treatment shown in the first WHO study was not confirmed. Most women had their menses within three days of the expected date, although women who took mifepristone reported slightly more delays.

Other new research into emergency contraception addresses less the actual regimen offered and more the other needs that many who seek emergency contraception have. One need is for screening for sexually transmitted infections. *Chlamydia trachomatis* is the most common sexually transmitted bacterial infection in western Europe, has drastic consequences for future fertility, and is mostly asymptomatic. Screening programmes usually impose an age cut-off of 25 years. Research from Edinburgh shows, however, that 5.3% of women, between 25 and 29 years, tested positive for *C trachomatis* at the time of a request for emergency contraception, well above the rate where screening is cost effective. Just 1.1% of attenders of general clinics of the same age tested positive.[3]

Another need is for better access. A new study in London found that many young women did not take emergency contraception when they needed it because they misjudged their risk of pregnancy or had personal difficulties getting hold of emergency contraception.[4] In Sweden some women found a cost of approximately €10 (£7; $11) too expensive for "two little pills," although others thought it was acceptable to pay this to avoid an abortion.[5] In Britain, where all contraception is free when obtained through the NHS, the pharmacy version costs £24.

Several clinical consequences of this new research are clear. Firstly, levonorgestrel as emergency contraception should now be given as "one stat" dose. Taking the two doses together immediately is as effective and obviates the risk of forgetting or delaying the second dose. Regulatory bodies and pharmaceutical companies should consider changing the licence. Doctors should already advise women of the new information while any necessary bureaucratic changes are made.

Secondly, the 72 hour cut-off point for starting treatment seems unnecessary. Two other recent studies of the closely related Yuzpe regimen have reached the same conclusion.[6 7] Clearly, no hormonal emergency contraception is as effective as the intrauterine device, whether within 72 or 120 hours of unprotected sex. However, for women who decline insertion of the intrauterine device, or in facilities that cannot offer them, hormonal emergency contraception definitely has a role for women who present beyond 72 hours.

Thirdly, ongoing contraception should be started at the same visit as emergency contraception. This will reduce the number of pregnancies conceived while waiting for the next menstruation. The WHO study showed that women who had intercourse between treatment and expected menses were more likely to be pregnant that those who did not.[2] Oral and injectable hormones have not been shown to damage an early pregnancy. A pregnancy test can always be advised if a normal period does not occur by a week after it was expected.

Fourthly, for many women the risk of infection may be higher than the risk of pregnancy. All services offering emergency contraception should consider offering testing for infection with nuclear amplification tests. First void urine specimens (rather than mid stream) or self taken swabs can be returned to a central point or

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sent through the post. If this screening is not available the commissioners of sexual health services should be made aware of this potentially avoidable harm.

Finally, we need to communicate better with women so that those at risk can perceive it and avail themselves of services. The challenge is not just in increasing knowledge. This can be done effectively with information campaigns.[8 9] It also lies in appropriate education that enables women to be aware of the possible risks of sexual behaviour and the ways to reduce those risks.

In short, hormonal emergency contraception has become even easier, but to deliver a holistic sexual health service we still have challenges to meet.

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Workplace bullying

The silent epidemic

Those who can, do; those who can't, bully.

Tim Field

Morbidity patterns from general practice worldwide highlight the high prevalence of mental health problems, the commonest being depression, anxiety, and sleep disturbance. Many of the sufferers admit to stress at work, and some of them are casualties of workplace bullying, defined as persistent, offensive, abusive, intimidating, malicious, or insulting behaviour; abuse of power; or unfair penal sanctions. These make the recipient feel upset, threatened, humiliated, or vulnerable, undermine their self confidence and may cause them to suffer stress.[1] Rayner and Hoelt describe five categories of bullying behaviour—threats to professional status, threats to personal standing, isolation, overwork, and destabilisation.[2]

A deadly combination of economic rationalism, increasing competition, "downsizing," and the current fashion for tough, dynamic, "macho" management styles have created a culture in which bullying can thrive, producing "toxic" workplaces.[3] Such workplaces perpetuate dysfunction, fear, shame, and embarrassment, intimidating those who dare to speak out and nurturing a silent epidemic. Various studies point to an emerging global phenomenon with a growing evidence base particularly from Scandinavia,[4] where Sweden and Norway are the only European countries with legislation specific to bullying.

Workplace bullying has been estimated to affect up to 50% of the United Kingdom's workforce at some time in their working lives,[5] with annual prevalences of up to 38%, and is becoming increasingly identified as a major occupational stressor.[6] In the United Kingdom costs have been estimated at £2-30bn ($3-48bn; €3-44bn) per annum,[6] although research indicates figures closer to the lower end of the range.

See Career focus

Of particular concern is the growing evidence of bullying among healthcare workers. A 1996 questionnaire survey of 1100 employees of an NHS community trust found 38% reported being subjected to bullying in the workplace in the previous year, and 42% had witnessed the bullying of others.[7] Staff who had been bullied had lower levels of job satisfaction and higher levels of job induced stress, depression, anxiety, and intention to leave. Similar rates were found in a recent survey of 1000 junior hospital doctors in the UK.[8]

The obvious question remains, "What can be done?" As practitioners we should be more aware of the possibility that workplace bullying may be contributing to the stress with which many of our patients present. Questions like "How are things at work?" should also become part of routine inquiry in patients presenting with anxiety, depression, or sleep disturbance—providing an opportunity to raise bullying. Bullying can also manifest itself in cognitive effects such as concentration problems, insecurity, and lack of initiative.[9]

When identified, we should be supporting and encouraging our patients in combating bullying. As general practitioners we should adopt an advocacy role for our patients and offer appropriate intervention after obtaining explicit informed consent. To be most effective in this role we need to be familiar with the issues and to know where to seek appropriate advice and help—much practical information and advice on identifying, preventing, and combating bullying is available on the internet and in books,[3 6] and can be adapted for handouts for patients' education. In addition, occupational health doctors and nurses can be helpful sources

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