MLABuddy

MLAbuddy Clinical Series

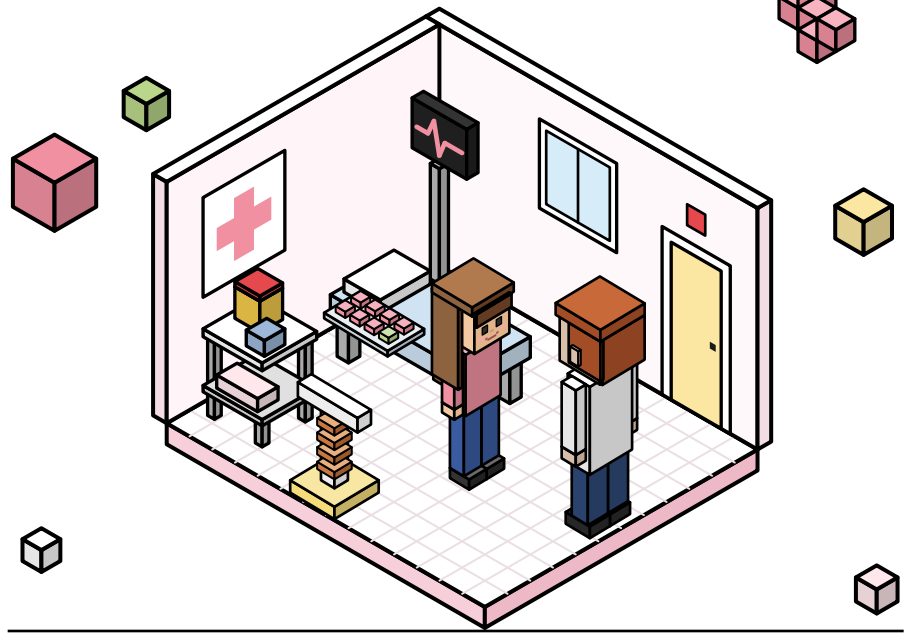
Pills, patients and practice

Contraception guide

For clinical years (Y3–Y5), OSCEs and licensing prep

Barbara Cardoso, Brunel University London

Sunday 8 November · 19:00 GMT · Online · Free



Today's session

01 **Methods**

02 **UKMEC**

03 **Emergency**

04 **Under-16s**

Meet your tutor



Barbara Cardoso

Final-year medical student

Brunel University London

MLAbuddy tutor

About me

- **Studying:** Medicine, Brunel University London
- **Placements:** Frimley Health NHS Foundation Trust
- **Teaching:** from a family of teachers

"See one, do one, teach one." Dr Webber, Grey's Anatomy

How I teach

- Confidence, not palpitations
- Memorable and simple
- Interactive AI practice
- Tips I wish I'd known

Ask me about

- Choosing contraception
- UKMEC categories
- Gillick and Fraser

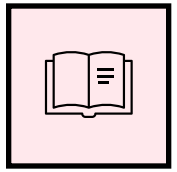
Disclaimer

This session is for educational purposes only.



The tutor's own view

Content reflects the tutor's clinical knowledge and experience, not the official position of MLAbuddy, the GMC or the Medical Schools Council.



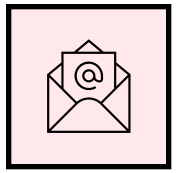
Guidance changes

Always check current national guidance (e.g. FSRH, UKMEC, BNF) and your local policy before applying anything you learn here.



Not medical advice

Nothing in this session is advice about an individual patient. Use it to learn and revise, not to treat.



Spotted an error?

Tell us at hello@mlabuddy.co.uk and we will review and correct the slides.

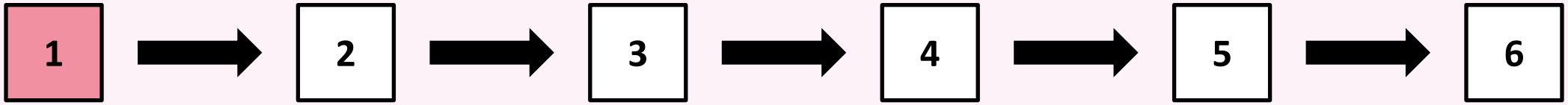
Today’s agenda

1	**Topic 1: Contraceptive methods** Hormonal methods, coils and missed pills
2	**Topic 2: Prescribing safely** UKMEC and combined pill red flags
3	**Topic 3: Emergency contraception** Copper IUD, ulipristal and levonorgestrel
4	**Topic 4: Under-16s** Gillick competence, Fraser guidelines and safeguarding
5	**SBA questions** Clinical knowledge checkpoint
6	**Live OSCE practice** Contraception counselling station

Session goals

1	Explain common methods of contraception
2	Match methods to patient priorities and medical risks
3	Use UKMEC categories 1–4 correctly
4	Apply Gillick competence, Fraser guidelines and safeguarding
5	Deliver a structured, patient-centred 7-minute OSCE consultation

The consultation: your OSCE roadmap



1 Ask	2 Screen	3 Offer	4 Compare	5 Check	6 Close
• Pregnancy risk • Previous contraception • Patient priorities	• Past medical history • Migraine with aura • VTE • Smoking • BP and BMI • Medicines	• Condoms • Suitable short- and long-acting choices	• Effectiveness • Duration • Bleeding • Side effects • Reversibility	• Understanding • Preferences • STI protection	• How to start • Back-up contraception • Follow-up • Safety-net

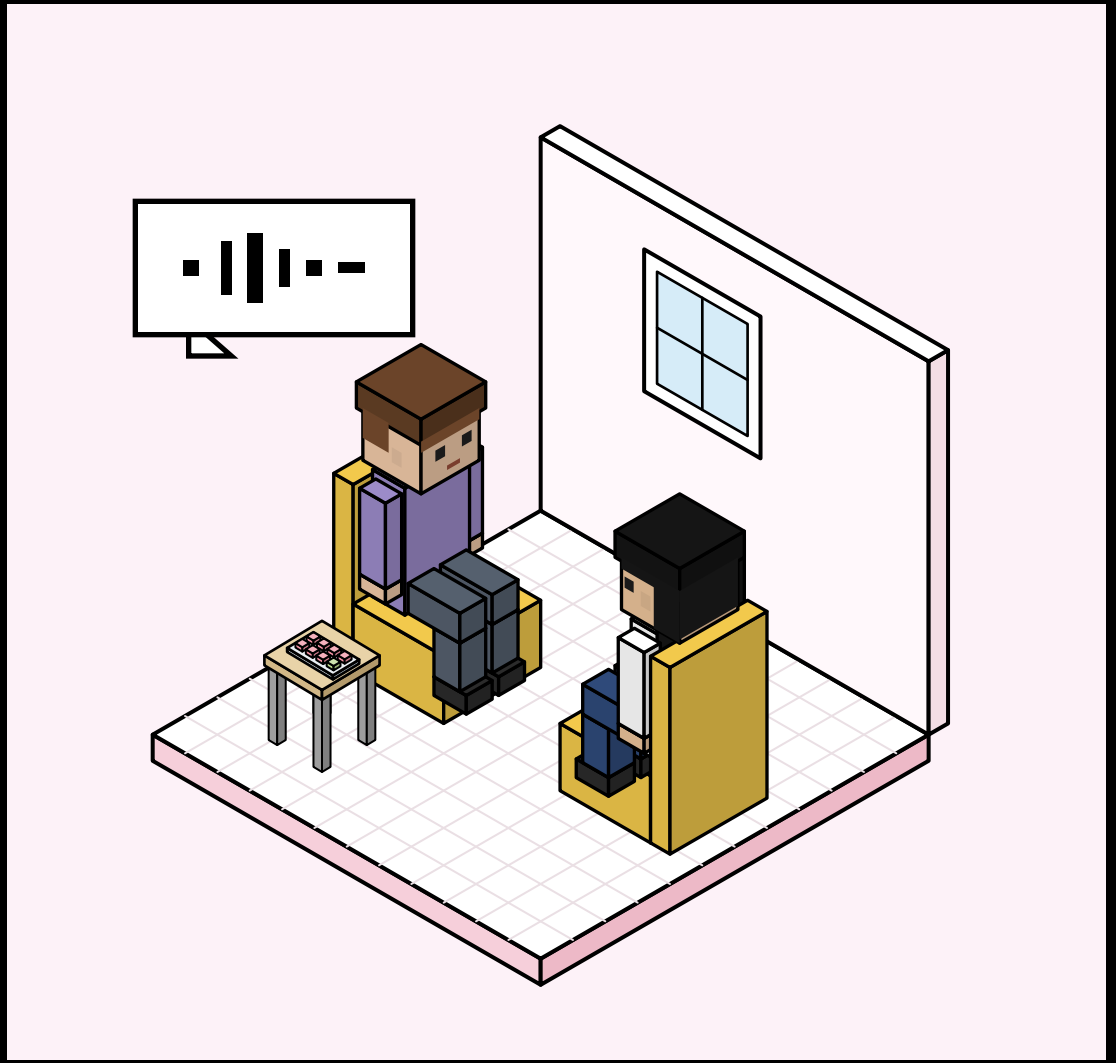
7-minute station: counsel the patient through each step, not just prescribe.

TOPIC 01

Contraceptive methods: choosing what fits

Key question: which method fits this patient?

01 Methods	02 UKMEC	03 Emergency
04 Under-16s	05 SBAs	06 Live OSCE



Combined hormonal contraception: how it works

Two hormones: oestrogen + progestogen

1 Stops ovulation

Main action: suppresses FSH and LH, so no egg is released.

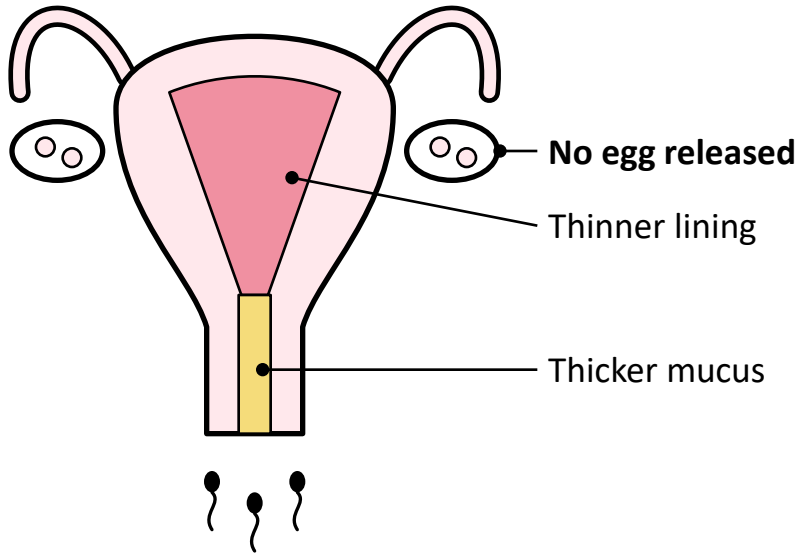
2 Thickens cervical mucus

Thicker mucus stops sperm entering the uterus.

3 Thins the endometrium

The womb lining becomes thinner.

Where it acts



Combined methods: regimen and benefits

Pill

How to use

Daily for 21 days, then a 7-day break

Benefits

Lighter, less painful periods; improves acne

Patch

How to use

Apply weekly for 3 weeks; 4th week patch-free

Benefits

Helps regulate periods

Ring

How to use

Usually 3 weeks in, 1 week out

Benefits

Regular periods

All three contain oestrogen + progestogen, so the same UKMEC checks apply.

Progestogen-only contraception: how it works

One hormone: progestogen only, no oestrogen

Thickens cervical mucus

Methods: **Levonorgestrel POP, hormonal IUS**

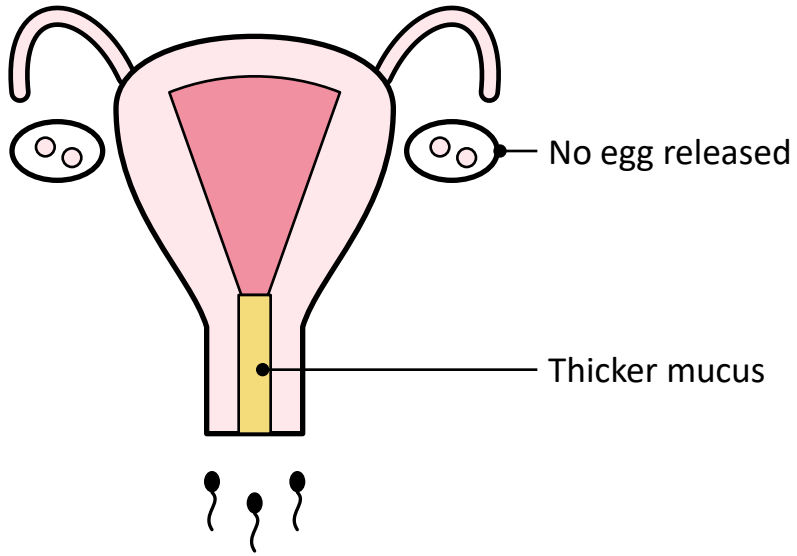
Effect: makes it difficult for sperm to enter the uterus.

Stops ovulation

Methods: **Desogestrel POP, implant, injection (DMPA)**

Effect: no egg is released for fertilisation.

Where it acts



Progestogen-only choices: regimen and benefits

Progestogen-only pill (POP)

- Daily pill with no oestrogen
- Suitable if oestrogen is not an option

Implant (Nexplanon)

- Over 99% effective, no daily pill
- UK licence: 5 years (2026)

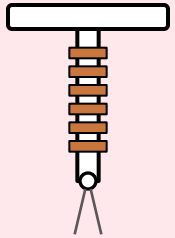
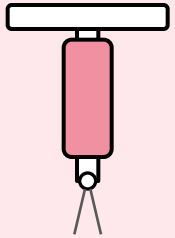
Injection (DMPA)

- Given roughly every 13 weeks
- May stop periods

Hormonal coil (LNG-IUS)

- Lasts 3–8 years, depending on indication
- Periods often lighter

Copper IUD vs hormonal IUS

	 **Copper IUD**	 **Hormonal IUS (LNG-IUS)**
Hormones	No hormones	Releases levonorgestrel locally
Duration	5–10 years	3–8 years
Bleeding	Can worsen bleeding and cramps	Lighter or absent bleeding
Emergency use	**Most effective emergency contraception**	—

Before insertion: check pregnancy and STI risk and suitability; discuss expulsion, perforation and infection risk.

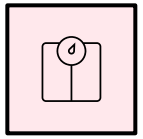
Missed pills: essentials

Pill type	Missed when	What to do
Traditional POP (levonorgestrel)	More than 3 hours late	Take ASAP + condoms for 2 days
Desogestrel POP	More than 12 hours late	Take ASAP + condoms for 2 days
Drospirenone POP (newer)	24 hours or more late	Take the latest missed active pill + condoms for 7 days
Combined pill	2 or more active pills missed (48+ hours since due)	Take the latest pill + condoms for 7 days. Fewer than 7 active pills left: skip the pill-free break

- **Missed pills + unprotected sex:** assess for emergency contraception.
- **Vomiting, diarrhoea and enzyme inducers** can reduce effectiveness; extra contraception may be needed.

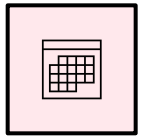
What patients will ask

Answer honestly, never over-promise, and check understanding before you move on.



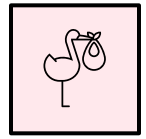
Will I gain weight?

Evidence links the injection to weight gain. Avoid promising no change.



Will it stop my periods?

Depends on the method. LNG-IUS may lighten or stop bleeding; copper IUD can increase it.



Will it affect my fertility?

Most methods are rapidly reversible. After the injection, it can take up to 1 year.



Does insertion hurt?

Insertion and removal can hurt. Acknowledge it; offer analgesia, support and options.



What about blood clots?

Oestrogen raises VTE risk. This applies to the combined pill, patch and ring.



What protects against STIs?

Only condoms protect. Discuss STI testing and dual protection.

Side effects you must know

Method	Side effects
Combined pill, patch, ring	Breakthrough bleeding, nausea, breast tenderness, **VTE risk**
Progestogen-only pill	Irregular bleeding; acne sometimes reported
Implant	Unpredictable bleeding; acne sometimes reported
Injection (DMPA)	Weight gain, irregular or absent periods, reduced bone density
Hormonal IUS	Initial spotting and cramps, then lighter or absent periods
Copper IUD	Heavier, longer or more painful periods

Contraceptive effectiveness

Percentage of people who avoid pregnancy over one year

Method	Typical use real-life use	Perfect use correct every time
Implant · hormonal IUS · copper IUD	**>99%**	**>99%**
Injection	**94%**	**>99%**
Combined pill · POP · patch · ring	**91%**	**>99%**
External condom	**82%**	**98%**

Remember: implants and coils stay >99% effective with typical use. Condoms also protect against STIs.

Source: NHS, contraception guide (typical vs perfect use over one year).

Spot question 1: choosing a method

Spot question

A 24-year-old wants highly effective contraception. She does not want a daily pill and would like her heavy periods to be lighter.

Which method is the best fit?

A	Copper IUD
B	52 mg levonorgestrel IUS
C	External condoms
D	Fertility awareness

Spot question 1: answer

Explanation

Answer B: 52 mg LNG-IUS

A long-acting method with excellent pregnancy prevention and a useful bleeding benefit.

Match the method to her priorities: highly effective, no daily pill, lighter periods.

Which method is the best fit?

A	Copper IUD
B	**52 mg levonorgestrel IUS**
C	External condoms
D	Fertility awareness

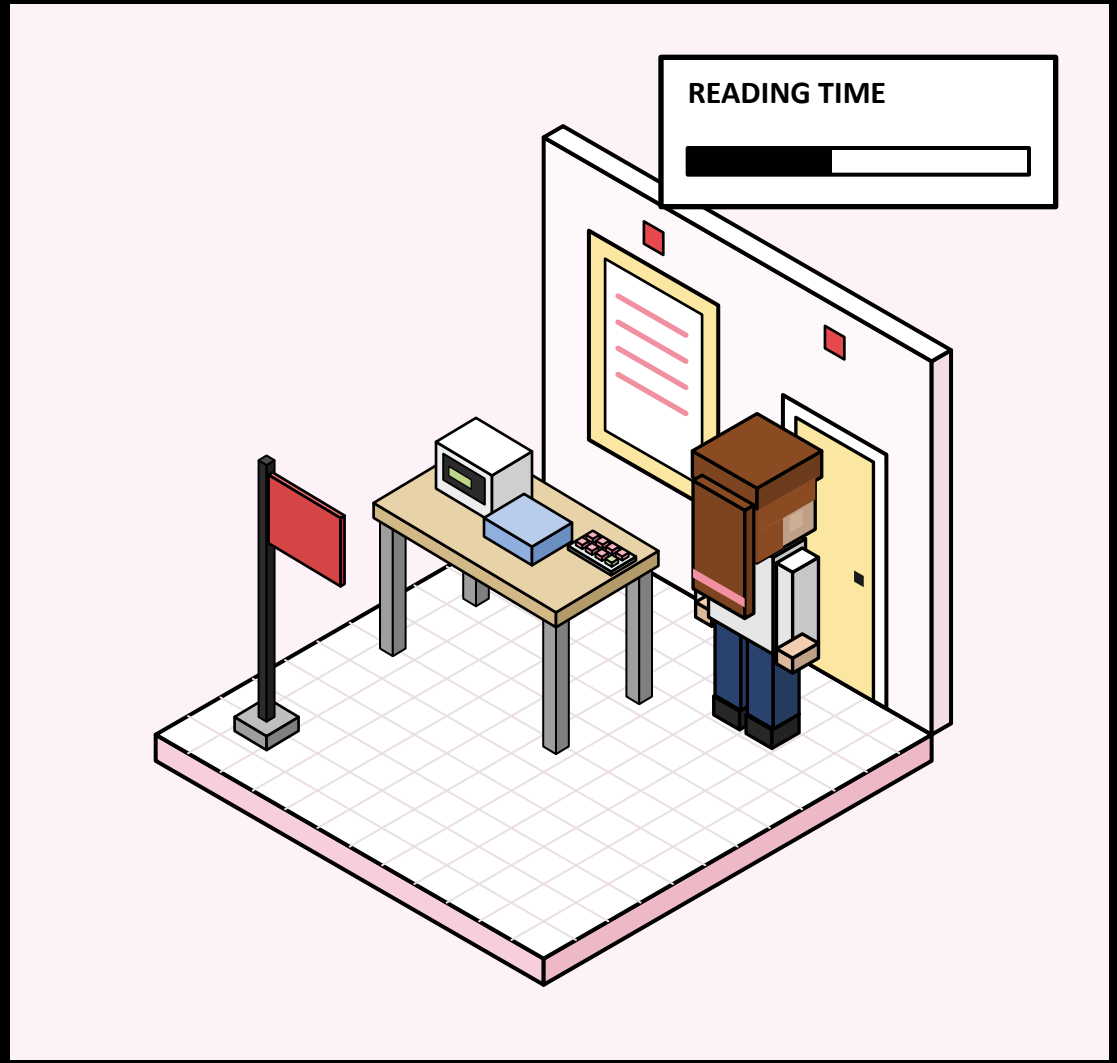
Sources: FSRH, Intrauterine Contraception guideline, 2023; NICE NG88, Heavy menstrual bleeding: assessment and management, 2018 (updated 2021).

TOPIC 02

Prescribing safely: UKMEC and red flags

Key question: who can safely take the combined pill?

01 Methods	**02 UKMEC**	03 Emergency
04 Under-16s	05 SBAs	06 Live OSCE



UKMEC: learn 4 numbers, not 400 rows

1	**UKMEC 1** No restriction on use
2	**UKMEC 2** Benefits generally outweigh risks
3	**UKMEC 3** Risks usually outweigh benefits; seek expert advice
4	**UKMEC 4** Unacceptable health risk; do not use

Categories are method-specific: check each method separately for the same patient.

Red flags before prescribing the combined pill

Any of these? Check the UKMEC category before prescribing combined hormonal contraception.

! Aged 35+ and smokes

Fewer than 15 a day: **UKMEC 3**

15 or more a day: **UKMEC 4**

! Current VTE or PE

Avoid CHC; assess history and current treatment

! Migraine with aura

UKMEC 4: stroke risk

! High blood pressure

Assess BP; the category changes with severity

! Current breast cancer

Hormonal methods: **UKMEC 4**

! Combined VTE risks

Obesity + immobility + thrombophilia

Spot question 2: migraine with aura

Spot question

A 22-year-old requests the combined pill. She has migraine with visual aura.

What is her UKMEC category for combined hormonal contraception?

1	No restriction
2	Benefits generally outweigh risks
3	Risks usually outweigh benefits
4	Unacceptable health risk

Spot question 2: answer

Explanation

Answer: UKMEC 4

- Oestrogen-containing contraception increases ischaemic stroke risk in migraine with aura.
- Discuss non-oestrogen alternatives, such as the implant or copper IUD.

Ask the patient: “Do you ever see flashing lights, blind spots or zigzags before the headache?”

What is her UKMEC category for combined hormonal contraception?

1	No restriction
2	Benefits generally outweigh risks
3	Risks usually outweigh benefits
4	**Unacceptable health risk**

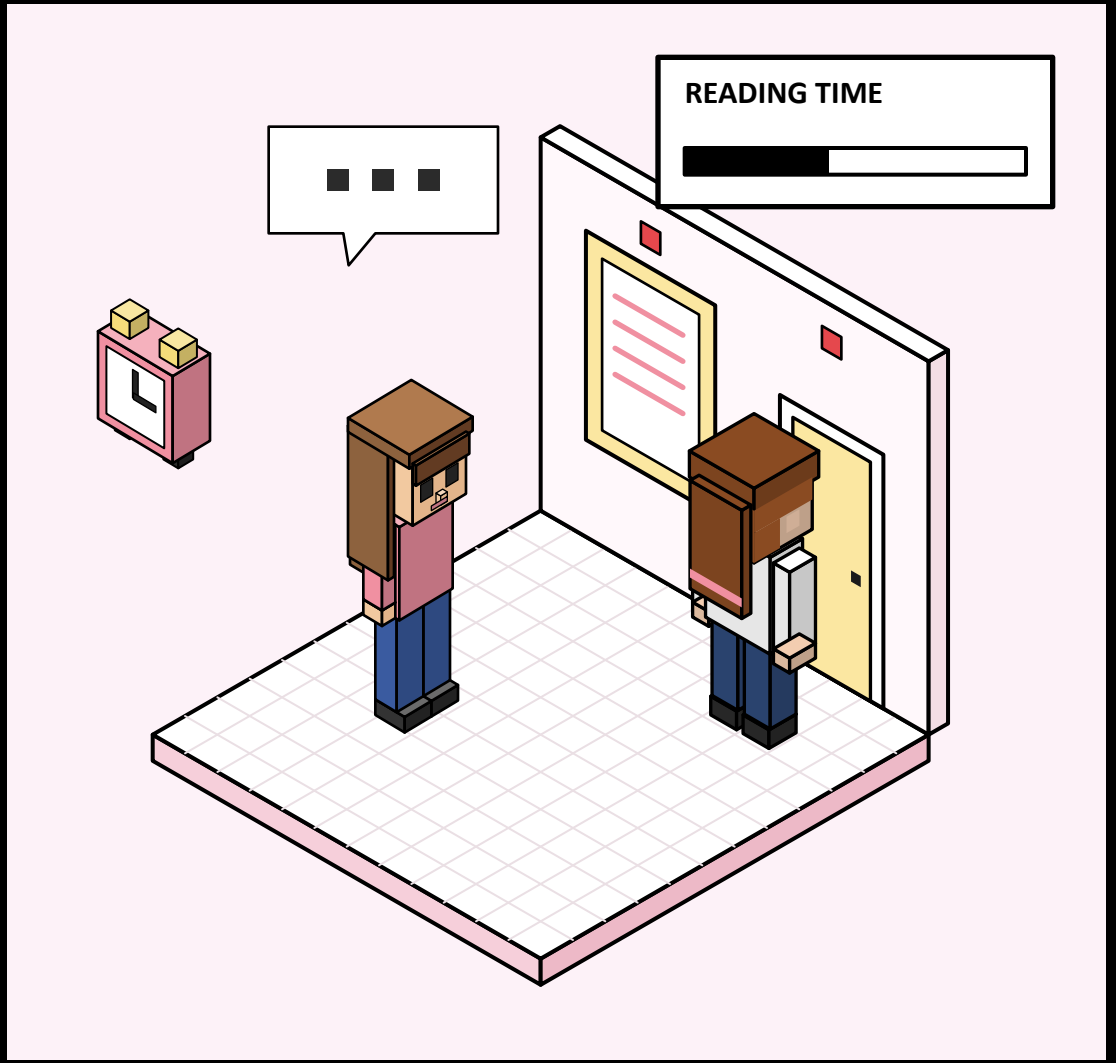
Source: CoSRH, UK Medical Eligibility Criteria for Contraceptive Use (UKMEC), 2025.

TOPIC 03

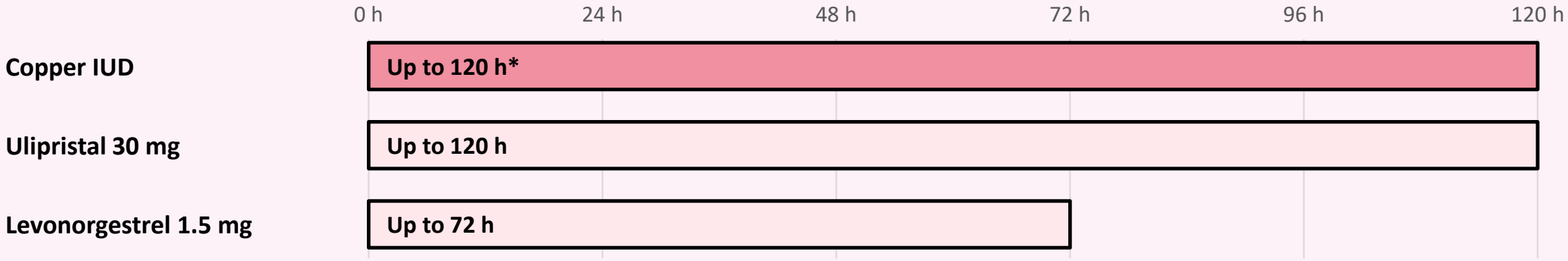
The clock is ticking: emergency contraception

Key question: which option, and how fast?

01 Methods	02 UKMEC	**03 Emergency**
04 Under-16s	05 SBAs	06 Live OSCE



Emergency contraception: three options



Copper IUD	Ulipristal 30 mg	Levonorgestrel 1.5 mg
Most effective. Fit within 120 h of UPSI.* Not affected by enzyme inducers.	Oral, within 120 h. Usually delay restarting hormonal contraception for 5 days.	Oral, licensed within 72 h. Hormonal contraception can start promptly.

Ask: date and time of each UPSI, cycle, current contraception, pregnancy risk, weight/BMI.

*Or within 5 days of the earliest estimated date of ovulation, whichever is later.

Spot question 3: 96 hours later

Spot question

Unprotected sex occurred 96 hours ago. The patient wants the most effective emergency option.

What do you offer?

A	Levonorgestrel 1.5 mg
B	Copper IUD (if eligible)
C	Wait for a pregnancy test
D	Double dose of the combined pill

Spot question 3: answer

Explanation

Answer B: copper IUD

- The most effective emergency method.
- If declined or unsuitable, consider ulipristal at 96 hours after assessing eligibility, interactions and earlier UPSI.

Tip: the “morning-after pill” does not have to be taken the next morning.

What do you offer?

A	Levonorgestrel 1.5 mg
B	**Copper IUD (if eligible)**
C	Wait for a pregnancy test
D	Double dose of the combined pill

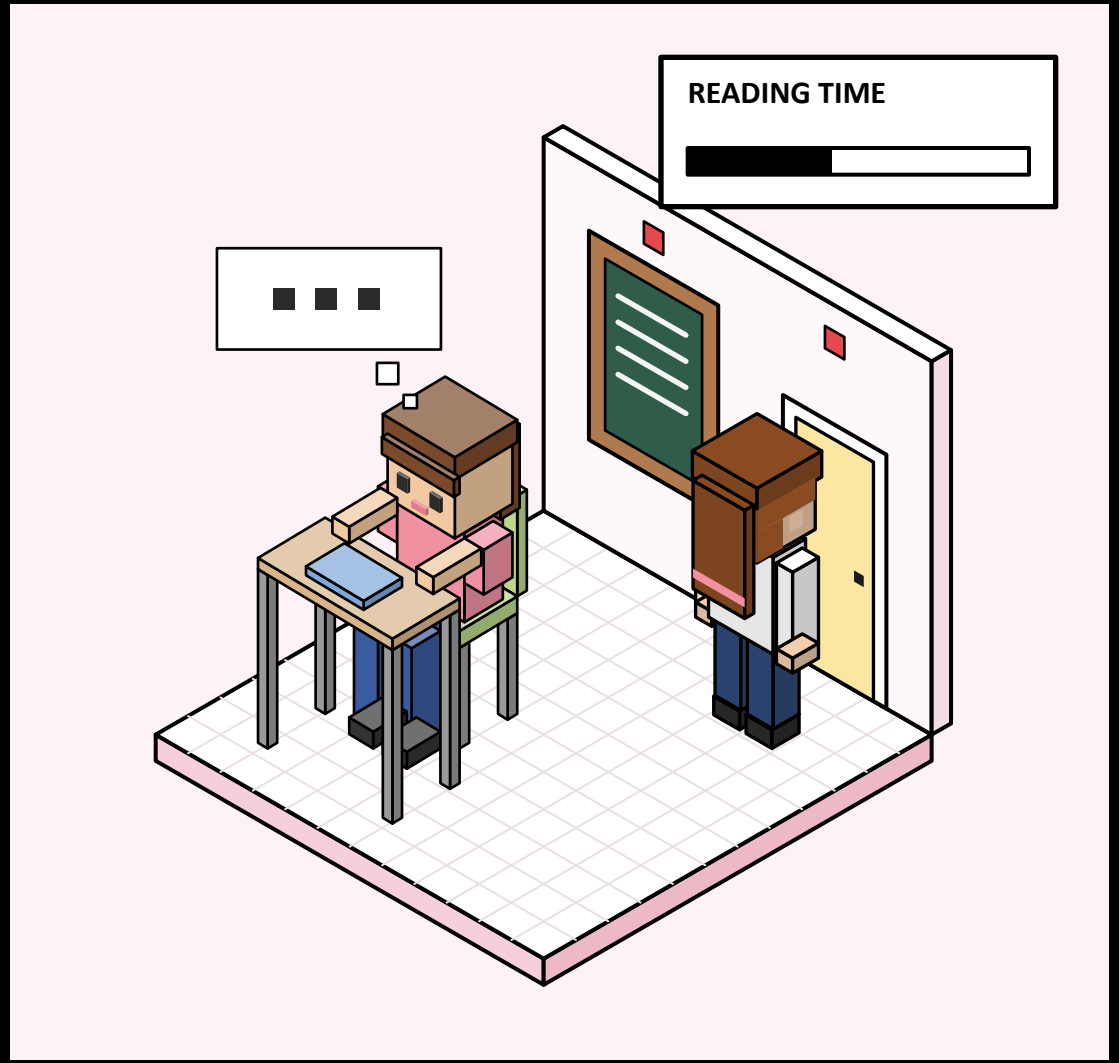
Source: FSRH, Emergency Contraception guideline, 2017 (amended April 2026).

TOPIC 04

Under-16s: Gillick, Fraser and safeguarding

Key question: can this young person consent?

01 Methods	02 UKMEC	03 Emergency
04 Under-16s	05 SBAs	06 Live OSCE



Gillick competence vs Fraser guidelines

Gillick competence	Fraser guidelines
Can this under-16 understand and make THIS healthcare decision?	**When can an under-16 get confidential contraceptive and sexual health advice?**
Covers: consent to treatment	Covers: contraception and sexual health advice

The Mental Capacity Act (MCA) 2005 does not apply to children under 16.

Assessing Gillick competence

1	**Can they understand** the decision and the information given?
2	**Can they retain** the information long enough to decide?
3	**Can they weigh up** the pros and cons?
4	**Can they communicate** their decision?

Competence is decision-specific. A competent under-16 can consent to treatment. Refusing life-saving treatment is legally more complex and may need the court.

Fraser guidelines: all five must apply

1	Understands the advice
2	Cannot be persuaded to involve parents or carers
3	Likely to have sex with or without treatment
4	Health likely to suffer without advice or treatment
5	Best interests: advice, treatment or both without parental consent

Spot question 4: confidentiality at 15

Spot question

A 15-year-old requests contraception and does not want her parents told.

What is your first approach?

A	Refuse without parental consent
B	Promise absolute confidentiality
C	Explore understanding, relationship safety and the Fraser criteria
D	Automatically phone her parents

Spot question 4: answer

Explanation

Answer C: assess, do not assume

- Explain confidentiality and its limits
- Assess Gillick competence and apply the Fraser criteria
- Check safeguarding and document your reasoning
- Encourage parental involvement, but it is not automatic

What is your first approach?

A	Refuse without parental consent
B	Promise absolute confidentiality
C	**Explore understanding, relationship safety and the Fraser criteria**
D	Automatically phone her parents

Sources: GMC, 0–18 years: guidance for all doctors, 2007 (updated 2024); Gillick v West Norfolk and Wisbech AHA [1985] UKHL 7.

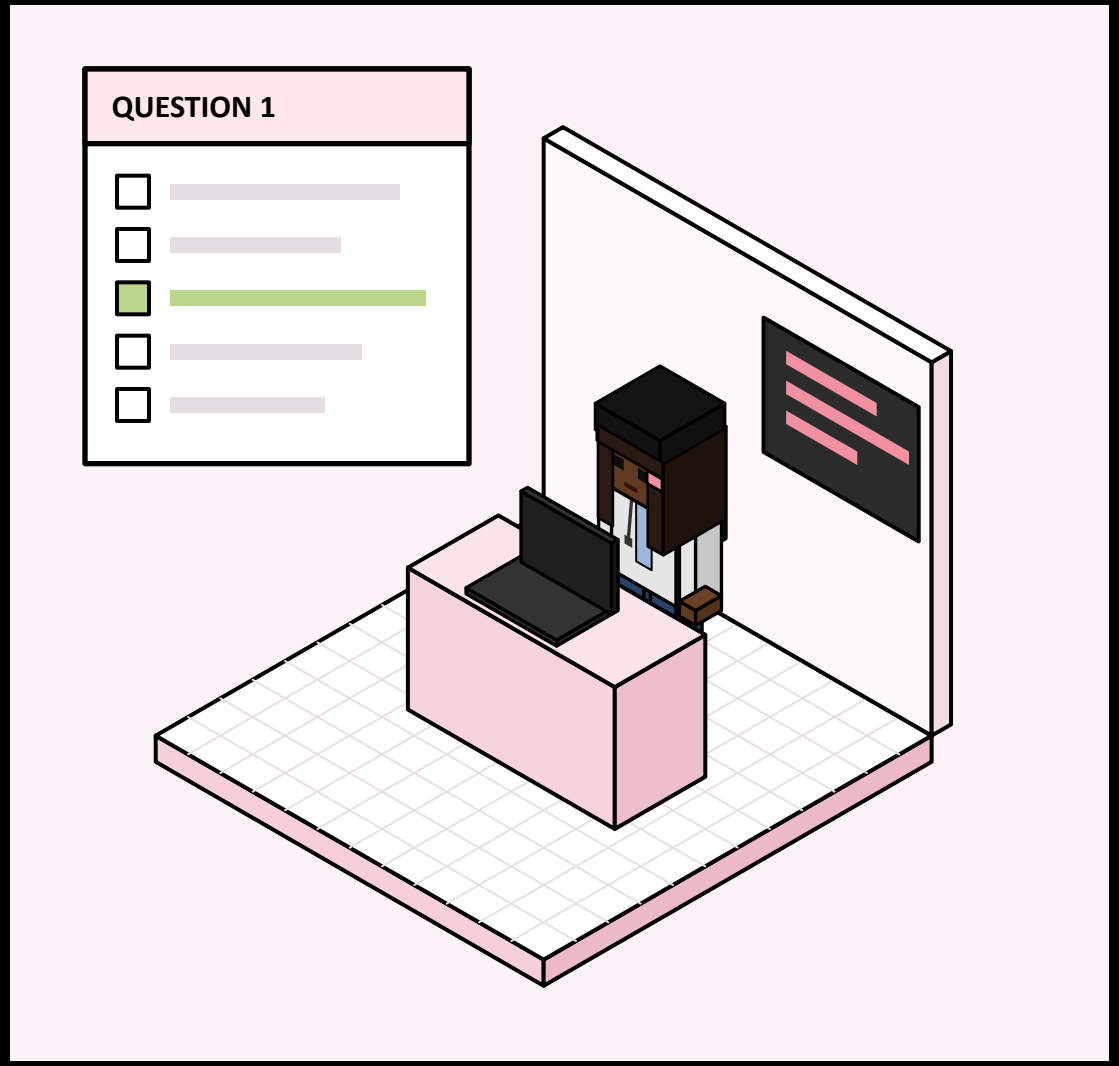
Key takeaways

1	**Know when not to prescribe the combined pill** Check UKMEC first
2	**Know which contraception suits which patient** Match the method to priorities and risks
3	**Emergency contraception is very high yield** Copper IUD first; know the time windows
4	**Don’t confuse Gillick competence with Fraser guidelines** Consent to treatment vs contraceptive advice
5	**For OSCEs, counsel, don’t just prescribe** Follow the six-step roadmap

SBAs

Clinical knowledge checkpoint

5 questions. Post your answers in the chat.



01 Methods	02 UKMEC	03 Emergency
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SBA 1: A smoker aged 37

Clinical vignette

A 37-year-old woman requests the combined oral contraceptive pill. She smokes 12 cigarettes daily, has a BMI of 29 kg/m² and has migraines without aura. Her blood pressure is 122/78 mmHg.

What is the UKMEC category for combined hormonal contraception, based on her smoking status?

A	UKMEC 1
B	UKMEC 2
C	UKMEC 3
D	UKMEC 4
E	UKMEC 2 if her blood pressure is normal

SBA 1: answer

Explanation

Answer C: UKMEC 3

Smoking at 35 or over, with fewer than 15 cigarettes a day, is UKMEC 3: oestrogen increases cardiovascular risk.

- **A/B:** risk is too high for UKMEC 1 or 2
- **D:** UKMEC 4 applies at 15 or more cigarettes a day
- **E:** normal BP does not remove the smoking risk

What is the UKMEC category for combined hormonal contraception, based on her smoking status?

A	UKMEC 1
B	UKMEC 2
C	**UKMEC 3**
D	UKMEC 4
E	UKMEC 2 if her blood pressure is normal

Source: CoSRH, UK Medical Eligibility Criteria for Contraceptive Use (UKMEC), 2025.

SBA 2: Heavy periods and aura

Clinical vignette

A 28-year-old woman has heavy menstrual bleeding, significant dysmenorrhoea and migraine with aura. She wants highly effective contraception and does not want to take a daily pill.

Which is the single best option?

A	Combined oral contraceptive pill
B	Copper IUD
C	52 mg levonorgestrel IUS
D	Contraceptive patch
E	External condoms

SBA 2: answer

Explanation

Answer C: 52 mg LNG-IUS

Highly effective, and reduces heavy bleeding and dysmenorrhoea.

- **A/D:** combined hormonal methods are UKMEC 4 with current migraine with aura
- **B:** the copper IUD may worsen bleeding and pain
- **E:** condoms don’t treat heavy periods

Which is the single best option?

A	Combined oral contraceptive pill
B	Copper IUD
C	**52 mg levonorgestrel IUS**
D	Contraceptive patch
E	External condoms

Sources: CoSRH, UKMEC, 2025; NICE NG88, Heavy menstrual bleeding: assessment and management, 2018 (updated 2021).

SBA 3: Epilepsy and emergency contraception

Clinical vignette

A 24-year-old woman requests emergency contraception 84 hours after unprotected intercourse. She takes carbamazepine for epilepsy and is happy to use long-term contraception. Pregnancy has been reasonably excluded and there are no contraindications to intrauterine insertion.

What is the most appropriate management?

A	Levonorgestrel 1.5 mg orally
B	Ulipristal acetate 30 mg orally
C	Levonorgestrel 3 mg orally as first choice
D	Offer a copper intrauterine device
E	Reassure her that emergency contraception is no longer effective

SBA 3: answer

Explanation

Answer D: copper IUD

Carbamazepine speeds up the breakdown of oral emergency contraception. The copper IUD does not rely on hormones or liver metabolism.

- **A:** standard dose is unsuitable (84 hours + enzyme inducer)
- **B:** enzyme inducers reduce ulipristal's effectiveness
- **C:** a double dose is less reliable and not preferred here
- **E:** emergency contraception is still possible

What is the most appropriate management?

A	Levonorgestrel 1.5 mg orally
B	Ulipristal acetate 30 mg orally
C	Levonorgestrel 3 mg orally as first choice
D	**Offer a copper intrauterine device**
E	Reassure her that emergency contraception is no longer effective

Source: FSRH, Emergency Contraception guideline, 2017 (amended April 2026), section on drug interactions.

SBA 4: Starting the POP after ulipristal

Clinical vignette

A 21-year-old woman takes ulipristal acetate 30 mg for emergency contraception. She wants to start the desogestrel progestogen-only pill.

What is the most appropriate advice?

A	Wait 5 days before starting the POP, then use condoms for 2 more days
B	Start the POP immediately, with no additional contraception
C	Start the POP after 24 hours
D	Wait 7 days before starting the POP, then use condoms for 7 days
E	Avoid hormonal contraception for the rest of the cycle

SBA 4: answer

Explanation

Answer A: wait 5 days, then condoms for 2 days

Progestogen can reduce the effect of ulipristal, so delay starting the POP.

- **B/C:** starting within 5 days is too early
- **D:** waiting 7 days, then condoms for 7 days, isn't necessary
- **E:** no need to wait until the next period

What is the most appropriate advice?

A	**Wait 5 days before starting the POP, then use condoms for 2 more days**
B	Start the POP immediately, with no additional contraception
C	Start the POP after 24 hours
D	Wait 7 days before starting the POP, then use condoms for 7 days
E	Avoid hormonal contraception for the rest of the cycle

Source: FSRH, Emergency Contraception guideline, 2017 (amended April 2026), Table 4: starting contraception after ulipristal.

SBA 5: A 15-year-old and her coach

Clinical vignette

A 15-year-old girl requests the contraceptive implant without her parents knowing. She shows good understanding of the procedure and says she is sexually active with her 26-year-old sports coach. She asks you to promise not to tell anyone.

What is the single best next step?

A	Prescribe the implant because she is Gillick competent
B	Refuse contraception until her parents consent
C	Promise confidentiality and prescribe if she meets the Fraser criteria
D	Explain the limits of confidentiality, assess immediate safety and seek safeguarding advice
E	Contact her parents immediately without discussing it with her

SBA 5: answer

Explanation

Answer D: safeguarding comes first

Understanding contraception does not remove the duty to assess possible exploitation or abuse.

- The age gap and his position of authority raise serious safeguarding concerns
- Explain confidentiality limits, explore coercion and safety, and follow local safeguarding procedures
- Do not automatically tell her parents or withhold appropriate care

What is the single best next step?

A	Prescribe the implant because she is Gillick competent
B	Refuse contraception until her parents consent
C	Promise confidentiality and prescribe if she meets the Fraser criteria
D	**Explain the limits of confidentiality, assess immediate safety and seek safeguarding advice**
E	Contact her parents immediately without discussing it with her

Sources: GMC, 0–18 years: guidance for all doctors, 2007 (updated 2024); GMC, Protecting children and young people, 2012 (updated 2024); Sexual Offences Act 2003.

LIVE

Contraception: live OSCE practice

Live simulation powered by MLAbuddy

01 Methods	02 UKMEC	03 Emergency
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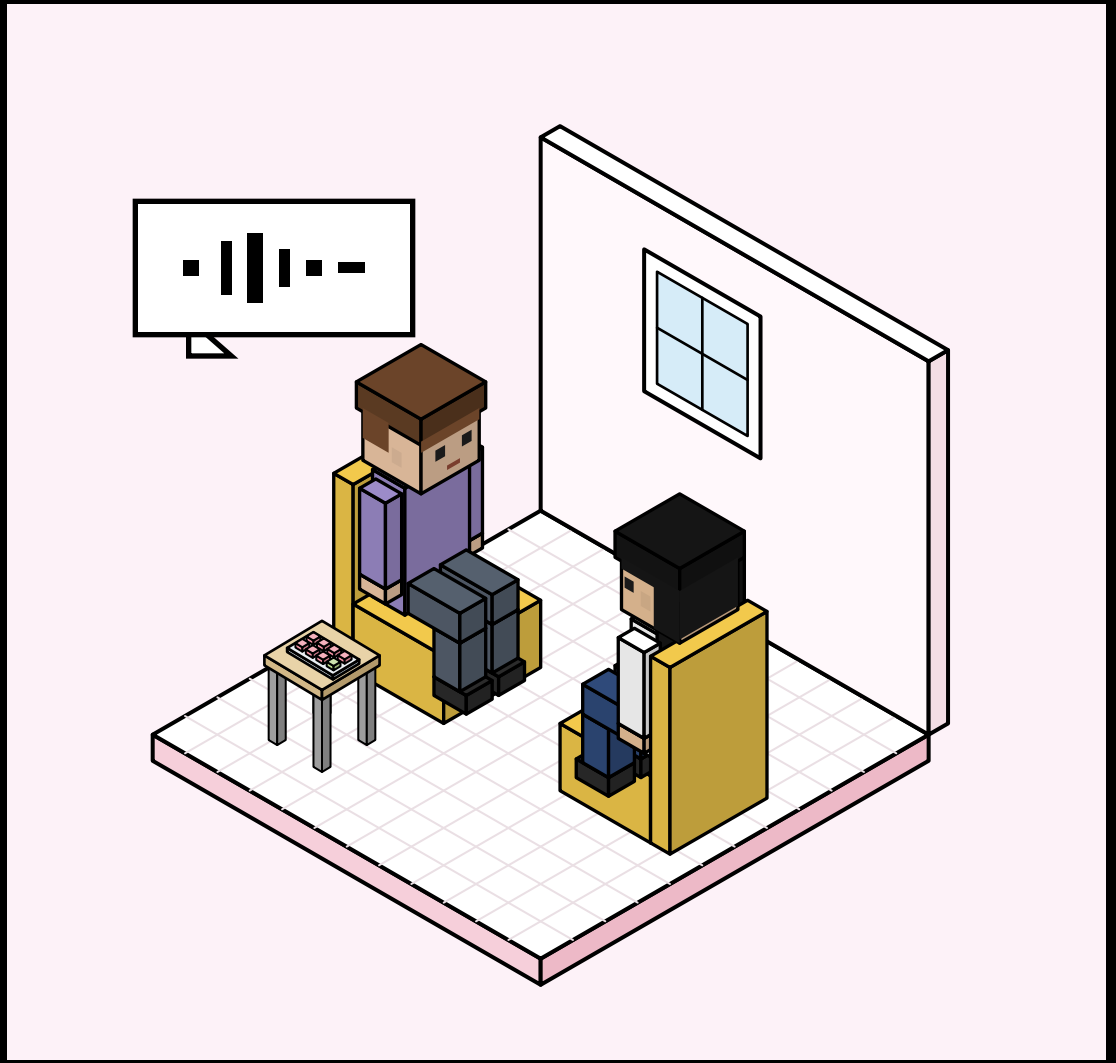


Congratulations to last session's challenge winners



Paediatric Seizures: Live OSCE Challenge

GH

Ghadir Hussain

Score: **53%**

2nd

Wins 2 weeks of MLAbuddy Premium

NS

Nurthana Subramaniam

Score: **55%**

1st

Wins 2 weeks of MLAbuddy Premium

HS

Hanin Salem

Score: **52%**

3rd

Honourable mention

Want to be next? Today's Contraception challenge is open now.

Your turn: take the session challenge on MLAbuddy

1. Join the free Sunday session › 2. Take the challenge › 3. Get marked & ranked

★ OPEN NOW — 6 DAYS LEFT



Contraception, UKMEC & Gillick Competence

Practise what Barbara taught today

1 station · 7 min · marked instantly

Take the challenge →

Apply what you learned

- ✓ **Contraceptive history:** pregnancy risk, PMH, priorities
- ✓ **Red flags:** UKMEC 3–4 for the combined pill
- ✓ **Patient's ICE:** ideas, concerns and expectations
- ✓ **Counselling:** how to start, back-up and follow-up

Station door prompt (7 minutes)

Candidate instructions	
Setting	GP surgery, routine appointment
Patient	Chloe Evans, 19, university student
Presenting complaint	Wants to start contraception. She currently uses condoms only.
Your task	Take a focused contraceptive history, discuss suitable options and agree a plan with Chloe.

07:00

minutes in the station

Sources: CoSRH UKMEC 2025; NICE CKS Contraception.

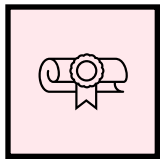
Keep practising on MLAbuddy: by system, by exam, or from your own notes



By clinical system

Pick a system and work through its stations.

- Paediatrics
- Gastro
- Neuro
- Sexual Health
- Derm
- Cardio
- + more



By skill or exam

Drill clinical skills, or follow an exam-specific module.

- UKMLA / CPSA
- Uni OSCEs
- PLAB 2
- MRCS B
- Specialty exams
- Interviews
- Viva
- History taking
- + more



Create your own

Describe a scenario or upload your notes, and Buddy builds a full OSCE station in minutes.

- From your notes
- Upload a PDF

Every station: a voice AI patient and an instant AI scorecard. **Start in Station Library or Create with AI.**

Exclusive offer for this session

15% off
all of MLAbuddy

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- All OSCE stations
- Create your own stations
- Create your own circuits
- Flashcards
- Teaching recordings

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Thank you for joining

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mlabuddy.co.uk/teachings/contraception-ukmec-gillick/feedback

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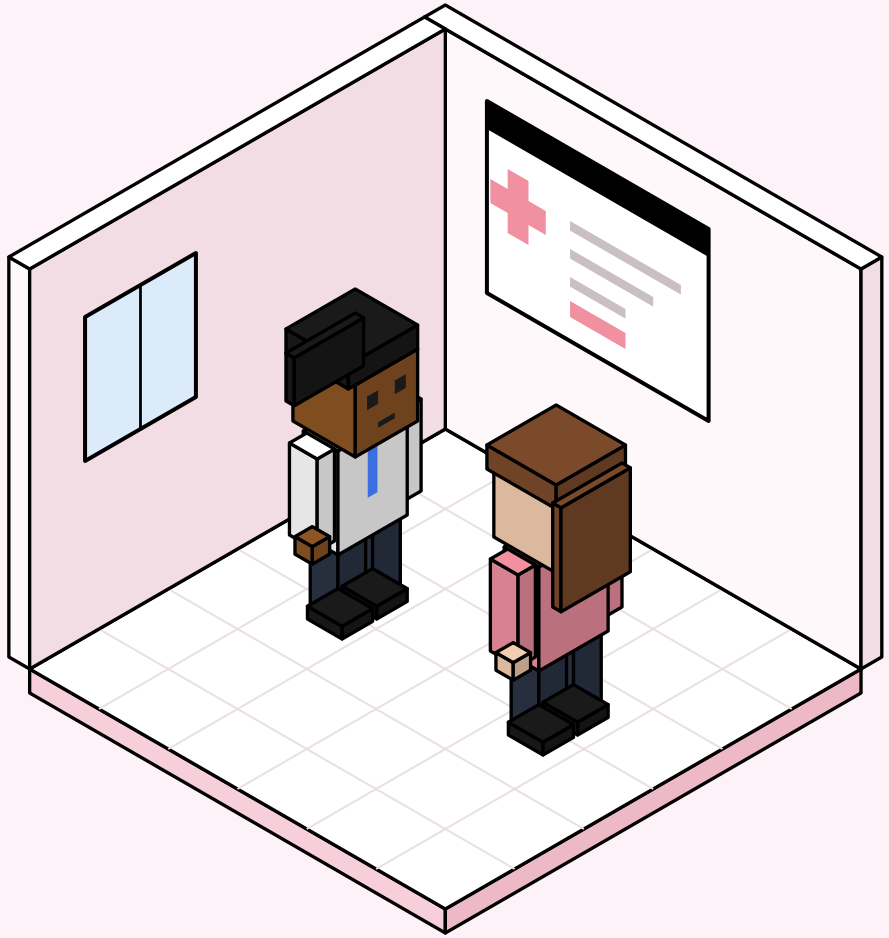

References

Guidance behind this session

1. **CoSRH.** UK Medical Eligibility Criteria for Contraceptive Use (UKMEC), 2025.
2. **FSRH.** Combined Hormonal Contraception guideline, 2019 (amended 2023).
3. **FSRH.** Progestogen-only Pills guideline, 2022 (amended 2026).
4. **FSRH.** Progestogen-only Implant (2021) and Injectable Contraception (2014) guidelines.
5. **FSRH.** Intrauterine Contraception guideline, 2023.
6. **FSRH.** Emergency Contraception guideline, 2017 (amended 2026).
7. **NICE CKS.** Contraception.
8. **NICE NG88.** Heavy menstrual bleeding: assessment and management, 2018 (updated 2021).
9. **Gillick v West Norfolk and Wisbech AHA** [1985] UKHL 7.
10. **General Medical Council.** 0–18 years (2007) and Protecting children and young people (2012), both updated 2024.
11. **UK Parliament.** Sexual Offences Act 2003.
12. **General Medical Council.** MLA content map.