GENERAL PRACTITIONERS AND CONTRACEPTION

Terms

THERE are now at least four terms commonly used to describe the process of controlling the occurrence of pregnancy. These are: ' birth control ', ' family planning ', ' contraception ', and ' fertility control '. None is entirely satisfactory, ' birth control ' because the intention is to control the start of pregnancies rather than the end or birth; ' family planning ' because of concern for the unmarried, those who choose not to have a family, and difficulty in including the idea of sterilization. ' Contraception ' is more satisfactory, and is the term used here, but even this has problems. Intra-uterine devices, for example, are probably not true contraceptives in the strict sense of the word.

The most satisfactory term is probably ' fertility control ' and this is widely used. It includes the idea of spacing as well as limiting pregnancies and enables data about abortion to be classified more easily. It is not used here because it is not yet easy for general practitioners to use this term in conversation with many patients.

Basic facts

There are in Britain about ten million women of child-bearing age (15–44). Of these, about one million at any one time, are pregnant or wish to become so. A further million are sub-fertile or married to men who are. In round figures there are thus about eight million women ' at risk ' to pregnancy.

More patients seek contraceptive advice from general practitioners than from all other medical sources combined.

Furthermore, general practitioners themselves provide effective contraceptive advice for more patients than all the clinics of the Family Planning Association, the local authorities, the hospitals, the Brook clinics and consultants put together.

Future trends in general practice

General-practitioner involvement in contraceptive care has increased and is continuing to do so at an accelerating rate. Ann Cartwright and Marjorie Waite in today's *Supplement* provides evidence to support this long term trend by showing that involvement of the general practitioner in this field is linked with age; the younger the doctor the greater the involvement. Nowadays, 77 per cent of general practitioners regard this work as 'essential'.

In the short term, she also reports a ' considerable ' increase during the last three years alone in the percentage of doctors who are prepared to introduce the topic of contraception.

About one in eight general practitioners is already fitting intra-uterine devices in the practice and about one in six have already acquired additional training in this field.

Postnatal examinations are best done in general practice and a majority of general practitioners now introduce the subject of contraception at this time. This reaches the most highly fertile group and it is particularly interesting that this supplement suggests that the number of women having more than four children appears to be less in those areas where general practitioners do this work most.

Theoretical considerations

Modern methods of contraception in the forseeable future will include oral contraceptives, intra-uterine devices and male and female sterilization. Medical involvement

is therefore inevitable. Recent suggestions that contraceptive services can and should be divorced from doctors will lead either to a greater medical risk, if for example, people with a history of pulmonary embolism are allowed to buy the ' pill ' across the counter, or alternatively a limited and less good service.

General practice more than any other branch of medicine concentrates on continuing care. Many modern contraceptive methods require after-care, particularly oral contraceptives and intra-uterine devices and, more often than is realised, sterilization. The patient who is being supervised by an interested general practitioner is more likely to have a depressive mood change detected by a doctor who knows her than by a series of strangers.

The problem in assessing modern medical methods is that side-effects may occur in many different parts of the body during long periods of time. Balanced opinions must depend on a detailed knowledge of total morbidity and a long-term morbidity at that.

A general practitioner was the first clinician in this country to record the association of an embolic disorder with oral contraceptives.

The oral contraceptive study of The Royal College of General Practitioners represents a unique example in the world of the potential for long-term multi-practice morbidity studies. Only a generalist will be concerned with complications in all the different specialties, and only the practitioner will have the long-term personal care which forms the ideal base for such research.

Vasectomy

The introduction of vasectomy had a significance far beyond its considerable importance as an additional method. First of all it re-emphasised the importance of the man's role and wishes; secondly, it provided a surgical solution which was possible in the community and did not need hospital services and thirdly it finally proved that contraceptive care is not a part of the specialty of obstetrics and gynaecology.

Discussing contraception with couples together has many advantages. Already thousands of patients are receiving vasectomy counselling in general practice.

Here general practitioners have a great advantage, often they know the man, and more important, perhaps the men, knowing their own doctor, may find it easier to approach him or her and discuss it in a familiar surgery than at a strange clinic.

J. J. Hobbs and A. de N'Yeurt describe in this *Journal* today a considerable extension of the general-practitioner's role. They report on patients whom they have not only counselled but operated on themselves. Furthermore, Hobbs has done this without charge. Such procedures have interesting training, medicolegal and medicopolitical implications and will be watched with interest.

Supplementary services

The general practitioner is already established as the natural source for contraceptive advice for most patients. It is important however that the existing supplementary services should be retained to meet the needs both of those patients, particularly young, unmarried girls, who may prefer the anonymity of a clinic and those doctors who for conscientious or personal reasons do not wish to be involved.

Clinics may be particularly valuable in areas where general practice is hard pressed. However, a growing number of women, and especially men, when offered an effective choice prefer to have care within general practice. It is sometimes forgotten that the patient has to declare the kind of advice sought by simply entering a clinic. Going to one's own doctor attracts much less attention.

Domiciliary contraceptive services have now been shown to be effective but expensive. As general practitioners and health visitors also have access to all the homes in need, a comparative study of basing such services on general practices would be interesting. General-practitioner care usually emerges as cost effective in most other comparable fields.

Contraception and the National Health Service

For years the National Health Service has excluded contraceptive care. Recently this policy has changed and the Department of Health and Social Security is now actively encouraging both local authorities and hospitals. Contraceptive advice is increasingly being provided free of charge to the patient and there is good evidence that removing the cost improves patient up-take.

Once the decision has been taken in one branch of the Health Service it cannot long be delayed in another—particularly the most important. Sooner or later contraceptive care will come within Health Service general practice. There are obvious ways in which the necessary financial provision could be made such as 'payments in accordance with public policy' or an annual fee per case. By making this one of the many 'options' available, the legitimate rights of general practitioners who do not wish to be involved in this work can be respected, while the work of the majority can be encouraged. It is necessary now that the general practitioner should formally establish within the Health Service his present position in the private sector.

Early in the twentieth century, welfare clinics were established to meet the child care deficiencies of general practice at that time. Today, a similar network of clinics is springing up—to meet the deficiencies of contraceptive care in general practice. Nowadays however, the work of welfare clinics is being rapidly reabsorbed into general practice. We believe that most of the work of contraceptive clinics will in time be similarly re-absorbed into general practice.

As long as there are personal doctors who deal with personal problems, the general-practitioner's position will be central. Family doctors are inevitably concerned with family size.

PRESCRIBING THE PILL

GENERAL practitioners are prescribing oral contraceptives more than ever before and are now writing more prescriptions for these compounds than all other doctors combined. How should such women be looked after? How often should they be seen?

The initial consultation

The initial consultation is important. As so many contraceptive methods are now available it is usual for general practitioners to review with their patients the available methods and seek the most appropriate solution. Certainly the condom, the diaphragm, the 'pill' and the intra-uterine device always need to be mentioned and for couples who may have completed their family, sterilization both male and female is of growing importance.

A careful history is needed to exclude the relatively few absolute contra-indications. It is necessary to know that the patient has not had any thrombo-embolic disorder, any significant congenital or acquired liver disease and is not about to be admitted to hospital for major surgery.