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.

Relative contra-indications include diabetes, depression, obesity, migraine, a family history of diabetes and thrombosis, wearing contact lenses, previous amenorrhoea, and ambivalence about the 'pill' itself. It is helpful to know the woman's plans with regard to future pregnancies, her views on alternative methods, and the man's views. Previous contraceptive use and a history of therapeutic abortion are always important.

On examination it is essential to measure the patients weight and blood pressure, test the urine, and to exclude any masses in the breasts. Pelvic examination is usual and there is something to be said for an initial cervical smear.

Comments have recently been made (Office of Health Economics, 1972) that general practitioners prescribed "often with no physical examination", whereas "women always receive a full physical examination at the Family Planning Association Clinics before an oral contraceptive is prescribed".

Although it is true that most of the physical examinations reveal no abnormality there are strong theoretical justifications for them, even allowing for the fact that general practitioners know their patients much better than clinic doctors. The women themselves feel more reassured having been initially examined.

After-care

Opinions vary on how often patients should be seen and therefore how long prescriptions should last. Clinically, this will depend on the frequency and rate at which complications occur in practice. Many practitioners and many clinics choose to see women three months after they have started, others find one month a more suitable time.

A consensus is emerging in general practice that six months is a convenient time for a regular review. It follows that prescriptions should rarely be for longer.

Follow-up consultations need not last long: five minutes is usually enough. All that is necessary is for the patient to be given a chance to say exactly how she feels, to discuss any symptoms and for the doctor to assess her emotional state and particularly her mood. As obesity and hypertension are two of the more important complications, weight and blood pressure should always be recorded and the urine checked. In practices with nurses, these tests can conveniently be delegated.

Opinions vary as to the desirability of repeat vaginal examinations, many clinics and a growing number of general practitioners arrange this every second appointment i.e. once a year and include a cervical smear. The scientific basis for this is not yet established. Such examinations are sometimes productive in revealing minor gynaecological conditions particularly infections with *Candida albicans*.

At least once a year it is wise to reassess the future contraceptive plan as the couple's situation changes with time and sterilization, particularly vasectomy, may become more suitable.

It is always important to impress the woman that any unusual symptoms should be reported, particularly increasing headaches or loss of libido.

Organisation

Most general practitioners strongly prefer to obtain the man's consent but it is doubtful if this is now legally necessary for an adult woman. Unmarried girls under the age of 18 present a common problem in practice and opinion is moving towards providing contraceptive care 'on request', if indeed the doctor has not himself introduced the subject (Marsh, 1972; Recordon, 1972).

Much more difficult is the girl under the age of 16. We believe her request should remain confidential to the doctor and despite the confused legal position he should prescribe if he believes it in the interest of his patient.

At present the Government and the British Medical Association recommend that contraceptive advice for social purposes should remain outside the National Health Service; the professional fee advised by the British Medical Association is 70p for a private prescription of six months' duration.

Growing point

General practitioners are already prescribing the 'pill' for nearly two million women in the United Kingdom. Already, about one in five of all women in the fertile age group is using this method—its popularity is steadily increasing.

Contraceptive care in general and prescribing the 'pill' in particular are growing points in general practice.

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THE FUTURE GENERAL PRACTITIONER—LEARNING AND TEACHING

AN important new book is published this month. It has been written by a working party consisting of six Fellows of the College, all experienced in teaching general practice. The Chairman was Dr J. P. Horder who during the last decade has been deeply involved in all the College's educational activities and who is at present the chairman of the education committee. The members were Professor P. S. Byrne and Drs P. Freeling, C. M. Harris, D. H. Irvine, and M. Marinker.

The book has been designed specifically for the general-practitioner teacher and adds an entirely new dimension to the literature in this field. It provides for the growing number of teachers a clear framework. It does not seek to specify a syllabus in detail but indicates the starting points from which any course organiser can be happy to proceed.

Some of the best features are the concentration on general principles and the neat way many of these are illustrated by examples. In this way the authors avoid becoming lost in detail and simultaneously have kept down the size of the book.

Obviously the ideas outlined will be studied by the growing number of vocational trainees and it will be interesting to hear what they think of it. It is not, however, a cram book and may well be read by many established specialists in other branches of medicine who are interested in modern ideas in general practice.

The book has, however, a third—and in the long run—an even more important characteristic. It represents one of the most systematic attempts, yet to appear anywhere in the world, to define the content of general practice itself. Such an immense task became inevitable once general practice declared itself a discipline. Teaching in any discipline needs to be related to a defined field.

The production of this kind of book can be seen as a further step in academic development following the foundation of the College in the 1950s, the introduction of an examination for membership in the 1960s, and the recent policy decision that universal vocational training should be mandatory in the 1970s (*see Editorial and Council report*).

It can be predicted now that further developments along these lines will continue in the 1980s.