## INTRODUCTION

Studies in 1967–68 and in 1970 showed that general practitioners were the most frequent source of professional advice on contraception for mothers of young children*. Even so, 52 per cent of the mothers interviewed in 1967–68 and 43 per cent of those seen in February 1970 said they had never discussed methods of birth control with a general practitioner. More recently, a survey in the summer of 1970 found that 14 per cent of married women under 41 were current users of general-practitioner family planning services, and the comparable proportion for unmarried women aged 16–35 was four per cent**.

About three quarters of general practitioners themselves in the 1967–68 study thought they were the most appropriate person to advise people initially about family planning, but they generally gave advice when asked and tended not to inquire whether patients wanted help or advice. Most of their discussions were about a single method of contraception—the 'pill'***.

These data about doctors were obtained in 1967 and early 1968 before the Abortion Act came into force. This Act may have influenced doctors' views as well as their practices. They may have become more aware of peoples' needs and problems and possibly more sympathetic or positive about contraception if they see it as a preferable alternative to abortion. Other changes during this time which may have affected doctors' attitudes and practices are related to the 'pill' and to sterilization.

The 'pill' has now been available for a longer time and more is known about it. At the end of 1969 there was much publicity about the greater risks associated with high oestrogen level pills.**** Since then, various other studies and assessments have been published which seem to have put the risk in a somewhat less alarmist perspective.***** For example Potts and Swyer (1970) conclude that "the mortality associated with the use of oral contraceptives or the IUD is of the same order of magnitude as the mortality due to unplanned pregnancies when less effective methods are used".

At the time of the earlier studies male sterilizations could only be carried out under the National Health Service if it was necessary for the man's health. In April 1970, the grounds were extended to cover the health of the wife. Also during this time there has been much more public discussion about male sterilization and a number of vasectomy clinics have opened.

## 2 AIMS AND METHODS

Our aims were to see how the doctors' views and practices have changed in relation to contraceptive advice and to explore their attitudes and practices about abortion and sterilization and the health hazards of the 'pill'. Data about abortion have already been published in *The Journal of the Royal College of General Practitioners.*******

* Cartwright, Ann. *Parents and family planning services*, p.238.
** Bone, Margaret. *Survey on Family Planning Services.*
*** Cartwright, Ann. 'General practitioners and family planning' and *op.cit.* p.68.
**** Letter from the Committee on Safety of Drugs in the *Lancet* (1969) **ii**, 1369.
***** Doll, Richard. 'The long-term effects of steroid contraceptives', Potts, D. M. and Swyer, G. I. M. 'Effectiveness and risks of birth control methods.'
****** Cartwright, Ann and Waite, Marjorie (1972). 'General practitioners and abortion'. *Journal of the Royal College of General Practitioners*, **22**, Supplement No. 1.

The study of general practitioners is part of a larger inquiry into the functioning of birth control services in England and Wales. The parts played by health visitors, domiciliary midwives, family planning clinics and hospital consultants are also being studied by the Institute for Social Studies in Medical Care. The Social Survey Division of the Office of Population Censuses and Surveys is looking at the services from the point of view of married and unmarried women. All parts of the study are being done in 52 areas of England and Wales.

These areas are a stratified sample of registration districts. The way in which they were chosen and the selection of doctors within the areas are described in Appendix 1. Local executive councils identified the doctors working in the selected areas.

One major difficulty about using local executive council lists as a sampling basis is that many doctors are on the list of more than one council. To overcome this problem the councils and the Department of Health and Social Security gave us information about the one authority 'responsible' for the doctors selected. When this was not a district covering the sample area the doctor was rejected from our sample.

Within the areas doctors were selected in such a way that all doctors in England and Wales had roughly a one in 23 chance of being included in the sample. This means that our sample of 889 doctors can be regarded as a national sample—not just an aggregate of doctors giving services in the study areas.

Six hundred and one doctors returned completed questionnaires: a response of 68 per cent. Younger doctors were more likely to reply than older doctors—the response fell from 77 per cent of those under 35 to 48 per cent of those aged 65 or more.* The response rate was also greater for those receiving rural practice payments—75 per cent against 65 per cent—and for those with a group practice allowance—72 per cent compared with 63 per cent. Throughout this paper attention has not been drawn to any difference which statistical tests suggest might occur by chance five times or more in a hundred.

As almost a third of the doctors did not answer our questions the results have to be interpreted with care. Those who did not reply were older and for other reasons too may have been less active and interested in giving their patients advice and help about contraception, abortion and sterilization. A study among general practitioners in Sheffield, however, in which response rates varied between 67 per cent and 96 per cent suggested that the different response rates had little or no effect on the distribution of answers*.

In addition, a comparison of patients whose doctor collaborated in a survey of birth control services with those whose doctor did not respond found only small differences suggesting that doctors who did not co-operate gave their patients only slightly less help with family planning than those who did.**

## 3 PERCEPTIONS OF THEIR ROLE

Recently there have been many suggestions about appropriate functions for general practitioners. To obtain some idea of doctors' views on the relative importance of birth control, general practitioners were asked whether they regarded the various activities listed in table1 as an essential part of their practices, as ideally part but not always practical, or as peripheral or not relevant.

* Cartwright, Ann and Ward, Audrey 'Some variations in general practitioners' response to postal questionnaires'.

** Cartwright, Ann op.cit. p.262.

TABLE 1

COMPONENTS OF GENERAL PRACTICE

| | *Cervical cytology screening* | *Regular physical examinations for the elderly* | *Birth control advice and help* | *Excising simple cysts* | *Advice and help with psychosexual problems* |
|---|---|---|---|---|---|
| | % | % | % | % | % |
| Essential | 53 | 11 | 77 | 14 | 46 |
| Ideal but not always practical | 39 } 92 | 72 } 83 | 20 } 97 | 46 } 60 | 45 } 91 |
| Peripheral or not relevant | 8 | 17 | 3 | 40 | 9 |
| Number of general practitioners (=100%)* | | | 601 | | |

* This is the total number of doctors who replied. Small numbers who gave inadequate information have been omitted when calculating the percentages, in this table and others.

Three quarters of the doctors regarded birth control advice and help as an essential part of their practice and less than one in 30 thought it peripheral or not relevant. Fewer doctors regarded the other four activities asked about as essential. About half thought this about cervical cytology screening or advice and help with psychosexual problems, one in seven or less about excising simple cysts or regular physical examinations for the elderly. Of course, the rest of the questions were about birth control services and the questionnaire was headed *Survey of birth control services.* If it had been about one of the other subjects it is possible that responses to this first question might have been rather different.

A third of the doctors thought it better for patients to go to family planning clinics rather than their own doctors for advice about birth control when they had a choice*. So more general practitioners recognised the need to give advice and help than felt that they were the most appropriate people to do so.

Nearly a quarter of those doctors who regarded birth control advice and help as an essential part of their practice thought it preferable for patients to go to clinics, but this proportion was much greater, nearly three fifths, for other doctors. However, only 12 per cent referred half or more patients elsewhere when the subject of birth control came up. This can be seen from table 2 which shows the percentage who referred different proportions of patients elsewhere.

The great majority of those making referrals, 93 per cent, referred patients mainly to family planning clinics. The main reason for sending patients to clinics was that several methods were available there. Only one per cent of all doctors, but a fifth of those who referred all their patients elsewhere, said it was because they had religious or other conscientious objections.

Many mothers feel diffident and embarrassed about raising the subject of contraception with their doctor, and the majority, 71 per cent, in the 1967–68 survey thought doctors should ask mothers who have had a baby whether they want advice about it without

* Question 2: 'When patients have a choice between clinic and general-practitioner services do you personally feel it is better for most patients to go to family planning clinics or to their own doctors for birth control advice?'.

TABLE 2

PROPORTION OF PATIENTS REFERRED TO CLINICS OR OTHER GENERAL PRACTITIONERS

| *Proportion referred* | % |
|---|---|
| None | *19* |
| Less than 10% | *48* |
| 10% but less than 50% | *21* |
| 50% but less than 90% | *5* |
| 90% but less than 100% | *3* |
| All | *4* |
| Number of doctors (=100%) | 600* |

* This is less than 601 because one doctor did not indicate whether he referred patients elsewhere or not. In other tables, too, small numbers of doctors who did not reply to particular questions have been omitted.

waiting for the mothers to ask them*. If doctors are to help those who are shy or inarticulate and others who feel their doctor is so busy treating people who are ill he will not have the time or interest to advise on birth control, they need to take the initiative and raise the subject themselves.

Doctors were asked whether they would introduce the subject of birth control themselves with a married woman patient who had three children and only one bedroom, a married woman with three children and no social or health problems and an unmarried woman who had had a baby. Seven tenths said they would do so in each of the first and last instances but only a third for a woman with three children and no social or health problems. We did not specify the ages of the women or the circumstances of the consultation in these hypothetical situations. Half of the doctors said they raised the question of contraception routinely with every mother they saw *postnatally*. The four per cent of doctors who referred all their patients elsewhere for birth control advice were not asked these questions. It has been assumed that they would not introduce the subject.

Only one per cent said they would not be prepared to discuss birth control with an unmarried woman who had had a baby, but in answer to another question, six per cent said they would discourage an unmarried woman who asked for advice and help from using birth control without either advising her themselves or referring her to anyone else**. (Again the four per cent who referred all their patients elsewhere were not asked.)

When asked whether they raised the subject of overpopulation when talking to patients about birth control five per cent said they did so often, 25 per cent sometimes.*** The proportion who would always raise the question of contraception at a postnatal examination was 77 per cent of those who discussed overpopulation frequently, 60 per cent among those who did so sometimes and 47 per cent among those doing this rarely or never. So it would seem that one reason for general practitioners raising the subject of birth control with patients may be their concern about overpopulation. Whether this approach is likely to be effective in its appeal to individual patients seems doubtful.

* Cartwright, Ann *op.cit.* p.50.

** Question 14: 'If an unmarried woman asks you about getting birth control advice and help are you more likely to: provide birth control help yourself, refer her elsewhere for help or discourage her use of birth control?'

*** Question 17: 'When talking to patients about birth control do you raise the subject of overpopulation as one of the reasons why birth control is important: frequently, sometimes, rarely or never?'

## 4 HELP AND ADVICE ABOUT DIFFERENT METHODS

The contraceptive methods most often recommended by the doctors are shown in table 3.*

TABLE 3
METHODS MOST OFTEN ADVISED

| | *Most often advised %* | *Next most often advised %* |
|---|---|---|
| 'Pill' | *90* | *5* |
| Diaphragm, cap | *2* | *24* |
| IUD, coil | — | *35* |
| Sheath | *3* | *18* |
| Withdrawal | — | — |
| Safe period | *1* | *1* |
| Sterilization—male | — | *8* |
| Sterilization—female | — | *4* |
| Other | — | *1* |
| Refers all patients elsewhere* | *4* | *4* |
| Number of doctors (=100%) | 595 | 564 |

*The question on methods advised was not asked if doctors referred all their patients elsewhere.

Nearly all the doctors who discussed birth control methods advised the 'pill' most frequently. The IUD, the cap and then the sheath were advised next most often.

One clear reason why more doctors did not advise the IUD was their anxiety about associated health hazards. Eleven per cent of them described these as 'considerable', and 46 per cent as 'moderate', while 38 per cent thought them 'negligible' and five per cent did not know. The proportions including the IUD among the two most frequently advised methods rose from seven per cent of those who thought the health hazards considerable to 54 per cent of those who thought them negligible.

A factor closely associated with the likelihood of general practitioners recommending the cap and coil was whether or not they ever fitted these themselves. Twenty-seven per cent of the general practitioners said they fitted diaphragms and 12 per cent fitted IUDs

TABLE 4
DIFFERENCES BETWEEN DOCTORS WHO FIT AND DO NOT FIT CAPS AND IUDS IN THE METHODS THEY RECOMMEND

| | *Doctors fitting* | | | |
|---|---|---|---|---|
| | *Cap and IUD* | *Cap but not IUD* | *IUD but not cap* | *Neither cap nor IUD* |
| Proportion advising the 'pill' most often | 100% | 97% | 93% | 93% |
| Method advised next most often | % | % | % | % |
| Diaphragm, cap | *23* | *54* | *2* | *17* |
| IUD, coil | *55* | *19* | *73* | *38* |
| Sheath | *10* | *15* | *9* | *23* |
| Other | *12* | *12* | *16* | *22* |
| Number of doctors (=100%)* | 39 | 119 | 28 | 352 |

*Excluding doctors who refer all their patients elsewhere for birth control advice.

*Question 4: 'After discussion, which method of birth control do you most frequently recommend or agree would be most suitable for the patient? Which method next most frequently?'.

including seven per cent who did both. So those who fitted caps were more likely to fit IUDs too than those who did not—25 per cent compared with eight per cent. Table 4 shows how this was related to the birth control methods they advised. Obviously their own skills in fitting or prescribing different methods are associated with their recommendations to patients.

Doctors were asked what they did if they became aware that a patient was using either the sheath, withdrawal or the safe period and was satisfied with it.* Replies are given in table 5.

TABLE 5

ACTION WHEN PATIENT USING NON-MEDICAL METHODS

| | *Sheath* % | *Withdrawal* % | *Safe period* % |
|---|---|---|---|
| Encourage them to continue | *72* | *5* | *21* |
| Encourage them not to use it | *7* | *78* | *52* |
| Not say anything | *19* | *12* | *21* |
| Never been mentioned | *2* | *5* | *5* |
| Other | — | — | *1* |
| Proportion who would also explain how to use it most effectively | *77%* | Not asked | *59%* |
| Number of doctors (=100%)* | 575 | | |

*Doctors who did not reply and those who referred all their patients elsewhere have been omitted when calculating percentages.

In general they encouraged people to continue using the sheath, discouraged the use of withdrawal and were more divided in their action over the safe period. Although over three quarters of the doctors said they would explain how to use the sheath effectively if they knew someone was using it, it seems likely that in fact the sheath is discussed only rarely with doctors. In the main survey for *Parents and Family Planning Services*, 48 per cent of the mothers had discussed family planning with their general practitioner and of these, nine per cent, that is four per cent of all mothers, said they had discussed the sheath; among fathers only 16 per cent had talked to a general practitioner about family planning and four per cent had discussed the sheath.** Eighty-five per cent of the mothers reporting use of the sheath by their husbands said they did not use any jelly or paste with it.***

Obviously there is scope for doctors to help their patients to use the sheath more effectively as it is the most commonly used method of birth control,**** but opportunities need to be created for this: they do not arise spontaneously.

The doctors were asked whether they thought men or women were more appropriate users of contraception 'just supposing male and female methods were equally reliable, safe and pleasant to use'. Overall 11 per cent thought the man, 23 per cent the woman and 66 per cent thought men and women equally appropriate. The fact that twice as many doctors opted for female rather than male methods in this hypothetical situation reflects the general emphasis of professional birth-controllers. However when a sample of mothers and fathers was asked whether 'other things being equal they would prefer a method in

* Question 12: 'If you become aware that a patient is using one of the three following methods and is satisfied with it do you usually: encourage them to continue, encourage them not to use it, not say anything or never been mentioned?'

** Additional unpublished data.

*** Cartwright, Ann (1971) 'Family Planning and Professional Advice'.

**** Glass, D. V. 'Contraception in marriage', Woolf, Myra *Family Intentions* p.83.

the man's or the woman's control' they were fairly evenly divided, slightly more of each group expressing a preference for methods in the man's rather than the woman's control.*

Most mothers, 87 per cent, and fathers, 85 per cent, thought there were some health risks associated with the 'pill'.** But this was the method most often advised by the majority of general practitioners and all but five per cent (the four per cent who referred all their birth control patients elsewhere and another one per cent) prescribed it. What do they think about its contra-indications and dangers?

## 5 PRESCRIBING THE 'PILL'

When asked to identify from a list of five conditions the two which they considered the strongest contra-indications to prescribing the 'pill', 98 per cent of the doctors who prescribed it identified recent pulmonary embolism as one (table 6). There was less unanimity about the second, but congenital liver dysfunction was most commonly mentioned, by 60 per cent, a view which seems to be in line with current research findings.***

The proportion who identified both recent pulmonary embolism and congenital liver dysfunction as the two strongest contra-indications to the 'pill' was 57 per cent: this proportion increased from 37 per cent of those who were unlikely to raise the subject of family planning themselves to 68 per cent of those who would do so in the three situations we asked about specifically.

So doctors who were most active in raising the question of birth control seemed more knowledgeable than other doctors about the hazards.

TABLE 6
TWO STRONGEST CONTRA-INDICATIONS TO THE 'PILL'

| | *Doctors selecting condition** |
|---|---|
| | % |
| Recent pulmonary embolism | *98* |
| Congenital liver dysfunction | *60* |
| Fibroadenosis of breast | *18* |
| Family history of diabetes | *10* |
| Migraine | *9* |
| Number of doctors who prescribed 'pill' (=100%) | 568 |

*The total is less than 200% (each doctor was asked to select two conditions) because some doctors selected only one condition.

Once their patients are on the 'pill' what prompts general practitioners to stop prescribing it? We listed five symptoms—depression, chest pains, 'spotting', deterioration of migraine and leg pains—and asked all the doctors who prescribed whether for each of these symptoms they would generally take the patient off all oral contraception at once, do this after three months, or do neither of these things. The results are shown in table 7.

* Cartwright, Ann *op.cit.* p.150.
** Cartwright, Ann *op.cit.* p.34 and additional unpublished data.
*** For data on the effects of the 'pill' see Kleinman, R. L. (Ed.) *Comments on Steroidal Contraception* Doll, Richard *op.cit.* and Sherlock, Sheila *Diseases of the liver and biliary system* p.380.

TABLE 7
ACTION ON POSSIBLE SIDE-EFFECTS OF 'PILL'

| | *Depression* % | *Chest pains* % | *'Spotting'* % | *Deterior-ation of migraine* % | *Leg pains* % |
|---|---|---|---|---|---|
| Take patient off all oral contraception at once | *26* | *65* | *2* | *39* | *61* |
| Take patient off all oral contraception after 3 months | *47* | *8* | *34* | *46* | *13* |
| Do neither of these | *24* | *22* | *62* | *14* | *20* |
| 'It depends' | *3* | *5* | *2* | *1* | *6* |
| Number of doctors who prescribe 'pill' (=100%) | 568 | | | | |

We understand that the cautious but well-informed doctor could be expected usually to take a patient off the 'pill' for *any* of the conditions listed except for 'spotting' (for which he should neither take the patient off the 'pill' at once nor after three months)*. Only for chest pains and for leg pains did a majority of the doctors say they would stop the 'pill' at once. For depression, chest pains and leg pains a substantial minority ranging from a fifth to a quarter said they would neither stop the 'pill' at once *nor* after three months.

In contrast to this possibly low level of caution in the presence of side-effects, some doctors seemed to treat with unnecessary caution their patients who have been on the 'pill' for a length of time with no side-effects. The Central Medical Committee of the International Planned Parenthood Federation stated in 1970 that: "There is no need to limit the length of time over which oral contraceptives can be used. There are no valid data to justify interruption in the use of oral contraceptives at arbitrary intervals".**

Yet 45 per cent of the doctors who prescribe the 'pill' said they would advise patients who were suffering no demonstrable side-effects to stop taking it after a certain length of time. And most of these doctors—25 per cent of all doctors prescribing the 'pill'—said they would do this after less than three years (table 8). The majority of those who would do this at all would advise patients to stop for between two and six months.

TABLE 8
ADVICE TO PATIENTS WITH NO DEMONSTRABLE SIDE-EFFECTS ABOUT STOPPING TAKING THE 'PILL'

| | % |
|---|---|
| Did not advise them to stop | *55* |
| Advised them to stop after: | |
| Less than 1 year | *2* |
| 1 year but less than 3 years | *23* |
| 3 years but less than 5 years | *15* |
| Longer than 5 years | *4* |
| Varies | *1* |
| Advised them to stop for: | |
| 1 month | *2* |
| 2–6 months | *31* |
| 7–12 months | *9* |
| Longer than a year | *2* |
| Varies | *1* |
| Number of doctors prescribing the 'pill' (=100%) | 568 |

* See Kleinman, R. L. (Ed.) *op.cit.* and Grant, Ellen C.G. 'Venous Effects of Oral Contraceptives'
** Kleinman, R. L. (Ed.) *op.cit.* p.45.

It might be more understandable if general practitioners were advising patients to come off the 'pill' altogether since little is known about the long term effects of the 'pill'. In that case the general practitioner could be regarded as performing his traditional role of protecting patients and not accepting the possibly premature assurances of specialists and experts.*

But there does not seem to be any evidence to suggest that it is helpful to take patients with no symptoms off the 'pill' for limited short periods. The fact that so many doctors recommend this reflects their anxieties about the 'pill'. The general practitioners who advised patients to stop taking the 'pill' for a time were more likely than those who did not to say they would help a normal healthy woman taking the 'pill' and worried about its health risks to consider alternatives and change to another method: 42 per cent compared with 29 per cent. Among all the doctors 35 per cent said they would do this, 62 per cent would reassure her and help her to continue with the 'pill'.

In relation to 'pill' practice, then, the picture emerges of general practitioners concentrating heavily on this method of contraception, one fifth of them possibly underestimating the importance of certain side-effects and nearly one half of them imposing arbitrary limits on the period of 'pill-taking'.

## 6 VIEWS ON SERVICES

When asked what changes if any they would like to see in the birth control services in their area half the doctors had no suggestions. The main points made by the others are summarised in table 9.

TABLE 9
SUGGESTED CHANGES IN BIRTH CONTROL SERVICES

| | *Percentage of general practitioners making suggestion* |
|---|---|
| Birth control services should be free or less expensive and integrated into the National Health Service. | *10* |
| Vasectomies should be more easily available, less expensive or on National Health Service. | *9* |
| More family planning clinics or more frequent or more accessible ones | *8* |
| More publicity or information about services | *6* |
| Better general practitioner service—should assume more or all responsibility and have increased facilities | *6* |
| More training for general practitioners | *3* |
| Female sterilization more easily available | *3* |
| More or better sex education in schools or for young people | *2* |
| Other suggestions | *15* |
| No change suggested | *49* |
| Number of doctors (=100%)* | 601 |

*The percentages add to more than 100 as some doctors made more than one suggestion.

* Fox, T. F. 'The personal doctor and his relation to the hospital'.

Other suggestions included:

"General practitioners who have done reputable house surgeon appointments in obstetrics and gynaecology who have had tuition from experts (teaching hospital consultants)—to allow them to work in the local family planning clinics without having to obtain this ridiculous certificate of the Family Planning Association".

"Freer advice and help to unmarried women."

"Birth control is much more than just pills, coils and mechanical devices. It must be seen as an integral part of general practice and future general practitioners must have thorough training in this. The clinics do their best but this sort of personal work should be done by the patient's doctor."

"It should be far more widely taught in medical schools and to nurses."

Nearly three quarters of the doctors thought present services were adequate, a fifth described them as inadequate and the others said they did not know or had qualifications.* But, when asked specifically who, if anyone, they thought should have means of birth control available to them free through the National Health Service only 11 per cent said specifically that no-one should. A further ten per cent left this question unanswered and may also have felt this.

At the other end of the scale 22 per cent felt that it should be freely available to everyone. Twenty-seven per cent thought it should be free for medical or genetic reasons and 26 per cent wanted it to be free for those who could not afford it. Other sorts of people mentioned here were those with large families (by ten per cent), 'problem families' or people with social difficulties (by nine per cent) and the mentally ill or retarded (also by nine per cent). A number of other suggestions were: married people; students; large poor families; unmarried mothers who continue to be at risk; coloured immigrants; families with two or more children; those to whom prevention of pregnancy is essential on medical grounds or are unlikely to use methods for which they pay.

One hypothesis that was explored was that doctors who regarded the services as inadequate were rather more active about raising the subject of birth control with their patients and more inclined to regard it as an important part of general practice than those who felt the services were adequate. This did not appear to be so.

## 7 STERILIZATION

More facilities for both male and female sterilizations were mentioned by a number of general practitioners as one of the changes they would like to see in birth control services (table 9).

When asked specifically 36 per cent felt services for male sterilization were inadequate in their area and a further four per cent described them as adequate only for people who could afford private treatment. Slightly fewer, but still 23 per cent regarded the services for female sterilization in their area as inadequate.

The circumstances in which they said they would introduce or discuss sterilization with patients are shown in table 10.**

* Question 18: 'So at present do you regard the services as adequate or inadequate, or don't you know?'

**Question 21: 'In each of the following situations would you introduce sterilization as a possibility for one partner or the other of a married couple, discuss the possibility only if asked directly or not discuss the possibility at all?' (Situations as listed in table 10).

TABLE 10

DISCUSSION OF STERILIZATION

| | *Couple aged 30 with three children, further pregnancies dangerous to mother's health* | *Couple aged 30 with three children, other methods inappropriate or unsuccessful* | *Couple aged 30 with three children, only one bedroom* | *Couple aged 30 with three children, no problems but couple desire sterilization* |
|---|---|---|---|---|
| | % | % | % | % |
| Introduce | *84* | *64* | *48* | * |
| Discuss if asked | *15* | *34* | *48* | *96* |
| Not discuss | *1* | *2* | *4* | *4* |
| Number of doctors (=100%) | 598 | 595 | 596 | 597 |

*Not applicable

They were more likely to introduce the subject of sterilization when further pregnancies would be dangerous to the mother's health than when other methods of birth control were inappropriate or unsuccessful. Half would raise the possibility of sterilization with a couple aged 30 with three children and only one bedroom: this compares with three-quarters who would raise the subject of birth control in a similar situation.

Doctors who were likely to raise the possibility of sterilization also tended to initiate discussion about birth control generally: there was a correlation of +0.48 between the two scores (based on the doctor's predicted action in various circumstances).

Sixty-one per cent of the doctors said that 'other things being equal' they generally considered male sterilization preferable to female sterilization, 26 per cent in general preferred female sterilization. Most of the others maintained that 'other things were never equal' or 'it is impossible to generalise—everyone is an individual and complex problem'. Two per cent disapproved of sterilization altogether.

The main reason for preferring male sterilization was that it was a simpler and safer operation than for the female. Ten doctors mentioned that it might be reversible. Reasons for preferring female sterilization were more diffuse. Just over a third of the doctors who held this view thought male sterilization had bad psychological effects on the man, his potency or the marriage.

> "Although vasectomy is much simpler it seems to be associated with more psychosexual problems".

One in seven felt female sterilization more customary and acceptable.

> "At present, in my practice, the accepted procedure as far as patients are concerned is female sterilization. Only a few men have so far requested sterilization or been receptive to the suggestion."

A similar proportion thought it more appropriate as the woman had the babies—"desirable that female has control of conception."

Other reasons given were that men might remarry and want a new family and the existing children were more likely to go with the mothers; male sterilization would increase male promiscuity; only female sterilization prevented the woman from conceiving; women could have the operation while in hospital after delivery; women were only fertile

until the menopause. Eight doctors spontaneously admitted that they favoured female sterilization because they were men.

Eleven general practitioners, less than two per cent, said they did any vasectomies. All were men.

## 8 CHANGES SINCE 1967–68

A number of findings in this study can be compared with results from an earlier survey of general practitioners in 1967–68.

In this survey doctors seemed more likely to raise the subject of family planning themselves. This is shown in table 11.

TABLE 11

INTRODUCTION OF BIRTH CONTROL IN DIFFERENT CIRCUMSTANCES IN 1967–68 AND 1970–71

| | *Percentage of doctors who would introduce discussion of birth control* | |
|---|---|---|
| | 1967–68* | 1970–71** |
| A married woman with three children and only one bedroom | *55%* | *71%* |
| A married woman with three children and no social or health problems | *21%* | *34%* |
| An unmarried woman who had had a baby | *51%* | *73%* |
| Number of doctors (=100%)*** | 531 | 601 |

* Cartwright, Ann, *op. cit.* p. 271.

** Twenty-six doctors who referred all their patients elsewhere for birth control help were not asked these questions in 1970–71. They have been included as not introducing the subject.

***These are the total numbers of doctors for whom data were obtained. Those for whom inadequate information was available have been excluded when calculating percentages.

*Changes in general-practitioners' attitudes*

The increases are considerable and if changes were to continue at similar rates one might expect that before very many years nearly all doctors would be raising the subject with unmarried mothers and married women with three children and only one bedroom. However, even if change continued at this rate it would be a long time before nearly all doctors were raising it with mothers whom they felt had no social or health problems.

However, between 1967–68 and 1970–71 the Abortion Act came into force and it seems plausible that this has made doctors more aware of unwanted pregnancies.

They may now see contraception as a means of reducing demands for abortion. Doctors' views on abortion have certainly changed during this time. In the earlier inquiry they were asked whether they thought a woman who had several children should be able to get an abortion when she found she was pregnant and did not want to be. Only 22 per cent gave an unqualified 'yes',* compared to the 69 per cent who said on the present survey they would recommend abortion when requested by 'a married woman with six children', and the 35 per cent who would do so for 'whoever requests it after she has given serious consideration to alternatives'.

Views on sterilization also seem to have become more liberal, although this is more difficult to pinpoint precisely as rather different questions were asked in the two studies. In 1967–68, ten per cent of general practitioners gave a definite 'no' when asked whether a woman with several children ought to be able to get herself sterilized if she wants to.**

* Cartwright, Ann *op.cit.* p.72

** Cartwright, Ann *op.cit.* p.73.

This may be compared with the one per cent to four per cent who were not prepared to discuss sterilization in the circumstances listed in table 10.

At the same time that general practitioners have become more liberal about abortion and sterilization and more inclined to discuss contraception with their patients, the advice they offer has become even more concentrated on the 'pill'. This is suggested by the data in table 12.

TABLE 12
METHODS MOST OFTEN ADVISED IN 1967–68 AND IN 1970–71

| | *Most often advised* | | *Next most often advised* | |
|---|---|---|---|---|
| | 1967–68* | 1970–71 | 1967–68* | 1970–71 |
| | % | % | % | % |
| 'Pill' | *77* | *90* | *12* | *5* |
| Cap | *6* | *2* | *33* | *24* |
| IUD | *3* | — | *30* | *35* |
| Sheath | *5* | *3* | *14* | *18* |
| Safe period | *4* | *1* | *2* | *1* |
| Sterilization—male** | — | — | — | *8* |
| Sterilization—female** | — | — | — | *4* |
| Other | *1* | — | — | *1* |
| None or only one | *4* | — | *9* | — |
| Not asked—referred all patients elsewhere† | — | *4* | — | *4* |
| Number of doctors (=100%) | 515 | 595 | 507 | 564 |

* Cartwright, Ann *op.cit.* p.75

** The doctors on the earlier study were asked which of *all* methods of birth control they advised most frequently and next most frequently. The more recent study was done by postal questionnaire so the methods were listed. Some doctors on the earlier study may not have thought of sterilization in this context.

† The 26 doctors in 1970–71 who referred all their patients elsewhere for birth control help were not asked this question. The doctors answering 'none' in 1967–68 are probably a comparable group.

The proportion who fitted caps themselves was 31 per cent in 1967–68, 27 per cent in 1970–71 and the proportions fitting coils in the two periods ten per cent and 12 per cent; no dramatic changes.*

## 9 VARIATIONS WITH AGE

There was a clear trend in the response rate with the doctors' age from 77 per cent of those under 35 to 48 per cent among those aged 65 or more. In another study about medicines older doctors were also less likely to co-operate; the response was 62 per cent among doctors under 50 and 47 per cent of those aged 50 or more. (Dunnell, Karen and Cartwright, Ann p. 133). It is possible that a doctor's interest in a particular subject may make him more likely to participate but whether positive and negative feelings about a subject tend to have similar or opposite effects is unknown.

Among those who replied older doctors appeared rather more likely than younger ones to regard birth control advice and help as peripheral or not relevant to general practice; five per cent of doctors aged 55 or more felt this, none of those under 35. Older doctors were also rather more likely to refer all patients with whom the issue arose elsewhere and less likely to raise the subject of birth control.

* Cartwright, Ann *op.cit.* p.59

TABLE 13
VARIATIONS WITH AGE

| | *Doctors aged* | | | | |
|---|---|---|---|---|---|
| | *Under 35* | 35–44 | 45–54 | 55–64 | *65 or more* |
| *Proportion* | | | | | |
| Referring all patients for birth control advice elsewhere | *0* | *4%* | *4%* | *9%* | *12%* |
| Raising the question of contraception routinely with every mother seen postnatally* | *69%* | *60%* | *45%* | *38%* | *35%* |
| Would introduce the subject of birth control to an unmarried woman who had had a baby* | *91%* | *81%* | *69%* | *69%* | *62%* |
| Identifying recent pulmonary embolism and congenital liver dysfunction as two strongest contra-indications to prescribing the pill* | *78%* | *65%* | *52%* | *40%* | *32%* |
| Regarding the health hazards of the IUD as 'considerable'* | *7%* | *9%* | *11%* | *17%* | *17%* |
| Number of doctors (=100%)** | 91 | 198 | 185 | 93 | 34 |

* Doctors referring all patients elsewhere have been excluded when calculating these percentages.
**Doctors who gave inadequate answers have been excluded when calculating percentages.

In an earlier study it was found that younger doctors more often than older ones said their most frequent action when they discussed birth control was to prescribe the 'pill'.* Here, when those who would refer all their birth control patients elsewhere are excluded, only six doctors, all aged between 40 and 64, said they never prescribed the 'pill' and the proportions who would most frequently recommend the 'pill' did not vary with age: it was over 90 per cent for all age groups.

The method *next* most frequently recommended was related to some extent to the doctor's age: the proportion saying male sterilization was 12 per cent of those under 45 and five per cent of those aged 45 or more, while the proportion saying the coil declined from 48 per cent of those under 35 to 27 per cent of those aged 65 or more. Older doctors were more likely than younger ones to regard the IUD as a 'considerable' health hazard (table 13.)

There was no relation with age in the proportion who ever fitted coils for their patients or did vasectomies, but older doctors were more likely to fit caps: 34 per cent of those aged 45 or more said they did so, 20 per cent of the younger doctors.

The proportion who identified both recent pulmonary embolism and congenital liver dysfunction as the two strongest contra-indications for prescribing the 'pill' from the list of five conditions fell from 78 per cent of those aged under 35 to 32 per cent of those aged 65 or more.

Earlier we showed that this was related to whether or not they raised the subject of family planning with patients in different circumstances: the proportion was 65 per cent of those who said they raised the subject routinely when seeing mothers postnatally, 49 per cent among those who did not. Table 14 shows that both age and an interest in birth control were related to the identification of these contra-indications.

Their predicted action when various symptoms developed in a patient taking the 'pill' did not vary with age, neither did the proportion who said they generally advised

* Cartwright, Ann *op.cit.* p.82.

TABLE 14

PROPORTION IDENTIFYING TWO STRONGEST CONTRA-INDICATIONS TO PRESCRIBING THE 'PILL' AS RECENT PULMONARY EMBOLISM AND CONGENITAL LIVER DYSFUNCTION ANALYSED BY AGE AND WHETHER OR NOT THEY INTRODUCE BIRTH CONTROL ROUTINELY WHEN SEEING MOTHERS POSTNATALLY.

PROPORTION IDENTIFYING CONTRA-INDICATIONS

| *Age* | *Raises subject of birth control routinely when seeing mothers postnatally* | |
|---|---|---|
| | *Yes* | *No* |
| Under 35 | *79%* (58) | *70%* (30) |
| 35–44 | *66%* (112) | *61%* (75) |
| 45–54 | *63%* (80) | *43%* (94) |
| 55 or more | *44%* (*41*) | *36%* (64) |

The figures in brackets are the number of doctors on which the percentages are based (=100%)

patients on the 'pill' who were not suffering from any demonstrable side-effects to stop taking it after a certain length of time.

In addition there was no clear trend with age in the proportion who would reassure a woman anxious about the health hazards of the 'pill' rather than help her consider alternatives and change to another method. So older doctors did not seem to have more anxieties than younger ones about the 'pill', but they were rather less active about contraception in general.

## 10 VARIATIONS WITH SEX

A study of mothers who had recently had a baby found that 57 per cent did not think the sex of the doctor would make much difference to the ease with which they could discuss birth control: 37 per cent thought it would be easier to talk to a woman, six per cent to a man. The proportion preferring a woman was higher among working than middle-class mothers.*

Do women doctors respond to this preference by being more active than their male colleagues about giving help and advice about contraceptives? At one level the answer is no. Women doctors were no more likely to regard such advice and help as an essential part of general practice nor were they any more likely to raise the subject with patients in the different situations we asked about.

In the earlier study women doctors were less likely than men to prescribe the 'pill' and more likely to fit caps themselves.** In 1970–71 they were still more likely to fit caps (table 15) but there was no difference in the proportion who said the method they were most likely to recommend was the 'pill', and the six doctors who never prescribed the 'pill' were all men.

However, when a normal healthy woman taking the 'pill' told them she was worried about its health risks women doctors were more likely than men to say they would help her consider alternatives and change to another method, the men would more often reassure her and help her to continue with the 'pill'.

When asked what they did when they became aware that a patient was using either

* Cartwright, Ann *op.cit.* p. 56 and p.200.
** Cartwright, Ann *op.cit.* p. 83.

the sheath, withdrawal or the safe period and was satisfied with it women doctors more often encouraged them to continue using the safe period. They were also more likely to explain how to use it most effectively. There was some indication that they were rather more likely to discourage use of the sheath, but that difference might have occurred by chance ($\cdot 05 < p < \cdot 10$). Rather more of the women doctors were Roman Catholics, 17 per cent compared with eight per cent of the men, but the non-Catholic women were still more likely than non-Catholic men to encourage use of the safe period.

TABLE 15
VARIATIONS WITH SEX

| | *Men %* | *Women %* |
|---|---|---|
| Proportion who fit caps* | *27* | *46* |
| Proportion advise caps as 'next most frequent method'* | *24* | *45* |
| Action when normal healthy woman taking 'pill' says she is worried about health risk* | | |
| Reassure her and help her to continue with 'pill' | *63* | *50* |
| Help her to consider alternatives and change to another method | *33* | *50* |
| Other | *4* | *0* |
| Action when becomes aware patient using safe period and satisfied with it* | % | % |
| Encourage to continue | *20* | *31* |
| Encourage not to use it | *53* | *41* |
| Not say anything | *21* | *24* |
| Other | *6* | *4* |
| Proportion who would advise how to use it most effectively | *58%* | *71%* |
| Action when becomes aware patient using sheath and satisfied with it* | % | % |
| Encourage to continue | *72* | *71* |
| Encourage not to use it | *6* | *13* |
| Not say anything | *19* | *14* |
| Other | *3* | *2* |
| Proportion identifying recent pulmonary embolism and congenital liver dysfunction as the two strongest contra-indications to prescribing the 'pill'* | *56%* | *71%* |
| Proportion who worked or had worked in a family planning clinic | *5%* | *29%* |
| Proportion of those working with other doctors who personally specialize in contraceptive advice | *9%* | *28%* |
| Proportion working in practices with special sessions for birth control | *8%* | *19%* |
| Number of doctors (=100%)** | 542 | 59 |

* Doctors referring all patients elsewhere have been excluded when calculating these percentages.
**Doctors who gave inadequate answers have been excluded when calculating percentages.

One clear difference between men and women doctors was that women more often identified recent pulmonary embolism and congenital liver dysfunction as the two strongest contra-indications to prescribing the 'pill'. Women doctors may be better informed about this partly because they were more likely to have worked at a family planning clinic. (Sixty-seven per cent of those who worked or had worked in such a clinic gave the 'correct' answer to this question, 56 per cent of other doctors: a difference which might have occurred by chance: $p = \cdot 10$.) If women worked in a partnership they were more likely to specialize in family planning than their male partners—this too may have made them more knowledgeable about contraception.

So the final picture that emerged of women general practitioners was that they were somewhat reluctant birth controllers. They seemed no more enthusiastic about such a role than their male colleagues but demands of patients—and also possibly their male colleagues—had led them to specialize in this field to some extent. They appear to have responded only in a limited way.

In many respects the most impressive finding is the lack of difference between men and women doctors—in the proportions raising family planning in different circumstances, fitting IUDs, raising the subject of overpopulation, discussing sterilization, preferring male to female sterilization or considering the man or woman the most appropriate user of contraception.

## 11 MARITAL STATUS AND CHILDREN

More of the women doctors, 27 per cent, than of the men, two per cent, were single. Altogether 93 per cent of the doctors were married, five per cent were single, two per cent widowed or divorced. The average number of children for the married and widowed was 2·5, only five per cent were childless. The few who were married but childless seemed least likely to discuss family planning with patients: only 35 per cent of them compared with 53 per cent of other married doctors said they would raise the question routinely with mothers they saw postnatally, and their score on raising birth control in the other three circumstances asked about was 4·3 compared with 4·9 for other doctors.

The single doctors did not differ from all married ones over this and the number of children did not appear to be related to this either. Roman Catholic doctors did not have significantly more children than doctors of other religions.

## 12 ORGANISATION OF PRACTICE

In the 1967–68 study it was found that doctors who looked after relatively large numbers of patients were no less or more likely to discuss family planning with their patients but they had a rather wider concept of their role. No differences in either of these characteristics with list size were apparent in the present survey. (Different criteria were used for list size on the two studies. In the earlier one doctors working in partnerships were asked to estimate the number of patients they personally looked after. In the present survey the data were obtained from the Department of Health and Social Security who use average list sizes for number of principals working together).

At first sight there were some differences between doctors eligible for a group practice payment allowance and those who were not. (These are practices of three or more doctors working together in close association from a common main surgery which can provide an economic and efficient service by sharing ancillary staff, providing a 24-hour cover and pooling their specialist knowledge).

Doctors who were in a group practice were more likely to raise the question of contraception. They were also younger, and when comparisons were made between doctors of the same age most of the variations between doctors in group practice and others disappeared.

Doctors working on their own were rather less likely than others to raise the question of contraception routinely with every mother they saw postnatally: 43 per cent of them did so, 54 per cent of other doctors. The single-handed doctors tended to be older, 34 per

cent of them were 55 or more, 18 per cent of other doctors; and few of them were women: six per cent against 11 per cent.

Apart from this no differences emerged in whether or not they fitted caps or IUDs, their identification of the two strongest contra-indications for prescribing the 'pill' or whether or not they advised patients on the 'pill' with no side-effects to stop taking it after a time.

## 13 THE INFLUENCE OF RELIGION

Nine per cent of the doctors indicated they were Roman Catholics. This is lower than the proportion in the earlier study, 14 per cent. Religion, however, varies considerably between areas so is subject to relatively high sampling errors particularly when the number of areas is small as it was on the earlier study—12. Thirty nine per cent said they were Church of England, 19 per cent other Protestants, 16 per cent atheists or agnostics, nine per cent Jewish, four per cent Hindu and four per cent had other religions. (Three per cent who indicated they had more than one religion have been excluded. They were mostly atheists or agnostics who had presumably been brought up with some religion.) Differences in attitudes and practices of the various religious groups are shown in table 16.

On a number of issues the Roman Catholics were the only clearly differentiated group. Twenty per cent of them compared with between one and four per cent of the others referred all patients elsewhere when the subject of birth control arose.

Among those *not* referring all birth-control patients elsewhere 84 per cent of the Roman Catholics, 95 per cent of other doctors, most frequently prescribed the 'pill'; 14 per cent of Catholics, less than one per cent of others, most frequently advised the safe period.

The proportion of all Roman Catholic doctors who never prescribed the 'pill' had not changed significantly since the earlier study: it was 28 per cent then* and 25 per cent in 1970–71 (assuming those who referred all birth control patients elsewhere never prescribed the 'pill'). Three doctors of other religions, less than one per cent, never prescribed the 'pill' because of health risks and another three per cent referred all patients elsewhere.

As in the earlier study more of the Roman Catholic and Jewish doctors were aged 55 or more and both they and doctors of 'other religions' were less likely than Protestants or atheists and agnostics to work in rural practices. In this study, the Jews and the Catholics were also those least likely to raise the issue of overpopulation as one reason why birth control was important. Doctors of 'other religions' were the group most likely to do this. Atheists and agnostics were most likely to introduce the subject of birth control, to discuss sterilization and to fit caps and IUDs.

One possible reason for Roman Catholic doctors being rather less active than others about birth control and being more inclined to advise the safe period might be that more of their patients were Roman Catholics. The observed differences might reflect the needs and beliefs of patients rather than the tenets of the individual doctors.

However, the survey in 1967–68 showed that Roman Catholic mothers were no more or less likely than other mothers to have Roman Catholic doctors.** In this survey we found no association between the proportion of Catholic general practitioners in the areas and the proportion of married women interviewed on the parallel survey (by the Social

* Cartwright, Ann *op.cit.* p.187.
** Cartwright, Ann *op.cit.* p.184.

TABLE 16

THE INFLUENCE OF RELIGION

| | *Roman Catholic* | *Church of England* | *Other Protestants* | *Jewish* | *Other* | *Atheist or agnostic* |
|---|---|---|---|---|---|---|
| | % | % | % | % | % | % |
| Regards birth control advice and help as | | | | | | |
| Essential part of their practice | *47* | *78* | *75* | *83* | *80* | *89* |
| Ideal but not always practical | *37* | *19* | *24* | *17* | *18* | *11* |
| Peripheral or not relevant | *16* | *3* | *1* | — | *2* | — |
| Proportion who would refer all birth control patients elsewhere | *20%* | *4%* | *1%* | *4%* | *2%* | *3%* |
| Proportion who would raise the question of contraception routinely with every mother seen postnatally* | *16%* | *58%* | *51%* | *39%* | *42%* | *71%* |
| Would raise subject of birth control with an unmarried woman who had just had a baby* | *43%* | *82%* | *74%* | *71%* | *62%* | *91%* |
| Would encourage use of:* | | | | | | |
| Sheath } if became aware | *59%* | *76%* | *75%* | *62%* | *67%* | *70%* |
| Withdrawal } patient using it and | *0* | *6%* | *7%* | *7%* | *8%* | *2%* |
| Safe period } found it satisfactory | *60%* | *20%* | *19%* | *13%* | *20%* | *11%* |
| Average score on discussing sterilization*** | 4·2 | 6·1 | 5·8 | 5·6 | 5·7 | 6·3 |
| Proportion preferring male to female sterilization**** | *51* | *64* | *60* | *57* | *71* | *72* |
| When talking about birth control raises subject of overpopulation:* | % | % | % | % | % | % |
| Frequently | *2* | *5* | *4* | *2* | *20* | *3* |
| Sometimes | *7* | *28* | *33* | *18* | *24* | *29* |
| Rarely or never | *91* | *67* | *63* | *80* | *56* | *68* |
| Proportion who:* | % | % | % | % | % | % |
| Fit caps | *9* | *36* | *25* | *22* | *13* | *35* |
| Fit IUDs | *2* | *10* | *13* | *18* | *13* | *18* |
| Neither | *89* | *60* | *69* | *67* | *78* | *57* |
| Proportion aged 55 or more | *35%* | *18%* | *18%* | *37%* | *13%* | *21%* |
| Proportion working in practice eligible for rural payments | *17%* | *35%* | *26%* | *2%* | *4%* | *37%* |
| Proportion working single-handed | *26%* | *17%* | *10%* | *34%* | *37%* | *16%* |
| Number of doctors (=100%)** | 55 | 224 | 110 | 52 | 46 | 92 |

* Doctors referring all patients elsewhere have been excluded when calculating these percentages.

** Doctors who gave inadequate answers have been excluded when calculating these percentages.

*** Doctors were given a score of two for each of the three circumstances asked about in which they would introduce the subject of sterilization and of one for those in which they would 'discuss the possibility only if asked'.

**** Those who did not know or disapproved of sterilization have been excluded.

Survey Division of the Office of Population Censuses and Surveys) who were either Catholics themselves or married to Catholics. This suggests that the doctors were not responding to the varying attitudes of their patients but acting on their own beliefs.

## 14 AREA DIFFERENCES

In the earlier study it was found that doctors in the north were less likely to raise family planning with patients in various circumstances, they less often fitted caps themselves, and had larger lists.* Similar differences, shown in table 17, were observed in the present study.

TABLE 17

GENERAL PRACTITIONERS IN THE NORTH AND SOUTH*

| | *Doctors in the north* | *Doctors in the south* |
|---|---|---|
| Proportion who raise the question of contraception with every mother seen postnatally | *48%* | *56%* |
| Proportion who would introduce the subject of contraception with an unmarried woman who had had a baby | *72%* | *80%* |
| Proportion who ever fit diaphragms for their patients | *22%* | *36%* |
| Proportion with list sizes of 2,800 or more | *36%* | *25%* |
| Number of doctors (=100%) | 300 | 301 |

* This has been defined crudely as those working in hospital regions approximately north or south of the Bristol-Wash line.

Doctors in rural practices, ie. those eligible for rural practice payments, were rather more likely than others to raise the question of contraception: the proportion who raised it routinely when they saw mothers postnatally was 59 per cent of those in rural practices, 49 per cent of others. In addition more of the doctors in rural practices fitted caps: 36 per cent against 26 per cent.

In contrast, health visitors working in urban areas were more active than those in rural areas in raising and discussing birth control.** Health visitors in rural areas more often referred people to general practitioners rather then clinics. Possibly because clinics are relatively inaccessible in the rural areas family planning has been more accepted there by both doctors and health visitors as the appropriate province of the general practitioner.

The differences between doctors in the north and south and between those in rural practices and others did not arise because of variations in their ages. Rather more of the doctors in the south than in the north were aged 65 or more; eight per cent compared with four per cent.

Does the level of contraceptive services in an area have any effect on the numbers of unwanted pregnancies? One possible index of unintended or unwanted pregnancies is the high parity birth rate.*** Table 18 shows that this is low in areas where 58 per cent or more of the general practitioners said they raised the subject of contraception routinely at postnatal examinations, and the high parity birth rate increases as the proportion of doctors initiating discussion declines. There is a less marked trend, but in the same direction, with illegitimacy rates.

So whether people get advice about contraception depends on the area in which they live: those living in rural areas in the south seem most likely to get help from their general

* Cartwright, Ann *op.cit.* p.209.
** Waite, Marjorie. 'Health visitors and birth control advice in 1970–71'.
*** See Woolf, Myra *Family Intentions* p.35. Cartwright, Ann *op.cit.* p.13.

TABLE 18

ASSOCIATION BETWEEN GENERAL-PRACTITIONER ACTIVITY AND THE HIGH PARITY BIRTH RATES AND ILLEGITIMACY RATES IN DIFFERENT AREAS

| *Proportion of general practitioners who raise the question of contraception routinely at postnatal examinations* | *High parity birth rate** 1970 | *Illegitimacy rate*** 1970 | *Numbers of general practitioners in areas* |
|---|---|---|---|
| 58% or more | 4·5 | 18 | 136 |
| 48% but less than 58% | 5·4 | 19 | 245 |
| 38% but less than 48% | 6·4 | 21 | 110 |
| Less than 38% | 7·2 | 24 | 97 |

* Births to women with four or more previous liveborn children per 1000 married women aged 15–44.

**Illegitimate births per 1000 single women aged 15–44.

Data from which to calculate these rates were only avalable for London Boroughs, County Boroughs, and Administrative Counties. Our study areas were made up of London Boroughs, County Boroughs and combinations of Municipal Boroughs, Urban Districts, and Rural Districts. In the last case the study areas were only a part of the administrative county.

practitioners. And there is some evidence to suggest that a high level of activity among general practitioners may be associated with a low rate of high parity and illegitimate births.

## 15 SUMMARY AND COMMENTS

Results from this study strengthen and confirm the conclusion from an earlier one: general practitioners are playing an increasing part in advising patients about birth control, but the type of help and advice they give is limited. Essentially they seem to be responding to a demand from more of their patients for the 'pill'.

Comparisons with the earlier study suggest that general practitioners are now rather more active in offering advice and initiating discussion of contraception and sterilization but the circumstances in which they do this are still in the main limited to situations where they perceive a medical or social need. Even so half of them said they raised the question of contraception routinely with every mother they saw postnatally—but half did not do so.

The nature of the help and advice they give is now even more concentrated on the 'pill'. Few doctors, five per cent, never prescribe it themselves and this proportion had not changed between 1967–68 and 1970–71. The proportion saying it was the method they most often advised had risen from 77 per cent to 90 per cent. General practitioners then, and probably now, are the most common source of prescriptions for the 'pill'.

This development and extension to their role has occurred within the last ten years—since the majority of general practitioners now practising left medical school. Their knowledge of oral contraception, as of other recent developments, depends on journals, postgraduate education, discussions with colleagues and drug-firm literature and representatives. Twelve per cent of the doctors had been on a family planning course. Only half, 57 per cent, identified the same two contra-indications to prescribing the 'pill' in a list of five; and there is a substantial amount of data to support the views of the majority on this. However, between a fifth and a quarter would not stop prescribing the 'pill' in circumstances when it may be advisable to do so.

The most striking indication of their doubts and anxieties about oral contraception was that nearly half of those prescribing the 'pill' said they would advise patients who were suffering no demonstrable side-effects to stop taking it after a certain length of time. (Most of them suggested stopping for between two and six months.) Neither the Family

Planning Association nor the International Planned Parenthood Federation recommend such a policy. (The International Planned Parenthood Federation specifically advises that this is not necessary. The Family Planning Association makes no specific recommendations about this.) The Food and Drug Administration in the U.S.A. imposed a limit on the early oral contraceptives but in 1966 recommended stopping such a time limitation.*

General practitioners may feel that in this area there is much that is still unknown to experts, however, their action seems somewhat arbitrary. If patients take their advice over this some increase in births or abortions seems an inevitable result.

General-practitioners' actions, attitudes and knowledge varied with their age, sex and religion. So the advice and help that people received also depended on these.

However, patients do not know whether or not their doctor will be prepared to help and advise them on different methods of birth control.* If general practitioners are not prepared to do this we think some alternative arrangement should be made for their patients to get help from other general practitioners and not just from clinics. Whether or not doctors are willing to give this type of help might be included in local lists of doctors which are available to the public and which now state whether or not he gives maternity services. Executive councils might consider it inappropriate to appoint to single-handed practices doctors who are not prepared to give advice about birth control. They could encourage single-handed doctors unwilling to do this type of work to join with doctors who are prepared to do it. The willingness of at least one member to give contraceptive advice and help could be a condition for the development of a group or partnership.

Most general practitioners, three quarters, regarded contraception as an essential part of their practice; but their activities in this sphere could be widened and made more effective if birth control services were provided within the National Health Service.

If contraceptive clinics were run directly by local authorities, or their successors, their aims and efforts could be more directed towards the education and support of other community based services involved in birth control. The clinic doctors would be part of these services and, as experts in contraception, one of their jobs would be to ensure that general practitioners, health visitors, midwives and social workers had the information, encouragement and support they need to provide widely based help. Another part of their job would be the co-ordination of birth control services: if a hesitant woman decided to take the 'pill', or an impecunious couple opted for the sheath, or a casual one with religious scruples wanted to use the safe period, they could arrange for home visits by the most appropriate person.

They could also be a pressure group concerned for example with the wide distribution of the sheath in supermarkets and slot machines. None of these possibilities can be fully exploited by a voluntary organisation with limited funds obtained mainly from clinic users. Without these supporting activities general practitioners, health visitors and others lack the expert advice and support they need to help their patients and clients to plan their families effectively.

* Advisory Committee on Obstetrics and Gynaecology. Food and Drug Administration *Report on the Oral Contraceptives.*

** A description of the casual way most people choose or acquire their doctors is given in *Patients and their doctors.* In 1967–68 seven tenths of the mothers either thought their doctor was a Roman Catholic or did not know whether he was or not. Cartwright, Ann *Parents and family planning services* p. 189.

## ADDENDUM

*General Practitioners and Abortion* by the same authors has already been published in August 1972 as supplement No. 1 to *The Journal of the Royal College of General Practitioners*. This is now available from The Longman Group Ltd., 43 Annandale Street, Edinburgh, EH7 4AT, Scotland, price 75p.

## APPENDIX I

### THE SAMPLE OF GENERAL PRACTITIONERS

*Sample of areas*

There are 506 registration districts in England and Wales. They were divided into four strata according to their population size:

| *Stratum* | *Population size* | *Number of districts* | *Total population* |
|---|---|---|---|
| First | Under 87,501 | 301 | 12,200,516 |
| Second | 87,501–150,000 | 107 | 12,209,578 |
| Third | 150,001–245,000 | 64 | 12,285,736 |
| Fourth | Over 245,000 | 34 | 11,897,170 |

Thirteen districts were chosen in each of the four strata after the districts within each had been further stratified by region and type of family planning service provided.*

So there are equal numbers of areas in the four strata and equal weight needs to be attached to the four strata as they cover approximately equal populations.

*The sampling frame*

The basic sampling frame was the lists of the local executive councils. In general these lists are prepared by geographical area in such a way that it is possible to identify the doctors working in our sample of registration districts. Where it was not possible to do this from their published lists local advice was sought.

One major difficulty about using local executive council lists as a sampling basis, is that many doctors are on the list of more than one council. To overcome this problem, the councils and the Department of Health and Social Security gave us information about the one responsible authority for the doctors selected. When this was not a district covering the sample area the doctor was rejected from our sample. This means that our final sample can be regarded as a national sample—not just an aggregate of doctors giving services in our study areas.

*Numbers of general practitioners*

The total numbers of general practitioners working in the four strata were:

| | | |
|---|---|---|
| Stratum one | (small areas) | 219 |
| ,, two | | 689 |
| ,, three | | 1171 |
| ,, four | (large areas) | 1958 |

* Based on a study of local authority services carried out by the Family Planning Association. *Family Planning* (1968) **17**, No.3.

Sampling fractions were related to the sampling fractions used to select the areas so that all doctors had roughly a one in 23 chance of being included in the study:

| | *Area sampling fractions* | *General-practitioner sampling fractions* | *Sample Numbers* |
|---|---|---|---|
| Stratum one | 1 : 23·2 | 1 : 1 | 219 |
| „ two | 1 : 8·2 | 1 : 3 | 229 |
| „ three | 1 : 4·9 | 1 : 5 | 235 |
| „ four | 1 : 2·6 | 1 : 9 | 217 |
| | | Total | 900 |

*Timetable*

Initial letters and questionnaires were posted to the 900 doctors in the week of 23, November, 1970. About two weeks later the first reminders (with questionnaires) were sent. Allowing for the Christmas holiday period, the second reminders (with questionnaires) were sent in mid-January, 1971. A small number of second reminders were held up by the long postal strike and were not, successfully posted until mid-March.

*Response*

Information from the Department of Health and Social Security and from the doctors themselves led us to omit 11 doctors from the sample for the following reasons:

| | |
|---|---|
| Retired | 6 |
| Ill throughout study period | 2 |
| Died | 1 |
| Moved from study area | 1 |
| Not dealing with relevant patient groups | 1 |
| Total | 11 |

Of the remaining 889 doctors in the sample, 601 (68 per cent) returned completed questionnaires.

Selected Department of Health and Social Security data about all the doctors in the sample enabled us to compare some characteristics of respondents with non-respondents. As shown in table A, respondents were more likely to be younger and to receive rural and group practice payments. To receive *rural practice payments* a doctor must have more than ten per cent of his patients in a 'rural practice area' (normally rural district council areas or urban district council or municipal borough areas with less than 10,000 population).

To receive *group practice payments* a doctor must be one of three or more working in close association from a common main surgery which can provide an economic and efficient service by sharing ancillary staff, providing a 24-hour cover and allowing the pooling of their specialist knowledge.

Shown another way, table B illustrates how respondents and non-respondents varied from the total sample of general practitioners.

There were no significant differences between respondents and non-respondents in sex, list size, type of area (designated, intermediate, restricted, open), number of principals in the practice, number of assistants in the practice, and whether or not maternity services were provided.

The biases to younger doctors and those receiving group and rural practice payments are common in recent surveys of general practitioners* and may suggest more a willingness to participate in surveys than any particular bias about birth control.

TABLE A

VARIATIONS IN RESPONSE WITH SOME CHARACTERISTICS OF DOCTORS

| | *Proportion who responded* | *Number of doctors (=100%)* |
|---|---|---|
| Age: | | |
| Under 35 | *77%* | 115 |
| 35–44 | *74%* | 266 |
| 45–54 | *70%* | 268 |
| 55–64 | *56%* | 167 |
| Over 64 | *48%* | 73 |
| Eligible for rural practice payments: | | |
| Yes | *75%* | 220 |
| No | *65%* | 665 |
| Eligible for group practice payments: | | |
| Yes | *72%* | 467 |
| No | *63%* | 418 |

TABLE B

COMPARISON OF RESPONDENTS AND NON-RESPONDENTS WITH TOTAL RANDOM SAMPLE OF GENERAL PRACTITIONERS

| | *Respondents* | *Non-Respondents* | *Total sample* |
|---|---|---|---|
| Age: | % | % | % |
| Under 35 | *15* | *9* | *13* |
| 35–44 | *33* | *24* | *30* |
| 45–54 | *31* | *28* | *30* |
| 55–64 | *15* | *26* | *19* |
| Over 64 | *6* | *13* | *8* |
| Eligible for rural practice payments: | % | % | % |
| Yes | *28* | *19* | *25* |
| No | *72* | *81* | *75* |
| Eligible for group practice payments: | % | % | % |
| Yes | *56* | *46* | *53* |
| No | *44* | *54* | *47* |
| Number on which percentages based (=100%)** | 601 | 288 | 889 |

**These are the total numbers. Four doctors for whom inadequate information was available about rural and group practice payments have been excluded when the percentages were calculated.

* For age and group practice biases see Cartwright, Ann *Patients and their Doctors*, p.269, and Cartwright, Ann *Parents and Family Planning Services*, pp.260–61. For *age bias* see Dunnell, Karen and Cartwright, Ann *Medicine Takers, Prescribers and Hoarders* p.133. For *rural practice bias* see Butler, John (University of Kent at Canterbury) *Third Progress Report—Designated Areas Project* (not published), p.11.

## APPENDIX II—QUESTIONNAIRE USED

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### SURVEY OF BIRTH CONTROL SERVICES—GENERAL PRACTITIONERS

Please tick your answers where appropriate

1. Recently there have been many suggestions about things that general practitioners should spend time on. Which of the things listed below do you regard as an essential part of your practice, which as ideally part but not always practical, and which as peripheral or not relevant.

| | *Essential* | *Ideal but not always practical* | *Peripheral or not relevant* |
|---|---|---|---|
| Cervical cytology screening | | | |
| Regular physical examinations for the elderly | | | |
| Birth control advice and help | | | |
| Excising simple cysts | | | |
| Advice and help with psychosexual problems | | | |

2. When patients have a choice between clinic and general practitioner services do you personally feel it is better for most patients to go to family planning clinics or to their own doctors for birth control advice?

   Clinics .....
   Own doctors.....

3. About what proportion of patients, if any, with whom the subject of birth control arises do you refer to clinics or other general practitioners?

   Refer none.....
   Refer less than 10%.....
   Refer 10%—less than 50%.....
   Refer 50%—less than 90%.....
   Refer 90% or more .....

   IF YOU REFER ANY (a) Do you refer them mainly to:—

   Family planning clinics .....
   or other general practitioners.....

   (b) For what reason(s) do you refer them?

   IF YOU REFER ALL YOUR PATIENTS ELSEWHERE FOR BIRTH CONTROL ADVICE PLEASE TICK HERE AND SKIP TO QUESTION 18. ☐

4. After discussion, which method of birth control do you most frequently recommend or agree would be most suitable for the patient? Which method next most frequently?

   PLEASE TICK *ONE* METHOD IN EACH COLUMN.

| | *Most frequently* | *Next most frequently* |
|---|---|---|
| Pill | | |
| Diaphragm, cap | | |
| I.U.D., coil | | |
| Sheath | | |
| Withdrawal | | |
| Safe period | | |
| Sterilization—male | | |
| Sterilization—female | | |
| Other (specify) | | |

   IF YOU NEVER ADVISE THE PILL PLEASE TICK HERE AND EXPLAIN WHY THEN SKIP TO QUESTION 11. ☐

5. Which *two* of the following do you consider the *strongest* contra-indications to prescribing the pill?

Recent pulmonary embolism .....
Family history of diabetes .....
Fibroadenosis of breast .....
Migraine .....
Congenital liver dysfunction .....

6. Do you generally advise patients on the pill who are not suffering any demonstrable side effects to stop taking it after a certain length of time?

Yes .....
No .....

IF YES After how long?
Less than one year .....
One year but less than three years.....
Three years but less than five years .....
Longer than five years.....

For how long a period of time?
1 month .....
2–6 months .....
7–12 months .....
13–18 months .....
19–24 months .....
longer than 24 months.....

7. For each of the following symptoms please tick whether you would generally take a patient off all oral contraception at once, or take a patient off all oral contraception after three months, or do neither of these things:—

| | *Off all oral contraception* | | *Would do neither* |
|---|---|---|---|
| | *At once* | *After 3 months* | |
| Depression | | | |
| Chest pains | | | |
| "Spotting", "breakthrough" bleeding | | | |
| Deterioration of migraine | | | |
| Leg pains | | | |

8. Do you change patients to a different *type* of pill because of side effects:

Frequently .....
Sometimes .....
Rarely or never.....

9. When a normal, healthy woman taking the pill tells you she is worried about its health risks, are you *more* likely to:—

(a) reassure her and help her to continue with the pill .....
or (b) help her to consider alternatives and change to another method .....

10. For a normal healthy woman in each of the following two age groups, do you think the risk of death is *greater* when she:—(PLEASE TICK ONE IN EACH COLUMN)

| | | *Age 20–34* | *Age 35–44* |
|---|---|---|---|
| | (a) takes the pill | | |
| or | (b) does not take the pill and is therefore exposed to greater risk of pregnancy | | |
| or | (c) the risks are about equal | | |

11. Do you think the health hazards of the I.U.D. are:—

Considerable .....
Moderate .....
Negligible .....
Don't know .....

12. If you became aware that a patient is using one of the three following methods and is satisfied with it do you usually:—(PLEASE TICK ONE IN EACH COLUMN)

| | *Sheath* | *With-drawal* | *Safe period* |
|---|---|---|---|
| Encourage them to continue | | | |
| Encourage them not to use it | | | |
| Not say anything | | | |
| Never been mentioned | | | |

Would you (also) explain *how to use* the following two methods most effectively, or not?

| | *Yes* | *No* |
|---|---|---|
| Sheath | ..... | ..... |
| Safe period | ..... | ..... |

13. As a general practitioner do you ever fit diaphragms for your patients?

Yes .....

No .....

What about I.U.D.'s?

Yes .....

No .....

As a general practitioner do you do any vasectomies?

Yes .....

No .....

IF YES About how many in the past 12 months?

N.H.S. .....

Private .....

14. If an unmarried woman asks you about getting birth control advice and help are you more likely to:—

Provide birth control help yourself .....

Refer her elsewhere for help .....

Discourage her use of birth control .....

15. (a) With a married woman patient who has three children and only one bedroom, would you introduce the subject of birth control yourself, discuss birth control only if she asked directly, or not discuss provision of birth control even if asked directly?

Introduce .....

Discuss only if asked.....

Not discuss provision.....

(b) Which of these three things would you do with a married woman with three children and no social or health problems?

Introduce .....

Discuss only if asked.....

Not discuss provision.....

(c) And an unmarried woman who had had a baby?

Introduce .....

Discuss only if asked.....

Not discuss provision.....

IF INTRODUCE Do you raise the question of contraception routinely with *every* mother you see postnatally, or not?

Yes .....

No .....

16. Just supposing male and female methods were equally reliable, safe, and pleasant to use, would you consider the man or the woman the more appropriate user of contraception in most cases, or are they equally appropriate?

Man .....

Woman .....

Equally appropriate .....

17. When talking to patients about birth control, do you raise the subject of overpopulation as one of the reasons why birth control is important:—

Frequently .....

Sometimes .....

Rarely or never.....

18. What changes, if any, would you like to see in the birth control services in this area?

So at present do you regard the services as:

Adequate .....

Inadequate.....

Don't know .....

19. Who, if anyone, do you think should have means of birth control available to them free through the National Health Service?

20. When nurses and health visitors are asked by patients about birth control, would you prefer that they:—

(a) tell patients only where to go for advice .....

or (b) discuss the various methods as well .....

21. In each of the following situations, would you introduce sterilization as a possibility for one partner or the other of a married couple, discuss the possibility only if asked directly, or not discuss the possibility at all?

(a) Couple aged 30 with three children, further pregnancies dangerous to mother's health.

Introduce .....

Discuss the possibility only if asked.....

Not discuss the possibility.....

(b) Couple aged 30 with three children, other methods inappropriate or unsuccessful.

Introduce .....

Discuss the possibility only if asked.....

Not discuss the possibility.....

(c) Couple aged 30 with three children, only one bedroom.

Introduce .....

Discuss the possibility only if asked.....

Not discuss the possibility.....

(d) Couple aged 30 with three children, no problems but couple desire sterilization.

Discuss the possibility if asked.....

Not discuss the possibility.....

22. Other things being equal, which do you generally consider preferable:—

(a) Male sterilization .....

or (b) Female sterilization .....

Why is that?

23. Do you think the services for *female* sterilization in your area are adequate or not?

Adequate .....

Not adequate .....

Not sure what the facilities are .....

24. .....

is/are identified by the General Register Office as the main maternity hospital(s) serving women from your area. Do you refer women for sterilization:—

Mainly to this/these hospital(s).....

Equally to this/these hospital(s) and to others (specify below) .....

Mainly to others (specify below).....

Have never referred any.....

25. Do you think the services for *male* sterilization in your area are adequate or not?

Adequate .....

Not adequate .....

Not sure what the facilities are.....

26. We are interested in approaching hospitals and clinics to find out the number of vasectomies performed. Please could you list any clinics and hospitals to which you have referred patients for vasectomy in the last 12 months.

.....

.....

.....

27. Do you have a conscientious objection to termination of pregnancy in virtually *all* cases or not?

Yes .....

No .....

IF YES, Can you think of any circumstances where you would recommend termination of pregnancy?

(THEN SKIP TO QUESTION 36)

28. Would you *generally speaking* recommend termination when it is requested before ten weeks by any of the following sorts of individuals after they have given serious consideration or alternatives:—

| | |
|---|---|
| (a) An unmarried girl aged 14 or under | Yes ..... No ..... |
| (b) An unmarried university student in her final year | Yes ..... No ..... |
| (c) A woman with severe kidney disease | Yes ..... No ..... |
| (d) A woman who contracted rubella during the first trimester | Yes ..... No ..... |
| (e) A married woman with six children | Yes ..... No ..... |
| (f) An unmarried poorly-paid working girl | Yes ..... No ..... |
| (g) *Whoever* requests it after she has given serious consideration to alternatives | Yes ..... No ..... |

29. Do you refer patients to a psychiatrist for an opinion on pregnancy termination:—

Frequently .....

Sometimes .....

Rarely or never .....

Is this more frequently or less frequently than before the Abortion Act 1967 was passed?

More frequently .....

Less frequently .....

About the same .....

30. If you would like to recommend a termination for a patient are you ever deterred by the difficulty of arranging it?

Yes .....

No .....

31. Would you like there to be more facilities for termination of pregnancy in your area?

Yes .....

No .....

IF YES Would you want more:

National Health Service facilities.....

Private facilities .....

32. Would you like to see special units for pregnancy termination established under the National Health Service?

Yes .....

No .....

33. About how many patients have you referred for a termination of pregnancy under the National Health Service in the last 12 months?

.....

About how many to approved other places?

.....

34. Can you give some idea of the number of patients you referred for National Health Service terminations in the last 12 months

who were turned down?.....

IF ANY What then, if anything, did you generally do?

35. Do you regard yourself as more likely or less likely to recommend pregnancy terminations than other general practitioners in this area?

More likely than others.....

Less likely than others.....

About the same.....

What about in England and Wales generally?

More likely than others .....

Less likely than others.....

About the same.....

*Finally a few details about yourself and your practice.*

36. Marital status Married .....

Single .....

Widowed, divorced .....

IF MARRIED, WIDOWED, etc. Have you any children? Yes .....

No .....

IF YES How many?.....

37. Religion Agnostic/atheist .....

Church of England .....

Church of Scotland .....

Hindu.....

Jewish.....

Moslem .....

Other Protestant .....

Roman Catholic .....

Other (specify) .....

38. Do you work single-handed or with others?

Single-handed .....

With others .....

IF WITH OTHERS Do either you or your partner(s) specialize within the practice in giving contraceptive advice?

Yes, I do .....

Yes, partner(s) .....

No .....

39. Are there special sessions for birth control help in your practice?

Yes .....

No .....

40. Are there posters or leaflets about birth control advice in your waiting room?

Yes .....

No .....

41. Do you spend at least 20 hours per week in general practice?

Yes .....

No .....

42. Have you ever worked in a family planning clinic?

Yes .....

No .....

43. Have you ever been on a family planning course?

Yes .....
No .....

IF YES What course?

44. Have you any other comments or suggestions to make about birth control services?

THANK YOU FOR YOUR HELP

If you would like to discuss anything personally please put a tick here ☐ and we will make an appointment either to visit or telephone you.

If you would like to be informed about the final results of the survey please put a tick here ☐

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