A family planning clinic in general practice

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For many years family planning has been a specialty shared in a haphazard way between general practitioners, family planning clinics and hospitals. Since local authorities in general declined, under the 1967 Family Planning Act, to make general practitioners their agents, it became clear that patients falling into categories able to receive free supplies had a financial incentive to leave their general practitioners for this important part of their care and attend only those establishments which became agents for the local authority.

Our practice decided that a properly-constituted family-planning clinic should be available within the practice for the use of those patients who wished to stay within our care and at the same time take advantage of the financial arrangements possible through a local authority. The practice is a group of five doctors working from a purpose-built surgery and cares for 10,000 patients. This report comes at the end of the first full year of working of the family planning clinic.

Organisation

Before starting the clinic, four agencies were brought together, namely the British Medical Association, the Local Medical Committee, the Family Planning Association and our practice. The Local Medical Committee approved the idea provided there were no serious objections from other local general practitioners and the Family Planning Association was quite willing to provide the necessary administrative framework. Because of the constitution of the Family Planning Association, it was not possible to restrict patients coming to the clinic entirely to those who were on the National Health Service list of the partners within the practice, but the majority of patients attending are ours. Before the clinic was set up an undertaking was given that any patients attending, who were not already ours, would under no circumstances be accepted on to any of our lists.

The clinic is mixed, offering all forms of currently available contraceptives, except sterilisation, on the premises. I staff it, and one other partner also holds the Family Planning Association diploma.

Results

TABLE 1
Number of patients seen during the first year

Patients attending	*Number of attendances*	*Number per week*
254	703	14

More recently attendance has been steady at about 20 per week.

TABLE 2
Choice of method

	Pill	*IUD*	*Other*
Surgery clinic	48·4%	41·7%	9·9%
FPA generally	58·42%	13·95%	27·63%

Discussion

Methods chosen other than an intra-uterine device or the Pill have been almost equally divided between sheaths, pessaries, and caps with pessaries. An interesting feature of these figures is that where both the Pill and an IUD are offered equally and immediately in one clinic, almost half the patients have wanted an IUD.

There seem to be two reasons for this. The first is the ready availability of each method side by side. The other is that many of the women attending the clinic are also having their post-natal examination at the same time (which is a great time-saving feature). Many of these women are breast feeding and opt for an IUD.

During the year two patients who requested the IUD have been unable to continue with the method. In the first case severe shock after insertion required immediate removal of the device: in the other case, the patient failed to retain the device. The majority of devices fitted have been the ' Saf-T-Coil '. During the year only one unplanned pregnancy has occurred as far as is known. No cases of pelvic infection were seen. All the patients who had their IUD removed to achieve pregnancy were pregnant within three months.

Summary

One year's work is reported of a family planning clinic under the administration of the Family Planning Association held in premises owned by general practitioners. The first year's work was successful and this may provide a pattern for family planning work within general practice.

Side-effects with the IUD have not been a great problem. When it is not necessary to visit another clinic or wait for fitting, the IUD will be chosen more often.

CANCER DEATHS

Carcinoma of the prostate is now the fourth commonest cause of cancer deaths in the male.

WHAT DO HEALTH VISITORS DO?

The health visitor may not be a social worker as such, but the evidence of this study does not support the opinion of the Seebohm committee that "The main functions of the health visitor and the social worker are distinct and the two roles may be incompatible in the same person". It is clear that there is considerable overlap of function and that this is an area where further research is urgently needed if the best use is to be made of scarce manpower resources both of health visitors and of social workers.

Clark, June (1972). *Nursing Times*. Occasional papers. 27 July.

TORSION OF THE TESTIS

Confronted with a possible example of testicular torsion, any doctor can make an attempt to untwist it there and then. In general the right testis should be 'unscrewed' and the left one 'screwed up' to undo the twist. If one forgets this in the heat of the moment, the simple mnemonic of 'open the doors' may remind one which way the testicles should go. Or, if rotation of the testicle in one direction makes the pain worse, one may twist the other way. The manoeuvre is simple and worth trying.

British Medical Journal (1972). Editorial, **4,** 505.