

## *Contraception in a practice community*

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To improve the quality of my medical advice, I felt a need for accurate up-to-date information that applied to my practice community which consists of the 9,200 National Health Service patients in a three-man practice. Shepshed has a population of 8,417. The practice caters for over 98 per cent of the inhabitants of Shepshed, and in addition, several hundred other patients living within a radius of about three miles.

The population is static as in 43/55 (about four fifths) of the random sample of married patients at least one of the couples originated within six miles of Shepshed. In the year under review 671 patients joined the practice and 466 left. Most of the men work in light industry, particularly hosiery factories, though there are some farm workers, coal miners and university students and lecturers.

For many years all the partners have been prepared to prescribe oral contraceptives during surgeries. However, until the practice family planning clinic was started, the nearest place where diaphragms were fitted was the Family Planning Association Clinic at Loughborough, over five miles from Shepshed; and the nearest centre for intra-uterine devices was the Leicester FPA. clinic, over 12 miles away.

On 20 October 1971 a clinic was opened where all methods of family planning could be discussed, and at which intra-uterine devices and contraceptive caps could be fitted, and condoms purchased. Oral contraceptives continue to be prescribed at ordinary surgeries, but are now also available at the practice family planning clinic.

In April 1972 the Family Planning Association opened a new clinic in Coalville, about five miles from Shepshed, where many services are either free or cheaper than in standard FPA clinics. I know of only three patients in Shepshed who have attended the Coalville Clinic, though there may be more. Conversely, only two of the 81 attenders at the practice clinic have not also been on the National Health Service list of the practice.

### **Patients and methods**

All attenders at the family planning clinic, and, with two exceptions, all maternity patients who had signed NHS form EC24 or those who had had a termination of pregnancy between 20 October 1971 and 19 October 1972, were interviewed by me.

They were asked what contraceptive precautions, if any, they had been taking most recently before coming to the clinic. When the answer was 'none' further questions were asked to check whether the couple had been using the withdrawal or safe-period methods. Failure to ask these questions would have made a big difference to the figures for the withdrawal method.

I tried to find out how long the most recent method of contraception had been used and how many pregnancies had occurred during its use. If the method had been employed before and after a pregnancy, ten months were deducted for a normal pregnancy, or the number of months the pregnancy lasted in the case of a miscarriage. The time spent waiting for each intended pregnancy was also deducted. In some cases further deductions were made for the time other methods had been used and for absence of spouse lasting more than a month.

It was assumed that all the terminated pregnancies had been unintended. All other maternity patients were asked whether the pregnancy had been intended at its onset.

People interviewed after March 1972 who said that the sheath or condom was their most recent method of family planning were asked if the method was used every time of intercourse. This was because it was noticed that none of the couples in the survey who had reported a failure had used the method every time of intercourse during the month the pregnancy began. I found

it helpful to regard the sheath used every time of intercourse and the sheath not used every time of intercourse as two distinct methods of contraception.

The family planning clinic patients and my maternity patients were interviewed at the surgery. My partners' maternity patients were seen at home. The interviews did not appear to cause patients any great upset, and indeed many seemed relieved and pleased at the opportunity of discussing their own contraceptive problems. As a result I felt it was practicable to interview a random sample of the married patients of the practice at their homes, and to ask a few extra questions.

The sample, totalling 55, was chosen from the alphabetically arranged records of female patients of the practice. Every ninetieth card was noted. If the card applied to someone married, or known to be living as married, and aged under 46 years, then an attempt was made to interview that person or her husband. If the individual did not fulfil the above criteria the next card in alphabetical order was examined, and so on.

In addition, members of the random sample were asked how many children they had, and how many of these were intended when the pregnancies began. They were then asked how many children they would have wished to have, and, if they already had that number or more, the age of the wife when the couple attained the preferred number of children. Next they were asked how often they had intercourse during the previous month, and how often on average while using their most recent method of contraception.

The criterion for abstinence was the same as that used by Cartwright (1970), namely no intercourse for at least two months. So members of the random sample who said that they had not had intercourse during the past month were asked whether they had had any intercourse during the preceding two months. Members of the random sample were then asked questions to check whether they knew of any couple wanting and needing domiciliary family planning help. They were asked who in a marriage should take the responsibility for family planning, and how long they had been married. In conclusion the person being interviewed was asked whether she (or he) was of Sheshed origin, and, if not, where she came from.

Some patients were included in more than one sample, e.g. several people included in the maternity series later attended the family planning clinic. Where this happened care was taken not to count the same information about the same person more than once in the total.

### Results

With three exceptions every member of each sample was interviewed by me. The exceptions were a member of the random series who preferred not to answer any of the questions, one of the maternity series who had left the district, and one of my partners' patients who had a termination of pregnancy.

The age was missing from four and parity was not recorded in two of the maternity series. One of the random sample failed to record any opinion about who in a marriage should be responsible for family planning.

#### *Unintended pregnancies*

In the maternity series, the pregnancy was said to have been intended in 64·7 per cent of cases, unintended in 31·5 per cent and 3·8 per cent expressed an intermediate opinion. The proportion of unintended pregnancies is similar to that found by Cartwright (1970) in a survey of 12 areas of England and Wales, and to the proportion of unplanned pregnancies found by Peel (1972) in Hull. The proportion of unplanned pregnancies found by Fraser and Watson (1968) in the London area was a little over 50 per cent.

In the random sample 26/109 (23·8 per cent) of the children were said to have been unintended when the pregnancy began. The difference between this figure and the proportion of unintended pregnancies in the maternity sample is not statistically significant ( $P > 0.05$ ).

The relationship between unintended pregnancies and parity is shown in table 1.

#### *Terminations and miscarriages*

There were five terminations which all occurred within the first seven months of the study and to people residing in the practice area. This gives a termination rate of 5/184 pregnancies, or 2·6 per cent. It can be argued that when terminations and miscarriages are being considered, pregnancies of less than 28 weeks duration at the end of the survey should be omitted. If all

TABLE 1  
UNINTENDED PREGNANCIES

	<i>Para. 0</i>	<i>Para. 1</i>	<i>Para. 2</i>	<i>Para. 3</i>	<i>Para. 4 and Para. 5</i>	<i>Para. 6 and over</i>	<i>Total</i>
Pregnancy intended	68	39	8	4	0	0	119
Pregnancy unintended	25	10	14	4	3	0	56
Opinion intermediate	5	0	2	0	0	0	7
Proportion unintended	25.5%	20.4%	*58.4%	50%	100%		31.5%

\* The difference between this proportion and the average for the maternity series is statistically significant ( $P > 0.01$ ).

pregnancies with an expected date of delivery on or after 12 January 1973 are excluded, the termination rate becomes 5/134 or 3.7 per cent.

There were 15 miscarriages in the maternity series. In 11 of these cases the pregnancy was said to have been intended and in 4 cases unintended. Of pregnancies with an estimated date of delivery after 11 January 1973 there were eight miscarriages, five of them in intended pregnancies. In either case the proportion of intended pregnancies is similar to that in the whole maternity sample. Thus there is no evidence for clandestinely induced abortion reducing the figures for terminations. This finding differs strikingly from that of Diggory (1971) who studied gynaecological inpatients in 1965.

#### *Family structure*

The number of children, including adopted children, in families in the random sample is shown in table 2.

TABLE 2  
FAMILY SIZE OF RANDOM SAMPLE

Number of children	0	1	2	3	4	5	6	7
Number of families	7	13	21	5	5	3	0	1

The average number of children is 2.04 per family, though some of these families are not yet complete. The average number of children in the families thought to be completed was 2.46.

The number of children couples in the random sample would have preferred is shown in table 3. (Each couple was allowed one vote. Where more than one preferred number of children was suggested a part vote was given to each number suggested. There were two 'don't knows' which were omitted.)

TABLE 3  
PREFERRED FAMILY SIZE OF RANDOM SAMPLE

Preferred number of children	0	1	2	3	4	5
Number of votes	1	8½	31½	4½	6	1½

The average ideal number of children was 2.20 per family. According to Potts (1971) and Baird (1971) this is exactly the family size needed for replacement of the population.

Of the couples in the random sample who thought their families were completed, the ages of the wives when they achieved the desired family size are shown in table 4.

TABLE 4  
PREFERRED NUMBER OF CHILDREN BY AGE

Age at achievement of preferred number of children	Age in years							
	18-20	21-23	24-26	27-29	30-32	33-35	36-38	39-41
Number of votes*	2½	9	7	11½	5½	1	1	1

\*Where a couple was uncertain about the ideal size of family a part vote was given for the age of achieving each number specified.

Since the survey excluded any woman over the age of 46 a mother who did not achieve her desired family size until she was 45 would not have more than a year in which her age at completion of her family could be noted, whereas a mother who had all the children she wanted in her twenty fifth year would have 20-21 years in which her age of completion of family might be noted in the survey. A correction can be made for this over representation of younger age groups by multiplying the totals for each age at completion by the reciprocal of the number of years that the person might be included in the survey following completion. Applying this correction the average age at completion of desired family size was about 28 years.

TABLE 5  
RANDOM SAMPLE—MOST RECENT METHOD OF CONTRACEPTION

Method	Number using method	% using method	% of couples who have practised contraception	Failures	Years (to nearest year)	Failure rate per 100 years
Sheath (unassorted)	17	30.9	32.1	1	122	0.8
Sheath every time of intercourse	13	23.6	24.5	0	83	0.0
Sheath not every time	5	9.1	9.4	1	39	2.6
Pill	15	27.3	28.3	1	49	2.0
Withdrawal	9	16.4	17.0	7	99	7.1
Safe period/withdrawal	4	7.3	7.6	0	16	0.0
*Sterilising operations	3	5.5	5.7	0	13	0.0
None ever used	2	3.6				
Cap	1	1.8	1.9	0	13	0.0
Safe period	1	1.8	1.9	0	5	0.0
IUD	1	1.8	1.9	0	4	0.0
Sheath/withdrawal	1	1.8	1.9	2	4	50.0
Cap/sheath	1	1.8	1.9	0	1	0.0
Totals	56 **18	100.0	100.2			

\* One was a female sterilisation, one was a hysterectomy, and the third was a removal of ovaries for endometriosis.

\*\* One couple used the sheath every time for 5½ years and not every time for ten years. This couple was included in both sub-groups, because the rule of recording only the most recent method was not applied to sub-groups of sheath usage.

*Most recent method of contraception*

The popularity and failure rates of the contraceptive methods used in the three samples are shown in tables 5, 6, and 7, arranged in order of popularity, except for sub-divisions of sheath usage.

TABLE 6  
MATERNITY SERIES—MOST RECENT METHOD OF CONTRACEPTION

<i>Method</i>	<i>Number using method</i>	<i>% using method</i>	<i>% of couples who have practised contraception</i>	<i>Failures</i>	<i>Years (to nearest year)</i>	<i>** Failure rate per 100 years</i>
Sheath (unassorted)	51	28.2	34.5	10	86	11.6
Sheath every time of intercourse	24	*	*	1	48	2.1
Sheath not every time	21	*	*	9	28	32.1
Pill	43	23.8	29.1	3	106	2.8
None ever used	33	18.2				
Withdrawal	32	17.7	21.6	28	120	23.3
Safe period	7	3.9	4.7	6	18	33.8
Sheath/withdrawal	5	2.8	3.4	2	3	80.0
Cap	4	2.2	2.7	0	5	0.0
Safe period/withdrawal	3	1.7	2.0	5	20	25.6
Pessaries	2	1.1	1.4	0	5	0.0
Safe period/withdrawal/sheath	1	0.6	0.7	2	15	13.3
Totals	181	100.0	100.0			

\* No percentages are given because some of the sheath users early in the maternity series were not asked whether or not they had used the method every time of intercourse.

\*\* Calculated before simplifying time at risk to nearest year.

Regarding popularity of methods, the only difference between the three groups which was statistically significant ( $P < 0.05$ ) was that members of the maternity series were far more likely than either of the other two never to have used any form of contraception.

In all three samples the Pill, the sheath and withdrawal emerge as by far the most popular methods, and are the methods used most recently by 84.4 per cent of people in the whole series who have practised contraception. In the random, maternity and family planning samples the corresponding figures are 79.3 per cent, 88.6 per cent and 79.8 per cent respectively. Three other recent studies in this country by Cartwright (1970), McCance and Hall (1972), and Peel (1972), have all shown the Pill, the sheath and withdrawal to be the most recent choice of over 75 per cent of people who take contraceptive precautions. A survey by Cliquet (1972) illustrates how very different preferences may be shown elsewhere.

Regarding the use-effectiveness of a method, there were several important differences between the three samples. The failure rate for the sheath (unassorted) was very much lower in the random sample than in either the maternity sample or the family planning clinic sample: in both cases the difference was statistically significant ( $P < 0.01$ ); there was little difference in

TABLE 7  
FAMILY PLANNING CLINIC SERIES—MOST RECENT METHOD OF CONTRACEPTION BEFORE FIRST  
ATTENDANCE AT CLINIC

<i>Method</i>	<i>Number using method</i>	<i>% using method</i>	<i>% of couples who have practised contraception</i>	<i>Failures</i>	<i>Years (to nearest year)</i>	<i>** Failure rate per 100 years</i>
Pill	29	35.8	36.7	0	79	0.0
Sheath (unassorted)	17	21.0	21.5	4	53	7.5
Sheath every time of intercourse	11	*	*	0	41	0.0
Sheath not every time of intercourse	5	*	*	4	6	71.8
Withdrawal	15	18.5	19.0	17	58	29.3
Cap	4	4.9	5.1	3***	14	21.0
IUD	4	4.9	5.1	0	12	0.0
None	2	2.5				
Safe period	2	2.5	2.5	2	1	343
Sheath/withdrawal	2	2.5	2.5	0	14	0.0
Sheath/withdrawal/ safe period	2	2.5	2.5	2	19	10.5
Safe period/ withdrawal	1	1.2	1.3	0	6	0.0
Abstinence (not yet started having intercourse)	1	1.2	1.3			
Cap/withdrawal	1	1.2	1.3	0	1	0.0
IUD and Pill	1	1.2	1.3	0	1	0.0
Totals	81	100.0	100.0			

\* No figures are given because not all sheath users in the early part of this series were asked whether or not they used the method every time of intercourse.

\*\* Calculated before simplifying time at risk to nearest year.

\*\*\* All failures occurred with the same person. She stated that two of the failures happened when she was using a diaphragm and spermicide.

failure rate for the sheath (unassorted) between the maternity and family planning clinic samples. There was a similar pattern for withdrawal and for the sheath not used every time.

For the sheath not used every time the numbers were smaller and the difference between the random sample and the family planning clinic sample did not achieve statistical significance at the five per cent level, and the difference between the random and the maternity samples was significant only at the five per cent level ( $P < .05$ ).

#### *Frequency of intercourse*

In the random sample, the stated frequency of coitus varied between 0 and 20 (average 7.3) times during the month preceding the interview. There were four people who said they had not had

intercourse during the month before the interview, but none of these denied having intercourse during the two months immediately preceding the interview.

The reported average frequency of intercourse during the most recent method of contraception varied between 1.5 and 16 (average 8.6) per month. The average during oral contraception was 8.6, during the use of the sheath every time of intercourse 9.3, during use of sheath (unassorted) 9.2, and for withdrawal 7.5. These differences were small and statistically not significant ( $P>0.05$ ).

There was a marked, and statistically significant tendency for stated frequency of intercourse to decline with age and length of marriage. It was not possible, with the sample available, to disentangle the separate contributions of these two factors.

There was no marked relationship between frequency of intercourse and size of family.

#### *Need for domiciliary family planning*

Only one person said she knew of any couple who would want family planning help from a doctor if it were available at home, but would never go to a clinic or see their doctor about it. The person said she and her husband were like that. She was aged 21 with one child and did not want any more, and may want to go on the Pill as long as a doctor does not insist on examining her.

There thus seemed no great reservoir of people known to patients but not to the staff of the practice, who require a domiciliary family planning service.

#### *Responsibility for family planning*

The replies of the random sample are summarised in table 8.

TABLE 8  
RESPONSIBILITY FOR FAMILY PLANNING—VIEWS OF RANDOM SAMPLE

	<i>Husband's Responsibility</i>	<i>Wife's responsibility</i>	<i>Responsibility of either or both</i>	<i>Don't know</i>	<i>Other</i>
Opinion of wife	7	1	26	3	7
Opinion of husband	2	0	2	0	1
Husband and wife interviewed and agree	1	1	5	0	0
Total	10	2	33	3	8

Where husband and wife gave different opinions each opinion is recorded.

Most members of the random sample felt family planning to be a joint responsibility, and of the few that did not, more regarded it as the husband's responsibility than the wife's. These findings are similar to those of Cartwright (1970).

When actions are considered, table 9 illustrates that in each sample nearly half the couples had most recently used a method where the male takes the main responsibility, and medical supervision is not usually involved.

TABLE 9  
USE OF SHEATH AND WITHDRAWAL

	<i>Random sample</i>	<i>Maternity sample</i>	<i>Family planning clinic sample</i>
Proportion of people using sheath and/or withdrawal as most recent method	49.1%	48.7%	42%

The above findings are in marked contrast to the opinion of the working party of the Royal College of Obstetricians and Gynaecologists that reported on *Unplanned Pregnancy* (1972).

### Discussion

#### *Errors of memory*

When the survey was devised attention was concentrated on the most recent method of contraception. This was to simplify the study and to reduce errors from distortions and inaccuracies of people's memories. In addition, I was interested in the picture as it is, rather than as it was. During the study, evidence accumulated that, although there was often considerable error in recall, there was little bias in the direction of these inaccuracies with increasing length of time.

The proportion of unintended pregnancies was 31.5 per cent in the maternity series. In the random sample 23.8 per cent of the children were said to have been unintended when the pregnancy began. In the random sample terminations and miscarriages were not counted and adopted children were classified as intended. The difference between the two proportions (the 31.5 per cent and the 23.8 per cent) was not statistically significant, and if the classification had been similar the difference would have been considerably smaller.

There were several people in the series who were interviewed about contraception more than once. They included ten members of the maternity series who later attended the family planning clinic before making any change of method, a number of sheath-users who were re-interviewed mainly to check whether they used the method every time of intercourse, and various other people. Allowing for the interval between the interviews, the time a method had been at risk was sometimes grossly over-estimated or under-estimated at the first interview compared with the later interview. However, the over-estimations were almost exactly balanced by the under-estimations.

#### *Terminations*

The proportion of pregnancies terminated in this series was 2.6 per cent of all pregnancies and 3.7 per cent of pregnancies that began at least 28 weeks before the end of the survey. Both proportions were very much below the national average of 9.7 per cent on 1970 figures, or 19.5 per cent on the figures available for January—March 1972.

What is the reason for the low proportion of Shepshed pregnancies terminated? The information about the miscarriages in this survey suggests that the rarity of terminations is not due to induced abortions being classified as miscarriages.

The attitude of the patient's general practitioner towards termination of pregnancy might be important. Cartwright and Waite (1972) reported a survey, *General Practitioners and Abortion*. Applying the relevant parts of their questionnaire to the Shepshed doctors revealed a wide range of attitudes. However, if weight is given to opinions according to the numbers of maternity patients seen, the Shepshed doctors appear at least as permissive towards termination of pregnancy as the national average.

In regions around Shepshed the local gynaecologists seem less prepared to terminate pregnancies than those in many other parts of the country. However, I do not know of any patient in the survey who continued with her pregnancy because she had been refused a termination by a local gynaecologist. Had there been any such cases I should certainly have known with my own maternity patients who formed over half the maternity series, and probably have known with my partners' maternity patients.

Much has been written about regional variations in the readiness of gynaecologists to abort unwanted pregnancies, comparatively little has been written about regional variations in demand for terminations. In Shepshed the low termination figures appear to reflect a low demand. Table 10 illustrates the considerable regional variation in the proportion of pregnancies terminated.

#### *Differences between the three samples*

Throughout the study it was realised that each of the samples would have its own biases. In the maternity series one would expect a disproportionate number of young couples, couples wanting children, fertile couples and couples unsuccessful with their contraceptive method. The family planning clinic sample might have a predominance of people interested in methods involving medical supervision. Both maternity and family planning clinic samples would be



TABLE 10  
FIGURES FOR TERMINATIONS BY AREA OF RESIDENCE

<i>Area of usual residence</i>	<i>Total live births</i>	<i>Total legally induced abortions notified</i>	<i>Terminations per 100 births</i>
England and Wales	784,486	75,962	9.7
Conurbations	262,646	33,769	12.8
Urban, with population under 50,000	173,096	14,153	8.2
Rural districts	168,274	10,857	6.6
East Midlands	55,755	3,582	6.4
Leicestershire (includes Leicester C.B. and Admin. County)	12,618	875	6.9
Jan—March 1972 England and Wales	189,981	37,166	19.5

Figures for January—March 1972 from Registrar General's Quarterly Return for England and Wales. Remaining figures apply to 1970 and are from the *Statistical Review* of England and Wales and the abortion supplement to the *Statistical Review*.

deficient in couples where there had been a sterilising operation and in other infertile couples. The random sample did not include the unmarried and might under-represent newly married couples, because there is sometimes delay in changing a NHS record card to record a woman's married name.

Many of the differences between the samples were as expected, but one that came as a surprise was the great difference between the family planning series and the random sample in the failure rate for withdrawal and sheath (unassorted). Three possible explanations were considered:

1. Confining attention to the most recent method may introduce considerable bias as people who are unsuccessful with a contraceptive method often change to a different method, thus the residue continuing with a less effective method tends to be composed of couples of low fertility or unusually able at using that method.
2. The average age of members of the three samples was approximately 33 years for the random sample, 29 years for the family planning clinic sample, and 26 years for the maternity sample at the time of the expected dates of confinement.

Could the observed differences have been due to a marked decline in fertility with increasing age? If all members of the random sample aged 37 and over are excluded, the average age of the remainder is lower than that of the family planning clinic series. The failure rate for withdrawal in members of the random sample aged under 37 was one in 34.5 years. The failure rate for withdrawal in members of the family planning clinic sample was 17 in 58.2 years. The difference between the two failure rates was statistically significant ( $P < 0.01$ ). Thus age differences alone do not appear responsible.

3. Attenders at the family planning clinic may be unrepresentative of the population from which they are drawn in regard to contraceptive failures. If this is true, then perhaps attenders at other family planning clinics may also be unrepresentative.

#### *Effectiveness of the sheath*

There have been two other recent English studies on the effectiveness of the sheath, by Peel (1969 and 1972). As may be seen from table 11 the results were similar to mine. They are in

marked contrast to a recent Belgian study by Cliquet (1972) and a widely quoted survey by Tietze *et al.* (1961) in Puerto Rico. However, in neither of these studies was the degree of user-failure ascertained.

TABLE 11  
EFFECTIVENESS OF SHEATH IN THREE RECENT ENGLISH SURVEYS

Author	Year of publication	People included in survey	Years method at risk (to nearest year)	Total failures	Method failures	Total failure rate/100 years	Method failure rate/100 years
Peel	1969	Group of highly fertile couples in Hull	127	4	1	3.1	0.8
Peel	1972	Couples married Hull 1965-1966	308	12	5	3.9	1.6
John		NHS patients of Shepshed practice	248	12	1	4.8	0.4
Aggregate of above studies			683	28	7	4.1	1.02

In each of the three Shepshed samples the majority of people classified as sheath users said they used the method every time. Among this group of people the failure rate would seem to be of the order of one per hundred years at risk, and thus compares well with that of intra-uterine devices and the Pill as taken.

#### Summary

During one year all maternity patients, all attenders at the practice family planning clinic, and a random sample of married women aged under 46 were studied. In the maternity sample 32 per cent of the pregnancies had been unintended. Terminations were rare compared with national figures.

In the random sample nearly all (53/55) had taken contraceptive precautions at some time—the ideal number of children averaged 2.2 per family, and the average age for achieving the desired family size was 28.

Among those who had taken precautions about 30 per cent used the Pill, 30 per cent the sheath and 20 per cent withdrawal as their most recent method. These methods had no obvious effect on frequency of intercourse. The failure rates of some methods showed marked differences in the three samples.

In all samples the majority of couples classified as sheath users said they used the method every time of intercourse. Among this majority there was only one pregnancy in 160 years.

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## GENERAL PRACTITIONERS AND CONTRACEPTION

### *Sex and social class*

More than a third of all pregnancies in married women are unplanned and half of these are unwanted, according to an assessment of the use of family planning services in England and Wales prepared for the Department of Health and published this week. The report is based on interviews with 3,500 women and reflects current attitudes; its most striking findings are the variations in those attitudes in women of different social classes.

. . . Further reduction in the number of unplanned pregnancies is an urgent need—as can be seen from the rising number of abortions carried out each year—but the report says that the problem will not be solved simply by increasing the number of clinics, for an important deterrent seems to be the lack of privacy—“everyone knows what you’ve come for”. Accessibility is specially important in socially deprived areas, where few women have use of a car, and for that reason the general practitioner’s role is vital. The reluctance of some women to approach him is partly due to shyness of discussing sex with a man, suggests the report, and partly a fear that he might not see the provision of advice on family planning as his job. An additional fear among single women seems to be that general practitioners may oppose the use of contraceptives by the unmarried. In all these cases propaganda by word of mouth can be effective—but only when the majority of doctors are convinced of the importance of fertility control in the care of their patients.

#### REFERENCE

- British Medical Journal* (1973). **3**, 121. Editorial quoting Bone, Margaret (1973). *Family Planning Services in England and Wales*. London: H.M.S.O.