

# The care of oral contraceptive users by general practitioners in Oxfordshire

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**SUMMARY.** A questionnaire was circulated to a sample of general practitioners in Oxfordshire enquiring about the supervision of women taking oral contraceptives. A high standard of care was being offered and the doctors believed that there was a wide range of conditions that should influence the prescription of oral contraceptives. We conclude that while suitably trained para-medical staff could provide the same standard of care as the general practitioners, this could not be achieved through the use of a package insert listing possible contraindications.

### Introduction

**I**N July 1975 the free general-practitioner contraceptive service was introduced and those methods of contraception requiring medical prescription, notably oral contraceptives and intrauterine devices, are now more widely available than ever before. However, in spite of this extension of birth control services, it has been estimated that as many as three million women at risk of pregnancy are not using any form of contraception (Family Planning Association, 1976). It has been suggested that many of these women would like to use oral contraceptives but are deterred by the need to discuss contraception with a doctor.

The Joint Working Group on Oral Contraceptives (1976) has now recommended that nurses, midwives, health visitors, and pharmacists who have completed a suitable course of training should be able to prescribe oral contraceptives. Some doctors are opposed to this, believing that the hazards of oral contraceptives are such that it is essential for a woman taking them to be under the supervision of a doctor (*Lancet*, 1976). Others have argued that even the most thorough medical examination would not reveal all those women likely to

suffer unusual harmful effects, and that the only advice necessary could be provided on a packet insert accompanying the pills.

### Aim

We sought to identify the conditions regarded by practising doctors as contraindications to the use of the Pill, and to find out what supervision they are currently providing.

### Method

A questionnaire was circulated to a one-in-two sample of the general practitioners included on the Oxfordshire Area Family Practitioner Committee's Medical List. Information was sought concerning conditions considered to be contraindications to the use of oral contraceptives and the procedures followed, both before prescribing them and during subsequent consultations.

### Results

One hundred and eighty-four doctors were circulated. Of these, 82 per cent replied to a first or second mailing. Six doctors (three per cent) were excluded, four had left the practice, one refused to answer the questions, and one completed the questionnaire on behalf of a colleague. A total of 28 doctors (15 per cent) did not reply. The respondents and non-respondents were compared for date of qualification, sex, and qualifications in obstetrics and gynaecology, as shown in the *Medical Directory* (1976). No statistically significant differences were found between the two groups. Of the 150 doctors who replied, three said that they never prescribed oral contraceptives, so the data presented here are based on 147 replies.

The doctors were asked which of a check-list of conditions they regarded as relative or absolute contraindications to the Pill and their replies are summarized in Table 1. In addition to those conditions

**Table 1.** Conditions\* considered by general practitioners to be contraindications to oral contraceptive used, shown as percentages.

	Absolute contraindication	Relative contraindication	Not a contraindication
Thromboembolic disease (venous or arterial)	97	2 <sup>†</sup>	1
Active liver disease	91	9	0
Breast cancer	86	8	6 <sup>†</sup>
Ischaemic heart disease	65	27 <sup>†</sup>	8
Intermittent claudication	63	30	7
Pruritus or cholestatic jaundice of pregnancy	45	39	16
Hypertension	44	52 <sup>†</sup>	4
Elective surgery or immobilization	44	46	10
Hyperlipidaemia	43	45	12
Primary amenorrhoea or oligomenorrhoea	40	43	17
Diabetes	20	55	25
Congenital heart disease	15	55	30
Toxaemia of pregnancy	9	41	50
Conditions producing oedema	9	68	23
Varicose veins	7	53	40
Migraine	6	60	34
Depression	5	67	28
Gall bladder disease	5	45	50
Epilepsy	3	41	56

\*Questions about chorea and porphyria were also asked, but the replies are not included in the analysis since more than 20 per cent of the doctors felt unable to answer.

<sup>†</sup>When asked if a family history of this condition was a contraindication, the majority of doctors chose this response.

listed in the questionnaire, cervical cancer, infections of the genital tract, and undiagnosed breast lumps were volunteered as contraindications by 54 per cent, 15 per cent, and 23 per cent respectively. Forty per cent considered that obese women should not use the Pill and 17 per cent thought that heavy cigarette smokers should be advised against their use. Several other conditions were regarded by fewer than ten per cent of doctors as reasons for not prescribing the Pill.

One hundred and three doctors stated blood pressure levels beyond which they believed the Pill should not be prescribed. The majority mentioned diastolic pressures in the range 90 to 100 mm Hg and systolic pressures in the range 140 to 160 mm Hg.

Table 2 shows the doctors' replies to questions about procedures followed routinely before prescribing oral contraceptives and investigations routinely undertaken at follow-up visits. 'Routinely' was taken to mean without discrimination at regular intervals, though not necessarily at every follow-up visit. Three quarters of the doctors said that they saw patients once they were established on the Pill every six months. None of the doctors saw their patients less than once a year. In addition to those follow-up procedures shown in Table 2, five doctors said that they asked about sexual problems, three measured fasting blood sugars and lipids in some patients, and two measured haemoglobin levels.

Eighty per cent of doctors did not think that there was a time limit for uninterrupted use of the Pill. The remainder suggested an interval of between one and 12 years with a median of five years. Some drew a distinction between parous and nulliparous women, with a shorter time period for the latter.

Thirty-one doctors said that some of the follow-up examinations were delegated to a nurse.

## Discussion

Since our sample was drawn exclusively from Oxfordshire, no generalizations can be made for the rest of the country. It appears that doctors completing our questionnaire were offering a high standard of care and believed that there was a wide range of conditions that should influence the prescription of oral contraceptives. It is possible that the replies were biased towards those doctors who were most concerned about hazards, though, as far as could be determined, there was no significant difference between the respondents and non-respondents. It is also possible that doctors' responses may have been influenced by the existence of the Working Group, which was mentioned in the letter accompanying the questionnaire. This knowledge may have encouraged them to report a more comprehensive level of health care than they might otherwise have done, despite reassurance that their replies would be

**Table 2.** Procedures routinely undertaken before prescription of oral contraceptives and at subsequent consultation, shown as percentages.

	Initial consultation	Subsequent consultation
Measure blood pressure	98	98
Vaginal examination	67	38
Record weight	67	64
Cervical smear	65	52
Breast examination	56	41
Enquire about side effects	—	97
Enquire about smoking	45	*
Leg examination	*	56
Record height	9	—
Test urine for glucose and protein	*	27

\*Questions concerning leg examination and urine testing at initial consultation, and concerning smoking habits at subsequent consultations, were not included in the questionnaire. Questions on all the other procedures given above were included.

treated in confidence and used for statistical purposes only. This might, for example, explain the high number (27 per cent) who said that they routinely tested urine at a follow-up visit.

Ischaemic heart disease (Mann *et al.*, 1976), thromboembolic disease (Vessey and Doll, 1969), breast cancer (Pearson *et al.*, 1954) and active liver disease (*British Medical Journal*, 1974) are well established contraindications to oral contraceptive use. Hypertension, hyperlipidaemia, and diabetes are indisputable risk factors for ischaemic heart disease, and Mann and his colleagues (1976) have shown that the effects of these risk factors and oral contraceptives are synergistic. Thus, the risk of myocardial infarction attributable to oral contraceptives is greater when the preparations are used in women with these conditions. Such women should usually be recommended alternative methods of contraception but, should these be unacceptable, the Pill may be preferred to the risks of pregnancy which are themselves known to be increased in diabetic and hypertensive women.

There is a well established increase in the risk of thrombosis after surgery and immobilization in women using oral contraceptives, and these conditions are clearly relative, if not absolute, contraindications (Vessey *et al.*, 1976). These conditions, as well as amenorrhoea and oligomenorrhoea have all been reported among women ceasing to use the Pill (Vessey *et al.*, 1976; *British Medical Journal*, 1976), and migraine is more frequent among women using the preparations than among those using other methods of contraception (Vessey *et al.*, 1976). These conditions, as well as

primary amenorrhoea, would, therefore, similarly be appropriately listed as relative contraindications. The case for regarding cervical cancer as a contraindication seems less certain. Despite studies attempting to establish a relationship between oral contraceptive use and cervical cancer, no association has yet been proved between these preparations and either the promotion or course of the disease, either invasive or *in situ* (Vessey, 1974).

Recent evidence of an association between use of the Pill and gall bladder disease (Royal College of General Practitioners, 1974; Vessey *et al.*, 1976), and a reduction in the efficacy of oral contraceptives when used by epileptic patients taking anticonvulsant therapy (John, 1976) suggests that patients with these disorders might also consider alternative methods of contraception.

It seems that the detailed history and examination undertaken by the majority of these doctors could be carried out by suitably trained staff, though clearly, as suggested in the report of the working group (1976), it would be necessary for such people to have a direct line of referral to a medical practitioner for women with contraindications. Hyperlipidaemia and chemical diabetes could be uncovered by neither doctor nor paramedical staff without the appropriate blood tests. Although such tests might theoretically be desirable, they are at present not feasible on a large scale. There is as yet no known method of identifying by history those women who may be at increased risk of these conditions, but older women and those with clinically detectable risk factors who wish to use oral contraceptives should perhaps be screened in this way.

We felt from the doctors' replies that the quality of care necessary for relatively safe use of oral contraceptives could not be maintained by the use of a packet insert. In particular, measurement of blood pressure seems to be an essential routine practice.

Generally, it was found that the conditions doctors said they were concerned about were the conditions to which they directed their enquiries and examinations. Nevertheless, while 94 per cent of them considered breast cancer to be a contraindication, only 56 per cent examined the breasts before prescribing, and even fewer examined them at follow-up. However, doctors were not asked whether they taught self-examination techniques or asked about any changes in the breasts, and this may explain the discrepancy. Some of the care offered could be regarded more as general preventive medicine. For instance, more doctors enquired about smoking habits than considered smoking to be a contraindication to use of the Pill, and more doctors weighed their patients than considered obesity to be a cause for concern. Similarly, breast examination, vaginal examination, and cervical smears may be general preventive measures that should be equally available to all women.

In conclusion, we feel it would be dangerous to take the Pill off prescription although suitably trained



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paramedical staff could be licensed to prescribe it (Newton *et al.*, 1976). We hope that those women wanting to use oral contraceptives who are deterred by the need to obtain a prescription will feel happier about consulting a nurse, health visitor, or midwife. As stated in the report, "any system which provides for alternative sources of supply is bound to have some advantages".

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#### Evidence to the Royal Commission on the NHS from the Royal College of Nursing

To meet new needs there must be a transfer of resources from the hospital to the community services: also the needs of patients in different types of hospitals should be reviewed and attention paid to those which traditionally have been accorded a low priority (Paragraph 43).

#### Reference

- Royal College of Nursing (1977). Evidence to the Royal Commission on the NHS.