A well woman clinic in an inner-city general practice

KATY GARDNER, MB, MRCGP
General Practitioner, Liverpool

SUMMARY. The operation of a well woman clinic in an inner-city practice was reviewed after three years. During this period, 489 women attended, 35 of them on two or more occasions; 369 cervical smears were taken, 13 of which indicated abnormality. This paper discusses the advantages of such a clinic and the possibilities for further development.

Introduction

WELL woman clinics developed from the cervical cytology clinics which were formerly part of the Local Authority services, because of the recognition that women coming for cervical smears often had other problems.[1,2] In addition, the increased awareness of common health problems in women—for example, premenstrual tension and dysmenorrhoea—and advances in screening techniques and treatment for carcinoma of the cervix, have highlighted the importance of prevention. Brown and Harris found that, contrary to popular myths about women frequently consulting their general practitioner, many women, especially those with small children, do not voice their problems to doctors.[3] The Black Report commented on working class women's failure to use preventive services, such as cervical cytology, and on the fact that morbidity and mortality rates are higher for working-class people than for the rest of the population.[4]

Well woman clinics are currently run by a number of agencies. Clinics in Islington (London), Cardiff and elsewhere are run by the District Health Authority in the same way as well baby clinics. These are 'open access' clinics. Some family planning clinics and Brook Advisory Centres have also extended their role to include counselling and screening procedures. The Women's National Cancer Campaign is a charity operating a mobile screening unit, which is available to factories and District Health Authorities on request.[5] The first National Conference on Well Woman Clinics, convened by the National Association of Community Health Councils, was held in 1981 and brought together the various groups running and campaigning for such clinics within the National Health Service.[6]

This paper reports the findings from a three-year review of a well woman clinic within a health centre in an inner-city area of Liverpool. At the start of the study, the practice comprised 5,800 patients and three doctors, with over 50 per cent of the female patients in the 15–44 years age group. During the course of the period under review, the practice expanded to four partners with a list size of 8,000.

Aims

The aims of the well woman clinic are:

1. to attract women who might not normally come to the surgery and who might otherwise feel inhibited about coming to the doctor;
2. to provide more time and a more informal atmosphere than is available in the general surgery;
3. to screen women for breast cancer, cervical cancer, hypertension and gynaecological abnormalities, paying special attention to those known to be most at risk;
4. to encourage self-help and self-examination, to increase women's knowledge of their own bodies and their own health, and to provide information and advice on avoidance of risk factors to health;[7]
5. to encourage and initiate, if possible, self-help groups or to refer patients to existing groups;
6. to extend the role of the practice nurse to participation in the running, conducting and planning of the clinic.

Method

A weekly session, run by the practice nurse and a female doctor, is held from 14.00 to 16.00 hours and is open to all women in the practice. Up to six women attend through self-referral or referral by a practice health worker, and four appointments are kept for women over 35 years of age, selected via the age-sex register as not having had a cervical smear in the last five years. Every woman spends at least 20 minutes with the nurse or doctor. Women selected for screening are sent for by letter, if necessary on two occasions. If they fail to attend, the nurse telephones or visits them at home, inviting them to attend either the clinic or the surgery at a time convenient to them.

The date of the woman's last smear is noted on the record envelope and in the age-sex register, which is also tagged when she attends the clinic for a smear test. Non-attenders have

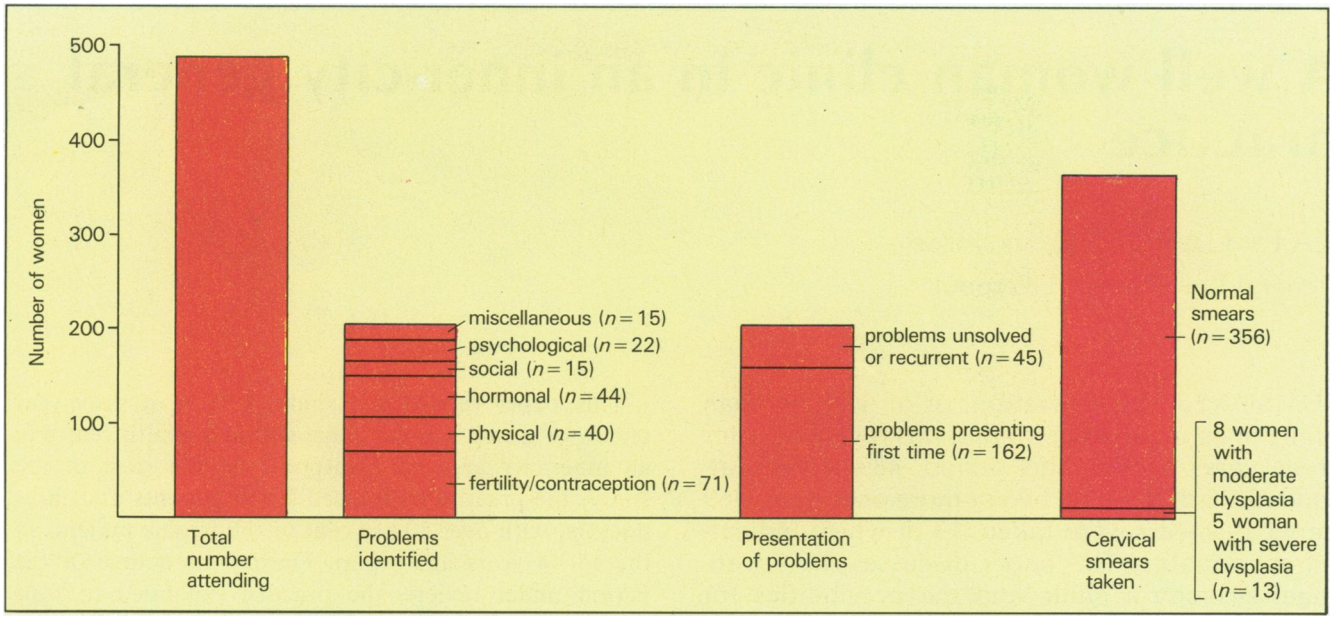


Figure 1. *Attendance at the well woman clinic during first three years (February 1979 to January 1982 inclusive).*

their age–sex card tagged for future call-up, and a marker is also placed in their case notes.

The full medical history of every woman attending is recorded, including occupation, smoking habits, and gynaecological and contraceptive history. She is given an opportunity to discuss any particular problems she may have. Blood pressure is measured, rubella immunity status ascertained, breasts and pelvis are examined, and a cervical smear taken if this test has not been done in the last three years.[8] Instruction on breast self-examination is given, along with advice on self-help for simple but unpleasant conditions such as thrush and cystitis. Patients can be referred to gynaecologists, self-help groups and counsellors skilled in psychosexual therapy, as appropriate.

A card index of all women attending is kept, in order to recall them at five-year intervals. For follow-up purposes, there is also a separate index of women with abnormal cervical smears.

Results

The clinic has been running for three years at the time of review (January 1982).

Figure 1 shows an analysis of the total attendance and problems encountered. Out of 369 cervical smears taken, 13 were cytologically abnormal and four of the patients concerned were subsequently found to have carcinoma *in situ*.

Figure 2 shows the response to systematic call-up of a cohort of women born between 1935 and 1944. (Call-up of a one-year cohort takes three months with the present system.) Two smear tests were abnormal in the group selected for screening.

Figure 3 shows that over the three years there was no change in social class composition of women attending the well woman clinic, although there was an increase in the number of unemployed. While we wanted to attract more women from social classes IV and V, we found on analysing the social class composition of the practice that attenders had been representative of the practice as a whole.

Discussion

The well woman clinic functions both as a screening service and a self-referral service, a combination possible only within general practice. The advantage is that prevention and treatment are not separated.[9] The practice, in conjunction with the local Community Health Council, provides leaflets on prevention and self-help, and books are available for borrowing. Doctors and health visitors cooperate by referring women to the clinic, and there are also referrals via women who have themselves attended, which is encouraging.

Initially, women born in 1954 were compared with women born in 1944 in order to identify the age group most likely to benefit from systematic screening. We found that the younger women were more likely to have had a recent cervical smear and to respond to recall. It is possible that older women are not so aware of the importance of cervical smear tests, or they may have less time to attend the surgery because of other commitments. We therefore decided to concentrate on women over 35 years of age for the selective screening; in any case, these women are at greater risk of getting carcinoma of breast or cervix. In fact, response to call-up was better than expected (Figure 2), although a visit or telephone call from the nurse was required in some instances, and attendance was occasionally several months after being sent for (Figure 2). The response was especially encouraging for a practice with a mobile

inner-city population and a high turnover of patients, all of which makes record-keeping and updating the age–sex register a major task. Markers in the records may have been an influential factor in the post-screening attendance rate and all partners in the practice have cooperated in this procedure.

The high incidence of carcinoma and dysplasia in our patients may partly reflect the composition of the practice, with its mobile population, many of whom are women on their own who have had multiple sexual relationships and whose partners have done likewise, and who have commenced sexual activity at an early age.[10,11] It has been estimated that 30 per cent of cases of moderate dysplasia progress to severe dysplasia, that most severely dysplastic smears are indicative of carcinoma *in situ*, and that with carcinoma *in situ* there is a 30 per cent chance of its developing into frank carcinoma.[12] We discovered five women with severely dysplastic smears; four of these women were found at cone biopsy to have carcinoma *in situ*, and one to have a microscopic carcinoma. Eight women were found to have moderate dysplasia, of whom six are now under surveillance and two have progressed to severe dysplasia. Women have presented with a number of problems which they might not normally have revealed. Many new diagnoses have been made, including ovarian cysts and hypertension. Inevitably when one goes in search of problems one finds them. In order to follow through these problems a multidisciplinary health care team is vital.[13,14]

The practice-employed nurse has extended her duties to include examining women and discussing their problems as well as instructing them in self-examination of the breasts. She also plays an important part in the call-up of women for screening. We are also fortunate in having psychologists and our own social worker in the Health Centre available for referrals. Good relationships with the local gynaecologists and the presence of a

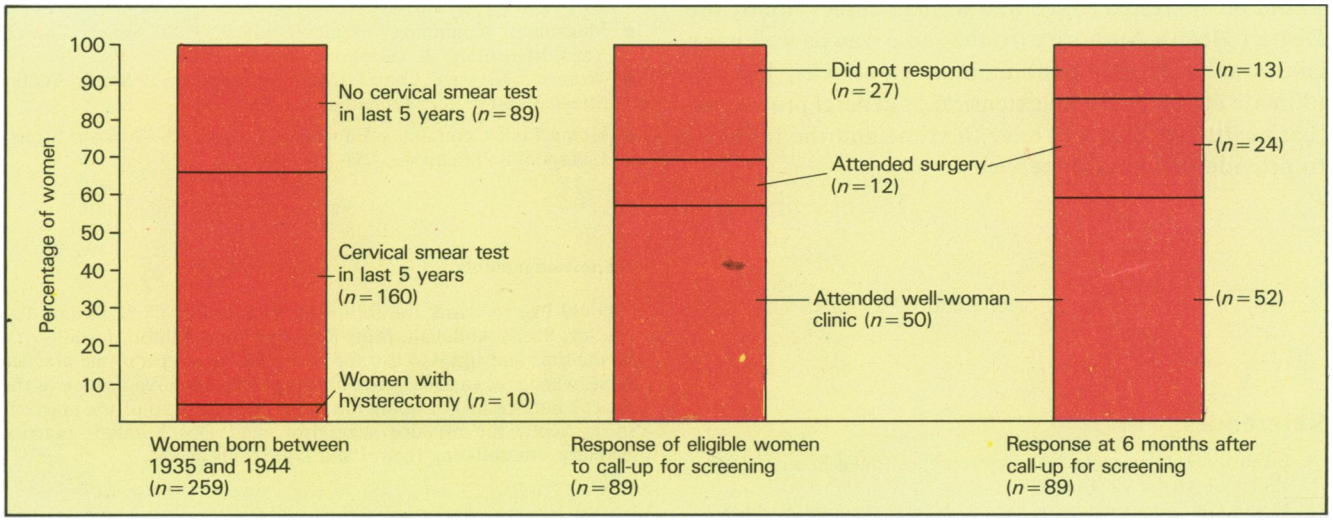
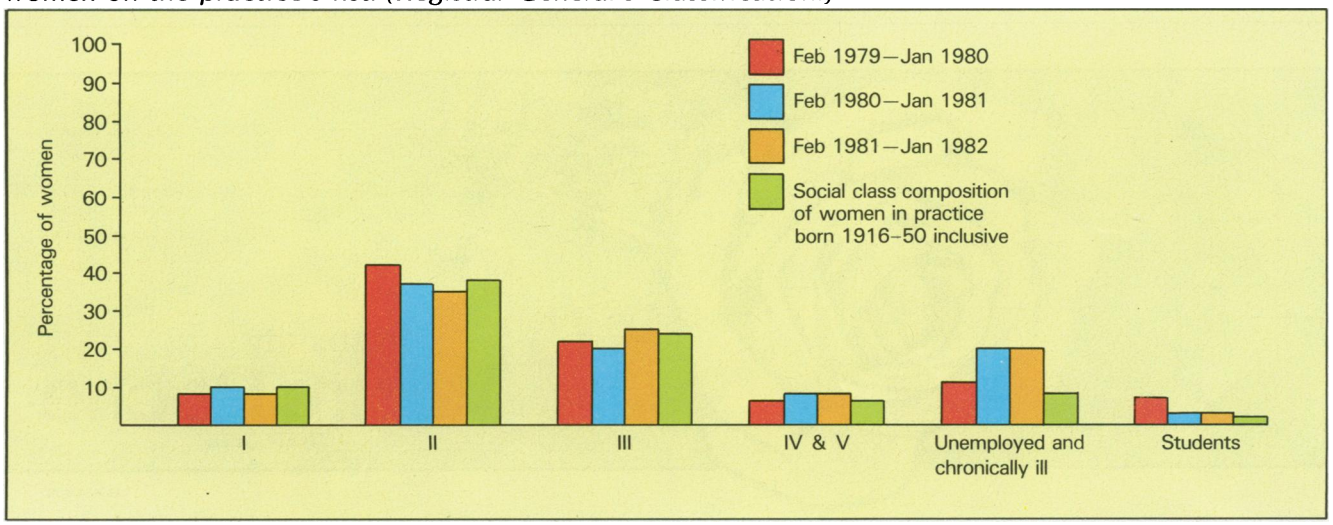


Figure 2. *Response to call-up for screening by a cohort of women born between 1935 and 1944, selected from the age–sex register.*

Figure 3. *Social class of attenders at the well women clinic compared with that of total population of women on the practice's list. (Registrar General's Classification.)*



woman doctor in the practice with special interest and experience in psychosexual counselling are advantages.

Perhaps the clinic's most valuable contribution is time to listen and talk in an unhurried atmosphere. We would like in the future to have more group discussions on different aspects of health. Better publicity and an extension of the patients' grapevine to explain the idea of the clinic are needed. To this end, we run a series of evening meetings within the Health Centre which are free, serviced by a crèche, and widely publicized locally. An unresolved problem is recall. Will five-year intervals be too long? Should we concentrate all our efforts on women who have never had cervical smear tests? How can we further encourage these women to come forward?

Conclusion

Running the well woman clinic has been more complicated than we expected, but also most satisfying. We would be interested to see well woman clinics run by the District Health Authority (in the same way as well baby clinics are currently run) in inner-city areas, but the ultimate goal must be an extension of general practice so that health workers will have the time and the facilities to provide this kind of service.

References

1. Edwards D. Gynaecological abnormalities found in a cytology clinic. *Br Med J* 1974; **4:** 218.
2. Marsh GN. Further nursing care in general practice. *Br Med J* 1976; **2:** 626.
3. Brown G, Harris T. *Social origins of depression.* London: Tavistock Press, 1978.
4. Sir Douglas Black, *et al. Inequalities in health.* P107. London: DHSS, 1980.
5. Leeson J, Gray J. *Women in medicine.* Pp 149-151. London: Tavistock Press, 1978.
6. *Report on National Conference of Well Woman Clinics.* Manchester: Manchester Community Health Council, 1982.
7. Buckley JD, Harris WC, *et al.* Case control study of husbands of women with dysplasia or carcinoma of the cervix. *Lancet* 1981; **2:** 1010-1014.
8. Spriggs AI, Hussain OAN. Cervical smears. *Br Med J* 1977; **1:** 1516-1518.
9. Last P. The best place for screening women is in the GP's surgery. *Modern Med* 1979; 19 April: 25-28.
10. Singer A. Cancer of the cervix. *Hosp Update* 1977; October: 553-565.
11. Beral V. Cancer of the cervix: a sexually transmitted infection. *Lancet* 1974; **1:** 1037-1040.
12. Kinlen LJ, Spriggs AI. Women with positive cervical smears but without surgical intervention. *Lancet* 1978; **2:** 463-465.
13. Acheson E, *et al. Primary health care in inner London.* London: DHSS, 1981.
14. Anonymous (Editorial.) *J R Coll Gen Pract* 1982; **32:** 69-70.

Useful organizations

- Islington Community Health Council, Liverpool Road, London N1. Telephone: 01-359 5066.
- Manchester Community Health Council, 1 St Anne's Church Yard, Manchester 2. Telephone: 061-832 8183.
- Women's National Cancer Control Campaign, 1 South Audley Street, London W1. Telephone: 01-499 7532.
- Home Link Community Education Project, 29 Grierson Street, Liverpool 8. Telephone: 051-708 5544.

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Address for correspondence

Dr Katy Gardner, Princes Park Health Centre, Bentley Road, Liverpool L8 0SY.