Well woman care: whose responsibility?

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Introduction

GENERAL practice primary care teams are taking more responsibility for preventive medicine and there is evidence that patients welcome health promotion activities on the part of their general practitioner.[1] Already, in some districts, as little as 5% of pre-school child health services are provided by clinical medical officers[2] and, although opinions about this vary, there is general agreement that this trend is desirable. There is much less consensus, however, that it is beneficial or desirable to transfer family planning and well woman services to primary care teams. The involvement of the community health services in family planning also varies widely. In the City and Hackney Health District there are 36 family planning sessions per week, excluding domiciliary services, and there were a total of 20 586 attendances in 1983. Family practitioner committee returns show that for the same year a quarter of general practitioners in the district did not offer coil fitting and several doctors made no claim for family planning services.

Survey of clinic users

As part of a study of family planning in the City and Hackney Health District, users of family planning clinics were asked why they chose to attend a clinic rather than their general practitioner. In 1983 one in three clients attending each of the 33 weekly sessions held throughout the district were interviewed when they attended a clinic. Information was collected about demographic factors and health knowledge as well as their reasons for choosing a clinic. The 127 clients who were interviewed were asked an open question: 'What made you come to this clinic rather than see your family doctor?' The results are given in Table 1.

Although 20 women chose a clinic because it was convenient, a substantial number gave more specific reasons for their choice. In general, these appear to reflect concern about the quality of the service provided — in particular, the thoroughness of check-ups and the specialized knowledge available. Some women felt embarrassed about approaching their general practitioner, either because they did not feel they had a good relationship with their doctor or because they knew him too well. A number of women also liked to feel that women's health was being taken seriously and they felt that doctors were rushed and did not have time for family planning.

A number of other points emerged from the results — the anxiety of some young people that their parents would find out they had seen the general practitioner, a desire to see a woman doctor and to be with other women, and a feeling that it was inappropriate to see a general practitioner when not actually ill. The time spent in consultation was also an important consideration for women who wanted a lengthier discussion of their health and choices of contraception.

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Table 1. Reasons given by women for attending a family planning clinic rather than their general practitioner for family planning services (n = 127).

Reasons	Number of times each reason was mentioned[a]
More convenient place or times	20
Clinic specializes in family planning	18
Embarrassed/do not feel comfortable with GP/do not know GP	16
Clinic does thorough check-ups	13
GP does not provide family planning or does not provide a particular method	10
GP does not do check-ups thoroughly	10
Recommended by GP	10
Can see a woman doctor	9
Not registered with GP (when first visited clinic)	8
Previous bad experience with GP	8
GP does not have time	7
Clinic has more time	7
Worried about parents or others knowing	7
Not ill or sick, not a patient	6
GP is not interested in family planning/ women's problems	5
Clinic is more approachable	5
Did not know GP could offer family planning	5
Clinic interested in wider health issues	4
Recommended by someone other than GP	4
Can be with other women	3
Can be seen with no appointment	2
Other reason	7

[a]Several women provided more than one reason.

Discussion

This study did not include women who currently attend their general practitioner for family planning and therefore the comments are biased in favour of clinics. Nevertheless, the reasons these women gave for choosing a clinic in preference to their general practitioner are important when considering how general practitioners respond to women's needs and interests. The provision by doctors of only one or two methods of contraception is not a family planning service; clearly, many women are aware of this limitation and also feel strongly that discussion and thorough check-ups are essential.

Underlying the feeling that women's health is not taken seriously are the very real barriers to the discussion of problems which ultimately relate to sexuality. Discussion of many women's health issues involves at least admitting to sexual activity and many minor ailments are associated with 'promiscuous' or 'unacceptable' sexual behaviour under the general notion of the sexual transmission of disease. Male general practitioners are less likely to be perceived as accepting sexuality than clinics[3] and consultation with a male general practitioner who may have an ambiguous sexual relationship with the woman[4] only makes full and open discussion more difficult.

Patients welcome their general practitioner's involvement in issues such as diet, exercise and smoking[1] and clearly family planning is similarly a preventive service for women who are not ill. In order to close the gap between providing contraceptives and offering a full well woman service not only must a

wide range of medical techniques be offered but also perspectives must be shifted towards health promotion and prevention. Central to a comprehensive well woman service is the notion that women can take control of many aspects of their own health and often need only information, reassurance or counselling to help them deal with factors which affect their health and to help them understand the natural changes their bodies undergo.

Gardner has shown that general practitioner based primary care teams can provide well woman clinics[5] and many general practitioners would like to respond to the increasingly articulate demands of women. Cooperation between the community health services and general practitioners could overcome some practical problems and would have positive advantages for clients. In the City and Hackney Health District there are few female general practitioners while the majority of clinical medical officers are women. The community health services employ many trained family planning nurses and should be able to provide medical and non-medical counselling expertise. If joint well woman sessions are held in general practice with a woman clinical medical officer and counsellor, and a general practitioner available to consult and to prescribe when necessary, the benefits to the clients would be considerable. The launching of such sessions would indicate that women's health issues are taken seriously, would make available appropriate advice, screening and information and would provide treatment for common minor gynaecological complaints without the need for referral.

A service of this kind would be complementary to existing family planning clinics and general practitioner consultations and would result in a more integrated approach to primary care.

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Minor tranquillizers, including the benzodiazepines, have been found to impair driving skills such as hand–eye coordination and reaction time. Several studies have also demonstrated an association between minor tranquillizer use and traffic accidents; however, the association may be due entirely to more frequent alcohol use or to the underlying anxiety found in users of minor tranquillizers. Whichever the case, patients taking minor tranquillizers do have higher accident rates. It is recommended that physicians emphasize the possible risks of driving while using these medicines, particularly if used with alcohol.

Source: Bauer RL. Traffic accidents and minor tranquillizers: a review. *Public Health Rep* 1984; **99:** 572-574.

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