Women's Healthcare Services in General Practice

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The Irish College of General Practitioners

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A National Survey of Current Service Provision and Attitudes of Irish General Practitioners

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Contents

Summary

Women's healthcare is a priority for government, for medical professionals and, of course, for women themselves. General practitioners will play a central role in the provision of an expanded service. While there is some data on the attitudes and preferences of women in this area, little information is available on the services provided by GPs, the barriers to a wider service or their attitudes. Such information is required to inform the development of women's health services.

This study, combining focus group discussions with a random, national survey was designed to provide this baseline data. A stratified random sample of 30% of Irish GPs (778) was surveyed and a further 13 participated in focus group discussions. Confidentiality was assured and a variety of views were expressed. The satisfactory response rate in summertime indicates a high level of interest in this area.

There is generally a high level of provision of family planning and women's health services throughout the country. A large majority of GPs believe that family planning is an integral aspect of general practice and that a comprehensive service is feasible. Female GPs, doctors under the age of 40, those with a Family Planning Certificate, rural GPs and those with a practice nurse are more likely to provide a broader range of services.

Three-quarters (75%) of GPs believe that women's healthcare is best delivered through a combination of dedicated clinics and routine surgeries, although at present 63% provide the service through routine surgeries only. GPs support the evolution of a two-level provision of care, with all GPs providing hormonal contraception and counselling on other contraceptive options and GPs with specialist skills providing IUCD fitting, diaphragm fitting and vasectomy. Such a system will require ongoing training, adequate remuneration and the further development of inter-referral structures. At present, two-thirds of GPs (67%) refer to GP colleagues for services which they themselves do not provide.

A total of 94% of GPs have spent at least six months in a hospital post in Obstetrics and Gynaecology, although the relevance of the experience was questioned. Of the respondents, 53% held a Family Planning Certificate and 54% were satisfied with their training in women's health issues. Lack of skill and lack of demand were the main reasons given where specific services were not provided.

In order to strengthen and further develop a women's health service within general practice, GP training and continuing medical education need to be restructured. Inter-referral structures need to be consolidated, with clearly outlined parameters and an adequate remuneration package. Strategies are needed to raise public awareness of the services provided within general practice.

Introduction

Women's healthcare services have been identified as a priority area by government (Department of Health 1995). Policy documents express a commitment to a comprehensive, quality service for women – quality maternity and gynaecology services and appropriate preventative services ('Shaping a healthier future' and 'A Plan for Women's Health'). The importance of consumer choice of service provider is acknowledged. The central role of general practice is recognised as it best provides the ease of access and continuity of care identified as basic principles. These reports give an undertaking that the role of the general practitioner will be developed and strengthened.

The increasing demand by the consumer for a high quality and comprehensive service is also evident. Irish women's first preference for information, advice and women's healthcare services is their general practitioners, whether in the areas of family planning or menopause care (Wiley and Merriman 1996, Saffron Report 1999).

In a survey of women attending a family planning clinic, 20% of respondents did not have a GP and a further 20% classified their GP as "not sympathetic, competent or interested". 65% of this group had never been offered contraceptive advice and were unaware of whether their GP offered family planning services (O'Donovan et al 1992). A study of women attending another family planning clinic reported that 77% of attenders had a male GP while 67% would want to attend a woman practitioner for a cervical smear and 35% would want to attend a woman practitioner for contraceptive services (Smith 1996).

While the views of Irish women on reproductive healthcare services have been explored to a limited extent, the attitudes and opinions of GPs as providers of these services have not been investigated. A 1993 review of family planning in Ireland concluded that little formal information was available on the provision of contraceptive advice through general practitioners (Prendiville and Short 1993) and the information available has not greatly increased since then.

A previous 1995 survey of general practitioners (ICGP 1995) documented the nationwide availability of contraceptive services and showed an improvement in service provision from an earlier (ICGP 1987) survey. While 97.5% of respondents provided contraceptive services and 97.4% carried out cervical smears in 1995, there were some concerns that the respondents might not have been representative as the response rate was only 43%. No published data exists on the provision of other reproductive healthcare services, such as pregnancy counselling or combined antenatal care in general practice or on the factors which might make the provision of these services more likely or the existing barriers to the provision of a more comprehensive service.

Many developments in the area of women's reproductive healthcare involve general practitioners and have made it advisable that GP training in the area of women's healthcare be clearly outlined. These include:

- the national Breast Screening Programme
- the national Cervical Screening Programme
- the revised Maternity and Infant Care scheme
- the increasing demand for domiciliary births
- the publication of the report on Women and Crisis Pregnancy
- the publication of the government Green Paper on Abortion.

Information on existing services, barriers to services and educational needs are required to inform the development of women's health services.

Aims and Objectives

The aim of the study was to generate information that would direct the development and strengthening of women's reproductive healthcare service provision in general practice.

The specific objectives of the study were:

- to assess the range of family planning and reproductive health services currently provided in general practice
- to gain insight into GP attitudes to and perceptions of family planning and reproductive healthcare service provision
- to identify barriers to the provision of a comprehensive women's healthcare service and gaps in service provision
- to gather views on GP training in family planning and reproductive health
- to identify the material and financial resources required to further develop family planning and reproductive healthcare service provision in general practice.

Methodology

A combined qualitative and quantitative approach was employed. The qualitative element, in the form of focus group discussions, was devised to explore current attitudes to women's reproductive health issues and to assist in identifying specific areas to be addressed in the quantitative element, the questionnaire.

Focus Group Research

The study was initiated by conducting two focus group interviews with practising GPs in order to explore the range of views on the current status of and future developments in women's healthcare in general practice. An interview guide was developed from a review of the literature and the experience of the researchers. The guide included questions relating to service delivery, public awareness, GP education and skills development and remuneration for use during the course of the interview. Open-ended, unstructured and probing questioning techniques were used to allow answers to emerge from the discussion and encourage respondents to communicate underlying attitudes, beliefs, values and feelings so that the full range of views and experiences in the group might be explored.

Participants were selected to represent a variety of views on women's healthcare in general practice. One focus group was conducted in Dublin at the UCD Department of General Practice with seven participants (five women; two men) and the other in a hotel conference room in Athlone with six participants (four women; two men). For both interviews, one researcher acted as interviewer while the other acted as note-taker. Both interviews were recorded and the findings were analysed thematically under the broad categories of the interview guide.

For validation and approval, a copy of the first draft report arising from the analysis was distributed to each participant to check the degree to which it accurately reflected their views.

The Survey

The Questionnaire

Based on the findings from focus group research, a questionnaire was developed. It included the following components:

- demographic information
  - age, sex and geographic location of respondents
  - the work environment in terms of practice location and size
  - practice organisation and employment of a practice nurse
- the organisation of women's healthcare service delivery
- the existing level of women's healthcare service provision
- the barriers to the provision of women's healthcare and the needs in relation to optimising service provision

- the level of training received in family planning/women's health
- the promotion of women's health services and how this could be improved
- referral patterns for women's health issues.

The Pilot Survey

The questionnaire was piloted on a sample of 23 GPs selected on the basis of their expertise in family planning and/or research in general practice. A total of 21 completed questionnaires were returned (91% response rate).

The instrument was positively received by all respondents with respect to relevance, clarity and consistency. Feedback highlighted the need to link responses to questions on the barriers to service provision and referral arrangements to specific services. The questionnaire was modified accordingly for final printing.

Postcard Reply System

A postcard reply system, as described by Cahalan, was used to permit anonymity. A reply card identifying the respondent was sent with each questionnaire, which itself had no identifiers. The respondent was asked to return the completed questionnaire in the stamped addressed envelope provided and to return the stamped addressed reply card separately to indicate that (s)he had completed and returned the questionnaire. On receipt of the reply card, the respondent's name was removed from the dataset and no further mailing was sent.

The Sample

There is no official register of GPs in Ireland. The sample for this survey was drawn from the database constructed in 1997 by researchers from the Department of Community Health and General Practice at Trinity College Dublin (O'Dowd et al 1997). The database was formed by merging the Irish College of General Practitioners' membership database with doctors listed in the Irish Medical Directory, yielding a sample frame of 2,556 names and addresses. A random 30% sample (778), stratified by county, was drawn from that database for this study.

The Procedure

The first mailing was sent in June 1998 and consisted of the questionnaire together with a prepaid reply envelope, prepaid reply postcard and a cover letter explaining the purpose of the study.

A second mailing was sent in July 1998. Follow-up phone calls were made in August to non-responders.

Results: Qualitative Research Findings

Discussion in the focus groups centred on contraceptive service provision. The issues arising from the discussion of contraceptive services were broadly applicable to women's healthcare services. Therefore, no efforts were made to address other specific issues, in the interest of allowing a free-flowing discussion within the time constraints.

GP Training

There was broad support for the view that women's health is a distinct area of healthcare generally and of general practice in particular, and that it should be promoted as such throughout all levels of medical training. However, widespread dissatisfaction with the quality and level of training received in women's health and family planning emerged from both group interviews.

The incorporation of the gender perspective into undergraduate training was viewed as an important first step in sensitising all doctors to women's health issues.

> "Women's health should be promoted as an important issue from the first day of medical school because it's not something you can simply pick up as a postgraduate".

> "Women's health and family planning should be given priority right throughout training - it is currently only given lip service".

Not all trainees in general practice are offered a six-month hospital attachment in Obstetrics and Gynaecology. The perception is that those who have completed this attachment have gained little experience relevant to general practice and have received little or no specific training in family planning. This lack of training in family planning had prompted one participant to request leave to attend a family planning clinic to gain experience in family planning while a senior house officer at a maternity hospital in Dublin.

Another problem identified in vocational training schemes was the lack of registrars' exposure to internal examination, smear taking or specialist family planning skills such as IUCD and diaphragm fitting. This was attributed to sporadic demand and lack of adequate numbers of patients for any meaningful or consistent experience.

> "I don't put in coils or fit diaphragms because I don't have the experience, so where will I get the training and enough experience to be able to do this and provide the option in my practice? It's very difficult to train trainees in the context of general practice because the demand for these can be sporadic and the patients are not there".

> "Trainee GPs are getting no experience in family planning, some of them are doing no internal examinations or smears or getting no hands-on experience".

The ICGP strategy to train Instructing Doctors in family planning within each training practice was said to have limited potential to address the problem because of this lack of opportunity for practical experience. In order to overcome these constraints and the low priority currently given to women's health in general practice training, the introduction of a module in gynaecology where GP registrars could develop skills in examination and family planning skills emerged as an option for consideration.

Skills in counselling were specifically identified as an important feature of any training programme for GPs.

> "Counselling is a major part of family planning and needs to feature more in training".

Two levels of family planning service provision were identified. A basic level of training in family planning and women's healthcare was considered imperative for all GPs. It was also acknowledged that specialist skills such as IUCD and diaphragm fitting are only maintained over time when used on a regular basis. Sporadic demands do not permit all GPs to maintain these skills. Therefore, specialist training for GPs with a particular interest in being expert resource persons in family planning was also considered essential for the provision of a comprehensive and sustainable service in general practice.

> "I don't think everyone needs to be skilled in IUCDs and diaphragms. So long as there is someone in every area, it's not necessary that every practice should provide these".
>
> "We can provide a comprehensive service within general practice, without everyone necessarily being able to do everything themselves, provided we have the infrastructure to be able to refer patients".
>
> "There should be two levels of training, a basic level of training in family planning for all GPs and also specialised training for people who want to become expert resource persons in family planning. Unless you have specialists in family planning, you can't provide a comprehensive service in general practice".

The Irish Family Planning Association (IFPA) was widely credited as having been an excellent source for GP training in the past. But, with the increasing integration of family planning into general practice, the nucleus of expertise previously provided by the IFPA was said to be dispersing back into general practice. Because of this, concern was expressed about the risk of losing this important training resource. The onus was therefore said to be on the ICGP to ensure that core training in family planning continues to be made available. It was recommended that the ICGP should explore the feasibility of establishing specialist family planning clinics within general practice to facilitate continuing training.

> "My concern is that, as the emphasis changes away from IFPA clinics to general practice, I wonder if the ICGP would see fit to take over the training at the same level the IFPA was doing and I don't see how that can be encompassed by the ICGP without having specialised clinics set up within the ICGP".
>
> "If the emphasis is going to go from the [family planning] clinics to women's health in general practice, it must not only be on the provision of the service but also on the continuity of the service and that's something that will be lost unless the ICGP addresses it".
>
> "The training would have to be on the same intensive level like that provided by the IFPA so that people who are interested in being a resource person for women's health could come and learn the finer points in women's health and family planning so that they could go out and continue that".

Study leave for GPs was identified as an important incentive for updating knowledge and maintaining skills in women's health and family planning, but problems were identified with current study day opportunities. GP study days organised at maternity hospitals were said to be designed from the hospital doctor's perspective, without any input on the issues of interest to the GP. The focus of these programmes is perceived to be on medical technology and surgical procedures. Hospital consultants who generally run these meetings were said to be ill-equipped to comprehensively meet the training needs of GPs in the women's health area. Consultation with GPs was called for to ensure that these study days would be of relevance to general practice.

Organisation of Women's Healthcare

There was broad support for the view that the reproductive health needs of women could not be comprehensively addressed in isolation. The general health of the woman and of her family and the social context were considered to be important. The ability of the GP to view a woman's care holistically was considered to be one of the great strengths of general practice.

Family planning and women's healthcare were viewed by the majority of participants as an aspect of practice that was uniquely different from the management of physical illness and disease. Women themselves were said to view their reproductive health needs within the context of their overall health; other related health issues were likely to arise in the course of the consultation. The emotional dimension was also said to demand time for counselling and discussion.

While there was broad support for the view that family planning and other women's healthcare services should be provided on request, time constraints imposed by busy clinics and full waiting rooms were said to compromise the quality of service afforded during routine surgery. Having the option of running dedicated clinics was generally favoured as they allow more time for counselling and discussion and thus provide increased satisfaction for both women and doctors. However, dedicated clinics can be difficult to organise for both single-handed practitioners and group practices, for a variety of reasons. The lack of funding commitment to develop the necessary infrastructure in general practice was identified as an underlying constraint.

> "What I found with dedicated clinics was that I was relaxed and women sensed that when I gave each half an hour. They told me problems I never knew before that, despite having known them for years. I enjoyed it".

> "Time is a big issue for me as I am on my own. I can't devote an afternoon per week for family planning or smears because I don't have the time. I try to slot it into routine work but I'm rushed and women aren't as comfortable because they know others are waiting".

> "Dedicated sessions were nice because you had time for the patient but it depends on the size of your practice. Once it goes over a certain size it's very hard to fit in designated time".

> "Specialist clinics are very popular and can become very busy".

> "Infrastructure is a big constraint. If you don't have the space you can't provide extra services. Basic requirements are the building, rooms for space, equipment and staffing. Then time and resources, but who is going to pay for all of this? General practice has been under-funded for years, which we are only now addressing. Despite all the policies of the Department of Health with respect to general practice it's only in the last few years that money is being put into it and only as a result of our own efforts".

Remuneration

Widespread dissatisfaction about the fact that GMS smears do not attract a fee emerged in both group interviews. Concern was also expressed that the lack of financial incentives to perform smears opportunistically was a factor contributing to the disadvantage of GMS patients in the uptake of this important preventive health measure. Furthermore, the view that fees for family planning and women's healthcare in general fail to adequately reflect the time spent on counselling also emerged.

> "Where fees are concerned, there's no consideration given to the time that it takes to prescribe the pill, you cannot do it adequately in 10 minutes".

> "Payment systems are procedure-based as opposed to the time it takes to provide a particular service".

The Gender Perspective

There was broad support for the integration of the gender perspective at all levels of general practice from education and training through to policy and practice. The gender matching of service provider and patient was identified as a particular problem. Where gender choice is made available, many participants believed that women are more likely to request the female doctor, despite the fact that the male doctor in the same practice may have extensive experience in women's health.

> "In our practice, while I thought I was doing well in relation to women's health, our smear rates have sky rocketed since we got a female partner". (from a male GP)

> "When women are given a choice, the majority of them will choose the female doctor because they feel they can communicate better with them and they have a better rapport by virtue of the fact that they are women".

However, some differences of opinion emerged in relation to the importance women place on the gender of the doctor providing their care. Either way, there was widespread caution expressed about developing services along strict gender lines where women's health might become the exclusive prerogative of female GPs and men's health the prerogative of male GPs.

The development of gender-sensitivity in training, policies, practices and attitudes throughout general practice emerged as an overriding priority. Such developments were said to be necessary to promote services in general practice that are acceptable to women; to minimise the marginalisation of the practitioner on the basis of gender; and to ensure the development of appropriate, comprehensive and equitable reproductive health services for women nationally.

> "I think, from the woman's point of view, when you talk about male versus female GPs, I think it's important to offer choice; not that women GPs only provide women's health, but rather that they have a choice".

> "While many GPs are men, for some reason it has gotten into the psyche that only female doctors can provide family planning or menopausal counselling. I think there's a risk here that the male doctor is being marginalised in women's health, not by our colleagues but by the public and, unless we tackle that, large areas of the country are seemingly going to be poorly serviced with regard to women's health".

Chaperones

Widespread concern was expressed about the vulnerability of male GPs to litigation in relation to conducting physical examinations of women in the absence of a chaperone. Fear of litigation was said to be a relatively recent phenomenon. This needs to be addressed as a priority in order to reduce the risk of male GPs opting to exclude themselves from women's healthcare provision.

> "I think that unless the issue of chaperoning is addressed, male GPs like myself may have to step back a bit from women's health. For example, if I have a young woman whom I've only seen once before coming to me at 7.30 in the evening requiring a vaginal examination, do I examine her or not? I think this is a horrendous new issue that we have to face".

> "I also think we are moving into a society where we cannot ever as a male GP examine a woman without a chaperone".

> "For men its not just for family planning that chaperoning is required - its the minute you lay a hand on someone's shoulder to do anything".

In order to strengthen the role of the male GP in women's reproductive healthcare, clear guidelines about acceptable boundaries and standards of practice in relation to personal examination of women by male GPs were said to be required as a priority. This need was felt to be particularly pressing in light of the RCOG recommendation that a chaperone should normally be present during a pelvic examination (RCOG 1997).

The employment of a practice nurse was widely viewed as a realistic solution to the provision of a chaperone but financial constraints were identified as a significant hindrance. A number of options were suggested to provide funding for the employment of practice nurses. These included:

- dedicated funding from the Department of Health for women's health service provision in general practice
- financial support from the health boards
- use of savings from the Indicative Drug Targeting scheme
- the cost of private consultations could be increased to fund the employment of practice nurses.

Ethical Issues

Reflecting the ethical dilemmas with respect to extra-marital sexual activity which persist for a significant minority in Irish society generally, a minority of GPs were also said to have ethical dilemmas about the provision of family planning services for women outside of marriage. There is a general perception that this group is proactive in promoting their moral objections publicly. However, in the context of little being done to promote the availability of family planning in general practice, participants believed that the views of the minority were perceived by the public to be applicable to all GPs.

> "There is a public perception that doctors are judgmental about sex outside of marriage and some of them are – they take a moral stance and make themselves very well known about their views while the rest of us sit back like armchair liberals not doing anything about it… the anti-contraception view predominates, even though they are in the minority".

The issue of morality was said to be a particular barrier in relation to the provision of emergency contraception although this was not confined to general practice. One participant also recalled the rejection by the Irish Family Planning Association of posters that proved particularly effective in promoting public awareness of emergency contraception in the UK. Religious biases in hospital policy were also said to exclude the provision of emergency contraception in many hospital family planning clinics.

In the context of general practice, there was a general agreement that emergency contraception was not as widely available as other contraceptive methods and that women living in rural areas are disadvantaged compared with women living in the cities. One participant recalled a woman who described being referred to as "a heathen" by a GP from whom she requested emergency contraception. Another participant pointed out the need for a compassionate approach when contraceptive errors occur.

> "We have to take a stance and help people where mistakes occur for them and where there is a risk of pregnancy, to be able to give them emergency contraception when they come looking for it".

Strategies to develop supportive attitudes and respect for the choices women make were considered important. Participants also called for a policy that clearly defines what family planning service provision in general practice entails and whether or not emergency contraception is part of it. The development of structures to promote a culture of inter-referral within general practice was also considered essential.

Inter-Referral

There was broad support for a position statement on professional obligations in relation to inter-referral so that the needs of the patient would not be compromised by the moral views and ethical dilemmas of the practitioner.

> "Definitely there are doctors who don't provide emergency contraception and don't tell patients where they can go to get it".

> "If GPs have ethical dilemmas about family planning or the emergency pill they should at least be prepared to refer people to those who are willing to do it. We need to clarify our position on this and whether or not there's an obligation on the GP who has difficulties about it to refer patients on to their colleagues".

There was also the view among participants that some women prefer to be anonymous and choose a doctor other than their family doctor for their contraceptive services and smear tests. In order to accommodate such choices:

> "There should be a family planning information service in each county where women could ring up and find out about who can they go to for the different services".

In the context of specialist skills being difficult to maintain because of sporadic demands, there was broad support for the establishment of a national register, which would identify those with specialist skills, to facilitate inter-referral. It was suggested that the ICGP should maintain this register. This would allow the provision of a comprehensive service while respecting the moral principles of those who do not wish to provide certain services. It would also facilitate a woman's choice of doctor for women's health services. Unlike the hospital setting where doctors commonly refer patients to each other, a culture of inter-referral is not associated with general practice. This was said to be gradually changing.

> "It would be useful if we had a register within the ICGP of GPs who do family planning and people with specialist skills. In my CME group, we have a list of people with skills in joint injection and other areas. A register in relation to family planning would also be very helpful".

> "The way we do it is that I don't do IUCDs but my female partner does; so I refer to her and she sends them back to me, which works fine. If there was more communication, there's no reason why doctors down the road couldn't also do the same".

> "We need a degree of openness about what we are good at; we can't all be good at everything. For example, I might be good at family planning but I'm no good on backs, so I send my patients down the road to a colleague who is".

However, while the development of a national register was considered imperative for the effective provision of women's healthcare in general practice, the expectation that some GPs would be

reluctant to publicly disclose their provision of 'controversial' contraceptive methods highlighted an important barrier that could prove difficult to surmount.

> "Some people won't want to put their name down because it could be more trouble than it's worth if you're going to get flack from your colleagues".

> "Providing contraception is not the same as providing emergency contraception. This is a very sensitive area and there has to be a consensus through the ICGP about whether people are going to be willing to put their names on a register and whether they can make this public".

Other potential difficulties were also identified in the development of inter-referral structures within general practice. The concern that inter-referral could potentially result in patients transferring their care was one such issue. That would need to be addressed.

> "so you wouldn't feel threatened that your patient wouldn't come back to you".

While the GMS scheme currently pays fees for inter-referral in some circumstances, such fees are not widely known, or claimed. The adequacy of existing referral fees needs review. Furthermore, while inter-referral for specific items such as smears or IUCD insertion might appear straightforward, other health issues often arise during the course of the consultation. This suggests a need to establish clear parameters for inter-referral.

Public Awareness

Evidence from Irish studies of the prevailing lack of knowledge by the public about the availability of women's healthcare, particularly contraception, in general practice was discussed. It was attributed to the fact that, unlike the Irish Family Planning Association and Well Woman clinics, no concerted proactive approach has been adopted to increase public awareness of the availability of such services in general practice.

Practice leaflets and posters in GP surgeries were considered useful but they are only accessible to those who visit the surgery. They fail to reach young women and teenagers who were generally less likely to visit the GP. Given that family planning is an important public health issue, sustainable social marketing campaigns by the Department of Health and the ICGP at national level, and by GPs at local level were viewed as important strategies to increase public awareness and strengthen family planning service provision in general practice. The view was also shared that such campaigns should address the gender issue and inform the public about the availability or otherwise of gender choice in relation to service providers in general practice.

> "I think the ICGP could do more to promote the availability of family planning by GPs through the print media, by placing ads in the national and local papers and in the tabloids to get broad coverage".

> "Collectively though we all have a role. Last year our faculty put an advertisement in the local paper but like any communication, it should be constant, once-off ads don't achieve much".

> "GPs are not out there engaging with the media like other practitioners in other areas. GPs should be out there promoting family planning on radio chat shows like RTE radio and 98FM, and local radio stations".

> "Family planning should be advertised in every pub and night club in the country, men's loos, women's loos, secondary schools, hospital waiting rooms, pharmacies. Leaflets should be given out by pharmacies about all methods of contraception".

> "Women should know whether or not they have the choice to see a female GP locally".

The importance of opportunistic promotion of family planning was also discussed, particularly for women at the extremes of the reproductive age. Women in their forties may be unaware of their risk of getting pregnant or unaware of the unreliability of natural family planning methods during the perimenopause. The need to promote awareness among teenagers of the availability of contraceptive services in general practice and to meet the specific needs of this age group was particularly stressed. Because of concerns about confidentiality, teenagers were said to be less likely to attend their family doctor, whom they perceived as parental peers, so that:

> "sadly the only time you pick them up is when they come for the morning-after pill".

The involvement of GPs in school health education programmes was viewed as an important means of dispelling such concerns and of promoting general awareness of the availability of contraception in general practice. Such programmes should not only address the biology of reproduction and facts about contraception, but also encompass sexuality and personal development. However, the experience of those participants who had engaged in school health education programmes was that the topic of sexuality and contraception was a most contentious one, not only for teachers and heads of schools, but also for parents on the boards of management.

> "I went into a school but I wasn't welcome to go back there. They also had a nun who was talking to them about abortion and the red blood around the seas of Ireland who had her facts all wrong. So instead of having a talk about personal development and sexuality, they were asking me if this and that really happened. We went through the stages of development and the cycle and about when you get pregnant etc. but it was unacceptable".

> "Back in the 60s and 70s, the emphasis was on teaching facts about contraception etc. but more recently they're finding that the more the child is empowered to have self respect and sexual awareness, the more they delay sexual activity... you can't teach contraception without looking at issues around sexual identity and self esteem and the self development of the child".

> "I'm involved as the doctor to a private boarding school and I asked if they wanted me to address the issue of sexuality and it was no, no, no".

Summary

There was considerable consensus that it is possible to provide a comprehensive women's health service within general practice but that the provision of such a service requires restructuring of both training and service delivery, with an emphasis on a preventive approach. Remuneration for GPs should adequately reflect the time required to provide such services and public awareness campaigns are needed to ensure that women know what services are available, and how to access them.

Results: Quantitative Research Findings

Response

The sample was initially cleaned by the researchers resulting in the deletion of 25 names. The reasons are given in *Table 1*. The first mailing (753 questionnaires) yielded 314 usable questionnaires and the deletion of a further 38 invalid names from the dataset (*Table 2*). In the second mailing 446 questionnaires were circulated. Questionnaires were completed and returned by 97 and a further 43 doctors who were no longer in practice were deleted from the dataset. The follow-up phone calls resulted in a further 34 names being deleted from the dataset and 46 questionnaires were posted to those GPs who had mislaid the previous ones. Of these, 39 were returned.

From a valid sample of 638, 450 doctors returned completed questionnaires. This represents a response rate of 70.5%. *Table 3* shows the response rates from each county.

Initial sample			778
Deletions:	Focus group	3	
	Pilot survey	5	
	Duplicate entries	3	
	Not currently in general practice	6	
	Retired	8	
	Total	**25**	
Adjusted sample			753
Subsequent	Retired from general practice	45	
deletions:	Deceased	10	
	Not currently in general practice	13	
	Change of address/'gone away'	17	
	Duplicate entries	3	
	On summer holiday	23	
Anonymous:	Not currently in practice	2	
	Retired from general practice	2	
	Total	**115**	
Valid sample			638

Table 1: Sampling procedure

First mailing:	**753 questionnaires and postcards sent**
	▮ 352 (46.7%) questionnaires returned
	▮ 305 (40.5%) reply cards returned
	▮ 2 (0.2%) explicit refusals
	▮ 399 (52.9%) no reply
Second mailing:	**446 questionnaires and postcards sent**
	▮ 140 (31.4%) questionnaires returned
	▮ 85 (19.0%) reply cards returned
	▮ 5 (1.1%) explicit refusals
	▮ 301 (67.4%) no reply
Phone-calls:	**84 contacts made**
	▮ 23 on holiday ▮ 3 'gone away'
	▮ 5 retired ▮ 2 not in practice
	▮ 1 deceased ▮ 13 explicit refusals
	▮ 46 questionnaires requested as previous ones lost
	– 39 questionnaires returned
	– 19 reply cards returned

Table 2: Survey procedure

County	Original sample	Deletions	Final sample	Response rate: Number	%
Carlow	9	1	8	4	50.0
Cavan	10	3	7	6	85.7
Clare	19	2	17	11	64.7
Cork	97	15	82	51	62.2
Donegal	28	7	21	17	80.9
Dublin	237	47	190	123	64.7
Galway	51	6	45	26	57.8
Kerry	30	5	25	17	68.0
Kildare	24	6	18	13	72.2
Kilkenny	12	1	11	7	63.6
Laois	9	2	7	2	28.6
Leitrim	4	-	4	2	50.0
Limerick	32	7	25	15	60.0
Longford	5	1	4	2	50.0
Louth	18	5	13	10	76.9
Mayo	24	2	22	12	54.5
Meath	21	3	18	12	66.7
Monaghan	10	4	6	6	100.0
Offaly	11	2	9	6	66.7
Roscommon	9	1	8	3	37.5
Sligo	14	-	14	7	50.0
Tipperary	27	2	25	14	56.0
Waterford	18	2	16	7	43.8
Westmeath	17	3	14	6	42.8
Wexford	20	3	17	9	52.9
Wicklow	22	6	16	14	87.5
Anonymous		4	-4	48	
Total	**778**	**140**	**638**	**450**	**70.5**

Table 3: Response to survey stratified by county

Demographic Characteristics

Personal characteristics	Study sample (n=450) (%)	National GP profile (%)	
Age distribution			
26-35	9.7	17	
36-45	38.6	37	
46-55	33.5	29	
56-65	9.7	10	
66+	4.8	7	
missing	3.3	1	§
Gender ratio M:F	70:30	70:30	§
Vocationally trained	49	40	§§
Practice characteristics			
Location of practice			
Urban	37.3	44.2	
Rural	21.5	18.3	
Urban-rural mixed	41.1	37.5	§§
GP Partnerships			
Single-handed	37.1	42	
Group practices	62.7	58	§
Composition of practice			
GMS list	86.2	73	
Private-only	8.6	8	§
Practice nurse	46.0	31	§§

§ ICGP, 1997 (n=2427); §§O'Dowd et al, 1997 (n=703)

Table 4: Characteristics of study sample compared to GPs nationally

Age and Gender

Three quarters of GPs in the sample were between the ages of 36 and 55 and the mean age was 46 years. Of the sample, 30% were female, ranging from 28 to 68 years (mean 43.2 years). Males constituted 70% of the sample, ranging from 29 to 74 years (mean 47.8 years). *Fig. 1* compares the age profile of the study sample with that of all practising GPs in the Republic of Ireland (ICGP 1997).

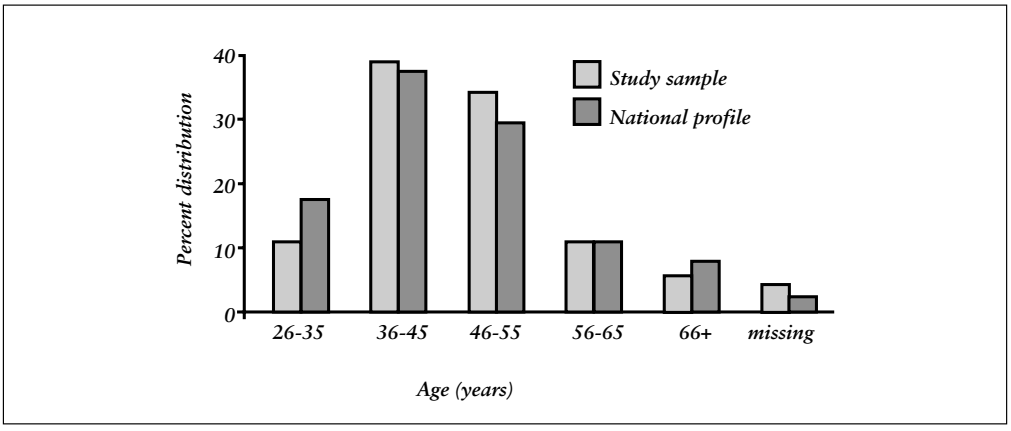

Fig. 1: Age distribution of the study sample compared with age distribution of GPs nationally

The predominance of males within the dataset (70:30) also reflects the gender mix of GPs nationally. However, of those under 40 years of age, 52 (50.5%) were female while 51 (49.5%) were male.

Practice Characteristics

Location of practices, GP partnerships and composition of practices broadly reflect the national profile and suggest that the respondents are representative of Irish general practice.

The higher proportion of respondents in group practice and the higher number of practice nurses reflect developments in the organisation of general practice since the earlier national profile.

Gender Mix in General Practice

While 58 (12.9%) practices had no male doctor, a significantly higher proportion (35.4%) had no female doctor active within the practice. Rural practices were poorly serviced with regard to female GPs compared to urban practices (52.5% and 34.5%; $p<0.01$) (*Table 5*).

	Frequency	Percent
Urban (n=167)	58	34.7
Rural (n=97)	51	52.6
Urban-rural mixed (n=185)	50	27.0
Total (n=450)	**159**	**35.4**

Table 5: Distribution of practices without a female doctor by location

A total of 207 (46.0%) GPs had a practice nurse. Over half (52%) of rural and mixed practices employed a nurse compared to 35.7% of urban practices (*Table 6*). Practice nurses were also most commonly employed in group practices.

	Frequency	Percent
Urban (n=168)	60	35.7
Rural (n=97)	45	46.3
Mixed (n=185)	102	55.1
Single-handed (n=167)	42	25.1
One partner (n=133)	61	45.9
Multiple partners (n=149)	104	69.7
Total (n=450)	**207**	**46.0**

Table 6: Distribution of practices employing a nurse by location and practice organisation

Of the 159 male-only practices, 58 (36.5%) employed a practice nurse compared to 51.2% of the 291 mixed gender practices. Of all 450 practices, 102 (22.6%) employed neither a female GP nor practice nurse, the greater proportion of these being rural practices (*Table 7*).

	Frequency	Percent
Urban (n=168)	44	26.1
Rural (n=97)	27	27.8
Mixed (n=185)	31	16.7
Total (n=450)	**101**	**22.4**

Table 7: Distribution of practices with no female GP or practice nurse

Respondents were asked to classify their view on the statement *"Female patients should always be offered the option of seeing a female GP or nurse for family planning / women's healthcare"*. The majority (69.7%) were in favour of gender choice (*Fig. 2*).

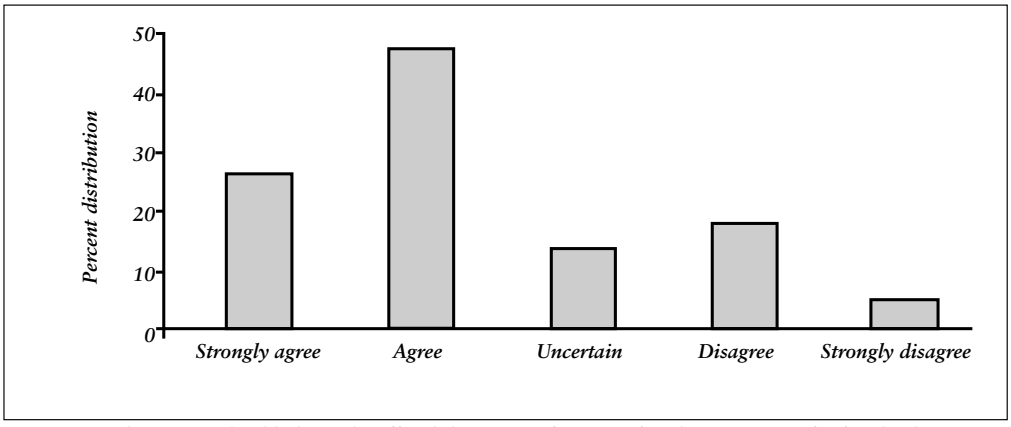

Fig. 2: "Female patients should always be offered the option of seeing a female GP or nurse for family planning/ women's healthcare" (n=445)

Significantly more male than female GPs opposed gender choice in family planning / women's healthcare (22.4% and 9.0%; $p<0.01$); otherwise there was no association with age or practice location. There was no association between the views of male GPs on gender choice and the availability of a female GP or nurse in their practices.

Respondents were also asked to similarly classify their view on the statement *"A female chaperone should always be present during personal examination of female patients by male GPs"* (*Fig. 3*). Views varied with 162 respondents (36.3%) in favour of male GPs always being chaperoned and 184 (41.1%) opposed to the need for a chaperone.

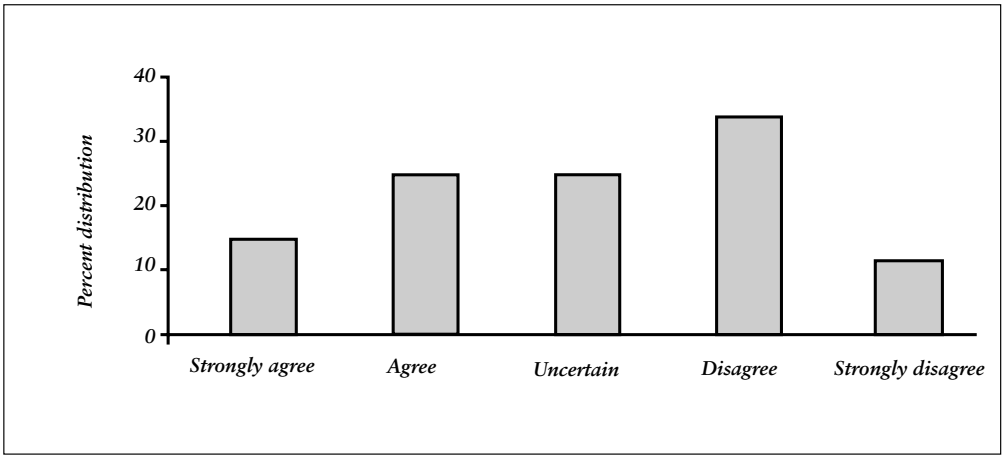

Fig. 3: "A female chaperone should always be present during personal examination of female patients by male GPs" (n=447)

Significantly more men than women opposed the need for male GPs to be chaperoned (47.4% and 26.3%; $p<0.01$); otherwise there was no association with age or practice location. The views of male GPs on chaperoning were not associated with the employment of a practice nurse.

The Provision of Family Planning Services

Almost all GPs provide hormonal contraception and over 90% provide sterilisation counselling and emergency contraception (*Table 8*).

	Frequency	Percent
Hormonal contraception	438	97.3
Sterilisation counselling	411	91.3
Emergency contraception	407	90.4
Natural family planning advice	373	82.8
Diaphragm advice	326	72.4
Diaphragm fitting	148	32.8
IUCD advice	310	68.8
IUCD fitting	77	17.1
Vasectomy operation	27	6.0

Table 8: Provision of family planning services (n=450)

The provision of hormonal contraception, emergency contraception, natural family planning advice and vasectomy operation did not vary with age, gender or practice location.

Sterilisation counselling was provided by significantly more GPs aged 40 years and under than those over 40 years (96.9% and 89.1%; $p<0.05$).

Diaphragm advice was also provided by significantly more GPs in the younger age group and by women more than men. Female GPs were significantly more likely to offer diaphragm fitting than male GPs (51.1% and 25.2%; $p<0.01$). Diaphragm fitting was also more likely to be provided by those aged 40 years and under than the older age group (42.9% and 28.8%; $p<0.01$); by rural and urban-rural mixed GPs than urban GPs (39.0% and 22.6%; $p<0.01$); by those who had worked in a family planning clinic than those who had not (60.3% and 28.5%; $p<0.01$) and by those who held a Family Planning Certificate than those who did not (73.0% and 27.0%; $p<0.01$). Of the 386 GPs who considered their smear-taking skills to be satisfactory, 64.2% did not fit diaphragms, although this rate was significantly better ($p<0.01$) than for those who were ambivalent or dissatisfied with their smear-taking skills (84.4%).

IUCD advice was also provided by significantly more women than men (75.9% and 65.9%; $p<0.05$) and by the younger age group more than those over 40 years (82.0% and 63.7%; $p<0.01$). GPs with a practice nurse were significantly more likely to fit IUCDs (23.2% and 11.9%; $p<0.05$). IUCD fitting was also more likely to be provided by those who had worked in a family planning clinic than those who had not (39.7% and 13.5%; $p<0.01$) and by those who held a Family Planning Certificate than those who did not (25.6% and 7.6%; $p<0.01$). Urban GPs were less likely to fit IUCDs than those in rural and mixed practices (8.3% and 22.4%; $p<0.01$).

Adequacy of Family Planning Services for Specific Groups

Respondents were asked about the adequacy with which the family planning needs of specified subgroups were met in their practice. The needs of teenagers emerged as those perceived to be most inadequately met (*Table 9*).

	Frequency	Percent
Private patients (n=438)	416	94.9
GMS patients (n=408)	378	92.6
Women in their 40s (n=441)	407	92.2
Teenagers (n=436)	366	83.9

Table 9: Adequacy of family planning services for specified subgroups

Attitudes to Family Planning in General Practice

Respondents were also asked to classify their view on the statement "*Family planning is an integral aspect of general practice*" and the majority (93.5%) agreed with it (*Fig. 4*).

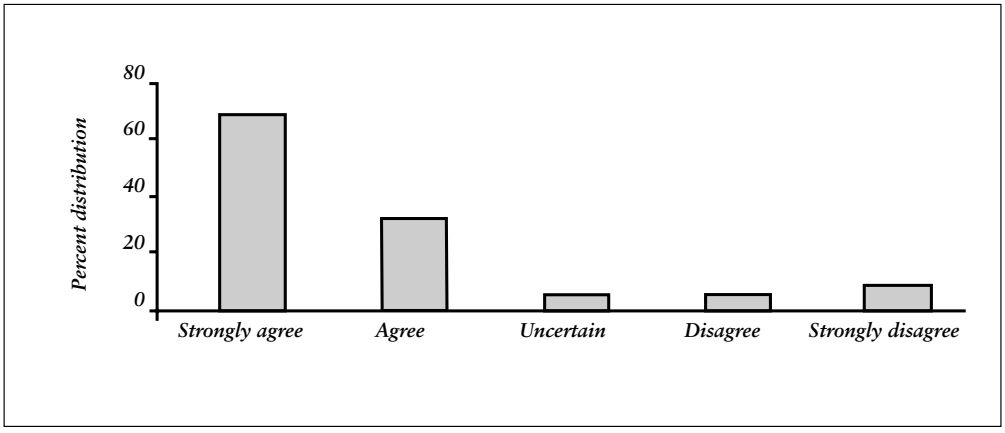

Fig 4: "Family planning is an integral aspect of general practice" (n=448)

Respondents were asked to classify their view on the statement "*The provision of a comprehensive family planning service is not feasible in the context of general practice*" and the majority (86.3%) disagreed with it (*Fig. 5*).

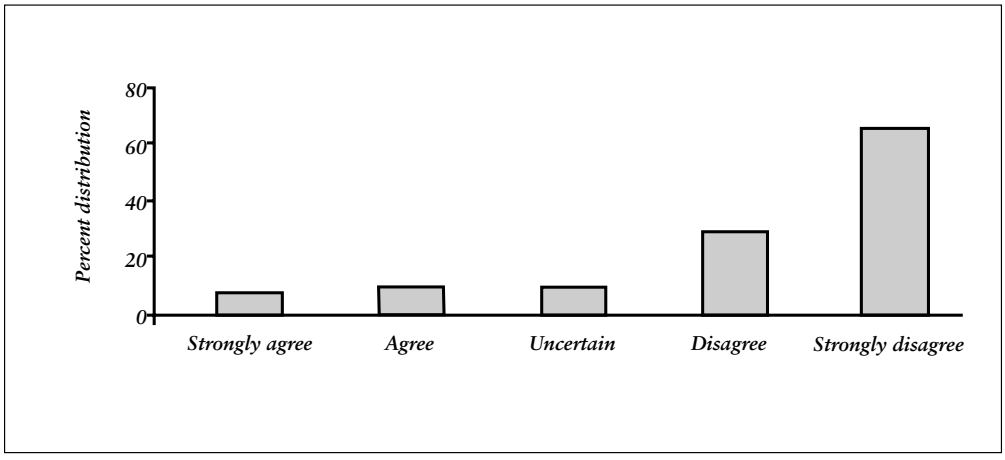

Fig. 5: "The provision of a comprehensive family planning service is not feasible in the context of general practice" (n=445)

The Provision of Women's Healthcare Services

Over 95% of respondents provided breast examination, combined antenatal care, menopause counselling, cervical smear tests and pregnancy counselling (*Table 10*).

	Frequency	Percent
Breast examination	448	99.5
Combined antenatal care	443	98.4
Menopause counselling	442	98.2
Cervical smear testing	429	95.3
Pregnancy counselling	429	95.3
Medical care after abortion	398	88.4
Psychosexual counselling	252	56.0
Home delivery	13	2.8

Table 10: Provision of women's healthcare services (n=450)

Cervical smear tests were provided by significantly more younger GPs than those over 40 years (99.2% and 93.8%; $p<0.05$); by those who held a Family Planning Certificate than those who did not (99.2% and 91.0%; $p<0.01$) and by those who had a practice nurse than those who did not (99.5% and 91.8%; $p<0.01$). Single-handed GPs were significantly less likely to provide cervical smear tests than those in group practices (90.4% and 98.2%; $p<0.01$). Furthermore, a negative self-assessment of smear-taking skills was significantly ($p<0.01$) related to the lack of cervical smear service provision.

Pregnancy counselling was also provided by significantly more GPs in the younger than the older age group (100.0% and 93.5%; $p<0.01$) and by those who hold a Family Planning Certificate than those who did not (99.2% and 91.0%; $p<0.01$). Medical care after abortion was more likely to be provided by those GPs who had worked in a family planning clinic than those who had not (96.8% and 87.0%; $p<0.05$) and by those who hold a Family Planning Certificate than those who did not (92.9% and 83.4%; $p<0.01$).

Mixed views emerged in response to the statement *"The role of the GP in antenatal care is under-utilised"*, although a majority (59.5%) agreed with the statement (*Fig. 6*). GPs in urban practices were significantly more likely to believe that their role in antenatal care was under-utilised than rural and urban-rural mixed GPs (67.3% and 53.9%; $p<0.05$); otherwise views on the issue did not vary with either age or gender.

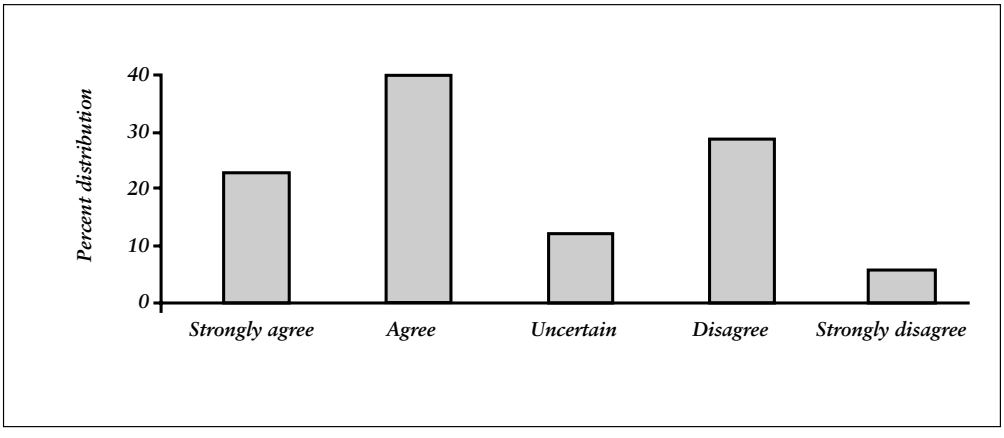

Fig. 6: "The role of the GP in antenatal care is under-utilised" (n=445)

Barriers to the Provision of Family Planning and Women's Healthcare Services

Where specific family planning or women's health services were not provided, respondents were asked to indicate the reasons for this. Lack of skill was by far the most common reason for the lack of service provision (*Table 11*).

	Frequency	Percent
Lack of skill	356	79.1
Lack of demand	207	46.0
Lack of facilities	150	33.3
Lack of time	127	28.2
Inadequate remuneration	74	16.4
Moral principle	60	13.3
Gender barrier	54	12.0
Lack of medical back-up	15	3.3
Fear of litigation	13	2.8

Table 11: Reasons for not providing family planning or women's health services (n=450)

Female GPs were significantly more likely than male GPs to identify lack of skill as the reason they did not provide services (87.2% and 75.7%; $p<0.01$). However, when the lack of skill in relation to vasectomy operation was removed from the equation, gender differences were no longer significant. 13 respondents commented that lack of skill in specific areas was directly related to the lack of demand.

Single-handed GPs were significantly more likely to identify the lack of facilities as the reason for not providing services than those working in group practices (43.1% and 27.1%; $p<0.01$). Those aged over 40 years were significantly more likely to identify moral principles as the basis on which they did not provide services than those aged 40 years and under (15.8% and 7.0%; $p<0.05$). Not surprisingly, significantly more men than women identified gender barrier as the basis on which they did not provide services (14.2% and 6.8%; $p<0.05$). Otherwise, reasons for the lack of service provision did not vary significantly with the other background variables.

Emergency Contraception

Of the 43 GPs who did not provide emergency contraception, 34 (79.0%) did not provide services on the basis of moral principle and 14 (32.5%) specified that they did not provide emergency contraception on this basis.

Other Family Planning Services

Of the 77 GPs who did not provide natural family planning advice, lack of demand was most commonly stated as the reason why this service was not provided. Among those who did not provide diaphragm fitting, IUCD fitting or vasectomy operation, lack of skill was most commonly stated as the reason why these services were not provided (*Table 12*).

Respondents were asked to classify their view on the statement *"Specialist skills in diaphragm and IUCD fitting are necessary for all GPs"*. While views were somewhat mixed, the majority (71.4%) did not believe that such skills were necessary for all GPs (*Fig. 7*). However, male GPs were more likely than female GPs to believe that such skills were universally necessary (20.8% and 8.3%; $p<0.01$) and those aged over 40 years were also more likely than younger respondents to believe that such skills were necessary (22.0% and 4.7%; $p<0.01$). Otherwise, views on the issue did not vary with practice location or with the provision of IUCD or diaphragm fitting.

	NFP advice (n=77)	Diaphragm fitting (n=302)	IUCD fitting (n=373)	Vasectomy (n=423)
Lack of skill	15.6	26.8	37.5	41.2
Lack of demand	18.2	14.9	16.3	2.6
Lack of time	5.2	4.3	3.7	4.4
Inadequate remuneration	3.9	2.6	2.4	2.3
Gender barriers	-	4.3	2.1	1.6
Moral principle	-	0.3	6.4	-
Lack of facilities	-	3.3	8.5	8.9

Table 12: Reasons for not providing natural family planning advice, diaphragm fitting, IUCD fitting and vasectomy (percent)

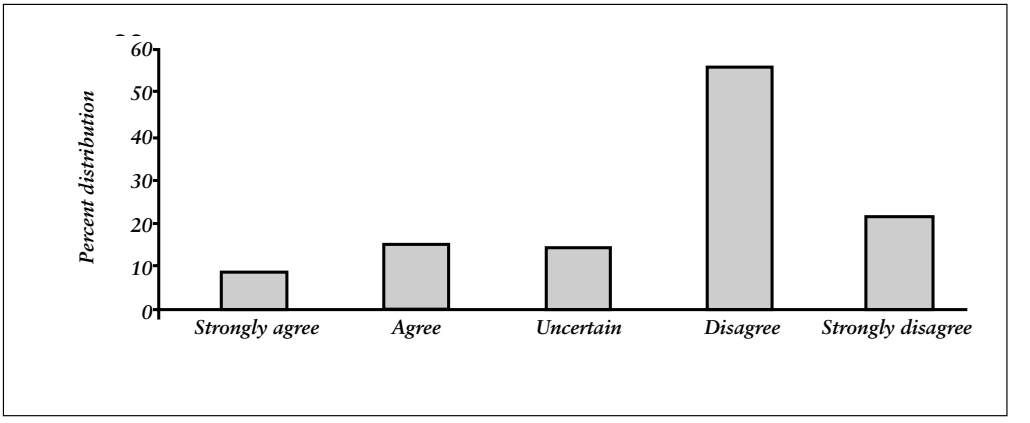

Fig. 7: "Specialist skills in diaphragm and IUCD fitting are necessary for all GPs" (n=445)

Other Women's Healthcare Services

Lack of skill was the most commonly stated reason for not providing psychosexual counselling and home birth services (*Table 13*).

	Psychosexual counselling (n=198)	Lack of home birth service (n=437)
Lack of skill	29.2	17.6
Lack of demand	5.0	11.2
Lack of time	13.6	10.2
Lack of facilities	-	8.2
Inadequate remuneration	2.0	3.8
Lack of medical back-up	-	3.4
Fear of litigation	-	2.2

Table 13: Reasons for not providing psychosexual counselling and home birth services (percent)

Twenty-one GPs did not provide cervical smear tests. Six of this group cited the gender barrier as the reason, all of whom were male with no female GP or nurse employed in the practice.

Of the 52 GPs who did not provide medical care after abortion, 13 (25.0%) did not provide family planning and women's healthcare services generally on the basis of moral principle though only one (1.9%) specified that they did not provide medical care after abortion specifically on this basis. Thirteen (25.0%) cited lack of demand as the reason why medical care after abortion was not provided.

Respondents were also asked to classify their view on the statement that "*Childbirth should ideally take place in hospital*" and the majority (81.4%) agreed with it (*Fig. 8*). Views on the place of birth did not vary significantly with age, gender, practice location or the provision of home birth services.

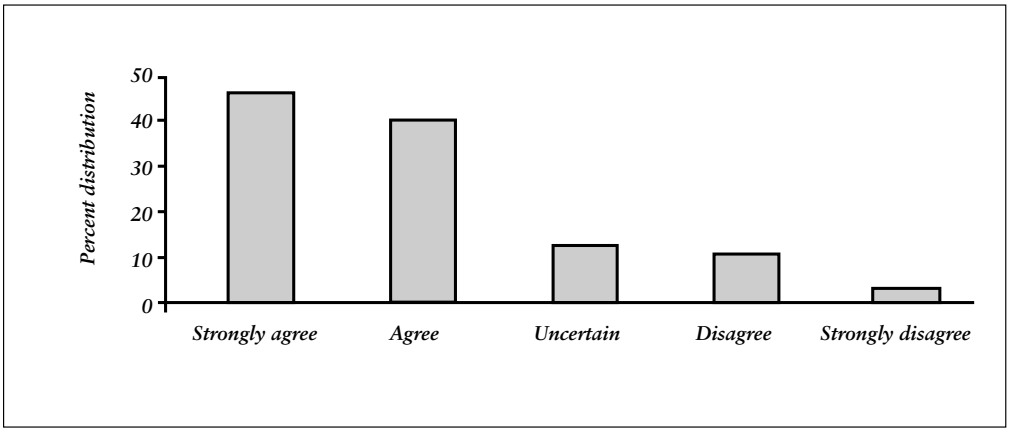

Fig. 8: "Childbirth should ideally take place in hospital" (n=447)

Referral Patterns

One respondent provided all specified family planning and women's healthcare services. Of the remaining 449 respondents, 431 (96.0%) referred patients for the services that they did not provide and 18 (4.0%) did not.

Of the respondents, 303 (67.4%) referred within general practice, 270 (60.1%) referred to family planning clinics and 151 (33.6%) referred to hospital services. Referral within general practice was evenly spread across age, gender and practice location. Significantly more female than male GPs (69.2% and 56.2%; p=0.01) and significantly more urban than rural GPs (68.5% and 52.6%; p=0.01) referred patients to family planning clinics. Those aged over 40 years were significantly more likely than younger GPs to refer patients to hospital services (60.9% and 48.4%; $p<0.05$).

Respondents were asked to specify the services for which they referred patients. Referral within general practice was most commonly for vasectomy operation, referral to family planning clinics was most commonly for IUCD fitting and referral to hospital services was most commonly for vasectomy operation (*Table 14*).

	General practice (n=303)	Family planning clinic (n=270)	Hospital services (n=151)
Vasectomy	38.2	18.1	37.7
IUCD fitting	28.0	29.6	9.2
Diaphragm fitting	13.8	15.1	-
Psychosexual counselling	2.6	5.1	13.2
Smear tests	1.9	0.3	-
IUCD advice	0.9	1.8	-
Emergency contraception	0.6	1.4	-
NFP advice	-	1.1	-

Table 14: Services accounting for referral within general practice to family planning clinics and hospital services (percent)

Respondents were asked to classify their view on the statement *"A national register of GPs who specialise in family planning should be established to facilitate inter-referral within general practice"*. The majority (73.1%) agreed with the statement (*Fig. 9*). A slightly higher proportion of those who referred patients within general practice agreed with the statement than those who did not refer, though the difference was not statistically significant (74.9% and 68.0%).

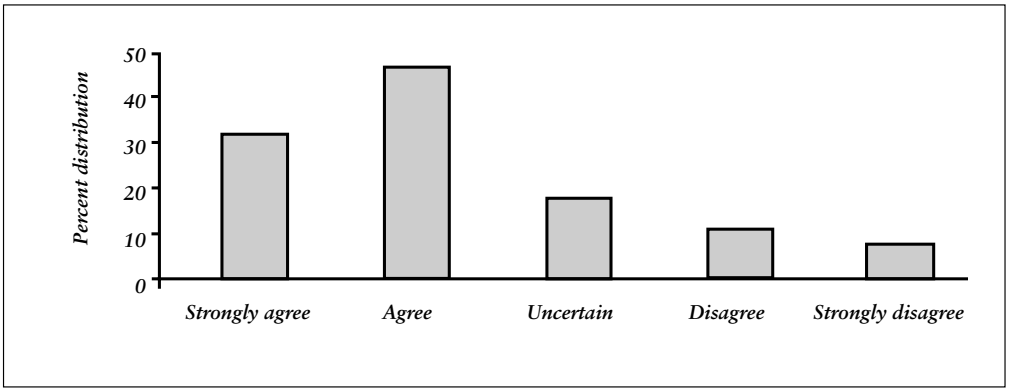

Fig. 9: "A national register of GPs who specialise in family planning should be established to facilitate inter-referral within general practice" (n= 447)

Respondents were asked to classify their view on the statement *"GPs who do not provide family planning on moral principle should refer patients to colleagues who do"* and the majority (86.6%) agreed with it (*Fig. 10*). There was no association with any of the background variables. Of the 60 GPs who did not provide services on the basis of moral principle, 35 (58.3%) agreed or strongly agreed with the statement, 18 disagreed or strongly disagreed, while six were uncertain.

A claim for family planning inter-referral fees was made by 30 GPs (6.6%) under the GMS scheme, while 418 (92.8%) had never made such a claim.

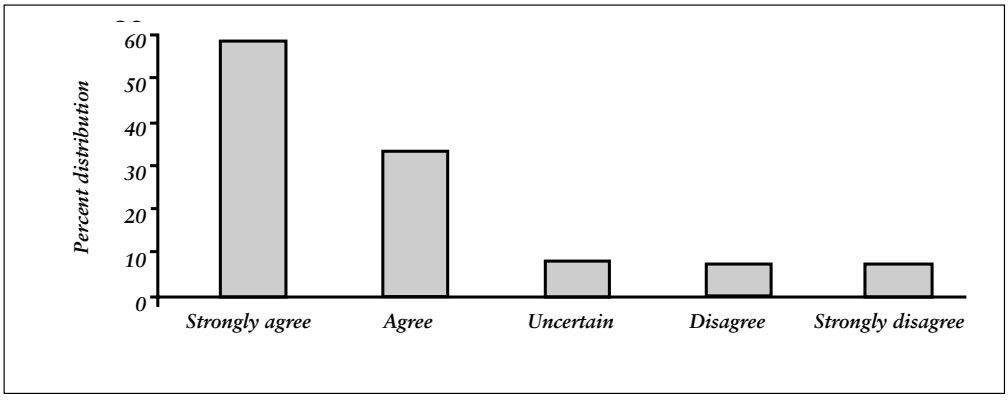

Fig. 10: "GPs who do not provide family planning on moral principle should refer patients to colleagues who do" (n=447)

Organisation of Women's Healthcare Services

Family planning and women's healthcare services are provided by 283 GPs (62.9%) during routine surgeries only; by seven (1.6%) through dedicated women's health clinics only; by 158 (35.1%) through a combination of both; two (0.4%) did not respond. There was no association with age. A higher proportion of female than male GPs provided the combination of both services, though the difference was not significant (41.4% and 32.5%). Significantly more rural than urban GPs provided the combination (41.2% and 28.6%; $p<0.05$), as did significantly more GPs working in group practices than single-handed GPs (42.8% and 22.2%; $p<0.01$).

A total of 338 GPs (75.2%) believed that women's healthcare could best be delivered through a combination of dedicated clinics and routine surgeries; 87 (19.3%) during routine surgery only; 19 (4.2%) during dedicated women's health clinics only and six (1.3%) did not respond. Five of those who did not respond commented that local circumstances and individual practice arrangements should dictate delivery arrangements, while 33 respondents volunteered reasons for preferring the combination. These can be classified as the increased efficiency of dedicated clinics (7), better quality of dedicated clinics afforded by more time (13) and the advantages of opportunistic service provision in reaching women (especially teenagers) too shy to attend dedicated clinics (13).

Regarding the supports needed to optimise their provision of women's healthcare, 255 respondents (56.7%) said they needed a practice nurse with expertise in this area; 139 (30.9%) said they needed structural expansion to make the necessary space available; 54 (12.0%) said they needed a female chaperone; 93 (20.7%) said they needed no additional support; and eight (1.8%) did not respond. Respondents also identified other needs. The need for training and refresher courses to update and maintain skills was identified by 29 (6.4%); 16 (3.5%) identified the need for increased remuneration for well woman checks, smears, diaphragm and IUCD fitting, vasectomy and counselling; nine male GPs (2.0%) identified the need for funding to employ sessional female GPs to run dedicated clinics and six (1.3%) identified the need for more time. Three respondents expressed concern about trends in the part-time employment of female GPs for dedicated women's health clinics; and a further respondent highlighted discriminatory health board policies which foster this trend.

> "The [named Health Board] offers £90 per session (once a month) for a women's health clinic. This fee is only payable if (a) the clinic is provided by a female doctor or (b) the provider has a Family Planning Certificate. With respect to (a) this is the only case I know of where male doctors are discriminated against on grounds of gender. Although this practice has two female doctors we will not apply for this grant on principle. This only leads to male doctors employing female doctors on a casual basis - not good for female doctors' career structure."

Education and Training

Vocational Training

Of the respondents, 221 (49.2%) were vocationally trained, 225 (50.0%) were not and four (0.8%) did not respond. Of the 221 GPs who were vocationally trained, 183 (82.8%) had received training in women's health and family planning during their vocational training.

When asked to classify their view on the statement "*Women's health / family planning should be part of the core teaching of vocational training schemes*", 424 (94.8%) either strongly agreed or agreed with the statement (*Fig. 11*).

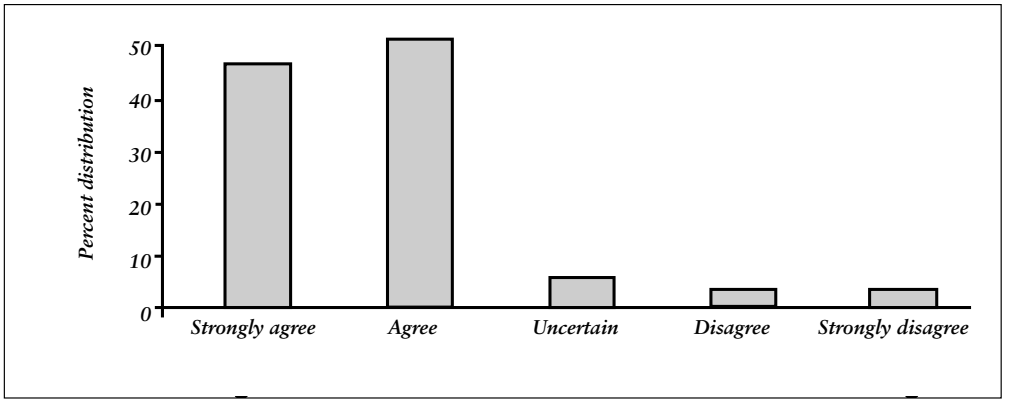

Fig. 11: "Women's health / family planning should be part of the core teaching of vocational training schemes" (n=447)

Obstetrics and Gynaecology Training

A majority of 425 (94.4%) respondents had six months or more hospital experience in obstetrics and gynaecology while 25 (5.6%) had none (*Table 15*).

	Frequency	Percent
More than six months	103	22.9
Six months	322	71.5
None	25	5.6
Total	**450**	**100**

Table 15: Hospital experience in Obstetrics and Gynaecology

Of all respondents, 273 (64.2%) considered their training and experience relevant; 143 (33.6%) considered it irrelevant; and nine (2.1%) declined to respond. There was little variation in perceptions about the relevance of training with age, gender or practice location. The following comments were made in relation to hospital training in obstetrics and gynaecology.

> "Gynae should be more emphasised during the six months Obs/Gynae training especially since home deliveries are no longer applicable."
>
> "In relation to hospital training in Obs and Gynae, I was fortunate that the consultant I trained with exposed me to much of the problems which might arise in general practice, but many of the hospital jobs of colleagues had little or no gynae training. This area could easily be improved."
>
> "There is an urgent need to structure the Obs/Gyn post for GP trainees in such a way as it is applicable to trainee needs ie. gynae clinics mostly, training in family

planning counselling, procedures and minimise time spent in theatre and working as interns clerking patients."

Family Planning Training

Of the respondents, 238 (52.8%) held a Family Planning Certificate. While certification in family planning did not vary with practice location, a significantly higher proportion of women had a certificate in family planning compared to men (66.9% and 47.1%; p<0.01). Those aged 40 and under were also more likely to have a certificate in family planning, compared to those over 40 years (78.9% and 42.7%; p<0.01). Of those who did not have a Family Planning Certificate, nine commented that they had completed the theoretical component of the course but had difficulties in getting access to an Instructing Doctor to complete the practical component.

When asked to classify their view of the statement *"Separate and distinct training for GPs who wish to specialise in family planning should continue"* the majority (84.5%) were in favour (*Fig. 12*). Significantly more men than women were opposed to separate and distinct training continuing (11.0% and 2.3%; p<0.01); otherwise there was no association with age, practice location or Family Planning Certification.

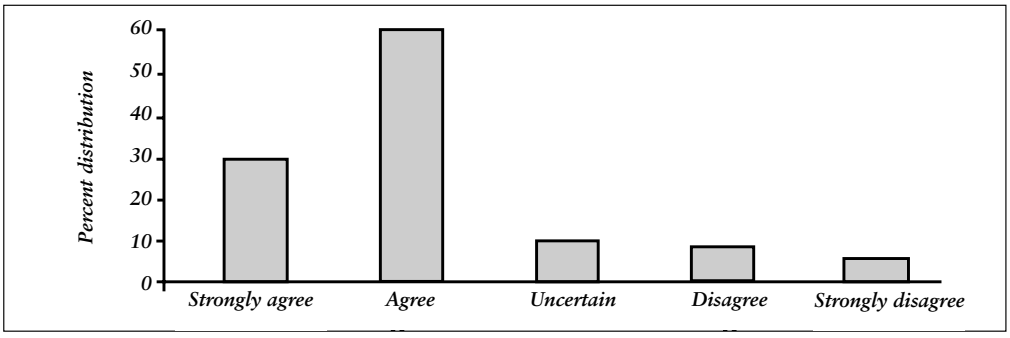

Fig. 12: "Separate and distinct training for GPs who wish to specialise in family planning should continue" (n=444)

Respondents were also asked to classify their view on the statement *"Skills in family planning cannot adequately be gained by trainees in general practice alone"* and the majority (61.2%) either agreed or strongly agreed (*Fig. 13*). Views on this issue were not associated with age, gender or practice location. However, those who supported the continuation of separate and distinct training were significantly more likely to agree/strongly agree that family planning skills cannot adequately be gained in general practice alone compared to those who opposed the continuation of such training (68.3% and 21.1%; p<0.01).

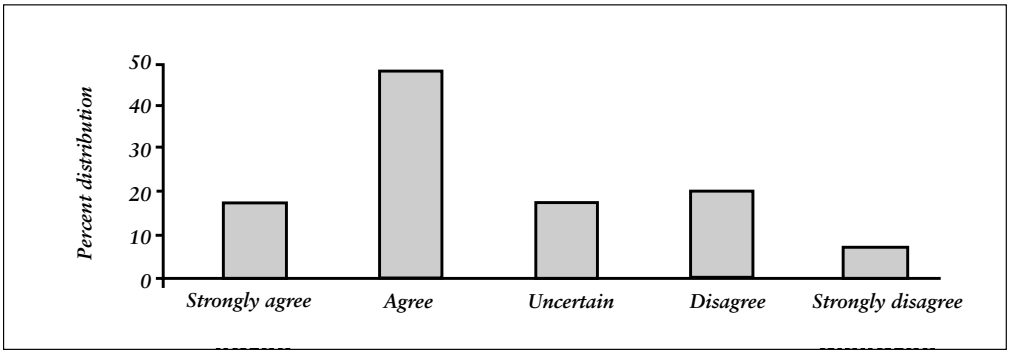

Table 16: Other sources of knowledge about family planning/women's health (n=449)

Assessment of Training in Family Planning / Women's Health

Of the respondents, 242 (53.8%) were satisfied with the training they had received in family planning/ women's health; 118 (26.2%) were ambivalent; 69 (15.3%) were dissatisfied; 16 (3.6%) considered the question non-applicable and five (1.1%) declined to respond. Women were significantly more likely to rate their training positively compared to men (61.1% and 50.4%; $p<0.05$); otherwise assessment of training did not vary significantly with age or location.

Assessment of Smear-taking Skills

Respondents were asked to assess their level of satisfaction with their smear-taking technique. A total of 386 GPs (85.8%) were satisfied with their technique; 34 (7.6%) were ambivalent; 20 (4.4%) were dissatisfied and 10 (2.2%) did not respond. Again, significantly more women than men were satisfied with their smear-taking technique (93.9% and 85.4%; $p<0.05$); otherwise a positive assessment did not vary significantly with either age or location. While a positive assessment of smear-taking technique was not associated with work experience in a family planning clinic, the association with Family Planning certification was high (89.9%; $p<0.05$).

The Promotion of Family Planning

A majority of 352 of the respondents (78.2%) said they promoted the availability of contraceptive services in their practice and 97 (21.5%) did not. It was most commonly promoted opportunistically (*Table 17*). The availability of emergency contraception was specifically promoted by 83 respondents (18.4%), while 366 (81.3%) did not do so.

	Frequency	Percent
Opportunistically	313	88.7
Practice leaflets	201	56.9
Posters in waiting room	200	56.6
Public talks	41	11.6
Local media	9	2.5

Table 17: Methods used to inform patients of contraceptive services provided (n=353)

Respondents were asked to classify their view on the statement "*The ICGP is not doing enough to promote the availability of family planning in general practice*". Views were mixed with one-third agreeing, one-third disagreeing and one-third uncertain (*Fig. 14*).

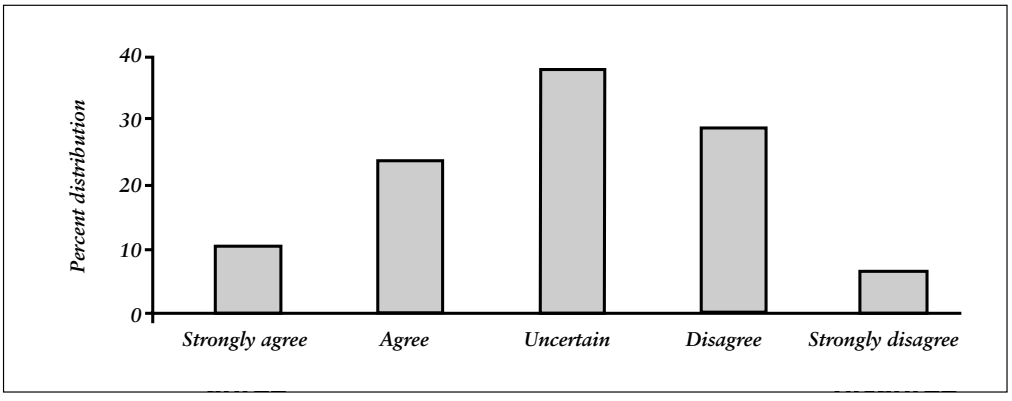

Fig. 14: "The ICGP is not doing enough to promote the availability of family planning in general practice" (n=445)

Discussion and Recommendations

Study Sample and Response

The absence of an official register of GPs in Ireland makes the selection of a representative sample for studies such as this difficult. We are grateful to researchers at the Department of Community Health & General Practice at TCD for supplying a random sample from their 1995 database. The finding that 109/778 (14%) of this sample were either duplicate entries (6), not currently in general practice (21), retired (55), deceased (10) or no longer at the address given (17) indicates the need for the establishment and regular updating of such a database.

The satisfactory response rate (70.5%), despite timing the study during the summer holiday period, indicates a high level of interest in the subject. Comparison with the ICGP 1997 National Survey and the Stress and Morale Study indicates that respondents are broadly representative of GPs nationally in terms of age, gender, geographic distribution and practice organisation. Trends such as the move from single-handed to group practice and the increase in numbers of practice nurses are confirmed. The gender difference in the under 40s (50.5% female and 49.5% male) confirms the increasing feminisation of general practice.

Gender Mix in General Practice

Despite the expressed views of 70% of respondents that female patients should *always* be offered the option of seeing a female GP or nurse for women's healthcare, 23% of practices employed neither. (In the UK the figure is 42%). However, this is an improvement on the situation reported in the 1995 ICGP survey when 55% of practices did not have a female GP working in the practice. The desire for gender matching in provision of services can be addressed by a combination of financial incentives to employ more female doctors and practice nurses, and the development of inter-referral arrangements. While supporting the rights of women to choose their service providers, awareness campaigns should be developed to educate both the public and doctors that women's health services is not and should not become the sole preserve of female practitioners.

Provision of Family Planning Services

There was a significant increase in the numbers of GPs providing a family planning service throughout the 1980s. In 1982, 81% of GPs were providing such a service. 10 years later, 96% of GPs were providing this service (Oliver and Comber 1994).

	1995 ICGP survey (percent)	Study sample (percent)
Hormonal contraception	96	97
Sterilisation counselling	91	91
Emergency contraception	Not asked	90
Natural family planning advice	85	83
Diaphragm advice	88	72
Diaphragm fitting	51	33
IUCD advice	76	69
IUCD fitting	25	17
Vasectomy operation	Not asked	6

Table 18: Comparison of family planning service provision between 1995 ICGP survey and the study sample

There have been no significant changes in the numbers of GPs providing hormonal contraception, sterilisation counselling and natural family planning advice since the 1995 survey.

Fewer GPs are now providing diaphragm advice or fitting or IUCD advice or fitting than in 1995. This drop is not easily accounted for. It is possible that the 43% who responded to the 1995 survey represent an "enthusiastic" group. Lack of demand and possibly lack of training in these particular services may also contribute.

Female GPs, younger GPs (under 40 years) and GPs holding a Family Planning Certificate were more likely to provide a broader range of services. Rural GPs and those with a practice nurse were more likely to provide an IUCD fitting service.

A total of 16% of GPs felt that the service they were providing for teenagers was inadequate. If we are to effectively tackle the levels of teenage pregnancy and teenage abortions, we need to target the improvement of services to this particular group as a priority. A public awareness campaign is needed assuring young women of the confidentiality of the service. The need to review timing of clinics to suit the needs of young women and the possibility of drop-in clinics must be examined. A pilot project in Cork at present is exploring the health needs of teenagers and how they might best be addressed.

GPs' most common reason for not providing particular family planning or women's health services was lack of skill (79%). Lack of demand (46%), lack of facilities (33%) and lack of time (28%) were the other commonly cited barriers. One in seven GPs (16%) did not provide particular services because of lack of adequate remuneration and one in eight GPs (13%) cited moral principle as the reason. Older GPs (over 40) were more likely to identify moral principle as a barrier. Emergency contraception and IUCD fitting were the services with which GPs had most moral difficulties. A total of 87% of all respondents and 58% of those with moral scruples believed that GPs who do not provide family planning on moral principle should refer patients to colleagues who do. The Medical Council's "Guide to Ethical Conduct and Behaviour" (Fifth edition) states that a practitioner with a conscientious objection to a course of action should explain this to the patient and make the names of other doctors available. The ICGP supports this approach.

Provision of Women's Healthcare Services

Level of service provision is high, with more than 95% of GPs providing breast examination, combined antenatal care, menopause counselling, cervical smear tests and pregnancy counselling. A total of 88% provide medical care after abortion. Only 3% provide a home delivery service.

Cervical smear tests have become more widely available in general practice rising from 77% in 1982 to 94% in 1992 and 95% in this study. Almost one third (29%) of those who do not provide cervical smear tests specifically cited the gender barrier as the reason. All of these GPs were male with no female GP or nurse employed in the practice. Strategies must be developed to address the gender barrier in order to provide a comprehensive women's healthcare service.

Urban GPs were more likely to believe that they are under-utilised in the provision of antenatal care than rural or mixed urban-rural practices. This probably reflects a difference in the role of the GP in antenatal care in cities, where women have easier access to major maternity units.

Referral Patterns

Referral to GPs colleagues is increasing, from 49% in the 1995 survey to 67% in this study. Referral to family planning clinics is around the same level (57% and 60%) and referral to hospital services for family planning services is falling, from 55% in 1995 to 34% in this study. Referral to general practice was evenly spread across age, gender and practice location. Urban and female GPs were more likely to refer to family planning clinics and older GPs were more likely to refer to hospital services.

While there is general support for inter-referral, only 7% of GPs had ever made a claim for an inter-referral fee for family planning services under the General Medical Services scheme.

Three quarters of the GPs surveyed were in favour of the establishment of a national register of GPs with special skills in family planning to facilitate inter-referral. Potential difficulties with the publicity associated with specifying which services an individual GP provides were signalled by the focus groups.

Information on the range of women's healthcare services provided by GPs is needed by other GPs to facilitate inter-referral. Whether there should be a single national register or local faculty-based registers is, as yet, unclear. The question of public access to the register(s) also needs to be addressed.

Service Delivery

The view of the focus group participants that skills in women's healthcare cannot be adequately gained in general practice alone and that two levels of family planning services should be offered in general practice were supported by the respondents to the questionnaire survey. It was envisaged that all GPs should provide hormonal contraception and advice on other contraceptive methods. GPs with a special interest and special skills would provide IUCD and diaphragm fitting, vasectomy etc. This restructuring would require ongoing education and training, registration of those with a special interest and structured inter-referral with an adequate remuneration package.

Two-thirds of GPs (63%) currently provide women healthcare services during routine surgeries only but three-quarters (75%) believed that this care could best be delivered through a combination of dedicated clinics and routine surgeries. The main advantages of dedicated clinics were described as better quality of service due to having more time for each patient and the increased efficiency of such clinics. The provision of a holistic service and the linkage between reproductive healthcare issues and "general health" were the main advantages of offering the service during routine surgeries. The latter option also has the merit of discretion, particularly for teenagers.

However, the focus groups strongly believed that inadequate funding and facilities make the establishment of dedicated clinics impractical in the current setting. These issues must be addressed within the IMO negotiations with the Department of Health and Children on a preventive services package for general practice.

Education and Training

According to 95% of GPs surveyed, women's health and family planning should be part of the core teaching of GP training schemes. The majority of those who were vocationally trained had received such training.

While the vast majority of GPs (94%) had spent at least six months in hospital posts in Obstetrics and Gynaecology, the relevance of the experience gained was questioned by both the survey responders and the focus group participants. Slightly over half the GPs (53%) hold a Family Planning Certificate.

Levels of satisfaction with training in family planning and women's health were low, with only half (54%) of the GPs surveyed being satisfied. Women expressed a higher level of satisfaction with training. However, 86% of GPs are satisfied with their smear-taking skills.

This would indicate that there is a pressing need for the development of ongoing education and training opportunities for GPs. Meetings, study days and CME meetings were identified in this study as popular sources of on-going training, but educational needs should be more closely examined.

Options could include workshops/small group meetings, either as stand alone meetings, as part of ICGP meetings such as the Annual Scientific Meeting, as part of CME programme or in co-operation with other groups such as the maternity hospitals and the Irish Association of Family Planning Doctors. There is a need for regional meetings as determined by local needs, in addition to national

meetings. Distance learning, either as modules in other programmes, such as the Family Planning and postmenopausal health modules in the Therapeutics Diploma or as a programme in its own right needs to be developed. Educational opportunities are also available in Forum and other ICGP publications such as the Clinical factfiles series.

Promotion of Family Planning

While 78% of GPs said they promoted the availability of contraceptive services in their practice, the majority do this opportunistically. Less than two-thirds (56%) advise their patients that they provide family planning services through posters in the waiting room or practice leaflets. Obviously, optimal utilisation of services requires that patients be fully informed of the range of services available. This needs a systematic approach and should not depend on opportunistic information giving. Awareness campaigns could be generated by the ICGP centrally and PROs at faculty level.

Views on the role of the ICGP in promoting family planning in general practice were mixed, with approximately one-third stating that the ICGP were doing enough, one-third stating that the ICGP was not doing enough and one-third "uncertain".

Changes in the structure of delivery of women's health services and the resulting payment structures will require discussion with the Department of Health and Children, the Health Boards and the Irish Medical Organisation.

References

Cahalan D (1951). Effectiveness of a mail questionnaire technique in the army. P*ublic Opinion Quarterly* **15**: 575-8.

Department of Health (1997). A Plan for Women's Health. Government Publications.

Department of Health (1995). Developing a Policy for Women's Health: a discussion document. Government Publications.

Department of Health (1994). *Shaping a healthier future*... A strategy for effective healthcare in the 1990s. Government Publications.

Donovan A, Ryan J, Donovan W (1992). Why choose a family planning clinic? *Forum (Journal of Irish College of General Practitioners)* **9**: 53-6.

Irish College of General Practitioners (1997). National General Practice Survey.

Irish College of General Practitioners (1995). Family Planning Questionnaire 1995. Report to the Department of Health.

Irish College of General Practitioners (1987). Survey of Family Planning Services. Internal report.

Medical Council (1998). A Guide to Ethical Conduct and Behaviour (Fifth Edition). Dublin.

O'Dowd T, Sinclair H, McSweeney M (1997). Stress and Morale in General Practice in the Republic of Ireland. Irish College of General Practitioners, Dublin.

Oliver B, Comber H (1994). Changes in the structure of Irish general practice over the past decade 1982 to 1992. Irish College of General Practitioners, Dublin.

Prendiville W, Short M (1993). A review of family planning in Ireland. *British Journal of Family Planning* **19**: 246–7.

Royal College of Obstetricians and Gynaecologists (1997). Intimate Examinations: Report of a Working Party. RCOG Press, London.

Saffron Initiative Steering Committee (1999). The Saffron report on Women's Lifetime Health Needs.

Smith M (1996). Why young women in Dublin choose family planning centres for their contraceptive needs. *British Journal of Family Planning* **22**: 145-50.

Wiley MM, Merriman B (1996). Women and Healthcare in Ireland: Knowledge, Attitudes and Behaviour. Oaktree Press, Dublin

The Irish College of General Practitioners