PERSONAL VIEW

Primary care and sex: too close for comfort?

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Most general practitioners (GPs) would agree that things sexual are an important part of their patients' lives, so why is it that sexual and reproductive health care is so variable within primary care?

Why is it that the UK, a highly developed country with a socialised health care system with free contraception (but only for women), has such bad sexual health statistics? We have the highest rate for teenage pregnancy in Europe, approximately one in three women receiving a termination in their lifetime, an epidemic of chlamydia in the under-25s, and an estimated 50% of conceptions unplanned.

Even the new contract for UK GPs[1] lists contraceptive services as an 'additional' service. What a missed opportunity, to class this and other preventative services as anything other than an absolutely integral part of general practice! They cannot just be neatly categorised and contracted out, important though clinics are for dual service delivery and specialist advice.

Hopefully payment will be adequate to encourage general practices to develop these aspects of their work. If not, many patients will be inconvenienced by lack of easily accessible 'one-stop' services within the practice setting.

How blinkered and short term to consider GPs capable of treating disease (an essential service) without encouraging more consideration of the wider picture.

Undergraduates and registrar GPs receive variable training in sexual and reproductive health dependent mainly on the interests and ethos of their tutors. The membership examination of the Royal College of General Practitioners (MRCGP) does not demand such knowledge of either trainer or registrar and no formal expertise is required of GP principals.

Equally, how can practice nurses, midwives and health visitors, for instance, be fully equipped for their jobs without core training in this area?

There are countless opportunities every working day in general practice to offer help to our patients: 99% of the population have a GP, averaging three to four consultations per year. It is not just obvious opportunities such as smear taking or the 65% of all contraceptive work that is done in primary care. Think of impotent diabetic patients, risk-taking drug abusers, a depressed homosexual, infertile couples, victims of domestic violence or sexual abuse, stressed mothers in baby clinics, teenagers with acne – for men and women, the list is endless. The overlap between reproductive health and mental health in particular is huge, so children are also often affected.

The Diploma of the Faculty of Family Planning is viewed as desirable training for GPs, and the Faculty has an innovative and visionary structured programme for training and re-accreditation, but where is the GP voice? Not one place is specified for a GP on its council[2] and Diplomates are represented by one place. The one nominee this year was a gynaecology specialist registrar.

The Sexual Health Strategy for England, whose emphasis seems to lean strongly towards infection control, proposes a stronger role for GPs, but the RCGP has only one representative on this body.[3]

Attitudes need to change! Primary care can deliver so much more cost-effective reproductive health care.

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Funding. None identified.
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3 www.doh.gov.uk/nshs/members

TWENTY-FIVE YEARS AGO: THEN AND NOW

In search of appropriate contraception: horses for courses

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All contraceptive methods are not created equal: to each individual a personal risk, perception, value and choice. Success of a programme depends on a public health approach in the provision of an appropriate mix of options in contraceptive services as an integral part of reproductive health care. A medical practitioner, who had run a family planning service in a developing country, was terribly shocked upon returning to England in the late 1960s to note that family planning was still 'a very personal subject and not to be discussed'.[1] It was not until the mid-1970s that changes in service delivery led to a closing of that gap with developing countries.

An epidemiological analysis demonstrated less risk with various contraceptive methods, as compared to that of pregnancy.[2] An association of oral contraception with cardiovascular complications had been known, albeit with 'sufficient grounds for thinking that the case against the pill is not yet proven'.[3] When informed of an increased risk, older women were often reluctant to switch away from their familiarity with oral contraception and the 'expectation of contraceptive security'[2] due to its effectiveness. Intrauterine devices (IUDs) already had a

long-standing reputation as being most suitable for 'feckless and fertile patients for whom no other contraceptive was effective'.[4] As condoms were not available on medical prescription, those users could not obtain free supplies of contraceptive commodities.[2] Concerns regarding ethical issues and informed consent restricted severely the utilisation of injectable depot medroxyprogesterone acetate and practitioners were advised to keep meticulous clinical records in the hope that a subsequent review of their experiences would lead to a relaxation in official recommendations.[5]

During the Fifth International Congress of Psychosomatic Obstetrics and Gynaecology in Rome, participants had an audience with the Pope[6] thereby exemplifying how reproductive health physicians can practise their religion very seriously and maintain a deep faith whilst carrying out their professional duties responsibly. Religious and cultural aspects of reproductive health should be addressed in order to increase acceptability, thereby improving quality of care through an increase in demand for services[7,8] to complement the supply side in the provision of commodities. Particular attention should be paid to the needs of special groups, such as the disadvantaged and young people, besides male involvement.

Basic research for contraceptive development has had its surprises, promising methods sometimes turning out to be merely promises. Conversely, research in reproductive physiology done for contraceptive development has been the basis of major advances in the treatment of infertility. Reflecting the long lag time for product development, it is only recently that several new methods have been approved for service delivery. Alternative delivery systems for hormonal contraception have led to the monthly injection, impregnated IUD and vaginal ring, subdermal implant and the transdermal patch. There has lately been a renaissance of female-controlled barrier methods with improved designs for diaphragms and cervical caps besides the introduction of female condoms. More recently, non-surgical transcervical sterilisation is being performed without general anaesthesia with the hysteroscopical insertion of a device in each Fallopian tube to cause scarring.

Irrespective of cost considerations, the latest contraceptive method might not be the best for a particular person. Individual choice is of paramount importance in the selection of a contraceptive method and decisions should be based on information 'free from the pressures exerted by the media, friends and relations, and regrettably in some cases by doctors themselves'.[2] Service providers and policy makers should emphasise their ethical obligations and put aside personal experiences, emotions and method bias to ensure the availability of, accessibility to, and counselling on a wide range of safe and effective contraceptive methods for informed choice by individuals.

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