General Practice Observed

Abortion Act in Somerset

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Summary

A survey conducted with a sample of 20% of general practitioners over six months in 1972 disclosed a request rate for termination approaching 10% of all pregnancies. The attitude and performance of the practitioner were considered to be important in the patient's requests for this, and patients were thought to know about these. This implies that in three-quarters of the practices there was a sizeable demand for abortion which remained latent.

Altogether, 20% of specialist consultations were made privately and in none of these cases was abortion refused. Under the Health Service the refusal rate was 19%, but 7 of the 12 women refused N.H.S. abortions subsequently obtained it privately.

Introduction

Early in 1972 the working of the Abortion Act was discussed at the Somerset Local Medical Committee and with consultant gynaecologists serving the area. There was uncertainty whether the normal patterns of referral were operating satisfactorily and no one was sure of the overall picture. The local medical committee agreed to co-operate in the establishment of a prospective survey and recommended practitioners in the county to participate. Since changes continually occur in the pattern of services the survey included a fairly large sample of practitioners and was conducted over a relatively short period of time.

Method

A sample of 20% of the N.H.S. general practitioners with main surgery premises in the administrative County of Somerset was constructed by random processes from the Executive Council list. Each of the 54 practitioners selected was asked to participate in a survey from 1 June to 30 November 1972 on all occasions when either a patient requested a termination or he suggested it. The survey was confined to consultations with the selected doctor and requests to locums, assistants, or other partners were excluded. On each occasion the practitioner was asked to complete immediately a two-page questionnaire on the personal details of the patient and her partner. The names and addresses of patients were known only to the general practitioners, who

allocated to each patient a survey number. Later the general practitioners completed a second form giving the experience of the patient after referral for termination.

All of the 54 general practitioners agreed to participate, though one felt that the questions relating to contraceptive practice were too embarrassing to ask of his patients. During the survey one general practitioner left the county, but the doctor assuming responsibility for the patients completed the returns. Once an unbiased sample of general practitioners had been obtained special efforts were made to ensure that the survey was conducted without default or omission. On completion all the participating doctors confirmed that all cases had been included.

Results and Discussion

An outline of the findings is presented in the diagram. Of the 96 cases reported an outcome desired by the women was achieved by various means in 91% of the pregnancies. Only nine firmly unwanted pregnancies continued to term, and one of these was the subject of an unsuccessful termination. The presence of an unwanted pregnancy does not provide legal justification for termination; the woman has to convince her medical advisers that one or more of the criteria laid down by the 1968 Act are satisfied. Though most of the women were able to do this the path to termination was not invariably straightforward and some shopping around of general practitioners and consultant gynaecologists was evident at all stages of the referral process. The six patients who from the outset elected to have terminations privately were the only ones who without exception got exactly what they wanted.

Of the referrals 81% were to local consultants normally used by the practice, and of cases so referred 84% were terminated. Only 10% were sent to more distant consultants within the region. Referrals outside the region and to pregnancy advisory bureaux together amounted to 9% of the total. The proportion of local referrals was similar to that in many other specialties in Somerset.

DISTRIBUTION OF REQUESTS AMONG GENERAL PRACTITIONERS

Many women experience dismay at discovering pregnancy but the emotion is frequently transient. To request termination a woman must not only decide that her pregnancy is unwanted but she must also resolve to approach her general practitioner. This latter decision is influenced only partly by her attitude to the pregnancy; her assessment of the prospects of securing abortion must also influence her decision. Thus the level of requests at any point in time may be influenced by views held by the patients on the attitudes and beliefs of their local doctors.

The 96 requests to a 20% sample of general practitioners in six months represents a yearly request rate approaching 10% of Somerset pregnancies. As shown in table I, however, the requests

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TABLE 1—Distribution of Abortion Requests among General Practitioners

No. of Requests (1)	No. of General Practitioners (2)	Col. 1 × Col. 2 (3)	Col. 3 as Cumulative Percentage (4)	Col. 2 as Cumulative Percentage (5)
Nil	17	Nil	—	100
1	16	16	100	69
2	7	14	83	44
3	5	15	69	26
4	3	12	53	17
5	2	10	41	11
6	1	6	30	7
7	1	7	24	6
8	2	16	17	4
Total	54	96		

were far from evenly distributed among general practitioners. A minority of N.H.S. general practitioners (26%) dealt with 69% of the requests, while a third received no requests at all. When referrals for termination are considered the concentration among this same minority is even greater and of N.H.S. referrals greater still (details not shown). Cartwright and Waite¹ reported 26% of general practitioners handling 60% N.H.S. referrals, whereas our busiest 26% handled 75%. This difference could be due to an incomplete response by general practitioners to Cartwright and Waite's survey.

To show whether patients' attitudes to abortion differed in different parts of Somerset—the survey practices were subdivided into five groups based on the catchment areas of the hospital centres serving the county. The variance of requests between the five areas was not significantly different from the "within area" variance (at the 5% level). Furthermore, there was no correlation between the number of requests made to the general practitioner and the percentage of rural payment patients on his list ($r = -0.25$). There was no correlation between the level of requests and the number of years that had elapsed since the practitioner qualified ($r = -0.18$). The influence of partnership was examined carefully, for it was appreciated that one partner in a group practice might undertake all the maternity work. Though one survey general practitioner did perform most of the maternity and gynaecological work for her group neither the presence nor the size of a partnership influenced in general the receipt of requests. Indeed two participating doctors from another group both had high levels of request.

Our findings lead to the speculation that the attitude and performance of the general practitioner is important and that a patient grape-vine is highly effective in this confidential field. If this be the explanation then in three-quarters of the practices there is a sizeable demand for abortion which remains latent. If public and professional attitudes to termination became uniformly more sympathetic the number of requests could rise to two or three times the present level.

CONTRACEPTIVE PRACTICES

It is often assumed that the widespread provision of a free contraceptive service would significantly reduce unwanted pregnancies and thus the demand for abortion. The survey therefore explored the contraceptive history of the patient and her immediate partner and sought information on contraceptive failures. The findings should be viewed with caution, as the history could not be verified in most cases and some histories might have been distorted to secure sympathy. Furthermore, no reports were made of pregnancies occurring after use of the safe period or coitus interruptus.

TABLE II—Contraceptive Methods Used by Patients Requesting Abortions

Contraceptive Methods	Patients	
	No. (= 96)	% (= 100)
None mentioned	50	52
Pill	14*	14
Sheath	15	16
Cap	8*	8
I.U.C.D.	7	7
Foam	1	1
Vasectomy	2	2

*1 patient using both pills and a cap spasmodically.

The contribution made by contraceptive failures was surprising. The use of I.U.C.D.s carries a failure rate of 2-3% a year, and so some termination requests were to be expected of this method. Failures on the pill, constituting 15% of all requests, occurred usually after prescription by a general practitioner. All these women had either stopped taking the pill or took it intermittently. A wide variety of reasons were given in these cases but none of the women had discussed their

problems with a doctor, nor had they sought other methods. Clearly widespread prescription of the pill is not a panacea and an efficient follow-up and advisory service is essential.

Of the patients given terminations almost one-fifth were sterilized or their partners underwent vasectomy. Of the remainder three-quarters received contraceptive advice from their general practitioners or from local authority family planning clinics. Unfortunately nine patients returned to their daily lives after termination without arrangements being made for regular contraceptive advice. This is disturbing.

HEALTH SERVICE AND PRIVATE MEDICINE

All consultations with general practitioners in our survey took place under the N.H.S. Altogether arrangements were made for 88 specialist consultations, of which 70 were Health Service and 18 private. A private sector in Somerset of just over 20% of referrals is slightly smaller than that reported in Hertfordshire (25%) by Eames *et al.*² Not unexpectedly the partners of these women were drawn exclusively from the top three social classes. Only six patients actually chose private consultations for themselves, however, and in the remaining 12 cases the decision was taken for them by the general practitioner. The reasons given to justify these general-practitioner decisions were varied and included: speed and efficiency (3 cases), grounds for termination were minimal and referrals to a private clinic guaranteed termination (2 cases), and case for termination was not sufficient to justify the use of an N.H.S. bed (7 cases).

The replies indicated that some general practitioners act on the belief that the Abortion Act is operated with a lower threshold in the private sector than in the N.H.S. The protection of Health

Service resources is interesting, especially as it influenced the direction to private medicine of 10% of all referrals. Such considerations surely do not arise as often in any other kind of Health Service consultation in general practice. Some minor redistribution between private and public sectors was carried out by the consultants. Four women referred privately were transferred to the Health Service, and seven of the 12 who were refused N.H.S. abortion subsequently obtained it privately, often by another consultant. Only once was the lack of an N.H.S. bed given as a reason for refusal.

As there can be no waiting lists for termination some rationing of the demands on N.H.S. resources is being exercised by the profession. It is curious that this is being performed mainly by general practitioners, for the consultants should be better able to judge the pressure on N.H.S. beds at any point in time. On the other hand, the inference is clear on the availability of resources between the two sectors—no one was refused a private abortion by a consultant in this survey, whereas the refusal rate was 19% under the Health Service.

We thank the Somerset Local Medical Committee, the participating general practitioners, and the consultant gynaecologists for agreeing to this exercise of self-analysis.

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References

- ¹ Cartwright, A., and Waite, M., *Journal of the Royal College of General Practitioners*, 1972, Suppl. No. 1, 22.
- ² Eames, J. R., Jamieson, J., and Hall, J., *Practitioner*, 1971, 207, 227.

Gazetteer of General Practices in the Aylesbury Area

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Summary

One reason for defects in communication between hospitals and general practitioners may be that hospital staff lack information about local practices. We compiled a handbook giving information about 55 (86%) of the practices which use the district general hospital group in Aylesbury. This included biographical details about each doctor in each practice, when he was available on the telephone, what ancillary staff worked in the practice, and so on. The handbook was given to 500 staff in all grades and departments in the group. It seems to have been effective in improving communications, relationships, and morale within the area.

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Introduction

The National Health Service's undoubted problems of communication have been the subject of exhortation, measurement, and attempted remedy ever since its inception—and they have been mentioned in a variety of publications.¹⁻⁹ In discussion about the relations between hospital and general practitioner or hospital and local authority there has been a tendency to make the hospital the whipping boy in the controversy. Lefever and his partners¹⁰ aired their disquiet in public recently, but also showed their awareness of the wider issues underlying their problem. In part they attributed it to lack of appreciation by hospital staff of the organizational and clinical problems of general practitioners. They also assumed that "... the hospital doctor usually does at least know whom to telephone or write to ..."—but this was an assumption which, with its implications, had already been challenged by Loudon¹¹ who questioned junior and senior members of the staff of the hospital in which he carried out his survey. Repeatedly he found that for all aspects of clinical organization and administration in general practice "these (questions) showed an almost total lack of any knowledge of present trends in general practice by a majority of the staff."

Before communication is possible the respondent must be identifiable and something known about him, and it is perhaps the assumption by general practitioners that hospitals have this information about them which is partly at the root