


Women's Health Services in General Practice: 2004

Ailís ní Riain, Rita Galimberti,
Sinead Burke, Claire Collins, Mary Dillon

Irish College of General Practitioners

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Forward

The Crisis Pregnancy Agency is very pleased to be involved in the development and publication of this important and insightful research on women's health services in general practice in Ireland.

This piece of research aims to assess the range of contraception and women's health services provided in general practice and to explore the role of the GP in the prevention and management of crisis pregnancy.

Since the last national survey on women's health services, undertaken by the ICGP in 1998, there has been a significant increase in the number of GPs providing crisis pregnancy counselling. The Crisis Pregnancy Agency welcomes this development as the role of the GP in supporting women through a crisis pregnancy is significant. We know from other research that a GP who is supportive, empathetic and willing to assist women with the practical they need to proceed with what ever choice they are considering can meet most of the woman's needs. It is therefore important to identify the factors influencing this important change, to inform service provision objectives in the future.

A vital strand of our Strategy is to work towards promoting the universal availability of services to enable people to avoid crisis pregnancy. The Agency is currently developing a framework of national standards for contraception services.

It is therefore essential for the Agency to have access to reliable data on the types of sexual and reproductive health services currently available to women in Ireland and the geographical spread of these services throughout the country.

I would like to thank the authors Ailis Ni Riain, Rita Galimberti, Sinead Burke, Claire Collins and Mary Dillon, for their excellent work and also the participating GPs who gave their time so generously for the qualitative interviews.

In addition to contributing to the evidence base for the development of our contraceptive framework, this research will also inform our work in the development of initiatives to equip GPs and other healthcare professionals with the skills to guide and support individuals on issues relating to the prevention of crisis pregnancy and the provision of counselling and medical services for women after crisis pregnancy.

Caroline Spillane
Acting Director
Crisis Pregnancy Agency

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Introduction

Access to a comprehensive range of women's health services has been identified in Irish national strategies as key to health gain for women (Department of Health, 1994; Department of Health, 1997; Department of Health and Children, 2001). In order to optimise women's access to a comprehensive range of women's health services, it is essential that current data is available on where services are provided, which services are provided and the barriers to service provision where gaps exist. General practitioners and practice nurses are key providers of such services. While family planning clinics are an alternative in major population centres, for many women in many parts of Ireland the GP is the nearest, most readily accessible service provider. Irish women's first preference for information, advice and women's healthcare services is their general practitioner (Wiley & Merriman, 1996; Saffron Initiative, 1998; Rundle et al, 2004).

The key responsibility of the Women's Health Programme at the Irish College of General Practitioners is to provide education and training for GPs in all areas of women's health, to improve the range and standard of services provided by them which will ultimately improve the quality of services for Irish women. Accurate and timely information on current service provision is required to ensure that the educational resources and courses are relevant and useful.

While some information on women's views and needs is available (Donovan et al, 1992; Wiley & Merriman, 1996; Smith, 1996; Department of Health, 1997, Sixsmith et al, 1997; Mahon et al, 1998; Smith & Bury, 2000; Rundle et al, 2004; Murphy-Lawless et al, 2004) there is relatively little information on GPs' views or levels of service provision. A number of earlier ICGP surveys provided limited data (Irish College of General Practitioners, 1987; Oliver & Comber, 1994; Irish College of General Practitioners, 1995). A national survey was undertaken in 1998 to identify what services GPs were providing in the areas of family planning and women's health, what services they were not providing (and why), what they would like to provide (and how) and the training and education they had received to date in the area of women's health (ní Riain & Canning, 1998). The 1998 survey combined a qualitative and quantitative research. Focus groups were convened to identify key themes and to inform the content of the subsequent questionnaire. The quantitative element consisted of a self-completed postal questionnaire, which was distributed to a randomly selected 30% sample of GPs which was geographically stratified. The information from this research informed the educational agenda for the first five years of the Women's Health Programme. Additionally, it was useful to provide objective information about GP service providers to external agencies, particularly the Department of Health and Children and the Health Boards.

With the widespread changes in general practice and the developments in women's health in particular over the next five years, it had become evident by 2003 that more up to date information was required. The Crisis Pregnancy Agency agreed to provide a research grant and the work was undertaken in 2004. The approach mirrors the 1998 survey, with minor amendments to the questionnaire developed and validated at that time. Qualitative information on this occasion was obtained through a series of telephone interviews, rather than the focus groups utilised in 1998.

Executive Summary

Access to a comprehensive range of women's health services in general practice has been identified as a priority by women themselves, by government and by general practitioners. Accurate information from general practice is needed to track the development of women's health services in general practice, to measure progress and to identify gaps.

This study describes the characteristics of both the general practice service providers of women's health care and the women's health services they provide. Changes since a similar survey in 1998 are identified and some of the key factors that have shaped these changes are explored.

Quantitative and qualitative research approaches were utilised, using a questionnaire to obtain a national picture of the women's health services provided by GPs and telephone interviews to provide more in-depth understanding of the issues. The questionnaire, an adaptation of the one used in a similar survey of Irish GPs in 1998, was circulated to 30% of Irish GPs, randomly selected and geographically stratified. Semi-structured telephone interviews were undertaken to explore GPs' views on the changes in providing women's health services over the past five years, and the challenges for the future.

There was a 60.2% response rate to the survey, providing 444 completed questionnaires for analysis. Responders were broadly representative of Irish GPs, when compared with the ICGP membership database. Results were compared with the 1998 Women's Health survey. Ten of the twelve doctors approached participated in the interviews.

The study identified increasing numbers of female GPs and increasing employment of practice nurses, in line with international experience. This has had a positive impact on women's health services. Three quarters of practices (74.5%) have at least one female GP in the practice, a significant increase from the 1998 finding of 64.6%. The corresponding rates for access to a practice nurse have risen to 71.7% in 2004 from 46% in 1998. Patients attending 90.1% of practices have access to at least one female healthcare professional, either GP or practice nurse. This reflects a significant increase from 77.4% in 1998. Female GPs and practices where patients have access to female healthcare professionals are more likely to provide a greater range of services overall, and are also more likely to provide a number of individual services, particularly those requiring specific skills or intimate examination.

More than 90% of GPs have provided a range of specific services since 1998 - hormonal contraception, emergency contraception, sterilisation counselling, cervical smears, breast examination, menopause counselling, combined antenatal care and pregnancy counselling. Between 1998 and 2004, significant increases were seen in the numbers providing hormonal

contraception (97.3% to 99.5%; $p < 0.05$), emergency contraception (90.4% to 97.1%; $p < 0.01$), intrauterine contraceptive device advice (68.8% to 90.3%; $p < 0.01$) and fitting (17.1% to 35.4%; $p < 0.01$), pregnancy counselling (95.3% to 99.1%; $p < 0.01$) and medical care after abortion (88.4% to 95.4%; $p < 0.01$). Overall, 85.6% of GPs provide four core contraceptive services (hormonal contraception, emergency contraception, IUCD advice and sterilisation counselling).

The majority of GPs (93.9%) are active in providing pregnancy-related care and GPs estimated that 10.4% of first visits in pregnancy in the month prior to the survey were for crisis pregnancies. The majority of doctors provide crisis pregnancy counselling (92.9%) and 88.3% also refer to other agencies for counselling. Post-abortion care is offered by 95% of GPs.

GPs were more likely to refer to other GPs for the services they themselves do not provide, and this preference has strengthened between 1998 and 2004. The major gap identified was in informing women of the services provided, with little changes in the promotion of services seen between 1998 and 2004.

The priority areas in women's health for further education and training were the management of sexually transmitted infections, gynaecological conditions, psychosexual medicine, the menopause and skills training (e.g. IUCD fitting).

GPs are motivated by their desire to provide the services that they believe to be in the best interests of their patients and aim for excellence in delivery of care with a focus on doing things well rather than simply doing more.

Analysis of the survey shows that changes in levels of service provision are primarily driven by patient demand. Lack of demand has resulted in lower numbers providing particular services. The interviews confirmed patient demand as the principal driver to changes in service provision. Other factors driving demand were increasing openness in Irish society, pharmaceutical company advertising, more informed women patients and the employment of others in the practice with specific skills e.g. IUCD fitting.

It is not possible to form a judgement on the adequacy of rates of provision of overall or specific services in the absence of an agreed framework for service provision. For example, while it is widely agreed that it is not necessary for every GP to fit IUCDs or to carry out vasectomies, there is no consensus as to how many GPs are required to provide these services in any given region or how they should be trained or supported.

This work identifies significant changes in the service providers and the services being provided and provides an evidence base for prioritising future training and research.

The Context

3.1 WOMEN'S UTILISATION OF GENERAL PRACTICE SERVICES

Internationally, GPs see more women patients than men and give them more medicine (McPherson and Waller, 2003; RACGP Online, 2004a). In 2001, there were 155 million consultations by women and 106 million by men in the UK (Office for Health Economics, 2004). Limited data from the UK suggests that women actually suffer more disease than men, and do not simply consult more for each illness episode.

The *First National Study of Workload in General Practice* in Ireland (Comber, 1992) showed that adult women in all age groups had higher consultation rates than men. The consultation patterns of males did not vary markedly with age, whereas women's rates showed two definite peaks with women aged 25-34 years accounting for almost 10% of all consultations and the second peak in the 65-74 year old age group.

In the UK, the Royal College of General Practitioners has long recognised the provision of competent family planning advice and contraceptive care as a sign of good medical care (RCGP Working Party on Prevention, 1981). The UK government, through the NHS, supports both GP and family planning clinic provision of contraception. General practitioners have become a major source of contraceptive advice and services in the United Kingdom (Rowlands, 1997). Between the mid 1970s and the mid 1990s a shift from family planning clinics to general practice took place (Wall & Houghton, 1997). The ratio of general practice to clinic attendances for contraceptive services has increased from 0.9:1 in 1975 to 2.3:1 in 1995 (Rowlands, 1997). It is estimated that 70% of publicly-provided contraception in the UK is provided by GPs, 25% by family planning clinics and 3% from hospitals (UK Department of Health, 1995). The reasons for this shift are complex and include changing consumer preference, family planning clinic closures and cutbacks, improvement in the services provided by GPs and in their promotion of these services. Rowlands (1991) singles out the increasing employment of practice nurses as a significant contributor to this shift. Nicholson and Carter (2003) contend that the diversity of the primary health care teams allows women a choice of practitioner, depending on their preference and also the nature of their complaint. They also view the role of practice nurses as vital and suggest that many women find that they relate better to nurses and consequently form better therapeutic relationships. Nurses typically spend more time with patients and involve those patients more fully with their own care (Fisher, 1995).

Contraceptive services are provided by 98% of all general practices in the UK (Wall & Houghton, 1997). No specific qualifications or previous training is required of GPs or practice nurses who provide contraception services (Rowlands, 1997). Any GP principal may apply to the health authority to be placed on the contraceptive list and is automatically added. Little is known about the scope or quality of GP-provided contraception services in the UK (Newman, 2001). A London study found little co-

ordination of GP-provided services and substantial variation in the contraceptive methods provided (Newman et al, 1997). With regard to the economics of contraceptive service provision, the cost per attender for family planning services is relatively low, regardless of whether that attendance is at a GP or a family planning clinic (McGuire & Hughes, 1995).

3.2 THE VIEWS OF IRISH WOMEN

While the level of information on the views of women regarding services is somewhat limited, Irish women, in common with women in Northern Ireland, consistently express a clear preference to receive information on health matters from their general practitioners (Wiley & Merriman, 1996; Saffron Initiative Steering Committee, 1998; Doherty, 2000; Rundle et al, 2004). Between 70% and 80% of women in the UK attend their GP rather than family planning clinics for family planning services (UK Department of Health, 1995; Kay et al, 1997) and 88% of women with menopausal symptoms had consulted their GP about these symptoms in a Scottish study, where the level of satisfaction with the service was high (Hanlon, 1996).

Miriam Wiley and Brian Merriman (1996) reported that the GP was the most popular source of advice on family planning (44%), followed by family planning clinics (25%). The Irish Contraception and Crisis Pregnancy (ICCP) study (Rundle et al, 1994) essentially confirmed this hierarchy of preferences among the women and identified marked gender differences in preference. Overall, 46% of respondents favoured the commercial route (chemists, vending machines etc) for contraceptive advice or supplies with 39% preferring the health professional route. Men are more likely to favour the commercial route (66% versus 27%), and women the health professional route (61% versus 17%). For women, the most popular overall preferences were their own GP (48%), then chemist shop/pharmacy (24%) and the family planning clinic (12%). For men, the most popular preferences were chemist shop/pharmacy (43%), vending machine (16%), their own GP (14%) and a family planning clinic or Well Man clinic (3%).

Aislinn Donovan and her colleagues (1992) surveyed 100 attenders at a family planning clinic. When they were questioned about the reason for attending the clinic, 10% stated that their GP was not sympathetic, competent or interested and 20% had no GP. Of those who had a GP, in 65% of cases the GP had never offered contraceptive advice and these women were unaware of which services, if any, the GP provided.

Mary Smith undertook two companion studies. The first surveyed 194 attenders who were seeking contraception at a Dublin family planning clinic (Smith, 1996). The second explored similar issues with 236 women who regularly attend a GP for contraceptive services (Smith & Bury, 2000). Of the family planning clinic attenders, 23% had no GP, 77% had a male GP and 12% had a female GP. Of those who had a GP, 54% did not know whether or not their GP provided contraceptive services and they had never asked. Thirty five per cent of the women wanted to attend a female doctor for

contraception. In the GP attenders study, 74% of the women were satisfied with the service they received from their GPs and 73% thought it was appropriate for GPs or practice nurses to ask all visiting women whether they required contraceptive advice.

Gender differences in accessing contraception were seen in the ICCP study (Rundle et al, 2004). Women were more likely to have accessed contraceptive advice and services through a health professional (GP or family planning clinics) than men (79% versus 37%) and less likely to have used a commercial route (chemist, vending machine) (48% versus 73%). Overall 79% of women had sought contraceptive advice or supplies from a health professional (70% from their GP, 8% from another GP, 26% from family planning clinics); 48% had accessed supplies or advice via the commercial route (pharmacy, vending machine, over the counter). The position for men was very different. Only 25% took the health professional route (20% from their own GP, 2% from another GP) and 73% took the commercial route.

Internationally, it is suggested that older women are likely to access contraception through the GP and younger women are more likely to attend family planning clinics (Ashton et al, 1992; Donovan et al, 1997; Rowlands, 1997; Mahon et al, 1998). However, recent research from the UK and Australia suggests that this may no longer be the case and that more young women now get their contraception advice and services from their GPs than is often assumed (Seamark & Pereira Gray, 1995; Lindsay et al, 1999; Churchill et al, 2000; Wellings et al, 2001). GPs in the UK are a significant source of advice and treatment for teenagers, even in settings where they have access to specific young person's services (Social Exclusion Unit, 1999). This pattern was repeated in the ICCP study with women over 25 being more likely to access contraception through the GP than those aged 18-25 (78% versus 68%). However, even the younger women (aged 18-25) were still significantly more likely to access contraceptive care through general practice than through family planning clinics (68% versus 20%). In their qualitative research, Murphy-Lawless and her colleagues (2004) explore the preferences of young women

> *"Many respondents reported having had successful first-time experiences with both family planning clinics and with GPs. Some found GPs preferable because they knew them locally. Some found clinics preferable because they were anonymous."*

In fact, some younger respondents preferred to go to their GPs because it provided greater anonymity, the only reason they could be going to a family planning clinic was to do with sex.

> *"I went to my family doctor…and I just said 'I'd like to go on the pill please', just like that, and he goes 'Alright so' and 'What age are you?' and he was very matter-of-fact and he was great. And since then, I mean, I went to family planning clinics and it was kind of like doing something seedy nearly." (Shop manager, 22, as reported in Murphy-Lawless et al, 2004, p31)*

There are limited data in relation to women's health services other than contraception. In 1993, 55% of Irish women would not mind whether the doctor carrying out a breast examination was male or female, while 43% expressed a preference for a female doctor (Wiley & Merriman, 1996).

In 1993, 65% of women had ever had a cervical smear (Wiley & Merriman, 1996). The report does not detail where the smear was taken. This had risen to 83% of 718 women in Dublin surveyed in 1999, one third of whom had had their most recent smear taken by a GP (ní Riain et al, 2001). Almost 70% of Irish women have expressed a preference to have their cervical smear taken by a female (Smith, 1996; ní Riain et al, 2001). GPs and practice nurses were the most common source of information about the Irish Cervical Screening Programme (ICSP) identified by women, outside of the Programme itself, in a recent evaluation (Women's Health Council, 2004).

Wiley and Merriman (1996) reported that 61% of women considered they had adequate information about the menopause. For all age groups, the GP was the source most women would use for information on the menopause. Only 13% of the 1,260 women interviewed for the Saffron Initiative report had sought information about the menopause (Saffron Initiative Steering Committee, 1998). This reflects the age range of the women interviewed (18-65 years), as many were probably too young to have cause to consider the menopause. Of these who had actively sought information, 85% had gone to their GP.

3.3 GENDER OF SERVICE PROVIDER

Although there is considerable debate about whether women prefer to consult women GPs and other primary healthcare professionals, relatively little research has been undertaken in this area. The findings on this topic over the past twenty years or so reflect not only the different settings in which the research was undertaken but also the changing consumer demand over that time. Women patients, in general, are more likely to choose a female than a male GP (Graffy, 1990; Ahmad et al, 1991; Bensing et al, 1993: van den Brink-Muinen et al, 1994; Philips & Brooks, 1998a). Studies investigating women's stated preference to consult a female or a male GP have produced less consistent results, although most reported a stronger preference for a female doctor where the consultation involves problems of an intimate or sexual nature (Nichols, 1987; Fennema et al, 1990; Weyrauch et al, 1990; Elstad 1994).

Women find it less embarrassing to attend a female doctor with woman's complaints and perceive female doctors to be more understanding of such complaints and more gentle when performing gynaecological examination than male doctors (Phillips & Brooks, 1998a). In a Belgian study, female GPs are rated more highly than men by both female and male patients undergoing intimate examination, in terms of explanation / communication, the technical aspects of the examination and in giving support to patients during the examination (van Elderen et al, 1998). Almost 70% of Irish women express a preference for a female smear taker (Smith & Bury, 2000; ní

Riain et al, 2001). Men show some same-sex preference, although not as overwhelming as women's (Fennema et al, 1990). They are more likely to prefer a male doctor for genital examination.

Many female teenagers feel more comfortable speaking to female doctors, for all their health needs but particularly for sensitive issues connected to sex and contraception (Malik et al, 2002). A cross-sectional study in primary care in the UK found that rates of teenage pregnancies fell when young people had access to female GPs or younger GPs, or where there was more nurse time available to them (Hippisley-Cox et al, 2000).

Women, as well as being the main users of health services, also constitute the greater proportion of service providers as nurses, midwives, radiographers, physiotherapists and other healthcare staff. Medicine was a male-dominated profession until the latter half of the last century. Over the past 40 years the number of women entering medicine has increased dramatically. It is predicted that by 2012 women doctors in the UK will outnumber men (Roberts, 2005). Internationally, the feminisation of general practice has proceeded at a faster rate than many other medical specialties (Johnston, 1998; Boerma & van den Brink-Muinen, 2000; Roberts, 2005). It has already impacted on general practice and is likely to have a more significant impact in the near future of general practice as the numbers of women continue to increase.

Women who express a preference to attend a woman doctor frequently cite greater empathy as the main reason (Nichols, 1987; van den Brink-Muinen et al, 1994; Phillips & Brooks, 1998a). Research with women GPs suggests that while some perceive themselves as having more empathy than their male colleagues, others do not: they see themselves as GPs who happen to be women rather than "women's GPs" (van den Brink-Muinen et al, 1998).

There is some evidence that women doctors have different consultation patterns, being more likely to be patient-centred and taking longer at each consultation (van den Brink-Muinen et al, 1994). Women doctors are also more likely to perform preventive screening tests, specifically for breast and cervical cancers, than men doctors (Lurie et al, 1993; Franks & Clancy, 1993; van Elderen et al, 1998).

In terms of work practice, women doctors are more likely to work part-time at some stage in their career (RACGP, 2004b; Graham & De La Harpe, 2004; Bradley et al, 1996). Women GPs are less likely to work in practices as principals, usually because of the conflict between out-of-hours duty and family commitments (Graham & De La Harpe, 2004; Sewell, 2001). This indicates the need for more flexible work patterns and more opportunities for flexible training (Gray, 2004).

3.4 WOMEN'S HEALTH AT THE ICGP

Policy Position

The *Future Organisation of General Practice in Ireland* (Irish College of General Practitioners, 1988), popularly known as the "Blue Book", is a wide-ranging statement of College policy at that time. It outlines the underlying principles of Irish general practice – equity and uniformity, patient choice, determinants of quality, sources of motivation, patient incentives and eligibility, extent of government interest, and the evaluation of change. In its priorities for reform, it calls for universal patient registration (that every person should be registered with a GP and that every GP should have an identifiable patient list) and lists eight services in preventive care that should attract special incentives. Three of the eight refer to women's health, specifically antenatal and postnatal care; family planning; cervical cytology and breast examination.

In a joint policy statement from the Irish College of General Practitioners and the Irish Medical Organisation, universal patient registration is once again called for and inter-referral is explicitly supported. Prevention services are identified as a health service priority which should be largely GP-based (ICGP & IMO, 2001).

ICGP Research on Women's Health Service Provision

The evolution of contraceptive service provision in Ireland can be traced through a series of ICGP publications (Table 3.4.1). Oliver and Comber (1994) compared changes in the structure of Irish General Practice over the decade 1982 to 1992. They reported that 81% of GPs were providing a family planning service in 1982 and that this had risen to 96% in 1992 but they did not detail any individual family planning services. An unpublished 1987 national questionnaire survey of GPs reported that 63% provided some level of contraceptive service and 55% provided cervical smears (Irish College of General Practitioners, 1987). In 1994, a questionnaire survey of all ICGP members was undertaken with 860 respondents, a 43% response rate. It provided evidence of the levels of service provision for a range of specific contraceptive services (Irish College of General Practitioners, 1995). At that time, 45% of respondents had a female GP in the practice, 51% of respondents held a Family Planning Certificate and a further 41% wanted to attend a family planning course. The most popular referral option for services not provided by the respondent was private obstetricians and gynaecologists (61%). Referral to other GPs was the fourth ranked option at that time (48%) with referral to family planning clinics (57%) and referral to public obstetric and gynaecology services (55%) being more popular. A national survey was undertaken in 1998 (ní Riain & Canning, 1998). The questionnaire that was validated at that time was amended to reflect changes in the interim and utilised in the 2004 survey reported here. Comparisons with 1998 results are highlighted in the results (Section 6).

Table 3.4.1: Women's health services provision by Irish GPs 1982 – 1998

Service	1982	1987	1992	1994	1998
Family planning	81%	63%	96%		
Hormonal contraception				96%	97.3%
Sterilisation counselling				91%	91.3%
Natural family planning				85%	82.8%
Diaphragm advice				88%	72.4%
Diaphragm fitting				51%	32.8%
IUCD advice				76%	68.8%
IUCD fitting				25%	17.1%
Cervical smear	77%	55%	94%	97%	95.3%
Antenatal care	96%		98%		98.4%

Section 4

Aims and Objectives

Aims

1. To assess the range of contraception and women's health services provided in general practice
2. To explore the role of the GP in the prevention and management of crisis pregnancy.

Objectives of the questionnaire survey

1. To provide data on level of women's healthcare services provided in general practice
2. To identify gaps in service provision and explore the barriers to service provision
3. To explore the reality of services for the prevention and management of crisis pregnancy in general practice
4. To identify referral patterns (including inter-referral)
5. To discover how women are informed about the range of services provided within each practice.

Objectives of the GP interviews

1. To explore the views of a range of GPs on providing women's health services in their practices
2. To identify the specific difficulties in providing services for specific groups
3. To capture the experience of GPs in managing crisis pregnancies
4. To identify the specific difficulties for GPs in supporting women with crisis pregnancies
5. To canvas GPs' views on the changes in women's health services over the past five years – in their own practices and in general.

Section 5

Methodology

A combination of quantitative and qualitative approaches was required to assess the range of contraception and women's health services provided in general practice and to explore the role of the GP in the prevention and management of crisis pregnancy. Quantitative research provides an objective means to collect information about people's knowledge, beliefs, attitudes and behaviour (Oppenheim, 1992) and postal questionnaires are widely used to collect data in health research and are often the only financially viable option when collecting information from large, geographically dispersed populations (McAvoy & Kaner, 1996; Edwards et al, 2002). Qualitative research provides more in-depth understanding of issues in their specific context (Sofaer, 2002).

A self-completed postal questionnaire was chosen to provide a national perspective on the activities of GPs in key areas of women's health and semi-structured telephone interviews were undertaken to provide further exploration of GPs' views on the developments in women's health over the past five years.

5.1 THE NATIONAL SURVEY

The quantitative element of this study was a cross-sectional national survey of members of the Irish College of General Practitioners, randomly selected and geographically stratified.

Questionnaire design and piloting

The questionnaire addressed

- Contraceptive services provided
- Other women's health services provided
- Reasons for not providing specific services
- Referral patterns for women's health services
- Organisation of women's healthcare services in primary care
- GPs' experiences of crisis pregnancy and its management
- GPs' education and training needs.

We also collected demographic data on respondents including personal and practice characteristics.

The questionnaire was designed with the 1998 survey instrument as its template to maximise opportunities for comparisons. A new section on crisis pregnancies was included. Research personnel at the ICGP and the CPA were consulted in questionnaire design.

The questionnaire was piloted with six GPs, selected on the basis of their expertise in research and/or women's health. The questionnaire was modified to reflect the comments of the piloted group and the analysis of their responses.

Sample selection

The Irish College of General Practitioners' membership database contains 2,750 members in 37 geographically based faculties. The 2,461 members and associate members within the Republic of Ireland account for about 95% of general practitioners currently practising in the jurisdiction (Irish College of General Practitioners, 2004). A 33% randomised sample was generated from each faculty by random allocation using SPSS random number allocation, resulting in a sample frame of 832 general practitioners.

Administration of questionnaire

The questionnaire was posted out with a FREEPOST envelope, a postage-paid postcard and a letter outlining the purpose of the research.

The postcard reply system, as described by Cahalan (1951), was utilised to permit anonymity. The reply card identifying the respondent was sent with each questionnaire which itself had no identifiers. The card and completed questionnaire were returned separately. The respondent could indicate one of three choices on the reply card – that they had completed and returned the questionnaire, that they were not in active practice or that they were not interested in participating. On receipt of the reply card, the respondent's name was removed from the dataset and no further mailing was sent.

Respondents' reply cards were included in a draw for a €125 book voucher. This incentive was detailed in the letter distributed with the questionnaire.

Two rounds of questionnaires were posted out in April and May 2004. No further attempts were made to contact non-responders.

Data analysis

Data analysis was carried out using the Statistical Package for the Social Sciences (SPSS), Version 12.0. Comparisons of proportions were carried out using chi-squared analysis. Comparisons of means between groups were carried out using t-tests and F-tests. Exact p-values are presented to three decimal places except where the p-value is extremely small, in which case a p-value of < 0.01 is used.

5.2 THE TELEPHONE INTERVIEWS

Method selection

Telephone interviews were undertaken to provide further exploration of GPs' views on the developments in women's health over the past five years, both in their own practices and generally,

and their views of their role in providing services. Semi-structured telephone interviews, rather than focus groups, were chosen in order to grant the participating GPs a level of anonymity, thereby hoping for more frank and honest discussion.

Interview guide

An interview guide was developed from the results of the questionnaire survey and the experience of the research group. The themes addressed were:

- Changes (if any) in women's health in the past five years or so and the influences on them
- Women's health services not provided in the practice and the reasons why
- How women are advised of the women's health services provided in the practice
- How GPs handle crisis pregnancies and their experiences of referral to other services
- Views on sub-groups whose needs are not well served at present
- Education and training needs of GPs
- STI services in general practice.

Sample selection

A purposive sample of twelve GPs was identified. These were selected by the research group to represent a spread of gender, age, geographical location and practice setting and a spectrum of views on women's health issues. Four GPs who had written to the general or medical press or to the ICGP women's health programme expressing conservative views were identified. Four GPs with a special interest in women's health ("enthusiasts") and four GPs who provide "standard" general practice services were also identified from previous interactions with the ICGP Women's Health Programme.

Research procedure

All telephone interviews were undertaken by one researcher (MD) who had not previously been associated with the ICGP Women's Health Programme.

Three phone calls to each GP were necessary to complete the interview process. All twelve GPs were contacted initially by telephone. This first contact served to outline the purpose of the interview. The interview guide was emailed or faxed to the doctor subsequently, along with an explanatory letter detailing the methodology and ensuring confidentiality and anonymity.

A second phone call established their consent to participate and scheduled the interview at a time convenient to the doctor. The interview itself was carried out in a third phone call.

GPs with a keen interest in women's health were chosen as pilot interviewees in order to finalise the interview guide. Minor adjustments were made to the questions based on these interviews.

Data analysis

The calls were not recorded. However, the pace of the interviews was such that the researcher could take comprehensive notes, including verbatim comments. These detailed field notes were transcribed immediately after each interview.

Data analysis was performed using a Framework Analysis, as described by Ritchie and Spencer (1994). This pragmatic approach to qualitative data analysis emerged from applied policy research and involves five stages: familiarisation, developing a thematic framework, indexing, charting, mapping and interpreting. Initial analysis and interpretation was tested in subsequent interviews.

5.3 ETHICAL CONSIDERATIONS

The study proposal was submitted to the ICGP Research Ethics Committee who stated that ethical approval was not required, as the survey did not involve patient contact or access by the researchers to patient records.

National Survey Results

6.1 RESPONSE RATE TO THE QUESTIONNAIRE

The initial sample was cleaned by the researchers resulting in the deletion of 14 names (Table 6.1.1). The first mailing (818 questionnaires) yielded 333 completed questionnaires (an initial response rate of 40.7%) and resulted in the deletion of a further 48 doctors from the dataset. In the second mailing, 437 questionnaires were distributed. One hundred and eleven completed questionnaires were returned.

Table 6.1.1: Sampling process

Initial sample			**832**
Deletions	Not in active practice	14	
Adjusted sample			**818**
	Not in active practice	64	
	Gone away/address unknown	3	
Valid sample			**751**
Reply cards returned			436
Completed questionnaires			452
	Questionnaires analysed	444	
	Late questionnaires	8	

From a valid sample of 751, there were 452 completed questionnaires returned. This represents a response rate of 60.2%. Responses were received from all counties in the Republic of Ireland. Eight questionnaires, received after the analysis was underway were excluded.

Comparisons throughout this report are to the 2004 membership database of the ICGP (accessed November 2004), the 1998 ICGP survey of Women's Health Service Provision (ní Riain & Canning, 1998) which was similarly randomised and geographically stratified and the 1997 National Survey of Irish General Practitioners which was a census survey (Nic Gabhainn & Kelleher, 1998).

6.2 DEMOGRAPHIC PROFILE OF RESPONDERS

PERSONAL CHARACTERISTICS

Respondents were asked to provide their age and gender and to indicate if they were vocationally trained (Table 6.2.1). Age and gender profiles were then compared with the same profiles for the ICGP membership as recorded in the membership database in November 2004.

Table 6.2.1: Comparison of personal characteristics of respondents with the ICGP membership database (November 2004)

	2004 WH Survey (N=433) %	ICGP Database 2004 (N = 2525) %
AGE		
35 and under	16.4	17
36-45	32.8	25
46-55	33.3	31
56-65	16.8	18
66+	0.7	9
GENDER		
Male	58.2	60.5
Female	41.8	39.5
VOCATIONAL TRAINING		
Yes	66.3	n/a*
No	33.7	n/a*

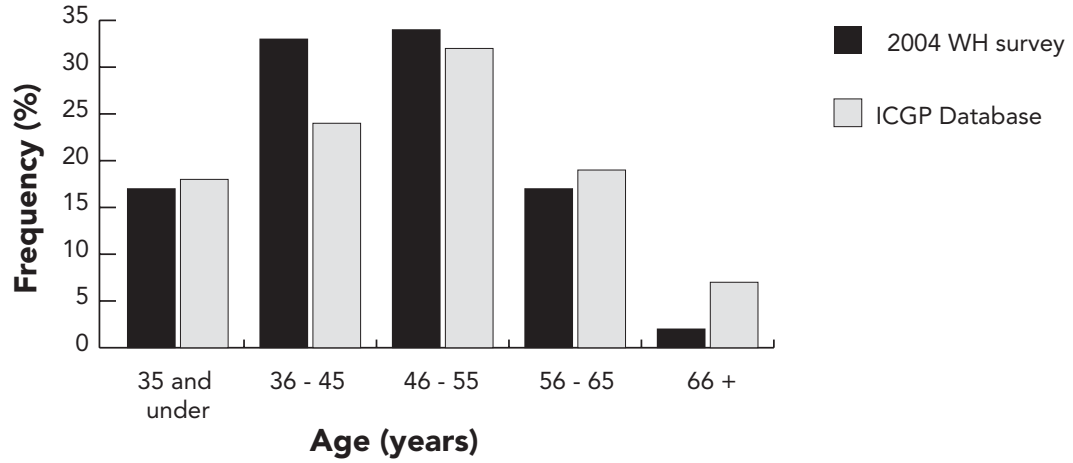
n/a* = not available

Age

The age profile of respondents is broadly reflective of that of Irish GPs generally, although slightly over-representing the 36-45 year age group and under-representing the 66+ age group (Figure 6.2.1). This suggests that we have had a higher response rate from those in active practice and that those who are retired or soon to retire were less likely to respond to the survey. This is a consistent with the 78 from the original sample group who returned post-cards indicating that they are not presently in active practice.

The mean age of respondents was 46.1 years (median age 46 years). One third of our respondents (32.2%) were aged 40 years or younger.

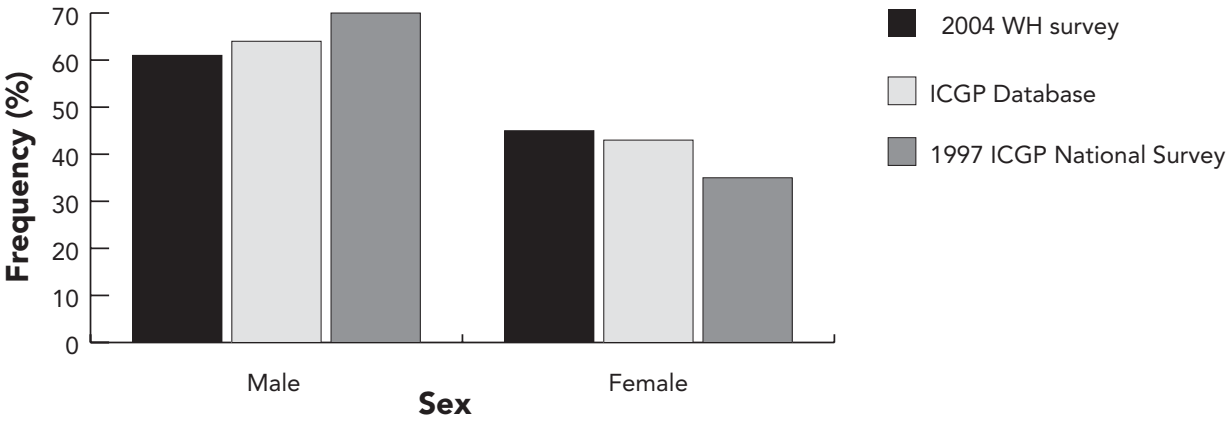
Figure 6.2.1: Comparison of age profile of respondents with the ICGP membership database (November 2004)



Gender

The gender profile of respondents is reflective of that of the membership database for 2004 and significantly different from the 1997 ICGP national survey, reflecting the changing profile of Irish general practice (Figure 6.2.2). This change demonstrates that Irish general practice is experiencing feminisation in line with international experience (Johnston, 1998; Boerma & van den Brink-Muinen, 2000; Roberts, 2005). Over the past half century, the number of women entering medicine has increased dramatically and the number choosing to specialise in general practice has increased at a greater rate.

Figure 6.2.2: Comparison of gender profile of respondents with the ICGP membership database (November 2004) and the 1997 ICGP national survey



Vocational Training

Two thirds of respondents (66.3%) indicated that they had completed specialist postgraduate training in general practice.

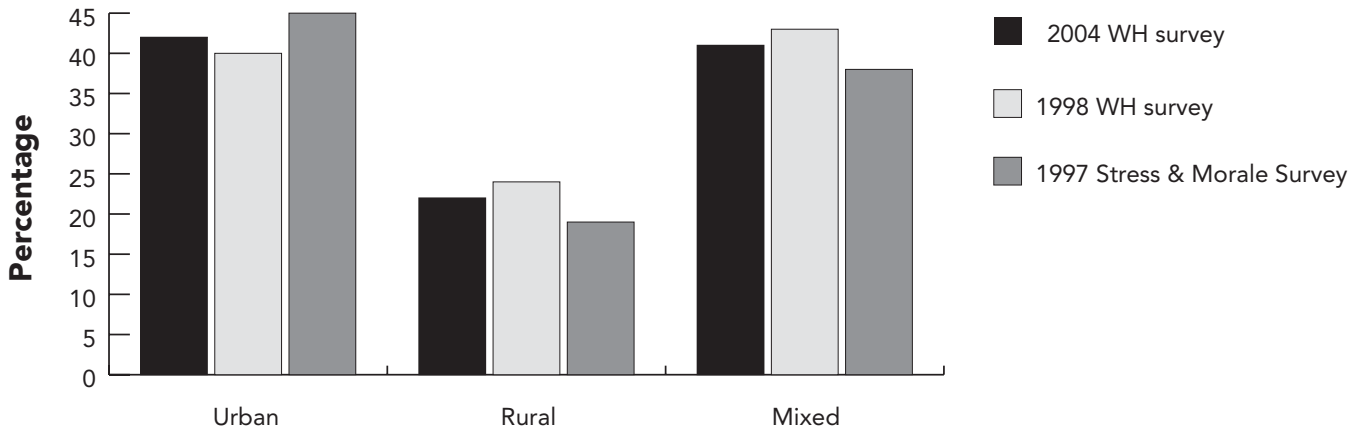
PRACTICE CHARACTERISTICS

Respondents indicated the location of their practices and described the numbers and gender of doctors in these practices, along with details of support staff and services.

Practice location

Respondents were distributed across practice locations with 40% practising in an urban setting, 19.8% in a rural setting and 40.2% in a mixed setting. This is reflective of previous profiling of Irish GPs in the Stress and Morale survey (O'Dowd et al, 1997) and the 1998 Women's Health survey (Figure 6.2.3).

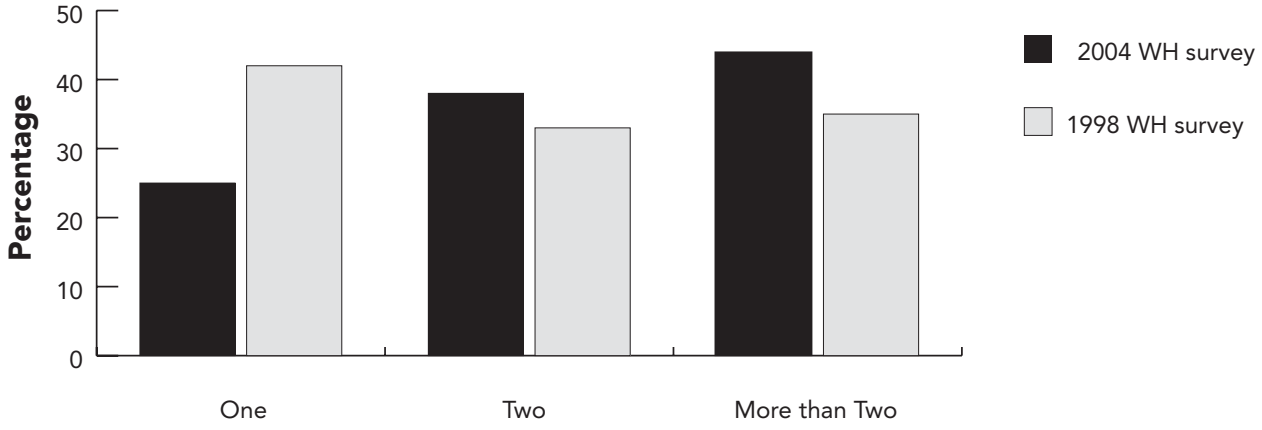
Figure 6.2.3: Comparison of the practice location of respondents with the 1998 Women's Health survey and the 1997 Stress & Morale survey



Total number of doctors in practice

Almost one quarter of respondents (23.4%) have only one GP active in the practice, 34.0% work with one other GP and 42.6% work with more than one other GP in their practice. This reflects the continued move away from single-handed practice to group practice since the 1998 Women's Health survey (Figure 6.2.4).

Figure 6.2.4: Comparison of the number of doctors active in the practices of respondents with the 1998 Women's Health Survey



While 53.2% of practices have no part-time GPs, 31.1% of practices have one part-time GP and 15.7% have more than one part-time GP.

Gender of doctors in the practice

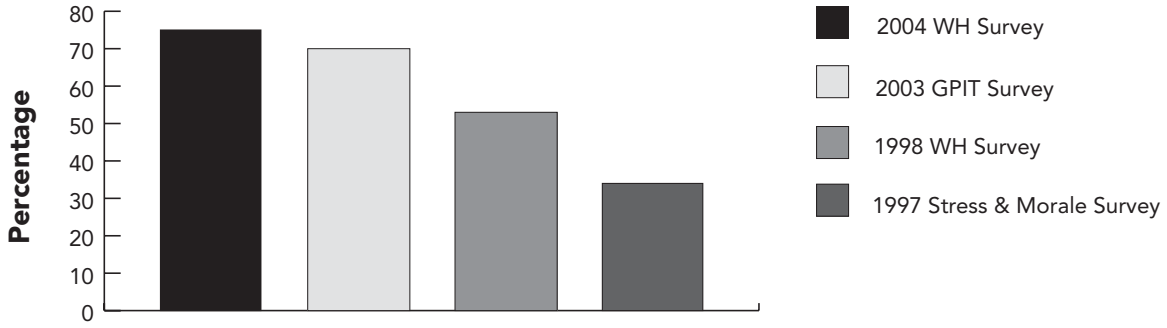
Three quarters (74.5%) of practices have at least one female GP in the practice, a significant increase from the 64.6% having at least one female GP in 1998 ($p < 0.01$).

While rural practices had been less likely to have a female GP in 1998, compared to urban practices (52.5% versus 34.5%; $p < 0.01$), there is no significant difference in 2004.

Support staff and services

In this study 71.7% of practices have a practice nurse, compared with 66% in the 2003 General Practice Information Technology survey (GPIT, 2003), 46% of practices in the previous ICGP Women's Health survey (ní Riain & Canning, 1998) and 31% in the Stress & Morale study (O'Dowd et al, 1997). This reflects the changing profile of Irish general practice and the increasing numbers of practices employing a practice nurse (Figure 6.2.5). Rural and mixed practices were more likely to employ a practice nurse than urban practices.

Figure 6.2.5: Proportion of practices having at least one practice nurse, compared with earlier GP surveys



Just under one half (44.8%) of practices have a practice manager, compared with 28% in the GPIT Survey (GPIT, 2003). A similar proportion (79.1%) of practices reported having a computer in the consulting room as in the national GPIT survey (83%) (GPIT, 2003).

Access to female health professionals

Patients attending 400 of the 444 respondents (90.1%) have access to at least one female healthcare professional in the practice – either the respondent, a practice nurse or a female GP. This reflects a significant change from the 1998 survey where the corresponding figure was 77.4% ($p < 0.01$).

6.3 CONTRACEPTION SERVICE PROVISION

A list of the ten most commonly provided contraception services was offered and respondents were asked to indicate whether or not they provided each of these (Table 6.3.1).

Table 6.3.1: Contraception services provided by respondents (N = 444)

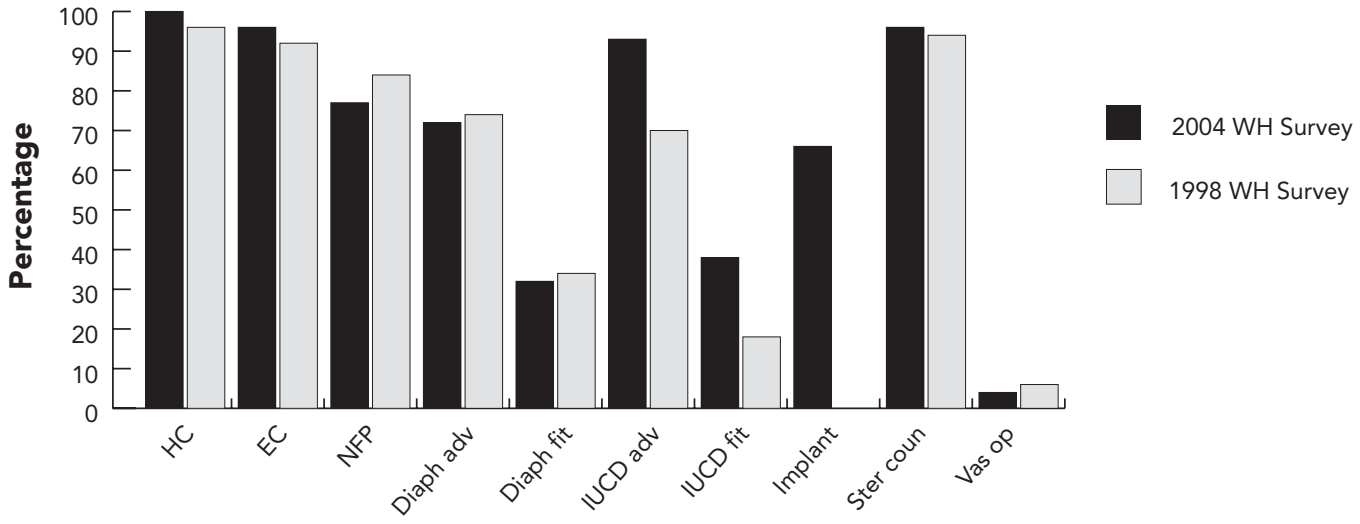
Contraception Service	GPs providing the service		GPs not providing the service	
	%	N	%	N
Hormonal contraception	99.5	441	0.5	3
Emergency contraception	97.1	428	2.9	16
Natural Family Planning	74.7	328	25.3	116
Diaphragm advice	70.4	309	29.6	135
Diaphragm fitting	29.5	127	70.5	317
IUCD advice	90.3	399	9.7	45
IUCD fitting	35.4	151	64.6	293
Contraceptive implant insertion	55.6	243	44.4	201
Sterilisation counselling	95.9	422	4.1	22
Vasectomy operation	3.2	14	96.8	430

Statistically significant differences were seen in all contraceptive service provision levels, with the exception of diaphragm services and implant insertion, when compared with the 1998 Women's Health survey (Figure 6.3.1).

A higher proportion of GPs provide hormonal contraception, emergency contraception, IUCD advice and fitting and sterilisation counselling in 2004 than did in 1998, while fewer GPs provide natural family planning advice and vasectomy operation. There was no significant difference in the likelihood of providing diaphragm advice and fitting between the two surveys.

The reasons for these changes are discussed in Section 6.4.

Figure 6.3.1: Comparison of contraception services provided by Irish GPs in 2004 and 1998



Hormonal Contraception (HC)

The vast majority of GPs provide hormonal contraception (99.5%).

Emergency Contraception (EC)

Just over 97% of Irish GPs provide emergency contraception. This shows a significant rise from the corresponding rate in 1998, which was 90.7% ($p < 0.01$).

Doctors aged 40 and younger were more likely, but not significantly so, to provide emergency contraception than their older colleagues (99.3% versus 95.9%). Male and female doctors are equally likely to provide this service. Practice location had no significant influence on the likelihood of providing this service. Single-handed GPs are significantly less likely to provide emergency

contraception than those in group practice (93.3% versus 98.2%; $p < 0.01$). The presence of a female health professional in the practice has no impact on the likelihood of emergency contraception being provided.

Natural Family Planning (NFP)

Almost three quarters of the GPs (74.7%) provide natural family planning advice. This proportion has dropped from 82.8% in 1998 ($p < 0.01$).

Neither the age nor gender of the GP nor the practice location had a significant influence on the likelihood of providing this service.

Diaphragm

Just over 70% of doctors provide advice about the diaphragm and 29.5% offer diaphragm fitting. Both of these percentages have dropped slightly from 1998 when they were 72.4% and 32.8% respectively but these changes are not statistically significant.

Younger GPs are significantly less likely than those over 40 years of age to provide diaphragm advice (59.6% versus 79.4%; $p < 0.01$) and fitting (17.3% versus 35.4%; $p < 0.01$). While there is no significant gender difference in the provision of diaphragm advice (71.5% females versus 69.4% males), female GPs are more likely to provide diaphragm fitting than their male colleagues (37.0% versus 24.1%; $p < 0.01$).

Intrauterine Contraceptive Device (IUCD)

GPs were significantly more likely to offer both advice about intrauterine contraceptive devices and to fit them in 2004 than in the previous women's health survey in 1998. In 2004, 90.3% of respondents provide IUCD advice, compared with 68.8% in 1998 ($p < 0.01$). Slightly over one third of respondents (35.4%) fit IUCDs and this rate has doubled since 1998 when it was 17.1%.

The likelihood of providing either IUCD advice of fitting is associated with a number of variables (Table 6.3.2). Doctors aged 40 and younger, female doctors, doctors who are vocationally trained and doctors who work in practices with a female healthcare professional (female respondent, other female GP, practice nurse) are all significantly more likely to provide IUCD advice ($p < 0.01$). With regard to IUCD fitting, doctors aged 40 and younger, female doctors and doctors who work in practices with a female healthcare professional are also significantly more likely to provide IUCD fitting.

Table 6.3.2: Characteristics of GPs providing IUCD services

		IUCD advice (%)		IUCD fitting (%)	
Overall		90.3		35.4	
Age	< 40	96.5		43.1	
	> 40	87.4	p < 0.01##	31.8	p < 0.05#
Gender	Male	86.7		29.1	
	Female	95.1	P < 0.01##	44.1	p < 0.01##
Training	VT	93.5		37.7	
No VT		84.2	P < 0.01##	29.8	p = 0.100
Practice	Single-handed	88.3		21.8	
	Group	90.9	p = 0.451	39.6	p < 0.01##
PN	Yes	94.0		40.4	
	No	80.6	P < 0.01##	22.2	p < 0.01##
FHP	Yes	92.2		37.2	
	No	72.1	P < 0.01##	18.6	p < 0.05#

PN = practice nurse; FHP = female healthcare professional in the practice; VT = vocational training
# significant at the 0.05 level ## significant at the 0.01 level

Contraceptive Implant Insertion

Contraceptive implant insertion is provided by 55.6% of doctors. Female GPs are more likely to insert implants than males (57.4% versus 39.5%; p = 0.035). Younger doctors are more likely to offer the service than those over 40 years (65.5% versus 50.9%; p < 0.01). There is no statistically significant difference in implant insertion rates between single-handed GPs and those in group practices. Implant insertion rates do not vary significantly with practice location.

Sterilisation Counselling

The majority of GPs offer counselling about sterilisation (95.9%). The likelihood of providing sterilisation counselling does not vary with the age or gender of the GP or the location of the practice.

Vasectomy Operation

Relatively few doctors provide vasectomy (3.2%) and this number has halved since 1998 (6%). This is a reversal in the general trend of increasing rates of contraceptive service provision. Vasectomies are almost exclusively provided by male GPs – of the 14 respondents who offer this service, 13 are male and 1 is female.

Geographic Variation

All services were analysed to look for differences in provision levels between Dublin city and county respondents and the rest of the country. With the exception of implant insertion, there were no

statistically significant differences. GPs outside Dublin were significantly more likely to offer implant insertion than Dublin GPs (62.2% compared to 42.2%).

6.4 REASONS FOR NOT PROVIDING CONTRACEPTION SERVICES

Where respondents indicated that they were not providing a specific service, they were asked to indicate the reasons for not providing it. They were given a range of options such as "lack of demand", "lack of skill" etc. and could tick more than one option in their response. They were also asked to indicate whether or not they referred patients elsewhere for these services, and if so, where they referred.

Where respondents are not providing specific contraceptive services the most common reasons overall are lack of demand and lack of skill (Table 6.4.1). GPs who do not provide natural family planning or diaphragm advice or fitting are most likely to identify lack of demand as the reason. GPs who do not provide IUCD advice or fitting, contraceptive implant insertion, sterilisation counselling or vasectomy all cited lack of skill as the most common reason. The absolute numbers who are not providing contraceptive options on moral principle are generally small – generally 1 or 2 respondents in each case. The notable exceptions to this are emergency contraception (13 GPs, 2.9%) and IUCD fitting (11 GPs, 2.4%).

Only two (0.5%) respondents do not provide hormonal contraception. Both stated that they do not provide this service because of moral principle. Neither of these doctors refers patients requesting the pill to other services.

Thirteen respondents (2.9%) do not provide emergency contraception. This compares with 9.6% in 1998 and represents a significant decrease in those who do not provide this service ($p < 0.01$). Those who do not provide emergency contraception cite moral principle as the reason why they do not offer it. Only three of the 13 who do not provide EC do not refer elsewhere. The remaining ten refer to other GPs, either in their own or another practice, or to family planning clinics.

Referral Patterns for Contraception Services (Table 6.4.1)

Where GPs do not provide a contraceptive service, the majority are willing to refer to other service providers. The most frequently preferred referral option is other GPs, either in their own or another practice (for emergency contraception, IUCD advice and fitting and implant insertion and vasectomy operation). Family planning clinics are the first choice referral for diaphragm advice and fitting and hospital services for sterilisation counselling.

GPs in 2004 are more likely to refer to other GPs for the services they themselves do not provide than they were in 1998. The corresponding referral rates to family planning clinics have dropped in this time frame.

Table 6.4.1: Principal reasons why contraception services are not provided and the most commonly cited referral options for these services

Contraception service	Do not provide (%)	Principal reasons for not providing (% of those who do not provide service) *	Do not refer (% of those who do not provide service)	Most frequent referral options (% of those who do no provide service) *
Hormonal contraception	0.5	Moral principle (100)	100	-
Emergency contraception	2.9	Moral principle (100)	23	Other GPs (69) FPCs (38)
Natural Family Planning	25.3	Lack of demand (76) Lack of skill (38) Lack of time (24)	22	FPCs (33) Other GPs (4) Other (15)
Diaphragm advice	29.6	Lack of demand (68) Lack of skill (55)	11	FPCs (37) Other GPs (21)
Diaphragm fitting	70.5	Lack of demand (57) Lack of skill (53)	5	FPCs (38) Other GPs (27)
IUCD advice	9.7	Lack of skill (54) Lack of demand (18) Lack of time (18)	5	Other GPs (60) FPCs (37)
IUCD fitting	64.6	Lack of skill (57) Lack of time (16)	1	Other GPs (55) FPCs (32) Hospital (11)
Contraceptive implant insertion	44.4	Lack of skill (51) Lack of demand (20) Lack of time (14)	3	Other GPs (50) FPCs (26) Hospital (9)
Sterilisation counselling	4.1	Lack of skill (33) Lack of demand (33) Lack of time (28)	5	Hospital (50) Other GPs (39) FPCs (33)
Vasectomy operation	96.8	Lack of skill (72) Lack of time (14) Lack of facilities (14)	0.5	Other GPs (46) Hospital (25) FPCs (19)

* %s may sum to > 100% as respondents could tick more than one response

FPC = Family Planning Clinic; Hospital = Hospital based services

6.5 CORE CONTRACEPTION SERVICES IN GENERAL PRACTICE

Contraception is widely regarded as an essential service provided by GPs and GPs themselves concur with this view. While it is neither desirable nor necessary that every GP should provide all contraception services personally, it is generally accepted that there are core services that every GP who chooses to provide contraception services should provide. For the purposes of this analysis we have defined these as:

- Hormonal contraception
- Emergency contraception
- IUCD advice
- Sterilisation counselling.

85.6% of Irish GPs provide all four of these services in 2004.

Female doctors are significantly more likely to provide all four services (90.1% versus 82.4%; $p = 0.027$). Younger doctors are also significantly more likely to provide all four services (93% of those aged 40 or under versus 82.1% of those over 40; $p = 0.002$). While single-handed practitioners are less likely to provide all four services, the difference just fails to reach statistical significance (79.6% versus 87.5%; $p = 0.054$). Practice location is a significant influence on the likelihood of providing all four services with 93.1% of mixed practices providing them compared with 81.6% of rural practices and 79.9% of urban practices ($p < 0.01$).

There was no significant geographical variation with GPs outside Dublin as likely to provide core contraception services as Dublin GPs.

6.6 PROVISION OF WOMEN'S HEALTH SERVICES OTHER THAN CONTRACEPTION

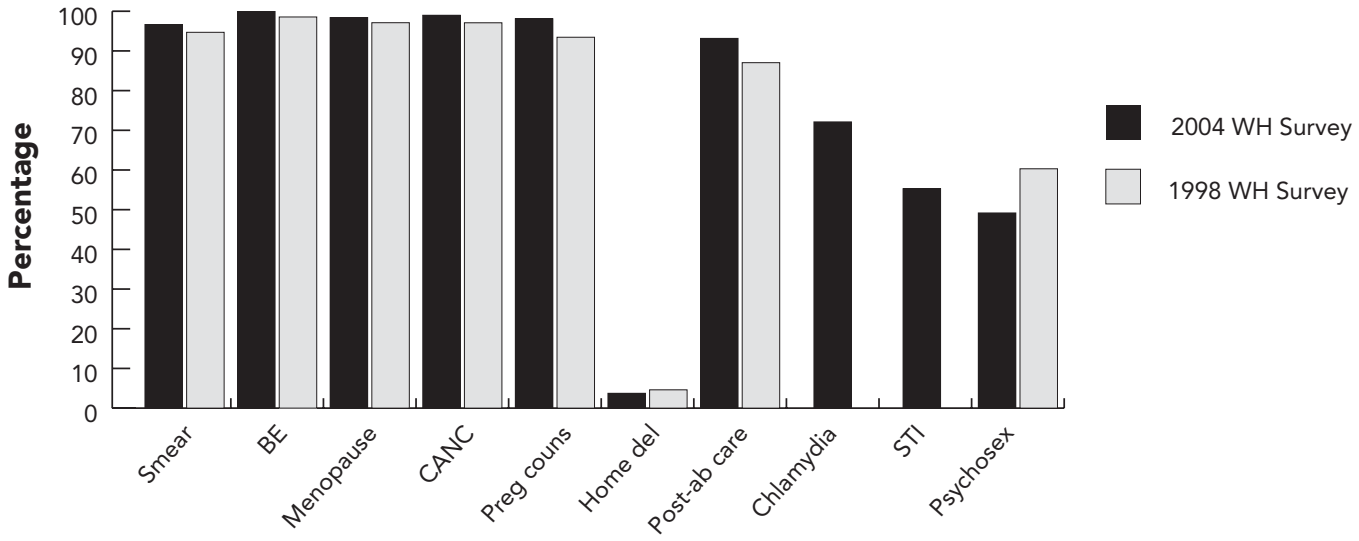
A list of the ten most commonly provided women's health services other than contraception was offered and respondents were asked to indicate whether or not they provided each of these (Table 6.6.1).

Table 6.6.1: Women's health services other than contraception provided (N = 444)

Women's Health Services other than contraception	GPs providing the service		GPs not providing the service	
	%	N	%	N
Cervical smear	95.7	423	4.3	21
Breast examination	99.8	442	0.2	2
Menopause counselling	99.3	440	0.7	4
Pregnancy counselling	99.1	440	0.9	4
Combined antenatal care	99.3	438	0.7	6
Home delivery	2.5	11	97.5	433
Medical care after abortion	95.4	418	4.6	26
Chlamydia testing	76.9	336	23.1	108
STI service	54.3	238	45.7	206
Psychosexual counselling	46.9	203	53.1	241

There were fewer significant changes in levels of service provision of these women's health services than were seen in contraception service provision. The proportion of GPs providing pregnancy counselling and medical care after abortion has significantly increased since 1998 and the proportion providing psychosexual counselling has decreased. All remaining services showed no statistically significant differences (Figure 6.6.1).

Figure 6.6.1: Comparison of women's health services other than contraception provided by Irish GPs in 2004 and 1998



Cervical Smears

Cervical smears are taken in the practices of 95.7% of the GP respondents. This proportion is unchanged since 1998 (95.3%).

Although the majority of respondents take cervical smears, only 61.2% take them frequently with 31.3% taking them occasionally. Younger doctors, those who are vocationally trained and those who employ a practice nurse are all significantly more likely to offer cervical smears than their relevant comparator groups.

Most cervical smears in individual practices are taken by female doctors (47.2%) and practice nurses (38.9%) with only 11% of respondents stating that most of the smears in their practice are taken by a male doctor.

While 87.5% of GPs are satisfied with their own competence in smear taking, 3.1% express dissatisfaction with their own competence. This represents no real change in self-rated competence since 1998 when the respective rates were 87.7% and 4.5%. Female doctors were more likely to be satisfied with their competence than male doctors.

Breast Examination and Menopause Counselling

The vast majority of GPs provide both breast examination and menopause counselling (99.8% and 99.3% respectively).

Services for Pregnant Women

The vast majority of GPs provide pregnancy counselling (99.1%) and antenatal care (99.3%). The number providing medical care after abortion has increased since 1998 (95.5% versus 88.4%; $p < 0.01$).

There were no significant associations between the likelihood of providing pregnancy counselling or medical care after abortion and the gender of the GP, single-handed or group practice, employment of a practice nurse or the presence of a female co-worker.

The difference in numbers between those who provide pregnancy counselling but not medical care after abortion has reduced from 6.9% in 1998 to 3.7% in 2004.

A very small number of GPs provide home delivery services (2.5%). This has remained essentially unchanged since 1998 (2.8%).

A more detailed analysis of the provision of crisis pregnancy services can be found in section 6.9.

Sexually Transmitted Infections (STIs):

Slightly more than half the GPs surveyed provide an STI service (54.3%) with three quarters (76.9%) providing testing for *Chlamydia trachomatis*.

Female GPs are significantly more likely to provide both STI services ($p = 0.026$) and chlamydia testing ($p < 0.01$) than their male colleagues. Single-handed GPs are significantly less likely to provide an STI service ($p = 0.016$) or chlamydia testing ($p < 0.01$) than those in group practice. Practices with a female healthcare professional (either GP or practice nurse) are significantly more likely to offer chlamydia testing ($p < 0.01$).

Geographical Variation

There was no statistically significant geographical variation for any individual service with GPs outside Dublin as likely to provide the services as Dublin GPs.

6.7 REASONS FOR NOT PROVIDING WOMEN'S HEALTH SERVICES OTHER THAN CONTRACEPTION

Where respondents indicated that they were not providing a specific service, they were asked to indicate the reasons for not providing it. They were given a range of options such as "lack of demand", "lack of skill" etc. and could tick more than one option in their response. They were also asked to indicate whether or not they referred patients elsewhere for these services, and if so, where they referred.

Where respondents are not providing specific women's health services, various reasons were given (Table 6.7.1). As the absolute numbers who were not providing breast examination (1), menopause

counselling (3) pregnancy counselling (4) or combined antenatal care (3) were small, no further analysis of these individuals was undertaken.

Table 6.7.1: Principal reasons why women's health services other than contraception are not provided and the most commonly cited referral options for these services

Women's health service	Do not provide (%)	Principal reasons for not providing (% of those who do not provide) *	Do not refer (% of those who do not provide service)	Most frequent referral options (% of those who do not provide service) *
Cervical smear	4.3	Gender barrier (53) Lack of facilities (26)	-	Other GPs (95) Hospital (37) FPCs (26)
Breast examination	0.2	-	-	-
Menopause counselling	0.7	-	-	-
Pregnancy counselling	0.9	-	-	-
Combined antenatal care	0.7	-	-	-
Home delivery	97.5	Lack of skill (49) Lack of demand (31) Lack of time (24) Other reason (41)	15	Hospital (41)
Medical care after abortion	4.6	Lack of demand (65) Lack of skill (20)	10	Hospital (25) FPCs (20) Other GPs (5)
Chlamydia testing	23.1	Lack of facilities (49) Lack of skill (32) Lack of demand (11)	0	Hospital (55) Other GPs (13) FPCs (9)
STI service	45.7	Lack of facilities (40) Lack of skill (37) Lack of time (25)	0	Hospital (69) Other GPs (10) FPCs (4)
Psychosexual counselling	53.1	Lack of skill (64) Lack of time (37)	0.9	Hospital (23) FPCs (15) Other GPs (7)

* %s may sum to > 100% as respondents could tick more than one response
FPC = Family Planning Clinic; Hospital = Hospital based services

Referral Patterns for Women's Health Services other than Contraception (Table 6.7.1)

The vast majority of those GPs who do not provide individual women's health services other than contraception are willing to refer patients to other services providers, with the notable exception of home delivery. The most frequently preferred referral option is hospital-based services (for requests for home delivery, medical care after abortion, chlamydia testing, STI service and psychosexual counselling). Where GPs do not provide cervical smear tests, they prefer to refer to other GPs.

6.8 RANGE OF CONTRACEPTION AND WOMEN'S HEALTH SERVICES PROVIDED

Of the total twenty women's health services specified in the questionnaire, the total number of services provided by each respondent ranged from 6 to 20, with a mean of 14.2 (median=14).

Age was not a significant predictor of the mean number of services provided with an average of 14.3 services provided by younger GPs and 14.1 by those over 40 years.

Female GPs were significantly more likely to provide a greater number of services than male GPs (14.6 versus 13.9; $p < 0.01$).

Single-handed GPs provided significantly fewer services on average than those in group practices (13.6 versus 14.3; $p = 0.01$).

The presence of a female in the practice significantly increased the average number of women's health services provided (14.3 versus 13.1; $p < 0.01$).

The practice location also had a significant impact on the average number of services provided with the average for mixed practices being 14.6 compared with urban (13.9) and rural (13.8) ($p < 0.01$).

The geographical location had no significant impact on the average number of services provided with GPs in the rest of the country as likely to provide services as GPs in Dublin.

6.9 MANAGING CRISIS PREGNANCIES IN GENERAL PRACTICE

Respondents were asked a number of questions about their management of crisis pregnancies. In the first instance they were asked to estimate how many women they had seen for the first visit in pregnancy in the month previous to completing the questionnaire. The majority of respondents are active in providing pregnancy-related care with 417 respondents (93.9%) seeing at least one woman for a first pregnancy visit in that time frame (Table 6.9.1). Almost half of these first visits (48%) were to doctors who saw between one and five women for a first pregnancy visit in the previous month. The modal number of first visits to a GP in the previous month was four. The mean number was 4.61 (95% CI 4.20 – 5.03).

Table 6.9.1: Estimate of the number of women seen for a first visit in pregnancy in the month previous to completing the questionnaire (N = 444)

Number of women seen for first pregnancy visit	Number of GPs reporting this number (%)
0	27 (6.1%)
1	23 (5.2%)
2	75 (16.9%)
3	78 (17.6%)
4	85 (19.1%)
5	48 (10.8%)
6	44 (9.9%)
7	7 (1.6%)
8	8 (2.0%)
9	0
10	26 (5.9%)
> 10	22 (5.0%)

Respondents were then asked to estimate how many of these women perceived the pregnancy as a problem or a crisis. Almost two thirds (285 GPs, 64.2%) had not seen a woman in a crisis pregnancy in the previous month. One hundred and fifty nine GPs (35.8% of respondents) saw at least one crisis pregnancy in the month previous to completing the questionnaire (Table 6.9.2). There was no significant difference in the mean number of women seen for a first pregnancy visit in the previous month between Dublin GPs and GPs outside Dublin.

Table 6.9.2: Women seen for a first pregnancy visit in the month previous to completing the questionnaire who perceived the pregnancy as a problem or a crisis (N = 444)

Number of women with problem or crisis pregnancy	Number of GPs reporting this number (%)
0	285 (64.2%)
1	125 (28.2%)
2	24 (5.4%)
3	7 (1.6%)
4	1 (0.2%)
8	2 (0.5%)

Of the total number of women seen for a first visit in pregnancy, respondents estimate that 10.4% of these pregnancies were crisis pregnancies. There was no significant difference in the proportion of first visits identified as crisis pregnancies between Dublin GPs and GPs in the rest of the country.

Respondents were asked to indicate whether they provide "pregnancy counselling" in Question 1. In Question 4 they were asked to indicate if they provide "crisis pregnancy counselling" specifically. While 99% of respondents report that they pregnancy counselling, 92.9% report that they provide counselling for crisis pregnancy. There are no statistically significant differences between GPs in terms of their age, sex or practice setting in their willingness to provide this service. While 37.5% of GPs who provide crisis pregnancy counselling report that at least one woman who attended in the past month for a first visit in pregnancy considered it to be a crisis the proportion for those who do not provide crisis pregnancy counselling was 19.4%. This difference verges on statistical significance ($p = 0.052$).

The majority of doctors are willing to refer women in crisis pregnancies to other agencies (376 doctors, 88.3%). This proportion includes those who provide the service but refer for further assessment and also those who do not provide the service themselves. The majority of doctors who offer a referral will refer to more then one agency. The individual agencies that respondents most commonly refer to are CURA, Marie Stopes, IFPA and Well Woman in that order (Table 6.9.3). One hundred and two respondents (22.9%) refer women to the +options directory for further information on counselling.

Overall, 1.1% of the respondents (5/444) do not provide crisis pregnancy counselling and do not refer women with a crisis pregnancy to other agencies. In the group who do not provide crisis pregnancy counselling, 83.3% are willing to refer to others and 16.7% are not. Overall 5.8% of respondents to the survey state that they do not provide crisis pregnancy counselling and have no demand for this service while 1.4% do not provide crisis pregnancy counselling although there identify a demand for this service.

Table 6.9.3: Agencies to whom doctors refer women with crisis pregnancies (n = 376)

Agency	Number of GPs who refer to this agency (%)
CURA	216 (57.4%)
Marie Stopes	199 (52.9%)
IFPA	126 (33.5%)
Well Woman	115 (30.6%)
Cherish	47 (12.5%)
Life	22 (5.8%)
PACT	13 (3.4%)

* % sum to > 100% as GPs refer to more than one agency

Post-abortion care is offered by 407 GPs (94.7%) to their patients. Therefore, there are doctors that do not provide crisis pregnancy counselling but will look after patients who have an abortion. Specifically, 76% of those doctors who do not provide the crisis pregnancy counselling will provide post abortion care.

Only 28% of respondents (122/444) indicated that they have received any specific training in managing crisis pregnancy. Almost half of those who have received specific training (41%) specified a short-term training course and one fifth (21.3%) did not specify the nature of the training received.

Despite the fact that 72% had not received specific training in the management of crisis pregnancy, only 51.6% would like to receive further training. This includes those who have previously received some training and want more and also people who want to receive training for the first time (Table 6.9.4). One quarter of respondents (26%) have not previously received any training in this area and do not want any. Almost half of those who have not had any specific training in managing crisis pregnancy would like some. Female and younger doctors are more willing to receive further training, even if they have already received some.

Table 6.9.4: Respondents interest in specific training on the management of crisis pregnancy (n = 444)

GPs who have had some training and want more	12.8%
GPs who have had training and do not want more	16.1%
GPs who have not had training and want some	44.3%
GPs who have not had training and do not want any	26%
GPs who did not answer both questions	0.8%

Two hundred and twenty eight respondents (51.4%) have heard of +options directory service provided by the Crisis Pregnancy Agency. Of those who have heard of it, two thirds (152/228, 66.6%) have used it and 92% of those who have used it (140/152) think it was useful.

6.10 ORGANISATION AND DELIVERY OF WOMEN'S HEALTH SERVICES IN GENERAL PRACTICE

Organisation of Women's Health Services

Contraception and women's health services in general practice are variously provided during routine surgeries only (72.2%); through dedicated women's health clinics only (1.1%); or through a combination of both 26.2%. The number of GPs who provide women's health services during routine surgeries only had risen significantly between 1998 and 2004 (from 62.9% to 72.2%; $p < 0.01$). This represents a reduction in the number of dedicated women's health clinics in general practice over that time frame as 35% of respondents in 1998 offered a combination of routine surgeries and dedicated clinics.

Services to Specific Sub-Groups

There was quite a high level of satisfaction among GPs about the services they provide for a number of specific subgroups, with the notable exception of refugees / non-nationals and teenagers (Table 6.10.1). GPs were least confident in managing these two groups. Excluding the respondents who state that the refugees / non-national women category does not apply to them, 33.3% of the remainder believe that they do not provide adequate services to this group.

Table 6.10.1: The adequacy of women's health services for specified subgroups

		Not applicable		Adequate	
	Response	**N**	**% of respondents**	**N**	**% of those applicable**
Teenagers	N=435	4	0.9	354	82.1
Women in their 40s	N=438	2	0.4	422	96.8
GMS patients	N=439	11	2.5	403	94.1
Private patients	N=439	4	0.9	423	97.3
Menopausal women	N=438	1	0.2	423	96.8
The over 65s	N=437	6	1.4	395	91.6
Refugees / Non-national women	N=426	99	23.2	218	66.7

Promotion of availability of women's health services in the practice

In 2004, 87.6% of GPs report that they promote the availability of women's health services in the practice. This reflects an increase since 1998 when the corresponding rate was 78.2%.

There was no significant association between the age of the GP or whether they worked in single-handed or group practice and the likelihood of promoting women's health services. Female GPs were more likely to promote these services than males (92.8% versus 83.9%; $p < 0.01$). Significant differences were also seen between practices with a practice nurse and those without ($p = 0.033$) and between practices with female healthcare professionals and those without ($p < 0.01$).

Of those who promote services, the most popular ways were opportunistically, using posters or leaflets in the waiting room and in practice leaflets (Table 6.10.2).

Table 6.10.2: How women's health services are promoted within the practice

Options for promoting services	Responses (N = 376) N*	%*
Opportunistically	341	90.7
Practice leaflets	190	50.5
Practice website	21	5.6
Local media	7	1.9
Posters / leaflets in waiting room	228	60.6
Public talks (schools, women's groups etc)	46	12.2
Other	16	4.2

* Frequencies sum to > 376 and %s to > 100% as respondents could tick more than one option

All respondents were asked whether they specifically promote the availability of emergency contraception. While 69 (15.5%) do, 335 (75.5%) do not and 40 (9.0%) did not answer this question.

6.11 EDUCATIONAL NEEDS OF GPs

Training in women's health

GPs were asked to indicate all sources of their education and training in the area of women's health and they report having received women's health training in a wide range of settings (Table 6.11.1). Almost 82% of the GPs received training in women's health as an undergraduate, with a significantly higher representation of those under forty ($p<0.01$). Almost two thirds (63.5%) had received women's health training as part of their vocational training. Of those vocationally trained, 91.8% had received training in women's health, compared with 82.2% in the 1998 study.

A majority (79.1%) report experience in an obstetrics and gynaecology post. However this rate has fallen from 94.4% in the 1998 study. Almost one third of respondents (31.5%) had worked in a family planning clinic.

Table 6.11.1: Sources of education and training in women's health as reported by GPs

Source	Frequency (N=444)	%*
Undergraduate training	363	81.8%
Vocational training	282	63.5%
Hospital post in Obs/Gynae	351	79.1%
Working in Family Planning Clinics	140	31.5%
Meetings / Study Days	327	73.6%
ICGP Women's Health Programmes	144	33.3%
ICGP CME Group	279	62.6%
Self-directed study	280	63.1%
Family Planning/Menopause Journals	156	35.1%
None	1	0.2%

* %s sum to > 100% as respondents could tick more than one response
CME = continuing medical education

Almost three quarters of GPs (73.6%) attend meetings and study days to update themselves on women's health issues. One third of respondents (33.3%) have participated in educational courses run by the ICGP Women's Health Programme. They were significantly more likely to be female (46.4% versus 24.1%; $p < 0.01$) and under forty years old (24.5% versus 13.2% $p=0.021$). Almost two thirds of GPs (62.8%) have addressed women's health issues at ICGP continuing medical education (CME) groups.

Almost two thirds of respondents (63.1%) undertake self-directed study and 35.1% read family planning and menopause journals. Those who read family planning and menopause journals are significantly more likely to be female and over forty years old ($p<0.01$).

Only one out of the 444 GPs indicated not having had any specific training in women's health whatsoever.

Further training

GPs were asked to indicate their preferences for further training, both in terms of the topics to be addressed (Table 6.11.2) and the formats to be employed.

With regard to the topics, the most popular area ranked in the top three preferences by more than two thirds of the GPs (68%) was the management of sexually transmitted infections. This preference was significantly more popular among those working in the greater Dublin area compared to the rest of the country (78.2% versus 64.1%; $p<0.01$).

The second most popular preference was management of gynaecological conditions ranked by 44.4% of respondents. This was significantly more popular among GPs aged 40 or under (52.4% versus 40.5%; p=0.024).

Psychosexual medicine was ranked as one of their highest preferences by 38.5% of GPs and it was significantly more popular among females than males (53.0% versus 28.3%; $p < 0.01$).

While 30.6% of GPs ranked issues relating to menopause and HRT in their top three, 30.2% mentioned skills training and 26.4% listed psychological and emotional problems. The areas less frequently ranked were contraception and family planning (16.4%), and antenatal care 24 (5.4%).

Table 6.11.2: Areas of women's health which GPs ranked in their top three preferences for further education and training

	Number (N=444)	Percent*
Management of STIs	302	68.0
Management of gynaecological conditions	197	44.4
Psychosexual medicine	171	38.5
Menopause/HRT	136	30.6
Skills training (eg. IUCD fitting)	134	30.2
Psychological/emotional problems	117	26.4
Contraception/family planning	73	16.4
Antenatal care	24	5.4
Other	14	3.2

* Frequencies sum to > 444 and %s to > 100% as respondents could tick more than one response

Preferred formats for further training

Respondents were offered a range of formats to rank for addressing their ongoing education and training needs (Table 6.11.3).

Almost two thirds of the GPs (64.4%) indicate that CME groups are one of their top three preferred formats in which they would like to receive women's health education and training, more popular among those over forty years old.

The next most popular options are specific day or half-day courses and practical skills training programmes, listed within their top three choices by more than half the GPs.

ICGP faculty meetings and distance learning and reading journal articles were less popular, each being listed by approximately one quarter of respondents and websites are the least popular option at 13.1%.

Table 6.11.3: Formats for women's health education and training which GPs ranked in their top three preferences

	Number* N = 444	Percent*
CME Groups	286	64.4
Specific half day or day courses	261	58.8
Practical (skills) training programmes	236	53.1
ICGP faculty meetings	119	26.8
Journal articles	113	25.5
Distance learning	113	25.5
ICGP (and other) websites	58	13.1

* Frequencies sum to > 444 and %s to > 100% as respondents could tick more than one response

6.12 COMMENTS FROM RESPONDENTS

The final section of the questionnaire provided respondents with a free-text space for any comments they wished to make and a number of GPs included one or more comments. A qualitative approach was taken to the analysis. All comments were reviewed and classified by at least two members of the research team.

The general tone of the comments was that women's health services provided by GPs are reasonably satisfactory and that the GP is ideally placed to provide the service. Many indicated that there was significant improvement over the past ten years. It was also stated that there was need for further improvement.

Some noted that lack of facilities or resources limited service provision; others were restricted by time constraints. The particular need for further sexually transmitted infection services was singled out by a number of respondents.

A number of GPs felt that the level of care was not standardised throughout the country and their impressions were that rural areas were particularly disadvantaged. Lack of remuneration for cervical smears and IUCD fitting for GMS patients was seen as significantly restricting these services. There were also medico-legal concerns regarding IUCD fitting by GPs.

While male GPs welcomed the higher level of involvement of female GPs and practice nurses in women's health services, some also felt marginalized and potentially deskilled by this development.

Many GPs indicated that they would welcome further training in practical skills and the management of sexually transmitted infections in particular, reflecting the quantitative information illustrated by the survey. The need for ongoing training was felt to be essential as women's health is seen as a significant portion of the work of the GPs and an area that is constantly evolving and changing. Short courses and continuing medical education (CME) meetings were highlighted as preferred formats. The cost of such courses, the lack of financial incentives to undertake further training, and the location of such courses (being too Dublin-based) were identified as limitations.

Three comments were made concerning moral objection to abortion, especially among catholic GPs. One GP felt that women should be told "the truth" about abortion. Another stated that he would not refer directly but would provide addresses and phone numbers.

A small number of GPs felt there was an overemphasis on women's health in general practice while others voiced the need for similar focus on men's health.

There were many positive comments with respect to the service provided by the ICGP; the email inquiry service, articles in Forum and roadshows were all highly commended.

The topics that respondents chose to address in these free-text comments were particularly helpful in guiding the development of the interview guide for the qualitative component of this research.

Section 7

GP Interview Results

7.1 PROFILE OF RESPONDENTS

Ten of the twelve selected GPs agreed to participate. The two GPs who were not willing to participate were from the conservative group. The characteristics of the ten participating GPs are described in Figure 7.1.1.

Figure 7.1.1: Characteristics of the GPs who participated in the interviews

Gender	Age	Location	Practice characteristics	Classification
F	Over 40	Outside Dublin	Group practice with PN	Standard
M	Over 40	Outside Dublin	Single handed, with female sessional assistant and no PN	Conservative
M	Over 40	Dublin	Single handed, with female sessional assistant and PN	Standard
M	Over 40	Outside Dublin	Single-handed, with PN	Standard
F	Over 40	Outside Dublin	Group practice, with PN	Conservative
F	Over 40	Dublin	Group practice, no PN	Enthusiast
F	Over 40	Dublin	Group practice, PN	Enthusiast
F	Under 40	Outside Dublin	Sessional assistant, no PN	Enthusiast
F	Over 40	Dublin	Group practice, PN	Enthusiast
M	Under 40	Outside Dublin	Group practice, PN	Standard

PN = practice nurse

Basic demographic details were obtained at the commencement of the interviews, but no effort was made to confirm or refute our provisional classification of the GP's views. We believed that attempting to do so could possibly have jeopardised openness and co-operation.

While all data gathered are included in the report it has been re-ordered from the original interview guide to reflect the overall emphasis of the GPs interviewed and to provide a logical flow in the report.

7.2 PROVIDING WOMEN'S HEALTH SERVICES

The GPs interviewed believe that there continues to be variation in the range of women's health services provided within individual surgeries around the country. While the enthusiasts were more likely to view themselves as having expanded the women's health services they provide over the past five years, the other two groups did not identify major changes, either in their own practices or more generally.

When asked if they felt their surgery offered women a comprehensive service, all ten GPs felt they did. However, their definition of a comprehensive service must vary as this response included those who offer a very limited range of contraceptive options.

> *'I am fairly certain that I give the best care I can to my patients.'*
> (Male conservative GP from outside Dublin)

> *'Well, I do feel that I give what I could consider a comprehensive service. I don't place IUCDs, mainly for ethical reasons. But we refer patients to the Family Planning Clinic in (local town) for IUCDs.'*
> (Female conservative GP from outside Dublin)

> *'Well, I don't give the service, but the female GPs in the surgery give it. It's certainly extensive, but perhaps not quite comprehensive. I mean, what is a comprehensive service?'*
> (Male GP providing standard services, outside Dublin)

The GPs did not believe that they themselves had to provide all possible options in order to offer a comprehensive women's health service. Many identified inter-referral arrangements as key. Most were happy to be able to refer women to a competent colleague.

The principal driver to service provision identified by the GPs was patient demand. The general view is that women patients are more demanding now than previously and that their demands are driven largely by the media, particularly women's magazines. Generally, the diaphragm is no longer popular while oral contraception, Implanon®, Depo® injections or Mirena® are.

> *'I think we operate on a 'what is sought' basis. If a patient comes to you with a question, or interest in a procedure, or we see something interesting in a journal or course, we do our best to find out about it.'*
> (Female enthusiast from outside Dublin)

A number of the GPs believed that pharmaceutical company advertising is an important demand driver both in terms of direct advertising to healthcare professionals and indirectly to women through

magazines etc. and that this has consequences in terms of the skills required for service provision. This was particularly identified in relation to certain brands of the pill and types of coils.

With regard to the reasons why GPs do not provide particular women's health services, most of the ten GPs believed that a combination of many factors contributed, particularly skills, demand, time and the GP's specialist interest. For example, one GP who does not offer other contraceptive services as a rule provides comprehensive natural family planning information and training, a service another more liberal GP was concerned was lacking in their surgery.

A few of the GPs felt the ICGP should play a role in guiding what services were considered compulsory in women's health provision.

> *'I don't think we can be absolutists. I think there are core competencies and then there are things beyond this core.'*
> (Male GP from outside Dublin offering standard care)

The finding from the survey that a higher proportion of GPs were willing to provide advice / counselling (e.g. crisis pregnancy counselling) than were willing to perform a technical skill (e.g. IUCD insertion) was confirmed in the interviews. GPs felt confident in their counselling skills. Providing services that required technical skills was viewed as time-consuming and carrying medico-legal risk. The necessity to perform the procedures frequently to maintain competence in the skill was also identified as a barrier.

> *'You can become some what limited by your skill, but you must be able to justify your service choices.'*
> (Female enthusiast from outside Dublin)

> *'It's a technical issue and also has legal implications if it [the coil] falls out…. or time involved in insertion. If other GPs in the area or practice offer it, then I don't see need the to perform this service.'*
> (Female enthusiast from Dublin)

The GPs interviewed cautioned against trying to 'do it all', and also feel there is a need for guidance on policy from the College.

> *'I think there should be a percentage of GPs who offer comprehensive women's health service. But I don't want to be the only GP fitting coils. The college can highlight the inter referrals maybe through faculty listings.'*
> (Female enthusiast from Dublin)

Male GPs as service providers

The GPs were specifically asked for their views on whether male GPs are becoming deskilled in women's health as this had been suggested by a number of respondents to the questionnaire survey who had added free-text comments. The interviewed GPs' views varied greatly. While they agreed that a large proportion of women prefer female practitioners for this service, and that many more female GPs and practice nurses are now working in general practice, there was less agreement on the consequences for male GPs. This preference of women patients for women doctors was viewed by some of the respondents as situational.

> *'….Irish women are more than happy to have a male obstetrician deliver their baby, but six weeks later won't let a male GP examine them.*
>
> (Male GP from outside Dublin providing standard care)

Of the four males interviewed, one was of the view that recent changes had not impacted on his own skills level and that he continues to provide the same range of women's health services in his practice. Another simply replied "women want women". A third expressed his concerns about the evolution of women's health as somehow separate and distinct from other general practice services and believes that this development, if continued, has the potential to result in widespread deskilling of male GPs. The female GPs generally identified the gender difference also. While some simply accepted this as a feature of modern times.

> *'I guess society has deskilled the male GP.'*
>
> (Female enthusiast from Dublin)

Other female GPs expressed frustration that this should be so.

> *'There is an assumption made that they [male GPs] don't perform women's services, can't perform them as well as female GPs. My male partner equally sees women for women's health as he has the same skills, education and training and is confident in his skills.'*
>
> (Female enthusiast from Dublin)

One female GP recounted how women's perceptions are actively challenged in their practice.

> *'Our young male GP was reluctant to take on the role of fitting Mirenas at first. But we felt it was best to show the male GP was as skilled in all areas of general practice. The practice nurse does the smears and the male GP places the Mirena with her assisting. The patients accept this.'*
>
> (Female GP providing standard care outside Dublin)

Both male and female GPs mentioned the need for a chaperone for male GPs due to the ever-increasing risk of litigation.

> *'Nine times out of ten I will call the nurse in to chaperone. I don't want to be perceived as at variance to the norm.'*
> (Male GP from outside Dublin providing standard care)

> *'Male GPs must be conscious of gender sensitivity and need chaperones, though now some say female GPs need a chaperone too.'*
> (Female conservative from outside Dublin)

A number of GPs spontaneously singled out cervical smears as the area where most changes have been seen.

> *'….and I tell them that they can get cervical smears from the lady GP who does sessional work here. I don't do them any longer.'*
> (Conservative male GP from outside Dublin)

Most of the GPs (both male and female) believed that the relationship that the practitioner establishes with the patient should be more important that the gender of the doctor.

Referral patterns

Referral to a GP colleague was the first choice of all the GPs interviewed with family planning clinics and hospitals as second line choices. Inter-referral within general practice was the preferred route as GPs felt greater assurance about the competency of their GP colleagues than family planning clinic doctors.

> *'I absolutely try and refer to another GP over referring to a family planning clinic.'*
> (Male GP providing standard care in Dublin)

One GP stated that women still chose family planning clinics.

> *'Women still feel they need to go to family planning clinics or well women centres for family planning, despite our promotional information. It's perceived expertise in contraception at family planning clinics.'*
> (Female enthusiast from Dublin)

Considerable disquiet was expressed about family planning clinics by the others interviewed, for a number of different reasons.

'I don't refer to family planning clinics as they are a disaster. I have women who have attended me for years, but go to [named family planning clinic] for their pills and get smears every six months and are charged for a full work-up every time. When clearly the RCOG and the ICGP have set out guidelines as to the frequency of smears. Its abhorrent, it's wrong…..'

(Male GP from Dublin providing standard care)

'I would like to be able to use the family planning clinics for advisory/referral more easily. Unfortunately there is no way to know what level of training the family planning doctor has.'

(Female enthusiast from Dublin)

'Family planning doctors are not always skilled enough.'

(Female enthusiast from Dublin)

'I don't receive feedback from any referral to the family planning clinic, come to think of it….'

(Female conservative from outside Dublin)

This group of GPs did not feel there were any major gaps in women's health services within their geographical locations. However, a number of them highlighted a difficulty with outpatient referrals, particularly for the public patients. One doctor suggested that GPs should have direct access to investigations such as ultrasound and dexa scanning for public patients as it's a 'major headache' to get these for public patients, while private patients can get them much more easily and quickly. Once again, inter-referral to GPs with a special interest in women's health was widely regarded as the preferred way to ensure access to services not provided in one's own practice.

Promoting women's health services

Without exception, all ten GP's felt that 'word of mouth' and opportunistic consultations were how most patients came to know what services are provided within the practice. Though many surgeries advertised the general promotion of women's health through leaflets, posters, and web sites, no one had specific advertisements for contraception services or emergency contraception.

'We do have information leaflets and posters for women's health clinics. We are not specific in our advertising of emergency contraception as we also have a large elderly population and don't want to offend them.'

(Female enthusiast from Dublin)

The overall impression was that none of the GPs interviewed had given a lot of attention to following up on any information they disseminate about the services they provide. While they are enthusiastic

about including this information in practice leaflets or displaying posters in their waiting rooms, they make no attempts to track which, if any, of these initiatives gets the patient in to the practice. This may account, at least to some extent, for why they take the view that 'word of mouth' is how most patients become aware of the services provided.

While many of the GPs were not enthusiastic about individual promotion of services by GPs they identified the College as having a role to play.

> *'It's hugely important that the college play a role in promotion. They must get the message out there that a holistic service can be received from their GP at a level that is as good as, or better than, the family planning clinics.'*
>
> (Female enthusiast from Dublin)

> *'The college could play a huge role getting the message out there that emergency contraception can be obtained from most GPs.'*
>
> (Female enthusiast from Dublin)

However, some sounded a note of caution about the expectations that might thus be raised.

> *'The college can certainly promote the general information…but to raise expectations for exact services then can be off-putting if the local GP doesn't offer these.'*
>
> (Female enthusiast from outside Dublin)

7.3 PROVIDING WOMEN'S HEALTH SERVICES FOR SPECIFIC GROUPS

Teenagers

The GPs interviewed all agreed that there are particular difficulties in providing a comprehensive women's health service for teenagers. Medico-legal issues are a major concern, while trying to best serve the sexually active teenager. Confidentiality of the teen, rights of the parents, and guidelines on the age of consent were identified as areas of concern or uncertainty. For the most part, it appears that teenagers use the GP for crisis situations (emergency contraception or crisis pregnancy), and rarely come for follow-up treatment.

> *'You worry about confidentiality as to how to contact them for follow up. I try to give a good consultation with openness and encouragement to come back to see me.'*
>
> (Female enthusiast from outside Dublin)

'If they are below the age of consent, even if accompanied by their parent—what to do? We need education that highlights this, not only for the GP but for the general public as well.
(Conservative female GP from outside Dublin)

Some GPs had developed their own set guidelines around age and offering services, others were more likely to decide on a case-by-case basis.

'You have to go with your gut instinct in most cases, legally less than 16 years old I believe you shouldn't be treating, but its frightening to think of these girls as sexually active without protection.'
(Female enthusiast from Dublin)

The issue of the cost of contraception was also identified as a significant barrier to effective use of contraception in teenagers.

'I worry where school kids can get forty euro or thereabouts…it's fine if the teenager has a medical card, but if there is a lack of cash, where do they get the money?'
(Female GP providing standard services, from outside Dublin)

With regard to specific contraception being offered, having regard to the concerns about the likelihood of teenagers returning for follow-up and the cost of contraception services, some of the GPs volunteered that longer acting contraception was preferable for this group.

'The Implanon is wonderful, and as far as teenagers go, it gives you three years of not worrying about them … which is a huge difference in their ability to act responsibly.'
(Female GP providing standard services outside Dublin)

Regardless of whether the GP would be considered conservative or liberal in their views on contraception, all were in agreement that the core of the service for teenagers is education. However, the content of this education was not explored in any detail in the interviews. The GPs believed that these persisting education needs might be addressed in a number of ways, particularly through extension of school-based programmes, or in combination with general practice.

'Maybe we should link with schools, let them know the GP can be seen for these services.'
(Female enthusiast from Dublin)

Refugees and non-national women

The number of refugee and non-national patients GPs are seeing is rising. The most obvious problem in dealing with this group is communication. The consensus view of the ten GPs was that patience and time in consultation with non-national patients yield improved results. There is general concern over misunderstanding of cultural or religious differences between GP and patient and vice versa.

> *'Refugees are very difficult to connect with on a range of levels. It seems that their ideas of what a general practitioner's consultation should be varies greatly from the Irish person's. With an Irish person you are on common ground, we need to find the common ground with refugees.'*
>
> (Male GP providing standard services outside Dublin)

It is difficult to meet the needs of someone with whom you cannot effectively communicate. There are appears to be a need on both sides to begin to learn of each other's culture and expectations from the consultation.

> *'Refugees….sometimes, due to cultural differences can come across as demanding and aggressive, but really it's a communication and cultural difference.'*
>
> (Female enthusiast from Dublin)

> *'It's very hard to give good antenatal care to someone with a different language. They can't ask questions.'*
>
> (Female GP providing standard services outside Dublin)

Sexually transmitted infection (STI) services

The provision of sexually transmitted infection (STI) services was specifically explored in the interviews as it is the first ranked in the educational needs assessment component of the questionnaire. The GPs interviewed all had some level of awareness of the magnitude of the task of dealing with sexually transmitted infections comprehensively. A few of the doctors have put considerable effort into setting up a comprehensive STI service in their practice. While some feel more training is needed, others take the view that the average GP already possess the necessary skills and it is largely the supportive resources and structures that are needed. However, most of the group agreed there are barriers to STI service provision. Lengthy consultation time, extensive form filling, necessary turn around time for laboratories are examples of the barriers mentioned. The cost to the patient was also identified as a significant barrier.

'Well, firstly, there is a huge cost factor for the patient…. Private patients have to pay for drugs that are expensive, whereas if they go to the clinics it is free.

(Conservative female GP from outside Dublin)

'I have issues about how I deliver this in practice. In terms of warts for example, some say screen for everything if someone comes in with warts (as the GUM clinics do), or should I just treat the warts alone?'

(Male GP providing standard services from outside Dublin)

'I feel in the dark about STIs. I feel strongly that I am not skilled or competent in this area.'

(Conservative male GP from outside Dublin)

'A GP in the country far from the nearest hospital or lab cannot give a comprehensive service. Yes in the town, but not in the country.'

(Female enthusiast from outside Dublin)

'We only recently can say we give a comprehensive STI service. It was hard work.'

(Female enthusiast from Dublin)

Several GPs also identified a lack of cooperation from the specialist service providers in this area, even though they have lengthy waiting lists. One GP specifically referred to genitourinary medicine specialists as 'protecting their empires'.

A number of the GPs suggested a role for the College in agreeing protocols with laboratories and in negotiating with the State for remuneration - for extended consultations, for the provision of equipment, and for further training. There appears to be a consensus that though GPs have the ability to do this work, they are not confident that the work they are currently doing is to the best standard because of time and resource constraints.

All the GPs agreed that contact tracing is not undertaken by the average GP. Some of those interviewed wondered whether GPs should actually be offering this service at all as they were concerned that in trying to take on too much one can become over-extended and not offer an equally high standard in all services. Several recommended that there is an urgent need to simplify referral pathways, particularly in this area.

7.4 CRISIS PREGNANCY SERVICES

Most of the GPs interviewed felt women still tend to attend other clinics rather than general practice for crisis pregnancy advice and services. A range of reasons were suggested why this might be so. These included anonymity, or if a relationship wasn't established with a GP prior to the crisis.

> *'It's multi-factorial really. Where the patient is at the time of the pregnancy—age, place in life, and so on. Also how they view their GP - are they male or female, how old are they, what stories have they heard from others,…… or do they think the GP is conservative……'*
>
> (Male GP providing standard services, from outside Dublin)

A few of the GPs suggested that women prefer to go directly to a family planning clinic, such as Marie Stopes, as it eliminates a referral step, as well as assisting with the social and financial support. There was also a suggestion that women were likely to choose where they go, depending on what option or outcome they had already decided upon. Those who were considering abortion were more likely to attend a family planning clinic while those who were going to continue with the pregnancy were more likely to attend their GP.

> *'So patients will go to their GP if they are following a certain course, keeping the baby—yes it's a crisis, but inevitably they keep the baby. If it's a crisis leading to termination, I think they are more comfortable with an agency.'*
>
> (Female enthusiast from Dublin)

> *'Most women considering abortion go directly to family planning or Marie Stopes. We are not given a chance to counsel.'*
>
> (Female enthusiast from Dublin)

All agreed that any GP certainly can provide crisis pregnancy counselling because of the counselling skills that GPs have. The general reaction was that counselling in its broadest sense is a large part of what GPs do every day and that crisis pregnancy counselling is part of this, not requiring special skills or training.

Though it is legal to openly discuss all options now, concerns were expressed that Irish GPs do not have enough information on the UK-based clinics to make a qualified judgment on referral.

One GP was concerned about using the term "crisis pregnancy" as it conveys a sense of urgency for the women to make what the GP considers to be a rash decision i.e. to have an abortion.

The conservative GPs struggle with their own beliefs while continuing to provide what is, in their views, a fair service to women.

> *'I do the best I can for my conscience and for the patient. I encourage them not to rush in to abortion, to have consideration for all options.'*
> (Conservative male GP from outside Dublin)

> *'I don't refer if the patient is looking for abortion. They are all aware of other GPs in the area who they can get information from.'*
> (Conservative male GP from outside Dublin)

The interviews then explored why more GPs in the survey were providing counselling and medical care after abortion than were providing initial counselling for crisis pregnancies. This was felt to be because more women actually presented to their GPs for medical care after abortion than attended before making their decision about the crisis pregnancy in the first place. The GPs believed that the woman was less likely to be concerned about whether the GP was conservative or liberal in their views after the procedure was over.

7.5 CHANGES IN WOMEN'S HEALTH SERVICES

We had hoped to identify changes in women's health services over the past five years from the interviews and get some impression of the factors driving these changes. Many of the GPs did not believe that the service being provided in their practice had changed significantly in that time frame. Some identified general improvements outside the practice but there was a lack of awareness of policy changes in this area and no evidence of a direct influence of healthcare policy decisions on the service provided by individual GPs in their practices.

Changes in society generally and in consumer demands in particular were identified as having contributed to the changes in women's health in Ireland over the past five years or so.

> *'There is more openness about lifestyle. The Crisis Pregnancy Agency has helped to let people be able to think about choices. The college has helped with roadshows and case studies at CME.'*
> (Female enthusiast from Dublin)

The GPs reported that women are becoming smarter consumers and being proactive in their choices. They are also more informed and more assertive in their requests for services now.

While most of the GPs didn't recognise changes within their own practices in the past five years or so, improvements nationally were noted. Mammography topped the list. The GPs also identified significant improvements in both the availability and quality of the smear taking services available to women. GPs with a keen interest in women's health certainly viewed the changes as greater.

> *'There is a better range of services offered. Also in fairness there is a better range of products. Also a sea change in regards to termination, related to better advice given.'*
>
> (Female enthusiast from Dublin)

7.6 CONCLUSIONS FROM THE INTERVIEWS

The ten GPs who were interviewed all gave generously of their time and spoke openly and frankly.

All the GPs interviewed, whether conservative or liberal, attempt to provide the services they believe to be in the best interests of their patients and share a common goal, namely excellence in delivery of care.

Their focus was on how much GPs can do well, rather than simply how much they can do and all displayed a genuine interest in continuing to strive to improve standards of care.

The overall picture painted was of increasing demands both from women patients and from the healthcare system generally, with little in the way of increased resources to support GPs in developing and expanding services.

There was a considerable degree of agreement on the issues discussed. Where varying views were identified, they appeared to stem from the individual GP's interpretation of how best to serve the women who are their patients.

Section 8

Discussion

This study describes the characteristics of both the general practice service providers of women's health care and the women's health services they provide. Changes since a similar survey in 1998 are identified and some of the key factors that have shaped these changes are explored. The feminisation of general practice and the increasing numbers of practice nurses have had a positive impact on women's health services. Female GPs and practices where patients have access to female healthcare professionals are more likely to provide a greater range of services overall, and are also more likely to provide a number of individual services, particularly those requiring specific skills or intimate examination. It is not possible to form a judgement on the adequacy of rates of provision of overall or specific services in the absence of an agreed framework for service provision. For example, while it is widely agreed that it is not necessary for every GP to fit IUCDs or to carry out vasectomies, there is no consensus as to how many GPs are required to provide these services in any given region or how they should be trained or supported.

More than 90% of GPs have provided a range of specific services since 1998 - hormonal contraception, emergency contraception, sterilisation counselling, cervical smears, breast examination, menopause counselling, combined antenatal care and pregnancy counselling. These services showed no significant association with the gender of the GP or the location of the practice.

GPs are more likely to offer intrauterine contraceptive device advice and fitting, and medical care after abortion in 2004 than in 1998. Fewer GPs offer natural family planning advice, vasectomy operation and psychosexual counselling with no significant changes in the numbers providing diaphragm advice and fitting, and home delivery. Changes in levels of service provision are primarily driven by patient demand. Lack of demand has resulted in lower numbers providing particular services and the interviews revealed that development of existing or new services was largely responsive to patient demand.

GPs are motivated by their desire to provide the services that they believe to be in the best interests of their patients and aim for excellence in delivery of care with a focus on doing things well rather than simply doing more. The interviews identified patient demand as the principal driver to changes in service provision. Other factors driving demand were increasing openness in Irish society, pharmaceutical company advertising, more informed women patients and the employment of others in the practice with specific skills e.g. IUCD fitting.

8.1 METHODOLOGY

Combining quantitative and qualitative approaches in the form of the questionnaire survey and the semi-structured interviews provides information that is "complementary and triangulated" (Britten et al, 1995).

The quantitative methodology, by means of a self-completed postal questionnaire, was suitable for collecting objective data from a nationally representative sample of Irish GPs. The questionnaire used permitted comparison between 1998 data and 2004 data.

For the qualitative component of the study, we chose to conduct interviews with twelve GPs by telephone, affording more privacy than focus groups. These interviews were carried out by a researcher not previously associated with the Women's Health Programme to encourage frank and honest discussion.

8.2 RESPONSE RATE

The response rate to the questionnaire survey was 60.2%. This was lower than that for the 1998 survey (70.5%). A number of factors are likely to have contributed to the lower response rate in 2004. Questionnaire fatigue among GPs is undoubtedly a major factor. This phenomenon has been widely described in international literature (Edwards et al, 2002; Kaner et al, 1998; McAvoy & Kaner 1996; MacDonald, 1993). The number of questionnaires circulated to Irish GPs each week has increased markedly since 1998. It is also likely that women's health services were viewed as being less contentious in 2004 and that a sense of complacency may have contributed to the lower response rate.

The 2004 response rate is in line with recent national questionnaires from the ICGP and other agencies. Examples include the 2003 GP IT survey (61%) and the 2005 Health Protection Surveillance Centre's survey of GPs on the issues of sexually transmitted infections (62%), despite intensive follow up.

The Irish response rates are higher than comparable surveys internationally, with a 36.3% response rate reported by the Canadian Medical Association to the Physicians' Response Questionnaire (Martin, 2000). Results from this study are considered accurate to within ±1.9% or 19 times out of 20. A questionnaire survey of Italian family physicians, inquiring about their management of women's health problems, particularly family planning, reported a 24.2% response rate (Girotto et al, 1997).

The impact of lower response rates has been the subject of much debate. Although older, more experienced, less well qualified and single-handed GPs in the UK were historically less likely to respond (McAvoy & Kaner, 1996), other studies have found few differences between groups of responding and non-responding GPs (Templeton et al, 1997). This uncertainty is further complicated by the fact that there is no consensus as to what constitutes a satisfactory response rate. However, the responders in this work were representative of Irish GPs, as shown by the demographic comparisons discussed in Section 6.

8.3 LIMITATIONS

The limitations of the questionnaire survey prompted research largely founded on the biomedical model of illness, rather than the bio-psychosocial approach taken to women's health in actual practice. Providing women's health services requires knowledge and skills, certainly, but also requires an open attitude and sensitivity. This work limits itself to investigating the provision of clinical services specific to women, for the most part involving particular skills. A range of problems that women present to general practice were not included because the questionnaire methodology would not allow any meaningful assessment of how the GP provided this service. Examples include mental health problems, eating disorders and violence against women.

The validity of questions on self-reported activity has not been widely addressed as this would require comparison of reported activity with an external data source and this is not often easily obtained for logistic or other reasons (Eccles et al, 1999). External validation in this way would be time-consuming and expensive. Where this comparison has been undertaken, simpler actions more frequently carried out show the greatest correlation. Therefore, criterion validity is likely to be high in this questionnaire as GPs were simply asked whether they provided specific services or not. The breadth of services inquired about would make external validation difficult. Even if self-reporting by GPs of their levels of activities overestimates somewhat what they do (and there is no proof that it does) the changing patterns between 1998 and 2004 reflect genuine changes in levels of service provision.

Respondents were simply asked whether or not they provided a range of services. No attempt was made to quantify the frequency that particular services were utilised, with the exception of crisis pregnancy counselling. While this makes it more likely that the responses reflect actual practice, the data collected does not distinguish between services that are provided on a daily basis and those that are requested less frequently.

8.4 CONTRACEPTION SERVICES

An increasing proportion of Irish GPs provide a greater range of contraception services in 2004 than six years previously. Significant increases in the numbers providing hormonal contraception, emergency contraception, IUCD advice and fitting and sterilisation counselling are seen in this study, in comparison with the 1998 research. This reflects increasing utilisation of contraception by Irish women (Rundle et al, 2004) and their preferred methods. Generally, doctors who do not provide particular services will refer patients to other service providers, with other GPs being the most popular referral destination. Core contraception services (hormonal contraception, emergency contraception, IUCD advice and sterilisation counselling) are provided by 85.6% of Irish GPs.

While 90.3% of GPs offered advice about IUCDs, just over one third (35.4%) fitted IUCDs in 2004. It is not possible to assess whether this number provides sufficient services for Irish women considering this

option. The principal reason given by GPs not providing this service is lack of skill. This is reinforced by the findings of the educational needs analysis where practical skills courses (including IUCD fitting) were given a high priority.

The drop in numbers providing natural family planning and the essentially unchanged numbers providing diaphragm advice and fitting reflects their dropping popularity as contraception options by women internationally (Guillebaud, 2003). It is challenging to ensure that a proportion of GPs should maintain skills in these less popular contraception options, while also learning the skills needed to provide newer options such as the implant, in the interests of providing a comprehensive service to women.

8.5 WOMEN'S HEALTH SERVICES OTHER THAN CONTRACEPTION

Many of the women's health services other than contraception included in this study involve less specific skills and less ethical dimensions than the contraception services. High levels of provision of many services were identified in 1998, specifically cervical smear, breast examination, menopause counselling, combined antenatal care and pregnancy counselling. These levels were maintained or increased slightly in 2004, although the magnitude of the increases was not statistically significant.

Another change in Irish general practice is identified in the area of testing for sexually transmitted infections (STI) and, specifically, for chlamydia. The failure to include these in the 1998 questionnaire reflects the low priority they were given at that time. By 2004, more than half the GPs (54.3%) were providing STI testing and more than three quarters (76.9%) were offering chlamydia testing. This rate is consistent with the 81% of GPs recently reporting that they carry out chlamydia testing in a recent survey commissioned by the Health Protection Surveillance Centre (in press, 2005). The variation in levels of STI services provided is echoed in the interviews. A range of barriers to STI service provision in primary care were also identified, including lengthy consultation time, extensive form filling, necessary turn around time for laboratories, the cost to the patient and lack of cooperation from the specialist service providers.

The survey gives no indication as to how these services are provided, or to whom. This need for more information is reflected in the GPs' educational needs analysis, where it was the first ranking topic for future education and training.

8.6 CRISIS PREGNANCY SERVICES

A significant increase in the numbers of GPs providing pregnancy counselling and medical care after abortion was seen between 1998 and 2004. The numbers who provide pregnancy counselling but not medical care had decreased from 6.9% in 1998 to 3.7% in 2004. These data indicate that women in crisis pregnancy who wish to attend GPs for their medical care are likely to have ready access to a GP who provides this service.

GPs who responded to this survey estimate that about one in ten of the pregnant women they see for a first visit regard that pregnancy as a crisis. This proportion is somewhat lower than that reported by women themselves in the Women and Crisis Pregnancy report (Mahon et al, 1998). This discrepancy may be accounted for by the suggestion from the GPs interviewed that many women with crisis pregnancies, particularly those considering abortion, simply do not present to GPs. Additionally, a pregnancy that may be a crisis to the woman may not be perceived as such by the GP unless this is explicitly discussed.

Relatively few GPs report having had specific training in the management of crisis pregnancy. However, many of the doctors interviewed suggest that the general counselling skills and crisis intervention techniques regularly employed by GPs adequately cover this area of counselling. This is supported by the survey finding that only half the respondents wished to receive further training in managing crisis pregnancy.

The majority of GPs also report referring women in crisis pregnancy to other doctors and counselling agencies. This group includes those who themselves provide counselling and also those who do not. GPs refer to more than one agency and those who are aware of the Crisis Pregnancy Agency's +options directory found it useful.

A number of the GPs who were interviewed suggested that women were likely to choose which service they would access in the first instance, depending on what option or outcome they were considering.

8.7 ADVISING WOMEN OF SERVICES PROVIDED

Access to services requires not only that services be provided but also that the intended recipients are aware of this. Ensuring that the practice population is aware of the women's health services provided in the practice is important as it contributes to the perceived value of the service for existing patients and also to the level of uptake by new patients (Rowlands, 1997). Irish research suggests that while women's awareness of GPs services is improving, there is scope for further improvement (Donovan et al, 1992; Smith, 1996; Smith & Bury, 2000; Rundle et al, 2004, Murphy-Lawless et al, 2004). Although the range of services provided by GPs has increased between 1998 and 2004, few differences are identified in how GPs inform their women patients of the services they provide. If we exclude the "opportunistic" promotion of services, then relatively little active promotion is going on. The reasons for this need further investigation. It is likely that they include general concerns about breaching ethical guidelines on advertising and specific concerns about promoting potentially contentious services.

The impression from the interviews is that GPs are enthusiastic about providing information on their services in practice leaflets or posters in the waiting room. The effectiveness of this has not been tracked, either by the practices themselves or nationally. Consequently, GPs perceive that "word of mouth" is how most patients become aware of services provided.

8.8 TRAINING IN WOMEN'S HEALTH

The fall in the numbers of GPs who gain hospital experience in obstetrics and gynaecology during their training, from 94% in 1998 to 79% in 2004 is significant. Currently, only about half of the GP training programmes offer Obstetrics and Gynaecology, largely because of its perceived irrelevance to the general practice setting. However, all GP trainees must complete a women's health module during their training programme. A detailed syllabus and logbook have been agreed on a national basis, and the timing and settings of this training remain the prerogative of each training programme. Because of the inclusion of this module, completion of an Irish GP training programme is recognised as the entry requirement for the Combined Ante-natal Scheme and also entitles graduates to the Family Planning Certificate. The development of this module is consistent with international approaches, for example that of the Royal Australian College of General Practitioners (RACGP Curriculum Statement, 2004b). A range of teaching and learning approaches are detailed in their curriculum statement on women's health, including placements and visits to a range of community providers of women's health services and courses with no mention of the necessity to complete hospital-based obstetrics and gynaecology placements.

8.9 THE IMPACT OF GENDER

The feminisation of medicine generally, and of general practice in particular, as identified in the international literature (Johnston, 1998; Boerma & van den Brink-Muinen, 2000; Roberts, 2005), also affects Irish general practice, as confirmed by this study. The rising numbers of women in general practice, both GPs and practice nurses, augurs well for the future of women's health services. Women's preferences for a female healthcare professional are widely described (Graffy, 1990; Ahmad et al, 1991; Bensing et al, 1993; van den Brink-Muinen et al, 1994; Phillips & Brooks, 1998a; Smith & Bury, 2000; ní Riain et al, 2001). However, not all women wanting to see a female primary healthcare professional necessarily want to see a female GP, as many would be will to see a nurse for health issues such as cervical smear testing and advice on breast examination (Phillips & Brooks, 1998b, ní Riain et al, 2001). The increasing number of practices with access to a female healthcare professional in Ireland, from 77.4% in 1998 to 90.1% in 2004, improves access to healthcare services for women.

This study also demonstrates that women GPs are more likely to provide a wider range of women's health services overall than their male colleagues. Having access to a female healthcare professional in the practice had a similar positive effect on the total number of services provided, compared with male-only practices (14.3 versus 13.1; $p < 0.01$). Women GPs were also more likely to provide core contraception services than their male colleagues (90.1% versus 82.4%; $p = 0.027$).

This increasing "sub-specialisation" in women's health by women GPs certainly addresses the expressed needs of women patients and is in line with the evolving GPs with a special interest, as

envisaged by the UK Sexual Health Strategy. Some women GPs, however, view themselves as GPs who happen to be women rather than "women's GPs" (van den Brink-Muinen et al, 1998). Another important reason that a balance is required is so that the holistic approach to a person's health, one of the great strengths of general practice, is not lost. There is also a risk of deskilling male GPs, if current trends persist.

With regard to the deskilling, the male GPs interviewed had mixed views about this at present. While one was of the view that recent changes had not impacted on his own skills levels, the others believed that it had either already impacted on their skills levels or had the potential to do so. Female GPs believed that the men had already been deskilled and expressed some frustration that this should be so.

8.10 THE IMPACT OF PRACTICE CHARACTERISTICS

This study confirms the trend away from single-handed practice to group practice, with a 14% drop in the numbers in single-handed practice between 1998 and 2004 ($p < 0.01$). Group practices show a tendency to be larger, with an increase of 9.4% in the number of GPs working with two or more other GPs compared with a 4.4% increase in the number of GPs working with one other GP. While differences in the likelihood of providing the total range or particular women's health services were seen in both rounds of the survey between single-handed GPs and those working in group practice, the differences were less in 2004, probably as a consequence of higher number of single-handed practitioners employing practice nurses.

Internationally, urban women generally have better access to healthcare than their rural counterparts (Standing, 1997). In Canada, general practice services in rural areas are generally declining where 30% of the population but only 11% of the physicians are rural (Johnston, 1998). The level and range of services being provided in rural areas there has declined and this problem has been accelerated by the larger numbers of women now graduating from medical schools as they are less likely to practice in a rural setting than their male colleagues.

Ireland, being a small wealthy country, has fewer truly remote areas and a similar urban / rural differential with regard to women's health services is not seen here. In fact, more services overall are likely to be provided in mixed practices than in exclusively rural or exclusively urban practices ($p < 0.01$). Mixed practices were also more likely to provide the four core contraception services ($p < 0.01$). The rural disadvantage is less than the urban disadvantage, although the former is the only source of disadvantage commonly recognised by policy and planning agencies at present. This urban disadvantage probably reflects both economic and demographic factors. Larger urban centres are more likely to have larger populations in deprived areas. The majority of Irish GPs own or lease their own clinical premises and real estate is more expensive in the larger urban centres. This may result in smaller premises which may account, at least in part, for the lower number of practice nurses employed in exclusively urban practices.

Women's health services are now more likely to be provided in routine surgeries alone, i.e. the combination of routine surgeries and dedicated clinics was less common in 2004 than in 1998. Some health boards had provided specific funding for the establishment of dedicated women's health clinics, following publication of the *Family Planning Guidelines* (Department of Health, 1995b) and the Plan for *Women's Health 1997 – 1999* (Department of Health, 1997) and this was reflected in the 1998 survey. A number of factors are likely to have influenced the reversal of this trend identified in 2004, including the increasing employment of practice nurses, the increasing numbers of female GPs in practice and the culture of general practice with its tendency to take a holistic view of patient care. This latter has impacted on how health board funding is provided. Some of the (former) health boards, influenced by their Primary Care Units, had changed to providing funding for the employment of female GPs to carry out routine surgeries, rather than for the establishment of dedicated women's health clinics.

Referral patterns for women's health services also show considerable changes between 1998 and 2004, as reflected in both the questionnaire and the interviews. The preferred referral option for the majority of services not provided by individual GPs is other GPs. This preference for inter-referral in general practice has strengthened between 1998 and 2004, with a corresponding drop in the referral rates to family planning clinics. This drop in popularity of the family planning clinics is likely to be a manifestation of the increasing confidence of GPs that they and their colleagues have better skills in women's health and that attendance at a family planning clinic is no longer necessary for women to access this expertise. This changing view of family planning clinics by Irish GPs is in line with the changing views of Irish women as detailed in recent research (Murphy-Lawless et al, 2004; Rundle et al, 2004).

8.11 THE IMPACT OF SOCIETAL CHANGE

The increasing openness about sexual matters in Irish society over the past decade is reflected in the increasing provision of services by the GP members of our society. The vast majority of GPs provide a range of women's health services, showing consistent increases from the first ICGP questionnaire from 1982 when 81% of GPs were providing family planning services to 2004, when more than 99% were providing hormonal contraception. The interviews identified this increasing openness as a significant driver for expansion in services. Services such as Breast Cancer Screening and the work of the Crisis Pregnancy Agency were also volunteered as examples of improvements in services for women generally.

GPs evaluated the services they provide to specific sub-groups of women as generally adequate, with two exceptions, teenagers and refugees / non-national women. Although levels of concerns about the adequacy of women's health services for teenagers had not greatly changed between 1998 (when it was the leading cause of concern) and 2004, it was overtaken with concerns about the adequacy of the women's health services provided to refugees and non-national women by 2004. The fact that this group were not specified in the 1998 questionnaire but are now a major concern for GPs reflects the immediate impact of societal changes on the services provided by GPs. It also demonstrates the need

for adequate structural and training resources when societal changes result in new demands on general practice. The GPs who were interviewed identified attention to communication as the cornerstone for improving the service to non-national women.

8.12 THE IMPACT OF THE IRISH COLLEGE OF GENERAL PRACTITIONERS

It is likely that the College through its GP specialist training programmes and the education, training and awareness promoted and delivered by the Women's Health Programme has contributed to the increasing range and levels of services provided and the striking increase in confidence in the expertise of other GPs (as reflected in referral patterns).

Just as the findings from the 1998 ICGP survey were useful in setting priorities for the Women's Health Programme over the following five years, this survey clearly signposts the agenda for future training in women's health. Education and training regarding contraception in general has largely been addressed. Emergency contraception, crisis pregnancy counselling and medical care after abortion are now a routine part of practice for most GPs. The top five educational and training needs identified by the GPs were management of STIs, management of gynaecological conditions, psychosexual medicine, menopause / HRT and skills training (e.g. IUCD fitting). They prefer these topics delivered through CME groups, specific half-day or day courses and practical (skills) training programmes.

This work also highlights the need for the College to take a role in informing women of the services provided by their GPs and to undertake further research with both GPs and women to establish how best this can be achieved.

Section 9

Recommendations

The findings from this research identifies a high level of general women's health services being provided in general practice by an increasingly female workforce who are motivated to continue to improve standards. A number of areas where further information is required to inform service development are also highlighted.

Recommendation 1

A framework to support the provision of women's health services is needed.

This framework should take as its starting point an evaluation of existing services, identification of service gaps and the resources required to improve existing services and develop new services. Contraception services, screening for women's cancers and the management of sexually transmitted diseases need to be addressed simultaneously.

Recommendation 2

The number and nature of GPs and other service providers required to provide a comprehensive women's health service needs to be quantified.

This requires the measurement of actual workload of existing service providers and review of consumer preferences.

Recommendation 3

Educational and training supports are needed for those providing services requiring special skills such as IUCD fitting and implant insertion.

In order to ensure that women receive a quality service, standards need to be agreed for services that require special skills. This needs to be supported by appropriate education and training supports and resources.

Recommendation 4

Mechanisms need to be developed to ensure that women can readily ascertain the range of services provided at any general practice surgery.

This mechanism needs to take into account the ethical guidance to the professional groups involved. The Irish College of General Practitioners should support GPs in their efforts to make this information available to patients.

Recommendation 5

GPs should have ready access to patient information supports.

A range of patient information leaflets and appropriate clinical guidelines should be available to support GPs and practice nurses in providing health services to women. These information supports should be readily accessible through a single agency. This will also improve public awareness of the range of services provided. It will require research into the most effective ways of disseminating such information in order that it will be utilised in the day-to-day working of the practice.

Recommendation 6

The role of the practice nurse in the provision of women's health services need to be explored and developed.

This will contribute to maximising the health gain to women and to improving efficiencies within general practices.

Recommendation 7

Formal structures need to be developed and resourced to support inter-referral between general practitioners.

This will ensure that current inter-referral patterns are supported and will improve access to services for women.

Recommendation 8

The educational and support needs of GPs in providing women's health services to specific vulnerable groups need to be addressed.

The health needs of non-national women should be addressed as a priority.

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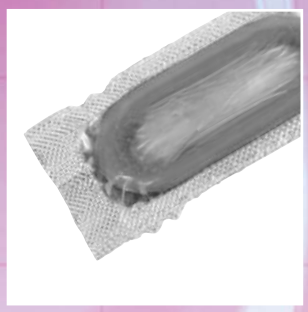

Women's Health Services in General Practice: 2004

THE IRISH COLLEGE OF GENERAL PRACTITIONERS
4-5 Lincoln Place, Dublin 2.
Tel: 01 676 3705 Fax : 01 676 5850
Web: www.icgp.ie