Contemporary Themes

Nurse specialists in family planning

JOHN NEWTON, GAIL BARNES, JAYNE CAMERON, PAULA GOLDMAN, JULIAN ELIAS

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Summary

In an experimental clinic, run by nurse specialists in family planning, a total of 768 patients were seen in the first year. Oral contraception was dispensed for 377 patients and 187 intrauterine devices (IUCDs) were inserted; a further 204 IUCD patients attended only for follow-up visits. All side effects were adequately diagnosed by the nurse specialist.

Introduction

Family planning has been the responsibility of the voluntary agencies in this country and, since the reorganisation of the health service, the area health authority. The usual family planning team has been the doctor assisted by the nurse.

In other countries, however, nurses and midwives with comparable education have provided family planning services after adequate training.¹ Some 27 countries from seven geographical areas are currently providing adequate training for nurse specialists in family planning.¹⁻² Previous reports have suffered from inadequate follow-up, loss to follow-up, and have provided only limited methods of contraception.³⁻⁴ We describe the training programme of nurse specialists, the selection of patients, and the results of the first year of work at King's College Hospital.

Nurse specialist training

The nurse specialists accepted for training had completed their basic family planning training and had worked regularly in family planning clinics. One (PG) had completed a nurse practitioner training course at Emory University, Atlanta, and she helped train the others.

The initial course was for two weeks. The objectives of this course were to combine additional theoretical training with practical training sessions to acquire the necessary skills of problem-orientated diagnosis, pelvic examination, and an understanding of abnormal conditions related to contraception and the fitting of intrauterine devices (IUCDs). Training by didactic tuition was to the standard of the Joint Colleges' (Royal College of Obstetricians and Gynaecologists and the Royal College of General Practitioners) certificate in family planning and

covered their syllabus together with additional tuition in patient categories suitable for nurse specialist work and conditions for which medical supervision was required. To learn the practical skills of pelvic examination and IUCD fitting the trainees examined, firstly, pelvic models, then an anaesthetised patient, and, finally, a conscious patient.

After this intensive course they worked under medical and senior nurse practitioner supervision (PG) for a further period of eight to 12 weeks before working on their own. Special premises were set aside with an appointments system and daily clinics for nurse specialist work. Each clinic was staffed by two nurse specialists and a receptionist. A doctor was on call for problem discussions or visits.

Patient categories

All patients were asked if they wished to attend a nurse specialist clinic and only those who agreed attended. At the initial interview a routine medical, reproductive, and social history was obtained. The data were recorded on our computerised data collection record system.⁵

The following patient categories were believed to exist: (a) the normal patient, suitable for nurse specialist clinic; (b) the patient with a relevant history or finding requiring further information such as blood test or report from another hospital. These would either be suitable for the nurse clinic or need medical consultation before continuing contraception; (c) those not suitable for a nurse clinic, with a medical history or condition requiring medical supervision—for instance, thromboembolism; (d) those with a problem developing with contraception during treatment; after assessment these might either continue in the nurse clinic or need consultation or referral to a doctor clinic.

Guide lines were laid down with regard to these possible categories for oral contraception, IUCDs, and other methods (barrier and injectable contraception). Before prescribing oral contraception the nurse specialist consulted a check list of (a) contraindications, (b) drugs which interfered with their action, and (c) conditions where caution was needed.⁶⁻⁷ Similar check lists were prepared for IUCDs and injectable preparations.

Supplies

Two low-dose oestrogen combined oral contraceptives were considered to be the primary choice but with specified low-dose oestrogen pills for those requiring a change of brand due to side effects, such as depression or breakthrough bleeding. Progestogen-only pills (two types) were also dispensed to suitable patients. The IUCDs fitted were the Copper 7, Progestasert 65, and the Lippes D. These supplies were kept in the clinic and dispensed as required. In addition pre-packed supplies of metronidazole, nystatin, antibiotics, and analgesics were kept in the clinic for treating minor gynaecological complaints after diagnosis.

Clinic visits

Initial visit—In addition to the history and a general medical examination, all patients were weighed, the blood pressure and a cervical smear were taken, and a pelvic examination was made. If necessary cervical or urethral swabs were taken and self-breast

Department of Obstetrics and Gynaecology and WHO Collaborating Centre for Clinical Research in Human Reproduction, King's College Hospital, London SE5

JOHN NEWTON, MB, MRCOG, senior lecturer
GAIL BARNES, SRN, nurse specialist in family planning
JAYNE CAMERON, SRN, nurse specialist in family planning
PAULA GOLDMAN, nurse practitioner, Emory University, Atlanta, USA
JULIAN ELIAS, MRCOG, WHO research fellow

examination taught. After discussion the appropriate method of contraception was dispensed, unless a relevant fact or abnormal examination required a phone consultation or doctor visit.

Follow-up visits—These were arranged at regular intervals, usually six weeks later and then every three months. Patients were encouraged to revisit the same nurse specialist for follow-up to improve continuity of care.

Results

There were 768 patients seen in the first year: 377 for oral contraception (OC) and 391 for IUCDs. Two main groups of patients were seen: those new to the nurse specialist clinic (54.3%) (236 on OCs and 187 with IUCDs) and transfer patients (45.7%) (141 on OCs and 204 with IUCDs) who had been seen in a medical clinic previously and then transferred to the nurse specialist clinic. Of this total clinic population a similar number of patients required some action by the nurse specialist in response to a symptom or finding; 82 (22.6%) on OCs and 96 (24.6%) with IUCDs. A phone consultation was needed to verify the history or examination of 31 patients (10 on OCs and 21 with IUCDs) and the doctor visited 46 patients (16 on OCs and 30 with IUCDs).

ORAL CONTRACEPTIVE USERS

Table I lists the symptoms found in this group of 377 patients using oral contraceptives. An event was described by 82 (22.6%) but only 14 (3.7%) stopped using the method (a closure). The nurse specialist coped adequately with all these conditions. The major events were breakthrough bleeding, headaches, excessive nausea, weight gain greater than 5 kg, and a raised blood pressure (an increase in systolic or diastolic pressure of 20 points greater than the initial reading or a pressure of 140/90, whichever was the lower).

TABLE I—Symptoms causing events and closures

	Events	Closures
Oral contraceptives:		
Breakthrough bleeding ..	41	5
Amenorrhoea	4	0
Headaches	8	1
Excessive nausea ..	8	0
Excessive weight gain ..	7	0
Raised blood pressure ..	6	3
Depression	5	2
Pregnancy	2	2
Chest pain	1	1
Totals	82 (22.6)	14 (3.7)
IUCDs:		
Pain and bleeding	24	20
Other medical	2	2
Partial expulsion	29	13
Total expulsion	2	1
Planned pregnancy	13	13
Other personal	1	1
Accidental pregnancy ..	1	1
Totals	72 (18.4)	51 (13.0)

The doctor was consulted by telephone on 10 occasions: to verify abnormal symptoms in four patients and an abnormal sign in four, and to discuss the choice of method in a further two patients. Both these had previous infertility and irregular cycles and were not advised combined oral contraceptives. The doctor visited the clinic for 16 patients. In six patients this was to verify the nurse's discovery of an abnormal finding, in a further six to check an abnormal anatomical finding (such as Bartholin's abscess), and in four patients to identify the type of vaginal discharge seen. One patient was thought by the nurse specialist to have gonorrhoea, and this was confirmed after the appropriate tests.

INTRAUTERINE DEVICE ACCEPTORS

A total of 187 IUCDs were fitted and a further 204 patients seen for follow-up; in addition 72 patients attended for IUCD removal. Of 14 difficult insertions owing to anatomical reasons six IUCDs could

be inserted by an experienced nurse specialist (PG) and the remaining eight were fitted by a doctor. "Lost threads" were found in 22 patients at follow-up; in 18 the thread was brought down by the nurse specialist using a hook or suction catheter. In four cases the doctor tried to identify the presence of the IUCD and in two of these an x-ray film was required to locate it. All but two of the 72 removals were managed adequately by the nurse specialist; in one the thread broke off and in the other the device became wedged and required removal under general anaesthetic by a doctor.

Table I identifies the events and closures of these 391 patients, the main problems being pain and bleeding (24) and partial expulsion (29). Removal for planned pregnancy was carried out in 13 patients. A total of 21 patients needed a phone consultation: in 13 to discuss treatment, mainly for vaginal discharge, in six to discuss management of bleeding problems, and in the remaining two to discuss the lost threads previously mentioned.

The reason for a doctor's visit in this group of patients was to verify the cause of pain (13) or because of discharge (3), abnormal anatomical findings (4), or excessive bleeding (6). In a further 14 patients there were IUCD-related problems: a tight internal os making removal or insertion difficult (6), difficult removals (2), lost threads (4), or a partial expulsion (2).

The frequency of the doctor's visits and phone consultations for both groups of patients decreased as the experience and confidence of the nurse specialists increased, two-thirds occurring within the first six months. Screening tests carried out included cervical smears on all patients who had not had one within the preceding 12 months. A total of 244 were taken by nurse specialists; 16 patients on oral contraception and 18 with IUCDs showed inflammatory changes. There were no cases of frankly abnormal smears and no spoiled specimens were received by the laboratory.

Discussion

For some years the delegation of family planning follow-up visits has used the family planning nurse,⁸ and in some clinics both IUCD and oral contraceptive follow-up visits have been delegated to the nurse.⁹ The concept of nurse specialists in family planning is not new: nurse practitioners have been trained in the USA since the 1960s²—and in developing countries.^{1 10} Europe has sadly neglected this logical extension of the family planning services at a time when resources are scarce: only the Netherlands and two research clinics in England currently provide nurse specialist training.

Critics of using nurses in family planning have often emphasised the inability of the nurse specialist to diagnose side effects accurately or to fit IUCDs adequately. This series of 778 patients seen in the first year of work shows the ability of the nurse specialist to diagnose important side effects (such as hypertension on oral contraception), and her ability in fitting IUCDs is seen with the 187 patients without a uterine perforation, or excessive expulsion. For the nurse specialist to function safely and efficiently a strong medical back-up with referral to a doctor is needed. The guidelines laid down for this clinic are similar to those of Ostergard and Broen⁴ and Rosenfeld.¹¹ They provide clear definitions of patients suitable for nurse specialist work and those who need medical advice, and in this respect the work is similar to the role of the general practitioner obstetrician.

Training is essential. Cummins³ assumed that nurse specialists could recognise contraindications to IUCD insertion; however, he found additional training was necessary to avoid complications. Ebanks and Gilkes,¹² reporting on the follow-up of these patients, found continuity of use was improved in patients when the IUCD had been inserted by a nurse specialist. Our series also emphasises the importance of adequate theoretical and practical training. The time taken to obtain these skills varies with the individual and may be as short as six weeks or as long as 12 weeks. Regular clinic sessions are important to maintain the skills and experience required. Rosenfeld¹³ also uses graded training for IUCD insertion and has achieved success in training paramedical personnel for developing countries.

The nurse specialist is able to dispense low-dose oestrogen pills with safety using a careful check list to avoid possible complications.^{14 15} Rosenfeld¹⁴ and Hubner¹⁵ have shown that

few side effects of the pill are related to the findings on pelvic examination; nevertheless, we experienced no difficulty in teaching bimanual examination. Rosenfeild also showed that an adequate check list of relevant history and signs would prevent those at risk receiving oral contraceptives. Cartwright¹⁶ has emphasised the need for adequate discussion in family planning matters, and the importance of a female attendant. We have confirmed both of these factors in our clinic experience over the first year. In addition, we think that the patient discusses her particular problems better with a nurse than with a doctor.

Current work will establish the continuity rate by method of contraception in the nurse specialist clinic and compare this with that of a matched control group of patients attending our medical family planning clinic. Nevertheless, the enthusiasm shown by the nurse specialists for this type of work and the high degree of patient care emphasises (as Morhead² said) that the doctor and nurse specialist in family planning can be a creative partnership.

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Letter from . . . Mississippi

Life in the Delta

A STYLE

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Summer was hot and humid in the Mississippi Delta. The usual temperature exceeded 30°C and the humidity was over 80%. Little did we notice the heat as we went from our air-conditioned homes to our air-conditioned cars to our air-conditioned offices. Even the children played indoors. Only the poor, mostly Black, live outside in the Mississippi summer. They spend hours on the porch of their shacks trying to keep cool. There is a constant battle with mosquitoes. The Delta, as the name suggests, is flat and monotonous to an English eye. It is farming country with three major crops: rice, soya bean, and, of course, cotton. The levées along the Mississippi river now protect the area from the floods of the past, though after a rainstorm the bayous (natural drainage ditches) overflow and the soil turns to thick sloshy mud.

Last spring was wet and muddy. The farmers could not plant on time because their machinery would stick in the mud. Wealthy farmers used aeroplanes for crop spraying and even seed planting. In our garden we were sprayed with pesticides, herbicides, and fertiliser. In the autumn it was cotton defoliants.

The poorer farmers still rely on daily paid labour. You could see them in the hot sun "choppin' cotton" for \$20 a day—not a lot in America. These labourers came to see me complaining of headaches, dizzy spells, and the "blindin' staggers." I had great

sympathy as I could not have stood a whole day working in the Mississippi sun.

The county in which my family and I lived is two-thirds Black. It kept reminding us of a developing country, though clearly it is not; it is still unbelievably a part of the USA. The Blacks are mostly poor, the men being either unemployed or daily-paid labourers with no unions to protect their rights. Statistics confirmed our impressions^{1 2}: Black infant mortality (1972) was 35.7 compared with 13.7 per 1000 births for the White population; half the population have incomes which are below the Federal Government poverty line; a third of the housing lacks adequate plumbing; a fifth of all fertile women (below 45 years) are pregnant annually. The statistics go on.

Mississippi is racially integrated, of course, with Blacks and Whites mixing in public areas. Although Mississippi has made considerable progress, legal integration does not overcome cultural and economic differences as well as personal racial prejudice. As an example, our local town has a fully integrated public school system with children of all races going to the same school in their area. The town has two high schools—one on either side of the train track. As it happens, Blacks and Whites are separated on either side so there is in practice a Black high school and a White high school. The few White families living in the Black area send their children to private schools. Our life was split. We had Black friends and White friends. It was only occasionally that we all met together, but some progress has been made. A decade ago we should probably have been physically threatened for working with the Black population. Instead, our White neighbours showed us great kindness.

Department of Family and Community Health, Meharry Medical College, Nashville, Tennessee 37208, USA
A STYLE, MB, DCH, general practitioner