consultations around teenage problems, abortion (spontaneous or induced), menstrual disturbance, marital problems, and when taking a history from new patients. Such patients can be directed to the family planning nurse for appropriate advice and care.

VALUE OF THE CLINIC

In one year in the practice the nurse has carried out about 1200 consultations that would otherwise have been undertaken by the doctors. When staff and resources are limited it is essential to use both more effectively. Delegating some work to nurses seems an appropriate way of freeing doctors to use their skills in treating patients whom only they can help.

This clinic is experimental and its medicolegal defensibility has never been tested in a court. Nevertheless, another experimental family planning clinic, where the concept of care by nurses has been carried even further, has been extremely successful.³ Accordingly, the doctors in the practice do not feel particularly at risk of litigation, and nor does the nurse because of the medicolegal cover provided by her membership of the Royal College of Nursing.

Well-woman clinic

Unlike the family planning nurse, who was recruited on a part-time basis especially to run the clinic, the nurse who was trained to run the well-woman clinic was already a full-time nurse-receptionist. The practice decided State-registered nurses were too highly qualified to be engaged in day-to-day documentation and filing and, with the advent of trained receptionists, were rarely needed for reception work. So the nurse could extend her consultative and clinical roles.

The main aim of the well-woman clinic was to ensure that all women aged 35 to 60 had had a cervical smear within the last five years. When patients attended for this, however, the nurse or doctor would take the opportunity to carry out a more comprehensive health check.

SCREENING PROGRAMME

The receptionists systematically screened all the records of women aged 35 to 60 and sent a letter inviting all those who had never had a cervical smear or who had not had one for over five years to make an appointment to see the nurse or their doctor to have this carried out. The letter was signed by the nurse and gave a list of the sessions when either a nurse or a doctor would be available. Care was taken to avoid sending for the chronically housebound or those who had had a hysterectomy. When the patients were seen by the nurse she had the medical record available and could make some general inquiries about well-being and their current health problems. She then took a menstrual history and a urinary history. If she detected important abnormalities in the menstrual history—for example, intermenstrual or postmenstrual bleeding—she referred the patient to her doctor. She routinely examined the urine for sugar and albumin and if there were any abnormal urinary symptoms she also sent a specimen for bacterial culture. If the patient complained of lassitude or looked unduly pale she measured the haemoglobin. The nurse examined the breasts and while she was doing this she showed the patient how to examine them herself. She also gave the patient a leaflet on breast examination to take home. The nurse then palpated the abdomen, feeling principally for any abnormal masses, inserted a vaginal speculum, visualised the cervix, and took a cervical smear. The patient was told to contact the nurse later for the results of the various tests, and these were brought to the attention of the patient's doctor.

A State-registered nurse is trained to use medical records, take relevant histories, and carry out breast and abdominal examinations, but using the vaginal speculum and taking cervical smears are new to her. The nurse was given a short "refresher course" on taking genito-urinary histories and on breast and abdominal examination. She was instructed how to use the vaginal speculum and she and the doctor who trained her took many cervical smears together and inspected many cervixes. She was provided with the relevant books and articles from the library of the local postgraduate centre.

RESPONSE AND FINDINGS

The overall response from patients was disappointing in that only

about a quarter of the patients invited came for their cervical smear. Nevertheless, this amounted to about 600 women having a cervical smear, over half of whom had never had a smear test. About one in five patients had a trichomonas infection detected in the cervical smear, but few had associated discharge necessitating treatment. About one in 10 of the patients had symptoms—for example, intermenstrual or postmenopausal bleeding—or signs—hypertension, cervical polyp, significant discharge—requiring referral to the doctor for further management. Hence a small but significant number of patients previously tolerating unpleasant symptoms or disregarding potentially dangerous ones received medical help.

Perhaps the most important and successful feature of the whole programme was the fact that 90% of the patients presented to the nurse for examination despite being offered an appointment with either the nurse or their own doctor.

There is nothing particularly unique about a well-woman clinic.⁴⁻⁶ The importance of our clinic is that it was run almost entirely by the nurse, again freeing the doctors to concentrate on areas where their skills are more definitely needed.

Could any litigation ensue as a result of any shortcomings in care in this clinic, the main defence would centre around that fact that the nurse has been trained and is considered competent to perform the examinations delegated to her. For her own personal protection she has to be a member of the Royal College of Nursing. The document *The Duty and Position of the Nurse*⁷ contains a statement jointly agreed by the British Medical Association and the Royal College of Nursing, and there is nothing in that statement that would preclude the type of consultations carried out in this well-woman clinic.

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Several patients work in a fibreglass factory making fibreglass boats. What is the danger of inhaling fibreglass particles and thereby damaging their lungs? Are special precautions necessary in working with the many different resins used in such work?

So far no long-term ill effects have been seen in workers exposed to glass fibres.¹ Studies with small animals, however, have shown that intrapleural implantations of finely milled glass fibres produce mesotheliomas.² The types of glass fibre used in boat building are generally so large as to be non-respirable. (Cutting and finishing of glass reinforced plastics has little effect on fibre diameters.) Styrene monomer is liberated during resin application. Investigations in small glass reinforced plastics workshops have invariably found styrene concentrations far above the current threshold limit value (TLV). (TLV = amount of a substance, usually expressed as parts per million in air, to which a man may be exposed for eight hours a day, five days a week, for all his working life without ill effects.) Long-term exposure of man to styrene has caused both central and peripheral nervous system disturbances. The former may result from inhalation, the latter from skin contact with styrene. Symptoms of overexposure have included listlessness, anorexia, nausea, vomiting, impaired night vision, lesions of the peripheral nerves, and disabling psychiatric conditions.³ Furthermore, detrimental psychophysiological effects have been found around TLV levels.⁴ To avoid ill effects from styrene, workshops should be fitted with efficient extraction systems where the fumes enter into the workplace air.

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