Practice Research

A practice audit of oral contraceptive users

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Although there has been a progressive shift in responsibility for family planning from family planning clinics to general practice, little has been published on the level of care provided to oral contraceptive users in general practice. Johnson and Thorogood reported on the care of oral contraceptive users by general practitioners in Oxfordshire, but this was by questionnaire rather than by direct measurement of their activities.¹ In our practice we have been considering an appropriate level of care and have agreed that the recommendations of the report on family planning of the Royal College of General Practitioners² were relevant and attainable. We decided in addition to evaluate any resultant change in the level of care we provided. We first had to identify our current level of care, which is the basis of this report. We plan to review our care again in two years.

Method

The practice has two men and one woman principals and a trainee, and a total patient list of 6000. The health centre is multipractice and has a treatment room staffed by two state registered nurses. Contraceptive care is provided during normal surgeries, there being no separate family planning clinic. The practice uses A4 records, but this does not include a separate contraceptive record sheet.

The records of all women currently taking oral contraceptives were reviewed. From these, the following criteria of care were measured: (i) a record of menstrual history; (ii) blood pressure recorded before starting oral contraception; (iii) blood pressure recorded at first check up visit (normally after three to six months); the following were recorded as being carried out at some stage while taking oral contraceptives: (iv) weight; (v) urine analysis; (vi) pelvic examination and cervical smear; (vii) rubella titre.

Although these criteria were inevitably arbitrary, they were designed to correspond with the guidelines in the report on family planning.² A strong case is made for recording blood pressure at the outset, at first review, and thereafter at least once a year. It is suggested that weight is recorded at the first visit as a base line and thereafter if the patient complains of variation in weight. Urine testing for glucose is not considered worth while in the age group likely to be presenting for oral contraception. Similarly, routine vaginal examination is not thought necessary for most women. Cervical cytology and rubella antibody testing, however, are advised as effective screening procedures in a receptive population.

Results

The age distribution of women included in the study is given in table I and is compared with that in the study by the Royal College of General Practitioners, *Oral Contraceptives and Health*.³ It was noted that there were differences in the care given to women who had been

taking oral contraceptives for more than one year and those who had begun in the past year. Therefore, in addition to looking at the care provided to all users, these two groups were compared.

Group 1 comprised those women who had been taking oral contraceptives for more than one year (83% of these women had been users for between one and four years); group 2 comprised those who were recorded users for under a year. The groups were similar in respect of marital status, nulliparity, history of therapeutic abortion, and type of preparation prescribed—that is, combined or progestogen only pill. Thirty per cent of women in group 1 had been prescribed oral contraception after pregnancy compared with 50% in group 2. Group 2 accounted for 32% of women in the study which accords with the study *Oral Contraceptives and Health* where 27% of women were in the first year of oral contraceptive use. The results for this group showed that pretreatment blood pressure, weight, urine analysis, and rubella titre had been recorded significantly more often than in group 1 (table II).

TABLE I—Age distribution of users of oral contraceptives in one practice

Age group (years)	No of users	Users as % of all women in the age group	Users as % of all users	Users as % of all users (Royal College of General Practitioners, 1974) ³
15-19	58	21.9	22.0	5.5
20-24	106	38.4	40.3	29.7
25-29	62	24.0	24.0	25.8
30-34	21	8.5	8.0	19.9
35-39	10	4.8	3.8	12.3
40-44	5	2.6	1.9	5.5
≥ 45	0	—	—	1.4
Total	262		100	100

TABLE II—Measurements recorded in two groups of oral contraceptive users (percentages are those of women who had particular examination performed)

Criterion of care measured	Percentage of all users (n = 262)	Percentage of group 1 (users > 1 yr) (n = 178)	Percentage of group 2 (users < 1 yr) (n = 84)	Significance of difference between 1 and 2
Menstrual history	35.8	33.7	40.4	NS
Blood pressure recorded before treatment	65.6	60.1	77.3	p < 0.01
Blood pressure recorded at first review	41.6*	38.2	50.7**	NS
Weight	63.0	54.5	80.9	p < 0.01
Urine analysis	51.9	44.9	66.7	p < 0.01
Vaginal examination and cervical smear	55.0	53.9	57.1	NS
Rubella titre	44.3	37.1	59.5	p < 0.01

*n = 245 **n = 67 χ^2 = tested data.

Discussion

Studies of audit from general practice have shown that a wide variation exists between perceived and actual performance.⁴ Impressions of performance also vary according to whether one asks general practitioners or patients. Johnson and Thoro-

good found that a high percentage of general practitioners reported that they carried out various routine examinations when prescribing oral contraception.¹ In contrast, using a questionnaire for patients, Cartwright⁵ found relatively low percentages of women who said that they had had these examinations done. The results of this study suggest that the selected criteria are being met somewhere between these two extremes (see table III).

TABLE III—Examinations performed at initial consultation as reported in two studies (all figures as percentages)

Examinations	Cartwright (1970) (338 patient respondents)	Johnson and Thorogood (1977) (147 general practitioner respondents)
Blood pressure	19	98
Weight	Not asked	67
Vaginal examination	29	67
Cervical smear	9	65
Breast examination	15	56

It is important to record blood pressure before prescribing contraception and at intervals thereafter, as in a small percentage of women blood pressure will increase while taking oral contraception. We found that only 65.6% of all users had had blood pressure recorded at the initial visit. Reasons for this may be that blood pressure was recorded in the past before a consultation for oral contraception or before a recent discharge from hospital after a confinement or termination. Despite this there seem to be many women who had no blood pressure recorded before starting contraception. Thus a valuable baseline measurement has been lost. It is perhaps of even more concern that only 38.2% of women in group 1 (users for more than one year) had blood pressure recorded on their first check up visit.

The findings for group 2 (users for under one year) are more encouraging, however. The improvement in recording blood pressure before treatment and more recording of weight and the results of urine analyses may well be due to a greater awareness coming out of the discussions that led up to this study. But it is more likely due to the increase in the number of women who now attend for postnatal examination. Over the past 18 months the practice has offered paediatric developmental screening. The first such visit is at six weeks—and the mother is invited to have her postnatal check the same afternoon. There is now virtually 100% attendance for postnatal examination.

There was also a great increase in the number of women who had rubella titre recorded. Until 1980 all primipara were referred to Aberdeen Maternity Hospital for routine antenatal care and initial blood tests were performed there, but copies of laboratory reports rarely reached the practice. Since 1980, however, all pregnant women have been routinely seen in the practice, all blood tests (including rubella titre) are done there, and rubella titres are recorded in the patient's notes. But even this is unsatisfactory as the women are already pregnant at the time of the test, which should ideally be performed when they first present for contraception.

The proportion of women who had the results of a vaginal examination and cervical cytology recorded was low. Vaginal examination is not generally considered as essential before starting oral contraception in women with a normal gynaecological history and to make it compulsory would undoubtedly deter some women from seeking contraceptive advice. There is concern, however, at the growing number of young women with cervical dysplasia that does seem to be related to sexual factors.⁶ Thus it is important that cervical cytology is offered to women in the first year or two of becoming sexually active—though some will refuse. The general practitioner's awareness of the onset of sexual activity is likely to coincide with the time of first presentation for oral contraception. Despite continuing contro-

versy over the frequency of and the age at which screening should start, it seems reasonable to offer this to women when they first present for contraceptive advice.

As a result of this study we aim at improving our standard of care to oral contraceptive users and plan to introduce the following routine: (i) record blood pressure at each initial consultation and also at each subsequent visit before prescribing oral contraception; (ii) record weight at initial consultation; (iii) advise on rubella screening at the initial or first review consultation; (iv) advise on cervical cytology examination (and vaginal examination) in the first year of oral contraceptive use.

It will be interesting to see whether we can achieve this standard in all our oral contraceptive users.

Conclusions

The aim of the study was to measure the medical care provided to oral contraceptive users in a general practice. A feature of the study was comparison between women who had been taking the pill for over a year with those who had done so for less than a year. Patient records were reviewed and information sought on menstrual history, blood pressure at initial visit and at first review, weight, urine analysis, pelvic examination and cervical smear, and rubella titre.

The main finding of the study was that better care was given to women who had been pill users for under a year, and we intend to improve on the care given to pill users and to reassess this.

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References

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- 3 Royal College of General Practitioners. *Oral contraceptives and health*. London: Pitman Medical, 1974.
- 4 Sheldon MG. *Medical audit in general practice*. Occasional paper No 20. London: Royal College of General Practitioners, 1981.
- 5 Cartwright A. *Parents and family planning services*. London: Routledge & Kegan Paul, 1970.
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ONE HUNDRED YEARS AGO This well-known personal attendant of Her Majesty the Queen expired at Windsor Castle on the evening of March 27th, in the fifty-sixth year of his age. We are informed that Mr Brown felt slightly indisposed on Friday, March 23rd, but continued to discharge his duties until the following evening; he then complained of general depression and an ill-defined uneasiness. On Sunday morning, an erysipelatous rash appeared on the face; it rapidly extended to the scalp, and he passed into the comatose typhoid condition commonly observed in the worst forms of erysipelas. He died at eleven o'clock on Tuesday night. He was attended by Dr James Reid, resident medical attendant to the Queen, Windsor Castle; and Sir William Jenner was called in consultation. No trace of any wound or injury could be found, nor could any constitutional predisposing cause of erysipelas be discovered. Mr Brown, who was the son of a farmer on the estate of Colonel Farquharson of Invercauld, had always enjoyed robust health until recently; but his friends have noticed during the last year a diminution of his accustomed vigour. (*British Medical Journal* 1883;i:631.)