



The role of Tasmanian general practitioners
in the provision of contraception, abortion
and sexual counselling services.

by

Maureen Davey

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DAVEY

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INTRODUCTION

This survey attempts first to explore and demonstrate the attitudes and current practices of the general practitioners with regard to contraception, sterilisation, abortion and sexual behaviour, second to determine the adequacy of undergraduate and postgraduate training in family planning, and, third, to examine the general practitioners self-perceived role in providing family planning services to the community.

Various types of studies on family planning have been undertaken. One type concentrates on contraceptive technology, the effects of various methods on the physiology of users, and the comparative safety rates. Another type analyses large, long-term surveys of contraceptive method-use in communities. The rarest type are those concerning behaviour associated with the use and provision of contraceptive methods. The motivations of individuals, either in choosing the kinds of contraceptives that they use, or in their reasons for not using them effectively are difficult to evaluate. Few studies have been concerned with that aspect of family planning embodied in this thesis, namely the attitudes and behaviour of the primary transmitters of family planning advice and information - currently the medical profession.

The study of behaviour associated with family planning is very important in the analysis of factors involved in the continuing high levels of unwanted pregnancies, when in fact relatively safe and effective contraceptive technology is now available. An editorial in the Medical Journal of Australia (Vol.2, No. 10, 1973) stated :

*.....there is adequate medicosocial evidence
that Australian women are burdened by a large*

number of unwanted pregnancies. An estimated 200,000 such pregnancies occur annually and include those resulting in illegitimate births, births of babies within the first six months of marriage, births of unwanted babies within marriage and abortions. This figure means that one in two pregnancies is unwanted.

This study is an attempt to rectify a deficiency in present knowledge of the behaviour and attitudes of the providers of family planning services. Family planning services are provided by general practitioners, gynaecologists, pharmacists, clinics and hospitals. All these services, and, perhaps, even more alternatives are necessary if knowledge about conception control is to be made available to each individual person.

General practitioners, because of their key role at the primary entry point into the health and welfare system, are the primary suppliers of family planning information and devices in Australia. Their opinions and behaviour were examined by interviewing 75% of the general practitioners in the urban areas of Launceston and Hobart. The interviews were conducted during April and May, 1976, and, as noted above, covered the topics of contraception, sterilisation, abortion, sexual behaviour and education of both the medical profession and community in these matters.

A comprehensive, factual and statistically reliable study of the general practitioners' behaviour and attitudes is needed for several reasons. Information on the needs of general practitioners is required by those responsible for the funding and delivery of educational services to doctors

and medical students. Statistics on the attitudes of general practitioners to the advertising and availability of contraceptives, to abortion and to sterilisation can be used by those groups lobbying on behalf of doctors, by legislators and by groups and individuals within the community. Knowledge of the extent to which general practitioners use specialist services and agencies, and the general practitioners' opinions on the need for further family planning agencies will be useful in the future development of family planning services. The information gained from the survey can also be used by general practitioners to assess their own levels of knowledge, attitudes and current practices in comparison with those of their colleagues.

METHODOLOGY

CONSTRUCTION OF THE QUESTIONNAIRE

An interview schedule was used in preference to a self-completed questionnaire. By asking the questions in person the response rate was maximised, and the cooperation and confidence of the general practitioner was gained. The effect of the interviewer's own views was minimised by asking the questions in a predetermined order and by standardising the wording of the questions.

The possible answers to the questions were often listed, and the answers obtained from the doctor indicated on the questionnaire by circling a coded number. All these factors allowed the interview to flow smoothly and rapport with the doctor easy to maintain.

The precoding of possible answers saved time, avoided ambiguities which could make subsequent analysis difficult, and allowed easy transference of data to computer cards. Precoding was used in the questionnaire except where it was difficult to anticipate all the likely answers. Open-ended questions were used in these cases.

Guidelines suggested by Jahoda, et al (1951: see Appendix I), were used in the construction of the questionnaire. The questions were divided into five sections; doctor classifying questions, contraception, abortion, sexuality and education.

TESTING OF THE QUESTIONNAIRE

The draft of the questionnaire was distributed to several people for criticism. These people included:

Dr. Stefania Siedlecky, Adviser on Family Planning to the Australian Department of Health in Canberra;

Professor John Leeton, Associate Professor in Obstetrics and Gynaecology, Monash University, Queen Victoria Hospital;

Dr. Trevor Lee, Lecturer in Geography, University of Tasmania;

Dr. John Davidson, Lecturer in Psychology, University of Tasmania;

Sr. Pat Hewitt of the Family Planning Association of Tasmania;

Dr. Alan Tucker and Mr. Stephen Lockwood of the Department of Community Health, University of Tasmania;

Drs. Carol Watson, Peter Murray, Alan Wallace and Professor Colin Wendell Smith of the Anatomy Department, University of Tasmania.

The suggestions received from these sources were included in the preparation of the final draft of the questionnaire. This draft was tested in trial interviews with medical doctors in the preclinical medical faculty, with some general practitioners who had not been randomly selected for interviews, and with other people using role playing techniques. These practice interviews helped to eliminate bias in questions, ensured the smooth flow of questions and improved the technique of questioning. The final questionnaire was then constructed and used in interviews with the selected doctors. (See Appendix II).

SAMPLE OF DOCTORS

The following factors were taken into consideration in choosing the sample of doctors :

- i) General practitioners were used because of their key role at the primary point of entry into the health and welfare systems for the majority of people. For this reason it was considered that a study of general practitioners would yield more information about family planning services than a study of gynaecologists, family planning clinics, pharmacists or of community attitudes.
- ii) The sample had to be of sufficient size to enable valid statistical analyses of the results which could then be applied to a wider population of doctors. As a total of 70 to 100 doctors was considered to be adequate, a sample which included 75% of the total number of general practitioners in the urban areas of Launceston and Hobart was used. This percentage gave a sample of 97 doctors.
- iii) The doctors chosen had to be representative of the total number of doctors practising in these areas. For this choice a complete sampling frame was needed. Lists were obtained from several sources, including the Royal College of General Practitioners. These lists were compared, and the resulting list was circulated to some local health workers for correction. In this way a complete and up to date listing of all general practitioners in active practice was compiled. However, doctors who worked in general practice for less than two half-days per week were considered ineligible for inclusion in the sample.
- iv) Only urban general practitioners were used in the

sample. Doctors in the country do not have ready access to specialists and hospitals, which makes the practice of medicine in country areas substantially different. There were too few country doctors to be used as a subset for comparative purposes, so their inclusion in the sample was not justifiable. Another reason for using an urban sample was to facilitate comparison of results with those of Barson and Wood (1972), who surveyed Melbourne doctors in 1971.

SAMPLING

The technique used was stratified random sampling (Jahoda, 1951). The population of doctors was divided into two groups according to the city in which they practised. This stratification of the population was made because it was anticipated that the difference between the general practitioners practising in the two cities (Launceston and Hobart) might be large compared with the differences between those practising within each city. This method of sampling would ensure that each population is equally represented. The stratification is a precaution against freak random results, it does not upset the random nature of the sample.

A random number table was used to take a simple random sample from each of these two groups. A total of 97 general practitioners were selected for the sample - 24 of these were from Launceston and 73 from Hobart. Ten doctors were randomly selected to be on a replacement list.

Doctors who could not participate in the survey through long term sickness or holidays were replaced. Those doctors who refused to participate because of a lack of interest, antagonism to the survey, or because they were too busy were not replaced.

MAKING CONTACT WITH THE DOCTORS

Letters were written to the newsletters of the Australian Medical Association (AMA) and the Royal Australian College of General Practitioners (RACGP) in the two months preceding the time of the interviews. These letters stated that the success of the survey was dependent on the cooperation of all general practitioners selected, and that individual replies to the questionnaire would be treated with the utmost confidentiality.

Certain key members of the AMA, RACGP, Family Medicine Programme (FMP) and General Practitioners Society of Australia (GPSA) were contacted and the project explained to them.

The preliminary contact with the selected general practitioners was by explanatory letter and a 'phone call. These preliminary steps, and my status as a medical student ensured an excellent response rate.

INTERVIEWS

As explained under 'Making Contact with the Doctors' the selected general practitioners had heard of my survey through medical society newsletters, my letter and 'phone call. An appointment for the interview was made at the time of the 'phone call.

Throughout the interview I restricted the transmission of my opinions to the doctors by being very careful about my comments, facial expressions, tone of voice and the way I asked the questions. If the doctor asked for my opinion on a particular question it was explained that we could talk about my views at the end of the questionnaire.

Trial interviews and tape-recorded role-plays ensured consistency in my technique and a familiarity with the wording and order of the questions which enabled me to look at the doctor when speaking, to avoid awkward pauses and to give full attention to maintaining rapport and recording the answers.

Most of the interviews were done in the general practitioners' surgeries before or after surgery hours, in the time reserved for drug company representatives, or in lunch hours. Some interviews were conducted in the doctor's home.

A very important part of the interview was the reassurance of the general practitioner that all responses would be confidential.

ANALYSIS OF RESULTS

Discussions with Dr. K. Rainsford of the Biochemistry Department and Dr. J. Davidson of the Psychology Department, University of Tasmania, led to the decision to use the SPSS (Statistical Package for the Social Sciences) system of computer analysis. The SPSS system required no previous knowledge of computer language or programming experience. Furthermore, this system allowed punch-card input and contained all the statistical routines likely to be needed.

An understanding of the SPSS system was gained by attending an introductory course on SPSS in the Geography Department, reading the SPSS manual (Social Sciences Data Service), and discussions with Dr. T. Lee of the Geography Department, University of Tasmania.

The questionnaire was organised such that most answers could be coded using the numerals 1,2,3,4,5,6.....etc. At the time of interview answers were written down as code, often accompanied by comments. Immediately after each interview the coding was checked and entered into the boxes provided on the questionnaire. After all the interviews were completed the questionnaires were edited to check for omissions and ambiguous answers and to code the openended questions.

The coded answers were punched onto computer cards. These cards were processed, using the SPSS system, on the University Burroughs B6700 computer.

Frequency distributions were calculated for all the variables. Cross-tabulations and the X^2 -test of significance were used to test the degree of association between variables. Where appropriate, the t-test was also used.

RESULTS

RESULTS

a. Response Rate

Of the 97 general practitioners in the sample, 87 (90%) agreed to participate in the survey. The reasons given by the 10 doctors who refused to be interviewed were :

too busy	7 general practitioners
not interested	1 general practitioner
on holiday	2 general practitioners

The two doctors on holiday were Launceston general practitioners who were absent from their practices for the entire duration of the survey.

The "too busy" reason is difficult to substantiate as I was available for the interview at any time of the day or week over several weeks. For these 7 doctors the unspoken reason for refusal could have been a lack of interest or outright antagonism to family planning or to participation in surveys.

b. Validity

How did I know the doctors were telling me the truth ? An estimate of the truthfulness is important because of the possibility that doctors might put forward idealised views, rather than how they actually think or behave in a particular situation. This distortion could be increased by failures of memory, unconscious omissions, repression of the unpleasant, distortion of recall, a tendency to dramatise and describe a desired or imagined role, and a fear of legal reprisal because of the possibility of some of their work being illegal, e.g. the prescribing of oral contraceptives for underage

girls, sterilisation and abortion.

The following checks were used to maximise the truthfulness of responses.

- i) Checks were built into the questionnaire to verify the consistency of responses.
- ii) The open-ended nature of some of the questions encouraged the doctors to discuss many of the issues at length. Doctors rarely have the opportunity to discuss their attitudes and actions in a completely confidential situation with someone they are never likely to see again, thus a large number of interviews ended in a discussion of the doctors general attitudes to sexuality and counselling in their personal and professional lives. These lengthy discussions in such personal and sensitive areas required an honesty from the doctors that was quite revealing.
- iii) The areas covered by the questionnaire formed a large part of the general practitioner's daily workload so the doctors had definite steadfast views and prescribing patterns. This meant that the problems of failure of memory and distortion of recall were minimised.
- iv) Another way in which the results were verified was by discussion with people who were in regular contact with a number of doctors interviewed in this study. The confidentiality of my interviews with the general practitioner was not breached during these discussions. The discussions were not quantified or formalised but no contradictions showed up between general

practitioners stated attitudes and the impressions of those in contact with the general practitioner. None of the information gained from these people was used in the analysis.

c. Classifying characteristics of the doctors

The first section of the questionnaire included questions about the general practitioner and his or her practice. The frequency tabulations for these characteristics are shown below. Interesting points to note are the large number of British doctors (44 or 50.6%) and the large number of women (17 or 19.5%).

The results obtained from cross-tabulations of the doctor classifying characteristics with other variables covered in the questionnaire are shown in results section (i).

FIGURE 1.

CLASSIFYING CHARACTERISTICS OF THE DOCTORS		
	frequency	%
(i) CITY OF PRACTICE :		
Hobart	67	77.0
Launceston	20	23.0
(ii) COUNTRY OF GRADUATION		
Australia	41	47.1
Britain	44	50.6
elsewhere	2	2.3
(iii) YEAR OF GRADUATION :		
1930-9	2	2.3
1940-9	10	11.5
1950-9	37	42.5
1960-9	24	27.6
1970-5	14	16.1
(iv) YEARS IN GENERAL PRACTICE :		
< 5	22	25.3
5-9	14	16.1
10-14	19	21.8
15-19	14	16.1
>20	18	20.7
(v) TYPE OF PRACTICE :		
group	57	65.5
solo	29	33.3
locum	1	1.1
(vi) SEX :		
male	70	80.5
female	17	19.5
(vii) MARITAL STATUS :		
married	79	90.8
previously married	4	4.6
never married	1	1.1
(viii) RELIGION :		
none	28	32.2
nominal	13	14.9
protestant	29	33.3
catholic	13	14.9
other	4	4.5
(ix) PROPORTION OF PATIENTS AGED 15 - 45 yrs :		
< onethird	27	31.0
1-2 thirds	48	55.2
>twothirds	12	13.8
(x) SOCIOECONOMIC CLASS OF PATIENT :		
predominantly upper	18	20.7
predominantly lower	24	27.6
cross-section	45	51.7

4. Contraception.

The second block of questions determined the doctors contraceptive prescribing habits, places used for referrals, and attitudes to the availability of contraceptive information and devices. The results obtained from these questions are presented in the tables and graphs on the following pages.

FIGURE 2.

FREQUENCY OF CONTRACEPTIVE CONSULTATIONS

- URBAN TASMANIAN GP's, 1976 (N=87)

no. contraceptive consultations/ wk.	number	%
none	2	2.3
1 - 4	8	9.2
5 - 9	14	16.1
10-14	21	24.1
15-19	19	21.8
> 20	23	26.4

- i) I asked each general practitioner, "About how many patients have you given advice on contraception in the last week (or an average week if the last week was atypical)." Advice on contraception included all consultations concerning contraception, even repeat prescriptions for oral contraceptives.

Two of the general practitioners, both married male Catholics who had been in general practice for 10-15 years, did no contraceptive consultations.

Almost half (48.3%) of the general practitioners

did more than 15 consultations about contraception in a week, 26.4% doing more than 20 (Figure 2).

- ii) Fifty-nine (67.8%) of the general practitioners initiated discussions on contraception with their patients (Figure 3), 15 (17.2%) frequently initiated discussions. The 15 general practitioners who frequently initiated discussions usually included a contraceptive history as standard questions in a general medical history.

FIGURE 3.

THE INCIDENCE OF GP'S INITIATING CONTRACEPTIVE
DISCUSSIONS (N=87)

	number	%
never	28	32.2
rarely	44	50.6
frequently	15	17.2
		} 67.8%

- iii) The frequency with which the general practitioners prescribed or advised each of the methods of contraception was ascertained. The results are shown in Figures 4 and 5 - the usually and frequently categories have been combined in Figure 5 for ease of illustration.

FIGURE 4.

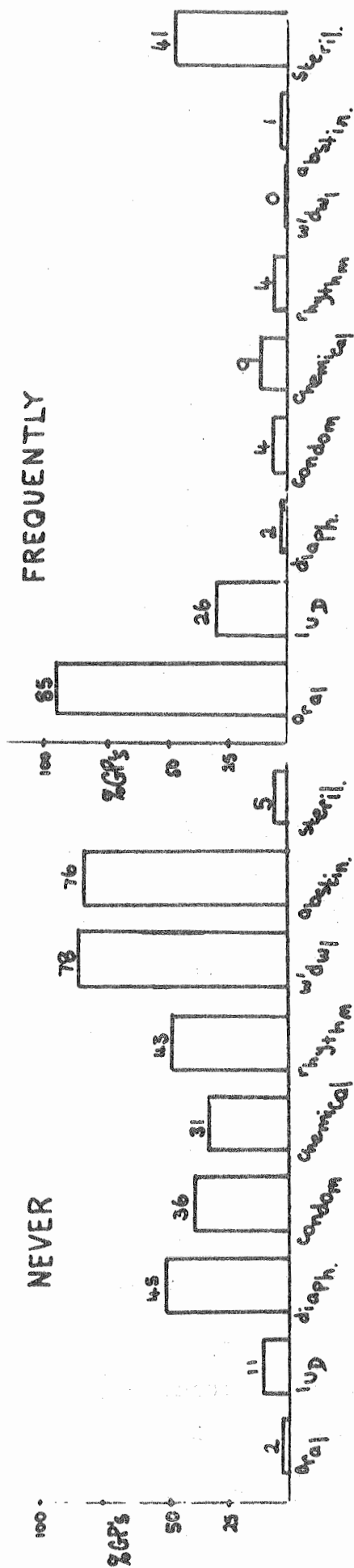
METHODS OF CONTRACEPTION PRESCRIBED OR ADVISED

(N = 87 GPs)

	never		rarely		frequently		usually	
	n	%	n	%	n	%	n	%
oral	2	2.3	0	0	6	8.0	79	89.7
IUD	11	112.6	50	57.5	26	29.9	0	0
diaphragm	45	51.7	40	46.0	2	2.3	0	0
condom	36	41.4	47	54.0	4	4.6	0	0
chemical	31	35.6	47	54.0	9	10.3	0	0
rhythm	43	49.4	40	46.0	4	4.6	0	0
withdrawal	78	89.7	9	10.3	0	0	0	0
abstinence	76	87.4	10	11.5	1	1.1	0	0
sterilisation	5	5.7	41	47.1	41	47.1	0	0
other	86	98.9	1	1.1	0	0	0	0

The most common method of contraception was the oral contraceptive or "pill". It was the method of first choice for 89.7% of the general practitioners. Only 2 doctors never advised or prescribed oral contraceptives. These 2 doctors never gave contraceptive advice (Figure 2).

Sterilisation was the second most common method of contraception advised by the general practitioners. It was advised frequently by 41(47.1%), rarely by another 41 and never



METHODS OF CONTRACEPTION PRESCRIBED OR ADVISED

-URBAN TASMANIAN GPs, 1976
N=87

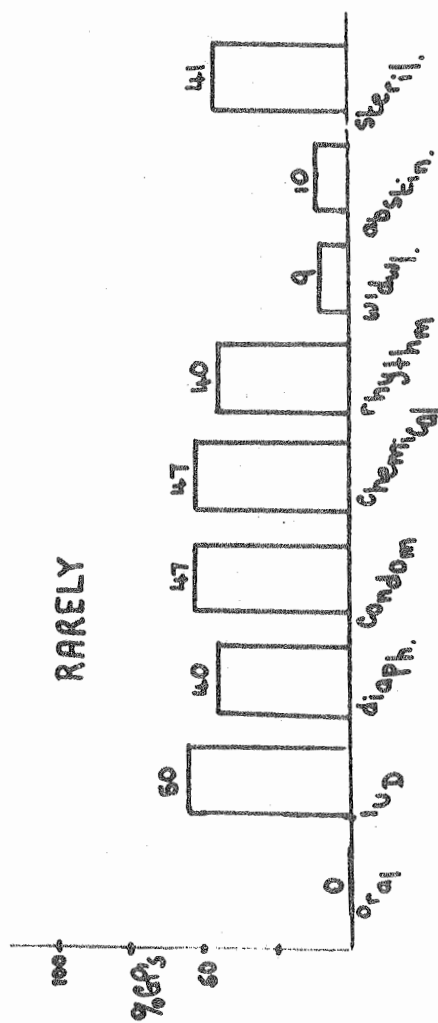


Figure 5.

by 5 (5.7%). No questions were asked to distinguish between the general practitioners attitudes to vasectomy and tubal ligation. However, the following quotes taken from different interviews illustrate the bias of some of the doctors ;

" I wouldn't have a vasectomy myself, and therefore my personal prejudices would influence what my patients were told. Although normal people, not just weirdo's, are now having it done."

" No male in his right mind would have a vasectomy. It's O.K. for deviants and those sorts of people."

" Female sterilisation is best. Not because of my own sexism, but because women have less psychological hang-ups than sterilised males."

Only two of the general practitioners would not refer for sterilisation if further pregnancies would result in risk to maternal physical or mental health, or if there was a substantial risk of foetal abnormality (e.g. genetic risks). Thirty-five (40.2%) would refer for sterilisation for purely contraceptive reasons, another 47 (54.0%) would refer depending on the age and parity of the woman (Figure 14). No statistical difference ($P \leq 0.05$) was detected in the religious affiliations of those general practitioners who would refer for sterilisation on purely contraceptive grounds (Figure 15).

The conditions of age and parity usually meant the person needed to be over 35 and have at least two or three children. Five general practitioners would not refer for solely contraceptive reasons. Several of the doctors, 15 and 14, respectively, performed vasectomies or tubal ligations themselves (Figure 8).

Intrauterine devices (IUDs) were advised frequently by 26 (29.9%), rarely by 50 (57.5%) and never by 11 (12.6%) of the general practitioners. Twenty-nine doctors inserted IUDs themselves, the remainder referring to gynaecologists, or occasionally to the F.P.A. or public hospitals. The religious affiliations of the general practitioners were cross-tabulated with the willingness to recommend and insert IUDs (Figures 6 and 7). Although there are no obvious statistical inferences that can be drawn, there appears to be a slight trend towards non-Catholic groups in their insertion and recommendation of IUDs.

FIGURE 6.

RELIGION AND USE OF I.U.D.s

GPs Religion	Frequency of advising IUDs					
	rarely or never		frequently		total	
	n	%	n	%	n	%
None	19	(67.9)	9	(32.1)	28	(100)
Nominal	9	(69.2)	4	(30.8)	13	(100)
Protestant	20	(69.0)	9	(31.0)	29	(100)
Catholic	11	(84.6)	2	(15.4)	13	(100)
Other	2	(50.0)	2	(50.0)	4	(100)
Total	61	(70.1)	26	(29.9)	87	(100)

$$\chi^2 = 2.17 ; \text{d.f.} = 4 ; P = 0.70$$

FIGURE 7.

RELIGION AND IUD INSERTION

GPs Religion	IUD Insertion							
	GP inserts		occasionally refer		refer for insertion		total	
	n	%	n	%	n	%	n	%
None	9	(33.3)	2	(7.4)	16	(59.3)	27	(100)
Nominal	3	(23.1)	2	(15.8)	8	(61.5)	13	(100)
Protestant	7	(25.9)	2	(7.4)	18	(66.7)	27	(100)
Catholic	2	(18.2)	0	(0)	9	(81.8)	11	(100)
Other	2	(100)	0	(0)	0	(0)	2	(100)
Total	23	(23.8)	6	(7.5)	51	(63.8)	80	(100)

$$\chi^2 = 8.4 ; \text{d.f.} = 8 ; P = 0.40$$

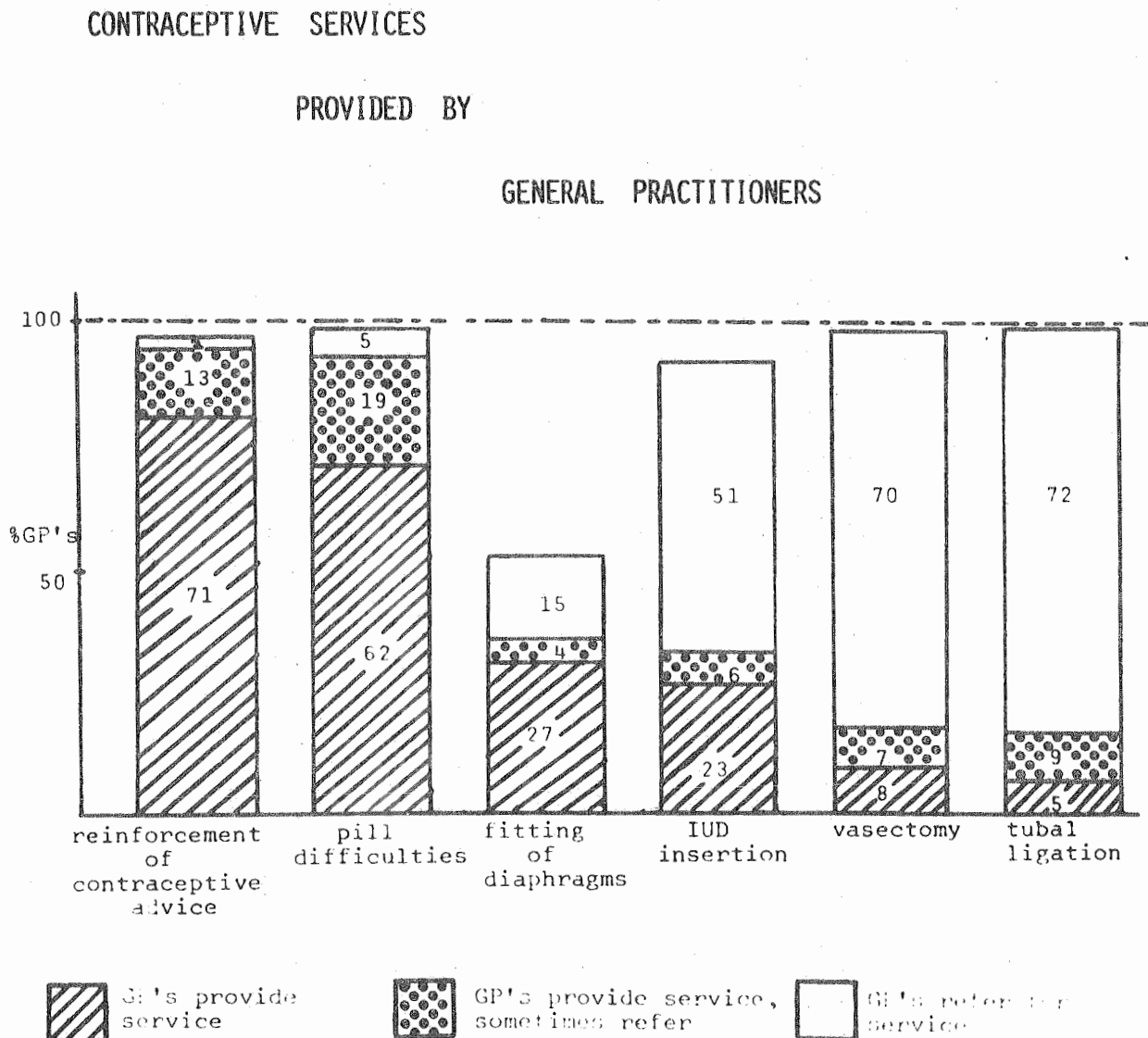
Diaphragms, condoms, chemical and rhythm or ovulation methods of contraception were all relatively unpopular - about 50% of the general practitioners advising their use rarely, 2 to 10% frequently, and the remainder never (Figures 4 and 5). Thirty-one (35.6%) general practitioners fitted diaphragms themselves (Figure 8).

Withdrawal and abstinence were only rarely advised. although one general practitioner frequently advised abstinence as a method of contraception.

The general practitioners were asked if they prescribed or advised any methods of contraception not previously listed. The only general practitioner who used any other method of contraception was one doctor who used the three-monthly progesterone injection rarely.

The general practitioners were asked if they used specialists, hospitals or clinics as referral agencies for particular contraceptive services. Very few general practitioners referred to these services for reinforcement of their contraceptive advice, or if women had difficulties adjusting to the pill. As Figure 8 shows, general practitioners referred mainly for sterilisation, insertion of IUD's and the fitting of diaphragms.

FIGURE 8.



Note : Not all columns add up to 100% because some GP's neither provide or refer for particular contraceptive service.

Most of the general practitioners (81) referred to gynaecologists, with much smaller numbers using the public hospitals (22), Family Planning Association (13), and Catholic Family Planning Centre (10). There is no Catholic Family Planning Centre in Launceston, but doctors can refer patients to a fortnightly clinic at St. Vincents Hospital.

FIGURE 9.

REFERRAL FOR CONTRACEPTIVE SERVICES - AGENCIES USED

agency	incidence of GP's using agency (N= 87)	
	n	%
family planning association	13	14.9
public hospital	22	25.2
catholic family planning centre	10	11.4
gynaecologists	81	93.1

Patients are referred for fitting of diaphragms, insertion of IUD's and sterilisation. Very few GP's referred for reinforcement of their contraceptive advice or for difficulties with the pill.

Two general practitioners would not prescribe the pill, another one would not prescribe if the woman was unmarried, and a further eight would not prescribe for girls under 17 (the age of consent in Tasmania). Of the doctors who would prescribe the pill for girls under 17, twenty-six insisted on seeing a parent first, thirty-four prescribed without regard to parental considerations, the remainder usually encouraged the girl to discuss it with her parents before prescribing. Fig.10 illustrates the dependence of prescribing habits on marital status and age.

FIGURE 10.

ORAL CONTRACEPTIVE PRESCRIBING HABITS

A. MARITAL / AGE STATUS OF PATIENT :

	Incidence of GP's who would prescribe pill (N=87)	
	n	%
married women	85	97.7
unmarried women	84	96.6
girls under 17	76	87.4

B. WITH GIRLS UNDER 17 :

never prescribe to girls U/17	11	12.6
insist on seeing a parent first	26	29.9
prescribe without regard to parental considerations	34	39.1

The prescribing habits of the remainder of GP's (16 or 18.3%) varied - usually the GP encouraged the girl to discuss it with her parents before prescribing.

The doctors were asked, *"Do you think the pill should be available on doctors prescription, from trained nurses in clinics, from pharmacies without a prescription or freely available in places such as supermarkets?"*

Fig.11 illustrates the results.

FIGURE 11.

GP'S OPINIONS ON THE AVAILABILITY OF ORAL CONTRACEPTIVES

source	incidence of doctors who thought o.c. should be available from particular source.	
	n	%
doctors prescription	87	100
clinics, from trained nurses	43	49.4
pharmacies	11	12.6
freely available	8	9.2

Almost half (49.4%) of the general practitioners thought the restrictions controlling the distribution of oral contraceptives should be relaxed to allow trained nurses to dispense the pill without a doctor's prescription.

The next question was, *"Has recent publicity (in the last 6 months) about the pill or IUD had any effect on your prescribing habits ? If yes, for what particular reasons and in what way ?"*

Publicity in medical journals had included articles advising the use of the recently marketed low oestrogen pills, the withdrawal of the sequential pills (e.g. Serial C), and articles on the side-effects and failure rate of the IUD (especially the Gravigard or Copper 7). Lay publicity had included several anti-pill articles and headlines in newspapers. The publicity had not affected the prescribing habits of 47 (54.0%) of the general practitioners. The effect on the other 40 doctors is tabulated in Fig.12.

FIGURE 12.

EFFECT OF RECENT PUBLICITY ON GP's CONTRACEPTIVE
PRESCRIBING HABITS :

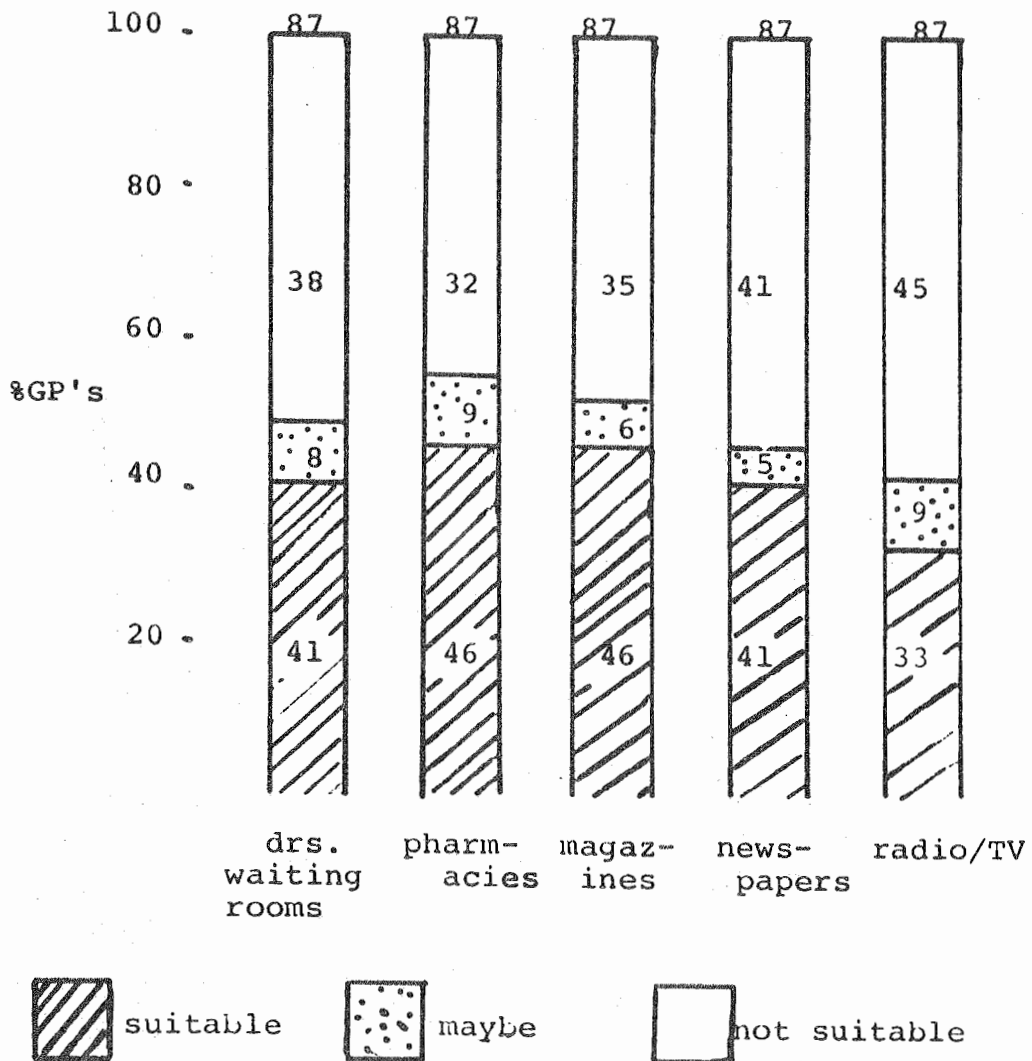
	n	%
no effect	47	54.0
pro low oestrogen pill	30	34.5
anti-pill	2	2.3
anti- IUD	8	9.2
	<hr/> 87	<hr/> 100.0

The general practitioners were asked, *"Do you think that publicity promoting the need to use contraceptives should be in doctors' waiting rooms, pharmacies, magazines, newspapers, TV or radio ? "* Publicity was defined to each of the doctors as meaning the dissemination of contraceptive information and/or the advertising of the availability of contraceptive services. It was expressly stated that brand advertising of contraceptives was not included.

FIGURE 13.

GP's OPINIONS ON SUITABLE PLACES FOR PUBLICITY

PROMOTING THE NEED TO USE CONTRACEPTION :



The usual reason for not wanting posters and pamphlets in their waiting rooms was that the displays might offend some patients. Only 6 of the 41 general practitioners who thought that this method of publicity was good had any contraceptive information in their waiting rooms. This contrasts with the widespread distribution of heart disease, blood pressure, and medical insurance literature in waiting rooms.

Reasons given by the general practitioners for

restricting the availability of contraceptive information included:

"We don't need advertising in Australia, because there is no population problem."

"Publicity is not necessary because people are not ignorant."

"There is no need for advertising in Australia - everyone knows."

"It is not desirable to encourage intercourse in the young."

"Womens magazines and articles are hopeless."

(although two doctors stated that womens magazines were of more use than medical journals).

"Publicity about contraception should stress advantages, not disadvantages. It is not the mass medias responsibility to interfere in a medical matter. All publicity should have medical authority."

One doctor who supported the need for more publicity about contraception thought there was a particular need to publicise contraceptive methods other than the pill to young doctors.

e. Sterilisation.

The next series of questions concerned sterilisation. The frequency with which sterilisation is recommended and the grounds accepted by general practitioners for sterilisation referral are included in section d(iii) on contraception and

in Figure 14.

FIGURE 14.

GROUND'S ACCEPTED BY GPs FOR STERILISATION REFERRAL

	Incidence of GP's who would refer for sterilisation					
	yes	%	depends	%	no	%
risk to maternal physical or mental health	83	95.4	1	1.1	2	2.3
risk of fetal abnormality	82	94.3	3	3.4	2	2.3
contraceptive reasons	35	40.2	47	54.0	5	5.7
mental retardation (with guardian's consent)	72	82.8	8	9.2	7	8.0

The religious affiliations of the general practitioners is cross-tabulated with the doctors willingness to refer patients for sterilisation on purely contraceptive grounds (Figure 15). The differences were not significant ($P \leq 0.05$).

FIGURE 15.

RELIGION AND STERILISATION FOR CONTRACEPTIVE REASONS

GPs Religion	Number of GPs who would refer for sterilisation					
	yes n %	depends n %	no n %	total n %		
None	9 (25.7)	18 (38.3)	1 (20.0)	28	(32.2)	
Nominal	6 (17.1)	6 (12.8)	1 (20.0)	13	(14.9)	
Protestant	13 (37.1)	14 (29.8)	2 (40.0)	29	(33.3)	
Catholic	5 (14.3)	7 (14.9)	1 (20.0)	13	(14.9)	
Other	2 (5.7)	2 (4.3)	0 (0)	4	(4.6)	
Total	35 (100)	47 (100)	5 (100)	87	(100)	

$$\chi^2 = 2.41 ; \text{d.f.} = 8 ; P = 0.97$$

The circumstances under which the general practitioners would suggest sterilisation to a patient are shown in Figure 16.

FIGURE 16.

Reasons for suggesting sterilisation	Incidence of GP's	
	n	%
never	19	21.8
medical or family planning	45	51.6
medical and family planning	5	5.7
other contraception unsuitable	14	16.1
other reasons	4	4.6

The major family planning circumstance which prompted the general practitioner to suggest sterilisation was where the general practitioner considered a patient had too many children (the acceptable number of children depended on the individual doctor and the family or woman under consideration). Because of the large number of general practitioners involved, a separate category was constructed for those doctors who recommended sterilisation primarily to women or couples who found all other methods of contraception unsuitable. Medical reasons included genetic risks of further pregnancies to the health of the woman.

Forty-five (51.6%) of the doctors would suggest sterilisation for medical or family planning reasons, with a further 14 (16.1%) suggesting it if all other

contraceptive methods were unsuitable. Five general practitioners (5.7%) would suggest sterilisation only if there were both medical and family planning reasons. Sterilisation was never suggested to patients by 19 (21.8%) general practitioners.

f. Termination of Pregnancy (Abortion)

The general practitioners were asked :

If a pregnant woman requested a termination in the first trimester, which of the following grounds would you regard as acceptable indications for the termination of the pregnancy.

The number of general practitioners who accepted each ground is shown in Figure 17. The religious affiliations of the doctors is cross-tabulated with the doctor's willingness to refer for abortion on request in Figure 18. There are significant differences ($P \leq 0.05$) in the religious affiliations of doctors who would refer for abortion on request ($\chi^2=13.01$; d.f.=4 ; $P=0.01$). Catholic general practitioners are significantly less likely than other doctors to refer on request ($\chi^2=6.73$; d.f.=1 ; $P < 0.01$).

FIGURE 17.

GROUND'S ACCEPTED BY GPs FOR TERMINATION REFERRAL (first trimester pregnancies) :

	n	%
	(N=87)	
never refer for termination	6	6.9
substantial risk to maternal physical health	80	92.0
substantial risk of maternal suicide	79	90.8
substantial risk to maternal mental health	78	89.7
pregnancy after rape	77	88.5
pregnancy after incest	75	86.2
increased risk of fetal abnormality	75	86.2
pregnancy in underage girls (U/17)	69	79.3
illegitimacy	48	55.2
socioeconomic hardship	54	62.1
on request of the pregnant woman	35	40.2

FIGURE 18.

RELIGION AND TERMINATION ON REQUEST

GPs RELIGION	No. GPs who would refer on request					
	YES		NO		TOTAL	
	n	%	n	%	n	%
None	17	(60.7)	11	(39.3)	28	(100)
Nominal	7	(53.8)	6	(46.2)	13	(100)
Protestant	9	(31.0)	20	(69.0)	29	(100)
Catholic	1	(7.7)	12	(92.3)	13	(100)
Other	1	(25.0)	3	(75.0)	4	(100)
Total	35	(40.2)	52	(59.8)	87	(100)

$$\chi^2 = 13.01 ; \text{d.f.} = 4 ; P = 0.01$$

The next question on abortion was,

"Should first-trimester terminations be performed by obstetrician-gynaecologists, by any medical practitioner with training in abortion techniques or by any person with training in abortion and contraceptive techniques?"

The replies are shown in Fig.19.

FIGURE 19.

GP'S OPINIONS ON WHO SHOULD PERFORM

FIRST TRIMESTER TERMINATIONS.

	Incidence of GP's			
	YES		NO	
	N	%	N	%
obstetrician-gynaecologists	84	96.6	3	3.4
medical practitioners	53	60.9	34	39.1
others	7	8.0	80	92.0

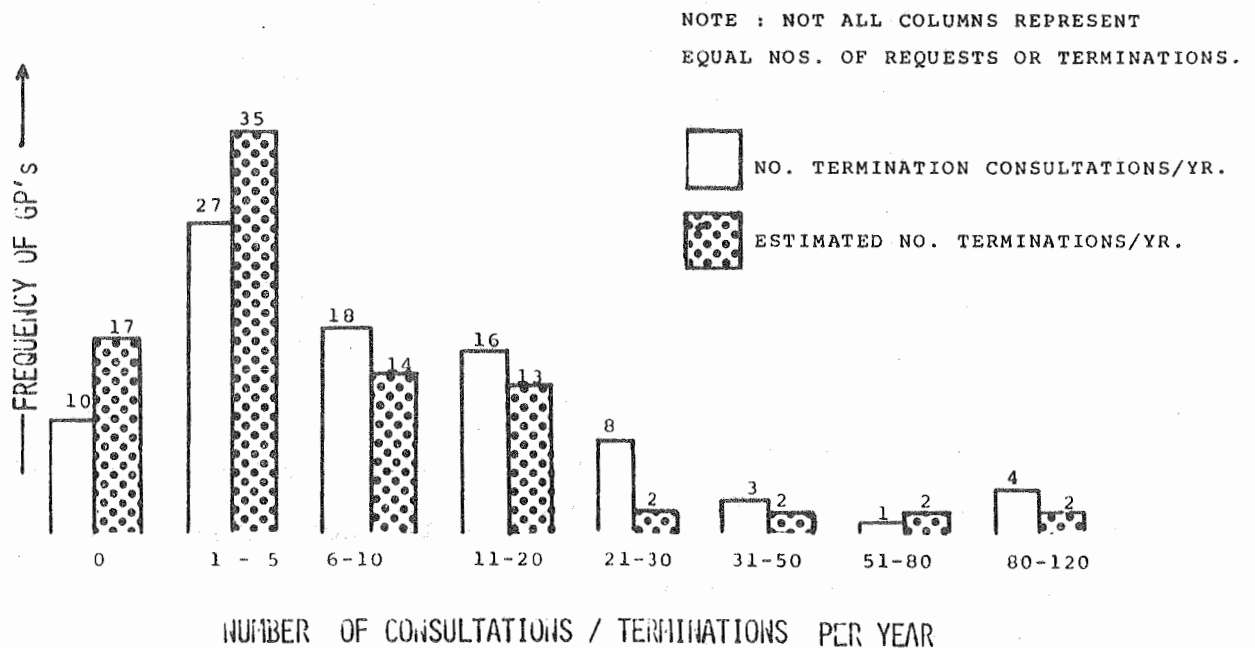
The frequency with which doctors are consulted about the possibility of a termination of pregnancy, and the number of these pregnancies they thought were eventually terminated was ascertained and the results shown in Figs. 20 and 21.

FIGURE 20.

TERMINATION OF PREGNANCY IN GENERAL PRACTICE (including referrals)

Number per year	Incidence of GP's -consultations		Incidence of GP's -terminations	
	n	%	n	%
none	10	11.5	17	19.5
1- 5	27	31.0	35	40.2
6-10	18	20.7	14	16.1
11-20	16	18.4	13	14.9
21-30	8	9.2	2	2.3
31-50	3	3.4	2	2.3
51-80	1	1.1	2	2.3
80-120	4	4.6	2	2.3

FIGURE 21.



The estimates of the number of terminations performed include terminations that were obtained without a referral by the general practitioner. Some women go directly interstate or to a gynaecologist.

A small number of general practitioners (4 or 4.6%) were consulted about abortion at least once per week. However, as Figure 20 shows, most of the general practitioners (55 or 63.2%) were consulted less than 10 times per year. The number of these abortion requests that the general practitioner estimated were eventually terminated was much smaller, as evidenced by the shift to the left in the dotted columns of Figure 21. The average (modal) general practitioner was consulted 6 to 10 times per year about abortion, but estimated that 1 to 5 of these pregnancies were terminated.

The total number of abortions estimated to have been performed was 822, an average of 10.1 per doctor. No statistical difference ($P \leq 0.05$) was detected between the number of abortion requests and the number of abortions performed, for each general practitioner.

The general practitioners were asked where they usually referred women for terminations. Many of the general practitioners referred to more than one place, the place depending on the grounds the woman had for requesting a termination and whether the general practitioner thought the woman should get a termination. Not all women referred were granted terminations - especially if the referral was to a local public hospital or gynaecologist.

FIGURE 22.

PLACES USED BY GP's FOR TERMINATION REFERRALS :

	n	%
self	5	5.8
gynaecologist	56	64.4
public hospital	33	38.0
interstate	32	36.8

Note 1. Some GP's refer to more than one source.

2. Not all women referred are recommended for terminations.

Eleven general practitioners (12.6%) never referred for termination of pregnancy. This number is 5 (5.7%) more than the 6 (6.9%) doctors who would not refer for any of the grounds listed in the questionnaire (Figure 17).

g. Sexuality.

The frequency with which the general practitioners were consulted about specified aspects of sexual behaviour was determined, occasionally was taken to be about once per month, and frequently about once per week. The results are shown in Figure 23. Figure 24 graphically illustrates the types of sexuality problems that general practitioners are consulted about frequently.

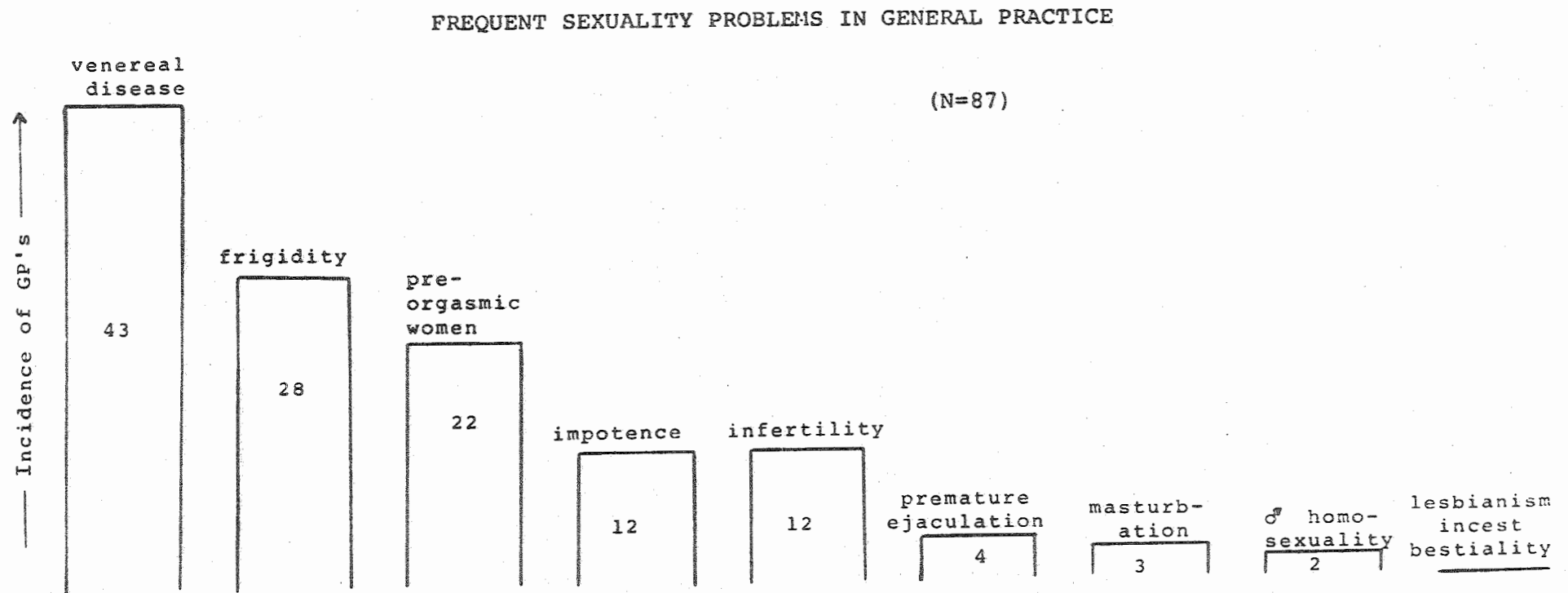
Although the term "sexual problems" was used, not all the listed aspects of sexual behaviour are necessarily problems. For example, homosexuality or masturbation were only classified as a problem if the patient presented this aspect of their sexual behaviour to the doctor as a problem.

FIGURE 23. TYPES OF SEXUAL PROBLEMS RANKED ACCORDING TO
FREQUENCY OF GP CONSULTATION.

SEXUALITY PROBLEMS IN GENERAL PRACTICE

	frequency of consultation					
	<u>never</u>		<u>occasionally</u>		<u>frequently</u>	
	n	%	n	%	n	%
venereal disease	2	2.3	42	48.3	43	49.4
frigidity	7	8.0	52	59.8	28	32.2
preorgasmic women	21	24.1	44	50.6	22	25.3
impotence	12	13.8	63	72.4	12	13.8
infertility	8	9.2	67	77.0	12	13.8
premature ejaculation	23	26.4	60	69.0	4	4.6
masturbation	59	67.8	25	28.7	3	3.4
male homosexuality	61	70.1	25	28.7	1	1.1
lesbianism	73	83.9	14	16.1	0	0
incest	81	93.1	6	6.9	0	0
bestiality	84	96.6	3	3.4	0	0

FIGURE 24.



I asked the general practitioners, "Where have you referred these patients if further advice and treatment is needed ? " The number of doctors who used the agencies I listed are shown in Figure 25.

The general practitioners tended to "treat" sexuality problems themselves. This treatment usually consisted of "talking to the patient" or providing reassurance. General practitioners were reluctant to refer because they did not know anyone with expertise in the area of sexuality and sexual problems. Referrals, if they were made at all, were primarily to other doctors - psychiatrists and gynaecologists. Books were recommended and lent to patients by many general practitioners (most commonly, Alex Comfort : *The Joy of Sex*. Simon and Schuster, N.Y., 1972). All other agencies were used infrequently (Figure 25). An interesting point to note is that for sexuality related problems the general practitioners referred more frequently to clergy than to social workers.

Figure 25.

AGENCIES USED BY GP's

FOR SEXUALITY PROBLEMS

	Incidence of GP's who refer to agency	
	n	%
psychiatrists	53	60.9
gynaecologists	50	57.5
books	50	57.5
marriage guidance	32	36.8
psychologists	21	24.1
clergy	18	20.7
urologists	15	17.2
social workers	15	17.2
VD clinic	6	6.9
encounter groups	5	5.7
F.P.A.	3	3.4

h. Education

The final section of the questionnaire consisted of questions on the adequacy of undergraduate and postgraduate medical education in contraceptive techniques, sexual behaviour and counselling techniques, and on the general practitioners attitudes to community education about family planning.

Figs. 26, 27 and 28 show the general practitioner's own opinions on the adequacy of their undergraduate medical education in these areas. When the figures are broken down according to the decade of graduation from medical school, it is seen that just as many of the recent graduates (1970-5) consider their undergraduate education in sexual behaviour and counselling techniques to be inadequate, although more of them consider their contraceptive education to be adequate.

FIGURE 26.

GP's OPINIONS OF THEIR UNDERGRADUATE MEDICAL EDUCATION IN CONTRACEPTIVE TECHNIQUES

Graduation Year	inadequate %	adequate %	overemphasised %	total n
average	85.1	12.6	2.3	87
1970-5	71.4	28.6	0	14
1960-9	91.7	4.2	4.2	24
1950-9	89.2	10.8	0	37
1940-9	70.0	20.0	10.0	10
1930-9	100.0	0	0	2

FIGURE 27.

GP's OPINIONS OF THEIR UNDERGRADUATE MEDICAL EDUCATION
IN SEXUAL BEHAVIOUR

Graduation Year	inadequate %	adequate %	overemphasised %	total n
average	93.1	5.7	1.1	87
1970-5	92.9	7.1	0	14
1960-9	95.8	0	4.2	24
1950-9	94.6	5.4	0	37
1940-9	80.0	20.0	0	10
1930-9	100.0	0	0	2

FIGURE 28.

GP's OPINIONS OF THEIR UNDERGRADUATE MEDICAL EDUCATION
IN COUNSELLING TECHNIQUES

Graduation Year	inadequate %	adequate %	overemphasised %	total n
average	90.8	9.2	0	87
1970-5	92.9	7.1	0	14
1960-9	87.5	12.5	0	24
1950-9	94.6	5.4	0	37
1940-9	80.0	20.0	0	10
1930-9	100.0	0	0	2

Although 85 - 93% of the general practitioners considered their undergraduate education in these areas to be inadequate, only 37 (42.5%) had been to any post-graduate courses (Figure 29). Twenty-three (26.4%) had only experience to add to their undergraduate education in these areas.

FIGURE 29.

POSTGRADUATE TRAINING OF GP's

IN CONTRACEPTION, SEXUAL BEHAVIOUR AND COUNSELLING

	Incidence of GP's	
	n	%
none	12	13.8
experience only	11	12.6
reading & experience	23	26.4
courses, reading & experience	37	42.5

The "none" and "experience" categories of responses have been combined as the general practitioners in both categories have obviously provided some contraceptive or counselling services.

The general practitioners were asked if they would go to any postgraduate courses (through colleges, hospitals, postgraduate education committees) about contraceptive techniques, interpersonal relationships, sexual behaviour or counselling techniques. The responses are shown in Fig. 30.

The proportion of doctors who said they were willing to go to a postgraduate course was similar for each topic - about 25% would attend a course, another 25% would possibly attend, with the remaining 50% definitely not interested in attending any postgraduate courses in these areas.

FIGURE 30.

WILLINGNESS OF GP'S TO ATTEND POSTGRADUATE COURSES

	<u>Incidence of GP's</u>		
	definitely no	possibly attend	probably attend
	%	%	%
in contraceptive techniques	55.2	21.8	23.0
in interpersonal relationships	51.7	25.3	23.0
in sexual behaviour	47.1	26.4	26.4
in counselling techniques	48.3	25.3	26.4

i. Community education.

I asked the general practitioners if they saw a need for community education about family planning. Ten (11.5%) saw no need for any education of other members of the community. Another 8 doctors, to make a total of 18 (20.6%), saw no need for family planning education in schools. The remaining 69 (79.3%) advocated the teaching of family planning in schools.

17% of those general practitioners who saw a need for community education about family planning (or 14.9% of the total number of general practitioners) considered that the teaching of family planning is the sole prerogative of the medical profession.

j. Cross-correlations between variables

The degree of association between the different variables was determined using the SPSS Crosstabulation and χ^2 -test functions.

Significant correlations ($P \leq 0.05$) are mentioned in the relevant results section and in the following list. Variables which were not significantly correlated are too numerous to mention, but those of particular importance are listed.

1. There was no significant association between the religious affiliation of the general practitioner and the number of contraceptive consultations per week, the frequency with which contraceptive discussions were initiated by the doctor, the referral of patients for contraceptive services including

referral for sterilisation on purely contraceptive grounds, the doctor's opinion on the advisability of widening the channels of pill distribution, or the doctor's opinion of the need for family planning education in the schools or community.

2. Catholic general practitioners were significantly less likely than other doctors to refer for abortion on request. The religious affiliation of the general practitioner was the only variable significantly associated with willingness to refer for abortion on request.

3. The frequency of contraceptive consultations was not significantly correlated with the sex, religion, country or year of graduation of the general practitioner, or with the general practitioner's opinions on the need for family planning education or wider availability of the pill.

4. There was no significant association between the frequency of initiation of contraception discussions by the doctor and the general practitioner's sex, religion, country or year of graduation or place of practice.

5. The rhythm/ovulation methods of contraception were more frequently advised by general practitioners in upper socio-economic class areas. These general practitioners were also more likely to be Catholic.

6. The willingness of general practitioners to prescribe the pill to girls under 17 was not correlated with any of the doctor classifying variables or with the doctor's opinions on the need for contraceptive publicity or availability of oral contraceptives.

7. The willingness of general practitioners to widen the methods of pill distribution was not associated with the

general practitioner's religious affiliations, sex, country or year of graduation, or frequency of contraceptive consultations.

8. The general practitioner's opinion on the need for family planning education in schools and the community was not correlated with the general practitioner's religion, sex, country or year of graduation, frequency of contraceptive consultations or opinion on the availability of oral contraceptives.

DISCUSSION

DISCUSSION

The attitudes and practices of the general practitioners I interviewed can be compared with the results of a similar survey of Melbourne doctors. Barson and Wood (1972) investigated the attitudes of Melbourne general practitioners to contraception.

There are differences in the methodology used for the two surveys. Barson and Wood used a self-completed postal questionnaire instead of an interview schedule, and their questions were limited to the topics of contraception and abortion while I included questions on sexuality and education of the community and general practitioners about family planning. The response rate obtained by Barson and Wood was 67%, whereas the response rate for my survey was 90%.

The postal questionnaire technique used by Barson and Wood was the main reason for their lower response rate. The 33% of general practitioners who did not respond could not be assumed to be a representative cross-section of all general practitioners, and for statistical purposes Barson and Wood assumed that all non-respondents lacked interest or training in birth control. They quote their results as a proportion of the respondents and as a proportion of the total sample. The wide variation between these two figures gives rise to problems in the interpretation of their results. These problems do not arise in my survey as it is considered justifiable to assume that a nonresponse of 10% will have an insignificant effect on the results (Schofield, 1969).

Also, the Tasmanian general practitioners differed in three respects from the general practitioners in Barson and Wood's sample. My sample contained significantly more women, recent graduates (since 1960) and British graduates than the Melbourne sample. With these considerations in mind, it is still worthwhile to make some comparisons.

Figure 2 shows that contraceptive consultations form a large part of the general practitioners workload : 48% of the general practitioners do more than 15 contraceptive consultations per week, with only 27% of general practitioners doing less than 10 per week. The number of contraceptive consultations has been correlated with some of the other practices and attitudes of the doctors. It is difficult to interpret this correlation accurately as the proportion of contraceptive consultations to all consultations is not known.

A comparison of Tasmanian general practitioners in 1976 with Melbourne general practitioners in 1971-2 shows a vast increase in the number of general practitioners willing to initiate contraceptive discussions. Contraceptive discussions were initiated frequently by 17.2% of the doctors I interviewed, and occasionally initiated by a further 50.6%. Only 34% of the Melbourne general practitioners ever initiated contraceptive discussions (Barson and Wood, 1972).

By initiating contraceptive conversations the doctor demonstrates his or her willingness and capabilities to discuss contraception and sexual behaviour. This demonstration would be reinforced by the general practitioners displaying contraceptive pamphlets and posters in their waiting and consulting rooms.

Six general practitioners (6.9%) actually had contraceptive pamphlets or posters on display in their waiting rooms, but many more (approximately 50%) of the general practitioners thought the dissemination of contraceptive information through displays of pamphlets or posters in their waiting rooms or in pharmacies was a good idea (Fig. 13). A similar number of general practitioners thought that magazines and newspapers were suitable places for publicity about contraception, but fewer, 37.9%, approved of contraceptive publicity on TV or radio. These figures show that almost half of the general practitioners did not recognise a need for the wider availability of contraceptive information. In fact, some general practitioners wished to decrease the present access to information. For example, although many widely distributed women's magazines (*Cleo*, *Cosmopolitan*, *Woman's Day*, *Women's Weekly*) regularly print articles on contraception and sexual behaviour, there were 35 general practitioners (40.2%) who considered magazines to be unsuitable places for publicity promoting the need to use contraception. Women's magazines, because of their wide circulation, would appear to be an ideal vehicle to effectively disseminate accurate, nonsensational information on contraception.

There was often an assumption, either implicit or expressed by the general practitioner, that contraceptive information and contraceptives are freely available in Australia. Most general practitioners saw population control as the primary reason for contraception. The needs of a particular woman or couple in planning a family of

optimal size and spacing of the children, with regard to the physical, mental and emotional needs, personal wishes and preferences of the individual parents were not the first consideration of these doctors.

During the last twenty years, the incidence of married women using some form of birth control has remained relatively stable at about 92% (Caldwell et al, 1972). However, there has been a considerable change in the contraceptive methods used. All methods of birth control, including abortion, are complementary to each other and trends in the acceptance of individual methods of birth control reflect this change. There are no universally available and acceptable methods of birth control, and therefore a wide variety of methods is needed to meet the varying needs of individuals and couples (International Conference on the Physician and Population Change, 1974).

The methods of contraception advised and prescribed by the general practitioners (Figure 4) can be compared with the contraceptive usage by the community. Leeton's (1973) survey of family planning methods used by married patients in general practice and at the Queen Victoria Hospital in Melbourne gave the results in the following table.

FIGURE 31.

The incidence of contraceptive methods of patients
in general practice and in Q.V.H.

Contraceptive method	Incidence in general practice	Incidence at Q.V.H.
	%	%
oral contraception	58	73
I.U.D.	13	20
diaphragm	2	0.5
condom	7	0.5
chemical	3	0
rhythm	5	1
withdrawal	5	1
sterilisation	7	4

Leeton, (1973)

Australian family physician

The patients at the Queen Victoria Hospital (Q.V.H.) were using oral contraceptives and the I.U.D. to a much greater extent than the patients in general practice. Diaphragms, condoms, chemical, rhythm and withdrawal methods were more commonly used by patients in general practice than by those at the Q.V.H.. This difference in contraceptive practice probably reflects differences in class and ethnic

origins of the two groups of patients (most of the patients at the Q.V.H. are migrants and working class Australians). From these results it might be expected that general practitioners with practices of predominantly upper socioeconomic class patients may recommend a wider variety of contraceptive methods than those general practitioners with predominantly lower socioeconomic class patients.

However, my survey showed that the only significant difference ($P \leq 0.05$) in the contraceptive prescribing habits of Tasmanian general practitioners practising in lower and upper socioeconomic areas was in the incidence of advising the rhythm and ovulation methods. These methods were advised with greater frequency by those general practitioners practising in upper socioeconomic areas.

The pill was the method of contraception usually prescribed by 79 (89.7%) of the general practitioners (Figure 4). It was frequently prescribed by a further 7 general practitioners (8.0%). These results back up Leeton's (1975) findings that by far the most popular method of contraception is the pill. He estimated that in 1975, 35% of all Australian women between 15 and 50 years of age were taking the pill, and that over 50% of all contraception in Australia was related to the pill. The only other methods that were prescribed or advised at all frequently were sterilisation and the I.U.D. All other methods were used rarely or never by over 90% of the general practitioners. These figures, together with comments such as *"women are inherently too modest to use the diaphragm"*, and, *"no-one uses condoms nowadays"*, confirm the sentiments expressed in a submission to the Royal Commission on Human Relationships (R.C. on H.R.

Submission 535) :

The married woman going to the doctor for contraceptives is almost automatically 'put on the pill' without the opportunity to discuss alternate methods, voice fears and understand the complicated procedure.

One of the occasions on which some of the general practitioners advised non-pill methods of contraception was during prescribed spells from taking the pill. Many of the interviewed general practitioners were still recommending spells from the pill every two or three years, despite research over recent years which shows that any risks associated with the use of oral contraceptives are as likely to appear in the first year of taking it as they are after 5 or 10 years of continuous use (I.P.P.F., 1974)

The results of the most extensive prospective study ever undertaken on the use of oral contraceptives were published by the Royal College of General Practitioners in 1974. The report of their findings states :

.....occasional rests from oral contraceptives will therefore be of unproven value to about 5 per cent of users, and of no value to 95%. On the other hand the risk of unplanned pregnancies, and their associated morbidity, with the interval use (or misuse) of other contraceptives is not inconsiderable.

General practitioners often stated that a fear of legal action produced a conservatism in their approach to contraceptive prescribing, sterilisation and abortion.

One area where this fear of legal action is particularly important is the prescribing of contraceptives to underage girls. Underage was taken to be under 17, as this is the age of consent in Tasmania.

Only 34 (39.1%) of the general practitioners would prescribe the pill to girls under 17 irrespective of parental considerations (Figure 10B). Eleven (12.6%) never prescribed to this age-group and a further 26(29.9%) insisted on seeing the girl's parents before prescribing. The prescribing habits of the remaining 16 (18.4%) varied according to individual circumstances.

Adolescents who approach general practitioners for contraceptives are generally sexually experienced (Siedlecky, 1975a). If the doctor refuses to give contraceptive advice, or prescribe the pill, he or she will not stop these young people from having sexual intercourse. Embarrassment or fear may prevent the adolescent from approaching further doctors for contraceptive advice.

The reason given by many of the general practitioners who would not prescribe the pill to an underage girl was that they feared legal action. This fear is groundless in the view of Finlay and Glasbeek(Part B,1974,p5). In their review of Australian family planning legislation, they maintain that a

doctor does not commit an offence in giving contraceptives to a minor. They state that it is very unlikely that the doctor could be charged with either aiding and abetting a crime (having sexual intercourse with an underage girl), or with corruption of a minor.

It is also very unlikely that the small exogenous doses of oestrogen in the pill could have any effect on the rate of epiphyseal closure and adolescent growth once the girl has passed the menarche (Leeton, 1974).

Laws relating to abortion can be divided into five categories: restrictive laws, moderate laws (allowing abortion for the purpose of saving the woman's life or health, or for rape, or for foetal abnormality), permissive laws (indications extended to include psychological and socio-economic factors), laws regulating the method by which abortions are provided and finally no laws at all.

In Tasmania the relevant parts of the Criminal Code are Sections 51(1) and 134(2) (Finlay and Glasbeek, Part A, p59).

s.51 (1) *It is lawful for a person to perform in good faith and with reasonable care and skill a surgical operation upon another person, with his consent and for his benefit, if the performance of such operation is reasonable, having regard to all the circumstances.*

This provision governs section 134(2):

s.134 (2) Any person who, with intent to procure the miscarriage of a woman, whether she be pregnant or not, unlawfully administers to her, or causes her to take, any poison or other noxious thing, or with such intent unlawfully uses any instrument or other means whatsoever, is guilty of a crime.

The questions for those making decisions about abortion are whether the operation is for the patient's benefit, and whether it is "reasonable, having regard to all the circumstances".

It appears that Tasmanian abortion laws are liberal by Australian standards (Woods, 1974) , but interpretation is difficult because there is an absence of decided case law to use as a guide to the meaning of the law.

In some cases the general practitioners stated that the law on abortion, or their interpretation of it, produced a conservatism in their referral patterns. However the abortion referral practices of the doctors appeared to be controlled more by the image of abortions and abortionists within the medical profession than by the law. Many general practitioners commented that they did not want to become known, within the medical profession or community, as a doctor who would freely perform or refer for abortions. Typical comments were, "I wouldn't want to become known as the doctor that will do terminations" ; "If you did that (referred for abortion on request) it would soon become known all over town,

and you would soon be doing nothing else", and, "abortions are dull and boring".

Over 60% of the general practitioners were consulted less than ten times per year about the possibility of a termination (Figures 20 and 21). A much larger percentage of general practitioners, 75%, estimated that less than ten of these women requesting abortions actually had their pregnancies terminated. Four doctors were consulted about abortions over 50 times per year. These doctors had obviously become known, within certain sections of the community, as being sympathetic towards women requesting abortions.

There is no significant difference ($P \leq 0.05$) between the mean number of abortions requested (14.5) and the mean number estimated to have been terminated (10.1).

The total number of abortions that the sample of general practitioners estimated had been performed was 882. From this figure for 75% of the general practitioners, the number of estimated terminations for all Hobart and Launceston general practitioners would be 1,176. The number of Tasmanian abortions known to be performed is 741 in Launceston and Hobart public hospitals (1975 figures, Department of Health Services), and 509 at Wainer's Fertility Control Clinic in Melbourne (1976 figures, Webberley). The number of abortions performed by private doctors, private hospitals, 'backyard' abortionists and other interstate clinics is unknown, but would be small compared with the number performed in public hospitals.

The indications accepted by the general practitioners for performing or referring for termination of a first trimester pregnancy are shown in Fig.17. Over 80% of the general practitioners would refer for termination if indications included risk to maternal physical or mental health, risk of foetal abnormality, pregnancy after rape or incest, or if the pregnant woman was under 17. A smaller number of general practitioners referred for socioeconomic reasons (62.1%), illegitimacy (55.2%) or on request (40.2%) : there were 19 general practitioners (21.9%) who referred for socioeconomic indications but not on request. The major difference between "on request" and "socioeconomic indications" is that in the first category the woman makes the decision, whereas with socioeconomic indications the doctor takes the decision on the need for termination of pregnancy.

It is only comparatively recently that the prime responsibility for termination of unwanted pregnancies has fallen on the medical profession. There were varying degrees of acceptance of this responsibility amongst the interviewed doctors. Over 90% of the general practitioners believed that first trimester terminations should be performed by medically qualified personnel, and not by paramedicals trained in abortion and contraceptive techniques (Fig.19). A total of 60.9% considered that general practitioners with training in abortion techniques, as well as gynaecologists, should be able to perform abortions.

Dr. Malcolm Potts (1974) argues, on the basis of world-wide experience and a study of the safety of outpatient vacuum aspirations of the uterus, that first trimester abortions are general practitioner rather than specialist operations. Others would argue that abortions are much safer when performed in special clinics by very experienced personnel (Wainer, 1974, p 56, 57). Wainer states that complications are more likely to occur when abortions are performed by local general practitioners or in hospitals by doctors who do not specialise in abortion.

It appeared from the interviews that the places of referral for abortion, rather than the grounds the general practitioner accepted, gave a fairly reliable indication of the general practitioner's views on abortion. Most of the referrals were to gynaecologists, public hospitals, or to interstate abortion clinics. Not all women referred for abortions had their pregnancies terminated. The outcome of the referral depended on the general practitioner's letter of referral, and the referral place used. Some of the general practitioners stated that they wrote unfavourable referral letters for women whom they considered did not need an abortion, and would refer these women to certain gynaecologists known to the general practitioner for their anti-abortion stand. If the general practitioner decided the woman should have an abortion he or she would often refer her to an interstate abortion clinic, or to one of the few local gynaecologists with liberal views on abortion. Referrals to public hospitals meant that the general practitioner had very little control over whether the pregnancy was terminated

because of the constantly fluctuating abortion policies of the public hospitals and of the doctors working in the family planning and obstetrics and gynaecology clinics of the hospitals. Referrals to public hospitals could thus be interpreted as indicating the doctor's ambivalence about abortion and/or willingness to leave the decision to someone else.

Although sterilisation was the second most frequently advised method of contraception in this survey, only 40% of the general practitioners would refer a patient for sterilisation on purely contraceptive grounds (Fig.14). This figure of 40% is almost identical to the 43% of respondents in the Barson and Wood survey (1972) who would refer female patients for sterilisation for contraception alone. Another 54% of general practitioners in my survey would refer if they considered the person requesting sterilisation was of suitable age and parity. These conditions usually meant the person needed to have two or three children and be over 35 years of age (Barson and Wood did not provide this 'depends' category in their questionnaire). These conditions of age and parity are contrary to the advice given by Dr. Christopher Tietze of the Population Council (Tietze et al, 1976). Tietze recommends that women should be advised to have their tubes tied as soon as they have reached a firm decision to have no more children, as the risks of the sterilisation operation go up after the woman is 30 and the benefits decrease as fertility declines.

There were two apparent reasons for the general practitioners hesitancy to refer patients for sterilisation. The general practitioners maintained that patients requesting sterilisation may later regret their decision to be sterilised because of a change of mind, remarriage or loss of existing children. The doctors also feared legal action. Wood, Leeton and Lewis (1974) maintained that this fear of legal action accounts for the low incidence of sterilisation in Australia relative to the incidence in Britain and the United States.

No specific statutory provisions have been made by any of the Australian legislatures to deal with sterilisation. Therefore, any questions of law are considered by reference to the general body of common and statute law (Finlay and Glasbeek, 1973, p 29). The relevant aspects are the possibility of assault or grievous bodily harm under the criminal law, the civil liability of doctors as it concerns negligence (which does not differ in this context from his or her general liability as a doctor) and the possibility of sterilisation constituting matrimonial cruelty. Finlay and Glasbeek (1973, p 35) maintain that voluntary sterilisation with consent is lawful if it is for a *"generally approved social purpose"*. Whether sterilisation satisfies the description of being for a *"generally approved social purpose"* does not rest on any immutable principle but on changing values in the community. This vagueness of the existing laws offers little reassurance to doctors making decisions about sterilisation. Clarification of the existing law is necessary although Hambly (1976) argues that the law may be more liberal

when undefined.

Over two-thirds of the general practitioners (67.7%) would suggest sterilisation to patients with large families, in the presence of genetic risks, or if other contraceptive methods were unsuitable (Figure 16). This initiation of sterilisation discussions by the general practitioner is very important in contemporary Australia where many years of fertility remain after most women have had the number of children they desire (which is usually between the ages of 25 to 30). These women will need an effective, safe, long-term contraceptive for twenty, or so, years between the end of childbearing and menopause. Maternal mortality associated with contraception is lowest with vasectomy, followed by female sterilisation or traditional contraception (diaphragm or condom) backed up by early abortion (Tietze et al, 1976).

Barriers to the successful use of contraceptives include attitudes of the persons wishing to use contraceptives, restrictions placed upon the availability of contraceptives (for example, the cost of medical consultation which is needed for most methods, the cost of the contraceptive itself, and the fact that contraceptives are not prescribed by some doctors or stocked by some chemists), the intrinsic failure rate and side-effects of the contraceptive method, and patient failure through ignorance of how to use the method effectively or through ignorance of their own anatomy and physiology. A comprehensive summary of the most important subjective and objective factors influencing contraceptive use is in Jo Wainer's study (1974, pp 70-77) of 10,000 women presenting at the Fertility Control Clinic in Melbourne for abortion and/or contraception.

Restriction of the availability of the pill to doctors' prescription is one barrier to the effective use of contraception. As a group of eminent scientists and doctors stated in a letter to the British Medical Journal (Smith et al, 1974) :

As a consequence of the present system of distribution, unplanned pregnancies and induced abortion, which might otherwise be avoided by the voluntary limitation of fertility, continue.

Almost half (49.4%) of the general practitioners interviewed in my survey considered the pill should be available from trained nurses in clinics, with 12.6% and 9.2% of general practitioners approving of distribution through pharmacies and supermarkets, respectively (Figure 11).

These findings clearly demonstrate that a large proportion of general practitioners believe the present restrictions on the availability of the pill should be relaxed, and would support recent moves to have the pill taken off prescription in Australia (Cox, 1975 ; *Medical Journal of Australia*, 1974 ; Elliott, 1976) and in Britain (Smith and Kane, 1975 ; *The Lancet*, 1974). The editorial comment in the *Medical Journal of Australia* (1974) said :

While contraception was limited to coitus interruptus, spermicidal creams and condoms, the profession was largely uninvolved. But the pill and IUCD changed that. The necessity for safety and the avoidance of complications

makes contraception an item of medical supply to be prescribed and sometimes dispensed only by a doctor. Are we, the profession, by our insistence on standards, now limiting contraception instead of widening it? In under-developed countries nurses insert IUCD's and health workers dispense the pillWould it be a matter in our Western society if the pill were purchased from a pharmacy or a department store without prescription.

There were legislative moves to establish a new category of nurses, the family planning nurse specialist, in the West Australian Legislative Assembly in 1976 (Elliott, 1976a). When fully trained and qualified, this nurse was to be legally able to prescribe and fit contraceptives. Medical lobbying was held to be one of the major reasons for the defeat of the bills (Elliott, 1976b). This strong opposition in Western Australia is contrary to the support of Tasmanian general practitioners for the wider distribution of oral contraceptives (Figure 11).

Smith and Kane (1975) consider the pill to be a suitable drug to take off prescription because people can make their own choice on whether to use the pill; it is easy to use (especially with modern packaging); the daily dose is the same for all women; it is one of the few drugs with which it is impossible to commit suicide; it is not addictive and a person's susceptibility to complications such as thrombo-embolism, hypertension and post-pill amenorrhea cannot be reliably identified in advance. In addition, preventative measures such as cervical smear tests and checks for breast

lumps and vaginal infections are as applicable to non-pill users as they are to women using the pill. Retrospective studies on side-effects of the pill would be unaffected by the method of distribution, but prospective studies would be difficult to conduct if the pill was available from sources other than doctors and clinic nurses.

Another argument used by those supporting the widening of the method of distribution is that the pill would become more accessible to certain groups who have previously been deterred by geographical or psychological barriers from using, or continuing with, the pill. The removal of the necessity to visit a doctor would give women greater confidence in the safety of the pill (Smith and Kane, 1975), and would remove the intimidation caused by the doctor's image as an authority figure. The major argument used by those general practitioners opposed to the widening of distribution channels is that this confidence is unwarranted, as they consider the pill is potentially too dangerous to take off prescription. The price of the pill may increase if it is taken off prescription.

The sexual problems about which general practitioners were consulted most frequently were venereal disease, female frigidity and failure to achieve orgasm, infertility and male impotence. Only a few general practitioners were consulted frequently about premature ejaculation, masturbation and male homosexuality, while lesbianism, incest or bestiality were only occasionally the subject of general practitioner consultations (Figure 23). A significant proportion of the general practitioners (8-26%) were never consulted about frigidity, failure to achieve orgasm, impotence or premature ejaculation. Over two-thirds of the general practitioners

were never consulted about male homosexuality, lesbianism, incest or bestiality.

Burnap and Golden (1967) have demonstrated that the frequency of sexual problems in general practice is positively correlated with the doctor's comfort with sexual problems. Doctors who are comfortable with their own and others sexuality will be able to elicit more information from patients than will embarrassed or anxious doctors. If the doctor is embarrassed about sexuality, his or her attitudes will be consciously or unconsciously transmitted to the patient, and neither doctor nor patient will initiate a discussion on sexual behaviour.

The results of this survey demonstrate that a large proportion of doctors are often consulted about a wide variety of sexual problems. The questionnaire did not include aspects of sexual behaviour that were too vague or too difficult to define to be included in the questionnaire; the role that sexual conflict and maladjustment may play in many ailments such as anxiety, depression, headaches, anorexia, backache, fatigue and peptic ulcers ; or the effects of illness such as diabetes, heart or neuromuscular disease on sexual relations. If these factors are added to the areas covered in the questionnaire, it is obvious that sexuality related behaviour and problems account for a large part of the average general practitioner's workload. Masters and Johnson estimate that half of all marriages are troubled by significant, if not serious, sexual problems (Lief, 1973). In a survey of Melbourne married women, 50% of the women admitted to some sexual problems

(Wood, Leeton and Lewis, 1974).

Domeena Renshaw (1976) states in her paper on physicians and sex therapy :

There are many questions about sex waiting to be asked of the family doctor - by the teenager, by the pregnant woman, the diabetic, by the post-coronary patient, the hypertensive patient, the post-stroke victim, the alcoholic, and by those who have been injured surgically (e.g. post-prostatectomy) or otherwise (paraplegics)..... unasked and unclarified, these questions about sex breed unnecessary anxiety, misplaced anger and even depression.

Renshaw considers that the vast majority of sexual problems encountered in general practice are well within the range of effective intervention by concerned and interested doctors.

General practitioners need to gain information and an understanding of the wide diversity of sexual attitudes and practices (Diamond, 1976), because without specific training the doctor is likely to settle for an answer in terms of his or her own sexual experience and moral background.

The inadequacy of undergraduate medical education in sexual behaviour, as expressed by 93% of the interviewed general practitioners (Figure 27), and the small attendance of general practitioners at postgraduate courses on sexual behaviour (Figures 25 and 26), led to the feelings of inadequacy and ignorance that many general practitioners

discussed during the interviews. Chaplin (1976, p 38), in her survey of sex counselling facilities available in Hobart, found that other professional groups such as psychologists, social workers, gynaecologists and clergy also considered their formal training in sexuality and sexual problems to be inadequate.

As Delys Sargeant(1976) states :

The medical and paramedical practitioners at large in our communities, have all been denied adequate undergraduate experience in testing, knowing their own sexual attitudes or in skills to communicate about sexual disorders. Their skills are absolutely dependent on valid experience in the field after graduation.

Many general practitioners admitted their own ignorance and inadequacy in dealing with sexual problems, but they were reluctant to refer patients with sexual problems to other professionals or agencies. The general practitioners referred primarily to psychiatrists and gynaecologists (Figure 25) and only a few general practitioners used non-medically qualified professionals or agencies. Unless a general practitioner had personal knowledge of a particular person or agency with experience in sexual counselling he or she was very reluctant to refer patients.

Although all professional groups have had very little training in sexual counselling, there are individual gynaecologists, general practitioners, physicians, psychologists and social workers who provide sexual counselling services in Launceston and Hobart.

The answers to the questions, "*Do you think your undergraduate medical education in , was inadequate, adequate or overemphasised ?*" are subjective. What one general practitioner sees as adequate, another may see as inadequate, or vice-versa. Some doctors may have answered in terms of the coverage of the topic, while others may have replied according to how useful the training had been in practice. However it is useful to know the general practitioner's opinions of their undergraduate education.

Contraceptive techniques, sexual behaviour and counselling techniques were considered to be inadequately covered in the undergraduate medical education of 85.1%, 93.1% and 90.8%, respectively, of general practitioners (Figures 26, 27, 28). Education about contraceptive techniques was judged to be adequate by significantly more ($P \leq 0.01$) of the general practitioners who graduated after 1970, than by the average general practitioner. This difference does not extend to the general practitioners' opinions of their undergraduate education in sexual behaviour and counselling techniques.

It can be argued that a large number of general practitioners would also consider their undergraduate education about many other common clinical conditions to be inadequate. This argument may be true, but at least a theoretical grounding is provided in most other areas. Doctors currently in general practice, have a basic knowledge of sexual anatomy and a little of sexual physiology, but they have limited formal training in the skills of counselling, or in the discussion of sex, sexuality or sexual practices.

Sexual functions, if spoken of in the medical course, are related to reproduction only, and sexual emotions and feelings are given scant attention (Diamond, 1976). The teaching of contraceptive techniques has often been included in medical courses, but over 56% of general practitioners in my survey graduated before the widespread use of oral contraceptives.

Finlay and Glasbeek (1974, p 5) believe that because the general practitioner is still the main source of advice the quality of family planning services necessarily depends on the amount of training given to doctors, particularly as part of their undergraduate training. The importance of including training in contraception, sexual behaviour and counselling techniques in undergraduate courses is highlighted by the large number of general practitioners who would not attend any postgraduate courses in these areas. Although 85-93% of general practitioners considered their undergraduate training to be inadequate, only 42.5% of the doctors had been to any postgraduate course in contraception, sexual behaviour or counselling. About 25% of the general practitioners said they would probably attend a course in any of these areas, another 25% would possibly attend and 50% would definitely not be interested in such courses (Figures 26 to 30).

There were two groups of doctors who were unwilling to attend postgraduate courses. Firstly, those general practitioners who were not interested in family planning because they thought it was a relatively unimportant part of their practice, and secondly, those general practitioners who did not want to admit an ignorance or interest in this

aspect of their work. The latter group believed in the "myth of sexual omniscience" (Vincent, 1968), they thought only they were ignorant of all the ramifications of sex. This myth inhibits doctors from asking questions or reading about sexual behaviour for fear of being labelled as having an exaggerated, perverse interest or being ignorant. Gochros' (1971) statements about the fears of social workers also apply to doctors :

If a social worker initiates or pursues discussions of sexual conduct, his motivations may be called into question. How will others, including the client, interpret this interest : as seduction, voyeurism, curiosity, working through his own problems, seeking vicarious satisfaction.

This fear of labelling, with the accompanying fear of personal and professional risk, also acts as a barrier to the provision of sexual counselling services.

As 53% of the general practitioners had only experience or reading to add to their undergraduate education in family planning it could be presumed that writing articles for medical journals would be an effective way of informing general practitioners. The value of journal articles may be questioned as the contraceptive prescribing habits of the majority of general practitioners has been unaffected by the many articles emphasising the side-effects of the IUD and pill published in the six months preceding the survey (Figure 12). The doctors had either not read the relevant articles in the medical or lay press, were already aware of anything recently published, or considered that recent developments

in contraceptive knowledge and practices did not indicate a need for change in their contraceptive prescribing habits.

Reading will provide information about contraception and sexual behaviour, but an understanding of the diversity of sexual attitudes, values and beliefs can only be gained by listening and talking in discussion groups (Diamond, 1976).

As previously discussed, about half of the general practitioners did not recognise a need for the distribution of contraceptive information through posters, pamphlets or articles in doctors' waiting rooms, pharmacies and newspapers or through publicity on radio and television. In fact, 11.5% of the general practitioners saw no need for any community education about family planning, and 20.6% did not consider that any aspects of family planning should be taught in schools. The primary reason given by this group of doctors was that sex education is the sole prerogative of parents. Ideally, all parents would provide their children with sex education and prevent the present prejudices and misunderstandings that many children have about sex (Schofield, 1968). The inadequate knowledge, fears, anxieties and embarrassment of many parents about sexuality prevent this ideal from being achieved.

An editorial in the *Medical Journal of Australia* (1973) considered the most important barrier to effective family planning was the overall lack of education in reproductive physiology, sexuality and family planning in our schools and universities. The need for education in Australian schools about reproduction, sexuality and birth control is emphasised in key papers by Simcock (1973), Battersby (1975), Siedlecky (1975b), Sargeant (1975) and

Leeton (1971). A survey of public opinion in the United States found that 71% of respondents were in favour of the provision of birth control information in high schools (Wood, 1974). Schoolteachers, religious instructors, parents or doctors are variously cited as being the most suitable to teach these subjects in schools, but as Leeton (1971) states, none of them are forward in accepting the challenge. Of the general practitioners interviewed, 15% thought the teaching of family planning was the sole prerogative of the medical profession.

Many general practitioners were afraid that information would encourage sexual activity and experimentation. Schofield(1968, p 39) in his extensive study of the sexual behaviour of 1,873 English teenagers claims that education given in schools does not inhibit or encourage sexual behaviour. He believes that children and adolescents should be provided with the knowledge to enable them to take responsibility for their own sexuality.

Irrespective of the doctors' views on sex education, most people gain contraceptive knowledge and information about sexual behaviour largely from nonmedical sources. A greater involvement of the medical profession in the media could help prevent and counteract the present sensationalism of these issues.

RECOMMENDATIONS

RECOMMENDATIONS

1. Referral Services

The channels for referral which are available to general practitioners should be more widely publicised. At present, few of the doctors, and presumably fewer members of the public, are aware of available facilities such as Family Planning Association and Catholic Family Planning clinics; abortion clinics; pregnancy support, abortion and sexual counselling services; and abortion referral agencies.

The people actually involved in these services need to make personal contact with the doctors, as many of the general practitioners were reluctant to refer unless they had personal knowledge of a particular person or agency.

2. The Law

Clarification of the existing law as it relates to abortion, voluntary sterilisation and the age of consent for medical procedures is necessary. Certain sections of the law need to be changed to bring them into accord with current medical practice. For example, despite widespread restrictive interpretations of the abortion law in Tasmania this study shows that 40% of the general practitioners would refer for abortion on request, and 60% for socioeconomic reasons.

There should be some mechanism for educating general practitioners about the legal aspects of their practices. Educative meetings, or widely distributed information sheets, about current laws relating to family planning in Tasmania would clear many misconceptions and fears now held by doctors.

3. Availability of oral contraceptives

Consideration should be given to legal changes which would allow the wider availability of oral contraceptives :

50% of the interviewed general practitioners considered the pill should be available from trained nurses in clinics, with 13% and 9% considering it should be available from pharmacies and supermarkets.

4. Medical Education

The general practitioners need to gain more information and an increased understanding of the diversity of contraceptive and sexual practices within the community, in view of the large number of medical consultations about contraception and sexual behaviour.

At the undergraduate level, medical students should receive a comprehensive education about all available contraceptive technology, the wide diversity of sexual practices, sexual behaviour as it relates to the practice of clinical medicine, and counselling skills.

A wide variety of postgraduate courses should be offered for the significant proportion of general practitioners who expressed interest in attending postgraduate courses and meetings. Particular areas of interest, as expressed by the general practitioners, were recent developments in contraceptive technology, treatment of common sexual problems (impotence, failure to achieve orgasm and frigidity), sexual counselling and counselling techniques. Courses need to be of varying duration, and at varying times of the day and week if they are to meet the needs of doctors.

Articles in medical journals will reach a certain

proportion of general practitioners. Consideration should be given to issuing local "information sheets", independently of medical journals and drug companies. These sheets could be used to disseminate information appropriate to local conditions (see section on the law).

REFERENCES

REFERENCES

- BARSON, M. and Wood, C. (1972). A survey of the role of the general practitioner in family planning. *Med.J.Aust.*, 1, 1069-1071.
- BATTERSBY, P. (1975). Teenage pregnancy and the age of consent. Paper delivered to *Women's Health Conference*, Brisbane, 1975.
- BURNAP, D. and Golden, J. (1967). Sexual problems in medical practice. *J.Med.Educ.*, 42, 673-680.
- CALDWELL, J., Young, C., Ware, H. (1973). Australia : Knowledge, attitudes and practice of family planning in Melbourne, 1971. *Stud. Fam. Plann.*, 4, 49-59.
- CHAPLIN, A. (1976). Referral networks and the provision of sex counselling in Hobart. Unpublished paper, Dept. of Social Work, T.C.A.E.
- COMFORT, A. (1972). *The Joy of Sex*. Simon and Schuster, New York.
- COX, L. (1975). Current Attitudes on the use of oral contraceptives. *Current Therapeutics*, 16, 6-7.
- DEPARTMENT OF HEALTH SERVICES. Personal communication.
- DIAMOND, G. (1976). The family doctor - sex therapist ? *Aust. fam. Physician*, FMP Suppl., May 1976.
- ELLIOTT, L. (1976a). Medical Act Amendment Bill, No. 2., Second Reading, *Hansard of W.A. Legislative Council*, 3356-3360, 3784-3802.
- ELLIOTT, L. (1976b). Personal communication.
- EVATT, E. (1975). Keynote address to *Women's Health Conference*, Brisbane, 1975.

FINLAY, H. and Glasbeek, S. *Family Planning and the Law in Australia*. Part A (1973), Primary family planning legislation.

Part B (1974), Secondary family planning legislation. Family Planning Association of Australia, Sydney.

GOCHROS, H. (1971). Sexual problems in social work practice. *Social Work*, 16, 3-5.

HAMBLY, D. (1976). Aspects of the law affecting provision of family planning services to young people.

Notes for *F.P.A. Seminar*, A.C.T., August 1976.

INTERNATIONAL CONFERENCE ON THE PHYSICIAN AND POPULATION CHANGE - summary report, *Med. J. Aust.*, 2, 67-75.

I.P.P.F. (1974). *Family Planning Handbook for Doctors*.

I.P.P.F., London.

JAHODA, M., Deutsch, M. and Cook, S. (1951). *Research Methods in Social Relations*. Dryden Press, New York.

LEETON, J. (1971). Barriers to birth control knowledge.

Panacea, 4, 61-64.

LEETON, J. (1973). A survey of family planning methods in general practice. *Aust. fam. Physician*, 2, 464-465.

LEETON, J. (1974). A rational approach to oral contraceptive prescribing. *Aust. fam. Physician*, 3, 132-136.

LEETON, J. (1975). Population control in Australia today.

Contraception, sterilisation and abortion.

Med. J. Aust., 2, 682-685.

MASTERS, W. and Johnson, V. (1966). *Human Sexual Response*.

Little, Brown, Boston.

MEDICAL JOURNAL OF AUSTRALIA (1973). Family Planning in Australia, 2, 473-4.

MEDICAL JOURNAL OF AUSTRALIA (1974), 1, 55-56.

POTTS, M. (1974). The woman and her foetus. Presented at *Abortion. The People Involved*, Brisbane, 1974.

PUDDY, E. (1975). Sex education and current trends in Australian society. Paper presented to *Women's Health Conference*, Brisbane, 1975.

RENSHAW, D. (1976). Physicians and sex therapy. *S. Afr. med. J.*, 50, 1092-1095.

ROYAL COLLEGE OF GENERAL PRACTITIONERS (1974). *Oral Contraceptives and Health. An interim report.* R.C.G.P., London.

ROYAL COMMISSION ON HUMAN RELATIONSHIPS. Submission 535 : Miss Yvonne Foster. Quoted in Manton, I. (1976). Medical education and general practice. A community within a community. *New Doctor*, 2, 35.

SARGEANT, D. (1975). Sexuality education : against teacher hangups. *Secondary Teacher*, 18, 9-10.

SARGEANT, D. (1976). Do doctors know enough about sex. If so, why aren't they telling. *New Doctor*, 2, 31-4.

SCHOFIELD, M. (1968). *Sexual Behaviour of Young People.* Penguin Books, Harmondsworth.

SCHOFIELD, M. (1969). *Social Research.* Heinemann, London.

SIEDLECKY, S. (1975a). Action Centres - the dilemma of adolescent sexuality. Paper presented at *Women's Health Conference*, Brisbane, 1975.

- SIEDLECKY, S. (1975b). Towards a national policy on family planning. *Health*, 25 (1), 24-26.
- SIMCOCK, B. (1973). Family planning in the Australian community. Paper presented at *State Annual Conference of the Child Health Association*, Launceston, 1973.
- SMITH, M. and Kane, P. (1975). *The Pill Off Prescription*. Birth Control Trust, London.
- SMITH, M. and 23 others. (1974). Distribution and supervision of oral contraceptives. Letter to *Brit. med. J.*, 4, 161.
- SOCIAL SCIENCES DATA SERVICE : *Statistical Package for the Social Sciences. User Manual*. University of California, Davis.
- SPIVACK, H. (1964). The doctor's role in family planning. *J.A.M.A.*, 188, 152-156.
- THE LANCET. (1974). 2, 933-934.
- TIETZE, C., Bongaarts, J. and Schearer, B. (1976). Mortality associated with control of fertility. *Fam. Plann. Perspectives*, 8, 1.
- VINCENT, C. (1968). *Human Sexuality in Medical Education and Practice*. Charles c. Thomas, Illinois.
- WAINER, J. (1974). *Abortion, the experience of a free-standing clinic in Melbourne*. Fertility Control Clinic, East Melbourne.
- WEBBERELY, H. (1976). Personal communication.

WOOD, C., Leeton, J. and Lewis, E. (1974). Sexual behaviour and family planning. In Krupinski, J. and Stoller, A. (eds.). *The Family in Australia*. Pergamon Press, Sydney.

WOODS, G. (1974). A legal tangle : the lawfulness of abortion in Australia. Paper presented at *Abortion. The People Involved*, Brisbane, 1974.

APPENDICES

Appendix I

Check list of points to consider in formulating questions

(from Jahoda, M., Deutsch, M., and Cook, S.W.,

'Research Methods in Social Relations, Part 2'

..... IPB/RES)

DECISIONS REGARDING QUESTION CONTENT (APART FROM WORDING)

- 1) Is this question necessary? Just how will it be useful?
- 2) Are several questions needed on the subject matter of this question?
- 3) Do respondents have the information necessary to answer the question?
- 4) Does the question need to be more concrete, specific, and closely related to the respondent's personal experience?
- 5) Is the question content sufficiently general and free from spurious concreteness and specificity?
- 6) Is the question content biased or loaded in one direction - without accompanying questions to balance the emphasis?
- 7) Will the respondents give the information asked for?

DECISIONS REGARDING QUESTION WORDING

- 1) Can the question be misunderstood? Does it contain difficult or unclear phraseology?
- 2) Does the question adequately express the alternatives in respect to the point asked about?
- 3) Is the question misleading by reason of unstated assumptions or unseen implications? Is the frame of reference clear and uniformed for all respondents?
- 4) Is the wording biased? Is it emotionally loaded or slanted toward a particular kind of answer?

- 5) Is the question wording likely to be objectionable to the respondent in any way?
- 6) Would a more personalized or less personalized wording of the question produce better results?
- 7) Can the question be better asked in a more direct or more indirect form?

DECISIONS REGARDING FORM OF RESPONSE TO THE QUESTION

- 1) Can the question best be asked in a form calling for check answer (or short answer of a word or two, or a number), free answer, or check answer with follow-up free answer?
- 2) If a check answer is used, which is the best type for this question - dichotomous, multiple choice ("cafeteria" question), or scale ?
- 3) If check list is used, does it cover adequately all the significant alternatives without overlapping and in a defensible order, Is it of reasonable length, and is the wording of Items impartial and balanced?
- 4) Is the form of response easy, definite, uniform, and adequate for the purpose?

DECISIONS ABOUT THE PLACE OF THE QUESTION IN THE SEQUENCE

- 1) Is the answer to the question to be influenced by the contents of preceding questions?
- 2) Is the question lead up to in a natural way? Is it in correct psychological order?
- 3) Does the question come too early or too late from the point of view of arousing interest and receiving sufficient attention avoiding resistance, etc. ?

Maintain CONFIDENCE of respondent (understanding of aims - explain)

TRUTH of response depends on

- 1) Understanding question: make them
 - a) simply worded and jargon free
 - b) unambiguous
 - c) specific (How many times... When did you last...
 - d) avoid double questions, hypothetical or conditional questions if possible.
- 2) Possibility of answering meaningfully:

Avoid feats of memory, respondent calculations, vague general enquiries.
- 3) Desire to please (give answer thought wanted)

Avoid leading questions suggesting some (but not all) alternatives. Take care over question order (first question of series likely to get a 'yes' reply.
- 4) Avoidance of offence by 'intrusive' or emotional questions.

('Classification' questions (age, occupation etc) are often seen as intrusive and are better put last on the questionnaire).

APPENDIX II : QUESTIONNAIRE

1. Did you get your medical degree in Australia ?
 1. Australia...
 2. British.....
 3. Other.....☐

2. In what year did you graduate ?
 1. 1920 - 9
 2. 1930 - 9
 3. 1940 - 9
 4. 1950 - 9
 5. 1960 - 9
 6. 1970 - 5☐

3. How many of the years since graduation have you spent in general practice ?
 1. less than 5
 2. 5 - 9
 3. 10 - 14
 4. 15 - 19
 5. over 20☐

4. Are you, or have you ever been married ?
 1. never married
 2. married
 3. previously married☐

5. Do you have any religious affiliations ?
 1. NO
 2. YES

If yes, what are they ?

.....

☐

6. Would you describe your patients as :
 1. predominantly upper socioeconomic class
 2. predominantly lower socioeconomic class
 3. a wide cross - section☐

7. What proportion of your patients would be in the 15-45 yr age group ?

8. About how many patients have you given advice on contraception in the last week ?
 1. none
 2. 1 - 4
 3. 5 - 9
 4. 10 - 14
 5. 15 - 19
 6. 20 - 24
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9. How many of these discussions were initiated by you, and how many by the patient ?

(a) by the patient

(b) by you

(% by doctor)

☐

10. Do you usually, frequently, rarely or never prescribe or advise the following methods when contraception is needed :

(1. never; 2. rarely; 3. frequently, 4. usually)

(a) oral contraceptives

(b) intrauterine devices

(c) diaphragm

(d) condoms

(e) chemical methods

(f) rhythm/ovulation

(g) withdrawal

(h) abstinence

(i) sterilisation

(j) other

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11. Do you ever refer patients elsewhere for any of the following services ?

(1. never; 2. occasionally; 3. frequently)

(a) reinforcement of your advice about contraception

(b) difficulties with the pill

(c) fitting of diaphragms

(d) IUD insertion

(e) vasectomy

(f) tubal ligation

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12. Do you refer these patients to :

- (a) the family planning association
- (b) the Royal Hobart Hospital
- (c) gynaecologists
- (d) Catholic family planning clinic
- (e) elsewhere

<input type="checkbox"/>	27
<input type="checkbox"/>	28
<input type="checkbox"/>	29
<input type="checkbox"/>	30
<input type="checkbox"/>	31

(1. Never; 2. Occasionally; 3. Frequently)

13. Do you prescribe the pill for the following categories of women :

- (1. No, 2. Yes)
- (a) married women
 - (b) unmarried women
 - (c) girls under 17

<input type="checkbox"/>	32
<input type="checkbox"/>	33
<input type="checkbox"/>	34

14. With girls under 17, do you : (1. No; 2. Yes)

- (a) insist on seeing their parents first
- (b) encourage them to tell their parents
- (c) express willingness to see parents if needed
- (d) give the pill without regard to parental considerations

<input type="checkbox"/>	35
<input type="checkbox"/>	36
<input type="checkbox"/>	37
<input type="checkbox"/>	38

15. Has recent publicity (in the last 6 months) about the pill or IUD had any effect on your prescribing habits ?

- 1. No
- 2. Yes

<input type="checkbox"/>	39
--------------------------	----

If yes, for what particular reasons and in what way ?

.....
.....

17. Do you think that publicity promoting the need to use contraceptives should be in : (1. No; 2/ Yes ; 3. Dont know)

- (a) doctors consulting rooms
- (b) pharmacies
- (c) magazines
- (d) newspapers
- (e) TV and radio

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18. Which do you think is the best way to advertise contraceptive services in pharmacies and doctors waiting rooms ?

- (a) displays of contraceptives
- (b) a sign saying " ask here for confidential advice or help regarding contraception"
- (c)
-

19. Which of the following indications would you accept for sterilisation (or for referral for sterilisation) (1. No; 2. Yes)

- (a) Risk of pregnancy to maternal physical health
- (b) risk of pregnancy to maternal mental health
- (c) increased risk of foetal abnormality
- (d) mental retardation (with guardians consent)
- (e) request by person for contraceptive reasons

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20. Under what circumstances would you suggest sterilisation to to a person ?

.....

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21. Do you think the pill should be available ; (1. NO; 2. Yes)

- (a) on doctors prescription only
- (b) from pharmacies or clinics, without a doctors prescription
- (c) widely available, including supermarkets.

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22. If a pregnant woman requested a termination in the first trimester, which of the following grounds would you regard as acceptable indications for termination (or referral) :

(1. No; 2. Yes ; 3. Don't know)

- (a) substantial risk to maternal physical health
- (b) substantial risk to maternal mental health
- (c) substantial risk of maternal suicide
- (d) High risk of foetal abnormality
- (e) low risk of foetal abnormality
- (f) pregnancy after rape
- (g) pregnancy after incest
- (h) pregnancy in underage girls (under 17)
- (i) illegitimacy
- (j) socioeconomic hardship
- (k) request of the pregnant woman
- (l) none of the above

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23. Whom do you think should be able to perform abortions in the first trimester ? (1. No; 2. Yes)

- (a) a qualified obstetrician and gynaecologist
- (b) any qualified doctor, with training in abortion techniques
- (c) public clinics staffed with people, other than doctors, trained in abortion techniques and contraception methods.

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24. About how many women have consulted you about the possibility of an abortion in the last 12 months?

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25. How many of these do you estimate were eventually terminated ?

.....

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26. Where do you refer most of your patients for terminations ?

- (a) yourself
- (b) another general practitioner
- (c) a private gynaecologist in Hobart
- (d) the Royal Hobart Hospital
- (e) private doctors interstate
- (f) an abortion clinic interstate
- (g) elsewhere

73

27. How often are you consulted about the following :

(1. never, 2. occasionally, 3. frequently)

- (a) premature ejaculation
- (b) impotence
- (c) frigidity
- (d) failure of a woman to achieve orgasm
- (e) Male homosexuality
- (f) lesbianism
- (g) masturbation
- (h) venereal disease
- (i) infertility
- (k) incest
- (l) bestiality

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28. Where have you referred these patients if further advice or treatment was needed ? (1. No; 2. Yes)

- (a) marriage guidance
- (b) psychiatrists

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- (c) psychologists
- (d) family planning clinics
- (e) VD clinic
- (f) gynaecologists
- (g) urologists
- (h) encounter groups
- (i) clergy
- (j) social workers
- (k) books

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29. Do you think your medical training in the following areas was inadequate(1), adequate(2) or overemphasised(3):

- (a) contraceptive techniques
- (b) interpersonal relationships
- (c) sexual behaviour
- (d) counselling techniques

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30. Would you attend further educational sessions in :

- (a) contraceptive techniques
- (b) interpersonal relationships
- (c) sexual behaviour
- (d) counselling techniques

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31. What do you see as the role of a general practitioner in the education of the community about these areas ?

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32. What do you think is the best way to educate the community about these areas ?

33. Is there anything else you wish to discuss ?

34. City of Practice ? 1. Hobart
 2. Launceston

☐ 105

35. Type of Practice ? 1. Solo
 2. Group
 3. Locum

☐ 106

36. Sex of Doctor ? 1. Male
 2. Female

☐ 107

APPENDIX III : DISSEMINATION OF RESULTS

1. September, 1976. The results of the survey were discussed with third year medical students at a weekend on sexuality and communication.
2. October, 1976. "Sex and Responsibility" weekend.
This weekend seminar was organised by the State Coordinating Committee for Family Planning. I presented a lecture, accompanied by slides, on the topic of General Practitioners and contraception to gynaecologists, Catholic Family Planning Centre representatives, general practitioners, and women from the Women's Liberation Centre.
3. November, 1976. "Contraception, Abortion and Sexual Behaviour in General Practice" seminars.
 - a. Launceston, 8pm, 23rd November
 - b. Hobart, 8pm, 25th November

These seminars were organised to enable discussion of my results with those general practitioners who had participated in the survey. The seminars were attended by 20 general practitioners, six medical students and Dr. Gillian Diamond (National Coordinator of Human Relations Education for the Family Medicine Programme). The seminars consisted of a slide presentation of the results, four hours of discussion and a wine and cheese. The doctors who attended the Launceston seminar are organising a follow-up seminar for April, 1977.
4. November, 1976. Lunchtime meeting at the Royal Hobart Hospital. An abbreviated version of the presentation used for the evening seminars was used for a lunchtime

meeting organised by the Family Medicine Programme(F.M.P.).
The meeting was attended by F.M.P. preceptors and trainees,
hospital doctors and medical faculty staff.

BIBLIOGRAPHY

- BEIGHTON, F. and Cole, J. (1976). *A Submission to the Royal Commission on Human Relationships*.
University of Melbourne, Melbourne.
- BERTUCH, G. and Leeton, J. (1971). The effect of publicity on oral contraceptive practice. *Med. J. Aust.*, 2, 1067.
- BLACKMAN, S. and Goldstein, K. (1975). *An Introduction to Data Management in the Behavioural and Social Sciences*. Wiley, New York.
- CARTWRIGHT, A. (1970). *Parents and Family Planning Services*.
Rutledge, London.
- DIGGORY, P. and McEwan, J. (1976). *Planning or Prevention*.
Marion Boyas, London.
- EDWARDS, A. (1958). *Statistical Analysis*. Holt, Rhinehart and Winston, New York.
- HARDIN, G. (1969). *Population, Evolution and Birth Control. A Collage of Controversial Ideas*. Freeman, San Francisco.
- GOODE, W. and Hatt, P. (1952). *Methods in Social Research*.
McGraw Hill, Tokyo.
- KAPOR-STANULOVIC, N. (1976). In defence of a psychological approach to studying fertility regulating behaviour. *I.P.P.F. Bulletin*, 5, 1-2.
- KINSEY, A., Pomeroy, W., and Martin, C. (1948). *Sexual Behaviour in the Human Male*. Saunders, Philadelphia.
- KINSEY, A., Pomeroy, W., and Martin, C. (1953). *Sexual Behaviour in the Human Female*. Saunders, Philadelphia.
- MAXWELL, A. (1970). *Basic Statistics in Behavioural Research*.
Penguin, Harmondsworth.

- BEIGHTON, F. and Cole, J. (1976). *A Submission to the Royal Commission on Human Relationships*.
University of Melbourne, Melbourne.
- BERTUCH, G. and Leeton, J. (1971). The effect of publicity on oral contraceptive practice. *Med. J. Aust.*, 2, 1067.
- BLACKMAN, S. and Goldstein, K. (1975). *An Introduction to Data Management in the Behavioural and Social Sciences*. Wiley, New York.
- CARTWRIGHT, A. (1970). *Parents and Family Planning Services*.
Rutledge, London.
- DIGGORY, P. and McEwan, J. (1976). *Planning or Prevention*.
Marion Boyas, London.
- EDWARDS, A. (1958). *Statistical Analysis*. Holt, Rhinehart and Winston, New York.
- HARDIN, G. (1969). *Population, Evolution and Birth Control. A Collage of Controversial Ideas*. Freeman, San Francisco.
- GOODE, W. and Hatt, P. (1952). *Methods in Social Research*.
McGraw Hill, Tokyo.
- KAPOR-STANULOVIC, N. (1976). In defence of a psychological approach to studying fertility regulating behaviour. *I.P.P.F. Bulletin*, 5, 1-2.
- KINSEY, A., Pomeroy, W., and Martin, C. (1948). *Sexual Behaviour in the Human Male*. Saunders, Philadelphia.
- KINSEY, A., Pomeroy, W., and Martin, C. (1953). *Sexual Behaviour in the Human Female*. Saunders, Philadelphia.
- MAXWELL, A. (1970). *Basic Statistics in Behavioural Research*.
Penguin, Harmondsworth.

RAPHAEL, B. (1975). Emotional factors in family planning.

Med. J. Aust., 2, 943-948.

TURABIAN, K. (1955). *A Manual for Writers of Term Papers,*

Theses and Dissertations. University of Chicago Press, Chicago.

WOOD, C. (1971). Social aspects of family planning.

Panacea, 4(2), 65-68.

