



Women's Health

One in a series of curriculum statements produced by the Royal College of General Practitioners:

- 1 Being a General Practitioner**
- 2 The General Practice Consultation**
- 3 Personal and Professional Responsibilities**
 - 3.1 Clinical Governance
 - 3.2 Patient Safety
 - 3.3 Clinical Ethics and Values-Based Practice
 - 3.4 Promoting Equality and Valuing Diversity
 - 3.5 Evidence-Based Practice
 - 3.6 Research and Academic Activity
 - 3.7 Teaching, Mentoring and Clinical Supervision
- 4 Management**
 - 4.1 Management in Primary Care
 - 4.2 Information Management and Technology
- 5 Healthy People: promoting health and preventing disease**
- 6 Genetics in Primary Care**
- 7 Care of Acutely Ill People**
- 8 Care of Children and Young People**
- 9 Care of Older Adults**
- 10 Gender-Specific Health Issues**
 - 10.1 [Women's Health](#)
 - 10.2 Men's Health
- 11 Sexual Health**
- 12 Care of People with Cancer & Palliative Care**
- 13 Care of People with Mental Health Problems**
- 14 Care of People with Learning Disabilities**
- 15 Clinical Management**
 - 15.1 Cardiovascular Problems
 - 15.2 Digestive Problems
 - 15.3 Drug and Alcohol Problems
 - 15.4 ENT and Facial Problems
 - 15.5 Eye Problems
 - 15.6 Metabolic Problems
 - 15.7 Neurological Problems
 - 15.8 Respiratory Problems
 - 15.9 Rheumatology and Conditions of the Musculoskeletal System (including Trauma)
 - 15.10 Skin Problems

Contents

Acknowledgements 5

Key messages 5

Introduction 6

Rationale for this curriculum statement 6

UK health priorities 6

Learning Outcomes 10

Primary care management 10

The knowledge base 10

Person-centred care 12

Specific problem-solving skills 12

A comprehensive approach 12

Community orientation 12

A holistic approach 13

Contextual aspects 13

Attitudinal aspects 13

Scientific aspects 13

Psychomotor skills 13

Further Reading 14

Examples of relevant texts and resources 14

Web resources 14

Promoting Learning about Women's Health 17

Work-based learning – in primary care 17

Work-based learning – in secondary care 17

Non-work-based learning 17

Learning with other healthcare professionals 18

Appendix 1 19

Domestic violence 19

References 21

Acknowledgements

The Royal College of General Practitioners would like to express its thanks to the principal author of this curriculum statement Dr Mohanna and the following organisations and individuals. This curriculum statement also draws on the Royal Australian College of General Practitioners' Women's Health Curriculum and the NHS Education Scotland Portfolio and Progressive Training Record (PPTR) and Attribute Guides.

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Created: December 2004

Date of this update: February 2009

Version number: 1.1

Previous versions: 1.0 issued February 2006, corrected and re-issued February 2007

Key messages

- Women-specific health matters account for over 25% of a general practitioner's time.
- Supporting parents or carers helps them care for their children and ensure that their children have optimum life chances and are healthy and safe.
- General practitioners have a key role in diagnosing domestic violence and dealing with its physical and psychological effects that include depression, anxiety, post-traumatic stress disorder and suicide attempts.
 - ◆ One woman dies every three days as a result of domestic violence
 - ◆ One in nine women using health services has been hurt by someone they know or live with.

Introduction

Rationale for this curriculum statement

Women-specific health matters, including contraception, pregnancy, menopause and disorders of reproductive organs, account for over 25% of a general practitioner's (GP's) time. In addition, women present with non-gender related issues in specific ways that the specialty registrar (GP) will need to become sensitive to: domestic violence, depression and alcoholism can all present differently in women. In society, women tend to take the larger role in caring for dependants – children, parents, ill or disabled spouses. This also brings special considerations.

Lifestyle aspects of women's health

Cigarette smoking is the most important modifiable, non-genetic risk factor for coronary heart disease, and accounts for 11% of all heart disease deaths in women. Smoking during pregnancy is associated with an increased risk of spontaneous abortion, haemorrhage, premature birth and low birthweight as well as many problems with the infant following birth. Smoking is also associated with infertility and subfertility in women as well as men.¹

There are increased health risks from obesity and the United Kingdom has the fastest growing rate of obesity in Europe, almost trebling in the past 20 years. Thirty-three per cent of adult women are overweight and another 20% are obese.²

In the general UK population only a fifth of women (21%) (compared with a third of men) meet the current guidelines for physical activity – of moderate or vigorous activity for at least 30 minutes at a time, on five or more days a week.

Approximately 3000 new cases of cervical cancer are diagnosed each year in England and Wales, leading to about 1200 deaths. About half of the women who present with late-stage cervical cancer have never had a cervical smear. The presence of Human Papilloma Virus (HPV) types 16 and 18 (and less commonly some of the other types of HPV) has been shown to be associated with the development of cervical cancer. The risk of acquiring HPV increases with having larger numbers of sexual partners, or a partner who has had many previous sexual partners.³

Many of these areas represent aspects that are open to modification following appropriate intervention and effective guidance from doctors.

UK health priorities

There remains no National Service Framework dealing just with women in general terms. Such a document of course would be attempting to cover the health needs of more than half the population as if they were a homogenous group. The needs of women vary throughout the life journey, with specific needs at certain times. There are however several sources that demonstrate government priorities in relation to the needs and roles of women.

In May 2008 the government published the *National Service Framework: improving services to women offenders*.⁴ Consistent messages from the literature on women offenders show that, although male and female offenders have broadly similar histories, women offenders tend to have more significant offending-related unmet health and mental health needs.

Research indicates high rates of substance misuse, especially opiates, amongst female offenders. Women's needs are complicated by often having sole responsibility for dependent children. Twenty-seven per cent of women offenders are considered a suicide risk and 27% are considered at risk of self-harm.⁵ Up to 80% of women in prison have diagnosable mental health problems. The comparable figure in the community is less than 20%. Approximately 50% of all self-harm incidents in prison are committed by women, even though they comprise only 6% of the total prison population. Women recently released from custody are 36 times more likely than the general population to commit suicide.

More than half the women in prison have a child under 16, and more than a third have a child under the age of 5.

The government vision includes a commitment to ensuring that, for women who are sentenced to custody, the facilities are appropriate to their needs, aimed towards improved wellbeing and a reduction in self-harm. There will be joined-up working with the Department of Health to ensure that women with mental or other health issues are diverted to suitable healthcare facilities on arrest or from court. Specific support for women who have been abused, raped or who have experienced domestic violence and those working in the sex industry are proposed.

In England, the Department of Health's *National Service Framework for Children, Young People and Maternity Services*⁶ was revised in 2004. This emphasises woman-focused care and considers birth, post-birth care for mothers as well as planning and commissioning maternity services. The Children's NSF is a 10-year programme intended to stimulate long-term and sustained improvement in children's health. Setting standards for health and social services for children, young people and pregnant women, the NSF aims to ensure fair, high-quality and integrated health and social care from pregnancy, right through to adulthood. It aims to ensure that pregnant women receive high-quality care throughout their pregnancy, have a normal childbirth wherever possible, are involved in decisions about what is best for them and have choices about how and where they give birth.

It contains two relevant standards for women's health:

Standard 2: Supporting Parenting

Parents or carers should be enabled to receive the information, services and support that will help them to care for their children and equip them with the skills they need to ensure that their children have optimum life chances and are healthy and safe.

Standard 11: Maternity Services

Women should have easy access to supportive, high-quality maternity services, designed around their individual needs and those of their babies.

As part of the government's commitment to reduce health inequalities, a target has been set to increase breastfeeding initiation rates by two percentage points per annum through the NHS Priorities and Planning Framework 2003–6, focusing especially on women from disadvantaged groups.

Teenage conception rates in the UK continue to be the highest in Western Europe at 90,000 per year, 7700 of these in girls under 16, and 2200 in girls under 14. Teenage birth rates in the UK are twice as high as in Germany and six times higher than those in the Netherlands. Tackling teenage pregnancy is a national priority and is central to the government's work to prevent health inequalities, child poverty and social exclusion. Girls from the poorest backgrounds are 10 times more likely to become teenage mothers than girls from professional backgrounds. One in every 10 babies born in England is to a teenage mother. These children are at high risk of growing up in poverty and experiencing poor health and social outcomes. Infant mortality rates for babies

born to mothers under the age of 18 are twice the average.^{7,8}

The Department of Health is working to modernise sexual health services, halt the spread of sexually transmitted infections and reduce the numbers of unintended pregnancies. The Independent Advisory Group on Sexual Health & HIV was established by the Public Health Minister in March 2003. Screening programmes such as cervical cytology, mammography and the National Chlamydia Screening Programme (NCSP) are still government priorities.ⁱ

Breast cancer and gynaecological cancers are also important NHS priority areas.ⁱⁱ Breast cancer is by far the most common cancer in women, accounting for 30% of all new cases. Large-bowel and lung cancer are respectively the second and third most common cancers in women. As with men, the top three cancers in women account for over half of all newly diagnosed cases (Figure 1 below).⁹

Figure 1: UK incidence of cancers in women 2001

Breast	40,790	(30%)
Large bowel	16,040	(12%)
Lung	14,740	(11%)
Ovary	6,880	(5%)
Uterus	5,650	(4%)
Non-Hodgkin's lymphoma	4,370	(3%)
Melanoma	4,130	(3%)
Pancreas	3,590	(3%)
Stomach	3,310	(2%)
Bladder	3,080	(2%)
Other	32,830	(25%)
Females: all malignant neoplasms excluding NMSC	135,410	(100%)

Breast cancer is the most common cancer in England and Wales. In 2000 there were almost 36,000 new cases diagnosed, 30% of all cancers in women and a rate of 114 per 100,000 women. Around 11,500 women died from breast cancer in England and Wales in 2002, a rate of 30 per 100,000 women. It is the most common cause of cancer death in women.

The breast screening programme was introduced in 1988 with the aim of reducing the number of women dying from breast cancer; over 1.5 million women are screened each year. Incidence rates have continued their upward trend, increasing by 70% since 1971, and by 15% in the 10 years to 2000.

Earlier detection and improved treatment has meant that survival rates have risen. Five-year survival was 73% for women diagnosed in 1991–5, and 78% for women diagnosed in 1996–9. Survival from breast cancer is better than that for cervical cancer and much better than for the other major cancers in women – lung, colorectal and ovarian. Death rates gradually increased up to the mid-1980s and then began to fall around the time that screening started. By 1998 mortality was around 20% lower than it would have been (based on predictions of pre-screening rates in various age groups). Falls occurred in all age groups, but were greatest in women aged 55 to 69.¹⁰

Each year, there are almost 3000 new cases of cervical cancer in the UK, just 1% of new cases diagnosed. Although there is a higher chance to develop cervical cancer later in life, it is the second most common cancer in women under the age of 35. The NHS Cervical Screening Programme across the UK screens women between the ages of 20 and 64 every three to five years. The screening programme has been very effective in reducing the number of cases diagnosed in the UK. Ovarian cancer is the fourth most common cancer among women in the UK. Each year, there are around 6900 new cases. Cancer of the uterus is the fifth most common cancer in women in the UK. Each year, there are around 6000 new cases. There are no NHS screening programmes for carcinoma of the ovary or uterus.

The GP and the primary healthcare team have important roles in raising awareness about breast and gynaecological cancers, promoting and participating in screening programmes, detecting early signs, referring quickly and then supporting the patient along her journey. The Department of Health has indicated the importance

ⁱ for more details please refer to the curriculum statement on *Sexual Health*.

ⁱⁱ for more details, please refer to the RCGP curriculum statement on *Care of People with Cancer and Palliative Care*

of the GP and primary care in its specific referral guidelines that are available for downloading from the main Department of Health website.¹¹

Women's health issues are similar in the other UK countries. The public health strategy for *Northern Ireland, Investing for Health*, published in 2005¹² and their Chief Medical Officer's reports have raised similar concerns but have also highlighted their worries about mental health, the increasing caesarean section rate, the poor uptake of breast and cervical screening, and the high teenage pregnancy rate.¹³ The strategy advanced a number of key aims and goals to address those problems.

In *Wales*, the Welsh Assembly Government, whilst not targeting women's health specifically as one of their main areas for health improvement, have ensured that aspects of women's health problems are covered in their public health strategies, e.g. *A Healthier Future for Wales*,¹⁴ *Promoting Health and Well Being*¹⁵ and *A Strategic Framework for Promoting Sexual Health in Wales*.¹⁶

In *Scotland*, despite gradual improvements in life expectancy and the implementation of specific initiatives – such as the cervical and breast cancer screening programmes that have led to earlier detection and treatment, and improvements in survival¹⁷ – there are worrying trends in Scottish women's health. Work published in 2002,¹⁸ comparing Scotland's health in an international context, has shown that, despite mortality rates from all causes among working-age Scottish women declining over the last 50 years, in comparison with 16 other Western European countries the decrease in Scotland has been less marked and Scotland has been ranked with the highest mortality in this age group since 1958.¹⁹

Trends in individual causes of death from the same study show that, for many causes, Scotland's position in a European context is worsening. Scotland had the highest mortality rate and thus the highest ranking among working-age women for oesophageal cancer (a rate that has risen since the 1970s), lung cancer (consistently ranked highest since the 1950s) and ischaemic heart disease (where the rate is falling but still lags behind other countries). Perhaps the most striking is the trend for lung cancer mortality. Mortality due to liver cirrhosis has risen steeply among Scottish working-age women since the mid-1990s; in contrast, the trend in mortality from 'external causes' (i.e. injuries, drowning, violence) shows a marked improvement for Scottish women.

Smoking among adult women did decrease considerably between the late 1970s (42% in 1978) and mid-1990s (29% in 1994) but has since remained relatively static.²⁰ Scotland still appears to have one of the highest smoking prevalences among women of any country in Western Europe and one of the highest, if not the highest, levels of obesity.²¹ Alcohol consumption among women in Scotland is also increasing. The proportion of women exceeding the recommended maximum weekly intake of 14 units a week increased from 13% in 1995 to 15% in 1998.²²

The National Institute for Health and Clinical Excellence (NICE) has a number of recent publications that are concerned with women's health.

1 Postnatal Care: routine postnatal care of women and their babies (July 2006)

The NICE clinical guideline on postnatal care covers the core care that every healthy woman and healthy baby should be offered during the first 6–8 weeks after the birth. Although for most women and babies the postnatal period is uncomplicated, care during this period needs to address any deviation from expected recovery after birth. This guideline gives advice on when additional care may be needed.

2 Antenatal Care: routine care for the healthy pregnant woman (March 2008)

The advice in the NICE guideline covers the routine care that all healthy women can expect to receive during their pregnancy. It does not specifically look at women who are pregnant with more than one baby, women with certain medical conditions or women who develop a health problem during their pregnancy.

This latter is covered in part by NICE guidance for pregnant women with diabetes (March 2008) which suggests such women should be offered advice and specialist support during their pregnancy, should have access to specialist services before they become pregnant and be advised on how to plan their pregnancy. Good glycaemic control can reduce the risk of miscarriage, congenital malformation, stillbirth and neonatal death. Two to 5% of pregnancies involve women with diabetes.

Learning Outcomes

The following learning objectives describe the knowledge, skills and attitudes that a GP requires relating to women's health. Because of the nature of illness presenting to the GP, this curriculum statement should be read in conjunction with the other RCGP curriculum statements in the series, e.g. *Sexual Health*. The full range of generic competences is described in the *core* RCGP curriculum statement 1, *Being a General Practitioner*.

Primary care management

- Demonstrate knowledge of women's health problems, conditions and diseases.
- Describe how practice management issues impact on the provision of care to women including choice and availability of female doctors.
- Maintain patient records that are accurate, facilitate continuity of care and respect the patient's confidentiality (particularly in relation to family issues, domestic violence, termination of pregnancy, sexually transmitted infections and 'partner notification').
- Be familiar with local support services, referral services, networks and groups for women (e.g. family planning, breast cancer nurses, domestic violence resources).
- Describe the importance of informing patients of results of screening, and ensuring follow up.

The knowledge base

Symptoms:

- Breast pain, breast lumps, nipple discharge
- Pruritis vulvae, vaginal discharge
- Dysparunia, pelvic pain, endometriosis
- Amenorrhoea, menorrhagia, dysmenorrhoea, inter-menstrual bleeding, irregular bleeding patterns, post-menopausal bleeding, pre-menstrual syndrome, menopause, menopausal problems
- Infertility – primary and secondary
- Urinary malfunction: dysuria, urinary incontinence
- Faecal incontinence
- Emotional problems, including low mood and symptoms of depression.

Common and/or important conditions:

- Abnormal cervical cytology
- Vaginal and uterine prolapse
- Fibroids
- Gynaecological infections including Bartholin's abscess and sexually transmitted infections (covered in detail

in the RCGP curriculum statement on *Sexual Health*)

- Gynaecological malignancies
- Miscarriage and abortion
- Ectopic pregnancy
- Trophoblastic disease
- Normal pregnancy and pregnancy problems including hyperemesis, back pain, symphysis pubis dysfunction, multiple pregnancy, growth retardation, pre-eclampsia, antepartum haemorrhage and abruptio, premature labour, polyhydramnios, abnormal lies, placenta praevia, deep vein thrombosis and pulmonary embolism, post dates, reduced movements, intra-uterine infection, intra-uterine death, foetal abnormality
- Sexual dysfunction including psychosexual conditions
- Mental health issues including anxiety, depression, suicide, eating disordersⁱⁱⁱ and the relationship between these, pregnancy and the menopause.

Investigations:

- Pregnancy testing
- Urinalysis, MSU (mid-stream specimen of urine) and urine dipstick
- Blood tests including renal function tests, hormone tests
- Bacteriological and virology tests
- Knowledge of secondary-care investigations including colposcopy and subfertility investigations.

Treatment:

- Primary care management of the conditions listed above (*Note: sexually transmitted infections and contraception are dealt with in depth in the curriculum statement on Sexual Health*)
- Menopause management including hormone replacement therapy
- Knowledge of specialist treatments and surgical procedures including: laparoscopy, D&C, hysterectomy, oophorectomy, ovarian cystectomy, pelvic floor repair, medical and surgical termination of pregnancy, sterilisation
- Understand the risks of prescribing during pregnancy
- Palliative care, including management of pain, vomiting, anxiety.

Emergency care:

- Bleeding in pregnancy
- Suspected ectopic pregnancy
- Domestic violence.

Prevention:

- Health education regarding lifestyle and sexual and mental health
- Pre-pregnancy issues discontinuing contraception, folic acid, family and genetic history and lifestyle advice
- Pregnancy care including health promotion, social and cultural factors, smoking and alcohol, age factors, previous obstetric history, diabetes and obesity, rhesus problems and use of antidepressants, hypertension

ⁱⁱⁱ GPs should take responsibility for the initial assessment and coordination of care of eating disorders, including the determination of the need for emergency medical or psychiatric assessment

and other medical problems, anaemia, acid reflux, leg ache and varicose veins, haemorrhoids, rubella testing and immunisation

- Risk assessment, screening and management of osteoporosis.

Person-centred care

- Communicate sensitively with women about sexuality and intimate issues (particularly in recognising the impact of past sexual abuse and genital mutilation).
- Recognise that many women consult for lifestyle advice, and that GPs should not over-medicalise these issues.
- Recognise the issues of gender and power, and the patient–doctor relationship, and know how to prevent these issues adversely affecting women’s health care.
- Recognise the needs of lesbian or bisexual women, i.e. understand that the partners of some women are women and understand the need not to make assumptions such as the need for contraception.
- Describe the importance of confidentiality and informed consent.
- Describe the issues relating to the use of chaperones.
- Describe the impact of gender on individual cognition and lifestyle, and formulate strategies for responding to this. For example, some women, such as those from low socio-economic groups, or living with an addiction, may have limited control over lifestyle choices.
- Detect whether the female patient wishes to see a doctor of the same sex and arrange this where practical and appropriate.

Specific problem-solving skills

- Demonstrate a reasoned approach to the diagnosis of women’s symptoms in a manner that is comfortable for both the patient and the GP using history, examination, incremental investigations and refer appropriately.
- Recognise the prevalence of domestic violence and question sensitively where this may be an issue.
- Intervene urgently with suspected malignancy and have a low threshold for the referral of breast lumps.
- Recognise and intervene immediately when patients present with a gynaecological emergency.
- Demonstrate an understanding of the importance of risk factors in the diagnosis and management of women’s problems.

A comprehensive approach

- Outline screening strategies relevant to women (e.g. cervical, breast, other cancers, postnatal depression) and discuss their advantages/disadvantages.
- Outline prevention strategies relevant to women (e.g. safer sex, pre-pregnancy counselling, antenatal care, immunisation, osteoporosis).
- Understand the importance of promoting health and a healthy lifestyle in women, and in particular the impact of this on the unborn child, growing children and the family.
- Understand the impact of other illness, in both the patient and her family, on the presentation and management, and of women's health problems.

Community orientation

- Understand the issues of equity and access to health information and services for women.
- Evaluate the effectiveness of the primary care service you provide from the female patient’s point of view.
- Appraise the role of well-woman clinics in primary care.

A holistic approach

- Discuss the psychosocial component of women's health and the need, in some cases, to provide women patients with additional emotional and organisational support (e.g. in relation to pregnancy options, hormone replacement therapy, breast cancer and unemployment).

Contextual aspects

- Be familiar with legislation relevant to women's health (e.g. abortion, contraception for minors).

Attitudinal aspects

- Recognise their own values, attitudes and approach to ethical issues (e.g. abortion, contraception for minors, consent, confidentiality, cosmetic surgery).
- Describe the impact of culture and ethnicity on women's perceived role in society and their attendant health beliefs, and tailor health care accordingly.

Scientific aspects

- Be aware of tensions between science and politics of screening.
- Describe and implement the key national guidelines that influence healthcare provision for women's problems (and note that the documents will vary across the UK following devolution).

Psychomotor skills

- Perform a gentle and thorough pelvic examination, including digital and speculum examination, assessment of the size, position and mobility of the uterus, and the recognition of abnormality of the pelvic organs, paying attention to professional etiquette, patient consent, comfort and information.
- Competently perform a cervical smear with sensitivity and care, providing a positive, informative experience for the woman that allows her to control the process and enhances her view of herself and her body.
- Perform a competent and sensitive breast examination, paying attention to explanation, informed consent, professional etiquette and comfort.
- Catheterisation.
- Change a ring pessary.

Further Reading

Examples of relevant texts and resources

- ADLER MW. *ABC of AIDS Diseases (5th edn)* London: BMJ Books, 2001
- ADLER MW. *ABC of Sexually Transmitted Infections (5th edn)* London: BMJ Books, 2004
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- WAKLEY G, CUNNION M, CHAMBERS R. *Improving Sexual Health Advice* Oxford: Radcliffe Medical Press, 2003
- WARRELL D, COX TM, FIRTH JD, BENZ EJ (eds). *Oxford Textbook of Medicine (4th edn)* Oxford: Oxford University Press, 2004

Web resources

Breast Cancer Care

This is the UK's leading provider of information, practical assistance and emotional support for anyone affected by breast cancer. Every year it is contacted by over 1,000,000 people with breast cancer or breast health concerns. It provides an excellent advice service for the public and healthcare professionals.

www.breastcancercare.org.uk/Professionalresources

British Menopause Society

This is a registered charity dedicated to: increasing awareness of post-menopausal healthcare issues and promoting optimal management through conferences, roadshows and publications. Its website contains useful information and academic papers on the menopause

www.thebms.org.uk

FPA

Formerly the Family Planning Association, this is the only registered charity working to improve the sexual health and reproductive rights of all people throughout the UK. The FPA no longer runs family planning clinics, having handed them over to the NHS in 1974. After initiating and running family planning services for over 40 years, it successfully lobbied for its service to be provided free by the NHS. It provides an excellent website for patients and health professionals

www.fpa.org.uk/

Faculty of Family Planning and Reproductive Health of the Royal College of Obstetricians and Gynaecologists

This faculty of the Royal College of Obstetricians and Gynaecologists was established on the 26 March 1993. It grants diplomas, certificates and equivalent recognition of specialist knowledge and skills in family planning and reproductive health care. It promotes conferences and lectures, provides members with an advisory service and publishes *The Journal of Family Planning and Reproductive Health Care*. The faculty website provides a wealth of information on sexual health and information about their Diploma Examination.

www.ffprhc.org.uk/

Marie Stopes International UK

This is the country's leading reproductive healthcare charity, helping over 84,000 women and men each year. It has nine specialist centres and a network of GP partners that provide services for patients seeking help and advice.

www.mariestopes.org.uk/

Menopausematters.co.uk

This is an independent, clinician-led website. It was founded by Dr Heather Currie, MBBS, FRCOG, MRCGP, MFFP Associate Specialist Gynaecologist and Obstetrician, Dumfries and Galloway Royal Infirmary, Dumfries. It is supported by a group of Scottish-based clinicians who are all experts in the field of menopause management: Their aim is to provide easily accessible, up-to-date, accurate information about the menopause, menopausal symptoms and treatment options, including hormone replacement therapy (HRT) and alternative therapies, so that women and health professionals can make informed choices about menopause management.

www.menopausematters.co.uk

National Library for Health

The aim of the National Library for Health (NLH) is to provide clinicians with access to the best current know-how and knowledge to support health care-related decisions. Patients, carers and the public are also welcome to use the site, because the NLH is open to all. The ultimate aim is for the Library to be a resource for the widest range of people both directly and indirectly.

The main priority for the NLH is to help the NHS achieve its objectives. However, it is also aimed at those healthcare professionals who are working in the private sector where common standards should apply. For example, the National Screening Committee is not only an NHS advisory committee, but its mission is also to promote the health of the whole population and its recommendations are relevant to the private sector. Part of the content of the NLH such as Clinical Evidence and the Cochrane Library is licensed from commercial providers. There are two other groups of health and care professionals whose needs will also be met by the

NLH – those working in public health and in social care.
www.library.nhs.uk

Patient UK

The website has information leaflets on many women's health topics, and an extensive directory of patient support and self-help groups. In addition, its extensive web directory lists many other sites that provide information and support on specific conditions (such as pregnancy).
www.patient.co.uk/showdoc/39/

Royal College of Obstetricians and Gynaecologists

The role of the Royal College of Obstetricians and Gynaecologists is 'the encouragement of the study and the advancement of the science and practice of obstetrics and gynaecology'. It is responsible for the training of specialists but its remit is much wider, including a responsibility to improve and maintain proper standards in the practice of obstetrics and gynaecology for the benefit of the public. It organises scientific meetings, congresses and courses, and produces evidence-based guidelines for appropriate practice and procedures. It also publishes patient information and maintains an informative website.
www.rcog.org.uk/

The Teenage Pregnancy Unit

This is a cross-government unit located within the Department for Education and Skills that was set up to implement the Social Exclusion Unit's report on teenage pregnancy. This website contains information about the government's Teenage Pregnancy Strategy, including guidance issued by the Teenage Pregnancy Unit as well as relevant publications from other government departments. There is also information about local implementation of the strategy and details about the Independent Advisory Group on Teenage Pregnancy.
www.everychildmatters.gov.uk/teenagepregnancy/

Promoting Learning about Women's Health

Work-based learning – in primary care

The period of time spent in general practice is ideal for gaining a better understanding about women's health. It is ideal for delivering training in screening, counselling and longitudinal care for women, and to reinforce that the nature of health care requires a balanced overview of all factors affecting the patient at any time. There is no substitute for clinical experience supported by a GP trainer and experienced members of the primary health-care team.

Work-based learning – in secondary care

Many specialty registrars (GP) will experience obstetrics and gynaecology in a hospital placement during their GP training programme. Others will spend dedicated time in a hospital placement during their GP-based phase. Whatever the organisational arrangements, the specialty registrar should focus his or her learning on the competences outlined in this curriculum statement.

Specialty registrars should take the opportunity to attend outpatient clinics in specialties directly relevant to women's health, e.g. gynaecology clinics, antenatal and postnatal clinics. Sexual health and family planning clinics are also excellent environments to gain a better understanding of women's health concerns and problems.

Non-work-based learning

Many deaneries organise courses for their specialty registrars on women's health issues to supplement their local programmes and to ensure that those specialty registrars who have not passed through a hospital-based placement in obstetrics and gynaecology are made aware of current management of women's problems. All specialty registrars will have the opportunity to discuss women's health issues as part of their GP training programme's educational sessions.

RCGP Learning Unit – *Professional Development Series – Update in Women's Health for General Practitioners*

The RCGP, in partnership with the University of Bath School for Health, has developed a series of courses called the *Professional Development Series* that are user friendly and relevant to everyday practice. Primarily developed for GPs and using a GP's perspective, multiprofessional teams have also found the materials to be a useful resource. While they are an excellent choice for established GPs' PDPs (professional development portfolios), specialty registrars will also find them very useful because all relevant learning goals are covered.

The Update in Women's Health is a short, flexible, case-based course for GPs. The course consists of videos of real patient consultations on CD and a textbook on women's health seen in general practice. The aim is to update GPs in diagnosis, investigation and management, including referral to secondary care, of common and 'red flag' conditions related to women's health. The course is evidence-based and encourages audit of aspects of the care of patients with a disorder in order to evaluate the user's own practice in specific women's health areas.

The course is divided into 12 topic areas:

Part 1

- Menstrual disorders
- Pelvic pain
- Miscarriage and termination
- Infertility

Part 2

- Breast disorders
- Gynaecological cancers
- Menopause
- Urinary incontinence

Part 3

- Contraception
- Gynaecological infections
- Psychosexual problems
- Emotional problems.

Full details are available via this web link: www.rcgp.org.uk/practising_as_a_gp/distance_learning/rcgp_learning_unit.aspx.

Learning with other healthcare professionals

Women's health and sexual health problems by their nature are often exemplars of teamwork across agencies. Joint sessions with nursing colleagues provide multidisciplinary opportunities for learning about the wider aspects of women's health both in primary and secondary care. Careful consideration and discussion of the roles of various individuals representing many professional and non-professional groups should be fruitful.

Appendix 1

Domestic violence²³

Domestic violence escalates during pregnancy, and is a significant factor in maternal and perinatal morbidity. Pregnant women are even murdered by their partners, with six cases reported in *The Confidential Enquires into Maternal Deaths 1994–96*.²⁴ For almost 30% of women who suffer from domestic violence in their lifetime, the first incidence of violence occurred during pregnancy.

Two potential victims – double the risk

Violence against pregnant women has been referred to as ‘child abuse in the womb’.²⁵ Studies have shown that women attending accident and emergency departments with physical injuries owing to domestic violence are more likely to be pregnant than women attending with accidental injuries.²⁶ For some women this could be an unwanted pregnancy – for example conceived through rape, or resulting from the woman’s inability to negotiate contraceptive use. In abusive relationships, women are often forbidden to use contraceptives. This is often used as a form of control and may even be the man’s attempt to commit the woman to the relationship through pregnancy.²⁷

The medical implications of domestic violence

Domestic violence in pregnancy has been linked to repeated miscarriage, antepartum haemorrhage, and premature rupture of membranes, premature labour, abruption placenta and low birthweight infants.^{28,29}

Studies have demonstrated that during pregnancy an abuser will focus attacks to the abdomen, breast and genitals. Abdominal injuries during pregnancy may lead to foetal fractures.³⁰ Injuries sustained by the pregnant woman may cause the rupture of her uterus, liver or spleen.³¹ Research would seem to indicate that mild to moderately abused women are recurrently admitted to the antenatal ward although the reason for their admission is never admitted. It is possible that all these women seek is a safe place of refuge for a night to escape from the abuse.³²

How women respond to their abuse

Women assaulted during pregnancy are more likely to respond to their abuse with self-destructive behaviour that is not beneficial either to her or the foetus. Abused women are more likely to abuse alcohol, drugs, prescribed and illegal.³³ Social isolation is the mainstay of male domination and control. Therefore women may be unable to physically gain access to anyone who can offer her support, family, and friends, voluntary or statutory agencies. They are often late bookers and may not attend for their antenatal care, often missing appointments.

Unfortunately, such women can be labelled by health care professionals as deviant and time wasting, with no thoughts for their unborn infant.³² What healthcare professionals sometimes fail to understand is that for many abused women they are just trying to find a way to survive through the week without a beating. Judgmental reactions by midwives can easily intensify the woman’s feelings of isolation. Depression, eating disorders, panic

attacks and anxiety are all common ailments from which victims of domestic abuse may suffer. Some will attempt and achieve suicide as a means of escape from the relationship.

Psychological impact can exceed that of violence

According to many women, the mental stress is far worse than the physical effects of the beatings. The impact of low esteem leads to a dependence upon the abuser. 'The body mends soon enough. Only scars remain ... but the wounds inflicted upon the soul take much longer to heal. And each time I re-live these moments, they start bleeding all over again. The broken spirit has taken longest to mend; the damage to the personality maybe the most difficult to overcome.'³³

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