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Personal child health records

Sir,
The national, parent-held, personal child health record, introduced in 1990, is intended to provide a single comprehensive record of a child's health and development and to replace the many varieties of parent held records previously in use.[1,2] Benefits will be greatest if the personal child health record is indeed widely used and a genuinely national record. A survey of district health authorities in England in 1993 explored the progress of the record towards fulfilling these goals. Of 145 districts, 99.3% responded to a questionnaire addressed to directors of public health, who were asked to pass them on to the appropriate person if unable to answer the questions themselves.

The personal child health record appears to have been rapidly adopted, particularly during 1991 and 1992. By mid-1993, the record was already used throughout 77 of 144 districts (53.5%), at least for new births. In a further 11 districts (7.6%) it was used in part of the district. Twenty two districts (15.3%) had definite plans to introduce this record. The remaining 34 districts had not introduced the record and had no plans to do so. There were 96 provider units in the 88 districts already using the record. Of the 96 provider units 76.0% had made local modifications; 41.7% had modified one or two sections only and 34.4% had made more widespread modifications.

Virtually all the provider units who commented felt that the personal child health record was being used by parents and health visitors on the majority of appropriate occasions (94.4% of 72 respondents and 97.4% of 76 respondents, respectively). Use by other professional groups was less satisfactory: 47.9% of 71 respondents reported general practitioners used the record on the majority of appropriate occasions, 35.8% of 67 for paediatric departments, 14.9% of 67 for accident and emergency departments, and 11.9% of 67 for other hospital departments. Several respondents commented spontaneously that general practitioners used the record for child health surveillance but much less well during other contacts.

Twenty seven units had audited the use of the record. Although others based their responses on less systematic feedback, the finding of poor use by some groups is nevertheless plausible. There are several reasons why general practitioners and hospital staff could be expected to be slower to use the record; these include difficulties using the record when a child is acutely ill, having less to gain from the record, less chance to reduce other record keeping, and inadequate training. Thus, this survey suggests that although the personal child health record is being widely adopted, there may still be some way to go before it is always a comprehensive record.

J ALISON SUMMERS

46 Alden Road
Helmshore, Lancashire BB4 4AQ

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Trainees' on-call arrangements

Sir,
I read with interest the survey on trainees' out of hours work reported by Elizabeth Goyder and Barbara Kneale (letter, November *Journal*, p.533). A similar survey was carried out at a regional study day for trainees in the West Midlands region in December 1993. Although the results are similar my conclusions are different.

A total of 111 people attended the study day, of whom 94 (85%) returned completed questionnaires. Most trainees were regularly on call, the commonest rota being a one in four but two had no general practice on-call experience at all. The hours of 13 respondents (14%) were limited either by a deputizing service or because their trainer was in a cooperative where a group of practices shared the on-call commitment. One of the 13 respondents was on call one night every three weeks. In common with Goyder and Kneale's results, nearly all trainees were doing the same on-call rota as their trainer. Trainees felt that there should be a balance between service commitment and learning opportunity, and that the value of the trainee year was lessened when a trainee was too tired.

As with principals, trainees' views of 24-hour cover varied. Of respondents, 33% felt that both trainees and principals should be on call at night, 35% felt that neither should. The remainder thought that it should be optional for the trainee, the principal or both. Overall, 57% of respondents thought that general practitioners should not be obliged to provide 24-hour cover for their patients.

Some trainees thought that continuity of care was not the issue when most doctors practise in group practices, and that the quality of care from tired doctors at night and in the following morning's surgery was likely to be reduced. Others commented, however, that professional integrity and the personal quality of general practice might be lost with the decision not to provide out of hours cover.

An area provoking most comment was the problem of unaccompanied doctors going into unfamiliar areas at night. Of trainees, 31% admitted to having felt threatened at some time during the day or at night when on call. Three trainees had called a police officer to accompany them on visits and three others indicated that they expected to do so at some point. One trainee had reported a patient's threatening behaviour to the police.

This survey shows that there is an enthusiasm among trainees to do the work, but that there are worries surrounding that commitment that are similar to those of principals.

The finding that 57% of trainees thought general practitioners should not be obliged to provide 24-hour cover compares with the results of another study which found that of 223 West Sussex general practitioners who had been in practice for a mean of 12 years, 86% felt that a general practitioner should be able to opt out of 24-hour cover.[1]

One of the features of general practice and for many one of its attractions as a career, is the variation in work patterns. Currently, trainees are equally remunerated whatever the on-call work. However, a night on call is not the same in all practices, making comparisons and standard setting difficult. With the fall in the numbers applying for trainee posts it is important that junior doctors consider these differences. Some districts in the West Midlands region have a good practice guide compiled by trainees leaving posts, containing details such as the rota, the support and the workload. If this were more widely established and available, perhaps from the regional advisers office, potential trainees could make a more informed choice.

Trainee pay already equates poorly with hospital junior doctors so there is a danger that the on-call issue could also become one of pay. Efforts should be made to show trainees the variation in general practice, and prepare them well for whatever style they choose.

KAY MOHANNA

42 Hazel Grove
Lichfield
Staffordshire WS14 9AS

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Teenage health

Sir,
The review article by Jacobson and Wilkinson highlights once again the failure of current policies regarding the sexual health of teenagers (September *Journal*, p.420). In the face of rising rates of teenage pregnancy and most sexually transmissible diseases,[1,2] clearly something fundamental is wrong with the health promotion strategies for this group.

While rightly laying stress on the importance of good communication, the authors neglected a most important part of any health promotion and disease prevention strategy in this age group — an emphasis on primary rather than secondary prevention. There seems to be an assumption that secondary prevention using condoms and the contraceptive pill will, in the long run, reverse spiralling rates of pregnancy and sexually transmissible diseases and that primary prevention by encouraging abstinence will not work. Both these assumptions are false.

In their study on sexual activity in teenagers, Zelnik and Kantner found that the pregnancy rates for sexually active females between the ages of 15 and 19 years increased when their sexual activity increased, even when contraceptives were used regularly.[3] The failure rates of contraceptives[4] and the risk-taking propensities of this age group are notorious.[5] The provision of contraceptives and education regarding their use actually encourages recruitment to the pool of sexually active teenagers. Summarizing their findings, Marsiglio and Mott concluded 'Prior exposure to a sex education course is positively and significantly associated with the initiation of sexual activity at ages 15 and 16.'[6] Dawson reaches the same conclusion: 'Prior contraceptive education increases the odds of starting intercourse (at the age of 14) by a factor of 1.5.'[7] The end result is a steady worsening of sexual health in this age group. It should be noted that far from preventing ill health, use of oral contraception is a risk factor for acquiring sexually transmissible diseases, especially chlamydial infection.[8] Reference is made in the review article to the situation in the Netherlands. Teenage pregnancy rates in the Netherlands are lower than in this country for the simple reason that the proportion of sexually active teenagers is much lower than in this country. The number of males and females having intercourse by the age of 16 years is a third lower than in the United Kingdom.[9] The younger the teenagers are, the more likely they are to take risks.[5] Any strategy which fails to try to delay the average age of first intercourse is doomed to failure.

The second false assumption implicit in the paper is that primary prevention strategies emphasizing abstinence will not work. No mention is made of primary prevention at all. Teenagers are not automatically sexually active. They respond to information and messages from their peers, from parents, teachers, the media and health professionals. Where the messages are presented clearly and consistently, affirming self worth and reinforcing the ability of teenagers to say no to sexual pressure, the gains in terms of lowered pregnancy rates can be considerable.[10]

There is one further consideration. The experience of the past 25 years exposes the disastrous effects on teenage sexual health of current policies focused on contraceptive provision. More than that, however, it builds in a factor which ensures that the cycle of family instability is perpetuated. The authors correctly identify the increased risk among girls from socially fragmented homes to become pregnant teenagers. What is often overlooked in these discussions is the relationship between pre-marital chastity and post-marital success. After correcting for other variables there is a link between pre-marital sex and subsequent divorce.[11] This means that current policies are ensuring further increases in marital breakdown in succeeding generations.

Of course there are limits to health promotion but a serious re-evaluation of current strategies is essential. More effective communication of the wrong kind of information is going to do even more harm to teenagers than before.

GREGORY GARDNER

64 Chelworth Road
Birmingham B38 0AE

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Vaginal examination

Sir,
Dr Arnot's letter (October *Journal*, p. 478), asserting that a bimanual examination be performed at the same time as taking a cervical smear, illustrates the confusion that surrounds this procedure. The purpose of taking a cervical smear is to screen for cervical cancer. The addition of a bimanual examination does not improve the accuracy of this screening procedure, which by definition is being done on apparently healthy asymptomatic women. Proponents of the pelvic examination argue that it is a useful opportunity to screen for other conditions such as ovarian and endometrial abnormalities. These advocates must show that the bimanual examination is able to detect, with reasonable certainty, abnormalities in asymptomatic women who really have a problem while avoiding unnecessary worry to well women who do not have a problem. In other words, the test should have reasonable sensitivity and specificity. Unfortunately, the pelvic examination has neither, particularly for perhaps the most serious gynaecological condition, ovarian cancer.[1] A negative pelvic examination may, therefore, be falsely reassuring. Of course, if the woman has symptoms, then a pelvic examination is necessary as part of the routine clinical assessment of her problem.

Every procedure in medicine has its opportunity cost; we cannot do two things at once. Although the women in Dr Arnot's survey did not find the pelvic examination to be particularly embarrassing, there are many who do, especially if the clinician is a man. Partly for this reason, many general practitioners have correctly delegated the task of screening for cervical cancer to nurses. Cervical cancer still kills many women, and there are still subgroups in the population who have been inadequately screened. It is hoped