

available to patients before they conceived.

Table 1 reports a survey in our practice over a four-month period of 129 patients already receiving antenatal care, including those making their first booking appointment with the community midwife. Patients were asked five questions by the midwife or doctor about their views on preconceptual care.

Table 1. Patients' views on preconceptual care.

	Percentage responding yes (n = 129)
Would you have liked to have read the Health Education Council's pregnancy book while contemplating pregnancy?	69
Would you have liked to have discussed things before becoming pregnant?	46
Were you offered such a consultation?	12
Did you talk with your doctor before becoming pregnant?	24
Previously, who provided your contraceptive care?	
General practitioner	71
Family Planning Association	13
No one	14
Other	2

The figures in Table 1 are the results of retrospective study and women who are not pregnant may be unaware of the idea of preconceptual care.

Perhaps it is up to doctors to provide information, to make it possible for patients to read the pregnancy book and to offer a preconceptual consultation if that is the couple's wish. General practitioners could have provided this service during contraceptive care for 71% of the 129 women in this series.

BLUE TEWSON

The Health Centre
East Street
Thame
Oxon OX9 3JZ

Sex and health promotion

Sir,
I read Michael Clarke's article (December *Journal*, p.555) with interest. It is right that we should use our well developed education and health services to promote healthier sexual behaviour.

However, in 1985 it was estimated that 4% of 12-year-olds have had sex, 47% of 15-year-olds and 90% of 18-year-olds.¹ I suggest, therefore, that it would be more logical to provide sex education through the schools than through primary health care facilities. Marion Crouchman points out that 'Adolescence is often associated with a reduction in contact with the family doctor, at a time when childhood illnesses are disappearing and when these children are not yet confident enough to present themselves at the surgery'.²

Before establishing new initiatives we should look at sex education programmes that are already in operation and showing results. A school based programme in Sweden has helped to effect a 38% fall in teenage pregnancy between 1974 and 1980.³

Although the education service is mentioned by Professor Clarke he does not look at ways to use it. After all, teachers are the 'professionals' in terms of education and schools provide a more practical framework for reaching the target population.

DANIEL LANG

The Health Office
Launceston
Cornwall PL15 8BY

References

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2. Crouchman MR. The role of the school medical officer in secondary schools. *J R Coll Gen Pract* 1986; 36: 322-324.
3. Brown P. Swedish approaches to sex education and adolescent pregnancy: some impressions. *Fam Plann Perspect* 1983; 15: 90.

Sir,

I was interested to read Professor Clarke's article (December *Journal*, p.555) proposing that a 'sex education and health promotion nurse' should be added to the primary care team. While I would support his suggested experiment I think he makes some optimistic assumptions about human sexual behaviour.

One of the advantages of the present 'pot-pourri' of agencies he mentions is that patients have several doors on which they can knock for sexual advice and help. I had the salutary experience of setting up and running a family planning clinic in a group practice and finding that despite the fact that I was female, enthusiastic and experienced in family planning and psychosexual medicine, some patients still chose to attend the local authority clinic in the building opposite. For some people it is important that the provider of contraceptive services is not the same per-

son who will look after them when they are ill. In addition, sexual activity is sometimes frivolous or irresponsible, and who wants their general practitioner to think them irresponsible? The same difficulties can arise if the 'health educator', who tries to inculcate sensible behaviour, has to be faced for help when one has not been sensible.

Nevertheless a trained nurse in the treatment room is of inestimable value, and in some practices experienced family planning nurses are already carrying out many of the functions Professor Clarke suggests. One of the problems of requiring one person to act as educator and provider of services is that someone who is good at giving advice is not always good at listening to people in trouble with this intimate area of their lives. It will not be easy to find nurses to fill this role. However, some have received seminar training in psychosexual nursing, which is equivalent to the basic training offered to doctors by the Institute of Psychosexual Medicine. Such nurses would have much to offer in a post such as that proposed.

From working closely with many nurses I have found that the more experienced they are the more they feel the need of adequate medical back-up, and an important part of the scheme would be to indemnify a doctor in the practice who was interested in the subject and prepared to offer support. In addition, close cooperation and sharing of information with the local family planning clinic and abortion services would make it possible to study the real difficulties that patients have in using the services provided.

RUTH SKRINE

Castanea House
Sham Castle Lane
Bath BA2 6JN

Women's preferences for sex of doctor

Sir,
Sally Nichols draws some relevant conclusions concerning the role of women doctors in cervical screening and mammography (December *Journal*, p.540), but there may be other factors which are important in planning future medical services primarily for women.

In 1985, as part of a survey looking at contraceptive choices and consumer preferences in women over 30 years old, patients were asked to comment on the factors that were most important to them, when seeking family planning. The patients were either attending their own general practitioner or the community