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.

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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.

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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 salutory 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 person 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.

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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

family planning clinic and they indicated three preferences from a choice of seven, plus any others they wished to include.

The results (Table 1) showed a difference of opinion between the two groups, but for both groups factors other than being able to see a woman doctor appeared to be important. Although this survey was concerned with family planning, its findings may well be relevant to the planning of other services for women.

Table 1. Factors considered most important by women seeking family planning services.

	Percentage of all preferences expressed	
	GP patients ($n = 53$)	Clinic patients ($n = 52$)
Good professional advice	29	29
Knowing the doctor	21	2
Convenient time to attend	16	15
Seeing a woman doctor	14	20
Convenient place	14	10
Pleasant clinic atmosphere	6	21
Seeing a different doctor than for other matters	0	3

n = number of patients.

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Women doctors

Sir,

I wish to take issue with Edwin Martin's supposition (December *Journal*, p.530) that when women doctors get married and have children this has to result in the disruption of their career. The physical process of having children does, of course, entail some absence from work, and many women also wish to take time off as maternity leave but this arrangement should be coped with within the career structure and not force an unwanted career break on women.

The majority of women doctors wish to continue in their career throughout their child-bearing years. A Medical Practitioners Union study[1] showed that out of 8000 women doctors only 19% were not working and of those most wanted to work, particularly part time, but found no jobs locally. A more recent survey[2] has shown 90% of women doctors in employment.

There appear to be two major problems to using women doctors fully. One is the (wrong) assumption that women will drop out, and so they often do not get appointed in the first place. The other is that women are still expected to take full responsibility for child-rearing and housekeeping, so they are often unable to work full time.

The solution to the first problem is for the profession to realize the women are as active and committed as men in their work and so be more prepared to appoint them. The solution to the second is to provide more part-time jobs, with flexible hours. Who knows, less than full-time commitment may appeal to male doctors too, enabling them to get to know their families.

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Training for obstetrics and gynaecology

Sir,

In 1981 the Royal College of General Practitioners in a joint effort with the Royal College of Obstetrians and Gynaecologists produced *Report on training for obstetrics and gynaecology for general practitioners by a joint working party of the RCOG and RCGP.* In this report they suggested a programme for training general practitioners who were doing office obstetrics (antenatal and postnatal care and family planning). They called this programme 'Shared care'.

For the past two years I have been corresponding with members of this working party and others in order to find a 'Shared care' training programme for two of my Bahraini family physicians. I have been totally unsuccessful. I hope that your readers might be able to identify such a programme.

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The General Practitioner Writers Association

Sir,

This association was formed about two years ago. It exists to improve standards of writing from or about general practice, whether this is research or more general writing. Membership includes academics and general practitioners as well as novelists and poets. There are many non-medical members who write about general practice. Though most of the 200 or so members are British we have many members in the Republic of Ireland and there are also members in Holland, Germany and Italy.

The association provides two workshop meetings per year, has a flourishing newsletter rapidly on its way to becoming a journal in its own right and offers £1000 annually in literary prize money. Most importantly, all members and their writing interests are listed in a register which is sent to publishing houses, journal editors and organizers of postgraduate educational meetings.

Membership currently costs £15 per year and as at least 40% of our members have been offered writing commissions as a result of joining the association the subscription may be quickly recouped.

Details are available from Mrs G.L. Byrne, The Cottage, 102A High Street, Henly in Arden, West Midlands B95 5BY.

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The College: academic or political?

Sir,

I joined the College, first as an associate and then as a member by examination for two reasons — first, to learn the views of the group of people who had contributed so much to improving general practice and, second, to be counted as one who believes that we all deserve a primary care service which aspires to high standards. There are of course immediate problems; the MRCGP examination has no clinical component, and the data base it seeks to examine on is still rudimentary. This leads me to believe that the unreconcilable pressures described by McCormick and colleagues (January *Journal*, p.30) are only so because we confuse the vision with present reality. My vision is of a College