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## Study of teenage care in one general practice

Sir,  
Teenage health issues feature in the *Health of the nation*,<sup>1</sup> and it has been suggested that adolescent medicine is sufficiently important to warrant its own medical speciality.<sup>2</sup> However, we have doubts regarding the feasibility of this suggestion.<sup>3</sup>

Work to date reveals health needs which teenagers feel are important, which are different from adult concerns for them.<sup>4</sup> Another report shows that teenagers would like to discuss many issues with a concerned adult, who could be their general practitioner.<sup>5</sup> Most recently an intervention study has confirmed that teenagers are happy to listen to advice regarding smoking.<sup>6</sup> However, there are no descriptive studies of patterns of consultation.

We set out to review notes held by our general practice in a Cardiff suburb to determine how often we see our teenage patients in the course of normal surgeries. Data on teenagers are not easily obtained because national morbidity statistics are produced for the age bands 5–14 years and 15–24 years.<sup>7</sup> We reviewed a systematic, non-random sample of 22% of the available notes of 11–19 year olds and recorded the medically defined reasons for all face-to-face consultations in 1991.

The consultation rates shown in Table 1 should be compared with the consultation rate for the practice as a whole in 1991, which was 4.01 consultations per person. Male and female 11–14 year olds consulted at a similar rate but infrequently compared with the rate for the whole practice. Further assessment of this age group showed consultations for similar reasons,

irrespective of sex, with upper respiratory tract infection and skin problems being most common. However, in the older age group males consulted rarely while females consulted at a rate above the practice average. This difference was not solely explained by gynaecological and contraception issues; female patients also consulted with more 'routine' morbidity such as respiratory infections and skin disorders. These results fit into patterns of morbidity previously found.<sup>7,8</sup>

Of the 58 older teenage girls four had had a termination of pregnancy in 1991 (none had a pregnancy which continued to term)—this pregnancy rate of 7% is nearly four times higher than the English rate of 18.6 per 1000 for 14–19 year olds.<sup>9</sup> Previous work in the practice revealed that this rate was not unique to 1991. This occurred despite use of oral contraception by 20% of 15 and 16 year olds and 60% of 17–19 year olds in the practice (according to patients notes), suggesting that peripheral suburban estates may need increased resources if the teenage conception rate is to be reduced.

Further research is needed into primary care provision of services for teenagers. Such work needs to be put in the context of adolescent health provision as a whole, as teenagers consulting are often uncomfortable in the surgery.<sup>10</sup> We need a coherent theory for teenager care which can be understood by the primary care team if we are to plan appropriate services. As today's teenagers will be tomorrow's adults and parents this would be a worthwhile investment.

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## Hospital anxiety depression scale

Sir,  
The hospital anxiety depression (HAD) scale, containing seven items in each of its subscales, was designed to detect significant anxiety and depression in general medical patients.<sup>1</sup> The subscales measuring anxiety and depression (scores ranging from 0 to 21 on each) have been shown to provide independent measures of these mood disorders in medical, but not in psychiatric, populations.<sup>2</sup> A study was undertaken to examine the validity of the subscales in a general practice population.

A total of 110 unselected attenders, aged 18 to 64 years at a group practice surgery in Liverpool were the subjects for this study. After obtaining informed consent they were asked to complete the HAD scale while waiting to see their general practitioner; following their consultation a psychiatric interview<sup>3</sup> was conducted, blind to the results of the HAD scale. As part of the interview, the Montgom-

**Table 1.** Consultation rates among teenagers in one practice in 1991.

	11-14 year olds		15-19 year olds	
	Male (n = 50)	Female (n = 50)	Male (n = 62)	Female (n = 58)
% of patients seen in 1991	78	84	69	97
Consultation rate	2.54	2.74	1.13	4.64

n = number of patients for whom records surveyed.