Speke Road, Woolton
Liverpool L25 8QA

MOIRA KELLY

Department of Sociology
Goldsmith's College
University of London
London SE14 6NW

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Patients' beliefs about inhaler treatment

Sir,

We should like to report the results of a pilot study that has revealed differences between patients' beliefs relating to symptomatic and preventive inhaler treatment. The study was conducted in one practice (C H's) which has three full-time and two part-time partners and 10 000 patients.

Transcripts of unstructured interviews conducted by C H with a stratified sample of eight patients, each taking both salbutamol and beclomethasone inhalers, were analysed qualitatively.[1] Eight themes emerged: positive and negative attitudes to inhaler use, satisfaction with the doctor, ease in obtaining inhalers, perceived benefits of inhalers, concern about side effects, desire for more knowledge about the inhalers and involvement of others in asthma management.

The themes were used to develop a structured interview, where questions relating to the eight areas of interest were answered using five-point Likert scales. Forty patients each prescribed both salbutamol and beclomethasone inhalers were randomly selected for the interview with C H. All agreed to participate. Inhaler use was defined as the mean number of puffs per day based on the numbers of salbutamol and beclomethasone inhalers ordered in the previous year. Rank correlations between the combined responses to the eight themes and measures of inhaler use were analysed as the variables were not normally distributed.

The results of the correlations are shown in Table 3. Satisfaction with the doctor was correlated with beclomethasone use, as one might expect from a preventive treatment where an element of trust is needed. It would also seem that the inconvenience of collecting an inhaler presents less of a barrier to action where the benefits are obvious (symptom relief) compared with when they are less tangible (symptom prevention).

Although the doctor–patient relationship was one of the three factors that emerged from a study by Sibbald and colleagues,[2] no distinction was made between treatments. Osman and colleagues[3] found that a dislike of asthma medication existed independently of whether the medication was for prophylaxis or relief, but no questions were asked about positive attitudes to using inhalers which appear in this study to have a greater influence than negative attitudes. It is possible that the more detailed exploration of beliefs about the two types of medication conducted in the present study allowed detection of a difference between treatments not found in previous work.

Further work is planned to confirm the key themes and to evaluate interventions for changing misconceptions about inhaler treatment.

CHRISTOPHER HAND

General Practice Development Project
Health Policy and Practice Unit
University of East Anglia
Norwich NR4 7TJ

CLARE BRADLEY

Department of Psychology
Royal Holloway
University of London
Egham
Surrey TW20 0EX

Table 3. Correlation of themes with inhaler use.

Theme	Spearman's rho: Salbutamol use (n = 40)	Spearman's rho: Beclomethasone use (n = 40)
Positive attitude to using inhalers	0.32*	0.31
Negative attitude to using inhalers	–0.12	–0.18
Satisfaction with the doctor	0.03	0.33*
Ease in obtaining inhalers	0.02	0.22
Perceived benefits of inhalers	0.26	0.37*
Concern about side effects of inhalers	–0.30	–0.26
Desire for more knowledge about inhalers	0.18	0.02
Involvement of others in asthma management	–0.04	0.17

n = number of patients in group. *P<0.05.

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Teenage sexual health

Sir,

We would like to respond to Dr Gardener's interesting reply (March *Journal,* p.161) to our review article on teenage health.[1] He raises several valid points which are worthy of further discussion regarding primary prevention of sexually transmitted diseases and pregnancy in teenagers.

Dr Gardner takes the opposing position to that expressed in our paper regarding a longstanding debate: are teenagers who are exposed to increased sex education likely to become more sexually active? He quotes papers that support his assertion that teenagers will have increased sexual activity, but there are several studies and reviews of the literature which strongly suggest that no such increase occurs.

In their large study of sex education and contraceptive provision in industrialized countries Jones and colleagues conclude that those countries which have easier access to contraception and better sex education provision have lower rates of teenage pregnancy.[2] Furthermore Voydanoff and Donnelly, summarizing work in the United States of America,[3] and Hudson and Ineichen, summarizing work in the United Kingdom,[4] independently conclude that increased sex education does not lead to increases in sexual activity among teenagers.

Gardner quotes the situation in the Netherlands where the rate of teenage sexual experience is one third that of the UK among those aged 16 years. However, the rates of pregnancy reported at a conference illustrate a success in the Netherlands with a teenage pregnancy rate seven times lower than that in the UK for all teenagers, and 11 times lower for those aged under 16 years.[5] It can only be successful contraception provision and sex education which accounts for the difference in these rates.

The Dutch attribute their success in some part to good communication between general practitioners and teenagers, and a non-judgemental attitude regarding sexual activity as a nation. The conclusions of our review article are based on the hopes that we could apply such

thinking better in the UK.

In summary it is difficult to agree that the primary aim of education should be to postpone first intercourse. Indeed, a recent review of sexual health education interventions quoted an American study which aimed to postpone first intercourse; the results were disapointing.[6] In principle it is a laudable aim, but in practice there is little to suggest that it can achieved by the primary care team. In addition we are wary of the potential side-effect of this approach which might encourage judgemental attitudes towards teenagers who have the courage to approach their primary care team for advice; furthermore the teenager may feel discouraged to attend a general practitioner or other primary care team member if the team is perceived to be excessively disapproving of teenage sex. We feel it is more practical to support teenagers to make sensible choices regarding their own sexuality without pushing them one way or the other.

LIONEL D JACOBSON
CLARE E WILKINSON

Department of General Practice
University of Wales College of Medicine
Health Centre
Maelfa
Cardiff CF3 7PN

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Health checks for elderly people

Sir,

We read with interest the paper by Chew and colleagues looking at the views and experiences of people aged 75 years and over with regard to the annual health check (December *Journal,* p.567). The authors report that 31% of their sample of elderly people reported having had a health check in the two years from 1990 to 1992, while 93% of respondents reported being in favour of them. This anomaly, a much higher level of approval than uptake, was also revealed in a trainee project undertaken by one of us (S D) which looked at patient expectation and experience of the annual health check for those aged 75 years and over.

The study practice is a relatively affluent, largely rural practice in Kent which on 31 October 1990 had 185 people aged between 75 and 80 years eligible for the health check (7% of the practice population). Every sixth eligible patient on an alphabetical list was visited by S D in February or March 1990 in order to discover their attitude towards the checks before the check became a term of service of April 1990. The same patients were revisited by S D during the period April 1992 to January 1993, that is after they could have had two health checks. Each person was asked if they approved of annual checks and, at revisit, if they had taken up the offer of a visit.

Of 31 eligible patients, 22 were visited by a S D in 1990, of whom 18 were revisited in 1992 (two had died, one had moved away, and one chose not to be interviewed again). Of the 22 elderly patients visited in 1990, 18 considered annual checks to be a good idea and four were ambivalent. Of those 18 who were visited again in 1992, 16 thought annual checks were a good idea while two were ambivalent. Only three, however, claimed to have had a health check. According to the other 15 elderly patients who reported having not had a health check, one had misunderstood the letter inviting them for a health check, four had not received a letter, six felt 'fit enough' and four saw the doctor regularly. According to practice records, five of the 18 patients had, in fact, had health checks. The uptake rate among the sample of 18 people was 28% with a whole practice uptake rate of 21.5% of 441 elderly people in 1990–91 and 13.3% of 459 in 1991–92.

As with all trainee projects, this one created more questions than it answered. It does, however, suggest that patient approval of a scheme does not guarantee a high uptake. When asked why they did not accept the invitation for a health check, the most frequent response was that it was a good idea but the respondent was too well to need it. While a patient's response to an invitation may be closely related to the manner of invitation, there is an important comment to make about Chew and colleagues' point regarding health service planning and consumer preference. Not only should the fact that elderly people value annual health checks be taken into account, but also reasons why they value them should be sought.

SIMON J DUNN

St Anne's Surgery
161 Station Road
Herne Bay
Kent CT6 5NF

MARTIN H PORTER

Tithe Yard Surgery
Church Square
Lenham, Kent

GPs and voluntary organizations

Sir,

People suffering with chronic diseases and their carers usually require many years of support, advice and information. Although general practitioners are in a key position to provide these services they often find it hard to do so because of time constraints. General practitioners should be encouraged to share the role of support of patients and their carers with a voluntary organization.

As a consultant in old age psychiatry and former national chairman of the Alzheimer's Disease Society (1987–94), I was interested in exploring this issue with reference to dementia and the Alzheimers Disease Society. A survey was undertaken in 1993 of the 55 general practitioners in my catchment area. I visited each of the 30 practices and saw 44 out of the 55 general practitioners and asked for information on the following: size of practice list; estimated number of people with dementia in the practice; whether the general practitioner referred people to the Alzheimers Disease Society; and whether the general practitioner referred people to other voluntary organizations.

Practice list size varied from 1000 patients to 10 500 patients. Nineteen practices had a list size of between 1000 and 4000 patients.

Only 30% of the general practitioners gave what could be considered a reasonable estimate of the number of people with dementia in their practice (matching the approximate number one would predict knowing the size of the list and assuming the list corresponded with a cohort of a general population across all ages). Most respondents (70%) had great difficulty with the concept of dementia as a diagnosis and how to arrive at such a diagnosis. Only 18% of respondents had ever referred a family to the Alzheimers Disease Society. Half of the doctors had referred three or more people to voluntary organizations ever and the other half had referred one or two patients (39%) or had never referred a patient (11%).

Two quite separate issues emerge from this study. The first is the problem of the