and over (n=6). The results are shown in Table 1.

Although several barriers to using the service were reported, such as fears about confidentiality, professional pride, GPs not admiting that there was a problem, and not having the time, GPs appeared positive about the value of the counselling service, in particular for dealing with personal problems. Furthermore, most preferred face-to-face counselling which would avoid 'crossed wires', and the majority said that they would use it. This suggests that emphasizing factors, such as the confidentiality of a service and its applicability to dealing with personal problems, may encourage GPs to seek help. However, despite this enthusiasm for the service, all GPs that said they would use it stressed that this would be 'if the need arose', 'as a last resort', 'if I had a problem', and 'if the problem were serious enough'. Accordingly, perhaps service use can only be facilitated by encouraging GPs not only to use the service if the need arises, but also to enable them to acknowledge when indeed this need has arisen.

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What do young people want from their GP?

Sir,

During adolescence, teenagers start taking responsibility for their own health. They visit their general practitioner two or three times a year.[1] By the age of 15, approximately 50% of boys and 60% of girls do so unaccompanied,[2] but there is evidence that they may be getting short-changed with regard to consultation time.[3] Accordingly, research outlining what teenagers want from primary care has been published.

Here, we report the views of a small study of teenagers in response to questions posed to them about primary health care. We used 188 adolescents aged between 16 and 17 years from two, large, mixed comprehensive schools in Oxfordshire, where we had been asked to talk to the sixth form classes. All of them completed the questionnaire, with 30% stating that they had visited their GP in the previous month. They were asked to list the following services that they required from their GP in order of importance:

- Having notices and magazines for young people
- Friendly and welcoming staff at the front desk
- Being able to telephone the practice and ask advice on an anonymous basis
- Having confidentiality ensured
- Having good written advice on contraception, exercise, diet
- Having a health centre-run clinic especially for young people.

Table 1. The percentage of 188 adolescents putting 6 different service provisions in primary health care in order of priority where 1=most important and 6=least important.

	Percentage (%)
Magazines	
1	2
2	2.5
3	6
4	10
5	16
6	63
Friendliness	
1	4
2	12
3	20
4	16
5	36
6	10
Phone advice	
1	15
2	36
3	19
4	20
5	6
6	3
Confidentiality	
1	65
2	20
3	7
4	5
5	2.5
6	2.5
Written information	
1	7
2	17.5
3	28
4	23
5	17.5
6	7.5
Special clinic	
1	7
2	12
3	20
4	26
5	22
6	14

The results can be seen in Table 1.

In response to the question, 'Were there things that you liked about visiting your local health centre?' half of the teenagers referred to the friendly atmosphere and attitudes of the doctors and receptionists and other staff. When asked, 'Were there things that you did not like about visiting your local health centre?' 25% responded that it was too quiet — 'very quiet in the waiting room', 'too morbid, sad and quiet', 'too quiet and stuffy'. The second most common complaint was that there was not enough time spent in the consultation itself, but too much time spent waiting — 'too short with the doctor, too long waiting to get in' — a complaint that may be shared by a wider age-group! There were also many respondents who obviously felt intimidated by the practice surroundings, and felt self-conscious because most of the other people there were older.

It is obvious from these results that confidentiality is of over-riding concern to young people. It is therefore essential for all practices to find ways of reassuring young people over this issue.

We feel that this is in an area that warrants further research.

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Doctors' authority

Sir,

Historically, the medical profession has been ridiculed, caricatured, scorned and attacked by some, and glorified, admired and idealized by others. In recent decades its authority has been submitted to profound changes, and as a result we asked three groups of patients their opinion on medical authority.

Group 1 (n = 68) were drawn from an out-patient clinic of the University of Vienna; Group 2 (n = 54) consisted of patients attending a 'naturopathic' GP practice in Munich; Group 3 (n = 89) were patients from a mainstream GP practice in Exeter. All were asked to give their opinion anonymously about the following statements:

1. The doctor has authority because he/she knows his/her subject
2. The doctor has authority because of he/she is morally correct
3. The doctor has authority because of his/her personality
4. The doctor does not have any special authority

The majority of those questioned (60-71%) felt that doctors do have a special authority, which is based to a large extent on the doctor's knowledge. The opinions are less clear cut as to whether this authority stems from the doctor's moral position or personality; 27-41 and 14-48% felt this was a basis for doctor's authority. Statement 4 (above) was thought incorrect by 40-50%. There were only marginal differences between the sexes and between different age groups in respect to attitudes towards doctors' authority. A comparison between proponents and opponents of complementary medicine suggests that opponents more frequently believe in the authority of doctors in relation to its basis on knowledge (90% versus 58%) and moral correctness (60% versus 39%).

These data imply that doctors are perceived to possess authority which is based mostly on their knowledge. It has been postulated that medical authority is based on factors other than knowledge.[1] The present results suggest that the moral correctness combined with a charismatic element may also be contributors to Aesculapian authority. The growing popularity of complementary medicine might, in part, be an expression of the patients' search for practitioners who treat their clients with the empathy of a traditional healer rather than the technology of modern medicine.

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Mothers as partners in antenatal care

Sir,

In Britain, antenatal care has evolved with little scientific basis. Consequently, we endeavoured to develop a more rational system by holding a meeting for our current pregnant mothers, and those who had recently given birth, with professionals involved in antenatal care. The result is an antenatal clinic with the following aims:

- Antenatal care sensitive to the needs of women
- High standard clinical care with less clinical measurement
- A comfortable setting for a group of mothers where education takes place through discussion.
- Flexibility of timing and availability of care
- Availability of a wide range of therapies.

The focus of the clinic is a half-hour meeting for the mothers, the midwife and the doctor, sometimes with a guest facilitator. Some aspects of pregnancy are discussed. Women are encouraged to question the professionals and to share their own experiences and feelings. Afterwards there is informal discussion over a cup of tea. The midwife and doctor are then available for individual consultation. We have a standard of five attendances — at booking, twenty-two, thirty, thirty-six weeks and term. Mothers may consult if they feel the need at any time during pregnancy. They may attend the clinic as often as they like. The midwife or doctor may suggest attendances for clinical reasons.

We encourage women to take responsibility for themselves and for their births, and give them the information to make choices. They are encouraged to take control of their births in terms of position, pain relief, and management of labour by discussion among themselves and with professionals.

Mothers who have recently given birth give encouragement in breast feeding and the care of new babies. A cohesive support group for mothers is important both before and after the birth when new mothers can feel isolated. Mothers are encouraged to bring their new babies to the clinic.

Groups evolve informally in antenatal clinics when people are thrown together while waiting, but we have given them the recognition and structure which enables mothers to use our group more effectively. Giving mothers the responsibility of choosing when to attend may seem risky, but we find this improves attendance by previous defaulters. There has been an increase in home births, which may be a result of increased opportunity for discussion. Mothers who experienced home birth gave encouragement to those considering it.

Ultimately our clinic gives greater satisfaction to doctor, midwife and mother.

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Health care provision for people with learning disabilities

Sir,

As a former journalist with a particular interest in disability issues and now working in clinical practice, I am greatly concerned about the possible medical and social repercussions on people with learning disabilities and their families as a result of the reduction in general practice recruitment.

Over the past 20 years, apathy and disabilist[1] attitudes from general practitioners (GPs) towards people with learning difficulties have been extensively recorded[2,3,4,5] as resulting in the subsequent mismanagement, inadequate care, serious illness and the non provision of health surveillance.[4,5] A reduction in the number of entrants into general practice may lead to bigger practice lists in order to deal with the shortfall in cover. A consequence of this may be that there is an erosion of the presently inadequate health care provision for this vulnerable group of people.

It is also depressing to note that, in 1988, Bax[6] records a disturbing proportion of young adults with a physical handicap that has been managed quite abysmally by their GPs. People with special needs and their families deserve equal treatment compared to the rest of the population.

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