

# Teenagers in primary care — continuing the new direction

*I would there were no age between ten and twenty-three, or that youth would sleep out the rest, for there is nothing in between but getting wenches with child, wronging the ancients, stealing, fighting.*

William Shakespeare, *The Winter's Tale*

YOUNG people continue to be a cause for concern to health professionals. Many general practitioners (GPs) see the teenage health agenda as stopping teenage pregnancy, drug use or smoking. All of these had targets set for improvements during the 1990s in the *Health of the Nation* document;<sup>1</sup> however, none were met. This was probably because GPs have little influence on risk-taking behaviours.<sup>2</sup> In contrast, they are rather more involved in the general primary health care of teenagers, and teenagers themselves have other health agendas.<sup>3</sup>

The role of the GP has always been first and foremost to provide a primary care service for all patients irrespective of age, sex, disease processes involved or social circumstances. It frustrates those who have an interest in teenage health that barriers to good primary care for teenage patients continue to exist and that these barriers create inequity of health care. Churchill *et al's* paper in this month's issue casts some important new information both on these barriers and their apparent effect on consulting behaviour.<sup>4</sup>

There is a large body of work suggesting that many teenagers are unhappy with the care they receive from primary care in general, and GPs in particular.<sup>5-11</sup> Most surveys suggest that approximately 20% of teenagers are dissatisfied with the care they receive, well above the quoted rate of 10% of adult patients expressing dissatisfaction.<sup>12</sup> Issues that teenagers have commented upon include bureaucratic and uncaring staff, delays in appointments, uncaring health professionals, perceived breaches in confidentiality, unfriendly atmosphere, inappropriate health promotion, lack of respect for the patient's viewpoint, and fear of embarrassment.

Churchill's paper records that these issues continue to be of concern, and it further demonstrates that a large proportion of teenagers disagree with a statement expressing overall satisfaction with care. It is apparent that many teenagers still view primary care poorly, which continues to be a disappointing finding, both for the present day and for the future. Nonetheless, the authors conclude that teenagers' negative perceptions of primary care have less of an influence on actual teenage consulting behaviour overall than had been previously thought. However, the researchers found that barriers to good primary care do apparently influence consulting patterns for psychological problems and contraception, both of which have potentially important consequences for teenage health.

The paper used a modified measure of satisfaction to assess attitudes to general practice care. It is notoriously difficult to measure patient attitudes and, further, they may change over time and be influenced by others, such as peers, parents, or even the media. The paper demonstrates that linking behaviour to attitudes is a complex interaction that is difficult to assess, just as it is in adult patients.<sup>13</sup> Moreover, it is not clear how much effect the doctor's age or sex may have on attitudes. A further question is how the provision of health care actually influences teenagers'

health behaviour; for example, another Nottingham team has recently demonstrated that the presence of younger, female doctors in a practice resulted in lower teenage pregnancy rates.<sup>14</sup>

There has been little published research on what actually takes place within general practice consultations in terms of communication, although it is known that teenagers of all ages and both sexes have shorter consultations than consultations for all other patients.<sup>15</sup> There may be several reasons for this, which include a mutual feeling that teenagers and doctors would prefer to spend as little time as possible in consultations.<sup>16</sup> Churchill's paper does reflect that this is an important barrier that could be addressed further, but it also points to an area of continuing research need for assessment of actual or simulated consultations with teenagers.

The most frequent negative comment made by teenagers about their care is of a lack of respect for them as people, or as users of the health service. They have commented on poor interaction in the form of patronising, judgmental or hectoring styles of communication.<sup>5,8,17</sup> No patient would appreciate 'skills' such as these and while they are not easy to change overnight, they are potentially open to improvements. This is important to consider, because the experience of teenagers in their consultations may influence their lifelong help-seeking behaviour.

Until recently, providing care for teenagers has not been seen as requiring specific skills. Certainly, within the United Kingdom teenage health has not generally been part of undergraduate or postgraduate medical curricula. However, a recently published report from South Wales has identified that many primary care providers view teenage health as an important aspect of training, both in terms of how to communicate with teenagers and how to assess risk.<sup>17</sup> Recent Australian work has demonstrated that training can be effective in the form of brief educational interventions over a short time period.<sup>18</sup>

In view of the negative comments made by teenagers, some form of alternative health provision has been suggested. A common trend these days is to recognise that 'standard' surgeries may not meet teenagers' needs, and that they could therefore be seen in specially run teenage health clinics.<sup>19</sup> Many practices recognise that other members of the primary care team can be invaluable in using clinic-based service provision. Recent work has suggested that the practice nurse would be a useful resource in this instance.<sup>20</sup> The whole notion of clinics and their effects on teenage health will need to be evaluated further.

A drawback to clinic-based health care is that most clinics have a high rate of non-attendance, or else they attract the 'worried well'. With regard to teenagers they further run the risk of falling foul of another version of the 'inverse care law',<sup>21</sup> in that those teenagers who are most 'at risk' are the least likely to attend for health advice.<sup>3</sup> The Churchill paper did not look at any particular risk assessment for the teenagers involved in the study; it is worthy of further investigation to determine if there are more or fewer barriers for those with greater anticipated health needs.

Teenagers represent 10% of the population and are a group for whom health care provision at present appears to be relatively unsatisfactory. It is imperative to recognise that the needs of adolescent patients are for respectful, non-judgmental primary care providers and for those providers to recognise that today's teenagers are young people who will become tomorrow's adults

and parents themselves. Deliverers of primary care need to respect the continuing research findings that barriers for teenage patients exist. Further, they should attempt to foster an improved atmosphere for teenagers and other young people to feel more comfortable when attending for primary health care. While Shakespeare's shepherd demonstrates how many will continue to view the young, all patients aged between 10 and 23 years are people too.

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## References

1. Department of Health. *The health of the nation: a strategy for health in England*. London: HMSO, 1992.
2. NHS Centre for Reviews and Dissemination. Effective Health Care. Preventing and reducing the adverse effects of unintended teenage pregnancies. *Effective Health Care Bulletin*. Volume 3: number 1. York: University of York, 1997.
3. Jacobson L, Wilkinson C. A review of teenage health: time for a new direction. *Br J Gen Pract* 1994; **44**: 420-424.
4. Churchill R, Allen J, Denman S, *et al*. Do the attitudes and beliefs of young teenagers towards general practice influence actual consultation behaviour? *Br J Gen Pract* 2000; **50**: 953-957.
5. Jacobson L, Wilkinson C, Pill R, Hackett P. Communication between teenagers and British general practitioners: a preliminary study of the teenage perspective. *Ambulatory Child Health* 1996; **1**: 291-301.
6. McPherson A, Macfarlane A, Allen J. What do young people want from their GP? *Br J Gen Pract* 1996; **46**: 627.
7. Kari J, Donovan C, Li J, Taylor B. Adolescents' attitudes to general practice in North London. *Br J Gen Pract* 1997; **47**: 109-110.
8. Donovan C, Mellanby A, Jacobson L, *et al*. Members of the Adolescent Working Party, RCGP. Teenagers' views on the GP consultation and their provision of contraception. *Br J Gen Pract* 1997; **47**: 715-718.
9. Jones R, Finlay F, Simpson N, Kreitman T. How can adolescents' health needs and concerns best be met? *Br J Gen Pract* 1997; **47**: 631-634.
10. Davies L, Casey S. The adolescent view of accessing health services. *Br J Gen Pract* 1999; **49**: 486-487.
11. Jacobson L, Mellanby A, Donovan C, *et al*. Members of the Adolescent Working Party, RCGP. Teenagers' views on general practice consultations and other medical advice. *Fam Pract* 2000; **17**: 156-158.
12. Rees Lewis J. Patient views on quality in general practice: literature review. *Soc Sci Med* 1994; **39**: 655-670.
13. Kinnersley P, Stott N, Peters T, Harvey I. The patient-centredness of consultations and outcome in primary care. *Br J Gen Pract* 1999; **49**: 711-716.
14. Hippisley-Cox J, Allen J, Pringle M, *et al*. Association between teenage pregnancy rates and the age and sex of general practitioners: cross sectional survey in Trent 1994-1997. *BMJ* 2000; **320**: 842-845.
15. Jacobson L, Wilkinson C, Owen P. Is the potential of teenage consultations being missed? A study of consultation times in primary care. *Fam Pract* 1994; **11**: 296-299.
16. Melville A. Caring for adolescents. *Fam Pract* 1989; **6**: 245-246.
17. Richardson G, Parry-Langdon N, Jacobson L, Donovan C. Bridging the gap? How do teenagers and health care providers view each other? Report submitted to NHS Executive, approved November 1999.
18. Sanci L, Coffey C, Veit F, *et al*. Evaluation of an educational intervention for general practitioners in adolescent health care: randomised controlled trial. *BMJ* 2000; **320**: 224-229.
19. Donovan C, McCarthy S. Is there a place for adolescent screening in general practice? *Health Trends* 1988; **20**: 64-65.
20. Gregg R, Freeth D, Blackie C. Teenage health and the practice nurse: choice and opportunity for both? *Br J Gen Pract* 1998; **48**: 909-910.
21. Hart JT. The inverse care law. *Lancet* 1971; **1**: 405-408.

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# Exercise: the right prescription in practice

THROW up your hands in horror! Here's another evangelist suggesting work for the weary, cynical, and already overburdened primary care team. Exercise is good for you, of that there is little doubt, and in many conditions. The most persuasive and comprehensive summary of the evidence is found in the United States of America's (USA's) Surgeon General's Report,<sup>1</sup> which records that exercise is of benefit in the prevention and treatment of cardiovascular disease, non-insulin-dependent diabetes, osteoporosis, and obesity, as well as producing a reduced risk of falling, and improved mental health. The most striking evidence is in relation to cardiovascular disease where the decreased risk attributable to regular physical activity is similar to other risk factors such as not smoking. But we might question if general practice is the right place for exercise promotion. Let's take a look at some evidence and the opportunities and risks of exercise promotion for patients and ourselves. A balanced viewpoint, we promise.

Health promotion interventions have, in general, produced disappointing results, so we should critically evaluate any new suggestions. Guidelines<sup>2-4</sup> indicate that we should take 30 minutes to 40 minutes of moderate physical activity five to seven days per week, a calorie expenditure of 1000 kcal (4200kJ) per week above our baseline activities of daily living. This is a much more acceptable target, with an emphasis on moderate physical

activity (and mention of physical activity rather than sport, training, or competing). And it need not be continuous, as the associated health benefits can be gained from an aggregate of shorter episodes of activity rather than a single, longer period.<sup>5</sup> The most effective programs are those that are home-based, of moderate intensity, involve walking, and have regular follow-up.<sup>6</sup> Several studies have questioned the compliance of exercise programs in general practice, with many stressing the high fall-out rates over a one-year period. It may be that we will have to consider exercise as a 'prescription', needing a regular review, but exactly who should monitor the prescription and undertake the review is not yet clear.

A recent systematic review of physical activity promotion in primary care in the USA<sup>7</sup> included a total of 13981 adults aged 17 years to over 85 years from 203 practices in eight trials. Five of the eight trials showed a statistically significant increase in participation. Short-term trials of less than one year, single risk-factor trials, randomised controlled trials, and those assessing a moderate level of physical activity were most likely to be effective. Only one of four trials lasting longer than one year was positive. The best results were from well-designed, uni-factorial (e.g. physical activity) interventions using the practice as the unit of analysis as well as the intervention. Long-term changes were best achieved with active follow-up, such as a phone call,

increased social support, and other incentives. They conclude that 'a five minute personalised activity message, followed by a written prescription for physical activity, such as briskly walking for 30 minutes a day, and a daily compliance log to be returned to the office, is a reasonable approach until further studies are completed'. Further studies are currently in progress.

A randomised controlled trial<sup>8</sup> of 714 inactive people (defined by questionnaire) from two general practice lists in the United Kingdom (UK) concluded that physical activity could be successfully encouraged in previously sedentary men and women. Limitations to promoting physical activity by general practitioners (GPs) have also been clearly identified.<sup>9,10</sup> A recent fascinating study of health promotion post-myocardial infarction by Cupples and McKnight<sup>11</sup> found, however, that while patients may have abandoned other aspects of health promotion at a three-year follow up, they were still active.

So, it is possible to encourage people to be active through primary care interventions, but GPs can hardly be expected to add it to the already overflowing third component of the Stott and Davis consultation model.<sup>12</sup> Thankfully, the evidence from studies cited above is that nurses, exercise counsellors or other trained staff are equally effective.

This is where we introduce a note of caution. Exercise prescription schemes seemed to offer the perfect answer, although the evidence is not convincing<sup>13,14</sup> and schemes to promote adoption are ineffective without efforts to maintain activity.<sup>15</sup> A GP writes out an advice slip that patients bring to the local leisure centre. Would you, should you, dare you? With a drug prescription we take responsibility for the medication having balanced the risks and potential side-effects of the medication. But, with exercise one cannot know if a patient is at risk without having taken appropriate screening tests, which may include an exercise stress electrocardiograph. Few of us have that facility easily available. One could argue that exercise assessment is a specialist skill, few GPs are trained in exercise assessment, and that such assessment would not, to use the legal jargon, fall within the normal area of expertise of a GP.

The Bolam rule<sup>16</sup> states that 'a man need not possess the highest expert skill — it is sufficient that he exercises the ordinary skill of an ordinary competent man exercising that particular art'. However, one might question if exercise prescription is an activity undertaken by the main body of GPs or if it is only undertaken by those with special expertise. In these circumstances GPs may begin to think twice about prescribing exercise directly and few will be comfortable signing the profusion of forms that patients readily present for our signature. The medical defence organisations have advised against 'prescribing' exercise, if a GP is unsure that they have the skill to make their own evaluation in each case, although it is appropriate to 'recommend' it.<sup>17</sup> Who should deliver the exercise programme? Many UK-based schemes utilise local leisure centres with cheap promotional induction sessions and membership fees. The cost is ultimately met by the patient and this may affect compliance. The individuals who advise patients attending leisure centres vary in experience from those with Higher National Diploma certificates to sports science graduates. Greater consistency needs to be established in these 'advisers', particularly if GPs are to be confident in their providers and indeed if the system should be tested in a court of law.

Finally, is exercise recommendation a unique subject? How much will our patients expect us to be good role models? Is it possible for us to sell exercise as a health tool to our patients if we too don't appear reasonably exercise conscious? It is a situation a little akin to a doctor who smokes telling a patient to stop smoking; although the advice is sound will the message be

heard? We don't know the answer to this. So, for the moment remember that you do not need to be an exercise freak to recommend that your patients become just a little more active. Or even become more active yourself!

In conclusion, there is considerable evidence that exercise is of benefit and it is entirely appropriate to encourage our patients to exercise, but the word 'prescription' signifies a much greater responsibility, which doctors should consider carefully. There remains, however, the much more fundamental question: should we be medicalising exercise at all?

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## References

1. US Department of Health and Human Services. *Physical Activity and Health: A Report of the Surgeon General*. Atlanta, GA: US Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 1996.
2. Pate RR, Pratt M, Blair SN, *et al*. Physical activity and public health: a recommendation for the Center for Disease Control and Prevention and the American College of Sports Medicine. *JAMA* 1995; **273**: 402-407.
3. NIH Consensus Development panel on Physical Activity and Cardiovascular Health. *JAMA* 1996; **276**: 241-246.
4. Secretary of State for Health. *The health of the nation: a strategy for health in England*. London: HMSO, 1992.
5. DeBusk RF, Stenestrand U, Sheehan M, Haskell WL. Training effects of long versus short bouts of exercise in healthy subjects. *Am J Cardiol* 1990; **65**: 1010-1013.
6. Hillsdon M, Thorogood M. A systematic review of physical activity promotion strategies. *Br J Sports Med* 1996; **30**: 84-89.
7. Eaton CB, Menard LM. A systematic review of physical activity promotion in primary care office settings. *Br J Sports Med* 1998; **32**(1): 11-16.
8. Stevens W, Hillsdon M, Thorogood M, McArdle D. Cost-effectiveness of a primary care based physical activity intervention in 45-74 year old men and women. *Br J Sports Med* 1998; **32**: 236-241.
9. McKenna J, Naylor P-J, McDowell N. Barriers to physical activity promotion by general practitioners and practice nurses. *Br J Sports Med* 1998; **32**: 242-247.
10. Harland J, White M, Drinkwater C, *et al*. The Newcastle exercise project: a randomised controlled trial of methods to promote physical activity in primary care. *BMJ* 1999; **319**: 828-832.
11. Cupples ME, McKnight A. Randomised controlled trial of health promotion in general practice for patients at high cardiovascular risk. *BMJ* 1994; **309**: 993-996.
12. Stott N, Davis RH. The exceptional potential in each primary care consultation. *Br J Gen Pract* 1979; **29**: 201-205.
13. Fox K, Biddle S, Edmunds L, *et al*. Physical activity promotion through primary health care in England. *Br J Gen Pract* 1997; **47**(419): 367-369.
14. Riddoch C, Puig-Ribera A, Cooper A. *Effectiveness of physical activity promotion schemes in primary care: a review*. London: Health Education Authority, 1998.
15. Harland J, White M, Drinkwater C, *et al*. The Newcastle exercise project: a randomised controlled trial of methods to promote physical activity in primary care. (Letter.) *BMJ* 2000; **7247**: 1473-1474.
16. Bolam vs Friern Hospital Management Committee [1957] 1 BMLR 1.
17. Burrows S. Exercise prescription: do we prescribe or do we just recommend? *Br J Sports Med* 1999; **33**(4): 287-288.

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# The Disability Discrimination Act: an opportunity more than a threat

THE Disability Discrimination Act was a major piece of legislation passed by the last Conservative government.<sup>1</sup> Although it became law in 1995, many of its provisions only came into force in October 1999. Despite the long preparation period, most general practitioners (GPs) seem to have little idea of the major effects that the Act has on their practices, both as service providers and as employers. Yet, since a major part of the role of general practice is the provision of services to the 6.5 million disabled people in the United Kingdom,<sup>2</sup> and many general practices employ 15 or more people and, hence, are covered by the employment aspects of the Act, GPs should have considerable interest.

The Disability Discrimination Act can be seen as a natural successor to the Sex Discrimination Act of 1975 and the Race Relations Act of 1976, although unlike these Acts it does not outlaw all forms of discrimination and is less comprehensive than its United States equivalent, the Americans with Disabilities Act.<sup>3</sup> Instrumental in applying pressure for legislation over the past 20 years has been the development of a powerful disability movement, mainly led by disabled people themselves. They emphasise the 'social model of disability', which sees disability as not a result of individual people's illnesses or impairments, as in the medical model, but because of society's response to disabled people, such as lack of facilities and equal opportunities.<sup>4</sup> One of the major criticisms of the Disability Discrimination Act is that although it is aimed at altering the social effects of disability, it uses an individualistic approach by which people have to prove they have a disabling impairment to have rights under the act.

The definition of a disabled person is 'a person with a physical or mental impairment which has a substantial and long-term effect on his ability to carry out normal day-to-day activities'. Different types of impairment are defined and 'long-term' is defined as 12 months or more. However, the definition of 'substantial' is vague, being 'a limitation that goes beyond the normal difference in ability that may exist between people', and will undoubtedly be tested in the law courts.

## Provision of services

Since December 1996, it has been against the law on the grounds of disability to refuse a service, offer a service that is not as good as the service provided to other people, or provide a service on terms that are different from the terms given to other people. However, the more concrete parts of the Act came into force in October 1999 and require service providers to take reasonable steps to adjust policies, practices, and procedures, including providing a service by alternative, reasonable means. For example, in a general practice surgery that has consultation rooms upstairs, the doctor or nurse must adjust their practice and provide the consultation in a ground floor room if a disabled person cannot readily climb the stairs. Service providers should also provide auxiliary aids and services. Examples in general practice are the provision of simple hearing aids, such as induction loops, well designed signs, and advertising that receptionists are available to help people with disabilities access the practice services.

By the year 2004, service providers will have to remove or alter physical barriers or provide service by other means. By then, the general practice described would have to provide a lift or stairlift, or move all consultation rooms to the ground floor,

and have a fully accessible disabled toilet. Existing building regulations already stipulate this on new or substantially reconstructed buildings<sup>5</sup> but it is going to involve considerable work and expense on older practice buildings. The government has not introduced additional funding for implementation of the Disability Discrimination Act but, presumably, the existing improvement grants available to general practices will prioritise such work.

Primary care groups and health authorities were recently advised by the Department of Health to audit current provision for disabled people in general practices, including physical access and communication.<sup>6</sup> Individual general practices can carry out their own audit using a checklist produced by the National Health Service (NHS) Executive<sup>7</sup> and local disability organisations will often provide a consultancy service, as does the Royal Association for Disability and Rehabilitation (RADAR). However, disability discrimination is at least as much about attitudes as about stairlifts and toilets and a recent survey found that the largest single barrier identified by disabled people in accessing NHS facilities was inappropriate staff attitudes and behaviours.<sup>8</sup> There is clearly a need for disability awareness training for all staff, including doctors.

## General practitioners as employers

The previous quota system, whereby employers with more than 20 employees were required to have people who were registered disabled as at least 3% of their staff, has been abolished, as has the registration scheme itself. This was widely regarded as stigmatising disabled people and impossible to monitor. Instead, since December 1996, it has been unlawful for employers with 15 or more employees to discriminate against current or prospective employees with disabilities because of a reason relating to their disability, unless there is a justifiable reason for doing so on legally acceptable grounds. Employers are responsible for making reasonable adjustments if their employment arrangements or premises substantially disadvantage a disabled employee or applicant. There are many issues that employers might need to consider, including, for example, changes to premises, equipment, and staff duties or even providing a reader or interpreter.

While the terms 'justifiable reason' and 'reasonable adjustment' are both vague, already legal precedents are being set by industrial tribunals. In one recent case,<sup>9</sup> an employee with serious back problems was dismissed. A tribunal held that this had been unfair as the employers had failed to make reasonable adjustments, such as allowing her to work from a ground floor office and partially from home. As employers, GPs need to be aware of these issues and be prepared to seek appropriate employment law advice.

Employers are often apprehensive about employing disabled people but a survey of employers with a positive attitude found that the adjustments necessary were often minor and that obtaining or retaining the best person for the job made sound business sense.<sup>10</sup> There is potential to employ and retain many more disabled people in general practices, as discussed in this month's *Journal* by Moloney *et al.*<sup>11</sup>

Although the implementation of the Disability Discrimination Act may appear daunting to general practices, it provides a real

opportunity to improve the quality of services for disabled people, both as patients and as employees. Unlike banks, shops, and restaurants, to which the Act equally applies, a large part of the core business of the NHS is helping people with chronic diseases and disabilities. People working in the NHS should therefore have a particular responsibility to embrace the act with vigour and enthusiasm.

The biggest long-term effect of the Act will probably be on the whole culture concerning disabled people, so that in years to come measures that currently appear radical will be considered basic human rights. When the Sex Discrimination Act first became law in 1975, there was consternation within the medical profession that at least 50% of medical students would be women. Twenty-five years on, this feels natural and the benefits are apparent in current general practice. Hopefully, one of the benefits of the Disability Discrimination Act will be to improve rights, services, and attitudes towards doctors who have or develop disabilities and to young disabled people who wish to enter the medical profession.<sup>12</sup>

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## References

1. *Disability Discrimination Act 1995*. London: The Stationery Office, 1995.
2. Martin J, Meltzer H, Elliott D. *The prevalence of disability amongst adults*. London: Office of Population Censuses and Surveys, 1988.

3. Gooding C. *Blackstone's guide to the Disability Discrimination Act 1995*. London: Blackstone Press, 1996.
4. Finkelstein V. The commonality of disability. In: Swain J, Finkelstein V, French S, Oliver M (eds). *Disabling barriers — enabling environments*. London: Sage Publication, 1993.
5. *Building Regulations 1991: Approved Document M: Access and Facilities for Disabled People*. London: Department of the Environment, 1992.
6. NHS Executive. *Implementing Section 21 of the Disability Discrimination Act 1995 Across the NHS*. (HSC 1999/156.) London: Department of Health, 1999.
7. NHS Executive. *Access to Health Service Premises: Audit Checklist*. London: Department of Health, 1999.
8. Freenley M, Cook R, Hale B, Duckworth S. *Working in Partnership to Implement Section 21 of the Disability Discrimination Act 1995 Across the National Health Service*. London: Department of Health, 1999.
9. Fletcher v Turning Point. (1300613/98.)
10. Watson A, Owen G, Aubrey J, Ellis B. *Integrating Disabled Employees: Case Studies of 40 Employees*. (Research Report 56.) Sudbury: Department of Education and Employment, 1998.
11. Moloney R, Hayward R, Chambers R. What is the NHS doing to retain general practitioners and staff with a health related impairment or disability? *Br J Gen Pract* 2000; **50**: 984-985.
12. British Medical Association. *Meeting the needs of doctors with disabilities*. London: BMA, 1997.

## Further information

There is a comprehensive government website containing documentation on all aspects of the Disability Discrimination Act at: <http://www.disability.gov.uk/dda>

RADAR has a detailed information pack on the Disability Discrimination Act and also has a consultancy service that can carry out disability audits or advise on local organisations: <http://www.radar.org.uk>

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