

Research paper

General practitioners' attitudes towards the provision of services to young people aged under 16: a cross-sectional survey

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ABSTRACT

Objective This study aimed to further explore the findings of our previous study which found that general practices with young general practitioners (GPs) and female GPs had lower teenage pregnancy rates (in women aged 13–19 years) and, specifically, to identify associations between responses to questions relating to the care of young teenagers and the age and sex of the respondent.

Design Cross-sectional survey of 621 GPs.

Setting Primary care, in the former Trent region of England.

Methods A questionnaire was sent to all GPs in four areas within what was the Trent Health region. These were chosen to represent areas with high (Barnsley and Doncaster), moderate (Sheffield) and low (Lincolnshire) teenage pregnancy rates.

Main outcomes measures Responses to questions concerning the provision of contraception to young teenagers, referral for termination in this age group, and also issues around confidentiality and their associations with the age and sex of the GP respondent.

Results Older GPs (aged 49 and over) were less likely than younger GPs (aged under 36 years) to prescribe contraception to young women aged under 16 years without parental consent (odds ratio (OR) 0.55; 95% confidence interval (CI) 0.33 to

0.93). They were also more likely to state that a parent or guardian could have access to the content of a consultation without the consent of the young person (OR 2.35; 95% CI 1.07 to 5.18), and to report that they rarely or never saw their young patients without a parent or guardian present (OR 1.97; 95% CI 1.10 to 3.53). The GPs in the older age group were more likely than those aged under 36 years to state either that they did not know if it was legal to prescribe contraception to young people aged under 16 years, or that it was illegal to do so (OR 4.27; 95% CI 1.50 to 12.22).

Conclusions Our previous study found that lower teenage pregnancy rates are associated with practices with young GPs and female GPs. This study has found that younger GPs are more likely to prescribe contraception without parental consent, and are also more likely to believe that a consultation between a GP and young person is confidential. This is likely to affect how accessible and acceptable young people view primary care services to be, and may also impact on their decision to consult with their GP to discuss contraception and sexual health issues.

Keywords: adolescence, contraception, general practitioner, primary care, teenage pregnancy

How this fits in with quality in primary care

What do we know?

General practices with young general practitioners (GPs) and female GPs have been previously shown to have lower teenage pregnancy rates (in women aged 13–19 years).

What does this paper add?

Younger GPs are more likely to express that they would prescribe contraception to patients aged under 16 years without parental consent, and are also more likely to believe that a consultation between a GP and young person is confidential.

Introduction

The UK has the highest rate of teenage pregnancy in Western Europe, despite a 4.5% reduction in conception rates between 2000 and 2001 in young women aged under 18 years.^{1,2} As outlined in the social exclusion unit report published in 1999, the government aims to halve these rates by the year 2010, in part by improving access to health care for teenagers.³ Teenage patients are likely to see their general practitioner (GP) at least 2–3 times per year; most consult with problems such as acne, respiratory conditions and musculoskeletal conditions.^{4,5} Although teenagers have reported that they are generally satisfied with the care they receive from general practice, young people are unsure as to how confidential services are and some may be too embarrassed to discuss sexual health issues.^{5–8} Some young people lack sufficient knowledge about general practice-based services, and also feel that their health concerns are not respected.⁷ In terms of the legal position regarding treatment of young patients aged under 16, the Fraser Guidelines came into force in 1986.⁹ These state that health professionals can provide contraception to young people aged under 16 years without parental consent, although the practitioner should endeavour to encourage the young person to discuss it with their parent or guardian. However, the health professional must be satisfied that the young person understands the advice given, that she is likely to continue or begin sexual intercourse, that without treatment her physical or mental health will suffer, and that the treatment is in the best interests of the young person. If these criteria are met then confidentiality must be upheld. These principles, known widely as ‘Gillick competency’, place a heavy burden on the healthcare provider, as they have to make the decision as to whether a young person meets the criteria for competency.

In 2000, we published an article, which reported lower teenage pregnancy rates associated with GP practices with young GPs, and female GPs, despite taking into account important factors such as deprivation.¹⁰ While we have some understanding of how

teenagers view primary care services, we lack understanding of the knowledge and attitudes of GPs to the care of teenagers, especially concerning contraceptive health. We undertook a cross-sectional survey of GPs to determine the attitudes and knowledge of GPs in relation to the care of young women under the age of 16 years. In particular we examined the effect of the sex and age of the GP on knowledge and attitudes to confidentiality, contraception and referral for termination.

Methods

The study sample

In 1999, all GPs from four areas in the former Trent Health region were sent a short two-sided questionnaire. These areas were chosen to represent areas with high (Barnsley and Doncaster), moderate (Sheffield) and low (Lincolnshire) teenage pregnancy rates (for young women aged under 16 years), according to rankings for the health region as a whole using Department of Health data for 1998.¹¹ These areas were similar in terms of overall population and also in terms of the proportion of the population aged 10–19 years, according to census data for 1998.¹²

Data collection tools

The questionnaire was developed to elicit information on several key topics. These were: exposure to young people (how often GPs saw young people aged 12–15 years and whether they saw them alone), frequency of discussion around issues of confidentiality with young people aged 12–15 years (how many young people they discussed confidentiality with and whether they thought a parent could gain access to the content of a consultation without the young person’s consent), prescribing of contraception to young people aged

12–15 years, referral for termination for young women in this age group (whether they prescribe contraception to young people aged 12–15 years, or refer young women in this age group for a termination of pregnancy, with or without parental consent), and issues around the legality of providing contraception to young people aged under 16 years. The questionnaire was piloted with GPs associated with an academic department of general practice.

Practice-level data including Townsend score associated with the practice (used as a measure of deprivation) and training status were also collected for inclusion in the analysis.

Data manipulation and analysis

The data were manipulated in Microsoft Access and analysed using SPSS version 9 and STATA version 8. Unconditional logistic regression was used to identify factors influencing dichotomous outcomes allowing for clustering of GPs by practice. Our main explanatory variables were the age and sex of the GP. Adjusted analyses included terms for age of GP, sex of GP, practice training status and Townsend score of the practice in the models.

We categorised age of the GP as under 36 years, 36–41 years, 42–48 years and 49 years and over, using quartiles defined in our previous study.¹⁰ These were not significantly different from those observed in the study sample. Continuous data were analysed using the independent samples *t* test with adjustment for clustering by practice.

Results

Analysis of responders and non-responders

A total of 951 questionnaires were sent to all GPs in the four areas. After two mailings, a total of 642 (68%) were returned. Of these, 621 responses from 294 practices could be identified, as the responder had not removed the code linking them to identifying information. The questionnaires returned with identifiers removed are not included in this analysis. Table 1 gives the characteristics of the responders. There was no difference in the response rate by area (areas with high, moderate or low rates, $\chi^2 = 0.02$, degrees of freedom (df) = 2 $P = 0.99$), though female GPs were significantly more likely to respond than male GPs (76.0% versus 64.9%, $P = 0.004$), and GPs aged under 36 years were more likely to respond than GPs aged 49 years and over (79.3% versus 56.5%, $P < 0.001$). Respondents were also more likely to be from training practices (76.2% versus 61.6%, $P < 0.001$)

and to be part of a regional research network (79.4% versus 63.4%, $P = 0.001$). The mean Townsend score for responders (0.99; standard deviation (SD) 3.23) did not differ significantly from the non-responders (0.85; SD 3.10), ($t = -0.66$; $df = 919$; $P = 0.51$).

Exposure to young people

Overall, 7% (42 of 613) of respondents estimated that they as an individual expected to see more than 40 young people aged 12–15 years each month, 14% (88) expected to see between 25 and 40 a month, 25% (156) expected to see 10–24 a month and the majority (53%, 328) expected to see fewer than 10 a month.

In adjusted logistic regression analysis GPs aged more than 35 years were less likely to expect to see more than 25 12–15-year-old patients in a month (see Table 2). As shown in Table 3, female GPs were not significantly more likely than males to report to seeing more than 25 12–15 year olds in a month (odds ratio (OR) 0.64; 95% confidence interval (CI) 0.39–1.04; $P = 0.07$).

Older GPs (aged 49 years and over) were more likely than the youngest GPs (under 36 years) to state that they very rarely or never saw young people alone without a parent or guardian present (OR 1.97; 95% CI 1.10–3.53; $P = 0.03$). Female GPs were not more likely than males to see young people without a parent or guardian present (OR 1.07; 95% CI 0.71–1.62; $P = 0.73$).

Confidentiality

Twenty-seven percent (167 of 615) of GPs reported that they discussed confidentiality with few or none of their patients aged 12–15. A further 22% ($n = 137$) discussed it with some of their young patients, and 51% ($n = 312$) reported that they discussed it with all or most of their patients in this age group. There was no association between age or sex of the GP and whether they discussed the issue of confidentiality with their young teenage patients.

Eighty-five percent (527 of 613) of the respondents stated that without the patient's consent, a parent could not demand to know the content of a consultation. In the multivariate analysis, GPs aged 49 years and over were more likely to report either that parents could have access to that information, or that they did not know (OR 2.35; 95% CI 1.07–5.18; $P < 0.01$) compared with the younger GPs (aged under 36 years). In univariate analysis, female GPs were less likely than males to report that parents could have access to this information, or that they did not know (OR 0.52; 95% CI 0.31–0.86; $P < 0.01$), though this difference was not observed in multivariate analysis (OR 0.61; 95% CI 0.36–1.04; $P = 0.07$).

Table 1 Characteristics of responders

Characteristic	Males <i>n</i> = 405 (%) ^a	Females <i>n</i> = 212 (%)	Total
Age (years)			
<36	60 (14.8)	54 (25.5)	114 (18.5)
36–41	104 (25.7)	71 (33.5)	175 (28.4)
42–48	113 (27.9)	55 (25.9)	168 (27.2)
>48	128 (31.6)	32 (15.1)	160 (25.9)
Total	405	212	617
Has family planning certificate			
Yes	192 (47.4)	114 (53.8)	306 (49.6)
No	213 (52.6)	98 (46.2)	311 (50.4)
Has MRCGP^b			
Yes	197 (48.6)	121 (57.1)	318 (51.5)
No	208 (51.4)	91 (42.9)	299 (48.5)
Is on the obstetrics list			
Yes	382 (94.3)	191 (90.1)	573 (92.9)
No	23 (5.7)	21 (9.9)	44 (7.1)
Practice is a training practice^c			
Yes	101 (24.9)	68 (32.1)	169 (27.4)
No	296 (73.1)	132 (62.3)	428 (69.4)
Practice is a research network practice^c			
Yes	59 (14.6)	15 (7.1)	74 (12.0)
No	338 (83.5)	185 (87.3)	523 (84.8)
Mean Townsend score ^c	1.068 (SD 3.13)	0.878 (SD 3.45)	0.998 (SD 3.23)

^a Variable of sex missing for four cases; ^b Member of the Royal College of General Practitioners; ^c Variable missing for 20 cases.

Prescribing contraception to young women aged under 16 years of age

The respondents were asked to report whether they prescribed contraception to young people with or without parental consent. Overall, 49% (302 of 614) of respondents reported that they did prescribe contraception to young women aged under 16 years without parental consent, and 275 (44%) stated that they would prescribe but *preferably* with parental consent. Only seven (1%) reported that they never prescribed contraception to this age group. In multivariate analysis, GPs aged over 49 years were significantly less likely than those aged under 36 years to report that they prescribed without parental consent (OR 0.55; 95% CI 0.33–0.93; $P < 0.01$). In univariate analysis, female respondents were more likely than males to state that they prescribed contraception without parental consent (OR 1.44; 95% CI 1.02–2.05; $P = 0.04$), though when adjusted for age, practice training status,

Townsend score and clustering by practice, this difference was not significant (OR 1.25; 95% CI 0.88–1.79; $P = 0.28$).

The majority of responders (93%, 579 of 620) stated that it was legal to prescribe contraception to this age group, and 7% either thought it was not legal or did not know whether it was legal. Older GPs were more likely than the younger GPs to respond that they either did not know whether it was legal to prescribe to this age group, or that it was illegal to do so (OR 4.27; 95% CI 1.50–12.22; $P < 0.01$). Sex of respondent was not significantly associated with this question (OR 1.16; 95% CI 0.57–2.38; $P = 0.68$).

Referral for termination of pregnancy

Twenty-nine percent (174 of 604) of respondents stated that they did refer young women aged under 16 years for a termination of pregnancy without parental consent, 47% ($n = 284$) stated that they did

Table 2 Response by age group of GP

Response	Age group (years)	n (%) ^a	Unadjusted OR (95% CI)	Adjusted OR (95% CI) ^b
Expects to see more than 25 patients aged 12–15 years in a month	<36	34 (29.6)	1.0	1.0
	36–41	33 (18.6)	0.49 (0.28–0.88) ^c	0.48 (0.26–0.85) ^c
	42–48	34 (20.2)	0.55 (0.30–1.00)	0.50 (0.27–0.94) ^c
	>48	29 (18.0)	0.49 (0.27–0.89) ^c	0.39 (0.21–0.74) ^c
Sees patients aged 12–15 years alone, rarely or never	<36	18 (15.7)	1.0	1.0
	36–41	41 (23.2)	1.42 (0.76–2.62)	1.46 (0.79–2.69)
	42–48	45 (26.8)	1.87 (1.04–3.38) ^c	1.90 (1.06–3.39) ^c
	>48	47 (29.2)	1.91 (1.06–3.43) ^c	1.97 (1.10–3.53) ^c
Discusses confidentiality with few or none of patients aged 12–15 years	<36	25 (21.7)	1.0	1.0
	36–41	47 (26.6)	1.27 (0.72–2.24)	1.34 (0.75–2.39)
	42–48	49 (29.2)	1.45 (0.81–2.61)	1.49 (0.81–2.74)
	>48	46 (28.6)	1.38 (0.78–2.43)	1.47 (0.83–2.67)
Agrees that parent can have access to content of a consultation, or does not know if access can be granted	<36	9 (7.8)	1.0	1.0
	36–41	26 (14.7)	1.94 (0.86–4.37)	1.88 (0.83–4.27)
	42–48	18 (10.7)	1.25 (0.53–2.92)	1.15 (0.48–2.75)
	>48	33 (20.5)	2.82 (1.31–6.05) ^c	2.35 (1.07–5.18) ^c
Prescribes contraception without parental consent to patients aged under 16 years	<36	62 (53.9)	1.0	1.0
	36–41	96 (54.2)	1.00 (0.63–1.58)	1.02 (0.63–1.63)
	42–48	85 (50.6)	0.88 (0.55–1.41)	0.90 (0.56–1.46)
	>48	59 (36.6)	0.50 (0.30–0.82) ^c	0.55 (0.33–0.93) ^c
Believes it is illegal, or does not know whether it is legal or not to prescribe contraception to under-16s	<36	4 (3.5)	1.0	1.0
	36–41	6 (3.4)	0.91 (0.24–3.36)	0.88 (0.24–3.25)
	42–48	7 (4.2)	0.96 (0.26–3.57)	0.94 (0.26–3.40)
	>48	24 (14.9)	4.49 (1.54–13.10) ^c	4.27 (1.50–12.22) ^c
Refers patients aged under 16 years for a termination of pregnancy without parental consent	<36	40 (34.8)	1.0	1.0
	36–41	49 (27.7)	0.74 (0.44–1.23)	0.74 (0.44–1.24)
	42–48	45 (26.8)	0.72 (0.42–1.26)	0.71 (0.40–1.25)
	>48	40 (24.8)	0.64 (0.37–1.11)	0.61 (0.34–1.08)

^a Cases not entered into analysis = 24; ^b Adjusted for sex, practice training status, Townsend score and clustering by practice; ^c $P < 0.05$.

refer but preferably with parental consent, 17.5% ($n = 106$) refer only with parental consent, and 7% ($n = 40$) stated that they did not refer for termination of pregnancy. GPs aged 49 years and over were less likely to state that they would refer for termination of pregnancy without parental consent than GPs aged under 36 years (26% versus 36%), but this difference was not statistically significant (OR 0.61; 95% CI 0.34–1.08; $P = 0.11$). Female respondents were not more likely than males to report that they referred for termination of pregnancy without parental consent (OR 0.91; 95% CI 0.63–1.32; $P = 0.63$).

Discussion

Summary of main findings

The main findings of this study were that younger GPs were more likely than older GPs to see young people for a consultation, and to see them without a parent or guardian present. Younger GPs were also more likely to prescribe contraception without parental consent. The youngest respondents were also more likely to state that, without consent, a parent cannot have access to the content of their child's consultation, and to state that it is legal to prescribe contraception to young

Table 3 Response by sex of GP

Response	Males (%) ^a	Females (%)	Unadjusted OR (95% CI)	Adjusted OR (95% CI) ^b
Expects to see more than 25 patients aged 12–15 years in a month	93 (23.0)	36 (17.0)	0.71 (0.45–1.13)	0.64 (0.39–1.04)
Sees patients aged 12–15 years alone, rarely or never	99 (24.6)	52 (24.8)	0.99 (0.66–1.49)	1.07 (0.71–1.62)
Discusses confidentiality with few or none of patients aged 12–15 years	114 (28.4)	52 (24.8)	0.86 (0.60–1.23)	0.89 (0.62–1.28)
Agrees that parent can have access to content of a consultation, or does not know if access can be granted	67 (16.8)	19 (9.0)	0.52 (0.31–0.86) ^c	0.61 (0.36–1.04)
Prescribes contraception to patients aged under 16 years without parental consent	185 (45.7)	115 (54.2)	1.44 (1.02–2.05) ^c	1.25 (0.88–1.79)
Believes it is illegal, or does not know whether it is legal or not to prescribe contraception to under 16s	29 (7.2)	12 (5.7)	0.74 (0.37–1.46)	1.16 (0.57–2.38)
Refers patients aged under 16 years for a termination of pregnancy without parental consent	113 (27.9)	60 (28.3)	0.99 (0.68–1.43)	0.91 (0.63–1.32)

^a Missing data for variable of sex = 4; ^b Adjusted for age, practice training status, Townsend score and clustering by practice; ^c $P < 0.05$.

people aged under 16 years. In terms of sex differences, in univariate analysis, female GPs were more likely than males to report that they did prescribe contraception to young people aged under 16 years without parental consent. Female GPs were significantly less likely than males to report that either a parent or guardian could have access to the content of the child's consultation with their GP, or that they did not know whether access was permitted. However, in multivariate analysis adjusted for age, practice training status, Townsend score and clustering by practice, no significant differences were observed.

Methodological considerations

The response rate to the questionnaire was 68% after two mailings. Analysis of the respondents and non-respondents revealed that there were some significant differences between the groups. As found in previous studies, the likelihood of responding decreased with

increasing age,^{13–15} also, female GPs were more likely to respond, and responders were more likely to be from training practices and practices that were part of a research network. There has been some research into the characteristics of the network associated with the study population.¹⁶ Practices that are part of this research network are less likely to be single-handed, more likely to be a training practice and also more likely to have at least one female GP. However, these practices do not have lower teenage pregnancy rates or levels of deprivation when compared to non-research practices, and so have a similar exposure and experience of teenage pregnancy in their practice population. Although as a consequence of selection bias, responders may differ from non-responders in terms of their knowledge and attitudes to contraceptive care for patients aged under 16 years, the differences observed between younger and older GPs are less likely to result from selection bias.

The age of a respondent was shown to be associated with many of the issues explored in this survey. It is possible that other factors accounted for at least part of the variation observed. Whether or not the respondent held a formal family planning qualification was not included in the analysis, and it could be suggested that younger GPs are more likely to hold this qualification, which would impact upon their response. In each of the age groups however, there was a similar number of respondents who reported that they held this qualification, which suggests that this would not impact significantly on the interpretation of the findings.

Discussion of findings

Confidentiality and exposure to young people

A study of consultation times has reported that young people tend to have significantly shorter consultations than adults, and young people attending alone have even shorter consultations than those who attend with an adult.¹⁷ Young people have also said that they feel that their health concerns are not always taken seriously by their GP, and that they have significant worries around confidentiality.^{5,7,8} These issues raise concerns over the relationship and communication that exists between the GP and his or her young patients. However, the results of this study suggest that the majority of GPs do discuss the issue of confidentiality with at least some of their young teenage patients. Similarly, the respondents in this study were, in the main, willing to see young people alone, but young GPs were more likely to state that they would always or often see young people without a parent or guardian present. It is encouraging that most of the respondents were willing to see young people alone, particularly as in a study of 1045 young people aged 13–15 years, it was reported that only 11% of males and 16% of females would want to be accompanied by their parent when visiting their GP.¹⁸

Contraception

The results of the questionnaire suggest that there is, for a small number of primary care professionals, some confusion over the legality of prescribing contraception to young women aged under 16 years. This is likely to be due at least in part, to the introduction of the Fraser guidelines in 1986, which ask GPs to determine, amongst other things, a young person's competence to make an informed decision.⁹ Since this study was completed, The Department of Health has responded to the need for clarity around this issue by publishing best practice guidance.¹⁹ Although the impact of this guidance on the health community is

not clear, it is possible that it has gone some way to clarify this difficult issue.

Overall, 49% of GPs who responded to this study, stated that they would prescribe to young people aged under 16 years without parental consent, and a further 44% stated that they would do so but preferably with parental consent. These findings are similar to those of Graham *et al*, who undertook a survey of GPs to describe the provision of emergency contraception to young women aged under 16.²⁰ In this study, 1.6% of GP respondents required parental consent before providing emergency contraception to a patient aged under 16 years. The high number of respondents in the current study willing to prescribe to under-16s without proof of parental consent is encouraging, particularly considering the findings of a recent US-based study, which reported that only one-third of young people accessing a clinic for contraception, would continue to do so if parental knowledge of their visit was mandatory.²¹ However, it should still be considered that within this study there were several single-handed practices where the GP responded that they did not prescribe contraception unless there was proof of parental consent. Taking into account that family planning clinics are not always accessible to this age group, there is concern that contraceptive advice may be difficult to come by for some young people.²² Perhaps young people would benefit from the assertion of the fact they can access contraception from any general practice, not just the one with which they are registered.

Age and sex of the respondent

In this study, the responses from younger GPs were significantly different from those given by older GPs for many of the issues included in the questionnaire. It is not clear why these differences were observed. It may be associated with differences in training, but there is very little evidence that this is the case. It has been reported that there is little training given to GPs in adolescent health, although there is evidence that such training has a positive effect on knowledge and skills associated with the management of teenage patients.^{23,24} What is known is that the age of a GP in relation to clinical practice and behaviour has been explored in previous studies, and has been shown to be associated with various outcomes. In a study of Australian GPs' views and use of tests in the detection of early prostate cancer, older GPs were significantly more likely to consider that tests with no evidence to suggest that they were effective were effective in detecting cancer and preventing premature mortality.²⁵ Older GPs have also been found to be less likely than younger GPs to use management and referral guidelines.²⁶ Whereas age was associated with differences in response to the questionnaire items, sex of the respondent was not. This was an unexpected finding as although there is no evidence to suggest that the age of a healthcare

provider has an impact on teenagers' use or perception of services, it has been suggested that the sex of the provider is an important factor, with one study reporting that 98% of young women would prefer to see a female GP for sexual health issues.¹⁸

Conclusion

Primary care has an important role to play in the provision of contraception to young people. This study aimed to further explore why in our previous analysis of general practice-based teenage pregnancy data we observed lower teenage pregnancy rates in practices that, amongst other characteristics, included younger GPs. The current study cannot give definitive answers to this question, but does provide evidence to suggest that younger GPs do have significantly different attitudes and self-reported behaviours from older GPs. Unravelling this issue and its impact on outcomes such as practice-level teenage pregnancy rates needs further investigation.

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JB designed the study, did the literature review, analysed and interpreted the data and drafted the paper. JH-C contributed to the design of the study, analysis and interpretation of the data. MP helped to develop the questionnaire and contributed to the interpretation of the data. CC gave statistical advice and assisted with the interpretation of the data. JH-C, MP and CC all contributed to the final draft of the paper.

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ETHICAL APPROVAL

Agreement to proceed with study given by the chair of the local research ethics committee.

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CONFLICTS OF INTEREST

None.

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