health promotion activities will persist within practice populations.⁸

The quality of the activity stimulated by incentives may not be high. Contraceptive services provided by general practitioners offer less choice than those provided by dedicated family planning clinics, yet incentives have encouraged the shift of contraceptive care away from such clinics into general practice. The growth of minor surgery in general practice may be another example of incentives promoting more rather than better care. Increased numbers of skin lesions, some of them malignant, have been removed by general practitioners. Incomplete excision occurs more commonly when the procedure is done by general practitioners who took up minor surgery after 1990,⁹ but the proportion of incompletely excised lesions is also increasing as time passes.¹⁰ When an underskilled workforce attempts to meet a demand but only partially succeeds, the potential exists for an increase in workload for specialist surgical services, which have to respond when treatment fails.

Has the boom in minor surgery performed by general practitioners relieved the pressure on hospital services in other ways? Much of the substantial increase in minor surgical procedures performed in general practice after 1990 has occurred among patients who would not otherwise have been referred to specialists.¹¹ Is this supplier induced demand or previously unmet need uncovered by new activity?

American experience of incentives for doctors suggests that they increase the intensity of medical practice,¹² but in Britain more time given to contact with patients and less to other work, such as education and communication, is seen as a threat to the quality of medical care.¹³ Mathematical modelling of general practitioners' behaviour at local level might allow family health services authorities to develop local packages of incentives that could offset the inherent perversity of the incentive approach (S Gallivan, personal communication). Concern about the suitability of incentives as the main lever to influence increasingly complex activity in general practice must, however, remain.

Perhaps we need to return to first principles. The organisation of general practice, including the incentives built into it, has less impact on how doctors work than the characteristics

of the population and the local economy.^{3,14} Incentives may become overvalued as an approach to promoting innovation and growth at a time when adequate resources for the development of general practice are not available. Tighter management of general practice, with reaccreditation and short term contracts, might be necessary to guide rapid development of the discipline, but these might be worth exchanging for enhanced funding for primary care. In the end carrots and sticks may make general practitioners behave more like donkeys than doctors. The time has come for an experiment to test the potential of well resourced and well managed primary care.

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Confidentiality, contraception, and young people

Explicit guidance at last

Reducing the rate of teenage pregnancy is an important objective of the health service in England,¹ Wales,² and Northern Ireland.³ Provision of contraceptive services and effective sex education is associated with comparatively low rates of teenage pregnancy,⁴ and this twin track approach forms the basis of current national and international strategies^{5,6} to reverse what has been for most of the past decade an increasing problem.

But the question must be asked why existing contraceptive services in the United Kingdom are proving inadequate when it comes to helping young people who are, or intend to become, sexually active. Part of the explanation must lie in the image created by the term "family planning," an activity with which most young people hope not to be involved. The contrast with the situation in the Netherlands, which has a rate of teenage pregnancy one seventh that of England and Wales, is particularly striking. Undoubtedly, frankness

when it comes to talking about sex, whether in school or elsewhere, is part of the explanation, but substantial differences also exist in the provision of contraceptive services to young people.

Behind the problems of image and the often inadequate facilities from which health authority services are provided lie the concerns that young people have about confidentiality. An evaluation of three contraceptive and pregnancy counselling projects set up by the Department of Health in 1986 emphasised that confidentiality was the single most important factor in the provision of such services for young people.⁷ The view that young people are unlikely to use a service if they are not reassured about confidentiality is reinforced in the handbook on this key area of the *Health of the Nation*.⁸

Although doctors' legal position regarding the provision of contraceptive services to young people under 16 was clarified by the House of Lords judgment in the case of *Gillick v West*

Norfolk and Wisbech Area Health Authority in 1985, uncertainty has surrounded the issue of confidentiality. While most doctors will respect the confidentiality of those seeking contraceptive advice, the suspicion has remained that a few, because of their personal beliefs, would breach confidentiality in the case of someone under 16.

The difficulty for the young person lies in distinguishing between those doctors they can and cannot trust. The consequences of such a breach of confidentiality might well be devastating for young people, and the chances of their pursuing a complaint against the doctor would be minimal. The General Medical Council's guidelines on confidentiality do not deal specifically with young people and contraception but emphasise that information about a patient should be disclosed without consent only in the most exceptional circumstances.⁹ An explicit statement of what represents acceptable professional practice in the specific instance of a patient under 16 seeking contraception has, however, been lacking.

The BMA, General Medical Services Committee, Brook Advisory Centres, Family Planning Association, and the Royal College of General Practitioners have now filled the gap. In a joint guidance note to be sent to all general practitioners next week they spell out in unequivocal terms that disregarding confidentiality in such circumstances is a serious breach of professional ethics. What is now required is a communications strategy so that young people will know that they can put their trust in doctors irrespective of whether

they work in general practice, family planning clinics, or Brook Advisory Centres.

Although progress is being made in medical confidentiality, a more sinister threat has arisen in the form of intimidation of those attending contraceptive services for young people. Premises have been picketed, and there have been threats to photograph those attending. This repulsive practice started in Belfast with the opening of a Brook Advisory Centre in September 1992 and now occurs in several cities across Britain. Such intimidation of young people seeking medical help is unacceptable in a civilised society and must not be allowed to succeed.

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Junior doctors and the EC draft directive on working hours

Britain should not have sought to exempt juniors

According to a grand jury in New York County, Libby Zion, who died a few hours after admission to hospital, might have survived had she "received the experienced and professional medical care that should be routinely expected at hospitals such as the one involved."¹ New York State's Court of Appeals decided that the two residents who had been on duty should not be charged with gross negligence.² At the time of Libby Zion's death they had been on duty for 36 hours. The grand jury regarded the problem as "systemic"; it criticised the state for allowing overworked interns to make major decisions in the emergency room.

In response a committee was set up, which recommended that the state should limit the maximum number of hours that interns could work. An editorial in the *Journal of the American Medical Association* commented: "Until recently, many defended the residency system as good for medical education and patient care, without scientific support for their beliefs. We now hear we should study the problem before making changes, but we cannot wait for studies to resolve all remaining questions—now is the time for action." According to the journal, reducing hours of work was the single most important way of reducing stress.³

Over recent years junior doctors' hours have been reduced in Britain. In September 1990, for example, there were 13 328 posts where the doctors were contracted to work over 83 hours a week compared with 370 in March this year (in many posts, however, doctors are working more than their contracted hours⁴). Yet, at Britain's behest, the European Council of Ministers decided earlier this year to exempt doctors in

training from the directive on working hours. Why did the British government invest so much of its prestige to prevent junior doctors from receiving the same protection given to the bulk of the European workforce? To ensure the safety and health of community workers the directive argues for a limit on maximum working hours and the granting of minimum daily, weekly, and annual periods of rest and adequate breaks.⁵

The need to ensure the quality of junior doctors' training is hardly likely to explain Britain's request for exemption: this concern is expressed in medical rather than government circles (and by seniors rather than juniors). The onus should be on those who argue that long hours are necessary for training to provide convincing evidence. Other European countries manage to train their doctors in a much less onerous fashion—for example, in Denmark, Norway, and Sweden junior doctors work 37-45 hours a week, and in the Netherlands they are limited to 48 hours. Moreover, the quality of postgraduate training is not ensured simply by long hours. Health and education authorities throughout Europe are increasingly trying to assure quality by deliberate measures such as setting standards, ensuring that the necessary facilities are available, and designing evaluation systems. Only once these measures have been implemented should we listen to claims that doctors have to work 65 hours a week in order to be properly trained.

The Danish labour minister, Jytte Andersen, chaired the meeting of the Council of Ministers that agreed the terms of the draft directive. In an interview with the *Journal of the*