authorities on an equitable basis to help with the startup and recurrent running costs of local out of hours general practice rotas above the level of individual practices. Available for this financial year and subject to review in subsequent years, this money amounts to an additional 55% of the current costs of night visiting in general practice and shows the government's own calculations of the extent of its underfunding of the out of hours service as a whole.

Funds may be awarded only for projects initiated and operated by general practitioners. Responsibility for the development of cooperative rotas and new methods of delivering out of hours care is therefore to fall solely on general practitioners' shoulders. Success will depend on whether a professional group that perceives itself to be in a crisis of low morale and recruitment⁷ can muster the necessary reserves of energy and enthusiasm to develop a better service at night. The task is a substantial challenge, given the current high level of call outs, the rising number of 999 ambulance

calls, and the progressively increasing rates of attendance at hospital accident and emergency departments.

The need for a responsive primary care service at night, separately organised and separately funded from the contract for general medical services, has never been more urgent. This deal hardly seems to bring us any nearer to its achievement.

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Primary health care and adolescence

Primary health care teams should remember the needs of adolescents

What do adolescents, aged between 10 and 18, need that can be supplied by primary health care? What do adolescents want from primary health care? How do adolescents use primary health care? What is in adolescent health for primary health care? The reasons for the present paucity of literature on these subjects include "labelling" of adolescents by health professionals as low users of primary health care services, confusion during the shift of responsibility for health care from parents to adolescents, the perception of doctors and nurses (shared by many parents) that adolescents are hard to understand and talk to, and a fear of unnecessarily overmedicalising adolescents' lives.

A cross sectional study found that adolescents reported coughs and colds (13%), hay fever (5%), skin problems (5%), and asthma (4%).¹ The commonest reasons for this age group to consult a general practitioner are respiratory illness, infective and parasitic diseases, diseases of the nervous system, and skin disease.² The main reasons for admission to hospital at the age of 16 are termination of pregnancy and childbirth for females and trauma for males.³ In both sexes the main cause of death is injury, followed by neoplasms and diseases of the nervous system.⁴

Recent research indicates that the main requirements of one group of adolescents from the primary health care services are confidentiality, the ability to telephone the practice without giving their names, and well written information designed specifically for them (A McPherson *et al*, unpublished findings). Sexually transmitted diseases, contraception, nutrition, acne, weight problems, and exercise were the subjects that they most frequently expressed an interest in discussing with a doctor or nurse.⁵

How do young people use the primary health care services? Surveys show that adolescents visit their general practitioner on average two to three times a year.^{6,7} They start making decisions about attending for health care by themselves at around the age of 15, and over 50% of boys and just under 60% of girls attend by themselves at the age of 15.⁷ Another feature is that general practitioners' consulting time with adolescents tends to be shorter than that spent with patients of other age groups—eight minutes rather than 10.⁸ It remains uncertain whether this is appropriate for the kind of ill-

nesses being seen or means that adolescents are being short changed.

These data provide evidence for concrete action. Firstly, the characteristics of the practice populations' 10-18 year olds should be defined (for example, the local unemployment rate, number of single mothers, and number of students). Secondly, it should be positively advertised to 16 year olds on the practice register that they can register with a general practitioner who is not the same one as their parents' and that everything they discuss with practice members will be treated with absolute confidentiality. Details of specific services provided by practices—for example, emergency contraception—should be provided, especially given young people's difficulty in gaining access to emergency contraception, even when they know all about it.^{9,10} Teenagers, especially those under 16, may find specialist family planning clinics more accessible than services currently offered by general practitioners.¹¹ Thirdly, adolescents should be involved in making practices more user friendly—for example, what do they think are suitable posters, leaflets, and magazines? Fourthly, practice staff need training to be responsive to what adolescents want—they should be able to ring practices for advice without giving their names and receive a friendly response. Lastly, information cards about the practice should be available in a form that is oriented towards adolescents.¹²

What's in it for primary health care? The first question is whether health promotion by primary health care teams prevents illness and therefore decreases work in the long run. The effectiveness of any health promotion to adolescents is as contentious as that to adults¹³ and is further complicated by the fact that teenagers' beliefs do not necessarily influence their behaviours.¹⁴ However, one preliminary study has shown that adolescents were at least willing to enter into a health promotion contract to give up smoking, even if no final outcome has yet been published.¹⁵ A second benefit is the personal one of increasing the satisfaction of dealing with a patient group more effectively; training resources in adolescent health may be better directed towards primary health care than to hospital specialists in adolescence.¹⁶ One further reward could be a realistic payment for reregistration of a practice's 16 year olds. This would recognise the primary

health care team's specific contribution in advertising its wares and enabling young people to access them.

However, to achieve its goals of ensuring better health for this age group, members of the primary health care team need also to remember responsibilities that lie outside their direct clinical practice: the most effective interventions in improving the health of adolescents are made by governments—improving education, reducing unemployment, and equalising the distribution of the gross national product.

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And now, evidence based editing

The third congress on peer review will be in Prague in September 1997

Peer review is slow, expensive, prone to bias, corruptible, and possibly anti-innovatory.¹ Yet it is central not only to the production of scientific journals but to all of science. Like democracy it may be an imperfect process, but it is better than the alternatives.²⁻⁴ Or is it? Just as nobody has conducted a randomised controlled trial of cervical screening against placebo so nobody has done such a trial of peer review. Such a trial would probably now be impossible—as it is deemed to be for cervical screening—but editors and others are beginning to research the process of peer review.⁴⁻⁶ Most questions about the peer review process cannot yet be answered on the basis of evidence, but some can: for instance, we have evidence that blinding reviewers to the identity of authors leads to them to produce better opinions⁷ and that structured abstracts contain more information than unstructured ones.⁸

Research into peer review was greatly encouraged by two international congresses on peer review research organised by *JAMA*⁴⁻⁶; and *JAMA*, together with the *BMJ* and Project Hope, is now planning a third congress to be held in Prague in September 1997. One reason for bringing the conference to Europe is to try to encourage research into peer review in that continent. Although some of the pioneers of peer review research have been European,¹⁻⁹ most of the work presented at the two previous congresses was American. As a spur to encourage research into the preparation, publication, and dissemination of health research, the *BMJ*, the *Lancet*, the *Nederlands Tijdschrift Voor Geneeskunde* (Dutch Medical Journal), and others have founded Locknet, a network of interested people named after Stephen Lock, former editor of the *BMJ* and one of the first proponents of research into peer review.¹⁰ Locknet has groups researching decision making processes in peer review, authorship, dissemination of the material (including to the mass media), scientific integrity, peer review in specialist journals, relations with the pharmaceutical industry, peer review in research funding, and peer review of economic evaluations. Anybody interested in joining should contact Richard Smith at the *BMJ*.

The second reason for holding the congress in Prague is that the processes of scientific debate and critical appraisal of all scientific material were deeply corrupted in the former communist states. And yet these processes are of fundamental

importance to the development not only of a scientific culture but also to the economies of these countries. More important for a developing country than food is the seed to grow food; just as important as the seed is to know how to grow the seed; and possibly most important of all is the possession of a culture that allows the scientific debate that leads to development of knowledge. We hope that by holding the congress in Prague we can contribute to the continuing development of scientific culture in the formerly communist countries.

We hope as well to be able to bring editors, scholars, and others from the developing world to the congress, and in addition to three days for presenting the results of research there will be one day devoted to teaching on peer review and one day to discuss how the new electronic possibilities (like the Internet) might improve the worldwide communication of health research. And peer review is central to that communication in order to ensure the dissemination of high quality, relevant, and accessible material. So far much more attention has been paid to quantity than quality.¹¹

Anybody interested in receiving more information on the congress should contact either of us.

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