relationship between a woman and her clinician should be built on trust, and the benefits and the risks of a procedure such as an episiotomy must be openly discussed to ensure truly informed consent.

The reexamination of the use of episiotomy that has occurred over the past 20 years underscores both the important role of systematic reviews in stimulating research and an often unappreciated issue in assessing procedures: what should be done with long standing procedures that have never been assessed using an evidence based approach. An important next step with episiotomy is to assess the relevant benefits of the midline versus the mediolateral technique. Randomised controlled trials should be conducted soon and their results disseminated broadly for the benefit of mothers and their children throughout the world.

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Fix what's wrong, not what's right, with general practice in Britain

It has provided better health than government spending deserves

British primary care is said to be the envy of the world. The spirit of experimentation anchored to a sound foundation of care led by general practitioners provides other countries with examples of accessible services, continuity of care, and innovative payment systems. Although Britain's healthcare statistics are not the best in the world they are far better than expected given the comparatively low funding of the healthcare system and the relatively inadequate systems of social support. Seen from the outside, Britain has clearly done something right with its National Health Service, which is based on and increasingly strengthened by its infrastructure of primary care.

The key features of a strong, functioning primary healthcare system are the ability to provide continuity of care and a comprehensive financing system. Until now continuity of care has existed in the United Kingdom because every patient is registered with a general practitioner (a patient list system). People thus have the possibility of developing a long lasting relationship with a general practitioner of their choice, increasing the likelihood of satisfaction among patients.[1] A relationship based on personal doctoring has multiple functions: it serves as the first filter for identifying new health problems, it serves as a place where advice on health issues can be given, it provides an opportunity for comprehensive management, it contributes to the cost effective use of resources, and it provides support and advocacy for the patient.[2,3] Some would argue that there is little evidence for the benefits of this system, particularly as regards cost effectiveness; this is not so. In the United States, a three year review of all the claims made by a random sample of patients aged 21 years and younger who were covered by Medicaid, the publicly funded US programme that provides health care to poor people, showed that being cared for by the same practitioner over time was associated with a reduction in hospital admissions and overall costs.[4] Another more general study showed that people who see the same practitioner over 12 months have significantly lower rates of hospitalisation in the subsequent year.[5] A recent study also found that continuity of care in a general practice is one of the most important variables affecting the total costs of primary health care, taking into account differences in morbidity and other factors known to influence the use of health care (De Maeseneer et al, unpublished data).

Several of the proposed changes to the NHS cut directly across this evidence of the quality and cost effectiveness of maintaining long relationships in primary care. Dual registration—in which patients register with one general practice at work and one at home—would dilute the essential longitudinal relationship between one primary care advocate (be they a general practitioner or a practice nurse) and the patient. Certainly, there are technical solutions that would allow information from the patient's records at both surgeries to be merged, but the real integration of such information and the building of trust take place in the personal meeting between the patient and the general practitioner. The NHS is expanding the provision of walk-in centres and phone lines staffed by nurses without evidence that they improve health or are cost effective.

To destroy the foundation of good primary care by setting up "docs in boxes" and freestanding "emergicentres" can only detract from what everyone admires about the British healthcare system. Primary care was

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never meant to be sporadic care: it requires care to be focused on a person over time. The health benefits of delivering primary care through a long term relationship with a single practitioner or small team at a local "single point of access" are clear.[6]

The second important feature of a strong primary healthcare system is a comprehensive financing mechanism. A recent report written jointly by the World Health Organization, the World Organisation of Family Doctors, and the Royal College of General Practitioners warns that no single form of payment system can easily remunerate the complexity of the tasks carried out by general practitioners.[7] It suggests that additional forms of payment, such as session payments, fees for service, and target payments, will be needed to motivate general practitioners. Target payments in particular can be used to strive for improved quality to implement specific government health policies, such as delivering successful immunisation and screening programmes. The report also states that a mechanism for basic funding that is derived from a weighted capitation system is the best way of allowing countries to identify and treat their own health priorities.

The current "red book" payment system for general practitioners (the system that sets out payments, reimbursements, and targets and is used to pay British general practitioners) has proved to be a flexible mechanism for the central control and direction of activity in primary care. Abandoning this system in favour of salaried service or other payment systems would be to disregard the available evidence, and abandonment could result in less health improvement occurring at the same cost.

The current registered list and payment systems for general practitioners have served the health of Britain well, and over decades they have delivered more health than international comparisons would have predicted. Rather than interfering with these aspects of primary care, the government's review of the NHS should consider the evidence from studies of the effects of organisational context and the mode of payment on the services provided by general practitioners. If incentives for quality and dedicated service have proved successful in primary care, is it now time to experiment and evaluate secondary care in the same way?

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Suicidal behaviour in gay, lesbian, and bisexual youth

It's an international problem that is associated with homophobic legislation

There is now a bitter debate in the United Kingdom over the repeal of Section 28 of the Local Government Act 1988, which forbids the promotion of homosexuality. This debate should be enlightened by accumulating research on the development of sexual orientation in adolescence and the mental health consequences of growing up in a climate of homophobic intolerance.[1] British research documenting the impact of homophobia has been corroborated by extensive research in the United States, Canada, and New Zealand.[2–4]

Sexual orientation emerges strongly during early adolescence. Youths with emerging identities that are gay, lesbian, or bisexual, living in generally hostile climates, face particular dilemmas. They are well aware that in many secondary schools the words "fag" and "dyke" are terms of denigration and that anyone who is openly gay, lesbian, or bisexual is open to social exclusion and psychological and physical persecution.[4] Some of their families too will express negative feelings about people who are gay, lesbian, or bisexual; youths in such families may be victimised if they disclose that they are not heterosexual.[5 6]

Youths who feel that they are gay must either hide their feelings from others for many years or face the risk of "coming out" to family and peers. Either course is perilous, and for some, one consequence of the confusion over their identity in a climate of intense intolerance and victimisation may be suicidal behaviour.[7] Epidemiological studies from North America and New Zealand show that gay and bisexual males are at least four times as likely to report a serious suicide attempt.[3 4 8–11]

Many schools allow a climate of homophobia

In the United States, more youths are disclosing their gay, lesbian, or bisexual orientation during high school, especially as more support services are being made available. However, many schools provide no assistance and allow a climate of homophobia to persist. For

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