reward for dealing with specimens referred by general practitioners.

TONY KEABLE-ELLIOTT

Chairman, General Medical Services Committee

BMA House,
London WC1

Opportunity in health visiting

SIR,—Did your correspondents read my letter (9 December, p 1646)? I am sorry that Jill Thornton and 34 other health visitor students (6 January, p 58) should take such exception to my questioning whether health visiting should remain a secondary profession with entry only through nursing. I do believe it is sufficiently important to warrant its own separate training. To quote an analogy from medicine: dentistry is sufficiently different from medicine for there to be a separate but sometimes related training. This does not mean that no dentist may have a full medical training, but the majority do not; most dentists enter dental school intending to become dentists, not doctors. Most health visitors entered nursing training courses intending to become nurses, not health visitors. There are large parts of nurse training which are not relevant to health visiting and for this reason I proposed a basic health care course as the preliminary training of a health visitor.

Finally, I would not presume to suggest the form which such a training might take but I am sure that a profession of such importance would agree its own training programme. I am glad of the enthusiasm expressed by Miss Thornton and her fellow-students and hope that they will question whether health visiting should remain a secondary profession or move forwards to take a prime position. I believe that this is an important challenge.

MICHAEL HALL

Shebbear, Devon

Nursing at a crossroads

SIR,—In reply to Mr I G Schraibman's letter (13 January, p 121) I would like to make the following comments and proposals.

Alarmed by the understaffing of hospitals and the difficulty of recruiting new nurses, Mr Schraibman suggests various adjustments be made to the current nurse training schedule. As most nurses at present do not take A levels, the majority will be leaving school at 16 years of age. To ensure that enthusiasts are not lost in the 18-month period taking them to the minimum entry age of 17½ years, Mr Schraibman suggests accepting 16-year-olds into a 12-month cadetship, the official training beginning at 17 years. I believe that these proposals are both impractical and dangerous.

Firstly, after the second world war, the Wood report, in an attempt to swell the inadequate numbers of nurses, both lowered the entry age and shortened the course. These measures proved ineffective in improving recruitment. Secondly, the drop-out rate is notoriously high in the first 18 months of training, when the student is at her or his most young and immature stage. This is surely likely to be a more frequent occurrence if the age is lowered to one where most people are just beginning to take control of their lives. Thirdly, the only practical

change that has had any positive influence on recruitment is substantial rise in salary.

The other aspect of these proposals is the psychological effect of lowering the age of our nurses, which I believe has dangerous implications. Mr Schraibman appears to underestimate the enormous responsibility of the nurse in the psychological, social, and physical care of a patient. Regimented technical skills play a relatively small part in full nursing care. A comprehensive, sensitive approach to the patient is essential in her or his proper rehabilitation. A 16-year-old, taken straight from the sheltered environment of school, is unlikely to have the maturity and awareness integral to the role of a good nurse. Moreover, a year's cadetship, if effective at all, is likely to forge the standard glib attitudes prevalent in the nursing profession, rather than to lay the foundations for a true understanding of the highly complex role of the nurse.

Having entered nursing at 20 years of age, after two years' experience of working at home and abroad, I feel there are far more radical changes to be made to improve the situation. If mature, capable, and responsible nurses are sought, then attitudes to the students must be changed. The repressive, authoritarian approach to nurses in training is barely tolerable to anyone with any self-respect. If it is tolerated, it often instils a similarly insensitive and unquestioning attitude in the student.

If, as Mr Schraibman says, nurses are the indispensable foundations of patient care, they should be treated accordingly both in status and in financial worth. I can assure Mr Schraibman that when nursing sheds its image of dedicated slavery performed by young girls bidding time until marriage, and becomes a viable profession for intelligent, responsible adults, recruitment will be no problem. Understaffing is indeed a difficulty, severely exacerbated by the continuing public spending cuts; but short-sighted, short-cut measures offer no solution.

ALISON HADLEY

London, NW3

SIR,—I was interested in the letter by Mr I G Schraibman (13 January, p 121) about the restructuring of the nursing shifts.

As a divisional nursing officer I am concerned with the implications to the service of a 37½-hour week, and a lot of work is at present being undertaken to find a satisfactory solution. The shifts suggested do not allow an overlap, which is essential for continuity, and no provision has been made for coffee or meal breaks. The present 40-hour week is exclusive of meal breaks and therefore any restructuring must be based on 37½ hours plus meals.

The majority of my colleagues could introduce a most satisfactory shift system. Unfortunately, this could cause hardship to the nurses involved, as we have a high proportion of married women with domestic responsibilities, and early starts with late finishes could cause conflict—which would eventually lead to staff leaving the service. Another problem is public transport, especially of outlying areas, as not all nursing personnel are fortunate enough to have the use of a car and a 7 am start could mean staff leaving home before 6 am. In the "old days" when a large proportion of staff were single and resident greater flexibility was possible.

The nursing fraternity would welcome help and suggestions from the medical staff as

restructuring of the nursing shifts also entails restructuring of the medical staff's ward and department commitments.

E L THOMPSON

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Prescribing—is a second opinion required?

SIR,—The Royal College of Nursing's view that it is illegal for their members and other nurses to write up a patient's oral contraceptive requirements in a delegation session at a family planning clinic seems to be derived, so far as I have been able to ascertain, from the *opinion* of the legal advisers of *their insurers* on an *interpretation* of a particular section of the Medicines Act 1978. But in matters legal there is surely more than one opinion?

The measures of adjustment to meet the situation created by this opinion in practice are cumbersome and time consuming. And inevitably there must be some ethical reservation about the wisdom of a doctor prescribing 13 packets of pills at a time, even when these are to be distributed at a nurse's discretion. What is *his* liability at law and with regard to indemnity? Could his action in so doing ever be interpreted as delegating prescribing? And so on. Furthermore, the new process, by the interruptions and pressure it creates, distracts the proper focus of attention from being on priorities such as changing pills where possible to the low-dosage type, etc, and altogether it disturbs the previous flexibility of the therapeutic contact.

In practice, the doctor is dependent on the nurse's verbal recommendation about required supplies for the patient she considers the doctor does not need to see. It seems to me a very fine point of law to consider that the nurse's writing this out for the doctor's consideration and approval is illegal but that her verbal communication of the same facts to him is (presumably) legal. Much has been made of the fact that under the old system the patient obtained her oral contraceptive supplies a little while (usually not much more than two hours) before the doctor actually signed the prescription and, of course, this is the point at issue. But would any court, in Britain at least, having regard to the safeguards, the high standard of nursing care, and the conscientious action of everyone in good faith, ever do more than simply observe that there was a technical impropriety at law but one for which no reasonable action at law or action for damages could properly be sustained?

Surely, in the present crisis of opinion, it is incumbent now on the medical defence societies, if they are not already doing so, to have defined at law what is meant by "prescribing medically"; to decide who is responsible in a delegation session (whether it is the doctor delegating or whether the nurse is responsible herself for any of the duties she carries out on a doctor's implicit or explicit instructions and, if so, which ones); what the legal risks are to a doctor in the circumstances and his liability in prescribing 13 packets of oral contraceptive pills (specifically with regard to negligence and the charge of delegating prescribing); and whether, in fact, the opinion on interpretation of the RCN's legal advisers is not open to question and dispute and may possibly even be untenable, depending on how prescribing medically is to be defined.

This last matter is of no small importance for, on the strength of this opinion, accepted, so far as I know, with what seems to me inadequate challenge, the whole of our profession is being stampeded into agreeing to an exception being made in the Medicines Act in respect of nurses (not to refer to pharmacists, though in this connection it is worth asking when it became accepted that prescribing could be divorced from the medical examination of the patient). If this exception is carried through it allows nurses to prescribe, in however restricted a sense—a task for which they are not trained as doctors are—without their being obliged to accept the responsibility which every doctor who prescribes must carry.

NORMAN CHISHOLM

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Revised career structure: first priority

SIR,—Mr D Innes Williams's article (13 January, p 144) on "Revised career structure: first priority" is timely, clear, and succinct and seems to me like a breath of fresh air in the current debate on this issue. It matters little whether the title be hospital specialist or consultant for the service career grade, with later progression to senior consultant. Clearly, though, no one would make the job title "subconsultant"; it was surprising the effect in my old school when we changed from prefects and subprefects to prefects and senior prefects!

MICHAEL H BEST

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Thoughts on hospital staffing

SIR,—In his paper on hospital staffing (2 December, p 1581) Mr I K Mathie spells out very clearly some of the problems of the present system and some of the solutions that are possible. He omits two very important points—firstly, that the current hospital staffing structure will continue to depend on substantial numbers of foreign graduates to fill SHO and registrar posts; and, secondly, that because of the considerable rise in medical graduates trained in UK medical schools that started in 1977 there will be increasing difficulty for registrars seeking their next job. This difficulty, already with us, will become more acute from August 1982, so that there is little time left for the profession to design and implement a new staffing structure for hospital medical staff.

These conclusions follow from a study of two tables in the DHSS document *Medical Manpower, The Next Twenty Years*, quoted by Mr Mathie. Table A7 details the medical school intake and medical graduate output from UK medical schools from 1960 to 1977. The rise in output from 1844 doctors in 1961 to 3045 in 1977 occurred in big steps in 1968, 1974, and (the largest)—296 extra graduates) 1977. The pass rates in the last five years have been about 92% (women do better at 94%), and their number has doubled from 486 in 1971 to 972 in 1977. The steep rise in output will continue to at least 1981, when 3350 doctors should qualify from UK medical schools.

Table A11 gives the breakdown of permanent hospital medical posts from 1970 to 1977. In 1977 there were 3240 HO posts, 9197 SHO posts, 6567 registrar posts, and

3017 senior registrar posts. There should be enough HO posts until 1981 to satisfy UK-trained graduates unless many more than 92% qualify. Even if every UK-trained graduate does two SHO posts there will be over 2600 posts left vacant. About 1400 doctors leave the hospital service each year, mostly to enter general practice, leaving the rest to compete for registrar posts. Again, there should be no problem for UK-trained graduates, and there should be 3300 posts over. This leaves a total of nearly 6000 SHO and registrar posts that could be and may need to be filled by foreign graduates. One way in which all these posts could be filled by UK-trained graduates would be to increase the medical school output of doctors to 4500 per year; another would be for all doctors to spend another term as SHO and as registrar. Both these remedies would exacerbate the problem of registrars finding posts when they have completed their contracts.

Each year about 700 consultants are appointed, usually from senior registrar posts. Thus about 700 senior registrar posts fall vacant each year. In 1977 there were a total of 3028 registrars who were UK and Irish born, and presumably half of them will have completed their two-year contract in 1978. With the inevitable rise in medical graduates by 1982, there should be over 3250 UK-trained graduates (excluding the Irish) in registrar posts, with over 1600 seeking further posts. Where will the excess registrars go?

If women medical graduates continue in full-time hospital posts in the same proportion to the men as when they qualified, then 1040 are likely to occupy registrar posts in 1982. Five hundred and twenty will be seeking senior posts, which they may very well want to do part time; they will be competing with 1080 men for the 700 senior registrar posts. It is more than likely that the women will be the unlucky ones, because they will be more difficult to fit into the staffing structure, however able they may be.

In my view the hospital staffing structure must change sooner or later, but the recent rise in medical graduate output from UK medical schools will force this change sooner rather than later. It must be in operation by August 1982, otherwise the solution will be forced on us, and it may then be both not of our choosing or to our liking.

MARTIN FOSS

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Fee for service or capitation fee?

SIR,—Like Dr T D Whitefield (25 November, p 1503), I read with interest the report by Dr K C Harvey regarding the Ontario Health Insurance Plan (28 October, p 1241). I also have worked as a general practitioner in both Britain and Canada, and endorse Dr Whitefield's comment that the fee-for-service system of payment raises the standard of medical care to the patient and is fairer for the doctors concerned.

I have to challenge Dr Harvey's final statement in his article, when he states that the attractiveness of the fee-for-service method of payment must be balanced against the level of controls, regulations, bureaucracy, and apparent reduced personal freedom which

follows its implementation. While the insurance plan (Medicare) might be under governmental control, the providers of medical services (physicians) most certainly are not. Apart from a few doctors employed by agencies such as the Workers Compensation Board and the Public Health Services, the vast majority of physicians in Alberta (and indeed in all provinces in Canada) are in private practice, and it is the intention of most physicians to keep it this way.

Can Dr Harvey, or any other proponent of the capitation-fee system, demonstrate its value and effectiveness as compared with the fee-for-service system? As a regular reader of the *BMJ*, I am astonished at the articles and letters which are published revealing all too clearly the shortcomings of the British system (for example, the letter from Dr G F G Woodman entitled "Shortcomings of the NHS: a yawning chasm," (21 October, p 1158)).

In Canada each provincial Health Insurance Plan is different, and there would be some merit in Dr Harvey's looking at the situation in Alberta, which has managed to avoid some of the difficulties experienced by physicians in Ontario. Physicians in Alberta can accept the Medicare benefit as payment in full, or ask the user (that is, the patient) to pay the balance if the physician's fee is greater than the benefit paid on his behalf by Medicare.

In Canada the political advantages of Medicare are now exhausted and it appears that the Government is anxious to find ways to limit its involvement in the health care delivery system.

A G DAWRANT

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Selection of medical students

SIR,—Bobbie Jacobson (Personal View, 9 December, p 1638) makes some telling observations about the selection of medical students. However, she does not make the necessary distinction between the "fairness" of a selection system and its "effectiveness."

A "fair" system is one which is explicit and open, under which applicants know all the rules and in which there are no hidden criteria. (An example is that used in the state medical schools in the Republic of Ireland, in which, to avoid any possible charges of discrimination, the only determinant of any significance is the applicant's school leaving grades.) An "effective" system on the other hand is one which fulfils its own objectives: the type of student sought is in fact selected.

Are the systems in our medical schools effective? It is difficult to tell, as it is customary practice neither to publish any objectives for the process nor to evaluate the result. Jacobson rightly suggests that this situation requires improvement. Are our selection mechanisms "fair" then? Polly Toynbee¹ recently sat in on a day's interviews at a teaching hospital: her description of the extraordinary processes which occurred suggests—if true—that, in this school at least, the process is far from fair. Certainly some schools establish targets for different groups of students (for example, reasonably enough, students from outside the UK); however, these can and do include unpublished quotas for women and, in the case of at least one school, Scottish (as opposed to English) applicants. The criteria operating in the selection process are thus not always made explicit.