wildly as they go into block with fewer intakes a year to help smooth the peaks and troughs, and compounding this is the edict that nurses in training shall not do "splits."

Your Briefing admits that the nursing profession has failed to lay down criteria for staffing hospitals, but the subject has to be urgently aired and I understand that the Joint Consultants Committee and the Central Committee for Hospital Medical Services are looking at the matter and will provide a counselling service to consultants in distress.

While the above points system has not been officially endorsed by my nursing hierarchy, they have failed to produce something better over the past 18 months as they nobly continue to try to plug the holes in the service, concealing the true facts until they lose their nerve. It is possible to go on to your wards and look at the duty rota for the ensuing weeks and provide your own early warning system, for you are unlikely to get any realistic warning from the nursing administration, especially if they do not accept your system and have none of their own.

I hope this letter will provoke a constructive debate in your columns and show that there is a way to stop the dilution of nursing skills, for an SRN yielding 5 points costs less than two auxiliaries yielding 2 points and the message is getting through.

R T MARCUS

Stratford Hospital,
Stratford upon Avon

Health Service planning and medical education

SIR,—The present unsatisfactory state of the relationship of Health Service planning to the needs of medical and dental education has been highlighted in Dr Robert Lowe's recent articles in the *Times Higher Education Supplement*. Minerva (29 July, p 362) hopes that his sensible suggestions will finally get an informed debate going.

The University Hospitals Association, comprising the deans of all medical schools in England and Wales and the chairmen of the medical executive committees of their designated teaching hospitals together with dental and postgraduate medical members, represents uniquely the aspirations and fears, the needs and problems, of the teaching districts. Because of their obligations to the students whom they have already admitted to their schools in good faith our members are especially aware of the impact of the effects of reorganisation and other measures on the present and future capacity of the Health Service to provide adequate resources for medical and dental education and research.

At a time when resources are quite insufficient to satisfy all needs there is increasing competition between the necessity to expand community services, to improve the level of care for the young, the mentally ill, and the elderly, and at the same time to sustain and expand medical and dental education to cope with the increased student numbers, to commission replacement hospitals, and also to improve technology for detecting and dealing with treatable illness. During the period of such limited resources the new medical schools at Nottingham, Leicester, and Southampton have become fully operational and the schools at Manchester, Liverpool, Charing Cross, Newcastle, Oxford, Leeds, Sheffield, and Wales are in the throes of

considerable expansion. Over the period 1974-9 the clinical intake of medical schools will have risen by about 25% in England and Wales. Because of the method of subregional allocation of finance by the RAWP and SIFT formulae clinical teaching is already in jeopardy in some London areas and even Southampton, which is in a gaining region under the RAWP formula. As the arrangements for safeguarding the needs of medical and dental schools are inadequate there are problems facing all teaching districts in the country.

While medical and dental education are the direct responsibilities of the Department of Education and Science through the University Grants Committee, the Department of Health and Social Security has its own clear responsibilities in these fields. It decides the numbers of doctors and dentists required for the NHS and thereby determines the size of the medical and dental schools. The DHSS also has the obligation to provide for the universities the clinical facilities required by them for teaching and research. However, by reorganisation the DHSS has delegated its specific national responsibilities to area authorities over which it no longer has direct control and to which it has allocated the primary task of providing local health facilities.

Dr Lowe suggests that a national forum should be established, representing all the many interests and earmarking revenue and capital allocation to teaching districts, because it is in the sphere of Health Service provision that the principal difficulties are occurring. If the existing medical schools both in London and elsewhere are to maintain their standards of teaching even for their existing students, let alone the increased numbers expected over the next four or five years, concerted action is necessary, and soon.

This association, representing all the medical schools and their associated hospitals in England and Wales, is fully aware of the current situation and because of the direct involvement of all its NHS and university members in clinical teaching it is in a better position than other institutions to make an informed and realistic contribution to the urgent discussions that should lead to some action, perhaps on the lines proposed by Dr Lowe.

DEREK R WOOD
Chairman,

DOUGLAS RANGER
Vice-chairman,

University Hospitals Association
(England and Wales)

London SE1

Training in community medicine

SIR,—The manpower situation in community medicine is very serious and there are currently 122 vacancies in established posts in England and Wales. It has been estimated that in the next five years this number will increase by at least a further 100. Such a situation would create problems for an established hospital specialty, but for a newly emerging specialty whose role is not well understood either within the profession or within the Health Service, and whose members suffered the full trauma of the reorganisation process, it is likely to be catastrophic.

The Department of Health and Social Security has been astonishingly complacent, encouraging practitioners within the specialty by its words emphasising the key role of

community medicine but by its deeds confirming the suspicion that it regards the specialty as a convenient temporary activity for redundant medical staff in the former public health service. Community medicine was retained within the management costs exercise, implying that it is an administrative specialty; a circular on recruitment proposed by the profession over a year ago has still not appeared; a working party set up at the initiative of the BMA was considered "inopportune" by the Department, which has belatedly recognised its importance; and finally, having agreed a single salary scale for community medicine trainees, the Minister now insists that entry to it must be in two separate parts because of the dangerous precedent which he considers might otherwise be established for junior doctors working in the hospital service.

In order to remedy manpower shortages over a five-year period community medicine needs a training programme which will produce 68 fully qualified trainees per year. The current programme is producing on average 12 such trainees per year, and over the past five years the programme has actually achieved an average of only 7 per year in England and Wales.

Community medicine has traditionally attracted entrants from three distinct groups: (1) mature entrants in mid-career; (2) women doctors usually via the community health services; and (3) a smaller group of young entrants for whom the specialty was a primary career choice. The existing contract for doctors in the training grades is based on the requirements of this third group. Over the past two years a group of doctors in the training grades has been advising the Central Committee for Community Medicine on a new contract, a key feature of which is a single salary scale. This has been developed specifically to meet the needs of the first two groups of doctors, enabling the former to enter the specialty at minimum financial disadvantage and recognising the necessity for many women doctors to remain at one base throughout the training programme. After two years on the scale each trainee would be subject to a rigorous educational assessment, at the end of which time those considered unlikely to achieve a career post would be encouraged to leave the specialty, since difficulty in re-entering clinical medicine increases rapidly after this time. Only after satisfying this educational assessment would further incremental progress on the scale be permitted. These proposals are acceptable to the educational bodies concerned and, in the view of the Review Body, do not breach the terms of its award. In your own columns Lord Hunter, whose committee set the course for the emerging specialty, has argued the need to attract more mature recruits from the clinical specialties,¹ and many would claim that such maturity is essential if doctors within the management process are to have the respect of their clinical colleagues. The Department obstinately refuses to shift its position, presumably in the belief that its present policies, which have so demonstrably failed, are the right ones.

Not only has the Department decided to impose its will upon a small group of doctors, but it has insisted that all doctors in community medicine and the community health services should be denied the money awarded to them by the Review Body in April last until their negotiators submit to the Department's

will and agree to its decision on the single salary scale.

My committee's final reluctant acquiescence to the Department's wording in the implementation circular which has now been promulgated is designed to prevent further financial hardship to those it represents and in no way implies that it concedes the principle of a single salary scale, nor that it condones the methods used by the Department to achieve its own ends under the pretext of so called "negotiations."

J STUART HORNER
Chairman,
Central Committee for
Community Medicine

BMA House,
London WC1

¹ Hunter, R B, *British Medical Journal*, 1976, 2, 1390.

Sexual pressures on children

SIR,—Rising generations have never accepted completely the values and standards of their parents, and parents have always felt outraged by their children's rejection of their beliefs. Both generations behave and react as they do to a large extent in accordance with emotions conditioned by their previous perception of life and only to a small degree determined by a rational appraisal of the present. An understanding of each other's position can only be gained by respectful listening and thoughtful evaluation of the other's beliefs and one's own. Such a reappraisal is a necessary preliminary to a change of attitude. We, the older generation, should be capable of a greater maturity than the younger and in my opinion should make the first approach.

There are societies in which premarital sexual intercourse is the accepted norm and, much as it offends our sense of propriety, we need to acknowledge that it is a possible ingredient of a stable society. If we believe it is harmful we need to be able to state clearly why and to what degree if we hope to persuade the rising generation and the teenage magazines of the error of their ways. The Responsible Society (29 July, p 353) mentions carcinoma of the cervix, the aftermath of abortion, and venereal disease as health hazards of teenage sex and "the positive health and social advantages of self-control." It deplores public expenditure on some educational activities concerning sex, though these might legitimately be regarded as a response to the permissive generation rather than a cause of it.

I for one would be grateful if the Responsible Society would list the "positive health and social advantages of self-control," quantify the health hazards of teenage sex, and compare them with other health hazards such as road accidents and substandard housing so that the problem of teenage sex, which is not an innovation of this half-century, may be seen in sober perspective, freed from our outraged feelings.

J B METCALFE

Madeley,
Telford, Salop

SIR,—I was saddened to see in the letter sponsored by the Responsible Society (29 July, p 353), and signed by certain eminent members of the medical profession, a distortion of the facts relating to the Brook Advisory Centres and therefore feel that anything else in the letter must be suspect. In this letter

there are so many half-truths that it is obvious that the signatories have not made it their business to obtain the correct information before seeking publication.

One example is the reference to BAC providing abortions. None of our centres have facilities for performing abortions, but where our doctors consider there are legal grounds and it is in the interests of the patient they will refer for termination to a hospital or clinic.

BAC are primarily concerned with helping young people to accept the responsibility of contraception and this is done within the context of counselling. As a medical centre we offer complete confidentiality to the client; but as some of us happen to be parents as well as practitioners we can understand the need to help in opening the avenues of communication between children and their parents. We also feel that a negative approach to the problems of teenage sex is no proof of a responsible or caring attitude.

We believe that we too can look on ourselves as members of a responsible society.

HELEN BROOK
President,
Brook Advisory Centres

London W1

SIR,—We agree with the Responsible Society that the sexual exploitation of "children" by adults can be damaging and is undesirable, but we take strong exception to their claim that the work done at Brook Advisory Centres is "promoting juvenile sex" and giving "callous advice." The use of the term "children" is emotive—we are not seeing prepubertal children but adolescents who are sexually mature and are trying to cope with their feelings in a society which artificially prolongs their dependence and tries to deny the reality of their sexuality. We recognise that a number of young people will have a sexual experience before they reach the age of 16. The figures for England and Wales in 1976 for illegitimate births (1400), abortions (3412), and gonorrhoea (637) in the under-16s are undeniable evidence. This is the tip of the iceberg—the ones who are found out.

When a girl under 16 comes to a centre, and they account for 3% of our new cases, one in five are already pregnant and 99% of them have already had a sexual experience. We do not believe the presence of Brook Centres encourages early sexual activity, for the young are disturbingly anticontraceptive, believing romance is all.

Our policy is to offer appropriate counselling and treatment, if it is requested, to try to reduce the potential damage. In addition to seeing a doctor, girls under 16 are also seen by a social worker, and both try to assess whether the girl is being exploited, pressurised, or having an incestuous relationship. They are asked if their parents are aware of their relationship and are encouraged to discuss it with them. We find that if a girl has a good relationship with her parents they may already be aware of her visit and, indeed, may have advised her to come, or she will find her own way of letting them know. But unfortunately many of the girls we see come from uncaring families or broken homes and are looking for attention or love in their sexual relationship that they do not get from their own parents. If the girl refuses to give permission for us to inform her parents or

refuses to tell them herself the doctor has to judge whether she is likely to continue her sexual relationship and whether withholding contraception will be more damaging than a possible pregnancy.

It is inaccurate to say that BAC provides abortions—we counsel a girl who is considering the outcome of an unwanted pregnancy and if she decides that an abortion is the only acceptable alternative and there are legal grounds we refer her to a second doctor, preferably one working within the NHS. A girl under 16 cannot have a termination without her parents' consent and this is always obtained, though it may be difficult to persuade the girl to give her permission.

We see much of our work with the young as a means of buying time for them to mature and giving them an opportunity to discuss their needs and make an informed decision as to how to act responsibly. To our mind the callous advice is to tell them they are too young, they are not to do it, and the law is being broken, and to inform the parents, against the girls' wishes, of their adolescent children's difficulties. In our experience most young people treated in this way continue surreptitiously with their sexual relationship in defiance of their parents and face an even greater risk of damage from unprotected sex.

The attitudes expressed in the letter from the members of the medical profession supporting the Responsible Society are unrealistic, and seem to show a greater concern with their professional standing with the parents than with the welfare of the young people who consult them with their problems.

FAY HUTCHINSON
KATHLEEN PIPPARD

Brook Advisory Centres,
London W1

RUTH COLES

Brook Advisory Centres (Avon),
Bristol

SIR,—The letter (29 July, p 353) from the Responsible Society pressure group follows now familiar lines: (1) The Family Planning Association, the Brook Advisory Centres, the Health Education Council, *et al* actively "promote" juvenile sex. (2) Their activities "undermine" the role of "responsible" parents (whose children for reasons best known to themselves prefer to seek their counselling and advice well away from their parents). (3) If these organisations did not exist and young people had no outside agency to turn to they would, by virtue of this vacuum, be much better protected against "sexual exploitation by adults."

In fact, neither Brook nor the other organisations hold it as an article of faith that "adolescent sexual intercourse is acceptable provided that contraceptives are used." They do, however, take the view that if adolescent (or any other) sexual activity does take place, then contraception must be used unless both partners positively desire a child.

This distinction is simple and obvious enough and it is therefore interesting that the views and attitudes of these organisations should have been so signally misrepresented for political purposes. Given this, it is perhaps not surprising to learn that privacy and medical confidentiality between doctor and patient, where the patient happens to be young, are held in such contempt by those