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Correspondents are urged to write briefly so that readers may be offered as wide a selection of letters as possible. So many are being received that the omission of some is inevitable. Letters must be signed personally by all their authors.

Drug firms' co-operation in clinical trials

SIR,—As an active clinical trialist running a clinical trials unit I wish to draw your attention to a major problem which we are beginning to encounter with certain drug firms. This is an unwillingness of one firm to provide matching placebo and active drugs for other firms wishing to carry out drug trials using these drugs as comparative agents.

I believe this is a major problem because the actual agent used, if not provided by the firm which makes the drug, may not correspond to that drug's biological profile. What is happening is that drug firms are producing their own versions of the active agents and are relying on biological dissolution time as sufficient evidence of equivalent biological activity. To my mind nobody has yet shown a direct correlation between biological dissolution times and bioavailability, and it is very hard, therefore, to rely on biological dissolution times without the bioavailability studies. Clearly it is a major undertaking for any drug firm to carry out biological availability studies on another firm's compounds, and yet this may become necessary if firms are not willing to co-operate with each other.

Very few clinical units are able to carry out estimations of the blood levels of active drugs. We are perhaps lucky in this respect at this hospital, where we can do this, but it would mean an awful amount of extra work if we were expected, every time we embark on a comparative trial, to carry out bioavailability studies on the drugs to make sure that we are using bioequivalent drugs. What is

really worrying is the number of trials that have been carried out in the past using products which were not proved to be bio-equivalent and this must call into doubt a lot of the published trials in, particularly, the rheumatological field.

It is perhaps the place of a clinician to point out to the drug industry that it is in its own interest to co-operate. Co-operation between the firms will produce better trials and at the end of the day the person who really matters, the patient, will be the one who will gain. I cannot see that any drug firm offering comparative drug material is going to be the loser because whatever happens their drug will be subjected to more papers and more expert assessment.

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Nursing shortages in NHS hospitals

SIR,—Your Briefing (15 July, p 222) draws attention to the facts underlying the shortage of clinical state registered nurses (SRNs) and much anger was voiced at the recent Annual Representative Meeting by those debating the motion "That this meeting is deeply concerned with the increasing burden of patient care that is placed upon an already overworked nursing staff and feels that there is an urgent and pressing need to increase the number of trained nursing staff who are

directly concerned with the care of the patient."

As a general surgeon I have found nursing cover lacking at times, but my problem has been to quantify the situation and lay down criteria so that facts back up any decision to limit the service. To this end I have developed a points system where a sister equates to 6 points, a staff nurse to 5, a state enrolled nurse (SEN) to 4, a student nurse to 3, a pupil nurse to 2, and an auxiliary to one, with appropriate adjustment for part-timers. Using this scale I can look at the duty rota for nurses on the wards and total up the points for the week and act accordingly. So far I have applied myself only to day staff and for our wards of 25 acute beds at this hospital I consider a total of 25 points to be the lower margin of safety. I mention this only as a guideline, for each one of us should do this exercise and formulate criteria, which will obviously vary according to the number of patients and the specialties involved.

Following a recent disaster I now insist that, within the points system, there should be two trained staff on duty during all normal working hours—that is, when lists are in progress and the ward is admitting emergencies. This has become necessary because of the familiar spectacle of senior staff, loyal and committed, trying to cope but being unable to delegate as the staff under them are inexperienced, though sometimes numerically adequate. In this situation I hold that substitution of an SRN by an SEN requires an extra pair of hands on the ward, as I think pressurisation and turbulence—that is, moving nurses around in times of crisis—contributed to the event.

Central in your Briefing is the relative increase in staff other than clinical SRNs, and it is skill and experience that are now sometimes so lacking on the wards; meanwhile the numbers of student and pupil nurses oscillate

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.

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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.

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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