impressions I gained from the Brook Advisory Centre conference held on 5 July entitled "Accepting adolescent sexuality."

(1) The conference attempted to establish that, since sexual feelings in young people are totally natural, indulgence in them is inevitable for those who want to mature normally. To prohibit this indulgence is to risk either unnatural development and years of fantasy, or parents "losing" their children—they must, therefore, accept as irrefutable the fact that most young people are sexually active.

(2) But parents do not accept their children's sexuality and its consequences, so other bodies must therefore step in who will; hence the Brook Advisory Centres, which, in the final analysis, provide practical help.

This rationale struck me, however, as unfortunate since it was a little too pat and simplistic. For example, what proof is there of the implication that all (or even most) of those who do not indulge in sex in adolescence are slightly "bent" in their development, while all those who do are free from fantasies? Surely what causes the problems is the absence of love, not the absence of sex? The underlying reasons behind adolescent sexual activity were more or less skated over: continual pressure from the media, films, TV, teenage magazines, sex education lessons (as one young boy pointed out, they talk of the "nuts and bolts" of sex but rarely mention love)—herein lies the heart of the problem.

Moreover, the conference concentrated excessively on the portrayal of parents as hypocrites, trying to compete with their young, jealous of them, lacking in understanding, self-centred, etc—hardly calculated, I would have thought, to "help in opening the avenues of communication between children and their parents." And what parent would, as Pauline Crabbe, Brook Advisory Centre social worker, claims she does, use the whole range of four-letter words with her clients in order to make them feel more at home? Tender loving care? To me this is callous in the extreme and it seems a very dangerous phenomenon in our society.

Finally, why is it that the advent of widespread contraception has coincided with our breakdown into an unstable society (divorce rate, abortions, etc)? Surely if the Brook Advisory Centres and similar organisations have been a success, we should be reaping the rewards by now.

MARY KINGSTON
Youth representative,
Responsible Society

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SIR,—Since it came under non-medical direction in 1968, the administration of the Family Planning Association has on many occasions put clinical family planning doctors in an invidious position. The FPA's high pressure "sales" approach—both to the public and to policymakers—has frequently produced fait-accompli decisions and "statements," without any opportunity for prior grassroots discussion on health considerations or the ethical implications for clinical doctors.

In view of the present correspondence on health, sex, and the young adolescent it ought to be known that when Parliament was discussing the National Health Service (Family Planning) Bill in 1973, the FPA put out a statement to the media that family planning should be available to all "irrespective of age."

The use of this phrase—without any qualification—was a clear mandate for the promotion of sexual intercourse to the underage teenage girl in magazines and the media of all kinds—without restraint. After all they could say: "The FPA says so."

What may not be known is that this "irrespective of age" aspect was never given to family planning clinical doctors for discussion before it was announced to the press. As chairman of a family planning doctors' regional group at that time I protested to the FPA administration about the absence of democratic discussion with professionals who would be directly concerned in advising and prescribing. But it was already too late.

"The FPA" and its sociological advisers had made another fait-accompli decision over the heads of clinical doctors. We and society and many young teenage girls are now paying the price—as many of us foresaw.

The fact is that the post-1968 FPA has never liked dissidents who care about health ethics, but happily family planning clinical doctors are professionally now quite separate from the FPA.

ELIZABETH ELLIOTT

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SIR,—Following publication of a letter from the Responsible Society (29 July, p 353) several correspondents have written in defence of the Brook Advisory Centres, and, in particular, the president has denied the allegation that they provide abortions.

This distinction between who refers and who provides is something of a red herring. The real practical question is why such a high proportion of pregnant girls seen by certain advisory agencies end up by having abortions. I have seen a report from the British Pregnancy Advisory Service giving a figure of 98%. Are Brook Advisory Centres any different? One wonders what kind of counselling is given to these young people, many of them very distressed when first seen and therefore vulnerable to advice that may be loaded. Is the counselling really objective? Are the arguments against abortion (there is a wealth of medical evidence here) fully explained? When and if the pros and cons are pointed out to the particular girl, does she appreciate the inevitable destruction of human life if abortion is procured? Finally, what programme of genuine support and care is offered to the client if she decides to have her baby? I for one do not believe that if full, frank, and objective facts were given to the client the proportion who would want to have abortions would be anything like as high as it is.

Examination of some of the information given by the Brook Advisory Centres leads one to conclude that they now regard abortion as merely another form of contraception. Brook Advisory Centres were originally set up to provide a comprehensive contraception service for the unmarried, particularly the young unmarried. I am prepared to believe that in the early days some of those taking part genuinely thought that all that was necessary was to press forward with the campaign and that this would slowly but surely result in pregnancy avoidance. What has actually happened is that, *pari passu* with this programme, the number of pregnancies in unmarried girls has progressively increased. There is no cause for surprise here: in my view it was inevitable and I held this opinion long before the present

situation developed. One of the results of this train of events is that Brook Advisory Centres are driven by what I would call their contraceptive logic to provide (sorry, arrange) abortions in ever increasing numbers.

J PHELAN

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Controlled prescribing

SIR,—Apart from the general interest of Dr Anne Savage's article on medicine in South Africa (29 July, p 329), she mentions a system of controlling the medicines that a doctor is able to prescribe—an illusion worth expanding on in view of the ideas being expressed in Britain at the moment.

Here in Britain our profession seems to maintain that we are all able to keep abreast of the large number of new drugs available (very difficult) and to be fully au fait with the comparative efficacy and cost of drug groups and the individual medicines within those groups (impossible) and that any outside control is an assault on our professional freedom (being left to bumble along in our own sweet way). In the South African health service well-respected members of the profession are placed on medicine selection committees. Taking into account up-to-date information on efficacy and cost, the committee then selects the range of medicines that should be available. Every now and then one of one's "favourites" did disappear, but there was always a perfectly good alternative. If a special drug was needed that was not on the list, then in fact it could always be obtained; one had to make out a separate type of prescription outlining why it was specifically indicated and I never saw one rejected. It worked very well and frankly I would support a similar system if it were introduced into our own Service.

C HOWLETT

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Proprietary names of drugs

SIR,—There seems to be an increasing tendency to promote drugs under their trade names and this may make it more difficult for doctors to recognise the active constituents in the various preparations. In view of both the increasing numbers of pharmaceutical preparations and the variety of reactions reported in the United Kingdom it is impossible for all doctors to be aware of all preparations and their adverse effects and the tendency to promote trade names would seem to increase the difficulties.

The problem of drug names was raised by the Medicines Evaluation and Monitoring Group in their Aberdeen and Dundee centres with senior and junior hospital medical staff and general practitioners. A total of 93 doctors were approached to ascertain whether they found the proprietary names for four specified drugs helpful in identifying the active constituents. No one was asked directly about the constituents and those classified as not knowing resulted from voluntary admission or by implication. Only one of the four proprietaries was deemed by the majority to have a helpful name; 78% of the doctors knew the ingredients of two of the remaining preparations, while the general practitioners appeared to

know slightly fewer overall; less than 30% of the doctors knew the constituents of the final drug, which was prescribed most frequently by the general practitioners, including those who had not known what it contained.

Most doctors favoured an improved system of naming but many suspected that it would be very difficult to implement, although insistence that the name chosen was related to the generic name or that the generic name was always given in brackets beneath the proprietary name, even if cumbersome, might be helpful.

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Prevalence of multiple sclerosis in north-east Scotland

SIR,—It is interesting to note in the epidemiological study reported by Drs D I Shepherd and A W Downie (29 July, p 314) that there is a "significant deviation from a random distribution" in the prevalence of multiple sclerosis in north-east Scotland. The local differences in observed prevalence may not reflect the true geographical incidence of the disease. The observed rate should be standardised for age, as the existence of a higher proportion of the population in early and mid-adult life, in areas of Aberdeen, for example, would increase the prevalence.

The other feature of note is the tendency for the observed prevalence to increase the nearer the area is to Aberdeen. This increase may reflect easier access to specialist diagnostic services, which are concentrated in Aberdeen.

The geographical distribution of HLAA3 and B7, if significantly correlated with the local prevalences, might support the observed differences in the latter. Such a study within a population at high risk would be of interest.

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Lorazepam unsuitable for day surgery

SIR,—A leaflet entitled "Ativan Injection in Day Surgery" has recently been circulated to hospital doctors and I am anxious to prevent any misconceptions that may arise. To my relief the manufacturers, John Wyeth and Brother Ltd, assure me that this document was not intended as promotion for the use of lorazepam (Ativan) in this situation but rather as a data sheet for anyone wishing to use it for day cases.

As an anaesthetist I strongly believe that a long-acting drug such as lorazepam, while excellent for use in certain situations, is in fact contraindicated in day-case procedures. Indeed, it has recently been shown¹ that significant plasma levels of lorazepam are still detectable 24 h after a single dose of the drug, and, although intravenous administration results in an initially rapid decline in plasma levels, this is followed by a very slow fall over the subsequent 24 h irrespective of the route of administration.

In their leaflet the manufacturers have, quiet correctly, included warnings about the

need for patients to be accompanied home and to be cautioned against doing anything requiring any degree of judgment for the rest of the day. However, when there are other, shorter-acting drugs on the market I feel that it would be a shame if a drug as promising as lorazepam for use in certain circumstances were discredited by adverse reports following its use in an inappropriate situation.

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¹ Dundee, J W, *et al*, *Anaesthesia*, 1978, **33**, 15.

Health education in schools

SIR,—Minerva may have been abashed (5 August, p 441) to hear an American health educator say that American schoolchildren have 180 hours of health education in their schooldays. The fact is that the hours of British-style health education cannot possibly be counted in this seemingly superficial way. I should like to know what constitutes the 180 hours in the USA—lectures followed by multiple choice questionnaires marked by a computer, perhaps?

In Britain health education is rarely taught as a curriculum subject in which the hours spent could be "clocked up." It should never be taught just as a series of facts to be poured into empty vessels. It is frequently integrated into the whole school curriculum—ideally, from the primary school to the end of the school career.

In secondary schools it crops up in the obvious subjects such as biology, home economics, and PE; it may also appear in rather more subtle form in drama, art, English, science, social studies, environmental studies, and religious education. Do we have to attach a special label to a topic for it to be considered as "education for health"? Doesn't the school medical officer or school nurse have a part to play in informal health education? I hope we never reach a state where health education is so tightly defined that we can indeed state that every schoolchild will have "done" x hours of it. Would it change their health-related behaviour for the better anyway?

To answer Minerva, perhaps that explains why American children often ask for Coke instead of milk.

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PUVA treatment of psoriasis

SIR,—I refer to the letters from Professor M J Ashwood-Smith and Dr S Igali (29 April, p 1138) and Dr M Whitefield and others (27 May, p 1418) concerning risks associated with the PUVA treatment of psoriasis. Dr Whitefield and his colleagues suggest that the 8-methoxypsoralen used in the photochemotherapeutic treatment, on excitation to its triplet state by light of wavelength around 365 nm, might act as a photosensitiser for dimerisation of adjacent thymine molecules in a single DNA strand as well as forming addition compounds with two thymines on opposite strands of the DNA spiral, which by blocking cellular division reverse the psoriatic

process. It was suggested that such photosensitised formation of thymine dimers may cause mutagenic and carcinogenic changes normally only associated with absorption of light directly by DNA in the higher energy region around 260 nm.

I wish to point out that the triplet energy levels of 8-methoxypsoralen (263 kJ/mol)¹ and thymine (315 kJ/mol)² are such that the triplet energy transfer from 8-methoxypsoralen to thymine invoked by Dr Whitefield and his colleagues may be excluded on energetic grounds, although the reverse triplet energy transfer process from thymine to 8-methoxypsoralen would be expected to be efficient. Psoralen triplet states can in fact only be quenched by thymine by non-energy transfer processes.³ Photochemotherapy of psoriasis by PUVA is therefore unlikely to lead to side effects due to reactions of excited states of pyrimidines or purines in DNA.

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¹ Mantulin, W W, and Song, P-S, *Journal of the American Chemical Society*, 1973, **95**, 5122.

² Eisinger, J, and Shulman, R G, *Science*, 1968, **161**, 1311.

³ Bensasson, R V, Land, E J, and Salet, C, *Photochemistry and Photobiology*, 1978, **27**, 273.

Stroke after acute myocardial infarction

SIR,—I read with interest the paper by Drs P L Thompson and J S Robinson (12 August, p 457) on the relation of stroke after myocardial infarction to infarct size. While I accept their conclusions on the basis of the analysis of aspartate transaminase levels, which showed a correlation coefficient of 0.85 with creatine kinase levels, I find the choice of the latter as the index of infarct severity rather unfortunate in the context of the study, since it is also present in brain and released into the blood in cases of cerebrovascular accident.

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Injuries to cricketers

SIR,—There has been considerable interest of late regarding the use of protective headwear in cricket by batsmen and close-in fielders. I am writing this letter in the hope that some British-based doctors will be motivated to conduct a survey of cricket facial injuries. If the extent of the problem can be defined by such a study surely this will be a further stimulus for cricketers to adopt the use of protective headwear—and, probably more important, facewear. Many readers will be familiar with the story of the county cricketer who, this season, was fielding close to the bat while wearing protective headwear but not facewear. He was hit by the ball and sustained severe facial injury.

Experience in Canadian ice hockey illustrates how a study of sports injuries can add impetus to the introduction of safety measures. Pashby *et al*¹ reported in 1975 a Canadian Ophthalmological Society study of eye injuries in ice hockey. A questionnaire was sent on two occasions to the 525 ophthalmologists who are COS members: 540 hockey-related eye injuries were reported, 15% of all injured eyes being rendered legally blind. The highest number of