Arabic and English, outlining the current teaching on fasting for Ramadan during pregnancy; the midwives copied this and use it when seeing women who are fasting.

Clearly, interpretation of the teachings on exemption from fasting differs greatly, and staff may not always appreciate that a woman is fasting. The issue of whether a woman is eating enough may arise only if she fails to gain weight. This study showed that a substantial number of pregnant women do fast, and this will not be known unless they are specifically asked.

JANE REEVES

Department of Public Health
Medicine and Epidemiology,
University Hospital,
Queen's Medical Centre,
Nottingham NG7 2UH

1 Rashed AH. The fast of Ramadan. *BMJ* 1992;304:521-2. (29 February.)

Corticosteroids and male infertility with an immunological basis

SIR,—Carolyn E Grundy and colleagues are premature in dismissing corticosteroids as being of doubtful efficiency in male infertility with an immunological basis and as having "unacceptable side effects"—particularly as they report on only three patients, in whom two clinical pregnancies were established.¹

In their references the authors fail to include an excellent paper by Hendry *et al.*² This reported a double blind, placebo controlled crossover trial in which 48 patients participated, with 18 months of follow up. This was a well designed study and showed a significant improvement in the pregnancy rate during steroid treatment compared with placebo treatment (31% *v* 10%).

We are conducting a similar trial of cyclical steroids. Until we have identified the different prognostic groups we are offering the treatment to men with antibody titres greater than 10%, regardless of the other semen variables, as long as investigation of the female partner shows no abnormality. A preliminary analysis of our results in this relatively unselected group of patients (30 patients and 105 cycles of treatment) suggests a cumulative pregnancy rate of 20% at four months of treatment. From previous work in this department these patients would be expected to have a cumulative pregnancy rate of only 4% at four months without treatment.

We think that although in vitro fertilisation with specially prepared semen will undoubtedly have a role in the management of these patients, particularly when there are other abnormal semen variables or female factors to be considered, cyclical steroid treatment will continue to be important, especially for those who do not have access to in vitro fertilisation.

M J PEARSON
C L R BARRATT

Department of Obstetrics and Gynaecology,
University of Sheffield,
Jessop Hospital for Women,
Sheffield S3 7RE

1 Grundy CE, Robinson J, Guthrie KA, Gordon AG, Hay DM. Establishment of pregnancy after removal of sperm antibodies in vitro. *BMJ* 1992;304:292-3. (1 February.)

2 Hendry WF, Hughes L, Scammell G, Pryor JP, Hargreave TB. Comparison of prednisolone and placebo in subfertile men with antibodies to spermatozoa. *Lancet* 1990;335:85-8.

The Bevan factor

SIR,—Those who believe that Nye Bevan would have had any truck with the NHS reforms do him a great disservice.¹ *In Place of Fear* sets out his

aspirations.² In the 1930s many lived in fear without hope. He wanted to create a system in which there was hope. It was not a vision of safety nets for the poor but of services all could use confidently.

"Society becomes more wholesome . . . healthier . . . if [citizens know that] not only themselves, but all their fellows have access . . . to the best that medical skill can provide." He believed that the service should not be influenced by self interest. "Economic man" and medicine, he believed, did not mix. The new system is propelled by self interest and financial incentives. General practitioners, he considered, "should be able to earn a reasonable living without having . . . a register . . . too large to allow good doctoring."

He saw the NHS as a triumphant example of collective action applied to "a segment of society where commercial principles are seen at their worst." Danger arose "at the point where private commercialism impinges on the service." So he would have not had sympathy with internal markets, which like insurance systems might be expensive, create anomalies, and cause "chaos of little or big projects." Extracontractual referrals would have been seen to create "frontier problems," destroying the "essential unity of the Service," and no system that delayed care until it was clear "that money would follow the patient" could have met with his agreement. Charity funding ("warm gushes of self-indulgent emotions") and the use of the voluntary sector would have been resisted lest they gave rise to "a patch-work quilt of local paternalism."

His enthusiasm for preventive medicine was tempered by his sympathy for the individual. "Not even the apparently enlightened principle of the 'greatest good for the greatest number' can excuse indifference to individual suffering," he said after quoting Dylan Thomas, "After the first death. . ."

He would have found the current tax debate familiar: "There being nothing in the public exchequer which was not wrung from the reluctant taxpayer, communal need and private greed were in constant war with each other." He felt he had created an institution protected from attack, and prophesied, "No political party would survive that tried to destroy it," unless it was destroyed "stealthily and in such a fashion that they appear to have no responsibility" for its destruction. Is stealth succeeding?

J A ROBERTS

London School of Hygiene and Tropical Medicine,
London WC1E 7HT

1 Warden J. The Bevan factor. *BMJ* 1992;304:338. (8 February.)
2 Bevin A. *In Place of Fear*. London: Heinemann, 1952.

Goya's living skeleton

SIR,—Geoffrey Hooper offers an alternative diagnosis of fibrodysplasia ossificans progressiva (formerly known as myositis ossificans progressiva)^{1,2} to explain the physical abnormalities of Claude Seurat, the "living skeleton."³ Unfortunately, the contemporary descriptions of Claude Seurat do not fulfil the triad of clinical features associated with this disorder: hard swellings usually over the shoulder girdle and trunk; deformities (scoliosis and torticollis) secondary to the developing swellings; and a short great toe or deformity of the thumb.² Contemporary accounts record Seurat's hands as "semi-flexed" and his feet as "well formed; a trifling overlapping of the toes is probably accidental."⁴

RICHARD PARK
MAUREEN PARK

Glasgow G46 6NY

1 Hooper G. Goya's living skeleton. *BMJ* 1992;304:509. (22 February.)

2 Wynne-Davies R, Hall CM, Apley AG. *Atlas of skeletal dysplasias*. Edinburgh: Churchill Livingstone, 1985:547.

3 Park RHR, Park MP. Goya's living skeleton. *BMJ* 1991;303:1594-6. (21-28 December.)

4 Hone W. *Every-day book*. Vol 1. London: Hunt and Clarke, 1826:1017-34.

Restricted entry to the tamoxifen trial

SIR,—Following the Medical Research Council's decision to restrict the tamoxifen breast cancer prevention trial to women at very high risk of developing the disease, the two major cancer charities have decided to do without the council's support. In view of the public interest in this matter I thought it might be helpful to the clinical community if I set out the council's reasons for its decision.

After comprehensive peer review members of the council continued to be worried by aspects of the toxicology of tamoxifen and by the proposed patient information leaflet.

The concerns about toxicology centre on the fact that tamoxifen induces liver tumours in rats at doses that, because of bioaccumulation in humans, can be considered to be similar to those to be used in the trial; there is therefore no dose or safety margin. The rat tumours are unusual in that they do not follow the normal pattern of hepatocarcinogenesis induced by steroids and are highly malignant.

An additional factor was that tamoxifen has recently been shown to form DNA adducts in rodents. This work has been published in the United States¹ and confirmed at the Medical Research Council's toxicology unit. There are still uncertainties concerning the suitability of the rat as a model, and so the toxicology unit is carrying out urgent studies of the metabolic pathways of tamoxifen in rats, mice, and humans.

Few women have received tamoxifen for longer than five to seven years, whereas the maximum incidence of liver tumours induced by known carcinogens occurs at eight to 10 years.

In view of these concerns the council emphasised that the issues should be set out clearly and explicitly in the patient information leaflet so that women could make a fully informed choice about entering the trial, and that the trial should go ahead only in women aged 40 and over who were at very high risk. This group would include women with a fourfold and greater risk of developing breast cancer. The charities have decided that the Medical Research Council will not now have a role in the study; the toxicology unit's studies are, however, continuing.

The council has no wish to spread alarm among women taking tamoxifen for proved breast cancer, for which it is a well tried and effective treatment. The council has taken the view, however, that until more evidence is obtained to inform better risk-benefit calculations for using tamoxifen in prevention the best course is to proceed with caution.

D A REES

Medical Research Council,
London W1N 4AL

1 Han X, Liehr JG. Induction of covalent DNA adducts in rodents by tamoxifen. *Cancer Res* 1992;52:1360-3.

Acute medical beds could be cut

SIR,—P J Toghiani's fears¹ about the implications of the Audit Commission's report on the management of acute beds² are based on misunderstandings. A 30% cut could not be made in the number of medical beds in isolation, nor is it suggested that wards are standing empty. Paragraph 58 of the report states:

If all districts could achieve lengths of stay and turnover intervals at least as low as the current best 25 per cent of districts (even after allowing for the

effects of age), there would be the potential to provide the current level of activity in medicine with 58 000 beds rather than the 85 000 currently in use. Part of the reduction would result from removing the organisational inefficiencies identified in this report. This would also do much to improve the quality of patient care. But the reduction could not be achieved without investment in community services to enable the lower quartile of standardised length of stay to be achieved. Such changes will take time and must be achieved against a background of careful monitoring of health care outcomes to ensure that they do not deteriorate.

The need for medical beds depends on both length of stay and the appropriateness of admissions.¹ The decision to admit is a professional one and is primarily for medical audit rather than the "organisational audit" carried out by the Audit Commission, although issues such as the seniority of the doctor with authority to admit were considered in the report. The Audit Commission has emphasised that the main concern is to identify the reasons behind the wide variations in length of stay and the provision of beds.⁴

Not all the influences on bed requirements will be directly under the control of the health service. Time spent waiting for ward rounds, investigations, or their results and the arrangement of transport home are, however, potentially avoidable. Variations in practice (like differing median lengths of stay) could be brought to the attention of clinicians. The resources saved should be redirected to community services, allowing swifter discharges and fewer inappropriate admissions or unnecessary readmissions. The mechanisms for ensuring the appropriate and efficient use of these resources are also within the Audit Commission's remit.

Analysis of organisational efficiency and variations in performance indicators is the basis for total quality management.⁵ The Audit Commission's report is original and important and is to be welcomed.

ROWAN H HARWOOD
JANE S LAUGHTON

London WC1X 9NB

- 1 Toghiani PJ. Acute medical beds could be cut. *BMJ* 1992;304:381. (8 February.)
- 2 Audit Commission. *Lying in wait: the use of medical beds in acute hospitals*. London: HMSO, 1992.
- 3 Smith HE. Acute medical beds could be cut. *BMJ* 1992;304:381. (8 February.)
- 4 Boyce J. Bed cuts in perspective. *Health Services Journal* 1992;102:17.
- 5 Berwick DM, Enthoven A, Bunker JP. Quality management in the NHS: the doctor's role. *BMJ* 1992;304:235-9. (25 January.)

Voting on trust status for St Mary's Hospital, London

SIR,—A headline in the news section recently stated that a meeting of 100 consultants and medical students had voted overwhelmingly against trust status for St Mary's Hospital, London; this is totally misleading.¹

What was reported was the result of a debate on trust status for St Mary's, organised by the medical school's debating society. I would not call this event representative of opinion at the hospital. What is statistically more valid is that before St Mary's Hospital pursued its successful application for trust status a ballot of consultant medical staff—organised by themselves—produced 75% support for trust status. At the time of this ballot just over a year ago the result was fairly unusual in its degree of support for trusts, particularly among teaching hospitals.

Reflecting on the decisions of the past, however, is rarely productive. It is the future that is more important, and as a trust St Mary's Hospital will be building on its achievements during the current year: 3% more patients treated in the first nine months; no patients waiting longer than two years

for admission; a deficit for the year of less than 0.5% of total turnover; and an expansion of several clinical services in 1992-3.

NEIL J GOODWIN

Chief executive,
St Mary's Hospital,
London W2 1NY

- 1 Headlines: St Mary's opposed to opting out. *BMJ* 1992;304:334. (8 February.)

Contraception for the under 16s

SIR,—In her article on under 16 year olds attending family planning clinics Luisa Dillner says that the news that the numbers have substantially increased over the past 10 years has "reopened the debate on how accessible contraception should be to children under 16." Another debate throughout that decade, however, has been between those who provide contraceptive advice and services to the young and those who observe the results of their efforts in terms of the sexual behaviour and reproductive health of teenage girls.

In 1976, a year after contraception became freely available on the NHS, 23 per 1000 girls under 16 attended family planning clinics in England. Eight years later the rate had more than doubled to 49 per 1000.² During that period the rate of under age conceptions rose from 7.9 to 8.6 per 1000 and abortions from 4.2 to 4.8 per 1000.³ In addition, the medical profession was becoming seriously worried by the rapidly escalating incidence of malignant cervical cancer among ever younger women, with a 50% increase in the number of positive smears in women under 25 since 1970 and a 60% increase in the incidence of precancerous cervical lesions since 1965.⁴

In 1984 the Court of Appeal, in the "Gillick case," outlawed secret contraception for schoolgirls, causing the rate of uptake of contraception to fall by a third during the following year, to 33 per 1000. When the conception and abortion rates remained unaltered in 1985 family planners concluded that the thousands of girls who had been unable to obtain contraception in secret had either used non-prescriptive methods or had abstained from sex altogether.⁵ Despite this welcome halt in the rise of under age pregnancies family planners were relieved when the final ruling by the House of Lords in 1985 reinstated the policy of secrecy, albeit only in the "most exceptional cases."

Six years have now passed since that ruling, during which the following have occurred:

- (1) Prevention of AIDS has formed the basis of all sex education, with the government, media, schools, and teenage magazines bombarding the young with propaganda on safe sex and use of condoms.
- (2) Whereas an estimated 1 in 7 girls in 1986 had had under age sex, the figure is now between 1 in 3 and 1 in 2.
- (3) Contraception among schoolgirls has reached its highest level of 67 per 1000.²
- (4) The number of girls under 16 requesting postcoital contraception for possible pregnancies increased by 50% between 1989 and 1990.²
- (5) Under age pregnancies have reached their highest recorded rate of 9.4 per 1000.³
- (6) Sexually acquired infections, such as chlamydia infection, that may impair reproductive ability are now at epidemic levels among teenage girls.⁶

We should consider the words of Brudenell, who was clearly ahead of his time when he wrote in 1980:

The gynaecological problems of sexual activity in young teenagers are well defined and relatively easy to deal with. Virginity, however, remains a state which, although no longer highly prized, has much to recommend it. The price that young girls may pay for having sexual intercourse would seem to be too high. The time has come to say quite clearly that it is wrong for

girls in their early teens to have sexual intercourse. The pleasures of sexual activity, including those of pregnancy and childbirth, will then be enjoyed in their more mature years without previously acquired gynaecological problems.⁷

VICTORIA GILLICK

Inform,
Wisbech,
Cambridgeshire PE13 1NJ

- 1 Dillner L. Increase in 16 year olds attending family planning clinics. *BMJ* 1992;304:275. (1 February.)
- 2 Department of Health Statistics Division. *Family planning clinic services 1976-86*. London: DoH, 1987.
- 3 Office of Population Censuses and Surveys. *Trends in conceptions to women resident in England and Wales*. London: HMSO, 1989. (Series FM1).
- 4 Cervical cancer hits younger women. *General Practitioner* 1984 Sept 28:3.
- 5 Kirkman RJE, Meads A. Family planning and society: was Mrs Gillick right? *British Journal of Family Planning* 1987;12:134.
- 6 Smithson A. Girls will be women. *Nursing Times* 1992;88:46-8.
- 7 Brudenell M. Gynaecological problems of the sexually precocious teenager. *Modern Medicine* 1980;25:45-7.

Commercialism in the NHS

SIR,—It is a shame that in his editorial on private practice Jonathan Boyce did not address some of the real issues that will severely test the uneasy relation between the NHS and the private health sector if the Tory party is returned to government this spring.¹ The Labour party talks of creeping privatisation—an accusation flatly rejected by William Waldegrave. What then should we make of the situation arising in my health district?

Local hospitals have published scales of charges for, among other things, outpatient consultations. Shortly after these were issued fundholding general practitioners were circulated with discount price lists produced by the very same consultants offering to hold clinics in general practice surgeries, the money of course going direct to the consultants. Presumably this work would be done in their own and not NHS time. And why not, some may ask: the general practitioner's budget benefits, the consultant gains, and of course the patient gets five star care. And the hospital? In this new free market health service how should we view such trading practices: as equivalent to an electrician working for a national generating company who moonlights at weekends, or perhaps more to a director of a retail company working the odd session for a competing company? Somehow I do not think that the director's main employer would tolerate it; should our employers?

As the number of fundholding practices increases just how much non-NHS time will consultants have to provide this upper tier of a two tier service? All we can hope is that Labour is returned and that it sticks to its promise of returning trust hospitals to health authority management and abandoning fundholding practices. Otherwise, watch out for the iron fist of commercialism, which will seek to preserve the interest of the hospital above all else—and who could dispute that?

ADRIAN R SCOTT

Derbyshire Royal Infirmary,
Derby DE1 2QY

- 1 Boyce J. Private practice. *BMJ* 1992;304:458-9. (22 February.)

Prison medicine

SIR,—The case for an independent prison health service has been put by several authoritative advocates. Consistent accounts of unethical medicine in prisons in the United Kingdom reflect on those concerned but also on the rest of the medical profession through its failure to exert the pressure necessary to bring about change.^{1,2}

Harding argues that among other factors it is the practice of medicine within the system—that is, the prison service, with its remit to reconcile the