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.

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- 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.

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- 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

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- 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?

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- 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