and alone. The loss of, and dearth of recruitment of, public health and community medical officers has been a tragic loss to the public service. No less grievous has been the eclipse of the former chief administrative officers of public health departments. These irreparable losses of expertise represent a setback to the expectations of community medicine which will take many years to overcome.—I am, etc.,

KENNETH VICKERY
Community Physician

Eastbourne

### Contraceptive Services

SIR,—Anyone reading Dr. M. V. Smith's letter (6 July, p. 46) stating that the Family Planning Association gave "wholehearted support for the decision to impose no age limit on supplies of contraceptives, following appropriate consultations," might be forgiven for believing that this "support" was the result of wide-ranging democratic discussion with F.P.A. clinic doctors who, along with nurses and lay workers, do the actual work. There was no such discussion. In fact, the first that clinic doctors knew about it was a public statement from the F.P.A.'s Executive in February 1973 calling for free contraceptives "irrespective of age." As chairman of a family planning doctors' group I protested at the time to the appropriate doctors' chairman on the F.P.A. Executive. I never had any satisfactory explanation and the F.P.A. continues to give the impression that an unqualified "no age limit" is acceptable to clinic professional staff.

Now that the Department of Health and Social Security and the F.P.A. have gone one step further and given "guidance" to doctors that the pill can be given to under 16s without parental knowledge, it is surely time that it was known that the much-vaunted democracy of the F.P.A. policy-making is a farce. Clinic doctors (who do the work) are only "advisers" in the F.P.A. and have a very small voice on committees —a voice that is easily (and often) ignored in such policy making. Luckily our contract still gives us clinical independence.—I am, etc.,

ELIZABETH ELLIOTT

Wisbech, Cambs

SIR,—I would like to take up Dr. M. V. Smith (6 July, p. 46) over his description of local health authorities who freely distribute contraceptives without imposing an age limit as "progressive and far-sighted."

"Progressive" they may be, for it is a term of doubtful merit—we all know examples of progress backwards. But "far-slighted"? Is it really far-sighted enough not to discourage young people who want sexual experience before marriage? I am aware of no objective research on this matter, but my impressions are that there are many older people who now deeply regret sexual experimentation in their youth; and I am inclined to believe that more stable marriages result between couples who were virgins before marriage. Certainly swapping of sexual partners before marriage often goes on to swapping after as well.

If this is so, surely it is more far-sighted —though much more difficult—to do everything we can to encourage young people to remain chaste and self-controlled rather than to offer them contraceptives without warning.—I am, etc.,

W. G. BENSON

Kennford, Exeter

SIR,—Closure of the debate on the Annual Report of Council under "Family Planning" (A.R.M. 2, para 13) at the Annual Representative Meeting in Hull prevented me from voicing what I feel must have been in the minds of many Representatives at the meeting that it is insufficient for the report to state the doctor's responsibility for the physical and mental care of our patients, however willing or otherwise they may be to participate in an all-embracing advisory service on contraception, without issuing a warning to society at large that the consequences of permissiveness, in the young in particular, could endanger the preservation of the family unit as the basis of all civilized society and run the risk of uncontrollable disease in the future. Either or both of these consequences could imperil survival of a sound social structure and I feel we would be failing in our duty as doctors if we remained silent on so important a matter.

*The Times* of Friday 12 July reported that a girl of 12 had given birth to a son in West Hill Hospital, Dartford, Kent, and that mother and child were doing well. One is tempted to amend this statement to read that both children were doing well and point out the distressing and worrying background, known to doctors and social workers in innumerable similar cases. A moment's thought would, I think, convince all those concerned with the future welfare of this country that further thought should be given to sex education, the degree of irresponsibility of the young to the jeopardy of their future, and the resulting undoubted acute misery in human relationships, the consequences of which must be the concern of doctors, educationalists, and politicians alike. —I am, etc.,

BERNARD HALFPENNY

Maidstone

### "Market Research" on Private Practice

SIR,—I was approached today by an organization calling itself the Specialist Research Unit asking me to give them an interview. I established that they were in fact a market research organization and I gave the inevitable groan expecting that I was to be queried why I prescribed brand X rather than brand Y and wouldn't it be better if I used new brand Z. However, it appeared I was required to give an hour of my time so that my attitudes to private practice could be evaluated. The area manager of the firm would not (or could not) disclose the name of their client.

In view of the present political climate I declined the interview as I believe that the attitudes of the profession at this moment should not be available to sources which might quite easily use such information to the profession's detriment.

I write to you in order to warn my colleagues that they may unwittingly agree to such an interview without being aware of its nature.—I am, etc.,

M. J. OLDROYD

Birstall,
Batley, Yorks

### Democracy in the Health Service

SIR,—"Democracy in the Health Service" is the self-assertive title given by the Secretary of State for Social Services in the Labour Government to a paper published recently.[1] It criticizes the National Health Service Reorganization Act 1973 for being bureaucratic, appointive, and undemocratic in that it "deliberately separates responsibility for managing the Health Service from responsibility for representing the views of the public as the consumer." This, it says, "is to challenge in a fundamental way the essence of democratic control."

The Government's proposals centre primarily on giving greater power to local authority councillors. The paper states that at least half of the nominees of the community health councils to the area health authorities should be local authority councillors and that one-third of the members of regional and area health authorities should be drawn from local government. Furthermore, R.H.A.s are encouraged to attach weight to prior service on C.H.C.s when making appointments to A.H.A.s Despite all this deliberate inbreeding, the document in a moment of supreme naivety states that "all members of health authorities should participate fully and objectively. . . . It will not be their responsibility to represent local authority, staff or Community Health Council interests."

The following points occur to me.

(1) Community health councils would become yet another arena for party political warfare. The prize of membership of a health authority would be up for grabs, local authority nominations to C.H.C.s (half the membership) would be in the patronage of the majority party, and in time even the other half of the membership, made up from voluntary organization nominees and R.H.A. appointees, might develop an increasingly party political complexion. To active party politicians this might seem to be a good thing and indeed they might question whether health and welfare could ever be other than party political issues. Seen from the other side, however, I wonder how many people who are actively working in health and welfare, or giving help in some form, would consider themselves to be active party politicians. It seems a pity that those who do not should be shouldered away.

(2) Party politicians will remain party politicians whatever authority they serve on, otherwise their prospects for re-election by their own party, let alone by the public, would be bleak indeed. Thus all authorities will become increasingly party political and the situation in health will resemble that in education. In the prevailing two-party system some authorities will chop and change their plans according to whichever local government is in power and other authorities will have their plans chopped and changed for them according to whichever national government is in power.

(3) In time the medical and nursing professions will be outnumbered on the various authorities by previous or current local authority councillors and others with party political loyalties. Then the true purpose of Mrs. Castle's paper will have been achieved —the professions will at last be ensnared; they will have the trappings of representation but in practice will be the servants of the ruling political party, who alone, in the

name of the people, define what is true democracy.—I am, etc.,

ROBERT LEFEVER

London S.W.7

[1] Department of Health and Social Security, *Democracy in the National Health Service: Membership of Health Authorities*. London, H.M.S.O., 1974.

### Financial Allocations for N.H.S. Staff

SIR,—At this time, when so many problems in the N.H.S., particularly staff discontent, appear to be getting critical and the dangers at long last generally recognized, I would like to draw attention to a most important financial factor which is, I am sure, not generally recognized, believed, or understood.

For some years it has been consistent financial administrative practice and policy to provide funds for staff, particularly nurses, on a basis of less than the agreed optimum establishment. Figures for hospital nurses are obtained from nurse:bed ratios, averaging 100 nurses per 100 beds in some hospitals but with higher ratios allowed for heavy dependency cases such as neurosurgical and maternity and lesser figures for some other types of patient. Finance is then made available for 90% of this figure and sometimes cuts are made in this if recruiting has been poor recently, the assessments being made on the numbers of people likely to be in post. Similar restrictions are imposed on other grades and types of staff to varying extents. Consequently attempts to recruit up to establishment are met with allegations of overspending and are thoroughly inhibited. (There are no doubt minor variations from the formula in different regions but the general effect is similar.)

It follows that the existing staff, already inadequate in numbers, become overworked and stressed by the increasing and continuing sophistication and rate of patient turnover in hospital practice; this becomes known, recruiting becomes more difficult, and the numbers in post even less. The financial allocations consequently dwindle further and the vicious circle progresses. Bed closure is only a temporary solution, as it can lose more funds eventually so long as this type of assessment is practised. I have watched this process, in spite of many protests, during four years' service on a hospital management committee, culminating in the temporary closure of one large general hospital to admissions in 1973.

The reason I write now is to emphasize that, whatever benefits to individuals are obtained as a result of the protests by various groups of hospital staff and the forthcoming review of the pay of nurses and paramedical staff, there will be no benefit to the N.H.S. or to the working conditions of hospital staff until finance is provided to cover the full agreed optimum staff establishments. Then, and only then, will it be possible to try to recruit to the agreed figures (or employ alternative grades of staff or labour-saving devices in lieu) and to work out for future developments of the N.H.S. what is really needed. Otherwise the vicious circle will inevitably reappear in a year or two.

Many working in the N.H.S. are aware of this problem, but I do not believe that it is well known to the general or even the professional public and certainly its significance is not understood by many of the lay members of the committees and authorities charged with our management. Being no longer a member of such a committee, I now feel free to express my views on this subject in public. I would even go so far as to suggest that no N.H.S. pay award be accepted unless enough funds are voted to let it cover the agreed establishment as opposed to the numbers presently in post—particularly since it is understood that the pay award arising from the review will be covered by a supplementary estimate and not taken out of existing N.H.S. funds.—I am, etc.,

P. M. BRETLAND

X-ray Department,
Whittington Hospital,
St. Mary's Wing,
London N.19

### Rescuing the N.H.S.

SIR,—At last we have as a profession captured the headlines of all the daily newspapers and not simply on the narrow issue of private medicine, important though this may be as a principle. Initially there was the terrible danger that we might once again be misconstrued by the public, but I would like to suggest that the following points will have dispelled criticism from most quarters.

(1) That at last we are pressing for realistic financing of the N.H.S. and social services in the form of a demand for a critical evaluation and an immediate injection of £500m.—£40m. will just not do.

(2) That at long last we are joining forces with the other health professions as a united front, instead of selfishly guarding our own interests.

(3) That the B.M.A. is now prepared to take radical action on behalf of doctors if the N.H.S. is not rapidly rescued.

Let all of us in the health professions from now on constantly apply pressure both locally and centrally to improve the lot of nurses, all other N.H.S. employees, and the N.H.S. in general.—I am, etc.,

ANTHONY E. HARDMAN

Oxford

SIR,—There can be no doubt that this country is facing an exceedingly serious financial crisis. We must recognize the likelihood of an inevitable lower standard of living, possibly for some years, if we are to survive as a prosperous nation without serious hardship for the less fortunate.

At the risk of being considered naive, I wish to suggest that the medical profession should take the initiative in accepting a voluntary reduction of salary. I realize only too well the great difficulties of such a proposal. One aspect concerns pensions; these should not be reduced and should a salary increase be successfully negotiated, pensions should be based on this, even though a part or the whole of the increase was voluntarily not taken up. Nevertheless, I think that such an action would be wise and forward-looking, and preferable to a compulsory salary reduction which could happen later as a governmental measure similar to the previous "Geddes axe."—I am, etc.,

J. S. MITCHELL

Department of Radiotherapeutics,
Addenbrooke's Hospital,
Cambridge

### Industrial Action and the Patient

SIR,—Nurses, technicians, radiographers, and ancillary hospital workers have a just grievance about their poor pay and conditions. They have all my sympathy. In recent weeks, however, in company with several medical colleagues, I have been watching with increasing anguish and revulsion the distress, suffering, and danger to life and health of patients resulting from industrial action by these professions. Yet it would seem that we doctors, who have been observing all this, are now only too eager to initiate similar action ourselves. The myth that such action can be successful without harming the patients is no longer tenable, as it has been exploded before our very eyes.

I should like to appeal to all those of my colleagues who think that industrial action by doctors is not morally justified to let their voices be heard in public, lest each of us should think that he is alone.—I am, etc.,

THERESA LAZAR

Birmingham

### Finance and the Health Service

SIR,—It would be disastrous if the present dispute over private beds in N.H.S. hospitals were allowed to obscure the more important issue of the adequate financing of the Service as a whole. The profession must make it clear that they are concerned with the standards of pay at all levels in the N.H.S. and not solely with their own. We must not let ourselves be manoeuvred into defending the wrong issues.

It may be useful for a whole-time paediatrician, in a specialty in which private practice is almost non-existent, to make some comments before the whole situation is confused by polemic. There are, for example, two points which should be disposed of. Firstly, the suggestion that the conversion of private beds to public beds in the hospitals will make a significant reduction in waiting lists. This can be seen to be obvious nonsense when one looks at the very small number of private beds in acute hospitals. Secondly, some doctors have argued that private practice is necessary for the maintenance of standards in the N.H.S. This seems to me to be a rationalization which is insulting to full-time consultants and shows a "second-class" attitude to N.H.S. patients. Naturally a large private practice will divert time and energy away from academic work, committee meetings, and teaching, but the distraction is less if both private and N.H.S. beds are under the same roof, and not miles apart. At present the private patients in an N.H.S. hospital are supported by a resident staff and the whole technological backing of a modern hospital. To remove private patients completely from the N.H.S. hospitals would encourage the growth of private hospitals or clinics which would be either well staffed and well equipped and ruinously expensive (oil sheikhs only) or inadequately equipped to deal safely with serious illness.

The financial constraints placed on the N.H.S. by a series of governments are producing a deteriorating standard of care which can result only in an increased demand for private practice. Also an increasing number of consultants will find that private practice