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We may return unduly long letters to the author for shortening so that we can offer readers as wide a selection as possible. We receive so many letters each week that we have to omit some of them. Letters should be typed with double spacing between lines and must be signed personally by all their authors, who should include their degrees. Letters critical of a paper may be sent to the authors of the paper so that their reply may appear in the same issue.

*Correspondents should present their references in the Vancouver style (see examples in these columns). In particular, the names and initials of all authors must be given unless there are more than six, when only the first three should be given, followed by *et al*; and the first and last page numbers of articles and chapters should be included.*

Starting medicine: the basic medical sciences course

SIR,—Preclinical education was accurately portrayed by Professor Peter Richards (27 August, p 597). Having recently completed this part of my medical education, however, I feel the need to raise four issues, which were conspicuous by their absence and which may be of some interest to your readers.

Firstly, the number of students on medical courses has risen beyond the point at which schools are able to maintain standards. Impersonality between students and staff may be inevitable, but what about between students themselves? Practical classes are generally very large and a good standard of supervision hard to maintain. Tutorials, ever increasing in size, have, in some cases, been abandoned altogether. Introductions such as closed circuit television do help, but most staff and all students are dissatisfied with a system that encourages schools to take ever increasing numbers of students in order to maintain research facilities.

Secondly, the role of lectures in the curriculum remains controversial, but there is no sign of reform. Course exams are naturally based on lecture material, but with a very variable standard of lecturing this can be justified only if printed lecture notes are made available (at the student's expense). In some way students must have more time made available for study; printed lecture notes would bypass the need for reorganisation of the curriculum by giving students the basic information, with an option of private study.

Thirdly, the quality of preclinical teaching is dependent on making the job attractive enough to talented enough people. Fewer and fewer preclinical departments have qualified medical staff working in them helping to keep pre-clinical courses on the right track. I under-

stand this is largely a question of pay. With the quality of our future doctors at stake the amount of money this entails has to be relatively insignificant. Cannot the pay of preclinical teachers be in some way brought into line with the pay of clinicians, say, according to the amount of time spent teaching preclinical students? Alternatively, can we not teach a subject such as physiology in the hospital, without integrating the whole course?

Fourthly, there are important subjects such as neurobiology and endocrinology that cross departments. Despite individual departments' efforts at cooperation basic misunderstandings

can creep in due to this arrangement. This cooperation might usefully be replaced by symposiums with relevant departments teaching together.

With our current economic climate there is strain at every level in all areas of public service. Both the Health Service and the universities are affected. Medical education is thus doubly under threat, and vigilance is required by those with power lest we be caught with no oil in our lamps.

C J SPENCER-JONES

Bristol BS8 4AN

Giving up smoking—are we giving up?

SIR,—The publication of the results of the Australian North Coast "Quit for Life" programme (15 October, p 1125) comes at a very opportune time. This highly commendable programme promoting healthy lifestyles showed that the imaginative use of the media, with and without supporting community programmes, can have an appreciable effect in reducing the prevalence of smoking beyond the short term. Comparable results from similarly styled programmes have recently been reported in southern Australia by the South Australian Health Commission (J Cowley, unpublished observations). In the United States and Finland the value of the planned use of the media in giving up smoking has been known for some time.¹⁻³

In Britain, however, with the highest prevalence of smoking related disease in the world, the use of mass media seems to have fallen into disrepute. The results of some initiatives have

not reached the perhaps over ambitious levels expected of them.⁴ As a consequence, it seems, the Health Education Council's programmes for 1983-4, which have just been published,⁵ de-emphasise mass media initiatives, particularly regarding giving up smoking in the general adult population. The results from New South Wales highlight the importance of the professional marketing of the health message in combination with the parallel development of supportive community programmes. Past British initiatives have tended to be isolated without ongoing support at primary care level. Should not the use of mass media in Britain be reconsidered in the light of the Australian experience?

Broad based programmes directed at encouraging more people to give up smoking which include media, professional, and community action are justifiable on four counts: (a) they work, as shown by Dr Eggar and his