CHC NEWS

For Community Health Councils

November 1976 No. 13

Dr David Owen talks to CHC NEWS on the publication of his new book

In Sickness and in Health

"The decision to establish community health councils will probably be looked back on by social historians as the most significant aspect of the whole of the NHS Reorganisation Act 1973. For the first time there exists a strong consumer voice to both criticise and champion the NHS."

This is the view of Dr David Owen who was, until last September, Minister of State for Health at the DHSS. In his 2½ years at the Department, he took a close interest in the development of community health councils, and several CHCs will, through meetings and correspondence with him, have been impressed and encouraged by his interest.

A book, based on his speeches has just been published, entitled *In Sickness and in Health* (Quartet Books, £4.95 cased and £1.50 paper). Dr Owen ranges over many important features of the NHS in these pages, but it is clear that the three issues closest to his heart were community health councils, resource allocation and preventive health.

Dr Owen believes that the CHC's influence and effectiveness depends absolutely critically on its access to relevant information. He thinks there should be a greater readiness among district management teams and area health authorities to give information to CHCs so that they may make informed criticism. Administrators at all levels should not use the administrative burden as an excuse for depriving CHCs of the legitimate information base they so badly need.

The role of the CHC secretary is crucial in determining the success or failure of the CHC, and hence Dr Owen believes it was very important to enable secretaries to be recruited from the widest possible field of applicants. But he is concerned about the wisdom of giving secretaries security of tenure, and wonders whether a 5-year appointment would be wiser, to protect those CHCs whose secretaries become "burnt-out". There will not always be people coming forward for CHC membership who have had past experience of the NHS through hospital boards and management committees, and while too much influence from the past is not desirable, there is a valuable repository of knowledge in members of this kind, which he feels will be missed if secretaries and other members lose their enthusiasm and drive. The need to look at health and personal social services together is a firm necessity, according to Dr Owen, and he thinks CHCs have a unique opportunity to ensure that this happens. He believes that the joint consultative committees must be built up, not as another bureaucracy, but as a mechanism for working across official boundaries and expecting people to work and plan in some areas of common concern as if they were part of one organisation. In the four key areas of community care: mental handicap, mental illness, physical handicap and the elderly he sees an overwhelming case for the involvement of CHCs (and voluntary bodies) on the district health care planning teams, although he recognises that this needs to be worked out locally.

On the question of closures, Dr Owen thinks CHCs have been given a very important power, and that their position is absolutely clear. It is a mutual responsibility for a health council and a management team to try to understand one another's viewpoint. They will not always agree, and when a contested closure comes before Ministers, he says CHCs can be sure that Ministers will read carefully what the CHC says if they put up sensible alternatives. Dr Owen emphasises however that Ministers must look for a reasoned, sensible case with an alternative costed option. They cannot be expected to be very interested by an argument which virtually amounts to no more than "hand off our hospital". "The inequalities of health care between different areas of illness and suffering . . . . . are totally unacceptable. And the present

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INSIDE...

YOUR LETTERS

SOCIAL SERVICES CUTS

from Eric Cohen, Member Southend CHC

In the August issue, Mr Alan Brookes writes about the "loopholes" in the Chronically Sick & Disabled Persons Act 1970 because of the definition of "need". Local authorities have constructed their own sets of criteria, and many are very stringent, thus acting to the detriment of the people who are supposed to benefit. Careful reading of Section 2 in particular, and the Act in general, shows that there is no justification for authorities taking the line they do and it is patently against the spirit of the Act and thus the will of Parliament.

Many people now consider the only remedy is to take suitable cases for testing in the Court to see whether the authority has carried out its statutory duty, or how it has been deficient in not doing so.

DENTISTS' PRESCRIPTIONS

from Fred J. Reynolds MPS, Member South Birmingham CHC

Dental Terms of Service (CHC NEWS, August) states: "a dentist is under obligation to issue the patient with a prescription for any drugs necessary for his treatment". It should be noted that from June 1st, 1976, drugs and preparations prescribable on FP 14 forms have been severely curtailed and only those items on an approved list will be paid for by the NHS. I am surprised that there has not been strong objection to the restriction placed on the dentists' freedom of choice of suitable medication on FP14. The dentist may supply and charge the patient for medication outside the list, but I believe this to be most undesirable and against the principles of the NHS service.

TRADES COUNCIL MEMBERS

from Andrew Harley, Member Brighton CHC

As one falling within this category, I am most aggrieved and equally bewildered to read in the column headed NEWS OF CHCs of your September issue, that a number of CHCs are upset and are indeed opposed to the inclusion of Trades Councils' representatives on these bodies. The grounds quoted therein for their objections are frivolous and hold no water at all considering the fact that at present half the membership of these are appointed by either the County or District Councils. So how could Trade Unionists introduce "an element of political bias" as feared by the objectors?

Also one must remember that when one uses such phrases as "Public freedom of choice" and "Public opinion" etc. Trades Councils are well and truly qualified to assert a right to these as they reflect the views of a massive section of the Districts' populace for, not only do they stand for themselves and their dependants, but also represent masses of workers in every walk of life, who, in turn comprise the public and contribute to the Services in the NHS.

and John R. Hunter, Member King's Lynn CHC

It was with some astonsishment I read your report of the remarks of Jack Humphrey, Chairman of West Somerset CHC in regard to the DHSS directive concerning Trades Council representatives on CHCs. As a serving member of King's Lynn CHC representing a local Cancer Research Group, and at the same time happening to be a member of Wisbech Trades Council I feel he has formed a totally wrong conception of the role of Trades Councils. They are not affiliated to any party. I personally am not a member of any political party. Trades Councils represent local workers of all types in their neighbourhood regardless of those workers' political opinions.

I fail to see how this particular directive can in any way reduce "the public's" fredom of choice. Mr Humphrey would do better to concern himself with the almost complete lack of any freedom of choice in the appointment of members to both RHA's and AHA's.

SHORTAGE OF CHIROPODISTS?

from Mrs E. L. Rann, Member Sutton & West Merton CHC

In reply to John Pottinger's letter in CHC NEWS 11, is there really a shortage of chiropodists or is it that the Area or District Chiropodist will dictate to the elderly where they will receive treatment — i.e. they will go to clinics and not to private practitioners who can be engaged as contractual chiropodists under the Whitley Council agreement? Sometimes the elderly who have attended a chiropodist during their working life are told under the NHS they must go to a clinic when becoming an OAP. Of course the Area will tell you it is all a matter of costing, but this exercise has been carried out and the private chiropodist proved to be less costly per patient. The Health Service like many other services is becoming a closed shop. It is so tied up with politics to the detriment of the patient.

RAISED GARDEN BEDS

from Mrs R. S. Kinsey, Chairman of Gardens for the Disabled Trust

At last a raised garden bed for the use of disabled people that permits the gardener to sit facing his work, as at a table. The Rosum Easygrow System was specially designed for the Gardens for the Disabled Trust, and can be supplied through them. Made in fibre-glass, these beds are both durable and good to look at, they are manufactured in units that bolt together, so that sizes range from 5ft 6ins. by 4ft to 17ft by 4ft. Drainage of the soil is carried out through the central pedestal which is filled with rubble. The depth of soil is 4ins. at the edges and 18ins., or more in the centre. Supplied through the Gardens for the Disabled Trust, Headcorn Manor, Headcorn, Kent, TN27 9NP. Price £80 (smallest size), excluding VAT and carriage.

COMPLAINTS CODE

from Ann Shearer, Campaign for the Mentally Handicapped

We note that the Code of Practice for handling suggestions and complaints does not cover the role of community health councils in any detail because they are not responsible for the investigation of individual complaints. But we cannot agree that the draft Code should therefore have excised three specific references in the Davies report to the ability of councils to help patient complainants (5.7, 5.12, 6.20). This means that the person complaining is deprived of the possible help of the CHC at three critical points — or may be: when he initially makes a written statement, when he is not satisfied with the outcome of an initial investigation and when he is told the result of a members' investigation (Draft, 3.6, 3.11, and 6.13). We find this quite wrong. We cannot agree either with the draft Code's excision of the Davies reference to CHCs in the suggested paragraphs for the staff handbook. (Draft, Appendix 1, Davies, Appendix 1). In view of the proven victimisation of staff who have tried to complain on behalf of patients in the past, we think it quite wrong that staff who wish to make such complaints in future should not have their attention drawn to the existence and interest of the CHC.

ARTIFICIAL LIMB CENTRE

from Barrie Taylor, Secretary SW Herts CHC

Members of SW Herts CHC visited the Limb Fitting Centre at Roehampton recently. They were impressed at the evident care being taken to put the patients' needs first. In CHC NEWS No 6, the author of the report *"Amputation"* drew attention to the plight of amputees who suffer unnecessarily because of the lack of liaison between medical and other staff at these Centres.

Our experience was quite the opposite. We found communications between staff and departments to be working well, and advances in technology being used for the patients' benefit.

We welcome all letters from our readers but request that they be kept short so that as many as possible can be included. We reserve the right to cut any contributions for reasons of space, and particularly those over 150 words.

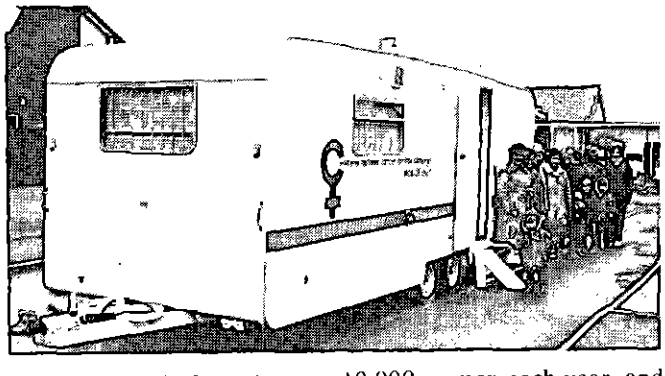
♀ Cancer prevention in women

Screening women for cancer of the cervix is taken for granted now, but before 1964 it was only available on a very limited basis. Studies have shown that the disease develops in distinct stages, and that screening in the early, pre-cancerous stages can identify women needing early treatment, and can thereby lead to a reduction of 50% in the death rate.

Some local authorities made the screening available from their clinics under Section 28 of the National Health Service Act 1946, but it was not until 1966 that the Chief Medical Officer of the Ministry of Health issued a circular announcing the availability of a comprehensive cervical cytology screening service under the NHS to all women, with special priority for those aged 35 and over.

The test is available from hospitals, GPs, health clinics, family planning clinics and certain voluntary organisations. In April 1973, women who had had 3 or more pregnancies were also made a priority group irrespective of their age, and in July 1974 a new form was issued for recording the tests done under the service and for facilitating the system of 5-yearly recall.

In 1974 about 2½ million cytotests were carried out in England and Wales. Women between the ages of 35 and 45, and particularly working class women who have had several pregnancies are at greatest risk of developing cervical cancer. Yet there is concern that although attendance at screening clinics is increasing, most of the people coming forward for the first time are younger than 35, and not in the priority groups. The use of mobile clinics can help to reach the women most in need of cytotests by taking the service to them instead of simply waiting for them to come forward. The Women's National Cancer Control Campaign has been particularly active in raising money to buy mobile clinics and encouraging area health authorities to use them in shopping centres, on housing estates, etc. and it has produced literature and films to help get the message across to the public. Not only have mobile clinics been shown to provide the test for relatively more of the high risk women, but they are also able to do the tests more cheaply than hospitals and clinics. So, from a cost-benefit point of view, mobile clinics have much in their favour, and the WNCCC is trying to let more people know about this.



For breast cancer the position is not yet so clear. The disease claims the lives of over 10,000 women each year, and is only curable if it is detected in its very early stages. Screening techniques are in the process of being evaluated and, at the moment, breast screening is not generally available under the NHS. Mammography, thermography and self-examination each play a part in early diagnosis, and there are now a number of breast clinics in hospitals which are reporting improvements in the survival rates.

But unless and until breast cancer screening methods become as effective as cervical screening, at least to those women who are at greatest risk, the success of early detection depends firmly on the vigilance of women and their general practitioners.

At a recent conference organised by the WNCCC, one participant described the case of a woman who had discovered a lump in her breast but was told not to worry about it by her doctor. She did worry, though, and went to see another doctor. He examined her and confirmed that she did have a lump which needed investigation. How isolated is this woman's case?

The WNCCC is determined to ensure that women learn about breast self-examination, and that the NHS makes facilities for early diagnosis available to those women known to be in high risk groups. Two other organisations which are promoting public education about cancer, and promoting more open discussion about methods of early diagnosis and treatment as well as prevention are: The Cancer Information Association, Marygold House, Carfax, Oxford, and The Tenovus Cancer Information Centre, Cardiff. The Women's National Cancer Control Campaign is at 1 South Audley Street, London W1.

In Sickness and in Health

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inequalities of health care between different income groups are a source of justified concern". Dr Owen emphasises, however, that these inequalities will not be corrected only by redistributing resources to the regions. A fundamental issue is to define an allocation system for areas and districts, and an important first step in doing this is to concentrate resources in primary care in poorly endowed areas.

He quotes research which shows that the middle class make more use of preventive services and may actually receive better care. But he does not think this should promote resentment against middle class NHS users; rather, there should be a more constant readiness to explore methods of improving the coverage of health care for everyone, and CHCs must ensure that the NHS is more responsive to consumer needs.

There are a number of preventative measures that CHCs should unequivocally investigate and provide according to Dr Owen. These are: screening for Down's syndrome in pregnant women over 40; fluoridation of water supplies; facilities for cervical cancer screening; a high standard of family planning service; effective and reasonable VD clinics; implementation by AHAs of chiropody services; anti-smoking clinics; services for alcoholism; body fitness classes; and possibly screening for breast cancer.

Dr Owen admits that CHCs cannot achieve these sort of goals alone; and that there needs to be a considerable change in attitudes, particularly on the part of the medical profession. "One interpretation of clinical freedom is that there is no need for an individual doctor to adjust either from or to a common medically agreed baseline or conception of need. This is a self-defeating concept . . . Clinical freedom . . . means responsibility, that is why so many doctors are afraid of facing up to the hard but true definition of clinical freedom, namely the responsibility it carries of involvement and the responsibility for choosing priorities within the totality of health care."

RESOURCE ALLOCATION -*the new formula*

As we all know, the supply of health services falls short of the demand for health care in this and other countries. So the available resources have to be rationed. In the past, this rationing was not fairly done, and richer places tended to remain better off, while poorer places became relatively poorer. Recently the necessity of making resource distribution more fair began to be recognised, and last year the Interim Report of the DHSS's Resource Allocation Working Party took a first step. It proposed a formula for distributing NHS funds to RHAs based on an estimate of the differential need for health care in each region which was adopted for 1976/77. On 29th September the second step in the process was taken with the publication of the Working Party's next report, called *Sharing resources for health in England*. If the DHSS adopts these new proposals, then from 1977/78 the distribution of NHS funds from Department to regions, from regions to areas and from areas to districts will become even more closely related to the need for health care that can be assessed for people in different parts of the country.

The basic theme of the 1976 RAWP report is that money for capital and revenue spending should be allocated to reflect the needs of the population according to a specially designed new formula. The formula enables populations to be seen not just as numerical groups, but as groups with particular health care needs. These needs are calculated by looking at the use made by men and women of different ages of hospital beds, out-and day-patient services, community and ambulance services and FPC administration, from region to region.

The formula also recognises the uneven historical spread of hospitals and other facilities, the fact that services are provided across administrative boundaries, and the different patterns of provision in London and South-East England, and in teaching hospitals generally. Perhaps the most significant feature of the new formula is that it makes considerable use of standardised mortality ratios (SMRs). The SMR compares the number of deaths actually occurring in a region with those which would be expected if the national death rates by age and sex were applicable to the population of that region. In this way the unique pattern of death rates in each region can be established, and calculated separately for each condition or group of conditions. The SMRs, as used in the formula, enable geographical variations in illness to be stated independently of regional differences in numbers of hospital beds and NHS manpower, and therefore represents a measure of the *effectiveness* of health care in different regions.

The report identifies the regions in greatest need of a bigger share of the available revenue resources as being North Western, Trent, Northern, Yorkshire and Wessex. To allow faster growth in these and other regions whose present allocations are below their resource "targets", the reports suggest restricting growth in the five regions whose present revenue allocations are above their "targets". These are Oxford and the four Thames RHAs. For capital allocations, the report's proposals would have the effect of restricting the level of investment in East Anglian, NE, NW and SW Thames, Oxford and Mersey RHAs.

But within regions both capital and revenue allocations to areas and districts must in turn take account of the differential needs for health care as measured by the formula, if redistribution is to be fair.

● **See also EDITORIAL p6.**

LEUKAEMIA

by Harry Packham, Chairman of Havering CHC

Most Community Health Councils during their day to day monitoring of the service provided tend to look at particular establishments, services or broad community groups. In Havering we do all this, but in addition we have tried to introduce a more personal element into our work by investigating the services available to a person suffering from a specific condition. This decision has lead us to examine the facilities available for the treatment of leukaemia. Other studies have concerned epilepsy and people dependant on renal dialysis. It may interest other CHCs to know the way in which we set about examining the service available to sufferers from leukaemia.

We held an initial meeting of the Working Party which consisted of four members of the Community Health Council. At this meeting we decided on our course of action. As a nurse who had recently been concerned with research into the condition, I was able to draw up a detailed description of the condition, it's incidence and treatment. This assisted the members and gave them a background of knowledge. I believe this to be an argument for some health service professional staff on a CHC, in that technical and professional information can be provided instantly, thus avoiding delay while this is obtained. The Working Party as an initial step met the local branch of the Leukaemia Research Fund. It was interesting to find that rather than provide us with information, this body was looking to us for this, because their role had been largely fund raising and there seemed a genuine desire to learn more about the condition, it's prevalence and prognosis in the light of developing treatments.

The Havering Medical Records Officer was able to show a declining incidence of leukaemia locally: 1972 — 13, 1973 — 12, 1974 — 9. This trend apparently is repeated throughout the nation, (if a report has a political content, it turned out to be this one: the declining incidence had followed on from the fairly general observance of the test ban treaty).

We approached our local general hospital, a number of teaching hospitals and national bodies and a very optimistic picture began to emerge from a situation which until recently was very grim indeed. The Working Party learnt that leukaemia is a disease of the blood, affecting the white blood cells, which are greatly increased in numbers, and immature forms appear in the blood. The condition is diagnosed by examining the blood and bone marrow. The disease, if acute, is especially likely to occur in children and can develop and kill the child in a matter of months. In untreated adult cases the average course is about two years. Modern treatment has extended life expectancy to five/seven years and recently some varieties appear to have been virtually overcome. A chronic variety of leukaemia occurs, mainly in old people, and rarely causes death. In our report we recorded in great detail the physiology, symptoms, diagnosis and treatments used. Local procedure, we found, was to refer patients in the first instance to Harold Wood or Oldchurch Hospitals for a blood test. If the diagnosis is confirmed, then the patient is referred to the Local Consultant Physician, or Paediatrician, or to a London teaching hospital or a well known special unit.

We will glady pass on to other CHCs what we learnt concerning the hospitals and units available in central London as well as information about research organisations.

PERSONAL VIEW

by Caroline Langridge Secretary of Wandsworth & East Merton CHC

In theory at least, the NHS is responsible to Government and accountable first to Parliament and ultimately to the electorate, or to put it another way, decisions about health care are basically political. Many CHC members have vociferously argued that they do not want to bring politics into the NHS as if somehow the health service is unaffected by politics, but this is to ignore the simple fact that decisions about the level of resources allocated to the NHS and the priorities to be adopted in allocating resources are at base political decisions and rightly so since in the end Government should be accountable to the electorate for how it spends the taxpayers' money.

CHCs represent the consumers' interest in health, but since they are made up entirely of members nominated either by the RHA, local authorities or voluntary organisations, there is no clear way in which CHCs can be said to be accountable to the consumers in their health districts. I stress the principle of accountability because it is a cardinal tenet of our system of parliamentary democracy that our elected representatives to whom we abrogate the power to govern, at either local or national level, are subject to the overall control of the ballot box and can, therefore, be removed from office should the electorate so wish. However imperfectly this system operates this basic accountability is lacking in the NHS in that executive control of the NHS rests with the RHAs and AHAs. Furthermore, the inherent bias in our class structure ensures that once again articulate middle class interests predominate in consumer organisations such as CHCs. The real challenge is to devise a system of representation which will clearly reflect working class interests, which is to say, the interests of the main users of the health service. These are fundamental issues which should be debated by CHCs particularly as there is a growing tendency for DHSS to treat CHCs as the authoritative consumer voice on health at a time when few CHCs can hope to be representative of the many communities within communities making up their health districts.

So far I have talked about party politics but the health service is also subject to the ramifications of medical politics and the overwhelming predominance of the professional in health matters. Many CHCs are being asked to agree to cuts in services as a result of the economic situation, however CHCs are not allowed to decide on such basic questions as the allocation of resources to individual specialities or the need for intensive care units etc. as these questions are held to be matters of clinical freedom. It is the prospect of being expected to sell reductions in basic services to the community which has led many people to question whether CHCs can be effective watchdogs or merely administrative eunuchs. Cynically I suspect that the introduction of consumer participation in the NHS at a time of fierce and agonising debate about the need to reduce public expenditure is no accident.

If CHCs are to be responsible for bringing about a fundamental revolution in health care which will give rise to a health service based on community need rather than professional status, they cannot afford to stand aside or ignore the political implications of their role.

News from CHCs

- The need to improve communications between the AHA and the CHC in Solihull has led to the establishment of quarterly liaison meetings between the two. The move follows an expression of concern at a Solihull CHC meeting over some of the serious financial and administrative problems faced by the single-district area. It is hoped that the liaison meetings will open another avenue of continued dialogue between the two bodies.
- The problems of middle-aged women suffering from the many distressing side-effects of the menopause are to be considered by Havering CHC. The subject was first brought to their attention by a number of women who approached the CHC's information desk at a local advice centre, and it was raised again by a member of the public at a recent CHC meeting. A great deal of distress can be relieved by proper treatment, and the CHC are now to examine the possibility of a menopause clinic for the district in detail.
- There's a new staff team at South Clywd CHC: Mr. I. L. Roberts has replaced Susan Jones as secretary, and Mrs Joyce Murray has been appointed as Assistant Secretary.
- Recently elected vice-chairmen for the coming year are: Mr. R. Bricknell of North Devon CHC, Dr. Margaret Gillison of Aylesbury & Milton Keynes CHC, Mrs. S. R. Whipp of Burnley, Pendle & Rossendale CHC, and Mrs. M. F. McDermott of Northumberland CHC.
- Intervention by Wirral Southern CHC has meant that there will continue to be sub-registration facilities at Clatterbridge hospital. A local authority plan to close the registrar's office has been scrapped following opposition from the CHC on the grounds that it would cause unnecessary inconvenience to patients' relatives, many of whom would have to travel a considerable distance to register births and deaths.
- The Sheffield CHCs' joint publicity campaign is full of bright ideas. This year they have invested in give-away badges (one is pictured here) and pencils inscribed with their names and phone numbers, and the legend "You can influence tomorrow's National Health Service". They have also produced a 1977 'Sheffield CHCs' Diary, which sells at 15 pence.

- S.W. Herts CHC has a new assistant secretary: Mrs. Penelope Mortimer took up her appointment in July.
- Four CHCs have chosen clergymen as their new chairmen: Rev. A. J. Postlethwaite has been appointed at West Cumbria CHC, Rev. Ralph Gurr at Enfield CHC, Rev. F. W. A. Ledgard at Northallerton CHC, and the Rev, M. M. Adams at the Isles of Scilly CHC. Other recently-elected chairmen include: Mrs. L. A. Mitchell, Calderdale CHC; Mr. Jack Moyses, Liverpool Eastern CHC; Mrs K. Grundy, Tameside CHC; Mr. G. E. Adams, North Devon CHC; Major F. G. Smith, Aylesbury & Milton Keynes CHC; Mr. Norman Nicholson, East Berkshire CHC, Mrs. J. M. McCallum, Northumberland CHC; and Mr. Ian McMinn at Burnley Pendle & Rossendale CHC.
- Bromsgrove & Redditch CHC are carrying out a survey on access for disabled people to public buildings. A questionnaire has been sent to supermarkets, recreation centres and other facilities in the locality.
- New Secretary at North Birmingham CHC is Mr. W. D. Baldwin, who took up his appointment on September 20th.

EDITORIAL

The new report of the Resource Allocation Working Party (discussed on page 4) represents an encouraging step forward in the effort to create equal opportunity of access to health care for people at equal risk. However, acceptance and implementation of its proposals by the DHSS will not automatically ensure that areas and districts adopt a more fair system of allocating their resources. As Dr Tom Heller pointed out (*The Guardian*, 29.9.76), districts which are identified for the receipt of extra funds on the basis of the RAWP formula may find virtually none of this new money actually being used to improve services for the patients. Instead, large portions of it may already be earmarked for payment to doctors in the form of overtime payments and merit awards.

Equally disturbing is the possibility that districts which are forced to cut spending will decide on short term closures and service reductions which bear no relation to a well thought out long term strategy. In both cases the spirit of the RAWP report will be violated and the patient, as the focus of this exercise in redistribution of resources, will suffer. CHCs will need, therefore, to be particularly vigilant in watching how their districts and areas respond to the RAWP proposals. They should strive to ensure that both cuts in expenditure and extra allocations of funds are treated by the NHS not as an attempt to gloss over the short term difficulties but as a part of a longer term strategy for enabling the service to provide health care rationally and fairly.

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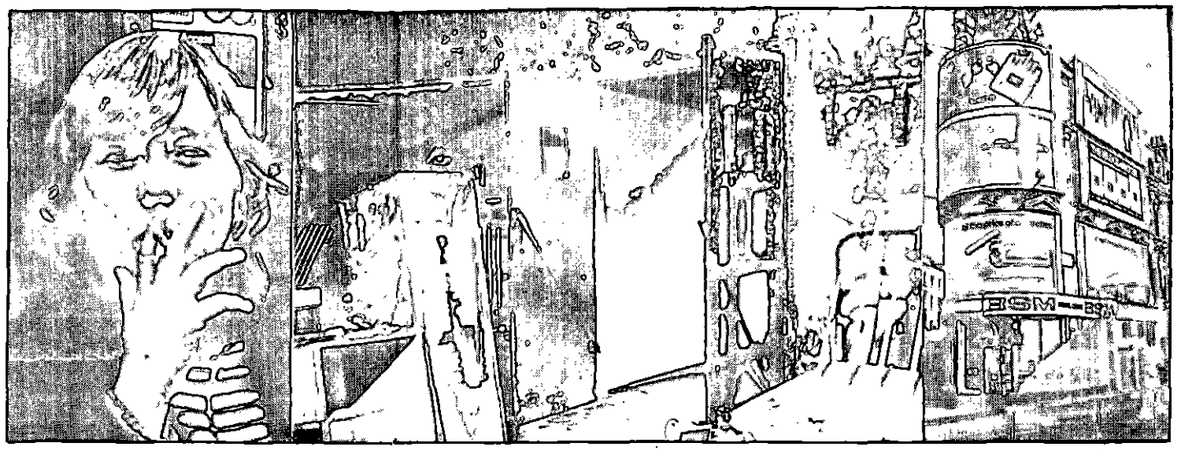


Damage caused by smoking — to health, to property and to the environment.

Photos: ASH

Action on Smoking

by Bobbie Jacobson, Deputy Director of ASH

Cigarette smoking is responsible for 50,000 premature deaths each year in this country from lung cancer, coronary heart disease, chronic bronchitis and emphysema — eight times more than those who die each year in road accidents. It was estimated, several years ago, that smoking cost the economy £510 million. There are 19 million adult smokers in the country, who despite health education and anti-smoking campaigns, still continue to spend in the region of £2,700 million each year on tobacco. In 1975 132,600 million cigarettes were smoked. The ill health and death caused by smoking is preventable.

ASH (Action on Smoking and Health) was established as a charity under the auspices of the Royal College of Physicians in 1971. Its main aim is to mitigate the damage to health caused by smoking, to discourage smoking, and to create an atmosphere in which smoking is seen as an unnecessary and harmful habit.

CHCs' Role in Preventive Medicine

CHCs' responsibility for public health has recently been emphasised in the Government document *Prevention and Health: Everybody's Business*. It stated that CHCs "have a special responsibility for developing the preventive aspects of their work."

Recent surveys also show that members of the community hold strong views on smoking: a majority of both smokers and non-smokers want to see further restrictions on smoking in all public places. Non-smokers now form the majority of the adult population. A recent ASH survey of acute hospitals revealed that over 72 per cent of hospitals sold cigarettes in their shops and 47 per cent sold cigarettes from hospital trolleys wheeled round wards where many of the patients were suffering smoking-induced diseases. A 1975 *Which?* survey showed that people were clearly not satisfied with the non-smoking provisions in hospitals: 68 per cent of smokers and 77 per cent of non-smokers wanted to see a ban on smoking in hospital wards. If the death toll caused by smoking is to be reduced there must be more effective action both at the national and at the local levels. CHCs, working in conjunction with those professionals in the local community who are concerned with public health, can help develop a co-ordinated preventive strategy.

Action taken by CHCs

In March 1976 Ash circulated all CHCs in England making five recommendations for action.

As CHCs are still responding, the full extent of their action on smoking and health cannot yet be gauged. Given CHCs' limited resources, the response, so far, has been particularly encouraging. Of the replies that have been received, it is possible to make certain general observations about the response to the ASH recommendations:

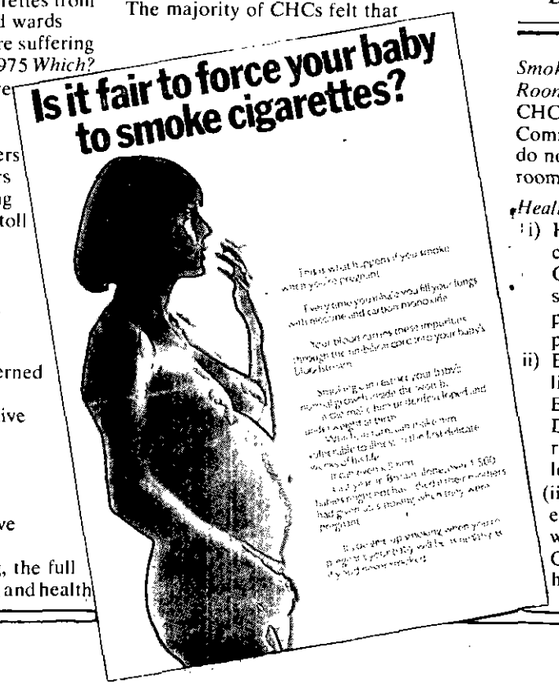
1. Over 90 per cent of CHCs do not allow smoking at their meetings.
2. Most, if not all, of the five ASH recommendations were approved, and many have been actively taken up.
3. CHCs felt particularly strongly about the lack of non-smoking accommodation in hospitals.
4. Other major areas of concern for CHCs emerged as: health education at all levels from schools to GPs' and dentists' surgeries.

Specific Action taken by CHCs

Smoking in Hospitals

The majority of CHCs felt that non-smokers have the right to be nursed in smoke-free areas, that smokers and non-smokers should as far as possible, be segregated, that the sale of cigarettes in acute hospitals should be banned (but that those in long-stay hospitals should be able to buy cigarettes), that visitors should be discouraged from smoking, and waiting rooms and corridors should be no-smoking areas.

Action taken includes: pressing AHAs, CHC Hospital Committees, District Management Teams, Leagues of Hospital Friends (the organisations responsible for arranging the sale of cigarettes in hospitals), for the above resolutions to be implemented.



Smoking in GPs' and Dentists' Waiting Rooms

CHCs have written to Family Practitioner Committees asking them to ensure that GPs do not allow smoking in their waiting rooms.

Health Education on Smoking

i) Haringey and other CHCs have co-opted Area Health Education Officers onto the relevant CHC sub-committees (health education, primary and community care, etc) to plan strategies for joint action.

ii) Eastbourne CHC, for example, had liaised with the Director of the Local Education Committee and his Department to ensure that the topic receives adequate attention, at all levels, in both private and state schools.

(iii) Eastbourne CHC, for example, arranged a joint seminar with the Area Health Education Officer and the HEC on the health hazards of smoking.

iv) The Havering CHC, for example, helps co-ordinate AHA anti-smoking campaigns. CHC members sit on the Area Health Education panel in order to work jointly with the AHAs.

Publicity

Many CHCs have been active in increasing general publicity on the health hazards of smoking. This includes:

i) Displaying ASH, HEC, and other anti-smoking literature on their stands.

ii) Compiling exhibits and exhibition stands on aspects of smoking and health in local and regional exhibitions, such as Agricultural shows, health shows, and Polytechnic and College Exhibitions.

iii) Distributing leaflets on smoking and health at seminars/talks and other appropriate opportunities.

iv) Asking hospitals to display smoking and health posters.

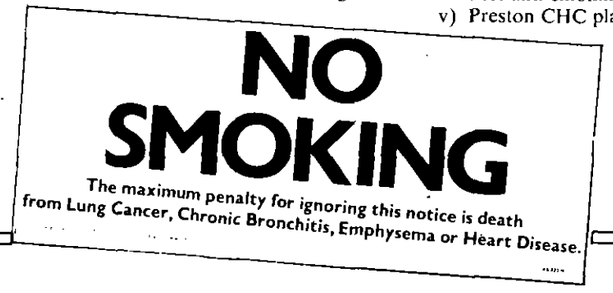
v) Many CHC members give talks at schools and to other groups on smoking and health.

Display of Tar/Nicotine Tables

i) CHC members themselves being as vigilant as possible, and reminding tobacconists to display the appropriate notices.

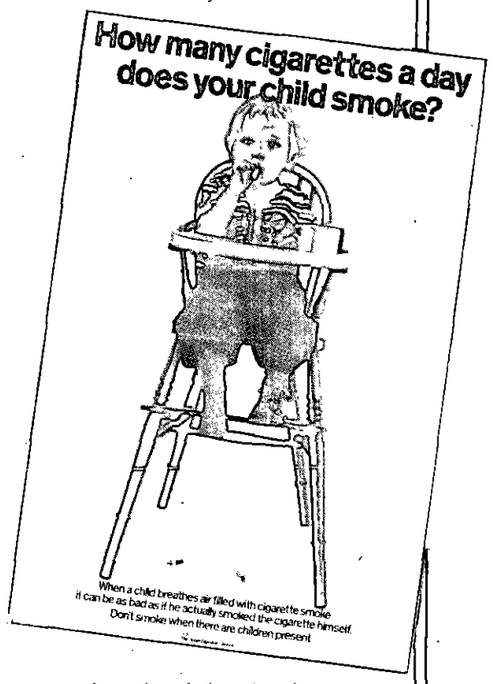
ii) Making representations to AHAs and to Environmental Health Officers urging them to be vigilant on this matter.

iii) Encouraging doctors to display the tables in poster form in their surgeries.



Campaigns

i) The Bromsgrove and Redditch CHC organised a "Give-Up Smoking" campaign in their area jointly with the Health Education Unit. In this campaign, a 24 hour "hot-line" phone was open to all smokers and ex-smokers who wished to discuss their problems. Advice centres have been set up, on occasion, in conjunction with the AHA and the Local Authority. Special publicity material was prepared for the campaign. One Surrey CHC launched a "Don't Smoke Day" where it asked people to sign pledges that they would not smoke.



ii) Weston is planning to organise a local campaign to increase non-smoking accommodation in cinemas.

iii) Weston CHC plans to organise a local campaign to encourage restaurants to conduct "no-smoking" experiments in which the CHC would monitor customer reaction by questionnaire.

iv) Weston and South East Staffordshire CHCs are organising a competition for local schools of art and other colleges where a prize would be awarded for the best anti-smoking posters/leaflets.

v) Preston CHC plan to launch an anti-smoking campaign directed at smoking during pregnancy.

vi) A Haringey CHC member runs the local Smokers' Advice Centre.

BOOK REVIEWS

REFERENCE BOOKS

Four recently published reference books may be of interest to CHCs — either as sources of information to be consulted occasionally in a public library, or as useful additions to their own collections.

The Health Education Index[1] lists over 5,000 aids to health education on 167 topics. Subjects covered range from abortion, accident prevention and adolescence to water safety, weight control and worms. Under each heading books, pamphlets, audio-visual aids, posters and wallcharts dealing with the subject are listed. Details of prices, availability and suppliers are given for each. The Index also contains an annotated list of voluntary organisations working in health education or related fields.

The **Bibliography of Social Policy and Administration**[2] covers most aspects of the institutionalised provision of care. Of most relevance to CHCs is the section on health services and medical care, which lists books and journal articles on various topics including finance and resource allocation, participation and social class usage, the mental health services, and the incidence of disease. Some other sections, e.g. those on information and advice services, the prevention and treatment of alcoholism and participation and community action — also list literature in which CHCs will be interested.

Although the BMA's **Research Funds Guide**[3] is principally concerned with sources of funding for clinical research, one or two of the organisations listed have a wider remit. Under each entry a note has been made of the type of grant that may be given, and the procedures by which application can be made.

There is an excellent introductory chapter giving general advice on grant applications which remains valid whatever the project for which funding is sought. CHCs may also be interested in the section which describes the way in which the DHSS and other official bodies process requests for financial support.

Pressure groups, as defined by **The Guardian Directory of Pressure Groups and Representative Associations**[4], include political parties, trade unions, consumer groups and voluntary organisations whose work has a campaigning element to it. The Directory includes informative sections on social interests and campaigns, and groups in the health and medical fields. Each entry gives a statement of the organisation's aims and has notes on its structure and activities to date.

1 **Health Education Index** *published by B. Edsall & Co. Ltd, £4.75*

2 **Social Policy and Administration in England — A Bibliography** *by Tessa Blackstone, published by Frances Pinter Ltd, £1.50.*

3 **Research Funds Guide** *published by the British Medical Association.*

4 **The Guardian Directory of Pressure Groups and Representative Associations** *edited by Peter Shipley, published by Wilton House Publications, £7.50 + 45p p&p.*

Laing & Schizophrenia

by Anthony W. Clare, Lecturer at the Institute of Psychiatry

A prominent British psychiatrist recently remarked, with more than a touch of irritation, that the average individual's enthusiasm for the ideas of Ronald David Laing is inversely proportional to his contact and experience with schizophrenics. Such a statement does reflect the fact that Laing's popularity has always been greater outside the psychiatric specialty than within it and it has been particularly high with parapsychiatric professionals, such as social workers and psychologists.

To understand why this is so it is necessary to go back to Laing's first book, *The Divided Self.** Even after more than a decade, it remains a fertile, insightful and provocative account of the disintegration of the self which occurs in some forms of mental illness. To many, Laing appeared to be one of the few psychiatrists who seemed to make sense out of nonsense, reason out of irrationality. Here was a psychiatrist for whom the mutterings and the gesticulations of the schizophrenic were not meaningless gibberish but valid if shadowy attempts to maintain contact with an elusive reality.

At the time, the book made a stir both within and outside medicine. Laing identified himself as a physician unusually versed in phenomenological analysis and skilled in its application in clinical situations. However, within a few years, Laing moved away from his medical base. Whereas in *The Divided Self*, schizophrenia was a desperate and agonising state of disintegration, it now became nothing more than a stigmatising label pinned by some people, usually in authority, on others.

R. D. Laing

Orthodox psychiatric treatment was portrayed as the process whereby the person was "inaugurated into a career of patient by the concerted action of a coalition (a conspiracy) of family, GP, mental health officer, psychiatrists, nurses, psychiatric social workers and often fellow-patients". Not surprisingly such a view, and Laing's reluctance to submit any of these causal theories to formal testing, resulted in his rejection by main-stream psychiatry as it provoked his adoption as a celebrated guru by a generation undergoing the heady and halcyon excitement of the psychedelic nineteen-sixties.

Subsequently, Laing totally ignored any evidence which conflicted with his view of schizophrenia as the understandable response of an individual to persecutory and destructive emotional demands made by others, usually his close family. The fact that schizophrenia is ubiquitous, being no more a respecter of societies or cultures than it is of persons, that the evidence in favour of parents driving their children mad is questionable to say the least, that orthodox psychiatry using drugs and psychotherapy can claim recovery rates as good as and better than those Laing and his colleagues have ever cared to publish, that medicine, including physical medicine, has always concerned itself with hypothetical disease whose causes are often obscure and whose pathology resists clarification — all such facts tended to be regarded by Laing with a haughty indifference. Laing has continued to explore some of his ideas on the complexity and ambiguity of human communications in a number of articles, theatrical productions and films. Yet his achievement in capturing peoples' imagination and making mental illness a subject of interest and speculation to numerous individuals outside the narrow confines of the speciality is unlikely to be diminished in the eyes of those for whom that first book remains a remarkable landmark in psychiatric literature.

***The Divided Self** *by R. D. Laing, Penguin 1965, £0.65.*

Health Trends

by Dr Colin J. Roberts,
Department of Community Medicine,
Welsh National School of Medicine

The most significant change that has taken place in health this century has been that now only a small minority of parents suffer the tragedy of losing a child. This century has seen, on average, thirty years added life for every new born child and this is due, almost entirely, to a reduction in mortality from the infectious diseases of infancy and childhood. In contrast, a 45 year old today can only expect to live six years longer than did his counterpart of similar age in 1900, and a 65 year old only about 2½ years.

Major improvements in health this century have not benefited all consumers equally and if the last seventy years is anything to go by the over 45's cannot expect to see much benefit, in terms of reduction in their individual risk of dying, from a substantial investment in health care.

The major improvements in health so far this century have largely derived from improvements in external environment in which the consumer lives and from modification of his immediate personal environment.

In Great Britain 1974, there were 650,000 deaths, of which 187,000 were due to heart disease, 90,000 to stroke, 94,000 to cancer, 82,000 to respiratory disease, 20,000 to accidents and 4,000 to suicide. To put these figures into some sort of perspective, they can be compared with a relatively low risk event such as leukaemia which accounted for 3,000 deaths. Today an individual stands a 75% chance of reaching 65, after which he has a one to two chance of dying from heart disease or stroke, and a one in three chance of dying from cancer. During the productive years (15 to 64) the most important single cause of death in men is heart disease, and among women in this age range it is cancer, with breast cancer being the most important single one.

In 1972, one in every twelve people in England and Wales were admitted to non-psychiatric N.H.S. hospitals — a figure which has been increasing by 1½ to 2% per annum. If this trend increases, in twelve years time, one in every three people will have been a hospital inpatient, in any one year. Around one half of these admissions are older people.

In any month, one million people are in receipt of sickness benefit; at any point in time some 5% of the workforce is off sick — a loss which now exceeds the number of days lost in strikes. Yet industrial accidents and prescribed industrial diseases (e.g. pneumoconiosis) account for only one tenth of this total.

In any year one in every two people consults his family doctor. Around a third of these consultations are for chronic illness and disabilities, the commonest being rheumatism and arthritis; one in twelve are episodes of acute serious illness of which half are now attempts at suicide. In 1974, in the Health Service, three hundred million prescriptions were issued; and 51 million pathological investigations and 40 million units of radiological treatment were undertaken.

Seven million people in the United Kingdom are over the age of 65. One quarter have defects of hearing, 2% defects of sight, and 10% increasing physical handicap which limits mobility and capacity for self help. Nutritional deficiency and increasing fragility of the bones, particularly the hip, are problems of increasing importance in the elderly. The last decade has seen a sharp increase in the frequency of certain serious diseases which are largely preventable, viz. alcoholism, drug addiction and veneral disease. As many as one in every hundred people in England and Wales may have a serious drink problem; self poisoning is now the second commonest cause of emergency admission to hospital; and forty-seven million prescriptions issued in 1973 by family doctors in England alone were for tranquillisers, anti-depressants and hypnotics. The annual return of special clinics dealing with venereal disease shows a threefold increase between 1959 and 1974.

Information presented here on contemporary morbidity is not meant to impress nor to overpower the reader with the magnitude of today's health problems, but rather to stimulate questions about which of the above categories of morbidity reflect a true need for health care, and which of these in terms of pain, discomfort, disability and possibly ultimately death, are in most urgent need of consideration. As I see it the main task for the Community Health Councils is not to plumb the bottomless depths of morbidity in order to identify areas of unmet need, but to participate constructively in discussions about which categories of morbidity should be considered first, and which, on reflection, might be reasonably considered as falling outside the terms of reference of the obligations of an egalitarian health care system. When resources are finite (as they always must be) perhaps the identification of a "priority" health need should always be accompanied by an opinion concerning where, from within the existing resource allocation, the money to meet this need might be found. If Community Health Councils are to participate fully in the health care planning process then they must not abdicate to impersonal bodies, such as Central Government or the Area Health Authority, the sole responsibility for advising on the allocation of resources. In order to exercise this responsibility they will need to have a proper understanding (as will the supplier) of the nature of the contemporary health problem, of the source and the magnitude of the available resource to meet the problem, and of the safety and of the effectiveness of the common contemporary therapeutic procedures.

CHC AS CATALYST

by Howard Knight, Secretary of Central Sheffield CHC

Many CHCs do not seem to realise that they themselves are a resource (staff, time, money, rooms etc.) which could be used by consumers to help *them* collectively to put forward their views on the NHS.

Making use of this model as described in the example below depends primarily on two points:

(a) the willingness of CHC to forego any kudos that might be available for particular activities; and
(b) the willingness of CHCs to recognise that in the long-term, "voluntary organisations of consumers" can provide a better critique of particular services than CHCs.

Example

In April, a letter appeared in the Sheffield "Star" from a mother of a child with Perthes Disease, who wished to give away a pram which had been built for her child. Several mothers (about fifteen) of children with Perthes Disease, contacted her and out of those telephone calls came a recognition that they had a lot of information and advice to exchange, and comments to make about the services. I, with the approval of my Chairman, contacted the mother and told her that we were prepared to offer assistance to the group to "get off the ground". This led to a meeting of mothers, grandmothers and one father-in one of the more sleazy city-centre pubs where we supped Guinness and listened to the Rolling Stones on the Juke Box (made the whole trip worthwhile!) and discussed problems. That meeting agreed that:

(i) parents had a lot of useful information, advice and ideas which they could offer to each other;
(ii) they wanted to continue meeting;
(iii) they wanted to contact all parents of children with Perthes Disease in Sheffield, and surrounding areas;
(iv) they wanted to hold special meetings with professionals (doctors, nurses, health visitors, social workers, teachers etc.) on particular topics;
(v) it would be useful to have a newsletter on an intermittent basis to send to interested professionals and parents.

The assistance which the CHC has given has been purely a resource:

(i) a meeting-room (two meetings have already been held on "Financial Benefits" (with a Welfare Rights Adviser) and the "History, Diagnosis and Treatment of Perthes Disease" (with a Consultant);
(ii) a letter has been sent to every parent whose child is on the books of a Sheffield hospital (arranged with three DMTs and the CHC) (paper, envelopes and stamps provided by the CHC);
(iii) a letter has been sent to every relevant professional in the city informing them of the group's activities and asking them if they want to receive the newsletter;
(iv) letters to local, national and specialist media informing them of the formation of the group;
(v) printing and sending out the newsletter;
(vi) advising the group how to make the complaints they have (e.g. non-information on benefits from any statutory agency).

Thus for the expenditure of say £100, the CHC has sponsored an ongoing "mutual-support, advice-giving, and service-critical" group with good contacts; the CHC, for its activities has had good "Press" in the local media and some nationals (½ page in the Weekly News); seventy parents have had some constructive relationship with the CHC (spin-off?); we've had enquiries from as far afield as Israel, Eire and Hertfordshire (two parents came from Wigan to the meetings!); constructive and well-documented criticisms are already being responded to by the NHS.

VITAMINS

by Dr Andrew Elder, London GP.

Vast quantities of vitamins are prescribed every day, and an equally great number are bought direct over chemists' counters. Not many of us know much about vitamins but we all have vague notions of them as 'good' things; health-giving substances, things you may need more of if you're not feeling too good. These ideas more reflect our need of magic than any reality, and are briskly exploited by the commerical world. Products that are 'vitamin-enriched' sell well; the consumer will feel healthier and stronger, 'life-enriched' after drinking or eating them. There is a lot of mythology surrounding the subject, as well as some precise physiology, and between the two there is a relationship mediated by the medical profession, dispensing some reality with one hand, but also feeding the transaction of magic with the other.

There are a small number of chemicals which are essential for the health of our bodies and which we are unable to synthesise. We depend on our diet for them. There are twelve vitamins presently known, and they are in a sense 'essential extras' in addition to the main foodstuffs: protein, fat and carbohydrate. A vitamin for one species is not necessarily one for another. Cats and dogs are capable of making their own ascorbic acid (vitamin C) and so for them it is not a vitamin.

Many of the diseases caused by vitamin deficiency, for example scurvy (vitamin C deficiency) and rickets (vitamin D deficiency) have been known for hundreds of years. The incidence of scurvy amongst sailors was for centuries a major factor in deciding the outcome of any sea venture, until the 1750s when a Scottish surgeon called Lind noticed that the disease could be both cured and prevented by a diet of fresh oranges and lemons.

These diseases are fortunately very uncommon today. Infants should have supplements but for most of us, our Western European diets are easily sufficient in vitamins. Those who do become deficient through dietary lack are mainly the elderly poor, the children of large and deprived families, alcoholics (the commonest cause of vitamin B deficiency) or dietary faddists. The other groups of people who need vitamin therapy are those who become deficient through insufficient absorption. There are a large number of illnesses — ulcerative colitis, coeliac disease, pernicious anaemia — which cause vitamin deficiencies in this way.

Many prescriptions for vitamins are issued under the hazy umbrella of 'subliminal' deficiency disorders, the symptoms of which are fatigue, irritability, lassitude and loss of appetite. There is no good evidence that these 'subliminal' states exist. Careful advice about diet would be a more rational approach to treatment than the prescription of vitamins, even if they did exist. Vitamin pills are preferred, though, because they have a powerful psychological effect, and because prescribing them is easy for doctors. Fortunately, unlike many other doctors' prescriptions, vitamins are relatively harmless.

Apart from being used as dietary supplements in the therapy of either real or imaginery deficiency states, vitamins have also been used in a wide variety of different conditions (unrelated to vitamin deficiency) as treatment, and in general with very little success. There are numerous examples, all of which have had enthusiastic support, such as high doses of vitamin C to prevent and cure the common cold. Vitamin E has been flaunted in the past as treatment for various things from coronary artery disease to habitual abortion. A recent leading article in the British Medical Journal was on the possible role of vitamin A as a cancer preventive. Who knows?

FPC Complaints

The DHSS has invited CHCs to submit their views on the procedures for handling complaints about family practitioner services by the end of December. Below we summarise the contents of a consultative paper that has been circulated, and separately, draw attention to other aspects, not specifically raised in the paper, but on which comments are also welcome. There will, in addition, be points which CHCs will want to raise, and which are not included here, for reasons of space.

BACKGROUND

At the moment the regulations lay down that complaints need only be investigated if they concern a practitioner's terms of service; they are handled by a Service Committee of the FPC; the Service Committee consists of 3 lay and 3 professional members and a lay chairman, appointed by and from the FPC; the chairman only has a casting vote.

MAIN POINTS OF THE PAPER

1. Need for independent procedure
Present system. The FPC both provides family practioner services and decides whether complaints about those services are justified.
Cause for concern: No independent element in this procedure.
Suggestions: 1. Secretary of State could appoint a panel of independent individuals from which all Service Committee chairmen will be drawn (Could be on a regional basis). 2. Panel members should have no connection with any administering authority (i.e. FPC, AHA, RHA). 3. Panel members should be legally qualified or very experienced. 4. Chairman should participate and vote on the same basis as other members of the Service Committee.

2. Size of Service Committees
Present system: generally 3 lay plus 3 professional members and the chairman.
Cause for concern: Present size considered daunting for parties to the complaint.
Suggestion: Size should be reduced to 2 lay plus 2 professional members and the chairman.

3. Role of FPS Administrator
Present system: Administrator advises parties to the complaint and may attempt to resolve the complaint informally and effect conciliation (i.e. without going through the Service Committee procedure) where possible. He is the FPC's and the Service Committee's servant and is responsible for carrying out any administrative action decided by the FPC following the Service Committee's recommendations.
Cause for concern: Possibility of conflict arising between the various roles the administrator is required to adopt.
Suggestion: The Service Committee could be served by a different officer of the AHA.

4. Legal representation of parties
Present system: Either party may be represented, but not by a paid advocate.
Cause for concern (1): Definition of "paid advocate" is not clear.
Suggestion: Amplify definition to clarify the position of MPs and paid officials of trade unions, professional associations and CHCs.
Cause for concern(2): Advantage of legal representation compared with desirability of keeping proceedings informal.
Suggestions: 1. Consider full legal representation for both parties. 2. No representation for either party.

5. Further aspects
A number of other proposals seek to remedy anomalies and minor difficulties in the current Service Committee procedure. There is not space to mention them all, but they include provision for:

- ★ complaints to be made orally
- ★ the time limit within which a complaint may be lodged to run from the date at which the event came to the complainant's notice
- ★ the outside time limit for appealing against a decision not to hear a late complaint to be extended
- ★ the outside time limit for making a complaint against a dentist to be reduced from 6 months to 3 months
- ★ the time limit for appealing against a decision not to hear a late complaint to be extended from 2 weeks to 3 weeks
- ★ an obligation to be imposed on a Service Committee to give reasons for its decisions
- ★ a complainant to be given a statutory right to an oral hearing on appeal against an adverse FPC decision
- ★ a requirement to be imposed on a practitioner to submit his comments on a complaint before a hearing takes place
- ★ a complaint to be abandoned or settled without a hearing if the patient does not, within a given time limit, take part or indicate his refusal to take part
- ★ where a Service Committee's investigation is followed by referral of the complaint to the NHS Tribunal (which considers whether or not a practitioner's contract with the FPC should be terminated), two suggestions have been made: (1) that the complainant should always be required to submit a written statement, and (2) that he should not then be allowed to introduce any evidence that has not already been raised.

OTHER POINT FOR CONSIDERATION

The suggestions contained in the DHSS's consultative paper constitute amendments to the existing procedure rather than any proposals for fundamental change. DHSS has, however, made it clear that CHCs need not confine their attention to the proposals that have already been made, but are free to take a wide-ranging look at the whole procedure or any aspect of it. Consequently, it may be important to remember that the present system does not seek to remedy patients' grievances about the family practitioner services. Service Committees are primarily disciplinary proceedings whose purpose is to establish whether or not a practitioner has complied with his terms of service. None of the proposals that have so far been put forward seek to alter this position.

It is also worth noting that although the great majority of complaints about GPs concern their manner, or contain criticisms of the appointment system or receptionist, there is at present no complaints procedure under which these matters can be raised. Again, this is not touched on in the DHSS paper.

It may be that CHCs will wish to raise these or other points in their own submissions.

Participative Management HC(76) 44

This circular commends the idea of participative management to health authorities and describes what is meant by the concept. Participative management is seen as a way of encouraging more health service staff to take a fuller part in the organisation of the services they provide, and to become involved in changing for the better the way they work.
There is an emphasis on improving communication both between management and staff and between disciplines and specialties: in the one case to give management a better understanding of operational problems and access to ideas based on staff expertise and experience, and in the other to promote better co-ordination of services.

It is suggested that working groups could be established consisting of staff and management engaged in the provision of particular services, to consider current problems or difficulties and to decide how these could be resolved by setting specific objectives, and to review the progress achieved. It is expected that this process would lead to identification of problems whose solutions will require the involvement of other departments and disciplines, and that participative management will thus gradually extend throughout the organisation.

The circular says that in pilot schemes that have been carried out, participative management has achieved improvements in services, working relationships, job satisfaction, communication and industrial relations generally.

Parliamentary Questions

REFERRAL TO CONSULTANTS

In reply to a series of questions from Mr David Watkins, Dr Owen said that although a GP is obliged to refer a patient to other NHS services as necessary, there is no obligatory procedure for referral to a consultant. Should a GP decide to refer, he may choose which consultant should be used, but will take into account factors affecting the patient's convenience and condition (e.g. distance, waiting times, etc.). It is usual for a doctor to refer a patient to an individual consultant, but it may occasionally be more appropriate to refer him to a hospital department. NHS consultants are obliged to provide hospital and specialist services, including diagnosis and treatment, to patients who have been properly referred to them.

COST OF TRAINING DOCTORS

The average cost of undergraduate medical education is about £40,000 per doctor, Dr Owen told Laurie Pavitt MP. The further cost to the taxpayer of post-qualification training varies from doctor to doctor.

CIGARETTE ADVERTISING

Dr Owen said that he was not satisfied that the voluntary code of cigarette advertising practice was working effectively, but that the Government had decided to make no changes until the code had been in operation for a full year. He added that in the meantime breaches of the code were being brought to the notice of the Advertising Standards Authority. Dr Owen was replying to a question from Sir George Young.

INDUCTION

38% of all hospital births in 1974 were artificially induced, reported David Owen in reply to a question from Mrs Audrey Wise MP.

CONSENT

Mr Robin Corbett asked the Secretary of State whether there were any forms of medical treatment for which a married woman had to have her husband's consent. Dr Owen replied that there were not. Health authorities had, however, been advised that where sterilisation is to be performed, the consent of the spouse as well as of the prospective patient should be obtained.

LABELLING OF DRUGS

DHSS has recently issed a consultation letter setting out proposals to strengthen requirements for appropriate warnings on certain medicines, said Dr Owen in reply to Mrs Audrey Wise. The warnings would cover any possible side-effects of the drug, and the dangers of combining it with certain foods or with alcohol. The proposals would not apply to medicines prescribed by doctors.

NOTES .....

- CHC NEWS is prepared in the month preceding its distribution, so we have not been able to report on the National Conference in this issue. There will be a full report in next month's paper.
- In CHC NEWS 9 (July) we asked if you would be interested in attending a Study Day to work on the practical problems of doing surveys. As a result of the replies, the Kings Fund Centre has agreed to hold the Study Day on Thursday 25th November at 126 Albert Street, London NW1. The day will be conducted by Dr A. N. Oppenheim — an expert on survey methods and research. Those CHCs who wrote in have already been invited to attend. The number of places is limited, but if anyone else is interested in attending, would they contact the Editor as soon as possible.
- Community health councils and the government should increase their efforts to extend public awareness of the work of CHCs, the rights and services available to the public, and the degree to which the individual contributes financially to the various NHS facilities.

  This is the view of the fourth National Consumer Conference held in Sheffield in July this year by the Cooperative Union*. The Conference has also recommended that only people who are willing to devote the necessary time and energy should be nominated to serve on CHCs.

  Two further recommendations emphasise the desirability of patient participation in the health service. One says that the NHS should be incorporated into the local government structure, and that additional efforts should be made to secure effective consumer participation. The other calls for the establishment of more health centres, and publicly financed patients' committees in those that already exist. (*Further details available from the Cooperative Union Education Dept., Stamford Hall, Loughborough, Leicestershire.)
- The recently published Price Commission report: *Prices of Private Spectacles and Contact Lenses* (HMSO, 65p) recommends that patients should be enabled to make an effective choice between NHS and private spectacle frames, and that opticians should stock and display the full NHS range.
- A paperback edition of *The Reorganised National Health Service* by Ruth Levitt (published by Croom Helm) is now available from bookshops at £2.95.

DIRECTORY OF CHCs

A directory of the names, addresses and telephone numbers of all the community health councils in England and Wales is now available, priced 60p.

Corrections are published monthly in CHC NEWS. Please notify the Editor of any changes.

Cheques and postal orders should be made payable to "King Edward's Hospital Fund for London" and sent with orders to: CHC NEWS, 126 Albert Street, London NW1 7NF.

Please note the following changes:

Page 2: West Cumbria CHC
Chairman: Rev. A. J. Postlethwaite
Page 3: Northumberland CHC
Chairman: Mrs J. K. B. McCallum
Page 7: Calderdale CHC
Chairman: Mrs L. A. Mitchell
Page 10: Worksop and Retford CHC
Secretary: J. H. Kitchen
Page 27: Sutton & West Merton CHC
Address: Mayfield House, Queen Mary's Hospital for Children, Carshalton, Surrey SM5 4NR
Telephone: 01 643 3000 Ext 289 +385
Page 28: Southampton and South West Hampshire CHC
Address: Grosvenor House (5th Floor), 18/20 Cumberland Place, Southampton
Telephone: Southampton 34321
Page 33: Isles of Scilly CHC
Chairman: Cllr B. K. Williams
Page 34: Gloucester CHC
Telephone: 413044
Page 35: Hereford CHC
Address: 1A Wyecliffe Terrace, Bath Street, Hereford
Page 37: North Birmingham CHC
Secretary: W. D. Baldwin
Page 40: Liverpool Eastern CHC
Chairman: Mr Jack P. Moyses
Page 43: Bury CHC
Chairman: Mr C. A. Caffrey
Secretary: P. Reynolds
Page 46: South Clwyd CHC
Chairman: Mr I. L. Roberts

Exhibition stands

A set of exhibition stands is now available on free loan to CHCs from the CHC NEWS office.

The set has 10 poster-sized panels and can be used as part of a stall at a local show, to illustrate a talk about the CHC, as a display stand at an exhibition or wherever there is an opportunity to publicise the CHC.

The kit is easy to assemble and dismantle, and when assembled, the stand's overall dimensions are 2.3 metres high x 3.0 metres wide (7ft 8in x 10ft).

CHCs wishing to borrow the stands should contact CHC NEWS to make a booking.