CHC NEWS

For Community Health Councils

January 1977 No. 15

INSIDE ...

Court Report

"Children have never been healthier than they are today, so why do we need to review health services for them now?" This was the question posed by Professor Donald Court at a press conference to launch the publication of *"Fit for the Future"* — the report of the Committee on Child Health Services of which he was Chairman.

He answered this question by saying that, given the state of medical knowledge, loss of life in infants and young children was unacceptably high. England is eleventh in the league table of fourteen comparable European countries, and although infant mortality rates are falling, ours are falling too slowly. In addition, the character of children's health needs is also changing such that the predominant problems now are difficulties around birth, chronic malformations and handicaps, and illnesses reflecting social disadvantage and marital breakdown.

The general practitioner, pre-school and school health services are not adapting to these changing needs, and Professor Court and his committee have identified a number of important targets for the future:

The child health service must become integrated and be child and family — centred; it must be comprehensive, linking prevention and treatment; it must be distributed more fairly across the country and in relation to need; the involvement of parents is vital — so the service must be both accessible and readily understood; staff should be adequately trained; there should be comprehensive and sustained support for handicapped children and their families; and the service should represent a mutual partnership between health, education and social work.

In order to achieve this major overhaul, the committee suggest that GPs should be able to receive a wider training to become general practitioner paediatricians; some health visitors should spend their whole time working with children throughout a defined neighbourhood; specially trained GPs working with school nurses can strengthen the services in primary and secondary schools; there should be consultant community paediatricians, working predominantly in the community and supporting the GPs; consultant paediatric nurses should be available to support the child health visitors, and there should be district handicap teams for the diagnosis and care of all handicapped children throughout the whole district.

The Court Committee feel that CHCs have a very important part to play in this scheme. After all, there won't be any children on CHCs, so they feel it would be an advantage if a number of members were parents of young children. (Chapters 16 & 21 contain specific recommendations about the role of CHCs.)

Copies of the report have been sent to CHCs who will want to study its proposals in greater detail. The DHSS is asking for comments to be sent in by 30 June 1977.

GOOD NEIGHBOUR CAMPAIGN

"Many elderly people — especially the very old, frail disabled, housebound and those living alone — face problems in coping with their daily lives. Winter brings added difficulties," stated Mr David Ennals in launching his "Be a good Neighbour" Campaign. "The campaign is designed to increase the awareness of the community to its responsibility for old and disabled people and, by generating a spirit of good neighbourliness in the ordinary man or woman, to bring to elderly people the kind of practical help many need."

Posters leaflets and car stickers are available to spread the message of the campaign to the public. Mr Ennals said that in the DHSS's consultative document on priorities, the health and personal social services used mainly by the elderly were given particular emphasis, "but whatever assistance may be forthcoming from statutory sources in current economic circumstances it is not going to be sufficient. Help from the community at large is needed."

Support for the Good Neighbour Campaign has been expressed by many organisations and individuals. Tom Jackson of the Post Office Workers' Union said that postmen were being encouraged to keep an eye out for the people they visit each day, and to let the statutory services know where they think a need exists. He added that postmen in rural areas would be prepared to deliver pensions to old people, where closure of sub-post offices had created difficulties. Counter clerks in all post offices could be on the alert for people who stopped coming in to collect their pensions regularly. Mr Nicholson of the Dairy Trades Federation explained that milkmen have a "Care Code" for taking action when they find any problems in the homes of old and lonely people they visit every morning. David Hobman of Age Concern stated that caring is too important to be left solely to the professionals. "No government can legislate for compassion," he said, "We must help the well-intentioned to become the well informed. Our expectations of the statutory services have been unrealistic in the last 10 years, and we must make greater use of voluntary effort — at the moment we are only seeing the tip of the iceberg."

YOUR LETTERS

NATIONAL CONFERENCE

Evelyn Ackroyd, Chairman Kings CHC

My Council have urged me to write to you to deplore the handling of the Order of Business Session at the National Conference on 3 November. Because the method of conducting business was both confusing and muddled to a great many CHCs present, my Council feels that the passing of the resolution "That the CHCs in England and Wales wish for a National Association of CHCs to be set up without further delay" does not reflect accurately the wishes of the majority of CHCs in England and Wales.

A. Leversedge, Secretary Barking CHC

Since there were many delegates at the conference who felt strongly that no opportunity was given to discuss amendments to the first resolution, and indeed left the conference as a sign of protest, it may prove helpful for them to be made aware of the action taken by Barking CHC. We have written to the Secretary of State setting out our dissatisfactions and suggested that no action be taken on the formation of a National Association, especially in view of the financial position.

The NE Thames Regional CHC Chairmen have also agreed to send a further letter to the Secretary of State in the form of a regional protest.

GOOD RELATIONS WITH AHA

Harry Richards, Chairman Walsall CHC

From time to time we read in *CHC NEWS* of the lack of co-operation between health authorities and CHCs and I feel that credit in this respect should be given where due.

In Walsall we enjoy a first-class relationship with the AHA and AMT. Information requested is supplied when available and our Secretary works closely with the team wherever possible. Members of the Team regularly attend our meetings to advise us and recently no fewer than five officials came to a discussion regarding the possible closure of a local maternity unit. In addition Area and CHC members have attended joint meetings at the RHA to discuss particular problems and, as a direct result of one such meeting, we hope that the local ambulance call system will be markedly improved.

We believe that health authorities now accept the CHC as an established and responsible body and we hope that, by co-operating with all concerned, we may play a worthwhile role in improving local health care services.

THE ARTIFICIAL LIMB SERVICE

L. C. Softley, Member Northampton CHC

I really must reply to the letter from Barrie Taylor in *CHC NEWS* 13. I wrote my paper (published in *CHC NEWS* 6) from 30 years experience and knowledge of the situation, and it is rather shattering when some members of a CHC visit a limb centre for, I suppose, an hour or two, and then tell me I am wrong. Please read my paper again, with the assurance from me that every word in it is true.

There are 10,000 new amputees per year in this country, and you know Barrie, just suppose that you were motoring, say, in the wilds of Yorkshire, and were involved in an accident that necessitated the amputation of a leg, you would NOT go to Roehampton to have it amputated. It would be done at the nearest hospital, and you would just have to hope that the surgeon who amputated knows what a limb fitter requires in the stump that is left. By what authority do you state "advances in technology are being used for the patients' benefit", until you know what is involved and have compared it with other countries? I do not know if SW Herts CHC have speakers to their meetings, but if they do I should very much like an invitation to speak.

SERVICE COMMITTEES

John Holden, Secretary King's Lynn CHC

I feel it would be of interest to all CHCs if you were to print the text of the proposal from Norfolk FPC regarding the participation of Community Health Council Secretaries at hearings of the family practitioner committee. For those CHCs who have not yet submitted their comments on the review of complaints procedure this may give them an opportunity to include something regarding the above.

The proposal was:

"This Society requests the Department of Health and the Secretary of State to advise CHCs that complaints which are brought to their notice should be referred to the appropriate health authority for the correct procedure to be applied without further involvement by those councils, and that details of service committee hearings are not reported to meetings of CHCs."

See also article on p10 (Ed.)

CHIROPODY SITUATION

Henry Smith MChS, Member Oldham CHC

Yes, there is an acute shortage of qualified chiropodists *(Letters, CHC NEWS 13)* due in the main to lack of appreciation in past years by the public and the medical profession of the importance of this profession. The Society of Chiropodists are aware of the situation, and new schools have been opened with consequent improvements, i.e. 4,879 chiropodists were registered at 1.6.75 and 4,976 at 1.6.76.

I am of the opinion, and am sure of the need (as are many of my colleagues in private practice as myself) for greater collusion between Area Chiropodists, Area Health Authorities and private practitioners, with a view to using more fully the surgeries and services of private chiropodists, under a contractual agreement with the NHS, to relieve in some degree the present shortage in community clinics and services.

ADVICE FOR WOMEN

Mary McClymont, Principal Lecturer in Health Studies, Stevenage College

With reference to the letter in the September issue of *CHC NEWS* from Eugenie Summerfield, may we point out that health visitors are, and have been for some years, prepared in their qualifying education course to educate the public for the changes in the middle years. Personal health counselling is freely available to men and women and health visitors would welcome the help of community health councils in publicising, supporting and extending this work. Health visitors are working closely with self help services in other fields and we should be very interested to hear of the developments envisaged.

GRANTS TO VOLUNTARY ORGANISATIONS

Bob Holland, General Secretary, Coventry CVS and Member Coventry CHC

The circular "Priorities for Health and Personal Social Services in England" says: "Health authorities should give every support to voluntary bodies in their work of harnessing community effort." However, financial assistance given by AHAs to voluntary agencies is in many instances absurdly small, when compared with grants from local authorities. In Coventry for example, the AHA gives a total of £1,400 in the current year to voluntary bodies while the City Council's Social Services Committee grants about £28,000.

It is most urgent that CHCs include evidence about this in their submissions to the Royal Commission on the NHS and that we collect it, in order to make a more effective lobby for voluntary organisations, which many of us represent. I would be most grateful if CHC members or secretaries could send me details for their districts urgently. I should like to send these details in with evidence for the Royal Commission from Councils of Voluntary Service.

HEALTH CENTRES

John Holden, Secretary King's Lynn CHC

May we through *CHC NEWS* ask CHCs throughout the country to advise how many health centres have been constructed within their district and how many actually conform to the original concept of a health centre?

Any further information regarding the general acceptance of health centres made (a) by the public, (b) by general practitioners, would be extremely useful.

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.

NOTES ON PRESS LINKS

JEREMY HARRISON

Assistant Director, Young Volunteer Force Foundation and publicity consultant to several voluntary organisations.

With the recent changes in CHC membership, many Councils may be appointing new press officers. For those who are taking on the job for the first time, I've made some notes on ways of keeping the CHC in the public eye.

It doesn't take all that much effort to keep up good relations with your local press. The trick is simply to get organised and follow some fairly simple guidelines:

1. Make a press list. This means the names, addresses and telephone numbers of your local papers, and any local radio stations. Then try to make sure you have a contact on each of them. You can then send any news you have direct to that contact. It will help you quite a lot if stories about the CHC are generally written by one person who knows some of the background to what it does. If you don't already know the correct addresses of your local papers, or if you're not too sure how many there are, look at a copy of Willings Press Guide in your library. You'll probably have to get radio station addresses out of the telephone directory. Don't waste your time with papers that don't directly serve your area. And don't worry about the nationals either. If you have that good a story you can rely on one of your local reporters to sell it to a national quickly enough.

2. It sounds obvious, but whenever you send anything to the press present it well. Check and double check for mistakes. Double space the typing. Put a succinct headline on it, and then tell the story as simply and quickly as possible. Whenever you can, finish it off with a quote from whoever you want reported as your spokesman. Then make quite sure that you finish up with the name and day and evening phone numbers of your press officer and the spokesman you've quoted. But make it look readable because most local newspapers have piles of appallingly presented information to deal with. The readable ones tend to get dealt with first.

3. Be sure you know when the weekly papers have their deadlines. If you are trying to tell a complicated story try to get it to them fairly early in their week so that they have time to follow it up. If you are putting over a simple piece of information you may do better to save it until a couple of days before the deadline so that it doesn't feel to the reporter like last week's news.

4. It is often convenient for everyone if you issue a press release. But a press release isn't a substitute for personal contact. That is why it helps a lot if you do appoint a press officer who can then keep in regular contact with local reporters. Reporters like to deal with people they can trust and know they can get in touch with quickly. The best thing to do is to make sure that you have some kind of contact with each reporter you deal with at least once every fortnight or three weeks, whether you have any immediate news or not. Let them know the kind of things that are likely to come up, and when. Apart from anything else, the more they know about you and your council the less likely they are to misrepresent the CHC when they do come to writing a story.

5. Beware of press conferences. It's easy to decide to call them, far more difficult to get anyone to turn up. Here are a few rules:

A. Only have a press conference about something when you know the reporters will want to question you about something, particularly if it is complicated.

B. Don't try to tempt them along with flash refreshments. They'll begin to wonder where the money is coming from. A decent cup of tea or coffee is quite enough.

C. Have as few speakers as possible. It looks ridiculous if you have more speakers than reporters.

D. Expect very few reporters, and organise things informally in a modest-sized room. There's nothing more embarrassing for a reporter than to be one of two or three lost in serried ranks of empty chairs. Very few local press conferences will attract more than half a dozen reporters. The vast majority will get no more than three or four. If possible, always give the impression that you are expecting fewer people than eventually turn up.

E. If you do have a very low attendance on your hands, don't hang around forever in the hope that someone else will turn up. Get on with the conference for the benefit of whoever has come. Never start more than five or ten minutes late, and never go on for more than about thirty minutes.

In most cases you will do far better by just inviting the odd reporter to have a drink or a coffee whenever something complex comes up, and make sure you welcome them at your AGM.

6. Never be afraid to ring the press up. What seems like pestering to you is probably music to their ears so long as it is couched in concern that they have got all the information they need, and so long as it is friendly. Reporters' great fear is that no one will ring up. Don't ring up and complain if a story doesn't get in, or doesn't get the coverage you think it deserves. That happens from time to time. It's not usually the reporter's fault. Bite your tongue and try to make sure the next story gets in.

7. Finally, don't forget the letters page. However good you are at getting stories in, your newsworthiness is likely to be judged to some extent by the numbers of letters your subject generates. Get in there and write some yourself. Many people only write to papers to complain that their name has been mis-spelt or their views misquoted. If you do have to correct something, try to get in touch with the reporter first. Don't go over his head to his editor if you can help it. Reporters appreciate that kind of thoughtfulness because they don't meet it all that often, and they usually respond well to people that demonstrate it.

Health Education

Everyone talks glibly about "health education" but have you stopped to think how many different interpretations can be put on these two words? To some it means sex education and anti-smoking propaganda, to others preventive medicine, and to a few the basic anatomy, physiology and hygiene which was taught in my youth. It should be all these things and very much more and because CHC members come from such divers backgrounds they have a tremendous role to play in seeing that the right patterns are set.

Every discipline in the health service has a role to play in educating all ages and levels of society; in the forefront of these are the health visitors, who although trained in methods of care are often totally lacking in the ability to market their very valuable products. However the true key to an informed and healthy society lies in school; the things which are implanted in your mind at an early age are far more clearly remembered than those learnt later on. A recent survey on educational methods showed that modern methods created far more mental stress than the three "Rs" — this small but important paragraph was mentioned only casually when the report was discussed — it's implications are enormous. A happy healthy child is one who knows friendly, firm discipline; the shifting sands of education today result in a sub-standard society who need constant caring and cannot care for themselves — education is the answer, so how can we go about it?

First return to conventional methods of education as a basis; second, but no less important, train and prepare teachers properly. It is no use asking a teacher to include health and hygiene in her school curriculum unless she is trained to do so. Equally it is no use expecting a teacher to

by June Ayling, Secretary of Maidstone CHC

prepare young people for life outside the academic field if they have had no such experience — we should insist on a period in industry as our EEC partners do, five years over there.

A small child learning to read can learn "health" words just as well as cat and dog, which brings me to the third necessity: proper teaching aids at all educational levels. Finally, in these days of having to show academic achievement on a piece of paper, there should be CSE and O level papers in Mothercare, Fathercare, Citzenship, How to use the Health Service, Health and Hygiene, and Use of Leisure. After school education does not cease; the HEC posters and documents have a tremendous part to play but need to be looked at with a different eye. The educated and informed can write the prettiest booklet which will appeal to the informed eye — but that is not the customer you seek. You are after a simple soul, educationally lacking and uninformed, possibly even illiterate. Graphic, simple literature, oft repeated is the only comprehensible approach to that individual. Industry can lend a helping hand in many ways; through clinics and encouragement to preventive screening and more recently through pre-retirement training. After the family have grown up and left why not buy a smaller house several years *before* you retire. Learn to use your coming leisure and to think about your retirement budget. Employers can give time off to do this by using the reduced working week in the final years of employment.

Many of the results of education will take years to be effective, so start now and look for a society with well planned homes, family houses and granny houses, an NHS with tip top facilities used by those who really need it and a caring community really given the wherewithal to help itself.

Nursing for the family

At the beginning of 1976 the British Red Cross Society introduced a nationwide series of lecture demonstrations, "*Nursing for the Family*", designed to teach the general public the basic techniques of nursing care needed to look after a sick, handicapped or elderly relative at home. The introduction of the demonstrations followed a survey carried out by the County Branches of the Red Cross which showed that "the lives of thousands of people are almost unbearable because they can not cope with the problems of looking after sick, handicapped or elderly relatives at home". The survey also highlighted the increasing pressures on district nurses which made it more difficult for them to spend sufficient time with their bed- or house-bound patients — some of whom need more than one visit a day. Added to this, according to the survey, people are discharged from hospitals much sooner than ever before and there is a shortage of long stay hospital beds for geriatrics and the chronically sick.

"*Nursing for the Family*" demonstrations are run by Red Cross County Branches throughout the country. The sessions, unlike other first aid and nursing courses run by the Red Cross, are non-certificated — the participants do not have to pass a final exam. The sessions consist of four 1½ hour lecture demonstrations given either by trained nurses or Red Cross Instructors and are usually spread over four weeks. Procedures like how to change the sheets with the patient still in bed, how to give a bed bath, how to administer medicines correctly, how to feed a helpless patient and how to avoid pressure sores are taught. The Red Cross hopes that once a family knows the basics of nursing care, it will be able to

by Sarah Parshall, P R Dept., British Red Cross Society

cope more readily and confidently on its own.

A recent evaluation of the courses carried out for the Society showed that thousands of people have already received the basic training since "*Nursing for the Family*" was launched, but only four per cent have been men. In a statement following the survey, the British Red Cross claimed that "Far too many men do not have the basic 'know-how' to look after their wives when they are ill. There is a tendency therefore for women to start going about their daily tasks too quickly after operations or childbirth simply because their husbands do not know how to cope." The size of this problem could be judged from recent DHSS statistics which showed that three-quarters of a million women were admitted to hospital in 1974 to give birth.

The Red Cross statement also claimed that: "Because of their lack of training too many men are no help to their wives when it comes to looking after a relative. Some are not even able to give their wives a break because they do not have the confidence that they would know what to do if something went wrong when their wives were out."

In most cases demonstrations are given free, though a nominal charge may be made to cover costs. Those who wish to attend sessions should contact their local branch of the British Red Cross — in their telephone directory under 'B' for British or 'R' for Red Cross.

Boxed reminder cards illustrating all procedures covered in the sessions can be obtained from The British Red Cross Society, 9 Grosvenor Crescent, London SW1X 7EJ, price £1.50 inc. postage.

PERSONAL VIEW

by Alfred Boom, Chairman, West Berkshire CHC.

Some sections of the hospital health service seem to have learned the trick of turning on the money tap without difficulty. Perhaps it is not a trick, it might be that old adage of *those who shout loudest and longest get most*; end up with more staff, expensive equipment and purpose-built buildings. Might it be that those who carry on with inadequate equipment and inadequate staff *in inadequate buildings* are those who will not take part in a public relations exercise for themselves, not wishing to spare the time nor the energy?

The government is proposing to turn off the money tap for the better off Regions. However, there will still be a scramble to get the lion's share of whatever new resources are allocated in the other Regions. We are all spenders of money, but when it comes to the decision on how to spend we take a public or private attitude. Are doctors, who are the principal hospital spenders, capable of realising that their private purse as against their public purse in spending starts from the same base? Further, can we expect those who require the resources and spend our money to be completely objective in discussing their needs?

Willis J. Elwood, Regional Specialist in Community Medicine for the North West Regional Health Authority, in his Essay which won the 1976 North West Regional Hospital Authority First Prize, writes, "The management of the National Health Service would be better if doctors were :- (a) more cost conscious, (b) more sensitive to the issue of efficiency in the use of resources under their control, (c) more questioning in the assessment of the effectiveness of what they are doing, (d) prepared to face the implications of the necessity of sharing on a more reasonable basis the limited resources available to them. (Lancet 25 Sept. 1976).

He goes on to question the principles of clinical freedom and particularly how this attitude might consume resources and money. Could it be, too, the awkward question of the mixing of the two systems within the health services, where individuals are paid from both private and public purses? Has it become too difficult for them to have a real regard for the general public need, and tend to be big spenders of money privately for themselves and publicly for us, the users of the services?

However, I certainly feel there is room for highlighting those features of spending which have caused a very uneven development of services, like mental handicap and mental illness. Those published critical comments on the consultative document, "Priorities for Health and Personal Social Services" suggest that many of the targets are unrealistic. Would it be that the document is not unrealistic, but is being questioned by those who find it hard to divorce the public and private attitudes?

The majority of Council *members* believe that it is their role to represent the consumer's interest and to review standards and therefore look closely at the way resources are allocated. But will the majority of *Councils* see their role as representing the needs of the consumer, and therefore will consumers be given an effective voice? And even if a Council decides that it has that role, how effective it can be is certainly a matter for concern. In the area where my own Community Health Council functions, every opportunity is taken to block discussion on the allocation of resources (both capital and revenue) and it is becoming extremely frustrating. If Dr. Ellwood's conclusions are right, then a dialogue must begin between Community Health Councillors and doctors who are chairmen of departments, and the other consultants who have influence and power, so that the views of the consumer can really be heard.

It is probably not so much being dishonest as exaggerated demands. An element of keeping up with the Jones'?

News from CHCs

- South West Cumbria CHC's annual report records how the Council intervened to save a village surgery threatened with closure. The doctor in residence retired and the Medical Practices Committee decided that the practice should be dispersed. Worried villagers approached the CHC, who suggested an immediate meeting of the various groups opposed to the closure. A letter to the AHA and a massive publicity campaign led to the reversal of the MPC's decision.
- At the request of the Warrington CHC, the local Family Practitioner Committee has agreed to give complainants information, as a matter of course, about their entitlement to claim for travelling expenses and loss of earnings, for attendance at service committee hearings.
- East Birmingham CHC has set up a joint committee with the Amalgamated Union of Engineering Workers to organise a national conference on employment opportunities for the mentally handicapped. (See also book review, p.8 — Ed.)
- Lincolnshire North CHC has agreed that its secretary should offer administrative assistance and advice to newly forming voluntary health groups.
- Felicity Voce has been appointed as Secretary to North Devon CHC. She replaces Mr R J Wilkins who left the Council in September.
- Derek Wainwright is the new Chairman of Roehampton CHC. Mr HE Buttery has been elected Chairman of SW Surrey CHC, and Cllr Mrs M Chenery is this year's Chairman at South Tyneside CHC.
- Mary Merricks of Cambridge CHC has taken over from Mr R Allen as Secretary to the Regional Meetings of East Anglian CHCs.
- Myrddin Davies, Secretary of Ogwr CHC, has been elected Mayor of the Borough of Ogwr — the largest district council in Wales.
- In our November news column we reported that Mr GE Adams was the Chairman of N Devon CHC, and that Ian McMinn had been elected Chairman of Burnley, Pendle and Rossendale CHC. In fact, N Devon's Chairman is Mr GE Andrews, and Mr McMinn is Chairman of North Tyneside. Mr W Ashworth is still Burnley, Pendle and Rossendale's Chairman. We apologise to all concerned.
- Trent CHCs have decided to form a regional association. Chairman is Cllr AA Goodson JP, of South Lincolnshire CHC, and Fred Riddell of South Derbyshire CHC is Secretary. The Association's Vice-Chairman is Mr H T Walker of SW Leicestershire CHC; Treasurer is Cllr G Moore of Barnsley CHC; and Mr GH Sharpe of NW Leicestershire is Auditor.

Photo: John Sturrock (Report)

- Wandsworth and East Merton CHC's banner at the recent demonstration against cuts in public expenditure.

EDITORIAL

In the current financial climate it is perhaps inevitable that the cost of CHCs is being questioned. Most of us would take the view that not only do CHCs cost very little, but that they are even more important at a time when health service resources are diminishing. It can, however, be a bit demoralising when newspapers or journals take a side-swipe (albeit ill-informed) at the public image of CHCs we are still struggling to establish. An editorial in *The Guardian,* for example, gave the impression that the money spent on CHC salaries was primarily responsible for the large growth in administrative costs over the last couple of years! In this instance a number of CHCs responded quickly to counteract this misleading impression, but it does highlight the need for constant vigilance. . . . It is clearly up to individual CHCs to convince their critics that the public can obtain value for money from its community health council.

It may often be helpful to put the financial record straight. In 1975/76 the total cost of the NHS in England and Wales was £5,458 million. Of this, £2.8 million was spent on CHCs — about 1-20th of one per cent of the total.

Another forum in which the cost-effectiveness of CHCs will no doubt be debated, will be the Royal Commission on the NHS. The Commission's statement on its future work programme (*The task of the Commission,* HMSO, October 1976) specifically states its intention of looking at (a) the effectiveness of CHCs in ensuring that services are responsive to local needs and (b) the role of CHCs in supplying information to the public. Many CHCs have already submitted their evidence, and hopefully even more will do so, even if they could not manage the deadline of December 31st.

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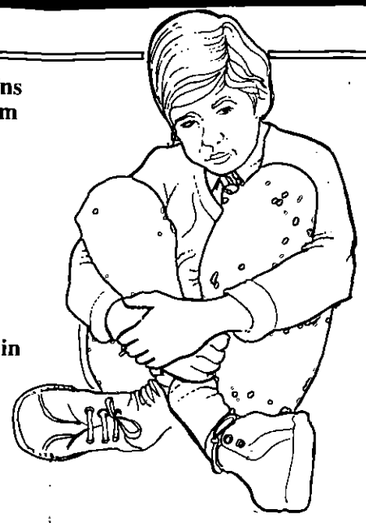
MAN, 27, admitted for routine varicose veins operation. Theatre sister wrongly books him for sterilisation. Sterilisation performed. Error discovered. 2 further operations necessary. Negligence claimed. damages of £1,400 awarded.

GP VISITS boy with pneumonia. Calls ambulance and gives mother note for hospital doctor. In ambulance mother reads note which says child might die, and in GP's opinion this might be merciful. Distraught parents inform national newspaper. Defence society's advice to doctors: give letters to ambulancemen not relatives.



DOCTORS' DEFENCE SOCIETIES

by
Dr. Michael Joffe

Practising medicine can be risky — doctors are fallible like the rest of us, and even the safest of treatments can occasionally misfire. Because of this, societies exist to give legal advice to doctors who find themselves in difficult situations such as an accusation of negligence. They also provide a kind of insurance service in case of legal fees. awarding of damages, etc.. Just as all drivers are required to be properly insured, all practising doctors have to belong to one of these societies.

Every year each society sends its members a report which contains a selection of cases — cautionary tales — and some general advice. This year's report from one of the biggest, the Medical Protection Society, contains some items which are of interest not only to its members but also to the "consumer".

One of these is called "Consent to Treatment". Almost everything a doctor (or dentist) does needs the patient's consent — if she or he is 16 or over and of sound mind; otherwise the consent of the parent or guardian is required. It does not have to be spelt out in words. If the doctor indicates that an injection is to be given, all that needs to be done is for the patient to roll up a sleeve. If a medical examination is necessary, consent may be given simply by undressing and lying down. It is assumed that when any treatment is given by mouth, the act of swallowing it is taken as consent.

In some situations, doctors are advised to get the patient's agreement in words.

According to the law, it is not necessary for this to be in writing, but the Medical Protection Society advises its members not to rely on the spoken word when a significant risk is present — because it is difficult to prove what was or was not said in the event of a dispute. The most important such occasion is of course when an operation is to be performed — excepting emergencies which cannot wait.

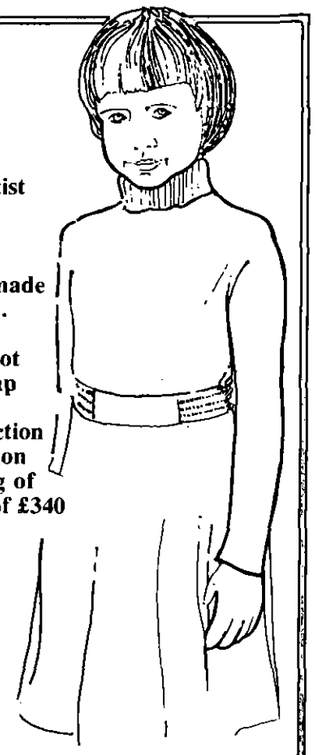
Written consent is a "wise precaution" for anything at all complex, especially if it involves a general anaesthetic. A special case is sterilisation: a doctor is recommended to get the consent of the spouse as well as the patient, especially if the operation is not being performed for strictly medical reasons.

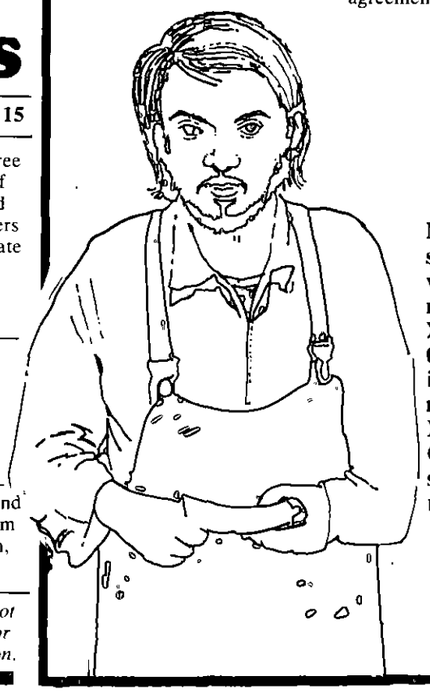
However consent is sought and given, whether by gesture, spoken word or writing, the doctor is responsible for making sure the patient understands what is being agreed to. Though this may sound simple, it is the most difficult part. As many people know from experience, doctors find it very hard to provide explanations at the right level for the person concerned, neither blinding her/him with science nor treating her/him as a fool. It is also up to the patient to ask questions, even though this is easier with some doctors than others. Not only is the level difficult, but also it is not clear from the doctor's point of view how much information should be given.

Most commonly-used treatments cause various forms of discomfort to some people, but not to others; and many have rare but more serious side-effects. To give too much information may frighten the patient needlessly, whereas enough data must be provided for a proper decision on consent to be made. The Medical Protection Society advises: "A mis-informed consent, or one given in ignorance of what is requested, is of no value." In addition, "no guarantee of success" should be given, for example in a sterilisation operation. There are some especially difficult situations such as controversial treatments (injections against whooping cough and smallpox are the examples given): written consent is advised because of the danger of reactions — to protect the doctor not the patient. And similar problems occur with trials of a new drug, or experiments. Great care is needed to make certain that the doctor gives an adequate explanation, and that it is understood, before giving consent.

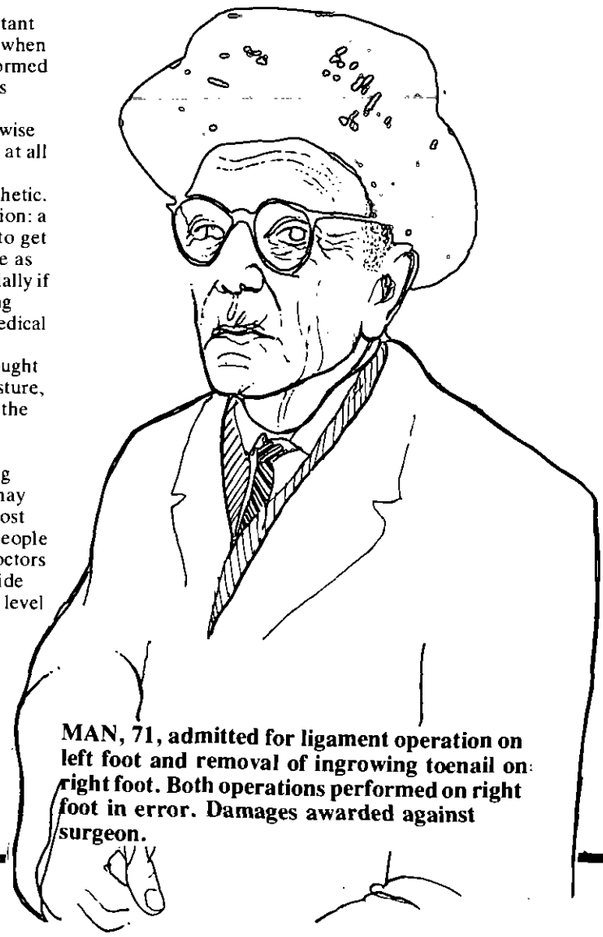
Another item in the same report is "Disclosure of medical records for the purposes of legal proceedings." Medical records are of course confidential — though they are *not* covered by legal privilege (like that between lawyer and client) as is often thought. The legal situation is set out for doctors: in the course of a legal action, the client may apply to compel disclosure of the records, to their owner in the first instance, which is the Health Authority for NHS cases. This is likely to happen in two kinds of legal case. Firstly, where the doctor is being sued for negligence, or secondly where the records contain evidence which is relevant to e.g. a divorce or a road accident. In the last-named case, the client is often an insurance company. The Court of Appeal has ruled that disclosure in any of these circumstances is to be made only to a doctor named by the client, never to the client or her/his lawyer. And disclosure is only ordered in cases in which a claim is likely to be made.

GIRL, 11, attends dentist for extractions. GP in attendance to give anaesthetic. Several unsuccessful attempts made to give injection in arm. Inhalation anaesthesia eventually used. Arm not dressed and no follow-up arrangements made to confirm healing of injection sites. Infection, ulceration and permanent scarring of arm results. Damages of £340 awarded against GP.





MAN, 22, using pneumatic drill feels something enter his eye. Attends hospital where doctor examines him. Nurse told to remove foreign body from surface of eye. No X-ray given. Patient subsequently develops eye trouble and is prescribed drops. Some improvement. Over one year later patient returns to hospital with further symptoms. X-ray reveals foreign body inside eyeball. Operation to remove it performed. Cataract subsequently develops and further operation necessary. Negligence claim settled for £3,750.



MAN, 71, admitted for ligament operation on left foot and removal of ingrowing toenail on right foot. Both operations performed on right foot in error. Damages awarded against surgeon.

BOOK REVIEWS

NEED AND THE NATIONAL HEALTH SERVICE: ECONOMICS AND SOCIAL CHOICE,
by A J Culyer.
Martin Robertson, 1976,
£6.50 hardback, £2.95
paperback.)

In this clear and concise book, an economist looks at the problems of allocating resources in the NHS. The author points out that indicators of some sort are required if a fair and efficient service is to be achieved and he believes that 'need' must be the basis of allocation. However, 'need' is not a simple unequivocal concept and most of the book is devoted to establishing how the values involved in defining need can be made explicit and subject to open discussion.

Currently, doctors decide what patients 'need' and they claim their decisions are based on 'clinical judgements'. As an example, Culyer applies his technique to the establishment of a 'fair' waiting list and shows how social values about the 'need' for admission can be taken into account in a systematic way. If his approach were introduced generally in the NHS, many doctors might feel that their authority was being undermined but many patients might find that the hospital's policy was more explicit and intelligible and, indeed, open to discussion. Culyer believes that decisions which involve social values should be taken by publicly accountable policy makers and not by non-accountable doctors, a view which many CHC members would endorse.

The subject matter of this book is undoubtedly of interest to CHC members but many will find it rather daunting because it is primarily an economist's book. However, its simple, jargon-free style helps the non-economist to understand its theoretical approach and those who persevere will find it provides a new perspective on some familiar problems.
Anne Weyman

EMPLOYING THE MENTALLY HANDICAPPED
by G. G. Callaghan. Copies available from: Lincolnshire North CHC, St. Mark's House, Lincoln, price 50p + 15p postage.

There are many publications on provision of health and social services for the mentally handicapped, but this pamphlet concentrates on the ability of mentally handicapped people to do purposeful and useful work. Its aim is to encourage employers to recognise that mentally handicapped people can do responsible and capable work, and to offer job opportunities to this sector of the workforce.

An additional benefit of the pamphlet is that it states in clear and sensible terms the key definitions of mental handicap, information about people working from within hospitals and training centres as well as in the outside community, and descriptions of various jobs which are suitable for people with different degrees of handicap. This pamphlet has been prepared by Geoffrey Callaghan, secretary of Lincolnshire North CHC, with the co-operation of his Council, and it is an excellent example of the ways in which CHCs can promote constructive change — in this case by linking together potential employers and employees.

ECONOMIC POLICY AND HEALTH
by Dr Peter Draper. (Copies from USHP, 8 Newcomen Street, London SE1, price 40p inc. postage.)

This 10-page paper is a vigorous criticism of our current approach to economic policies because we ignore proper consideration of health issues. Dr Draper argues that unquestioning pursuit of policies for increasing the nation's output of material goods and services creates abrupt and ill-considered changes in the NHS budget, and promotes over-consumption and health hazard for workers of all levels. The health costs of conventional economic wisdom are wasting economic resources, so Dr Draper calls for more informed and honest debate of these important issues.

MEDICAL NEMESIS
by Tom Heller, University of East Anglia

In his book *Medical Nemesis* *, Ivan Illich delivers a flagrant broadside attack on all our notions and preconceptions regarding the medical profession and the entire health care system. He takes as a starting point the fact that many medical interventions are ineffective and that the high technology, curative approach to medicine is frequently just an expensive way of delaying inevitable death.

His main theme is that the health care system has now become a positive danger to health in three ways. Firstly that many medical interventions are highly dangerous in themselves, poorly understood and frequently misused. Secondly that attempting to cure people's illnesses that have been caused by various other factors in society (e.g. poor social environment, etc.) diminishes any attempts to change those fundamental causes of ill-health. Most importantly that the health care system has taken over all healing and caring functions and has thereby diminished individual and community methods of coping with pain, illness and death for ourselves. Through these mechanisms the health care system is becoming too big for its boots and retribution (nemesis) must ensue.

His analysis therefore has important implications not only for those within the system, but for critics including CHCs who might advocate increased expenditure on health care, better coverage of currently available facilities, etc.

Illich's critique of the health care system is one part of his concerted attack on the way that our entire society is organised, and he illustrates similarities between the organisation of health care and the other contradictions within advanced industrial society. His desire to return to pre-technocratic forms of society is unrealistic simply because we have to start from where society has now reached. However, critical reappraisal of all technological and "professional" interventions must surely lead to a more balanced approach whereby their effective contributions can be appropriately used by the whole of society.

All the arguments that Illich uses have been documented

Ivan Illich
Photo: Marion Boyars

before, but his flamboyant presentation has made it impossible to ignore this attack on much of the accepted thinking about health care systems. His more outrageous suggestions and sweeping denouncements have stimulated this type of vital debate even in those 'corridors of power' where such thoughts would have been unthinkable a few years ago. Although the style of his writings is occasionally quite difficult, and sometimes appears imperfectly documented, his contribution has been to initiate the debate and begin the analysis necessary to move forwards to a more appropriate organisation of society including different forms of health care system.

Although Illich himself gives only scanty hints for positive action, and does not divulge in any detail the sort of health care system that he would approve of, his contribution is by no means negative. His work should be essential reading and represents a positive stimulus for us all to examine what we are currently doing in health care and what we as "professionals", activists for change, individuals or potential patients really are advocating as the best method of caring for the sick and needy in our society.

Revised edition now available from bookshops entitled* ***Limits to Medicine* *published by Marion Boyars, £2.50*

The Quality of Surgical Appliances

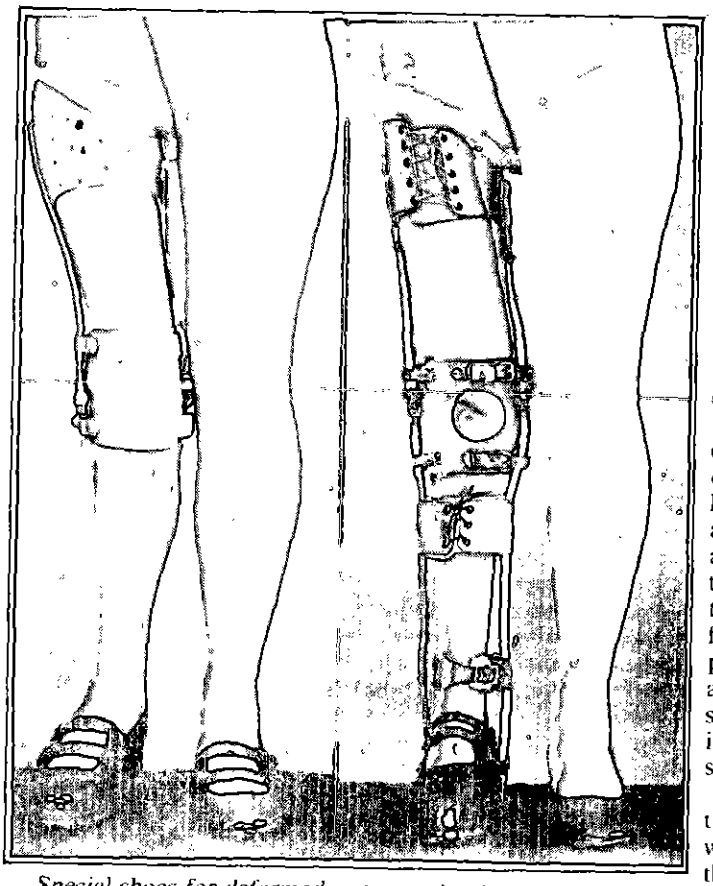
by Peggy Jay, Occupational Therapist

At one time the terms "physical disability" and "cripple" were almost synonymous, and anything like a caliper, boot, shoe or corset which made walking at all possible was a boon, whatever its appearance. Nowadays, attitudes have changed and handicapped people wish to be like normal people. Anything which draws attention to their disability rather than minimising it is unacceptable.

The Orthotic (Surgical) Appliance Service and the orthoses supplied through the NHS have been much criticised lately. To try to get at some of the facts, a survey was sponsored by the National Fund for Research into Crippling Diseases*. As an occupational therapist working with the Research Institute for Consumer Affairs, I interviewed nearly 200 patients living in the London area who had long leg callipers, specially made (surgical) footwear or lumbar supports.

Very many of those interviewed disliked the appearance of their orthoses. Most of the calipers were cumbersome, with metal bars and straps that not even trousers could disguise, and the design had hardly changed over many years. The shoes were nearly all in a plain lace-up style, sometimes looking more like football boots. Women used to dressing up for smart occasions found them particularly distressing. The lumbar supports, especially those worn by women, were usually heavy corsets often with laces and hook and buckles and straps, and difficult to put on without help. They looked like something from a bygone age, and younger women brought up on tights found them embarrassing.

Work has been done to improve appearances. Three different versions of a cosmetic caliper have been developed in this country, lighter in weight, closer fitting, and much less obtrusive than the conventional caliper. Although not suitable for all caliper wearers, the new design could benefit a good proportion of them. The survey showed that patients who had asked for the new one were often not even being assessed to see if it would suit their case. Even more disturbing, some of the few we saw who had the new type could not wear it because of incorrect fitting.



Special shoes for deformed feet need to be fairly high in front to give firm support. Laces are an obvious fastening, but why not a strap and buckle, or Velcro, unless there is some medical reason for lacing. Even with laces, the shoe could be made to look more dressy and attractive with, say, a brogue flap to hide the laces or a pattern of stitching or punched holes. No wonder that some of these custom-built expensive shoes are rarely, perhaps never, worn.

The shoes provided are of the serviceable, walking type, but many patients are elderly, spending much of their time indoors. We met only one who had been given a pair of surgical slippers. Younger people too would appreciate lighter shoes or sandals for social occasions and leisure time, to alternate with stronger ones needed for the daily round of walking and standing. The NHS regulations stipulate that patients are entitled to a second orthosis. Quite rightly, it is usual to delay ordering this until the first is deemed satisfactory, but unfortunately the second one is sometimes forgotten or, on rare occasions, the consultant refuses to sanction its order.

The regulations also state that "The frequency at which replacements will be necessary cannot of course be arbitrarily determined as much will depend on the individual circumstances and disability of the patient. The sole criteria for deciding whether replacement is justified should be the serviceability of the appliance and the continued clinical need". Too often this is honoured in the breach rather than the observance. Hospitals, perhaps for administrative convenience, rule that new shoes or corsets may be supplied after one year. We interviewed young, active people on their feet all day and wearing badly worn-out shoes. At the other end of the scale, one woman had accumulated six pairs and explained that she did not go back every year to claim her entitlement.

Orthoses supplied through the NHS are usually produced under contract by private firms. An orthotist, or fitter, acts as the link between hospitals and firm, so that the patient never meets the person who actually makes his appliance. This appears to contribute to the fact that orthoses are not always as comfortable or as functionally efficient as they should be. Firms do not get paid for alterations to an ill-fitting appliance, unless the need for these is due to some change in the patient's condition. The fitter may therefore try to persuade the patient that no alteration is necessary, a situation often compounded by inadequate medical supervision.

The DHSS has now accepted that appearance is a factor which must be considered in the provision of orthoses. New materials have made it possible to develop better looking and less cumbersome calipers, shoes and corsets, but much remains to be done to make people aware of these, so that patients may benefit.

*A report of this survey entitled **The Patients' Viewpoint** by Peggy Jay, MBAOT, SROT, and Michael Dunne, MBE, BSc, is being published by the National Fund for Research into Crippling Diseases, Vincent House, 1 Springfield Road, Horsham, Sussex.*

FPC ATTITUDES

by Arthur Harman, Secretary of Cuckfield and Crawley CHC

I consider CHC/FPC relationships marginally the most dangerously fragile bubble in that simmering brew — our NHS. By comparison, RAWP, abortion, fluoride, etc., will be long surfacing. The Society of FPCs 1976 Annual Meeting demonstrated this undeniably.

I was a delegate (as a member of West Sussex FPC): could not avoid wearing "two hats" — but perhaps, thereby, was forced to objectivity.

I listened to a debate described by the President "of as high a standard as he could remember" (albeit based on false premises!) about alleged threats to impartiality/confidentiality of service committee hearings; arising, of course, from CHC involvement — particularly Secretaries' rapidly-being-acquired expertise

One Management Committee member asked "Why is it necessary for FPCs to go on to the defensive?", but it seemed sadly salutary that criticisms flowed from areas as diverse as Greenwich, Merton, Oldham, City and East London, Newcastle (almost) — and CHCs took a real belting from Norfolk, who started.

Doctor/dentist bashing may be fun; may be fashionable. But those not experienced (if only because of the review of complaints procedures) know what a complex minefield we tread. Obviously, with a case: go to it. But ensure your strategy and tactics — or lose before you start. Then those you claim to represent will justifiably criticise you. Next, N. Tyneside's formidable female basically sought abolition of CHCs, proclaiming "their cost and . . . inability to represent the public because of . . . lack of interest by the public . . ." I was among those startled to hear from her that one Council encourages complaints with prizes of trips to London, and pocket calculators (not really true).

This time I participated, which (modestly) created interest, stressing the obvious: the NHS must work cohesively for patients, including FPCs, CHCs and Uncle Tom Cobley. I cleared some of the previous confusion (I think); swiped one reverend FPC Chairman who thought too little of "paid officers"; thought the Royal Commission would examine FPCs/CHCs dispassionately, and commended the Management Committee for offering co-operation with a CHCs' National Association.

Others were constructive — one speaker alerted us to the danger to FPCs were North Tyneside's motion accepted. Happily it was lost.

Rt. Hon. David E. earlier had unknowingly(?) blunted hostility with his good, depressing, familiar speech, wherein he stressed that CHCs have a major role: ". . . greater co-operation and consultation can remove . . . doubts, and lead to a greater understanding of **the public's** point of view". He made it plain that CHCs are here to stay. Others, with me, emphasised that. Mark Twain was recalled as believing "we should always be giving attention to the future, because that is where we are going to live". Accepting that FPCs have over 63 years of traditional history, and CHCs, though carrying the burden of (minimal) NHS public participation, are in their ebullient adolescence, maybe that is not a bad motto.

Undoubtedly there has been mutual corntreading around the country, but if we are all going to act like china-shop bulls; sheep in wolves clothing; not give a monkey: then — nuts.

We'll get a dog's breakfast.

SURVEY ON FLUORIDE

by Mrs. S. N. Wansbrough, Chairman of Winchester and Central Hampshire CHC

When the Hampshire AHA requested the Hampshire CHCs to sound public opinion on the subject of fluoridation of the public water supplies, my CHC decided to do this by polling a random sample of residents in our district. An additional advantage was that it would enable us to test the feasability of mounting a proper statistical enquiry at acceptable cost.

The population of the Winchester and Central Hampshire district is 180,000 of which some 140,000 are over 18. The Regional Statistician advised that a poll of 180 respondents, randomly selected, would provide a statistically satisfactory sample. Accordingly, every 600th name was chosen from the electoral registers in our area to provide a total of 230 names and allow for non-response.

Postal questionnaires were despatched in March 1976, and after one follow-up reminder, together with two envelopes marked "Gone away". This represented a response rate of 88 per cent, a rate which is unexpectedly high. The sample also proved to be representative in that the age and sex structure matched that of the district.

The questionnaire was kept simple. Respondents were asked their sex, where they lived, their age group and whether or not they had children of school age or younger. They were then asked whether they were aware that at the present time there is some public discussion about the proposal to add fluoride to the water supply; and finally, whether they were in favour of this being done.

This survey was originally designed to establish clearly the difference between those for and those against fluoridation. In the event, out of the total of 200, 99 (49.5 per cent) were in favour, 59 (29 per cent) were against and 43 (21.5 per cent) were unable to decide. There were no significant differences between the rates in favour of fluoridation as between men and women; nor were the age differences significant whether you take those with children or those without children or all together. However, those with children were slightly more in favour of fluoridation than those without. Three-quarters of those against fluoridation had no young children.

Family situation		Are you in favour of adding fluoride to the water supply? Yes No.	Yes %	No No.	No %	Don't knows No.	Don't knows %
Has young children	male	15	60	8	30	3	10
	female	28	62	8	20	9	18
No young children	male	22	39	19	33	16	28
	female	34	49	23	32	15	19
TOTAL		99		58		43	

The great majority of respondents were aware of the present debate on the subject, but a number wrote declining to express an opinion on the ground that they did not know the facts sufficiently either way.

As a CHC we believe that this modest test project achieved what it set out to achieve. The rules of the game of public opinion polling have been faithfully followed and Hampshire AHA which commissioned the study may rest assured that opinion in our district is significantly in favour of fluoridation. The cost, we feel, has been modest — just over £50 — and in appropriate cases, using the same sampling frame of electoral registers, similar exercises could be conducted.

Help in the Home

The Local Authority's Role

Although CHCs have no formal responsibility towards those services which fall within the remit of Social Services Departments, most, nevertheless, have an interest in the broad spectrum, and particularly in those local authority provisions which affect client groups like the elderly, the handicapped and the chronic sick. One such provision is the home help service. In a parliamentary answer in May last year, David Owen stressed that the government sees the home help service as an important part of domiciliary provision — and one which "has an important part to play to enable people to remain in their homes for as long as possible".

The duty of local authorities to provide a home help service "adequate to the needs of the area" was established by Section 13 of the Health Services and Public Health Act 1968.

In October 1971 DHSS issued a circular (Circular 53/71) explaining the scope of this duty, and placing it in the context of a wider spectrum of practical help for people in their homes. This circular constitutes the latest official guidance on the subject.

Circular 53/71 indicates that the survey which each local authority is obliged to make of the number and needs of handicapped people in the area could form the basis for an assessment of how extensive the home help service should be. Although it is acknowledged that the bulk of the work may continue to be with the elderly, the circular makes it clear that the needs of other eligible groups should not be overlooked. People caring single-handed for an elderly or infirm relative can be eligible. And younger families can also be helped, for example, where long-term illness or severe handicap (especially in a child) gives rise to serious difficulties; where either parent is away — perhaps in hospital; or to enable a parent to rejoin the family more quickly after an illness. Home help for even a relatively short period can often give significant relief. The provision should be seen as a service to the whole household, and not merely to one individual in it. Providing support for a household may also provide an important element of preventive help. Section 13 of the Health Services and Public Health Act also gives local authorities the power to provide a laundry service on behalf of households where there is a person eligible for home help. Although perhaps most obviously helpful in cases of incontinence, the service need by no means be restricted to this. It is rather seen as a natural extension of the power conventionally used to clean a house and its fittings.

In the past, many local authorities have relied on a medical certificate as the principal evidence of need for home help. Many referrals still come from Health service sources in cases of illness, and full weight needs to be given to these, but the circular points out that an unclean home occupied by people not able — for whatever reason — to clean it or provide for themselves, constitutes a social problem which does not require medical authentication, and there is no need to refer to the health services about it. It is felt that a close working relationship between the health and social services should produce sound principles and practice adapted to local needs and capabilities.

The circular, then, sees the home help service as part of a wide spectrum of practical help in the home which can be provided by the health service and social services, jointly or separately. It also makes the point that it will often be to the greatest benefit of the client to offer not the services of a home help, but an improvement in the physical circumstances in which he or she lives — removal to sheltered (or even simply better) housing for example, or the provision of suitable aids and appliances to make self-care possible.

Parliamentary Questions

FPC OBSERVERS

Joan Maynard MP asked whether the Secretary of State intended to allow CHCs to appoint observers to FPCs to act in a similar role to the CHCs' observers on AHAs. Roland Moyle replied that the Secretary of State's consent is not required for this. He pointed out that this kind of arrangement already exists in some areas, but added that the Department is currently considering whether it would be helpful to issue general guidelines on the subject.

SERVICE COMMITTEES

Asked whether the Secretary of State would alter the Service Committee and Tribunals Regulations to make it clear that a CHC Secretary is not a "paid advocate" and is therefore allowed to represent a member of the public at a service committee hearing, Roland Moyle stated that he had received legal advice to the effect that, under the regulations as they now stand, CHC secretaries should not ordinarily be regarded as paid advocates. He also drew attention to the fact that the whole question of assistance to and representation of parties at sevice hearings is one which is currently under review. (The question came from Joan Maynard MP.)

BOUNDARIES

In answer to a question from Clement Freud MP, Roland Moyle said that there is no formal procedure for reviewing or altering health authority boundaries. He added that he would be reluctant to ask the NHS to face further radical changes so soon after the major reorganisation of 1974.

MENTAL PATIENTS

At the end of 1974 there were approximately 100,000 mental illness patients receiving treatment at psychiatric hospitals, and in psychiatric wards of district general hospitals, said David Ennals in reply to a question from Jack Ashley MP. Nine per cent were day patients, 86 per cent were in-patients in psychiatric hospitals and five per cent were in-patients in general hospitals.

JOINT FINANCING

AHAs are only required to give the Secretary of State details of jointly financed projects which require a capital expenditure of more than £50,000. To date he has been notified of 28 such projects. They include homes for the mentally handicapped, adult training centres, homes for the mentally ill, homes of the elderly, day centres, a sheltered housing scheme, and a meals on wheels kitchen. Roland Moyle gave this information in reply to a question from John Hannan MP.

DEPUTISING SERVICES

Roland Moyle told MPs that existing guidance on commercial deputising services provides that an FPC should not give its consent to any arrangement under which a deputising service would care for a practitioner's patients on his behalf every night and every weekend.

DIABETIC CHILDREN

In response to a question from John Farr MP, Roland Moyle said that diabetic children who need insulin injections can be supplied with disposable needles through hospitals if, in the consultants opinion, this is clinically necessary.

CHEMISTS' SHOPS

197 pharmacies in England closed between January and September this year, Roland Moyle told David Crouch MP. The figure comes from the registry of pharmacies kept by the Pharmaceutical Society of Great Britain, which also reveals that only 69 new pharmacies opened in the same period. There has been a total net reduction of 571 in England alone since the beginning of 1974.

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: Durham CHC
Address: 39 North Road
Durham DH1 4SE
Telephone: Durham 69133
Page 4: South Tyneside CHC
Chairman: Mrs M Chenery
Page 11: Doncaster CHC
Chairman: Cllr G Gallimore
Page 11: Rotherham CHC
Address: The Guardian Centre
Henry Street
Rotherham S65 1HZ
South Yorkshire
Telephone: Rotherham 79381
Page 14: North Bedfordshire CHC
Address: 41 Mill Street
Bedford
Secretary: D J Wardrop
Page 16: Harrow CHC
Address: 4th Floor
Equitable House
Lyon Road, Harrow
Middlesex
HA1 2EH.
Page 24: St Thomas's CHC
Address: 2-4 Cleaver Street
London SE11
Telephone: 01-582 3288/3238
Page 24: King's CHC
Chairman: Mr W H Alexander
Page 25: South West Surrey CHC
Chairman: H E Buttery Esq.
Page 26: Cuckfield & Crawley CHC
Chairman: Mr W J Clarke JP
Page 27: Roehampton CHC
Chairman: Derek Wainwright
Page 29: Winchester & Central Hampshire CHC
Telephone: Winchester 60661
Page 33: North Devon CHC
Address: 19b Alexandra Road
Barnstaple, North Devon
Secretary: Felicity Voce
Page 37: East Birmingham CHC
Address: 203 Bordesley Green East
Birmingham B9 5SP
Telephone: 021 784 5388
Page 46: Clwyd North CHC
Chairman: Mrs Margaret Roberts
Page 52: East Anglian Region
Address: c/o Cambridge CHC
21 Trumpington Street
Cambridge CB2 1QA
Secretary: Mary Merricks
Telephone: Cambridge 62638
Page 61: Index
Insert: Blackpool, 42

NOTES.....

BACK PAIN

A working group set up by DHSS to study the problem of back pain met for the first time in November. The group is chaired by Professor Archibald Cochrane.

Back pain is responsible for 7 million working days lost each year and accounts for around £100 million in sickness benefit and NHS treatment.

Among the subjects to be studied by the working group is the possible development of back pain clinics providing guidance on prevention and early treatment. Existing services and provisions will also be reviewed with the aim of making them more effective.

WHEELCHAIR INSURANCE

The Central Council for the Disabled has negotiated a low cost insurance for users of electric wheelchairs. For £5 a handicapped person can be covered for accidental damage, fire and theft for up to £600, and for legal liability for death or injury to third parties or damage to property up to £150,000. There is also a 'get you home' clause to cover taxi fares of up to £50 following accidental damage or theft.

BRIGGS REPORT

The Secretary of State has reaffirmed the government's commitment to introduce legislation implementing the recommendations made in the Briggs Report on nursing, in 1972.

He said that it was unlikely that time could be found to do this in the present parliamentary session, and he stressed that it was therefore important to make progress in the meantime where possible within existing legislation and available resources.

Mr Ennals has suggested that a Briggs Steering Committee be set up to advise on immediate action and the longer term transition.

DRUG REACTIONS

The Committee on Safety of Medicines have written to doctors asking them to report any actual or suspected reactions to beta-blocking agents — a group of drugs used to treat certain heart diseases, high blood-pressure and angina. The committee has said there is no cause for immediate concern, but that they wish to be certain that reactions are not being overlooked.

'SCHIZO'

The wording of advertisements for the film 'Schizo' has been strongly deprecated by Roehampton CHC as misleading and demoralising to schizophrenia sufferers and their relatives. The CHC has made its views known to Warner Bros., the film's distributors, and to MIND who have now referred the matter to the Advertising Standards Authority.

HOSPITAL PATIENTS — CONTRIBUTIONS TO MAINTENANCE. CIRCULAR HC(76)53

Patients who live in hospital but go out to work elsewhere are required to make a contribution towards the hospital's maintenance.

This circular describes how the amount of that contribution is calculated, and announces that the maximum amount which hospitals can claim has now been increased to £16 per week.

It is stressed that charges to patients should be flexible to take into account individual circumstances, and should above all contribute to the patient's rehabilitation by providing him with a financial incentive to go out to work, while at the same time giving him the responsibility of paying for his board and lodging.

PHYSICAL EDUCATION

A campaign being organised by the Physical Education Association is aimed at discovering to what extent health and physical education are integrated in the school curriculum.

Teachers and pupils have been asked to submit details of combined syllabuses, and to comment on the value of physical education's contribution to total health.

It is hoped that the campaign will "provide a major stimulus for physical educationalists to re-examine their responsibilities to the nation for the health of its individual members, and to work more closely with teachers of other disciplines for that purpose."

Consultation on Closures

Several CHCs are having to fight to retain their statutory right to be consulted when substantial variations in local health services are proposed. Some AHAs have tried to by-pass the CHC altogether, or have been unwilling to follow the full consultation procedure. Lack of consultation over the proposed closure of St Leonard's Hospital in East Grinstead has led Cuckfield and Crawley CHC to complain to the Health Service Commissioner of maladministration on the part of West Sussex AHA. And in Brent, the CHC has sought legal opinion and has been advised that the Brent and Harrow AHA has acted ultra vires in making closures without proper consultation. Brent Council, at the request of the CHC, is considering legal action to compel the AHA to restore the services.

EXHIBITION STANDS

A set of exhibitions stands is now available on free loans to CHCs.

The kit has 10 poster-sized panels and when assembled, the 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.