CHC NEWS

For Community Health Councils

May 1977 No. 19

More training for receptionists

Doctors' receptionists need more training, not only in typing and practice administration, but in understanding patients.

Over 50 CHCs and Scottish local health councils have supported the resolution which South Tyneside CHC circulated to all councils and a further 40 councils have expressed qualified support.

The resolution urges the government to "devote greater financial resources to adequate training of doctors' receptionists". The DHSS, replying to South Tyneside, has welcomed their interest in the subject and the initiative taken by the CHC in discussing it with their local medical committee. Mr G. H. Talbot, on behalf of the DHSS, says that the need for appropriate training for receptionists is appreciated, and a working party at the Department is considering the matter. It will prepare a report recommending further action to be taken by the DHSS.

The Joint Committee on General Medical Services has received a paper prepared by Mrs Dilys Palmer, South Tyneside's Secretary, which contains extracts from the correspondence she received from other councils. Copies of it are also being sent to the Welsh Office and the Scottish Home and Health Department.

Ennals' attack on waiting lists

A battle against lengthening waiting lists has been announced by David Ennals, in a major speech made at a weekend school of the Institute of Health Service Administrators.

The regional review of management arrangements for in-patient admission — set in motion in August 1975 by DHSS Circular HSC(IS)181 — is now complete, and in his speech Mr Ennals drew attention to several valuable ideas emerging from it:

- Appointment systems organised on a departmental basis can reduce waiting time. "If one consultant is booked for many weeks ahead, the consultants agree among themselves for new patients to be seen by whichever of them can fit in the earliest appointment".
- Pooling of beds between consultants can improve bed-occupancy and reduce admission waiting time. "If consultants who have successfully moved in that direction could make this known to their colleagues, who are doubtful, this would help to reduce some of the worst of the queues".
- Better co-ordination between hospital and domiciliary services can reduce lengths of stay. "Moreover, if day surgeries and the use of day hospitals were developed to their full potential, many patients now on the waiting list could be treated sooner and bed space could be released".
- If GPs were given up-to-date local information they could send their patients to hospitals with the shortest waiting times. "I hopw therefore that more hospitals will adopt this practice. Sometimes a longer journey is more tolerable than a longer wait".

Mr Ennals also said he hoped "carefully spaced appointment systems" would be introduced in out-patient departments which do not already have them. Booking systems for admission should be used which give patients "the maximum time to plan their arrangements ahead". In some districts patients who cannot yet be given an admission date are sent letters at intervals, to keep them in the picture, and Mr Ennals hopes this will become the general practice.

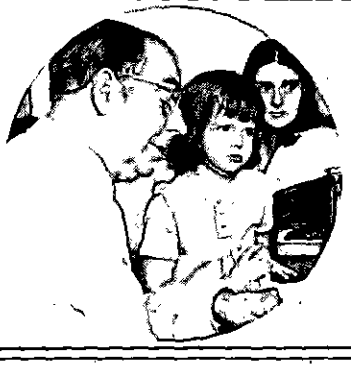
The immediate objectives for Mr Ennals' attack on waiting lists remain those set in 1975 — in general no urgent case should have to wait more than a month, and no non-urgent case more than a year.

One reason for long waiting lists is "bottlenecks" in the system, caused by shortages of staff, equipment or premises in particular departments. According to the DHSS, the regions spent nearly £8m in 1976/77 on capital projects to overcome such bottlenecks.

Class and Health

David Ennals has announced a new research project to investigate the relationship between social class and health differences. It will be undertaken by Prof Peter Townsend of the University of Essex, Prof Jeremy Morris of the London School of Hygiene and Tropical Medicine and Dr Cyril Smith of the Social Science Research Council. The team will be reviewing all the existing literature on the topic and may be commissioning special research where they feel gaps exist or there are leads that need following up.

The research is not aiming to prove or disprove any particular hypothesis at this stage.



YOUR LETTERS

THREE REACTIONS TO BRIAN THOMAS'S "PERSONAL VIEW"

T. R. Pitts, Secretary Rugby CHC and J. C. R. Roberts, Secretary S. Warwicks. CHC

We were very disturbed to read the article entitled "A Personal View" which was written by our colleague who is Secretary to the Bromsgrove and Redditch CHC (*CHC NEWS 17*).

Without wishing in any way to pass judgment over the particular issue which caused our colleague to be requested by his GP to look elsewhere for his treatment, we are extremely concerned at the overall tone and comments of the article. Many of us have spent considerable time since CHCs were set up to try to improve the relationships between the caring professions and patient, particularly when, at the beginning, CHCs were viewed, and to a degree are still viewed with suspicion by many senior administrators and members of the medical profession.

We strongly feel that the best interests of the patient can only be served when all parties realise that they have a common interest and that there certainly should not be unnecessary discord or animosity. This article could very easily ruin these efforts and therefore its tone and content merely aggravate a situation which nationally does not appear to be improving.

John Dafforne, Secretary Oldham CHC

It seems to me that the whole situation raised by Brian Thomas hinges on the use of the phrase "patients friend". When I was asked recently to undertake this very role, I made it very clear to the FPC that in the first place I was not an advocate, nor did I wish to be an advocate; in the second place, therefore, I did not expect or even wish to be in a position where I would cross examine the "other side", this I did not feel to be my role in any way, although I was prepared to be asked if I wished to add anything to the statement that my "friend" had already made.

In the event this even was not necessary because both the "friend" of the other side and myself were not allowed to address the Service Committee but we could talk freely and advise freely our respective "friends". This worked extremely satisfactorily from my point of view and I had no complaints whatsoever with either my reception or treatment, nor had my "friend" who I was supporting.

Apparently these Service Committees are not run as legal proceedings — at least so I am led to believe — but rather as informal gatherings of a group of people wishing to see that fair play is obtained to both sides in the question of the complaint under review. If this is so universally, I can well see that it will be a disaster for it to degenerate into a legal court situation of cross examination and counter cross examination, etc.

Arthur Harman, Secretary Cuckfield & Crawley CHC

No one else can constructively comment on Brian Thomas's own troubles (except that it is *CHCs* who are expected to advise and assist). However, two aspects are consistently overlooked:

1. Service Committees contain 50 per cent lay members. Another has a casting vote. Having often (as an FPC member) sat for up to three hours, listening, questioning, arguing, I have no patience for inexperienced pyro-maniacal language about FPCs.
2. NHS practitioners operate through legal contracts. Because provision may be (undeniably, often *is*) unsatisfactory does not mean that practitioners are doing anything wrong, or illegal. Gutter abuse achieves nothing; change can only be brought about politically.

Having said that, I consider that existing procedures are insufficiently used, and, (allied to 2 above) alone in my FPC I supported the Council on Tribunals' proposals for change as to Service Committees. I believe this will come — but patients will need strong advice and encouragement.

COPING WITH REPORTS

Emrys Roberts, Chairman of the Society of Secretaries of Welsh CHCs

The feelings of all CHC Secretaries were given tangible expressions by Mrs Keep in her letter "Coping With Reports" (*CHC NEWS 16*). The Society of Secretaries of Welsh CHCs has divided its members into some four groups and as each new report arrives it is allocated to one of these groups to summarise and also to draft a commentary for use by all our colleagues. We do feel some such joint approach is necessary if we are not all to become bogged down repeating each other's chores.

At the same time there are certain difficulties in using one centrally produced summary and commentary for one's members if one has not read the full report oneself. I think this would probably be the failing of any such service provided centrally for all CHCs in England and Wales. I think, however, it can work on a Welsh basis and on a regional basis in England where the secretaries meet fairly frequently and can get to know each other and recognise each other's strengths and weaknesses, and respect each other's opinions.

DISCHARGE PROCEDURES

A. J. Bradford, Secretary Northallerton CHC

Since its inception Northallerton CHC has been studying the arrangements for discharge of patients from hospital, especially where elderly people are concerned. Recently an attempt was made by the district management team to introduce the "Going Home" form which originated in the Humberside Area. Unfortunately the experiment foundered and we would be interested to hear from any other CHCs which have been investigating discharge procedures so that we can compare notes and exchange information.

ABORTION RIGHTS

Mrs. Molly Jones, Utley, W. Yorks.

I have been advised to write to you about a problem I hope could be the concern of every community health council. All over the country women who consult their GP for an abortion and are refused are not aware of their rights under the present law. The position under the terms of the 1967 Act is that a doctor who is against abortion on moral or religious grounds is legally obliged to refer his patient to one who is not. But where a doctor's opposition to abortion is based on other grounds — perhaps his individual judgment on the circumstances of each case — there is no legal requirement that he sends his abortion-seeking patient elsewhere. Instead the onus falls on the woman herself to find a second opinion, to which she is entitled. It seems to me that we need a very simple leaflet available in clinics, post offices, citizens advice bureaux, etc., so that women know they can seek a second opinion.

INSURANCE FOR CHC MEMBERS

Mrs. Terry Cowan, Secretary Mid-Surrey CHC

I was very interested to read in the "News from CHCs" of the March edition of *CHC NEWS* that Yorkshire RHA had agreed to insure their CHC members against accidents while on CHC business.

I thought you might be interested in the letter I had from the DHSS when, as the Secretary to the SW Thames Regional Association of CHCs, I took up this very point with the DHSS on behalf of CHC members in our region.

The DHSS replied that CHC members would have the same insurance entitlements as voluntary workers (described in HM(72)6). The letter continued to say that there would be no need for health authorities to take out private insurance policies either for their own staff and members or for CHC members, so would therefore not be permitted to use public funds for this purpose. The Department would further consider the use of non-Exchequer funds for this purpose as undesirable. Would it be possible to know what other RHAs have taken out insurance cover in this way.

SPECTACLE FRAME CHART

Leon Screene, Administrator Kensington & Chelsea & Westminster FPC, 14 Bishop's Bridge Road, London W2 6AF.

In consultation with the Local Ophthalmic Committee, my Committee has prepared a chart showing the frames which are available under the general ophthalmic services. The chart, which is in colour and also shows the type of side and the colours in which such frames are normally available, is 16in. × 14in. in size. There has been a considerable demand from other

FPCs for distribution to ophthalmic establishments in their areas, and a new supply is currently on order. Copies of the chart may be ordered from me at a cost of 25p each.

HEALTH SERVICES BOARD

June Ayling, Secretary Maidstone CHC

Members of our CHC were concerned that the Health Services Board was formulated after consultation with everyone other than CHCs. We would be interested to hear the views of others.

TRAVELLING EXPENSES LEAFLET

Alfred Boom, Chairman, West Berkshire CHC

Leaflet H.11 has just become available and what should, I would have thought, been a very simple matter, providing travelling expenses, seems to have become very complicated and in my opinion an off-putting exercise to any claimant. I think the form that has been designed expects far too much from the person who is going to make an application, and that the information on page 1 is completely contradictory to the information on page 2. I have written in these terms to Mr Ennals, and the DHSS has sent a reply which does not, I feel, answer my points.

However, the Department agrees to bear my points in mind when preparing the leaflet for revision in the autumn. Do other CHCs agree with me about the need for these improvements?

PRESCRIBING COSTS

P. F. Lumley, Manager, Information Services, The Association of the British Pharmaceutical Industry

I must challenge several extravagant claims made in the article "GPs Prescribing" (*CHC NEWS 16*), which cannot be supported by objective evidence:

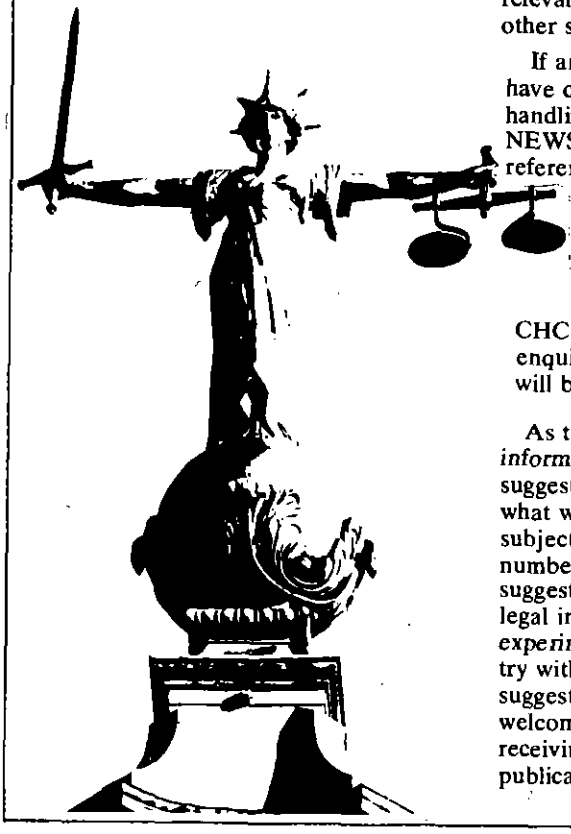
1. As a proportion of total NHS expenditure, the costs of medicines prescribed by family doctors declined from 7.7 per cent to 6.7 per cent between 1963 and 1975, in spite of the number of prescriptions written in England and Wales increasing from 205m. to 304m.
2. Purely in economic terms, if all doctors were to prescribe generic preparations — where alternatives to branded products exist — the savings achieved would be of the order of only 1 per cent of the total NHS drugs bill of about £400m. (excluding wholesale and retail distribution costs).
3. Slow release preparations have been demonstrated to possess considerable clinical advantages.
4. By definition, any variation in molecular structure produces a new chemical entity and necessitates all the pre-clinical and clinical data required for a 'new' product licence.
5. The prescription quoted in the article indicates to a pharmacist that the patient in question is almost certainly suffering from active tuberculosis. Without these so-called "expensive" medicines, the patient would probably be in a sanatorium costing the NHS thousands and not hundreds of pounds.

Legal Information Service-*an experiment*

This article is about the setting up of a legal information service for CHCs. There is evidence of a growing demand for reliable interpretations of official documents and an interest in clarifying the legal position of CHCs themselves. So, through the CHC NEWS office and items in CHC NEWS itself, we hope we can provide a means of meeting some of these needs.

At the CHC NEWS office we are receiving a growing number of enquiries about the legal interpretation of official documents. These can relate to the family practitioner services, e.g. in connection with the role of CHCs in service committee hearings; they can concern consultations over proposed closures, e.g. the action of Brent CHC reported in *CHC NEWS 17*; or they can deal with the disclosure of information from a patient's hospital records where a claim for compensation for injury is being made.

In these and other instances, CHCs need access to reliable advice about the meaning of regulations and official documents. Without this it can be difficult to be sure of the most appropriate action to be taken in each case.



From the CHC NEWS office we wrote round to legal advice centres and community law centres in different parts of the country to find out if they had any experience in handling health problems. On the whole the answer was no, although one or two centres had been asked for advice by people appearing before industrial tribunals in connection with unfitness to work.

Some CHC secretaries and members have of course already gained practical experience of the NHS's own complaints procedures by acting as "the patient's friend". Others have helped individuals who have wanted to complain to the General Medical Council and other professional disciplinary bodies. As CHCs become better known, more and more people are likely to come forward to ask for help and advice, and for this reason we think it would be useful to pool such experience as there is amongst CHCs, so that knowledge can be shared, and individual CHCs can be better equipped to help the people that seek their advice.

CHCs with the kind of experience in helping people we have described might therefore like to write in to CHC NEWS with brief accounts of particular issues they have handled. We can publish selections from these on a regular basis.

In addition we can publish information and examples of good practice of relevance to CHCs that we discover from other sources.

If any CHC members and secretaries have difficulties with matters they are handling, we invite them to use the CHC NEWS office as a point of contact and reference. We will pass on whatever information we have that may be helpful, and put you in touch with people who have had similar experience. We could also publish in CHC NEWS those details of particular enquiries and the answers to them that will be of general interest.

As those of you who already use the information service will know, these suggestions are simply an extension of what we already try to do on other subjects. We are prompted by the numbers of queries on 'legal' matters to suggest this extension of our services. The legal information service is therefore an experiment which we recommend you to try with us. Any comments and suggestions on this would be most welcome, and we look forward to receiving your enquiries and items for publication as soon as possible.

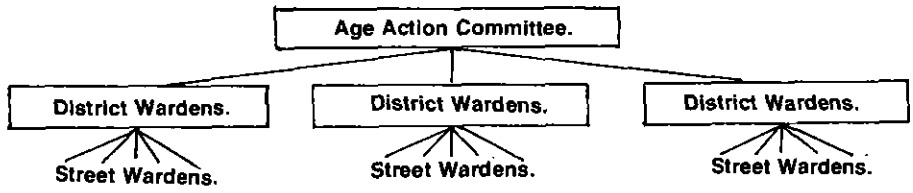
AGE ACTION IN ABERDARE

by D. J. Thomas, member of Merthyr Tydfil & Cynon Valley CHC

There is a very active Patients Committee at the Health Centre, Aberdare. It consists of a very varied membership and at their meetings discuss a wide range of topics. There is open discussion with the doctors and it is possible to offer many useful suggestions for the efficient running of the centre. Arising from one of their meetings, the question of looking after the infirm aged, and the avoidance of hypothermia was discussed. The Cynon Valley Borough with a population of 70,000 has a 14 per cent incidence of senior citizens. It also has a high incidence of homes lacking basic amenities. A public meeting was called under the chairmanship of the Mayor and from this meeting a committee was formed and included postmen, milkmen.

milkmen, newspaperman and many others. I am a member of this committee and of the Patients Committee.

The CHC Secretary is also a member of the Age Action Committee. We required a basis for our spreading the gospel of 'good neighbourness' and decided to make use of the Old Age Pensioners Association as a start, and to attract the younger element and other voluntary bodies to the scheme. The Old Age Pensioners Association were asked to organise general meetings of the public within their district which the Age Action Committee would attend to give information on the scheme, and organise local committees and appoint street wardens.



The Age Action Committee are readily available to the District Wardens and seek to stimulate their activities. There are approximately 20 District Wardens and a large number of street wardens, although up to the present time, the system has not started in all parts of the Area. In the village in Ynysybwl, a similar system has been in operation for some time prior to the establishment of the Age Action Committee, and is complimented for the excellent way they cover the district. However, we look to the organisation to advise and help on major matters. Some districts have made cards for windows, available to the aged; others are trying to expand the bleeper system, but this is rather expensive.

We find there are two objections to this scheme. First the independence of some aged people, and secondly those who say they are already doing this work in their particular street. But surely this important community work should be organised. They should know who to contact and how. The police? The doctor? The Social Services? We have appeared on a community programme on the BBC2 "Open Door" when many of the things we believe and practise were shown in operation.

Hypothermia is the scourge that can be controlled by supervision of the older sections of our communities. Good neighbourliness is the answer. There should never arise the situation where an old person is found dead in their home weeks after their death.

These are our beliefs and our aims at Aberdare.

Help towards mobility

by Caroline Crimp, Chairman of the Association for the Welfare of Children in Hospital

As from 13th April this year the 5-10 years age group became eligible to receive the new Mobility Allowance. This means that all children who satisfy the requirements should now be receiving an extra £5 a week to enable them to enjoy a little more easily the world about them. As, apparently, all those already entitled are not claiming this benefit it would seem an appropriate time to recount some facts about the allowance which CHC members can pass on to interested groups and parents.

Basically the allowance is available for anyone from 5 years to retirement age who:

1. Normally lives in the UK and has been residing there for a total of 12 months out of the 18 months preceding the application;
2. is unable (or virtually unable) to walk because of severe physical disablement;
3. is likely to remain so for at least a year;
4. is able to make use of the allowance — i.e. must not be permanently confined to house (or hospital).

This last point caused us (the committee of the Association for the Welfare of Children in Hospital) some concern on behalf of the children who are in long stay hospitals. We thought the clause was a little ambiguous and wrote to the DHSS for clarification. From the reply we gather that 'confined to hospital' would mean literally unable to be removed because of coma, danger to life, linkage to essential medical equipment etc. Parents are normally able to continue claiming for any child in hospital and may use the benefit in any way appropriate to their circumstances to enhance the child's well-being. In special cases this may mean using it to visit and take out a child who would otherwise remain unvisited because of the cost of travel. The Secretary of State must be satisfied that an amount at least equal to the Mobility Allowance has been or will be spent on the child's behalf.

In cases where the parents lose contact the local or hospital authority could become eligible to claim on the child's behalf. Unfortunately there is no inbuilt safeguard to ensure that money will be used particularly for the child and not drawn into general administration. Local council members might well keep their ears and eyes open on this point. The allowance is normally granted for a specific period after a medical examination and renewed on a further medical examination.

It is payable in addition to the attendance allowance. There is a right of appeal if the claim is disallowed. Full details are given in leaflet NI 211 available from local social security offices. It also contains the claim form MY. 1., a section on three-wheeler cars, and a very useful list of the benefits available to the handicapped.

PERSONAL VIEW

The gardens after which Caryl Gardens, a multi-storey tenement block near the south docks in Liverpool, took its name, have long disappeared under concrete and asphalt. In other ways, too, the red brick blocks show signs of the decay which has ravaged the surrounding area and placed enormous strains upon the seven thousand people who have their homes in this part of the city.

If your are a single parent on social security here, or if your are a pensioner (as thousands are), finding it impossible to pay the rent and fuel bills, it is easy enough to abandon hope. Yet Caryl Gardens is the home of a pioneering neighbourhood council, about to operate a form of self help health which vividly tests the principles of health education.

The Southern Neighbourhood Council receives a small grant from the Liverpool City Council. £2,500 of this is paid to seven local women, neighbourhood workers, who visit pensioners in the blocks. They see that the old people receive the social services and social security payments to which they are entitled. A pensioner living alone gets a weekly visit, a pensioner with a family, one a month, and the workers are always on hand for emergency calls. The women want to extend their role to include health care, and it is obvious why — they have established the foundations on which quite a sophisticated form of service can be built, service which the "professionals" despair of providing.

Under a different political system this move would not be surprising and in China a parallel is easy to find. This Liverpool neighbourhood is organised along similar lines, the community is separated into streets and sections of tenements with one neighbourhood worker caring for the families in her patch. The involvement of essentially untrained lay workers in health matters compares with the extensive use which the Chinese make of community members in health and medical care.

Last year our health council suggested to the Authority that here was a chance to translate the DHSS document *Prevention and Health* into practice to meet the needs of a hard pressed community. The workers wanted to learn about first aid, home

By Jane Leighton, Secretary of Liverpool Central & Southern CHC

nursing, contraception, baby and child care in addition to adding to their growing knowledge about the problems of old people. The neighbourhood council offered to make one room in its advice centre into a health post so that information on the project, and health education was accessible.

Several months went by before our proposal was discussed and approved by the District Management Team but since then the Authority has moved quickly and enthusiastically. The residents have described what they need and a year's programme of education begins next month under the direction of a health visitor who fits the programme in as part of her work.

The request for a programme of this sort initially caused some health professionals to shiver. It did not pass unnoticed that the project could undermine the traditional order between the ill and ignorant and the omnipotent professional. The project should also have provoked some debate about the use of local people to supplement services which should more properly come from the statutory authorities. These neighbourhood workers receive £6 a week for augmenting deficient local authority services. Was it correct to widen their responsibilities to include the health service?

Prevention and Health is Everybody's Business says the DHSS. But a decision to devolve responsibility and resources to people for collective action is one thing. The encouragement of individual solutions to social problems because the government has other economic priorities, quite another. Nevertheless, there is no argument over the need, per se, for more health education and preventive work. And calls from people for education and training, particularly from those who traditionally have barely been reached by the health service must be encouraged.

A sharing of knowledge and experience could signal fundamental changes in the way the medical system is organised. As the doctor in charge of the educational programme remarked on leaving the Southern Neighbourhood Council "Think what it will do for the people".

News from CHCs

- Worthing CHC have produced a very thorough report of their survey *Concern for the Elderly* (£1) which would be a useful model for anyone else wishing to undertake a similar survey. This one was carried out with money from the Manpower Services Commission (see *CHC NEWS 8*) and almost 2000 elderly people were interviewed. Around 27% of the total population in the District is elderly and gaps and shortcomings were discovered in most services.
- East Herts CHC have written to their AHA protesting that the "lay" member of their district's ethical committee is a technician in the pathology department of a local hospital. The DHSS asked AHAs to consider choosing CHC members as lay representatives [HSC(IS)153] but in this instance there was no approach to the CHC nor was any unsolicited information given to it on the subject. The CHC is now seeking the opportunity to appoint a lay representative on ethical committees in the district.
- Responsibility for advising complainants should be taken away from FPC administrators and given to a totally independent body such as a CHC. This is one of eight detailed proposals for changes in the FPC complaints procedures sent by Medway CHC to the DHSS. Following local press publicity about the proposals many local residents have contacted the CHC with their own evidence of difficulties in making complaints about the family practitioner services in the area.
- Yorkshire should have more chiropodists available in the future. Following pressure from Wakefield West CHC and others, a chiropody school is to be developed at Huddersfield Polytechnic on a regional basis and it is hoped that the first students will begin their courses in September.
- Hillingdon CHC have asked their AHA to mount a campaign to publicicise the five 'well-women' screening clinics in the borough. This followed complaints to the CHC from members of the public that such clinics did not exist.
- Because the Borders area is very enthusiastic about Rugby football, the Local Health Council are placing ads in rugby club programmes reading 'Score a Try for the health services in your area, Convert your good ideas into action through the Borders LHC'. This is part of a ten-month publicity campaign which is also using posters, car stickers, exhibitions and free calendars.
- Following TV publicty on *That's Life* the three CHCs in Norfolk have been granted observer status on their FPC. They may only attend and speak at the public parts of the meetings, even where the CHC has already been involved in a complaint being discussed 'in committee'. In Yorkshire, a meeting was set up between Wakefield FPC, the AHA and Wakefield East CHC because the FPC had said they were not prepared to reply to letters about complaints from the CHC secretary. Because the CHC secretary is paid out of public funds and complainants pay taxes, the FPC maintained that he must be regarded as a paid advocate. Following the meeting the FPC is now prepared to enter into informal discussions about complaints with the CHC.

EDITORIAL

On 1 April this year, charges for NHS dental treatment rose steeply. The maximum charge for most courses of treatment has gone from £3.50 to £5. The maximum charge for dentures has risen from £12 to £30. Crowns, inlays and gold fillings now cost £10-£30. The DHSS does not intend the charges to deter people from seeking regular treatment, and many groups are exempted from paying them. Whether the charges deter or not is an open question. But a more obvious deterrent to seeking treatment is the problem of the patient's responsibility to establish at the start of a course of treatment if she or he wants this to be carried out under the NHS.

This problem is not new, but it has been given added attention by CHCs, the Health Service Commissioner and at least one MP. In the Commissioner's *Second Report, 1976/77* he concludes his investigation of case W.350/75-76 (in which a woman complained to the FPC about a dentists bill of £290 for treatment which she believed had been carried out under the NHS) in saying: "I cannot believe that this sort of case, if at all widespread, is in the best interests of the NHS or indeed the profession. I very much hope that the Department and the dental profession will renew their discussions about ways of avoiding its recurrence".

On March 11th, Laurie Pavitt MP asked what action had been taken in the light of this statement, and Roland Moyle replied that the matter had been discussed again between the DHSS and the profession. David Ennals was now "considering whether any change of practice is desirable". Surely we know the answer: change is desirable, not difficult to achieve, and should be done without delay.

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Peter Huntingford writes about a new working relationship between doctors and the people who seek their advice

DOCTORS AND PEOPLE

I realise that certain of my attitudes create tension and anxiety, and not everyone will share them. If a question is answered with a question, and if the only rule made is that there are no rules, life can be difficult.

I hope that my attitudes will go on changing. My primary objective is to strive for a new working relationship between doctors and people. As a profession we have taken away responsibility from individuals for the care of their own lives and health. Doctors are not entirely to blame for this, because they were given this responsibility at a time when people were afraid, because little could be done to protect or preserve life. Modern medical technology has changed this. But we, as people and as doctors, must not allow ourselves to be taken over by our own technology. Doctors must not delude themselves that other people cannot understand the technology and cannot manipulate it in a responsible way. I feel that the time has come for doctors to give back the responsibility for the care of life and health to the men and women concerned, or at the very least to share it more freely with them. This is necessary, because there are signs that some doctors at least are the servants rather than the masters of their technology; that people have perceived and are no longer (in my opinion rightly) willing to accept this situation, and that doctors have not perceived this because they are confusing their priestly and technological roles. The protected and elite position of doctors within society could be justified when they were solely priests, but as technicians their status must change.

The main method to be used in creating a new relationship between doctors and people, so far as I am concerned, is to make those seeking my services independent of me as quickly as possible. To this end, I believe that the following attitudes are relevant:

Listening is more important than talking.

All questions are valid, require an answer and are worth answering. But the answers are only valid if they reply to the question and are truthful. So far as we can tell the corollary is that the commonest answer must be "I don't know".

Rules are meant for guidance only and to be broken; they should be kept as few as possible. Everything we do should have a reason. It is important to understand these reasons in order not to deceive ourselves or to mislead others.

Mistakes are seldom crucial unless they are ignored and not acknowledged.

Words are important, if only because they reveal attitudes and pre-determine relationships. Jargon of all sorts is best avoided because it prevents thought and questions, and maintains an artificial unnecessary barrier. "Patients" and "cases" are people like ourselves, but by using such words we deny this. Likewise, "treatment" is something that we do for "patients".

Reassurance can only be given from a relationship of trust. Sooner or later the receiver of reassurance will realise that trust was misplaced, if eventually the giver is revealed either as a deceiver of the recipient or of himself. In other words, reassurance can be given if I don't know and say so, but it is not reassuring if I don't know and pretend that I do. However extensive our knowledge, if we have not taken time to listen and understand the problem of the presenter's terms, reassurance can also not be given.

Emotions are qualities that we all share. If we feel emotion in common with those we are serving, it is helpful and not a hindrance to them if we show it.

Time is not saved by looking at the clock, but by ignoring it. So far as doctors are concerned this means that five minutes listening and one minute talking, rather than the reverse, will save time in the long run, if not for me, then for my colleagues and also for those seeking our services.

All of us are people and it follows that we should deal with each other in the way that we would wish to be dealt with. We all have problems, but other people neither necessarily share ours, nor can they always learn from them. We should let other people learn from themselves. We should not need to be needed, or at least not meet our own need by making ourselves indispensible.

I try to recognise the defensive barriers that I erect in order to extend my own boundaries and horizons so that I do not keep other people out by my defences. I try to respond to a proposition by saying "Yes, it's possible and worth considering" rather than "No, it's impossible and not desirable".

There are no absolutes. There is always need for change to improve. But improvement does not always follow change. This is the price we pay for making the experiment. It's like abortion — some people need to experience an unwanted pregnancy to know whether they want to be pregnant or not, and some people don't even know then, they have to have an abortion to know whether they really wanted a child or not.

I have been forced to question my own attitudes, because I was fortunate to be involved with a group of consumers who have raised and continue to raise their voices in questioning the attitudes of myself and others like me who wish to care for them. Sooner or later, the realisation comes that fulfillment of this wish cannot be achieved by caring alone, but only if we also know what is wanted by those for whom we care.

Much of the present conflict doctors face today is derived, I believe, from this failure as professionals to expand their egocentric view, and an insistence that this view is the correct one.

The conflicts existing between women and those caring for their health provide illustrations of the gap between professional and consumer thinking. The medical professions generally assume that all women wish to be mothers, infertility and childlessness being unhappiness, those women who do not share these either totally or in part are not quite normal, women who find themselves pregnant and reject the situation are irresponsible not to have forseen and avoided the possibility, and that safety and health have the same meaning for everyone. In all these conflicts between women and the profession, I feel that the underlying common cause is a defensive reaction on the part of doctors to fears that their image, role and status in society are threatened. To prevent change doctors claim they know best; their expertise, skills and opinions cannot be properly examined and questioned from outside without destroying so-called clinical independence and freedom, and interfering with the doctor-patient relationship. No data are provided to support these claims.

Objective evaluation by outside observers of medical activities is prohibited. Criticisms and even questions often provoke irrational responses.

Doctors by imposing their own professional values through the advice that they give prevent other people from contributing to and broadening the base of the teaching and learning situations offered during medical consultations. Doctors generally find it easier to talk than to listen. Hence, my mistrust of concepts involving counselling. The medical profession demonstrates a reluctance to accept new roles as exemplified by the hair-splitting arguments about whether or not the provision of family planning services is a medical or social activity. Surely, the whole of medical care is a social activity?

Faced with such attitudes, the resolution of conflicts between women and those caring for their health cannot occur unless doctors are willing to accept change without feeling threatened; value time given for discussion without watching the clock; listen without feeling the need to talk and advise; continue questioning medical attitudes and actions; share the choices and decisions with those whose bodies are concerned; and give back responsibility for health to individuals. None of these changes in attitude can be achieved unless doctors are willing to discuss the issues in public and particularly with consumers. It is also vital that consumers should be actively involved with determining needs, the means used to solve the problems, and with measuring the acceptability and effectiveness of the chosen methods.

I believe that the emergence of women's self-help groups is another expression of present conflicts in providing health services. But, self-help groups also provide hope for the future of finding new models of health care. As a doctor I find the needs expressed by women in self-help groups and the methods that they are using in caring for each other provide me with a great deal of knowledge and insight. In no way do I wish to modify their activities since this would in my opinion hinder the development by women themselves of new ways to meet their health needs and to resolve the conflicts arising from clashes with the paternalistic attitudes of the medical profession.

I wonder how far you can come along with me? I have tried to be as honest with myself (and, therefore, with you) as I can be. Many will reject my views by saying that people do not want to take responsibility for their own health, or that I am taking the easy way out. I agree that many men and women do want others to take responsibility for their health, but unless we try to give back responsibility we shall never identify those who do and who don't wish to carry it themselves.

We shall delay the process of informing men and women, and especially of showing that they really do have a choice. Giving away responsibility is very time consuming. It is not an easy way out, because it is the ultimate responsiblity.

Peter Huntingford, Professor of Obstetrics and Gynaecology in the University of London

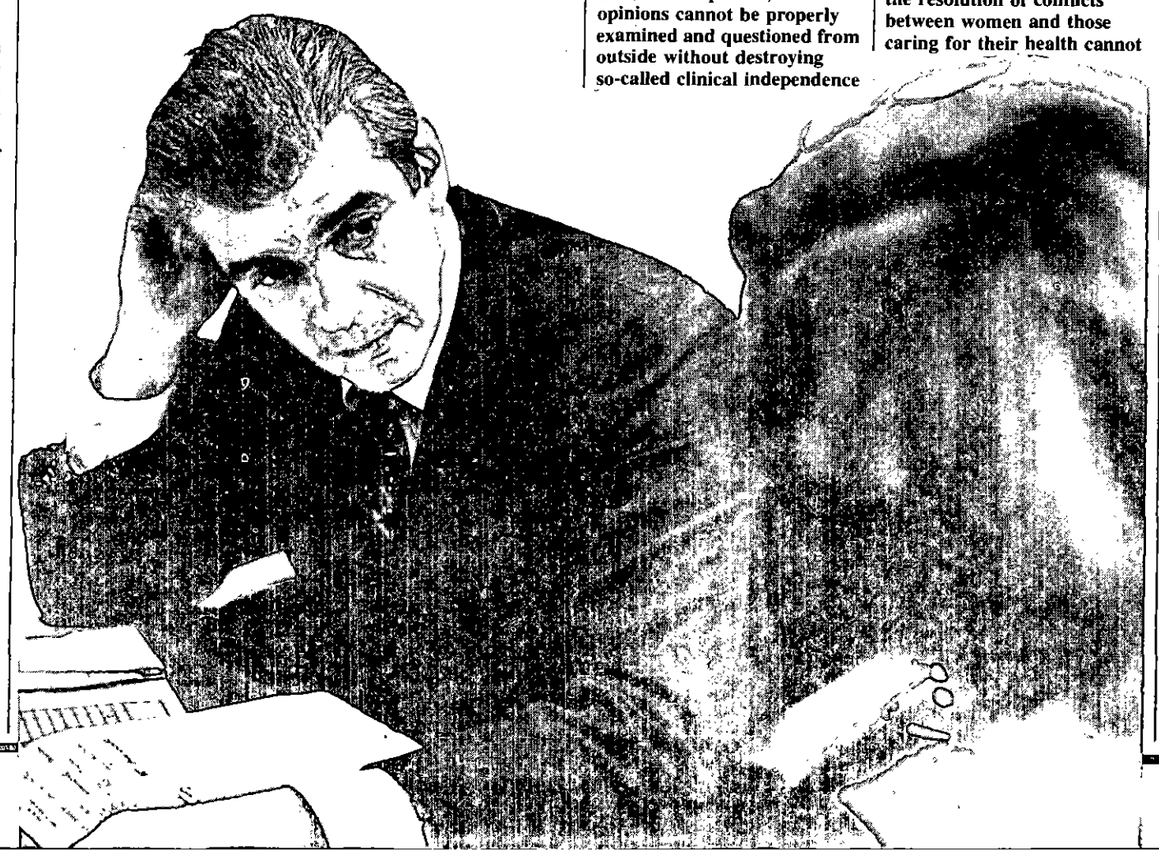

Photo: The Observer

BOOK REVIEWS

THE REORGANISED NHS *by David Taylor (available from: Office of Health Economics, 162 Regent Street, London W1, price 70p).*

This 35-page booklet is a sequel to the Office of Health Economics' 1974 pamphlet on the same subject. That earlier publication proved to be a useful brief introduction to the new administrative structure. Now their new booklet, published exactly 3 years after reorganisation, updates and supplements the information in the first one. It attempts to put the problems of the NHS into their proper context and to balance them with reference to the "many desirable qualities of Britain's health care system and the services it provides".

The first part of the booklet summarises the way the reorganised structure is now working, and the second part looks at the progress of the last 3 years. The author wisely states that many comments on the "failure" of the 1974 reorganisation have been made after far too little practical experience of the new system's performance. He does not think it is realistic to expect the advantages of the planning system, for example, to become apparent for several more years.

He also has optimistic things to say about community health councils. He points out that although the health of the community is the ultimate objective of the NHS, much of the "crisis" relates to its being an employer rather than its being an efficient provider of services to consumers.

A POLICY FOR WARMTH *by Muir Gray, Marigold Johnson, Michael Dunne and Jonathan Seagrave. Fabian Tract 447, 62p inc post from 11 Dartmouth Street, London SW1 9BN.*

The continuing problems of hypothermia are being thrown into sharpening relief by the cost-of-energy crisis. Anyone wanting a background briefing on the subject, coupled with sensible suggestions for reforms and improvements, would do well to get hold of this Fabian Society pamphlet.

"The hypothermia admission rate is one yardstick by which we can judge our services for elderly people. No elderly people develop hypothermia at home in Saskatchewan or Sweden. It usually indicates a breakdown of one (or more than one) of housing, health, social or income support services, or the communication between them", say the authors.

One of the pamphlet's suggestions is that community physicians should set up surveillance, and health authorities should make sure their staff know the basic facts about hypothermia and are properly equipped with low-reading thermometers so that they can diagnose the condition.

Further proposals are that health education and environmental health officers should liaise more with social services departments, community workers and voluntary services in educating the public, and that CHCs could take the initiative here by monitoring both the educational work itself and also its outcome in terms of the numbers of people admitted to hospital with hypothermia.

HEALTH NEEDS HELP *by Muriel Skeet and Elizabeth Crout. Blackwell Scientific Publications, £1.95*

Patients, voluntary workers, volunteer organisers and professionals participated in this study of the role and preparation of volunteers in the NHS and the results make interesting reading. Three areas of the country were looked at, two rural and one urban and the participants themselves helped make decisions about the nature of the study.

This action-learning process was considered helpful by all concerned. One in four of the sample of volunteers was in full-time employment and it was shown conclusively that not all voluntary workers are middle class. The authors recommend that those organisations that use and provide volunteers need to define their needs and roles more accurately and suggest a number of ways in which volunteers could be used to help provide the services that are needed rather than the services that voluntary agencies want to provide. Another recommendation is that CHCs should institute surveys in their areas "to establish local needs and to decide what voluntary assistance is required to help meet those needs". They would also like to see a special committee of enquiry set up to consider the voluntary worker in the NHS.

SCIENCE AND SANITATION

Asa Briggs, Provost of Worcester College, Oxford

When Edwin Chadwick passed from the centre of the stage in 1854, the chief sanitary reformer for more than twenty years thereafter was Sir John Simon, a doctor who quite deliberately retained his lectureship in pathology at St Thomas's Hospital after he became an administrator. The switch from Chadwick to Simon was more than a change of style, therefore — from the abrasive to the conciliatory. Simon's scientific concern — to observe dispassionately and to experiment — contrasted sharply with Chadwick's reliance on sanitary commonsense, the direct evidence of the eye and the nose. Simon agreed with Chadwick on the need for publicity if the public health of the nation were to improve, but he saw more clearly than Chadwick did that a partnership of experts was also necessary. He eventually gathered around him a team of doctors with "high qualifications and experience" in what was in effect a new medical department of state.

Sir John Simon

Simon was born in 1816 and he was only thirty-two years old when he became Medical Officer of Health of the City of London, entrusted, as *The Times* put it, with "the sanitary condition of the most populous and important city in the world". He served there until 1855, dealing with the cholera epidemic, enforcing cleanliness, and interesting himself in housing as well as in water supply. As Chadwick's reputation fell, his rose. And when he left, it was not because he was turned out of his job but because he resigned, with the Commission of Sewers paying tribute to his "profound scientific knowledge and practical talent". In the same year Simon became first Medical Officer to a new General Board of Health. Following the Public Health Act of 1859 he was transferred to the Privy Council. He did not retire from public service until 1876.

During these years England began to take the routines of public health administration seriously, with two Acts of Parliament in 1866 and 1875 laying down a sanitary code, the best in Europe. Doctors still knew very little about the causes of disease, but Simon was already dreaming of a national health service. It was not until after the end of the first of the great wars of the twentieth century that a Ministry of Health was set up and not until after the second that the national health service was created, but Simon pointed the way. In his own time he was sometimes singled out as "the greatest of Victorian civil servants".

His *Sanitary Papers*, produced in the 1850s, are sensitive and extremely revealing documents, as revealing as the great blue books of the previous decade, and his massive study *English Sanitary Institutions*, published in 1890, the year that Chadwick died, is a monumental testimony not only to his own intellect and spirit but to the energy and enthusiasm of his own age. In some respects we are still living on its capital.

VACCINE DAMAGE

Photos: Ricardo Moura

The Secretary of State's decision not to concede compensation to vaccine-damaged children means that the argument about the risks of whooping cough vaccination is bound to continue. Some CHCs have already had enquiries from the public about vaccination *hazards*.

As Mr Ennals told the Commons on 8 February, it is important "that the public should be aware both of the general benefits and the hazards of vaccination". Public mistrust of whooping cough vaccination has caused a fall of nearly 60% in the take-up rate over the last three years, and an alarming side-effect is a 25 to 30% drop in the take-up of diphtheria, tetanus and polio vaccinations.

It is accepted in medical circles (1), and has been acknowledged repeatedly by the Government, that "there is some slight risk in any vaccination procedure". This is well documented in Sir Graham Wilson's book "The Hazards of Immunisation" (2), which in 1967 picked out *smallpox and to a lesser extent* whooping cough as the two most risky vaccines. Routine smallpox vaccination was ended in this country in 1971, because the disease had been wiped out.

Minor and transient adverse reactions such as fretfulness, a temperature or a swollen and painful arm, are fairly common when babies are vaccinated. But occasionally these symptoms are accompanied by screaming and vomiting, shock, collapse and fits. Even so most of these babies are well again within days, but in just a few the symptoms do not fully recede and it gradually becomes clear that permanent brain damage — vaccine damage — has been caused.

Common features of this are major physical handicap, blindness, deafness, recurrent fits and epilepsy. Death sometimes occurs early, but other almost totally crippled vaccine-damage cases cling to life with an amazing tenacity.

On the other hand, less severely damaged children can with special care lead happy and fruitful lives. The reason for vaccine damage remains a mystery, and no one knows how many vaccine-damaged children there are in Britain.

There is disagreement within the medical profession about the frequency of vaccine damage following whooping cough vaccination, and there is no way of resolving this argument at the moment because available figures are not sufficiently reliable. Conservative estimates generally quote the range one in a hundred thousand to one in a million, but critics of whooping cough vaccination usually suggest risks as high as one in ten thousand.

The uncertainty arises because of the failings of the Committee on the Safety of Medicines' voluntary "yellow card" system, through which doctors are supposed to report adverse reactions to drugs, including vaccines, which they prescribe. Feeling in the *profession is that* under-reporting of vaccine

reactions is widespread. This applies to all vaccines, but except in the case of whooping cough there is no reason to doubt that the risk is less than one in a million.

Parallel with this argument about the safety of whooping cough vaccination is another one — equally unresolved — about how well it protects against the disease and how much it deserves the credit for reducing the incidence of the disease *since the war*. Meanwhile parents must balance the risks against the benefits as best they can, bearing in mind that small epidemics of whooping cough tend to occur in cycles and that one is being officially predicted for the end of this year. Whooping cough is generally a mild disease nowadays, but can occasionally still be a killer in young children.

The viewpoint of the Government's advisory body, the Joint Committee on Vaccination and Immunisation, continues to be that "the hazard to children *from contracting whooping* cough exceeds the hazard associated with immunisation". One of the committee's members is however on record (3) as *recommending selective* vaccination against whooping cough — in "communities where there is overcrowding and poor maternal and medical care", but not in other less deprived areas.

Parents must also bear in mind that there are definite contra-indications against whooping cough vaccination — signs indicating that this would be unduly dangerous for their particular child. These signs fall into three categories:

ONE: A history in the child or its family of fits, convulsions or epilepsy; of any other disorder of the central nervous system; or of any evidence of cerebral irritation during the neo-natal period, such as might be caused by asphyxia or low blood sugar level.

TWO: Current or recent colds, infections or other acute illnesses. Vaccination should be delayed until recovery is complete.

THREE: Serious local or general reaction — including convulsions — to a previous vaccination.

A *personal or family history* of allergy may or may not be a contra-indication, depending on the circumstances of the individual case.

The Joint Committee has issued GPs with details (4) of these contra-indications, and parents who are at all worried should make very sure that their GP is fully aware of this advice, has all the relevant case history details and has examined their child with the advice in mind prior to vaccination. Vaccinations are not compulsory in this country, though they are "strongly recommended" by the Government, so if parents are not satisfied they have an absolute right to say No.

The Department's most recent advice (5) asks doctors and nurses "to do everything they can to improve liaison between family doctors and clinics which undertake immunisation, so that contra-indications to, and special indications for, *vaccination are more widely* discussed in relation to individual children".

Where parents do object to whooping cough vaccination — and so refuse the "triple" (diptheria/whooping cough/tetanus) vaccine for their children — GPs have been asked by the Government to offer diptheria/tetanus "double" vaccine instead, plus

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Alcohol abuse by doctors

by Lady Mary Marre, Vice-Chairman, Edgware and Hendon CHC

The growth of heavy drinking and alcoholism among all sections of the community, including women and young people, is a problem which is growing. Doctors are no exception and evidence of the abuse of alcohol amongst them is a matter of professional and public concern. To see what more could be done to improve the position, the Society for the Study of Addiction and the Medical Council on Alcoholism brought together 22 people in London on 26 January 1977, representing the Royal Colleges, the British Medical Association, the two principal medical defence organisations, with observers from the DHSS and Scottish Home and Health Department. There were two lay people present, an experienced member of the GMC, a solicitor, and myself, invited as a CHC member.

Clinical accounts of alcoholic doctors were given, and reference made to recently published research carried out in Scotland and England, which suggests that doctors are more prone to alcoholism than others in their same social class; middle-aged doctors and those hailing from Scotland being at greater risk.

The Merrison Report (1975) had drawn attention to the fact that one in six of doctors dealt with by the Penal Cases Committee of the GMC is likely to be psychiatrically ill, the largest category of such being those addicted to alcohol or drugs.

Though some come to the notice ot the GMC as disciplinary cases, many GPs may appear before local service committees on complaints pointing to breach of contract for professional services. Some, in private practice, may come to notice very late or not at all. Surprisingly, in contrast to arrangements in other countries, only those on disciplinary charges can effectively be prevented from practising. The others are largely free to practise in other areas, or as locums.

The GMC has put forward proposals, adopted in modified form by the Merrison Committee, to arm itself with powers to enquire into competence to practise, and to take steps to ensure treatment, or suspend doctors whose services fall short of those expected, by reason of alcoholic excess (or for other conditions).

Pending legislation, it emerged from the discussion that much could be done now. More use should be made of NHS machinery for dealing with hospital doctors — the so-called "three wise men" procedure — providing it were better understood, and that it could be set in motion, not just by senior medical colleagues but also by junior doctors and by nursing and other staff. Certain specialties were more likely to encourage drug dependence — which sometimes proceeds to alcohol dependence as well — and are potentially more hazardous to patients. In these very groups — theatre teams for example — the natural reluctance to draw attention to the behaviour of a colleague is heightened by team feeling. It was emphasised that there should be wider understanding of the safety issues involved.

The family doctor is not subject to this procedure (which does not operate in Scotland, even for hospital staffs) so greater responsibility is thrown on to the partners of the alcoholic doctor, and in a single-handed practice even this safeguard is absent. Patients make few complaints, which is not surprising considering the present service committee procedure and public attitudes to drink. There was general agreement that prevention was called for, especially as alcoholism usually results from many years of regular excessive drinking. Neither as qualified practitioners nor as medical students have doctors had much, if any, instruction about the hazards of excessive drinking, how it develops, how to avoid it. The profession is now convinced of the need to put its own house in order. CHCs might assist by enquiring whether the three wise men procedure is active and in use in their own health districts, and in considering how some such procedure might be adapted to cover general practice. We all know how vulnerable are patients who complain about their GPs, especially on matters of this kind.

Nursing in the community

The work of the district nurse is to look after people of all ages in their own homes. After qualifying as a state registered or enrolled nurse, there is a course of study and practical work under supervision. 840 nurses passed the final examinations in January this year. PAM HOLMAN, a district nurse in Medway, writes about her work.

A typical day for me starts at 8 am with phone calls from colleagues, doctors, receptionists or frantic patients. Occasionally I get woken up at 5 am with the news that "mum has passed on". I make reassuring noises and fall back, either to sleep or more usually worrying that the relatives are not able to cope with their grief. But I am not on duty until 8.30 and that is that. At 8.45 I leave home with bag, overall and my precious diary full of lists of patients and the most essential phone numbers.

Diabetics first — a quick injection of insulin into a bared arm then they can have their breakfasts. Ill or dying patients next, to clean, make beds and refresh them. Clean dressings to be done next, then patients who are too incapacitated to get up themselves or more likely *won't* get up until you arrive at the bedside: wash 'em, dress em and convince them that life is still worth living even though it is only a trip to the toilet and into the kitchen to boil an egg.

A break for coffee with a lady who is dying of cancer comes next then a quick flip into one of my three surgeries to talk to the GP about his patients. I spend at least 30 minutes with a 55-year-old woman who has had a subarachnoid haemorrhage leaving her with brain damage and great difficulties of movement with her right arm and leg. I have taught her husband to give her physiotherapy and he washes and dresses her daily. With a lot of patience and perseverance we help her to stand on her good leg, to walk with a frame even though she doesn't really know what she is doing. We make her face up each day and play with educational toys like jigsaws and blocks and she really is beginning to show some signs of improvement which is more than she did when lying in a hospital bed all those weeks.

Home for lunch at 1 pm broken with yet more phone calls. Another patient from the Nursing Office and will I have another pupil to take round with me next week please. One of my colleagues rings up with a problem to talk out — being on our own we have only each other to talk to although we can call on our Nursing Officer if we need another brain to help us. In the afternoon I call at one of the local hospitals to discuss with a consultant about a patient's leg ulcer which won't heal up. Another blanket bath to an old lady who has senile dementia who vehemently denies that she is dirty and hates all her clothes coming off. Pop into a youngish 35-year-old to reassure her about her varicose veins. Two more dressings, another jab of insulin to that rampant old lady of 70. Then home for book-keeping, answering the phone and tea. Some nights I am on call until 7 pm. My last job of the day is to pass on the patients who need the twilight nurse.

I gave up hospital nursing when it seemed to me that the patients were coming in on an endless conveyor belt and it was hard to remember their faces let alone their names. Many ward sisters seem to forget that we are their equals in status and that we are not poaching their patients. Most GPs are splendid to work with but the ones who are not cause us an enormous amount of extra work. Consultants too are gradually becoming less resentful at what they used to see as our interference. After all, many more people are nursed in the community than in hospital.

EYES ON THE NHS

This summary of the statutory provision of NHS ophthalmic services and opticians' terms of service follows similar articles on doctors' and dentists' terms of service (CHC NEWS 8 & 14).

The terms of service for opticians offering National Health Service treatment are specified in the NHS (General Ophthalmic Services) Regulations 1974: Statutory Instrument 1974 No. 287, amended by S.I. 1974 No. 527.

The regulations require each FPC to draw up a list of the names and addresses of qualified opticians practising in the area, giving the times at which they are normally available to patients. The list is in three parts, covering (a) ophthalmic medical practitioners who are doctors with special training in ophthalmology who test sight and prescribe lenses; (b) ophthalmic opticians who have undergone at least three years full-time study enabling them to test sight and prescribe lenses; and (c) dispensing opticians whose training enables them to dispense and supply optical appliances only.

The ophthalmic list, together with copies of the Regulations and Terms of Service and a current statement of the charges payable by NHS patients must be made available for inspection by any interested person at the FPC's offices.

Any optician whose name is on the ophthalmic list is required to make all the necessary arrangements for the provision of general ophthalmic services to his patients. He must provide adequate accommodation and equipment, keep a proper record of each patient's treatment (which must be retained for at least 7 years), exercise due care and attention and proceed with "reasonable expedition" when supplying ophthalmic appliances. A person who wishes to have his sight tested under NHS provision may, if he has previously had a sight test, apply to any optician whose name appears on the ophthalmic list. If he has not had a sight test before he must obtain recommendation for a test from his doctor before approaching an optician.

Once the sight test has been carried out, the optician must issue the patient with a prescription for any optical appliance that is necessary. If, on the other hand, he considers that the patient does not need an appliance or would not, for some other reason, benefit from ophthalmic treatment, he must convey his opinion to the patient's doctor.

When a patient applies for the replacement or repair of his spectacles (or any other optical appliance) the optician can require him to have a sight test before agreeing to undertake the work. In fact if the patient's eyes have not been tested for a year or more, or if he is under 16, the optician is obliged to give him a test before proceeding with the work. Unlike doctors, opticians do not have a list of patients, but are paid a separate fee for each item of treatment carried out under the terms of their contract with the FPC. The items for which the NHS will pay an optician are the subject of a Statement issued by the Secretary of State. This Statement also specifies the various charges to be made to patients for treatment or appliances. Among the items which may have to be paid for is the repair or replacement of any item — unless the patient can show that this was not necessitated by his own actions. To do so, he should submit a claim to that effect to the FPC which must then consider the matter, decide whether or not to waive or reduce the charge, and inform both the patient and the optician of that decision.

An optician can also demand payment from the patient concerned for travelling expenses in connection with a home visit and for any "loss of remunerative time" caused by a patient's failure to keep an appointment.

As from 1 April 1977 NHS charges payable by patients are: £2.90 for each single-vision lens; £5.50 for each fused glass bifocal lens and £6.50 for other types of lens. (Contact lenses are also sometimes available through the NHS but only on medical grounds). Children under 16, or older children still in full-time education, old age pensioners, and families in receipt of Supplementary Benefit or Family Income Supplement, or otherwise on low incomes, are usually exempt from charges (see leaflet M11 from local social security offices). The FPC has discretion to waive charges where it considers that payment may involve undue hardship.

The Price Commission recently issued a report on Prices of Private Spectacles and Contact Lenses which gave useful information on the costings and incomes of dispensing opticians and suggests, among other things, that a wider variety of NHS frames should be made available.

Complaints against opticians have to be made to the FPC on the basis of failure to comply with the terms of service, and must be made in writing not more than 8 weeks after the event that gave rise to the complaint. (In some circumstances later submissions may be investigated.) The procedure that the FPC adopts in investigating complaints is laid down in the NHS (Service Committees and Tribunals) Regulations, and is currently under review by the DHSS.

Parliamentary Questions

CONSUMERS' VIEWS

A household survey "to examine patients' experiences of and views about access to primary health care services" has been commissioned by the Government, David Ennals told the Commons. But he rejected a call from Patrick Jenkin, MP, for an independent inquiry into "consumer satisfaction among NHS patients attending health centres".

INFLATION

Revenue allocations to health authorities for the year 1977/78 are based on an average inflation rate of 10 to 15 per cent, Mr. Ennals told Mr. Jenkin. NHS pay settlements up to the end of July are assumed to give increases of 5 per cent, and up to 6 per cent thereafter. RHAs will be allowed to carry forward underspent revenue allocations, up to 1 per cent of their 1976/77 cash limits.

DAY CENTRE PLACES

Planning guidelines indicate that about 29,500 day centre places for the mentally ill are needed in England and Wales, whereas the actual figure in March, 1976, was 5,200. Comparable figures for mental handicap are 74,000 places required and 39,000 achieved. The respective guideline figures themselves are 0.6 places per 1,000 population and 1.5 per 1,000. Answering questions from Bruce George, MP, Mr. Moyle explained that such guidelines are only tentative and the level of need can only be fully determined locally.

PAY BEDS REPORT

Consultations on the phasing out of pay beds are taking longer than expected, so Mr. Ennals has extended the deadline for the first report of the Health Services Board to 16 July. He was answering a question from Dr. Colin Phipps, MP.

TEMPORARY CLOSURES

John Cartwright, MP, asked Mr. Moyle if he would "take steps to discourage AHAs from closing temporarily hospital facilites, about the long-term future of which they are involved in public consultation". Mr. Moyle said that AHAs have been asked "to inform CHCs of any substantial temporary closures at as early a stage as possible".

OVER-50s' MOBILITY ALLOWANCE

People aged 5 to 51 are now eligible for mobility allowance, and the age-groups between 51 and retirement will be phased in gradually up to the end of 1979, Alf Morris told Ian Stewart, MP.

NOTES.....

CHCs AND PLANNING

Douglas Weller of the Health Services Management Centre has produced a study on *CHCs and Planning in the NHS* (£1 from Park House, 40 Edgbaston Park Road, Birmingham B15 2RT). He identifies three factors which will affect the quality of information provided by CHCs *to* the NHS: their ability to obtain information from and about the community, their access to information from the NHS, and their ability to use both sorts of information to comment upon plans and proposals. 14 CHC secretaries and 14 District Administrators in the London area were interviewed and there was agreement between the two sets of interviewees on a number of points. Causes for concern however, include the obstacles put up by health administrators which may deny effective participation to CHCs, the ability of CHCs to handle what is sometimes very complicated data, that two-thirds of the DAs believe DMTs and AHAs to be as or more representative of patients' views than CHCs, the political composition of CHCs, and the potential for conflict caused by differing views on the need for professional autonomy and confidentiality.

CHCs AND THE ELDERLY

Age Concern has published an updated version of its *Information Pack for CHCs.*

It contains a review of literature and reports on matters concerning the elderly and a round-up of activities of CHCs during 1976. Price £1.15 including postage, it is available from Age Concern, Bernard Sunley House, 60 Pitcairn Road, Mitcham, Surrey CR4 3LL.

PREGNANCY ADVICE BUREAUX

Following publication by the DHSS of a register of approved pregnancy advice bureaux, the Brook Advisory Centres have pointed out that the register only applies to fee-charging bureaux. Doctors and others working in clinics and agencies which do *not* charge fees do not need to register and nursing homes may accept referrals from them.

HEARING TESTS

Minister for the Disabled, Alfred Morris, has endorsed the view of the Advisory Committee on Services for Hearing-Impaired People that *all* children should be given hearing tests at about the age of 8 months. He believes that insufficient attention is paid to the belief of parents that their child might have a hearing loss and any delay in diagnosing deafness can have grave consequences for the child.

ABNORMAL OFFENDERS

The second volume of *A Human Condition* (MIND £2.50) is a very thorough review of the law relating to mentally abnormal offenders. An offender will have a hospital order made about him because of his unfitness to plead at the trial and the order may have no relevance to the offence committed, which could be a very minor one. A number of proposals for reform are made including the way regional secure units should be monitored and administered and proposals for changes in the system of Mental Health Review Tribunals. MIND believes that transferring a patient from a special hospital to an NHS hospital near his home is the first major step in his rehabilitation. The issue should be *when* to transfer, not *whether* to do so.

HEALTH AND SAFETY SQUAD

A flying squad of specialist inspectors from the Health and Safety Executive is now operating in the North West. It is using the first of seven mobile laboratories which will all be equipped with sufficient instrumentation to analyse 95% of all samples taken in and around workplaces. The HSE expect that they will be able to produce solutions for many problems more or less immediately. By making a greater impact on employers HSE hopes that enforcement will be easier.

HN(77)50 NON-RECOGNITION OF ADVISORY COMMITTEES

This Notice announces that the professional advisory committees covered in Section 8(2) of the NHS Reorganisation Act 1973 are not going to be recognised within the next 2 or 3 years. Section 8(1) concerns Regional medical, dental, nursing and midwifery, pharmaceutical or optical committees and these have been recognised. Section 8(2) concerns the recognition of advisory committees of any other categories of persons providing services forming part of the NHS or any two or more of the categories mentioned in Section 8(1) but David Ennals does not feel it would be in the interests of the NHS to add to the costs of administration at the present time.

HC(77)5 EMPLOYMENT OF DISABLED PEOPLE

Although the NHS is not bound in law by the provisions of the 1944 Act concerning employing disabled people, this circular stresses that Ministers feel that Health Authorities should regard the quota as a minimum to be exceeded. The Act provides that employers with 20 or more employees should ensure that a quota of 3% of them are registered disabled people. Each Health Authority and Board of Governors should designate a staff member as Disabled Persons Officer to have overall responsibility for the recruitment and career development of disabled people.

VACCINE DAMAGE

Continued from page 9

the standard polio vaccine on a sugar lump or as syrup.

If parents have a child with signs of handicap which they feel could have been caused by vaccination, they could — in addition to talking fully to their own GP — contact the Association of Parents of Vaccine Damaged Children (2 Church Street, Shipston-on-Stour, Warwickshire).

This was set up in 1973 to press for state compensation in vaccine damage cases, and for more open discussion of vaccination hazards.

FURTHER READING

1. Neurological Complications of Pertussis Inoculation, M. Kulenkampff, J. S. Schwartzman and J. Wilson. Archives of Disease in Childhood, January 1974, p46.

2. The Hazards of Immunisation, by Sir Graham Wilson. Athlone Press, 1967.

3. Whooping Cough Vaccine, by George Dick. British Medical Journal, 18 October 1975, p161.

4. Immunisation Against Infectious Disease, DHSS/SHHD/WO, July 1972; Immunisation Against Whooping Cough, CMO 17/74, DHSS, 11 June 1974.

5. Immunisation Against Communicable Diseases, CMO(77)7, DHSS, 14 April 1977.

Directory of CHCs

This Directory gives addresses and telephone numbers for all CHCs in England and Wales, plus names of chairman and secretaries. Price 60p from CHC NEWS office. Corrections are published monthly in CHC NEWS.

Please note the following changes:

Page 4: South Tyneside CHC
Telephone: South Shields 568219

Page 6: Harrogate CHC
Telephone: Harrogate 865779

Page 16: Hounslow CHC
Chairman: Mrs A Roberts

Page 35: Worcester CHC
Chairman: Mrs J M C Clark

Page 47: Brecknock & Radnor CHC
Address: 11 The Bulwark, Brecon, Powys
Telephone: Brecon 4206
Chairman: Cllr N F Reay

Page 47: Ceredigion CHC
Address: 5 Chalybeate Street Aberystwyth, Dyfed
Telephone: Aberystwyth 4760
Chairman: Cllr J O Williams

Page 55: Association of Welsh CHCs
Address: c/o Ceredigion CHC 5 Chalybeate St, Aberystwyth, Dyfed
Chairman: Cllr W D Evans
Secretary: Mr J R Evans
Telephone: Aberystwyth 4760

Exhibition stands

A kit comprising 10 panels is available on free loan to CHCs. Overall dimensions when assembled: 7ft 8ins high x 10ft wide. Bookings and further information from CHC NEWS office.