CHC NEWS

For Community Health Councils

May 1978 No 31

Stricter rules for GP deputising

A CODE OF practice for commercial deputising services — which some GPs use to guarantee themselves free time at night and weekends — has been published by the DHSS.

Circular HC(FP)(78)1 says the new code aims to 'ensure beyond doubt that deputising services are adequately staffed, efficiently run with sound operational policies, and subject to satisfactory and continuing local control'. CHCs are nowhere mentioned in the code, even though several have been instrumental in exposing serious inadequacies in their local deputising services.

Local Medical Committees are asked to appoint *Professional Advisory Committees* (PACs), to advise FPCs on proper professional and ethical standards for deputising. PACs will have ten or more members including 'users' of the services, ie GPs. There is no provision for lay representation. Each PAC will appoint a *liaison officer*, to check periodically that agreed procedures are being followed.

CHCs should study the code carefully. Sections of it specify that:

- Deputising doctors must satisfy the PAC of their competence and suitability. They must normally have had at least six months' GP experience.
- The number of doctors on duty must be adequate for the population covered and type of area.
- A duty doctor must be available to assess medical priority of calls and give medical advice to callers.
- The service must be able to consult the patient's own GP when needed.
- A doctor from the service must visit the patient if requested, unless the patient's own GP instructs otherwise.
- PACs will review deputising services periodically, and can advise FPCs to withhold consent for GPs to use a particular service.

The switchboard of a London deputising service. Photo: Medical News

Editor resigns

RICK ROGERS, who became editor of CHC NEWS in February, resigned from the post at a meeting of the magazine's editorial board on 13 April. It was his wish to aim the magazine at a broader readership, while the board preferred to maintain the existing approach.

Hormonal pregnancy tests

Christine Davy

THE GOVERNMENT'S Committee on Safety of Medicines has agreed that there is an association between the use of hormonal pregnancy tests and congenital abnormalities. Parents of some of the hundreds of children thought to have been affected have formed the Association for Children Damaged by Hormone Pregnancy Tests to fight for compensation for the victims of this 'second thalidomide tragedy'. Congenital deformities that may have been caused by the drugs include heart defects, spina bifida, mental handicap and cleft palates.

The first evidence that the drugs could be linked to deformed babies came 11 years ago, when Dr Isabel Gal published a study in the scientific journal *Nature*. This report was read by the DHSS and the Dunlop Committee on Drug Safety, but no action was taken.

However, in 1969 the Committee on Safety of Medicines initiated a study on congenital abnormality and drugs taken in pregnancy. In June 1975, the Committee published a warning, based on the interim results, that hormonal pregnancy tests could possibly be associated with congenital abnormalities. The final results of the study confirmed this, and a further statement was published in November 1977.

The Association was formed on 8 February, 1978, at a meeting chaired by Jack Ashley, MP. It has been told that claims for compensation could be 'out of time' if they are not filed soon. It therefore faces the enormous task of trying to identify all the affected children. The Committee on Safety of Medicines has refused to contact the families identified through the studies to tell them about the Association and the possibility of compensation.

The hormonal pregnancy tests are in the form of two small tablets given out by GPs. Hormone preparations which have been used for this purpose are: Amenorone; Amenorone Forte; Disecron; Menstrogen; Norlestin; Norlutin A; Norone; Orasecron; Paralut; Pregornot; Primodos; Secrodyl.

Community health councils can help to identify affected children by contacting GPs, paediatricians and consultants in mental handicap; writing to special schools in the districts; interesting the press in the problem; and contacting voluntary organisations concerned with children's ailments. The Manchester CHCs are taking some of the administrative burden from the Association by acting as a national 'postbox', and all enquiries should be made to them at: Pearl Assurance Buildings, St Ann's Churchyard, St Ann's Street, Manchester M2 7LN.

Christine Davy is Secretary of North West Surrey CHC.

Complaints

A CONSULTATION document on health service complaints procedure has now been issued by the DHSS, as previewed in our *Health News* section last month. The document does not cover complaints about medical treatment — a further consultative document on this 'will be issued later'. Also excluded are complaints about family practitioner services, which are handled by FPC service committees. Circular HN(78)39 says it would 'greatly assist the consultation process' if CHCs would make their comments to the Department 'on a regional basis'. **Comments must reach the DHSS by 31 August.**

Index

CHC NEWS
May 1978 number 31

126 Albert Street
London NW1 7NF
01-267 6111

CHC NEWS editorial and information service staff
Dave Bradney, Janet Hadley

CHC NEWS is published each month and is available on subscription at £2.50 a year. It is distributed free to members and secretaries of Community Health Councils in England and Wales. (There is a special discount rate if five or more copies of each issue are ordered. Special and overseas rates can be supplied on application.)

CHC NEWS is published by the Association of Community Health Councils for England and Wales. It is designed by Ray Eden and printed by the Chesham Press Ltd, 16 Germain Street, Chesham HP5 1LJ.

Letters

Conference creches

I have just declined another opportunity to attend a CHC conference on health matters. It is one of the several missed opportunites this year. Yet I am willing to devote time, energy and enthusiasm to meetings, seminars and conferences.

The reason I can't attend? The conferences are held on weekdays and I am rapidly out-growing the good will of family and friends to babysit my young daughter.

If CHCs are to attract younger members, particularly women who have an important opinion to voice as NHS consumers, then surely some thought should be given to enabling them to attend meetings. I have not yet attended a conference with a creche.

The timing of most of these functions effectively excludes people with jobs, those caring for young children, the sick or elderly.

Margaret Edwards
Member, Rochdale CHC.

FPC dissatisfaction

Why did Christine Hogg (*Surveying satisfaction with GPs*, CHC NEWS 29) have to spoil what was a good article by making such a sweeping statement as 'Most FPCs see their role as merely administering a service and will not use the powers they have to monitor it'? What does she mean by 'most FPCs'? Has she carried out a survey.

I should be interested to know, as this FPC would resent most strongly such a comment being made about it.

John Williams
Administrator,
Nottinghamshire FPC.

Christine Hogg replies: *I am pleased that Nottinghamshire FPC takes a positive line in ensuring high standards of service. My impression is that this is rare, but I would like to be proved wrong. What is the experience of other CHCs?*

Abortion figures

May I offer a few clarifications to the abortion figures given by Ruth Levitt in *The NHS in figures* (CHC NEWS 29)?

Of the 125,000 abortions performed in 1976, 98,000 were on women resident in England — the balance being on foreign visitors.

Of the abortions on women resident in England, 48 per cent were in NHS hospitals. The corresponding figures for 1977 were 99,000 and 49 per cent — a slight improvement.

The regional variation figures given in the article are by place of operation. Thus the 100 per cent NHS figure for Wessex means that there are no private abortion clinics there: not that Wessex women are particularly fortunate in their health service.

The most recent figures by place of residence are for 1975 and show very great variation between areas and districts. Our congratulations go to Hartlepool where 96 per cent of abortions are within the NHS. We award wooden spoons to Birmingham South and Rugby — both six percent. Six districts have proportions below 10 per cent. As all are in the West Midlands, we were very pleased to see that, as a result of CHC representations, the RHA has voted £50,000 for daycare clinics.

With provision so variable, we hope that other CHCs will follow this lead.

David Flint
Abortion Law Reform Association,
88 Islington High Street,
London N1 8EG.

Requests to CHCs

CHCs are receiving an ever-growing stream of requests from other CHCs to take action in line with what these individual CHCs feel necessary. Sometimes these requests refer to relatively trivial matters *eg* the extension of prescriptive authority for surgical appliances; sometimes they refer to matters outside the scope of NHS legislation *eg* drug safety. Seldom are these requests of such great urgency or importance as to merit the considerable additional work that a full response to them entails. On the other hand, most requests do refer to matters of legitimate interest to NHS users.

I cannot help feeling there is a need for a filtration procedure through which such requests should pass before they are broadcast to all CHCs. Perhaps it would be helpful if ACHCEW were to take on this role voluntarily pending the establishment of some formal procedure.

Jack Rossiter
Secretary, East Roding CHC

Getting Wakefield wrong

I would like to correct two errors in *News from CHCs*, CHC NEWS 29. I do not know where you got your information from relating to this CHC's views on the brain scanner, but in fact the Council as a body made no statement upon the subject.

The Chairman, Mr Enright, made an enquiry to the Area Health Authority as to the need for a scanner in Wakefield when there was already a facility in Leeds which was by no means used to capacity. In his letter to the Chairman of the AHA, Mr Enright referred to the need for a new accident unit at Pontefract and not at Wakefield as you suggest.

G Tollefson
Secretary, Wakefield E CHC

Editor: Our apologies to Wakefield Eastern

Tetracycline and teeth

I have recently received an enquiry about a side effect which tetracycline can have on the teeth. When prescribed for young children for medical conditions, their teeth can subsequently become discoloured yellow.

According to the DHSS, this problem is widely known in the medical and dental professions, but no warning has been issued by the Committee on the Safety of Medicines.

I would be very pleased to have any information from other CHCs — such as, any cases reported to them; the outcome of any compensation received.

Gloria Crosby
Secretary, Croydon CHC

Breast Feeding

Many mothers in our district stop breast feeding their babies soon after leaving hospital. We feel this is because, in an area of social deprivation, mothers have to return to work for financial reasons alone.

We would be grateful if other CHCs would let us know if in their districts any firms provide creche facilities where children can be cared for and mothers can breast feed.

Gwen Davey
Secretary, Newham CHC.

Safety in the home

ACCIDENT is a misleading word. It implies an unhappy coincidence of unforeseen and unavoidable events. But accidents don't 'just happen'. The Chief Medical Officer of the DHSS says in his 1976 annual report: More is known about the events leading to accidental injuries than is the case for many other causes of incapacity or death. The possibilities for prevention are correspondingly high.

In 1974, 6,717 people died in Britain as a result of an accident in the home. This was almost as many as those who died from road accidents.

Over 60 per cent of all fatal home accidents involve people aged 65 and over. Nine per cent of deaths happen to children under 15. Figures for injuries show a striking contrast. Twenty-five per cent of all home accidents happen to children under four years old, and children under 15 account for 44 per cent. Eleven per cent of all accidents at home happen to elderly people.

What sort of accidents occur? In 1974, burns and scalds accounted for 13 per cent of all home accidents and poisoning alone caused 11 per cent of the deaths. However, six out of ten home accidents are falls.

The new Home Accident Surveillance System (HASS) in the Department of Prices and Consumer Protection (DPCP) has gathered details from people attending accident units of 20 hospitals in England and Wales. But many accidents are a 'near miss', or are treated with first aid. These never come to light. However, in the first six months of HASS, 30,000 cases were analysed, giving a detailed picture of the products and features of the home involved in accidents.

Accidents happen most often in the kitchen or living room. The outside of the house and the stairs come next. Different age groups are at risk to different kinds of accidents. For children there are the dangers of their surroundings — open fires, electrical equipment which they don't know is dangerous, and wrongly stored household items. Also inadequate supervision is often a reason why children get hurt at home. The elderly are especially vulnerable to falls and are more likely to have household equipment which is worn and dangerous.

There are two main ways of reducing accidents in the home. Information about the dangers can help people avoid unnecessary risks. Secondly, the environment itself can be made a safer place by improving the design of homes and the products used in them.

RoSPA (Royal Society for the Prevention of Accidents) carries out a programme of home-safety education. It is also in touch with local authorities' home safety committees. Elspeth Maclean, RoSPA's Director of Home Safety, reckons that about 60 per cent of local authorities, mainly at district council level, have a home safety committee or an officer in the environment health department whose job is to promote awareness of the dangers in the home. With very small budgets, the committees' scope is limited. They run activities such as school competitions, and campaigns for the return of old medicines.

The committees usually include a few councillors from the environmental health committee, officers from that department and invited representatives from local groups who the committee think may be interested. CHC NEWS spoke to several people connected with the committees who named groups such as the police, fire and ambulance services, gas and electricity boards, St John Ambulance, Red Cross and the WRVS. None mentioned CHCs — most had never heard of them. The reverse is also true. Most CHCs, even those who have been involved with home safety, did not know if there was a home safety committee in their district.

About 20 CHCs so far have shown an interest in safety in the home as an aspect of prevention of ill-health. The most popular CHC activity has been to get people to return old medicines for safe disposal. This is attractive, partly because you can see some results — in sackloads. The Isle of Wight CHC's campaign netted two cwt of pills. In N Derbyshire, 70 sacks of medicines were collected in two weeks. The CHC had co-operated with several local home safety committees and a detailed joint report on the campaign is available.

Photo: Joy Warren

The Isle of Wight CHC's campaign haul – two hundredweight.

St Helen's and Knowsley CHC has expressed concern about dangerous household items such as cleaning fluids, calling for childproof containers and warning people to store them where children cannot reach. This kind of work has much less immediate rewards. But it is still valuable and there are several bright and clearly designed leaflets available from RoSPA and the Health Education Council.

This is the consumer's side of the problem. What about central government and manufacturers of the goods? Reducing home accidents is mainly the concern of the Department of Prices and Consumer Protection. In 1976 a consultative document from the DPCP set out the main aims of their consumer safety policy: to ensure that goods on the market are reasonably safe; to warn people about the hazards of products in the home and how to avoid them; and to get unsafe goods found on sale removed or made safe as quickly as possible. In a book published by the Social Science Research Council, called *Accidents in the home*, this approach is criticised for concentrating too narrowly on products, with the danger of ignoring other possible targets. For example, it might be better to improve existing homes and equipment, rather than monitoring new products. Better now product safety may not be the best way of cutting cost of home accidents.

What does the DHSS think about home safety? There is very little in the recent White Paper on *Prevention and health*. A DHSS spokesman said, 'This is not really our province'. Does the DHSS assume that the DPCP is the only ministry which should be concerned? How practical is it to pressure or require manufacturers to make safer goods? Elspeth Maclean of RoSPA says that a foolproof electric plug could be easily made, but would cost about £5 or £6. 'Who would buy it?' she asks.

In the United States, the government can require manufacturers to research into safer products. In Britain we have legislation aimed at ensuring safety for people out at work. Within the terms covered by the Health and Safety at Work Act 1974, about 1,000 people are killed each year. Could we not use this law as a model for legislation in the home, the place of so much unpaid work?

It would require anyone who designs, makes, imports or supplies any article used in the home to ensure, 'so far as is reasonably practicable', that the goods are safe when they are being properly used and to do any testing or research needed to achieve this. In addition, designers and producers would have to 'carry out . . . any necessary research with a view to the discovery, and, so far as is reasonably practicable, the elimination or minimisation of any risks to health or safety to which the design or article may give rise'.

'May give rise' means that the research must allow for *any* risks to health or safety, even if the product is being incorrectly used.

Making our homes safer requires a wide variety of strategies. It is clear that both education and the law are involved in this vital aspect of prevention of ill-health. We know that many accidents can be prevented and CHCs can help.

where to find out more

RoSPA Cannon House, The Priory Queensway, Birmingham B4 6BS (021-233 2461).
Health Education Council 78 New Oxford Street, London WC1A 1AH (01-637 1881).
Consumer Safety Unit DPCP, 1 Victoria Street, London SW1H 0ET.
The home accident surveillance system, free from the DPCP.
Consumer safety: a consultative document (Cmnd. 6998) free from the DPCP.
Accidents in the home edited by Sandra Burman and Hazel Glenn (Croom Helm for Social Science Research Council, £5.95).
Report of the joint committee on the campaign for the return of unwanted medicines. Chesterfield and North East Derbyshire (North Derbyshire CHC, 87 New Square, Chesterfield, Derbyshire).

The way backward?

Alan Tyne

MENTAL HANDICAP is quoted as a 'priority area' in health and social service planning and provision. The DHSS in particular has given repeated emphasis to the need to maintain spending and to go in improving services in the face of cuts elsewhere. But how much change has really happened? Are the words matched with actions?

Priorities for health and social services in 1976 reaffirmed the targets laid down in the White Paper *Better services for the mentally handicapped* (Cmnd 4683). It said that progress towards these targets must be maintained even if at the expense of other areas. Savings were to be made in general, acute and maternity hospital services, so that improvements could be maintained in mental handicap and other 'Cinderella' services.

The way forward (September 1977) repeats many of the same words, yet they lack conviction. The early section of the paper hints at the sheer magnitude of the economic problems which may slow our progress generally. The second chapter pinpoints more specific areas of priority — not just 'mental handicap', but the 16 to 25 year olds and residential provision for children.

Recent government statements suggest some satisfaction over progress towards other goals (*eg* adult training centre places and adult hostels). But little evidence is produced to support this rosy view.

Little is said about the five-year programme of hospital improvements, initiated in *1969*. Yet the latest DHSS figures show that in 1975, three quarters of the hospitals with over 200 beds had failed to achieve these very minimal standards for space, staffing and the provision of such things as adequate meals, storage space and even personal clothing for residents.

While the DHSS continues to narrow down its goals, it is becoming clear that, at ground level, what policies it does have are being ignored. An appendix to *The way forward* summarises some of the main points from an analysis of RHA strategic plans. Paragraph two points out:

> All regions foresaw slow progress in providing district-based services for the mentally ill and handicapped and in closing large psychiatric hospitals. There were widespread doubts about the ability of local authorities, despite joint financing, to provide residential and day-care services for these groups. Most regions still had large institutionalised populations. Several commented on the increased revenue cost of providing treatment in smaller centres. But the main problem appeared to be a conflict, at least in the shorter term, between the priority for services for the mentally ill and mentally handicapped proposed in the consultative document, and the pressures on regions to invest in acute services. The Thames regions maintained that they had to use capital first for rationalisation of acute services . . .

If you look closely then at what is happening locally, the scene is very disturbing. The transfer from the acute to the chronic sector just is not happening, and mental handicap services are still being starved of resources. Authorities are still adhering to the old and long-established medical priorities for the acute sector. Secondly, where authorities do make money available, it is almost all ploughed into traditional hospital units, rather than into community-based care. So all the evils of the old system are perpetuated. Finally, where improvements are seen, they are nearly always selective, and catering only for the more mildly handicapped. Within the services, it is the severely handicapped who are increasingly the 'poor relations'.

What can CHCs do about this?

1 — minimum standards

Get hold of *Facilities and services of mental illness and mental handicap hospitals in England 1975* (HMSO, £4). Find out how *your* local hospitals have progressed towards the 'minimum standards' they should have reached by *1974*. Better still, get the DHSS circular: RHB chairmen 10/69, *Interim measures to improve hospital services for the mentally handicapped*, which lists the standards in great detail. Question every bit of spending on other services until these bare minima are achieved. Keep them constantly in front of the people who decide how the money shall be spent.

2 — community care

When money *is* made available, question any proposed development of hospital-based services and in every case show how care can be better provided in the community.

3 — the severely handicapped

Insist that the severely handicapped get their share of the improved services. This can only be done by ensuring they don't get 'separate' or 'different' services from everyone else.

It is clear that government does not intend to point out forcibly to the authorities which *is* 'the way forward'. Unless CHCs do so, there is every indication that we may begin to drift slowly *backwards*.

Alan Tyne is information officer of the Campaign for the Mentally Handicapped.

Personal view

Sam Keyte

COMMERCIAL ADVERTISEMENTS are usually colourful, sometimes subtle and above all they strive to demand attention. Their presenters seem to be confident that we will favour their product only if we can be led to believe that it will increase our sexual attraction. The Health Education Council has occasionally followed this lead from commercial advertisers and used sex as a selling point. I think this is a mistake and the Health Education Council should not adopt such standards.

The promotion of sex as the all-important interest in life is becoming more and more discredited as we get bored or disgusted with the advertisers' efforts. There is plenty of evidence that the exploitation of sex in this way is socially harmful and therefore harmful to health. The extraordinary decrease in some diseases is largely due to social changes and not so much to medical care. Conversely, the increase in mental ill health is in some part due to the pressures of high-powered advertising on the lines of sex worship and the false values engendered. Health educators should resist joining in with this sordid exercise.

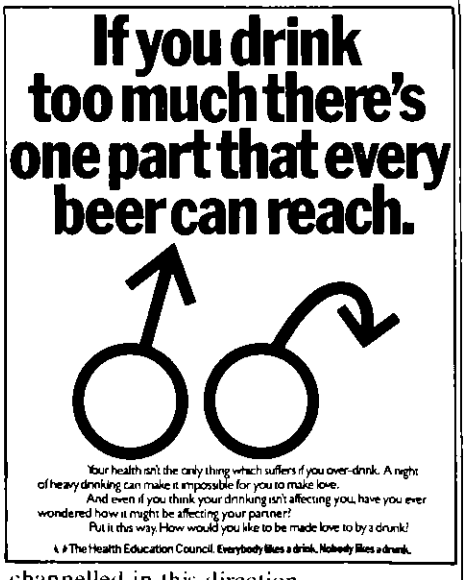
Some commercial advertising experts are already having second thoughts and appreciate that most prospective car buyers are not much interested in the near naked lady sitting on the bonnet, they mind more what is inside the bonnet. Is it sensible for the Health Education Council to almost quote a well-known beer commercial and add, 'A night of drinking can make it impossible for you to make love'? To imply that sex matters most and that it is totally permissible is damaging to a healthy view of life. There are better ways of combating drunkenness.

Many people who recognised the male sex symbol in the poster and who read the small print must have been rebuffed at its crudity which obliterated the message.

Real education, being concerned with values, is a slow process, requiring a steady development of understanding and realisation. We need to be wary of spectacular claims and talk of 'evaluating campaigns'. I have reservations about the influence which advertisements, posters and films can have. There can be no doubt that the best health education comes from one to one correspondence such as is achieved by GPs, nurses and best of all, midwives and health visitors in the home. I feel strongly that more resources should be channelled in this direction.

CHC members should obtain and examine the Health Education Council's publications. They will find that most of them are first-class and deserve solid support, but I believe that using people's desire to be sexually attractive and equating good health with male sexual competence does more harm than good.

Sam Keyte is a member of Ipswich CHC. He is a retired teacher and he represents the CHC on Ipswich Health Education Committee.



News from CHCs

❑ **Dartford and Gravesham CHC** has persuaded the AHA not to close Livingstone Hospital — a small GP hospital in Dartford. The closure proposal was first made two years ago and as well as a local action group which organised a petition, the CHC put forward counter-proposals. The AHA has accepted many of the CHC's ideas, though, as Peggy Smith, the CHC secretary acknowledged, 'the price was to concede 13 maternity beds which will be transferred to an excellent maternity unit just over a mile away and to agree to the closure of 32 beds in an acute hospital which according to regional norms is over-bedded'. She added 'the CHC has derived tremendous satisfaction from proving that the closure of a small hospital was not inevitable'.

❑ All three CHCs within **Manchester** AHA have jointly hired an advertising agency to help them project the CHCs' image in a 12-month publicity campaign. They aim to reach three main groups — consumers, organisations outside the NHS, and groups within the NHS. There is a total budget of £4,500.

❑ The DHSS has replied to **West Birmingham CHC's** letter which drew attention to local consultants' objections to research methods which the CHC wishes to use in a survey on elderly discharged patients. The DHSS said, 'We would expect that a health authority would disclose the names and addresses of individual patients after discharge only with the knowledge and consent of the doctor responsible for the patients during their stay in hospital, and after those patients have been given a clear opportunity to refuse to co-operate in any survey if they wish'. The CHC had had no trouble interviewing patients actually in the hospital, and considers that the DHSS reply is unsatisfactory.

❑ Proposals to create a single district area in Somerset have won the support of **West Somerset CHC** (pop. 280,000). The CHC agrees with the AHA's estimates that the merger will save almost £200,000, but wants assurances that staff reductions will not be made from among staff involved in direct patient care.

But **East Somerset CHC** (pop. 80,000) is worried that the interests of patients will be damaged in the merger and that the AHA's estimates are based on inadequate research. The AHA has recommended that the two CHCs should remain until a year after the merger when a review will take place. East Somerset fears this will result in just one CHC, and secretary Maurice Rumming warned, 'CHCs should watch that what happens to us today doesn't happen to them tomorrow'.

❑ **Sandwell CHC** campaigned successfully for joint financing funds to provide better accommodation for an industrial therapy unit for the mentally ill. Wages will go on being paid by the NHS, so there are almost no revenue consequences. A factory in Smethwick, owned by the borough council, has been adapted at a cost of £13,500 and includes a canteen. The CHC is now campaigning for the unit to be open at weekends and in the evenings as a social club for patients, many of whom live alone.

❑ Michael Quinton, **Bristol CHC** secretary, and Emrys Roberts, secretary of **South Gwent CHC**, were guests on a lunchtime HTV 'phone-in' programme. The programme is part of a series highlighting organisations which can help the elderly, and it provided a chance to explain the work of CHCs.

❑ Twenty thousand publicity cards, designed for the elderly, have been distributed by **Warrington CHC**, with the CHC's address and phone number. Home helps distributed them and some sub-post offices displayed them. Requests for help have been on a wide range of problems.

❑ A joint meeting between **Haringey CHC** and the local community relations council has been held to discuss screening for thalassaemia. This is an hereditary blood disease common among the Cypriot community. The under-use of health services by some minority ethnic groups was also discussed. The CHC is hoping to get invited to speak to community groups linked to the community relations council.

❑ A joint committee of CHCs in **Birmingham** is willing to advise the AHA in preparing an information booklet on local facilities. But because of the limited resources of the CHCs, the committee agreed that the publication should be the responsibility of the AHA.

❑ *Barnsley CHC received more than 200 entries for a dental health competition organised in schools among children aged 11-16. There were prizes for posters, pictures or short stories. It is hoped that the stories will be published in a booklet for younger children.*

❑ *How do I fit in?* is the title of a 12-page guide to local NHS facilities, published by **Renfrew District LHC**. Twenty thousand have been printed at a cost of £1,000.

❑ Shortly after the opening of the new district general hospital in Shrewsbury, members of **Salop CHC** visited to check on access for the disabled, especially in Outpatients' and in the Accident and Emergency department. They found that alterations were needed on telephones, signs, doors with springs and toilets for the disabled.

❑ **North Camden CHC** has set up a group to arrange meetings on topics with ethical implications, such as spina bifida screening, medical experiments and life-support systems. The CHC has already organised a meeting on the 'medicalisation of bereavement'.

❑ More than 50 GP receptionists attended a lunchtime seminar arranged by **West Berkshire CHC**. They discussed training, appointment systems, links between GPs and hospitals, prescriptions, records and allocation to GPs' lists. Invitations had been sent to the GPs, asking them to pass them on to their receptionists, if there were no objections. Only one GP told the CHC that he did object.

❑ Roland Moyle, MP, the Minister of Health, accepted **Lewisham CHC's** invitation to speak to an open council meeting. He is the MP for Lewisham East. At the CHC's suggestion he discussed the Resources Allocation Working Party (RAWP) and was questioned by the public and by members of the CHC.

The CHC is also opposing S E Thames RHA's proposals for future maternity services, which are based on the assumption that it is better that all babies should be born in hospitals. It argues that a mother's right to choose a home birth is being eroded for administrative reasons and wants to hear from mothers who have been unsuccessful in obtaining home birth facilities.

❑ **The Society of CHC Secretaries** has been launched, and its aims are, 'the development of good practices, the exchange of views and information among members, and the representation of concerns and interests of members to appropriate bodies (but not to act as a trades union)'. Ron Brewer of **Tower Hamlets CHC**, East London, is the contact for the Society, which has elected an executive committee and has plans for an autumn conference.

❑ **North Birmingham CHC**, whose vice-chairman Markley Taitt is a postman, has reminded the head postmaster in Birmingham of its willingness to act as a referral point for any postmen who find elderly or disabled people needing help. A national agreement between the postmens' union (UPW) and the Post Office enables postmen to help in this way.

SPINA BIFIDA SCREENING

Spina bifida is a numbing tragedy for any family to endure. Last June screening techniques were perfected which could prevent four-fifths of those tragedies from ever happening, and save the country money at the same time. *CHC News* sets out the mounting evidence in favour of a national screening programme, and looks at the arguments against.

IN SEVERE spina bifida or *spina bifida cystica* *the neural tube* in the developing embryo has failed to close properly. At birth the baby has a gap in its spinal vertebrae through which a *cyst* protrudes, like a big blister on the baby's back. In most cases, abnormal spinal cord tissue bulges into the cyst, causing permanent and irreversible disability. Most of these babies also have *hydrocephalus*, a gradual build-up of fluid within the brain.

In the 1960s a special unit in Sheffield set out to give 'total care' to all babies admitted with spina bifida cystica, and in 1971 Dr John Lorber published a detailed and distressing study (1) of these patients. 'Massive efforts in treatment' had kept half of them alive for two years or more, but with grave physical and mental handicaps. Few could walk unaided and a third were chair-bound. Incontinence and severe kidney infections were constant problems. Dr Lorber concluded that for humanitarian reasons 'Only those should be given active treatment who may look forward to a life without grave handicaps'. So began an argument about which patients, if any, should be 'allowed to die'.

Since no-one yet understands what causes spina bifida, the only alternative to this dilemma is to detect the disease before birth and offer the mother an opportunity to have an abortion — but that alternative only existed in theory until the UK Collaborative Study on Alpha-Fetoprotein in Relation to Neural Tube Defects reported last June (2). In this 2½-year project, based on 18 of the UK's leading medical centres, over 17,000 pregnant women were studied in an attempt to find out how to do safe, reliable mass screening for severe spina bifida.

What has emerged is a way of detecting 'high-risk' pregnancies by measuring the amount of protein called alpha-fetoprotein (AFP), using a simple blood test given to all pregnant women at 16 to 18 weeks. If the AFP level in the mother's blood serum is more than 2½ times the normal level, this means there is a 1-in-20 chance that the baby has spina bifida cystica. There is also a 1-in-20 chance of *anencephaly*, another neural tube defect in which the brain does not develop properly. By taking 2½ times as the 'warning' level nearly 80% of all spina bifida cystica cases and 90% of anencephaly cases will be amongst the pregnancies identified as 'at-risk'. The drawback is that about 3% of normal pregnancies will also exceed the limit, so that around 13,500 of the 15,000 or so 'at-risk' mothers who might be offered second-stage screening would in fact have unaffected foetuses.

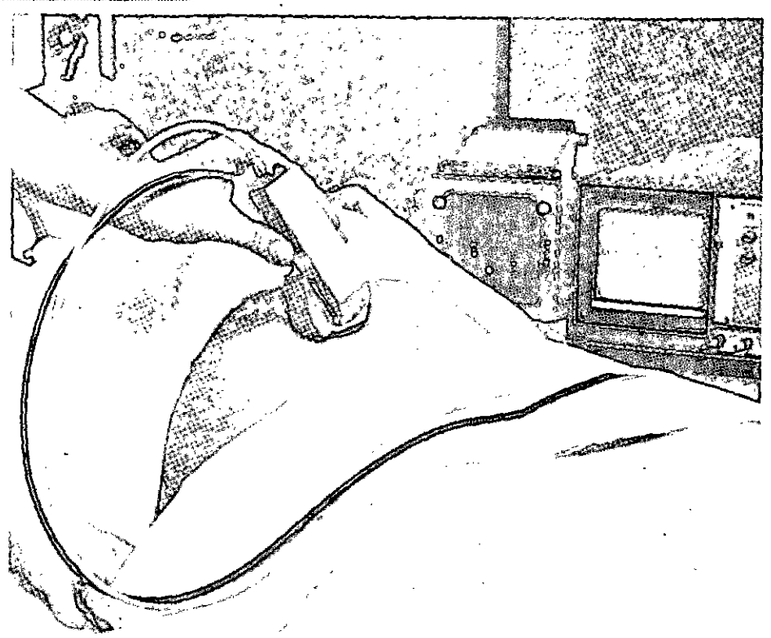
The next step is to counsel the 'at-risk' mothers, explaining what the risks are and what procedures would be used in the second stage. First the technique of *ultrasonography* is used to 'photograph' the foetus in the womb. This checks that the mother 'has her dates right', it detects anencephaly, and it can identify other reasons for high AFP, for instance a multiple pregnancy or stillbirth. If no alternative explanation appears, *amniocentesis* is used to take a small sample of the fluid surrounding the foetus in the womb. AFP is then measured in this *amniotic fluid* to give a final diagnosis with better-than-99% reliability. Amniocentesis would not normally be done unless the mother had at least provisionally decided to have an abortion if the test proved positive.

AFFECTED PREGNANCIES IN THE YEAR 1975*	UK TOTAL	ENGLAND AND WALES	SCOTLAND	NORTHERN IRELAND
Spina bifida: live births	1094	837	161	96
Spina bifida: stillbirths	196	161	24	11
Anencephaly: live births	101	78	8	15
Anencephaly: stillbirths	1035	835	132	68
Total affected pregnancies	2426	1911	325	190
Total affected pregnancies per 1000 live births in 1975	3.5	3.2	4.8	7.3

** The most recent year for which complete figures are available.*

Last August the DHSS sent a draft circular to RHAs and professional bodies, suggesting the introduction of a screening service. It is understood that these proposals were fairly well received by the RHAs, but there have been objections from the Royal College of Obstetricians and Gynaecologists (RCOG). For the time being David Ennals has set up a professional working group 'To advise on what guidance might be given to health authorities on the introduction into routine ante-natal care of a service to detect neural tube defects'. A campaign in Parliament, led by Conservative MP for Ripon Dr Keith Hampson, has put pressure on the DHSS in the form of an early-day motion signed by over 200 MPs, calling for screening to be introduced. David Ennals has confirmed that the Government is 'committed to the early introduction of a demonstrably safe and effective screening service as soon as the problems can be resolved'.

Some of those 'problems' were revealed in a letter from two leading members of the RCOG, published in *The Times* of February 14. They argued 'that introduction of a national screening campaign now would be a mistake' because of uncertainties about the safety of amniocentesis, and because increased demand for ultrasound and amniocentesis could produce lower standards of expertise and care for some patients.



An ultrasound scan in progress Photo: B & K Laboratories

The RCOG's concern is not well supported by the facts. Major studies of amniocentesis in the USA and Canada have shown that 'in practised hands, the procedure carried out in a major health centre at about 16 weeks is safe, accurate, and reliable, when monitored by ultrasound . . . the miscarriage rate seems to be no greater than that in control pregnancies' (3).

The RCOG's claim that problems would arise from the 'great expansion of diagnostic amniocentesis, needed to carry out the second-stage screening also seems implausible. Using DHSS figures (4) it can be shown that the work of the entire second-stage programme in England and

Continued on page 11

Putting your heart into it

THIS IS THE year of the Health Education Council's 'Look after yourself' campaign — £1m is being spent on national publicity for regular exercise and more sensible eating. If it works there could be an upsurge of demand for fitness courses, clubs and centres.

CHCs can promote the campaign locally by asking health authorities, local authorities and voluntary organisations to copy successful health and fitness campaigns which have already sprung up in some places. Organisers of these campaigns generally say their events are over-subscribed, so CHCs need have no doubt that time devoted to this kind of work is time well spent.

But why exercise? Briefly, the reason is to counter the effects of sedentary work, inactive leisure, stress and worry, diets laden with fat and carbohydrate, and unhealthy habits like smoking and excessive drinking. If you don't use your body it deteriorates — and in many people this has already gone so far that they no longer have the spare capacity to run for a bus or lift a heavy weight without risking a heart attack. Regular, vigorous exercise improves the function of the circulation, lungs, heart and

other working muscles. It may also reduce blood cholesterol levels, high blood pressure and obesity, though further research into these effects is needed.

Any exercise is better than none — so walking, gardening, using the stairs instead of the lift and even leisurely games such as golf are not be sneezed at. More effective are games involving a greater though fluctuating amount of effort, like soccer, tennis or squash. Best of all is continuous 'dynamic exercise' — physical exertion in which the muscles contract and relax in a rhythmic manner throughout the whole exercise period. This provides gentle, steady but prolonged demand on the heart, rather than the short, severe bursts which occur in most sports. Jogging (slow, rhythmic running), cycling and swimming are the best types of dynamic exercise, and in a non-competitive setting the individual can adjust the severity of this to suit his or her own physical condition.

Dynamic exercise offers a sense of well-being and alertness, and a way of shaking off everyday tensions and stresses. Jogging requires no previous experience and little equipment. The only essential buy is a pair of jogging shoes, costing from £4 upwards. These should be lace-up with flat soles and a cushioned inner sole, to prevent bruised heels and jarred joints. Jogging can be done in an organised group or 'from your own door'. Cycling means buying a bike, which can cost anything from £70 to £150 new. A further disadvantage is the danger of riding on busy roads, but against this must be set the incentives of increased mobility and the large financial savings which can be made by cycling to work.

For the average unfit person there is next-to-no health risk in starting dynamic exercise, provided it is done gradually and sensibly. Discomfort or breathlessness normally just mean 'Ease up for a moment', but people at all worried by discomfort should consult their GP. People over 50 should see their GP before beginning exercise, and so should people with heart, joint or muscle trouble or abnormal blood pressure, people grossly overweight and people who recently had an operation or serious illness.

Notes on some successful 'Fitness and health' schemes

☐ West Midlands and East Midlands Regions of the Sports Council set up 'Run for your life', a campaign to promote jogging. Based on a *Try Jogging* poster and a useful leaflet: *Heart disease is one of our greatest killers.* Co-operation from many local authorities, many new jogging clubs set up. Report published of 'Run for your life' seminars in Birmingham and Nottingham. West Midlands RHA is financing reprints of the leaflet.

☐ Suffolk, Norfolk and Cambridgeshire AHAs produced leaflets on health, diet and lifestyle, emphasising parents' role as 'health educators'. Suffolk AHA and Ipswich Borough Council followed up with *Exercise for life*, a leaflet promoting swimming and jogging. Jogging club formed, publicised through 'celebrity jog-ins'.

☐ Oldham AHA is running 'diet, exercise and anti-smoking' campaign. CHC members spoke at series of evening meetings on slimming. Great demand for free diet advice from the AHA's campaign caravan. Open meeting in the town hall featured exercise ranging from 'It's a knockout' to morris dancing.

☐ Wiltshire AHA and Bath City Council running ten-week 'health and fitness' courses at the Bath Sports and Leisure Centre, for men of 30-60 who have had or are at risk of coronary thrombosis. Course includes exercises, games and jogging. Follow-up shows some change in personal habits by the end of the course — people taking more exercise, eating less fat, giving up smoking.

where to find out more

Look after yourself (free from the HEC, 78 New Oxford Street, London WC1).

Everyday fitness and health published by the HEC and the Sports Council (70 Brompton Road, London SW3). Free from the HEC.

Jogging for fitness and pleasure by Cliff Temple. (Sunday Times/World's Work, 1977, £1).

Richard's bicycle book by Richard Ballantine (Pan, 1977, £1.50).

Healthline

Well woman clinics

How can I find out if there's a well woman clinic in my area?

The Woman's National Cancer Control Association is compiling a national list of well woman clinics. While it cannot distribute the list, it will advise what is available locally. Contact Kate Passord at 1 South Audley Street, London W1Y 5DQ (01-499 7532).

Islington CHC has five such clinics in its area and has become a useful source of information. It has just produced an actionpack on well woman clinics. Contact Marcia Saunders at the Liverpool Road hospital, Liverpool Road, London N1 0QE (01-226 3043 ext 14).

See also the CHC NEWS article *Well woman clinics* (January 1978).

When is a private bed not a private bed?

My CHC has been contacted by a woman whose father just suffered a stroke and was admitted to hospital as an emergency. No NHS bed was available and the father was put in a bed earmarked as private. The family is now worried about having to pay for the use of the private bed. Can you advise us?

The Department of Health and Social Security has stated that all beds in NHS hospitals are available to NHS patients. Private beds can be used for NHS patients when needed — especially in an emergency. There is no question that such a patient is liable for the bill.

Choosing your own doctor

What right does a woman have to be treated by a doctor of her own choosing while she is pregnant? A woman has contacted my CHC because her doctor says she must go to a GP *he* chooses. Her own doctor is not registered to provide maternity medical services.

The doctor is wrong. Paragraph 23 of Statutory Instrument 1974 no 160 NHS (General Medical and Pharmaceutical Services) Regulations 1974 covers this. In the section on GPs' terms of service, paragraph 23 states that:

A woman who, after a doctor has diagnosed that she is pregnant, requires the provision of maternity medical services may arrange for the provision of such services with either *(a)* any doctor on the obstetric list, or *(b)* the doctor on whose list she is included, or *(c)* any doctor who has under regulation 21/1 accepted her as a temporary resident.

The obstetric list is made up of doctors whose experience in obstetrics is for the time being approved by the Local Obstetric Committee or the Secretary of State. A GP's terms of service oblige him to render 'all necessary and appropriate personal medical services of the type usually provided by general medical practitioners'. He is *not* obliged to provide contraceptive services, or maternity medical services (except in an emergency), unless he has undertaken to do so with the FPC *ie* he is on the obstetric list. See also *GP's terms of service* in CHC NEWS 8 (June 1976).

Vasectomy

In cases where a man undergoes an operation for a vasectomy, should the permission of his wife be sought first?

There is no legal requirement that a wife must give her consent before her husband has a vasectomy operation. However, the DHSS has advised health authorities that it endorses the advice given to its members by the Medical Defence Union that the wife's agreement should be obtained if the couple are living together. It is felt that this helps to ensure that both partners fully share decisions on the methods of family planning they adopt and to reduce the risk of subsequent regret by either partner.

The Healthline column publishes selections from the queries received by our information service. This service is for CHC members and secretaries, and for other organisations and individuals interested in the NHS and the work of CHCs.

Contact the information service on 01-267 6111 ext 267, or write to the CHC NEWS information service, 126 Albert Street, London NW1 7NF.

Book reviews

Directory of projects (England and Wales) 1978/79 available from Barry Rose (publishers), Little London, Chichester, Sussex PO19 1PG (£3.50 inc p & p).

This directory gives details of over 1,000 projects set up for adult offenders, alcoholics, drug takers, homeless single people and people with a history of mental illness. It has been co-produced by CHAR, the Cyrenians, FARE, NACRO, SCODA, and MIND. The 'life' of the directory has been set at two years during which time update lists will be available from any of the above organisations.

The projects have provided the information themselves and the directory makes the point that a listing indicates the existence of a project and not any standard of service.

The guide is arranged geographically (by county, with a special London section), and by category of the service offered for each disadvantaged group *eg* day centre, treatment, accommodation, counselling.

A listing explains where a project is; who's in charge; which organisation manages it; what it is and who it is for *eg* self catering bed sit accommodation for homeless male recidivists aged 25-60 on release from prison; whom it won't take *eg* no drug takers; whether there's a time limit if residence is offered; how many people it can cater for.

National agencies are listed separately as are the organisations which manage such projects.

This is a valuable guide for any professional or any voluntary group which has to refer disadvantaged people to the facilities which can help them.

The social challenge of ageing edited by David Hobman (Croom Helm, £8.95).

Japan is like Britain in many ways — a modern industrial society enjoying many of the doubtful benefits of urban, high technology living. Like us, the Japanese have a rapidly growing proportion of old people among the population. Yet as many as 75 per cent of old people live with their children in Japan — and the survival of respect for the elderly as a strong social value gives old people a social role to play. I learned this from a chapter called *Ageing in Eastern society* in this wide-ranging and thought provoking book.

Problems which may face us all when we grow old are often discussed as purely medical or purely social or economic questions. As individuals, old people often find they are treated as sick or incompetent in a very prejudiced way. This book is not like that — it takes an all round look at social, cultural, medical, psychological and even the widest environmental problems, ranging well beyond the usual discussion on housing design.

As David Hobman, the director of Age Concern writes, 'Old age is not a disease nor is it a social problem'. I think his book will help to convince anyone who disagrees, and will be extremely useful background reading for anyone who is thinking about policies for the elderly.

Books received

The childbirth book by Christine Beels (Turnstone books, £2.50).

Equalities and inequalities in health edited by C. O. Carter and John Peel (Academic press, £4.80).

Primary health nursing by Anne Lamb (Bailliere Tindall, £4.75).

Coronary care in the community edited by Dr Aubrey Colling (Croom Helm, £12.95).

Look back at Tunbridge: a review of the DHSS report 'Rehabilitation' and its implications available from the Disabilities Study Unit, Wildhanger, Amberley, Arundel, West Sussex (£2.22 inc p & p).

What is a nervous breakdown? by A. R. K. Mitchell and **Looking at retirement** by Ivor Felstein, both available from Family Doctor Publications, BMA House, Tavistock Square, London WC1H 9JP(30p each plus 8p p & p for each title ordered).

The CHC and the Tatchbury Mount report

Clifford Offer

Last month, Gavin Weightman discussed some of the implications of the first public report of the National Development Team for the Mentally Handicapped. In this article, a member of Southampton and SW Hampshire CHC gives the CHC's response to that report.

TATCHBURY MOUNT hospital has been a cause for concern ever since 1971 when a report was produced by the Hospital Advisory Service. This report listed a number of failings within the hospital, but was withdrawn by the DHSS following threats of legal action by the Medical Superintendent.

The community health council first became involved when its members started making regular visits to the hospital. From the beginning, their reports reflected anxiety over the conditions in the hospital and the quality of care afforded the patients. At the same time, the Council received a number of individual complaints.

Despite the reports, and a court case in 1977 over a charge of assault by one of the nursing staff at the hospital, it seemed to the CHC that all concerned were reluctant to come to grips with the problems of the hospital. It was not until these were made public at a CHC meeting that the Regional Health Authority called for an enquiry by the National Development Team into mental handicap services in Hampshire.

Although the Team is an independent body, it seemed at one stage that they would be unable to complete their enquiry. As medical and nursing staff combined to prevent the Team entering the hospital, it came as a surprise to many to discover that the Team had no powers to override these objections. The CHC, out of concern for the patients, petitioned the Secretary of State to use his powers to ensure that the enquiry did take place. In the event, these were not necessary as the opposition was withdrawn. This incident does, however, raise questions about the powers the National Development Team has, and whether they should be strengthened in the interest of mentally handicapped people.

When the Team reported in February, the RHA immediately made their findings public. The report confirms many of the impressions gained by the CHC. It speaks of custodial care, inefficient management, poor communications and a lack of any coordinated programme of training. The Team recommends that all patients be regarded as potentially trainable; that ultimate placement in the community should be the aim to which everyone should work; that assessment and appropriate programming with regular review should become established procedure for every patient, including those seen in the community by the Mental Handicap Team; and that greater use be made of outside specialists.

As a CHC we welcome this report. Not only does it put on record matters which have given us concern in the past, it also makes possible a concerted and coordinated programme of improvement to be set in train over the next two years. We feel, however, that two weeks was not long enough to meet the terms of reference and that this is particularly reflected in a failure to deal fully with aspects of community care. While these matters were touched on, there was a need to deal in greater depth with what it means to care for an individual in the community, whether it be by social service departments, other agencies or parents.

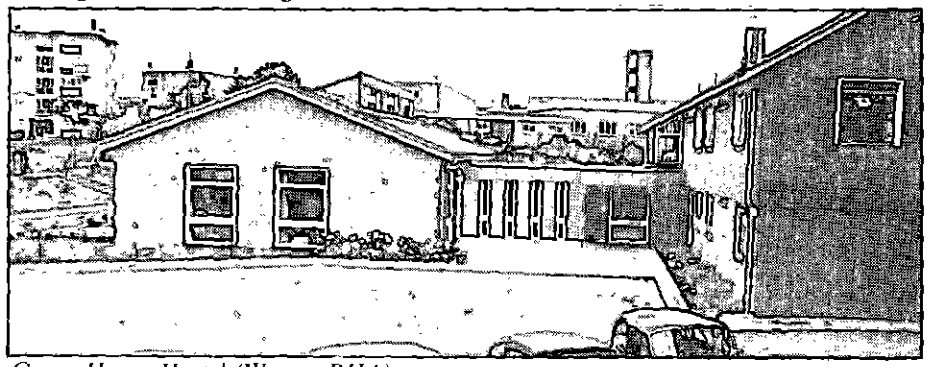
One of the most disturbing aspects of this report is the way in which personal opinions about staff members have been recorded without any attempt to substantiate their validity or apportion blame. Comments such as 'He felt that many of the problems stemmed from the fact that the Divisional Nursing Officer did not get on with the Medical Superintendent between whom there was little or no verbal communication' are bound to reflect on the persons involved. Yet there was no attempt to determine the truth of such a statement. There is no excuse for a public report to be compiled in such a casual way. But it does highlight a method in the method of reporting. Had the Team devoted more time to evaluating what was said instead of reporting it at length, we might have had a document which was short, concise and did not allow the wood to be concealed by the trees.

When making public the report, the RHA Chairman announced an immediate grant of £300,000 for the improvement of physical conditions within Hampshire hospitals. This was a response to the Team's findings that 'the majority (of the wards) needed a great deal done to make them into comfortable living units'. While the CHC welcomes any money being made available for improvements, this must not be allowed to obscure the real issue which centres on attitudes to care.

The Team found the attitudes of some training staff to be: 'They cannot do much for this patient, it is a waste of time'. Allocating money to upgrade facilities will not change these attitudes. Until all staff see their work in a wider context than 'custodial care' and are prepared to withhold professional jealousy in the interests of better communication, the patient is still in for a raw deal. Time and energy need to be devoted to improving staff morale and ensuring that all concerned are made aware of modern concepts in the care of the mentally handicapped.

The report reveals disturbing differences in standards throughout the hospital. Of one ward, it says 'the environment was unsuitable and unstimulating, badly equipped and overcrowded'; of another 'the quality of life in this particular setting was good'. The hostels were found to be no different. But perhaps more serious is the fact that the Team found occasion to comment on what they saw as a disparity between the favourable staffing levels and the poor services provided. Management has to be asked how this situation was allowed to develop and what steps they will be taking to ensure uniform and high standards.

Wessex is one of the most advanced regions in its provision of hostels for the mentally handicapped. The fact that some hostels included the more severely retarded and, at the same time, were not working well has led the Team to recommend some of the more difficult residents be returned to the hospital to be replaced by the less dependent. Their recommendation needs clarification as it is clear from the report that many of the deficiencies in hostel care had nothing to do with the degree of retardation in the residents. What is more, recommendations appear to be at variance with DHSS policy.



Grove House Hostel (Wessex RHA)

Clearly this whole area needs urgent review, and we welcome the setting up of a Policy Review Group at regional level to look at general policy, including the working of the hostels. It would be appropriate if a member of the CHC were invited to join this Group. Meanwhile it is imperative that no resident is returned to hospital simply because the Team found problems in caring for them in the community.

On a more domestic note, there is no mention in the report of the Team's meeting with the CHC, which raised many of the fundamental issues covered. This poses questions as to the importance the Team attached to the role of the CHC in the overall situation. Bearing in mind that CHCs are constituted by statute, the Secretary of State needs to be approached in order to ensure that the Team has a responsibility to take CHC views seriously in future enquiries.

Clifford Offer is a member of Southampton and South West Hampshire CHC, and a team vicar in the Southampton team ministry.

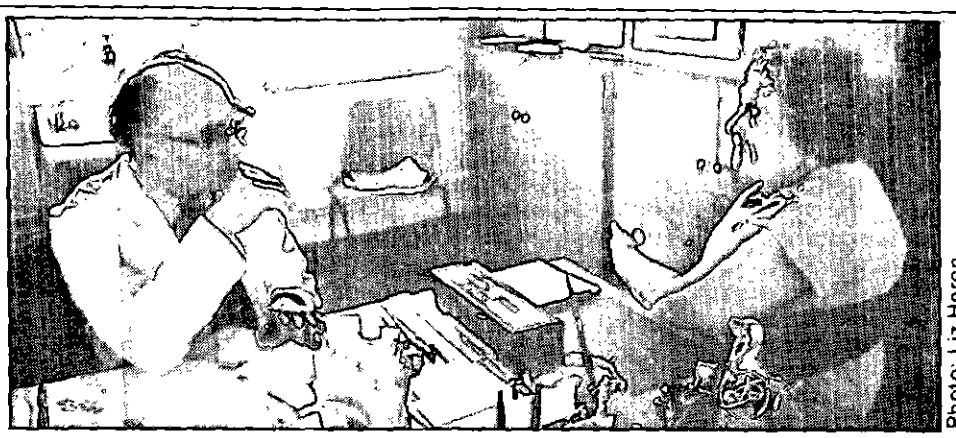


Photo: Liz Heron

Drugs and the NHS

Ruth Levitt

THE SUPPLY of drugs to patients is an essential component of the National Health Service. Treatment of ill health relies more and more on the actions of medicines, and we now take this very much for granted. But it was not always so. Only in the last hundred years have discoveries by chemists and doctors meant that illness could be checked without recourse to surgery, bleeding or other cruder methods of intervention.

We could not envisage a life without drugs now. Every day more than half the adult population and almost one-third of children take some form of medication. Not all these drugs are supplied on prescription by the NHS — very many are bought over the counter in chemists' shops or off shelves in supermarkets. Donald Gould, a medical journalist, has strong views about this. He wrote recently:

We are hooked on the foolish and ignorant idea that health and prosperity can be packaged in capsules and bottles and swallowed whole and, as a result, we indulge in a continuing orgy of self-poisoning.

Not all medicine taking is necessarily foolish, though. The introduction of antibiotics, for example, has transformed formerly serious and even fatal infectious illnesses into shorter and much less dangerous spells of discomfort. Psychiatric treatment too has benefited from modern drugs which enable hundreds of patients to live relatively normal lives outside hospital instead of being institutionalised for months or even years with little prospect of rehabilitation.

On the other hand, Donald Gould quotes figures suggesting that 30 per cent of hospital patients have some kind of unwanted effect from the drugs they take. Moreover, in 5 per cent of hospital admissions, a drug has contributed to the condition which brings the patient in. He concludes:

. . . it is safe to assume that outside hospitals a vast amount of ill health is, in fact, the result of unrecognised drug poisoning.

Governments seem to be aware of the dangers of careless drug taking and have tried to introduce some controls over the availability of both bought and prescribed medicines. The Medicines Act, passed in 1968, represents a package of legislation designed to safeguard standards of manufacture, sale and use of drugs. There are very strict rules governing the activities of pharmaceutical companies, and a whole series of steps need to be gone through before a drug can be put on the market. Even so, some drugs still turn out to have dangerous side-effects, and the Act provides a number of measures to monitor these and limit the harm that may be done.

The Medicines Act has its critics all the same. A number of manufacturers and retailers find the controls excessive, and they campaign vigorously for less intervention in their commercial activities. Other observers point to the inadequacy of the Act in preventing harmful drugs from coming on to the market and causing avoidable suffering.

The pharmaceutical industry is a large and important part of the economy. Despite very high research and development costs, profitability is higher than for industry as a whole, and significant foreign earnings are achieved by British-based companies. The industry is able to spend a lot on advertising, and a number of medical newspapers and journals exist solely because of the support drug companies are able and willing to provide. David Ennals' attempts to restrict drug companies' advertising met with vociferous opposition and charges that such esteemed journals as the *Lancet* and *British Medical Journal* might have to cease publication as a result.

Successive governments have tried to limit the costs to the NHS of prescribed medicines. Since 1958, agreements have been negotiated between the pharmaceutical companies to check the drugs bill. The government now has the ability, through the Prescription Price Regulation Scheme, to license pharmaceutical products compulsorily, to monitor the profitability of the companies and to control the content of drug advertisements. This is a voluntary agreement which covers most, but not all, of the companies, and they negotiate with the government through the Association of the British Pharmaceutical Industry.

Nevertheless, no government can be certain of fixing the NHS drugs bill at a given level. Part of doctors' clinical judgement involves decisions about prescribing drugs, so they are effectively free to choose whichever drugs they think their patients ought to have. The charge that some people pay when they have their prescriptions dispensed by the chemist represents only a small fraction of the actual cost of the drugs. The fact that neither the doctor nor the patient really pays directly for the drugs over the counter means that price does not act as a barrier or deterrent to the use of very expensive medicines.

In some cases, of course, it is absolutely necessary for expensive drugs to be prescribed. But there are very many drugs which are closely similar in composition and effect, but which cost significantly different amounts. The problem here is that pharmaceutical companies market their products under brand names to ensure continuity of sales. Often, therapeutically identical preparations which are not sold under a brand name can be obtained at lower cost. The drug companies strenuously advertise their *branded* drugs to doctors, to persuade them to stick to the particular varieties they manufacture. For its part, the DHSS produces a number of listings which show costs of comparable branded and non-branded drugs in order to persuade doctors to be more cost-conscious and choose cheaper drugs, where they exist.

The Prescription Pricing Authority collects all prescriptions dispensed by chemists under the NHS, in order to calculate how much chemists need to be paid for supplying drugs to patients. As a result, it is able to look at the prescribing habits of individual doctors and to compare the information with average patterns. Very occasionally, a doctor may be warned that he is prescribing excessively or choosing too expensively. But the system does not provide any effective deterrents to bad practice. So the NHS has to be reconciled to hoping that doctors will not succumb to all the persuasive powers of the drug companies, and will bear in mind that every time they write out a prescription they are spending taxpayers' money. This goes for hospital doctors too, for they are equally free to choose what drugs their patients will take.

On the question of drug safety, the Medicines Commission has a central part to play. It is charged with advising the Secretary of State on the implementation of the Medicines Act.

Community health councils will know that it recently recommended pain-killing tablets should cease to be available on a self-service basis. This met with such opposition that the proposals had to be modified simply to restrict packs to 25 tablets that were sold in child-resistant containers, while allowing self-service sales to continue.

The Commission also recommended that

a number of other over-the-counter medicines should become available on prescription only. It further called for greater controls over the wording of labels on medicine packs and bottles. All these moves, designed to improve the safer use of drugs, met with criticism and opposition, and several concessions have had to be made to retail chemists over their introduction.

Two other important bodies, established under the Medicines Act, have a significant part to play. The Committee on the Safety of Medicines advises the DHSS under section 4 of the Act on the 'safety, quality and efficacy of medicinal products and upon adverse reactions to such products once they have been marketed'. It operates the *yellow card system* which asks doctors to report any cases of unwanted side-effects resulting from particular drugs they have prescribed. The latest annual report of the Committee states '. . . there is still thought to be under-reporting', and it is working on improvements to the system.

The Committee on the Review of Medicines has the job of monitoring the effects of drugs which first went on to the market before the more stringent controls introduced by the Medicines Act came into operation. A number of drugs have subsequently been withdrawn or their marketing modified.

The Medicines Act has provided this country with quite sophisticated arrangements for controlling the manufacture and sale of drugs. There are few other countries, apart from the USA, which have made comparable progress. Nevertheless, it is extremely hard for the government to maintain what it regards as a satisfactory relationship with the pharmaceutical industry, chemists and the medical profession, while at the same time protecting the interests of patients who consume the medicines. There appears to be no shortage of advice to the government on this from a variety of interest groups. Yet the question still remains as to whether the protection is adequate.

Ruth Levitt is a lecturer at the School for Advanced Urban Studies, Bristol University.

Spina bifida screening *continued*

Wales could be handled by not more than five radiographers, ten staff nurses, five consultants and five registrars. With such small requirements for trained medical staff it would be hard to argue that standards of care and technique cannot be maintained.

The RCOG also argues that a small number of healthy pregnancies will be mis-diagnosed as spina bifida, and probably aborted. Even if the amniocentesis test were 99.9% reliable, this would still happen once in every thousand cases. But this criticism looks at the problem the 'wrong way round', with the benefit of hindsight. A more patient-oriented approach would be to ask: 'What would be the best advice any mother could be given after such a diagnosis?' The answer would seem to be: 'You have only one chance in a thousand of bearing a healthy child'. A letter from the organisers of the Collaborative Study, published recently in *The Lancet* (5), points out that amniocentesis is already offered as part of 'established clinical practice' to several groups of 'at-risk' mothers with a considerably lower chance of having an affected baby than high-AFP mothers.

The Economic Adviser's Office of the DHSS has done two detailed cost-benefit analyses of spina bifida screening (4,6), to compare the cost of setting up a national programme with the savings from reduced use of hospital resources, and reduced expenditure on appliances, social security benefits and special education. According to the more recent DHSS study the scheme would cost £1.1m to set up and £0.6m annually thereafter to run. But at a conservative estimate it would be self-financing by year two and would be making an overall 'profit' by year five.

These calculations, however impressive, are based solely on the diagnosis of spina bifida in cases where the child will survive. Anencephaly is always fatal, and like anencephalic and spina bifida stillbirths it imposes no major costs on the community. Economists and medical specialists have no way of measuring a family's grief when pregnancy ends in this way, but that does not mean the relief of such distress should not weigh heavily in the balance (see Table).

All the arguments must seem very academic to the parents of such tragic children — particularly in areas like Northern Ireland, Scotland and Wales where there are abnormally high rates of spina bifida and anencephaly. No-one knows how many mothers would refuse an abortion in the almost-certain knowledge that they would bear a spina bifida child, but surely every 'at-risk' mother has a right to know and to choose for herself.

Where to find out more

1 *Results of treatment of myelomeningocele* by J. Lorber (Development Medicine and Child Neurology, volume 13, 1971, page 279).

2 *Maternal serum-alphafetoprotein measurement in ante-natal screening for anencephaly and spina bifida in early pregnancy* (The Lancet, 25 June, 1977, page 1323).

3 *Who's for amniocentesis?* (The Lancet, 7 May, 1977, page 986).

4 *Economic consequences for the public sector of a spina bifida screening programme* by Norman Glass (DHSS Economic Adviser's Office, April 1976).

5 *Screening for neural-tube defects* by Nicholas Wald et al (The Lancet, 4 March, 1978, page 495).

6 *Costs of screening programme for neural tube defects* by Sally Holtermann (DHSS Economic Adviser's Office, November 1977).

Correction: the NHS in figures

In *The NHS in figures* (CHC NEWS 29, March 1978), the section on community health services contained a misprint. The number of people who went to GPs for family planning services in 1976 was under two million (1,898,000) and not 'under 2,000' as stated in the article.

Parliamentary questions

Appeals against FPC decisions

Since 1974 there has been a right of appeal against FPCs which refuse to investigate because notice of complaint has not been given in time, Mr Moyle told Jack Ashley. In 1976 six out of 55 such appeals were successful, and in 1977 11 out of 53 succeeded.

Drug hazards and CHCs

Sydney Tierney called for a DHSS investigation into the number of people suffering side-effects from the heart drug Eraldin, 'in view of the disclosure of ever-increasing numbers of . . . side-effect sufferers being monitored by CHCs'. David Ennals said this 'would not be useful'. Jack Ashley asked Roland Moyle to request CHCs to publicise the connection between hormone pregnancy tests and birth defects. Mr Moyle replied that 'This would not be an appropriate activity for CHCs'.

Spectacles on the NHS

Over 7m. pairs of spectacles were prescribed in England and Wales in 1976, Mr Ennals told Patrick Jenkin — 24 per cent of these were NHS lenses in new NHS frames, 31 per cent were NHS lenses in new private frames, 18 per cent were NHS lenses in existing frames.

Disabled employees in the NHS

No AHA has yet achieved the Government's 3 per cent quota for the employment of registered disabled people, Alf Morris told Andrew Bennett. Figures for AHAs in the North Western and Mersey regions range from 0.4 per cent to 1.7 per cent.

Emergency hospital treatment

People requesting emergency treatment from a hospital with no functioning accident and emergency service should be given 'essential first aid' by staff, Mr Moyle told George Rodgers. They should then be transferred to an A and E department elsewhere.

Needs of ethnic minorities

Arthur Lewis asked Roland Moyle what account was taken of stresses on the social services in places with large ethnic minority communities. Mr Moyle said grants to local authorities were available through the Urban Aid scheme, and under section 11 of the Local Government Act 1966.

Scanner

New planning guidelines

A major re-statement and up-dating of Government policies for the NHS has been issued under cover of circular HC(78)12, *DHSS planning guidelines for 1978/79*. The 26-page document consists of seven parts:

1 — confirms that the aims of the *Priorities* document and *The way forward* are still valid, and reports recent trends in service development.
2 — clarifies and develops some guidelines, including advice on how to define a community hospital and how to distinguish between 'natural' and 'distorted' patient flows between districts.
3 — lists reports and guidance affecting the NHS likely to appear in the next year.
4 — gives 'illustrative projections' for 1981/82, showing how planning objectives can be financed.
5 — discusses operational and strategic planning, asking all regions and areas to prepare ten-year plans 'at least in outline'.
6 — looks at manpower assumptions.
7 — deals with spending assumptions, slightly revising figures in *The way forward*.

The DHSS is sending additional guidelines to RHAs on 'points specific to their regions'. RHAs will issue regional guidelines and advice on interpretation to AHAs.

Rights of mental patients

Is it fair? is a booklet from MIND designed to rejuvenate the campaign for mental patients' rights in readiness for the expected White Paper on reform of the Mental Health Act 1959. In 40 pages it deals with informal admission to hospital, compulsory admission and detention, the review tribunals and mentally abnormal offenders (50p from MIND Bookshop, 155 Woodhouse Lane, Leeds).

Phasing out the pay-beds

The speed at which remaining pay-beds can be phased out depends crucially on the supply by the DHSS of better information on private medical care, the Health Services Board has warned in its first annual report. In 1977 the board withdrew 1,356 pay-bed authorisations out of a total of 4,444. The report also repeats the board's recommendations on common waiting lists, and discusses its powers of control over the private health sector. *HSB annual report 1977* (HMSO, 45p). Meanwhile the Government has announced increased charges for private patients in the NHS (HN(78)27). The daily charge for a pay-bed in an acute hospital goes up by about 8½ per cent, and charges to private out-patients are also increased.

Nursing bill killed off

The Government has dropped its Bill to reorganise the training of nurses, health visitors and midwives, because of pressure on Parliamentary time caused by devolution. Roland Moyle said a Bill along the lines of the Briggs report (*Report of the committee on nursing*, HMSO, 1974) would be introduced 'as soon as legislative time can be found'.

Danger in hospitals . . .

'Despite its reputation as a place of healing and safety, the

hospital is filled with potential hazards for both patients and workers. Constant stress, infection, exhausting shift rotas, microwaves, X-rays, bad wiring, chemicals, slippery

floors, backache, bad ventilation — all take their toll on the hospital workforce'. *Hospital hazards*, a leaflet from the British Society for Social Responsibility in Science, gives details of these major hazards and explains the legal situation (12p inc post from BSSRS Hospital Hazards Group, 9 Poland Street, London W1).

. . . and in the laundrette

A series of alarming accidents in commercial and local authority laundrettes is reported in *Health and safety in manufacturing and service industries 1976* (HMSO, £2.50). In one case a child was killed by fumes of dry-cleaning solvent, and three other children had arm amputations following accidents with spin-driers. Other accidents involved electrical faults and wet floors. Two other reports from the Health and Safety Executive are *Audiometry in industry* (HMSO, 50p) and a consultative document on air pollution, noise and vibration in the workplace. (HMSO, 50p).

Compensation for medical accidents

A new tax-free benefit of £4 a week for all severely handicapped children, beginning at two years old, is amongst the many proposals of the Pearson report*. The main recommendation is a 'no-fault' compensation scheme for victims of road accidents, but the report does not extend this approach to damage caused by drugs, vaccinations and other medical procedures. It does however suggest that proof of negligence should no longer be required — proof of cause and effect should be sufficient.
*Royal commission on civil liability and compensation for personal injury, Cmnd 7054-1, HMSO, £7.60 (Vols II and III £3.60 each).

Breast or bottle

Many mothers believe that breast feeding is better, but half of those who begin feeding this way, give up too quickly. Hospitals often keep babies in nurseries at night, where they get bottles, and staff do not advise or encourage mothers. This is the evidence of a survey carried out by the Office of Population Censuses and Surveys. It shows that feeding on demand, which helps to increase the milk supply, is prevented by rigid hospital feeding routines. *Infant feeding 1975: attitudes and practice in England and Wales* (HMSO £7 + post).

HN(FP)(78)10: contraceptive supplies

Fertility thermometers and temperature charts are now being issued free to patients advised by their GP to use the rhythm method of contraception.

HN(FP)(78)19: orange badge scheme

Explains a new scheme for issuing orange badges, which exempt blind and some disabled people from certain parking regulations. Local authorities have been asked, in LASSL(78)3, to issue a special medical certificate form for completion by GPs. A certificate will not usually be required if the applicant is receiving mobility allowance.

HN(FP)(78)15: GPs asked to publicise kidney donation

Asks FPCs to forward kidney donor cards and a poster to every GP in their area. A letter from the Chief Medical Officer (CMO(78)5) asks all GPs to cooperate in publicising donation.

Directory of CHCs: changes

A directory of the names, addresses and telephone numbers of all the community health councils in England and Wales is available from CHC NEWS, 126 Albert Street, London NW1 7NF; price 60p. Cheques and postal orders should be sent with order and made payable to *ACHCEW*.

Corrections are published monthly in CHC NEWS. Please notify the editor of any changes. This month's changes are:

Page 3: **Northumberland CHC** Chairman: Rev Alec Beniams
Page 6: **Airedale CHC** Telephone: Steeton 54666
Page 10: **North Nottingham CHC** Chairman: Councillor Miss L. M. Darnell
Page 22: **Dartford and Gravesham CHC** c/o The Oast House, Manor House Grounds, Swanscombe Street, Swanscombe, Kent DA10 0BS (Greenhithe 845512)
Page 30: **Aylesbury and Milton Keynes CHC** Secretary: Mrs Jeane Lewington
Page 39: **Walsall CHC** Chairman: Mr T. Alex Taylor
Page 40: **Macclesfield CHC** Rock House, West Park Hospital, Prestbury Road, Macclesfield, SK10 3BL (0625 20267)
Page 43: **Central Manchester CHC** Secretary: Mr N. Harris