COMMUNITY HEALTH NEWS

Association of Community Health Councils for England and Wales

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NEWS

"Working for Patients" - What they are saying

The Royal Colleges: "There will be risks to patient care" and the old and the chronically sick will suffer because they are "bad business" was the response of the Joint Consultants Committee representing the Royal Colleges. They were particularly opposed to the "opt out" proposals and the response came as the Government announced fifty more hospitals it has chosen to prepare for resource management - the first step towards opting out. The JCC says that experience with such hospitals in the US has shown that they become centres whose prime management aim is the financial success of the hospital rather than providing adequate care to the community as a whole. "There will be pressure to encourage the admission of patients with conditions that can be treated with financial benefit to the hospital rather than to admit those patients - often the chronic sick - whose treatment is likely to lead to little or no such financial benefit. Sir Anthony Grabham, who chairs the JCC said the Government had disregarded the main problem of the NHS, its gross underfunding. "What the NHS needs is more doctors, nurses and operating theatres. Spare us from more reorganisations. Just give us adequate funds."
(The Daily Telegraph 21.3.89)

The BMA and GPs: The BMA is openly opposed to the Review and has warned that if implemented it will "destroy the comprehensive nature of the service" and seriously damage patient care. The decision of the 80-strong BMA Council was unanimous, following a two-day meeting. It approved a determined campaign against many of the key proposals including the self-governing hospitals, the internal market ideas and GPs as budget holders. The BMA believes this will fragment the care of patients with the government apparently believing that health care consists of one-off episodes and single consultations with doctors. A full scale campaign is to be mounted which will include media advertising, Parliamentary lobbying and leaflets and posters aimed at patients in GPs surgeries. GPs themselves have been holding nationwide meetings to discuss the Review to which they are almost unanimously hostile. In many areas doctors are seriously considering resigning from the NHS if its proposals are implemented.
(The Independent 3.3.89)

And Even the Managers Do Not Like It!

One of the most interesting responses to the NHS White Paper has come from the Institute of Health Services Management. In the words of Duncan Nichol, Chief Executive of the NHS, it is "absolutely crucial that managers at all levels are seen to be running with the proposals... but we won't get much right if we

don't get the climate right." After expressing support for some of the "thinking behind the White Paper", the IHSM lists its misgivings and doubts which include the opt-out for hospitals (which it considers will push up pay among other things), GP practice budgets - with their incentives to avoid expensive patients and tax relief for private insurance for the elderly which introduces a two-tier health system.

Nor do the managers think the two proposals with which they do agree - separating finance from service provision and linking workload to funds - can be realised. The IHSM says it wanted the government to test three separate methods for the NHS, instead of which the government has "adopted one untried and untested model which it intends to introduce nationwide." Lastly, the IHSM concludes that on top of the unnecessary risks involved in implementing the White Paper as it stands, the government has still failed to address "the endemic underfunding of the NHS". (**The Guardian** 28.3.89)

New Fears over Radiation Treatment

It now looks as if it was not just the unfortunate patients at the Royal Devon and Exeter Hospital who have received the wrong doses of radiation. Several hundred cancer patients may have been put at risk through having been given underdoses because of errors in output from radiotherapy machines in hospitals, according to Mr. Roland Blackwell, president of the Institute of Physical Sciences in Medicine, quoted in **The Guardian** (26.3.89).

Underdoses of radiation can be as dangerous as overdoses because the tumours may not be effectively killed. He did not give the name of the hospitals at which the incidents had occurred but said it had come to light following re-checks after it had been revealed that 207 Exeter patients had been given overdoses. The low level doses appear to have occurred at three separate centres and Mr. Blackwell emphasized that checking procedures have now been tightened up. Other problems arising in the radiotherapy service have surfaced at a Surrey hospital which was unable to provide radiotherapy for 60 patients because it did not have enough staff to operate its equipment safely. Radiotherapy treatment for new patients was suspended at St. Luke's Hospital, Guildford, from March 13 and did not resume until March 29 when a locum returned from holiday.

But the revelations really bring to light a more serious and underlying problem. Mr. Blackwell said there is now an "impending crisis" in radiotherapy because of the national shortage of medical physicists, who are responsible for checking safety and output levels from the machines. "People do make errors and it takes two people to do re-checks. If there are insufficient staff then it is not possible to make these checks." St. Luke's and the Royal Marsden are the only two radiotherapy centres in South West Thames RHA and both have had trouble attracting suitably qualified staff because of the low basic salary of £8,200. Nationally, in the last eighteen months,

thirty per cent of basic grade medical physicists have left the NHS and although the International Commission on Radiological Protection recommended that there should be 214 of them to ensure basic standards, there are now only 105.

The New Two-Tier Eye Testing System

Under the heading of "Consumer Safeguards in Relation to Sight Tests", the Government has introduced a two-tier system into the new private test (which most people including pensioners will be paying for from April 1st 1989). It was generally assumed that statements by Tony Newton (the then Secretary of State for Health) in the House of Commons meant that if a two-tier system was introduced the Government intended the NHS test definition (ie a complete test with medical examination of the eye) would be used as a minimum standard. The reality is likely to be different. With only 10 days for comment, caring organisations and professional bodies were told that a refraction-only test exempting private tests from a full eye care examination for the purpose of detecting signs of injury, disease or abnormality will be introduced as an alternative to the full eye examination previously available for all under the NHS. The refraction-only test is second class compared to the NHS defined test.

The introduction of the refraction only test may lead to 3,000 extra cases of blindness a year as well as increases in other disabling diseases at a cost of an estimated £37M a year. The British College of Optometrists has published figures which estimate that 732,000 patient referrals were made by optometrists to GPs during 1988. Referrals were made for cataracts, glaucoma related conditions, hypertension, diabeties, macular degeneration and retinal detachments. The majority of referrals were made in the 51+ age group. In the main, elderly people will only receive free eye tests if they qualify as being on a low income under a means-tested scheme. They will not recieve free tests as of right. It is feared that elderly people, put off by the excessive bureaucracy involved in means testing, will opt for the inevitably cheaper refraction-only test and therefore miss out on essential medical care. (The cost of a full eye examination is now being estimated at £15). Furthermore, the British College of Optometrists inform ACHCEW that sight deficiencies may have a disease basis, so that a "duty-to-care" would imply that a full examination of the eye should be carried out whenever a defect in vision is noticed. The refraction-only test would not allow optometrists to fulfill this "duty-to-care".

However, the refraction-only test may be carried out only if the patients sign to say they are happy to forego a full eye examination, if the practitioner displays a prominent sign to the effect that the test may not include the full examination and that any prescription carries a statement to the effect that a full examination has not been carried out. It is not yet clear if optometrists can legally opt out of this "duty-to-care" for which they are obliged by their specialist knowledge. However if this exception is allowed, a massive public awareness campaign to inform people exactly what the refraction-only

"second class" test means will be necessary and should be sponsored by the Department of Health.
(**Daily Telegraph, The Times, The Independent** 16.3.89)

And Still They Keep On Growing

Hospital waiting lists have grown by almost 30,000 to reach 691,100 - an increase of 4.5% over the previous year, according to Health Minister David Mellor. The lists are now longer than at any time since 1984 despite an extra £25M a year being spent by the Department of Health to try and reduce what **The Daily Telegraph** (15.3.89) describes as: "a politically damaging statistic." More than a quarter of patients wait over a year for treatment, just over half are treated within six months. Mr. Mellor said that 941,000 in-patients and 359,200 day patients were treated from the lists in the six months up to last September when the lists stood at 691,000.

The figures appear to reflect the effects of closure of more than 3000 NHS beds last winter as health authorities suffered the cash crisis which triggered off the Government's NHS review. Robin Cook, Labour's health spokesman said: "These figures are the delayed effect of last winter's cash crisis" and he accused the Government of "slipping the figures out" on Budget Day to avoid adverse publicity. The only regions which did not show a sharp rise were South East Thames, Wessex and the West Midlands, with rises highest in the North West and North East Thames, where lists rose by over 10%. David Mellor attributed the rise in part to last year's unrest that became widespread in the NHS generally in the last few months of 1987 and early months of 1988.

Stacking Statistics...

News that some civil servants are now baulking at what they are being asked to do with statistics arose in the run up to the Budget when reports appeared that the Central Statistical Office had resisted attempts by the Chancellor to revise the balance of payments figures to present the budget deficit as less than it really is. In an analysis in **The Guardian** (15.3.89) a number of instances are given.

"More Money Goes to the NHS" - The truth, says the analysis, depends on where you start from. For example, a proportion of the extra money provided has to come from "efficiency savings" and health authorities own income generation schemes as well as pay for a proportion of the NHS staff pay awards. Moreover, if inflation rises above the Government's prediction the cash increase is automatically eroded, quite apart from the fact that NHS inflation is higher than general inflation. When trying to persuade voters that more is spent on the NHS the Government adds back in the sale of NHS assets as well as the assumed "efficiency savings" and, as the **The Guardian** notes "Hey presto, spending looks higher." Frank Field MP is undertaking research on baby death figures and has discovered that the gap in baby deaths between social classes is actually widening. Although the data on which he bases his research is published in OPCS "Monitors",

hardly anyone, he says, would have access to the full set of monitors which are vital to such analysis and no one in Government is taking in the message revealed by these statistics.

Sedating Old People

Old people are being kept sedated in private nursing homes often without any medical review of their problem, according to the British Geriatrics Society. (**The Independent** 13.3.89). The Society says that Britain is returning to a system like the old poor law infirmaries where the elderly were cared for in the 19th century. Elderly people are being admitted to homes with conditions that could easily be reversed, thus allowing them to continue living in the community.

The abuses were discovered during a survey of 351 patients in private nursing homes in the Weston-super-Mare area. One fifth of residents in the area had never seen a doctor, half were sedated at night and one in ten were given drugs "prn" - that is at the discretion of the staff. Dr.Ian Bowler and Dr. Clive Bowman of Weston General Hospital who undertook the survey said: "The high rate of sedation may be a reflection of inadequate patient management, albeit a common form of expedient care of problematic patients. However, the low level of routine review of those on "prn" sedation we believe to be a matter of great concern." Present policies cost the taxpayer £1bn a year and are often not in the best interests of the elderly. It would be better if they were assessed by doctors and health workers before being admitted to residential homes - this is mandatory in the USA. "The apparent loss of responsibility to the individual patient by the statutory services is in need of urgent remedy", say the doctors.

Reappraisal of Cancer and the Pill

Women who have been on the contraceptive pill for more than four years before having a baby have an increased risk of breast cancer according to a new analysis of available data. (**The Independent** 10.2.89). Evidence as to whether or not the pill does increase the risk of cancer has always conflicted but it appears that a new analysis of American studies does show that the risk of breast cancer has been overlooked. Professor Julian Peto of the Institute of Cancer Research in Surrey re-analysed the American data which had previously been taken as proving a lack of any association between breast cancer and the pill and was often used to reassure women as to its safety. Professor Peto claims that his studies of the same data show that, contrary to the researchers own analysis, there was a significant excess of breast cancer in women who had taken the pill for more than four years before their first full term pregnancy. The risk appears to increase in step with the number of years a woman has taken the pill and increases by about a quarter after she has taken it for between four and seven years, doubling after twelve years. This observation tends to support the idea that the pill actually causes cancer, or at least promotes the growth of breast tumours in some women. Professor Peto concludes: "The results of all major studies thus appear to

be consistent with some increase in the risk in women aged up to about 35 or 40."

Budgeting for Bad Health

In the Budget, the Chancellor chose not to raise the amount of excise duty on cigarettes and alcohol. This has met with almost universal disapproval. It is widely thought that the reason he did not do so was because it would have added 0.5% to the rate of inflation when the Government is already embarrassed by the rising rate. Health organisations have launched a blistering attack. David Simpson, director of Action on Smoking and Health said it was a "disaster for public health. Smoking is already starting to increase for the first time in a decade. For the third year running the Chancellor has ignored the strongest possible demands from the medical profession for a measure which would save lives as well as make money to help pay for the damage smoking causes."

Don Steele, director of Action on Alcohol Abuse said: "The drinks companies have already given the best part of £250,000 to the Tories this year, and he (the Chancellor) appears to be repaying the favour. The real price of alcohol in this country has halved over the last thirty years and consumption has doubled. His decision will mean the trend will continue - just at a time when one in five beds in NHS hospitals are occupied by people suffering from drink-related diseases or drink-related injuries."

The British Medical Association said the Chancellor's attitude was "simply incomprehensible" and that the nation's tobacco addiction would increase by around 3.5%. "The Chancellor knows very well that the cost of alcohol and cigarettes has a very significant effect on smoking and drinking habits. He also knows that smoking and the abuse of alcohol are responsible for a substantial proportion of the nation's ill health and loss of life expectancy." "Surprise" was expressed even by International Distillers and Vintners, Britain's major wines and spirits company. The reaction of the Brewers Society was quite simple: "Cheers to the Chancellor".
(**The Guardian, The Independent, The Daily Telegraph**.15.3.89.)

Without a Leg to Stand on

Certain limbless people are now being refused spare artificial legs, according to an article by amputee Malcolm MacEwan in **The Independent** (14.3.89). These are now only supplied to people in certain favoured categories, he writes. Those are war pensioners, children, people in employment, those who the DHSS considers to be "very active", those who are overweight and/or subject to breakages and those subject to "stump fluctuations". The only purpose of this decree, he says, appears to be to save money at the expense of those in genuine need. The main victims are the elderly, the severely disabled, the unemployed and women without paid jobs. All of them now have to face buying a spare

limb which can cost hundreds of pounds. There is no foundation to the theory that these people do not need spare limbs. If these people cannot afford a spare limb they can find, if something happens to their only one, that they immediately become almost completely disabled, often having to be pushed around in wheelchairs.

The idea that only the "very active" need spare limbs could only occur to bureaucrats who have not experienced what it means to have an artificial leg, says MacEwan. "This country is richer today tht it has ever been. It can easily afford to treat the limbless properly. Public opinion must shame the Disablement Service Authority into withdrawing its directive. For if the Government can get away with this, it will look for other economies at the expense of the disabled and explore other ways of making them pay for their appliances - as we have already to pay for our dentistry and spectacles."

The Family Planning Association and the White Paper

The FPA, in a letter to the Department of Health on the NHS White Paper, points out that DHA Family Planning Clinics are recognised as a necessarily self-referring relatively anonymous service provided by DHAs in the interests of public health. Because of the preventive nature of FP services, their post-Griffiths management has been largely with DHA Community Units. GPs are currently paid item-of-service payments for contraceptive advice. About 1.3M women attend DHA FP clinics and 2.6M seek advice from GPs. What, asks the FPA, will be the future of these services and what choice will patients have? Overall the White Paper does not offer a clear view of the future of DHA FP services and the current lack of detail on the matter is worrying. What happens, for instance, if a hospital with a DHA FP Unit chooses to opt out? Whatever happens, a level of FP services must be provided which meets the needs of residents within a district especially those not registered with GPs, those whose GPs do not offer contraception or if they do, only promote the pill, those who for personal or cultural reasons will not consult GPs and those with special difficulties in the use of contraception.

Compensation cut for Victims of Industrial Accidents and Diseases

It is proposed that some benefits will be withdrawn from the victims of industrial diseases and accidents. Savings in the region of £38M are being sought. The Governments argument is that such sufferers are being compensated twice over - for instance they may be entitled to damages from their employer as well as a variety of social security benefits such as sick pay and invalidity benefit to compensate for loss of earnings, industrial disablement benefit for loss of amenity and income support for basic living. New regulations would require employers or insurance companies to deduct from the agreed damages and pay back to the DSS the amount of social security benefits the victim has received. Why, so the argument goes, should the taxpayer spend money paying double compensation?

The House of Commons Select Committee on Social Services disagrees with this premise, arguing that it is superficial and rests on the fallacy that where damages are paid, they provide full compensation. In about half the cases decided by courts, a reduction is made for contributory negligence and anyway most cases are settled out of court, often for less than the amount a court would have awarded. Court awards have, in any event, been widely criticised as inadequate. Even under present law a proportion of benefit is deducted by the courts in assessing damages. While there are grounds for tidying up and rationalising the system this does not seem to be the object of this particular exercise. Tony Lynes, writing in **New Statesman & Society** (3.3.89) says: "The aim of clause 18 (the new regulation) is to reduce social security's share to nil wherever possible, regardless of the cost to victims."

Health Department to Carry Out Ethnic Monitoring

The Department of Health is to carry out ethnic monitoring of promotion and job prospects following a pilot study later this year. In a Parliamentary written reply on 22 February last Kenneth Clarke said that every opportunity had been taken to remind health authorities of their responsibilities under both the Race Relation and Sex Discrimination Acts. "My department supports the work of the King's Fund task force and has also established the national steering group on equal opportunities for women in the NHS. In the area of health care services, in 1982 my department appointed an adviser on ethnic minority health." Her work has already involved her with advice to Asian women on rickets, the Asian Mother and Baby campaign, and the appointment of link-workers, among other things. "Altogether", said Mr. Clarke "we have provided over £75M since 1984 for a variety of innovative projects to improve access to health care for ethnic minorities."
(**Healthcare Parliamentary Monitor** 13.3.89)

A Call for More Research into Power Line Cancer Links

Growing concern that cancer may be linked to exposure to the electromagnetic fields of power cables brought a call from leading scientists for more research. (**Daily Telegraph** 23.3.89). Dr. Leslie Hawkins of Surrey University, speaking at the Institute of Physics, said that these fields might not directly cause cancer but might prompt the growth of cancers caused by other environmental factors. The first properly controlled study linking cancer with electro magnetic fields in western Europe was carried out in Colorado in 1979 and appeared to support similar research emerging from the Soviet Union. However Dr.John Male of the Central Electricity Generating Board said that research had been beset by false trails but the CEGB was now planning a major study into the possible link. Dr. Richard Saunders of the National Radiological Protection Board said: "There are several areas of biological interaction which have important health implications and about which our knowledge is limited. Further experimental work should investigate these possibilities."

Alcohol Code being Flouted

Leading drinks manufacturers are flouting the rules governing alcohol advertisements and are using increasingly psychological techniques to get their message across, says the Federation of London Alcohol Groups. The Federation represents local health education departments and counselling services and has made eight complaints to the Advertising Standards Authority in eight weeks. Three have so far been upheld. Although the code of practice is supposed to prohibit pictures of consumption in a dangerous environment, Tuborg lager showed a swimmer drinking lager,and the Great Australian Beer Drinking Company showed three young people drinking on a beach. 38% of drownings among 25 to 29-year-olds are linked to the consumption of alcohol. Among advertisements withdrawn following pressure was one from Oddbins on Croft Port which went: "Percy Croft... used to say that any time spent not drinking port was time wasted. He didn't waste much time; he drank about six bottles a day and died an extremely contented octogenarian." **Daily Telegraph** (18.3.89).

Long Waits for Court Hearings

Children whose parents allege they were brain damaged at birth are being forced to wait until their late teens or early twenties to claim compensation because new, more stringent, rules preclude their parents from obtaining legal aid. Parents are now being told to delay such claims until their children are sixteen and can claim legal aid in their own right. Ten years ago more than 70% of the population qualified, now this figure is down to under 50%. From 1 April the situation will worsen again with only those families with £6035 disposable income or less qualifying for legal aid. One family featured in **The Guardian** (23.3.89) were having to sell their home in order to try and get help for their daughter, Ceri, nearly two who is a spastic. A report from a consultant supports their view that the condition was caused through failure to respond quickly enough to signs of foetal distress. Her solicitor is pressing the Lord Chancellor's Department to amend the legal aid rules for such children, a move supported by Conservative MP Peter Thurnham who had been approached by a constituent in a similar situation to Ceri's parents. Such cases can cost between £25,000 and £100,000 to fight and the outcome is always uncertain.

More Concern over Organ Donation

The number of people who disapprove of hospital staff asking families of patients in intensive care units about organ donation has risen substantially in the past year, according to a Gallup poll quoted in **The Nursing Times** (22.3.89). 22% of those questioned said they would not like to be asked - double the number polled last year. However 70% of those questioned said they would be prepared to donate their kidneys. The misgivings about being asked for permission for organ donation from a relative worries the British Kidney Patients Association who would like to see the introduction of a system of "required

request" where doctors would be obliged to asked relatives about their wishes before turning off life support systems. Elizabeth Ward of BKPA said she felt the survey reflected people's concern over the recent "kidneys for sale" controversy. 87% said they disapproved of people buying or selling kidneys from live donors.

Closure of Small Maternity Units

The National Childbirth Trust notes with alarm the rising rate of closure of small maternity units in spite of vehement protests from the consumer. In rural areas this is forcing women to travel long distances for antenatal care and delivery. Reasons put forward include cost cutting and shortage of key staff. The onus, says the NCT, lies with those closing small units to demonstrate that this is in the best interests of the mothers and babies for whom they are making their decisions. It has not been proved that there are solid financial advantages, since no genuinely comparable figures have ever been issued. Have DHAs budgeted for extra community midwives owing to a rise in demand for home births? For extra funds to cover increased demands for ambulances to get mothers to hospital? For the provision of flying squads to deal with emergency deliveries for women "caught short" in labour? For improvements to existing overcrowded and impersonal central clinics to cope with the extra in-flow?

And More Problems with Long Distance Travelling

Back in 1987 Cornwall and Isles of Scilly DHA put into effect economies which resulted in the closure of one small maternity unit in Penzance and also the abolition of the hospital car service. Both have resulted in real problems. One recent example is of a cancer patient, breadwinner in a low income family without a car who, as he became progressively ill and disabled (he had bone cancer) had to travel forty miles on two local slow bus services every time he visited the DGH for treatment. No help was forthcoming from the Department of Social Security and - eventually - his wife stopped even trying. He died just before Easter.

FROM THE JOURNALS

Cot-Death

Cot death, or Sudden Infant Death syndrome, is now the commonest cause of death between 28 days and 12 months accounting for two-fifths of all postneonatal deaths. But in spite of recent publicity, doctors say the cause still eludes them. Striking ethnic variations warrant further investigation for although overall postneonatal mortality is little affected by the ethnic origins of infants, as defined by their mothers' countries, the incidence of cot death is particularly low in babies whose mothers come from Bangladesh, India and Africa, which is surprising in view of the fact that these communities often suffer from many of the factors thought to predispose towards the condition, e.g. low income, high parity, short birth intervals

and low birth weight. These factors however might well be set off by the low prevalance of smoking and less illegitimacy.

One recent paper reports the low incident of the syndrome in Hong Kong, only 0.29% per 1000 live births and one explanation offered was that the positioning of babies on their backs, a normal practice in Hong Kong, might protect them. But there is no real proof as to whether babies who lie on their fronts are really more at risk although some studies in Holland suggest there just might be a connection. Many babies dying of Sudden Infant Death syndrome do, however, show evidence of having had a viral upper respiratory tract infection. Yet another study asks if such babies have a defect in their natural immune system. Overall, experts seem to agree that the area for future research lies in looking at the respiratory systems of babies. Whether or not babies should sleep on their fronts or backs is not certain although it is felt that the effects of nursing positions on the airway and mechanics of respiration merit further study. (**British Medical Journal** 18.3.89).

Living Donor Transplants

A survey has been carried out to determine for the first time the extent of transplants from living donors in the UK and Ireland and the views of transplant surgeons on future developments. Questionnaires were sent to 32 transplant centres in 18 regions, covering the extent of experience of the subject, sources of donors, their ages, the recipients, and the outcome. Replies gave data on more than 1200 transplants from living donors. They accounted for 0.25% of the total experience of health regions. Two centres had abandoned living transplants all together, 60% of transplant surgeons favoured expansion of the donor programme to meet a shortage of kidneys from the newly dead, and the remainder thought that existing programmes were optimal.

Those who wished to see an expansion suggested that it could take place in two stages - firstly, relatives could be routinely screened as possible donors (if they agreed) and secondly, family members other than blood relatives could be considered particularly as a source of kidneys. Doctors felt that provided families were given adequate information and support and donors carefully selected, the option of renal transplantation from living donors should be more widely discussed. (**BMJ** 25.2.89) (This is interesting in view of the **Nursing Times** story quoted previously).

Long Stay Patients in Psychiatric Hospitals

Do such patients want to leave hospital? This is the question asked in a paper in **Health Trends** (Vol.21). A study undertaken in 1982 showed that there was near unanimity on the importance of the consumers' voice in health service planning, and with the lack of attention to the views of those in long stay mental hospitals. However the study did seem to show that patients were realistic about the advantages and disadvantages of leaving after years in hospital although they were handicapped by lack of information

about alternatives and about what support they might receive in the community. It was, therefore, decided to repeat the survey beginning in 1985. It is not, perhaps, surprising that some of those who said they would be happy to remain where they were, changed their minds when offered alternatives. It was, however, surprising how many of the patients knew of plans to close or run down mental hospitals even though little had been done to inform them. Of the 126 respondents on preferences as to outside accommodation, 70% wanted a room of their own, a small number opted for a group of companions to share a house with but only five patients actually wanted to share a bedroom with someone else. Those who organised the survey emphasize, however, that it is cruel to send people out of hospital if there is no proper provision for them in the community, including backup support.

A Snooper's Charter?

FPCs and Health Boards are to be given powers to enter practice premises and inspect them. They have agreed to a list of facilities that must be checked to see if they are acceptable or not. These include the suitability of equipment and instruments, the standard of decoration, confidentiality of patient records, adequate reception and waiting areas, are cross infection measures up to standard?, are emergency resuscitation arrangements adequate? Are drugs kept securely?, etc. However, according to the **General Dental Practitioner** (March 89) these questions are "vague and open to interpretation by local busybodies and snoopers". The journal appears positively hostile to the idea and the comment column ends by saying that such checklist fails to recognise "our professional status" and suggests it was negotiated on the dentists' behalf "by people who are not dentists."

What do Patients Want to Know?"

The question is asked in the **Journal of the Royal College of GPs** (March 1989). Information, it says, is power and if the Patients' Liason Group had known about the content of the White Paper before a recent seminar on the above subject the agenda might well have been different. The aim of the seminar was to help those attending to help doctors give patients the information they might want and, in particular, to match what the doctor might want to say with what the patient wanted to hear. Ex-CHC Secretary Nancy Dennis, late Chair of the Patients' Liason Group, described the substantial progress that can be made where there is communication, discussion and participation between doctors and patients. She and others emphasized however that it is the services which matter, rather than the information we produce and that efforts should be made to mould the practice rather than the patient! Maureen Pearson, now Chair of the Committee, drew a distinction between the priorities of doctors and those of patients and her comments concluded with a statement which firmly placed the day's discussions into a framework of a health service, not a health market.

Can GPs Offer Counselling

It has been suggested that GPs are in a prime position to counsel patients with psychiatric problems and many doctors do use counselling skills on a regular basis. Few however have received special training in counselling and the difference between the use of counselling skills and the process involved is not always understood. A paper in **The Journal of the Royal College of GPs** (March 89) suggests that, while recognising the role of the GP, there is still a need for trained counsellors to work alongside them and that this is of benefit to patients and all members of the primary care team. The British Association of Counsellors encourages counsellor accreditation, recommending that counsellors meet recognised standards of training and supervision and accept a code of practice and ethics. It has been suggested that only those satisfying such standards should call themselves counsellors - this is perhaps the final consideration when asking if GPs should counsel.

Would You Tell?

Would you willingly report a colleague for bad practice, asks the **Nursing Times** (1.3.89). And having done so, would you then have the courage to follow it through to the highest level? The question arose during a discussion with student nurses when one asked what should be done if a patient had a complaint about a member of staff. The writer of the article looks at both sides of the question. In some cases, particularly where staff are young and inexperienced, they might misunderstand what they see or be taken in my manipulative patients. On the other hand, the person who threatens to blow the whistle on a genuine piece of malpractice might well be intimidated or victimised by other staff out of a misplaced sense of loyalty.

The advice given is that if it is felt a complaint is genuine and can be substantiated, then it must be capable of being reported both informally and formally in writing, it must be well constructed and sensible with as much information about it as possible made available to substantiate it (preferably with a witness) and thirdly the complainant must know who to go to and a friend or tutor could be helpful in taking the case further. Obviously it is upsetting for any nurse against whom a complaint is made but the system does give staff the freedom to act in the knowledge that, if anything they do seems to be wrong, they will be given the chance to explain it.

Reporting Adverse Drug Reactions

Advice on the reporting of adverse drug reactions is readily available to health care professionals in the British National Formulary and the APBI Data Sheet Compendium says the **Journal of the Royal College of GPs** (March 1989). The Committee on the Safety of Medicines recommends that all adverse reactions should be reported on new drugs but that for established ones only serious suspected reactions should be noted. Serious reactions

are those which are life threatening, disabling, incapacitating or which result in prolonged hospitalisation. Adverse reactions are reported by the use of the yellow card system. The article looks at currently agreed procedures, and notes that new laws on product liability impose a considerable burden of record keeping on doctors if they are not to find themselves legally liable for supplying a defective drug and the General Medical Services Committee advises that they are unlikely to be at risk if they adhere strictly to labelling regulations. The writer, however, casts doubt on the benefits of generic prescribing saying that more information is needed as to the source of generic products. However the piece does seem somewhat naive. It is never suggested that the CSM might well be wrong, that it should not keep secret how it arrives at its decisions as to whether or not to licence a drug and that there is considerable concern among many doctors that the yellow card system is insufficient. (See **Special Feature**).

Special Feature

The Health Conspiracy

This is the title of an extremely good book written by Dr. Joe Collier which is so interesting it is worth particular emphasis. The "conspiracy" referred to is that of the drug industry and the way it markets its products combined with the dichotomy which makes the Department of Health both the controller of standards and a commercial sponsor of the drug companies. Dr. Collier looks first at doctors and at the way they are selected - with the cards stacked heavily against students from a working class background, against women (80% of all GPs are male, 99% of all consultant posts in general surgery and 95% of consultant posts in general medicine), and against ethnic minorities. White middle-class doctors are very often bad communicators while also being the natural prey of the drug companies.

It hardly needs to be emphasized what big business we are talking about. The exact profit on UK sales is kept secret but some trends can be estimated. During the period 1976-1986 the foreign earnings for UK companies increased by 13% - in 1986 it was £1,536M - and this in spite of worldwide recession. "Countless drugs are marketed in this country which are of no clinical value", says Dr. Collier, and a proportion are likely to be doing more harm than good. Hundreds are duplicates, the "me-too" drugs. A section entitled In the Pocket of the Industry looks at how the industry operates, its use of volunteers and how it organises trials (and how this can be done in such a way as to bring about the desired results) and how it sells its products to GPs.

You might imagine, writes Dr. Collier, that the Department of Health "cracks down on the drug industry's dream machine". In theory it should, and strict guidelines are laid down by the 1968 Medicines Act, but in practice the blunt answer is no, it is not doing so. In 1984 when Kenneth Clarke was Health Minister he said the industry had flouted the Act thirty-one times but he did

nothing about it and Mr. R. Wing, the chairman of the ABPI said on BBC's **Newsnight** (12.9.84) that at that time false claims and inadequate warnings were so common that the entire industry would collapse if drug directors were forced to resign every time a breach was uncovered. Dr. Collier looks at four case histories in detail (including Opren), the Government as "double agent" and ends with a stirring plea for far more participation by the consumer. Many of the practices of the drug industry are untenable but will only be properly exposed when doctors and patients "regain control over treatment." Among his sensible conclusions are that there should be limits put on profits earned by "me-too" medicines, scientists working in the industry must remember their first duty is to science and likewise the first duty of doctors is to patients and that far stricter curbs need to be put on advertising. Government must separate its support for the drug industry by controlling its profits and abuses. The commercial side should be looked after by the Department of Trade. New licencing rules should require companies to give verifiable evidence of genuine clinical efficacy for all new drugs. The role of Ethical Committees needs investigation and tightening up. There should be a "no fault compensation" scheme for drug victims, and profits earned by the industry should be made public. A new Medicines Directorate should oversee the whole area. Racism, sexism and classism need to be eliminated when choosing medical students and students taught to be vigilant when they come to deal with the drugs industry. Doctors also need to be reminded that they are there to treat patients and medical training needs to reflect this humility and humanity.

Patients, asserts Dr. Collier, do have the power to bring about change. They need to assert their rights and, when it comes to drugs, question what they are and what they are supposed to do and report adverse effects. "As citizens they must in every way, through the ballot box and pressure groups, ensure the Government serves them above the doctors, the drug industry and self interest." All of this, he concludes, can be achieved within the existing framework of the NHS.

The Health Conspiracy by Dr. Joe Collier is published by Century Press at £4.95.

AROUND THE CHCS

Central Manchester has set up, and services, the City-Wide Manchester AIDS Forum where individuals and representatives from the three Manchester Health Authorities, City Council and Voluntary Organisations working with HIV and AIDS, work together on a regular basis to solve associated problems. A small working party has been formed with the objective of setting up a City-Wide Needle Exchange. It is recognised that if drug users cannot be dissuaded from injecting then it is important that they are supplied with clean needles to minimise the risk of sharing. Three health authorities put up the money and the city council provided the premises and staff for the City-Wide scheme. The outlets are mainly pharmacists, together with some voluntary organisations and Community Drugs Teams.

Each individual Needle Exchange contacts the City Council and orders its supplies. These are delivered by the City Council. Used needles are collected by the Cleansing Department from the various exchanges. The three Manchester Health Authorities supply needles, syringes, swabs, condoms, etc. to the City Council central distribution point on receipt of orders from relevant Officers. Unlike similar schemes, pharmacists have not been offered any financial reward. Those taking part do so on a voluntary basis. The Community Drugs Teams have been crucial in recruiting pharmacists and maintaining them within the overall scheme. Monitoring of some pharmacists in the scheme has been carried out and further information is available from Manchester.

Rochdale CHC has written to Kenneth Clarke pointing out that the Health Service Commissioner Reports for November 1988 contained instances of very serious criticism of the Independent Professional Review Procedure operated by RHAs, presumably the responsibility of the Regional Medical Officer in each case. They ask him if he can tell them whether he has any record of disciplinary procedures being commenced against the responsible officers where, to quote the Commissioner: "I found such serious maladministration at every stage of the IPR process; seldom have I come across such a category of mishandling... woefully inadequate handling by the RMO and his successor..." The CHC also seeks clarification as to the RMO's accountability for the clinical complaints procedure which the Commissioner's Report seems to call in doubt. Are the RMO's responsible to the RHA for this process?

East Herts CHC called a meeting on 27 February last to discuss the proposed breast screening programme in its area where the Regional Co-Ordinator and District Medical Adviser gave assurances as to the form it was going to take. The service will be available from mid-April 1990 with a mobile unit for primary screening so that no woman would have a journey of more than twenty to thirty minutes. Screening will be for all women from 50 to 64 and those over 64 can refer themselves for screening. The secondary assessment unit for those needing referral afterwards, will be at the Luton and Dunstable Hospital and as it was recognised that travelling could cause problems a number of London hospitals would be made available as alternatives. Assurances were given that the number of units would be sufficient to cover the screening population on a three year call/recall system and that adequate time would be given to each woman. The CHC feels that the meeting was effective and that the mobile units were good news but it was clear that some women were unhappy about the secondary assessment unit. He said the CHC thought this the second best option and that it would be carefully monitoring the situation both prior to the opening of the service and after it was up and running.

Waltham Forest CHC considers its maternity services are going down hill at an accelerating rate. The CHC is horrified to learn that mothers are now told that the length of stay in the main Whipps Cross maternity ward is 48 hours and this now appears on

leaflets handed to pregnant women. Some women are just refusing to leave. The CHC feels that the strain put on some women, especially first time mothers, is quite unacceptable. The service also runs with long waits for everything - at appointments in antenatal clinics, for attention within the post natal ward. The closure of one post natal ward was supposed to be temporary but this has now stayed closed year after year with no sign it will re-open and with strain on staff becoming increasingly apparent.

The main concern of the CHC is over the "complacency" of the DHA - indeed the Wanstead consultation paper from the DHA stated that services, including maternity care, has actually improved! It also boasts that maternity services activity has increased by approximately 13% to 4,200 births per year with a reduction in in-patient beds and post natal stay down to two days on average "achieved through the re-focussing of services in the community". The CHC challenges the cost to the quality of care. At a recent meeting of the DHA where the question was raised, it was answered by telling members that if they want more staff they would have to say which services they want to cut to provide the money.

INFORMATION WANTED

Salford CHC asks if any CHC has produced a leaflet/booklet about breast cancer and/or breast cancer screening?

Bolton CHC is considering ways of consulting ordinary people about Health issues. Under consideration are:-

Recruiting a panel of people who the CHC would write to from time to time on specific questions.

Using local free newspapers to appeal for comments.

Asking people on the street and/or by knocking on doors.

Bolton would like to hear from any other CHC who has tried any of these strategies or, indeed, has any other ideas.

Burnley, Pendle and Rossendale CHC is concerned over risks posed by Hepatitis B. Following guidance issued by the DHSS in July 1988, DHAs now have responsibility to offer immunisation to staff at risk of exposure. Those at highest risk include doctors, dentists, nurses, midwives, students and trainees who have direct contact with patients or their body fluids. There is a high prevalance of the disease among patients in long-stay mental handicap institutions and this CHC has the highest number of mental handicap beds in the country. The cost of immunising all staff in the district is estimated at £194,130. In view of the precarious financial position of most DHAs there is a real possibility this will lead to further cuts in other areas of service.

The CHC has raised the issue with local MPs and the Health Minister to little effect as "it appears this concern has been raised only by Burnley, Pendle & Rossendale CHC". The CHC asks

if other CHCs could clarify the situation in respect to their own DHAs. Secondly, if similar problems are being experienced elsewhere, the issue could be furthered directly by ACHCEW as a national concern in a bid to influence a change in policy in the resourcing of the immunisation programme. The current government view is that all RHAs received increases in real terms to their overall financial allocations for 1988/89 and over £1bn of the "new money" released in 1989/90 should go to improvements such as Hepatitis B immunisation.

CHC Publications, Reports, Surveys, etc.

Barnet CHC has looked at the prevalence of MRSA (Methicillin Resistant Staphylococcus Aureus) in its hospitals and the procedures drawn up, and measures taken, by the DHA to combat it and control its spread. Outbreaks nationally have been attributed to over use of antibiotics, poor isolation facilities and regular transfer of patients between hospitals. Overall the CHC found that the DHA was alert to the problem and dealing with it and this interesting report concludes that while it is impossible to eradicate MRSA completely, its spread can be greatly reduced by following strict procedures and that Barnet seems to be doing this. When outbreaks have occurred they have been dealt with efficiently and effectively.

Central Manchester CHC, in conjunction with Richard Freeman from Manchester University, has carried out a study of the availability of condoms and their role in the prevention of the spread of HIV. Following on from this, work is now being carried out in conjunction with the DHAs to ensure the widest possible distribution of condoms.

Barking, Havering and Brentwood CHC has drawn to our attention that its survey into Antenatal Care at Harold Wood Hospital was omitted from our current bibliography of CHC Reports. On the whole they found patients satisfied with the care they received except for the vexed question of appointments where three quarters of those questioned said they were dissatisfied in some way and some women pointed out that while appointments began at 9.30 a.m., doctors never arrived before 10 a.m.

Ealing CHC has just released its report **Using Clinics in Ealing.** Members visited all the clinics in the borough and the report covers everything from the smallest three-roomed clinic to the largest and busiest. At the smallest they discovered that the clinic clerk had had her desk moved into the entrance hall where sessions regularly take place. This lack of privacy makes confidentiality difficult when the clerk is dealing with members of the public. Ealing makes a large number of recommendations covering everything from where the clinics are situated, to the services the public needs from Health Visitors, District Nurses, Chiropodists, Dentists and many others that work there. There are also many suggestions to help users such as more signposts, locking facilities to prevent prams and buggies being stolen, disabled parking spots and lights on paths to isolated clinics at night. The CHC also feels that services for women should be

improved and that there should be a Well Woman Service as distinct from Family Planning, most especially to cater for women past childbearing age and other groups who would not use a FPC. This is a quite splendid, down-to-earth report on a service which affects everyone.

Warrington CHC has surveyed its accident and emergency services at its General Hospital. There were comments on the "terrible seating" in some of the waiting areas, lack of privacy, long waits - although this was mitigated if patients were told why or assured help was on its way - especially for X-rays. However the feeling of most patients seemed to be that the department coped well and one actually said: "Please do not go private. I have just returned from Canada, a country where Health Care equals what insurance you are covered for!"

GENERAL PUBLICATIONS

Medical Audit - A First Report, What, Why and How?

This new Report comes from the Royal College of Physicians and seeks to introduce doctors to the concept of the medical audit. It notes that assessment and analysis of doctors practice has been carried out for centuries and has formed the experimental test for theories of medical practice and the basis of medical education. "The standards set by experts have always been a yardstick against which others could measure their performance." Rapid advances in medical technology and the growing opportunities for medical intervention are accompanied by public questioning of the appropriateness and adequacy of medical care while providers of resources - private and NHS - look for higher efficiency and greater productivity at optimum quality. This has led for calls for a more systematic evaluation of the quality and effectiveness of doctors' work.

The Report does emphasize that adequate audit should measure quality as well as quantity of care. It goes on to suggest ways this can be achieved, how to set up a medical audit scheme, how to monitor it and use the data and gives some examples, including Confidential Enquiries Into Maternal Deaths (which began in 1952) and the National Quality Control Scheme for pathology labs. There are also two appendices, one suggesting the form to be used by visiting Fellows when auditing case notes and the other the form used by a medical unit in Birmingham for regular audit meetings. The Report is obtainable from the Royal College of Physicians, 11 St. Andrew's Place, London NW1 4LE.

"I Can't Afford to Work Here Any More" is the self-explanatory title of a booklet from NALGO on the recruitment and retention of administrative and clerical staff in the NHS. It confirms what we all know - that there is a growing crisis in recruiting and training staff, mainly caused by the appallingly low pay levels in the NHS but also by lack of promotion prospects (especially for women), inadequate training and general concern over the state of the NHS and future plans for it. A useful publication.
Available from: NALGO, 1 Mabledon Place, London WC1H 9AJ.

Health at Work? - A Report on Health Promotion in the Workplace is a new publication from the Health Education Authority based on a study undertaken by the old Health Education Council in 1986. It is interesting and looks at both self-inflicted problems - smoking, lack of exercise, etc. and stresses and strains caused by working conditions and types of work, with particular emphasis on women. It ends with a Charter for Action on Health at Work which is desperately overdue. "What is clear from this study", it concludes, "is that we need to overcome the inertia that is inhibiting the development of workplace health for the vast majority of British workers and workplaces. The leading edge of health at work activity may have indicated the direction that the service is going; but there is no indication that the middle will follow or that the trailing edge will ever catch up. The underlying reluctance of many to take on the health tasks that clearly need to be tackled must be overcome." This is one of the most important reports to have come from the HEA in a long time and one can only wonder why it has received so little publicity. It is strongly recommended to CHCs. Available from the HEA at Hamilton House, Mabledon Place, London WC1H 9TX.

Working Partnerships by Maurice Broady & Rodney Hedley looks at the way many local authorities are trying to relate their services to their constituents. The authors believe that community development is increasingly influencing the way they operate and this book sets out to provide evidence of what they are doing in the field. Five local authorities are looked at in depth - Crewe & Nantwich, Thamesdown, Newcastle-on-Tyne, Cambridge and Cambridgeshire. The book also considers how local authorities are developing this aspect of their work in conjunction with voluntary agencies and other organisations and at the advantages and disadvantages of different approaches. Published by Bedford Square Press, available from bookshops at £6.95 or by post from: Harper & Row Distributors Ltd, Estover Road, Plymouth PL6 7PZ. Price £7.82 (incl.p&p).

COMING EVENTS

How the Health Service Works - An introduction to the NHS for voluntary sector members of JCCs and others. A series of lectures to be held every Monday at 32 Tavistock Square, London WC1 by the University of London Centre for Extra Mural Studies, Birbeck College. The course costs £40. Details from Virginia Peters, Centre for Extra Mural Studies, Birbeck College, 26 Russell Square, London WC1B 5DQ.

NHS - The Way Forward? is the overall title of the Spring conference of the Socialist Health Association on 15 April next to be held at the MSF Offices, 79 Camden Way, London NW1. The keynote speaker will be Shadow Health spokesman Robin Cook MP. Conference fee is £5. Details from Rosemary Ross, SHA, 195 Walworth Road, London SE17 1RP. (01)-703-6838.

Anti-Racist Strategies and Perspectives in Training Two-day course on 18/19 April to be held at 32 Tavistock Square, London

W.C.1. Fees: Large voluntary organisations £130, small voluntary and statutory organisations £45. Details from Virginia Peters at the address as for the JCCs Study Course.

Weston CHC is holding a seminar day on that subject of growing concern - "ME" - myalgic encephalomyelitis. It will be held at the Commodore Hotel, Kewstock, Weston-super-Mare and it costs £12. The date is 11 May next. Details from Weston CHC.

West Essex CHC is holding a one day Conference on "Care of the Dying", based on its report on the subject which examined the care and support offered to dying patients and their families. It will be held on 18 May next at the Alexandra Social Centre, Princess Alexandra Hospital, Hamstel Road, Harlow, Essex. Conference fee £5. Details from the CHC.

The Disability Alliance is running a training programme on Disability Benefits. The course runs weekly from 21 April to 25 May and covers attendance allowance, mobility allowance, incapacity for work, benefits and community care and recent changes. The day course fee is £40. Courses will take place at the 336 Conference Centre, 336 Brixton Road, London SW9 7AA and the Spastics Society, 12 Park Crescent, London W1. Details from 25 Denmark Street, London WC2 8NJ.

1992 - Good or bad for food and public health is a one day forum jointly hosted by The McCarrison Society, The London Food Commission and The Local Authority Food Policy Network. It is to be held on 25 April next at Manchester Town Hall. Further information and booking forms available from: Mrs E. Fletcher, Forum Organiser, 25 Tamar Way, Wokingham, Berkshire RG11 9UB. Telephone 0734 782209. The conference fee is £40 which includes coffee, lunch and afternoon tea.

DIRECTORY CHANGES

page 6. NORTH LINCOLNSHIRE CHC. Secretary is W.C.M. McCarthy Telephone number is 0522 545215.

page 9. HILLINGDON CHC. New Secretary is Mrs Jan Date.

page 15. EAST SURREY CHC. Post code is RH2 7AQ. Telephone number is 0737 241686.

page 17. SOUTHAMPTON & SOUTH WEST HAMPSHIRE CHC. Telephone number is 0703 630283.

page 26. WIRRAL CHC. New Secretary as from 3 April will be Mrs Judith Edwards.

page 33 GRIMSBY CHC. Should be p.3 not p.33 in index.