CHC NEWS
For Community Health Councils
May 1980 No 54

Rising prescription charges 'will deter patients'

Twelve million fewer prescriptions could be issued because of this year's increases in the prescription charge.

The charge went up from 45p to 70p last month, and will rise again to £1 on 1 December. The latest rise, announced as part of this year's Budget package, is expected to raise £30m in 1981/82, and from now on the Government plans to increase charges "annually in line with costs".

According to the Pharmaceutical Services Negotiating Committee, the body which negotiates with the Government over chemists' pay, experience shows that at least half a year's expected growth in the number of prescriptions issued is lost following each rise in the prescription charge. On that basis the PSNC has forecast a drop of six million prescriptions following the April increase, and the December drop could be larger or smaller depending on how the public reacts to two rises spaced only eight months apart. "There is no doubt that there is a deterrent effect", a PSNC spokesman said.

In 1978, chemists in England and Wales dispensed 331m prescriptions, of which about 63% were exempt from charge. The categories of people exempt are: children under 16, men over 64 and women over 59; people receiving supplementary benefit or family income supplement, and their dependants; others with low income; expectant mothers and mothers with a child under one year old; people with certain medical conditions; and war and service disablement pensioners, where the prescription is required because of their disablement. Details are in DHSS leaflets FP91 and M11.

From 1 April 1981, people aged 17-20 will no longer be exempt from dental charges on age grounds, raising £9m in 1981/82. From the same date a £2 charge for sight tests in the general ophthalmic service will be introduced, raising £11m. Children under 16, those still at school and people with low incomes will be exempt from this charge.

● See page four for Budget analysis.

Action on Debendox

Parents who suspect that their children were damaged in the womb by Debendox, the controversial morning-sickness drug, have formed an action group. Despite reassurances from the Committee on Safety of Medicines, they want Debendox withdrawn from the market pending further investigations. For details see letter on next page.

INSIDE....

Photo: Hampshire Area Ambulance Service

Patients first

The Association of CHCs for England and Wales has made its detailed response to *Patients first*, the Government's consultative paper on the NHS. ACHCEW has not only made a case for the survival of CHCs, it has also commented on wider proposals for NHS reorganisation and has made recommendations for the future of CHCs. All councils will receive a copy of ACHCEW's paper.

The people's voice in the health service

An up-to-date and readable account of the work of CHCs has been badly needed for some time, and when better for one to appear than during the last month of the *Patients first* consultation? In 68 pages, Ruth Levitt's *The people's voice in the NHS* describes how CHCs have developed from a twinkle in Sir Keith Joseph's eye into bodies now grappling with the complex problems of representing public opinion — bodies capable of originating "many interesting and exciting developments" in the NHS. The book gives key examples of good CHC practice, and makes useful suggestions for improving CHCs' commitment and effectiveness. As a contribution to the immediate debate it should be influential — as an introduction to CHCs for outsiders and new members it will be valuable for years to come.

The people's voice in the NHS, by Ruth Levitt, is published by King's Fund Books and distributed by Pitman Medical. Price £2.50.

Your letters

Debendox damage?

Catherine Tricker, 16 Southsea Avenue, Watford, Hertfordshire

An action committee has been formed by parents concerned about the possible link between birth defects and the anti-nausea drug Debendox. Along with other mothers who suspect that taking Debendox early in pregnancy caused their children to be born with deformities, I am becoming increasingly concerned that:

- Debendox should be suspended, pending more thorough investigation and
- All cases of possible adverse drug reaction such as ours should be reported to the Committee on Safety of Medicines.

There may well be many more mothers who took Debendox and later gave birth to malformed babies, or had stillbirths because of more serious malformations. Their doctors may have failed to report to the Committee on Safety of Medicines that Debendox had been prescribed, perhaps because they do not agree of that we should suspect this drug of being responsible for birth defects.

In my own case, my son was born in December 1978 with serious malformations of his left hand and arm, for which no explanation could be offered. I did point out to the doctors concerned that I had taken Debendox for nausea, but this was brushed aside as if of no relevance. Genetic counsellors have assured me that the cause was not of genetic origin.

When I started the course of Debendox tablets I was about six weeks pregnant—the critical time for limb formation I believe—and it was definitely the only drug I took during my pregnancy.

On behalf of the action committee, I would be pleased to hear of any further cases of suspected Debendox damage, and to offer parents the support of our group.

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But what do the *members* do?

Eileen Cook, Member, East Dorset CHC

Since CHCs began there have been many papers and articles on the role of CHCs, but few—if any—on the role of CHC *members*.

Members cover a wide range of interests. Those appointed by local authorities often have experience of social services, housing and so on. The nominees of voluntary bodies, and of the RHA, also give their time and expertise. What a wealth of prospective influence!

But what do we *do*? We arrange for all these busy people with differing interests to meet in public to discuss their local NHS. We impose upon each individual an identical method for carrying out this duty: visits to hospitals and clinics, study days, project groups, ad hoc committees, attendances at seminars, etc etc. Then we are surprised when many members — especially local authority appointees — object to the time commitment and are sometimes unable to read all the papers that come their way.

Maybe we should rethink the part that members can play, freeing them to use their expertise *in their own fields*. Maybe we should drop any pretence of "management", and stress instead the importance of members' influence in the district, and how this can be of help to the NHS.

COUNTY COUNCIL MEMBERS would be expected to convey to the council, via its sub-committees on which they serve and through other members and officers, the CHC view on social services, education etc. They would carry back to the CHC informed comment on restraints, difficulties and endeavours of the county council. DISTRICT COUNCIL MEMBERS would do likewise.

VOLUNTARY ORGANISATION MEMBERS, AND RHA APPOINTEES would visit the health establishments in their district, and attend seminars, committees and project groups. They would give talks to voluntary groups and local communities, conduct surveys and familiarise themselves with all parts of the NHS, as would local authority members if they so wished. All members would be expected to put forward to the public the *aims* of the NHS, and to glean from local people their views and needs. At COUNCIL MEETINGS the chairman would call upon relevant members to report to council as necessary.

Such changes might alter the role of some secretaries. The CHC SECRETARY would guide members and plan, with the chairman, specific areas of responsibility for each member. Members would then develop their particular area. Secretaries would be expected to attend regular training sessions, organised on a regional basis but based on a national curriculum.

THE CHC would then be seen to be a body of interested, involved, informed and influential members of the public. It would liaise with public and professional alike — interpreting the wishes of one and the constraints on the other — and by doing so it would help to improve health care in its district.

Adding insult to injury

Joan McGlennon, Secretary, N Surrey CHC

We have recently been involved with a case where a person's name was removed from his GP's list, as a result of a stay of more than two years in a psychiatric hospital.

The patient was completely unaware of his removal from the list. When he had cause to visit his GP for a physical condition, several months after his discharge, he was shocked to be told that he would have to find another doctor. This caused considerable trauma, and we feel strongly that it should be someone's specific responsibility to notify people in long-term care if they are removed from their doctor's list. An officer at the establishment where the patient is receiving care should also be notified, so that appropriate arrangements can be made on discharge.

As we wish to pursue this matter further, it would be most helpful to know whether any other CHCs have information on this subject.

Spreading the word in waiting rooms

Miss B Keagan, Age Concern Greater London, 54 Knatchbull Road, London SE5 9QY

We would be grateful to receive any information from CHCs which have either made a study of, or had experience of, the effectiveness of using GP waiting rooms as a source of information — eg by distributing leaflets, displaying posters etc. Please get in touch with us at the above address.

Fluoridation and the Pittsburgh court case

G J A Stern, 6 Eton Court, Shepherds Hill, London N6

Aubrey Sheiham *(CHC NEWS 51)* claims that the finding that fluoridation increases the cancer death rate by about 5% "was analysed by two independent statisticians appointed by the Royal Statistical Society, and was found to be false".

I am as much an independent statistician and Fellow of the Royal

Continued on page ten

We welcome letters and other contributions but we would like letters to be as short as possible. We reserve the right to shorten any contribution.

Comment

With *Patients first* in the limelight, the Health Services Bill has been slipping quietly through Parliament. Part II of the Bill, which repeals various state controls on private medicine, is generally accepted as being politically controversial, but lately Part 1 has also been causing concern. The Government says Part 1 simply gives it powers to implement whatever proposals emerge from the consultation process. But critics have been suggesting that *Patients first* may be governmental "window-dressing", intended to divert attention from provisions in Part 1 which could undermine the foundations of the NHS.

Suspicions centre on Clause 5 of the Bill, which would require health authorities not to spend more than they are given by the Government, plus any extra income they can raise themselves. The Secretary of State could "direct" authorities on how to avoid overspending, and such directions could be "specific in character". If authorities disobeyed, he or she could invoke the "inquiry and default" procedures of the NHS Act 1977—perhaps appointing [illegible] commissioners.

In other words, a system of legally-enforced cash limits is on the way. Until now, authorities which overspend have been faced with nothing worse than having that amount docked from their next year's allocation. This option has been little used so far, but when all the sums are finally done it may become clear that in 1979/80 several authorities were forced into overspending. The amounts they "owe" will be deducted from this year's allocations, but Clause 5 will prevent them from overspending again in 1980/81. The cuts they deferred in 1979/80 will then be unavoidable. Meanwhile — overspending having become *illegal* — the caution that led authorities to underspend by about 2% during the early years of the cash limit system will be strongly reinforced. Permanent under-financing will be built into the NHS.

But there is worse to come, because Clause 5 also opens the door for some future government to decide that the NHS should depend much more on voluntary finance. At present the NHS Act 1977 says that the Secretary of State must pay authorities "the sums needed to defray" approved expenditure, but the replacement wording in Clause 5 only mentions *sums not exceeding* the amount allotted *towards* meeting authorities' spending. "Sums not exceeding" means "not more but could be less", and "towards" means "this amount won't be enough".

In this light Clause 4 of the Bill — which would allow authorities to make public appeals and collect donations to finance NHS services — begins to look threatening. Imagine the situation if some future Secretary of State announced that cash limits would all be cut by 10%, and that authorities must find voluntary finance or cut services. In such a crisis, hard-pressed administrators could end up spending much of their time devising fund-raising schemes, and NHS staff could find themselves running these events instead of getting on with their proper work. Even then the money might just not be forthcoming, especially in poorer areas. And even where it was, it would probably bring with it the distortions which large chunks of voluntary finance tend to impose on NHS planning.

Clause 5 offers the NHS institutionalised underfinancing, damage to the planning system, reduced local independence and the prospect of a second-class service in poorer areas. In the end it will be NHS *users* who will suffer.

Health News

Lead report calls for more research and an attack on pollution "hot spots"

Research showing that low levels of lead pollution can damage children's intelligence is "highly suggestive" though not wholly convincing, says the Lawther report on *Lead and health* (1).

The research (2), carried out by Dr Herbert Needleman in Boston USA, is described as "by far the most comprehensive so far undertaken". There is an "urgent need" for further work of this kind, though some improvements in experimental design should be included, says the report.

The report calculates that adults living in the inner city, in air containing an average of one microgram of lead per cubic metre (ug/m^3), get on average 16% of their body lead from air, with the rest coming from food and water.

But Lawther also points out that some people live in "hot spots" where the average air lead level may be as high as $6ug/m^3$, and in such places air is probably the major source of body lead. Air lead levels in hot spots should not be allowed to exceed $2ug/m^3$, says the report, and measures to achieve this could include further reductions in the lead content of petrol.

City children get on average between 3 and 10% of their body lead from air, the report concludes. It makes no allowance for the lead children swallow while playing in dusty streets, and suggests that this is not a major factor.

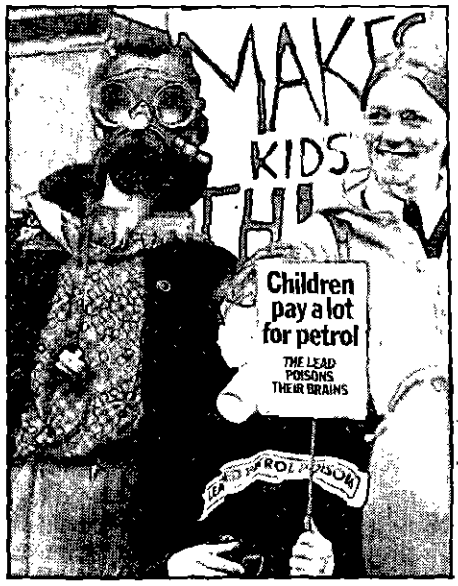


Photo: Neil Gibson

The report makes 22 recommendations in all, including suggestions for stricter control of the more familiar sources of lead — paint, drinking water and cosmetics. On the vexed question of lead in petrol, Lawther recommends that lead emissions from traffic should be "progressively reduced", but says that this does not need urgent attention.

The report also contains the results of 37 blood lead surveys carried out in Britain as part of the EEC blood lead survey. In four of the groups surveyed — adults in Glasgow, children of lead workers in Chester and Leeds, and children living near a lead works in Chester — blood lead levels exceeded the EEC safety standards.

Professor Michael Rutter, one of the members of the Lawther working party, has published his own independent assessment of research on lead and children's IQ (3). He concludes that the Needleman research provides "the most impressive evidence to date on the possibly damaging effects of raised lead levels in the range usually previously considered harmless, and which are found in some 20% of children in the general population". He warns that a drop of five points in children's average IQ, the figure suggested by Needleman's research, would imply a doubling in the number of mentally retarded children — those with an IQ under 70.

1. *Lead and health: The report of a DHSS working party on lead in the environment*, HMSO £4.50.
2. See *New England Journal of Medicine*, 29 March 1979, pages 689-95.
3. *Raised lead levels and impaired cognitive/behavioural functioning: A review of the evidence*, by Michael Rutter. Supplement to *Developmental Medicine and Child Neurology*, February 1980 issue.

Views about CHCs

The National Union of Public Employees says CHCs should stay "because they protect the community interest". NUPE

Continued on next page

Health News

Continued from previous page
promises to fight any move by the Government to abolish the councils. The Confederation of Health Service Employees believes CHCs are a "vital component" of the NHS and that their powers should be strengthened.

Other bodies have been more guarded in their response to the Government's consultative paper *Patients first.* The British Medical Association has given a cautious welcome to the document as a whole but is sitting on the fence about CHCs. While the association "recognises the value and the necessity of the patient's voice", it says that provided some form of local representation is preserved, "it would, on balance, be prepared to accept the loss of CHCs". In spite of reservations about CHCs' record to date, the Royal College of General Practitioners is more positive. It argues that "it is important that some form of consumer voice be heard and we wish to see a system that will enable this to be done in the most economic, simple and effective way".The Royal College of Nursing has also given subdued support.

Transporting NHS patients

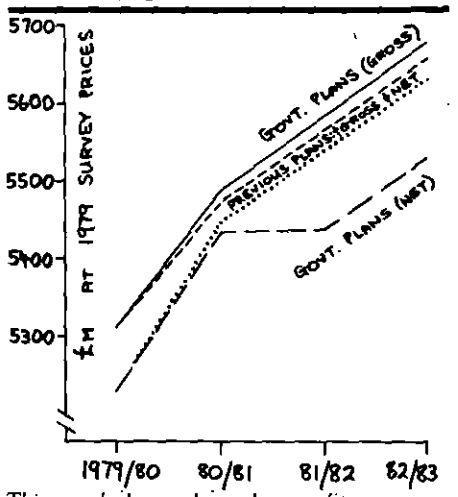
A national working party to review the transport needs of NHS patients has been set up by RHA chairmen. Chaired by Mr W M Naylor, Trent RHA's regional administrator, the working party will look at the transport needs of all kinds of patients — from A and E cases to people living in inaccessible rural areas. It will consider the various options for meeting these needs, assess the part the ambulance service can play in this, and make recommendations to the regional chairmen and the Secretary of State. Comments are invited, and should go to ACHCEW's Ambulance Services Working Party by 1 July, or direct to Mr Naylor at Fulwood House, Old Fulwood Road, Sheffield, by 31 July.

The Budget and the NHS

In last month's Budget the Government confirmed its intention of maintaining and even increasing total expenditure on the NHS. Patrick Jenkin announced that in 1980/81 there would be a "modest growth" of ½% in the level of health authorities' expenditure compared to the planned level of 1979/80. And as the 2½% which was "squeezed" out of the NHS in 1979/80 is being restored the actual increase is 3%. However health authorities' cash limits still only provide for an increase of 14% in wages and prices. As estimates for inflation over the coming year suggest a rate of 16-17% this growth may prove even more "modest" than the Secretary of State has suggested.

During 1981/82 and 1982/83 the Government's proposed expenditure each year on hospital and community health services in Britain, *net* of charges, is £98m less than that planned by the previous government at comparable 1979 survey prices. But in terms of *gross* expenditure the present government is to spend £20m more than was planned by the last administration. By 1981/82 the difference between planned gross and net expenditure will be running at £148m a year which has to be made up in charges and "additional income". The Government's White Paper* is vague about where this revenue will come from but mentions tighter controls on the use of the NHS by foreign visitors and further measures to recover accident costs.

Although the White Paper stresses that "co-operation between the NHS and the private sector is being encouraged", income from private patients is still only estimated as £30m a year from 1980/81. There is an assurance that health authorities will not be expected to make up the gross expenditure using funds they have raised under their new powers in the Health Services Bill (see Comment, page 3) so the source of much of this extra revenue remains unknown.



This graph shows planned expenditure on hospital and community health services in Britain, at 1979 survey prices. The solid line represent's the present government's plans for gross expenditure, and the long dashes show its net spending plans. The short dashes represent gross expenditure planned by the previous government, and the dots show its planned net spending. The difference between gross and net expenditure is accounted for by charges and "additional income" (see story).

The increased prescription charges, dental charges and ophthalmic charges which were announced in the Budget (see story on page one) will be used to help meet the rising costs of the family practitioner services, which are determined by demand rather than cash limits. By 1980/81 over 11% of the total expenditure on family practitioner services will be met by charges, compared to 7% in 1978/79. From the White Paper it appears that all charges will in future "increase annually in line with costs", but no further details have been issued by the DHSS.

RAWP redistribution continues — very slowly. Although the four "worst-off" regions will receive a percentage increase in their revenue twice that of the "best-off" region, these increases are only 0.6% and 0.3%, so the gap between better-off and worse-off regions remains virtually unchanged. In 1980/81 the worst-off region, Trent, will move from 8.2% to 7.5% below its RAWP "target", and the best-off region, NW Thames, will increase its distance above its target from 12.45% to 12.7%. In fact all four of the better-off regions receive allocations which take them further from their RAWP targets.

Joint Finance is expanding in line with expected inflation. The planned level of spending is £38m in 1979/80 and £45m in 1980/81 at 1979 survey prices.

Capital expenditure on hospital and community health services was over £500m a year in the mid-1970s (at 1979 survey prices) but by 1979/80 it had declined to £399m. The White Paper does not give separate figures for capital and current spending after 1981 but the proposed capital allocation for 1980/81 is £441m, and comparison of the various tables of planned expenditure suggests that this rate of capital spending will continue.

* *The Government's Expenditure Plans 1980/81 to 1983/84. HMSO £6.25.*

Health centres under review

The Government is reviewing policy on health centres and drawing up guidelines on them for health authorities, according to reports in *General Practitioner* magazine which have not been denied by the DHSS.

Based on its policies while in opposition, and its actions since, the Government appears to favour a reduction in the health centre programme (see *CHC NEWS 46*). *GP* says that the new guidelines will urge health authorities to establish new health centres only in areas such as inner cities, where there is "a clear community gain" and support from local doctors. Other sources of finance for GPs' premises are being encouraged — the borrowing limit for the General Practice Finance Corporation, which grants loans to GPs for building or improving premises, is to be quadrupled.

Patients' charter

The 1980 National Consumer Congress has called for a patients' charter of rights to health care. The congress, made up of representatives of a wide range of consumer groups, instructed the National Consumer Council to draw up a charter of patients' individual legal rights to health care. The NCC is to incorporate in the charter positive statements on health education, prevention and the rights of the individual to "contribute positively to the improvement of health services in all their aspects". Congress also urged "the retention of community health and local health councils in any reorganisation carried out by the Government, as the only statutory representative of NHS user needs".

There were also resolutions committing the NCC to increasing public awareness of good nutrition and to improving opportunities for disabled consumers.

THE EXTOWN SCANDAL

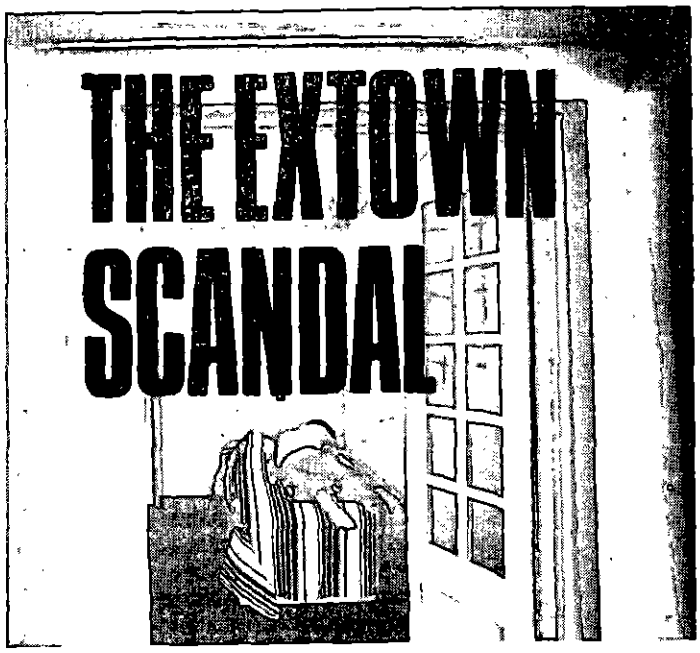


Photo: Mike Abrahams

Can you be sure there isn't a hospital like Normansfield, Farleigh, South Ockendon or Ely in your CHC's patch? How can you find out whether all is really well in your local mental hospital? And how much do you know about the basic issues of mental health? Last year the three CHCs in Manchester arranged an all-day seminar to find out more about the mental health services and identify ways in which CHCs could and should be more effective.

The seminar was conducted as an informal discussion between eleven CHC members and four professionals from a Manchester psychiatric hospital — a nurse, a psychiatrist, a GP and a social worker. For most of the day the participants were divided into two groups.

The highlight of the day was for the group to consider in detail the behaviour of the mental health sub-committee of an imaginary CHC, at a time when a national TV programme had just revealed a major scandal at a mental illness hospital elsewhere in the country.

According to the briefing notes for this exercise, there had been mistreatment of patients, appalling conditions — and a cover-up. A new member of "Extown" CHC's mental health sub-committee wanted the CHC to be sure that no such scandals were tucked away in "St Bruno's" — the mental illness hospital in Extown's district.

The suggestion at first received no support. There was no evidence and no wish to be branded as "scandal-mongers". But at the next meeting it was agreed to seek reassurance from officers of the area health authority. This produced a "categorical reassurance", with an acknowledgement that far more money was needed in St Bruno's, as in many other under-funded mental illness hospitals.

Extown CHC had visited St Bruno's three times since 1974, always escorted by senior hospital staff. Now they visited again, in the company of the senior psychiatrist, nursing officer and hospital administrator. Poor physical conditions were noted, such as leaking roofs and cold food. A letter about this was sent to the area administrator. The chairman of the fictitious CHC's sub-committee firmly squashed the suggestion of further follow-up — reminding group members of the trust and understanding which had developed with senior area officers.

At this point a sudden new twist to the story stunned everyone. In a letter to the CHC, a local GP alleged a "catalogue of neglect" at St Bruno's. The hospital became a focus of interest to local journalists. To verify the allegations the CHC chairman sought a meeting with the area medical officer. At the meeting, the chairman was told that the GP who had written was a difficult customer who was pursuing a private feud with the psychiatrist at St Bruno's. Nevertheless, the chairman pressed for a more substantial assurance that the allegations were without foundation. It was agreed that there should be a meeting between all the parties — three weeks hence.

The scandal of St Bruno's broke in the national press just four days later. The "appalling" facts revealed by local reporters led to a public enquiry being immediately set up and the area team of officers being severely criticised. The hospital psychiatrist was suspended.

As for the CHC — the full council held a "vexed discussion". Some members argued that the CHC should have acted sooner, and certainly should have gone onto full alert after receiving the GP's letter. Others defended the CHC's record — a "responsible organisation had to tread reasonably carefully within defined channels".

Could the CHC have done better? The seminar's task was to consider the whole story in detail. To help the group analyse Extown CHC's action, the project notes systematically questioned every step taken by the mental health sub-committee.

For instance, when the group resolved to seek reassurance that St Bruno's was not in the same league as the TV scandal hospital, its action was to write to the area administrator and to meet the senior staff at the hospital. The project notes asked: "What better methods of obtaining information about conditions at the hospital might have been used? Could the group have been more positive in deciding what information was needed? In what ways might the AHA response to the request for reassurance have been better?"

When the GP's allegations of malpractice reached the CHC, the council took the letter to the area medical officer. The project notes ask: "What other course of action might have been taken?"

The two groups discussing St Bruno's and the record of Extown CHC found themselves asking fundamental questions about how a CHC works. What choices of obtaining information are open to a CHC? How can visits be made more effective? How far and when should information be accepted on face value? Should a CHC get involved in an issue raised by a TV programme? One group said it should, provided the CHC then asked the correct questions. The other said, "No — this would indeed be 'scandal-mongering' ". It pointed out that the CHC should have been familiar with conditions at the hospital and should have noticed that staff morale was low, as a warning sign of trouble.

In the general discussion which followed, it became clear that to be effective the CHC must do its homework, with no short cuts. Members on a visit, or at meetings with health service staff, need to be familiar with what has been written about good and bad practice. This can be gleaned from Health Advisory Service Reports and others, and also by comparison with experiences of visits elsewhere. Without such background knowledge one might visit a hospital psychiatric ward and think "how nice", because patients sit neatly and quietly "upright in chairs". An informed CHC member should see the lack of activity and therapy and think, "how dreadful".

The rest of the day was spent with the CHC members questioning the four professionals about aspects of mental illness and its treatment. There was a very wide-ranging discussion and people asked about issues such as the differences between psychiatric in-patients and out-patients, about the limitations of drugs in treatment and about training for GPs in the diagnosis and treatment of mental illness.

The seminar programme was mainly designed by Nick Harris of Central Manchester CHC and Neil Pearlman, South Manchester CHC's former secretary. Much time and thought went into planning the day, in co-operation with the professional staff and a lecturer from the extra-mural department of Manchester University. The efforts certainly bore fruit according to one participant — "we learnt more in those eight exhausting hours than in a whole year of committee meetings".

Copies of the briefing notes about Extown can be obtained from Nick Harris, Central Manchester CHC, St Ann's Churchyard, St Ann Street, Manchester M2 7LN.

Book reviews

Medical education and primary health care

edited by Horst Noack, Croom Helm, £9.95

This book collates a number of papers presented to an international conference in Switzerland on "The contribution of medical education to primary health care". I found it absorbing reading, agreeing with its recognition of the necessity to foresee future primary care needs in this country if costly secondary care in hospital is to be minimised.

The main themes running through the book are the need to emphasise the importance of primary care during doctors' education and the need to promote liaison between general practitioners and hospital doctors, to achieve the best total care for patients.

There has been a tendency to regard budding family practitioners as somehow lacking in ambition, and the practising GP as having little to contribute to modern medicine. The emphasis on clinical sciences is not wholly helpful in the training of family doctors, and students need some sociology and epidemiology in their curriculum. Primary health care should be an integral part of medical education. Its institutions and staff should provide learning environments and encourage improved communications between hospital and family doctors. A general practice course in many medical schools is welcomed.

We are told that sound primary care is the foundation stone for most successful health care systems. I think CHCs will find this book a useful addition to their library shelves for reference now and in the future.

Fiona Drake
South East Cumbria CHC

Health care: priorities and management

by Gwyn Bevan, Harold Copeman, John Perrin, and Rachel Rosser, Croom Helm, £16.95

This book, which follows a research study made at the request of the Royal Commission on the National Health Service, gives a fair but very detailed account of the running of the NHS. The use of statistics, technical terms and initials which are only spelt out once may defeat new CHC members, but seasoned members will find it worthwhile to persevere with this book.

The historical perspective starts with Beveridge's ideal plan to provide full preventative and curative treatment of every kind for every citizen. It includes Churchill's comments on the early years of the NHS "The most wild miscalculations . . . an enormous addition to the burden of the nation . . . the grossest carelessness." The authors succeed in describing the whole organisation factually and dispassionately. They make a few attempts to lighten the subject, pointing out that the centenary year of the publication of Lewis Carroll's poem on the Snark coincided with the equally multidisciplinary RAWP of the DHSS. However they are facing the problem that there are no short cuts when giving all the facts — the result is a good reference book rather than a good read.

Margaret Campbell
Oxfordshire CHC

Behaviour modification: 2nd edition

edited by W Stewart Agras, published by Little, Brown and Co (Boston), £8.15.

This clearly written but technical book would be a valuable introduction for the determined reader interested in the techniques of behaviour modification, which are frequently used in mental illness and mental handicap hospitals.

Behaviour therapists assume that patients' "problem" behaviours are best treated directly, rather than by searching for some underlying internal cause. They believe that problem behaviours are "maintained by their consequences", and so can be changed by altering these consequences, using *negative reinforcement* to discourage undesirable behaviours and *positive reinforcement* to encourage more acceptable conduct.

This approach has the advantage of bypassing the complex theories of psychoanalytic psychotherapy — ego, id and so on — and it also dispenses with the fraught and labour-intensive process of helping patients to recognise underlying problems, decide what they can do about them, and try to accept what cannot be overcome.

Behaviour therapy has its mild and its harsh faces — from helping a woman overcome a fear of leaving her home, using simple praise as the reinforcement, to the use of electric shocks on alcoholics and homosexuals.

One logical outcome is the "token economy", in which plastic or cardboard tokens "exchangeable for a variety of consumer goods and pleasurable activities" are used to control the behaviour of a group of patients through a complex system of rewards and fines. Unfortunately, as the book notes, "token systems are economic systems in miniature", and counter-therapeutic practices such as saving, lending, forgery, theft and robbery can develop.

Nearly all the treatments described in this book raise ethical questions, and it is disingenuous to compare behaviour therapists with parents, who would "feel guilty if they neglected to send their children to the dentist, where they will be subject to pain-inflicting needles and drills in order to achieve widely agreed-upon positive consequences".

The contrast between behaviour therapy and the "insight-oriented" therapies is not as extreme as some would claim, yet who can feel entirely happy or secure with a school of therapists who consistently see "sexual deviations" as diseases to be treated?

Epidemiology for the uninitiated

by Geoffrey Rose and D J P Barker, British Medical Association, £2.50

Why is there a higher incidence of cancer of the large bowel, gallstones and varicose veins in industrial countries than in the non-industrial world? These conditions are among those which have been labelled the "diseases of civilisation" and lack of fibre in the diet of people in industrial countries has been blamed. This conclusion has been reached by using the techniques of epidemiology — the study of diseases in relation to populations.

Population does not mean just in one country or several countries. For purposes of epidemiology it could mean all the people on a GP's list, or all the workers in a certain factory, or all children of school age.

This book was written as a series of articles in the *British Medical Journal* — so it is aimed at doctors. But as a guide to understanding medical surveys and a warning not to take "facts" at their face value, it is a book which could prove useful to most CHC readers.

An examination of hang-gliding accident cases in a casualty department recommended that flying should be banned between 11am and 3pm because that was the period when most accidents occurred! As well as a failure of down-to-earth common sense, the authors of this study made a basic epidemiological error — they failed to relate the number of accidents to the number of hang-gliders *at risk* — ie to the hang-gliding population.

Epidemiological studies can be tremendously useful in assessing the causes of disease over large areas or over long periods of time. They are also a tool for evaluating the effectiveness of preventive measures, such as breast cancer screening. This has been found to reduce the number of cancer deaths among women who were screened, compared to those who were not. On the other hand, early detection and treatment of diabetes has not been found to improve the life chances of people with this condition.

Epidemiology is not an ivory tower discipline, for it has immediate local application. Why is there apparently a high incidence of bronchitis in a particular town and can anything be done about it? What is the extent of unmet need among old people in the district? What is the immunisation take-up rate among small babies and what steps can be taken to improve it? All these are basic issues for planning the health services and can be answered by using the tools of epidemiology.

Books received

Nurses, patients and families by C J Rosenthal, V W Marshall, A S Macpherson and S E French (Croom Helm £8.95).

Can we really afford heart transplants?

*by Lois Wingerson**

Someone who cannot afford to pay the rent is ill-advised to start investing in diamonds. Like diamonds, heart transplants make a fine investment for the future, but they are an expensive luxury for anyone who has other good uses for the money.

The hard-pressed DHSS invested in diamonds when it decided to devote £100,000 to a heart transplant centre at Papworth Hospital, after a private philanthropist had promised three times that much money for the centre. It is too late to change that, but not too late for the public to consider what the NHS should do once that £100,000 runs out. Even if the Papworth programme is successful, it is debatable whether heart transplants will prove to be giving the best possible return on the investment.

"Heart transplantation is now an established procedure in several centres abroad," said Patrick Jenkin when he announced his decision to support Papworth. This statement conveyed the impression that Britain is falling behind in medical progress. But these operations are far from "established", except at Stanford University in California. Several eminent American surgeons, such as Dr Michael DeBakey in Texas, have tried heart transplants and abandoned them. Insurance companies and the US government have not yet decided whether or not these operations are still "experimental". A committee of lay people has decided that a heart transplant programme will not be set up at Massachusetts General Hospital, in Boston, because it does not represent "the greatest good for the greatest number."

The Papworth programme will certainly save a few lives. With more than ten years of experience, the Stanford surgeons now do just under 30 transplants a year — 65% of patients survive the first year and half live for five years at least. The surgeons at Papworth think they can do about ten transplants a year, and they may benefit from the Stanford experience to achieve similar results in much less than ten years. Perhaps they can save six or seven lives a year.

People tend to avoid arguing that these six or seven people should die. The vision of smiling, hearty transplant patients on the TV screen makes them all too real. The public never sees on TV the thousand or more people who die each year because the NHS cannot afford the kidney treatment or coronary bypass operations they need to survive. It is much easier to argue the economic question, if only because the statistics are so slippery. The NHS has given detailed estimates of the cost of heart transplants, but no equally detailed figures exist for other operations so there is no reliable basis for comparison.

So is a heart transplant really expensive? Depending on who is talking, the extra £100,000 going to Papworth Hospital is either a massive amount or it is chickenfeed. It is pocket money next to the £500,000 the NHS spent recently on a linear accelerator to treat cancer patients at Charing Cross Hospital. To Action on Smoking and Health, the anti-smoking organisation, £100,000 is both a vast sum and peanuts at the same time. It is about one-third more than the DHSS gave ASH last year to combat smoking — a major cause of heart disease — but next to the £80m the tobacco industry spends to promote smoking each year it is a drop in the bucket.

Next to a heart transplant, other operations come cheap. Comparisons are off-the-cuff and unreliable, but they are the best available at the moment. The DHSS Transplant Advisory Panel has estimated that, as part of a one-year programme of eight operations, heart transplants cost about £17,300 each at 1979 prices. By comparison, heart surgeons say a pacemaker operation costs about £900, a heart valve operation about £500, and coronary artery bypass surgery without valve replacement about £750. A kidney transplant costs about £1150 in the first year. For a fair comparison, normal staff and bed costs must be added to these comparative figures.

To the advocates of heart transplants these comparisons are ridiculous. There is never an economic return on a hernia or cataract operation, they argue, but a successful heart transplant transforms an invalid into a productive citizen who repays to society the cost of his operation many times over. An expert on insurance calculations recently estimated that the savings from a successful transplant performed on a 25-year-old family man earning £5000 clearly outweighed the cost.

But no-one using this economic analysis seems to consider the assumptions behind it: that all successes will be family men with fairly high salaries; that there will be no transplants for the unemployed, single people or housewives; and that lives are not worth saving unless the cost can be recovered later. It also takes for granted that people who have had heart transplants will resume work.

Many people are now arguing† that the £100,000 would be better spent on preventing hearts from failing than on replacing them. But perhaps a more immediate issue is the lack of attention for kidney transplants and coronary artery bypass operations — which could save far more lives for the money. A successful kidney transplant costs less than a tenth the cost of a heart transplant, and it also costs considerably less than regular treatment on a kidney dialysis machine. About half the people in the UK who need dialysis or a transplant — perhaps a thousand a year — die for lack of treatment.

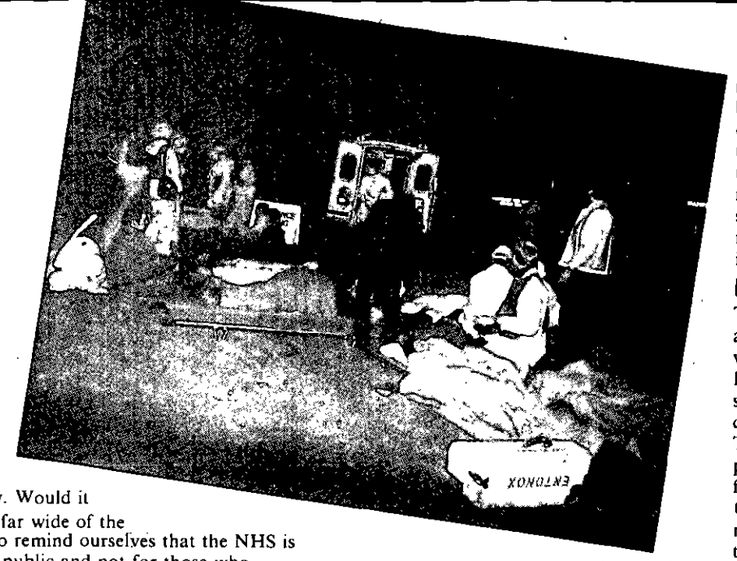
Coronary artery bypass can be a lifesaver for someone who has severe hardening of the arteries. But in Britain many of these people die for lack of a bypass operation, which costs far less than a heart transplant. At the moment this operation is controversial in the US, because many people think it is often done unnecessarily. Will the current debate about transplants distract attention from the potential and the problems of this operation? Will the NHS decide to save the lives of six people who need heart transplants at the expense of sixty who need coronary bypass, or some of the thousand who need kidneys?

Photo: Adrian Mott, Nursing Times

* *Lois Wingerson is* New Scientist *magazine's biomedicine consultant.*

† *For example see* Transplanting priorities, *in New Scientist of 17 April 1980, pages 136-8.*

A suitable place for treatment?



by Kenneth Lee, Nuffield Centre for Health Service Studies, University of Leeds

Statements such as: "The public needs to be 'educated' in the correct use of accident and emergency departments", are either unbelievably naive or downright insulting. Far from "abusing" the services, it could be argued that it is the public's intelligence that is being "abused" — by the seeming inability of policy-makers to take seriously the views and needs of the potential patient.

During the past decade or so, there has been a growing interest in the role of accident and emergency departments. In particular, views have been expressed about the so-called "inappropriate" use of accident and emergency (A and E) services. The term "casual attender" has even been coined, as a derogatory remark.

Why is it, one wonders, that countries — often with radically different methods of financing their health services — are, nonetheless, experiencing increasing use of their A and E departments? The immediate response of course is that in many countries (including Britain) the A and E department offers the public open and unfiltered access to medical care — and a point of access moreover where the medical services are often free or heavily subsidised. But this is an inadequate explanation. To say that a service is largely free of charges does not guarantee that it will be used. Rather, we may have to look at the factors which cause people to perceive that they are ill, and the choices of care which they feel they have. In other words we need to understand the determinants of the demand for hospital treatment at the A and E department.

Why do people come to A and E departments?

What is the process by which a person arrives at the hospital's door? Apart from certain categories, ie unconscious cases and maybe the psychologically disturbed, most patients do come to the A and E department of their own accord, or are referred by non-medical sources, such as family, neighbours or by-standers. Even in the minority of cases when the patient travels to hospital by ambulance, or is advised to do so by the family doctor, it requires some final decision — if only agreement — on the part of the patient.

The arrival at hospital can be viewed as the last step in a number of decisions made by the patient, as follows:
Whether to seek medical attention or not;
What type of medical attention to seek;
Where to seek help;
When to seek help.

Influences

Innumerable factors determine whether we decide to seek medical care, the type of medical care we seek, and the amount and quality of medical care we ultimately receive. And yet maybe what we are observing are not only changes in organisational arrangements (eg availability of GPs), but also changes in consumer opinions and preferences for medical care. If this is the case, then it should be hardly surprising to find members of the public increasingly exercising choice — at least for some health conditions — as to which part of the medical care system they believe can best offer them help.

Nationally, the picture is clear-cut: attendances at A and E departments in England now account for over half the total number of new out-patient attendances, and nearly one-third of all attendances (1977 figures). Expressed in different terms, new A and E cases per thousand population increased in England from 154 to 192 between 1967 and 1977, whereas new out-patient cases barely rose over the same period (from 160 to 164).

The crux of the problem is that we have not so far recognised the reality of this situation, and planned accordingly. The dominant view of the patient and his needs, as expressed in policy statements, is still one which reflects professional views about how patients "ought" to behave. These statements are not, of course, based on how patients actually do use the service; rather, they contain implicit moral prescriptions about how the patient should use the NHS.

Can the policy-makers be so certain that the vast majority of those who attend the A and E department do so without due thought and consideration about the significance of the symptoms to them, and without some clear idea as to what they want the doctor to do? One doubts it. The undeniable fact is that most people most of the time want to "use" the service, not "abuse" it.

Observing the scene in casualty departments in different parts of the world, one constantly hears doctors bemoan the fact that the cases they receive are not "urgent", and that there is a good deal of "trivia", if not "rubbish", in their case loads. But can it be polarised in that way? Members of the public are not doctors; they make a lay diagnosis and believe — maybe naively on occasion — that the doctor can do something to help them. It is only to be expected that the casualty doctor is confronted with a wider frame of reference than narrowly defined clinical conditions. For instance, perceptions of illness — as seen in terms of mental and social well-being — may figure more prominently in the minds of patients than physical conditions.

It follows that to condemn the general public for "incorrectly" using the A and E department is to expect the lay person to be capable of making a medical diagnosis and to assume that "needs" should and can only be measured in terms of medical severity. Would it be too far wide of the mark to remind ourselves that the NHS is for the public and not for those who provide and organise the services on our behalf?

No-one is going to deny the fact that it is within the province of the hospital doctor to assess the "urgency" of the patient's medical needs; we would not want it otherwise. We can also admit that many A and E cases are not immediately (or even potentially) life-or-limb-threatening, but this does not alter the fact that they are perceived as important by the patient. Indeed, one is often struck by the lengths to which people will go to make their way to the A and E department.

So what should be done? It is to be hoped that thirty years' experience of the NHS, and insights gained from other countries, will convince us that we cannot continue to operate with outmoded ideas. Once it is accepted that all those who demand medical care from A and E departments have to be accommodated — in the sense that a response is required — then the function of A and E medicine broadens to embrace almost all forms of medical care. Though it will be uncomfortable to some to see it in such terms, at least such a change will have been a response to consumers' wishes.

Confusion in planning

For too long it has been assumed that "severity" of illness or injury was the determining factor underpinning the planning of A and E services. However, it cannot be defined in that way. This yardstick can really only be applied *beyond* the primary care level, and in circumstances where the general practitioner is the public's sole access to the NHS. The dilemma for many countries, including Britain, is that there exist two schools of thought and practice: the "critical care model" of emergency care, which argues for a specialty of emergency medicine; and a "primary care model", which argues for what is called a "specialty in time".

This dilemma is at the heart of much of today's confusion. Put bluntly, the demand for accident and emergency services has not turned out to be what policy-makers and those running the service would have chosen to make it, nor indeed what some still intend to make it become. In simple terms, the A and E department is on the boundary between the community and specialist hospital treatment. This has considerable implications for the future planning of services and supports the view that some reconciliation of both professional and lay interests is both necessary and desirable.

Redefining A and E services

To bring about such a reconciliation, A and E will have to be fully recognised for what it is: not only Accident and Emergency — defined in a narrow clinical sense; but Anything and Everything — defined in a broad patient-centred sense. The presenting symptoms of the A and E patient will then range along a continuum from the "worried well" to the life-threatening emergency. One cannot reasonably expect the general public only to visit the A and E department in the most extenuating circumstances.

One can go even further and suggest that instant solutions that appear to offer solutions nationwide are unlikely to prove helpful. A "good" geographical distribution of general practitioners able and willing to offer such a "specialty in time", ie a service available twenty-four hours a day, seven days a week, will largely negate the necessity for an A and E department to respond to Anything and Everything. Conversely, a "poor" distribution of general practitioners unable or unwilling to offer such a "specialty in time" strongly suggests that such facilities be made available elsewhere. To treat A and E as a special case to be planned outside the NHS system is, in essence, sheer folly. Local determination of policy based on a careful analysis of local needs and local services appears the only feasible approach possible.

Though this conclusion will be disturbing to some and distasteful to others, it cannot be otherwise. The truth of the matter is that the future planning of A and E services, and their present organisation, have to be considered not only within the framework of primary care and specialist care, but also within the framework of the public's wishes and expectations.

Photos: Hampshire Area Ambulance Service

Photo (right): Wessex RHA

Further reading

1. **Accident and emergency services,** report of the Standing Medical Advisory Committee (Platt Report) HMSO, 1962.
2. **A year in the life of a major A and E department,** Nuffield Centre for Health Service Studies, University of Leeds, 1977.
3. **Casualty services in England and Wales — a survey of provisions of accident and emergency services** by Anthea Holme and Joan Maizels, Association of CHCs for England and Wales, 1979.
4. A series of weekly articles on accident and emergency services appeared in the *British Medical Journal* between 6 October and 24 November 1979. The series includes **What are A and E departments for?** (6.10.79), **The network of services** (13.10.79), **How should departments be run?** (27.10.79), **The needs of the community** (24.11.79) and an editorial, **Improving image of A and E** (24.11.79).
5. **Home accident surveillance system,** Department of Prices and Consumer Protection, 1978.
6. **DHSS Annual Report 1977,** Cmnd 7394, HMSO 1978.

Healthline

Maternity care

Which CHCs have done surveys on maternity care?
Newcastle-upon-Tyne CHC has done the most recent large scale survey. A very comprehensive survey was carried out by Cambridge CHC in the spring of 1977. Other survey reports on all aspects of local maternity services and patients' views have been published by King's, North Camden, Crewe, Bexley, South Birmingham, Edgware/Hendon, Canterbury and Thanet, North Staffs, and South West Herts. High Wycombe did a survey on ante-natal care.

Requests for copies of reports should go direct to the CHC concerned. *CHC NEWS* is always glad to receive a copy of CHCs' survey reports.

Viruses and the mentally handicapped

I have been told that there is a virus, transmitted by the saliva of mentally handicapped people, which can affect foetuses in the same way as german measles. Can this be true?
Almost certainly this is a virus called cytomegalovirus (CMV), which is quite widespread in western Europe. Its symptoms are fairly mild and nonspecific — sufferers often think they have a mild dose of flu. The danger to the foetus occurs when a mother becomes infected early in pregnancy, and it has been estimated that some 100-150 babies are born every year with severe mental handicap attributable to CMV. The virus is transmitted only by direct, person-to-person contact, such as kissing or sexual intercourse, *but* the National Society for Mentally Handicapped Children assures us that there is no evidence whatsoever that mentally handicapped people are more likely to be CMV carriers than anyone else.

Donating your body for medical research

What arrangements should I make to donate my body for medical research?
A simple written statement of your wish, signed by you and your next of kin should be kept with your personal papers. The bequest must be made without reservations. A standard letter sent to enquirers by H M Inspector of Anatomy stresses that there is no guarantee that a body will be accepted — it all depends on factors such as the cause of death and the possible interest of the coroner. As soon as possible after your death your next of kin should inform the inspector, or if you live outside south-east England, your local medical school.

The body may be kept for up to two years, and parts of it for even longer. Expenses for a simple funeral will normally be borne by the medical school. For more details write to H M Inspector of Anatomy, DHSS, 14 Russell Square, London WC1B 5EP, or to the professor of anatomy at your nearest medical school.

Drug safety

What is the Committee on the Review of Medicines?
After the thalidomide tragedy in the early 1960's, the 1968 Medicines Act was passed to provide a system for checking on the safety of medicines and licensing them. Since September 1971, when the Act became law, all new medicines have had to meet the approval of the Committee on Safety of Medicines (CSM) before they can receive product licences and be sold in Britain. But around 35,000 products were already on sale, none of which had received any independent assessment — these were all granted Product Licences of Right (PLR).

Since 1975, the Committee on the Review of Medicines (CRM) has been reviewing all these drugs, category by category — anti-rheumatic agents, analgesics, psychotropic drugs. Progress was so slow that in 1978 review methods were speeded up. The CRM's work has tightened up the information which manufacturers give doctors about dosage, precautions and so on. There is an article about the CRM and its work in *Health trends* February 1980.

Report on stroke patients

Has there been a report published recently on provision for stroke patients?
Yes. It's called *The needs of people who have suffered strokes*, price 30p inc post from Coventry Voluntary Service Council, 14 Spon Street, Coventry, CV1 3BA.

The Healthline column publishes selections from our information service. This service is for CHC members and staff, and for others interested in the NHS and the work of CHCs.

Your letters

Continued from page two

Statistical Society as Dr Oldham and Professor Newell — the two statisticians referred to by Aubrey Sheiham — and I can tell your readers that Dr Sheiham has omitted the most important part of the story.

In 1978 there was a court case in Pittsburgh, USA, in which the plaintiffs asked that fluoridation be stopped on the grounds that it increased cancer deaths. The defendants called in a whole galaxy of pro-fluoridationists, including Professor Newell, who tried to defend his paper. The court decided in favour of the plaintiffs, and ordered that fluoridation be stopped on the grounds that it might well cause cancer to increase.

Commenting on the evidence given by Professor Newell and others, the judge said: "Point by point, every criticism made (of the cancer link) . . . was met and explained by the plaintiffs' . . . In short, this court was compellingly convinced of the evidence in favour of the plaintiffs". The pro-fluoridation authorities have of course appealed — but only on grounds of jurisdiction, not of fact.

A letter to this effect will shortly appear in the journal which published Professor Newell's paper, but it is surprising that even without this Dr Sheiham did not know of this court case, which exhaustively examined the evidence and concluded in favour of there being a link between cancer and fluoridation.

Aubrey Sheiham replies: I did, of course, know about this case, which was heard in the Court of Common Pleas (CCP), Allegheny County, Pennsylvania. The CCP's Judge Flaherty ordered the local water authority to stop fluoridating its drinking water. The authority applied to a higher court, called a Commonwealth Court, which granted a stay of the injunction. The Pennsylvania Department of Environmental Resources (DER) then did a full review of the evidence, and concluded that the main evidence submitted by the plaintiff in the CCP hearing had been "unconvincing". It found no proof of a link between fluoride and cancer. The water authority considers that the outcome of the DER review terminates Judge Flaherty's order, and so is continuing to fluoridate.

The Conservative response to *Patients first*

J Logan, Member, Eastbourne CHC

I would like to comment on your Health News report in *CHC NEWS 52* that the Conservative Party will not be responding to *Patients first*. It is of course a paper on the Government's proposals, so in that sense the Conservatives as a government should respond to other people's views, not their own proposals.

However, a great deal of discussion and comment is taking place within the Conservative Party, through its three-way discussion programme. Several hundred discussion groups, all over the country, each involving upwards of ten people, are looking at *Patients first*. They include not only party members but also people with knowledge of the NHS, regardless of their politics. Summaries of the views expressed by these groups will go to the Minister, and he will reply.

Surely this is a truly democratic response, rather than an official reply by "A Spokesman" before real discussion has taken place?

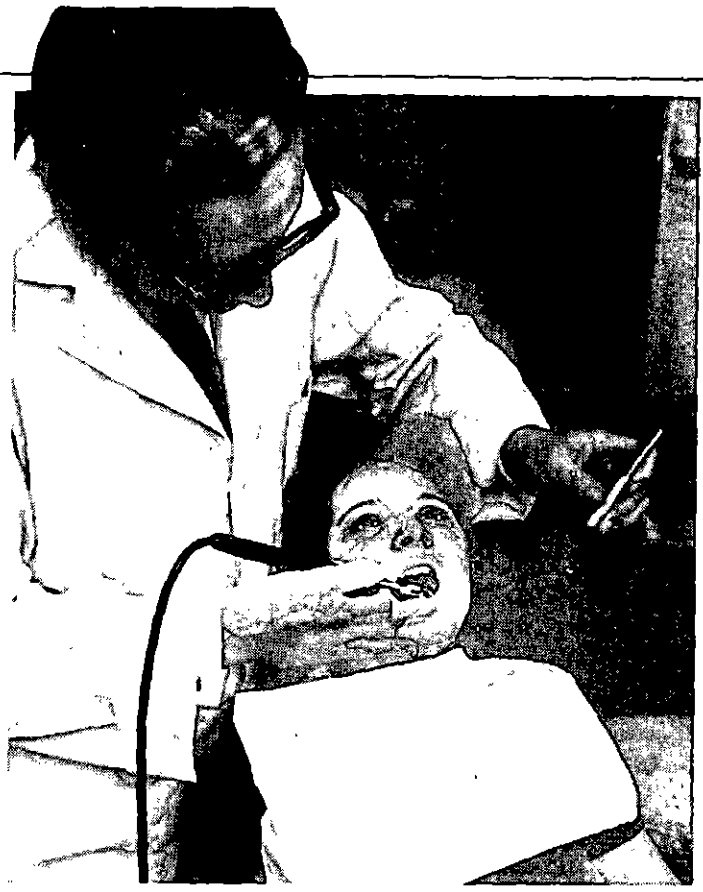


Photo: Jon Lyons

Dentists' terms of service

Just like GPs, most dentists are self-employed. If they choose they can contract with their local Family Practitioner Committee (FPC) to provide *general dental services* — dental treatment and dental appliances — to NHS patients. Most dentists also work privately.

Like GPs, they are free to accept or refuse anyone wanting NHS treatment, but unlike GPs dentists do not have a permanent "list" of patients. A dentist's commitment to any patient is limited to a single course of treatment — the amount of treatment necessary to produce *dental fitness*. Dental fitness means "such a reasonable standard of dental efficiency and oral health as is necessary to safeguard general health".

Section 35 of the NHS Act 1977 makes it the duty of every Area Health Authority to make arrangements with dentists in its area for the provision of NHS services. These arrangements are administered by the FPC for that area. Section 56 of the Act gives the Secretary of State power to intervene if the number of dentists willing to do NHS work in an area is inadequate, or if for some other reason "any considerable number of persons" in an area or part of an area are not receiving satisfactory services.

Dentists work for the NHS under *terms of service* set out in *The NHS (General Dental Services) Regulations 1973* (1), as modified slightly by *The NHS (General Dental Services) Regulations Amendment Order 1974* (2). The FPC has a duty to ensure that its dentists comply with these rules (3), and complaints that dentists have broken their contract with the FPC are normally investigated by its *dental service committee*. The FPC may also have a *denture conciliation committee*, to investigate complaints about the "fit and efficiency" of NHS dentures.

Complaints about "infamous or disgraceful professional conduct", which could lead to dentists being removed from the Dentists Register, are a separate matter, dealt with by the General Dental Council (4).

Each FPC must maintain a list of all dentists who have agreed to provide NHS services in its area. Dentists on the list must be registered with the General Dental Council as being professionally qualified, as laid down in the Dentists Act 1957. The FPC's *dental list* must contain names, practice addresses, normal hours of work and partnership details. Copies of the list must be available for inspection at the FPC's offices, and at other "convenient" places such as post offices and libraries. Patients can apply for NHS treatment to any dentist on the dental list.

According to their terms of service, NHS dentists must employ a "proper degree of skill and attention", using suitable equipment and working from premises with "proper and sufficient surgery and waiting room accommodation". They must satisfactorily complete "the treatment necessary to secure dental fitness which the patient is willing to undergo", except in the case of "occasional" treatment such as some kinds of emergency treatment and repairs to dentures. Emergency treatment means "any treatment immediately required for the relief of pain or other urgent symptoms". Treatment must normally be completed within six months.

When a dentist is absent, treatment may be given by a deputy. Deputies may practise from a different place and at different times, "due regard being had to the convenience of patients". Treatment may at any time be given by a partner or an assistant, provided that "reasonable steps are taken to secure continuity of treatment". When necessary dentists must arrange for a doctor or another dentist to administer a general anaesthetic. They can prescribe, supply and administer drugs. They must record all treatment, and must retain all treatment records and X-ray films for at least a year. Records are the dentist's own property.

Dentists must visit patients "whose condition so requires" at home, or at "any place where that patient may be", provided it is not more than five miles from the surgery. If a patient requires treatment which a dentist is unable to carry out, the dentist must take "all necessary steps" to refer the patient to another dentist or to a hospital dental specialist.

Dentists charge patients according to a scale of charges set out in *The NHS (Dental and Optical Charges) Amendment Regulations*. The current version of this (5) lays down £8 as the maximum figure for some courses of treatment, and gives other figures for dentures, bridges, crowns, inlays, pinlays and gold fillings. There is no charge for examination (ie a check-up), emergency treatment to stop bleeding, repairs to NHS dentures and home visits. Also, several groups of patients are exempt from NHS dental charges, on income, age and other grounds.

Patients receiving NHS treatment for which a charge may be made have to sign the *dental estimate form*, FP17, three times in all. The first signature is an application for NHS treatment, following which the dentist should indicate whether the patient has been accepted for NHS work. The second signature is an undertaking to pay the appropriate charge, or a claim for exemption, as appropriate. The third signature is to certify that to the best of the patient's knowledge the work has been satisfactorily completed.

It is important to remember that the first signature on FP17 is only an *application* — it does not guarantee that a patient will receive NHS rather than private treatment (6). The only way patients can be sure is to tell their dentist *at the start of each course of treatment* that they want NHS work (7). However, it is also worth noting the General Dental Council's view that *the dentist should make clear to the patient* the nature of the contract — and that failure to do this may constitute unprofessional conduct (4).

Notes and references

1. Statutory Instrument 1973 No 1468. Also includes terms of service for salaried dentists working for health centres and other premises.

2. SI 1974 No 53.

3. See SI 1974 No 455, *The NHS (Service Committees and Tribunal) Regulations 1974*, especially Regulations 6 and 13.

4. See Healthline item in *CHC NEWS 53*. The General Dental Council's address is 37 Wimpole Street, London W1.

5. SI 1980 No 352. Alternatively, see circular HN (FP)(80)9.

6. See News from CHCs item in *CHC NEWS 52*.

7. See *Your teeth and the NHS*, DHSS leaflet NHS4. And *Dentists*, in *Which?* magazine, November 1979, pages 641-4.

● Statutory Instruments are available from HMSO.

Falling out with doctor

by Mrs Gwanwyn Evans, Member, Brecknock and Radnor CHC

Many people do not realise that their doctor has the right, without giving any reason, to remove them from his list. There are probably parts of Britain where this right can present a problem, but when we investigated locally we found that in Powys cases of removal average less than two per year — so the problem is numerically minute.

Perhaps the reason for this is that in thinly-populated, "remote" counties like Powys, communities are small, with everyone knowing everyone else. Along with the "knowing" goes a great deal of caring. New GPs discover that in quite a short space of time they get "involved" with patients and their families, and with the relationship of one family to another. Moreover, the rapport between GPs and the Family Practitioner Committee (FPC) here is also generally good.

It is only, then, on very rare occasions that GPs conclude that they cannot continue to be consulted by and treat a particular patient. The main reasons that GPs give in such cases are: persistent and unnecessary calling out for trivial matters, excessive calling out at night, and generally being too demanding.

Knowing the patient, the other members of the family, their home and their environment makes it extremely difficult for a GP to discontinue giving treatment. In any case, because of the distance to the next practice, the patient would have little alternative but to choose the GP's practice partner, if the GP has one or is in a group practice. If this happens there is always the chance that the doctor who has "done the removing" will one day find himself, in the absence of his partner, face-to-face in the consulting room with the patient he has "removed".

If patients cannot find an alternative doctor, they can apply to the FPC, which must endeavour to place them. Because of distance, the FPC invariably finds that it cannot justify removing the patient from the existing practice. Moreover, if the patient were to be placed with a doctor some distance from the home of the patient, the doctor would in turn have the right to appeal against accepting that patient, because the patient would not live within that particular doctor's catchment area.

Consequently, the FPC administrator is faced with trying to persuade a practice to "put up with" a "difficult" patient. There *are* instances, in South Wales, where patients "go the rounds" of as many doctors as there are in a practice, and eventually end up where they began! That way at least each doctor in turn gets some relief!

But the problems are more severe when a single-doctor practice is involved. If the FPC can prevail on the doctor to continue, the situation is not a pleasant one but doctor and patient have no alternative but to make the best of it. If the doctor is adamant, then the FPC is obliged to give the patient to a doctor in the nearest adjoining practice. The distance the patient then has to travel to this doctor — perhaps 15 to 20 miles each way — may deter him from being so "difficult" in the future, if he is later reinstated with the original doctor.

As I have explained, removal from a GP's list is very rare in Powys. This is not meant to give the impression that the doctor's power to remove a patient from his list is constantly being frustrated in rural areas, and in defence of doctors who insist on removal it must always be remembered that patients also have the right to change doctors whenever they choose.

The only way in which the situation could be improved, we feel, is to discourage single-doctor practices — but many thinly-populated areas would not provide a living for even two doctors. When removal from a doctor's list is necessary, we feel that only the "offending" patient should be removed, not the whole family. We have corresponded with the Welsh Association of CHCs about this problem, and it has agreed to pursue cases of hardship to particular patients if we so request.

OUR PENS ARE MIGHTIER THAN OUR TEETH!

by Susan Jenkins, Secretary, and Elizabeth Cameron, Assistant, Leeds West CHC

Round about the second week of each month, a fearful cry can be heard throughout the hallowed walls of Leeds General Infirmary — "Oh no! Not Newsheet time again?" Before our eyes swim visions of our two-sided A4 publication, 300 manilla envelopes and the reception we know we are going to get in the post room when we wander in with all those envelopes.

Yes, it's Newsheet time again. But what is the purpose of producing such information? The key word *is* "information". We are aiming to help the people we represent become better informed. So we offer topical items on NHS developments in Leeds and we give names and addresses of self-help and voluntary organisations. We advertise health education literature — a paragraph on cystitis brought 50 plus requests for leaflets — in fact we put in anything which will keep the public abreast of health developments. We even publish the occasional cartoon!

The main objective is to reach as many people as possible, and here our local press, radio and TV come to our assistance. They often pick out one or two of our paragraph-length "articles" and develop them into a newspaper column or even a full-scale radio or TV discussion. For our part, we distribute in bulk by internal mail to libraries, advice bureaux, local councillors and AHA members, health centres, hospitals, trade unions and playgroups. Every GP in Leeds receives a copy through the family practitioner committee. The most expensive element is the individual mailing which includes MPs and secretaries of voluntary organisations such as hospital friends, Rotary clubs, community associations and church centres. And, after Issue 47, our audience is still growing!

Marooned as we are inside a city district general hospital, cut off by high rents and shark landlords, the Newsheet often seems a life-line link to the community we serve, and it is in fact the most common way the public gets to hear of us. At the same time, we fondly hope that we help to inform NHS staff — like those who did not know that there was an area strategic plan until it was mentioned in the Newsheet. Perhaps we even reach those staff who seem to have forgotten that the community outside the hospital still exists.

The congratulations we receive outweigh the burden of production — writing is a little less than a morning's work, since we collect possible items

When is a complaint not a complaint?

by Sue Baggott, Assistant, Hillingdon CHC

Over the past year the number of formal complaints made about the NHS through Hillingdon CHC has dropped to single figures. However, this does not mean that we are not receiving complaints from the public, but reflects the assistance we have had from family practitioners, hospital staff, social services — in fact all those involved in the care of the patient — in sorting out problems informally and speedily. This method of working has been built up on mutual trust.

So often a member of the public will call at our office in a very angry and distressed state, wishing to make a strong complaint against a hospital or family practitioner. If this happens we first listen carefully to the circumstances. Frequently the complainants will feel better for having "got it off their chest". Once the situation is clear to us we can take action.

The complaints which may be the most distressing for a patient or relative are those which need immediate action. Perhaps the person concerned or their relative requires urgent attention and for some reason things do not seem to be moving quickly enough or in the right direction. In such a situation the NHS formal complaints procedure is far too lengthy and cumbersome. We explain this to the person concerned and ask which they feel is the more important to them — to make a formal complaint, or to try to get care as soon as possible.

Very often the problem comes down to a lack of communication or understanding. Perhaps a patient did not made it clear to the doctor exactly what his or her symptoms were. He or she may have been distressed at the time, even frightened. When no medical help seems forthcoming relatives become worried, unaware that the patient has not really "told all" to the doctor.

In another situation a relative may have been too upset to understand the doctor's explanation of what is wrong with the patient and what treatment is being given. The patient's recovery then seems to the relative to be unaccountably slow.

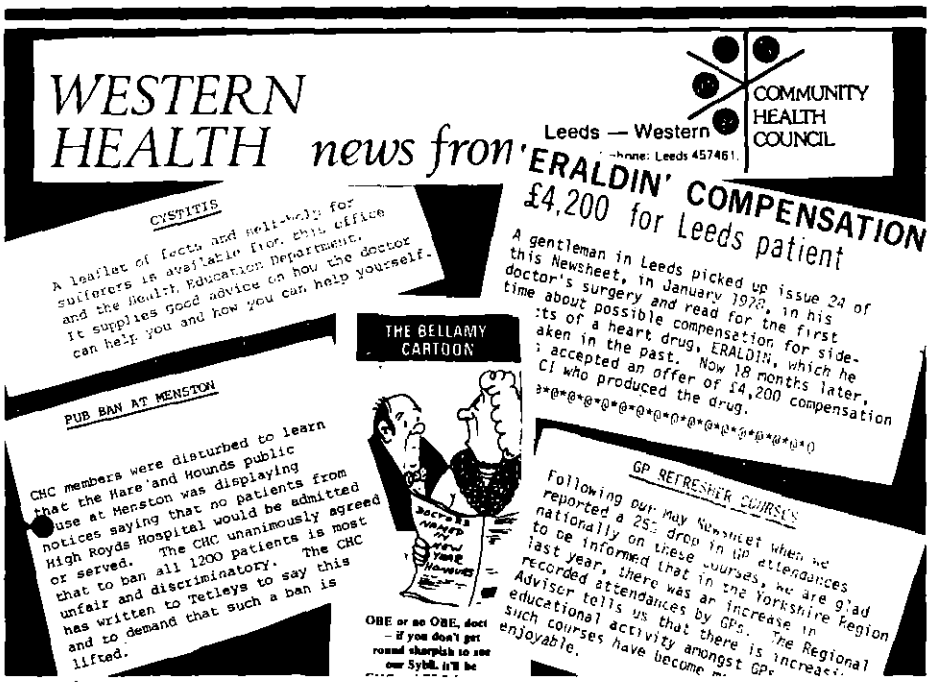
In the majority of such cases we find that a phone call from our office to the doctor or hospital concerned can restore communication between doctor and patient or relative and clarify the situation for both parties. Often when we ring them about a problem, doctors say "well, if the patient had only come to me and asked, I could have explained it all to him". But people sometimes become lost for words when faced with a consultant or feel that they are wasting a busy GP's time.

Even when the problem is less urgent we sometimes feel that a patient would not gain anything by making a formal complaint. An example would be a patient who has been struck off a GP's list for "no reason". The patient is angry and wishes to complain to the authorities most strongly about the doctor's attitude. We explain as clearly as possible that the doctor, rightly or wrongly, has every right to do this and that the patient could really be using time and effort to better advantage in trying to find another GP. We can then offer practical help either by giving the patient names and addresses of other doctors in the area, or by putting him or her in touch with the family practitioner committee who will allocate a GP if all else fails.

There are of course times when a problem is not solved quite so easily — sometimes we need to keep in touch with a complainant over a considerable period of time to check that communications between them and the doctor have not broken down again. We may also call in members of the CHC who have a special interest or expertise in various aspects of health care for their advice.

Of course if either we or the patient feel that a formal complaint ought to be made, the patient is given every help in writing the necessary letter and following the case through. However, a member of the public who has initially wanted to make a complaint will often see the advantage of taking an alternative course of action which is quicker and frequently more effective.

Provided that the patient is satisfied, so are we.


WESTERN HEALTH news from Leeds — Western

COMMUNITY HEALTH COUNCIL

'ERALDIN' COMPENSATION

£4,200 for Leeds patient

A gentleman in Leeds picked up issue 24 of this Newsheet, in January 1978, in his doctor's surgery and read for the first time about possible compensation for side-effects of a heart drug, ERALDIN, which he had taken in the past. Now 18 months later, he has accepted an offer of £4,200 compensation from the CI who produced the drug.

CYSTITIS

A leaflet of facts and self-help for sufferers is available from this office and the Health Education Department. It supplies good advice on how the doctor can help you and how you can help yourself.

PUB BAN AT MENSTON

CHC members were disturbed to learn that the Hare and Hounds public house at Menston was displaying notices saying that no patients from High Royds Hospital would be admitted or served. The CHC unanimously agreed that to ban all 1200 patients is most unfair and discriminatory. The CHC has written to Tetleys to say this and to demand that such a ban is lifted.

THE BELLAMY CARTOON

OBE or no OBE, doct — if you don't get round sharpish to see our Sybil, it'll be

GP REFRESHER COURSES

Following our May Newsheet when we reported a 25% drop in GP attendances nationally on these courses, we are glad to be informed that in the Yorkshire Region last year, there was an increase in recorded attendances by GPs. The Regional Adviser tells us that there is increased educational activity amongst GPs such courses have become m enjoyable.

from journals, minutes and reports made over the previous month. The NHS does our printing — photo stencils and offset litho — and packing in envelopes takes a longish afternoon (and an occasional bribe to the assistant secretary!)

Our success stories include the man suffering from side-effects of the heart drug Eraldin, who picked up a Newsheet in his GP's surgery and ended up £4200 richer from a compensation award 18 months later. Occasional gripes come from the family practitioner committee which has taken exception to the most mildly-worded paragraph on how to make a complaint against a GP.

Doing the Newsheet has also given us the feeling that we ought to be able to answer questions like "Is there a self-help group for people with myasthenia gravis?", so over the years we have collected the directories of voluntary associations, both locally and nationally, and we have tried to keep our local list up to date.* Since a library information service from outside our area now rings us, we feel quite proud of this too!

We believe we have found a successful formula — not too long so it can be read on receipt, not too burdensome or expensive — and the feedback is a definite regular morale-booster for CHC staff with those familiar unloved feelings!

* The directories we use most are: a local directory of voluntary organisations published by the Council for Voluntary Service; *The King's Fund Directory* (see *CHC NEWS 45*, page 7); and *Help! I need somebody*, compiled by Sally Knight, published by Hertfordshire Library Service, County Hall, Hertford SG13 8EJ, 30p inc post.

VACCINE DAMAGE: *a Government betrayal*

*by Rosemary Fox, Hon Secretary, Association of Parents of Vaccine Damaged Children**

After a four-year campaign for state compensation, vaccine-damaged children became eligible for lump sum payments of £10,000 under the Vaccine Damage Payments Act 1979. This was not compensation.

David Ennals — then the Social Services Secretary — described it as an urgent measure of help, brought forward because the Pearson Commission's recommendation on vaccine damage would take time to study. Pearson (Cmnd. 7054-I, HMSO 1978) had proposed that the Government should be strictly liable *in tort* for vaccine damage, which means that monetary damages would be recoverable through the civil courts. The £10,000 payments would not pre-empt or prejudice consideration of the Pearson recommendation, Mr Ennals added.

One year later, when the Act was going through its final stages, the opposition health spokesman asked David Ennals to repeat this assurance, because the payments should be regarded "purely as a single payment to help people while we are still examining the wider issues". A nice definition of "interim"!

The opposition is now the Government and the opposition spokesman is now the Minister for Health, but vaccine-damaged children appear to have little hope of justice. Secretary of State Patrick Jenkin who appeared to have little involvement in the matter during Parliamentary discussions on the payment scheme — now disputes the Pearson recommendation. The £10,000 payment *is* the preferential treatment for vaccine damage, he says. Since it was all that Parliament agreed to in the past, and since David Ennals didn't call it "interim", and didn't set money aside for further compensation, the payment has to be regarded as final. All initiative in the matter would have had to come, it seems, from the previous Government!

Under the payment scheme approximately 350 children and young adults have so far been officially recognised, on the "balance of probabilities", as severely vaccine-damaged. When all claims are investigated the final figure will be between six and seven hundred. All these children are totally handicapped, with mental ages of about 18 months. They cannot communicate, read, dress themselves, find food if they are hungry or warmth if they are cold. Most suffer epileptic attacks, are often sick, incontinent, hyperactive and destructive. They need, and will always need, constant care and attention.

This is the price that has been paid over the last 30 years in the war against smallpox, diphtheria and polio, and in the attempt to control whooping cough. If the country enjoys freedom from dangerous infectious diseases today, it is because an average of more than 20 children a year were disabled to achieve it.

The parents of these children have accepted the tragedy as best they can. They will never, however, accept the injustice whereby the state allowed a secret risk to fall on their healthy babies and then left them to cope with the tragic results as best they could. There was a glimmer of hope when David Ennals took action — not only to acknowledge the injustice but to try to minimise needless damage in future. Patrick Jenkin has now dashed these hopes because he can see only the disability and not the principle, and because — or so it seems — one can safely say in opposition what one can later overlook in power.

Parents started on their campaign with doubts and anxieties, because they did not want to upset immunisation or undermine public confidence in it. They cannot, however, accept an injustice of this magnitude, and they are encouraged by the knowledge that some of the most eminent medical and other professional bodies supported their cause in evidence to the Pearson Commission. They will continue their fight.

If, in the process, other parents become worried, the fault must lie entirely on the shoulders of a Government which recently expressed the view that if children suffer ill effects from vaccination, parents can be assured that social security benefits are available. While such an attitude prevails neither vaccine-damaged children nor immunisation schemes can have much to hope for.

**The APVDC can be contacted at 2 Church Street, Shipston-on-Stour, Warwickshire.*

Parliament

Support for CHCs

"That this House acknowledges the contribution made by CHCs in monitoring the provisions for patients provided by the NHS administration, and believes that the voluntary service and public accountability principles represented by CHCs must be allowed to continue in the interests of patients and the community." This is the text of an *Early day motion*, tabled in the House of Commons on 13 March by six Labour MPs. By mid-April it had attracted 52 signatures.

Valium

Doctors are being warned, in guidelines issued by the Committee on the Review of Medicines, to prescribe long-term and high doses of tranquillisers such as Valium with "considerable care". Athough this group of drugs, known as benzodiazepines, are not thought to be addictive, evidence suggests that they do not work very well when taken over long periods. And when treatment is suddenly discontinued patients may suffer from anxiety, sleeplessness, nausea and tremors. The data sheets issued to doctors by the drug companies are being amended (Lewis Carter-Jones MP, Eccles, 5 March).

Patients ready to leave special hospitals

There are 135 men and 48 women locked up in special hospitals such as Rampton who are thought to be ready for transfer to a less secure hospital. The majority have been waiting for more than one year and 23 patients have been waiting for more than four years (Robert Kilroy-Silk MP, Ormskirk, 5 March).

Advice about London

The Advisory Group on London will consider the city's special needs and will look at the reports of the Flowers Committee and the London Health Planning Consortium. No chairmen or members have yet been named, but there will be representatives from the DHSS, University Grants Committee, London University, the four Thames regional health authorities, the post-graduate boards of governors, the Greater London Council and the London Boroughs Association. (Renee Short MP, Wolverhampton NE, 4 March).

Closures

Between 1st January 1979 and 31 December 1979, it was decided to close permanently 32 whole hospitals or units. The closures involve 2271 beds but not all have yet been implemented. In two cases the closures were made after being referred to the Secretary of State for Social Services (Edwin Wainwright MP, Dearne Valley, 26 February).

Complaints bill

The health Ombudsman's scope to investigate complaints would be extended if a Private Member's Bill succeeds. The Health Service Commissioner (Powers) Bill enables complaints involving decisions of "clinical judgement" to be investigated. Jack Ashley MP (Stoke-on-Trent South) said his bill would "prevent the medical establishment from gagging an aggrieved patient by murmuring the incantation 'clinical judgement' ". The bill is unlikely to become law.

Scanner

Development Team for the Mentally Handicapped

Health care planning teams for mental handicap services often ignore the views of parents and are not even aware of deficiencies which are "all too obvious to the consumer", says the second report of the Government's advisory team on services for mentally handicapped children. It is a wide-ranging report which notes extensive problems with the laundering of personal clothing in mental handicap hospitals. It says that where laundrettes have been established clothes last longer and do not go astray so easily. The team also expresses concern about the use of secure accommodation in mental handicap hospitals — "patients placed there rarely moved to other wards even if this was considered in their best interests".
Development Team for the Mentally Handicapped – second report 1978-1979 (HMSO £2.75).

Tranquil birth

Guidelines for parents who want their baby to have a "Leboyer birth" are set out in a new leaflet from the Association for Improvements in the Maternity Services. Frederick Leboyer's book, *Birth without violence*, advocated a delivery with dimmed lights and low voices, and the baby being placed immediately on the mother's stomach. *A "Leboyer" style birth* (30p inc post) from AIMS, c/o 21 Iver Lane, Iver, Bucks, SLO 9LH.

Doctors' careers

The present career structure for hospital doctors is "seriously flawed", according to a report from a King's Fund working party. The report calls for a decrease in the number of "junior" hospital posts, to be compensated by increased opportunities for permanent specialists. It also urges better career opportunities for married women and much greater involvement by GPs in hospital work. *The organisation of hospital clinical work* (£1.50 plus 25p post), from King's Fund, 126 Albert Street, London NW1.

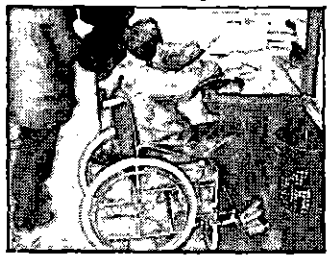
International Year of Disabled Persons

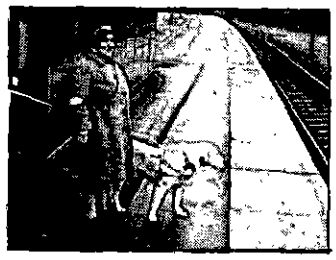
The symbol chosen by the United Nations for 1981 – the International Year of Disabled Persons – represents two people holding hands in solidarity and support of each other in a position of equality.

Research about planning

At the West Midlands RHA research is being carried out to identify what kind of financial information is needed by health planners and doctors for the organisation and management of their units. It will also attempt to design better systems for the collection of NHS financial information. A booklet describing the aims of the project is available free from Val Little, NHS Financial Information Project, W Midlands RHA, Arthur Thomson House, 146 Hagley Road, Birmingham B16 9PA.

Steps and signs



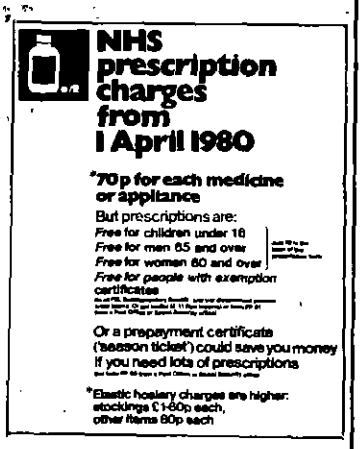


Banks, pubs, police stations, post offices, hospitals, shops, trains, buses and other public places pose problems for all kinds of handicapped people. With help from a wheelchair user, a blind person with a guide dog, two partially deaf young people, three deaf teenage girls and a mother with two toddlers in a double collapsible pushchair, a research team tested public buildings and transport in a North London suburb. The post office writing bench is too high for a wheelchair user. The suburban station has no announcements to inform a blind person about the approaching trains. **The adaptation of existing public buildings for use by the handicapped** *(£3 inc.post) from Polytechnic of Central London, Built Environment Research Group, 35 Marylebone Road, London, NW1 3LS.*

Directory of CHCs: Changes

An updated version of the Directory of CHCs was last published in October 1978, and each CHC was sent a copy. This version is now out of print. Work on a 1980 version is now in progress, and an announcement will be published in *CHC NEWS* as soon as this is available. Meanwhile changes to the 1978 directory will continue to be published each month on this page. Please notify us of any alterations in address, telephone number, chairman or secretary.

Page 3: Calderdale CHC Chairman: Mrs M B Kulvietis
Page 4: Central Derbyshire CHC Secretary: Dr Christine Schofield
Page 6: North West Herts CHC Chairman: Dr D J Fruin
Page 7: Kensington-Chelsea-Westminster N W District CHC, 81 Westbourne Grove, London W2 4UN. Tel: no change.
Page 14: Hereford CHC Chairman: C O T S Tudge
Page 20: Vale of Glamorgan CHC, 24 Broad Street Parade, Barry, South Glamorgan. Tel: Barry 744010 or Barry 744035.
Page 22: South West Thames Regional Association of CHCs, c/o Chichester CHC, 16 North Pallant, Chichester, Sussex PO19 1TQ. Chairman: Mrs P Stinchcombe; Secretary: P G Fletcher. Tel: Chichester 781912.



Going up

HN(FP) (80)9;HN(80)6; HN(FP) (80)6; HN(80)4

Charges for NHS dental treatment went up in April. The maximum cost to a patient for each ordinary item such as a filling is now £8. The charge for a crown is £18. Prescription charges have been increased – to 70p per item. In November the cost will rise to £1. Wigs and elastic hosiery now also cost more. Fees for private in-patients in NHS hospitals have been increased.

Discharge from hospital

Is the title of a survey of social workers' views of the arrangements for elderly people when they return home from hospital. The survey looks at several aftercare schemes which make use of volunteers to "befriend" old people who live alone. Social workers believe this extra support is much needed, especially during the first 48 hours after discharge. From Age Concern Greater London, 54 Knatchbull Road, London SE5 9QY (£1 inc. post).

Matthew Trust

Is a charity which gives "practical and professional help to patients of Special Hospitals, victims of crime and others with similar needs". The Trust has been calling for a public enquiry into conditions and the management of Rampton Hospital. Peter Thompson, the Trust's founder, was a patient at Broadmoor for four years. Matthew Trust, 38 Bedford Place, London, WC1 5JH. Tel 01-405 9031.

News from CHCs

☐ In March the **Association of Scottish Local Health Councils** held a special general meeting to discuss the Royal Commission on the NHS and the Government's consultative paper, *Structure and management of the NHS in Scotland.* The meeting was addressed by Jean Robinson, former chairman of the Patients' Association. Conference devoted considerable time to criticising the controversial report on LHCs by Bochel and MacLaran (see *CHC NEWS 50,* page four) which prompted the Scottish Office to abandon its promised review of health councils.

☐ Casualty departments have been the focus of considerable CHC activity lately. Camden and Islington AHA's plan to close the casualty department of the Royal Northern Hospital in Islington have been set aside while a senior civil servant carries out an independent inquiry into the plan and the AHA's overspending generally. Health Minister Gerard Vaughan appointed the adjudicator after meeting **Islington CHC**, five local MPs, hospital staff and local groups, who all made strong representations against the closure. The CHC feels that the Minister took this step when the lack of research and planning behind the AHA's proposals became embarrassingly obvious. **Hillingdon CHC** has been in the forefront of a campaign to retain a 24-hour service at Mount Vernon Hospital casualty department. After meetings and deputations Hillingdon AHA agreed to withdraw the closure plan but the victory was short-lived. Proposals of the London Health Planning Consortium leave a question-mark over the future of the whole hospital, and the AHA has now shelved the development of a new £8m surgical block at Mount Vernon. Harefield Hospital, world famous for its pioneering work in paediatric cardiac surgery as well as heart transplants, is also threatened by the consortium's plans. The CHC is very concerned about the future of both hospitals and is organising a large public meeting as part of its effort to mobilise opinion. As a result of its experiences the CHC is now writing a guide to running such a campaign.

In a closely argued 24-page report detailing its objections to the closure of the A and E department at Clatterbridge Hospital, **Wirral Southern CHC** concludes that the duty placed on CHCs to submit alternative proposals is "an unreasonable burden" as CHCs do not have the necessary information. Instead it argues that AHA plans to centralise A and E facilities elsewhere will make transport for those living in parts of South Wirral difficult and expensive, and will place impossible strains on the new A and E unit.

☐ Bereavement, holidays and wheelchairs are all subjects included in a *Pensioners' A to Z of health* which has been compiled by **Wandsworth and East Merton CHC.** The CHC also organised a pensioners' health course which proved very popular.

☐ *As its contribution to the Health Education Council's ante-natal care campaign,* **South Tyneside CHC** *paid for a half-page cartoon advertisement in its local paper. It also persuaded the paper to publish a feature article on the facilities available to pregnant women under the NHS.*

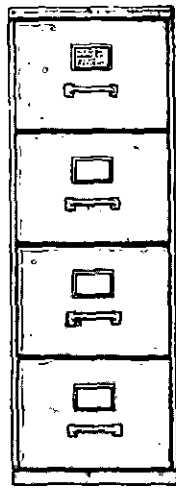
☐ **South Tees CHC** has drafted a questionnaire about the use of ante-natal services. One way in which it has been distributed has been through publication in the local paper. Replies were received from 150 women, only two of whom were completely satisfied with their experience of maternity care. Lengthy waits at clinic or hospital, brusque impersonal examinations and lack of facilities for small children at clinics were among the main criticisms. This information has been welcomed by administration and the CHC anticipates positive improvements in services.

☐ When Staffordshire AHA realised that **North Staffordshire CHC** was planning a late-night visit to St Edward's Hospital for the mentally handicapped, it banned the visit as being too distracting for staff. After pressure from the CHC it reluctantly withdrew its ban. The CHC made "a very satisfactory visit". It feels that visiting institutions at night is an important part of a CHC's brief.

☐ Rather than call an evening meeting to canvass opinion about the proposed closure of a nine-bed maternity unit at Skegness Hospital, **South Lincolnshire CHC** hired a shop in the middle of Skegness on a Saturday morning. Shoppers called in to discuss the closure and CHC members went into the street to talk to passers-by. Over 500 people were consulted in this way and only nine of them favoured closure. With this evidence of public feeling the CHC is urging the AHA to preserve the unit.

☐ Following their participation in the *Good practices in mental health* project (see back page, *CHC NEWS 51*), the **Sheffield CHCs** have published a report describing some of the best schemes in their area. These include a group home for younger ex-psychiatric patients started by local students, the first citizens' advice bureau to be set up within a mental hospital and an out-patient clinic for people with marital and sexual problems.

☐ **Southend CHC** was also involved in the *Good Practices* project and in a recent report lists such schemes as the local branch of Gamblers Anonymous, group therapy sessions for the parents of mentally handicapped children and the "adoption" of a ward of psychiatric patients by members of the Women's Institute.



THE CASE FOR:

"The right of every adult patient to have access to his or her own medical notes if they wish to."

☐ *At ACHCEW's last Annual Meeting a large majority carried a motion supporting the right of adult patients to have access to their medical notes if they so wish.* **Central Birmingham CHC** *has now produced a leaflet on the subject, intended as "a starting point for informed discussion". Copies are available free from the CHC.*

☐ **West Essex and District CHC** has produced a comprehensive report about its third annual *Prevention and Health Day,* held last May. Speakers, including a psychiatrist, GP and social worker, discussed aspects of stress in everyday life.

☐ In **Huddersfield,** the AHA and Kirklees Council have been working together to identify all potentially lead-polluted sources of water, following prompting from the CHC. 900 out of 1100 dwellings at risk have now been checked, and 74 private water supplies have been shown to have a lead content above the World Health Organization safety norm. **Peterborough CHC** was concerned when it heard that the London Brick Company had applied for planning permission to build a new brickworks locally. The CHC was aware of possible dangers to health from emissions of fluorine and sulphur dioxide gases. It submitted an objection, using as evidence a report by a firm of consultant engineers commissioned by Bedford County Council when faced by a similar application. The Department of the Environment has now promised a public inquiry.