

CHC NEWS

For Community Health Councils

October 1980 No 59

Invest in the future

The health service needs more investment not more cuts, and in particular extra resources are required to improve the care of the elderly. These were the main messages from this year's annual general meeting of the Association of CHCs, held in London last month.

The meeting—attended by delegates from 204 CHCs—expressed its alarm about the effects of cuts on patient services and carried a motion from Kensington, Chelsea and Westminster (NW) CHC that investment in the NHS "should be maintained at sufficient level to improve and develop services to make it a National Health Service, since investment in good health is investment in the future."

CHC chairman Naomi Honigsbaum, proposing the motion, said the Government was surreptitiously dismantling the NHS and argued that if Britain could find resources to start the NHS directly after a World War then it can certainly afford to maintain present services, and to reduce the vast inequalities in health care revealed

AGM tells the Government

recently by the Black Report (see article on page six). ACHCEW should press the Government to spend a bigger share of the gross national product on the NHS, she added.

A motion from South Birmingham CHC, carried overwhelmingly, called for additional funds to improve services for old people who are mentally ill or physically infirm, and a motion from North Hammersmith and Acton CHC asked for special funding for "small, local psycho-geriatric units" in districts where DHSS guidelines would not otherwise be met.

National publicity was another major theme of the AGM, which backed a call from Aylesbury and Milton Keynes CHC for ACHCEW to increase its efforts to ensure "powerful, effective, national

publicity for the work of CHCs." Aylesbury secretary Jeanne Lewington, proposing the motion, said CHCs should not have to spend an enormous amount of time on publicity, which should be a top priority for ACHCEW. North Tyneside CHC secretary Beryl Sloan argued, in contrast, that local publicity was more important: "We should be educating ourselves to do press releases, look at all the angles and not miss a trick. We want to give it priority locally, not just shove it onto ACHCEW". The general feeling seemed to be that ACHCEW should encourage the DHSS and the Health Education Council to do the publicity work, and that national publicity should complement local efforts rather than replace them.

The question of opening meetings of ACHCEW's standing committee to the press and public was raised again by East Berkshire CHC. At last year's AGM the same proposal narrowly failed to win the two-thirds majority necessary for constitutional changes, but this year it succeeded 151-18, despite warnings that additional costs could be incurred. It already costs about £2000 every time the standing committee meets.

Local Health Councils—the Scottish equivalent of CHCs—are currently being threatened with the axe by the Scottish Office, and a delegation from the Association of LHCs attended the AGM to give a progress report. The Scottish Office, it seems, has yet to explain why it believes the Scottish population has no need of the services which CHCs will continue to provide in England and Wales. In an emergency motion, the AGM paid tribute to the work done by LHCs and called on the Government to think again.

AGM agreed several new policies on primary health care. A motion from Leeds Western CHC urged the DHSS to encourage GPs to prescribe drugs by their chemical or "generic" names rather than by their trade names. Brand-name drugs are often much more expensive than their generic equivalents, and despite warnings from some delegates that substitution can occasionally be dangerous, this motion was

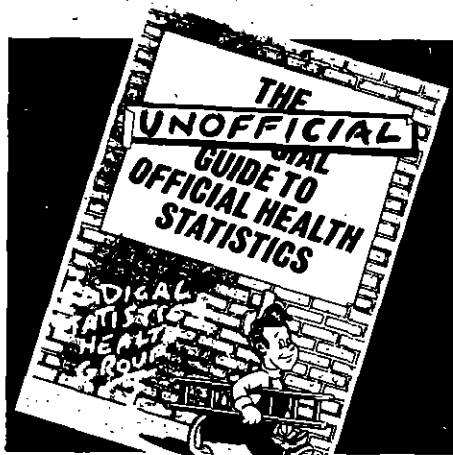
Continued on page four

Official statistics — an unofficial guide

Much of the statistical information used by NHS administrators is "employed to overwhelm the reader rather than to sustain a reasoned argument", according to a new guide to health statistics* produced by the Radical Statistics Health Group. The figures that are collected are often not particularly relevant to the decisions being taken and not as accurate as their official status would imply. And while there is considerable duplication in the collection of some statistics there are also large gaps in the available information.

With CHC members especially in mind the guide critically describes the existing sources of statistics for the different sections of the NHS and for local authority social services, and explains where these various figures can be found.

As far as treatment is concerned, hospital statistics tell us little beyond whether the patient died or left the hospital alive. Community health service statistics are surprisingly sparse and their accuracy could be improved — they should be "treated with great caution" says the guide.



As an illustration of the gaps and duplications of health service statistics the guide analyses the data available for pregnancy and childbirth. Abortion may be included in three different surveys but no comprehensive system exists for collecting data about handicapped babies — there is not even an agreed definition of handicap. *The unofficial guide to official health statistics, Radical Statistics Health Group, 9 Poland Street, London W1 (£1.25 inc post to community health councils and individuals).

INSIDE... Class inequality and health

Page 6

Where the cuts are falling hardest

Pages 8 and 9

Your letters

Oxford method of building

Margaret Aldington, Vice-chairman, Aylesbury and Milton Keynes CHC
For some time this CHC has been concerned with problems arising from the use of the Oxford method of building. We are anxious to know if other CHCs are finding similar problems in their districts.

The Oxford method is a computerised, factory-produced building system, supposedly flexible enough to accommodate all specialties. In our experience this has led to modifications in almost every building, thus outweighing any financial gains hoped for in mass production. Plasterboard internal walls are proving inflexible once erected — being more awkward to adapt or move than other materials and not strong enough to support any subsequent fixtures normal to hospital usage. They are also unsuitable for some units. In addition the grid system has so far produced inadequate storage space, over-long corridors, poor ventilation, inaccessible plumbing, etc. It also seems to take no cognisance of maintenance problems, for which no separate costings seem to be available. Over the last three years we have accumulated considerable detailed evidence — from staff and from our own experience — which we can make available to any interested CHC. We should very much like to hear from other CHCs which have experienced difficulties with this building method.

Dealing with repeat prescriptions

Bob Payne, Secretary, Rotherham CHC
One of the problems that concerns my CHC

CHC NEWS

OCTOBER 1980

No 59

362 Euston Road, London NW1 3BL
01-388 4943

CHC NEWS and Information Service Staff:
DAVE BRADNEY (EDITOR)
JANET HADLEY, JENNY KEATING

CHC NEWS is distributed each month free of charge to members and secretaries of Community Health Councils in England and Wales. It is also available to subscribers at £3.50 per annum (or special discount rate if five or more copies of each issue are ordered). Special and overseas rates on application.

Published by the Association of Community Health Councils for England and Wales, designed by Ray Eden and printed by Feb Edge Litho (1979) Ltd., 3-4 The Oval, London E2

The views expressed in signed contributions are not necessarily to be taken as those of CHC NEWS or the Association of Community Health Councils for England and Wales.

is the length of time repeat prescriptions may be issued without the patient being seen by the GP. For example, relatives of a mentally handicapped adult told us recently that since 1966 they have been obtaining regular repeat prescriptions for Largactil tablets — 100 at a time — and that never once in this period has the patient been reassessed either for physical condition or the suitability of the medication. The relatives also admitted that in the absence of any advice to the contrary they adjust the daily dosage to suit what they consider to be the patient's needs. Perhaps this is an extreme example, but I think it could be quoted in support of a system of "patient medication records", where the pharmacist would keep a record of the medicines dispensed to patients. Reference is made to this in the report of ACHCEW's conference *Pharmaceutical services in the '80s*. In the case I have quoted a pharmacist operating a medication record system would have been able to advise the patient's relatives to seek further medical advice much sooner. GPs, however, may see this as an unwarranted restriction on their freedom to prescribe the drug they consider best for the patient.

Complaints about locum doctors

Philip Marsh, Secretary, Central Nottinghamshire CHC
Recently the CHC was asked to advise a mother who wished to make a serious complaint about the medical care of her young baby. The Nottinghamshire Family Practitioner Committee informed the mother that as the doctor concerned was a locum and not included on their lists, they could not pursue the complaint against him. The complaint must be taken up against the principal of the practice which had engaged him.

As the principal had not been involved in the medical care of the baby at that time and the mother had never had cause to complain about the medical care provided by him for her family, she was most reluctant to take a step which could jeopardise this good relationship.

We have written to the health minister, Dr Vaughan, about this problem. It could be solved by ensuring that all locums and doctors involved with vocational training schemes are on the medical lists of the local FPC. As a point of interest, our local deputising service has the vast majority of its locums already on the FPC list.

Accountability

Graham Girvan, Secretary, Bexley CHC
The statement by a Birmingham surgeon, Mr A Gourevitch, at the BMA's conference, that "CHCs are accountable to no one" should not pass without comment. CHCs are accountable to the establishing body, to the bodies that appoint their members and ultimately to the community.

However, doctors seem to have less accountability. I have recently been informed by the SE Thames RHA that the RHA can request, it can suggest, it can ask,

but it cannot insist that a consultant admits a patient to hospital. What price accountability?

Beware becoming the NHS banker

Nick Harris, Secretary, Central Manchester CHC
Graham Hills' article, *Raising cash for the NHS (CHC NEWS 56)*, highlights the dilemma facing CHCs as a consumer movement in the NHS. Local needs demand local responses but can such responses be taken out of their political and national context?

The Government's ideas can be summarised as follows: As a nation we are short of money so that revenue and capital expenditure on the NHS must be curtailed (in practice drop) and redistribution of resources must wait. To overcome resources in health service provision private funding and voluntary help must be encouraged to an unspecified degree.

Few would presumably argue with that scenario and initially one's response is to encourage CHC involvement in these developments. Certainly community action is a major way of increasing CHC visibility. But what is the long-term effect of these developments?

The NHS is forced to accept money for priorities over which it has no control, and which may not be the "planned" needs of the area. Scarce staff resources have to be utilised on these externally determined priorities. The service becomes dependent on the voluntary finance available, private health services develop to meet the needs for which funds are available. The health service becomes distorted — a patch-work quilt. The alternative strategy for CHCs can be a political fight against such developments or it can be to "facilitate a debate on health service priorities".

Support and advice can be given to community groups working on health service issues. Health can be brought back to the local agenda from where it has been missing for too long. Yes, let us mount "health development years", but beware becoming the banker responsible for bailing out the NHS.

Euthanasia

Mrs Peggy Lajeune, 42 Church Road, Warlingham, Surrey
I was rather troubled by the letters published in opposition to Mrs Lark's letter (*CHC NEWS 55*). They seem to have been written by those who hold some kind of religious faith, in spite of the fact that the vast majority of our society is not Christian.

In my view, the essence of being human is surely found in using one's capabilities and energy in some kind of psychologically satisfying activity. It is true that some people confine their interest solely to their families, homes, pets and gardens. But wider education has encouraged many to be active in affairs outside their own small worlds and they would find life quite

Continued on page ten

Comment

In its consultative papers on priorities the last government singled out services for the elderly, mentally handicapped and mentally ill for extra growth. The present government has promised that this autumn it too will be settling out its strategy and priority for health. In an arena with so many powerful and influential groups competing for funds it is obviously sensible to draw up guidelines for spending — perhaps even to " earmark " funds for necessary but unglamorous projects.

So far the Government has said that "services for the most vulnerable, including the mentally handicapped, should be protected as far as possible". But there is mounting evidence that it is precisely these "vulnerable" groups which are suffering most in the present financial situation. Although the Government's stated policy for such patients is to continue the switch from institutional to community-based services, the two reports described on pages eight and nine show that cuts are now threatening this policy with total extinction.

Social services provided by local authorities are vital if vulnerable groups

are to be cared for within the community — yet this year's Budget announced a cut of nearly 7% in spending on personal social services, on top of cuts in 1979. The NHS received a supposed growth of ½%, but of course its expenditure is inextricably linked with that of social services. For instance, a mentally handicapped child whose parents get no support from social services is very likely to end up needing NHS care. Patrick Jenkin has said that it is impossible to estimate the effect of these cutbacks on the NHS.

Mr Jenkin also says that the gaps should be filled by the family and volunteers, but they need support from local authorities — and when resources are severely curtailed local authorities give priority to their statutory duties at the expense of other projects.

But the present cuts are not the only cause for concern about priorities. The Black Report (see page six) shows that despite all the optimism surrounding the birth of the NHS, the difference in health between social classes in this country is wider now than it was in 1948.

The recommendations of this report

have been dismissed by Mr Jenkin as financially "unrealistic" — yet delegates at the Association of CHCs' AGM last month voted for investment in the health service to be maintained "at sufficient level to improve and develop services to make it a National Health Service". As the motion rightly pointed out, "investment in good health is investment in the future".

There can never be a "correct" figure for the proportion of the nation's income to be spent on the NHS — but there does seem to be a growing realisation that health, in the broadest sense of the word, needs a higher priority when public spending plans are being drawn up. The ACHCEW resolution reflects this changing mood.

More money will not of itself solve all the problems, but unless health is given a higher national priority no Government document on priorities within the NHS will be able to achieve very much. Unless health gets a higher priority CHCs will be left to continue the melancholy task of acquiescing in cuts and closures, and priority services at best will just be those parts of the NHS where the cuts fall slightly more gently.

Health News

Cause for complaint

The Department of Health has finally dumped its controversial review of family practitioner complaints procedures, which began in 1976. It has told the Association of CHCs that "Ministers have now concluded that it has not been established that the complaints procedures are in need of radical alteration."

CHCs were consulted during the first "round" of the review, in 1976, but not during the second round in 1978. The second consultation document (1) made several proposals which clearly would have been of benefit to patients wishing to complain against GPs, dentists, chemists and opticians — but immediately came under heavy fire from the professions (2).

Since mid-1979 the Department's story has been that a decision was being deferred so that the views of the Royal Commission on the NHS could be taken into account. But once the commission had announced that the 1978 document's proposals "should go a long way to meeting the criticisms of the existing system" this position became untenable.

Now the DHSS says it will proceed only with "a number of proposals for relatively minor changes which have either commanded the support of all the bodies involved in the review or are of a technical or uncontroversial nature". Details will be announced later.

1. Family practitioner services: Review of service committee procedure, DHSS 1978.
2. See CHC NEWS 36 page three.

One in the eye from Doctor Vaughan

The Government is to investigate the optical manufacturing industry, following persistent complaints in recent years about overcharging and poor quality frames. Health Minister Dr Gerard Vaughan has announced that "In far too many cases the price of glasses in the UK is too high and the quality of frames is too low. This position is clearly unsatisfactory, and the Government is looking into it urgently with a view to securing changes". Working in conjunction with the industry, Dr Vaughan hopes to improve the quality of NHS spectacles.

As long ago as 1976 a report from the Price Commission noted that an element of "charging what the market will bear" often enters into opticians' calculations, and called for "more competition, less reticence about prices, and a more rational and more open system of pricing" (*Prices of private spectacles and contact lenses*, HMSO 1976).

Consultation corner

It's an up-and-down period for CHCs in their attempts to ensure adequate consultation on matters of national policy. On the credit side, pressure from the Association of CHCs has persuaded the Medicines Division of the DHSS to agree to consult the association about "questions of general policy arising under the Medicines Act in which the NHS patient has an interest".

The division's previous policy, based on

Patrick Jenkin's view that CHCs should "concern themselves with local interests in the health services in their immediate area", was that CHCs should not be consulted routinely. ACHCEW's argument that CHCs also need to be consulted when only a national solution will solve a local problem brought the response that the division has "no wish to be difficult or niggardly about consultation", and it now says it will "aim to be liberal" in deciding what to consult ACHCEW about.

Central Birmingham CHC has taken the DHSS to task for issuing its views on *Prevention in the child health services* as a Departmental paper rather than a circular (see CHC NEWS 55 page one). Says the DHSS: "The present Government in accordance with its policy of reducing the numbers of communications with field authorities, decided that guidance should not be issued but that the paper should be made available to those who are interested". Central Birmingham, backed by ACHCEW, is pressing for the paper to be re-issued as a circular, because CHCs were originally consulted about it on that basis and "unless it has 'circular' status there is no obligation on anyone in the service to take the slightest bit of notice".

On the debit side, ACHCEW's complaints about the circulation of the consultative paper *The future pattern of hospital provision in England* — only one copy of which was sent to each CHC — seem to have fallen on fairly deaf ears. The DHSS view is that "Because the

Continued on next page

Health News

Continued from previous page
consultative paper was a small typescript document, recipients were invited to photocopy it as many times as they required for their own use. The alternative would have been to publish the paper through HMSO, in which case, for reasons of cost, the initial distribution would have been strictly limited and all additional copies would have had to be purchased from HMSO at a price much greater than that of a photocopy.

Hospital noises

Much of the noise in hospitals at night could be controlled — if staff were made aware of how noisy they can be. Heavy footsteps, loud talking and clattering equipment all disturb patients' sleep. An article in *Nursing Times* (31 July 1980, page 1363), says that noise levels in hospitals have increased over recent years, mainly because of more intensive treatment and increased use of equipment. The study compares noise levels in wards of different designs.

Patients to keep their own records?

The idea of patients looking after their medical records themselves has been put forward by the Professor of General Practice at Manchester University. In the *Journal of the Royal College of General Practitioners* (July 1980, p420) Professor Metcalfe points out that often patients' records are unavailable to GPs because in many surgeries about 10% of records cannot be found, and most doctors do not take records on home visits, let alone out of hours calls. If the patient kept the record this would not happen.

The suggestion that patients would lose

their records is dismissed, because "patients who are given responsibility act responsibly". Nor does the professor fear that patients would learn facts which would upset them — instead an informed "sharing" of information would take place between doctor and patient.

Calling all access groups

A national network of local access groups for the disabled is being planned by RADAR — the Royal Association for Disability and Rehabilitation. As a first step it wants to locate such groups and find out what assistance they need. If you know of a local access group please contact John Stanford, Housing/Access Officer, RADAR, 25 Mortimer Street, London W1N 8AB. Tel: 01-637 5400.

Kidney Donor

Other Donor

I would like to help someone to live after my death

This multi-organ donor card is now available from the DHSS. On the reverse, donors can indicate that after their death their kidneys, eyes, heart, liver, pituitary gland or pancreas may be used for medical purposes. Circular HN(FP)(80)23 asks Family Practitioner Committees to send cards to GPs, and to send order forms to local chemists. AHAs have been asked to display the cards in "suitable hospital areas". Further supplies are available from DHSS (Leaflets), PO Box 21, Stanmore

Happy families?

Family life has changed immensely over the last hundred years. A new discussion paper from the Study Commission on the Family entitled *Happy Families** describes demographic and social changes, discusses what is happening to the family now, and raises issues which affect its future.

The commission, an independent body funded by the Leverhulme Trust, is hoping that its paper will stimulate written responses from individuals and organisations with an interest in the family, and says that CHCs might like to comment on such issues as health and the family and care of the elderly.

*£1.80 inc post from the Study Commission on the Family, 231 Baker Street, London NW1 6XL Tel: 01-486 8212.

Better-value season tickets

Prescription "season tickets" — officially known as prepayment certificates — will become even better value when the prescription charge increases to £1 in December. A single prescription will then cost 43% more, but the annual and four-monthly season tickets will only cost 25% and 22% more respectively. The annual certificate will increase in cost from £12 to £15, and the four-monthly certificate from £4.50 to £5.50.

Anyone needing more than 15 prescription items in a year, or more than five over four months, will save money with a season ticket. Tickets bought at pre-December prices will remain valid for their full period. Applications must be made on form FP95, but applicants should first check leaflets M11 and FP91 to make sure they cannot get prescriptions free.

INVEST IN THE FUTURE

Continued from page one
substantially carried. Swansea/Lliw Valley CHC called on the Secretary of State to allow the NHS Ombudsman to investigate complaints involving clinical judgement, and North West Herts CHC urged the DHSS to produce improved complaints procedures. South Warwickshire and Southend CHCs proposed that Family Practitioner Committees should be legally obliged to consult CHCs before approving changes such as branch surgery closures. On dentistry, Crewe CHC proposed a change in the law "to allow the public to assume that they are accepted as NHS patients unless the dentist specifically indicates otherwise".

Ealing CHC suggested that the Government should set up a special scheme to assist the NHS in deprived communities, along the lines of urban aid and educational priority areas, but the meeting rejected this idea — partly because some delegates felt that special treatment for "pockets of deprivation" would amount to abandoning the RAWP formula for the re-allocation of NHS resources.

Another motion perhaps surprisingly rejected was Maidstone CHC's suggestion the ACHCEW "put pressure upon the Department of Education to include health education as a compulsory school curriculum subject, in both junior and secondary schools". Some delegates were concerned about the problems of sex education in schools, but most were probably deterred by the awkward fact that at present there are no compulsory school subjects in Britain except religious education.

The AGM voted for: a "substantial increase" in the death grant; proper funding for services provided under the Chronically Sick and Disabled Persons Act 1970; better arrangements for the discharge of elderly people from hospital; exemption from prescription charges for everyone "suffering from chronic physical and mental illnesses"; and a review of the present arrangements for joint planning and funding.

The temperature rose slightly when a proposal to increase ACHCEW's annual

subscription from £150 to £250 was debated. Delegates suggested that ACHCEW could find cheaper office accommodation outside London, and that membership of the association would drop if the sub was increased. Other argued that a London HQ makes it easier to keep in touch with the DHSS and other national bodies, and that a move out of London would make ACHCEW less accessible for many CHCs. Chairman Rod Griffiths added that the Government has advised RHAs to add the cost of the ACHCEW subscription onto CHCs' annual budgets, so member CHCs should not lose any money because of the increase. Eventually the £250 sub was approved 148-21.

Rod Griffiths, Dan Merlin Thomas and Eric Thomas were all re-elected unopposed, as ACHCEW's chairman, vice-chairman and treasurer respectively. The two-day AGM considered 28 motions in all, and finished with time to spare. Next year's meeting will be in Aberystwyth on 18-19 September, and from now on only one AGM in four will be held in London.

When is medical research unethical?

Medical research is vital both for discovering new methods of treatment and for preventing problems that such methods may cause. Research benefits everyone, yet the work must often be done on patients who may already be feeling ill, in pain, anxious and scared.

Research on children poses extra dilemmas. When the treatment for leukaemia has caused a child's hair to fall out, her mouth is too sore for her to eat, and she screams at the sight of a white coat, her parents may well feel reluctant to agree on her behalf to yet another type of experimental drug treatment or yet another blood test.

The law lays down a minimum code to protect patients from professional neglect or assault. Beyond that much is left to each doctor's goodwill and good judgement. Patients' consent should be "fully informed and freely given", but this rarely happens in practice. Lay people often feel obliged to consent and are bewildered by the complexities of research. Doctors feel reluctant to frighten patients with too much explanation and they are often not trained in how to talk and listen to patients.

Research falls broadly into two kinds—therapeutic (of direct benefit to the patient) and non-therapeutic (of general potential benefit to other patients or adding to basic knowledge). It used to be the case that in the strict view of the law parents could not give consent on their child's behalf to any procedures which were of no direct benefit and which entailed some risk of harm (1). But in 1975 a DHSS circular endorsed a recommendation by a working party of the Royal College of Physicians, which stated that "clinical research investigation of children or mentally handicapped adults which is not of direct benefit to the patient should be conducted, but only when the procedures entail negligible risk or discomfort and subject to the

provisions of any common and statute laws prevailing at the time". The circular warns that parental consent in these circumstances still does not bring the research within the law as it now stands (2).

Each health district has an ethical committee. The committee's task is to safeguard patients and the reputation of the medical profession in research projects. Most of the members are doctors with research experience and there is also a lay member. The committee considers the ethical issues involved in proposed research projects. The DHSS circular asks health authorities to consider choosing a CHC member to be the lay person. Before approving local medical research the

with a nurse, a scientist and two administrators who may not vote. An average of 75 projects are submitted each year. At its monthly meetings the committee examines each project carefully, looking at the objectives, design, numbers of subjects and controls, the tests and the degree of discomfort likely to be experienced.

The ideal consent form has been described as having six items, which explain: the purpose of research, the procedures, the risks, the benefits, the subjects' right to withdraw at any time and an invitation to ask questions (3). Consent forms are usually only used for major procedures. There is a vague area of implied or assumed consent — for example, lifting

painful it is, the more directly beneficial the research should be to that child.

The guidelines state that, "Although the law in Britain does not recognise an 'age of consent', children much younger than 16 often have enough understanding to collaborate altruistically in a project". The BPA considers that "Parental or guardian's permission should normally be obtained — with rare exceptions such as the comparison of two treatments for some emergency condition — after explaining as fully as possible the nature of the procedure ... It is an advantage if the parents can be present during the procedure."

The National Association for the Welfare of Children in Hospital (NAWCH) has welcomed the BPA guidelines. We think more attention should be given to the problems of explaining research to parents and to the parents' need for unhurried, informal talks with someone informed but not necessarily involved in the project, such as a nurse or a social worker. This kind of work is left to the family doctor or health visitor, but they may be far from the hospital, especially when seriously ill children travel to the regional centres.

NAWCH would like to see a wider use of consent forms, which should include a section with an even firmer emphasis on the child's need for the parents' presence than is conveyed by the BPA's acknowledgement that having the parents present is an "advantage".

CHCs could do much to assist patients involved in research. They could ensure that there is a layperson on each ethical committee who is experienced in persuading professionals to appreciate the patients' point of view.

References

- 1 Report of the Medical Research Council for 1962-63 (Cmd 2382)
- 2 Supervision of the ethics of clinical research investigations and fetal research HSC (IS) 153
- 3 Gray, Cooke and Tannenbaum, *Science* 1978 201, 1094.
- 4 Guidelines to aid ethical committees considering research involving children, British Paediatric Association 1979.

by Priscilla Alderson*

committee checks that the projects are well-founded scientifically, statistically and ethically.

The Court Committee on services for children said that when research involved children "ethical committees should scrutinise such proposals with special care and will normally require the advice of experts in obstetrics or paediatrics if these specialties are not represented on the committee". The Medical Research Council said paediatric research "must be submitted to the highest ethical scrutiny and self-discipline". Yet there is no legal force to this advice. The worst that researchers who bypass ethical committees can be threatened with is that the committee may alert the editors of research journals and request them not to publish the work.

An article in the *British Medical Journal* last year (27 October 1979, page 1042) described an ethical committee in Harrow health district, which contains the Medical Research Council's establishment at Northwick Park Hospital. The committee has 16 people, 11 doctors and one layperson who may vote,

the arm ready for an injection is a form of consent. Agreement that the patient's consent was free and informed is more important at law than the signed piece of paper.

The British Paediatric Association's publication *Guidelines to aid ethical committees considering research involving children* is based on the acceptance of four principles:

- 1 That research involving children is important and should be supported and encouraged and conducted in an ethical manner.
- 2 That research should never be done on children if the same investigation could be done on adults.
- 3 That research which involves a child and is of no benefit to that child is not necessarily either unethical or illegal.
- 4 That the degree of benefit resulting from research should be assessed in relation to the risk of disturbance, discomfort or pain.

Much of the guidelines describes and balances this risk/benefit ratio (4). Risk may be negligible, minimal or more than minimal, and benefit therapeutic or non-therapeutic. The more risky or

*Priscilla Alderson is the Chairman of the National Association for the Welfare of Children in Hospital, and until recently was a member of Tunbridge Wells CHC.

The Government has dismissed a major report on the state of the nation's health*. The report's authors were so alarmed that their 400-page report was not going to be drawn to the attention of the national press that it took the very unusual step of holding an unofficial press conference to publicise it and to counter Secretary of State Patrick Jenkin's statement that the report's proposals would cost too much.

The working group which produced the report was chaired by Sir Douglas Black, president of the Royal College of Physicians and former chief scientist at the DHSS. It calls for a wide range of new policies in several government departments — all aimed at reducing the stark inequalities in health between different social classes in Britain.

Patrick Jenkin has said that to implement the recommendations is unrealistic "in any foreseeable economic circumstances". Some of the recommendations go directly against the grain of present government policy.

The report examines the rates of ill-health and death according to social class and it

THE COST OF CLASS

population into five groups. They are class I: professionals such as lawyers, accountants, doctors; class II: managers, schoolteachers, nurses; class III: secretaries, shop assistants, butchers, carpenters; class IV: agricultural workers, postmen, bus conductors; class V: labourers, cleaners, dockers. Married women who do not give an occupation of their own are classified by their husbands' occupation.

There are marked differences — at all ages — in the mortality rates of social classes.

"At birth and in the first month of life, twice as many babies of 'unskilled manual'

old, class differences in the infant mortality rate have been increasing. Indeed class inequality is especially alarming in children's health. For example accidents now account for one third of all deaths among children. But they are ten times more likely to kill class V children as their peers in class I.

The working group also found "worrying" class differences in the use of health services. The evidence on this is very complex — factors such as the higher rate of sickness combined with under-provision of services in working class areas demand cautious interpretation of the statistics. But Black firmly concludes that there is "severe under-utilization" by working class people of the preventive services such as screening, immunisation and family planning. The group also suggests that while working class people consult their GPs more frequently than middle class people, they may receive poorer care.

Causes are complex. The report stresses the importance of material conditions — housing, jobs, income — rather than explanations which are based on genetics or attitudes to health. Some aspects of inequality can be tackled fairly directly. It has been shown that better ante-natal care does help prevent perinatal deaths. The authors pinpoint early childhood as the period where intervention could have the greatest impact in breaking the link between class and health.

Thirty years of the Welfare State and the National Health Service have achieved little in reducing social inequalities in Britain

also looks at class inequalities in the use of available health services. The quality of statistical material is very variable and some of the factors which influence health are notoriously hard to quantify. The trends in inequality of health are also considered and international comparisons are made.

The best known indicator of health inequality is the *mortality rate* — it is used in the "RAWP" formula for allocating NHS resources. The most easily available measure of social class is that of *occupational class* — which tends to reflect other inequalities such as housing, education and financial resources. Occupational class is the measure used by the Registrar-General to divide the

parents (class V) die as do babies of professional class parents (class I)." Chronic sickness among adults is more than twice as high among unskilled manual workers as among professionals. If death rates in classes IV and V had been as low as those in class I, then in 1970-72, 74,000 people under the age of 75 would not have lost their lives. This figure, which is based on the latest statistics available, includes 10,000 children.

To some extent the health experience of people of all ages in the unskilled and semi-skilled manual classes (IV and V) has actually deteriorated, compared to that of the professional classes. Despite the general decline in deaths to babies under one year

Book reviews

Introduction to psychotherapy

by Dennis Brown and Jonathan Pedder, Tavistock, £3.25

The therapeutic community

edited by Elly Jansen, Croom Helm, £12.50 and £5.95 (paper)

The whole mind book

by Denise Winn, Fontana, £2.50

As the diagram to the right clearly shows, there is now a whole thicket of therapies to puzzle the newcomer in the confusing field of psychotherapy. Many readers will have heard of Freud and Jung, but other names on the chart will be less familiar. Provided the bewildered

newcomer is just a seeker after truth then perhaps no great harm has been done, but if he or she is someone in urgent need of help with deeply personal problems, that is a much more serious matter. In such a case *Introduction to psychotherapy* would be valuable — a book written by two psychotherapists in simple, fairly jargon-free language, giving clear explanations of the various therapies available today, how they evolved, and what basic principles they share.

What is psychotherapy anyway? The book's authors say it is "the use of personal relationships to help people in trouble". It is a sort of conversation, but "it is not a superficial chat and does not seek quick, temporary relief by reassurance and suggestion. It

involves talking honestly and with increasing familiarity and intimacy, between people who are equally committed to understanding the sufferer and his problems, with the aim of bringing about change".

The underlying assumption is that "the personality, like the body, has a natural tendency towards healing and growth", so that these will occur if only the right conditions for them can be created. Psychotherapy "is much more than doing clever detective work, fishing around in the unconscious and making shocking revelations. It must involve the establishment of a working alliance in which trust, talk and understanding help a person to accept the hitherto unacceptable".

Useful chapters deal with group psychotherapy — the form of therapy most generally

available on the NHS — family and marital therapy, therapeutic communities (alias "social therapy"), encounter groups, and the whole gamut of newer but potentially very valuable approaches such as Gestalt therapy, bioenergetics, psychodrama and primal therapy. The book ends with a discussion of the factors which should be considered when trying to decide what type of therapy might best suit a particular patient.

The therapeutic community takes a much deeper look at "social therapy" in practice, with 25 articles examining the role of the "halfway house" in providing non-medical care in the community for mentally ill people. Edited by the director of the Richmond Fellowship, it draws on the fellowship's work for many of its examples. The

The report makes 37 recommendations and has three main policy objectives:

- To give children a better start in life.
- To encourage good health among a larger proportion of the population by preventive and educational action.
- For disabled people, to reduce the risks of early death, to improve the quality of life whether in the community or in institutions and as far as possible to reduce the need for the latter.

The working group calls for child benefit to be increased at once from £4 to £5.70 and to be maintained at 5½% of gross male industrial earnings. It wants higher child benefits for older children to be introduced, and the maternity grant (now £25) to go up to £100.

It also urges the establishment of a new *infant care allowance* over a five year period. The provision of school meals should be a duty for local authorities. Urgent steps should be taken to reduce accidents to children at home and on the roads.

The report wants the Government to spend £30 million in 10 experimental areas, carefully selected for their high mortality rates and adverse social conditions. These areas would be very carefully monitored. Within them there would be free milk for children, special measures to increase attendance at ante-natal clinics and adequate day-care and nursery school provision for the under-fives.

Above all, we consider that the abolition of child poverty should be adopted as a national goal for the 1980s

A much sharper shift of health and personal social service resources into "community care" is called for, with a much more clear cut definition of what that well-worn phrase really means. The report recommends "that the resources to be allocated should be based on the future planned share for different services", rather

than on existing spending patterns. In other words, closer integration between stated priorities, planning, and the way the cash is actually handed out.

Government is called on to do more to encourage positive health. It's no good telling people in the inner cities that exercise is a Good Thing if they have nowhere to run

The monitoring of ill-health should evolve into a system also of monitoring health in relation to social and environmental conditions

about. The working group wants the Government to set national goals for health. It calls for an end to virtually all tobacco advertising, an increase in the tax on cigarettes and for the tobacco industry to submit plans to do itself out of business over a period of ten years. Measures to prevent alcoholism are also required. Ante-natal screening for Down's syndrome and spina bifida should be more widely available as should screening for severe hypertension in adults. The report is silent about fluoride.

In addition there should be an independent health development council and greater co-ordination between government departments to ensure coherent national policies for reducing health inequalities.

Measures to help the disabled and elderly should include: a comprehensive disablement allowance, special funding, like

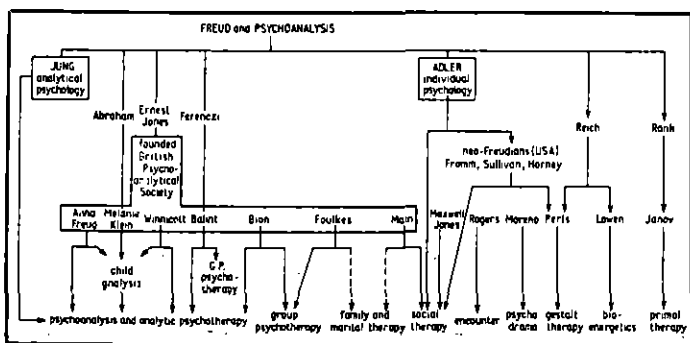
conference Sir Douglas Black gently chided the Secretary of State for conjuring up an astronomical bill which assumes that all these measures have to be paid for *at once*, and from additional resources. Many of the recommendations could be paid for out of existing funds, by shifting the balance of resources, or by administrative action.

The school population is declining — the money saved could provide better services for children under school age. The married man's tax allowance for childless couples could be abolished and the money spent on improving child benefits. Better care in the community will create savings on the bill for hospitals. All these suggestions are in the report.

Few Governments are keen to welcome reports initiated by their predecessors in office. This working group was set up by David Ennals, then Secretary of State for Social Services in 1977. Sir Douglas and his colleagues, Peter Townsend, Professor of Sociology at Essex University, J N Morris, Professor of Community Health at London University, and Dr Cyril Smith, Secretary of the Social Science Research Council, responded gloomily to the news of unemployment over the two million mark, with predictions that unemployment would only sharpen health inequality and increase the need for the measures they advocate. But it seems that no-one in the Government is willing to listen.

Inequalities in health: report of a research working group. DHSS, 1980.

Copies are available from the Policy and Planning Unit, Room D403, DHSS, Alexander Fleming House, Elephant and Castle, London SE1 (£8 plus 50p post).



section on politics and planning is particularly interesting, frankly admitting the dangers of community care policies when implemented with insufficient funding.

But if — like me — you find that no amount of study will overcome your tendency to go mentally blank at the drop of a concept, perhaps *The whole mind book* is the answer. In dictionary form this is "an

enjoyable canter from A-Z through all things psychological". Using simple language it goes from "abreaction" to "zen", explaining androgyny, co-counselling, depression, obsession, psychopath, Rolfing, stammering and transcendental meditation on the way. Each time I've used it I've learnt something new.

Dave Bradney

The social context of dentistry

by Peter Davis, Croom Helm, £10.95

Dental caries, it is said, is the first disease of civilisation because of its long-recognised relationship to the affluence of society. In the more advanced industrial societies a full dental care programme costs up to 10% of total health costs. It is estimated that employment of one dental hygienist can reduce by half the incidence of caries for 2,000 children at a fraction of the cost of the fillings needed if the caries develops.

This book traces the practice of dentistry from its origins when travelling tradesmen drew teeth as a sideline to its present place in society as a highly respected, clinically sophisticated profession. The reader is led through chapters

on the development of the manpower structure in dentistry, the relationship of the State and the British social class system to the profession, and also the influence of personal lifestyle and culture including diet on disease of teeth and gums. The fluoridation of water supplies and salt supplies is briefly discussed.

In conclusion the reader feels that the profession has changed little in principle — remaining an individual service given by each dental practitioner to his patient and being largely untouched by organisation on a national scale. I feel the book would be interesting to those CHCs involved in dental health education programmes or those with an interest in primary care.

Fiona Drake, SE Cumbria CHC.

National Development Group for the Mentally Handicapped

According to the NDG many health and local authorities have now begun to develop better services for the mentally handicapped, "but there is now a real danger that we shall be returning to levels of provision which we thought had been left behind many years ago."

There is "decidedly alarming" evidence about the impact of Government spending cuts on mentally handicapped people and their families. The report speaks of buildings standing empty because the money to staff them cannot be found, and places where social work support for the families of mentally handicapped people has been withdrawn except for emergencies.

The social education centres (better known as adult training centres) are now full, and plans to extend them and build new centres are being shelved. In most cases mentally handicapped school-leavers are no longer being admitted, and unless "special needs" units for these young people can be provided using joint finance they will just have to stay at home without services or go into a long-stay mental handicap hospital. Some older mentally handicapped people are being "forced out" of SECs because of pressure to admit younger people in urgent cases.

Parents of mentally handicapped young adults and adolescents are now faced with having to look after their children indefinitely, without social work support and with no chance of short-term care to take the strain off the family now and again.

Progress in discharging people from long-stay mental handicap hospitals has been insignificant when compared with the targets set in 1971 by the White Paper *Better services for the mentally handicapped* (HMSO, Cmd. 4683). "By doing nothing, the Government is in effect condemning many thousands of people to spend the rest of their lives in hospital". The NDG is particularly scathing on the subject of mentally handicapped children in hospital: "We were initially hopeful that our advocacy of better children's services would meet with some success in the DHSS. But after more than five years, we have come to the conclusion that the DHSS is years behind field authorities in its thinking. The 1971 White Paper grossly overestimated the number of hospital places that would be required for children and the DHSS has progressed at a snail's pace in recognising the changes in the attitudes both of parents and of staff providing services for children".

TWO CRITICAL REPORTS

The NDG recommends that the DHSS should investigate ways of encouraging a transfer from the present pattern of services to one that is locally based, including a close look at how to release "resources which are at present tied up in outdated services". In a climate of cuts the "ear-marking" of central government funds is essential if the priority given to the mentally handicapped is to increase, but in the short-term health authorities "may have to assume a greater

responsibility for developing facilities in the community which local authorities could take over at a later date".

Regional and Area Health Authorities should draw up strategic plans setting year-by-year targets for the transfer of mentally handicapped people out of hospital into the community.

Many mentally handicapped adults now in hospital could live in ordinary houses, some of which would not need residential staff.

Some housing associations are working well with health and social services authorities in this field, but much more needs to be done. "Too many people still work on the assumption that mentally handicapped people will all sooner or later need to live in hospitals, or at best in highly staffed hostels".

The DHSS should provide "leadership and firm backing" to help re-locate as many as possible of the 3000 mentally handicapped children still left in hospitals. Says the NDG: "We simply do not accept that the country cannot find the resources to provide better services to the five or six children involved per 100,000 population".

There should be a much greater commitment to staff training, and in particular the staff of the social education centres (ATCs) "have not received the consideration which they deserve". In three or four years there will be more mentally handicapped adults in SECs than in hospitals, and the SECs "represent the core of community services for mentally handicapped adults".

Personal Social Services Council

Local authorities provide crucial services for the priority groups — the physically and mentally handicapped, the mentally ill, the elderly and children. Yet last November a Government White Paper (Cmd. 7746) announced a cut of nearly 7% in spending on personal social services for this year, on top of smaller cuts announced in June and July of 1979.

The PSSC collected information on 100 of the 116 social services departments in England and Wales. Of the 100 it found that 79 have had to make cuts in services or increase charges with direct effects on service provision. Most Labour authorities have made cuts, but conversely very few Conservative authorities have wielded the axe as energetically as the Government wished. On average, authorities cut back 2-3% last year and are cutting a further 2-3% this — though another round of cuts may come later this financial year.

The reports lists how savings are being made: children's homes and day nurseries are closing, and fostering and boarding out services are being reduced; old people's homes are closing, plans for new day centres are being deferred, home help services and meals on wheels are being reduced and aids and adaptations are being cut; residential services for physically handicapped people are being cut and clubs, day centres and sheltered workshops are a major source of savings; residential care for mentally handicapped people is being cut and the work of adult training centres is being curtailed; homes and hostels for mentally ill people are being closed or deferred and day care for the mentally ill is being cut back.

Charges are being introduced — or increased — at day centres, day nurseries and playgroups, and for home help, meals, transport and aids and appliances. Increased charges, says the report, "may help to maintain services in the short-term, but they can result in a rapid drop in use, as is most evident in

the case of the school meals service ... One likely outcome is that pressure on the health service and education, which provide some equivalent services at no charge, will increase".

A common strategy has been to defer or abandon new schemes, in preference to cutting existing provision. This is easier in practice, and is often also politically more acceptable — though it hits hardest at priority groups whose numbers are rising or who are suffering from past under-provision. It also "provides strong counter-evidence for the notion that cuts will foster a creative response to need. Innovative developments are likely to be more easily cut than traditional services. Many of the schemes deferred or lost might have resulted in ultimate savings by assisting the shift from costly residential and hospital care towards community care and prevention. Deferring the rationalisation of services because of immediate costs is also likely to increase waste and inhibit long-term savings".

Bitter criticism of the Government's policies for the health and personal social services has begun to surface in official and semi-official reports over the last few months. One focus of dissent has been the House of Commons Social Services Committee, which recently criticised the DHSS for its "apparent lack of strategic policy-making" (see CHC NEWS 58 page three).

But even more telling, paradoxically, are the two critiques which have been published because of the Government's decision to axe two of its main advisory bodies — the National Development Group for the Mentally Handicapped and the Personal Social Services Council. Had these quangos been allowed to continue, it is arguable that such strong and authoritative criticisms might never have seen the light of day.

Here we look in detail at the NDG's final report, and at a report prepared by former staff of the PSSC.

- **Services for mentally handicapped people:** *Unfinished business* can be obtained by sending 25p to Professor Peter Mittler, Hester Adrian Research Centre, Manchester University, Manchester M13 9PL.
- **Cuts in local authority spending on personal social services costs £1 from the Social Priorities Alliance, 26 Bedford Square, London WC1.**



A question of cash

All these arguments boil down to a disagreement about how to allocate the nation's resources, and it is interesting to compare the various views on this:

Patrick Jenkin, in a speech last October, made it clear that "Reductions in public spending plans are an essential part of the strategy for economic recovery, and... this Government came into office with a clear mandate to do this".

He later acknowledged that the effect of such "massive" cuts would be "sharp and

uncomfortable".

Responding to the NDG report, in a letter to the group's chairman Professor Peter Mittler, Mr Jenkin claimed that the situation is "not quite as gloomy" as the NDG believes, "but it has to be accepted that the rate of progress may be affected by the present economic situation, and that our ability to secure improvements depends to a large extent on the success of our policies to revive the wealth-creating sector of the economy".

The NDG's view is that cuts in services "are not only unacceptable in themselves but are also economically questionable ... Cutting back on community services will only make increased demands on the NHS, both because more people will need to go into long-term hospital care and because the physical and mental health of parents and other members of the family will suffer ... It is not good enough to say that we must wait for better times; mentally handicapped people have waited quite long enough already".

The former PSSC staff argue that "the implication that the options can be reduced to a straight choice between cutting social services or economic disaster is false. The strategy allows for growth in defence and law and order, and for far more modest cuts in other services, notably health. It is quite unreasonable that the personal social services should be given almost the lowest priority".

Healthline

Getting the best from capital spending

We are trying to trace a DHSS discussion document about capital investment in the NHS, issued last year. Do you know what this is, and can you tell us a bit about it?

This sounds like *Review of health capital: A discussion document on the role of capital in the provision of health services*, sent by the DHSS to regions and areas in October 1979. It looks at the history of capital investment in the NHS, the present state of the hospital stock, the need for flexibility in organising services and balancing capital against revenue spending, and the possibility of applying the technique of *investment appraisal* to NHS capital spending. This technique presents options "in a way that allows the full range of costs and benefits to be seen clearly, unobscured by technical complexities", and would "provide the means for consultation both between professions within the NHS and between NHS authorities and other bodies such as local authorities, CHCs and the public". Copies of the review are available from Jonathan Tross, Room D403, Alexander

Fleming House, Elephant and Castle, London SE1.

Postgraduate teaching hospitals

Can CHCs in London help with complaints about postgraduate teaching hospitals?

London's twelve specialist postgraduate teaching hospitals are each managed by their own board of governors, not by the area health authorities. Their patients can seek the advice and assistance of CHCs in the same way as other NHS patients, but CHCs have no statutory relationship with local boards of governors and so have no formal rights. The consultative document *Future management of the London specialist postgraduate hospitals* (DHSS 1978) said that the Secretary of State "regards it as desirable to establish a relationship with CHCs and he intends to issue guidance to that end".

Publications on mental handicap

What reports and pamphlets did the National Development Group for the Mentally Handicapped produce, and how can I get hold of them? Before it was axed by the Government the NDG

produced five very useful pamphlets, and copies of these are still available free of charge from the DHSS, Room C411, Alexander Fleming House, London SE1 6BY:

Pamphlet Number 1. *Mental handicap: Planning together* (July 1976).

No. 2. *Mentally handicapped children: A plan for action* (March 1977).

No. 3. *Helping mentally handicapped school leavers* (May 1977).

No. 4. *Residential short-term care for mentally handicapped people: Suggestions for action* (May 1977).

No. 5. *Day services for mentally handicapped adults* (July 1977).

In October 1978 the NDG also produced a report entitled *Helping mentally handicapped people in hospital*, and in September 1979 two chapters of this report were reprinted as a booklet called *Creating a learning environment*. Both are available free from the DHSS Store, Scholefield Mill, Brunswick Street, Nelson, Lancs.

For details of the NDG's final and highly critical report *Services for mentally handicapped people: Unfinished business*, see page eight of this issue.

CHCs in print

On this page in August we gave details of CHCs which have published newsletters, guides to local health services and leaflets about particular aspects of the NHS. Here is some additional information:

Guides to local NHS services (general information)

Cheshire CHCs (pack of six leaflets)
Walsall

Guides to local services for special groups of NHS users
Harrogate (mental handicap)
Vale of Glamorgan (access guide for the handicapped)

CHC newsletters

West Berkshire
Bexley
Islington
King's

Leaflets about particular aspects of the NHS
Brent (GP services)

The Healthline column publishes selected items from the work of our information service. This service is for CHC members and staff and for others interested in the NHS and the work of CHCs. To contact the information service, write to or ring CHC NEWS, 362 Euston Road, London NW1 3BL (Tel: 01-388 4943).

Your letters

Continued from page two

pointless if their ability to make their contribution in this way was removed. Mrs Lark, and several thousands of others, feel this very strongly — she has merely stated a very sensible practical reason to support her own personal view of life and death. The idea that it is necessary or desirable to continue to live as long as possible, in any condition, whether life is pleasurable or useful to its owner or not, is a most foolish philosophy. It is certainly very cruel and wicked for society to *compel* anyone to live beyond their desire to do so. Of course, it must always be a matter of choice — but the choice should be legally available.

Mrs Gladys Withers, 59 Edgetfield Avenue, Upney, Barking, Essex.

May I suggest that the readers who replied to Mrs Lark read her letter again. She is not, if I understand her correctly, suggesting the legalisation of voluntary euthanasia to assist the NHS, but is saying that making it possible for those of us who *wish to choose* euthanasia when life has become intolerable through incurable disease would automatically ease the pressure on the NHS.

I too am elderly, and when I can no longer care for myself the knowledge that I

could request euthanasia and have my wishes respected would be a tremendous relief.

I have for some years now been a member of the Voluntary Euthanasia Society (now known as Exit) and it is encouraging to know that it is doing its utmost to promote the necessary adjustment to the law. The thought of being cared for by my family, community or state, absolutely terrifies me, but for those who are brave enough to face up to such an existence, I hope there will always be an abundance of care.

Lastly, may I point out that Mrs Lark does not plead that Christian ethics be ignored, only that *outdated* Christian ethics should not be allowed to cloud the issue.

Mrs D Munday, 23 Buckfast Avenue, Kirby Cross, Frinton-on-Sea, Essex
Replies to Mrs Lark's letter ignore the word "voluntary" and its meaning. When any person is beyond recovery, if they request an ending to life or have signed a declaration to this effect at a prior date, it should be possible to implement their wishes as a statutory right.

Hospice provision for all will take years to achieve (meanwhile thousands continue to suffer), and in any case should be only for

those who desire this way of treatment.

Freedom to endure a lingering suffering until death is ours — freedom to have a quick peaceful end is not. Dictatorship of our choice, by religion or parliament, is unpardonable. Are we humans to continue to be treated in a less humane way than our friends the animals when we reach our ebb?

● *Ed: This correspondence is now closed.*

Medical audit

Dr Rod Griffiths, Member, Central Birmingham CHC

I have been asked to speak at a meeting next year on medical audit (ie when the work of individual doctors is reviewed by themselves, their colleagues or an outside body according to certain indicators — eg cost, patient satisfaction, speed of patients' return to normal life). The general title is "monitoring practice and learning from mistakes". I would be very interested to hear from any CHCs or individuals who have done work or have views on medical audit.

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.

What is Warnock worth now?

by Jean Davis, Chairman, North Camden CHC

Just before Parliament broke up for the summer holidays, the Government published its long awaited 'White Paper on education for handicapped children'. The document sets out the Government's intention to replace the current system of categories of special education — laid down by the 1944 Education Act — with the framework proposed by the Warnock Committee in its report, *Special educational needs*².

Handicapped children will no longer be slotted into special schools according to which statutory categorisation of disability can be fitted to them. Children will be assessed according to their degree of learning difficulty and their individual educational needs.

The Government accepts in principle the idea that handicapped children should have the chance to go to ordinary schools, though its White Paper qualifies this acceptance with escape clauses about what is "reasonable and practicable". There is also a strengthening of parental rights. These are important changes which will be widely welcomed. But earlier in the year the Secretary of State for Education and Science, Mark Carlsle made it clear that some of the Warnock recommendations have "major implications for central and local government expenditure". Such recommendations, he implied, are not likely to be implemented under present conditions.

So how far does the Government's commitment to Warnock go? Let us look for a moment at the background to the Warnock Committee's proposals.

The underlying philosophy of the report is summed up in the idea of *special educational need*, "seen not in terms of a particular disability which the child is judged to have, but in relation to everything about him, his abilities as well as his disabilities". The extent of childhood handicap is conceived as far greater than is allowed for in the present system of special education. According to the Warnock Report, *at any time one child in six is likely to need some form of special educational provision, and up to one in five will need such provision at*

some time during their school life. The report therefore recommended that the planning services for children and young people should be based on estimates of that order — that 15-20% of the child population will need special educational provision.

The core problem outlined in the report is that a very large proportion of the child population needs or is likely to need some form of special educational provision because of physical, mental and social handicaps. It has to be stressed too that children with recognised physical and mental handicaps, and those whose problems have a mainly social background do not fall into distinct and separate groups.

The range of problems encountered in children with learning difficulties is far wider than can be covered by or compressed into the existing system of statutory categorisation of handicapped children in the schools. The committee therefore recommended as one of its main proposals that this categorisation (according to the Handicapped Pupils and Special School Regulations 1959) should be abolished, and with it the sharp distinction between "handicapped" and "normal" children.

There are 29 pages of recommendations at the end of

the Warnock Report and only some of the most important can be mentioned here.

First, the whole issue of meeting special educational need was seen to depend on the establishment of the basic programme of health surveillance for all children recommended by the Court Report¹.



Secondly, a vital section of the report dealt with children under five. It recommended that the education of children with disabilities or "significant difficulties" should not be subject to any minimum age limit. It therefore urged a substantial increase in nursery education as the context within which special needs could be met. This sounds somewhat hollow today in view of the widespread cuts in nursery education.

The central section of the report covered the range of special educational provision,

which must be both "extensive and flexible".

The underlying principle is "... that children should be educated in a common setting as far as possible ... It follows that we whole-heartedly support the principle of the development of common provision for all children." The report thus proposed an acceleration of the present trend towards integrated education.

Warnock did however recognise that some children with particularly severe or complex difficulties may need facilities which cannot easily be provided within the ordinary schools. Far from recommending the abolition of special schools (as was alleged in some quarters when the report was published in 1978) it strongly supported the idea that they should provide resources of skill, experience and specialised equipment, as well as intensive short-term help for some children who may otherwise be attending ordinary schools.

The report singled out three sets of recommendations as priority areas for action. One was pre-school provision. Secondly the committee wanted to see improved services for handicapped people over 16. At present these youngsters are a badly neglected group. Thirdly, the report called for an extension of teacher training.

What is clearly evident is that Warnock's priorities demand the allocation of additional resources. And it is precisely in relation to these priority areas that the Secretary of State has indicated that the recommendations are not going to be fully implemented in the foreseeable future. Whatever the Government's commitment to the principles of the Warnock Report, the lack of Government cash means that the purpose of the Warnock Committee is only too likely to be frustrated.

Background to the Warnock Report

A committee of enquiry, chaired by Mary Warnock of St Hugh's College, Oxford, was set up in 1973 by Margaret Thatcher, then Secretary of State for Education and Science. Its report was published in May 1978.

The committee was required to review educational provision for children and young people with physical and mental handicaps. It was to make recommendations about the most effective use of resources for such provision. In considering what should be provided for children, it was to take account of the medical aspects of their needs, "together with arrangements to prepare them for entry into employment".

In 1979, 184,996 children in England and Wales were assessed as requiring special education within the framework of assessment laid down by the 1944 Education Act. This represents 1.8% of the school population.

1. *Special needs in education* Cmnd 7996, HMSO £1.75

2. *Special educational needs*. Report of the Warnock Committee, Cmnd 7212, HMSO 1978.

3. *Fit for the future*. Report of the Court Committee, Cmnd 6684, HMSO, 1976.

Go to hell, said the doctor

by *Pauline Phillips, Secretary, East Herts CHC*

Mr Y, a man in his thirties, has a history of kidney trouble. Early one evening in 1978 he became ill and was in great pain, so his wife rang the GP for a house call. It was refused. Later, his mother, who lived with them, rang the deputising service, fearing further kidney problems. A doctor called, examined a blood-stained urine sample, and left overnight medication, a prescription and a note for the GP. Next morning, Mr Y's wife went to the surgery, gave the receptionist the papers and told her the deputising doctor had suggested something be added to the prescription to reduce Mr Y's temperature. An item was added but the local chemist said it was a form of paracetamol suitable for a child.

Two days later — a Saturday — Mr Y was worse, and repeated attempts to get the GP to visit failed. His wife was told he must come to the surgery or call the deputising service. As, by this time, Mr Y's genital area was so inflamed that he could hardly walk, let alone dress, the latter course was the only option. A different deputising doctor came, said he was not sure what was wrong, and that Mr Y should have tests done in hospital which would, he said, be impossible over a weekend. He advised them to "hang on till Monday" using the existing medication and ask the GP to admit Mr Y then.

On Monday morning, Mrs Y rang the

surgery twice to ask for a visit and was twice refused. Mr Y's mother then rang and had an angry exchange with the GP who put the phone down on her. When she rang again, asking what to do the GP said "Go to hell". Mr Y's mother then dialled 999 and explained the situation to ambulance control who agreed to send an ambulance. The ambulance and the GP arrived almost simultaneously. After a confused few minutes the GP sent the ambulance away. He did not examine Mr Y and repeated that he should come to surgery. Mrs Y's mother then threw the GP out of the house and drove her son on a ten-mile "nightmare journey" to hospital. He was admitted as an emergency, delirious, with a temperature of 103 degrees.

Mr Y's mother initiated the complaint against the GP whilst her son was still in hospital. It was over two months before the FPC sent her the GP's comments which included allegations that she was bringing the complaint because she was mentally ill. He maintained that Mr Y was not complaining, despite the fact that he had endorsed a copy of his mother's letter at the request of the FPC. The GP further claimed that nothing in the deputising doctor's notes indicated the need for a house call, and accused Mrs Y senior of obstructive and aggressive behaviour. Eventually the FPC agreed to a service committee hearing, which took place six months after the original complaint.

At the hearing (which I attended as

patient's friend) the GP interrupted the proceedings at the outset demanding to bring in evidence matters relating to Mrs Y senior's past medical history. He also stated that his case would be conducted by another doctor, whom he had brought with him as his "friend", as Mrs Y senior was her patient. We were all asked to withdraw while these matters were considered.

After ten minutes we were recalled, and the GP was told that evidence of Mrs Y's past medical history was irrelevant, and that he must conduct his own case as Mr Y was his patient. Mr Y's wife, whom we called as witness, was harangued and bullied under "questioning" by the GP until he was reprimanded by the chairman. He was reprimanded again later for aggressive "questioning" of the complainant, for interrupting the proceedings, and for making speeches instead of answering questions from the committee. His evidence under questioning was so much in conflict with the complainant's that at one point he was asked whether he was saying that everyone was lying. He said yes. Both my complainant and her daughter-in-law stood up very well to this ordeal, which lasted over two hours. The committee found that the GP's written and oral evidence was unreliable, and that he was in breach of paragraph 13 of his terms of service (see *CHC NEWS* 53, page six). They recommended that £150 should be withheld from his fees.

He appealed to the Secretary of State and the case was re-heard by a DHSS tribunal eleven months after the original events. I presented the complainant's case at the tribunal and, five months later, we heard that the appeal had been dismissed and £200 deducted from the GP's fees.

This is the second in our occasional series of complaint cases dealt with by CHCs. See CHC NEWS 56 page five for the first one. CHC NEWS is interested to receive details of other cases for possible publication.

ECT

by *John Baker, Secretary, Portsmouth and South East Hampshire CHC*

Last year this CHC was presented with a petition by the Havant Vigil Group, a local organisation, asking us to support the group's call for an independent national enquiry into the use of *electroconvulsive therapy* (ECT).

The petition pointed out the lack of knowledge about how ECT works, the danger of permanent memory loss and brain damage, the possible abuse of patients' rights, and the fact that several countries have laws restricting the use of ECT. The CHC asked its Psychiatric Services Study Group to make enquiries.

A meeting was held at St James Hospital, the local psychiatric hospital. The hospital

management team offered full cooperation. A consultant psychiatrist liaised with the study group and gave a detailed explanation of the history of ECT, when and why the treatment is used and how it is administered.

ECT was introduced in 1937, and is now used mainly to treat depression. It consists of administering a series of electric shocks to produce the equivalent of a major epileptic fit. As recently as the 1950s patients had to be restrained during treatment, because the shocks actually produced convulsions, but improvements in techniques during the 1960s overcame this problem.

Nowadays ECT begins with a medical examination. A short-action anaesthetic is then used to put the patient to sleep, a muscle relaxant is administered and breathing is assisted with oxygen. Two electrodes are then placed across the temples, and a carefully controlled shock is then administered. The muscle relaxant "modifies" the fit, leaving only a slight twitching of the face, hands and toes. The most important side-effect of ECT is memory loss, which wears off rapidly.

Members were then invited to talk to patients before and after treatment. Most

could not remember having had ECT, but said they felt better. Members asked for statistics, and were interested to note that the amount of ECT treatment given has declined by 50% over the last five years, mainly because of advances in drug treatment.

Members asked for reassurances that whenever possible informed consent is obtained from the patient or his next of kin. The consultant explained that this was the case, and that if this was not possible two consultants must give their approval. On the day members visited St James only one patient was given ECT without his consent — he was refusing food and drink and was considered to be in urgent need of the treatment as a life-saving measure.

The study group reported back to the CHC at a public meeting, to which members of the Vigil Group had been invited. Most council members accepted the report but a minority were still not satisfied that we knew enough about the situation in other parts of the country, so it was agreed to widen the enquiries.

Publicity given to the study group's report in the local press brought only a minimal response from the public. This came mainly from former patients and

by Martyn Smith, Secretary,
West Birmingham CHC

West Birmingham is a predominantly inner city district with the typical problems of the inner city. There is poor health and unsatisfactory housing, people have relatively poor working conditions and the hospitals are old. But the RAWP formula for allocating health service resources does not take proper account of inner city pressures nor of the cost of regional specialties, and so Birmingham has been under dangerous financial pressure.

Although West Birmingham CHC has been considering the question of savings in the area of clinical responsibility since before RAWP, financial pressure has focussed attention on savings in general and this is an important area.

In Birmingham in 1979/80 over £21 million was spent on medical and surgical supplies and on diagnostic departments, such as radiography and pathology. The CHC is convinced that if clinicians were cost-conscious they could easily make a 1%

THINK BEFORE YOU SPEND!

saving and £200,000 is a very useful sum.

The CHC at first concentrated on this unsophisticated approach. Members suggested that doctors might be asked to think whether all the tests they ordered were appropriate for the particular patient. Similarly questions could be asked about pathology test call-out costs, over-prescribing, waste of supplies, etc. Surely these small percentage savings could be made without reducing patient care, and would even improve the individual attention given?

But there is the problem of "defensive medicine". Tests are routinely ordered to protect a doctor from a one-in-a-million

chance of something going wrong because the doctor has not spotted it. The other side of the coin is the person who suffers because resources are used on defensive medicine, but the law says that person has no case. The answer to the problem is "no-blame" compensation, but that is another story.

CHCs clearly have a proper interest in the pattern of care provided by health districts, either between or within specialties. But it is usually the consultant who chooses whether to deal with patients whose conditions are expensive to treat or to attend to others — perhaps in equal need — whose cases are cheaper to treat but are perhaps considered less interesting.

Much of this happens because doctors are trained to deal with cases as though there were no resource constraints at all, except perhaps the waiting list. Clinicians, individually or collectively, are not wont to assume responsibility for patients who do not get to see them. But if we stipulate that resources are limited and that some consensus can be reached on degrees of urgency, it does not seem wholly unreasonable to suggest that patterns of care might be planned for the general benefit of all patients rather than, as happens on some occasions, by the whim of a particular doctor.

It is impossible to pinpoint the effect of a campaign for savings in the area of clinical responsibility. Other developments such as changes of staff, new drugs, and changes in treatment have more effect on the routinely published statistics and in any case changes of attitude work through slowly. One can only hope that the CHC has had an unacknowledged effect. Our strategy now seems to be accepted by the district management team, although it will never be clear how deeply the philosophy has permeated to staff who deal with patients.

How should a CHC respond to management claims about lack of money when it believes that savings which could be made are not being made? This year several proposals for improved community services which the CHC supported have been turned down because, Birmingham AHA says, there is no money available for them. Is it the CHC's duty to demand such schemes even though management might see this as an unreasonable attitude?

Or should CHCs take the issues separately, arguing for the savings strategy but, when the time comes to discuss planning matters, considering management's financial statements at face value? For the danger is that by pursuing what it thinks right, the CHC might ensure that the district management team disregards all its proposals as unrealistic. At present, West Birmingham CHC tends to argue the issues separately, but if no suggested developments take place the tactics might have to change.



families of patients who had received ECT and were critical of it. Complaints appeared to relate to treatments given well before the improvements in techniques were introduced.

We then sent letters to all CHCs in the south and west of England, asking for local information. The information from those CHCs which have responded has endorsed our findings. We also investigated what is happening nationally. The Medical Research Council says that ECT used with proper safeguards has not been shown to cause permanent memory loss or brain damage. In the MRC's view the risks involved in ECT treatment nowadays are smaller than in some standard treatments of other illnesses. Controlled trials of ECT are taking place at selected centres, eg at Edinburgh, Guy's Hospital and Southampton, in an attempt to prove scientifically that ECT works. The Royal College of Psychiatrists is collecting information on the use of ECT, and aims to produce a report next year.

In view of these enquiries, the CHC has concluded that:

- ECT may be used as a final resort when other therapy has failed, and when the alternative may be a permanent reliance on

anti-depressant drugs with their own undesirable side-effects.

- Where it is effective ECT does give relief from acute depression and does not carry greater risks than other methods of treatment.

- ECT procedures should be fully explained to patients, and whenever possible informed consent should be obtained.

- It is appreciated that not all psychiatrists use ECT, because opinions are divided about whether it achieves satisfactory results.

The CHC welcomes the research being carried out by the Royal College of Psychiatrists, and will wait until the college's report is published before considering further action.

Further reading

The use of ECT, a memorandum from the Royal College of Psychiatrists. British Journal of Psychiatry, Volume 131 (1977), pages 261-72. ECT, forty years on, The Lancet, 27 October 1979, pages 888-9.

Does ECT work? World Medicine, 26 July 1980, page three.

A jurisprudential and ethical examination of ECT, by Larry Gostin (MIND's policies on the use of ECT, free from 22 Harley Street, London W1.

Parliament

The House looks at homelessness

City and Hackney CHC's report *Homeless and healthless* (see CHC NEWS 57 page one) was brandished in the House of Commons by junior minister Sir George Young, during an adjournment debate on health care for the single homeless. Sir George accepted that the best approach was to improve the present service, including discharge arrangements, rather than set up separate medical services for the single homeless. The DHSS has reminded hospitals that home circumstances affect aftercare, and unless aftercare is adequate the full benefit of hospital treatment may be lost. Sir George congratulated the CHC for being concerned about the homeless as well as its established residents (Hansard, 29 July).

"FPC — Keep out!"

The Public Bodies (Admission to Meetings) Act 1960 applies to health authorities but not necessarily to committees set up by them, such as Family Practitioner Committees. According to Patrick Jenkin "Much of the work of FPCs consists of matters, affecting individual family practitioners and patients, of a kind that have normally been considered in private since the inception of the NHS". Before 1974 the work of FPCs was done by Executive Committees, which were subject to the Act, but

even then "this was only in respect of their executive functions and, even when discussing matters falling within the executive functions, they could by resolution exclude the press and public". Mr Jenkin is "not convinced that any useful purpose would be served" by legislation extending the Act to FPCs (Tom Ellis, Wrexham, 29 April).

Joint finance

£61m has been allocated for joint finance in 1980/81, an increase of 15% in real terms over 1979/80. It is for health and social services authorities to decide how the money should be used, as part of their collaborative planning. Indications are that about 40% of joint finance is being spent on services for the elderly, and about a third on the mentally handicapped (Dr Roger Thomas, Carmarthen, 29 July; Frank Hooley, Sheffield Heeley, 29 July; Christopher Price, Lewisham West, 25 July).

Home help charges

Local authorities can make "reasonable" charges for home help, using powers in the NHS Act 1977. But the amount charged "should not be such that a recipient of the service would need, because of that charge, to seek supplementary benefit or an addition to SB" (Hal Miller, Bromsgrove and Redditch, 29 July).

Deafness committee gets the chop

The Advisory Committee on Services for Hearing Impaired People will be wound up later this year, when its sub-committee studying services for hearing-impaired children has reported. Although concern has been expressed by some organisations for the deaf, Patrick Jenkin is "satisfied that services for the deaf and hearing-impaired and advice to Ministers in this field will not be prejudiced". Last year ACSHIP cost £5300 to run (Alf Morris, Manchester, Wythenshawe, 28 July).

£5 to call an ambulance?

A standard charge of £5, imposed whenever a call for an ambulance was shown to be "unnecessary", would discourage genuine calls and would be very complicated and costly to administer. The DHSS believes that the public should be educated to make fewer mistakes about when an ambulance is needed, and has produced posters to help with this (Dr Roger Thomas, Carmarthen, 22 July).

Asleep on the job?

Doctors who work a "one-in-two" rota are contracted for 64 hours of on-call and standby duty, on top of their basic forty-hour week. Some 36% of senior registrars, 34% of registrars, 26% of senior

house officers and 36% of house officers are contracted for at least this many hours. The DHSS accepts that such long hours are undesirable, and is discussing changes with the profession (Dr Roger Thomas, Carmarthen, 30 July).

Fluoridation policy

Fluoridation of public water supplies has been the policy of successive governments since 1962. So far only 9% of the population of Britain receive fluoridated water, even though 85 of the 90 English AHAs have asked their local water authorities to introduce it. Where fluoride is introduced the Government has agreed to indemnify water authorities against any possible claims for damage to health (Nicholas Winterton, Macclesfield, 28 July; Keith Best, Anglesey, 31 July).

Waiting it out

In England and Wales in 1977, patients needing an operation on their veins had to wait an average of 35.4 weeks for admission to hospital. For hernia operations the average was 21.8 weeks, and the comparable figures for the various medical specialties were as follows: traumatic and orthopaedic 20.6 weeks, ophthalmology 19.3, gynaecology 11.8, ear nose and throat 22.4 and other surgical 15.7 (Greville Janner, Leicester West, 22 July).

WOMENS NATIONAL CANCER CONTROL CAMPAIGN

by Elizabeth Ellett,
PR/Information Officer,
Womens National Cancer
Control Campaign

Even in the rain women will queue up outside a Womens National Cancer Control Campaign (WNCCC) mobile clinic for a cervical smear — yet in their millions they fail to take advantage of the statutory facilities available to them locally.

The work of the WNCCC is therefore twofold. The first task is to provide effective health education. Major meetings are arranged, speakers are supplied, and a range of teaching aids offered which includes films, audio-visual programmes, posters and leaflets. All are aimed at urging women to have regular tests and to

carry out monthly self-examination of their breasts.

The second aspect of the work is to organise screening programmes where appropriate. This involves working closely with area health and local authorities, CHCs and voluntary organisations such as the Women's Royal Voluntary Service. Screening programmes are based either in the premises of the organisation with whom we are working or in one of the WNCCC's five mobile units, which will be parked on a busy shopping precinct, or a factory site or adjacent to a hospital with which the Campaign is working.

Even in these programmes health education is being carried out — urging women to have tests regularly in future, showing them how to carry out breast self-examination, giving each woman a

descriptive, illustrated leaflet, and wherever possible, details of the local facilities as well.

The WNCCC was founded in 1965 and is a health education charity with a predominantly lay membership. Its activities are carried out under the guidance of a medical advisory committee whose members have a specialist knowledge of cancers in women.

The Campaign works closely with area health authorities as well as recognised bodies in health education and preventive medicine. It is grant-aided by the DHSS but has to supplement its income very considerably by fund-raising activities.

The strength of the WNCCC lies in its ability to bridge the gap between the medical profession and the general public. In doing so it brings significant benefit to women through its health education and screening programmes. For further information contact the WNCCC at 1 South Audley Street, London W1Y 5DQ. Tel. 01-499 7532/4.

Scanner

Parents under stress

Following publicity about parental violence parents have formed local groups all over the country to help each other cope with the tensions of child-rearing. Most of these groups offer a confidential telephone service for parents in times of stress, some provide meeting places and offer practical help. There is now a National Co-ordinating Committee of Self-Help Groups for Parents Under Stress which produces newsletters, information sheets and a list of local groups. Its secretary is Caroline Baisden, 29 Newmarket Way, Hornchurch, Essex.

How to live with multiple sclerosis ...

The Multiple Sclerosis Society has produced a booklet for newly-diagnosed MS sufferers. Called *So you have MS?* it describes the disease, dispels some of the myths and seeks to help patients with some of their initial reactions and problems. Useful addresses are provided. Copies available (on receipt of large sae) from the Multiple Sclerosis Society, 286 Munster Road, London SW6 6AP.

... and psoriasis

The Psoriasis Association has also brought out an information leaflet for sufferers, *Living with psoriasis*. Send a 50p research donation for a copy to the association at 7 Milton Street, Northampton NN2 7JG.

Arthritis and rheumatism

General practitioners need better training to help them recognise and respond to patients suffering from rheumatism and arthritis. *Arthritis - treatment in general practice* says that many rheumatic sufferers experience "dissatisfaction and disillusion" with treatment from family doctors. The booklet is published by the Arthritis and Rheumatism Council which funds research into rheumatic diseases and publishes a range of cheap leaflets for patients. The council is at Faraday House, 8-10, Charing Cross Road, London WC2H 0HN. Tel: 01-240 0871.

Teaching doctors to talk

Ideas for improving doctors' communicating skills are discussed in a booklet called Talking with patients written by a Nuffield working party. The importance of listening to



the patient is stressed, and the use of video-tape to improve students' interviewing techniques is strongly advocated. Copies are 50p plus 22p post from the Nuffield Provincial Hospitals Trust, 3 Prince Albert Road, London NW1 7SP.

After-care schemes

Ways in which voluntary organisations can become involved in helping elderly people discharged from hospital to home are discussed in an Age Concern guide, *Hospital after-care schemes*. Improvement of the statutory services is seen as the first priority for voluntary groups but then the guide describes steps a group should take if it wishes to initiate an after-care scheme itself. Copies are 95p inc post from Age Concern England, Bernard Sunley House, 60 Pitcairn Road, Mitcham, Surrey CR4 3LL.

... and Crossroads Care Schemes

The Crossroads Care Attendant Scheme Trust has produced a new booklet, *Crossroads care attendant schemes*, describing the scheme and explaining how to set one up locally. The Crossroads Scheme aims to help disabled people remain in their homes. Care attendants

are recruited who provide extra assistance in the home to ease the strain on the relatives looking after the patient. The booklet is 35p plus 10p post from the trust at 11 Whitehall Road, Rugby, Warwickshire CV21 3AQ. An up-to-date list of local schemes and publication list are also available on receipt of a sae.

Housing for single people



Access to permanent housing for single people is a comprehensive guide for advice-givers to the limited opportunities open to single people to obtain housing from local authorities or housing associations. Practical and social problems which may face single people moving into their own flats are also discussed. Copies are £2 inc post and are available from any of the three organisations which jointly produced it - CHAR (Campaign for Homeless Single People), 27 John Adam Street, London WC2; NACRO (National Association for the Care and Rehabilitation of Offenders), 169 Clapham Road, London, SW9; the Cyrenians, 13 Wincheap, Canterbury, Kent.

Drug warning

The Committee on Safety of Medicines has issued a warning about use of the drug clofibrate to all practising doctors, dentists and pharmacists in the UK. Marketed as Atromid S by ICI, it is a drug used in the primary prevention of heart disease to lower cholesterol levels. Following the report of a World Health Organization trial the CSM believes that the drug should no longer be used in this general way — its use should be restricted to certain specified conditions.

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 1: South East Cumbria CHC Chairman: Coun R S Harrison

Page 1: South West Durham CHC Chairman: Coun Ted McCourt

Page 2: Gateshead CHC Chairman: E T Dixon

Page 3: Scarborough CHC Chairman: Mrs L Cooper

Page 3: Harrogate CHC Secretary: John Lee

Page 4: East Leicestershire CHC Chairman: D E Pearson

Page 4: North Nottingham CHC Chairman: Mrs P Ingram

Page 6: East Hertfordshire CHC Chairman: J. Chaplin

Page 7: Hillingdon CHC Joint Chairmen: Mrs S Court and Mrs Gill Rhodes

Page 8: Barking CHC Chairman: Miss M E Vigor

Page 8: Enfield CHC Chairman: Ann Loxley

Page 9: Bexley CHC Chairman: Mrs G Hall

Page 11: Worthing CHC Chairman: Mrs Marjorie Dingemans

Page 11: Kingston, Richmond and Esher CHC Chairman: M O Tinniswood

Page 13: Northampton CHC Chairman: M Harcourt

Page 15: Central Birmingham CHC Chairman: Ms Anne Cramer

Page 16: Walsall CHC Chairman: Coun Mrs R Parks

Page 17: Liverpool Eastern CHC Chairman: Mrs S J Fleetwood

Page 18: Oldham CHC Chairman: Coun N E Bennett

Page 20: Ogwr CHC Chairman: Coun Thomas Rees

Page 23: East Anglian Regional Association of CHCs c/o Great Yarmouth and Waveney CHC, London House, The Prairie, Lowestoft. Tel: Lowestoft 68115. Chairman: Major P F Rodwell. Secretary: Ray Allen.

News from CHCs

□ **Central Birmingham CHC** set an example for the city's family practitioner committee when it duplicated the official application form for prescription "season tickets" and distributed copies to chemists' shops and doctors' surgeries. The FPC had refused to give the CHC bulk supplies of the forms and so the council took matters into its own hands, hoping to make the season tickets better known. The DHSS had also refused to give the CHC any copies of the application forms. But now the FPC has had second thoughts and says it will be sending a "small supply" to all doctors and pharmacists.

□ A knowledge of first aid is a more than usually sensible precaution in the scattered Isles of Scilly. Thanks to an initiative by **Isles of Scilly CHC**, island residents have had a chance to learn first aid. St John's Ambulance courses are being taught by a local doctor and police sergeant.

□ **South Manchester CHC** took exception to the regional health authority's poster aimed at persuading people to use the ambulances sparingly. The slogan, "Ambulances are not taxis" was deemed to be "offensive" and likely to worry already ill people. The council took the matter to the North Western CHCs' regional meeting, which eventually agreed to ask the region to withdraw the poster. A revised, more gently worded one should be published, say the CHCs. Rosemary Hutchinson, secretary of South Manchester CHC, commented; "We believe the poster is aimed at the wrong people — much of the abuse of the service is caused by administrative staff at the hospitals, not sick patients".

□ "Panic planning" was how **Liverpool Eastern CHC's** secretary Frank Rose described proposals to transfer long-stay elderly patients from two hospitals into Sefton General Hospital. The measures were supposed to save money and help the area health authority keep within its cash limits. But when the council visited Sefton General, together with members of **Liverpool Central and Southern CHC**, they found only one vacant ward,

supposedly awaiting more than 200 patients. The CHCs pointed out the area team's duff arithmetic at the next AHA meeting and the proposals were hastily withdrawn.

This episode also revealed a new twist to the theme of "when a closure is not a closure". The AHA had been proposing to shift all the patients and staff to Sefton General — this it claimed was not two closures, but merely a "transfer of services", so there was no need for a consultation procedure.

□ A survey of outpatient transport by **Islington CHC** found no evidence of abuse of ambulances. The survey report appeared in *Ambulance Journal* (July 1980). Patients were mainly elderly and long-term users of the service. The CHC makes several recommendations about clinic appointment systems which it believes will make things run more smoothly.

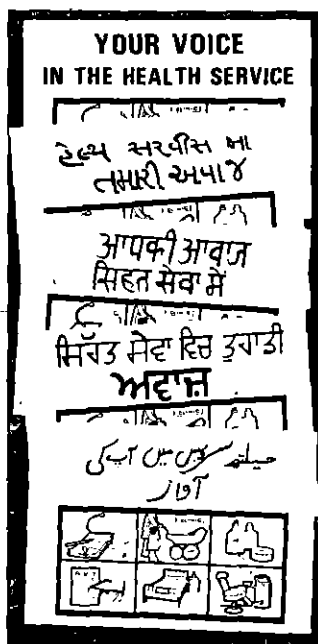
□ There will still be eggs for breakfast in **West Berkshire's** mental handicap hospitals. The authorities planned to save £12,000 a year by switching to "continental breakfasts". The CHC expressed concern that this would reduce patients' diets below the level recommended in the DHSS' *Hospital meals survey*. Now patients will get a "light breakfast" — which means that eggs will be served three or four times a week.

□ Thanks to steady pressure from **Scunthorpe CHC**, the new hospital to be built in Goole to replace five small hospitals will not now be a community hospital, but will have the facilities of a "mini-district hospital". The original plans were for a GP unit only, but now there will be consultant cover, operating theatres, X-ray and pathology facilities, nurse training and limited accident and emergency cover. It is 22 miles to the nearest district general hospital.

□ The Society of CHC Secretaries and the Society of Secretaries of Welsh CHCs have agreed to take part in a study of CHCs' "administrative functions". They were invited to take part by the NHS National Staff Committee for Administrative

and Clerical Staff, as part of an investigation into the recruitment and career development of administrators. At the first meeting of the working party, they agreed to ask all CHC secretaries what they expect out of their careers and what role secretaries should have in the NHS.

□ Four **Cheshire CHCs** have contributed £375 each to publish six information leaflets. The topics covered are dentists, maternity services, chemists, child health services, doctors and elderly people — the CHCs have had more inquiries about these subjects than any others. Each CHC will distribute the leaflets in its own health district.



□ **Publicity leaflets** about **Walsall CHC** have been printed in Hindi, Gujarati, Urdu and Punjabi. The CHC is also going to translate its guide to health services in the district. **Edgware/Hendon CHC** has produced 1200 sets of six leaflets for parents of mentally handicapped children. The leaflets cover education, short-term care facilities, clubs, adult training centres, full-time residential care and so on.

□ Using a simple postal questionnaire, **Harrogate CHC** obtained 400 local mothers' views about the district's maternity services. The questionnaires were sent out eight weeks after discharge from hospital and there was an 80% response rate. The survey

report, *Maternity services* is very detailed, with sections on comments from women on everything from ante-natal clinics to stitches to smoking in day-rooms. The CHC recommends an improved ante-natal appointments system, a co-ordinated policy on breastfeeding and that babies should "be left with the parent(s) a little while after birth and not whisked away to the nursery".

□ **North Camden CHC** has also surveyed its maternity services by interviewing women who brought their babies for the six-week check to clinics and GPs' surgeries. A summary of the CHC's report recommends further measures to encourage early ante-natal attendance, such as issuing leaflets with commercial pregnancy testing kits. It says hospitals are "insensitive to the effect that excessive waiting times have on the state of mind of the woman waiting". The council also believes that the number of episiotomies (a cut at the mouth of the vagina to ease the emergence of the baby's head) is rather high and should be reviewed.

□ **Hull CHC** asked department stores in the city what facilities they made available for mothers to breastfeed babies. Only one had taken any steps to provide a place for breastfeeding. Two stores said they would do so if asked, but insisted that they didn't want any publicity. "What they're so worried about, I don't know!" said CHC secretary, Irene Watson.

The CHC has lost its fight to have the buildings of the former Townend Maternity Home and the Hull Hospital for Women put to use for the community. The CHC ran a public opinion poll on alternative uses (see *CHC NEWS* 55), but the RHA has decided to sell the site.

□ **West Essex CHC** has published *Care of the dying*, a report on a day conference it held in May. *Caring for the mentally handicapped in Oxfordshire* is the report of an Oxford CHC working party, and is largely based on consultations which the CHC conducted through a series of public meetings.