COMMUNITY HEALTH News

ASSOCIATION · OF

COMMUNITY HEALTH COUNCILS

FOR · ENGLAND · & · WALES

30 DRAYTON PARK · LONDON N5 1PB
TEL: 071-609 8405
FAX: 071-700 1152

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NUMBER 70 FEBRUARY 1992

NEWS

86 units and trusts in deficit

A leaked document shows that 86 NHS units and trusts (out of a total of about 400) were in deficit by more than £100 000 at the end of November. It gives details about a number of NHS "hotspots". The memorandum, which had been circulated by an Under-Secretary at the Health Department to members of the NHS Management Executive, was written just a fortnight after NHS Chief Executive, Duncan Nichol, had painted a glowing picture of the state of NHS finances, predicting a broad financial balance by the year end. The memo points out that all but 29 of the units/trusts expect to clear their deficits by the year end, something that can be achieved only by "slamming the brakes on patient care", according to Opposition spokesman, Robin Cook.

The memorandum also notes that "noise" (i.e. publicity) on the shortfalls should be minimised – prompting Mr Cook to accuse civil servants of covering up for ministers.

Independent/Times 6 February 1992

Mole unearthed

A health manager on secondment to the Performance Management Directorate within the Department of Health was dismissed from the Ministry following claims that he had leaked the memo referred to above; photocopies of the document provided by Robin Cook to journalists enabled the man to be traced. The incident has led William Waldegrave to warn that civil servants may not be prepared to give their loyalty to Robin Cook in the future – his dependence on a breach of faith "rules [Robin Cook] out as a serious minister".

Using leaks, however, does not seem to be the preserve of one party. Readers may recall that towards the end of last year MP Jerry Hayes resigned from the Health Select Committee after a draft report of the Committee was leaked to the Health Department. The leaked document was allegedly used to put pressure on Conservative Committee members to omit from the final report the sections most critical of the Government.

Guardian 14 February; Independent 15 February 1992

Whose duty to care?

Duncan Nichol, Chief Executive of the NHS, has resisted pressure to clarify the criteria determining whether someone should receive care from the NHS. Having stated that "If, in a doctor's professional judgment, a patient needs NHS care, then there is a duty upon the Health Service to provide it", he appeared to undermine this statement by saying: "There is no general duty on a health authority to provide in-patient medical or nursing care to every person who needs it." The boundary between health and social care is blurred, particularly in the case of people with long-term illness. It remains to be seen whether Mr Nichol's optimistic injunction: "let us work collaboratively" will be adequate to deal with the dilemmas health authorities and social services departments will face.

Guardian 30 January 1992

Patient dies after operation refused

A patient denied a heart operation because of the working of the NHS reforms died of a heart attack just before Christmas. Guy's and Lewisham Trust had a contract with Lewisham and North Southwark Health Authority to carry out 240 heart catheterisations in the financial year. Last September the consultant cardiologist at Guy's, Graham Jackson, was told to stop carrying out the procedure on any more local residents since the contract had already been fulfilled. He was allowed to continue to treat patients from Maidstone and Eastbourne since the contract with their DHA had not been fulfilled. As a result a patient who was listed for a catheterisation in October had to be told the operation could not go ahead and he was put on the waiting list. He died in December. The operation might not have saved the man's life, "but he did not get the chance and should have been allowed one", said Dr Jackson.

Graham Jackson, who is a member of the Conservative Party, blamed the new system which is "run by financial people and accountants [who] don't talk to the patients".

Observer 9 February 1992

Spending on managers escalates

The extent to which the NHS *is* being run by "financial people and accountants" (see above) is hinted at by recently released official figures on NHS staffing. Staff graded as "general or senior managers" in England rose from 510 in 1986 to 9740 in September 1990. Taking the year 1989 to 1990, nursing and midwifery staff fell from 486 750 to 479 740; over the same period administrative and clerical staff rose from 141 570 to 145 980. The Health Department says that this reflects "the strengthening of financial, personnel and information systems", all of which are required to operate Government reforms.

The Government has claimed that numbers of management and support staff have fallen over the last decade. This, however, is the case only because of the privatisation of many ancillary services. If ancillary grade workers are excluded from the figures, total management and support staff have risen by 12% over the period 1981–1990.

Guardian 10 February 1992

Another £2 m for waiting lists

In its determination to clear the two-year plus waiting list by the end of March, the Government has allocated a further £2 million to the initiative. Anthony McKeever who two months ago was given the task of clearing the list by the deadline now has a total of £4 million to spend. This brings the total expenditure on waiting list initiatives in 1991/92 to £39 million. The same amount is to be made available next year. However, with over 29 000 patients still waiting more than two years at 31 December, it looks doubtful whether the target for this year is attainable.

Guardian, 11 February 1992

Fee discourages eye tests

Only 4.1 million people had NHS eye tests last year compared to 12.5 million in 1988/89 and 5 million in 1989/90. Charges for eye tests were introduced in April 1989, with exemptions for certain groups. Opticians fear that the fall in tests could lead to the late diagnosis of certain serious diseases, which they might otherwise pick up at an early stage.

Independent 12 February 1992

Another 35p on prescriptions

Prescription charges are to rise on 1 April for the 14th time since the Conservatives took office in 1979. The announcement of the 35p rise to £3.75 was made some weeks earlier than is customary, presumably in hope that it will fade from the memory before the general election. Prescription charges were 20p in 1979 (and in 1971) and will have risen almost 19-fold by the time Parliament is dissolved. Defending the rise, the Health Minister, Virginia Bottomley, pointed out that whereas one in three prescription items had to be paid for by patients in 1979, only one in six now attracts a charge since so many recipients are exempt.

It was also announced that the cost of a "season ticket" for prescriptions will rise from £48.50 to £53.50. The maximum fee for a course of dental treatment on the NHS is to rise from £200 to £225 (it was £150 in 1990/91).

Official figures published in the same week show that the proportion of NHS spending accounted for by tax and national insurance fell from 97.5% in 1978/79 to 94.1% in 1991/92. The share accounted for by charges rose over the same period from 2.2% to 4.2%.

Guardian/Daily Telegraph 14 February 1992

A dignified ending

The Government has welcomed new guidelines which recommend that babies stillborn before 28 weeks and miscarried foetuses should be given a "dignified" burial or cremation. There has been no legal obligation to bury or cremate babies born dead before 28 weeks, and many hospitals had failed to recognise that parents need the body of their baby to be treated with respect. The report recommends that hospitals should have written policies and offer choice to parents; it also says that staff need training in how to help such parents.

The report, *A dignified ending,* is available from the Stillbirth and Neonatal Death Society, 28 Portland Place, London W1N 4DE for £7.95 plus £1 p&p.

Independent 5 February 1992

Poor standards in smear tests

The National Audit Office has exposed serious shortcomings in the quality of the cervical cancer screening programme, but by contrast has praised the breast cancer screening programme for its quality assurance procedures.

In *Cervical and Breast Cancer Screening* the NAO says that guidance on taking smears is not followed universally, and there are wide variations in how smears are interpreted. In North West Thames 3.5% of smears were recorded as abnormal in 1990/91 compared to 11% in North East Thames, a difference not attributable to true variations in incidence. This situation may lead to cancers being missed in some regions and women suffering from unnecessary anxiety and potentially damaging treatment in others. Two of the three regions visited were not having the lab work checked by external assessors, and fail-safe systems to check that all women with abnormal smears are contacted were not always in operation (1/6 districts) or formally documented (3/6). The report acknowledges, however, the success of both programmes in encouraging more women to attend.

Times 14 February 1992

Ten years of undertreatment

Nearly 1000 patients receiving isocentric treatment for cancer at North Staffordshire Royal Infirmary have been given insufficient doses of radiotherapy for a period of ten years. The error was caused by the incorrect programming of a computer by a medical physicist.

North Staffordshire Health Authority has set up a telephone hotline for surviving patients and the relatives of those who have died: experience at a similar incident in Devon suggests that urgent counselling will be required. Senior staff at the hospital have said that there is no clinical evidence to suggest that any of the 447 patients who have died since receiving treatment did so because of the error. However, a cancer specialist at the Hammersmith Hospital suggested that at least some of the deaths were likely to have been caused by the underdosage. The hospital's general manager said the question of compensation will be considered after the clinical review has been completed.

Guardian/Daily Telegraph 7 February 1992

Treating pets "unacceptable"

Plans to use the radiotherapy unit at the Royal United Hospital in Bath to treat pets have been abandoned. There had been plans to use the NHS facilities for pets in the evenings, after they had been vacated by human patients. The scheme would have been non-profit making, but vets would have been charged costs. The plan met with apparent approval from Wessex RHA, and a refusal to become involved either way by Mr Waldegrave, but was dropped after the District Health Authority ruled it "unacceptable".

Daily Telegraph/Times 16 January; Hansard Col 546/Independent 28 January 1992

Disability Living Allowance

The new Disability Living Allowance is to be introduced in April. Many people with learning difficulties who do not currently receive Attendance or Mobility Allowances may be eligible. For the mobility component of the new benefit this includes people with severe mental impairment and severe behavioural problems, or more generally those who need someone with them when out of doors. For the care component it includes people who are 16 or over and unable to prepare a cooked main meal. In addition, some people who already get Attendance and Mobility Allowance may be eligible to receive higher benefit.

Claims should be made as soon a possible. The "claim pack" is 40 pages long, so many claimants may need help. An information booklet on the new arrangements is available from: New Benefits for Disabled People; FREEPOST BS 4335; Bristol BS1 3YX or phone free of charge: 0800 100 123.

DSS Circular 3 Feb; 1992 Community Care 6 Feb 1992

Dentists win on treatment plans

The Department of Health has given way to demands from the dental profession that it should not be compulsory to issue treatment plans for all courses of treatment. Dentists are still required to draw up plans in a number of circumstances, including on the request of a patient (or parent of a child). Details of the new requirements have been sent to all FHSAs.

NHS Management Executive, letter to GDPs, 27 January 1992

FOCUS ON SERVICES FOR ELDERLY PEOPLE

Getting rid of Granny

Many readers will have seen BBC TV's *Panorama* programme, "Getting rid of Granny" which gave a distressing account of lack of care and inappropriate care of elderly people whom one might have expected to be a priority for the NHS. In particular it focused on patients discharged from NHS care to residential and nursing homes. The programme drew an angry response from the Department of Health, which criticised it for being very partial. The Department of Health also complained that the survey failed to show the wider context in which health authorities are working.

The *THS Health Summary*, while also criticising the programme for its one-sidedness, welcomed the fact that it challenged the agenda set by the centre. The article tries to home in on the roots of the problems. NHS long-stay beds for the elderly have been massively cut, even when private beds "bought" for the NHS are allowed for. Health services managers are much more likely to be evaluated on waiting list figures than on the quality of nursing homes they register (and switching resources from long-stay patients to acute care can give an impressive boost to activity figures).

Elderly people are more vulnerable than most, and elderly patients need security and protection as well as often requiring continuous nursing. Yet these are the people who are bearing the brunt of uncertainties over community care. Once a patient is deemed to need social rather than medical care, he/she becomes a political football vulnerable to changes in local authority priorities and benefit arrangements. There are obvious problems to face now and, even more so, in 1993. But as a society, we just have not bothered to address them.

THS Health Summary, January 1992, p1-2; DoH press release, 17 January 1992, H92/26

Call for guidance to protect elderly people

In a report published in January, Counsel and Care called on the Department of Health to draw up guidance on the rights of residents in nursing and residential homes to reasonable freedom of movement and the rights and duties of staff to restrain them under certain circumstances. Many methods are used to restrain elderly people: locking in, tying to furniture, use of drugs, video cameras and electronic tags. Jef Smith, general manager of Counsel and Care pointed out that many of these methods would not be permitted in prisons or psychiatric hospitals and said that to use them on elderly people was outrageous. The Department of Health had rushed through guidelines relating to young people when pindown was exposed, and should do something similar for elderly people.

What if they hurt themselves? is available from Counsel and Care, Twyman House, 16 Bonny Street, London NW1 9PG, £5.

Abuse of elderly people at home

Elderly people are at risk of abuse in their own homes as well as in residential homes. Officials of the Social Services Inspectorate were surprised by the level of abuse of elderly relatives that they found while preparing an official report: *Confronting elder abuse: an SSI London Region survey*. The report documents physical, psychological and financial abuse and neglect, typically of elderly females by an adult son or daughter and often taking place over a long period. It claims that abuse is "potentially a significant and increasing problem" and calls for action to alleviate it. Such action might include changes in the law to protect elderly people. The former head of the SSI also warned the Government that extra funds would be needed to support carers if community care is going to succeed.

Independent 30 January 1992

FOCUS ON MENTAL HEALTH

Homeless and mentally ill

In late January, the Secretary of State for the Environment, Michael Heseltine, hit the headlines when he remarked that it might be necessary to take steps to deal with the "hard core" of homeless people with mental health problems who refused offers of help. Many felt that Heseltine had "raised the spectre" of forcing homeless mentally ill people back into institutional care; and were therefore relieved when this was "chased away" by William Waldegrave's announcement shortly afterwards that the Department of Health was allocating a further £8 million to its Homeless Mentally Ill initiative (thereby doubling the number of places in the initiative's short-term hostels to 150).

However, some felt that Heseltine's remarks had indirectly drawn attention to a serious gap in the 1983 Mental Health Act. *The Guardian* reported that some psychiatric and hospital staff feared that the Act's emphasis on patient rights could sometimes be at the expense of patient needs – these professionals felt that the move away from compulsion had left them powerless to help those who needed but refused medication. Similar concerns had been aired in mid-January in the House of Lords. Speaking on behalf of the National Schizophrenia Fellowship, Lord Mottistone opposed the Government's proposals for an amended Code of Practice to the 1983 Act, as insufficiently clear regarding the criteria for compulsory admission to hospital. He stressed the NSF's frequent experience of GPs and social workers who did not seem to realise that the Act allowed compulsory admission in the interests of the patient's health (as well as in the interests of the patient's safety and for the protection of other people). Yet Professor Elaine Murphy (a psycho-geriatrician and Vice-Chair of the Mental Health Act Commission) argues that the problem lies not with the 1983 Act, nor with GPs' lack of understanding of it, but with the fact that doctors have nowhere to send patients. Long-stay psychiatric hospitals having been run down, psychiatric beds in general hospitals are filled by patients in need of some form of long-term care.

Further, according to MIND, most homeless people with mental health problems have not come from long-stay hospitals; it emphasises that many people have developed these problems while sleeping rough. MIND therefore stresses the need for prevention, and for the Government to provide affordable housing. A member of Camden MIND observed that "the answer to homelessness is to provide housing. That's got lost in this debate about so-called 'nutters' on the street." Few are confident, however, that the Department of Health's Homeless Mentally Ill initiative provides such an answer. Many housing and mental health groups feel that its £20 million budget is hopelessly inadequate. Further, the initiative is aimed only at central London – and Shelter has estimated that of the 15 000 mentally ill people sleeping rough, only 1100 are doing so in central London.

Hansard, 16 Jan, Cols 407-23; Independent 20 Jan; Department of Health Press Release 21 Jan (HP92/31); Guardian 24 Jan; Community Care 30 Jan 1992

Mentally ill offenders

If one in three homeless people is estimated to be suffering from some form of mental illness, the same is believed to be true of one in five sentenced prisoners. The Home Office and Department of Health have completed a review of services for mentally disordered offenders in England, resulting in a number of linked reports. The main objective is that mentally disordered offenders needing care should receive it from health and social services rather than in custody. The many recommendations are based on five criteria, namely that care should be provided:

- on the basis of individual need
- as far as possible in the community
- near the patient's home
- only at the level of security justified by the patient's dangerousness
- with the aim of maximising rehabilitation and the prospect of independent living.

It is suggested that local policies agreed by the police, health, social and probation services should aim at the avoidance of prosecution of

mentally abnormal offenders, and there are recommendations on the facilities required to achieve this. Facilities also need to be available to cater for mentally ill people in general: closure of mental illness hospitals is unacceptable if suitable services are not yet available in the community. Appropriate provision should be made for patients who require long-term care in a secure environment.

The difficulties lie not so much with coming up with recommendations of this sort, many of which have been aired often enough in the past, but with implementing them. The Chairman of the review, Dr John Reed, suggests an action plan: (a) local assessment of need; (b) setting up a "permanent national focus"; and (c) disseminating examples of good practice.

The action plan too has a familiar ring to it, and if it is to be put into effect it will require more commitment and better organisation than has been brought to bear to date, not to mention adequate funding.

Independent 8 February; BMJ 1 February 1992, p 267-8.

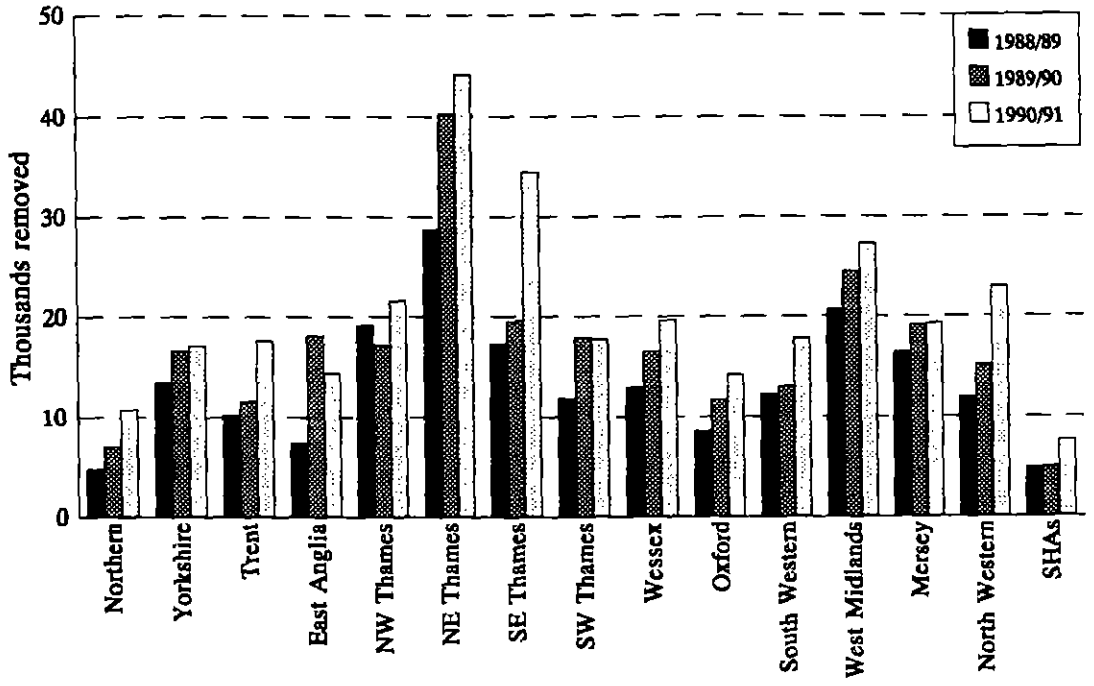
PARLIAMENTARY NEWS

What's what on waiting lists

Amidst the flurry of claims and accusations on waiting lists, one could be forgiven for being confused. Some more figures became available in January which add another factor into the equation. Robin Cook, Shadow Health Secretary, tabled a question asking how many patients have been removed from waiting lists (a) by admission for treatment and (b) for reasons other than treatment. The graph below summarises the answer to part (b). As the graph shows, there has been a general increase in the number of patients removed from waiting lists without receiving treatment, and a very marked increase in some regions. The inclusion of these patients in overall figures may lead to a false interpretation of waiting list statistics.

Perhaps unexpectedly, numbers of patients admitted for treatment from waiting lists in England were lower in both September 1990 and March 1991 than they had been in March 1990; it is only when the patients represented in the graph below are added in that there appears to have been an improvement. It is also interesting that no figures were

Patients removed from waiting lists without receiving treatment, by region



Source: Hansard 29/1/92 Cols 600-601

provided for September 1991, despite all the attention that waiting list statistics are receiving from NHS managers. Commenting on the figures, Under Secretary for Health, Stephen Dorrell conceded that "one or two health authorities may have overstepped the mark".

Illustrating what the figures can mean in practice, Robin Cook has produced letters informing two patients waiting for over two years that they are being removed from waiting lists, in one case because the relevant list was being scrapped, and in the other because the patient's district health authority will not pay King's College Hospital for a cataract operation.

Hansard, 29 January 1992, Cols 599-602; Independent 13 February 1992

Arguments continue about waiting list targets being allowed to override clinical priority. In evidence to the House of Commons Select Committee on Health, Paddy Ross, Chairman of the Joint Consultants Committee, said pressure to clear lower clinical priorities in an East Anglian hospital had led to a woman having a hip replacement done privately. Similar complaints were made by other witnesses.

Independent 13 February 1992

New Select Committee member

Conservative MP Tony Durant has been chosen to replace Jerry Hayes on the House of Commons Health Select Committee. Some doubts have been expressed over Tony Durant's independence in view of the fact that he was in the Government Whip's Office from 1984 to 1990 and that he does not list health as one of his special interests. Such arguments can be expected more generally after the election when MPs from all sides seek to get appointed or reappointed to Select Committees.

BBC 2, "Scrutiny", 7 & 14 February 1992

FROM THE JOURNALS

A spoonful of sugar

A survey of 20 families of young people with severe and profound learning difficulties and behavioural problems has revealed worrying levels of drug-giving to this group who are unable to consent to or refuse treatment. Parents expressed concern both over the long-term, regular medication that their children are receiving and about drugs used for short-term control. On the long-term side children are often given a cocktail of drugs – anti-epileptic, antipsychotic and/or sedative; further drugs may also be given to control, for example, Parkinsonism. Many are known to have serious physiological side-effects in the long-term and some may damage cognitive performance. At the same time, the usefulness of some of the drugs as a long-term measure is under question.

Parents are concerned that drugs are not necessarily prescribed on the basis of diagnosis, but simply to control unwanted behaviour, for example during a period of respite care. If a drug is thought not to be working, the response may simply be to up the dose rather than to reassess the treatment. Some side-effects may be obvious to parents, but not to doctors who see the young people only rarely or care staff who have a high turnover rate. Some side-effects cannot be seen at all; the young people concerned are unable to explain how they feel and their distress may be misinterpeted as just another behavioural problem requiring intervention.

By the nature of this survey, all the young children involved had parents in some sort of position to argue on their behalf and to assess their progress. But as the author, Jane Hubert, points out, there are many children with severe learning difficulties for whom this is not the case.

Community Care, 13 February 1992, p16-17

AROUND THE CHCs

A delegation, including the Chair and Chief Officer of **Tower Hamlets CHC**, has put a strong case to the Secretary of State for Health for keeping acute services at Mile End Hospital. The CHC fears that Royal London Trust's centralisation plans may in practice put at risk the viability of Mile End as a hospital serving the local community. The centralisation policy has already resulted in children's beds being moved to a recently-opened children's unit at Whitechapel. However, ten of the beds in the new unit remain unopened, with the effect that elective surgery has stopped and waiting lists are growing. The Secretary of State's approval is required for the Trust to proceed with its plans, and his decision is awaited.

Patients and staff of Ponteland and Lemington Hospitals in Newcastle have been celebrating the lifting of the threat of closure which has been hanging over them for four years. The DHA had proposed, in the face of local opposition including that of **Newcastle CHC**, to close the two hospitals and relocate the elderly patients in housing association accommodation. The health authority would have paid the housing association £1 million, and £3.4 million would have been raised privately. The decision was put into the Department of Health's court and last month the Under Secretary of State for Health, Stephen Dorrell, turned down the health authority's proposals. This was on the grounds that they were not consistent with the requirement on the NHS to provide continuous health care, as set out in the White Paper "Caring for People".

A threat to beds for elderly patients remains real in Glossop where the DHA is considering the closure of two wards at Shire Hill Hospital. The proposals are opposed by **Tameside and Glossop CHC**, along with health staff and local people, who argue that the proposals would reduce rehabilitation services for the elderly and might result in elderly patients prematurely entering long-stay accommodation. The CHC calls instead for the development of rehabilitation services for elderly people at Shire Hill Hospital on a permanent basis in line with earlier DHA reports.

Islington CHC has supported calls by Islington Pensioners Forum for the continued availability of dental treatment on the NHS. Since the new dental contract was introduced it has become harder for people to find an NHS dentist, and some dentists wrongly assume that people do not want NHS treatment. The CHC has called for clear signposting at dental surgeries and urges people to make it clear to dentists that they want NHS treatment.

Huntingdon CHC has analysed the information leaflets produced by 21 general practices in the district. The main features of the leaflets are tabulated and an analysis discusses the range of information provided and the tone in which it is given. The process has enabled the CHC to highlight some areas in which the service offered to patients differs widely between practices: for example home visits and repeat prescriptions. Copies of the table and analysis are available from the CHC.

Dewsbury CHC has been assessing the "rights" in the Patient's Charter, and the performance of the district in relation to them. Most of the rights are met, except the really important one: the right to receive health care on the basis of clinical need can hardly be said to be effective while theatre lists for joint replacements are frozen. There are also problems relating to the provision of information. Detailed work on implementing National Charter Standards and setting local standards is going on in four Patient's Charter Working Groups, attended by the CHC's Chief Officer.

The CHC has also produced a brief checklist of points for both staff and patients to bear in mind in order to ensure a quality service in the NHS.

The Department of Health is carrying out a two-year project looking at good practice initiatives in primary health care, with particular reference to ethnic minority groups. As part of the project a survey of **all CHCs** will be carried out. FHSAs and primary health care facilitators will also be surveyed. The project aims to produce a compendium of good practice, recommend future projects in this area and make recommendations for future action.

CHC PUBLICATIONS

Some diabetes sufferers' experiences of care in the Lancaster District
Lancaster CHC, £1.50

This survey of satisfaction was prompted by a request for information from a GP. The sample: people who responded to adverts in press and posters in local GP surgeries and outpatient clinics were sent a questionnaire to be returned freepost. Judging on national prevalence rates of diabetes, one would expect 1300 people living within the district to have diabetes, so the 71 responses need to be treated with some caution.

Given uncertainty as to what questions should be asked, the questionnaire allowed free-form comments under a number of general headings. The answers are reproduced in this document and are categorised into "positive", "negative" and "no comment". High levels of satisfaction were expressed, though there is some criticism, mainly concerning hospital-based services (especially waiting times) and of lack of information and advice.

The detailed responses will be useful locally, and may be useful both in Lancaster and elsewhere in helping to frame suitable questions that would ease analysis of future surveys on this subject.

GENERAL PUBLICATIONS

Power and dependence: social audit on the safety or medicines
by Charles Medawar
Social Audit, Box 111, London NW1 8XG, £11

"Drugs are remarkably safe": the view is that of the present chairman of the Committee on Safety of Medicines. This book hardly backs him up, but the focus of its criticism is on the safety of the *system* used to regulate drugs. *Power and dependence* makes its impact by reiterating time and again the cycle that applies to so many new drugs: a trickle of favourable reports develops into a stream; the drug becomes fashionable and is widely prescribed; after a while (the process is a long one) the favourable reports dry up; accidents start being reported; the drug falls into relative disrepute; it may eventually be abandoned.

Charles Medawar takes as his case study drugs used to treat anxiety and insomnia because, he explains, they are well known. One also suspects that they illustrate his thesis more persuasively than any other class of drug. There has been a history of one drug replacing another, once worries were raised that the earlier one causes dependence. The list of drugs comes as a bit of a shock. Starting early in the last century, the line is as follows: alcohol, opium, morphine, cocaine, heroin, chloral hydrate, bromides, barbiturates, benzodiazepines, and lastly buspirone and zopiclone. Some quotes give a flavour of how mistakes repeat themselves – an expert on injecting morphine (1868): "as to the question of danger, let me say, positively, that there is absolutely none"; heroin as first promoted by Bayer in 1898: "a non-addicting cough suppressant" for infants; an influential 1978 report on benzodiazepines (the group that includes Librium, Valium, Mogadon): "the dependence risk is very low ... probably less than one case per 50 million months in therapeutic use".

The book takes the reader through the history of the drugs on the list. In each case, despite a changing social, regulatory and professional context, there has been over-optimism and over-use.

The author believes that this state of affairs is not inevitable; rather it is the outcome of power structures and cultural assumptions involving the Government, the medical profession and the pharmaceutical industry. The industry needs to promote its products; and it uses all its considerable skills and power in doing so. Companies must

differentiate their products from the others on the market, leading to a mass of similar drugs each promoted as having unique benefits. There is little reason for the industry to publicise risks, or to go looking for them.

Doctors may not have an interest in denying the risks of drugs, but they do need to believe in their benefits. Just as there is a placebo effect for patients, the suggestion that there is a pill for every ill may persuade doctors of their own effectiveness. Poor information on side effects, a failure to recognise that the information is deficient and an insistence on "clinical freedom" all reinforce the availability of numerous similar drugs and their over-use. Again and again there has been a failure to recognise when patients are dependent on drug; the author convincingly explains why it is so easy for this to happen, particularly with drugs of this kind.

The third actor, the Department of Health, has a dual role: promoting the trade interests of the pharmaceutical industry and controlling it. Mr Medawar argues that the Government has been too willing to comply with the industry's calls for self-regulation, and the Committee on Safety of Medicines has been over-reliant on post-marketing surveillance of drugs rather than rigorous pre-licensing scrutiny. The CSM tends to assume that doctors will be perfect prescribers and will report back all adverse reactions (neither of which is likely to be the case).

There is of course also the consumer. But the consumer has been excluded from the system, except as an end of the line recipient or occasional litigant in a damages case. This has led to another kind of dependence: of passive and ill-informed consumers on a providing system which they need to trust, but perhaps should not. The secrecy surrounding the drug licensing process and the failure of UK drug data sheets adequately and promptly to reflect risks keeps doctors ill-informed, let alone their patients. This secrecy, the author argues, is as damaging a part of the system as any, and is unnecessary. It strengthens the need to insist that drugs are safe, rather than potentially dangerous substances which need to be used safely. It enables past mistakes to go unrecognised and uncorrected. And it insulates decision makers from scrutiny by the public on whose behalf they are supposed to be acting.

Complaints procedures interim report

London FHSA Complaints Consortium
Convener: Fedelma Winkler, Director of Planning, Barking and Havering FHSA, 117 Suttons Lane, Hornchurch, Essex RM12 6SD

Enormous variations in how FHSAs investigate complaints prompted nine London FHSAs to come together to improve and standardise their complaints handling procedures. This interim report identifies under a number of headings (e.g. Access, Conciliation) areas in which practice varies and outlines the range of variation. It also briefly lists examples of research and development in progress, with contact names for more detailed information.

School meals: take action!
and
School Meals Factsheet 1

The School Meals Campaign, 102 Gloucester Place, London W1H 3DA, phone 071 935 2099
£2.50 inc p&p

A new campaign to support school meals has been launched with the support of MPs from all parties and 53 national organisations. The campaign calls on the Government to:

- reintroduce nutritional guidelines for school meals and to provide advice on how to monitor them;
- to support school caterers in implementing the guidelines;
- to provide adequate resources to ensure that school meals are available to all children.

It also calls on parents to get involved and support their school meals service. The booklet, *School meals: take action!* sets out a Charter, a Checklist and an Action Plan to help them do so.

Since the 1980 Education Act, schools have been allowed to abandon midday meal provision except for children entitled to free meals, and 400 000 children lost the right to free school meals in 1988. It appears that these changes have had their effect, since figures show a substantial reduction in children eating school meals over the last decade and worrying estimates of children, especially girls, receiving below minimum recommended nutrient levels.

INFORMATION WANTED

Newham CHC would like to hear from any CHCs who have come across patients' complaints being attached to their medical records. The CHC is concerned that other practitioners' views about the patient are coloured when they look at the records and find letters of complaint attached.

North Devon CHC is looking at local speech therapy services. They would like to hear from any CHC which has undertaken work on the adequacy of the provision in its district. In any event, they would be grateful to hear from any CHC: (a) the population of their district and (b) speech therapy establishment in whole time equivalents.

"Will I still have a choice about where I have my baby? **Yes.**"

The NHS Reforms and You, July 1990, Page 3

Maternity Alliance has been contacted by a number of women who, because of the contracting process, have not been able to choose where to have their babies. MA would like to hear from any CHCs who are aware of such instances.

Contact: Maternity Alliance, 15 Britannia Street, London WC1X 9JP, phone: 071 837 1265.

FORTHCOMING EVENTS

Quality in primary health care: what does it mean for you?

Exploring PHC in the light of the new GP and dental contracts, voucher system for spectacles and role of community pharmacist and community nurse. Panel of speakers includes Chief Executive of Essex FHSA, a GP, an NHS dentist, an optician, a community pharmacist and a community nurse.

- Health Promotion Day Conference
- organised by West Essex CHC
- Princess Alexandra Hospital, Harlow
- 14 May 1992
- £8

Early applications recommended, to:
West Essex CHC
Herts & Essex Hospital
Haymeads Lane
Bishop's Stortford
Herts CM23 5JH
Phone: 0279 655863

Moving on the health of the people: health and transport issues for directors of public health.

Exploring how directors of public health can develop transport and health policies. Will provide practical guidance on including transport issues in annual reports and on collaborating with relevant agencies.

- one day seminar
- organised by Transport and Health Study Group, Public Health Alliance and South Birmingham HA
- Birmingham
- 1 May 1992

Details from:
Public Health Alliance
Room 204
Snow Hill House
10-15 Livery Street
Birmingham B3 2NU
Phone: 021 235 3698

Schizophrenia Training Consultancy

The STC is running a series of study days, conferences and courses which include:

Who's who in mental health:
information on current psychiatric practice

- study day
- YWCA Central Club, London
- 29 February 1992
- fees from £1 (unfunded user) to £20 (statutory org'n)

User involvement:
a practical approach to making it happen

- 2 day course
- King's Fund Centre, London
- 14-15 May 1992
- fees from £1 (unfunded user) to £140 (statutory org'n)

Know your rights:
introduction to the 1983 Mental Health Act

- study day
- YWCA Central Club, London
- 26 September 1992
- fees from £1 (unfunded user) to £20 (statutory org'n)

For details of these and other events send sae to:
Mrs Pam Jenkinson
Director, STC
69 Shepherds Lane
Bracknell
Berkshire RG12 2BU
Phone: 0344 420202

Making teamwork work for patients

- one-day seminar
- organised by Patients' Liaison Group, Royal College of General Practitioners
- April 1992
- London
- £65 including lunch and papers

Application forms from:
Conference Organiser
RCGP
14 Princes Gate
Hyde Park
London SW7 1UP
Phone: 071-581 3232

ACHCEW STAFFING

Angeline Burke has replaced Lorna Ryan as Development Officer, and Clare Collins has taken over from Carole Auchterlonie as Research/Information Officer.

DIRECTORY AMENDMENTS

The Chief Officer for Hillingdon CHC should listed as Dr Audrey Jacobs, not Dr Audrey Roberts.