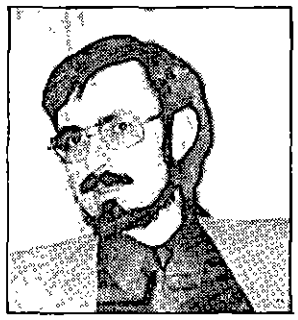
CHC NEWS

For Community Health Councils January/February 1983 No 83

Doctors and patients

-a new alliance



Photos: General Practitioner

Leeds West CHC Secretary Sue Jenkins, RCGP Honorary Secretary Dr John Hasler and ACHCEW Chairman John Austin-Walker at the press conference to announce the new move

The Royal College of General Practitioners (RCGP) has started the new year with an initiative which could break new ground in doctor-patient relationships.

A Patient Liaison Group will be set up within the RCGP, and it is hoped that regional groups will follow. At least half the membership will be patient representatives *nominated through the Association of* CHCs in England and Wales (ACHCEW), with the rest of the group drawn from the RCGP's own membership.

ACHCEW's Secretary Mike Gerrard has welcomed the initiative as a "bold and courageous move" which "shows that the College wants the whole-hearted involvement of the public".

Plans for the group's activities are not yet finalised but it is expected to work along lines drawn up by a working party of the RCGP's communications division, which reported in the January issue of the *Journal of the RCGP**.

The working party — members included Leeds West CHC Secretary Sue Jenkins and Central Birmingham Chairwoman Anne *Crerar — says that surveys which report* high levels of patient satisfaction with GPs may disguise problems such as repeat prescribing without consultation, a fear of criticising doctors and ignorance of alternative styles of practice. Where dissatisfaction *is* voiced it highlights factors such as inaccessibility, poor communication and inability to work with other professionals.

The group is proposed as a means of increasing collaboration between patients and doctors — centrally at first, and later within the RCGP's regionally-based faculties. The working party's suggestions for the group's functions are:

- sending patient representatives to other RCGP committees,
- supporting those representatives,
- initiating areas for discussion by the RCGP's ruling council,
- initiating activities in the RCGP's faculties and in health districts,
- reviewing central and local liaison arrangements.

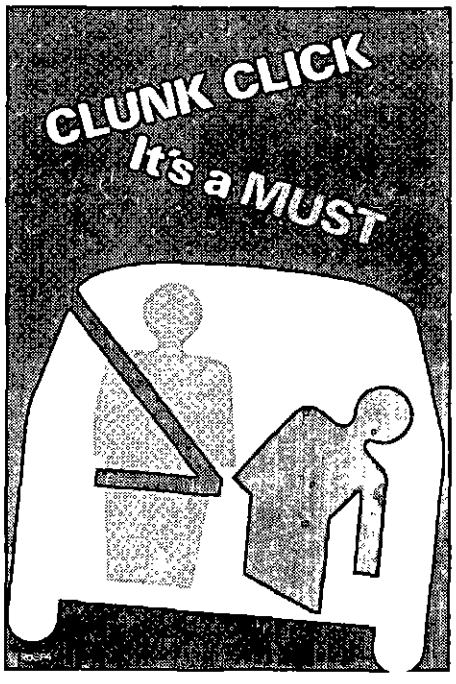
Once established the RCGP hopes that the group will encourage faculties to set up similar groups with patients' organisations locally.

The groups' roles could expand to include participation in GP training, in preventive medicine and in protecting primary care resources. Hospital facilities used by GPs might also be areas of activity, and so local medical committees would be invited to send representatives to the local groups.

ACHCEW is acting as agent for nominations to the patients' side of the central group, but group members will not be acting as CHC representatives and need not be CHC members. Scottish local health councils and district committees in Northern Ireland will be invited to submit nominations through ACHCEW.

*For copies of the report send an s.a.e. to the Communications Division, RCGP, 14 Princes Gate, Hyde Park, London SW7 1PU.

BELT UP IN '83



From 31 January the use of seat belts becomes compulsory for drivers and front seat passengers in most vehicles. The maximum penalty for those who do not "*clunk click*" *will be £50.*

A small range of exemptions includes taxis and milk floats but there are no automatic medical exemptions. GPs can issue exemption certificates and the BMA's private practice committee recommends a £19 fee for the medical examination — whether or not a certificate is issued.

People receiving benefits or registered as disabled can apply through the Department of Transport for free medical examinations at their DHSS Medical Boarding Centre.

Application forms come in the leaflet *Seat belts, the law and you*, free from DHSS offices and road safety officers.

INSIDE.....

Book reviews

We can speak for ourselves

by Paul Williams and Bonnie Shoultz, Human Horizons Series, Souvenir Press, £5.95

It is a sad fact of life that those who speak up for themselves are most likely to get the best deal. Mentally handicapped people have often received the worst deal. The standards of their health care have consistently fallen far below acceptable levels and they have been deprived of many basic human rights — to work, education, decent housing.

This book demonstrates that mentally handicapped people *can* "speak for themselves", and through self-advocacy groups can begin to run their own lives to an extent often thought impossible by others.

The self-advocacy movement has its roots in the USA where people leaving long-stay hospitals found they lacked some of the skills and abilities needed to live fully integrated lives in the community. In the mutually supportive groups they have learnt their rights and responsibilities and how to exercise them. Above all, self-advocacy has helped mentally handicapped people to see themselves as valued and responsible adults — not helpless dependents.

Self-advocacy is beginning to emerge in Britain now — often through groups in adult training centres — and whether we are staff, volunteers, parents or friends of mentally handicapped people self-advocacy concerns us too. If mentally handicapped people are to take greater control of their own lives the rest of us have some letting go to do.

Alison Wertheimer, Director, Campaign for Mentally Handicapped People.

Portrait of a poison — the 2,4,5-T story

by Judith Cook and Chris Kaufman, Pluto Press, £2.95

This book will revolt you — and so it should. It relates the scandalous tale of the chemical 2,4,5,-T. This substance was used as a weapon of devastation in the Vietnam war, and was the cause of death and environmental disaster after a factory explosion in Seveso, Italy. Yet it is sold in Britain as a common weedkiller.

No-one quite knows how *dioxin*, the essence of the poison works. But in human beings it causes hideous birth defects and also cancer. There is acknowledged evidence of this from abroad. In Britain there is a suspicious trail of illness, miscarriages and birth deformities among workers and the families of workers involved with dioxin. Due to trade union pressure British Rail and many local authorities have banned the use of dioxin-based weedkiller, but the government has avoided taking action.

Eight times the official Pesticides Advisory Committee has ruled the poison as safe, if proper precautions are taken. Such complacency echoes alarmingly the official inertia which has been shown by the British government over lead in petrol and asbestos.

The campaign against 2,4,5,T spotlights the inadequacy of the whole system of pesticide safety and control in Britain. The chemical has been outlawed in the United States. This book puts its case with cold, well-argued passion. It is a call to arms.

Janet Hadley
ex-CHC NEWS

Your letters

Learning research

Dr William Belson, The Survey Research Centre, 58 Battersea Park Road, London SW11.

Readers may wish to know that in May and June I plan to present nine short training courses — two days each — on the methods of social and business research. Course fees will be halved for CHCs.

The course units deal with introducing survey research, sampling, question design, interviewing methods and control, data analysis, report writing, group discussion, and opinion and attitude measurement.

The courses will be held at the British Institute of Management in London. Further details are available from me at the address above or telephone 01-720 4800.

Depo Provera — how is it used?

Marge Berer, Co-ordinating Group on Depo Provera, 374 Grays Inn Road, London, WC1. Tel: 01-278 0153

We are seeking information on women's personal experiences of the contraceptive injection Depo Provera (DP) and information from health workers on use of the drug. We need this evidence before 15 March to present to the public hearing on DP beginning on 25 April (see *CHC NEWS* 82 page 3).

We are concerned that the side effects of DP are being shrugged off as unimportant, that women are being pressurised to accept the drug after rubella vaccinations and childbirth, or are given it without their knowledge. Further, we are unconvinced by claims that the drug is safe.

The drug's manufacturers want a long-term licence for the contraceptive. This would mean that DP would become available alongside other contraceptives as a first-choice method. We anticipate that a heavy advertising campaign by the drug company would encourage doctors to recommend the drug to women as an "easy" choice — easy for the doctor too — when other contraceptive methods might do just as well or even better.

Because a small number of women are unable to use other methods, we cannot support a ban on DP. We want to see a short-term licence as at present, with added restrictions including an informed consent procedure and follow-up on all women using DP. In this way abuses could be reduced to a minimum.

DP is one in a long line of contraceptive methods being developed to prevent pregnancy by disrupting women's hormonal cycles. If these drugs are allowed to come onto the market unquestioned, research will never be done on safer methods which do not affect women's health.

The manufacturers of DP stand to lose profits because women are questioning the need for their drug — we believe women stand to gain from our challenge.

Please send your information on DP to us at the address above.

Finding FPC lists

Shirley McCarthy, Secretary, North West Herts CHC

What do other CHCs think about the anomaly concerning professional lists — of GPs, dentists and opticians — held by post offices? Most local Crown post offices have declined to hold lists because they lack the resources to update from amendment sheets, but DHSS literature and medical cards advise people to consult lists at post offices.

The Hertfordshire family practitioner committee is about to issue new professional lists but will not send them to post offices.

My CHC would particularly like to hear reactions on this from other shire counties.

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CHC NEWS and Information Service Staff:
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DITH BANBURY

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Comment

Many people believe "hard-sell" marketing of breast milk substitutes is a problem for the third world, where women eke out tins of powdered milk in the mistaken belief that their babies will have a better start in life.

But the hard sell happens in the UK too, and as the recession bites deeper, more health visitors are reporting that free samples dispensed by manufacturers' representatives are in great demand by women who cannot afford to buy artificial baby food, but still believe bottle is best.

The reasons for this continuing belief were exposed last year by War on Want in a report(1) which "skimmed the surface" with a brief survey, yet found widespread use of posters, leaflets, booklets, direct advertising, free samples and gifts to mothers — all to persuade them to bottle feed their babies.

And health workers receive from manufacturers the same sort of "hospitality" as do doctors from drug companies eager to push up prescribing levels.

Meanwhile public resistance to breast feeding continues. Breasts may be displayed but not used in public. Facilities in shopping centres are few and far between. Creches at work are becoming more, not less unusual.

Now the Government has issued a draft code of practice for marketing, drawn up with the aid of the Food Manufacturers' Federation, and bearing its clear stamp of authorship.

The Government is committed to implementing the World Health Organisation code on breast milk substitutes, yet the draft UK code endorses much of the bad practice condemned by the WHO code.

War on Want houses the European branch of the International Baby Food Action Network (IBFAN), and both groups want to see the draft withdrawn. In letting the manufacturers rewrite the WHO code to suit themselves the DHSS has "given healthy profits priority over healthy infants" says IBFAN.

Yet the WHO code itself is "in shreds" says IBFAN's latest report (2), with 15 million violations recorded in 1982.

1. *Breast or bottle - factors influencing the choice of infant feeding in the UK* is £1 inc post from War on Want, 467 Caledonian Road, London, N7 9BE.

2. *Breaking the rules - 1982. A year end compilation of violations of the international code of marketing of breast milk substitutes* by IBFAN is £1 inc post from War on Want as above.

Health News

Fags are a gas

The Government has finally bowed to pressure from anti-smoking campaigners to publish the carbon monoxide yields of individual cigarette brands. Carbon monoxide is implicated in the raised rate of coronary heart disease amongst smokers — though nicotine may also aggravate arterial damage.

Yield levels are included for the first time along with tar and nicotine yields in tables* published regularly by the DHSS.

*Available from the DHSS leaflets unit, Canon Park, Government Buildings, Honeypot Lane, Stanmore, HA7 1AY.

Act for mental health

Implementing the new *Mental health (amendment) Act 1982* gets under way with the DHSS' search for members of the Mental Health Act Commission. The Act received royal assent last autumn and will take effect from September.

The Commission — which will have the status of a special health authority — will arrange visits to detained patients, investigate complaints and review the use of the Act's detention powers. It will also be responsible for the new "consent to treatment" procedures and will draw up guidelines on practice.

Health circular HC(82)17 explains some of the changes made by the Act — further guidance is promised for later in the year.

Man and womanpower

Health service staff are "the most valuable and costly resource employed by the NHS" says Edith Körner in the latest interim report from the steering group on health services information. *Manpower information - a report from working group E* is now out for consultation — comments are required by 14 March.

It recommends data sets (see *CHC NEWS* 82 page 1) for the control and efficient use of staff, and describes trials in the Exeter, Hereford, North Tees and South Birmingham health districts which will test out the recommendations. As with previous reports, seminars will also be held to discuss the proposals.

Supplies of the report are limited, but individual copies can be obtained from the steering group secretariat, Room 921, Euston Tower, Euston Road, London, NW1.

Cutting the losses

Health Minister Kenneth Clarke has started a review of security arrangements in hospitals following a report* from the National Association of Health Authorities (NAHA) which claimed that thefts and attacks on staff are a growing problem.

Items worth £833,473 were reported lost through theft, fraud and arson in 1980-81, but NAHA believes the true figure is much higher.

Health circular HC(82)19 emphasises the problem of linen losses and asks health authorities to develop "security strategies" within the year to safeguard stores, linen and equipment.

**Losses, thefts and security in the NHS - first report of NAHA's security committee* 45p inc post from NAHA, Park House, 40 Edgbaston Park Road, Birmingham

Prescribing change

The Association of CHCs' Chairman John Austin-Walker has written to Health Ministers expressing concern at the delay in publishing a report on prescribing.

His letter was prompted by Ministers' conflicting statements on the report of the DHSS' Greenfield working party on effective prescribing — which is thought to recommend that pharmacists should substitute cheaper "generic" drugs* if doctors prescribe brand name equivalents. Doctors could opt out of the substitution scheme by ticking a box on the prescription form for the brand to be prescribed.

While Health Minister Kenneth Clarke has promised "we shall act on Greenfield soon" his junior Minister Geoffrey Finsberg maintains that "prescribing must be left to the doctor's judgement". Estimates of potential savings from generic substitution range from £30 million to £170 million, but the DHSS claims higher figures are "totally unreasonable" and Mr Finsberg says "overall savings to the NHS would be very small indeed".

Mr Austin-Walker is asking for clarification of the Government's intentions. He points out that Ministers introduced charges for overseas visitors — despite the dangers to staff/patient relationships — on the basis of a "dubious" potential saving of £4 to £6 million.

*For a discussion of the "generic" issues see *CHC NEWS* 61 pages 8 and 9.

Dental gaps

The first legislation for 25 years on dentistry may prove to be a missed opportunity for reform. The *Dental Bill* was introduced quietly in the House of Lords last November and has already had its Second Reading.

It deals mainly with changes to the structure of the dental profession through expansion of the General Dental Council membership and widening of its duties, but no provision is made for extra consumer representation.

A new procedure for suspending those unfit to practice through addiction or illness will bring the profession in line with doctors, and dental hygienists will have more freedom to work without direct supervision by dentists.

The Bill will probably reach the House of Commons by late spring.

● Two other health-related Bills are going through the House of Commons now,

Continued on back page

THE COMMITTEE ON RESTRICTIONS AGAINST DISABLED PEOPLE

Breaking down barriers and opening doors

by Joe Hennessey, Secretary of Durham CHC and Member of CORAD

Discrimination against disabled people is widespread — and there should be legislation to make this illegal.

These are the major conclusions of the committee on restrictions against disabled people (CORAD) following a two-and-a-half-year investigation.

CORAD was set up by the MP Alf Morris in 1979 when he was Minister for the Disabled. When Reg Prentice became the new Minister — following the general election and change of Government that year — he agreed that the committee should continue its work.

In all respects though, CORAD acted completely independently. We were not tied by the priorities or wishes of any government in our deliberations and recommendations.

The chairman of CORAD was Peter Large, who had chaired the Silver Jubilee committee on improving access to public buildings, as well as being a leading light in organisations such as the Disablement Income Group, the Association of Disabled Professionals and the joint committee on mobility for the disabled.

Many of the other CORAD members also had disabilities and people were chosen for their knowledge and personal experience of the problems of disability. Amongst our number were experts in a variety of areas including law and the design and construction of buildings, and most had experience of work in organisations of and for disabled people.

CORAD was given the following terms of reference:

> "To consider the architectural and social barriers which may result in discrimination against disabled people and prevent them from making full use of the facilities available to the general public — and to make recommendations".

The committee had to define what was meant by discrimination. We came up with the following:

> "The *unjustifiable* withholding — whether intentional or not — of some service, facility or opportunity from a disabled person because of that person's disability".

It was accepted that there could be some circumstances when discrimination against a disabled person would be justified — in the employment field, for instance.

If the physical requirements of a particular job could not be met by a person with a disability an employer would be justified in excluding that person from consideration for the job — we did not suggest there should be blind bus drivers or deaf piano tuners!

To start with we invited evidence from a very wide range of organisations and individuals, and over 700 responses were received. This may be felt to be a rather low figure but many of the responses were made on behalf of groups of disabled people and contained multiple examples, so the pool of experience drawn on was of many thousands rather than mere hundreds of disabled people.

So what kinds of discrimination were found? Nearly 75% of complaints were about access to buildings and a substantial number of these related to mythical fire regulations.

Our report forcefully states:

> "To deny disabled people entry to buildings or use of facilities inside buildings — whether wilfully or by tolerating barriers that they cannot cross — is discriminatory. This kind of discrimination, which leads to disabled people being kept out of sight and denied their rightful share in society, leads to many of the other kinds of discrimination. It is part of the way in which society has always been structured around a concept of people as uniformly fit and able-bodied".

Problems of access to public transport and pedestrian precincts are covered in the report. The inner London boroughs which do not recognise the Orange Badge for parking concessions are accused of discrimination against disabled people who wish to visit these areas of central London.

Over 100 letters to CORAD referred to people being refused access to premises because they were a "safety hazard". Our report gives some illustrations of this and says it is a problem not only in places of entertainment. It has stopped people obtaining jobs and university places, interfered with their careers, and prevented them taking evening classes and taking part in many other social activities.

After access the next most common concern was around employment — 40% of people alleging discrimination cited problems in this area.

We found that discrimination occurs at every stage. Mention that you are disabled on an application form and you will be less likely to get an interview for the job.

One well-qualified man had only one interview from 50 applications when he mentioned his disability. On the next 35 forms he did not disclose his disability — and he got 12 interviews.

In another case a man called at a firm to enquire about a job for which he was qualified. The receptionist telephoned the department concerned and was told to send him up, but when she then mentioned that he was in a wheelchair the reply was "Tell him there are no vacancies".

Many other examples of this sort of discrimination are included in the report.

Education, entertainment (with some dreadful instances), civic and social rights and insurance are also covered as areas where discrimination exists.

The report acknowledges that the problems described have been well known for some time and that a certain amount *has* been done — not least by governments — to attempt to remedy some of them.

But CORAD argues that the remedies have not worked and in some areas have not even been tried.

> "No comprehensive solution has been proposed"

says the report. We then go on to argue the case for legislation.

Many committee members initially felt that anti-discrimination legislation —

> "with its overtones of belligerance and conflict" —

was an over-reaction that might be counter-productive. We also believed that much discrimination resulted not from ill-will but from ignorance — for which education seemed a more suitable remedy than legal penalties. And there would be practical difficulties and considerable expenditure.

But after looking at all the disadvantages most carefully CORAD concluded that the case in favour of legislation was much stronger than the arguments against.

The first practical advantage would be that an individual disabled person would have access to the law to secure the right to equal treatment. Legislation would provide a foundation on which good practice could be built.

> "The majority of people comply with legislation. It is true that legislation cannot make people love each other but it can make people behave properly towards each other and this is what we seek to achieve. Legislation would at least give disabled people the confidence to integrate into society, knowing that they had a statutory right to equal treatment and that in the last resort they could have recourse to the law".

CORAD looked at the experiences of America and Canada — both of which have already enacted anti-discrimination legislation in respect of disabled people. We also examined the UK legislation against discrimination on grounds of race and sex, and looked at the way in which anti-discrimination laws work, here and abroad.

Having considered all this, our report recommends that:

> "There should be legislation to make discrimination on the grounds of disability illegal. The law should cover all areas where discrimination occurs and particularly employment, education the provision of goods, facilities and services, insurance, transport, property rights, occupational pension schemes, membership of associations and clubs and civic duties and functions".

We also recommend that there should be a regulatory body or commission with powers to investigate, conciliate and if necessary take legal action on individual complaints of discrimination.

The report suggests that it may be helpful to amalgamate the Commission for Racial Equality, the Equal Opportunities Commission and the proposed new body into one commission concerned with promoting equal opportunities for all groups of people who suffer discrimination.

In all CORAD makes 40 recommendations to the Government — including those already mentioned. They cover education, employment, access to buildings and facilities, pedestrianism, Orange Badges, the media, representation of disabled people on public, private and voluntary bodies, and other areas.

The CORAD report concludes:

> "We are convinced that legislation is practicable and that it represents the best way of combating discrimination. We believe that it need not be expensive, that it would not, if sensibly drafted, antagonise public opinion and that it would represent a major step forward in the progress to a truly humane society".

When publishing the report the Government said it was unconvinced about the need for anti-discrimination legislation, preferring more education and publicity to build on the improvements achieved over the last decade.

The present Minister for the Disabled — Hugh Rossi — said:

> "Before considering the introduction of such far-reaching legislation we would need to have good evidence that there were significant breaches of human rights and I do not think the report provides this evidence. There are some very telling anecdotes but without any attempt to validate or quantify them it would not be right to base major policy changes on them. The committee's questionnaire elicited a very low response which suggests that such cases, disturbing as they are, are the exception".

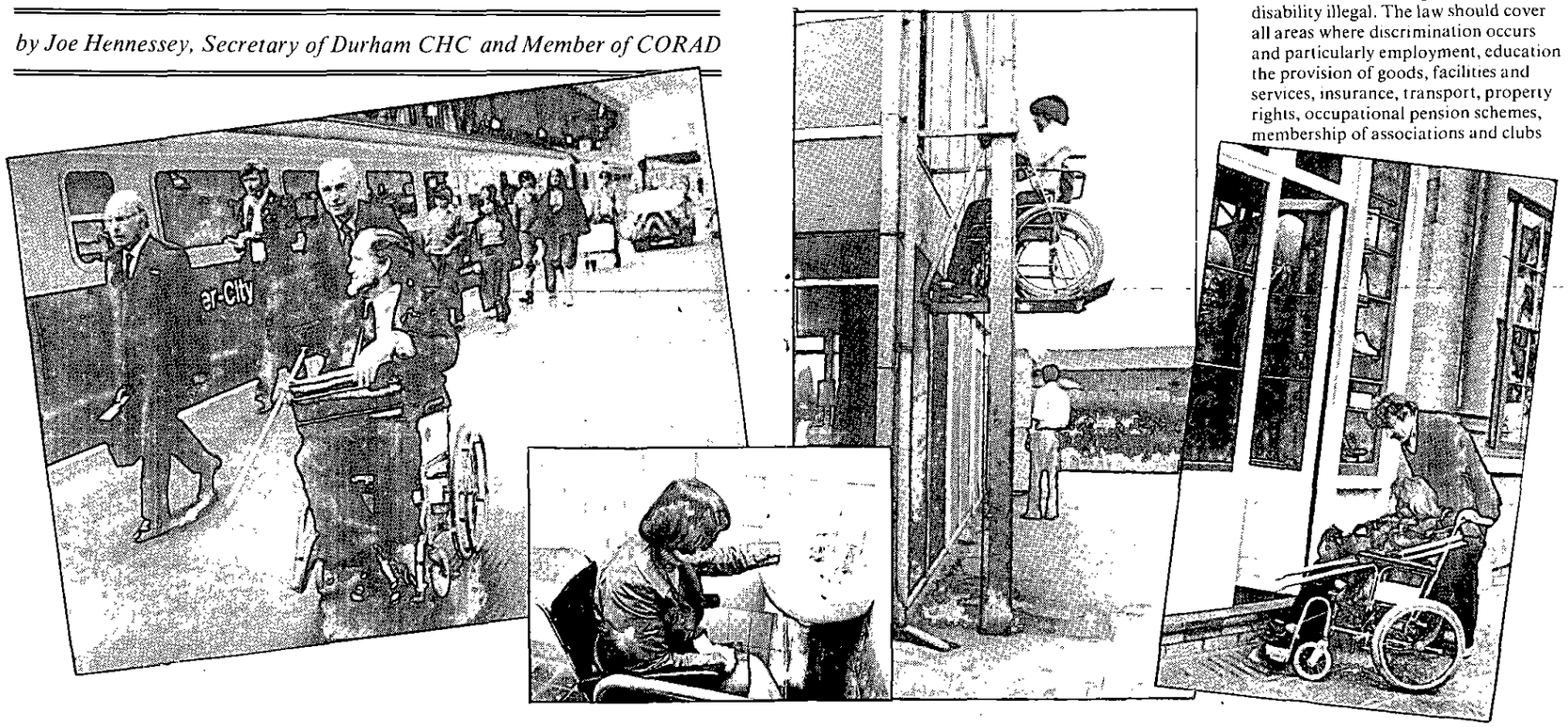
He also claimed that the report had not considered in detail the practical difficulties of implementing legislation.

He concluded that:

> "It is now up to the disability organisations and the community as a whole to make known their views on how to improve the participation and integration of disabled people".

I hope that CHCs will consider the report and respond to the invitation to make their views on it known to the Government. By no means all the recommendations in the report call for government action and it is interesting to note that many of those which are not the direct concern of the Government have Mr Rossi's support.

The main, unresolved argument is whether there is widespread discrimination against disabled people — which CORAD says exists but about which the Government is "not convinced" — and if the problem exists, how it should be tackled.



Photos: Margaret Murray for the Spastics Society

The *Report of the committee on restrictions against disabled people* costs £5.35 from the DHSS Publications Unit, PO Box 21, Stanmore, Middlesex, HA7 1AY

How ethnic minorities use health services

*by Dr MRD Johnson and Mr M Cross**

The presence of black and brown people in the British population — in particular in the large cities — is not especially new, but it seems the providers of services in those cities have only recently begun to come to terms with the implications of this presence.

Earlier discussions often implied that it was a passing phase, and that it would be resolved by assimilation — or more drastically, by repatriation of one sort or another.

But increasingly it is realised that the ethnic minorities are now a permanent part of the population. Culturally and socially they will form a distinctive group of users or clients for the foreseeable future.

Where there is some recognition of a minority presence it is often seen as a "problem". A recent paper from the Royal College of GPs (1) saw the presence of ethnic minorities as placing a strain upon GPs in all areas surveyed. In only one city was this seen as counter-balanced by the presence of doctors of Asian origin.

Yet the situation has never been properly investigated.

Ethnic minorities of Asian and Afro-Caribbean origin now form about 4% of the population — as much as 14% in Greater London and nearly 11% in the Metropolitan West Midlands.

A large-scale household survey in inner areas of the West Midlands conurbation was carried out in 1981 — specifically in wards of Birmingham, Coventry and Wolverhampton which contain substantial proportions of these ethnic minority populations.

We looked at use and receipt of health services, including primary care.

Information from the 2161 interviews shows that clients from the ethnic minorities do not make excessive or unjustified demands upon a health service to which — as some wrongly allege — they do not contribute proportionately.

We found that, contrary to expectations, over 99% of all groups — white, Asian and Afro-Caribbean — were registered with a GP. Only about 10% were not registered with a GP practising in their immediate area of residence.

Nearly 95% told us about their doctor in detail. It is noteworthy that 66% of Asians were registered with a GP of Asian origin and a further 10% were registered with practices containing an Asian doctor.

One in four of the whites in our survey was also registered either with an Asian doctor (9%) or a "mixed" practice, and so were more than one in three Afro-Caribbeans.

Of the 171 practices identified, 59 were Asian and 21 were "mixed". It was notable that where more "mixed" practices were to be found, white respondents' suspicion of "foreign doctors" was least!

It is sometimes stated that ethnic minorities represent a "burden" on health services by making excessive demands.

Certainly the survey demonstrated that Asian households were more likely to have visited their GP in the last year and to have visited more frequently.

Afro-Caribbeans were not significantly more likely to have needed a doctor, although those who had seen their GP tended to have been more frequently — often for long-standing conditions or for repeat prescriptions.

However, whites were much more likely to have bypassed the GP by visiting hospital out-patient or emergency clinics. These services were used by ethnic minorities only after referral by their GP.

Asians were most likely to have had a domiciliary visit, white responses were close to those of Asians, and Afro-Caribbeans were *least* likely to have called the doctor out. Given the larger number of children in Asian households, one might reasonably expect them to be more likely to *need* a domiciliary visit.

Asians made few visits to the GP for "vague or poorly described symptoms" — as we classified their responses. Visits were genuinely based on need — and were mainly physical problems. Most psychological problems were reported by white respondents.

While Asian parents appeared to be marginally less likely to have attended child health clinics, the differences were very slight and gave no cause for alarm. Indeed their take-up of immunisation services was considerably better than that of white parents in the survey and particularly few took only some of the recommended vaccinations.

Afro-Caribbeans reported nearly 100% take-up of rubella vaccinations, compared to only about 75% of whites and Asians.

Finally we considered the proposition that Asians do not believe in "western medicine", or rely heavily on Unani or Ayurvedic practitioners.

While this may be the case in Bradford or London, in the West Midlands we found peculiarly little use of these methods.

Virtually none of our white or Asian respondents had been to a herbalist or "non-western" healer although a small number of whites had attended osteopaths.

An opinion question showed that the majority of Asians felt scientific medicine was preferable to traditional remedies. Less than a quarter believed traditional remedies had value for many conditions. But white respondents were quite likely to believe this and so were Afro-Caribbeans.

Asians were as likely as whites, but not more so, to have consulted a private doctor. A surprising proportion of Afro-Caribbeans had paid for a second opinion or for "better treatment".

We conclude from our survey that there *are* differences between ethnic groups in British society, but these do *not* represent a threat to the NHS, nor an excessive demand upon its resources by minority communities.

While there *is* higher usage, it appears to be linked to needs which can be closely related to sociological inequalities such as housing, employment and income.

And it is *not* the case that the ethnic minorities are opting out of the NHS, creating a "reservoir of illness" or a subsystem which could threaten community health schemes.

We hope that future reports will cease to regard ethnic minorities as problems, but will examine their needs as individuals and their problems in the context of other aspects of racial discrimination and disadvantage.

1. *Inner cities* by Dr Keith Bolden. Occasional Paper 19, price £3 inc post from the RCGP, 14 Princes Gate, Hyde Park, London, SW7 1PU.

Photo: Raissa Page

Dr Johnson is Research Fellow and Mr Cross is Deputy Director of the Social Science Research Council Research Unit on Ethnic Relations at the University of Aston in Birmingham.

Scanner

How to get noticed

Instructions on how to produce the most effective and interesting displays on health service noticeboards are given in a new booklet aimed at GPs and health workers. The booklet gives advice on the best choice of position for noticeboards and the information to be displayed. Also included is step-by-step guidance on the use of lettering, layout and lighting to produce attractice and effective displays. *Getting the message across* — developed after a series of health education courses in Avon — is obtainable at 85p inc post from Cecilia Platts, Room 48, Central Health Clinic, Tower Hill, Bristol, Avon BS2 OJD.

A volunteer's aid

A guide designed for volunteer organisers new to their job has recently been published. It describes a practical approach to structuring the first three months work — to gain a clear picture of what the job involves and the contacts necessary to do the job effectively.

Although specifically aimed at workers in London, the principles put forward are felt to be applicable to a wider audience including community, social, health, and youth workers and staff in voluntary organisations.

Starting out: a guide for new volunteer organisers in London is available at £1.75 inc post from London Voluntary Service Council, 68 Chalton Street, London NW1 1JR.

Putting feet first

People working with the elderly or with disabled adults can now hire a training package to help with foot problems. *The tender foot kit* includes samples of ready-made orthopaedic footwear, examples of shoe adaptations, special footwear, types of insoles, hosiery and other aids. Slides, lecture notes and lists of manufacturers are included. Available for hire at £30 (transport extra) from the Disabled Living Foundation, 346 Kensington High Street, London, W14 8NS. Tel: 01-602 2491.

The Foot Health Council is planning a *Good foot week* for October 1983 to concentrate on foot health education for the elderly and children. The Council — which includes representatives of health authorities, chiropodists, health educators and footwear manufacturers — has published a *Children's foot health register* of retailers which stock a full range of fittings and provide staff trained to measure children's feet. Free with a 12½p stamp from Donald Beaton, the Foot Health Council, c/o Chiropody Department, St Leonard's Hospital, Nuttall Street, London, N1 5LZ.

Complaining about a complaint

A CHC recruited the health ombudsman to help with a patient's complaint after the local FPC delayed for over a year in starting the formal complaints procedure. The ombudsman is not permitted to investigate FPC activities under the complaints procedure, but he *was* able to comment on the administration of the case. He criticised the FPC for "inexcusable delay" in dealing with the patient's complaint and recommended that cases should be monitored regularly by the FPC. *Report of the health service commissioner — selected investigations completed April-September 1982.* HMSO £8.55.

A winner in the 1982 Plain English Awards, this leaflet is published by Mencap. Awards are given for examples of good, plain English and clear, simple layout. Mencap's leaflet explains what being mentally handicapped means and how improved public attitudes could help handicapped people and those who care for them. Several of the judges commended the leaflet for its design, good size of type and for having, "an open and friendly appearance with some cheerful illustrations." Let's get it straight *is £4.50 inc post for 100 copies from MENCAP, National Centre, 123 Golden Lane, London EC1*

CHC Directory: Changes

Changes to the CHC Directory are published on this page in each issue of *CHC NEWS*. Please let us know if your entry needs updating. Single copies of the directory are available free — send an A4-size self-addressed envelope and 25p in stamps.

Page 3: Bradford CHC Chair: Lorna Overend
Page 3: Sunderland CHC Chair: Mrs E Donnison
Page 4: Pontefract CHC Tel: Pontefract 796470
Page 8: Canterbury and Thanet CHC Chair: Patricia Shephard
Page 8: Hastings CHC Secretary: Mr R M A Wade
Page 13: Rugby CHC 18 Warwick Street, Rugby CV21 3DH. Telephone number remains the same
Page 15: Burnley, Pendle and Rossendale CHC Chair: Mrs M C Lupton
Page 18: North West Thames Regional Forum of CHC Chairmen c/o Ealing CHC 119 Uxbridge Road, Hanwell W7 3ST. Secretary: Penny Grondona
Page 18: Oxford Regional Group of CHCs c/o Northampton CHC Chair: Philip Wilkinson, Secretary: Jackie Walker
Page 18: Mersey Regional Group of CHCs Chair: Mr E Hebron, Secretary: Mr G W Favager
Page 19: Mersey Regional Association of CHC Secretaries Chair: Mr D Wormald, Secretary: Mrs H Clarke

Nuclear reassurance

"The most likely outcome of any accident at a nuclear plant is that no-one would be hurt at all" says a new booklet aimed at the authorities which would have to help clear up the mess.

In an emergency at a nuclear power station or waste plant an operational support centre (OSC) near the site would direct emergency operations and liaise with police, emergency services, health, water and local authorities and government agencies. The public would be told to stay indoors, to take potassium iodate tablets or to evacuate. Health authorities might have to treat casualties amongst site personnel but contamination levels amongst the public "would require little action apart from reassurance". Local liaison committees — which provide a channel of information between nuclear plants and the local community — would have no specific role in an emergency. *Emergency plans for civil nuclear installations* by the Health and Safety Executive is £2.75 plus postage from HMSO or booksellers.

Health circulars

HC(82)18: revises guidance on staff catering costs.
HN(82)39: describes urgent action needed to improve safety standards of electrical equipment in post-mortem rooms.

Other publications

Community development — towards a national perspective. Price £2.25 inc post from the Community Projects Foundation, 60 Highbury Grove, London N5 2AG.

I want to appeal — a guide to supplementary benefit appeal tribunals 2nd edition. Price £2.30 from bookshops or (post free) from the National Association of Citizens Advice Bureaux, Training Department, 110 Drury Lane, London WC2.

Self-help and the patient — a directory of national organisations concerned with various diseases and handicaps. Updated 8th edition price £1.75 inc post from the Patients Association, 11 Dartmouth Street, London, SW1H 9BN.

News from CHCs

☐ A DHSS civil servant has backed down on advice given to the North Western RHA during the row over **Salford CHC's** women and health meetings (see *CHC NEWS* 74 page 8). The RHA's legal adviser was "doubtful whether CHCs have powers to organise such courses". The CHC challenged his opinion, so he wrote to the DHSS for clarification. The DHSS reply was not very clear — it said: "it is very doubtful whether CHCs have the power to organise lectures", that they may run "workshops or meetings" as part of their duty to review local services, but that the letter-writer was "unable to trace any precedents" for CHC health education courses. The CHC challenged this opinion too and — after six months' deliberation — the same civil servant has admitted that "CHCs do have a role in health education" and that "it would be improper for me to suggest ways in which the CHC ... should do its job".

☐ **Bloomsbury CHC** resurrected a former CHC's "bogus patient" ploy — described in *CHC NEWS* 75 page 5 — to investigate difficulties in finding a GP in its district. Volunteers representing an elderly man, a young, single woman and a married woman with children phoned every practice on the FPC list during surgery hours, and responses were analysed. Only 43% of calls produced a positive response and a breakdown of responses by patient and by area showed that the elderly have the toughest time in finding a doctor, while GPs in the former North East Westminster district are markedly more reluctant than those in the former South Camden district to take on new patients. The single woman "patient" was most often quizzed on permanence of residence, and the CHC sees this as a reflection of the large homeless population in the district.

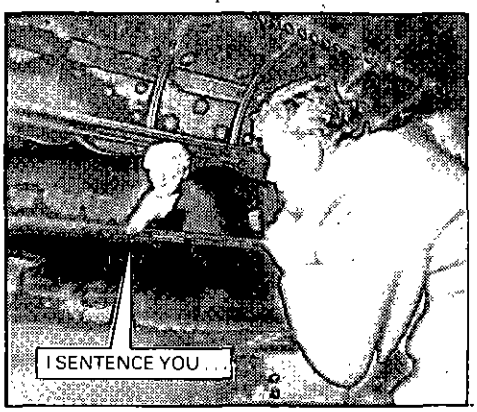
☐ Meanwhile **Weston CHC** is trying to discover why out of 551 patients removed from Avon FPC lists at the request of GPs over one quarter of them were from Weston-super-Mare. The local Age Concern informed the CHC of the problem because they believed that elderly people in particular — up to six a week — were being affected. The CHC has written to both the DHA and the FPC but as yet no explanation has been forthcoming.

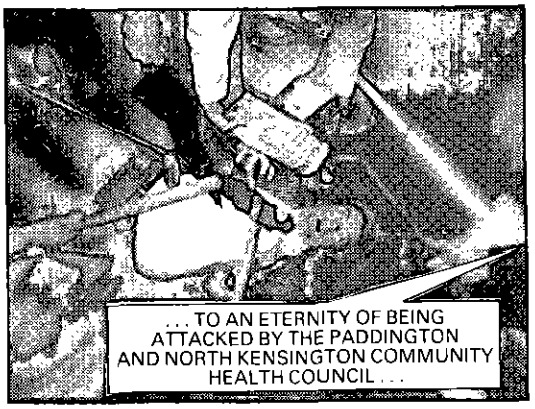
☐ **Salisbury CHC** took to the road in search of the public's views on complicated DHA plans for future services. A caravan lent and driven by a St John's ambulance brigade member covered well over 400 miles to spend a day in each of 16 towns around the district. CHC members talked to the public, distributed a short questionnaire and held public meetings in the evenings. The gruelling schedule covered six weeks and exposed the DHA's inadequate explanation of a complex package deal incorporating closure, change of use and a new hospital development. A poor response to the questionnaire showed that the public found it hard to disentangle these issues, but the meetings and caravan chats put the CHC firmly on the map. And CHC members revelled in the direct involvement in their CHC's work.

☐ A former CHC secretary was awarded an OBE in the New Year's honours list. Dilys Palmer was secretary of **South Tyneside CHC** from its inception until her retirement some three years ago. She gained the award for her work with Washington Development Board.

CHC surveys and publications

Health services for two city communities — a report on surveys in two Bristol areas **(Bristol CHC).** The experience and views of some caliper wearers **(Cambridge CHC).** Strathclyde House — survey of opinions of patients, visitors and staff **(E Cumbria CHC).** St Bernards Hospital — a report on psychogeriatric and long-stay wards **(Ealing CHC).** A survey of patients attending the county hospital ante-natal clinic **(Hereford CHC).** NHS useful initials *and* Health service costs in Nottingham **(Nottingham CHC).** Booklet on national health and related services in East Surrey **(E Surrey CHC).**





Photos: General Practitioner

☐ *These pictures are from the popular "Dr Goodman" photo-story strip in* General practitioner. *The conscientious doctor comes in for a lot of stick in the course of his work, but criticism from* **Paddington and North Kensington CHC** *has promoted him to the magazine's letters page in recent months. Always open to new ideas for good practice, Dr G's attempt at anti-sexist treatment of a woman patient enraged the CHC. A letter was dispatched complaining of the "disgraceful portrayal of a woman being examined in front of a stranger without saying a word" — Dr G thought the drug rep was her husband, she was apparently incapable of enlightening him and the drug rep said nothing either! The CHC's letter has provoked much mirth from* GP's *readers, as well as the predictable jibe of "humourlessness".*

Health News

Continued from page 3

although — as Private Members' bills competing in a packed legislative timetable — neither is likely to become law yet.

A "ten-minute rule" Bill to make drug manufacturers liable to pay compensation was presented in December by MP Jack Ashley, who said it was "scandalous" that no Health Minister appeared to debate the issue. His Bill is due for a Second Reading on 4 February.

And MP Donald Stewart has presented a Bill to implement the CORAD report (see pages 4 and 5). He came fourth in the ballot for Private Members' Bills and the progress of his Bill depends on how fast those above him in the ballot are dealt with. Second Reading is timetabled for 11 February.

Written info hope in MRC trial

As controversy rages over the Medical Research Council's spina bifida vitamin trials, the MRC is considering a proposal that women recruited to the trials should have information in writing before giving their consent.

Around 2000 women who have already had spina bifida babies will be randomly allotted to one of four groups, receiving minerals only, vitamins and minerals, minerals and folic acid or all three. Folic acid has been linked with a reduction in spina bifida births and vitamins may also play a part, but there is no evidence that mineral supplements reduce the likelihood of spina bifida.

The trials are expected to last five years but their findings may be distorted by ethical committees in areas of high spina bifida incidence refusing to take part.

The Association for Improvements in the Maternity Services (AIMS) believes past trials show that doctors cannot be relied upon to give information verbally. AIMS will "create a stink" if the MRC rejects the proposal to explain the trials in writing.