CHC NEWS

For Community Health Councils

June 1983 No 87

Legislation ditched in pre-election rush

Several major Bills were thrown overboard in the last-minute leap towards the polls last month — and some of the legislation that did go through was shorn of the more controversial clauses in time-table deals made between Ministers and their Opposition shadows.

The demise of the *Police and criminal evidence Bill* was greeted with relief by many organisations — including the British Medical Association — which were not satisfied by Home Office concessions made during its progress through Parliament. The BMA is pledged to continue its campaign of opposition to the Bill should it be reintroduced by a future Government.

But we are more likely to see the return of the *Data protection Bill* — which the BMA is preparing to oppose by mobilising industrial, commercial and consumer opinion.

One legislation casualty which passed almost unnoticed was the provision in the *Finance Bill* to refund value added tax to health authorities which pay private contractors for ancillary services. Treasury Ministers have undertaken to reintroduce major lost clauses of that Bill — raising the ceiling on mortgages for instance — but no such commitment has been made on the VAT measure.

The *Housing and building control Bill* was ditched after the House of Lords put up a spirited fight against a clause compelling grant-aided housing associations — including those providing sheltered homes — to sell off property at discount prices.

Loss of family practitioner committees' proposed independence was the price Health Minister Kenneth Clarke paid to salvage the *Health and social services and social security adjudications (HASSASSA) Bill*. A duty to admit the public to non-confidential parts of FPC meetings was retained after former Health Minister David Ennals championed CHCs' views on this measure.

Mr Clarke promised to revive the withdrawn FPC clauses "at the earliest possible opportunity".

Meanwhile he seized the chance to plug a legal loophole recently publicised in the media — *HASSASSA* provisions on nursing homes were amended to control cosmetic laser treatment and other potentially hazardous techniques through registration of clinics.

Representation of voluntary bodies on joint consultative committees survived with *HASSASSA* — and in the *Dental Bill* lay representatives on the General Dental Council were increased from three members to six, while doctors on the GDC were reduced from six to three.

The "first statutory recognition" of the glue sniffing problem slipped into law as the *Solvent abuse (Scotland) Act 1983* which originated as a private member's Bill brought by Glasgow MP David Marshall. It makes glue sniffing grounds for referral to the unique Scottish children's panels — which provide informal settings for children to discuss their problems.

Pregnancy in the round

Ordinary people are the experts on ante-natal needs suggests a study of voluntary activities in the field. *Health in the round — voluntary action and ante-natal services** combines analysis of NHS services and the contribution volunteers can make, along with full information on 40 projects studied in detail. Much of the help parents need can be provided by people with no medical training, conclude the authors, and volunteer projects are especially successful in helping those least likely to use existing services. Yet the professionals are often hostile towards voluntary effort when they should be forming partnerships with community initiatives.

*by Rosemary Allen and Andrew Purkis. Published by the Bedford Square Press for the National Council for Voluntary Organisations. Price £4.95 from bookshops or £5.57 (inc post) from Macdonald and Evans Distribution Services, Estover Road, Plymouth, PL6 7PZ.

● A local branch of the National Childbirth Trust is holding a symposium this month to publicise little-known aspects of its work. As well as the usual ante-natal classes, Barnet's NCT branch also helps out post-natally — with equipment loans, support for adopting parents and others, and a breast milk run for premature babies. Further information from Elana Overs, 46 Kingwell Road, Barnet, Herts.

Photo: Chris Taylor

Change ahead for ACHCEW

The search is on for a new recruit with the skills and strength of character to step into the shoes of Mike Gerrard — Secretary of the Association of CHCs in England and Wales — who is leaving at the end of July to take up the demanding post of chief executive to the Shetland Islands council.

Mike has been the Secretary of ACHCEW since its establishment in 1977 and has played a crucial role in the development of CHCs' influence and expertise within the health service. His successor will be appointed this month by a panel of ACHCEW's standing committee members.

"I hope the new Secretary will bring to the post a sense of adventure and a willingness to innovate" Mike says. "CHCs need someone who will revive the excitement of the early days — and who can equip ACHCEW to meet the challenge of a new Government".

The new Secretary may not be in post until the autumn — but it is hoped that the panel's choice of successor will be able to attend ACHCEW's annual general meeting in Sheffield this July.

Your letters

What about the patients?

Marion Wilton, Member, Barnet CHC

I agree very much with your statement — in *CHC NEWS* 85 page 3 — about the Institute of Health Service Administrators' conference on efficiency in the NHS.

But you could have mentioned that CHCs were represented at the conference — by at least four members from different CHCs. I tried at the end of the morning to put over a similar view to yours by pointing out that the word *patient* had not been used all morning.

Following this the afternoon speakers made reference to patients prompted by my comments.

The day certainly confirmed my view that administrators would be happier without patients to disrupt the otherwise smooth running of the hospitals.

Patients and GPs — equal freedom of choice?

Don Watson, Secretary, North Tyneside CHC

"I have been requested by Dr X to remove you and the members of your family named below from his list of NHS patients."

This curt news from the family practitioner committee (FPC) greeted a couple in their nineties in our district recently, leaving them confused and distressed. The standard procedures which this and other cases revealed have sparked off a local campaign to change the law.

At present a doctor may remove a patient from his or her panel without having to give any reasons to anyone — including the FPC, which simply administers such cases.

The standard justification for this is that patients are also free to remove themselves from panels without giving reasons. But what freedom of choice does a patient really have? Is it on equal terms with their doctors?

The original GP's co-operation is required by the prospective GP, and this can cause problems for a patient wishing to change doctors. We are finding an increasing number of GPs who will not accept new patients unless they are new residents. The only alternative is assignment by the FPC — the very opposite of freedom to choose.

My CHC believes the system is unfairly weighted against the patient and fears that the secrecy surrounding the removal procedure has too great a potential for cover-up.

Nevertheless the publicity which some recent cases have attracted in this region has helped the individuals concerned and the FPC has agreed to re-write its removal letter in a more sensitive way.

We hope this attention will help to prevent GPs from acting in too high-handed a way and we urge other CHCs to publicise similar cases in their districts.

More on birth control costs ...

Sheila Fleetwood, Chair, Liverpool East CHC

Suzie Hayman makes an excellent point in her letter in *CHC NEWS* 85.

The study by William Laing which she mentions is the second report he has prepared on the cost-effectiveness of family planning services and both were funded by the Family Planning Association (FPA).

The first report was published by PEP — now the Policy Studies Institute — in 1972. It had a wide impact on policy makers at a time before family planning became a free service integrated into the NHS.

Ten years later the FPA asked the PSI to look again at the costs and benefits of the service. In its report the PSI acknowledged its gratitude for the opportunity to return to the subject after a period of such change in organisation and financing of the service and in public attitudes to birth control.

The FPA continues to campaign for the promotion and development of family planning clinic services by the new health authorities. In support of this the FPA's North West of England region held a conference in Wigan in October which was well attended by CHC members and by chairs and officers of health authorities.

... and benefits

Marge Berer, Office Worker, National Abortion Campaign, 374 Gray's Inn Road, London WC1

At a time when Victorian morality threatens to overcome us all the cost-efficiency of NHS family planning clinics is the *least* important reason for maintaining them — no matter how true it may be.

The struggle for safe and available birth control began in Victorian times and only since 1974 has the law made availability a right for all in the UK. It is no accident that birth control services — which cater almost exclusively for women — are under threat, nor that morning-after contraception and very early abortion facilities are not available as a right on the NHS.

Women's health and our right to decide if and when to have children are at stake. GPs' services are no alternative. Many women are reluctant to go to their GP for birth control advice — not least because many GPs do not provide the full range of available methods.

Specialist clinics are the best possible way to ensure access for women. If we once accept that we do not have a right to the best possible services we will lose them — as we will lose the right to a national health service generally.

The rules on political sacking

N G Downs, Secretary, Tameside and Glossop CHC

I was interested to see on the front page of *CHC NEWS* 85 an account of the High Court proceedings which followed Lambeth council's attempt to replace a CHC member after a change in political control in the borough.

A similar situation arose here six years ago. After local elections in 1977 the Conservative party gained control of the Greater Manchester council and attempted to replace its CHC member — a Labour councillor — on the then Tameside CHC by a Conservative councillor.

I informed the establishing authority — the North Western regional health authority — that in my view the regulations did not permit this. After consulting its own legal advisor and those of the DHSS, the RHA confirmed my interpretation.

The local authority was informed and agreed that this interpretation was correct.

Coping nationally

Irene Smith, Chair, Coping with Cancer — Northumbria, 17 Surrey Close, Ashington, Northumberland

After a TV programme last year and a subsequent local radio phone-in several cancer patients, relatives and other interested people met to form Coping with Cancer — Northumbria, with the backing of North Tyneside, Newcastle and Northumberland CHCs (see *CHC NEWS* 78 page 8 and 79 page 12).

We have issued an information bulletin, formed three thriving local groups with more planned, and our next major project is a telephone information service which will be staffed by trained volunteers.

We have received interested responses from other groups and Professor Calman of Glasgow Univeristy would like to arrange a meeting of groups in the autumn for general discussion and mutual support.

To prepare for this we would like information from CHCs about Coping with Cancer projects in their area, with the aim of compiling a register of contact points throughout the country.

CHC NEWS

JUNE 1983 No 87

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GILL KENT (EDITOR),

CHC NEWS is the national magazine for community health councils. It is distributed in bulk to CHC offices for the use of their members. Individual subscriptions are available at £10 a year. Discounts of 25% over 20 copies and 50% over 30. Back copies 50p each.

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

Comment

If there is one thing politicians should have learned from this election it is that private health care is an emotive issue. Many people can still remember the fear of falling sick without the savings to pay for doctors and drugs, and the NHS — for all its faults — is still a massively popular institution.

On the other hand, people are willing to tolerate a certain amount of queue-jumping by those who can afford it — so long as it is kept firmly on the fringes of health care.

But what happens when a Government actively encourages the profit-making sector to come out of the shadows? Can the NHS survive if it becomes ever more reliant on a disparate collection of companies accountable only to their shareholders and — let's face it — in it mainly for the money?

Leaked papers seized upon by parties facing the polls are likely to be used to support the dogma of the moment. The *real* issue behind *Co-operation between the NHS and the private sector at district level* is just what it says — cooperation.

The draft circular is dated February, was circulated to RHA chairs in late March, but was published by the DHSS only after the Labour party threatened to do it for them.

The most remarkable thing about the document is its anecdotal tone. A ragbag of ideas for putting business the way of the private sector, it begins with the premise that "partnership" is A Good Thing Thing, but soon descends to the level of "we know a chap who can do it for you cheap".

Perhaps more interesting is the accompanying paper which was *not* published by the DHSS — the briefing note prepared by two RHA administrators. They also accept the concept of co-operation, but take the circular to task for failing to do it justice.

In particular, they point out that we know far too little about the private sector and how it operates.

Whether you believe that private medicine supports or undermines the NHS, CHCs must be involved in discussions on the developing relationship between the two. Because — as the NHS Consultants Association recently pointed out — CHCs are powerless to monitor health care in the private sector, and unable to help patients who leave the protective confines of the NHS.

Health News

Prevention loses heart

The results of a six-year UK heart disease prevention trial seem to throw doubt on the value of health education in preventing disease. But a Belgian trial on similar lines had more success in reducing heart attacks and death rates.

Both trials were part of a five-centre European prevention project co-ordinated by the World Health Organisation, and in the UK involved over 18,000 men aged 40-49 employed in 24 factories.

Factory medical departments gave the men advice on stopping smoking, exercise, hypertension treatment, weight control and diet to lower cholesterol levels. While the men claimed to have reduced smoking, other risk factors for heart disease showed little change. There was no clear effect on deaths or heart attacks but the men reported less angina and other chest pain.

In Belgium nearly 20,000 men were given similar advice — along with counselling by trial team doctors. The study found reduced risk factors and lower death rates.

Both studies are in the *Lancet* 14 May 1983. *UK heart disease prevention project — incidence and mortality results* by Geoffrey Rose and others, pages 1062-5 and *Belgian heart disease prevention project* by M Kornitzer and others, pages 1066-70.

Drug trial ethics

A code of practice drawn up by the Association of the British Pharmaceutical Industry on GP drug trials has been agreed with the British Medical Association and the Royal College of GPs — but the DHSS has not yet decided on regulation amendments allowing drug companies to pay GPs for conducting trials (see *CHC NEWS* 85 page 10). Patients taking part in trials may be supplied drugs free of prescription charges if the pharmaceutical services negotiating committee agrees.

The code says all the trials must be approved by ethical committees. The GP must tell patients if they are being recruited for a trial and with "special groups" — such as children, the elderly or mentally handicapped people — the trial protocol must state how consent was obtained.

Code of practice for the clinical assessment of licensed medicinal products in general practice is in the *British medical journal* Vol 286, 16 April 1983 pages 1295-7.

Morning after the launch before

The launch last month of the Family Planning Association's campaign to popularise "morning after" birth control came one day before a ruling by the Attorney-General that preventing implantation of a fertilised ovum is *not* the same as procuring a miscarriage.

He was replying to claims by an anti-abortion group that clinics prescribing contraceptive pills to be taken post-coitally are committing a crime under the *Offences against the persons Act 1861*.

After the ruling gave the all clear Health Minister Kenneth Clarke referred the birth control technique to the committee on safety of medicines for their advice on the risks and benefits of its use — although the drugs used are already licensed as contraceptives the license does not cover post-coital use.

Trial studies of the technique are discussed in *Post-coital contraception — methods, services and prospects. A symposium presented by the Pregnancy Advisory Service*, price £2 plus 50p post from PAS, 11-13 Charlotte Street, London W1.

The FPA sees post-coital birth control as a way of preventing abortions. It has produced posters, a fact sheet and a statement from its medical advisory panel to alert GPs to the advantages of the hormonal and IUD methods. Further details from the FPA, 27-35 Mortimer Street, London W1.

News in brief

- Following a symposium on a worryingly high rate of stillbirths and deaths of newborn babies the Welsh Office has proposed a small catalyst team of one doctor and one nurse — supported by a larger survey team — to monitor and advise on local services, to review individual deaths and to produce an all-Wales perinatal mortality survey. A forum of professionals and health authority representatives will advise on maternity services in general.
- New control limits for asbestos — implemented last January — are explained in a guidance note from the Health and Safety Executive which stresses that the limits are *not* safety levels. There is a statutory duty to reduce asbestos exposure below the new limits "if reasonably practicable". Further controls are under review. *Guidance note EH10 — asbestos control limits and measurement of airborne dust concentrations*, HMSO.
- The DHSS has earmarked £6 million for projects to tackle drug misuse. *HN(83)13* gives guidelines for health and local authorities and voluntary bodies on the grants scheme, suggestions for local initiatives and sources of advice.
- As the Warnock committee on fertilisation and embryology (see *CHC NEWS* 79 page 10) begins considering submitted evidence, the British Medical Association and the Royal College of Obstetricians and Gynaecologists have both published reports on "test-tube baby" techniques. The BMA's *Interim report on human in vitro fertilisation and embryo replacement and transfer* is in the *British medical journal* Vol 286, 14 May 1983 pages 1594-5. The *Report of the RCOG ethics committee on in vitro fertilisation and embryo replacement or transfer* is £1 inc post from the RCOG, 27 Sussex Place, Regent's Park, London NW1.

Carry the card
and wear the watch tag

by Brian Maunder, Secretary, Swansea/Lliw Valley CHC

Kidney transplantation has become a reliable and preferred treatment for sufferers from kidney failure. Transplantation of other organs such as heart, liver and pancreas may soon prove comparably reliable and successful — but transplantation requires donors, and the numbers of these are never sufficient to match the number of patients who could survive to enjoy happy and successful lives

In June 1980 the DHSS and the Welsh Office issued revised multi-organ donor cards with new wording which led my CHC to express concern to the Secretary of State for Wales over the possible repercussions for the surviving relatives of donors.

The new card stated that following his or her death the donor authorised the use of various organs or the whole body *for medical purposes.* This meant there was a possibility that the signatory of a multi-donor card might unwittingly be consenting to organs or the whole body being used for medical research.

In contrast the kidney donor card stated that the donor's kidneys could be used specifically *for transplantation.*

In our view the multi-donor card rendered unnecessary and worthless the complex provisions of the *Anatomy Acts* of

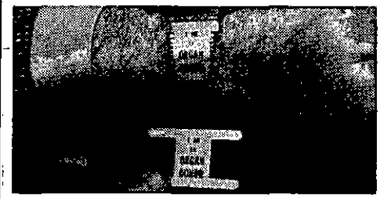


Photo: South Wales Evening Post

1832 and 1871 as well as the *Human Tissues Act 1961* — which gave strict rules and safeguards on the donation of bodies for medical research.

As often happens, the CHC's genuine and legitimate concern was roundly and wrongly criticised by others — including local medical staff — as opposition to transplantation itself. The situation was not helped by the fact that immediately after press coverage of the CHC's views the BBC screened Panorama's controversial investigation into brain-death criteria.

After actively pressing — with help from our local MPs — for the donor card to be reworded the CHC was pleased when cards were subsequently issued with the offending phrase amended to allow for either *transplantation* or *the treatment of others.*

As a result of its interest in the subject the CHC decided to promote the up-take of the new cards. A week-long campaign took place in October last year. The success of this brief effort was remarkable and encouraged the CHC to undertake a lengthier campaign early this year.

It was also felt that if a display of transplant information, staffed by volunteers, could be taken to a number of sites in the area an even greater number of cards could be distributed.

To this end a series of meetings were convened with representatives of the local health education unit and social services department, West Glamorgan Dialysis Support Group, the Wales Kidney Association, various other appropriate voluntary organisations, the transplant unit at Cardiff Royal Infirmary and the local medical staff who had previously been so critical of the CHC.

The meetings culminated in two displays touring West Glamorgan using sites which included hospital out-patient departments, health centres, shopping centres and major stores, local authority premises, factories, the Driver and Vehicle Licencing Centre and many other local premises.

A recent TV programme on transplantation was edited for showing on video as part of the display and students at the local institute of higher education designed new and original posters for the campaign.

During the planning stage we considered the particular problems of identifying organ donor card carriers at the scene of accidents and the problem of broaching the subject of donation with critically ill patients' relatives — who rarely know the views of the patient on donation.

We believe a relatively simple and cheap solution has been found in the production of watchstrap tags bearing the words *I am an organ donor* (see picture).

Attached to watch-straps the tags will act as a signal to police and ambulance staff at the scene of an accident and to medical and nursing staff in accident units — and as a guide to undecided relatives.

If any other CHC is encouraged to undertake a *Carry the card* campaign they can be assured of any assistance they might require from Swansea, where we have issued 25,000 cards during our campaign (see *CHC NEWS* 82 page 8 on a major campaign in the North Western region).

The tags are available from DAT Engineering Co Ltd, Market Road, Richmond, Surrey at £65 plus VAT for 1000 tags in silver or gold colouring (Tel: 01-876 6244). Swansea CHC can supply individual samples and further details. New tags now in production will carry the messages *I am a diabetic, I have a heart pacemaker* and *I am allergic to penicillin.*

Our apologies to John White — author of the centre page spread in *CHC NEWS* 86 — for the mistakes we made on the name of his organisation. He is in fact honorary development officer of the Association of Professions for the Mentally Handicapped (APMH).

DEPO PROVERA-
local use of a controversial drug

Brent CHC was one of eleven CHCs which joined the Co-ordinating Group on Depo Provera to produce evidence for a public hearing on the drug — reported on page one of *CHC NEWS* 86. This article is adapted from a submission to the public hearing written by Jeannette Mitchell, former Secretary of Brent CHC.

Early in 1979 Brent CHC became aware that repeat injections of the controversial contraceptive Depo Provera (DP) were being given to local women.

Enquiries to the health authority revealed that 18 women had been given DP by May 1979 and that a further eleven had been referred by the senior consultant gynaecologist at the Central Middlesex hospital to family planning clinics for the injection.

Although seven were no longer on DP, of those who were receiving the drug at the time of our investigation the majority had had more than one injection.

Yet DP is not licenced in the UK for long-term use. The short-term licence for DP covers a single, three-month injection in cases where women have had rubella immunisation or where they are waiting for their partners' vasectomies to take effect.

We put an appeal into local newspapers asking women who had been given DP to contact the CHC, and seven women came to talk to us about their experiences. Six of them had received DP in Brent and the seventh had been given DP in the neighbouring district of Barnet. Of the seven women six were black.

The level of side effects reported by all but one of these women disturbed us. The majority of the women were worried by menstrual irregularities and by feeling "out of sorts". Menstrual disruption appeared in almost all cases and two women attributed severe mood changes to the drug. Nausea and weight gain were common — with one woman reporting a six stone increase in weight during a two-year period of having DP injections.

Research studies on DP concentrate on the possible risks of cancer and infertility which DP may be associated with but our experiences of interviewing women who have had the drug suggest that everyday problems have not been adequately investigated.

We were also worried by the failure of health service personnel to take side effects seriously.

One woman was told that newspaper reports about the effects of DP were "a lot of rumours" by a clinic receptionist. Another woman asked about side effects before having the injection and was told that there were none except that her periods would cease. The woman who had suffered the greatest weight gain was told by consultants that "there is nothing wrong with being 13½ stone" — she is 4 foot 11 inches tall and weighed 7½ stone before having the injection.

The ease with which doctors and nurses dismissed these women's fears about the drug does not bode well for its future use.

In several of the cases we found doctors were either badly misinformed themselves — or unwilling to inform their patients properly. The consultant gynaecologist we spoke to justified his use of the drug on the basis of a study he said had been done in Queensland, Australia — but he failed to respond to our repeated requests for details of the study or where it had been published.

Information on the drug was given to women only after they threatened to stop accepting the injections. One woman claimed she had been given the injection without consent after having a baby and another woman was told that the injection was "the pill in concentrated form".

The high proportion of black women amongst those who came to talk to us is striking. Despite assurances from the consultant that he would be happy to give DP to his wife or daughter there is no doubt that in Brent DP has been given more readily to black and Asian women.

In our annual report for 1979-80 we commented:

"We fear a double standard may be operating. Women who are the least well-informed, the least well able to speak the doctor's language and the least in a position to take legal action are expected to take risks and put up with side effects which would be unacceptable to women who are better informed and able to argue back."

None of the women we spoke to had had any serious discussion with the doctor on the possibility of using barrier methods of contraception. A woman who could not use the pill or the IUD was offered DP and told "there is nothing else unless you want to get pregnant".

Teaching women to use barrier methods is time consuming. It involves establishing a rapport with the patient and may require an interpreter — so it is possible that busy hospital doctors have resorted to DP before exploring the possibility of using safer contraceptives.

But one reason for the apparently high proportion of black and Asian women receiving DP may be that doctors are employing dangerous stereotypes about black women's unreliability and lack of knowledge of their bodies.

For instance, the senior gynaecologist told us that barrier methods were not offered to Asian women because they often do not know where their vaginas are.

Our investigations have however had an effect on the use of DP in our district. After we questioned the health district's policy on DP the number of women being injected with the drug dropped and when we last enquired only five women were on DP.

Photo: Jenny Matthews/Format

Simple but ingenious

by Pat Saunders, Member, Portsmouth CHC

There is a variety of disabilities which prevent a person from drinking from a cup or tumbler. Many paralysing conditions simply mean a person is unable to lift anything and some disabilities result in uncontrollable spasm. Arthritic conditions mean picking up a cup can be done only with great pain.

There are also temporary upper limb disabilities which may mean inability to pick up a cup for a period of some months. Being permanently or temporarily confined to a prone position in bed can also create drinking problems.

There are, therefore, many disabled and elderly people who are unable to drink unaided except through a straw.

Each time you drink through a straw you draw up a column of air before the liquid arrives at your mouth. A mug of tea might involve six such columns of air and all this air goes into the stomach. A day's normal intake of liquid results in quite a large amount of air being taken into the stomach.

At best this may cause discomfort and exascerbate the impact of dyspepsia — at worst an accumulation of gases in the chest cavity may accelerate the failure of a weak heart.

The Pat Saunders Straw has a small valve which holds the level of the drink at the top of the straw, so after drawing up liquid initially, no air is taken into the stomach. Apart from medical benefits, the straw is more pleasant to use than an ordinary straw — in fact it is easily controlled and is much the same as drinking from a cup — and it eliminates the loss of dignity for the disabled person resulting from accidents arising from spilled drinks.

I have personally used the straw for all my drinking for over three years and have used one single straw continuously for fifteen months.

The straw can be sterilised where it is used in a hospital or community setting and in the domestic situation it may be boiled or cleaned with denture cleanser daily. It may be used for both hot and cold drinks and is unaffected by mildly acid citrus drinks. A conservative estimate of the life of a straw would be six months.

The straws come in packs of two — one 7 inch and one 10 inch straw in a plastic container — at £1.50 inc VAT from Nottingham Medical Aids Ltd, 17 Ludlow Hill Road, Melton Road, West Bridgford, Nottingham NG2 6HD Tel: 0602 234251.

CHC member Pat Saunders and straw

Book reviews

When pregnancy fails —coping with miscarriage, stillbirth and infant death

by Susan Borg and Judith Lasker, Routledge, Kegan Paul, £3.95.

This book discusses first of all the grief of parents and its effects on marital and family relationships. It is based largely on personal statements made by bereaved parents and emphasises their need for understanding and support.

A chapter is devoted to baptism, funerals and the role of the clergy, while under the heading "Possible causes ... is progress killing our babies?" attention is drawn to hazards such as pollution, drugs, and tobacco. The work of various support groups is described and the wisdom of further pregnancy and adoption discussed.

This book can certainly be recommended to health professionals and CHC members would find it interesting and valuable. But it must be borne in mind that statements by bereaved parents are personal and subjective, often vague and may reflect a somewhat inaccurate understanding of the process of childbearing. Readers — especially prospective parents — without specialised obstetric knowledge may find the book confusing and distressing.

This American publication is based on American procedures but there are lists of useful organisations which are adjusted for the British reader. References and suggestions for further reading, a glossary of terms and an index are also included.

Olive Keywood, former member, Worcester CHC

An introductory guide to counselling

by Elizabeth Foggo Pays, Ravenswood Publications, £4.95

As one of the author's former students, I was interested to hear of the publication of this book.

Elizabeth Foggo Pays' courses were intended to give students a basic grasp of the theoretical knowledge and practical skills needed for any form of counselling — and did this very successfully.

This slim volume however was put together posthumously from the author's lecture notes and this is disappointingly apparent. Every important area is covered but only in the most superficial way, limiting the book's usefulness considerably.

It could be of some value to those who want to increase their interpersonal skills and would like to find out what counselling is about before seeking further knowledge or training — or as a useful checklist for people setting up some kind of basic training in counselling.

Areas covered include definitions of counselling, use of language, motivation, problem solving and attitudes. There are also some suggestions for further reading.

Hilary Roberts, former member, Greenwich CHC

Establishing a geriatric service

edited by Davis Coakley, Croom Helm, £14.95

Written by professionals for professionals, this book describes model policies — based on UK experience — for a comprehensive and caring geriatric service. Chapters include the historical development of services, operational policies, the team approach, orthopaedic and psychiatric services for the elderly and social aspects of care. There is also a chapter dealing with education and research in the field.

Although there is a brief description of CHCs in the glossary I would have liked to have seen them mentioned — along with bodies such as Age Concern, Citizens' Advice Bureaux and the social services — in the section on information services to which professionals are urged to alert the elderly.

The book is an excellent guide for anyone contemplating establishing a geriatric service or improving an existing one. The underlying emphasis is on "whole person" treatment and the interest for lay people may be in comparing the model with facilities in their own districts.

Wenonah Hornby, Assistant, Hull CHC.

Personal and community health

by Olive Keywood, Blackwell Scientific Publications, £4.00

Olive Keywood's book is written primarily for student nurses and student midwives studying health and community care.

As such, it gives clear information in an easy-to-read form. It would also provide a useful background for secondary school teachers planning health course syllabi.

The text is well set out and supported by useful sub-headings. A list of books for further reading is given at the end of each chapter. Briefly, this paperback is a digest of health and could make a useful examination crib as well as stimulate deeper studies.

Unfortunately the illustrations appear to have been chosen quite haphazardly and without any purpose. Neither do they add to the interest of the book.

Mrs D M Sinstadt, Secretary, Plymouth and District CHC

Parliament

Occupational deafness

Ministers have accepted proposals from the Industrial Injuries Advisory Council to extend the occupational deafness scheme by reducing the minimum qualifying period of employment from 20 years to ten and increasing from one year to five the period in which claims must be made. Implementation depends on regulations to be laid later in the year (Ivan Lawrence, Burton, 26 April).

Regionally secure

By the end of 1985 over 500 places should be available in 12 permanent regional secure units (RSUs) in 11 regions. By then another 140 places will be under construction in two other regions and a 20-bedded RSU is planned for the remaining region. The first permanent RSU opened in November 1980. Another two are expected to start admitting patients in the next few months. Seven others are currently under construction. All regions have some secure facilities — including over 600 places in interim secure units (Robert Kilroy-Silk, Ormskirk, 15 March).

Laser safety

The DHSS working party on safe use of lasers in medical practice recommends that specialist advice should be available locally — perhaps from existing radiological safety committees — that local rules for safe use should be established and local registers should be kept of laser users and locations. Proposals are now out for consultation. The DHSS has no information to help estimate the cost to the NHS of treating patients injured by clinical misuse of lasers (Terry Davis, Stetchford, 25 April).

Screening recall

The DHSS and the Department of Industry are offering £½ million to RHAs for micro computers to recall women for cervical smears. Each English RHA will be offered one computer — to be used by one FPC in each region — with second computers supplied as funds permit. The Mersey, South Western, Northern, West Midlands, East Anglia and Yorkshire RHAs will have priority — in descending order — for second computers because proportionally fewer women in these regions have been screened in the past. Installation will cost RHAs up to £3,000 per computer but a free software package will be available to all FPCs — whether allocated equipment under the scheme or not (David Crouch, Canterbury, 12 May).

Whooping cough

Health authority reports show that uptake of pertussis vaccination rose by 7% in 1982 to 53% — up 22% since 1978 (Elaine Kellett-Bowman, Lancaster, 29 April).

Scanner

Long term wear

Clothing for the elderly and long stay patients is the subject of two booklets from the Disabled Living Foundation. *Clothing needs of the elderly person* is the report of an enquiry funded by the Centre on Policy for Ageing. It examines the information available on suitable clothing for the elderly — launderability, texture, inflammability — and how it can best be conveyed to those who would find it useful — price £3.50 inc post.

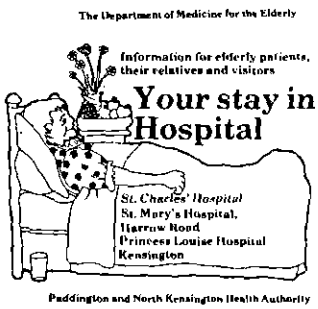
A guide to the introduction of a personalised clothing service gives advice to hospitals wanting to inaugurate this service. Patients should as far as possible choose their own clothes says the booklet which outlines other factors to be considered when purchasing — source and financing, style and quantity of clothing. Storage and care of clothing including laundering, repair and replacement are also discussed — price £1.60 inc post. Both booklets available from the Clothing Advisory Service, 346 Kensington High Street, London W14 8NS.

Screening the elderly

A simple nine-point questionnaire developed at a Glasgow health centre can identify elderly people with unmet health needs while also reducing the GP's workload. All elderly people on the GP's list are sent a letter with nine questions on their health and ability to cope. Those who answer negatively — or who fail to respond — are followed up by a health visitor. The system — which can be adapted to local conditions — is described in *The elderly at risk — a critical review of problems and progress in screening and case-finding* by Rex Taylor and others. No 6 in the Research Perspectives on Ageing series, it costs £2.50 inc post from Age Concern England, Bernard Sunley House, 60 Pitcairn Road, Mitcham, Surrey, CR4 3LL.

Incontinence year

A series of meetings arranged by the Royal College of Nursing found such lack of knowledge about incontinence that some attenders felt an International Year of Continence is needed to encourage discussion of the problem. Of around three million UK sufferers from incontinence no more than 10% receive any specialist help, and "vast amounts" are spent on pads and other aids although their use has not been properly evaluated. There is an "urgent need" for a social policy to help incontinent people, says the report of the meetings, and CHCs are amongst a range of organisations urged to press for action. *The problem of promoting incontinence — an account of 16 study days convened by the Rcn and Squibb Surgicare Ltd* is free — in limited quantities — with an sae from the Rcn Publications Department, 20 Cavendish Square, London, W1M 0AB.



Aimed at the elderly, their relatives and visitors, this patients' information booklet introduces in clear print the local hospitals and the hospital team. Helpful details include discharge procedures, what to bring along, pensions and benefits during the stay and how others can help. Produced by the department of medicine for the elderly in Paddington and North Kensington DHA, single copies are free with a stamped addressed envelope from the health education department, 304 Westbourne Grove, London, W11.

Check your rights

Two useful new guides cover money problems for the sick and disabled. *Statutory sick pay — loading the dice* (£1 inc post) explains the new sick pay maze and warns that the employer-paid benefit will expose workers with poor health records to the risk of harassment or dismissal. The Government has privatised an important part of the social security system, says the guide, and the scheme gives no protection from employers who refuse to pay up. *Housewives' non-contributory invalidity pension (HNCIP) checklist* (80p inc post) runs through the detailed personal questions faced by married women applying for the discriminatory HNCIP (see *CHC NEWS* 78 page 3). The guide aims to help women who have been refused HNCIP to prepare their case for appeal. Both guides are from the Disability Alliance, 21 Star Street, London, W2 1QB.

Health circulars

HC(83)10: revises NHS charges for overseas visitors from 1 April and gives — in line with a recent legal judgement — a new definition of "ordinarily resident" to include those "lawfully living in the UK...for settled purposes" and students on courses lasting over six months.

WHC(83)10: the Welsh equivalent of *HC(83)10.*

HN(83)14: details two changes to the welfare food scheme from 4 April.

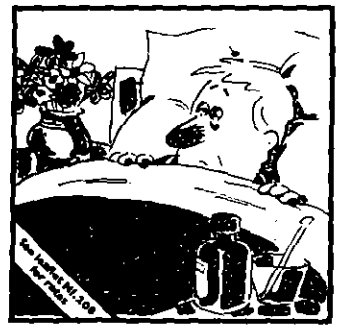
HN(FP)(83)14: introduces new monitoring arrangements and statistical return for general ophthalmic services.

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 Secretary: Judy Thomas
Page 5: Cambridge CHC Secretary: Margaret Martin
Page 11: Milton Keynes CHC Chair: Mr D Taylor, Secretary: Mrs S Fielding
Page 15: Manchester North CHC Secretary: Margaret Weller
Page 18: Northern Region Association of CHCs Chair: Frank Allason
Page 19: Northern Regional Association of CHC Secretaries Secretary: Carol Knock c/o South Tyneside CHC

Check your right to Statutory Sick Pay



DHSS leaflets

New leaflets on: invalidity benefit (NI 16A), industrial injuries — disablement benefit (NI6) and death benefits (NI10), mobility allowance (NI211 and 243), NI contribution rates and statutory sick pay rates (NI208), check your right to SSP (NI244), SSP and sickness benefit (NI16), and dental treatment (D11).

Other publications

Key statistical indicators for NHS management in Wales No 1, 1982. Price £2 inc post, and *Mental health statistics for Wales No 2, 1982.* Price £3 inc post from the Statistical Publications Unit, ESS1, Welsh Office, New Crown Buildings, Cathays Park, Cardiff, CF1 3NQ.

Local accountability — the need and scope for health authority published annual financial reports. Price £2 inc post from the Chartered Institute of Public Finance and Accountancy, 1 Buckingham Place, London, SW1E 6HS.

Perspectives on pre-school home visiting edited by Geoff Aplin and Gillian Pugh. Price £2.50 inc post from the National Children's Bureau, 8 Wakley Street, London, EC1.

Single payments for baby goods — know your rights No 2. Single copies free with an sae, 5p each plus postage for bulk orders, from the Maternity Alliance, 309 Kentish Town Road, London, NW5. Tel: 01-267 3255.

Counselling in London — a directory of counselling services. Price 60p inc post from the London Voluntary Service Council, 68 Chalton Street, London NW1 1JR.

Work experience for mentally handicapped adults by Carol Scott. Price £1.50 plus post from MENCAP, 123 Golden Lane, London EC1Y ORT.

News from CHCs

☐ Interest in well-women clinics shows no signs of flagging — we have found 16 CHCs currently involved in clinic campaigns — but opposition from GPs on the grounds that they already provide the services women need is finding favour with financially pressed DHAs. Yet from all over the country the same message is coming through — GPs do not have the time to talk and do not take women's problems seriously.
☐ **Tameside and Glossop CHC** decided to back a campaign for two clinics after a mini-survey of local women found that only 55% would discuss health problems with their GPs while 83% would use a clinic providing check-ups and counselling.

☐ **Norfolk CHC**'s two-year battle — see *CHC NEWS* 80 page 12 — has attracted hostile coverage in the medical press but after speaking to thousands of women about the proposal for a clinic the CHC has found only two women against the idea and has had over 1000 letters in favour. Now the FPC is asking all its GPs about the services they provide and what facilities they think are needed.

☐ A shortage of women GPs is a problem in Norfolk — and in other districts. **Brecknock and Radnor CHC** believes that women in rural parts of the district are not consulting GPs because they are all male. The **Welsh Association of CHCs** has taken up the district's problem with the Welsh FPCs.

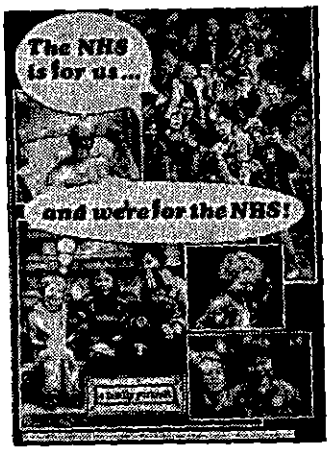
☐ And response to a questionnaire circulated by **North Tyneside CHC** gave the need for women doctors as the main reason for supporting well-women clinics. Self-referral was also seen as important and women felt clinics should be located in health centres.

☐ Meanwhile **Burnley, Pendle and Rossendale CHC** is worried by a suggestion that proposed women's screening clinics could be staffed by men. The CHC's long-standing proposal for a clinic with facilities for counselling and self-help groups seemed to gain support from a DHA report citing the highest death rates for women of any district in the North Western RHA — standardised mortality ratios for women are "significantly higher than the national average" says the report. But the district's plan is to extend a network of existing cervical cytology clinics to take in breast screening and health education — but no provision for self-help groups or lay involvement — and screening would be run by a male doctor already employed by the DHA. Other staff may be recruited but the DHA is adamant that the *Equal opportunities Act* outlaws advertising for female staff — and the district medical officer has proposed calling the new service "women's health clinics" to avoid the "feminist overtones" of the well-women title. CHC members on the clinic action group have "made it quite clear that male staff are unacceptable" and are pressing for self-help and voluntary input to be integral to the extended clinic service.

☐ Since **Central Birmingham CHC** started discussing well-women clinics local doctors have branded the idea as a "fashionable gimmick" — but the CHC says a need for the service is demonstrated by complaints about a 12-month waiting list for the area's only menopause clinic. Women come from throughout the West Midlands RHA for treatment of menopause problems but an empty managerial post has lengthened waiting lists, GPs seem unable to help, and women are turning to an FPA clinic which costs them £30. An unmet need at the other end of the age scale was shown by the 13-year old whose mother approached the CHC because her GP took no interest in the child's menstrual troubles.

☐ **South Derbyshire CHC** is concentrating on the older age-group. It wants a menopause clinic and is trying to get GP support for the scheme. Health visitors and family planning nurses have written to the CHC vouching for a known need, and local Samaritans say they frequently give a listening ear to women who cannot find NHS help.

☐ A critical remark by Professor Eric Wilkes of Sheffield University at the **Society of CHC Secretaries'** Spring seminar runs counter to **Wigan CHC**'s experience. The Professor claimed well-women clinics are of "doubtful value" because they are used by low-risk middle-class women — but CHC Secretary Bessie Goldthorpe has been providing unobtrusive help to a working-class well-women group who hope to establish a clinic in the most deprived part of the district. The DHA has promised the use of a room in a local clinic — Bessie announced the victory on air during the recent BBC TV *Well women* series — and now the group is seeking professional input to add to their self-help sessions.



☐ *Hard sell advertising by private health companies inspired* **Islington CHC** *to produce this poster to rally support for the NHS. It is unlikely to be reported to the Advertising Standards Authority for making false claims — as some private health adverts have been — and the Health Education Council was so impressed that it has circulated copies to all health education officers.*

☐ Praise for supportive country GPs comes in *Medical services in rural areas* — an important new study by **Exeter CHC** which highlights prescription deliveries, chiropody, branch surgeries and transport. Based on questionnaire responses from 65% of the district's parish councils, the study describes how villagers cope without chemists, regular public transport and other basic facilities taken for granted by town-dwellers. Advice is given on avoiding the pitfalls of a prescription collection/medicine delivery service — security is important and multiple prescriptions can cause prepayment problems — and country-dwellers are reminded of DHSS assistance with travel to hospital. Undertaking the study has developed the CHC's contact with far-flung corners of its district and it is now testing the feasibility of "mini-CHCs."

☐ An excellent new guide from **City and Hackney CHC** combines general advice and specific information on local maternity facilities. *Pregnancy and birth in Hackney and the City of London* lives up to its sub-title of *How to make the maternity services work for you* by explaining at each step — from pregnancy tests to breast feeding — what facilities are available and how to choose the most appropriate, what policies operate in the units, what function each professional has and how to identify them, and how to cope after the birth. The consultants are named, the technology of birth is described and welfare rights are explained. While local detail is very thorough, the fair-handed assessment of medical techniques, the advice on keeping healthy, the description of ante-natal tests and discussion of position in labour will be invaluable to women anywhere.

☐ A rare honour has been posthumously paid to the former chair of **West Cumbria CHC**. The Anne Burrow Thomas health centre in Workington was named after the woman — a county councillor and former mayor of the town — who campaigned for its establishment. Mrs Thomas chaired the CHC from its inception in 1974 to 1976 and was a member of the health centre commissioning team before she died. Her daughter and grand-daughters were present to see a plaque unveiled in her memory at the centre's opening ceremony.

CHC surveys and publications

Short term care for mentally handicapped children in Barnet (**Barnet CHC**). Maternity care — the way forward (**Bolton CHC**). Abortion in Islington and Hornsey — what to do and where to go (**Islington CHC**). A guide to old people's homes and nursing homes in Oxfordshire (£1 inc post, **Oxfordshire CHC**).