INNOVATION IN EVERYDAY HEALTH CARE

13 & 14 February 1986

THE CONFERENCE PAPERS

Organised by the GLC

with assistance from the Kings Fund

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FOR COPIES OF:

The London Industrial Strategy (Health Care and other chapters

Commercial Medicine in London by Ben Griffith and Geof Rayner with John Mohan

The Health Effects of Control Over Your Own Work - a review of the scientific literature by Michael Joffe

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INNOVATION IN EVERYDAY HEALTH CARE

The Conference Papers

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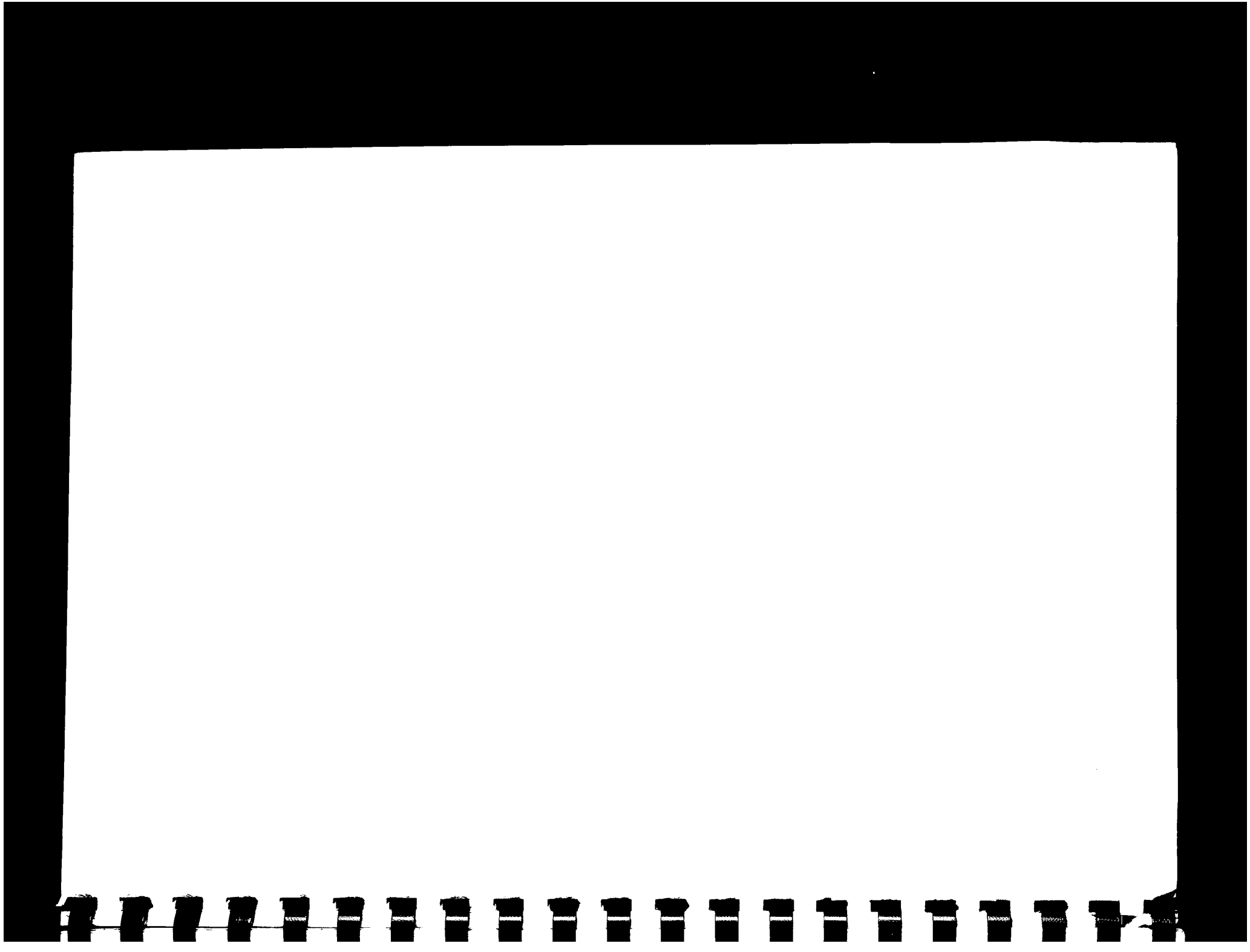


PREFACE

The Conference Papers fall roughly into three parts:

a) the speeches
b) the workshop summaries
c) an information section

a) the speeches

Because there was such a short time between the conference and the abolition of the GLC in which to prepare the papers, the speeches have only been lightly edited from the transcripts of the recordings. This has been done merely to complete sentences, rejoin infinitives and clarify minor confusions which were more marked in the written word.

Just before each speech is a visual representation of the main idaes and themes of each speaker. These are a `one person' view of the relationships between the ideas and themes which will hopefully help us all use the written material in a different way.

b) workshop summaries

There are summaries of well over half of the workshops which took place and, for the balance, the pre-conference synopses have been included,(this latter group being marked with an asterix). Some of them are quite brief but there are contact addresses included with all the summaries so that more detailed information can be obtained from the workshop organisers.

c) The information section is at the back of the booklet and is really self-explanatory. The layout is in the Contents list and if there are further queries the names and addresses of the Conference organisers are inside the front cover.

From the feedback we received, both from the wall sheets (see information section) and from talking to people attending the Conference, there are a few points it might be useful to pass on to all of you who are planning future meetings.

Workshops and more workshops was the message both from participants and from workshop organisers. Most people found them very stimulating and particularly enjoyed the mixture of experiential and discussion-based groups. People wanted more workshop slots on the programme and even longer time slots than the planned one and a half hours.

The home groups were a newer ides for most people and while a few of them really took off with the grouos talking on over their allotted time, for others it was a more confusing experience. That could have been helped by the organisers having chosen a facilitator beforte the group started but it may be that the structure has to be there for those who want to use it and othe people will make connections in different ways.

The feedback sheets on the walls were well used and are printed, unedited, at the beginning of the information section. They speak for themselves.

We thoroughly enjoyed the time we spent organising the Conference and being there with everyone at the Conference itself. There are many people we would like to thank for their ideas and support and positive encouragement but these people deserve a special mention:

Jeanette Mitchell for the inspiration and determination with which she lay the Conference foundations in her work on health in the GLC

Liz Wynn and Jane Hughes of the Kings Fund Centre who were always there

with their vast fund of knowledge of the community health field and who jointly organised with us at the Conference

Robin Murray for his calm encouragement and support

Lesley Doyal, Gene Feder, Jane Foot, Maureen MacIntosh, Jane Salvage and many others who shared ideas and information with us

Workshop organisers, who with little notice but much enthusiasm wrote notes and summaries and ran workshops which were a great success

All the helpers at the Conference and Mrs Nazim of the Institute of Education for her patience with our `last minute' approach

Whole Bookshop, who laid on the bookstall at four days notice and did it with such a calm grace

P.S. The collection taken at the Conference for the Wendy Savage Appeal was well over £300.

Sue Berger, Martin Durkin and Richard James
Conference Organisers for the Greater London Council

INTRODUCTORY SYNTHESIS

Nine Key Areas may be identified:

1) More of the same

a) More conferring

Participants expressed great appreciation of this chance to get together. Many groups had previously been working in isolation and found valuable support at the conference. It was also the first chance some had to talk to people in different disciplines. We should

i) develop a strong network of people involved in health innovation
ii) hold another conference.

b) More innovation

Times are changing - new patterns of illness; new technologies; shifting attitudes to social roles. The medical model and the NHS are baroque - yesterday's answers. We need to stimulate and nurture people's creative instinct to rise to the challenge that these problems create.

2)Prevention

This needs to expand beyond the traditional welfare state and health education. There is much to be done in Occupational Health - resisting the dehumanisation of work being caused by the pressures of large-scale industrialism. There is also much that can be achieved through creative community action - helping people to identify the problems underlying their symptoms and to take appropriate action.

3) Medical Practice

Healing is essentially an individual matter and is easily undermined by high-tech medicine or authoritarian professionalism. Statistical method is appropriate only at the population level and is irrelevant to individual sufferers.

Medical education and research is largely inappropriate (being hospital-based, industrially funded and patriarchically administered). It should be redirected with reference to community requirements.

Health professionals should be (at least) aware of and (preferably) fluent in a wider range of facilitative skills. Interventions should be appropriate and enabling. This requires sensitivity and empathy, and the time to use them. It also requires prolific and unprejudiced liaison between all parties involved.

Professionals should be more accountable to their public.

4) Non-medical NHS workers

All have a lot to offer beyond their formal roles. They should become more involved in co-operative planning and management. Paramedics could expand their role beyond that of servants-to-the-doctors and become a resource to the patients in their own right.

5) Complementary Alternative Medicines

There is a great and growing demand, from all kinds of people, for the low-tech healing arts. In a commercial context there is exploitation of either the consumer (who ends up paying twice for health care) or the practitioner (who may choose to work for little return). Yet integration

into the NHS is a problem, not merely because of finance, but because of the tyrany of the patriarchal, pseudo-scientific establishment.

These approaches are Complementary in that they provide something the establishment does not, but they are also radically Alternative and will be diminished if they are simply subsumed under medicine.

One solution is for funding to be allocated by the community, at local level, to the style of health care chosen by the community.

6) Self-help

We must avoid the risk of victim-blaming and ignoring the responsIbility of social factors FOR illness. Conversely we must acknowledge that healing is a natural propensity of living organisms - that individuals have response-Ability TO their illness. Professional health care and welfarism carry the risk of diminishing this responseAbility, but it can be nurtured by appropriate education in self-healing skills. This is best done within a peer group (yes, even children!). Sharing responsIbility enhances responsAbility.

7) Funding

Insecure and short-term funding is a major barrier to the development of new initiatives. Adequate funds should be provided by

a) central government - along the lines of the Arts Council or Urban Aid
b) local government - rate-relief, cheap accomodation or direct grants
c) FPCs - modifying GPs' pay-structure could stimulate initiative rather than stifling it.

8) Political Action

At government level, there is an urgent need to resist the erosion of Common Law which is threating the practice of Alternative Medicine in this country.

Local government should be lobbied to give support to innovative schemes. The GLC has done this in various ways, as Robin Murray describes. (See also the London Industrial Strategy chapter on Health Care.)

Trade Unions should struggle for democratisation in the health service.

In the community, people can support each other in challenging the existing systems (eg by lobbying manufacturers to produce wholesome food) and in identifying and following better paths to health.

9) Accountability

Problems arise because workers can shelter behind a professional identity or inside a gross bureaucracy. Accountability should be enhanced by:

a) patients' right of access to their own medical records
b) more community representation in appointment of staff and allocation of funds
c) co-operative management of health-care teams, with community representation.

Opening visualisation

Hello. I am Richard James and I'd like to welcome you to this conference on 'Innovation in Everyday Health Case' on behalf of the organisers. We'd like to start by offering you a short visualisation which will help us all to truly arrive here; to set aside distractions and focus our attention on our theme for the next two days. So. I invite you to make yourself comfortable; loosen any restricting clothing, uncross your legs, sit straight and perhaps close your eyes. And let us take a few nice big breaths together. In..... Out..... (heavy breathing into microphone). Noticing any tensions in our bodies; noticing what thoughts and preoccupations and engaging our minds and, as we breathe out, beginning to let go of them. Letting go of a little more tension, with each out-breath.....

Now I'd like you to cast your mind back to the first time you heard about this conference..... What was your first reaction? Remember the scene - where were you? Who with? What were you doing at the time?..... Now bring your attention forward in time, and remember when you made the decision to come, filled out your booking form (legibly, I hope!) and sent it in to Martin..... What were your feelings about the conference then?..... Now come forward again to the time you woke up this morning..... How was it? Did you leap out of bed with glee, looking forward to the day? Or did you feel 'oh no, not another conference, why did I sign up for it'?..... And now bring your attention right here, right now. How do you feel now? What do you hope to get out of the next two days? Do you have any anxieties about them?..... Now I'd like you to use your imagination. Imagine you are in a bubble. Like a large soap bubble, just big enough to enclose your body and expanding and contracting a little with each breath..... Feel how it pulsates in and out and see how it shimmers in the light..... Now I'd like you to expand your bubble. Let it grow a little larger each time you breath in..... Soon it will be big enough to take in the people sitting next to you. Your bubble and theirs will start to overlap..... Let your bubble grow more now, to take in all the seats in your section of the room..... Still growing - bigger and faster, to take in the whole room. And even more to take in the whole building..... Now we have one huge bubble, enclosing all of us and all the people beavering away outside to make all of this possible. And still we are breathing together..... Conspiring, to take Marylin Ferguson's phrase..... Breathing together, conspiring, hoping together, co-inspiring each other..... We all have our own visions and we all share a common hope - the hope for better health..... I hope the next two days help you to get closer to your vision. And I hope you enjoy them. Thank you.

INNOVATION IN EVERYDAY HEALTH CARE CONFERENCE

DAY ONE - MORNING

Lesley Doyal, Chair

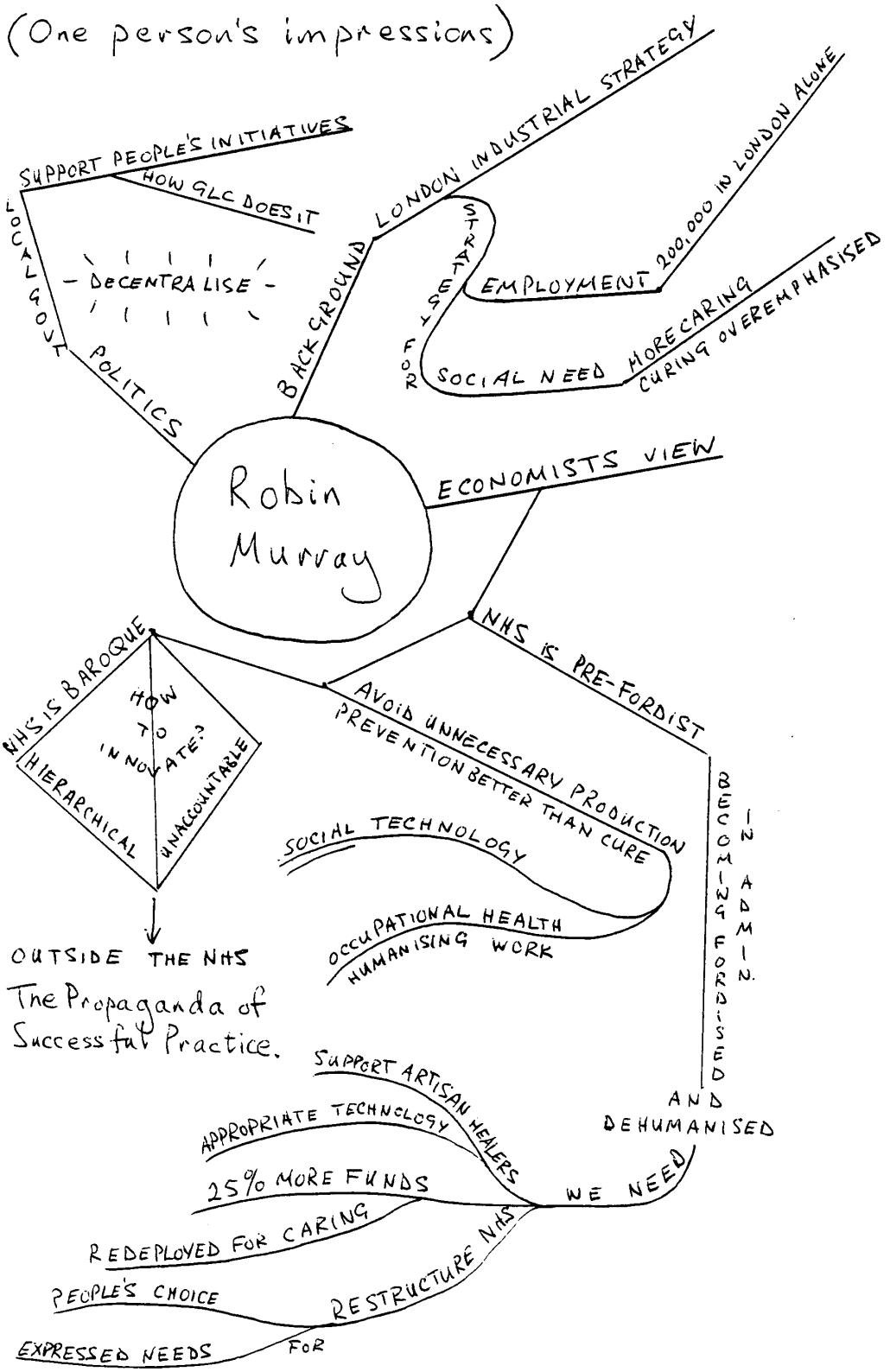
Welcome everybody to this conference on Innovation in Everyday Health Care. I welcome you on my own behalf and on behalf of al the organisers, but I especially welcome you on behalf of someone who is a great friend of many of us but who unfortunately, as many of you probably know, is not able to be here today because she is ill. Jeanette Mitchell had the original vision for this conference, it was her idea, she did a great deal of th initial planning and Robin is going to talk in a while about some of the of the other work that she has actually done for health while she has been at the GLC. I am sure that you will join me in wishing her very well and hoping that she will be back with us soon, and I hope that the conference will live up to her expectations.

In Jeanette's place the conference was organised at short notice and very ably by a group of people who I would like to mention, and who I think are going to identify themselves so that if you want to speak to them later on you are able to. On behalf of the GLC the conference was organised by Richard James who you just met, Sue Berger and Martin Durkin, and on behalf of the King's Fund, Liz Wynn and Jane Hughes.

For the opening session we have two speakers, Robin Murray and Alex Scott-Samuel. Robin is Head of Industry and Employment at the GLC.

OVERVIEWS OF THE SPEECHES

(One person's impressions)



INNOVATION IN EVERYDAY HEALTH CARE: SOME INDUSTRIAL ISSUES

This conference was the idea and initiative of Jeanette Mitchell, who works in the Industry and Employment Branch of the GLC. It was one of the proposals made in the chapter she wrote on Health Care in the London Industrial Strategy. That chapter is sandwiched between other sectoral chapters - motor components, instrument engineering, furniture, printing - sectors which are normally considered the core of any industrial strategy, at national or local level. In the words of classical economics, they are the productive sectors which provide the wealth to pay for the unproductive sectors, like social services and health care, while sectors like housework - itself an important part of everyday health care - rarely gets any mention at all.

The Labour Manifesto - on which the present administration was elected in 1981 and which laid out the basis for industrial initiatives in London - specified that a London industrial strategy should be produced which was centrally concerned with employment on the one hand and production for social need and not merely profit on the other. On both scores health care was more important than say reproduction furniture or cable television. Over 200,000 people work in London's hospitals, surgeries and clinics. The level of informal care in the household is, of course, much higher. The needs were also clear, not just for the chronically sick but for the disabled (of whom we estimate there are between 170,000 and 320,000, with some form of disability in London's labour force alone) and the increasing number of elderly people who need care as much as cure. In addition some economists were arguing that it was in labour intensive sectors, like education and health care, that major productivity increases could be foreseen which alone would be able to pull the economy as a whole out of its depression as consumer durables had done during and after the

1930's. So health care became a priority for the Industry and Employment branch and I want briefly to talk about three of the points which have arisen from treating health care as an industrial sector.

First, it is clear that health care is subject to some of the same pressures which are transforming the more conventional sectors of the London economy. London industry grew on mass production and what became known as Fordism. Its characteristics were standardised products, dedicated machines geared to the particular product and semi skilled labour operating under the discipline of time and motion study. By the early 1970's this wave of expansion had run its course. Markets became saturated. Consumers were demanding variety and becoming less predictable (notably in the record industry, films and clothing). The mass production factories lacked the flexibility to respond to these sudden switches and the downturn in demand. In many sectors like furniture it was the most modern but inadaptable factories which went bankrupt first. At the same time, in Japan first, then Germany, Northern Italy, parts of France and more recently the USA, computers were allowing new flexible production systems to develop which could adjust to bespoke demand, short runs and unpredictable shifts in the market. The new systems known as 'flexible specialisation' have led to the restructuring (and from London's point of view too often the destruction) of industry after industry. It has allowed the growth of sub-contracting and franchising, with independent owners, co-ordinated by centralised computer systems.

Now health care is in many ways pre-Fordist. Many of the developments which most concern us are the results of attempts to introduce standardised methods of intervention and treatment in childbirth for example, or the GP's pills. The recent boom in private health care has been centred on those operations

which can be relatively standardised and subjected - in a less extreme form-to flow line principles. We demand a return to artisan forms of treatment, geared to the needs of the individual patient, not the economy of the system of production. Indeed much health care is necessarily of this form. It depends on individual relations between the carer and the cared for, or between the curer and the meet to be cured. There is a contradiction between the need and the tendencies of production.

Where Fordism cannot be introduced into treatment, it is introduced into the conditions within which the treatment takes place: in the provision of hospital food for example; or in the replacement of smaller by larger hospitals. Or costs are shifted from paid to unpaid labour. Or it is the procedures and administration which are standardised - significantly on the model of the multi-divisional private corporations.

Now one part of the answer is defensive: to argue for smaller hospitals and more local long stay units; for doctors and nurses with more time; and smaller units of administration. In London this has meant resisting the effects of health cuts, notably in hospital closures. All this requires more resources. The LIS argues for a 25% increase in the NHS budget, devoted principally to an expansion of caring and providing a further 50,000 jobs in London.

There are two limitations, however, to a purely defensive position. First, there has been growing critism of even the pre-Fordist medical systems: its treatment of symptom rather than cause; its lack of holistic outlook; the narrowness of medical training and the profoundly unequal relations between doctors and other workers in the health service. This was sharply posed to

the GLC when we were asked to take over and fund certain hospitals which were threatened by the cuts. We decided not to do so because the medical and social systems represented by those hospitals were as much a part of the problem as part of the solution. Any restructuring of health care has got to be centred round the service provided, an increase in choice, a tailoring to individual need.

But there is a second limitation, which is economy. We may argue for increased resources but with a declining economy, we will be remarkably successful to get all that is needed - certainly under the present government. Just as GLC supported firms operate in and against the market, so non-commercial medicine operates in and against the budget. The public budget is less clinical than the market as a discipline on production but it is a discipline nonetheless. In developing new systems of health care, particularly labour intensive ones which we wish to see universally available, we do have to address issues of production and productivity or they will be addressed for us. This means that we should consider what aspects of modern technology, if any, are appropriate for health care, particularly those computer based systems which allow flexibility and individual response. User friendly diagnostic systems might be one example. Decentralised yet co-ordinated administrative systems another. Flexible specialised wholesome catering services another. My point is that we cannot ignore the issues of economy, or of technology in any progressive restructuring of universal health care.

In summary then, the progressive part of the NHS was that it offered a universal service regardless of the ability to pay. But if offered a restricted standardised service through a system whose organisations and methods closely paralleled those of the large private mass producers. It came

to be seen as inflexible and unresponsive to user needs, at the very time when those needs were changing. And it met an ever stronger budgetary constraint by increasing standardisation at the expense of need, by shifting the costs of care from the NHS to the home and by cutting costs, most notably by weakening labour through privatisation. It responded to crisis in the manner of many British manufacturers (as well as the present government) by cutting labour costs and services rather than restructuring the service on the basis of the needs of users, skills of workers and the potentialities of new systems of production.

A second general lesson from the industrial approach is that there are some industries where the greatest savings and advances in productivity can be achieved by avoiding the need for production altogether. Energy is one example in which even private energy companies in the United States see the fourth energy source, namely conservation, as that which offers the greatest return to investment. Urban planning similarly can reduce the need for transport, just as any production planner optimises the flow of materials on the factory floor. Health care is a further example. Just as historically the health of Londoners improved primarily because of better housing, cleaner water, better food and education, rather than more doctors, so now we know that it is still housing, food, smoking, the environment and work and wages which will determine improved health and life expectancy. The technological need in health care in London is not the hardware from the drug companies and the medical instruments sector but the social technology which ensures that health considerations are taken into account in housing, planning, food and labour policy.

Occupational health is particularly important. Anyone who has experienced the

tyrannical speed of the line in London factories, who has seen the systematic deskilling of many London jobs, will recognise that the tendencies in the organisation of work are at complete variance with the human values of the wider society. These conditions are translated both into ill-health and the costs associated with it, with no mechanism, public or private, for taking these human and economic costs into account. The humananisation of work is as important a public issue now as was the procurement of sewers and clean water in the nineteenth century.

There is a good argument within national government for the Chancellor of the Exchequer to come under the Minister of Industry, so that finance is made to serve industry, rather than vice versa. Is there not a case for going further and putting all such ministries under a Minister of Health? Health should be the dominant not the subordinate consideration in all aspects of public service. Market economies have always had a bias towards the production of goods and services that can be sold. They cannot deal with needs that can best be met not by production but by social reorganisation. That is why a strong position for the Department of Health is required within the government.

Thirdly, there is the question of how a large public service like the NHS, outside the market and insulated from user influence, can innovate. A number of other public sectors, most notably the BBC, pose a similar question. One necesary path is within the NHS itself: making it more publicly accountable, less hierarchical and with greater say for those who work in the industry. But I do not think these changes will necessarily solve the problem of strategic innovation. It is striking indeed that many of the most important innovations in health care - represented in this hall - have come from outside

the NHS altogether, whether it be the hospice movement, or women's health groups, herbalism, acupuncture and so on. There has been a vigorous debate about whether innovation outside the NHS should be supported: not simply because many of them are restricted to treating mainly those who can pay but also because it shifts innovative effort away from the NHS. At the GLC we have come down in favour of supporting innovative groups outside the NHS, as well as those within it, on the grounds that with the NHS as it is, many of these groups have little chance of showing what can be done and it is the propaganda of successful practise which will be particularly important in changing the NHS. Indeed in any national programme for restructuring the NHS, we suggest that a substantial body of funds be allocated to finance local initiatives offering services with a preventative focus. These could be initiatives by doctors, alternative practitioners, other health workers, psychotherapists and counsellors, or initiatives by users. They could include self help and education, occupational and environmental health, alternative medicine and natural healing.

We have followed a similar approach in the cultural industries funding the alternative distribution sector in record production, video, books and broadcasting, as well as a wide range of independant producers. Certainly for a local authority, we felt this would be a more effective way of having an impact on cultural production than by a head-on attempt to change the BBC. Similarly in other areas, the GLC has followed a policy, not of expanding itself to provide services, but funding independent groups to do so. In our field of industry and employment, we have funded around 200 such groups, to advise co-operatives, support trade unionists, or provide resources for the unemployed, women's employment groups, black employment groups and so on. The great advantage of this policy is that initiative and creativity is

decentralised. If a group falls apart or fails to deliver the service, the money is stopped and made available to new groups who want to take over.

As applied to health, however, the significance of such a policy of voluntary funding, is not to provide an alternative health economy to the NHS but to be a laboratory for innovations which can be taken on by the NHS.

What do we conclude? The NHS is in crisis and is likely to go deeper into crisis as private health insurance threatens to spread to the new skilled workers at the heart of flexible specialisation (of whom the EEPTU members are good examples). Like those military machines that Mary Kaldor has called the Baroque Arsenals, the NHS is still geared to the challenges of the last war and the administrative structures which go with it. It is a Baroque NHS, dominated by curing rather than caring, by intervention rather than prevention and insulated from the needs of users and much of the creativity of the health workers.

The answer to a decining NHS is not just more central funds, though these are needed. Rather these funds should be used to restructure the NHS: towards caring, towards innovation and universally available alternatives of health care, towards a more open career structure within the NHS and a more democratic control of it, towards more local units for long stay patients and more support services for those people caring for and being cared for at home.

Furthermore health needs to be given a more central regulative power within central government, in relation to housing, employment, industrial policy, planning and education.

These changes will not come about through simple changes in central government. They will be based on the health movement of groups such as those represented at this conference. There are parallels with the movement for healthier food and with the women's movement which has at last been given political support by some local authorities but still awaits similar backing at a national level. In relation to health, local government should perform a similar role: using its limited powers and resources to support the movement of users and practitioners and to join with them in the pressure for central government support. Nor can a restructured health service be run centrally as in the past. Planning for needs cannot be done centrally. Needs have to be identified locally and many of them met locally.

At the GLC we have consciously not attempted to become a health care provider. Rather we have:

- funded the many Health Emergency Campaigns throughout London

- developed a number of health technology projects, through the GLEB Technology Networks: including diabetic diagnostic systems and a number of low technology projects, such as aids for the disabled

- initiated a £3.6 million European project, of which GLEB is the managing agent, to develop human centred automatic factory systems which build on skill rather than dispense with it.

- undertaken a major study of occupational ill health arising from the shift to one person operated buses

- started the London Food Commission to campaign for healthy food and internally have been trying to improve the quality of food in GLC canteens and ILEA school food

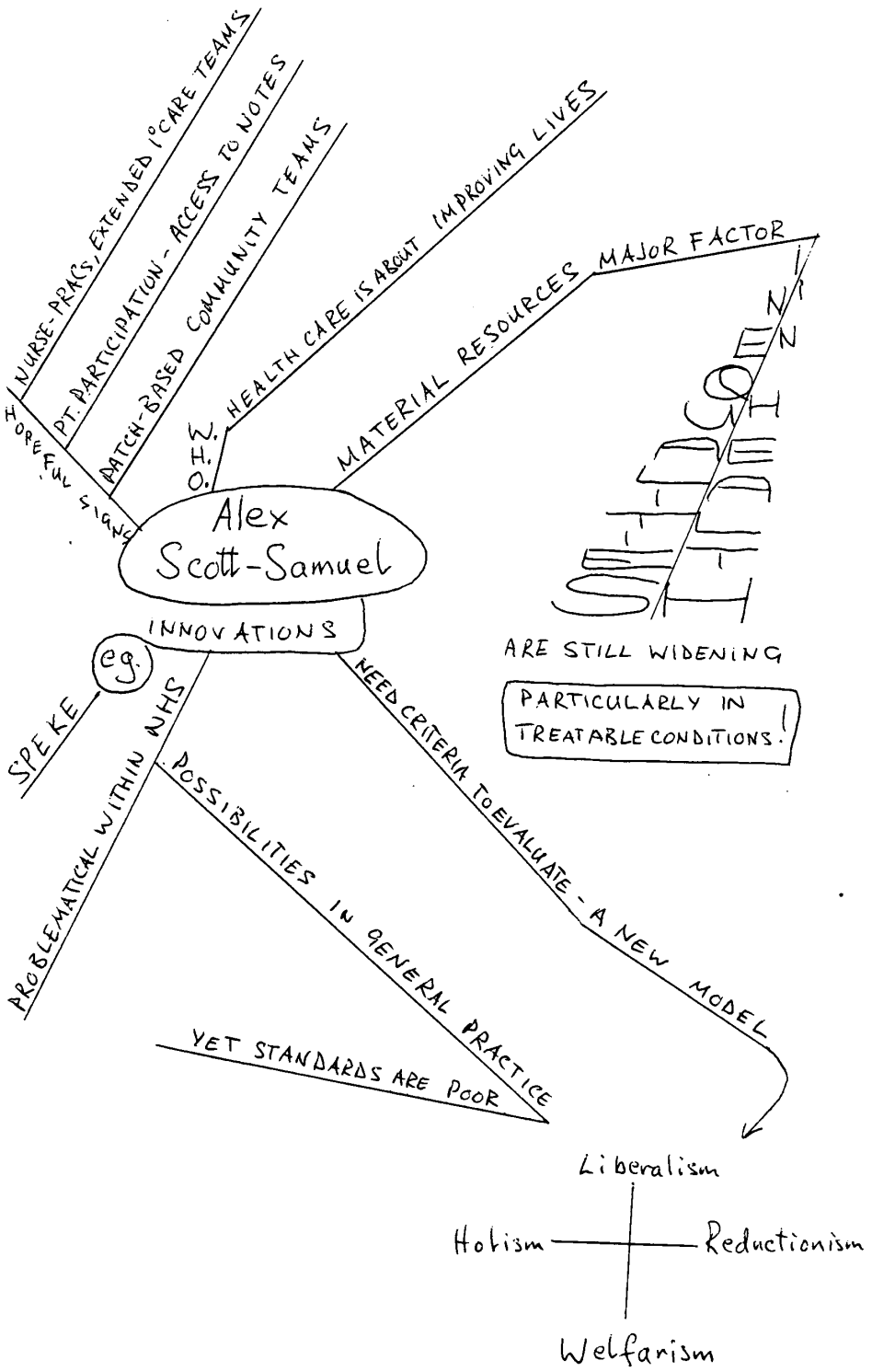
- funded the many Health Emergency Campaigns throughout London

- funded some alternative health care projects

- produced studies of the existing state of health care in London and the need for changes (notably on Commercial Medicine)

Some of this is endangered by the abolition of the GLC, though GLEB and their technology networks, as well as the Food Commission look set to survive. We hope too, that at least some of the Boroughs will continue to extend support to these policies.

I have the impression that it is not the diagnosis of the problems of health care which are the problem. As with health care itself, diagnosis has improved greatly over the last decade. The problem is cure. And the cure will be in part a question of extending the many creative projects developed by the health movement. In part it will be a question of politics and getting government support for a restructuring of the health services along these new lines. I hope this conference will contribute to both these ends.


NURSE-PRACS, EXTENDED PCARE TEAMS
PT. PARTICIPATION - ACCESS TO NOTES
PATCH-BASED COMMUNITY TEAMS
W.H.O. HEALTH CARE IS ABOUT IMPROVING LIVES
MATERIAL RESOURCES MAJOR FACTOR
HOPEFUL SIGNS
Alex Scott-Samuel
INNOVATIONS
eg.
SPEKE
PROBLEMATICAL WITHIN NHS
POSSIBILITIES IN GENERAL PRACTICE
NEED CRITERIA TO EVALUATE - A NEW MODEL
YET STANDARDS ARE POOR
INEQUALITIES
ARE STILL WIDENING
PARTICULARLY IN TREATABLE CONDITIONS!
Liberalism
Holism
Reductionism
Welfarism

Alex Scott-Samuel is a community physician in Liverpool

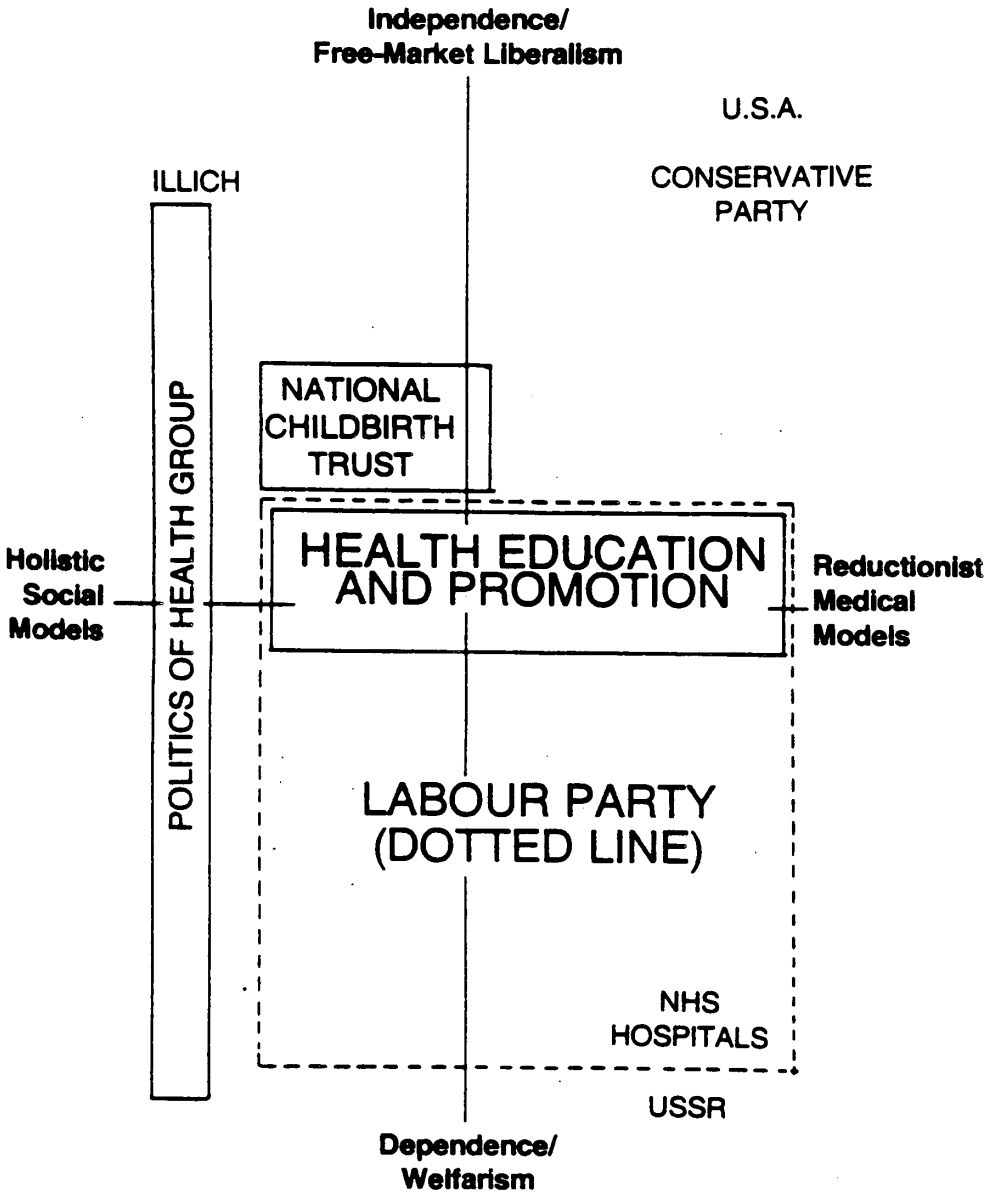
I won't go into the general background to why we're all here because we probably share a fairly common analysis of the issues and problems that are relevant in health today. We all know that health is very much more about improving lives rather than saving them, and that health care tends to be dominated by a medical profession which is still on the whole concerned with saving lives, and increasingly by administrators, treasurers, business persons and others who are also increasingly concerned about saving money. In that context obviously our concerns are somewhat different. You might recognise this, from pages 12 to 13 of the GLC Industrial Strategy on Health, the green document which forms part of the paving stone that Robin referred to. I think it summarises very well both the major determinants and the major causes of health inequality, and I think that it's very much those kind of issues that I won't go through in detail because you know it and you can to which we need to address ourselves. Particularly in the present context where, for instance, the Black Report reinforced very much that these material issues are things that do determine health and these are also the kind of things that are very much less available, let's say, in the present climate. Particularly the aspects that you might call the 'social wage', the way that the public sector makes up for what many people don't take home as a wage in their pocket. Obviously when the social wage goes down the health inequalities tend to increase. Even in the context of a developing, or until recently developing welfare state, in as much as the social wage includes the distribution of welfare services there is more and more evidence that welfare services are unequally distributed and that perhaps contributes to the inequalities. What is particularly interesting in the context of these kinds of issues is that you may be well aware of these issues and of the fate of the Black Report, but you may be unaware that our Government is actually committed to doing something about them. This is mainly in the context of WHO. Firstly, let me show you the declaration of Alma Ata which was signed in fact by all member countries in 1978, and particularly in the paragraphs which I have marked 4, 5 and 6. Paragraph 4: 'The people have the right and duty to participate individually and collectively in the planning and implementation of their health care'. Paragraph 5: 'Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures'. Paragraph 6: 'Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development. Perhaps, most importantly, it forms an integral part of the country's health system of which it is a central function and main focus'. Whether or not primary health care currently is the central function and main focus of health care in this country is perhaps something of interest 7 years after this declaration was signed. More recently, in 1984, the target of health for all went through the European region of the WHO. In other words, European member states all endorsed these targets towards the WHO strategy of health for all. Once again, this strategy includes targets which are everything that one would want to see included in such a document.

Target 1: 'By the year 2000 the actual differences in health status between countries, and more importantly between groups within countries, should be reduced by at least 25% by improving the level of health of disadvantaged nations and groups'. 'Within individual countries this implies, above all, a need for willingness in recognising the problem and for political will in

designing social policies that go to the roots of social group formation in terms of guaranteed minimum income, assurance of the right to work', etc. So these are all points to which our Government formally committed itself. Target 26: 'By 1990 all member states through effective community representation should have developed health care systems based on primary health care supported by secondary and tertiary care as outlined at the Alma Ata conference. I won't go into any more at this stage but there are other targets which go into detail about intersectoral policies from other parts of the economy about involving people in participating in health policy and about creating healthy public policies generally. In theory, all of these things we would like to see happening are already there, it's just a matter of making it happen there's more and more evidence that the inequalities in health are increasing. In a very interesting paper recently, a Finn, Coscinan, looked at British data on health occupational mortality using a summary measure which I won't explain, other than to say that one figure summarises the extent of inequality between social classes in mortality in England and Wales. For both men and married women over the last 30-40 years inequality has been steadily increasing. What is particularly interesting is that Coscinan shows that the inequality is increasing primarily in preventable diseases, the ones where medicine is most successful. The implication would clearly appear to be that the benefits of medicine are reaching the better-off in society more than they are reaching the worse off. Inequality is clearly something that has been with us for a long time, and I was interested to discover this document recently and to find that as long ago as 1805 Charles Hall, a physician in Tavistock was writing 'The people in a civilised state may be divided into many different orders, but for the purpose of investigating the manner in which they enjoy or are deprived of the requisites to support the health of their bodies and minds they need only be divided into two classes, vis the rich and the poor'. 181 years later relatively little seems to have changed. Charles Hall's message is very much that of the Black Report and very much the purpose the WHO target number 1 which I mentioned. If we just look very quickly at the kind of reasons why it would seem that health is political, and particularly in this context today that we are looking at. I think it is useful not just to look at single dimensions like morbidity and mortality but to take at least two dimensions which I do here (see diagram). Across, as you can see I have a dimension running between holistic social models of health on the one hand and reductionist medical models of health on the other hand. I have got an alternative dimension at 90° running from independents' consumerism, free market liberalism at the one end and dependents', welfarism on the other hand. It is interesting to try and put some of the issues that people like us are considering in health on something like this and it helps sort out some of the confusions. Why do there sometimes appear to be negative aspects to things that sometimes also appear to be positive? When you look at Ivan Illich in the top left-hand corner you can see that he is positive in a sense that he's holistic, but perhaps negative in a sense that he's very much somebody whose ideas tend to encourage the free market consumerist shopping around approach and you can see the problems. At the top right-hand corner in terms of the most narrow and conventional medical models of health, and also the free market stance. We have, in my opinion anyway, the health market in the United States and the policies of the Conservative Party, while down at the right you might equally be doubtful about seeing next to each other NHS hospitals and USSR, in other words soviet health policy. But if you think about it the absolute dependence on the welfare state and the medical model are more or less identical in both. I have put a few other examples on. It is interesting to try and conceptualise health ideologies in these terms because it helps you separate out the good elements from the bad elements. When you are trying to innovate I think this kind of thing is particularly important.

AN AID TO CONCEPTUALISING HEALTH IDEOLOGIES

Alex Scott-Samuel (after an idea by Professor David Metcalfe)



The two dimensions (holism/reductionism; dependence/independence) make a convenient basis for classifying and comparing the positions of political parties, countries, pressure groups etc with regard to health ideologies. Some suggestions have been illustrated — see if you agree / try a few of your own!

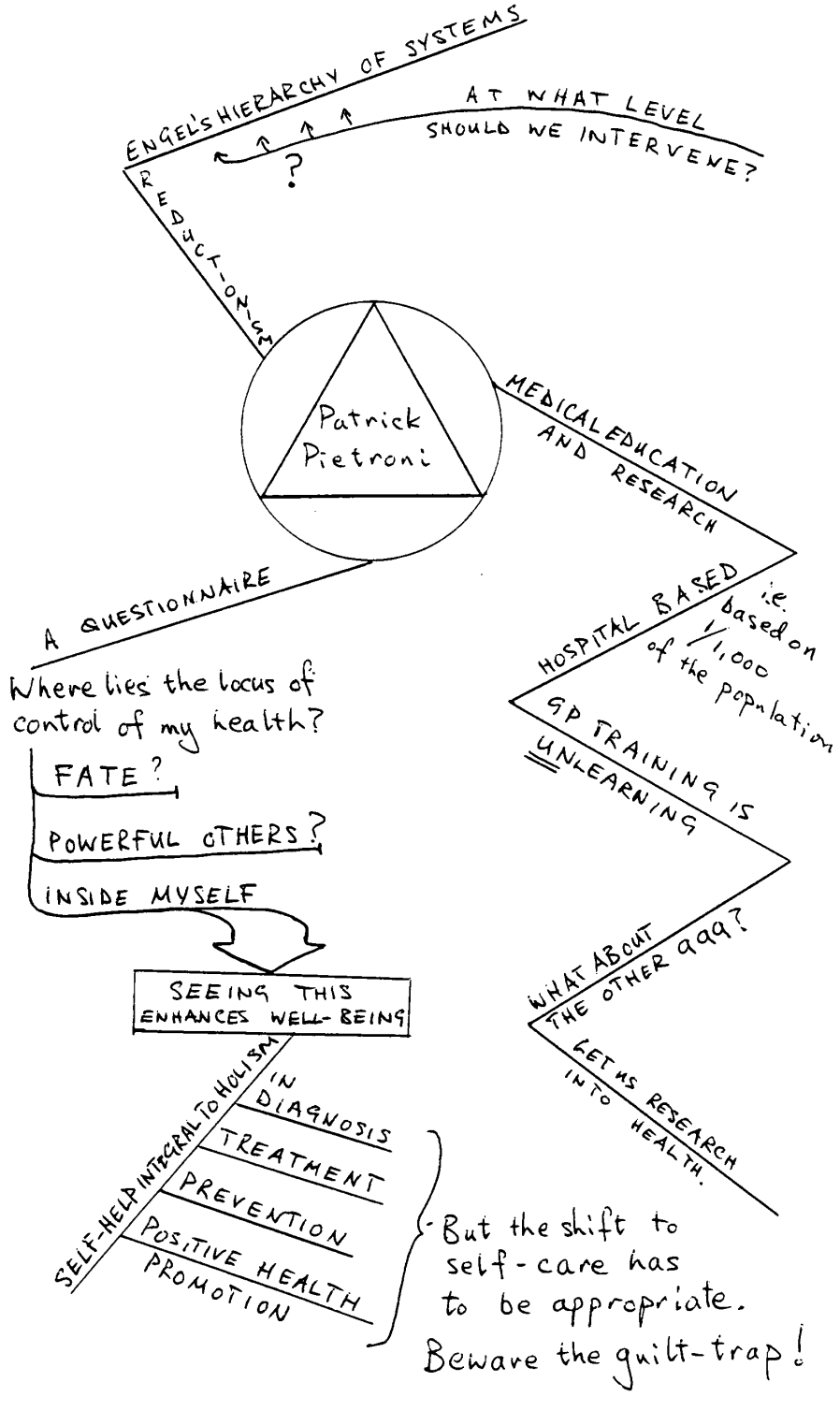
I shall say one two words about the ideas of Jeannette Mitchell as expounded both in the GLC documents, and in her Penguin book 'What Is To Be Done About Illness and Health?', particularly in the last chapter where the idea of what (in a GLC proposal that never saw the light of day) she called a centre for health, how that might have happened. She meant a health centre in the sense of a community centre in the broadest sense of the word which would involve not merely conventional medical care, albeit with the boundaries broken down between different kinds of health workers, but the availability of all kinds of holistic and alternative practices that are represented here today. The needs that are not met in the health service such as occupational health, the needs of particular groups in society that are not met such as ways in which the NHS fails to meet the needs of racial minorities etc.

I would add a note of caution as somebody who works with NHS budgets and is aware that we live in a relatively cold climate. What I would generally say about introducing alternative practice into the NHS is that both alternative practices and existing allopathic practices need to have comparable criteria applied to them. To give an example of the kind of thing I mean, I have a letter here from the Right Honourable Gregorious Yansen, MD of the Ministry of Health and Immortality in the World Government of the Age of Enlightenment who is connected with the Maharishi Mahesh Yogi who has a world plan of perfect health based on Ayurvedic medicine. I know nothing about Ayurvedic medicine, but what I want to say is that obviously when something like this arrives as this did at my health authority, obviously one doesn't say automatically say 'Yes this looks excellent, we must introduce it into the NHS'. What I am saying is we must have criteria and perhaps those criteria don't exist. We also brought in the broader health workers like environmental health officers, for instance, and social workers, those from primary care teams that could be involved. Unfortunately I can't say GP's as much as I'd like to because we found them difficult to get them involved, but also the whole broad range of people whose work has a bearing on health. The DHSS officer, police, probation, community organisations, housing action people, the local housing department officer etc., everybody whose work had a bearing on the public health. And over a couple of years we raised a lot of major issues in relation to things like DHSS benefits, entitlements and availability, environmental health problems, housing repairs and their effect on health, fuel poverty, access to health care from this peripheral estate where veyr few people had cars and where it was difficult to get to hospitals and where the ambulance system did not seem to be very effective. Unfortunately we had one of our perennial reorganisations in the NHS in 1982 and at these reorganisations the planning structure tends to get reviewed, and when it did so unfortunately the Speke Neighbourhood Health Group disappeared. In my and the group's views it disappeared because it was too successful. It was a thorn in the flesh constantly feeding in recommendations to the health authority and the local authority, the kinds of recommendation that they couldn't run away from and which unfortunately they didn't feel often they were in a position to respond to. So I think innovation in the NHS is something that is fraught with problems.

Just quickly to mention one or two straws in the wind. In Hackney for instance, the community health services are moving onto a patch basis where local teams of clinical medical officers and health visitors will be looking at neighbourhood needs. I would like see that kind of team augmented with an environmental health officer in every area of every district in the country because, to me, neighbourhood health care of that sort is what the NHS ought to be addressing itself to.

I went to a meeting last week where GP's from Sheffield were talking about holding meetings with patients to discuss practice policies, producing practice newsletters and annual reports, encouraging patients to come to the surgery to read their notes. It is nice to hear that these kind of things are happening. Progressive GP's like Julian Tudor-Hart and Ian St Eves have been writing over the last few years about the kind of developments extended primary care teams, nurse practitioners and so on, involvement with all the different community health workers to get across to communities in a more positive way than at the moment.

Finally, what is really needed above all is the kind of demonstration project that was recommended in the Black Report. Not just putting some new formula into operation all around the country so that if it fails we have to have another massive reorganisation, but trying something out in one or two needy areas. Many reports now, the Atchenson Report, the Harding Report, both of them DHSS, and the Black Report itself, have suggested that experimental salaried GP's could be set up under Section 55 of the NHS Act serving a defined population in an inner city area. In such areas surveys of need could be undertaken and the kinds of ideas that I've been discussing like participation, de-mystification, the involvement of alternative approaches to therapy, taking on issues like occupational health, addressing the needs of particular groups whose needs aren't being met at the moment, whether they are gender groups, whether they are racial groups whether they are groups defined by their poverty or by the housing in the area that they live in, where all of these kinds of needs can be addressed. I very much hope that in this meeting we are going to start making progress along those lines.


ENGEL'S HIERARCHY OF SYSTEMS
AT WHAT LEVEL SHOULD WE INTERVENE?
?
REDUCTIONISM
Patrick Pietroni
MEDICAL EDUCATION AND RESEARCH
A QUESTIONNAIRE
Where lies the locus of control of my health?
FATE?
POWERFUL OTHERS?
INSIDE MYSELF
SEEING THIS ENHANCES WELL-BEING
HOSPITAL BASED i.e. based on 1/1,000 of the population
GP TRAINING IS UNLEARNING
WHAT ABOUT THE OTHER 999?
LETS RESEARCH INTO HEALTH.
SELF-HELP INTEGRAL TO HOLISM
IN DIAGNOSIS
TREATMENT
PREVENTION
POSITIVE HEALTH PROMOTION
But the shift to self-care has to be appropriate.
Beware the guilt-trap!

DAY ONE - AFTERNOON

Patrick Pietroni

The conference is on Innovations in Health Care and I wasn't quite sure what to touch on in this talk this afternoon, and they are more snippets and thoughts rather than anything formed and polished. I just hope you'll excuse it if it is a little tentative because certainly I don't feel that I have any clarity about which direction health care is going to go in this country and which way it should go. I had some thoughts and we are certainly trying to put some of those into practice but I think we are all experiencing a major transition, not only in medicine and in medical care but also in our culture and our society. I think in some ways it's very exciting, but it also makes for quite a bit of uncertainty. What I'd like to do is sort of put a couple of references and frameworks and then talk about some of the work we've been doing at Lisson Grove Health Centre and some of the ideas that we've tried to bring together.

Most of you will probably know this particular model or this hierarchy of systems which was first outlined by Engels (see diagram). Basically, health care does start with a person and that is something often we all forget in our rush and hurry of what we are doing. In most cultures and in most towns the person has been felt to have a spirit, a mind and a body. Certainly medicine as I have been taught and trained as a doctor in the Western world in the latter part of the twentieth century, most of what I've been taught and what I have been brought up to believe and understand about the proper study of medicine has been about ~~the~~ body. Not only that, it has been about dividing the body up into smaller and smaller bits from systems to organs to tissues to cells and molecules, ~~and~~ the further down that ladder we go the more exciting it is in scientific medical research to try and identify the cause of the disease. That's certainly the road that most doctors are taught at medical school, and the kind of skills they are given really arise from the study of illness or health (although mostly illness and disease,) from that particular viewpoint. A cell is part of a tissue, a tissue is part of an organ and so on, and a system is part of a body, and a person is also part of the family and so on up, a family is part of a community, and a community is part of society and so on. I would like to illustrate this hierarchy by giving a very simple clinical example that might walk in, certainly into my general practice surgery, and it might walk into different health care centres which aren't housed by doctors.

If you take a 35-55 year old male who comes into the GP's surgery with abdominal pain and he turns out after examination that he has a duodenal ulcer the doctor will primarily say that if affecting his body, it's affecting the gastric intestinal system, it's affecting the organ of the duodenum and he knows what tissues it's affecting and he knows which cells, and now we also know which molecules go wrong when you get a duodenal ulcer and what's going on. The treatment at the moment as far as the medical problem is concerned is to give a drug which interferes with the molescular attachment of particular acid-secreting cells and that relieves the symptoms of this man's duodenal ulcer. The introduction of this particular drug in the last 5 to 10 years is a miracle of modern medicine. It has made a tremendous difference in the treatment of duodenal ulcers. But you might ask yourself, why has this man got a duodenal ulcer? I think that most people will accept that in people with ulcers (or certainly duodenal ulcers) there tends to be an element of anxiety, of tension and worry, and you say that it's nothing to do with his body, it's his mind, that he's tense, anxious and upset and what he needs is

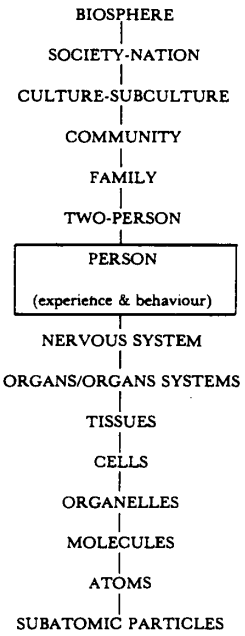


FIG. 1.—Hierarchy of natural systems (after Engel).

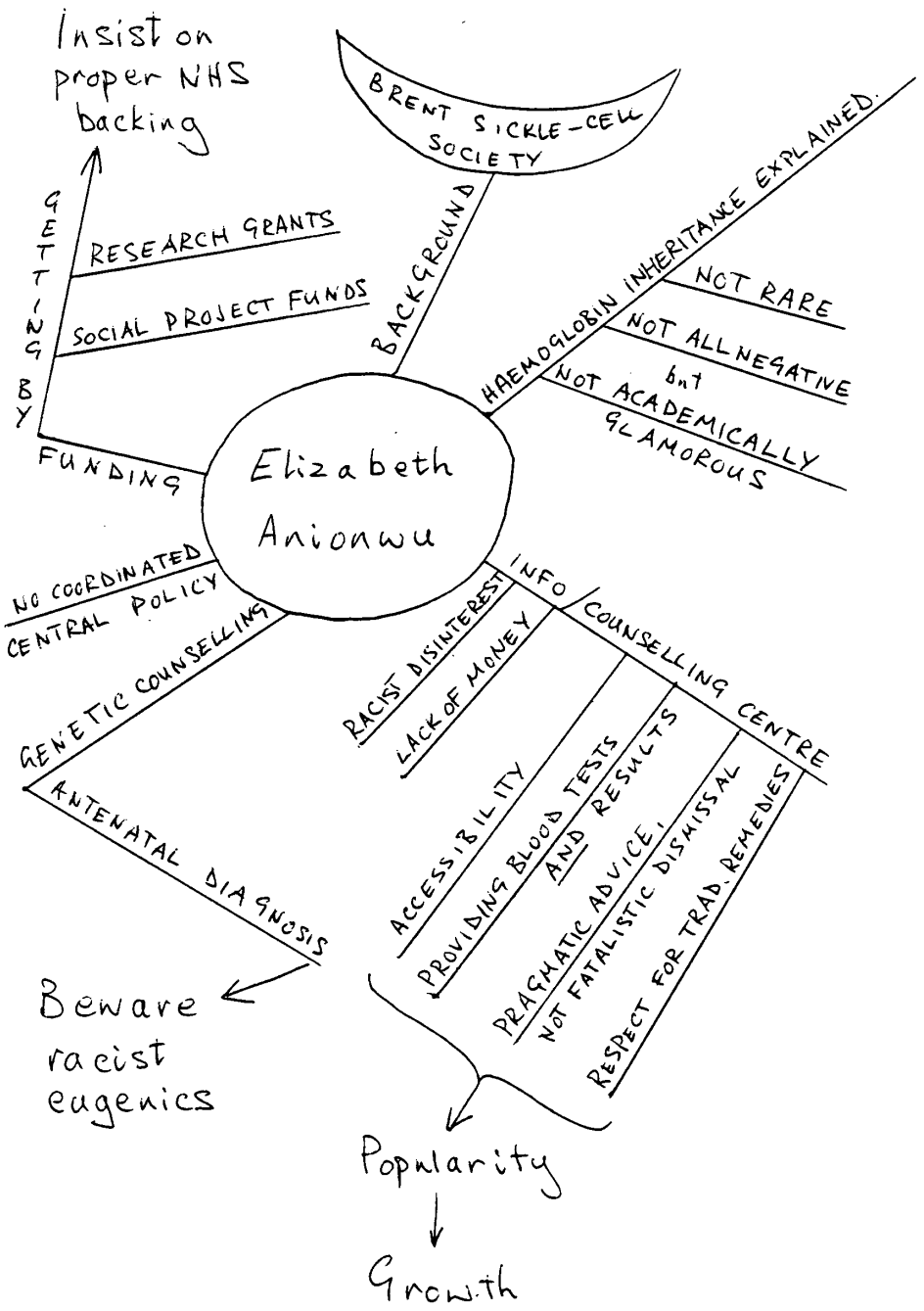
someone to talk to, maybe a bit of counselling, and he'll be alright. Let's skip the spirit for the moment because that is an area which is still relatively tentative in health care, and someone may say 'Why is he anxious, worried and tense? Why is he upset?' 'He's been having a lot of family problems. He's been quarrelling with his wife much more and really what he needs is marital counselling, because if you got a marriage counsellor to sort out the marriage problems then he wouldn't be so anxious and tense and therefore he wouldn't get his bodily symptoms and so on. But someone may say 'Hold on, why is that family quarrelling? Why is there a disharmony between the man and wife?' 'Actually, he's lost his job. His factory was closed and he's been made redundant. He's got very depressed as a result, angry, he's been drinking, and that really the problem is finding a job. Find him a job, he won't get so angry, he won't have quarrels with his wife, he won't get tense and anxious and so on. And we could move on. 'Why is he unemployed?' He's unemployed because our society has a particular political framework and a particular political party in power which has a particular economic policy which produces 4 million unemployed. So actually it's not finding hime a job, it's changing the Government policy and so on. So the question is, in the health care business, at which level are you going to interfere? At which level is it appropriate for the doctor or for the health care giver to interfere? What level is it appropriate that we should be dealing with in primary health care? Should we be dealing with his symptoms and his duodenum, or should we be dealing with his family, his social, his community, or indeed the political concerns that may result? I ask those of you who are in primary health care or any health care delivery system to actually work with that model when you get your next client or patient and see how far down and how far up the ladder you can go in terms of trying to find the meaning for that particular presentation. It is possible to actually work both up and down, and many of us who work up here. Indeed one could say that the greatest health threat to the nation is the threat of nuclear war and that really all our efforts of health care as health care practitioners should be the prevention of nuclear war and not worry about cells and atoms down here. This model provides lots of questions but not answers, and if we can move on a little bit and produce another set of figures which again will produce a lot of questions but few answers.

If you take 1,000 adults between the ages of 16 and 65 in any one month, 750 will develop a symptom of some kind. Of those 750, 250 will go to a GP; and of those 250, 10 will be referred to a hospital; and of those 10, it will go to a teaching hospital. All the teaching that medical students and doctors get is on that 1. Is it any surprise that we are so useless when it comes to dealing with the health care needs of the population at large? Most of the job of general practice teaching is really a job often of unlearning, of getting medical students to unlearn some of the facts and figures that they have learnt in hospital. It's not that it's not appropriate. We obviously need our hospitals and need our hi-tech medicine, but it's when we try and export it into this group here and the skills that we learn at hospital are totally inappropriate for the skills that we need in primary care. The question that I am interested in is what the heck do the 500 do who develop symptoms and don't actually go to a GP? And what about these 250 who actually don't get symptoms, what about his business of health? Our title is Innovations in Health. Can we learn from that group, can we learn from that 500 who develop symptoms and don't go to a GP what it is that they do? And indeed, what can we learn from those 250 who don't develop symptoms? Our research at Lisson Grove has really been about research in these two groups because most medical research is aimed at that one person in the hospital

usually, and most of our understanding of disease comes from studying that one individual. I think we can turn it upside down and say that we could probably learn quite a bit about disease if we studied health. What is health? How does one define the concept of health? The World Health Organisation definition is more than just the absence of disease and I think that's now accepted. It's something to do with well-being, it's something to do with social, psychological, physical integration. It is interesting that one senior clinician was heard to comment that 'the definition of health as accepted by the World Health Organisation is only seen in two conditions. One, in manic patients, and two, in patients just before they have a heart attack. That may be so, that the sense of well-being, the sense of joy, the sense of being full of life may be a delusion and it may be that the lot of the human being is sadness, is depression, is a sense of hopelessness and helplessness, and certainly a sense of hopelessness and helplessness is something which generates both physical and psychological and social illness. It is this sense of hopelessness and helplessness which I feel pervades quite a lot of the patients who come to me in general practice. What is it that you can do?

I would like to introduce you to one more concept which we are beginning to play around with and that's the Health Locus of Control. It's a measure via a questionnaire and it tests people's beliefs that their health is or is not determined by their behaviour. Using this scale you can measure the perception by which you feel that your health is determined by what are called 'powerful others'. People who feel that their health is determined by powerful others and would say 'I can only maintain my health by consulting health professionals. When I'm ill I need to go and see a doctor'. So that their sense of locus of control of health is in powerful others. There are groups of people who will feel that their locus of control is chance. 'It doesn't matter what I do, whether I'm ill or not ill, it's fate. It seems that my health is greatly influenced by accidental happenings'. Then there's a third measure which is called the 'internal locus of control', and that's the perception that people have that they can make themselves better. 'If I am sick I have the power to make myself well again'. Using this questionnaire you can get a measure of how people's perceptions of where their health locsi is. Whether it is mostly powerful others or whether it's internal. What I feel health care is about in some ways is about shifting and playing around with these perceptions, and that the job of a healer, of whatever description he or she may be, whether it's a doctor, a physiotherapist, a social worker, at some level we are dealing with people's perceptions of their health. It could be said, and I think there's some pretty good research and studies to indicate it, that the more you can shift people into actually believing that they have some internal sense of control over what happens to their body, their pysche and their social situation, the more they are likely to respond to scores of well-being. It is divorced from the actual disease in the sense that, and here's two clinical examples, you can have a chap who gets a coronary, goes into heart failure and eventually has a heart transplant, and you can see that as a miracle of modern health care. His perceptions may not have changed about himself and he sees that powerful others got him well again. Or else you can have a lady who has gone to the Bristol Breast Cancer Health Centre with cancer and after about two weeks of their particular approach she said, 'For the first time in my life I know why I'm alive. I know who I am. I have a sense of the purpose of what my life is. And if it took cancer to get me this far then I'm glad I got cancer'. She died two months later, but she spent the next two months of her life alive. Now what is health? The person who has the heart transplant who believes that powerful others got him better or the person who has a sense of understanding of

themselves and their particular place in their life and why they are there? We can debate that. If we accept that moving people towards an internal locus of control is part of our job then the whole issue of self-care is critical in the delivery of health care systems. I see no difference between someone going to see a doctor and having a physical examination and history-taking investigation and drugs and being given tablets, to someone going to see a complementary practitioner and maybe having his hair analysed and his charas measured and aura determined and being given a host of diets and minerals and possibly vitamins. It's the same model of health care in my view that the patient remains a passive recipient of the expertise of the practitioner, and it's that which we need to shift. We need to shift the relationship between the practitioner and the client, the patient. We need in some ways to encourage the concept of self-care, but self-care in what? Self-care in prevention? Self-care in diagnosis? Self-care in medication? Self-care in treatment? Or self-care in health-promotion? There's a lot of work done on this issue of self-care and I think that the whole thrust of the thinking, certainly in general practice, has been towards preventative and promotion of health care. What we are trying to do at Lisson Grove and in some of the new models of primary health care delivery is that we are trying to bring together these three streams. The traditional medical component of ordinary everyday what you would understand as medicine, a complementary medicine component, and a self-care component. I personally believe that without the self-care component, I don't think that you could practise what I would understand by a holistic approach. Doctors who use a self-care model and complementary practitioners who use a self-care model may well be doing a holistic practice. But without that, without encouraging the patient, without giving the patient or the client some understanding of how they can involve themselves in their health care then I think that we are missing the boat. This is not very easy and some may ask whether it is appropriate if you have very deprived and depressed and impoverished unemployed, poorly housed clients as we do in our area. Is it appropriate to ask them to take responsibility for their care? Is that responsibility not part of the community and part of the health service? Is teaching them to relax and meditate decreasing their rightful anger so that they won't protest against the system that produces the poor housing and the lack of jobs? My own clinical impression is that the reverse actually happens. If you do get people who are deprived and feel hopeless and helpless and give them some sense of control over their own feeling-state, by introducing them to certain health care preventative measures, they then do go on and become more active in their social environment and take up the political and social battles that need to be fought. I don't think it's an either/or situation, but the problem with self-care is that it can actually be used by politicians as avoiding their responsibility. As I said in my brief description of this talk, it sometimes can sound like coming out of Thatcher doctrine. "All you have to do is stand on your own two feet and look after yourself. For Christ's sake, why the hell do you think you come to us?" One has to be very careful with the whole issue of self-care. One has to be very careful with the issue of guilt because the patients not only have to deal with their problems that they have with their illness but they are then told that it's also their responsibility. I've certainly seen many casualties who have gone to some of the newer-approaches-to-cancer centres who feel totally oppressed by the diet that they have to eat and the sense of guilt that they have then taken on because somewhere in their life they caused their own cancer. I think that the self-care model can be abused just as much as the medical model has been abused. I just raise this as a caution at this stage so that we don't go overboard on the self-care model.


Insist on proper NHS backing
GETTING BY
RESEARCH GRANTS
SOCIAL PROJECT FUNDS
FUNDING
BRENT SICKLE-CELL SOCIETY
BACKGROUND
HAEMOGLOBIN INHERITANCE EXPLAINED.
NOT RARE
NOT ALL NEGATIVE
but
NOT ACADEMICALLY GLAMOROUS
Elizabeth Anionwu
NO COORDINATED CENTRAL POLICY
GENETIC COUNSELLING
ANTENATAL DIAGNOSIS
Beware racist eugenics
INFO
RACIST DISINTEREST
LACK OF MONEY
COUNSELLING CENTRE
ACCESSIBILITY
PROVIDING BLOOD TESTS AND RESULTS
PRAGMATIC ADVICE; NOT FATALISTIC DISMISSAL
RESPECT FOR TRAD. REMEDIES
Popularity
Growth

Elizabeth Anionwu, Founder, Sickle Cell Society and Worker at Brent Sickle Cell Centre

Ladies and gentlemen, in the next fifteen minutes I really want to race through some of the developments that have occurred in Brent in particular, but also at a national level, in relation to two inherited blood disorders, one called Sickle Cell and the other Thalasseamia. I don't want to concentrate on the medical aspects, I want to try and look at how come the National Health Service failed to recognise the significance of providing information, screening and counselling services for the affected population. I thought I would try and put into perspective how we started, and it is very much 'we'. I work with a team of counsellers at the Brent Sickle Cell Centre but the original action occurred towards the end of 1976 when, as a community nurse tutor based at Central Middlesex Hospital, I met up with the person who is now my boss, Dr Milica Brozovic, a very dynamic community-oriented doctor, which is quite rare. We both realised we had an interest initially it was Sickle Cell. From my own point of view it was because I had been accosted way back in 1971 by a very good friend, Jessica Huntley, who some of you may know runs the Walter Rodney Bookshop in Ealing, who wanted to know why it was that an activist in Shepherds Bush had died of leukaemia. There was an impression that because he was young and black that he died of Sickle Cell disease. Whilst as a newly trained very naive health visitor I was able to distinguish between the two conditions, I couldn't give much information on Sickle Cell. Jessica really attacked me and said "If people like you don't know about it, how the hell can us in the community know about it?" She was very right, but at that point I didn't do very much about it. It wasn't until we set up a self-help group in Brent at the end of 1976, the beginning of 1977, that it really forcibly hit me through talking to parents and adults affected by the condition the unnecessary anguish that they were really having to undergo. That anguish was caused through ignorance and apathy amongst health professionals, and at that point as well there wasn't any support group within the community. In the text there is an artistic impression of one of our women with Sickle Cell disease in Brent and this just highlights what was going on and how it was being experienced (see illustration).

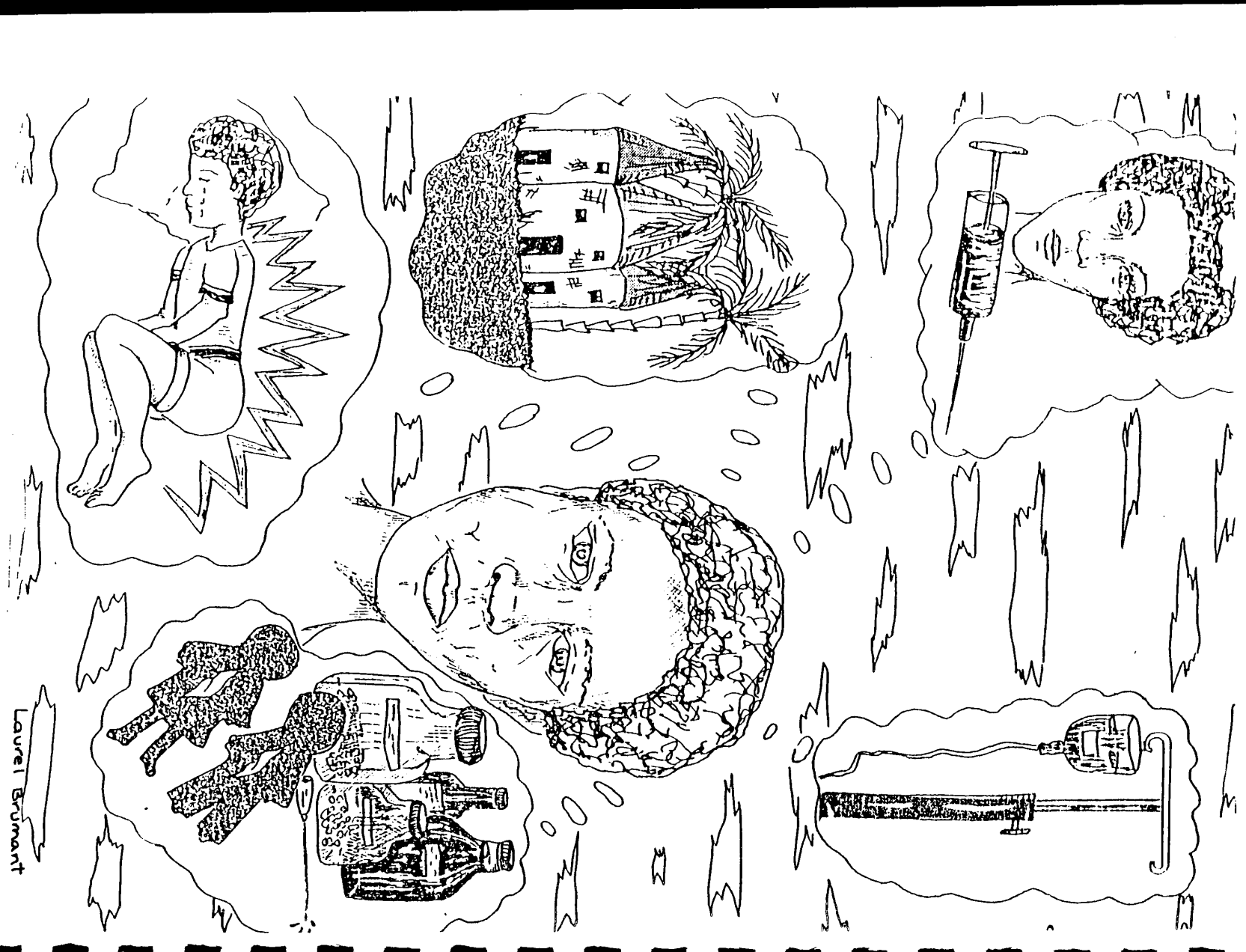
The two conditions, Sickle Cell and Thalasseamia, are similar in that they are brought about by the individuals inheriting a different sort of haemoglobin from both parents. Haemoglobin is the substance that carries the oxygen in the red blood cells, but for our purposes, more important is the fact that we all inherit a haemoglobin type from both our parents. Certainly until I go involved in this work, I never received any lectures about Sickle Cell disease or the nature of haemoglobin. It's easy to confuse a haemoglobin type with a blood group type but they are quire separate, and we inherit this haemoglobin type on a pair of genes, alongside with all other sorts of characteristics. The most common haemoglobin type throughout the world has been given the letter 'A', and assuming that we all have haemoglobin 'AA' that means that we have inherited one gene 'A' from one parent and another gene 'A' from the other parent. But when we come to have children we only pass on one or other of our set of genes from whatever haemoglobin type we have inherited. So here's the classic method of inheritance in that both parents have haemoglobin 'AA' and of course all their children will have it. The important point is that they will get only one of each parents' pair of genes and it's a matter of chance which gene they pass on. It doesn't matter if both parents have this particular haemoglobin type. It does matter, as you will see, with other haemoglobin types.

There are in fact 300 other haemoglobin types but I'm only going to talk about three very briefly that do have relevance in terms of Sickle Cell and Thalasseamia. The origin of these haemoglobins is in the malarial areas of the world where if you inherit, for example, Sickle haemoglobin from one parent and 'A' from the other, that is 'AS' or 'Sickle Cell trait', you do seem to have some protection against malaria in the early part of your childhood. This is an extremely important point that there is a very positive aspect of what appears to be an abnormal haemoglobin. In a certain combination it's not abnormal and in fact you are better off than the so-called normal 'AA' combination. I would like to just briefly go through the various combinations that can give rise to clinical problems if they are passed on in a certain way to the child. Suppose you have both parents with Sickle Cell trait. They are perfectly healthy, anybody with a trait is perfectly healthy and they will not know they have it unless they have a special blood test. However, it's a matter of chance which genes you pass on to your children so there is a chance that each parent could pass on the Sickle gene and that will result in a child with Sickle Cell Anaemia. But the parents could also have children with 'AA' or children with Sickle Cell trait and it really is a matter of chance. All their children could be born with the illness, none of their children could be born with the illness, it's just like throwing up dice. About one out of ten Afro-Caribbeans have Sickle Cell trait without knowing it. It's also found in other ethnic groups such as people from the Eastern Mediterranean, Asia and the Middle East.

Another haemoglobin that is not often discussed but is also relevant is one called 'Haemoglobin C'. That's found in about one in fifty people of Afro-Caribbean origin and a slightly higher incidence from people from certain parts of Ghana, and if you get the combination of 'S' and 'C' that is generally a milder type of Sickle Cell disease but can given rise to hip, shoulder and eye complications.

Finally, the other combination that is also seen is Sickle and Thalasseamia. Thalasseamia means that you are not quite producing enough haemoglobin, but if you only inherit it from one parent you have what's called 'Thalacaemiatrait', sometimes also known as 'Thalasseamia Minor'. I will come to the more well-known aspect of Thalasseamia. Most people have understood that it mainly affects people from the Eastern Mediterranean countries, but it also does affect Afro-Caribbeans (about one in fifty), although it is a generally milder type. If you have both parents, one carrying the Sickle and one carrying the Thalasseamia gene, they can have children with a condition called 'Sickle Thalasseamia' which again is a type of Sickle Cell disease. One form can be very severe and one can be mild.

I'd like to come on to Thalasseamia. If you take the Eastern Mediterranean communities about one in six or one in seven Cypriots carry the Thalasseamia gene in the form of Thalasseamia trait. One in twenty Asians carries the gene, and the incidence does vary within various parts of Asia. It is also found in the Middle East and it's also found in the English population, as one in a thousand English people have Thalasseamia trait. If both parents have Thalasseamia trait it has the same genetic implications. Every time they have a baby there's a one in four chance that the child could have a condition called Thalasseamia Major which is an extremely severe form of anaemia and after the age of about six months the child gets progressively weaker and will not survive unless he or she has monthly blood transfusions for the rest of their life. We are talking now about two different conditions but with a lot


Laurel Brumant

of similar features in terms of inheritance, in terms of possible clinical management, hospitalisation. As far as the family is concerned we've always felt that we should be providing services for both Sickle Cell and Thalasseamia.

What was the situation and what still is the situation in Britain? I hope I have highlighted that we are not talking about rare conditions, we are not talking about conditions that only affect black people. When we first started in 1976/77 this was the constant response we got, "Its only a sort of rare tropical illness. Send them down the School for Tropical Diseases and that's the end of it". One of the areas that we looked into was actually identifying the need. Through the local self-help group, which is now the Sickle Cell Society, one of the first things that was obvious was that it was very difficult for families to get information from their family doctor, the health visitor, the hospital doctors and nurses. Looking at it as a health professional now, and I am going to confuse you because one minute I'm going to talk about myself as a health worker and the next minute I'm going to talk about my community involvement, because I think that is the most commonsense approach. From the health worker's point of view I certainly didn't get any lectures about Sickle Cell disease, I hadn't a clue what it was, and, like many parents, we had to go to medical references. If you were lucky you saw perhaps a couple of sentences which said "This is an inherited illness confined to the Negro population and they do not survive childhood". Can you imagine a parent sitting in a library receiving that sort of information and it's totally incorrect by the way? We could say "This is a genetic condition, surely these regional genetic counselling centres should have taken it up?", but they haven't, with the odd exception. There's only usually one in each region, they're either stuck away in the tombs of the teaching hospital, very inaccessible. Also, Sickle Cell and Thalasseamia is a little bit too boring for the geneticists. It's straightforward Mendelian inheritance, any fool could sit down and counsel people about Sickle Cell. It doesn't have any intellectual academic potential, they don't have to sit down with their calculator and work out odds and, certainly from that point of view, genetic counselling centres have not been in the lead to provide better services.

As a result of that several of us felt that there was a need for specialised information and counselling services and many of the ideas for our centre did arise from my trips to the United States. I met this lady, for example, who was a nurse practitioner running the Los Angeles Sickle Centre and one of the lessons I learnt was that it has to be extremely easily accessible to the community. They don't want to have to go and get permission from the doctor to go to such centres. When I kept coming back to Britain I would be so enthused by the American situation, don't forget it was just after the end of the Civil Rights era in the late 1970's when I was going, and I would come back to staid, stuffy old racist Britain and they would say "You really have got a bee in your bonnet, it really isn't a big problem. Anyway, this is a sort of luxury service. They are not the only ones that have difficulties communicating with doctors". And also the direct racism, the attitudes towards the 'at risk' community, "They are not very bright, they don't get married, and they're a bit irresponsible so this really would be a luxury service", and the final thing, "We don't have any money".

Despite this we set up the first centre in Brent on a research budget and it was interesting that this very hospital, for those of you involved in Brent's politics, was the one they wanted to close down. Now you can't get a corner of this hospital in terms of space. But at the time that we were looking around for accommodation the hospital had been threatened with closure, closed down and then re-opened due to community activity, so we found a couple of rooms there. With a very small research budget we opened up the centre which was me, a desk, and six months later a phone.

The centre has really taken off and we now have two other counsellors. There is an exhibition which I have set up here at the conference and which is available which gives a little bit more detail. We have got two counsellors as well as myself, there is Marvel Brown and Nina Patel who has recently started and is a Gujuerati speaking health visitor, who is developing a similar strategy in terms of Thalasseamia. We have had over 2,000 people use the centre. 75% have referred themselves and I think that speaks for itself. Why do they come? A lot of people have actually been screened for Sickle and other things before an operation or during pregnancy. They may have been lucky to be given some results but usually the way they are told the result if very confusing. They are usually told they are Sickle Positive and they don't know whether that means Sickle Cell Trait or whatever. One of the features of our Centre is that people can have blood tests if they want, again without any permission from their general practitioner, and they then get told the results directly.

The other aspect of our work is to try and break down what has been very technically presented. You can really get put off if you start getting interested in the subject and then people start spouting things like 'amino acids' and 'globin chains' and 'helixes' and 'replacement amino acids'. What we have tried to do is to try and break down this information so that the health professionals don't have this power of knowledge so that the community feels threatened, confused and helpless. So that has been one particular area of our work.

We are not only accessible for anyone in the community who is interested, who wants information testing, but we also give specialised long-term counselling to individuals and parents affected by the actual illness. Our main experience in Brent has been with Sickle Cell disease but we are now trying to develop a similar service for Thalasseamia Major, but let's just talk about Sickle for this moment. Coming back again to the same lady who did the paintings, we were finding that patients with Sickle Cell disease were not getting basic information for them to feel that they have some control over their illness. They were presented with a bleak depressing picture that there was nothing they could do, they were going to die before they were 21, and we ended up realising there was practical advice and information that you can give to families. A very simple example which maybe very boring, is that if you drink plenty of fluids you can actually reduce the amount of painful crises that is a feature of the illness. We also respect the health beliefs of our community. In my own research, both in Jamaica and here, it was clear that families didn't feel confident to talk to doctors about suggestions for management. There is a well-known chewing stick used in Nigeria called 'Orin at a' and there is another kind that a parent brought recently. The point that I'm trying to make is that if you look at research in Britain it is very medically oriented research. There has been very little research on nutrition, very little on alternative aspects, and yet we're dealing with an illness for which at the moment there isn't a cure. So this is an illness families have got to try to get to grips with.

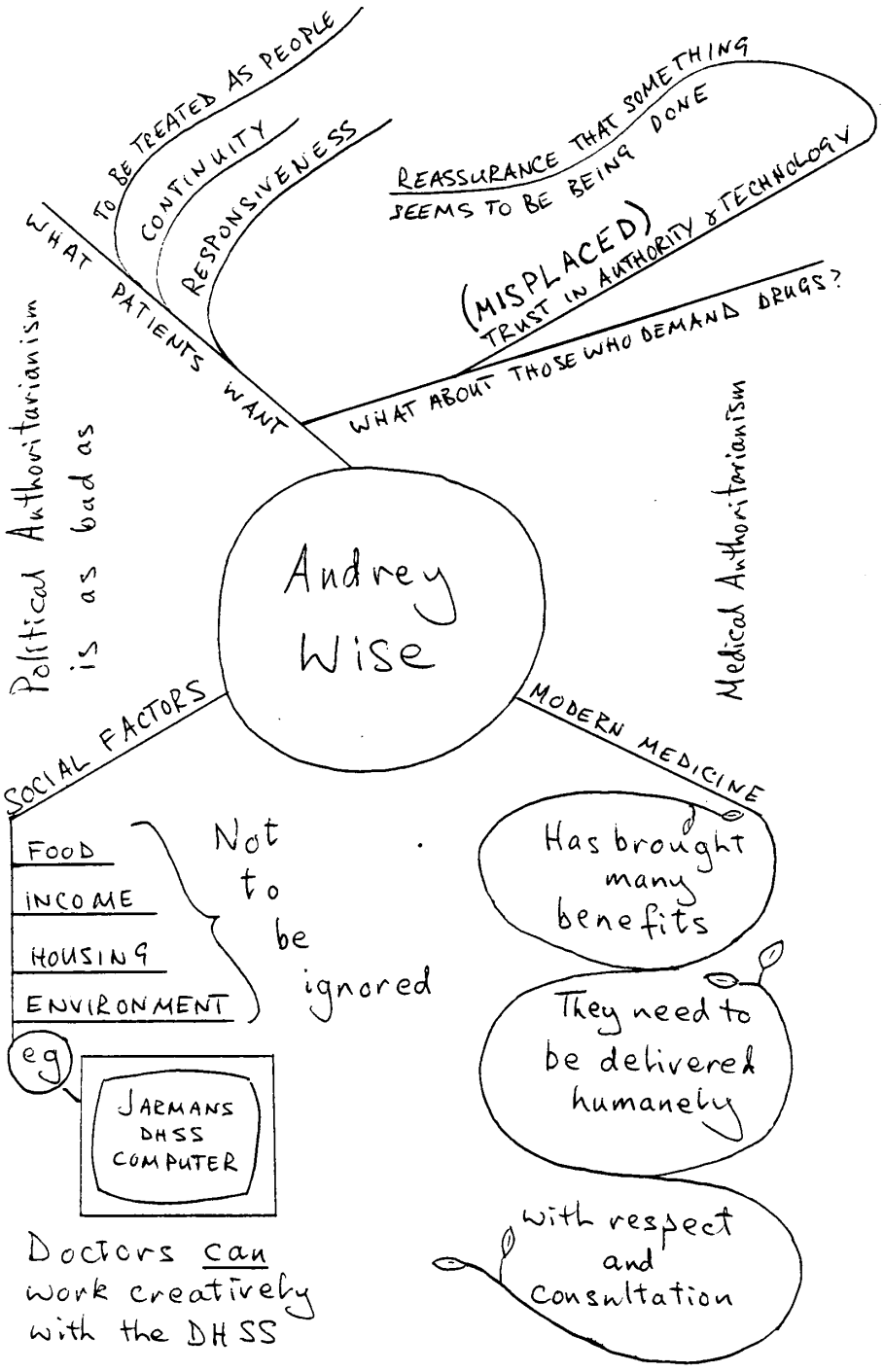

O Positive
Laurel Brumant

I am switching now to what we do at the Central Middlesex Hospital in which we're linked with the Haematology Department. An area that has caused grave anxiety is this fact that you can identify 'at risk' people, we've said 10% of the Afro-Caribbean population have the trait, but in the wrong hands, in racist hands, in this sort of eugenic approach the community feel threatened and feel that it is being used against them. What I mean by this is that there is an attitude that if you can identify at risk couples you can test the unborn baby. Some people feel our services should be directing people not to be having children by somebody with the trait, to push anti-natal diagnosis, detect the illness in the unborn baby, and terminate the affected foetus. In the hands of racists, who feel that black people breed far too quickly anyway, you can imagine the dangers that this engenders. This is really just to show that we feel that couples have choices and they are the only people who should make those choices, and they should not be directed by the views of health professionals.

The other area that has caused grave concern to the Sickle Cell Society is that although you can test the new born baby for the illness and there a lot of energy has been expended on testing the unborn baby, the test having been published way back in 1971, only one-third of London hospitals test at risk babies, ie. where they know the mother has the trait of the illness. Babies are leaving hospital very vulnerable to death in the first two years of childhood through infections and other problems if they are not diagnosed. Why should we be making a fuss? We know that at least 100 babies are born with Sickle Cell in the London regions alone compared to 12 babies a year with Phenylketonuria for which, I am sure you are aware, every baby in this country is tested for. That's an area that health workers and community groups really need to be looking at how they can support and it is an area that the media have neglected with one exception, in 'The Observer'. These are some of the areas of work that we do at the Sickle Cell Centre. All babies are tested at the Central Middlesex Hospital, parents are counselled about the results and there are other areas of work undertaken as well.

What is the situation at the moment? There are now seven Sickle Cell Centres set up in Britain, five of them in London, and three research projects, all manned mainly by health visitors, but they are all on short-term funding. It's very ironic, but I suppose it's understandable when you know the politics of it, but the bulk of them are funded by the Department of Environment, not the Department of Health. What's the logic behind that? I've sat down and thought about it. You probably start off with a research budget and when the research budget finishes you knock on the doors of the Health Authority who say 'we don't have any money'. Somebody then scratches their heads 'this affects blacks. Urban programme money, inner city programme money, that's for blacks. Go along to the Department of Environment, you'll get a grant from them', and it takes us off their backs for maybe three or four years, and this is the situation that we're in. As far as Brent is concerned we are not going to go for any further urban programme funding when it runs out in two years. We are insisting that we should be funded by the Regional health Authority. We are the only centre in the region, we get referrals from all over the region, and it is about time it was accepted in the mainstream NHS funding.

Finally, there is a report by the Runnymede Trust called 'Sickle Cell Anaemia, Who Cares?' and it's based on the findings of what's going on in 100 health authorities in England and is really is very depressing and shocking reading. Whilst there are a few health authorities trying to deal with it and provide services, the majority are not. There is no co-ordinated policy from the DHSS, and they are only having the odd informal meeting because of pressure from community groups. I would just like to conclude that some people may get the impression that things are going well in Sickle Cell because it's received a bit of publicity in the last few years. I would like to put it in the context of the two conditions, Sickle Cell and Thalaseamia, and state that things are not going well. They are going well, as I've highlighted, on short-term funding, and it's only through health workers working and being part of community groups. We are not there as advisers, we are part of the community, and we are not there as experts to community groups. Where I think we might have been a little bit successful, not very much, is when people do get confused about our roles. 'Where are you with, the centre or the society?'. Does it matter?


Andrey Wise
WHAT PATIENTS WANT
TO BE TREATED AS PEOPLE
CONTINUITY
RESPONSIVENESS
REASSURANCE THAT SOMETHING SEEMS TO BE BEING DONE
(MISPLACED) TRUST IN AUTHORITY & TECHNOLOGY
WHAT ABOUT THOSE WHO DEMAND DRUGS?
Political Authoritarianism is as bad as
Medical Authoritarianism
SOCIAL FACTORS
FOOD
INCOME
HOUSING
ENVIRONMENT
Not to be ignored
eg
JARMANS DHSS COMPUTER
Doctors can work creatively with the DHSS
MODERN MEDICINE
Has brought many benefits
They need to be delivered humanely
with respect and consultation

Audrey Wise Member of the National Executive of the Labour Party

As a matter of fact this set up in which I have to talk to you is a prime example, in the educational field of the sort of thing I most object to in the medical field. I feel the equivalent of having walked into a huge district general hospital and I feel as if it gets in the way of actually talking to you, just as I feel that the normal medical set up gets in the way of actually communicating with the doctor.

I want to start by saying that what patients want is what I have been asked to talk about and agreed to, but I am very conscious that that in itself makes a fundamentally wrong assumption because it is a clear impossibility. The main point that I want to say is that patients are actually people. There is no such thing as 'a patient' with just a stereotype clapped on them so you can say 'this is what a patient wants' or 'what the patient wants'. Patients are actually people, although they very rarely feel like people. All too often they feel as if they are some sort of raw material being processed. Generalisations are inevitable but I have got this qualification in my mind and I would like you to have it all the time.

I would say that what patients want is to be treated as people, is to have choices, is to be met with responsiveness, and is to have continuity, that in not feel that they are being handed from hand to hand or on some sort of conveyor belt. That is not what is normally regarded as the wish of patients. Many health professionals, and here again I don't want to generalise too much because there are excellent health professionals at all levels, like the one we have just heard, but certainly many health professionals would say that what patients want is to go to the doctor and get a prescription and that they feel robbed if they don't get a prescription. If you take up with doctors why there are so many tranquilisers used they argue that when people come to them there is pressure for prescriptions. That is used as an excuse for the over-prescription of tranquilisers and the over-prescription of antibiotics, in particular. It might be right to an extent. Perhaps a lot of patients do want a prescription, perhaps they do feel disappointed if they come out without one, but I would suggest that that doesn't tell you anything. What you need to know is why do they feel like this. I believe that the ones who feel like that do so because a prescription stands for confidence. It suggests that the doctor knows what is wrong with them and can do something about it, preferably cure them. What they are seeing in the prescription is confidence on the part of the doctor and hope, and they are seeing an expression of interest. They can interpret this as meaning that the doctor thinks they are worth bothering with, that it isn't a hopeless thing and that they are not beneath contempt. They are also seeing an expression of authority and we are trained in all aspects of our lives to welcome and respect authority and to feel uneasy if there isn't a manifestation of authority. When patients want prescriptions they are acting out a role which they have been set by medicine and by society. I want to challenge that because I think that many, many patients now are overtly, consciously challenging that and that many more would be ripe to challenge it if they felt that there was any alternative.

I believe that there are other ways of getting hope and getting confidence, and I don't speak as somebody who is anti-medicine or anti-hospitals or anti-doctors. I have had major illness and major surgery; I have had prolonged chemotherapy and six months in hospital; I have given birth to two children and brought them up and that brings you into contact with health

questions. So I start off as very conscious that I am standing here in a good state of health because I have had assistance from the medical establishment. But even while I was getting this it was in a sense impeded. I mentioned having an operation. I was in bed and I was just at that stage when you wonder whether it is really the best thing that you have actually come round because you are feeling so absolutely dreadful. All medical professionals who have never had anything like this expect you to instantly feel better, and they come along and say 'you'll be feeling better now' and I just clenched my teeth. The very first contact I had with the surgeon was that he came in with his entourage and they all stood around the bed and it felt as though there were dozens of them. I was in a ward on my own (for medical reasons) so this little room was full of people and the surgeon looked at me and did something and then said to the others, not to me, 'the next operation will be in three weeks'. I had no idea. A next operation? So I then gathered all my strength together and said 'just a minute, what operation?', and they all looked at me as though the bed had spoken. I have never forgotten it because he then felt impelled to actually address me, the last thing he had expected to do when he came in the room. I was just the raw material. He said 'yes, we have always intended there would be another one' etc. I thought that meant that something had gone wrong with the first one because you don't expect a second one unknown to you unless something has gone wrong with the first one. I thought they had found something they didn't expect, - you can imagine. So that greatly attacked my confidence in the whole set up, in them, in me, in the course of my illness and it made me, at a time when I was extremely vulnerable, feel both very angry and very unsure. To this day I have got no idea whether he was telling me the truth or not, and no particular expectation that he would be telling me the truth, and that is a very dangerous thing because that can't help you to recover. So even though I was grateful and impressed and conscious of the resources which had been spent on me and many times told myself how lucky I was not to be a citizen of the United States of America, nevertheless they were undermining it themselves. That is just one small example of the way people feel when they are in the hands of the medical establishment, and often I think doctors themselves feel like this. I'll come back to that in a minute.

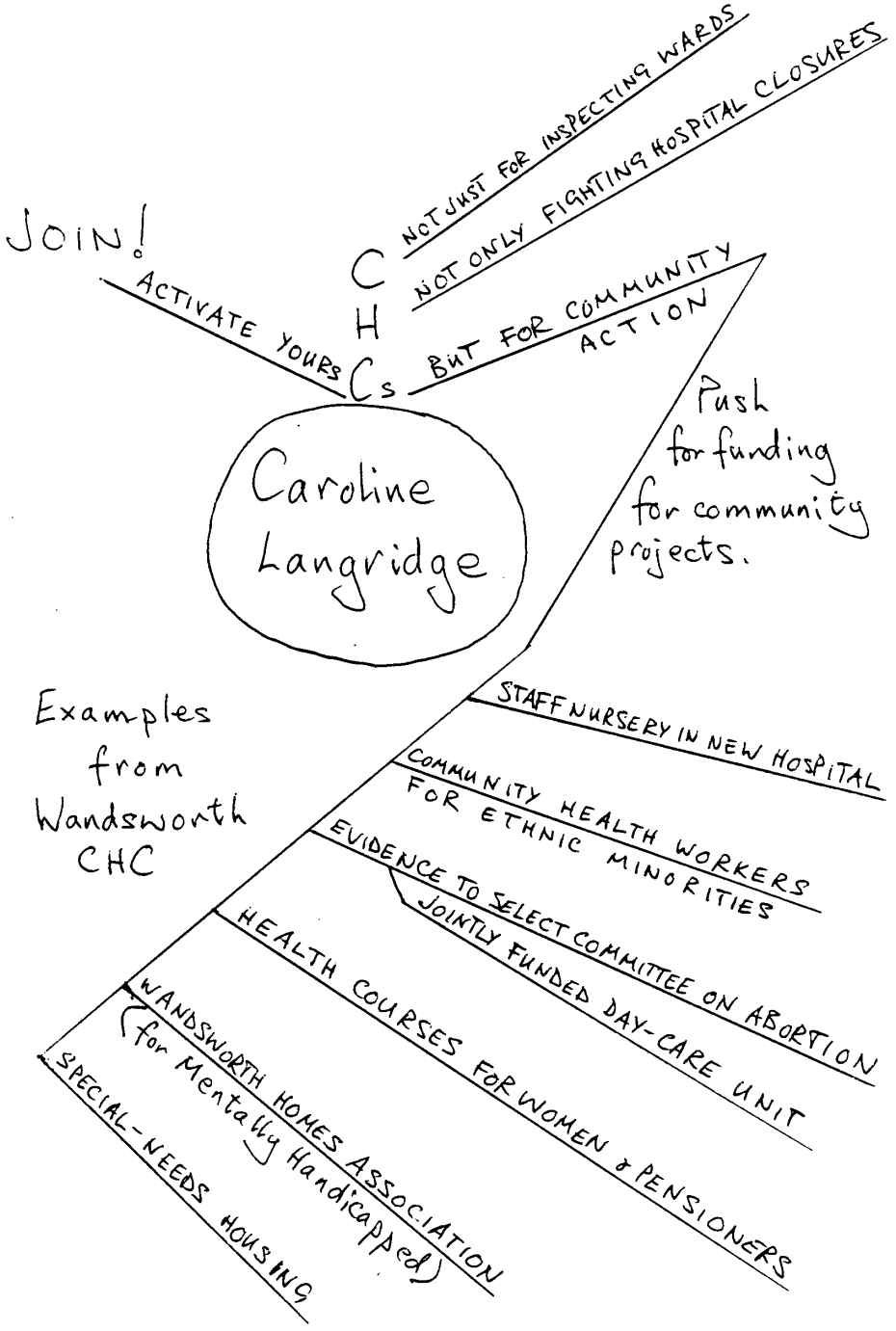
I think that we must give people other ways of getting hope and confidence and feeling that people are interested in them and having use of resources and the authority to obtain resources. We must find other ways because the existing ways aren't working, quite apart from anything else. I remember the active political generation immediately preceding mine very confident that the coming of a National Health Service would mean that you put in a lot of resources in the beginning but that gradually people would get healthier. My parents and grandparents, who were very politically active, didn't foresee the need for health resources as a bottomless pit. They also had an attitude towards health which was that they weren't just concerned about getting a National Health Service free at the time of use, freely available to everybody who needed it, they also saw health in terms of good housing, which they also expected, and better incomes and more nourishment. I think that my parents and grandparents were absolutely right when they thought that. I have got an election address from my grandfather in 1934 standing for the local council in which he is talking about health and housing in the same breath, and how right he was. What we have got instead of that is a situation where the health services or the medical services have a perpetual job of picking up casualties that ought never to have been created. Some things come from genetics as we have just heard in that fascinating talk, but most things don't. I will read you a piece which I read in a magazine which I bought last week, not a medical

magazine and I'll tell you which one in a minute. An article called 'Poor, Poor Britain' - 'The effect of poverty on health is casusing deep concern. Government statistics show the perinatal death rate in Social Class Five (the bottom) to be nearly twice that in Social Class One (the top). Babies born to Class Five parents are more likely to be underweight than those born to Class One parents. The dangers of inadequate diet before and after pregnancy are stressed in a DHSS report which warns that it may impair a baby's growth and endanger the health of both mother and child'. It goes on to talk about the cost of this diet and how it is half the supplementary benefit of a single parent. 'Professor Brian Jarman, Head of the Department of General Practice at St Mary's Hospital, London, believes there is ample evidence that the nation's health is being influenced more by social than medical factors! "Too often illness is caused by inferior social conditions and the cure is to remove the cause" he said. "As doctors we are treating merely the symptoms and not the cause"'. It goes on "To help them (as people who are not receiving their full entitlement to benefits) Professor Jarman designed a computer programme which can deal in minutes with even the most complex cases. Now a DHSS officer works with the computer in the centre'. I would have liked to have heard the dialogue between that doctor and the DHSS office that brought that about. "As a result many patients have been able to claim additional benefits and Professor Jarman is satisfied that their health has improved as a result. "A patient from a one parent household came to us with chest pains" he said, "having eliminated other possible causes we decided her problem was stress caused by financial difficulties. The computer revealed that she was entitled to family income supplement and when she got it the pain disappeared"'. That is fascinating. That is delightful because it appears in 'Woman's Own' of 8 February. That is giving very, very valuable medical health information to millions of women in this country and it illustrates a doctor who is to be exempted from the sort of strictures that I have been putting on medicine. But is is a lone voice. Most single mothers going to a doctor with chest pains will find that he eliminates, if he bothers, common causes, does obvious checks, and then what will be do? You know as well as I do - put her on tranquilliers, and it will probably cost more in the long run that way than the woman getting her family income supplement. Because her getting her family income supplement and the chest pains disappearing have rebound effects on the care of her kid and her life so that you have a multiplier from that money, whereas the accumulative effect of tranquilliers is in quite the opposite direction. So there, in a nutshell, are two approaches to health and which is best for the patient and which does the patient really want?

How many women want to be told it is all in their mind and how many women get told that. Or, even worse in a way, how many women get treated as it is is all in their mind without even being told, so they don't have a chance to argue, they just get this mysterious prescription. A friend of mine actually went to the doctor with chest pains and got given a tranquilliser without being told and passed out just a few minutes before she would have been driving her children to school, so this came home to me very much.

I think that social change is absolutely imperative, and that includes not only more money. We are accustomed to talking about more money for the health service but I think more income for a lot of the population is equally a health matter. We are accustomed to some extent to linking housing and health. I noticed that on the leaflet - 'Innovation and Everyday Health Care' there is a box which says "Housing Action as Health Prevention", which is absolutely right. But how far, even those of us who are thinking about this

topic, how far have we got from really thinking about environmental issues in a broad sense. There is no box on here about food, and yet food - the lack of it, the wrong food, food that is doctored right from the time the seeds are planted or the calf is born -food, in my view, is a major health preoccupation and patients are expressing views about this load and clear, and patients before they get to be patients, which is even more important. Of course there are obstacles to people interested in health, there are obstacles in the way of dealing with issues about food because at the heart of that issue, probably more than any other, is the whole question of profit. It is not only in the field of private medicine that profit-making gets in the way of proper approaches to health, in my opinion. It is there in the field of food and in the field of smoking, so I think that a rounded approach to health would certainly include environmental concerns in that very wide way. As has been said, this cannot be separated from political considerations. When we talk about political considerations I don't think we should make the same mistake as we are expected to make when we approach doctors. I am not suggesting that everybody removes their faith from the medical establishment and reposes it in the political establishment. I am a member of the National Executive Committee of my party but what I want is not faith to be expressed in that body, what I want is enormous pressure and what I want is reinforcement when we take faltering steps in the right direction and loud cries of alarm, dismay and anger when we take steps in the wrong direction. Otherwise we are just substituting one looking up to authority for another, equally harmful. I believe that the most essential job which faces us all is to build confidence in our approach. If we build confidence in our own approach then we will give people with that confidence the force, the feeling that they are entitled to demand better living conditions in the widest senses. We will give them confidence in facing up to establishment figures wherever they need to be faced up to, and confidence to distinguish between one kind of establishment or professional and another kind. I think that the field in which this confidence is most essential, is in relation to women's health in general, and to childbirth in particular. I wanted to say something about the questions relating to pregnancy and childbirth but I obviously can't because of time, except to point out that in a situation where only 13% of obstetricians and gynaecologists are female there has to be something wrong. And in a situation where a gynaecologist/obstetrician who is supported wholeheartedly by the women she treats is pilloried by a section of the medical establishment there must be something radically wrong and so I think that what patients want is an alteration, we want more doctors in fact like Wendy Savage, and that is probably a good point on which to end.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ACTIVATE YOURS
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NOT JUST FOR INSPECTING WARDS
NOT ONLY FIGHTING HOSPITAL CLOSURES
BUT FOR COMMUNITY ACTION
Caroline Langridge
Push for funding for community projects.
Examples from Wandsworth CHC
STAFF NURSERY IN NEW HOSPITAL
COMMUNITY HEALTH WORKERS FOR ETHNIC MINORITIES
EVIDENCE TO SELECT COMMITTEE ON ABORTION
JOINTLY FUNDED DAY-CARE UNIT
HEALTH COURSES FOR WOMEN & PENSIONERS
WANDSWORTH HOMES ASSOCIATION (for Mentally Handicapped)
SPECIAL-NEEDS HOUSING

Caroline Langridge Wandsworth Community Health Council

I would like to start by saying that like Audrey I don't think you can divorce politics from the NHS, and CHCs, who where they have managed to achieve anything, have done it in spite of the politics rather than because of it. CHCs were set up in 1974 and were an innovation. It was the very first time in which the community had been given the voice in the NHS, but like most innovations it had its faults. We have never really been given the power and the resources that we need to have really transformed the NHS, but, going back to politics that wasn't exactly on the agenda. What we did get, when in 1974 there was an election and a new Labour government, was a well known paper called 'Democracy in the Health Service', in which Barbara Castle extended our powers and gave us perhaps our single most important power, which is that we have to be consulted about changes in use and about hospital closures. But I am not really going to talk to you about that today because I want to focus on the positive side. The negative side is that very, very few CHCs indeed have managed to stop hospital closures and I am no more successful than anybody else Wandsworth, where I work, has lost over 900 hospital beds in the last twelve years and is set to lose another 400 or 500 in the next two years. There is very little I can do about that except to build a campaign to make people aware of the circumstances surrounding those decisions and to make them angry and to make them demand change. I also deeply resent the concentration on hospital closures because, apart from being a negative thing, most CHCs, and we are no exception, feel that they have to fight hospital closures. Through closures money is being taken away, particularly from areas like inner London, and that money is being lost to the health service. If the money were on the table for different kinds of health care I think we would have perhaps been in the forefront of some of the battles to make major changes. I don't particularly want to see hospitals continue. Audrey talked about the difficulties of going into a large district general hospital. We all need a certain level of health care but I don't want to be perpetually fighting to retain every single acute hospital bed in London. Instead I want to fight for the resources for change, for innovation, to really develop a health service that meets our needs, that is controlled by us, and I don't see that fighting to retain hospital beds, which in essence is fighting to retain male medical power, is necessarily a very progressive thing to do.

I would like to take you on from that, and I would like to talk about our CHC and how we have managed to achieve a few innovations. I would like to talk about why we have managed to achieve that because there are many people who would say to me "CHCs, they are no good, they don't do anything". I think if people say that, they have to look to themselves and ask why have some CHCs managed to achieve change. The main reason why they have managed to achieve change is because of the people who made up the CHC founder members and who set the tone for what those CHCs would do.

Wandsworth had a long history of community action and the membership of the CHC who appointed me were predominantly community activists, some of you are sitting here today. Our first Chairman, Sue Holland, set up the first neighbourhood counselling service in the entire country, in Battersea. It was closed down by the tories when they took control of Wandsworth in 1979. Nonetheless that was the very first neighbourhood counselling service and Sue has gone on to build on that work in White City, and I know that other people are now setting up similar projects. But I don't think we should forget that that first one happened in Battersea. It is not surprising that Sue and some of the other members set up right up from the word go a social policy group on

our CHC and said to me, as the paid officer "Don't waste your time going on endless hospital visits, let us look at the way in which health interacts with other aspects of social policy. Let us look at housing, let us look at unemployment, at poverty, and let us see what we can do in Wandsworth to improve the health of people living in Wandsworth rather than just going around and making endless comments about the catering and whatever about local hospitals". So at their best, building on that, I think that we have represented an alternative voice in Wandsworth. Alex talked yesterday about introducing innovation into the NHS and he talked about the Speke Neighbourhood Forum. He pointed out how it became a very powerful body which embarrassed either its district health authority or area health authority, and in the end it was so embarrassing it was disbanded. We haven't been disbanded as yet but we have certainly caused our health authorities their share of embarrassment.

What have we done, what is this much vaunted innovation that I have talked about? I would like to pick up on one other aspect of the speakers yesterday. Robin Murray at the start spoke about the importance of local government involvement in health, and where we have achieved innovation I think it has been because we have managed to persuade other authorities to spend their money on funding things which are more traditionally regarded as health care. As Elizabeth has pointed out, whenever you want to do something new in the inner cities almost certainly you are told "That is social deprivation, why don't you look to inner area programme?". Although we are angry too that we haven't been able to get many projects funded from mainstream programming, and I hope that that will change in the next ten years, I haven't given up yet. I should say, interestingly enough, whilst the Labour Party supported many radical initiatives when it was in control in Wandsworth Council, we have managed to persuade the Conservative dominated Wandsworth Council in the last year to also put money into things which are more traditionally regarded as health care. So don't be put off if you live in what seems to be an unfruitful area, carry on.

So what have we done? One of the first things that we did was to give evidence to the Select Committee on abortion. This is, if you like, straight NHS mainstream programming. In 1975 we gave evidence and we campaigned to get a daycare abortion unit set up. In 1979 after four years campaigning, and I might say after the personal intervention of David Ennals in 1979, we actually opened a daycare abortion unit at the South London Hospital which was run by women for women and which has now sadly closed. Fortunately we managed to persuade our health authority that it be financed on joint finance money, but again we could only do this with the support of Wandsworth Council who agreed that money which is traditionally spent on social service projects be spent on the daycare abortion unit. It was only the sixth daycare abortion unit in London, and when the South London Hospital closed it moved into St. James' Hospital, another hospital which is under threat. But we will continue, no matter what the outcome on the St. James' issue. We are determined that Wandsworth will continue to have a daycare abortion unit.

Moving on from that, St. George's Hospital in my area is a newish hospital, being rebuilt, which is going to be one of the most dominating hospital buildings in the whole of Europe, training more medical students than most hospitals. But this hospital which was going to have over 5,000 people working on site had no facilities for staff, particularly for women. In the climate at that point in our history of equal opportunities much thought was being given to encouraging women to go into medicine, but no provision was

being made for childcare. In 1981 we set up the innovative Blackshaw Nursery Centre which is the first, and I am sad to say the only one, in the country which is open for 15 hours a day. It opens at 7 o'clock and doesn't close until 10 o'clock and is specifically designed around meeting the needs of childcare workers working on the St. George's site and in other hospitals. If they work shifts, if they are at work either from 7.00am through to 4.00pm or from 1.00pm till 9.00am they have to have childcare facilities which recognise that need. And although we have only got 48 places and there is always a huge demand for places, we have been a major help in helping women to carry on with their careers and progress through the structure. I am interested in women doctors, it is one of my long standing interests, but I am not only talking about the privileged elite. I am talking about nurses, about domestics, about many women who not only want work because that is what they would chose to do with their lives, but talking also of two parent low income families where women have no choice because they desperately need that income even if it is reduced by having to pay out childcare fees.

From 1974 onwards we have been interested in ethnic minorities and health and back in 1975 we tried all ways round to try and get a research project off the ground looking at the take up of health care by ethnic minorities. We were continually thwarted on the grounds that we couldn't have access to records and that the Ethical Committee wouldn't allow this. We carried on pursuing it. We didn't get very far with the research, but finally, after an exceedingly long struggle, in 1974 we saw the appointment of a community health worker for Asians and in this year's inner area programme there is another application for an Afro-Caribbean community health worker going through. So after all that time we have at long last seen some change. We spent time running pensioners' health courses, we have run women's health courses, we have developed special needs housing with Wandsworth Council, and this is Conservative Wandsworth Council. The criticism of the special needs housing programme is that the only way you get rehoused in Wandsworth these days is to be in the special needs group, ie. mentally ill, mentally handicapped, single, homeless or whatever. Nonetheless, we have seen major change in encouraging a vast investment in special needs housing, particularly for the single, homeless and rootless, the ex-Camberwell people, which has really taken off in Wandsworth.

To come onto perhaps the latest scene, in the last two years we have set up a new group called Wandsworth Homes Association which is providing housing for the mentally handicapped. In three years we have managed to achieve a situation where this year we opened our first house in January, and we are soon opening another three. When I say 'we' perhaps I ought to explain that the CHC doesn't do these things on its own because it couldn't. By and large what we tend to do is to set up an organisation with other people in the community - a new charity, a new voluntary organisation - to fight for the money to do that. To work with people, to work through the community, to empower them, to teach them the skills that we have acquired over the years so that they can go on and do these things, and it is working in partnership with the community which I think the CHC is all about.

Finally, what can you do about your CHC if you think "Okay, it's wonderful in Wandsworth, but what about the rest of the world?" I would strongly urge you as health activists to get involved with the CHC, to become members of the CHC, and if you don't like what it is doing take it over and change its policy because however limited they are, CHCs are there, they are a vehicle for you.

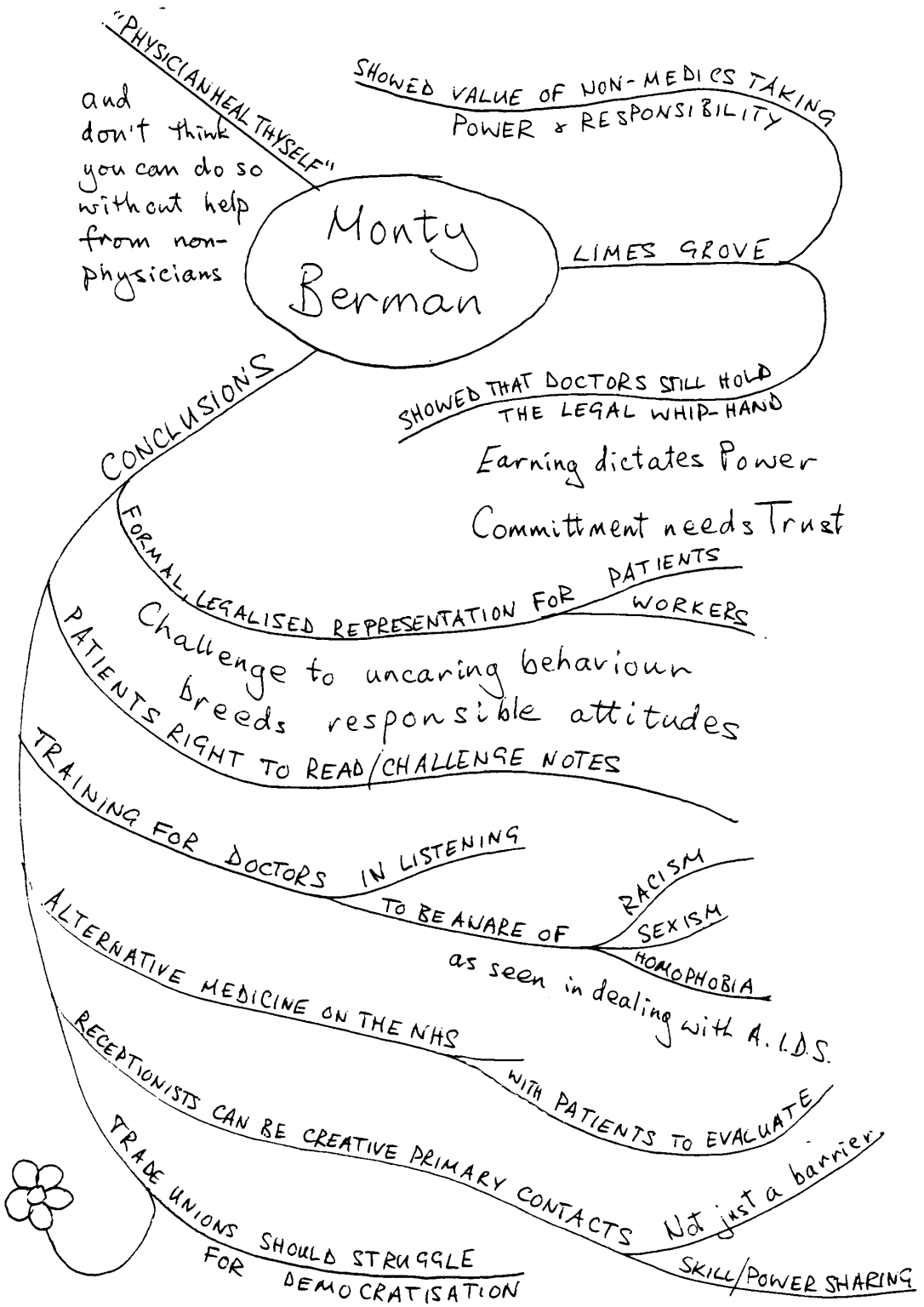
We have to be given information, we have to have a dialogue with the health authorities, and although that dialogue is often a very difficult process, if you don't interact into that how are you going to get the system to change?

Beverley Beech Chair of the Wendy Savage Campaign

I am delighted to have been asked to give you some information about the campaign and I am sure many of you will have seen the details about the enquiry. What has happened is that Wendy Savage is one of the few women consultants in the National Health Service and she has recognised that there is a need for women to receive care in their communities. She works in Tower Hamlets, one of the most socially deprived areas in London, and has set up a daycare abortion service. The consultant obstetricians in her area believe in high technology and they don't believe in using it 'appropriately', they believe in using it routinely and frequently. She, on the other hand, believes that it has a value when labour deviates from normal and when the woman then becomes in a condition where technology has to be used, and for that reason she tends to do ceasarian sections rather later than her colleagues. Her colleagues eventually found that they couldn't tolerate working with her any longer and they carefully went through her case notes in order to select five carefully chosen cases which they believe showed her to be an incompetent obstetrician. They sent it off to a colleague, who coincidentally had argued against her appointment as obstetrician in that area, for an unbiased opinion of her abilities, and from that they then saw the Chair of the Health Authority who recommended the introduction of the section 112 procedure to suspend her. That procedure is now going ahead and there is an inquiry. Our campaign has, over a period of time, very vigorously tried to draw public attention to it. It has had the support of not only the women and the parents and the men in the community, but, very significantly, three quarters of the general practitioners in the area signed a petition saying that the inquiry was quite outrageous and they wished her to remain looking after their patients and providing their care. Also, all the medical students signed a petition saying that they wished her to continue teaching. Wendy Savage stands not only as an individual woman who is trying to give care to a specific group in a community, but she also represents a view reflected widely in the country as confirmed by the Women's National Commission which showed that over 80% of women preferred to see women. We are quite confident that she will not be found guilty because if they look at these case notes in an objective way they will see that in three of the cases there are very healthy little toddlers running around as examples of her 'incompetence'. But if this inquiry were to find her guilty then we are going to have an enormous surge of more technology used on women; those consultants who are trying not to do early ceasarian sections, who are trying to keep the technology to the background, are going to be under increasing pressure to carry out early ceasarians and to carry out forceps deliveries and to continue with the centralisation of care despite the evidence that it is of little benefit to low risk women.

One of the real difficulties that Wendy Savage has is that this is not a legal inquiry and on discovering that the solicitors representing her were also representing the Health Authority, she decided that she would change solicitors and the Medical Defence Union then said they were not prepared to continue paying her legal fees. Her legal fees will be anything in the region of £50,000 to £100,000. Even if she wins she will have to pay those costs so I would appeal to you to help in as generous a way as you can.

Contributions to: Sam Smith
20 Melford Grove
South Woodford E18 2DX
Cheques payable to 'Wendy Savage Appeal Fund'


Monty Berman
"PHYSICIAN HEAL THYSELF" and don't think you can do so without help from non-physicians
SHOWED VALUE OF NON-MEDICS TAKING POWER & RESPONSIBILITY
LIMES GROVE
SHOWED THAT DOCTORS STILL HOLD THE LEGAL WHIP-HAND
CONCLUSIONS
Earning dictates Power
Committment needs Trust
FORMAL, LEGALISED REPRESENTATION FOR PATIENTS WORKERS
Challenge to uncaring behaviour breeds responsible attitudes
PATIENTS RIGHT TO READ/CHALLENGE NOTES
TRAINING FOR DOCTORS IN LISTENING
TO BE AWARE OF RACISM SEXISM HOMOPHOBIA as seen in dealing with A.I.D.S.
ALTERNATIVE MEDICINE ON THE NHS
WITH PATIENTS TO EVALUATE
RECEPTIONISTS CAN BE CREATIVE PRIMARY CONTACTS NOT just a barrier
SKILL/POWER SHARING
TRADE UNIONS SHOULD STRUGGLE FOR DEMOCRATISATION

Monty Berman

I was a member of the late lamented Limes Grove Practice and in a sense it is important that I tell you something about the history of that very quickly because the Leyton practice which some of you may have heard about is in fact a rose out of the ashes, as it were, of Limes Grove. In a sense, although there is no more a Limes Grove, it was really one of the first and most important radical developments within the National Health Service for a change in the concept of the nature of power. Although it was not an entirely successful one there was a great deal about it which was important. It was a collective, there was an equal pay collective and the medical profession as such was challenged by non-medical personnel all the time. The structure of that practice nine years ago was established not by the doctors, not by the staff, but by the patients. The patients attended a meeting and decided what sort of practice they wanted and it was that which was the basis for the development of the practice. For anyone who says that it is not possible for people to make a contribution to the nature of change in the National health Service I give you this as a history, for when we failed, when the fight took place between the doctor and the rest of the collective, on two separate occasions, patients attended a meeting to discuss the problem that had arisen, 750 on the first occasion and 500 on the second. I can only suggest to you that if people are prepared to come out at night to a hall to discuss the problem of a practice which they felt was particularly important tin their lives because they were part of it, then there is hope in the future if we listen to the people who actually use the service. Not only is that an important factor but the other factor is that the medical profession, whatever that profession is, whether it is alternate of non-alternate has to be at the service of the people who use a practice, in whatever form. That is the history and that is the lesson of Limes Grove. The failure was technical. The failure was that we didn't sign an agreement, the failure was that we didn't have contracts, the failure was that we didn't see and confront the doctor with her need, which was money, and that ours was less concerned with money. That was the issue that was at stake. The doctor could have gone elsewhere and set up a practice somewhere else and got the sort of money that she was looking for, but in a sense she had taken possession and felt it was her practice and in that sense was where the failure lay. And that is where some of the failure lies in all our work when we take professionalism and use professionalism as a basis for extracting ourselves from the nature of the people that we work with. In that sense Limes Grove is an important contribution to the history and development of changes that can take place in the National Health Service.

For me at the end of that it was an extremely bitter experience because it ended up in court cases and an enormous struggle with the trade union movement as well. If I stand back on it now and look at what happened I can only say that I look back on it with an enormous amount of love and caring and I use the word more and more often in my life because I think it is an important word to remember. That it was love between us, between the people that we worked with than made it possible to succeed in the way it did, whatever mistakes we made. Perhaps some of the mistakes we made that caused the end rift were because there was not perhaps enough love. That in a sense leads me into the fact that some of you have discussed which is that if we believe that there is a change necessary, then that change has to come on a broader spectrum than the sort of spectrum within which we are operating in these

organisations, whether they are part of the alternate scene or part of the allopathic scene. Organisations which are exclusive for medical personnel will automatically contain the power that they are not prepared to share. That goes for the whole spectrum, whether it is the BMA or the CMA, wherever it is, until we understand that democratic processes now have to play a part in the future of all health services. The patients, or as Audrey Wise quite rightly says, us, the people, must have a right at all levels of health in contributing towards the democracy or the democratisation of those health areas. In general practice patients should have the right to criticise, to demand, to experience, to share in what happens in that general practice. We need to establish bodies in the future that will create and allow that situation. We need to allow, as the GLC programme proposes, that workers in hospitals should have a say on management boards. That regional health authorities should have some form like a Parent and Teachers' Association in exactly that form, something that forces them to listen absolutely and not in theory but in actual practice. All of this will require education, and the education is not only for the medical student who is not taught the sort of thing, but it is needed in all our schools, the right to share in the process of health. We need to train at that level. I am making these pleas because I believe that we need directions, and I believe that those directions come out of the experience that we are having in this conference which is that we need to share. The thing that has impressed me all the time is this need that everything one feels that we need to share professionalism, we need to share experience, we need to share skills. If we are prepared to do it at the level at which we are professionals we must begin to share it at the level where people are not professionals and that is where some of future lies, that is where the changes are going to come from. Changes that come from doctors or come from acupuncturists or come from pyscho analysts or pyschiatrists are not good enough unless they have the input of the people with whom they are treating. It is nonsense to exclude them from the process of decision making. Part of those patient rights are to do with patients' notes. The one thing we did at Limes Grove and the one thing that is done at Leyton is that every patient has the right to look at their notes, and not only to dead them but to question the professional as to what is written about them. I can give you innumerable instances and you have probably heard enough, but the one that has left a marked impression on my mind was the one from a consultant gynaecologist to the GP which said "This girl is not capable nor mature enough to have a baby". That was a man making a very fundamental decision about a woman. She happened to be 28. Those sort of statements must not be allowed to remain on people's notes and we cannot get an alteration to that until we, as patients, begin to demand the right to see them. Not wait for the doctors to agree to give them to us, but to challenge and that is the point that I am trying to emphasise. We have to challenge at all sorts of levels, it doesn't have to be the grand gesture of a political party, and it hasn't got to be the grand gesture of the media, but it can be the direct confrontation between patient and GP, patient and nurse, patient and alternative practitioner, all the time without stop. And that requires education, it requires people to almost be trained in the right because we have in our society given up our rights and we need to fight for them back again.

I want to just make two last points and I am going to make them in an example. The present campaign in the media about AIDS is not just the media. If you look very closely at the medical input into the whole AIDS issue you will see one of the most disgusting and most disgraceful behaviour patterns that started in America, was repeated in France and is beginning to be repeated here. Everyone is trying to get money in order to do research work in order to be first there without really understanding why this is happening to the patients behind them and without actually standing up and being really counted in the homophobia that has been going through the press. It seems to me quite clearly that we need to challenge something like this very exactly at the level in the general practice and at all those levels of health where people need to get information. I can't think of any way of making the change more emphatic than pleading for ways and means and of constructing those ways and means and of planning those ways and means towards a democratic future. I am not talking about my political party because I believe that we have forgotten that although we have the mother of all parliaments it has turned into some sort of debating chamber in which the rights of people are yet not enshrined. It is that right that we have to the future for ourselves and our children and our children's children that must be the issue that we take up at all levels apart from the nitty gritty that we have to keep with everyday. If we don't do that we will not build the basis that we need for the future.
I am sure that people will want to respond to what Monty has said. It is curious in a way, what he has said was very similar to the discussion that was taking place in the workshop that I was at this morning where I think we all ended up feeling that there were so many strategies that we needed to work out to take on this whole issue of how we were going to empower people to have some kind of democratic right in health care, in planning it, in using it and so on. I think if in the discussion that we have now we can try to reflect that there are going to have to be action at a number of different levels, and that no single course of action is going to be the right one. What I am asking you in a sense is not to come with a speech about the way forward, let us listen to each other sympathetically and see how we can include all of the ideas that I think we are all going to have.

Question. 'How can we educate people, instead of indoctrinating them that "doctor knows best"?'

Monty

I can only share with you what happened at Limes Grove which I think in a way was part of the problem. I don't think it is the whole way of doing it but there is one route which is that if you feel strongly enough about something then you put up a notice and you say "People who are interested and whose members of this practice might like to meet to discuss ways of making it more democratic". You might even get, surprisingly enough, the doctor to help you, or the nurse or the receptionist. I think it's making contact with people and talking and sharing everywhere where you can start to collect people together who will then take on some sort of responsibility towards going forward. In a sense the challenge has to come from within each and every one of us to move forward. We can spend a lot of time here thinking of exact ways, but I think the response starts from within oneself to get the thing operative and moving. Does that really answer the question?

Discussion

I think we have to get together and I think you need to give some support in order to get basics started and once you have got it started it should be escalating from there. We have been educated for two generations that the doctor knows best and it is very hard to go against that. We are trained in acceptance and the doctor is trained to think that he does know best.

Hugh Lowe, Secretary of London Health Emergency.

I am going to agree very much with Monty and I think disagree a little bit with the Chair. Somebody just said that for forty years or two generations or whatever the time might be we have all been bossed around by the doctors; It is very much longer than that. However, two generations ago when the National Health Service was set up a new element entered into the whole question of health care. There was some negative things which I will go on to in a minute which happened at the same time and that was very simple. Health care was to be delivered free at the time of need or the point of use etc. I totally support all those people who think that there are various ways in which we should be empowered to control the medical profession etc., but you must go back to that. There is no way in this society that you can do things without money. Maybe in some other society you can, but in this society you cannot do anything without money. We need money for all our health services and we have to fight for that because otherwise we have a very skillful establishment and it is extremely good at taking people's progressive ideas and turning them around and bringing them out in reverse. It has done it about industrial training where it took up the cry of the people who protested against the apprenticeship system, and what did you get? You got YTD which is very much worse than the apprenticeship system. It has taken up the cries of all those people who said "Shutting up people in mental institutions is a very bad thing, it shouldn't be done and they should come out". It has taken up that and what is it doing? It is shutting all the mental institutions and throwing everybody onto the community with no support at all or very little. These things are really very important.

The negative things that went with setting up the National Health Service was that it was de-democratised from the start. People did not have power in the Health Service. I can remember, being older than most other people in this room, that there was a battle about this at the time as it was to have power in the hospitals and on the ancestors of the DHAs. They were a little more democratic then than they are now. This was built in and the whole thing got controlled by the medical profession and the bureaucrats at the DHSS and that is what happened. The other thing that was built in was the division about health between the secondary system, that is the hospitals and so on; the primary care system which is the GPs; and the other part of care which falls to the responsibility of local authorities, and between these three divisions it was possible to push the ordinary person about from place to place. That, I think, has the affect that we have got to go back and get right. I would like to emphasise that I am totally with everybody who wants to, what I would generally call democratise and empower ordinary people with respect to the health service. Incidentally, don't forget that part of that empowering is empowering the non-medical or even some of the medical people who work inside the health service because the average cleaner and the average nurse even has no power either inside the Health Service and so they are analysing the fight. We must not forget that there is this overall need to make anything that people want in the way of improving democracy realistic. We have to go back to this question, we must have a health service funded to adequately meet a free use of its facilities at the time of need because you can then start to do things with this word 'need' and what you mean by it and make demands on

the service, and how much of the national product should go to it and so on. Thank you.

Maurice Newbound - National Health Network

Can I just do two things. One is talk on behalf of our home-group which I have been asked to do, and also just reply to the one about not doing anything without money. Whilst some amount of money may be required, and I am talking about a lot, give a case history on how you can actually yourself set up a group of communication straight away. Monty mentioned that we must do this, must get people talking to each other and get the groups together. A very simple way indeed, which you can do tomorrow if you want, is sit down and write out a press release to your local paper and decide to start a meeting group, a health group. We have just done this in Somerset. About five weeks ago we sent our first press release out to the local papers, we got headlines because we made it very positive and said that this was going to happen, there was going to be a Somerset Health Group set up. It was just people coming together to talk and to meet and to listen about all the different options which are open. If there, as we have often said, five thousand or five million people know of all the different alternative therapies, complimentary therapies that are available, let us say there is five million that means there is fifty million that haven't got a clue and they are confused and they want to know what alternatives there are. So we just purely put this announcement in the paper, we had a room for up to about forty people, we filled it with sixty and we turned another forty away for who we arranged another meeting the following week. So already, without money other than just producing that press release, we have a group of people who want to meet regularly each month and to listen to talk amongst themselves like you have been doing for the last two days. So anybody can do this. You can do it yourself and you are able to do this now.

Regarding the actual conference here, just combining with that, the points that came out were that very much the practical side was more welcome than the abstract complaint. In other words, one can make lots of complaints all the time but it is how to do that was very much welcome indeed and I had to convey that. The other thing is, which one or two of our group felt, that the conflict between holistic and the orthodox seem to come more and more as the two days went along rather than the other way around, they were expecting to go the other way. We all felt that it was a wonderful concept for the two days to be here.

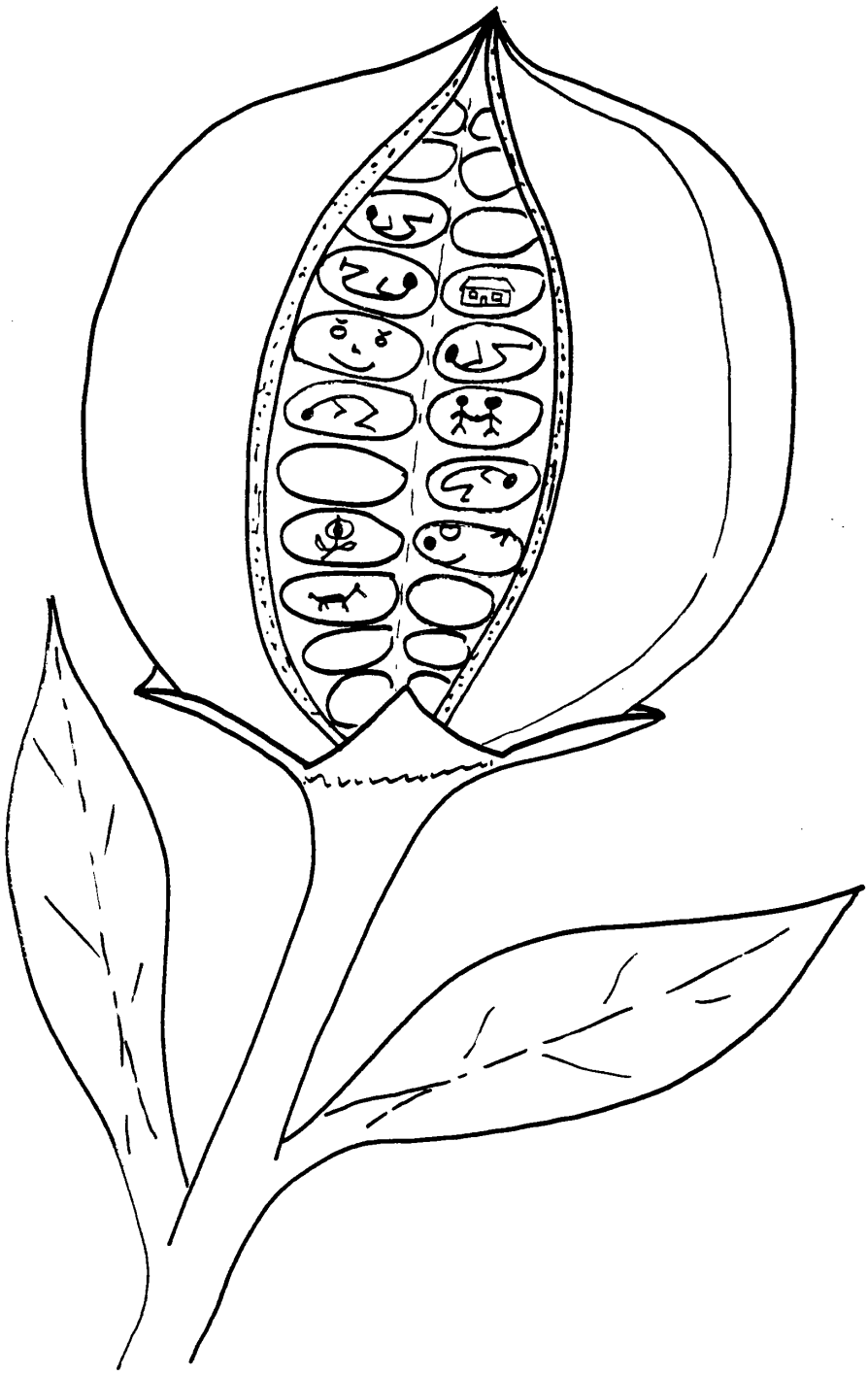
I will just pass one bit of good news. Often people sound as if things aren't happening out there and that we are not making progress, but in fact our organisation which is the Natural Health Network, we are in the process of doubling every six months virtually and every week we have a new health centre met up in the country and now there are over 54 independent groups which are setting up and this is happening everyday. So it is going on all the time and there is tremendous progress and tremendous cooperation between the orthodox and the wholistic side. Thank you.

Chair

I would just like to end my bit by saying that I have found the conference tremendously exciting and I think the onus is on all of us in a way to take away the things that we have learned and to ensure that change does come because it is not going to happen unless we do it. I also want to abuse my position as Chair just by saying in answer to the question that was asked over

there that there are also community health councils which Caroline Langridge mentioned this morning, and I say that as somebody working as a development worker for the London Association of Community Health Councils. If your CHC isn't one that you like you can also get in there and change it and they have resources and they have ways of getting into the Health Service and I would like you take that away with you as well.

I think one of the things we forget is that we can actually change people's attitudes a lot by talking about the times and ways in which we do challenge the status quo ourselves. We do talk about that in our women's groups or in our everyday life or whatever and that is a very good way of communicating the idea that you don't have to do what your doctor says. You can actually question it or whatever so you don't have to think we've got to set something up before we can actually make any changes.



Closing Visualisation

What I want to do is to offer you another visualisation with which to close and bring the conference into a nice circle back to where we started and hopefully give you something to take away as well. I think what we have just been talking about leads into that very nicely. I think that we the public, we the consumers are in fact the people who have been creating all the change. The changes that we have been seeing have been coming from the bottom-up as it were rather than the top-down in alternative medicine which is my field. So, I invite you once again to make yourselves comfortable, probably uncross your legs, loosen anything uncomfortably tight. Close your eyes and let yourself settle a bit by focusing your attention on your breathing as we did at the beginning. Just take a few nice big breaths and if you find you have accumulated some tensions during the past couple of days, take this opportunity to let them soften a little. Just notice where the tense bits are and when you breathe out let the breath carry away some of the tension. A little bit more with each breath. You may remember, if you were here at the beginning, the image of a bubble. We all formed our own image of being inside a big bubble which enclosed the whole institute and all of us attending the conference and all of the other people outside this room working away to make it possible. If you could take this moment to think in acknowledgment of those people, what they have been doing over the past few days, the past few months and remember the image that we had. Remember what we wanted to get out of it, what our hopes and fears Have your hopes been fulfilled? I'd like you to picture that bubble once again as vividly as you can or imagine that you could feel that bubble and what it's like to be inside that bubble. Imagine it beginning to change; instead of being something like a soap bubble it's beginning to become more solid and more firm and you have a solid sort of sphere there. Inside it you've got lots of little germinal seeds. Each of you is a germinal seed of some sort and the whole bubble is changing into a pod. Imagine it as a seed pod and it's getting ripe. Riper and riper. Limes Grove was like a seed pod. It germinated and it grew and it had its life, then it burst and it scattered seeds all over the place, you know about Leyton. I think Isis is a seed from Limes Grove too and there are others. The GLC is like a huge great seed pot and with many many seeds inside it. Many of which have been sown already and lots more about to be scattered to the winds. The bursting of a seed pot might be quite a painful event but it does lead to something new and positive. I'd like you to picture how you can go out of here when the seed pod bursts and how you can nurture these seeds. All the seeds need watering, imagine yourself watering your own seeds, weeding the soil that they're growing in and making sure they get the sunlight that they need. You can imagine them growing into little seedlings and then up into large flourishing plants until we've got a whole jungle of wonderful innovative schemes producing beautiful flowers. I'd like to think that you can carry that image with you and hold it in your mind. Hold that image of the finished product as it were, a flourishing jungle of flowers because that's what we're aiming for. In some sense I don't know what your jungle means to you. It might be quite different from mine but we all have a common thread. I think that by holding it in mind often holding that positive image alongside the energy of strength that we need; strength for the confrontations and pushing up these tender little shoots through the concrete hard ground. That the growth is an organic process and we are all contributing to that just by putting our thought and image into that. I'd like to thank you all for sharing that process. I'd like to acknowledge once again Jeanette Mitchell's role in initiating the whole thing and persuading the GLC that it was worthwhile and the many innovative projects which have been represented here. Thank you all and good night.

INNOVATION IN EVERYDAY HEALTH CARE 13 & 14 February 1986

Workshop Programme

THURSDAY AM (MORNING)

A 1 Sharing Health With Parents
with Dr Kate Ashley and others

A 2 Neighbourhood Mental Health: from Personal Symptom to Public Action
with Sue Holland

A 3 Community development in General Practice
with Maggie Cochrane and others

A 4 City & Hackney Multi Ethnic Womens Project
with Fedelma Winkler and others

A 5 Empowerment through Adult Education Alternative Medicine Courses
with Dave Butt & Delcia Thorpe

A 6 Health Initiatives in Shoreditch
with Gerry Harris & Robin Rusher

A 7 Let me Introduce You to Your Body
with Manas Marmara

A 8 Collective Work and New Roles in General Practice
with Debbie Clark & Adi Cooper

A 9 What's In It for the Homeless?
with Pat Logan & Becky Vidler

A 10 Tai Chi EXP
with Stephen Russell

A 11 District Nursing - the Problems of Changing our Practice
with Mary Twomey

A 12 Is Home Birth Turning the Clock Back or Forward?
with Michel Odent

A 13 Learning in Later Life
with Alan George and others

A 14 Reflexology EXP
with Christianne Heal

EXP = a more active/experiential workshop

INNOVATION IN EVERYDAY HEALTH CARE 13 & 14 February 1986

Workshop Programme

THURSDAY PM (AFTERNOON)

B 1 Hackney Health Mobile
with Louise Parsons

B 2 Chalkhill Neighbourhood Project
with Debbie Peters & Pat Wickstead

B 3 Endometriosis Society
with Sharon Fordham & others

B 4 North Kenton Community Health Project
with Angela Oxberry & others

B 5 Towards a Good Food Policy
with Maggie Sanderson

B 6 Tower Hamlets Health project
with Richenda Power

B 7 Sheffield Occupational Health project
with Sue Lawson & others

B 8 Intuitive Massage EXP
with Marie James

B 9 Yoga EXP
with Don Nicholls

B 10 Body Structure & Health Part EXP
with Tom Myers

B 11 From Primitivism to Modernity CANCELLED
with Rudi Braithwaite, Dr Barrett & Master Koo

B 12 The Work of the Womens Therapy Centre focussing on eating problems
with Mira Dana & Birgitta Johannson

B 13 Housng & Health: Cause for Concern?
with Eileen McCloy & Marjorie Collins

B 14 Children Teaching Children
with Diane Pampling

EXP = a more active/experiential workshop

INNOVATION IN EVERYDAY HEALTH CARE 13 & 14 February 1986

Workshop Programme

FRIDAY AM (MORNING)

C 1 Changing Health Visiting Practice
with Vari Drennan

C 2 The Womens Health Shop
with Sue McWhirter

C 3 Moving Diabetic Care Out of the Hospital
with Dr John Yudkin & Dr Brian Hurwitz

C 4 Womens Action for Mental Health
with Janet Brown

C 5 Pensioners Health Forum,
with Christine Smith

C 6 Womens Health Information Centre: Self Insemination
with Lise Saffron

C 7 Biomechanics and the Future of NHS Chiropody
with Clive Chapman

C 8 Consumerism - Beyond the Supermarket
with Fedelma Winkler & Helen Rosenthal

C 9 CancerLink - the Missing Link
with Ruth Roth

C 10 Indian-style Head Massage EXP
with Narendra Mehta

C 11 The Fitness Jungle- Movement Re-evaluation Technique EXP
with Chris Connolly

C 12 Holistic Medicine Community Programme - A Pilot Project
with Julienne Maclean

C 13 Tower Hamlets Maternity Service Liaison Scheme
with Paula Uddin

C 14 Eurythmy EXP
with Jacqueline Neilsen

EXP = a more active/experiential workshop

INNOVATION IN EVERYDAY HEALTH CARE 13 & 14 February 1986

Workshop Programme

FRIDAY PM (AFTERNOON)

D 1 Community Based Health Education
with Jean Spray & Karin Greenwood

D 2 Haringey Women & Health Centre
with Jennifer Alert

D 3 Brent Well Mens Clinic
with Colin Nolder & Brian Lammmond

D 4 Self-help - Our Experience of a Holistic Appproach to being Well
with Felicity Kelly

D 5 Independent Midwives Association - the Home Birth Option
with Rosie Brooks

D 6 Use of Self & Senses in Preventative Health & Clinical Practice
with Dr Stanley Jacobs EXP

D 7 Metamorphic Technique EXP
with Claire Glaser

D 8 The Isis Centre - a Multi-disciplinary Alternative
with Dr Richard James

D 9 Constructive Movement EXP
with Naomi Milne

D 10 It's Never Too Late
Margaret Graham

D 11 Buswork and health: Stress and Productivity
with Tina McCrea

D 12 Becoming a Resource to the People - the Implications of the Birmingham Nurse Practitioner Study
with Barbara Stilwell

D 13 Presentation & Discussionby the Members of the New Cross Natural Therapy Centre
with Penny Lowery & others

D 14 Who Cares About Local Needs & the Public Health?
with Myra Garrett

EXP = a more active/experiential workshop

A1 THE RIVERSIDE PROJECT - SHARING HEALTH WITH PARENTS

The Riverside Project began in 1979 as a response to the concern about the high level of child health problems in a disadvantaged area of Newcastle-upon-Tyne. One of the four original aims of the Project was:

> 'To encourage families and the local community to assume a greater share of the responsibility of the health of their children'

This is the aim that we chose to talk about at our workshop.

We did not want to give a formal lecture. We tried to involve everyone as much as we could and explained this at the outset. First of all we introduced ourselves and told the group of our involvement in the Project. We then got the group to introduce themselves, tell us about what they did and why they had chosen to come to our workshop. People came from various backgrounds and included a school nurse, a health visitor and a mother! The thing that they all had in common was that they wanted to find out how we had tried to work with parents to provide better access to good health.

We did a brainstorm exercise - we asked the group to think of different ways of reaching parents. The list again was varied and included:

> Talking with parents (not to), access to records, groups, video, role play, gaining people's confidence, clarification of roles and many more.

Our idea was to see if people could think of the same things we had thought of or even new ideas. We would then be able to tell people whether or not we had tried things out and the reasons why some ideas were more successful than others and why some ideas had been rejected.

We went on to give a brief outline regarding the background of the Project. Why it was started, the Project's aims, the funding of the Project, the Project area - the housing and facilities, what medical provision the doctors in the Project team were responsible for in the schools, clinics and nurseries and finally the community work aspect of the Project.

Chris described how a centre had been set up. How in the early days small groups of women had met in a classroom next to the administration base in a local school. How the women themselves had found the place very daunting and authoritarian because of the location. How they had looked for other premises and found a library basement nearby which was very accessible and en route to the shops. She described the work which had gone into acquiring funds from various sources to refurbish the premises and how they have actually set up a management committee to run this centre. A lot of hard work had been done by the community workers involved but as a rule they tried to take a back seat and only act as a resource. Chris went on to talk about a typical week of activities at the centre. She also talked about the outside group work which she was involved in at a singles homeless women's project and a speech therapy group.

One group we consider to be very successful when it came to disseminating knowledge was the 'information group'. Marion talked about how this group came about and how they came to make information leaflets. The group found

that a lot of them had common problems. One problem they talked in depth about and which came up time and time again was bedwetting. They found that the available literature was hard to understand and took no account of parents' feelings about this problem. They decided to try and make a leaflet and this they did after many weeks of discussion, writing, showing their ideas to professionals and other mothers, enlisting the help of the secretarial staff at the Project and a lot of hard work. Only a little help was given by the Project staff in the production of the leaflet. After this first initial leaflet, the group was confident enough to go on to make others. They were, after the 'bedwetting', 'children's infections', 'Now that you know you're pregnant...', 'Talking to the Doctor', and 'Sleeping patterns in babies and young children'. Copies of these leaflets were made available to the workshop. These leaflets are often used by health professionals in the area.

At this point we found ourselves running out of time and quickly brought Kate Ashley into the discussion. She talked briefly about how the doctors in the team worked in a different way in the schools. She described how they put into practice a class review system: routine medicals are not done in the schools, only selected medicals. She told us that the school nurse, school doctor, parents and teachers are all involved in selecting which child would benefit from a medical examination. Close monitoring had shown that they did not miss any more problems doing the selected medicals than the routine ones. This enabled the doctor's time to be used in other ways. They were more available to parents to talk over problems and they were also available to do small health campaigns concerning things like asthma and accidents.

We were by this time well over time but it was encouraging to note that nobody wanted to leave the circle. We did talk briefly about the brainstorming exercise we had done at the beginning of the session and then to tie the workshop up we asked people's opinion on what they had liked about the workshop and what they did not.

Of course we did not get any adverse comments but we did get some positive feedback. All three workers felt recharged after the workshop and felt privileged and lucky to be working in such a project. In our work we often feel that we are not getting anywhere and change is very, very slow but after this conference we will all be going back to Newcastle with new sights and hopes and above all the determination to carry on.

A 2 NEIGHBOURHOOD MENTAL HEALTH : FROM PERSONAL SYMPTOM TO PUBLIC ACTION

Sue Holland, White City Mental Health Project
129 Bloemfontein Road, London W12 01 749 9451

In this workshop Sue Holland, a clinical psychologist, described two mental health projects she has been engaged in during the past two decades. The first a walk-in shop front counselling service in a Battersea high street of the 1970's, which was undergoing a`gentrification'; the second a counselling service for depressed women on a hammersmith council estate of the 1980's which is undergoing `ghettoisation'.

The philosophy underlying this work is that the question of mental

health/illness is both profoundly subjective and profoundly political. Intervention and prevention must be addressed to both the internalised social structures (object relations) of the human psyche and the external social structures (class,gender,race) of society and state.. Prescriptions for `treatment' which follow from this will include both psychotherapeutic intervention at the psychic level, and political action at the structural level. This is not a model adopted by the present British Welfare System of psychiatry.

To illustrate the theory and method of this radical approach to mental health work in a neighbourhood setting, a diagrammatic set of paradigms for social theory and therapeutic intervention is a useful aid to grasping the relation between theory and method. This theoretical model has proved useful in trying to convey the quality of the changes involved in a theapeutic program which moves the person from individual Symptom, into psychic Knowledge, into shared Desire, into Social action.(The diagram was handed out, it being based on a series if adaptations from Burrel & Morgan (1979), C. Whittington & R. Holland (1985) and Sue Holland's therapeutic practice. See diagram)

The Battersea Action & Counselling Centre (alias the People's Aid and Action Centre) started in 1972, out of the collective efforts of a group of community activists, including mental health professionals. It was situated in a shop on a high street, and provided skilled psychotherapy/counselling, a day nursery for under 5's, and a green grocery for old age pensioners and the unemployed. The Centre`s original intention of linking people with social networks which would tackle material and environmental problems was relatively easy in the early days when tenant struggles were at a peak. Later as these grass-roots organisations became absorbed within the system of urban estate management, the centre had itself to initiate the kind of structures and resources which would help to move people from private symptoms to public actions. This proved to be too hard a task for the centre's staff, most of whom were educationally privileged radicals with no roots in the working class community. The crucial self-criticism here is that the staff failed to engage the working class clients/users in a way which would give them authority and identification with the centre. The centre was closed by the incoming Tory administration and reopened as a cocktail bar!

This bitter lesson was remembered in setting up a new project in Hammersmith for depressed women and their families. The central task for this new venture in the field of mental health was to be the transformation of passive receivers of mental health services into active participants in the and where does it come from?' Then by way of group work into the radical humanist mode: `What do you want of yourself and others?' Finally, the most difficult to achieve, the radical structuralist mode: `What is to be done?' `How can we change a bit of the world we live in?' Some, though not all, of the women have moved through all four modes from symptom to individual psychotherapy/insight, to group experience/shared desire, and finally to public action in the form of setting up their own mental health project, Womens Action for Mental Health, with a GLC grant and a building. This involved the women in public speaking, campaigning and asserting their demands on the Housing authority. They were able to persuade their friends and neighbours that the mental health of women and their families was a matter for neighbourhood concern and public interest.

The model of neighbourhood mental health is in contrast to the now

fashionable growth of mental health centres which are little more than territorial moves of the psychiatric hospital into the `community'....i.e. the hospitalisation of the community rather than the radical communilisation of the `patient'.

Note: A fuller version of this work will appear later this year in the book `Psychiatry in Transition', edited by S. Ramon & M.G. Gianichedda

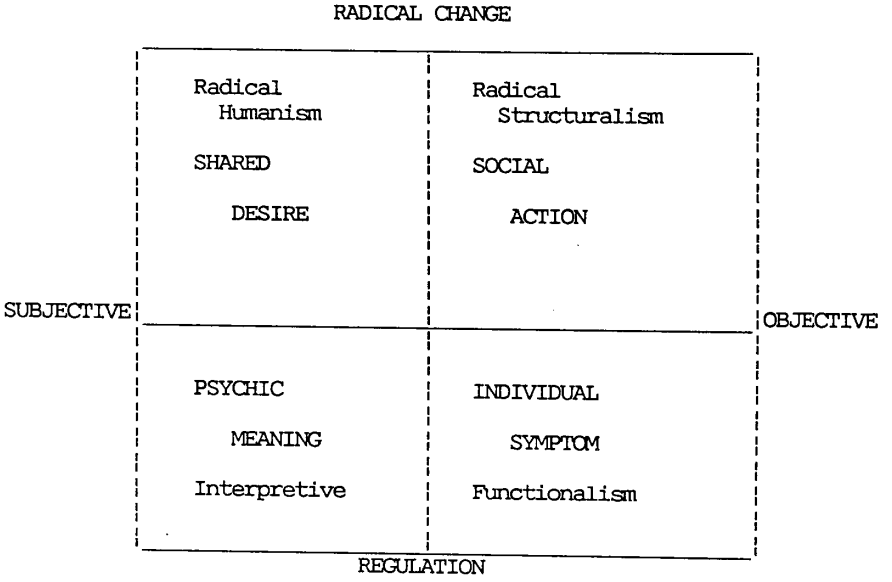


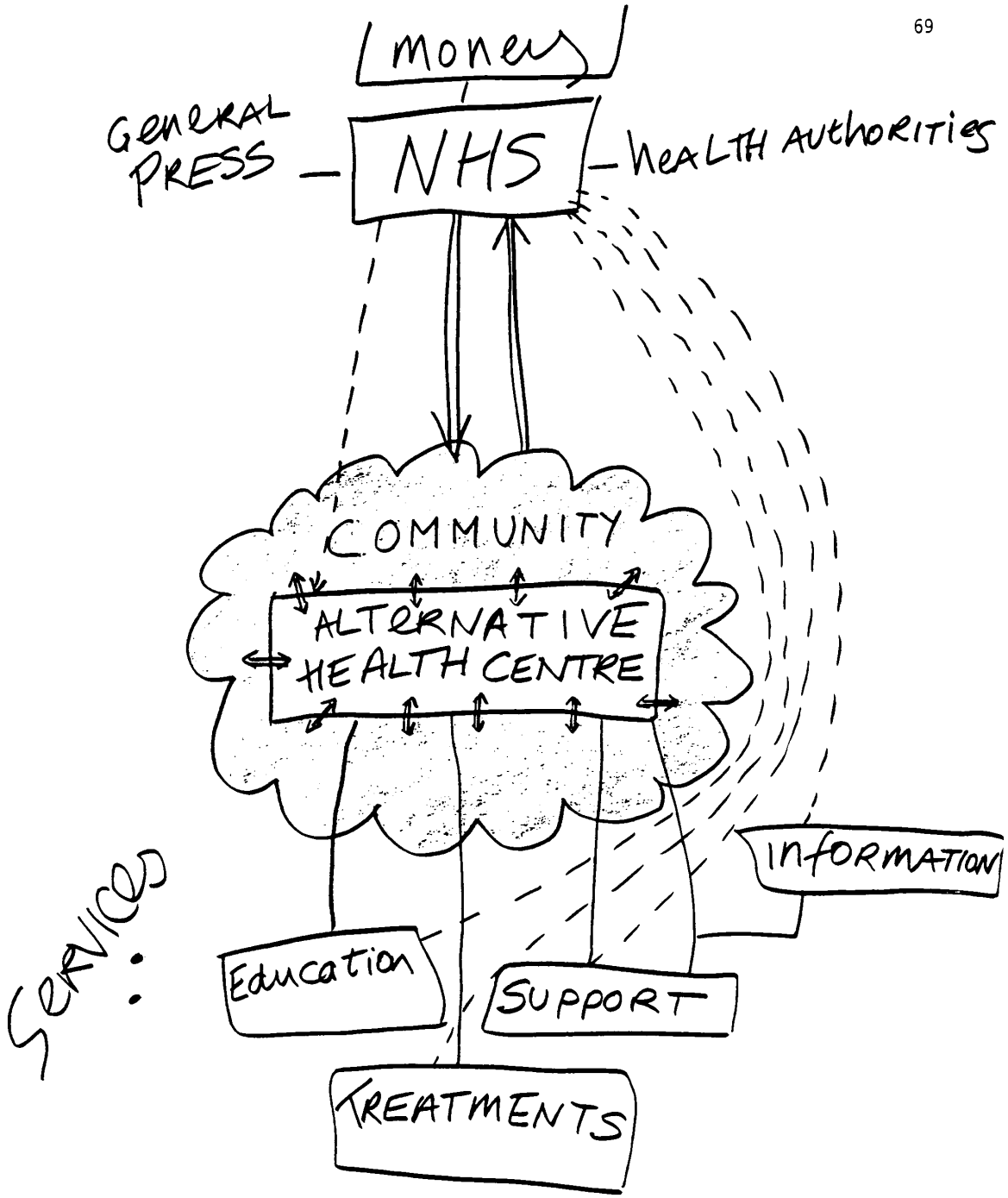
Fig 1 (Adapted from Burrell & Morgan (1979)

The horizontal dimension runs between the objective and subjective poles. Objectivism emphasises a natural science model; the organism, or even the machine. Things are measured and quantified. The other polar extreme is subjectivism which emphasises the unique qualities of human experience, interpretation of meanings and use of symbols. The vertical dimension at one end suggests a relatively static or slowly evolving social situation, and the

A3 COMMUNITY DEVELOPMENT IN GENERAL PRACTICE

Wells Park Health Project is a community health project in Sydenham, South London. The Project has close links with a general practice, with the aim of creating a more responsive and accessible health service. Our workshop discussed the background to the project and the importance (and difficulties) of community health projects working with health workers as well as with users of the health service. The workshop also covered the following ares: the problems of short term funding and the limitations it places on community development work; evaluation; and the implications of community health projects being initiated either by the community or by local professionals.

Maggie Cochrane and Deidre Parrinder
The Wells Park Health Project
106 Wells Park Road, London SE 26 01 291 3332



- - - - - → IDEAL COOPERATION (DREAM)

⟹ influence

FROM THE 'TOWER HAMLETS HEALTH PROJECT' WORKSHOP B6

A 4 PATIENT ADVOCACY - AN EXPERIMENT IN EMPOWERING NON-ENGLISH SPEAKING TO USE THE MATERNITY SERVICE

This workshop will be led by workers from the Hackney Multi-ethnic Women's Health Project. This project pioneered the development of CHCs into individual patient advocacy. The workers will describe how they tackle professionalism, sexism and racism inside the NHS on a day to day basis and seek to bring about changes in the structures as well as supporting individual women in their use of the services.

The workshop will explore how this model of empowering users of the health service can be developed and applied to other areas.

Hafize Ece and Mariam Achala c/o 210 Kingsland Road London E2 01 739 6308

A 5 EMPOWERMENT THROUGH ADULT EDUCATION ALTERNATIVE MEDICINE COURSES

During the last four years, the Chequer Centre, which is part of the ILEA Adult Education Service, has run numerous alternative medicine and health courses aimed at the general public.Although courses are generally run for just one term, two hours a week, the emphasis has been placed on providing knowledge which is not only useful but also enabling and often empowering both to participants and to their friends and family.

by David Butt and Delcia Thorpe, of the Chequer Centre 01 388 6048

A6a HOXTON COMPLEMENTARY MEDICINE CENTRE

The need

Over the past decade and more Shoreditch has seen a drastic decline in Health Service provision at the same time as a rise in the number of vulnerable people who need GP and community services more than ever before.
The Metropolitan Hospital was closed in 1976, St Leonard's in 1984 and St Matthew's is due for closure very soon. GP services are overstretched and services like chiropody and physiotherapy are increasingly hard to come by. Wenlock ward has both the highest percentage of elderly in the borough (24%) and highest number of people over sixteen permanently sick (186 in institutions); Moorfields ward has a similar growing elderly population who desperately need health provision for routine chronic complaints. A large proportion of our pensioners also live alone which increases their need for caring services. Our part of the borough also has some of the worst housing conditions which exacerbates existing ill health.

Our organisation

Our group came together in June 1985 as a direct consequent of the low level and often poor quality of the service provided to both fight for better provision and to look at our own alternatives. The Tenants Associations in Hoxton have been well established for many years and often work together on issues of joint interest especially when the groups most affected are not able to adequately speak up for themselves. Each of the tenants associations run clubs for the elderly and know where the needs are. Tenants representatives with years of experience in community issues and the elderly themselves make up the bulk of the group.

The health centre

Aims

In seeking to set up an alternative health centre we want to give the people of Shoreditch real choices in the way they wish to look after themselves. We want people to take more responsibility for their own health and to have the necessary "health education" available to them.

The project wll prioritise the over 55s age group as this group is both in the majority and suffers with chronic conditions, i.e., back problems, rheumatism, arthritis, digestive complaints, bronchitis which immobilise and debilitate adversely affecting the quality of people's lives. We are well aware, however, that such a project as ours working in the community will bring to light other needs which at the present time are largely hidden. We aim to keep the project flexible enough to deal with any new needs as they arise while initially targeting the olderage range.

Organisation

The centre will be run by a management committee comprising of local tenants and users plus representatives of each of the therapies offered, local councillors and officers and NHS representatives including local GP services. NHS involvement at this level is seen as essential.
This management group would directly employ an education/admin.worker,

receptionist, accounts clerk and cleaning staff and would employ practitioners and therapists on a sessional basis as and when required, who would be self-employed. This would both keep the time consuming employer responsibilities to a minimum and afford the community the greatest amount of choice of therapies available.

The daily running of the project

The project would be open 5 days per week for 50 weeks of the year. With the premises we have isolated, three clinic rooms would be available for permanent use plus a reception and refreshments area. The eduction/administration worker would be free to develop the work of the centre specifically with a health education brief - setting up self-help groups etc while the receptionist, part-time accounts clerk and cleaning staff would ensure the smooth daily functioning of the project. We aim to provide when working to capacity, 100 hours of treatment per week with a further 25 hours of treatment space offered to the NHS to allow their services to be locally accessible to the community. We hope to work in conjunction with the NHS wherever possble and encourage their involvement in the project.

We have also decided to make a small charge for the service, the maximum that we feel people on very low incomes could afford so that people feel that they have contributed to the running of their own centre and value the treatment being provided. A charge of 50 pence per month regardless of the number of treatments is proposed. This small sum of money would be used to develop the outreach work of the centre, finance a small lending library of health education literature, allow people to attend occasional conferences and courses related to the work of the project. The users of the centre would help determine these areas and would be encouraged to become involved in the wider work of the project.

Health Education

We aim to make the outreach work of this project as extensive as possible. Local tenants halls are available for exercise classes, anti-addiction groups, dietary advice, cooking classes etc. We hope to attract a wide range of people to these activities not only those who choose to come to the project for individual sessions.

Health related issues

We believe that a whole range of social environmental and economic factors affect our well being and that our health project cannot work in isolation from other services, notably housing, social services, DHSS. In October 1985 the Arden Estate Project is opening in the centre of Hoxton in similar premises to those required for this project to provide a whole range of advice, welfare and community services. The health project would work completely in tandem with this decentralised service so that any other needs an individual may have could be tackled at the same time. These two projects would also be mutually supportive and therefore more effective.

Further support

Various colleges of complementary medicine have been approached with a view to a possible research supportive role for this project. The project already has the full support of the local community so is guaranteed success. We want our

project to have as high a standard as possible because that's what people deserve.

Finance

Our project over four years will cost £340,000 but the benefits to the people who use it will be incalculable. We believe the project is also cost effective in keeping people healthier, mobile and out of institutional care so that they are not a drain on other resources. Waiting lists for NHS provisions would be shortened and take up of meals on wheels, home help services, transport services, should not be as high as forecast once the project is in operation. All known funding agencies are being approached with regard to financing this project.

Conclusion

Nothing in life can be enjoyed without good health. The general health of the bulk of our community is needlessly in decline. This trend can be easily reversed by helping to finance this project.

Gerry Harris, CDU, Hackney Town Hall, Mare Street, London E8 (01 986 3123)

A6b THE SHOREDITCH CENTRE OF COMPLEMENTARY MEDICINE

This project which is still in the early stages of planning and fundraising, is closely linked to the Hoxton Complementary Medicine Centre scheme. Its roots lie in the GLC model project in South Tottenham for a Centre for Health.

Many of the features of internal organisation envisaged for that Centre are likely to be shared by the Shoreditch Centre. There will be six treatment rooms with a core group of practitioners, health development workers and other staff, with a group of up to eighteen other health workers drawn mainly from complementary and community health. There will also be a large room for groups, workshops and classes related to the clinical work. With good practice, a strong and democratic management group comprised much in the same way as that described in the Hoxton project paper and a vital, straightforward research programme, the Centre can develop a rich experience using complementary medicine in a political context.

There are three very important differences between the Tottenham project and the Shoreditch Centre. They are the relationship to the community, the relationship to the NHS and the funding.

The growth of the exciting local complementary health work being done by people in the Hoxton estates into converting a flat as a Complementary Medicine Centre for the over-55s is a strong root. In the two or three years that it will take to set up the much larger Complementary Medicine Centre just across the road from the flats, there will already have developed a history of knowledge of how to work together, trust and excitement. At the end of the four year life of the Hoxton Centre, things will be ripe to take over the road into the new, more broadly aimed Shoreditch Centre. As the third conclusion in the GLC pamphlet on Health Care says, writing of the Tottenham experience,

> Local groups are likely to want to put more into developing and running local health initiatives if they have been involved directly in devising

them themselves than if they are proposed centrally.

The second relationship is to the NHS. Again, this relationship has already been initiated in the Hoxton project. It will be taken a further stage in the Shoreditch Centre, since the Centre will be in a new building which will also house the four GPs who practice in the South West Hackney area (who are presently not housed in the most salubrious accommodation). The GPs' Health Centre and the Complementary Centre wll be clinically independent, although working with good will and that of the District Health Authority is a firm start. The new building is to be the result of collaboration between the DHA, Hackney Borough, the Family Practitioners' Committee (who need a new Centre but lack the capital) and the working group for the Complementary Centre, as well as a large Housing Association (who wish to build sheltered homes on the site as part of an integrated scheme.

The orthodox and the complementary will share the same catchment area. They will share the same building. Everyone concerned, including the GPS, have expressed their support for the arrangement. The fifth conclusion

> the relationships between intiatives outside the NHS and health service provisions needs more thought. The hope for 'exemplary practice' is that
>
> it provides directions for change within mainstream provision. It is also possible however that as new projects outside the NHS are developed, pressure on the NHS to change may be undermined.

Because this is to be an example of practice in co-operation, this last danger should be avoided. The Centres should meet at root and branch.

Finally, funding. The Centre will be a Trust and there is a fund raising programme of £850,000 underway. This money will not only be enough to set the Centre up in a new building. It will also generate enough income to allow the Centre to make charges nominal or nothing for several thousand treatments a year. Treatment income will also come from charging people outside the catchment area at the low end of the scale for complementary medicine such as acupuncture and osteopathy. So not only will the two Centres share a building and a catchment area, but also within that area, their skills wll be equally accessible to people

> doctors, health authority officials and others in official positions are not closed to this kind of development.

Who is?

Robin Rusher, Traditional Acupuncture Clinic, 188 Old Street, London EC1
01 251 4429

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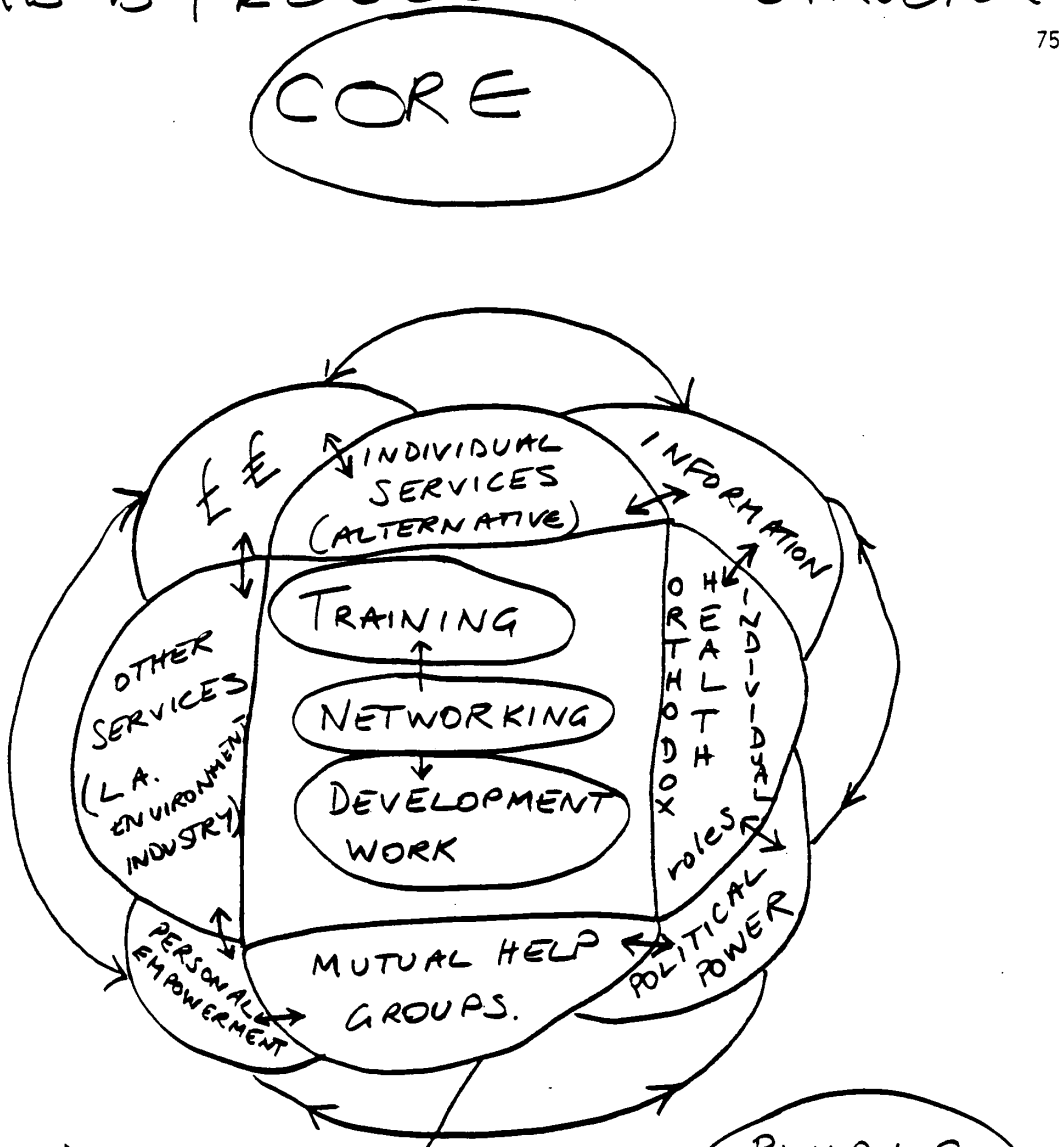

BUILD UP TO THESE FROM CORE

ALL

WE HAVE TO BE IN CONTROL OF THESE

FROM THE 'TOWER HAMLETS HEALTH PROJECT' WORKSHOP B6

A7 HEALING SPACE

"Healing space" is a therapeutic approach based on the following beliefs:-

1 Healing is a creative learning process. It involves learning how we prevent ourselves from realising our full potential as human beings.

2 All deep healing is self-healing and all methods of healing are effective insofar as theyhelp create a healing space, i.e., the conditions necessary for our own biological self-healing mechanisms to work.

3 We grow up being told what is right and wrong by other people. Most of us have had little if any opportunity to find out the truth for ourselves. In order to find our own Truth, we have to be allowed to learn from our own experience. Truth is biological and we humans need to learn what every other animal knows, viz that we are part of nature and are designed to co-operate and not to dominate.

4 Destructive, manipulative, competitive behaviour is a result of disconnection from our biological core. When I feel good in myself, I have no desire to compete, to pollute the environment, to destroy life.

5 We are conditioned to believe that it is wrong and dangerous to be ourselves. Our conditioning: our fear of life: is maintained by chronic contractions of our muscles, organs and energy fields. It is usually necessary to work on different levels and very often necessary to work on a body level, in order to enable us to change our belief systems, release our fears and allow our biological life-energy to flow and make us whole again.

Healing space works with somatic process - with the emotional life of the body and uses neo-reichian bodywork, movement, massage, gestalt structures, visualisation, imagery and talking as appropriate.

Neo-reichian bodywork works primarily with breathing and pulsation to help us rediscover a natural bálance between taking in and giving out; between containment and release.

Healing space is a system of emotional re-education. It is an educational process and not a clinical method. It forms part of the neo-reichian approach.

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A8 COLLECTIVE WORK AND NEW ROLES IN GENERAL PRACTICE

LGNHS was initiated by 3 workers from the Limes Groves practice (ex-collective). The basic principles of our practice are equal pay, collective working, non-hierarchy, skill-sharing, empowering patients, positive discrimination. Some of these principles are grounded in our constitution/ contracts. We consider that equal pay is essential for equal status within the collective and consequent shared responsibility. As workers we are committed to Socialist Feminist politics - this affects the way we work with each other and with our patients. We recognise that, whilst people with health problems - physical or emotional - need to be able to be dependent to varying degrees, generally this dependence is focussed on the doctor. At Leyton Green we try to encourage dependency, where appropriate, on the practice as a whole, rather than individual GPs. We encourage patients to share responsibility for their health care needs - this may include, patients access to their medical records, long consultations, self-help initiatives.

Current staffing includes a women's health worker, clinical psychologist (acting as locum for psychotherapist), nurse practitioner, 2 GPs - one male, one female, one part-time reception/admin worker who are all members of the collective. We also have an active primary health care team which meets weekly. This includes a district nurser, health visitors, social worker, geriatric health visitor, midwife, child and family guidance worker, Some of these workers were initially apprehensive about our collective style of working but have since become not only satisfied with our way of working but also full of respect for it.

After this introduction to the practice, the workshop split into two groups for a roleplay. At present our collective is considering employing another alternative health worker in order to carry out our commitment to wholistic medicine. The role play centred on a collective meeting where a discussion of this new worker was on the agenda.

Workshop participants took on all the roles of members of the Primary Health Care Team. The issues that were raised in the discussions included: prioritising alternative medicine; patients needs; financial constraints; interaction with other workers. Neither group aimed at a consensus decision on the employment of an alternative health worker, thereby illustrating the difficulties of consensus decision-making. Interactions within the role-play showed how difficult it was for participants to consider themselves equal members of the Primary Health Care Team as alongside GPs. This is borne out in the Practice, especially when we have limited contact with external workers and agencies.

In the brief discussion after the role play, some of these problems were again raised. It is interesting to note that our equal pay policy left many of the non-doctors impressed at salary levels, whereas the doctors were generally horrified. There was a lot of interest shown in the Practice - by people wanting to work with us or visit us. We felt that the workshop provided people with practical experience of collective working in General Practice.

Adi Cooper and
Debbie Clarke
Leyton Green Neighbourhood Health Service
180 Essex Road
London, E10 6BT 01 539 0756 (01 556 1821 out of hours)

A9 WHAT'S IN IT FOR THE HOMELESS?

Becky Vidler of Arlington House explained how her new role as Positive Health Worker differed from the traditional visiting nurse/medical officer in that her role was to enable hostel staff to respond to the health needs of single homeless people, and to open up access for single homeless people in local GP health-centres and hospital facilities. One sobering sign of progress was the reported comment of the local police surgeon. He now was called to the hostel every few months to certify a death whereas, previously, he had been called twice a week. Much of the ensuing discussion focussed on the role of local GPs. It was not, however, an exercise in GP bashing. What was commented upon was the need for better support structures for GPs - the Camberwell Project supported by King's College Medical School was mentioned as an example. It was also observed that health service bureaucracies were isolated and at odds with one another making collaboration difficult at the level of primary care. The GP attending the Workshop suggested that GPs did not know which agencies to turn to and that health visitors might co-ordinate such an exercise. An educational role for GPs and health service workers was also identified, which would take on board the differing cultural, ethnic, sexual, age and class differences amongst homeless single people. Finally, health workers expressed a difficulty in identifying which local GPs would be likely to be sympathetic. It was suggested that one useful approach would be to invite GPs to a luncheon meeting.

In summary, the overriding need was felt to be for serious local planning.

Becky Vidler, Arlington House, 220 Arlington Road, London NW1 01 482 3374
Pat Logan, 13 Camberwell road, London SE5 01 701 4319

* A10 TAI CHI (Cancelled)

The ancient Chinese martial art which teaches inner stillness during times of action. A dance of slow-motion shadow boxing, comprising 100 postures, is performed daily. It is easy to learn for young and old alike. Regular practice leads to inner tranquility, outward grace and agility, stress reduction, increased energy and blood circulation, a more positive outlook, and ultimately, spiritual awakening.

Stephen Russell, who trained in the USA under various masters of the art, will demonstrate the form, some practical applications, and introduce participants to the physical experience of Tai Chi.

Please wear comfortable clothing. No athletic prowess is necessary.
by Stephen Russell 01 794 9029

* A 11 DISTRICT NURSING - THE PROBLEMS OF CHANGING OUR PRACTICE

District Nurses have the opportunity to challenge the existing relationship between patients and health workers within the NHS: they can attempt to give patients control over their nursing care. Attempting to change these relationships has implications for both patients and workers, however, and it is important to consider these when encouraging health workers to change their practice.
Mary Twomey, Chorlton Health Centre, 1 Nicholas Road, Chorlton, Manchester 21 061 861 8923

A12

Is Home-birth Turning the Clock Back or Forward?

Michel Odent 01 485 0095

This picture was made one day when everyone was on the piano and was singing together, just an example of what it's possible to do in a hospital. It's also possible in a hospital to create a homelike environment for childbirth and this picture is a birthing room we have in a state hospital; not far from an operating theatre, but at first glimpse you can see it's very different from a conventional delivery room. Compared with the conventional delivery room it is a homelike place for many reasons, so this is also something we can do in a hospital. It's also possible in a hospital when the woman is in labour to help her to do more easily the kind of inner trip a woman has to do to give birth, and especially it's possible to reduce any kind of sensory stimulation. It's always possible to reduce the light, to have a dim light. Even in a hospital it's possible to give many labouring women the kind of privacy they need, although it is very difficult in our society to know exactly what kind of privacy a woman needs to give birth. We are in a new society, it is now different. In the context of the nuclear family, the person with whom many women have a feeling of privacy is the baby's father, and it is more and more common in our society that the mother-to-be (the labouring woman) is assisted by the baby's father who is an intimate person, he is a sexual partner. It is a phenomenon which happened only about 15 years ago at the time when our obstetric units became bigger and bigger, at a time when women were searching for a feeling of privacy, and at a time when many of them were frightened by the idea that they might have to give birth among anonymous persons. Of course, they have many possible attitudes to the baby's father and there are many possible kinds of relationship between the couple. The man is sharing the experience much more, this is something quite new. Even at the beginning of the century at the time when homebirth was a rule the baby's father was often present, not far away, his presence was still there but he was much more used for some practical task such as feeding and passing of water and so on. But he wasn't really sharing the experience, it was much more women together so this is a new phenomenon with many possible attitudes.

This slide is much more the man playing the role of a coach who wants to control the process, telling his wife to be in the best position, how to breathe and so on. We found that in this case the labour is often long and difficult for there are many possibilities. Here you see the kind of man who feels that his wife or his partner really needs complete privacy with protecting from outside the privacy of his wife. He says 'Please don't disturb my wife, she's giving birth', and on the door you can read 'Private'. This is an attitude that we have observed many times and often this kind of man really feels what the needs of the woman in labour are. So while this man in protecting the privacy of his wife she can more easily go to another planet, change her conscious level, do the kind of inner trip she has to do. In other words, she can more easily secrete the hormones she has to secrete to give birth. She is not lonely but she is not disturbed by the presence of an experienced midwife so that she has the feeling of security.. Also she is a little like a mother, she's a feminine person, and the kind of privacy many women need to give birth is not always the kind of privacy they have with a sexual partner, the baby's father. To give birth a woman has to defecate, to empty her rectum, and it's not what many women do in the presence of their sexual partner but it was what they did in the presence of their mother. Perhaps at that time they need somebody like a substitute for the mother much more, an experienced and caring person. Even inside a hospital there are many possibilities and ways not to disturb the labouring women. There are cases where the midwife has to be more active but it is always a primitive contact. An experienced midwife does not need many words, she does not need to stimulate too much the upper brain.

All these slides were made during the first stage of labour and the first stage of labour is certainly the most important one, the long period of dilation of the cervix is a most important time during labour. It is really the time when the labouring woman will or will not reach the necessary hormonal balance, the specific conscious level so that she can give birth by herself.

At the time when the baby is not far away, when the woman is in such an atmosphere of privacy so that she can be spontaneous you can without repeating many internal examinations feel what happens because when the baby is not far away the attitude is different. Many women want to grasp something or somebody. Often they want to flex the knees. It means that the baby is not far away. This slide is an example of a woman who suddenly wants to flex the knees, grasp something, or what is possible is that when the woman feels that there is somebody who can support her shoulders she will flex the knees and help the baby to come in such a supported squatting position which is very common in all of the places where the priority is really not to disturb this physiological process. It is also common at that time that the mother dares to shout out, she feels spontaneous so she dares to do what she is not permitted to do in our daily social life at the time of the delivery of the shoulders. It is not exceptional when you don't disturb the process that the baby is born with the cord. This woman is really on another planet and we know what it means now, we know a little more about the hormones which are involved during the process of childbirth. We know that the labouring woman must not secrete too much adrenalin and other similar hormones that we secrete when we are cold or when we are frightened. We know also that she has to secrete endorphins. We know also the properties of the endorphins upon the state of consciousness, the depressed memory, but also we know that what we call the system of morphine - like hormones is strongly involved and this is why some women in some cases are really in an ecstatic state, as if they had had some kind of drug. All these simple rules are well known in any place where the priority is really not to disturb the labour and I wanted to show you from this point of view what it is possible to do inside a hospital.

What is also possible to do inside the hospital is not to disturb the process of labour when we have to face the high risk case. It is especially when we are expecting a difficulty that it is still more important not to disturb the physiological process. For example, take an obese woman like this one with a bad breathing capacity, the baby would be much more endangered if she was flat on her back that if she was vertical. This is the same with whatever difficulty we are expecting. Take the example of a breach delivery. It is another good reason not to disturb the physiological process. At the time of a breach delivery when the baby is coming it is always better not to have to touch the baby, not to have to pull the baby and you can easily guess that when a woman is supported like this one the baby can come much more easily so that we have nothing to do and this is the ideal situation. Whatever difficulty we are expecting the strategy is always the same.

There is also something which is possible to do in the context of a hospital. The first stage of labour is long, difficult and painful, but we must also say something about the first contact between mother and baby. It is also possible to maintain a feeling of privacy at the time of the first contact between mother and baby. During the first hour following birth it seems that many things happen and it is certainly an important time, perhaps it is what we call a sensitive period in the bonding process. It is important not to disturb this first contact between mother and baby, and even in a hospital we can try to make this time as positive as possible. It is also the time of the delivery of the placenta, what we call the third stage of labour. The best way at that time to help the delivery of the placenta or at least not to disturb it, is to give mother and baby the possibility of being in close contact. It is the contact between mother and baby which helps the mother to secrete the right hormones and make the detachment of the placenta as easy as

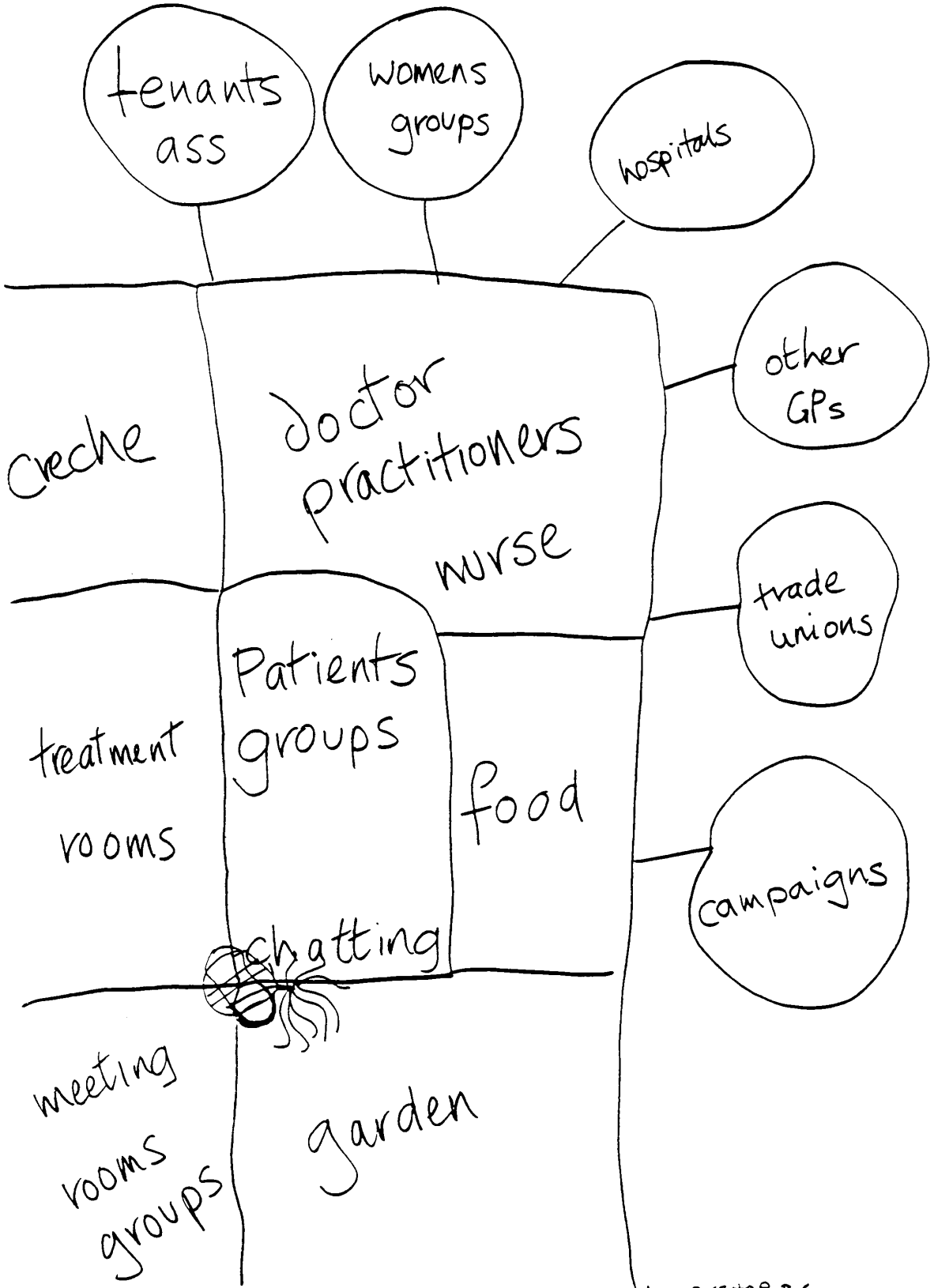
possible and prevent a haemorrhage. It is a time often when many people disturb the privacy. The baby is born, we start the congratulations and so on while it is so important to have as few people as possible in the birthing room to maintain this feeling of privacy. Privacy is really the key word when you consider what to do in not disturbing the process of childbirth. The detachment of the placenta will be easier if by chance the baby can find and stimulate the nipple, this is a way to reinforce the reflex which will make the detachment of the placenta easier.

You will notice that all these women are sitting on the floor holding their baby in their arms which is a very spontaneous attitude. In such a position there is no compression of the vena cava, this is another way to prevent haemorrhage. No compression of the big vessel of the vena cava. The most dangerous position at this time of the birth would be the semi-seated position with the baby on the mother's tummy because there would be the heavy baby compressing the uterus and vena cava, this would be the worst position in terms of prevention of the haemorrhaging. When a woman is really free and spontaneous it is not what she is doing. If she wants to lie down she will be on one side with the baby close to her or like this one. The baby must not be cold, it is always necessary to have an extra heater and wrap the baby in a warm blanket. It is possible to bath the baby at the time of delivering the placenta when the mother wants to give the baby to another person. It is not routine but it is a possibility and then the placenta is delivered.

I wanted to tell about another possibility of hospital birth. When the first stage of labour is long, difficult, painful, when the dilation is five centimetres but it is not efficient, it is a time when there is a strong demand for drugs, for intervention. We found that at that time when a woman has the possibility to relax in a pool full of warm water and it is better if the pool is large enough so that the woman can be absolutely free to be in the kneel position, we found that very often it is a way to make the second half of the first stage of labour much easier, less painful and much faster; to go from five centimetres up to complete. Then when the baby is not far away many women want to leave the pool and go back to the birthing room and give birth normally like any other women who didn't need the water. In some cases it happens that some women don't want to leave the water because it is too comfortable and generally speaking when a woman is in labour she doesn't like to go from one place to another because it often inhibits the labour. If it happens that a woman is in the water, the baby is coming and she doesn't want to leave this place, we must be ready in this case for some babies to be born under water. It is important to know that it is possible because in any place where there would be such a pool to help some women to release their inhibitions during the first stage, now and then there will be a birth underwater. It is important to know that the first breath of the baby is triggered by the first contact with the atmosphere and the sudden difference of temperature. It is important to know that the new born baby is perfectly adapted to immersion, exactly like a dolphin. So if by chance it happened, don't panic, let the baby come in the water and we will bring it to the surface. This slide is with an underwater camera. Another on with an underwater camera, and this woman is grasping the edge of the pool while the baby is coming. It does not hurt the baby's head because there is no gravity. Touching the baby at the bottom of the pool. Another baby which is still under water attached to the placenta, a baby we have to get carefully at the bottom of the pool and bring it gently to the surface. This is not the time of the first eye to eye contact. Another birth under water. It is often very, very emotional. This was a very interesting story. This woman was assisted by her sister. This is something which is also possible to do in a hospital, to come with a significant person. Her sister was also a mother who had the same kind of experience, so thanks to the presence of her sister

and also thanks to the help of water this woman could give birth to her first baby by herself, although as you can see this baby was huge, about eleven pounds or more. After birth under water the atmosphere is often very emotional. Water is really magic, it is a way to release many inhibitions and people dare to express freely their emotions.

These are just some examples of points I wanted to stress, just to say that it would be possible to introduce the home inside the hospital, and to say that if we have such an attitude it would be possible also to be more ambitious in terms of statistics. Not only to have low mortality rate but also to have a low rate of intervention in general - manual removal of placenta, transfer to paediatrics and so on. A longer period is necessary to appreciate some other data, for example, the maternal mortality rate that we must not forget because during this last five years in many countries the rate of maternal death has been slightly increasing. The rate of maternal death is normally in the region of 1-3 per 10,000 and in some countries it has been increasing in parallel to the increasing number of caesarians. So these are some points of what is possible to do in the hospital.



FROM THE 'TOWER HAMLETS HEALTH PROJECT' WORKSHOP 86

A13 "LEARNING IN LATER LIFE"

presented by Alan George, the Polytechnic of North London, Lilian Greene and David Symberlist, students on PNL's course, Learning in Later Life.

The workshop presented a case study of the Polytechnic's course for older people, 'Learning in Later Life' which has run continuously since 1981.

The LLL course aims to provide a varied educational programme on ten study days each term. There are no entry requirements nor exams. The focal point for the morning is 'Study Special', a series of thematically linked lectures by Polytechnic staff. Recent topics have included Third World Studies, the Modern Novel in London and the Unemployment and the future of Work. Other options available during the day include Health and Fitness, Drawing, Introduction to Computers, Relationships, Video Production and Music and History workshops.

LLL attracts 60-70 students each term. A programme committee of students advises the course tutor and assumes responsibility for a range of planning and operational tasks.

Participants in the workshop were shown excerpts of a Channel 4 programme, 'Retired, Not Out', developed and performed by LLL members and broadcast in the 'Years Ahead' series. The video includes a series of sketches on the theme of ageism and these were derived from the group's own experiences with their families, with young people and in the community.
Discussion in the workshop centred on the importance of not discriminating against older people by assuming that they have no educational or developmental needs. Older people, particularly once retired, are liberated from the time constraints of paid work but the LLL experience suggests that the provision of educational programmes can help structure this freedom and create new opportunities and experiences.

Further details on LLL and the Channel 4 programme 'Retired, Not Out' from:

Alan George
LLL Course Tutor
Polytechnic of North London
383 Holloway Road
London
N7 ORN

01-607 2789

* A 14 REFLEXOLOGY - AN EXPERIENTIAL INTRODUCTION

A delightful form of relaxation, based on a Chinese form, linking points on the feet with all the organs of the body. This method is a simple technique of foot massage easily learned and a pleasure to receive. It can be useful in the treatment of migraine, sinus trouble, etc. Come with bare feet and try it.

by Christianne Heal, of Kentish Town Women's Health Centre
169 Malden Road NW5 Tel: 267 0688

B1 THE HACKNEY HEALTHMOBILE

The Hackney Healthmobile is a 30 ft long caravan with two consulting rooms, a waiting area and a treatment room, which became operational in October 1984. The caravan, designed by members of the Department of Community Medicine of the City and Hackney Health Authority, was made by Portakabin of York. Since its launch it has been used to hold three regular clinics which have toured the District, and has undertaken promotional activities for special events, such as No Smoking Day and Alcohol Week.

The Healthmobile was purchased in the summer of 1984 from funds allocated to inner city health authorities by the DHSS to improve standards of primary health care following recommendations made by Acheson in the Report on Primary Health Care in Inner London (1981). Hackney has many of the problems which the report highlighted: high unemployment, low grade housing, an ageing population, overcrowding, a large proportion of single-parent families and a rich variety of different ethnic groups - all of which contribute to make it one of the most deprived boroughs in the country.

The health services in Hackney also have certain features that tend to reduce access for the population described above. Health care in the district is strongly influenced by a large teaching hospital in its southernmost corner, with very little identification between Bart's and the London Borough of Hackney. The hospital services are traditionally hierarchical, with many of the lowest paid jobs being done by non-unionised black women and the highest paid jobs (consultants) dominated by white middle class males. This inevitably creates tensions that unfortunately are often apparent in patient care. Racism and sexism in the Health Service and a lack of understanding of different cultural attitudes to disease and illness are some of the reasons that the groups often in greatest need of health care are the most reluctant to use the services provided.

The Acheson Report also looked at conditions in General Practice. Hackney has a high proportion of single handed GPs and a high proportion of GPs over 65 years of age. Few practices have ancillary or attached staff and there is very little preventive work done. All of these are factors that have been identified as indicators of the quality of General Practice.

There has been a growing awareness of these problems in City and Hackney Health District, and the Healthmobile was one of the many initiatives to increase flexibility and improve access to the health services.

The Healthmobile is at present used for a Mother and Child Clinic for the homeless families in Finsbury Park on Mondays, the Hackney Heart and Stroke Project on Tuesdays and Wednesdays, and a Well-Woman clinic on Fridays. This

Table 1: Use of the Hackney Healthmobile by Homeless Families

	Total Children Seen	BCG	OPT or DT with OPV	Measles	Other Immunisations	Other Attendances
AM						
35 Clinics	242	49	97	7	11	13
PM						
31 Clinics	126	17	43	14	6	10
TOTAL	368	66	140	21	17	23

Clinics were held on 35 days between 1.1.85 and 31.12.85. This means that 13 clinics were cancelled excluding bank holidays. 368 children were seen and 267 immunisations given.

Since June 1985 the Healthmobile has been registered as a treatment centre on the Child Health Computer, and appointments have been sent for clinics. Table 2 shows that between 1.7.85-31.12.85 155 immunisations were given, but only 6 of these were the result of a specific appointment. However, this is a common experience in Hackney, and health staff frequently find that families attend a clinic a week or two after their appointment.

Table 2: Analysis of Immunisation results for period 1.7.85-31.12.85

	Appts made	Appts kept	Appts not kept - reason given	Appts not kept - no reason	Unscheduled Immunisations
Healthmobile	74	6	22	46	149

Source: Child Health Computer

Projections from the number of immunisations recorded by the Child Health Computer infer that more people were seen in the second half of the year. However, the sources of data are different so the statistics are not strictly comparable.

Statistics of attendance are only a very crude indicator of what staff and families think about the service. Semi-structured interviews will be conducted to measure satisfaction as part of the evaluation. However, the staff in particular have listed several problems that will be discussed here.

Firstly, the nursing staff in particular, do not like working on the Healthmobile. There is very little space, no privacy and no toilet. For Child Health Clinics, this means that it is difficult to do developmental assessments and the noise of the generator prevents hearing testing. IUCDs cannot be inserted during Family Planning Sessions because there is no where for the patients to lie down during recovery. All of these problems can be overcome with willing staff, but if the goodwill breaks down, can become major

leaves Thursdays for ad hoc clinics, occupational health of other clinics on demand.

Hackney Healthmobile Weekly Programme	
MONDAY	Homeless Families
TUESDAY	Heart and Stroke
WEDNESDAY	Heart and Stroke
THURSDAY	Flexible
FRIDAY	Well Women

Activities on the Healthmobile are co-ordinated by a part-time administrator who maintains links with the clinic staff, transport, the police and organisations in the community. She is responsible to the administrator in charge of Health Centres in the district, but there is a steering group of people involved in using the Healthmobile that develops operational policy and planning.

The initial cost of the Healthmobile was £7,900 and it is now run on a budget of £15,000 funded out of Inner City Partnership monies. The budget for 1986 is:

	£
Administration	6,426.78
Clerks	1,300
Driver	2,000
Cleaner	600
Petrol	1,000
Publicity	900
Expenses	2,500
	14,726.78

The Healthmobile is currently being evaluated with a view to taking it on to mainline funding. Almost a year after its opening, the Healthmobile continues to be met with enthusiasm by local residents and is increasingly realised as a valuable extension of the Community Services in Hackney.

Evaluation

Table 1 shows the number of children seen during 1985 as recorded manually by the CMO.

obstacles to co-operation and the provision of a good service.

Secondly, the Healthmobile is fraught with all the problems of a mobile service. Breakdowns are inevitable, the heating is often inadequate, transport is frequently difficult and the Administrator spends a large amount of her time smoothing over these mechanical failures. Unfortunately, the Monday clinics are the most vulnerable. Four are cancelled any way because of bank holidays, and if anything is likely to go wrong, it is more likely not to work after a weekend. This means that in 1985, 27% of Monday clinics were cancelled, and there has been considerable disruption already this year, mainly because of the weather. Cancellations disrupt patients as well as staff as appointments are sent out but there is no way of letting families know that the Healthmobile will not be doing a clinic. This has created a lot of justifiable anger in the homeless families.

Finally, communication needs to be improved. There needs to be a better system of advertising where the Healthmobile is going to be, and when. Cancellations also need to be given more notice. Also there is no way of communicating out of the Healthmobile. A telephone would be a great assistance.

Despite these problems the Healthmobile has been very popular and has had a good response from the public. It would be a big disappointment if we could not provide an efficient service or had to cancel the whole project due to lack of co-operation from the relevant departments. For the homeless families it is felt that the ten children seen each week would probably not otherwise attend a clinic, and the Healthmobile has probably meant that 267 immunisations were given which otherwise may not have been. Obviously, this is only supposition - the answer must await the full evaluation. Meanwhile, the Healthmobile does appear to be offering a useful service to the homeless families of Hackney.

Dr Luise Parsons 01 739 8484
Dept of Community Medicine St Leonards Hospital, Nuttall St, London N1

B 2 CHALKHILL NEIGHBOURHOOD PROJECT - WOMEN'S HEALTH

Deb Peters, Pat Wickstead
Chalkhill Neighbourhood Project,
369-371 Greenrigg Walk, Chalkhill Estate, Wembley, Middx
Tel: 01 908 0404

About 20 people attended the workshop. We started off by asking the group why they had chosen the workshop. These are some of the reasons they gave:

- The opportunity of hearing how Health Visitors worked in an alternative setting
- How Health Visitors and Social Workers worked together and how complementary practitioners can work in community health care provisions
- How you identify the needs of a community and how this is translated into services and resources with reference to the particular health needs of women

We gave a brief introduction outlining the background of the Chalkhill Project and the work we have done and are currently engaged in. In addition

we described what it was like to be part of a multidisciplinary team both from the Health Visitor's and Social Worker's point of view. We tried to describe the benefits that accrued to individual clients and the community from this approach.

The group spontaneously began asking questions ranging from management structures in the Health and Social Services to our work with General Practitioners and the Health Centre.

We tried to demonstrate that as workers we did not always need money to promote change but that it was vital to challenge traditional ways of working and to try and sensitise the services to meet stated or unstated needs.

We also stressed the importance of `community development', i.e. to do face-to-face work with individuals and groups in the community with the aim of ascertaining their needs as well as encouraging people to take more power for themselves.

We gave an example of the Women's Health Week which local women were invited to help plan and organise. The week itself was a success but most importantly women were able to carry on meeting together both on a social level and in different groups that focus on various issues (e.g. health, activities, women's rights, etc).

B 3 ENDOMETRIOSIS - HOW CAN WE ALL HELP?

Sharon Fordham, Caroline Hawkridge, Leslie Mabbett
Endometriosis Society, 65 Holmdene Avenue, London SE 24 9LD
01 737 4764

Endometriosis

Endometriosis is a disorder caused by the occurrence of endometrial tissue outside the uterus (usually within the abdomen) which responds to the normal hormonal cycle. Each month the tissue grows and bleeds causing inflammation and scarring in the pelvis. It mainly affects women in their reproductive years, although a few post-menopausal cases have been documented. The consequences vary. Endometriosis may not cause any symptoms in one woman while another may be debilitated by severe pelvic pain. Yet the first woman may wonder why she can't conceive and the second woman may be suffering from physical and emotional disturbance in her sex life. A third woman may be unable to cope with her children because of the pain or have to have regular time off work. Diagnosis can be vague and delayed unless a laparoscopy is performed. This surgical procedure requires brief hospitalisation, but is the best way of assessing what is happening in the pelvis. Unfortunately the present treatment options pose further problems of their own and there are no easy answers. A woman may have to face major surgery or motivate herself to take hormones for six or more months with the possibility of unpleasant side effects. Current treatments seek to alleviate the symptoms and prevent the recurrence of endometriosis for as long as possible. Their success varies and most women have had to face the fact that there is no universal cure or guaranteed end to the problem, although they may gain relief.

Few women will have heard of endometriosis before their diagnosis. One of the reasons for the general lack of public awareness may be that

endometriosis is not fatal and so has not aroused attention. Indeed there have been a few cases where the women did not even know they had the condition until it was discovered by accident during surgery for other reasons. However for others, endometriosis threatens the quality of life itself. Endometriosis and its treatment can raise important and difficult questions about what we hope for in life: Do I want children and can I have them? Can I have a happy and pain-free sex life? How will I feel about myself after a hysterectomy or facing an early menopause? Many partners will also be involved in these problems. In spite of the threats that endometriosis can pose, it is only occasionally discussed. Far from being rare, it is described in the medical literature as the second most common gynaecological complaint. 40% of sufferers experience infertility. It frequently requires major surgery and/or long-term expensive drug therapy.

The Endometriosis Society

The Endometriosis Self-Help Group was formed in March 1981 when a group of sufferers met in London. The meetings were informal with the aim of offering mutual support and understanding. The women felt they benefitted enormously from the opportunity to share their experiences with fellow sufferers. Many of them had felt very alone with a disease no one had ever heard of.

The following March an article appeared in Good Housekeeping magazine which discussed endometriosis and mentioned the groups address. They received 1,000 replies. By September 1982 the Endometriosis Society had been registered as a charity, to be formally administered by a group of trustees. There are now over 80 local groups throughout the country as well as the national organisation.

Our aims are:

To encourage self-help and mutual support amongst endometriosis sufferers

To encourage greater awareness of endometriosis, its symptoms and its consequences amongst the medical profession and the general public

To encourage further research into better treatments for endometriosis and its associated infertility, and assist where possible

To encourage further research into the epidemiology of endometriosis to improve the recognition of `at risk' groups and encourage earlier diagnosis

There is still a great need for a better understanding of endometriosis. Some of this understanding will come from medical research aimed at improving treatments and helping infertile patients. However much of the knowledge needed to appreciate the nature of the disease and its potential effect on a woman is already available and can be used to be diagnosed at an earlier stage. The possible impact of endometriosis on a woman's life also needs to be considered. This does not mean dwelling on illness or disability but rather recognising the difficult experiences, adjustments and questions that any illness can bring. Endometriosis is no exception and sufferers need support and understanding when faced with decisions about their treatment, their fertility or doubts about surgery or their motivation through long periods of hormone therapy.

Endometriosis: How Can We All Help?
The Conference Workshop

At the workshop we reviewed what Endometriosis is and the range of services the Endometriosis Society offers (e.g. information sheets, discount alternative medicines, contact with a local support group, workshop days, etc). We also discussed many of the issues surrounding endometriosis which we try and address (e.g. Why do many women find it difficult to get early diagnosis? Why is endometriosis labelled the `career woman's disease'? Do only white middle class women get it or are they the ones that get diagnosed?).

For further information, contact the Endometriosis Society at address above.

B4 HEALTH CARE IN THE NEWCASTLE AREA

Angela Oxberry, North Kenton Health Project, 98-112 Newlyn Road
North kenton, Newcastle upon Tyne 091 284 6092
Leo Pike, Tyneside Womens Health Project

The session began with a brief history of the development of Community Health projects in the Newcvastle area. All have temporary and insecure funding, being variously Local Authority partnership, Health Authority partnership, Tyne & Wear and charitable funding.

The first projects set up in 1981 and the most recent in 1985. They are:

North Kenton Community Health Project)	
Riverside Health Project	)locally based & managed projects
Walker Health Project	)
Information worker	A central post to assist the other projects
Ethnic Minorities Health Project	Within Community Relations Council, not locally managed or based
Tyneside Womens Health Project	Does outreach work in Newcastle & Gateshead & has a management committee drawn from the area

There are also other health groups in the district run by community workers and community activists, etc in areas not served by existing projects. The projects meet regularly and co-ordinate their work in order to be more effective. We have strong local support and links both with residents and grass roots workers however...

The discussion centred on the difficulties of working together with the statutory sector to bring about changes. We were concerned about consultation and participation in services from a local level upwards, and ways of working with Health and Local Authority employees. There was a lively discussion with virtually all of the dozen and a half attenders participating.

A variety of viewpoints and degrees of experience of community health projects was evident. The main point of agreement was that locally based Health Service employees should have more flexibility built into their work. Experience

differred widely. The Health and Local Authoritryy administrations seemed to take on different personalities in different areas and the North/South divide was evident.

Both group leaders and group found the session most enjoyable. The opportunity to exchange ideas with people from different work backgrounds and geographical locations was very valuable and something that happens only too rarely for most of us.

B5 TOWARDS A GOOD FOOD POLICY

Maggie Sanderson, Community Dietician, St Leonards Hospital,
Nuttall Street, London N1

The NACNE and COMA report on diet and acrdiovascular disease have both recommended changes to the traditional British diet. Both reports have given precise quantitative goals for fat, fibre, sugar and salt intakes for the nation as a whole. So far, the only startgey used has been one of education which, for the most part, has been directed almost entirely at the consumer. There are many other groups involved in the food chain and there are other strategies that could be appplied to all of them. The workshop will try to identify some of these groups and look at the range of policy options that can be used to effect the most successful implementation of a good food policy.

B6 COMMUNITY BASED ALTERNATIVE HEALTH CARE

'Pathways', Tower Hamlets Health Project
Richenda Power, Jessica Darling, Sanne van der Toom
30 Brownfield Street, London E14 01 987 5503

This workshop was designed to encourage information sharing and to stimulate creativity in planning a community based alternative health care centre. About 12 participants came to discuss their experiences with the practitioners and development worker presently working in the centre.

We started by introducing ourselves. It turned out that everyone present was related either by profession or by interest to the field of 'alternative' medicine. (This however is not surprising.) Among them were acupuncturists, a health visitor, healers, an 'orthodox medical' student, etc. We asked everybody why they were interested in our workshop and why they came along to it. There was pretty much a consensus of ideas. Some people worked in similar centres to our own, some stressed the political perspectives, or wanted to discuss the problems of practising privately. Also the relation between alternatives and orthodox medicine was mentioned and how the link between the two could be restored.

Richenda Power, one of the osteopaths/naturopaths working in the centre then explained the history and the aims of Tower Hamlets Health Projects.

The centre is one of the innovative health care projects funded by the GLC, through the energy and work of Jeanette Mitchell. In September 1985 the 3 women practitioners founded what was at that time called the Tower Hamlets

Health Workshop, at 30 Brownfield Street, an estate building in Poplar, East London. The centre finds itself in a transitional stage at the moment, having changed from a single handed GP surgery to a group practice made up of several different alternative practitioners with meeting space for local community groups.

Richenda summed up the aims of the project: Recognition of women's major contribution to health care (both in paid and unpaid work)

- Taking a feminist perspective to health care in general

- Provision of information about and promotion of high level health by natural means

- Providing what local people want (by means of democratic management)

A major point is how to put these aims into practice?

The centre wants to see local people involved both as clients and as practitioners and activity organisers, etc. Activities should cater for everybody. We would like to see more practitioners with various backgrounds involved, especially those from local ethnic groups (herbalist, homeopath, etc.). The premises are currently being made accessible for disabled people. Activities for/with lesbians and gays are stimulated.

An achievement well worth mentioning has been the successful pressure on a local shop (Boots) to stock natural food supplies (already available in most West End branches but not in Poplar).

So far 30% of Jessica's, Sannes' and Richendas' patients are non-white people. We want to do everything to improve this figure and to get rid of the stereotype that alternative health care is for middle class whites only. Jessica, the acupuncturist, pointed out that most of her patients are residents of Poplar, and even the majority come from the Brownfield Street council estates. Not necessary to state that Poplar (E14) is almost entirely a working class area. For those people who are not able to pay the full fee of £15 (for the first consultation) and £10 (for the following sessions) a lower sum of money is charged (normally the half of the normal fee). A substantial amount of Jessica's patients are from the Chinese community in Tower Hamlets as she has been brought up in China and speaks Mandarin fluently.

Several items were put forward by the participants. Some practitioners gave voice to the problem of being the 'last resort' for many patients. The value of giving information on a wide range of treatments and thus creating a real choice was much stressed. Some participants were concerned about the power of existing large dominant structures and how they could be used. After this discussion we did a 'design your own system' exercise. Crayons and large sheets of paper were handed out and everybody was asked to draw her/his own alternative health care system/structure, what services it would provide, how they saw this health centre fitting amongst existing powers and structures and how it is embedded in the local community. Beautiful drawings came out of this. Unfortunately, there was not much time left to discuss more than a few of the ideas sparked off. Some items seen as important were: accountability for the public - space for children, breaking out of the medical model of

professional practice - facilitate access to information - mixing of different professionals and lay people - tapping creativity in people and claiming our own existing knowledge and cross hierarchical flexibility.

Much more can be said about our workshop and the work being carried out in the centre. We would like to hear from people interested and we look forward to an event as fruitful as this one.

* B 7 OCCUPATIONAL HEALTH PROJECT

We are based in six doctors' surgeries in Sheffield. We are a group of people with a combination of skills - experience and knowledge of local trade unions and how to organise in the workplace - and some workers have an industrial hygiene background. Most of our work is centred in and around the waiting room, talking to people about their jobs, past and present. We try to bring people together with similar work-induced health conditions, e.g. deafness, respiratory problems, and we work with them preventatively, helping them take the issues back to the workplace.

Sue Lawson . 0742 441 421 or 0742 392 541

B8 INTUITIVE MASSAGE

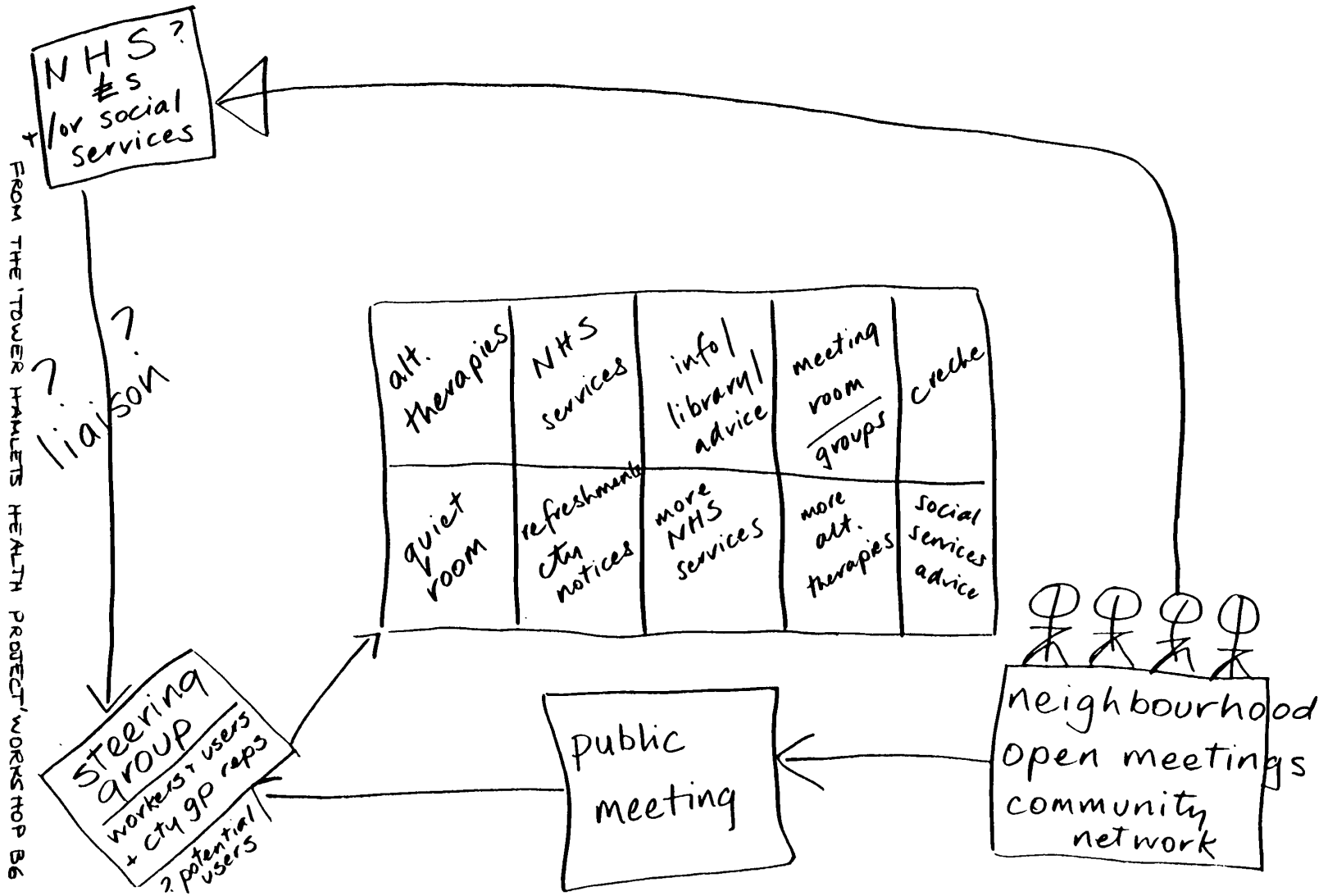
by Marie James, ISIS Centre, 362 High Street, London N17 01 808 6401

A limit of 16 participants was set, but 18 turned up, enticed by the promise of an experimental workshop, a waiting 'something relaxing and nourishing for themselves' after the more heady theoretical offerings of the Conference.

We loosened up by shaking our muscles, limbs and joints and got our energy moving with a brief Do-In self-massage - a brisk slapping along the energy pathways of the body. Wasting no resources (!), we then made a circle and all massaged the neck, shoulders and back of the person in front till we were quite pink and bubbly with energy and laughter.

Marie demonstrated a simple head, face and neck massage sequence on a willing volunteer. Then splitting into pairs, first one partner and then the other tried out the same sequence as Marie talked them through it again, giving each person a chance to experience both giving and receiving.

Just time enough then for a brief exchange of feedback with pairs before all coming together again for comments, wider questions and feedback as a group. We talked about basic principles of intuitive massages and how they differed from Swedish massage techniques rather as `reductionist' medical philosophy differs from the holistic approach. We discussed training courses and how to avoid picking up symptoms; through centring oneself and respecting the other's self-healing powers rather than straining to `cure' them ourselves. Several `first-timers' to massage declared themselves delighted with the effects - and judging from the 18 relaxed and glowing faces to leave the workshop, a good time was had by all. What more could one ask?



FROM THE 'TOWER HAMLETS HEALTH PROJECT' WORKSHOP B6

B9 HATHA YOGA

Yoga is an age old science/philosophy/discipline that can cater for one's spiritual as well as physical health. Initially it aims to relax the mind and body and bring about a sense of general well being.

The workshop introduced the participants to the subject by showing them how to breathe 'through' the abdomen when in a relaxed state and then expanding the breath so that the ribs and upper chest are lifted filling the lungs completely and comfortably.

Simple stretching exercises - to the ceiling, floor and from side to side - warmed the body up.

The bulk of the workshop consisted of holding simple postures (asanas)... standing poses, balances, forward bends and back bends and sitting twists. Apart from putting people back in touch with their bodies, loosening stiff joints and muscles and developing a sense of proprioception, the asanas aim to free the subtle nerves (nadis) in the body to allow the vital energy (prana) to flow more efficiently and effectively. Holding the mind still on the body as you take up a position helps calm the mind as much as the body.

The workshop ended with twenty minutes of complete relaxation (savasana). Temple bells were gently played as people were talked through the relaxation from toe to head.

Future sessions would develop breathing exercises covering such things as alternative nostril breathing and the cleansing breath (kapalabhah) and develop postural ability. Simple meditation techniques would be introduced - such as holding the mind still on a candle flame, on the breath, a sound or on a pictorial design.

Yoga can be practised by anyone; from the age of five upwards. In its quiet, gentle way it is of great help in re-introducing mobility to the body, calming the mind and developing concentration, and, of course, relaxing and energising the body.

Don Nicholls
(Diploma British Wheel of Yoga)
102 Broadwater Road
London, N17 6ET 01-801 1771

* B 10 BODY STRUCTURE AND HEALTH

Though we pay little attention to educating posture and movement, chronic imbalance can lead to pain and limitation. This section will focus on structural analysis and assessment of psychological and physiological effects of our way of standing, moving and presenting ourselves.

Tom Myers, who has been a practising Rolfer since 1976 and has been lecturing on structural anatomy and exercise physiology for various groups since 1982. 01 267 6083

* B 12 THE WORK OF THE WOMENS THERAPY CENTRE, FOCUSSING ON EATING PROBLEMS

This workshop is for women and men who want to know more about the approach we use at the Womens Therapy Centre in working with women with eating problems such as compulsive eating, bulimia and anorexia. We will demonstrate this approach through talk, discussion and verbal exercises.

by Mira Dana and Birgitta Johannson, therapists working at the Womens Therapy Centre 01 263 6200

* B 13 HEALTH AND HOUSING : CAUSE FOR CONCERN

Our Tenants' Association looks after 1,690 tenancies housing 7,000 people but the greatest problems are experienced by people living in the REEMA (large panel building system) blocks.

The Tenants' Association's problems include:

* unemployment at 49%
* infant mortality well above national average
* severe damp throughout the estate
* high hospital admission rate for bronchitis and upper respiratory tract infections, affecting particularly children and the old
* Legionnaires disease outbreak last November

Our campaign is for improved housing because we know improved health will result. We will talk about our campaign in the workshop.

by Eileen McCloy, vice Chair East Glasgow CHC, 041 552 8239
Marjorie Collins - both are Tenants' Association members

B14 LEARNING FROM CHILDREN WORKING

In this workshop we explored the dimensions of one health worker's involvement in a children's club where children taught other children about health.

Discussion centred on 3 areas of interest:

(1) the development of the club at West Lambeth CHC

(2) evaluation of the club

(3) development in other settings.

(1) The development of the West Lambeth Club

The children came after school for an hour once-weekly. Their ages ranged from 3-15. Many children attended with their younger brothers and sisters. They came from the immediate neighbourhood of the CHC and were able to walk there, usually without adults accompanying them.

The children defined for themselves the topics they would like to learn about (diet, tooth care, the body, medicine in the home, breathing). The club

worker, initially a voluntary worker and later a worker paid from a special central/local government partnership fund for the regeneration of deprived inner city areas, helped the children with sources of information (books, people, films, models).

The children defined for themselves the topics they would like to teach (the five senses, foetal and children development, environmental health and nutrition), the materials they would like to use (quizzes, questionnaires, posters, songs, discussions) and the places where they would like to do their teaching.

(2) Evaluation

Key themes in the children's experience of health education practice were identified: health education as a pleasurable activity, perceptions of health, competence and responsibility and social networks.

The methods used to examine these themes were: participant observation, interviews with the children and the use of the critical incident technique (a sharply focussed description of a significant event which throws light on the subject or issue under observation).

(3) Setting up Health Clubs

We have observed from our own and other work that the most important prerequisite for starting a children's health club is for the adults involved to regard the children as people first. Adults tend to underestimate what children know, what they can learn and their capacity for taking (appropriate) responsibility (2). Children are still often seen as passive recipients of

adults' knowledge. They are not taken seriously. Listening to what children have to say about health, what they would like to do and how they would like to do it, comes next. The adult's main functions then are to enable these things: by suggesting people, places and books and by accompanying children when they go out to teach. This is very demanding work and requires of adults that they relearn how to behave in an enabling way, which is not didactic.

The third prerequisite is that the adults concerned should feel confident themselves about their health knowledge and about their ability to relate to children.

The setting of the club is important: the children should feel that they have a space which is theirs and where they can leave things on display until they come again.

The children also need to feel that the job they are doing is useful; they do not want to play at a project; they want to work. This type of work is most popular with chilren aged 7-11; when they reach secondary school age, they feel that they must 'grow up' and become helpers in the club or they become preoccupied with other activities at school and with homework.

Conclusion

The idea of peer learning (3) and peer teaching (4) is not new in education. The idea of peer teaching in health is not new in third-world countries where children teach others in their villages about rudimentary health care and

assist the paramedics (5). However, it is less often found in this country in non-school settings. Nevertheless, we feel this approach has a valuable place with health promotion activities. A more detailed account of this work will appear in the forthcoming issue of Radical Community Medicine, 38 Weston Park, N8.

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C 1 CHANGING HEALTH VISITING PRACTICE

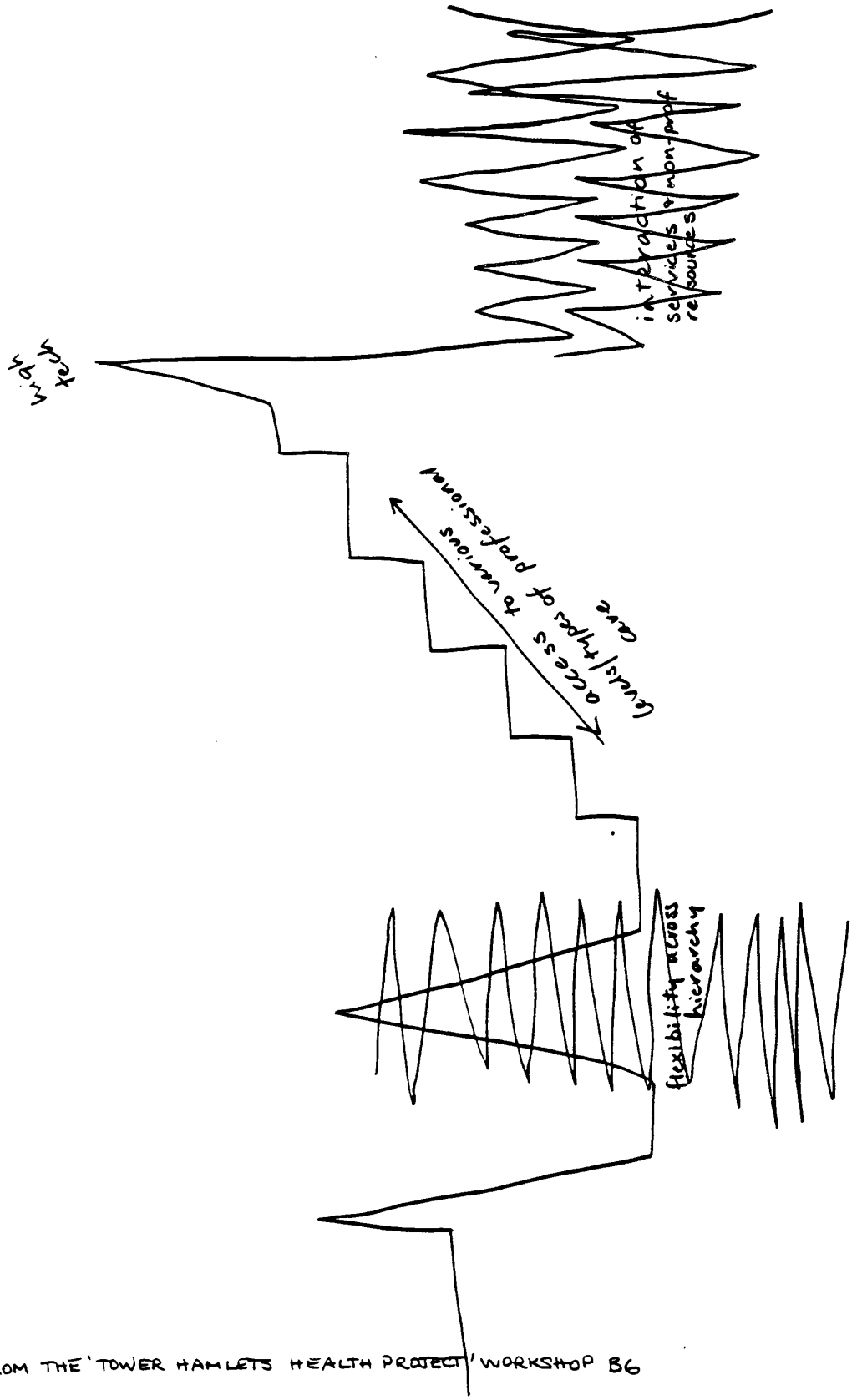
Vari Drennan, Health Education Dept, 287 Harrow Road London W9 3RL
01 286 3275

In September 1983 the Community Nursing Service, in Paddington and North Kensington Health Authority, funded an eighteen month research project to examine how a health visitor can work within existing community groups to promote awareness of health issues in an inner city area. The main focus of the project was the exploration of community work practices as a method for health visiting to become more responsive to the community it is set in.

The research health visitor made contact with forty local community groups, working closely with twenty three of them. She acted as a source of information on health issues to the community groups. She also created opportunities to talk about health and initiated discussions as asked for by poeple in the community. At the same time she took information from the community groups about their perceived needs back into the health service.

In documenting the work and monitoring it the research health visitor has been able to point to feedback from the community groups and some outcome indicators which together with the description of the process evaluates the work. Out of this the research health visitor has been able to highlight the changes necessary both in the training and structures of health visiting which would allow health visitors to work in this different way.

The report is available from the Health education Department, 287 Harrow Road, London W9 (01 286 3275) at £3.50 including postage. Cheques should be made payable to Paddington & North Kensington Health Authority.



FROM THE 'TOWER HAMLETS HEALTH PROJECT' WORKSHOP B6

* C 2 THE WOMENS HEALTH SHOP

A Womens Health Shop was open for just over a year in Edinburgh to provide information and advice about health and to reinforce the relationship between informal and formal care. It was staffed by nurses. The shop has now closed down because the funds ended but there are plans for a possible reopening.

The workshop will be presented by Sue McWhirter. a health visitor, who worked in the shop and will discuss how the shop was set up and the way it worked.

Sue McWhirter c/o Breast Screening Clinic, 26 Ardmillan Terrace,
Edinburgh 11 031 346 1824

* C 3 MOVING DIABETIC CARE OUT OF THE HOSPITAL

We want to explore the problems with the traditional view of diabetes as a hospital based disease and explore both the devolution of care from such a setting and the participation of the person in the care of the disorder specifically for diabetes but as a model for a number of chronic diseases.

Dr John S Yudkin, Consultant in Diabetes
Dr Brian Hurwitz, GP, both at Whittington Hospital, Highgate Hill,
London N19 5NP 01 272 3070 x 4119/4737

* C 4 WOMENS ACTION FOR MENTAL HEALTH

We are a GLC funded grassroots intitiated neighbourhood project for women. In the workshop we want to talk about the way in which we got going and what we are now doing in our project.

Janet Brown WAMH 131 Bloemfontein Road, London W 12 01 749 9446

C 5 PENSIONERS HEALTH FORUMS

Christine Smith, Oxford House, Derbyshire Street, London E2
01 739 9001

A series of Pensioners Health Forum meetings were held in Tower Hamlets during 1985. This workshop will describe the aims and processes involved in setting them up, and the content of, and the issues raised by, both pensioners and health professionals at the meetings.

How can these ideas be used to influence changes in the Health Service?

C 6 SELF-INSEMINATION

Self-insemination is a way of getting pregnant that does not involve any sexual contact with a man. Technically, it is very simple, needing no training and no medical equipment. It can be done by the woman herself without the help of doctors. The practice of artificial insemination (AID) is not a medical procedure (unless, of course, a medical procedure is defined as anything that doctors do). It is offered in NHS and private clinics, not because of the need for medical expertise, but because it is labelled as a treatment for male infertility. When taken out of that context, as when a fertile single woman requests sperm, medicine becomes an instrument of social control. The decision to have a chilkd is not just up to the woman who will be the mother. She is turned into a patient and the doctor decides whether she is worthy of reproducing. Nearly all clinics reject lesbians and most are unhappy about single heterosexual women. This workshop will discuss the issues around finding donors, health and genetic screening of donors, safety of AID, sex selection, attitudes to doing self-insemination and legal aspects.

Lisa Saffron Women's Health Information Centre, 52 Featherstone St.
London EC1 01-251 6580 or 6589

C 7 BIOMECHANICS AND THE FUTURE OF NHS CHIROPODY

Clive Chapman, District Chiropodist, Haringey Health Authority,
Tottenham Town Hall, London N15

Biomechanics is the application of mechanical laws to living structures, particularly to the diagnosis and treatment of foot pathology. With the use of Biomechanics it is possible to diagnose and treat the potential for deformities like bunions, claw toes and postural problems in both adults and children. In the workshop the principles of Biomechanics in diagnosis and treatment will be explained and a biomechanical examination demonstrated. How this approach can be incorporated in to NHS chiropody will be discussed.

C8 CONSUMERISM AND HEALTH CARE - Beyond the Supermarket Model

An account of the workshop lead by Fedelma Winkler and Helen Rosenthal, from the Greater London Association of Community Health Councils, c/o 6 Manor Gardens, London, N7.

Introduction

Users of the Health Service have little or no power in the formulating of policy in the health service, nor any say in the delivery of service. Where does 'user power' fit into the arguments for democratising the health service? What is the place and role of the Community Health Councils?

The workshop will explore our attitudes towards consumerism in the health service and what our response should be to the emphasis on customer relations emanating from the new managerial structure.

Since the Griffiths Report of 1982 on Management of the NHS there have been endless articles in Health Service journals on consumerism. To date, this has been limited to doing consumer satisfaction studies on areas which are non-threatening to the professionals, such as waiting times in out-patient departments, or attitudes of NHS receptionists. The role of the Community Health Councils, the statutory bodies that often present themselves as 'the Patients' Friend' has been left undiscussed, just as it was in the Griffiths Inquiry itself. This may be in part the fault of the CHCs, which were set up with a hope and a prayer in 1974, with no blueprints. Their performance has been very variable, and there has been little or no attempt to work out a model of how CHCs should be working. This has been both their strength and their weakness.

Radical CHCs have found it hard to engage with current 'supermarket' notions of consumerism. What we set out to do in this workshop was to look at the potential for a radical theory and practice of consumerism.

Everyone of us will at some time use the NHS as individuals, e.g., when we are sick, have as accident, or in pregnancy or childbirth. While some workshop participants reminded us that much ill-health could be prevented and cured by structural changes in society, the workshop decided to focus on strategies for empowering users, both individually and collectively.

The discussion in the workshop started with seeing consumerism as being concerned with marketing the services, and choice for users. Against this was pitched the need for changing structures in the NHS, such as 'democratisation', improved consultation procedures, and development of self-help and patient participation groups. In discussion, the limitations of these suggestions for empowering users were recognised. The example was given of how local authority social service and housing committees, despite their democratic structures fail to represent the interests of users. A radical theory of consumerism should at least include the following:

1 Freely available, detailed information on local health services researched and written by users.

2 Patient advocacy schemes in hospitals.

3 User input into medical, nursing and all NHS professional education.

4 Patient representative groups, such as patient participation groups and patient councils linked into CHCs.

5 Independent scrutiny of individual complaints about the NHS.

6 Clinical audit and routine monitoring of outcomes of medical interventions, with information freely available to users.

7 User representation on decision-making bodies, with appropriate support structures linked into CHCs, to ensure representativeness, and independence from management.

Fedelma Winkler, CHC City & Hackney, 210 Kingsland Rd, London E2
Helen Rosenthal,GLOCHC, 6 Manor Gardens, London N7

C 9 CANCERLINK - THE MISSING LINK

Ruth Roth, CancerLink, 46 Pentonville Road, London N1 9HF

'My main reason for being involved in our local support group is to find a way to live with cancer.' - Rachel from Oxford CancerLink, who has cancer herself and has just completed a CancerLink training course for volunteers.

The diagnosis and treatment of cancer creates a profound impact on the lives of individuals with cancer, their families and friends. CancerLink support groups enable people to share their experiences with others who are in a similar position. Ruth Roth will talk about the psychological and emotional support provided by CancerLink suppport groups and information service. Information will be available about Training Courses for volunteers wishing to set up CancerLink groups.

C10 INDIAN-STYLE THERAPEUTIC HEAD MASSAGE

The workshop was limited to 20 participants although many more wanted to attend.

Because of limited time the workshop was designed in such a way that every participant had the opportunity to give and receive just a few of the many useful techniques that are normally included over a weekend course.

These techniques include massage of neck, shoulders, scalp and the face.

The workshop was organised in three parts: (1) An explanation of the history and benefits. (2) Demonstration of the techniques. (3) Practical experience.

(1) Head massage has been practised in India for over a thousand years. Originally it was women who used the technique so as to keep their long hair in healthy condition. Various oils have been used very effectively over the years, e.g., coconut oil, sesame, almond or olive oil. They believed that the

secret behind a lustrous growth of hair is regular massage of the scalp and hair with these oils. The oil improves the texture of the hair and the scalp massage improves the circulation. This has the effect of nourishing the hair roots and so prevents excessive hair loss. It is for this reason that men, too, can benefit from this type of treatment and from the relaxation massage brings. When using the oil, the hair is not washed for six to eight hours so as to get maximum benefit.

The benefits derived from massage:

Scalp massage (a) Stimulates and improves scalp circulation which helps to promote texture combined with strength and growth of hair. (b) Relaxes the scalp and tones up subcutenous muscles, thus helping to reduce headaches, eye strain and such like.

Face massage Soothes, comforts and rebalances energy flow having one with a feeling of peace and tranquility.

Neck and shoulders (a) Eliminates muscle tension and stimulates circulation. This helps to get rid of waste material from the body and distributes oxygen to all the tissues. (b) Restores joint movement; it also stretches and mobilises the tissues of the neck and shoulders.

General benefits Once learned it is a readily available therapy at one's fingertips. It requires very little space as it can be done sitting up, on the floor or on a chair. It can be done anywhere because it does not require any removal of clothes.

Particular benefit The sense of relaxation and well-being that head massage brings has to be experienced to be understood. We live in stressful times and head massage is one of the ways of coping with all the tensions. It does not solve the problem, but induces considerable relaxation which goes a long way to dealing with the stress situation.

(2) Demonstration of techniques. A volunteer was demonstrated upon while the rest of the participants were watching and/or making notes.
(3) Practical. The participants then paired-up and followed instructions of the techniques which were demonstrated previously. They then changed over. In this way all participants experienced both giving and receiving the massage.

Conclusion By the end everyone seemed to have enjoyed it judging by the expressions on their faces. They considered it an extremely worthwhile experience. Their comments included words such as `wonderful', `sense of lightness', `very pleasant', `thoroughly relaxing'. Many said this was a good opportunity to experience the massage and wanted to pursue it further.

Weekend courses are regularly held. For further information contact the organisers.

Narendra Mehta, BA, LCSP, MCP 01-609 3590
Keith Heatherley, ITEC, LCSP(Assoc)

* C 11 FITNESS JUNGLE : MOVEMENT RE-EVALUATION TECHNIQUES

The emergence of self-regulating movement systems like the Feldenkrai's method, the Alexander technique and Eutony present a genuine possibility for empowering the individual to create change in the use of their body. In conjunction with mental rehearsal techniques they create learning situations which can be carried into daily life and movement.
This workshop will present a number of historical perspectives on the development of Movement Awareness Systems and the experience of how they work.

Christopher Connolly
18 Kemplay Road London NW5 01 435 8145

* C 12 HOLISTIC MEDICINE COMMUNITY PROGRAMME - A PILOT PROJECT

This workshop will be presenting a holistic medicine community programme which is currently being conducted at Lisson Grove Health Centre in an inner city London area. We will be discussing how the project was developed, which includes research that is being carried out relating to this particular model, as well as the practical details and current issues which surrounded setting up this programme in different NHS settings.

by Julienne Maclean, Dept of GP, Lisson Grove Health Centre 01 724 2391
Gateforth Street, London NW8

C 13 MATERNITY SERVICES LIAISON SCHEME

Paula Uddin, Mina Sol, Anwara Dewan
Rm 14, Brady Centre, Hanbury Street, London E1 01 377 8725

Within Tower Hamlets population there are an estimated 20,000 Bengali, 2,500 Somali and 2,500 Chinese/Vietnamese women. These figures illustrate clearly the need for the work of MSLS, taking into consideration that there are no bi-lingual people on the staff to communicate with the women before, during or after pregnancy. Statistics of our work show that last year the nine Community Health Workers have helped over a thousand women and children.

Clients are accompanied from home to hospitals, clinics, DHSS, Housing, Social Services, Law Centre, dentists and chemists. Each client is accompanied throughout the period of 8/10 months pregnancy and work with them includes all aspects of life related to living in the inner city. Our aim overall with our clients is to promote more self-reliance.

Hospital work

Our work in this area has evolved from simply seeing clients in hospital to actually helping to improve the services they receive once inside the hospital. To this end, MSLS is running Health Education sessions with Parentcraft teachers in ante-natal and post-natal wards. Two workers are attached to each of the hospitals for this purpose.

MSLS has actively sought to strengthen links between the Project and the Health Service, with a view to ensuring that the latter becomes more responsive and appropriate to our clients needs. Success in this area is slow and cannot be easily measured. However, we have a close relationship with the Director of Midwifery and we meet her on a regular basis. We also have a place on the Maternity Services Liaison Committee which comprises a consultant, Director of Midwifery, local GP and Community Health Council.

Although the link with the Director of Midwifery is important, the link with the staff is vital. We are at present trying to establish 6 weekly meeting with the midwives.

As in the past year the ever increasing time spent in waiting rooms is a problem. In an effort to resolve this we have begun discussions with the maternity services. On a practical level we will soon bein an experiment in which one of our workers will accompany one of the Community Midwives to patients' homes, taking the history, thereby obviating the need for waiting rooms. Eventually we hope that this role could be taken over by the MSLS workers in the community as well as in hospital thereby freeing the midwives to attend to other important jobs.

GP and Health Centre work

We welcome the change of attitude in our clients' preference for community and shared-care and we felt that our workers had a key role in encouraging more women to take up community care. Five of the nine workers are now attached to five Health Centres or GP units. They are available in the clinics during ante-natal and post-natal sessions and each of the workers is linked with one health visitor. The health visitor is very crucial especially where we have not received a positive response from the GP.

Campaign work

Campaign work has been particularly women-oriented this year in Tower Hamlets. We have been actively involved in rate-capping, as this threatens the future funding of voluntary groups; the Wendy Savage campaign, the suspension of the only woman consultant in the local obstetric department who is offering choices in ante-natal care; homelessness, as early as this year a family was burnt in a bed & breakfast hotel and local families occupied Camden Town Hall. MSLS regularly visited the families to show solidarity and support. We have a very close liaison with the Tower Hamlets Health Campaign through which we attended the Mile End Accident & Emergency closure march. We also submitted several contributions to the Tower Hamlets Health Inquiry which is chaired by Professor Jarman.

Racism

The absence of `racism' and related incidents is perhaps noticeable in this report but this is not because workers or clients have stopped suffering or noticing it. Discrimination towards clients in the workers presence have become very much more subtle and complex. Our opinion is that the less overt forms are because of our previous work. Nevertheless, there have been an abundance of incidents, familiar to all of us throughout the public services.

As far as the maternity services are concerned our impact has made possible a marked change in some attitudes, although there is an immense gap remaining in the delivery of a more appropriate service.

Racism remains a major factor affecting peoples lives. It is more so when reiterated by institutions and people in power. In a so-called multi-racial borough there has been very little discussion on adopting an Equal Opportunity Policy or appointing anyone remotely representing our interest on the District Health Authority. Is it any wonder that our women are receiving an unequal care and treatment. No one will claim that either of the suggested acts will solve all the difficulties in providing a more suitable care but it would give progress one more ladder to climb on, and it will certainly help take the service providers away from the notion that they are doing our communities any favours. The most recent example of this paternalistic attitude is the `Health Report on Ethnic Minority' by the District Medical Officer.

The following topics were discussed at the workshop:

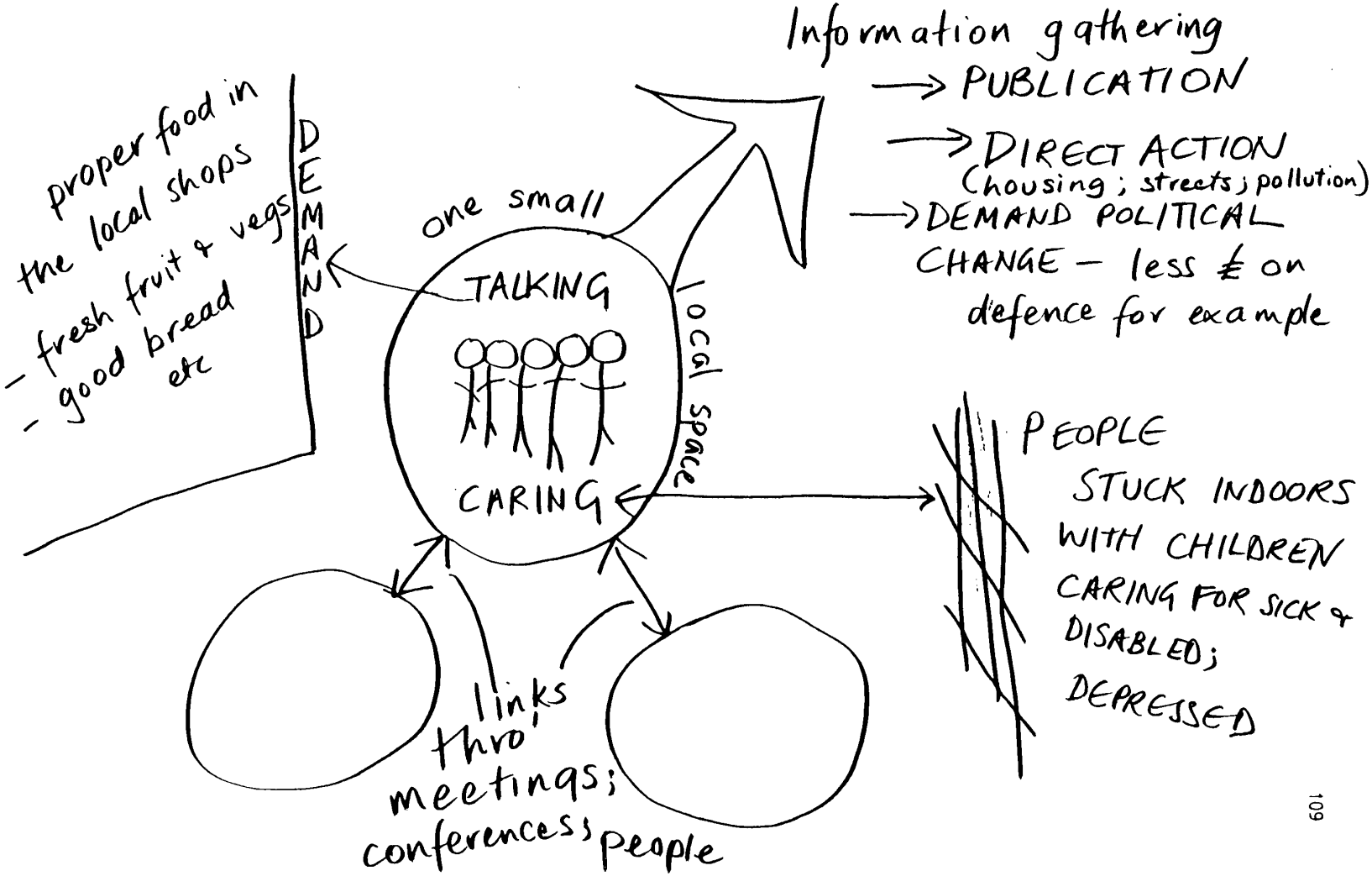
1. The role as a Community Health worker for the Chinese/Vietnamese community.
2. The role as a Community health Worker for the Bengali community.
3. The services that MSLS provide.
4. Function and structure of MSLS and its management committee.
5. Problems that MSLS met within the NHS and how we challenge them.
6. Liaison with other similar projects in London.
7. Funding situation.

C14 EURYTHMY

Our workshop was a little shorter than anticipated - about one rather than one and a half hours, so we had to leave out a few exercises. We were 9 people, and also a photographer and a little girl watched us with great interest! One hour is little time to introduce people to the idea of eurythmy as an artistic form of movement, as well as to its educational and curative aspects, but everyone was very receptive and willing to enter into the spirit.

We concentrated on a few fundamental elements in eurythmy: trying to experience within ourselves the balance between the forces of weight and light, and the contrasting movement of inbreathing and outbreathing. We then explored eurythmy as 'visible speech' and worked with the five vowel sounds, trying to experience what each sound 'said' to us, and then feeling our way into the eurythmy gesture for that sound. Lastly, we explored the world of rhythm, and felt how the different combinations of short and long rhythm can develop different qualities - being 'woken up' with the lively, short syllables, and strengthened by the long, strong syllables, and we finished by stepping and jumping a 'happy anapest', joined by the little girl and photographed by our cameramen!

Although time was too short to work with specific curative eurythmy exercises, we at least had a 'taste' of the different elements of eurythmy, and of their potential for healing.



FROM THE 'TOWER HAMLETS HEALTH PROJECT' WORKSHOP 86

D 1 COMMUNITY BASED HEALTH EDUCATION

Jean Spray & Karen Greenwood , Health Education Officers
Health education Department
287 Harrow Road, London W 9 01 286 3275

In the workshop we began by describing a `typical' Health Education Department both in terms of the areas of work covered and those individuals normally recruited as Health education Officers (ie professional background). The point was made that Health education departments within District Health Authority structures are often reactive and not in a primary policy making position. We desribed the history of community-based Health Education work which developed after the employment of an HEO community development in 1980. The difficulties of attempting to develop this style of work as one worker within a department, which was supportive but had many other traditional Health education functions to fulfill, were outlined. We described aspects of the (CD) work which was mainly direct group work. This style of work contrasted sharply with current professional development in Health Education which favoured `training the trainers'.

The community-based work had an effect on other parts of the department`s work namely training and resource development, details of which were given. The community development work in the department coincided with a significant development of community health work outside the NHS. There was a brief description of the history of the Health Education Council's sporadic involvement in and support of community development theory and practice.

D 2 HARINGEY WOMEN AND HEALTH ASSOCIATION

Jennifer Alert, Annexe C, Tottenham Town Hall, High Road
London N 15 01 801 3152

Haringey Women and Health Association provides information, advice and counselling on women's health. It also runs a centre where groups meet to discuss health issues relating to women, campaign for improvements in health services for women, share experiences and offer mutual support. The centre also runs a massage course, and the workshop will include a practical demonstration as well as a general discussion on the work of the project.

D 3 BRENT WELL MENS CLINIC

Colin Nolder, Deputy Community Unit Administrator, Brent Health Authority, Wembley Hospital, Fairview Rd, Wembley,Middx
Brian Lamond, Senior Nurse, Brent Health Authority

In NOvember 1985 Brent Health Authority opened a new clinic which combines a family planning service and a health screening programme exclusively for men. Colin Nolder and Brian Lamond will explain why they opted for a mens health care service, the philosophy behind establishing the service in practice and their experience of the clinic now it is in operation.

D 4 SELF HELP - OUR EXPERIENCE OF A HOLISTIC APPROACH TO BEING WELL

Would you like to take the opportunity of meeting people who have used this positive approach to combat illness? This informal discussion group will enable you to do this and find out more about the holistic approach.

by Felicity Kelly, Mansfield Community Health Project 0623 642304

D5 INDEPENDENT MIDWIFERY - THE HOMEBIRTH OPTION

The workshop was to look at the way Independent Midwives, working outside the NHS, practise and how this differs from existing hospital and community based care. We began by describing the work of Independent Midwives.

We practise alone or in groups of 2 to 3; a GP may or may not be involved. (Many people are not aware that a midwife is legally able and trained to work on her own if no medical cover is forthcoming.) We do the same amount of visits antenatally and postnatally as the NHS, as well as attending births. We are in touch with the Supervisor of Midwives in each Health Authority in which we work. However, our general manner of practising has developed with a very different emphasis from the conventional one. We don't believe pregnancy involves just a baby, uterus and pelvis. Information, social and emotional factors, the environment in which a woman gives birth and the relationship with her professional attendants directly affect the outcome of pregnancy, labour and mothering. Therefore time, patience and love have become the principles of our service.

We work as practitioners in our own right, booking women mainly for homebirths and giving continuity of care throughout pregnancy and following the birth. In general, we work without drugs or intervention, allowing the natural birth process to take its course. Our aim is to help women develop confidence in their own ability to give birth naturally - explaining, encouraging and supporting them and their partners at this very special time.

Most members of the workshop group had used NHS maternity services. Many had been misinformed about the availability of homebirth and told it was unsafe. This has never been proven and was discussed thoroughly.* All had felt alienated and confused by the number of professionals they came in contact with. As they could never predict which attendant they would have, they couldn't be certain their previous discussions or requests would be respected. Everyone agreed this was a very unsatisfactory start to motherhood.

Obviously, Independent Midwives believe the way we practise gives the best start to family life. A thinking, caring, healthy family means less cost to the NHS. Although we are outside the NHS, we hope to be altering people's, and especially professionals' awareness to another perspective. The group agreed the NHS should provide a homebirth service on these lines as do most Independent Midwives. One proposal would be that midwives be contracted to the NHS, like GPs, with direct access to NHS facilities, i.e. obstetric consultation, use of laboratory facilities and delivery rooms if transfer to hospital is necessary.

We also feel the public should be properly informed of the real risk/safety issue around homebirth vs. hospital birth - the onus being on obstetricians to prove their policies are safer. And last, that midwives be recognised as the best persons to care for normal, healthy women by medical staff and the public.

*Reference: 'We have the Technology'- Nursing Times 20 November 1985

Rosie Brookes/Patti White/Gwen Atwood Tel: 01 278 6783

D6 THE SELF AND THE SENSES (Cancelled)

Why do we have five special senses - hearing, touching, seeing, tasting and smelling? It is because those special senses put us in touch with the five corresponding universal elements which compose all nature - space, air, light, water and earth, in their physical and subtle states.

This relationship between the individual and the universal allows us not only to experience our environment, but also makes it possible to actually absorb these elements into our bodies and minds in order to maintain them in a healthy dynamic balance.

These elements are absorbed, however, not just in the modified forms of food and drink, or heat and breath, or in a general unchanged way, like space, but also in five highly refined forms known to us as sound, texture, colour, taste and odour.

And these in turn are linked to certain complementary activities such as speaking, handling, walking, reproducing and excreting.

So far, twenty factors have thus been listed. And they can all be explored in the course of therapeutic interviews in terms of their excessive use, underuse or misuse. We shall have a chance to explore some of these different measures as they apply to our own lives in the workshop part of the seminar. It will be sufficient to note for the moment that these measures

are the outward reflections of inner states of mind.

In reality, these twenty factors are all associated with a pattern of subtle energies. These energies are arranged in three main streams, each stream having five sub-divisions.

A knowledge of their characteristics and distribution makes it possible to understand a wide variety of symptomatic body experiences, which are not uncommonly interpreted as `just imagination' or as `neurotic'. Whereas actually many body aches and pains are manifestations of specific imbalances in the energy system, before the disease process has penetrated into the physical tissues of the body - which is the point at which modern medicine generally steps in with a more or less definite programme of diagnostic and therapeutic action.

Now the frame of reference from which this article has been drawn may have the capacity not only to illuminate certain problems in psychosomatic medicine as indicated above, but may also throw light on certain other important problems in therapeutic practice. These are: what kind of complementary therapies should we recommend for what conditions; why do different therapeutic approaches sometimes give such confusing and even contradictory advice in treating the same condition; why do some therapies work for some people and not for others; how do we develop a systematic preventative approach using natural factors like food, lifestyle and body care, that will minimise the need for both conventional and complementary medicines; and how do we convey significant medical and health information to the lay public using an intelligible but not too technical language?

In a more sociological context, one of the most serious causes for disease and destruction in our society is the rapid weakening in the natural inner worlds do come into greater harmony with each other, it becomes much more possible to stay with our true selves and still play our parts in the affairs of the world.

Even at the everyday level, there are simple natural activities to guide us towards a healthy, happy and free life. They are convenient, inconspicuous, and actually quite pleasant disciplines. Such, for example, as just sitting quietly for a few minutes two or three times a day, and being aware of the senses and elements around us; or simply looking at a beautiful object for a similar time; reading a few lines from a great work of literature or scripture and reflecting on them for a moment or two; breathing deeply for a little while many times during the day; pausing quietly for a few seconds at the beginning and end of each activity; letting the attention rest fully on the sound of the other person's voice without any interrupting commentary or criticism.

Out of any of these activities may arise moments of heightened awareness, stillness and peace. The experience of oneself becomes more expansive, a deeper insight into the nature of things may arise, as well as a knowledge of the next step that may need to be taken by us.

Such simple kind of practices have been shown even to help people recover from moderately severe mental illnesses. This was demonstrated by the author in a planned and structured project many years ago in Shenley Hospital, St Albans, and in University College Hospital, London.

Thus, only a state of ignorance might delude us into believing that such activities are not important, or that we don't have time for them. For such a state of ignorance brings us right up to the very question of self-identity. And there is no question more important, or more lasting, than that one.

So let us choose one of these activities now and see where it leads us.....(experiential)

It is hoped that a course will be arranged later in the year, probably in autumn or winter, to discuss more fully some of the points raised in this article. The substance of the course will be on the `Science of Life', an ancient science in a new form. Further information may be had from: Dr A. Deavin, 15 Commondale, Putney, London SW15

by Dr Stanley Jacobs - Consultant visiting psychiatrist to Lambeth, Southwark, Lewisham, Camberwell and to ILEA; Executive member of British Holistic Medical Association.

D7 METAMORPHIC TECHNIQUE - Practice and Principles

Metamorphosis uses a gentle massage of the spinal reflexes in the feet, hands and head to facilitate a process of creative change in the person.

This workshop introduced the practice, with participants working on one another's feet, and gave a summary of the principles behind the work and how we can see present-day illnesses and difficulties as related to stresses occurring during the pre-natal period. Yet it is the person's innate power to heal themselves that brings about change.

Examples of how this work is being used in the community, e.g., with stroke patients and the mentally handicapped, were given, and further possible areas of application of this work were discussed.

Claire Glaser 01-831 8367

D8 THE ISIS CENTRE FOR HOLISTIC HEALTH and
D13 THE NEW CROSS NATURAL THERAPY CENTRE

These are two centres which offer alternative medicine with a social consciousness, but no social funding. Each was founded by practitioners using their own funds, supported by bank loans, etc. (See descriptions from pre-conference literature.)

The workshop was attended by about 24 people, who first went round detailing their subjects of interest. Discussion on the following topics ensued:

- Regret was expressed that public funding for such projects was so difficult to find. Practitioners can offer sliding-scales of fees but often feel uncomfortable about it. Yet this seems the best compromise - even for

medically-qualified practitioners of alternative medicine, who feel unable to work freely within the NHS as it is at present.

- Premises are a problem. Both groups lacked the capital to buy property and are therefore operating in rented houses. This is expensive and discourages improvements. Both have poor access for the disabled, having no consulting rooms on the ground floor.

- Each centre houses a number of practitioners with various skills. Each group aspires to a coherent team approach, but finds this difficult to achieve as the various workers are present at different times - a result of commercial constraints. Even so, a fair amount of cross-referral is possible, and case-discussion is very valuable in breaking down the isolation often experienced in single-handed practices.

- Both groups have educational aims, as well as therapeutic, and offer classes in various self-help and mutual help skills.

- Each group has some contact with local NHS agencies. We find that a few doctors (particularly hospital consultants) are very helpful and keen to cooperate, while others (notably certain GPs) are disinterested, rude or hostile. NHS workers in all other grades seem keen on liaison.

- The issue of advertising was raised. One speaker pointed out that doctors (e.g. the BHMA, she said) were particularly wary of associating with non-medical practitioners because they indulge in unprofessional behaviour such as advertising. This really got the group going. On the one hand, the acupuncturists and osteopaths present pointed out that they are not allowed to advertise and so are just as professional as doctors in this matter. On the other hand, the majority of the group declared their antipathy to professionalism. They would prefer practitioners to be allowed to advertise their services, provided this was done in a responsible and accountable way. There is a need for more information about practitioners to be available, not less.

- This raised the issue of how to choose a practitioner. Who to go to? Who to refer one's patients to? There was general agreement that personal referral was best, regardless of other criteria. It was also agreed that a minimum standard of training is valuable in certain fields, particularly those involving active and potentially dangerous interventions, such as
It was also argued that personal qualities and attitudes are sometimes more important than professional training. This is perhaps more true in the less interventionist healing arts such as healing and counselling. It follows that the practitioner has a responsibility to keep themselves healthy, centred and self-aware, to be able to perform well.
On balance, the group favoured the system of Common Law under which anyone can offer their services, provided that they remain publicly accountable for their actions. Professionalism was seen as opposed to this accountability.

- The importance of influencing government policy was raised. This was agreed, with the rider that the most valuable and pertinent action is likely to come from the community, rather than ivory-tower policy-makers. The government should be encouraged to support a diverse range of practices and innovative projects by means of funding at both central and local levels, and by curbing over-restrictive legislation such as the Natural Medicines Act which is currently going through.

The workshop finished with a brief period of silent contemplation, holding hands in a circle.

Isis Centre, 362 High Street, London N17 01 808 6401
New Cross Natural Therapy Centre, 309-311 New Cross Road, London SE 14
01 251 4429

* D 9 CONSTRUCTIVE MOVEMENT

Stretching and strengthening bodywork, when taught in a non-competitive and supportive environment, may be utilised both as a preventive practice, to glean insight into our current an future patterns of health, and well-being and as remedial or corrective techniques. The use of imagery to enhance muscular response and postural change will also be explored in this awareness-through-gentle-streching practical session. No previous experience necessary. Wear loose, comfortable clothes.

Naomi Milne, 38, Alkham Rd, N16 Tel: 01-806 8994

D10 IT'S NEVER TOO LATE (Yoga-based exercises for the Elderly)
Margaret Graham

This workshop is concerned with a system of yoga-based exercise for the elderly. Not just the 'over 60s' sometimes catered for by Sports Centres and Adult Education but for the frailer, older person perhaps already resident in sheltered housing or residential home, or enjoying the support of the local community or club. Most won't have 'exercised' since 'physical jerks' in the playground and would be appalled at the idea of lying on the floor - even supposing they were physically able.

Started experimentally in 1980 at Ifield Park (a voluntary, charitable home in Crawley where I had worked for many years) it was greeted with enthusiasm by its residents. Average age is about 84 and most suffer the usual range of disabilities in this age group. They are, nevertheless, a lively cross section of the community - the nature of this home encourages independence and 'non-institutionalisation'. Their enthusiasm for the twice weekly half hour classes remains unabated.

Why yoga? Partly because I had enjoyed health benefits from its practice and hoped to 'pass it on'. But mainly because the slow, thoughtful movements can be adapted to every individual, even the most severely handicapped. It is easier to find the fine line between effort and strain. Yoga also incorporates breathing techniques, relaxation, visualisation, meditation - all of which can be sensitively included in adapted classes. The yoga title may initially put off some people. Hence the preference for such classes being called 'Gentle Exercise and Relaxation'. No elderly student I know has ever opted out on realising the yoga connection.

Medical research seems to now verify what the ancient yogis knew centuries ago. There is scientific evidence of improvements in health once older people regularly practice such appropriate exercise. Recently a local GP brought a British Medical Journal article to my attention. It concerns osteoporosis - demineralistation of bone, frequently found in post-menopausal women. It says 'Calcium supplements alone will at best only arrest bone reduction.....but a

combination of dietary supplements and a specially devised exercise programme can reverse the process by building up a reserve of bone mass.' The medical profession are anxious to keep arthritics moving, and often prescribe gradual exercise programmes for post-coronary patients. Relaxation is taught in many hospitals for a great variety of conditions.

However, when embarking on our scheme we were careful not to promise miracles. We had no idea what results would appear. In fact, they've been very encouraging. We not only underestimated the body's healing power (even in extreme old age) but also the sheer hard work and concentration the students would put into it. Within weeks they were telling us of 'knobs' on fingers going down; of feet feeling warmer; of being able to reach that zip at the back of the neck; of being able to 'drop off' more easily at night. No doubt there is a physiological element too - but does it matter? Observers soon noticed general improvements in the group - in posture and balance, increased confidence and a more positive frame of mind. After class chat tends to

revolve around improvements in health instead of subtle competition as to who has the worst varicose veins or takes the most pills.

News of our classes spread. There were requests for talks and courses of classes locally. Yoga teachers, care staff, therapists wanted worksheets. In response the British Wheel of Yoga published 'It's Never Too Late' describing our 'experiment' and detailing basic exercises and variations. It has sold far beyond the original yoga field and is being used and recommended by homes, hospitals, geriatricians, community schools 'Elderly' organisations, church groups, etc. But most of all the demand has come from older individuals themselves. Feedback shows similar health improvements to the original group.

The Centre for Policy on Ageing, with the professional help of the Keep Fit Association, 'Extend', British Wheel of Yoga and other such bodies are attempting to list and evaluate the range of 'in house' physical activity opportunities currently available. The ideal we are all working for is good exercise facilities available in every home.

Discussions with BWY colleagues reveal the following difficulties which first have to be surmounted:

(1) Lack of trained teachers

A BWY teaching diploma (or equivalent) is the ideal qualification but suitable people could undertake BWY 'disabled' courses such as currently available at Almondsbury, Bristol (though this is threatened by dwindling finances).

(2) Attitude of staff -

particularly matron or warden from whom others take their lead. Management may be keen, but if staff - perhaps already stretched - don't want the home's daily routine disrupted it will be uphill work or even impossible to make the class 'take off'.

(3) Difficulties arising from heavy medication of residents

It is very hard to initiate the necessary participation if the majority of the group is drugged into doziness.

(4) Lack of finance

Homes or clubs generally expect these necessarily short exercise sessions to be taken by an unpaid volunteer. Much as we enjoy our work 'job satisfaction' doesn't pay the rent! Finance is usually found, either by the NHS Council, home or individual for such visiting professionals as chiropodists, physiotherapists, hairdressers even. We maintain that as we are every bit as necessary to the comfort and well being of an elderly man or woman.

If the goodwill is there these problems are not difficult to surmount. Many older people are demonstrating that they are eager to help themselves - to work for health improvements. Why should they be left out of the 'fitness boom'.

I think it is right that we should respond by providing the right home and community environment, the teachers, the facilities and the money which can bring this about.

MARGARET GRAHAM 59 Ifield Drive, IFIELD, CRAWLEY, Sussex
TEL: CRAWLEY 23951

* D 11 BUSWORK AND HEALTH : STRESS OF PRODUCTIVITY

One Person Operation of buses represents a considerable intensification of work for busworkers - in effect, one person is doing two people's work. The effect is particularly strong in London where road congestion is high and buses are crowded. A sharp intensification of work typically has effects on the health of people doing the job.
The workshop will be showing the video "...And then there was one." The video was made in 1985 by Triple Vision with a grant from the GLC. It shows how the conversion to one person operation has affectred the lives of London bus workers and their health. It illustrates how the continued extension of OPO intensifies the work of those who remain on the buses and causes stress for those who are thrown oonto the dole queue. This procxess disproportionately affects women and black people.
The video is part of a larger project which is investigating the effect of buswork on busworker's health using a survey of busworkers in thirteen garages across the fleet.

Contact: Tina McCrea, Room 4, County Hall, SE1. Tel: 01-633 4610

D 12 BECOMING A RESOURCE TO THE PEOPLE -
THE BIRMINGHAM NURSE PRACTITIONER PROJECT

Barbara Stilwell
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021 4721 301 x 3618

A three year project, which ended in October 1985, sought to evaluate the role of nursing in general practice, by allowing patients open access to a nurse and by encouraging the nurse to practise as autonomously as possible.

This meant that the nurse had to undertake a special training which extended her role into areas previously the province of physicians. The nurse was expected to be able, by physical examination, to detect abnormalities and for some of the commonly encountered illnesses, to treat them herself, sometimes using prescribed medication.

Records were kept by all the doctors and the nurse in the practice, about patients who consulted all of them. Age, ethnic origin and sex were noted, as well as the problem the patients came about and the ones which they discussed. The outcome of the consultation was also recorded (i.e. referrals, investigations and treatment).

Patients' and colleagues' attitudes to the presence of a nurse practitioner were sought by questionnaires. The nursing care offered to the patients was different from the usual medical model expected in general practice. Appointments were for 20 minutes, and during this time the nurse focused on long as well as short term health problems.

Health promotion was therefore an important component of each consultation, whatever the initial reason for that consultation. The style of consultation was deliberately informal: patients called the nurse by her first name, and she did not wear a uniform. Patients were treated as partners in their care, able to accept or reject proferred information.

Open ended questions were used, in order to allow patients to voice concerns of importance to them, and while attempts were made to motivate patients by informing them of the results of, say, smoking or obesity, the information and advice given was responsive to their expressed needs. Emotional and social problems were tackled as valid concerns which impeded healthy development.

In our preliminary analysis we have found that 60% of patients, when given the opportunity to do so, raised non-medical concerns with the nurse practitioner, most of which centred on behaviours affecting health. Patients were enthusiastic about this new style of care, in particular about the opportunities it gave them for asking questions and receiving information in an informal setting.

This research project took place in an inner city general practice, and most patients were working class or unemployed. Such patients are those most at risk from early death from diseases which are often preventable by lifestyle changes.

We are encouraged by the enthusiasm for this style of care, and by its observed effects on behaviour, to hope that nurses who undertake this role in general practice might favourably alter the present unacceptable health inequalities.

`Nurses will become resources to poeple rather than resources to physicians; they will become more active in educationg people on health matters. Nurses can voice the feelings of the people whom they serve, and can give them credibility and reasoned support.' Dr Hafden Mahler, Director General WHO, June 1985 WHO Features No 97

FROM THE 'TOWER HAMLETS HEALTH PROJECT' WORKSHOP 86

D14 WHO CARES ABOUT LOCAL NEED AND THE PUBLIC HEALTH?

Myra Garrett - Tower Hamlets Health Campaign
980 0445. St Margaret's House, 21 Old Ford Road, London, E2

The following article, taken from SIREN the paper of the Tower Hamlets Health Campaign, formed the basis of the workshop discussion.

'Over the years, reorganisation in health and in local authorities have effectively demoted public health concerns regarding prevention and a healthy environment. Remember the old council Medical Officer of Health? A powerful figure, eliminated in the 1974 reorganisation and transformed into the District Medical Officer (DMO) in the health service. The degrading of public health as an issue and a discipline was almost complete.

'Now we have the Griffiths reorganisation, which will do away with the DMO. Although the DMO was supposed to discharge the public health function in liaison with the local authority in truth in Tower Hamlets there has been hardly any activity from either side for years. Exactly what will happen to the present DMO or who will become the 'proper Officer' to liaise with the local authority awaits the arrival of the new General Manager on 3 February. Whoever moves where to which post, it seems likely that public health will be even further downgraded.

'On the local authority side, environmental factors which contribute to ill health often get caught up in bureaucratic tangles. Environmental Health Officers, for example, cannot take the Council as a landlord to Court for a public health violation, yet Council housing conditions continue to worsen. Hackney Council has worked out a system for the EHO's to serve a notice on the Council which can be used by the tenant in Court action. Outside London, notably in Sheffield, Oxford and Leeds, local Councils have established Public Health Committees. These have wide powers, including the selection of nominees to the DHA, FPC, CHC, etc., the environmental health service and liaison with the health authority. They have also set up broadly based consultative machinery to work in conjunction with the Committee.

'The way forward seems to be for local authorities, which are at least democratically elected, to develop the political will to put public health back on the agenda. The Tower Hamlets Labour Party has adopted as part of its manifesto a promise to set up a Public Health Committee. The independent Health Enquiry panel has been presented with evidence from several sources recommending the same, partly as a way of continuing the work of the Enquiry, especially with regard to assessing local need and consultation. The Health Authority has shown itself consistently unable to carry out either of these vital functions.

'A proposal for a public Health Committee will be debated at the Inquiry Open Day. All Tower Hamlets Councillors and political parties have been invited to attend and discuss this initiative. In addition, the Health Campaign will be putting forward a proposal for setting up a 'Health Strategy Group' to carry on the work of the Inquiry and to campaign for the Health Committee in the run-up to local elections in May.

'The outcome of these important discussions will be widely publicised. A Public Health Committee in Tower Hamlets could begin to make a real impression on the unrepresentative and unresponsive Health Authority we have now.

'Contacts in local authorities where health initiatives are being pursued are:

Nottingham Health Strategy Group, J. Ashley, 13 Birkland Avenue, Nottingham

Phil Fryer, Oxford City Council, 109 St Aldates, Oxford

Sue Jenkins, Leeds City Council Health Unit, 2 Hunters Tow, Leeds

Mandy Moore, Health Advisor, Greenwich Borough Council, Riverside House, Beresford Street, London, SE18 6PW

Geoff Rayner, Health Liaison Officer, Lambeth Borough Council, 138 Clapham Park Road, London, SW4

Colin Thunhurst, Sheffield Health Strategy Group, 274 Granville Road, Sheffield 2

John Whitfield, Waltham Forest Borough Council, Town Hall, Forest Road, London, E17

'The following London boroughs reported to the AMA some sort of health (usually liaison) groups: Greenwich, Haringey, Richmond, Lambeth, Lewisham, Waltham Forest, Hackney. AMA has indicated an interest in organising a 'Local Authority's Health Initiatives' gathering.'

The participants in my workshop indicated much interest in these initiatives, although most had heard nothing of them. A London-wide gathering of existing health groups in local authorities and those, like Tower Hamlets, interested in getting something going, would be very useful, especially to those of us in the latter category.

General Feedback chart

ORGANISATION POOR - staff on desks not briefed adequately.
GYM MOST UNSUITABLE for a home group - no heating, bleak and remote.
Some speakers not well prepared.

Moaning Minnies, Yours TINA (referring to above)

``GOD BLESS THE ORGANISERS''

WELL DONE

LOOK FORWARD TO THE NEXT ONE!

To organisers - thanks!

Workshops were best, big plenary sessions don't give much chance for discussion/questionning.
Evening rception was good, pity more people didn`t go. What happened to the vegetarian buffet?

Idea of conference very good but more attention to detail needed. No acknowledgement of application form (so didn't know whether to book in patients for these two days). Not enough time for registration so everything started late. Unheated gym unsuitable and two remote. No facilitators for home groups (programme said there were). Documentation arrived too late. Bad organisation of refreshments (eg milk ran out, hot water arrived late) Robin Murray's talk excellent - set the whole philosophical tone of the conference.

Why no interest in birth control to put a stop to the world's over-population?

The opportunity for more workshops would be nice.

I really liked the idea of the home groups which gave a big conference a human scale. The food was yum, too.
I really liked the breadth of the conference - anything goes! Allowing us to express all of ourselves (or at least many different aspects).

Too many workshops - too little time.

Where were the working classes?

Cancel plenaries and home groups to allow us to do twice as many workshops.

Time-keeping abysmal - lack of courtesy to participants.

All workshops and talks very interesting, thought provoking and useful on some, or many levels. Especially good to have the experiential ones amidst.
Food very, very good, fresh, well presented and plentiful.
Needs to happen again.

Workshops nice and herbal tea much appreciated.

1. Standing conference on Innovation every year
2. National directory of local initiatives produced annually - GLC funded!!

Two workshops in one room is distracting and unsatisfactory.

Childcare provision could have been much better - well meaning and kind women but not happy with my child being in a separate building and planning all seemed very as hoc. V. tiring for parents.
BUT conf in general enjoyable and welcome space for chats.

General feedback contd

Gained a lot. Hope there's another one so faults ironed out. Thank you very much.

Too many interesting workshops on at the same time. More days and spread them out.

Shame no input from well women centres - especially out of London (eg Calderdale (Halifax) - has anyone heard of us)

Very flexible and minimum of bureaucracy - much appreciated.

Too much - drop half the plenaries and allow time for discussion of issues in groups. If such a timetable is planned you need better organisation. But good try and great idea.

It would have been useful to know who everyone else was so contacts could be made. Home groups a good idea but didn't seem to work. Initial group visualisation exercise very welcoming, thanks. Range of workshops very good but as always more time would have been nice.

Time keeping is always a difficulty.

Sent to Coventry because I was a smoker! No freedom of choice on the subject. Where was my Democratic Rights?

Up in smoke!

One does not have a right to put others' health at risk!

No workshop on PMT - why? Also no workshop on menopause.

Seconded.

Oh for a conference hall that did not have nasty flourescent lighting which makes me feel dizzy and exhausted - Whole spectrum lighting please!

Time keeping is important for small groups.

Thanks for all the good energy.

Home groups - nice idea but for me (Gym!) didn't work at all. It would have been nice for non-Londoners to be in home groups with any others from our geographical area. Also a conference list saying where we all have come from would have been really uselful to aid local contacts.

Here, here!

Yes! No-one there 9.20am Friday.

Plenty of Why not enough how.

Well done - thank you - hope there will be another one.

Stimulating and interesting. Glad I came.

Feedback - One Thing that Excited me today

My trip to the loo.

The man in the red jumper!

The things that are starting to happen. Thank God.

Ditto.

The committment to getting holistic ideas across to the general public.

Michel Odent's wonderful pictures.

Yes I agree there's hope.

Lots of good people and good ideas involved.

The women from Glasgow!

The coffee cake.

That so many people have radical new visions of health-care. I'm not crazy after all.

One Thing I Learned Today

How to be a balloon.

There are GPs in existence prepared to work for £9000 pa - what a miracle.

They can walk on H_2O

NOT TO TALK SO MUCH.

that Wendy Savage is a HEROINE.

The GLC is capable only of paying lip-service to confronting institutional racism and sexism.

(Well maybe they are not too bad on sexism)

That too many people are more interested in whinging and doctor-bashing (we all know what's wrong with the medical establishment) than coming up with creative, constructive INNOVATIONS, which is what this conference is supposed to be about.

Here, here

That its not only me who feels really frustrated with the health care system - and that its not only me with some decent ideas for a change.

One Thing I want to see Changed

MEN

... eradicated

The Government (seconded twice)

As if that will make any difference!?

I want to see children taught health education.

One thing I want to see changed, continued:

I WANT TO SEE DOCTORS SHOWN UP FOR THE FRAUDS THEY ARE.

I want to be taught by children.

Public funding for complementary health care - redistribution of NHS resources.

CHAOS

CAKE ON FRIDAY

PMT and MENOPAUSE WORKSHOPS

PERHAPS IF WE DIDN'T STUFF OURSELVES FULL OF CRAP, OR LET OTHER PEOPLE PUT POISONS IN OUR FOOD WE MIGHT BE A LITTLE BIT BETTER OFF!

THE LEADERSHIP OF THE 1st DIVISION (LIVERPOOL).

Can we see some projection of the issues discussed into the future?

MORE STEP-BY-STEP CAMPAIGNING IDEAS PLEASE.

Informing public (eg. of facilities in NHS)

Everything !

HOME GROUP 1

Alex Scott Samuel

Stephen Russell

Mary Twomey

Barbara Stilwell

Mira Dana

Michel Odent

Lee Adams

Anita Ademuye

Ainsworths

Pauline Amos

Adele Anderson

Jean Anderson

Susan Anderson

Daria Archer

F Armstrong

Jill Ayers

Emma Bagg

Alison Barclay

Mel Bartley

June Batheja

Berry Beaumont

Joanna Benson

Ruth Bernard

Graeme Betts

Graham Bickler

Mary Bigelow

Sue Biggs

HOME GROUP 2

Caroline Langridge

Alan George

Christianne Heale

Jean Spray

Pat Wickstead

Dr Kate Ashley

Carrie Birch

Helen Black

Sarah Blackwell

Sue Blenner Hassett

Vera Bolter

Anne Bowling

Julie Bradley

JlKate brown

Pamela Bruckshaw

H.M. Bruton

Ian Buchanan

Bennie Bunsee

Ernest Coates

John Cohen

Miriam Cohen

Norma Cohen

Louise Cook

Anya Cioper

Gerry Cooney

Siop Cooper

HOME GROUP 3

Elizabeth Anionwu

Maggie Cochrane

Christine Smith

Sharonnl Fordham

Clive Chapman

Angela Oxberry

Jenniufer Cousins

Sarah Gabert

Marianne Craig

Maureen Cromey

Jihn Crouch

Elizabeth Cruse

Linda Cullerton

N Cusack

Jane Dammers

Dr Judith Danby

Cllr Daniel

Dick David

Anne Davies

Deborah Davison

Loiuse Dawson

Peter Deadman

A.M. de Carteret

Wendy Dawson

Gill Dennis

Hema Derlukia

HOME GROUP 4

Monty Berman

Leo Pike

Maggie Sanderson

Vari Drennan

Colin Nolder

Cathy devine

Yvonne Dhooge

Cynthia Dickson

NOra Docherty

Helen Doig

Chris Dolovan

Jane Dowsett

Angi Driver

Maggie Falshaw

Gene Feder

Dr Elizabeth Fender

Julian Fifield

Anne Fleissig

Jane Foot

Chris Ford

Lesley Forrester

Jane Foster

M.E. Fox

Brian Fisher

Eric Froggatt

HOME GROUP 5

Patrick Pietroni

Felicity Kelly

Richenda Power

Rosie Brooks

Stanley Jacobs

Pauline GarvionCrofts

Alison Geddes

Lillias Gillies

Mrs Goddard

Elinor Goldschneid

M.T. Goodsonn

Lindsey Graham

Carol Grandison

Angela Greatley

Judy Greenn

Anthony Griew

Sian Griffiths

Liz Quist

Madeliene Halliday

P Harris

Roger Harris

John Harvey

Sandra Hatton

Alison Haworth

Eileen Hayes

HOME GROUP 6

Audrey Wise

Don Nicholls

Robin Rusher

Becky Vidler

Keith Holton

Lynne Howells

Janet Hunter

Antonia Ineson

Patricia Izard

E Jayne

Maggie Jamieson

Christopher hedly

Judith Hemming

M Henderson

Derek Hepstinall

S Jenkins

Lynda Jessop

Jennifer John

Chris Johnston

Katherine Jones

Sally Jones

Shelagh Joyce

Nirveen Kalsi

Fred Kavalier

HOME GROUP 7

Leslie Doyal

Sue Lawson

Naomi Milne

Paula Uddin

Gerry Harrios

Kingston & Esher CHC

Natalie Kennard

Martin King

Stella King

Dr A Kingston

Riva Klein

Charlotte Knowles

J Lacey

Petron Lashley

Sheila Laws

Ms Lenton

georgy Leslie

Margaret Lewis

jenny Leyton

Jim Lin

Dr Anne Livesay

Hugh Lowe

Leonard Lowe

Greg Lucas

H.F. Lunn

HOME GROUP 8

Claire Glaser

Christopher Connolly

Margaret Graham

Julienne Maclean

Jennifer Alert

Joan Mager

Sonya Markham

Rachel Martineau

MlBarbara Maskews

Vanessa Matthews

Elizabeth McAlister

Hazel MCAuthur

Katrina McCormick

Christopher McEvedy

Jane McKears

Angela McKee

Megan McCormack

Penny Mares

Dr Ian Mason

Kathy Meade

Lynn Meritiou

Keith Miller

Mrs Moghaddon

HOME GROUP 9

Louise Parsons

Dr Maureen Roberts

John Yudkin

Janet Brown

Dave Butt

Felicity Moir

Muriel Moloney

Linda Monteith

Olivia Montuschi

Virginia Morley

Suzanne Morris

Mrs MottramEvelyn Muller

Liz Murphy

Pam Muttram

Maurice Newbound

Ann Noble

Alison Norman

Eileen O'Keefe

J.G. Olly

PPeng Ong

Archie Onslow

Nikki Ould

Robert Owen

Beryl Pack

HOME GROUP 10

Janet Brown

Tina McCrae

Manas Marmara

Adi Cooper

H Paine

Martin Pallett

Maggie Pearce

Adele Peronne Dodds

E Peser

John Peverall

Anne Phillips

Jan Pietrasik

John Poole

julian Pratt

Rosemary Price

Soena Purvis

Morgan Pye

Paul Quinn

Linda Reilly

Mrs Richardson

Sue Ripley

Sarah Richardson

Laura Robertson

HOME GROUP 11

Jaquie Neilsen
Lisa Saffron
Fedelma Winkler
Narendra Mehta
Sue Holland
Debbie Clark
C Robins
Katie Rogers
Carmel Rooneyt
Christopher Rourke
Ms E Rourke
Helen Rushworth
Hessie Sachs
Judi Sadgrove
Jane Salvage
Marianne Scruggs
Andy Sills
Michael Silver
Hermit Singh
Christine Shearman
Ms Slowman
Sue Spilling
John Smith
Jan Smithies
Ruth Stern
Rosemary Steel

HOME GROUP 12

Ms Peters
Marion Lockey
L Mabbett
B Lamond
Caroline Hawkridge
Ruth Roth
Dr Marie Stewart
Denise Stirrup
Ms Stromwalls
P Sullivan Jones
Anne Tibbs
Mary Tidyman
Jane Tilston
Hazel-Anne Trotter
A Turner
Helen Utidjian
Desiree Van der Berg
Sue van Morris
Helen Vaughan
AJS Walker
Barbara Wallace
Ruth Wallis
Joan Walters
David Ward
Alison Watt
Jenny Webb

HOME GROUP 13

P Fulton

C Forrester

Brian Hurwitz

Karin Greenwood

Delcia Thorpe

Mark Welfare

Cllr Walsh

Alsion West

Carol Weston

Deborah Wilson

Jacqueline Williams

Stephanie Williams

Gwen Wilson

Greta Wilson

Mary Wilson

Sara Wilson

Jenni Wislon

Valerie Wise

Jane Wood

Anne Woodhouse

Tim Wright

Peri Yousef

SPEAKERS ADDRESSES

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Community Health Co
1 Balham Station Rd
SW2

Monty Berman
2 Hillside
Highgate Rd
NW5

Patrick Pietroni
c/o BHMA
179 Gloucester Place
NW1 6DX

Audrey Wise
c/o the Conference organisers (see inside front cover)

Robin Murray
Room 6b
County Hall
SE1

Organisations Represented at the Conference

Adult Education - McEntee School, Walthamstow

Age Concern, Brent

Arlington House

Balham Family Centre

Blackpool Health Promotion Advisory Service

Braintree College of FE

Brent Sickle-cell Society

Brent Well-men's Clinic

Brighton Natural Health Centre

British Acupuncture Association

British Holistic Medical Association

BHMA Students Group

British Postgraduate Medical Federation

Camden Trades Council Support Unit

CancerLink

Chalkhill Neighbourhood Project

Chequer Centre

Ch'ien Clinic

Chinese Information and Advice Centre

City and Hackney Heart Disease and Stroke Prevention Programme

City and Hackney Multi-ethnic Women's Health Project

Clinic of Chinese Acupuncture

Clissold Park Natural Health Centre

College of Osteopaths

Community Consultants

Community Dentistry - London Hospital

Community Health Councils - Bloomsbury
Brent
City and Hackney
Doncaster
East Glasgow
East Yorkshire
Gloucester
Greater London Association of
Haringey
Kingston and Esher
Leeds West

Community Health Councils contd:
Liverpool
Maidstone
Newcastle
Salisbury
Shropshire
South Birmingham
Southend
Waltham Forest
Wandsworth

Community Health Initiatives

Community Health Project, Edinburgh

Community Medicine Dept - City and Hackney HA

Community Service Volunteers

Community Task Force

Council for Acupuncture

Council for Complementary and Alternative Medicine

Deansgate Health Centre

District Chiropody, Haringey

Edinburgh Women's Health Shop

Endometriosis Society

Good Housekeeping magazine

Greater London Council

Greenwich Health Rights Project

Hackney Health Mobile

Haringey Women and Health Centre

Harrow Rd Clinic

Health Authority - Aylesbury Vale
Bath
Blackburn
Bloomsbury
Brent
Brighton
Cambridge
City and Hackney
East Anglia
Exeter
Hampstead
Haringey
North Manchester
Oldham
Oxford
Paddington and North Kensington
Riverside
Sheffield
South-east Thames
South Birmingham

Health Authorities contd:
South-west Surrey
Wandsworth

Health Education - Addenbrookes Hospital
Brent
Brighton
Hampstead
Islington
Northampton
Northumberland
Paddington and North Kensington
Sheffield
St Georges Hospital
St Leonards Hospital
Suffolk
Uxbridge
West Lambeth
W. Suffolk
Wren Street

Health Education Council

Health Promotion Services

Health Promotion Unit

Health Rights

Health Visitor magazine

Health Visitors Association

Hillingdon FPC

Hospitals - Addenbrookes, Cambridge
National Temperance, NW1
St Georges
St Leonards, N1
St Thomas's, SE1
Whittington, N19

Hoxton Complementary Medical Centre

Independant Midwives Association

Institute of Education

Institute of Kirlian Practitioners

Isis Centre for Holistic Health

Islington and Hornsey Health Emergency

Journal of Chinese Medicine

Kentish Town Health Centre

Kentish Town Women's Centre

Kings College School of Medicine

Kings Cross Centre Campaign

Kings Fund Centre

Labour Party

Learning Network

Leyton Green Neighbourhood Health Service

Limes Grove Practice

Lisson Grove Practice

London Black Women's Health Project

London Community Health Resource

Mansfield Community Health Project

Mary Ward Legal Centre

Maternity Services Liason Scheme

Medical Architecture Research Unit (PNL)

Medical Campaign Project

Metamorphic Association

Middlesex Hospital Medical School

Midwives Information and Resource Service

National Institute of Medical Herbalists

Natural Health Network

Nature Health Associates

Neighbourhood Health Project, Liverpool

New Cross Natural Therapy Centre

North Kenton Community Health Project

Nurse Practitioners

Occupational Health Project, Sheffield

Oxford City Council

Oxford House Settlement

Pensioners' Link

Persona Grata Consultancy

Polytechnic of North London

Pulse Magazine

Radical Community Medicine

Radical Nurses Group, London

Register for Traditional Chinese Medicine

Riverside Child Health Project

Riverside Community Health Angle

Royal Holloway and Bedford New College

Rudolph Steiner House

Salford Community Health Project

Save The Children

Services to Community Action and Tenants (SCAT)

School of Herbal Medicine

Scottish College of Alternative Medicine

Senior Nurse Magazine

Sense: the National Deaf, Blind and Rubella Association

Shoreditch Centre for Complementary Health

Single Homeless in London

Social Services - Hammersmith and Fulham
Lambeth
Mowsecoomb, Brighton

South Bank Polytechnic

SE London Consortium

South Thames College

Steels Lane Health Centre

Thamesmead Family Service Unit

Tower Hamlets Community Health Services

Tower Hamlets Health Campaign

Tower Hamlets Health Project

Tower Hamlets Health Promotion Services

Traditional Acupuncture Society

Training in Health and Race

University College London Health Centre

University of Bradford

Waterloo Health Project

Wells Park Health Project

White City Mental Health Project

Women's Action for Mental Health

Womens Health Information and Support Centre

Women's Health Information Centre

Womens Health Team, Manchester

Women's Therapy Centre

Whole Bookshop, 197 Picadilly, London W1 Tel: 01 734 4511

GLC

Working for London