epidemics hair analysis proved a simple, quick, practical, and accurate method of measuring the body burden.[18 19] Such instances may recur but fortunately they are rare. In general, then, just as the feasibility of a surgical operation is no indication for its performance so the availability of an atomic emission spectroscope is no justification for feeding it with hair digests.

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1 Taylor A. Usefulness of measurements of trace elements in hair. *Ann Clin Biochem* 1986;**23**:364-78.
2 Creason JP, Hinners TA, Bumganer JE, Pinkerton C. Trace elements in hair as related to exposure in Metropolitan New York. *Clin Chem* 1975;**21**:603-12.
3 McDonald LD, Gibson RS, Miles JE. Changes in hair zinc and copper concentrations in breast-fed and bottle-fed infants during the first six months. *Acta Paediatr Scand* 1982;**71**:785-89.
4 Gibson RS, DeWolfe MS. Changes in hair trace metal concentrations in some Canadian low birth weight infants. *Nutrition Reports International* 1980;**21**:341-9.
5 Petering HG, Yeager DW, Witherup SO. Trace metal content of hair. I. Zinc and copper content of human hair in relation to sex. *Arch Environ Health* 1971;**23**:202-7.
6 Deeming SB, Weber CW. Hair analysis of trace minerals in human subjects as influenced by age, sex and contraceptive drugs. *Am J Clin Nutr* 1978;**31**:1175-80.
7 Hambidge KM. Chromium nutrition in man. *Am J Clin Nutr* 1974;**27**:505-14.
8 Gross SB, Yeager DW, Middendorf MN. Cadmium in liver, kidney and hair of humans, fetal through old age. *J Toxicol Environ Health* 1976;**2**:153-67.
9 Schroeder HA, Nason AP. Trace metals in human hair. *J Invest Dermatol* 1969;**53**:71-8.
10 Grandjean P. Monitoring of environmental exposures to toxic metals. In: Brown SS, Savory J, eds. *Chemical toxicology and clinical chemistry of metals*. London: Academic Press, 1983:99-112.
11 Holzbecher J, Ryan DE. Some observations on the interpretation of hair analysis data. *Clin Biochem* 1982;**15**:80-2.
12 Thatcher RW, Lester ML. Anatomically related variations in trace metal concentrations in hair: a comment. *Clin Chem* 1983;**29**:1691-2.
13 Sky-Peck HH, Joseph BJ. The 'use' and 'misuse' of human hair in trace metal analysis. In: Brown SS, Savory J, eds. *Chemical toxicology and clinical chemistry of metals* 1983:159-63.
14 Hilderbrand DC, White DH. Trace element analysis in hair: an evaluation. *Clin Chem* 1974;**20**:148-51.
15 McKenzie JM, Alteration of the zinc and copper concentration of hair. *Am J Clin Nutr* 1978;**31**:470-6.
16 Clanet P, DeAntonio SM, Katz SA, Schneiner DM. Effects of some cosmetics on copper and zinc concentrations in human scalp hair. *Clin Chem* 1982;**28**:2450-1.
17 International Atomic Energy Agency. Activation analysis of hair as an indicator of contamination of man by environmental trace element pollutants. Vienna: International Atomic Energy Agency, 1977. Report IAEA/RL/41H.
18 Bakir F, Damluji SF, Amin-Zaki L, *et al*. Methylmercury poisoning in Iraq. *Science* 1973;**181**: 230-41.
19 Ishihara N, Urashiyama K, Suzuki T. Inorganic and organic mercury in blood, urine and hair in low level mercury vapour exposure. *Int Arch Occup Environ Health* 1977;**40**:249-53.

Consumer representation in the NHS

How important should consumers' views be in deciding the future of health services? How can the opinions of local people be obtained? And how can those views be incorporated in such management functions as planning? These are some of the dilemmas that government, the health departments, and the NHS have faced increasingly since 1974. Until then locally elected councillors had been responsible for both managing local authority health services and representing consumers, while local people selected to serve on hospital management committees performed a similar combined role for the hospital service. In the early 1970s the then Conservative government planned to adopt a similar combined role for health authority members in the reorganised NHS. The Labour government that came to power shortly before reorganisation believed, however, that combining management responsibility and consumer representation could lead to a conflict of interests. Thus separate bodies to represent consumers were established: community health councils in England and Wales, local health councils in Scotland, and district committees in Northern Ireland.

Because the bodies were late additions to a structure that had never envisaged separate consumer representation the bodies' members started life as uncertain about their task as were the health authorities, health departments, and ministers. The diverse activities and experiences of consumer bodies over the past decade reflect this uncertainty. In addition, changes in the organisation and management of the NHS in the 1980s have tended to exacerbate the problems. Meanwhile, central government has been reluctant to review the extent to which consumers are being heard and listened to in the NHS.

The Association of Community Health Councils in England and Wales has thus commissioned its own review.[1] What emerges is that no two community health councils are alike. Some have been actively engaged in health education, health authority planning, and carrying out surveys to determine unmet need in the community. In contrast, others have been largely reactive, responding to national and local consultation documents, monitoring existing services, and helping people with their complaints. The review includes examples of important achievements in all these topics, but of greater interest is the discussion of the conflicts and dilemmas that the councils have faced. Fundamental questions are raised about the future not only of community health councils but also of health authorities.

Four issues stand out. Firstly, the independence of the councils is inevitably limited by their dependence on regional health authorities for finance and on district health authorities for information. Secondly, health authorities' policies may add to the councils' difficulties: one recent example is how community care means that NHS patients become local authority clients and are thus no longer represented by the community health councils. Another example has been the recent managerial enthusiasm for quality assurance, which in many districts has concentrated on measuring consumer satisfaction—in which the community health councils have been active since 1974 but from which they are now in danger of being excluded. Thirdly, the councils have no strong regional and national structure. Thus many key strategic decisions made regionally or nationally are not subjected to consumer views. And, finally, community health councils have to consider whether a formal consumer body within the NHS structure acts more as a safety valve to contain consumer criticism than as a force for change.

What then is the future for the councils? As the Association of Community Health Councils for England and Wales recognises, their future is partly dependent on that of health authorities. The current method of selecting members has resulted in many authorities being dominated by white, middle class, middle aged men.[2 3] If the current demand for democratising the NHS by replacing selection with election continues to gain support then the composition of health authorities might become more representative. What effects such a change might have on services is uncertain, but would we then need a separate body to represent consumers' views? Many people think not, and this is one of the many issues that the association's discussion paper raises and that needs to be considered by community health councils throughout England and Wales.

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1 Hogg C. *Community health councils: a review of their role and structure*. London: Association of Community Health Councils for England and Wales, 1986
2 Klein R, Lewis J. *The politics of consumer representation*. Bath: Centre for Studies in Social Policy, 1976.
3 Steel D. Managing health authorities: one member's view. *Public Money* 1984;**4**:37-40.