HEALTH ON LOCAL RADIO

Sir,
I was interested to read Dr Rogers' account of his experiences in health broadcasting (October *Journal,* 1980). We have had an independent local radio station in Cardiff since April 1980. It has a unique structure: 50 per cent of the shares are owned by the Cardiff Radio Trust, which is a community-based organization, so that the local community has a real say in the running of the station. The participation of local people in the planning and making of programmes is carried out through workshops. There is a health workshop and a workshop for the disabled.

Membership of the health workshop comprises representatives from the local health authority, patient support groups and pressure groups, and members of the general public. The workshop is not responsible for all the health broadcasting of the station. Its functions are:

To stimulate discussion about health broadcasting, i.e. how political issues should be dealt with.

To plan and produce the programmes that its members think are important.

To promote good health education by radio.

To encourage self-help and community action.

Workshop productions have included short health promotion and information advertisements that run with the commercials, a series of programmes for the elderly, interview material from local conferences and on topical issues such as legionnaires' disease, and information about local activities and support groups.

Whilst the radio station benefits from the time and effort put in by the workshop, we too have benefited in many ways. We have learnt how to use the medium of radio for health promotion and how to work together on issues of common interest. (We had feared that the health authority and other official bodies would not be keen to work with pressure groups and the consumers of the service.) We have taken the initiative to encourage and promote health broadcasting, rather than leaving it to the journalists and radio producers. We have learnt what the health consumers of local radio want, and have modified our programmes accordingly. For instance, when we were preparing the series on health and the elderly we had intended to deal with incontinence, stroke and other geriatric problems. However, when we consulted a panel of elderly people, we discovered that diet, finance, accommodation and social isolation were the problems that were more important to them.

In areas where such public participation in health broadcasting does not occur, general practitioners might like to consider setting up similar workshops. Health broadcasting is then influenced by those used to communicating to people in their homes about their common problems, rather than by experts called in by the radio station.

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GRANNY-PROOF BOTTLES

Sir,
We wish to endorse the findings of Pagan Burns and Douglas Jenkinson (September *Journal,* p. 555) on the use of child-resistant containers.

In a study, recently completed, we tested the ability of 74 elderly individuals attending day care centres to open and close the range of child-resistant containers available in Britain. After demonstrating the necessary techniques to each individual, the following number were able to use the containers:

Clic-loc 28 (38 per cent)

Poplok 40 (54 per cent)

Snap-Safe 30 (40 per cent)

Modified (Povey, 1979; Bellamy and Thomas, 1979) Snap-Safe 40 (54 per cent)

These figures confirm the low geriatric acceptability of these containers.

Our findings also show that confusing instructions and poor eyesight were important factors in the subjects' failure to open particular containers.

Burns and Jenkinson suggest that the solution is to supply medicine in conventional containers. This we assume to mean a vial or a screw-capped bottle. Many vials are unsatisfactory because they let in moisture, and those which are effective in this respect tend to be difficult to use (Bellamy *et al.,* 1979). Although screw-capped containers are recommended for the elderly (Gibson, 1978), we found that though many could open them, very few were able to apply sufficient torque to reclose them properly, thus endangering the stability of the contents.

Our conclusion, therefore, is that a container designed specifically for this section of the community is required. Its chief features should be ease of opening and a moisture tight seal.

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MULTIPLE SCLEROSIS

Sir,
I am a 28-year-old SRN with multiple sclerosis. It was diagnosed over five and a half years ago, in France. For over a year now I have had a relapse with no sign of a remission.

On a personal level, the doctors and nurses who have looked after me at various stages and the staff in the unit for the young chronic sick, where I am now (I am usually the youngest), have been marvellous.

However, what has been depressing is an apparent general reluctance to do anything other than feed me, give me a bed, and look after me generally.

I am aware that Norwich is not a research centre, and I also realize that a lot is being done to overcome the problem. I first met with this reaction, which from my side of the fence seems so much like apathy, in correspondence with the Multiple Sclerosis Society. I wanted to know if anyone was collecting data on such basic matters as place of birth, number of siblings, occupation, present abode, family background etc. It may well be that this is already going on, but I have never come across it, and the Multiple Sclerosis Society's reply was negative and dismissive. I've been hospitalized for over a year and in that time have had no treatment other than occasional pain killing drugs and physiotherapy. I do not want any newly diagnosed person to read this and think that they are finished, because they may not be. Perhaps I was one of the lucky ones because I worked for the NHS for four years.