young, whether they write or not." Impulse drove Joyce abroad—to claustrophobic Trieste, where the bora is said to cause madness; to the distracting temptations of Paris; and to windy Zurich, home in the 'thirties of that other great exile, Thomas Mann. He affected not to regret his youthful impetuosity, but like all true exiles he had a love-hate relationship with his native city. And the Irish love Joyce. Critics need reminding that members of the family are entitled to make irreverent comments, humorous or disparaging, about each other; it's bad manners for outsiders to do so.

While Joyce is the star of these essays—the last 60 pages are devoted to a superb clinical history—many other Irish literary characters are lovingly evoked by Lyons. He is at pains to point out that although Oliver St John Gogarty—another of his heroes²—and Joyce fell out, the two men were still capable of longstanding friendships. Gogarty, for example, befriended "AE" (George Russell) and Yeats; among his papers were the temperature charts obtained during Yeats's serious illness in 1929-30, printed here for the first time and providing a diagnostic challenge for medical readers.

"They took it asunder I hurd thom sigh. When will they reassemble it?" Joyce wrote in *Finnegan's Wake*. The value of Jack Lyons's excellent essays is that they continually put the record straight: they should send the dottier critics packing and the ordinary reader back to the masterpieces themselves.

ALEX PATON

1 Lyons J. *James Joyce and medicine*. Dublin: Dolmen Press, 1973.

2 Lyons J. *Oliver St John Gogarty. The man of many talents*. Dublin: Blackwater Press, 1980.

In brief . . .

Incontinence has been claimed to be the most commonly stated reason for non-accidental injury to children. The dangers of unsuccessful management of this quite common condition are therefore obvious. Despite this, textbooks generally devote at most a page to the condition, and the "How to bring up perfect children" books for parents are equally unhelpful. *Nocturnal Enuresis: Psychological Perspectives* by R J Butler (£15 paperback. Bristol: Wright, 1987. Distributed by Butterworth. ISBN 0-7236-0899-7) sets out to change all that. It brings together in a readable way not just the psychological perspectives but the anatomy, the physiology and, to coin a phrase, the sociology of bed wetting. There are chapters on the maternal perspectives, and the chapter on the bedwetting child's view of his condition is excellent.

The appendices on enuresis alarms, books, and guides for parents and questionnaires for children are invaluable. The author's suggested combined psychotherapeutic and buzzer alarm approach has been proved to be highly successful. The book also produces the evidence confirming the uselessness of drug treatment.

A must for all health care professionals responsible for the developmental surveillance of children, the book can also be recommended to parents who want to understand why their children wet the bed, and what they can do about it; and for those of us who remember those grim and dismal mornings of wetness in early life it will certainly strike a chord.

Medicolegal

General practitioners block closure of cottage hospital

CLARE DYER

Twenty four general practitioners, the entire medical staff of a cottage hospital in Tonbridge, Kent, last month won a High Court ruling quashing Tunbridge Wells District Health Authority's decision to close the hospital pending consultations over its future use. Mr Justice Hutchison held that the health authority had acted unlawfully in failing to consult the community health council before taking the decision to close the hospital. The court challenge, brought with financial backing from the hospital's league of friends, has only bought time for the doctors: there is nothing to stop the authority taking exactly the same decision once it has properly consulted the community health council. But in the mean time the news that the nurses' pay award is to be fully funded by the Department of Health and Social Security has relieved the immediate financial pressure that led to the closure decision, and the authority has now decided that its funds should allow the hospital to stay open until 31 March 1989, when further consideration will be given to its future.

The action was brought by a general practitioner in Tonbridge, Dr David Goodridge, and the 23 other members of Tonbridge Cottage Hospital's general practitioner committee, who applied for judicial review of the authority's decision of 12 January to close the hospital on 1 April to allow the authority to balance its books for the next financial year. The closure was described as temporary, pending consultations about the future use of the hospital, which the authority intended to use as an acute rehabilitation unit for elderly mentally ill patients.

The doctors challenged the closure decision on three grounds, arguing that it was unlawful because it had been taken without regard to the doctors' contracts, which required three months' notice, or to the statutory obligation to consult the community health council; and because the meeting at which the decision was taken had been held in private, contravening the Public Bodies (Admissions to Meetings) Act 1960. Regulations made under the National Health Service Act 1977 lay a duty on district health authorities to consult community health councils about proposals for any substantial development of the health service in the district or for any substantial variation in the provision of service. Consultation is not required if the authority is satisfied that in the interest of the health service a decision has to be taken without allowing time for consultation. In this case the authority should notify the council

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immediately of the decision taken and the reason why consultation has not taken place.

Procedure for closure

A health service circular in 1975 about closure or change of use of health buildings (HSCIS 207) provides that responsibility for determining closure or change of use rests with the area health authority (now the district health authority) subject to the formal agreement of the community health council. It makes recommendations for the procedure to be followed when proposals involve a substantial variation in the provision of services. This entails preparation of a consultation document requiring comments within three months from various bodies, including the community health council. In another document dated 7 December 1979 and known as the "de Peyer letter", the DHSS emphasised the importance of implementing the consultation procedures laid down in the circular and pointed out that when circumstances did not permit the full period of consultation community health councils and other bodies should be given as much time and information as possible. It also stated that urgency would not always rule out the possibility of consultation, that the authority should do what it could in the time available, and that temporary closure could, and often would, amount to a substantial variation in services.

The questions for the court were: Did the proposals amount to a substantial variation in the provision of health services and was the health authority satisfied that in the interest of the service a decision had to be taken without allowing time for consultation? Mr Justice Hutchison said that it was impossible to accept that any reasonable authority could have concluded that the proposal did not amount to a substantial variation. Although the proposal was nominally for temporary closure, if carried out it would mean that the hospital would never again open as a cottage hospital. He questioned whether the matter had ever been considered by the authority but said that even if it had been a decision that consultation was unnecessary could not be supported. The crucial question therefore was whether the authority was satisfied that in the interest of the health service the decision had to be taken without allowing time for consultation. The only evidence was the district general manager's statement to that effect in his affidavit. His lordship said that it told him nothing about the views of the authority itself or even whether the matter had been discussed and a decision taken. He could not regard it as evidence that the authority was satisfied on the relevant matters.

In an unreported case on 20 February 1984 Richmond, Twickenham, and Roehampton Area Health Authority successfully resisted a challenge by the local authority, the London Borough of Richmond upon Thames, over failure to consult the community health council before taking a decision to close a hospital. But in that case a reduction in expenditure was urgently needed before the end of the then current financial year, and the evidence was that the authority would have consulted the community health council but for the urgency. In this case the minutes of the relevant meeting made no reference to the community health council or the question

of consultation. Moreover, the proposal was not for immediate temporary closure but for closure some two months later. It seemed that there had been time for some consultation; the authority was facing not a crisis in the current year's expenditure but a problem in its budget for the next year. From the evidence available the matter of consultation with the community health council had not even been considered. If it had been, given that the authority had consulted other bodies, it was inconceivable that an attempt would not have been made to consult the community health council. A further pointer was that the authority did not act as it was enjoined to do in cases in which it concluded that time did not permit consultation.

Decision for closure quashed

A judge has discretion in judicial review cases whether to grant relief even if he decides a decision was unlawful, but in this case Mr Justice Hutchison said he was quite satisfied that the proper exercise of his discretion required that he should quash the decision. When he heard the application in the middle of April the hospital had still not been closed, and the necessary consultations could be made fairly quickly.

On the question of the doctors' contracts his lordship said that although the authority should have had the existence of the contracts in mind and did not, the consequences of that failure were such that he would not be justified in granting the relief sought if that were the only ground on which the doctors could rely. He said that he did not propose to decide whether the decision was unlawful because it was taken in private. He could not conceive that a decision to sit in public would have made the slightest difference to the decision taken.

Not the first case

This case is not the first court challenge to a decision to close a cottage hospital. In 1984, 25 general practitioners succeeded in having a decision for immediate temporary closure of the Northwood, Pinner, and District Hospital quashed.¹ In that case there was a prospect of a deficit in that current year and the proposal was to close the hospital immediately without giving the doctors three months' notice. The decision was quashed because the judge decided that the relation between the doctors and the authority was so fundamental that it was quite wrong as a matter of law for the authority not to have regard to the relation before deciding even on temporary closure. As granting relief to the doctors would result in only a short period of delay before a decision about permanent closure could be taken properly the court exercised its discretion to quash the decision to close the hospital temporarily.

Reference

- 1 Regina v Hillingdon Health Authority, ex parte Goodwin and others. *Industrial Case Reports* 1984, 800.

Is there a risk of penicillin allergy in the children of parents who are allergic to penicillin?

There is always a risk of penicillin allergy occurring in any child irrespective of the family history. Whether there is a genetic predisposition to react adversely to penicillin, something that might be predicted from the family history, is a point that for many reasons has proved difficult to settle in practice. Adverse reactions to penicillin take many clinical forms, are often difficult to distinguish from manifestations of the disease being treated, and are mediated by different mechanisms. Moreover, such reactions are often ephemeral and do not recur after subsequent challenge or treatment. Unlike with well defined IgE mediated immune responses to precisely characterised allergens, a multiplicity of mechanisms that make up clinical adverse reactions to penicillin obscure any inherited adverse immune response of

this kind. It is not even certain that there is an increased risk of adverse reactions in children with clear cut atopic disorders such as bronchial asthma or children with a family history of such disorders.

Thus the doctor should consider a child with a family history of possible adverse reactions to penicillin to be neither more nor less at risk of such reactions than any other child. The decision to prescribe penicillin and the way in which it should be given depend on the usual clinical criteria. Indeed, clinical judgment is everything in assessing patients who may be allergic to penicillin because of the difficulties of intradermal challenge. Negative results convey some reassurance but this can never be absolute.—A M DENMAN, consultant physician, Harrow, Middlesex.