From the Community Medicine Conference

Boycott out of date planning for nuclear war

Government urged to take account of BMA report

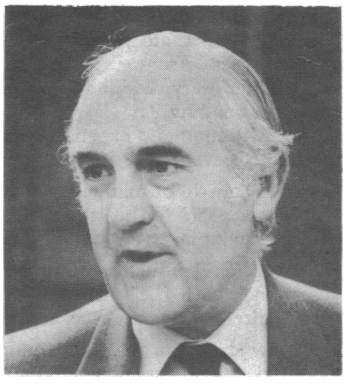
One subject dwarfed all others at the annual conference of community medicine: nuclear war. A procedural attempt at the start of the day to neutralise any discussion on the BMA's board of science report *The Medical Effects of Nuclear War* was roundly defeated, and Dr Stuart Horner, chairman of the Central Committee for Community Medicine, devoted much of his opening address to the conference to the question. Sir John Stallworthy, chairman of the board of science's working party, opening the afternoon's debate on the report, emphasised the sombre warnings on the catastrophic consequences of such a war that he and his colleagues had sounded in their report.

Dr Horner, a co-opted member of the working party, painted his perspective of nuclear war for the conference. "This is either the most important matter that this association has ever considered," he declared, "or we have all been wasting a very great deal of time on an utterly irrelevant subject. Throughout it all I have had to remind myself of one chilling fact. The weapon that man has created and declined to use still remains to be invented. The issue is not if nuclear weapons will be used but when and where."

Referring to his two years of "hard labour" as a member of the working party, Dr Horner hoped that the conference would support the proposal that planning for a nuclear attack should be based on the Department of Health and Social Security's draft circular that was due to be issued in August and not on an out of date one. "I have yet to meet a community physician who believes that the creation of an air raid precaution system envisaged in circular HDC (77)1 has any relevance to the needs of a nuclear catastrophe."

Addressing those who criticised community physicians for being political, the CCCM chairman reminded his audience of their predecessors' campaigns against the private water companies—"those Victorian purveyors of death from cholera"—and against child poverty and malnutrition at the turn of the century, and their recent campaign against the tobacco barons. "We must not tailor our professional advice," he declared, "to the political expediency of the times nor must we say only what our political masters want to hear." It had not been pious resolution that had brought ministers to their door, he said, referring to the visit of two government ministers to the CCCM's May meeting, when the BMA's report on nuclear war had been discussed. It had been the prospect of determined action by the profession. "We face a political climate in which the practice of community medicine will not easily flourish. It will be a very ominous sign indeed if the specialty shows that it is prepared to lie down and do whatever politicians want at the very first important issue it has to face."

CCCM chairman, Dr Stuart Horner.



Dr John Sarginson, chairman of the negotiating subcommittee.

The last of the 1983 craft conferences—the annual conference of community medicine—met on Saturday 18 June. Dr A W Macara, a senior lecturer in community medicine at Bristol University, was in the chair, and he was re-elected as chairman for the 1983-4 meeting. His deputy, Dr David Miles, a district medical officer in Buckinghamshire, was re-elected deputy chairman. The one day meeting heard reports from the chairman of the Central Committee for Community Medicine, Dr Stuart Horner; and the chairmen of the Scottish CCM, Dr H B Brown; the negotiating subcommittee, Dr John Sarginson; and the community health doctors subcommittee, Dr Kathleen Dalzell. The chairman of the working party that had produced the report on the medical effects of nuclear war, Sir John Stallworthy, addressed the conference before the debate on the report. Some of the conference's decisions were published on 25 June (p 2086).

Impossibility of "local" war

Sir John Stallworthy told the conference at the start of the afternoon session that no one who had read the report would be surprised to hear that long before the working party had finished he and his colleagues had realised that "no one on earth knew how big the problem was." After explaining some of the background to the report Sir John said that even among those people classified as "enemies" there was "the same fear, the same hope that a way could be found round the building up and the storing of weapons which could destroy humanity completely." All the authorities had agreed, he warned, that it would not be possible to have a local nuclear war. If there was a major attack a great deal of Europe and America would be destroyed and masses of people would be left to die because nothing could be done for them. "The world as we know it would disappear."

The main debate was opened by Dr David Miles proposing from Buckinghamshire, "that this meeting congratulates the board of science and education; welcomes its report on the medical effects of nuclear war; and believes that it is necessary to plan for: (*a*) all major emergencies, including conventional war, and (*b*) a nuclear attack on the United Kingdom."

Supporting the motion on behalf of Oxford, Dr Alex Gatherer argued that doctors should not read the report as meaning that they should refuse to plan for major emergencies: they should continue to do what they could in planning and educating the community in basic first aid, home nursing, and some aspects of survival.

But Dr S J Watkins disagreed, maintaining that there could be no realistic plan for a nuclear attack. On the periphery of a bomb a district would have more casualties than the entire acute medical services of the country could deal with. Outside the area of destruction doctors would be faced with starvation, epidemics, and civil disorder, without drugs or medical services.

On a more pragmatic note, Dr Joan M St V Dawkins (CCCM) reminded the conference that community physicians were charged with statutory responsibilities. The circular HHC (77)1 was being revised and a draft would be available for discussion in August. Their leaders should now be making representations about providing advice.

Also taking a pragmatic line, Dr A W Tranter (South East Thames) urged community physicians to play their part in planning for the best use of available resources. Their response to this threat should be the same as for any potential need, and he suggested concentrating on the needs of individuals and families. Dr Gabriel Scally, a young doctor from Northern Ireland, however, did not see how anyone could believe it possible to plan for a nuclear attack. It was a waste of resources. Furthermore, the motion prompted the dangerous notion that civilisation could survive a nuclear war.

After Dr John Sarginson, chairman of the CCCM's negotiating subcommittee, suggested that there could perhaps be thousands or millions of survivors and, taking up Dr Tranter's point, argued that much could be done to teach individuals how to care for themselves, the meeting voted. Parts (*a*) and (*b*) were approved, the latter by a large majority.

Present guidance "wholly unrealistic"

Dr Horner, who had temporarily "stepped down" as CCCM chairman for the nuclear debates, formally moved a proposal from his constituency (South East Thames) on planning for a nuclear war:

"That this conference believes that present planning guidance is wholly unrealistic to deal with the health problem which will occur following a nuclear attack and calls upon all doctors to take no further part in such planning until guidance is issued which takes account of the criticisms outlined in the BMA report on nuclear war."

An amendment from Dr David Miles to add "and that the BMA be asked urgently to advise the government on the preparation of such guidance" was quickly approved, after which Dr Vivienne Parker from Yorkshire spoke to the substantive motion. She urged the conference to approve it as it provided an opportunity to persuade their colleagues of the implications of nuclear war.

In Dr A W Tranter's view, however, the conference should reject the motion. The subject was too important to be left to the government; advice and guidance should be a two way process, and if community physicians withdrew that could not happen. He argued that guidance was now available in the board of science's report and he did not want another circular. But according to Dr S D Horsley it would be immoral to continue the charade of planning with guidelines that were unacceptable.

Speaking for the Central Committee for Community Medicine, Dr John Sarginson described the motion as "a crafty compilation of two or three different ideas" put together so that everybody was likely to support at least one part but would have difficulty in supporting the others. The motion implied that it was not possible to plan other than by accepting the guidance that was issued. "What nonsense," he declared, "we have all planned services in some way or another contrary to the normally accepted wisdom."

If the conference insisted on voting on the motion as a whole the CCCM would ask, Dr Sarginson said, that it should be rejected because the committee believed that community physicians had a duty to plan at all times. If, however, the meeting wished to vote on the three separate ideas the central committee would urge it to accept the first and third parts and reject the second calling for doctors to boycott planning.

Although Dr Horner said that he had sympathy for what Dr Sarginson had said, he urged the conference to vote on the motion as a whole.

The conference supported Dr Horner and carried the motion.

The chairman of the conference, Dr A W Macara, with his deputy chairman on his right, Dr David Miles, and the secretary of the CCCM, Mr John Hopkins, on his right.

It then took the meeting only a short time to conclude the debate on nuclear war by supporting a "conscience proposal" put forward by Dr J M Dunlop (CCCM). The motion, from the Yorkshire regional CCM, proposed that NHS staff who for reasons of conscience did not wish to take part in civil defence planning for nuclear war should be excused from it without detriment to their contracts or job security. The conference representatives gave their support despite reservations expressed by Dr Sarginson, who warned that if every community physician dropped out for conscience reasons outsiders might be brought in to do the planning.

Single unbreakable thread: a commitment to prevention

During the morning the conference had dealt with its more traditional subjects, and in the section of his opening address on these Dr Horner referred to the single unbreakable thread that linked community physicians and community health doctors—"a commitment to the prevention of disease rather than its care or cure."

He had been delighted by the support and encouragement from other sources. Regional medical officers had set up health promotion groups, the Department of Health and Social Security and the Faculty of Community Medicine had begun new initiatives, a joint working party on collaboration in local government had produced a report, which would go out for consultation in the autumn, and a further working party was being set up to look at policy advice to the government on the problems of alcohol abuse.

The previous day the executive subcommittee had met Mr Roy Griffiths, who was conducting a management inquiry into the NHS. He had spent over an hour with the subcommittee, which now had a clearer idea of his brief and his approach to his work.

Turning to manpower, Dr Horner said that there were almost exactly the same number of posts established as before the 1982 reorganisation but with fewer community physicians to fill them. "Is there any other specialty that could be confident of recruiting the same number of posts again if the way that its work was done was totally reorganised with an emphasis on doing the same work at less cost?" That, he said, was an emphatic vote of confidence in the specialty.

He was pleased that the community health doctors subcommittee seemed to have reached a substantial accommodation with representatives of the General Medical Services Committee. The problem was whether community health could be squeezed or cajoled into a training structure designed for the hospital specialties and which many believed was inappropriate to its needs or whether the profession could accept that a specially designed training structure was required to meet the evolving needs of a group of doctors whom many in the profession believed to be evolving in the direction of the dinosaur.

The specialty's strongest allies were the junior doctors, who were beginning to recognise that the increasing number of women graduates would be sacrificed on the altar of medico-political expediency if the profession refused to tackle the problem of the career structure. The training programme and the career structure proposed for community health doctors had been designed with the needs of women in mind.

When trainees had negotiated a work sensitive contract based on their out of hours work, Dr Horner said, many senior community physicians had expressed some embarrassment about whether there was any out of hours work. But the Office of Manpower Economics' survey had confirmed the existence of such work and the right of trainees to be remunerated for it. The review body, however, had never made any secret of its objections to a work sensitive contract, and the specialty had to decide whether the present trainees' contract should be replaced by an all inclusive contract as the DHSS and the review body preferred.

Dr Kathleen Dalzell, reporting on the work of the community health doctors subcommittee, which she chairs.

After hearing a concise report on the state of community medicine in Scotland from Dr H B Brown, chairman of the Scottish Committee for Community Medicine, the conference turned to examine the contentious topic of "distinction and meritorious awards." The debate started with an argument whether a proposal from Dr Horner thanking the CCCM for its "thorough review" of the application of the system to community medicine and endorsing the proposals (29 January, p 413) was an amendment or rider to a motion from South West Thames RCCM recommending a review and, if necessary, a search for alternative methods of remuneration. The meeting decided, firstly, to approve Dr Horner's proposal as an amendment and, secondly, to pass it as the substantive motion. Perhaps not surprisingly for such a much discussed matter the short debate threw up no original criticisms or new ideas.

Conference composition

The annual conference of community medicine comprises:

- Three representatives from each of the 14 NHS regions in England.
- Six representatives from Scotland.
- Four representatives from Wales.
- Two representatives from Northern Ireland.
- Members of the Central Committee for Community Medicine.
- Members of the BMA council practising in community medicine who are not members of the CCCM.

All doctors working wholly or mainly in community medicine or in the community health services receive the annual report, which is discussed by regional committees for community medicine. The committees then submit motions for consideration by the annual conference. Motions are also referred from other groups by the joint agenda committee.

Confidentiality

A recent decision by the Law Lords allowed that an elected councillor had the right of access to medical information relevant to an adoption case about which he had "a need to know." This has caused widespread concern not just among doctors, and there was an anxious debate on a motion put by Dr Alex Gatherer from Oxford requesting the BMA council to ask doctors to withhold confidential information from local government authorities "until its confidentiality can be assured." Cooperation between health services and local government was, he said, important—for example, in the case of handicapped children. Discussions were needed to work out acceptable methods.

From Yorkshire Dr A W McIntosh saw the motion as presenting difficulties, giving as an example medical officers in environmental health, who were officers of the local authority. For his part Dr H D Wilson (Scotland) regarded the motion as applying to all information in the possession of the local authority. Some local authorities had medical advisers, and perhaps confidential information might be passed to them. Social workers with whom he had discussed the problem were worried and wanted a solution.

Dr L M Mayer-Jones (South Western), however, objected to the motion, believing that medical information could be edited. The motion might be misrepresented to mean doctors' withdrawal of cooperation with local authorities and that would not be in patients' interests.

There would have to be a change in the law, according to Dr David Bell (Scotland). Dr Mayer-Jones was, he believed,

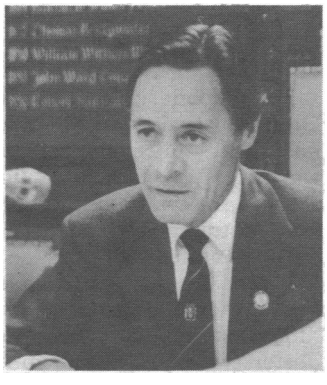
confusing medical information with medical opinion. What patients regarded as sensitive was up to them, so the doctor must treat all information from them with absolute confidentiality.

The chairman, however, corrected Dr Bell, saying that legal advice given to the BMA had stated that it was not always possible to make a distinction between information and opinion in a report.

Dr John Sarginson described a practical example in which the parliamentary commissioner on local government had been concerned. All sorts of people had wanted to see the records about a recommendation for rehousing. The doctor making the recommendation had obtained information from other practitioners as a doctor in his own right; he had obtained this information on a shared basis and, having looked at it, had then made a recommendation to the local authority. Only that recommendation was the local authority's property, Dr Sarginson emphasised. If and when that doctor retired he would have to decide about his confidential medical records; he could destroy them, return them to their originators, or pass them on in a confidential manner to his successor. That mechanism, concluded Dr Sarginson, had been accepted without any question by the commissioner, who commended it.

The secretary of the BMA, Dr John Havard, intervened to explain some of the consequences of the appeal. The decision did not change the law. It had been an adoption case, and the ruling was reached on the basis of the local council's responsibility and the "need to know" principle. When a councillor needed to know, the director of social services examined the records and removed any medical information. If the councillor still insisted on seeing the medical information he had to put his case before the whole of the council. Several proposals had been put forward by the BMA's committee on doctors and social workers: firstly, there should be a code of practice for councillors; secondly, and Dr Havard thought appropriately, there should be amending legislation. What worried him about the motion was whether the conference was firing its guns too soon, with patients suffering if it was implemented immediately.

Dr A W Tranter, district medical officer for Bromley and former deputy chairman of the CCCM.



Dr A W Macara, a senior lecturer in community medicine at the University of Bristol, chaired the conference for the second year. He was re-elected for 1983-4.

After Dr Horner had suggested that it would be wise to pass the motion as a reference to the committee the conference accepted his advice.

Community health doctors

The future of community health doctors has been widely, at times heatedly, discussed within the craft and the profession during the past three years or so. Dr Kathleen Dalzell has emerged as a vigorous proponent of this group of doctors and now chairs their subcommittee, which was constituted in 1980. She opened her report of its work by thanking Sir Douglas Black and the Faculty of Community Medicine for acting as coordinators in setting up the working party to consider training in community health. The working party had been able to see its way through the early training of community health doctors in the context of general professional training, which would be in accord with the prevailing climate of opinion in the profession. Consideration of the advanced training posed a more difficult task, and further discussion was needed before firm proposals could be made. But whatever impediment lay ahead community health doctors remained resolute and intended to maintain progress.

Dr J B Viret speaking to the motion from South West Thames about the appointment of consultant paediatricians with a special responsibility for child health services.

The 1981 Education Act, Dr Dalzell said, had been one of the most important pieces of legislation affecting children that had been passed this century. Its implementation on 1 April 1983 had brought help to 20% of children, though that might be an underestimate of the number of children who had special educational needs, she added. The extension of better educational opportunities to this vulnerable group was a most important development and one to which community health doctors made a unique contribution. The work of community health doctors was much concerned with the early ascertainment and assessment of special educational needs in the formative preschool period.

Health authorities, Dr Dalzell told the conference, had an obligation to ensure that doctors were available to local education authorities to fulfil the requirements of the Act. It could not be right to contemplate even for one moment the dismantling of the service. The training body and the programmes which the subcommittee were pursuing were the best guarantee, she said, of safeguarding this branch of the work of community health doctors.

The motion in the section after Dr Dalzell's speech dealt mainly with the career prospects for community health doctors. A call for a principal medical officer grade was referred to the CCCM, and one, from the Northern Ireland Hospital Junior Staff Committee, urging continuation of the campaign for "posts of consultant status in community health" was passed despite Dr Horner's request that it should be taken as a reference.

To no one's surprise the meeting endorsed the concern of the South West Thames RCCM at the appointment of consultant paediatricians with special responsibility for child health services. Finally in this section, a somewhat ragged debate on a five point proposal ended with the conference agreeing "to support actively the training needs of community health doctors" in child health, family planning, and environmental

health. The representatives declined, however, to support training in adult health or community mental health.

The task of defining the boundaries of community health doctors' responsibilities and relating their work to doctors in other crafts is undoubtedly set to consume yet more committee time.

Later during the morning the meeting accepted some broad brush motions on disease prevention and health promotion. Among these one from Northern Ireland (passed as a reference) set the profession's sights on a national health promotion authority, a parliamentary select committee on health promotion, as well as local health promotion committees. A more modest objective was set by a suggestion (approved) from the BMA's Greenwich and Bexley Division urging the Department of Health and Social Security to look into all aspects of the national immunisation programmes with a view to improving the present figures for uptake.

While the meeting agreed that adequate and accessible facilities should be provided for treating alcohol and related disorders, a terse demand from the Lewisham Division to make it an offence to be intoxicated with alcohol or drugs in a public place was "passed over" because of difficulties in defining "offence," "intoxicated," and "public place."

Terms and conditions of service

To switch to such mundane matters as terms and conditions of service after the "life and death" debate on nuclear war could not have been easy for the conference. But Dr John Sarginson's presentation of his year's stewardship as chairman of the negotiating subcommittee was received with careful attention.

Touching on the consequences of the 1983 review body report he contrasted sadly the changes to the units of medical time rates for hospital doctors with the community physician trainees' inability to secure a more rational and appropriate method for calculating salaries. He hoped that when national agreements had been reached on training programmes for clinical medical officers and senior clinical medical officers more appropriate salary scales could be negotiated. Negotiating a principal clinical medical officer grade would not be achieved until the two others had been sorted out.

Much time had been spent in explaining the non-hierarchical nature of community physicians in a department of community medicine. His subcommittee was suggesting that the chief officer responsibility should be recognised by a flat rate supplement for all population bands added to the community physician scale. The further small supplements to chief administrative medical officers and the teaching supplements would remain. Draft evidence was being prepared for the 1984 review, Dr Sarginson reported. One element was that merit awards should not be abated by the supplement, and discussions on this were continuing with the Central Committee for Hospital Medical Services.

The subcommittee was negotiating a revised edition of the terms and conditions of service and seeking a draft model contract for community physicians. The Department of Health and Social Security had refused to agree comparability with consultants on several points—home to office milage on a regular basis and an extra session for hard pressed community physicians in understaffed departments.

Dr Sarginson told his conference colleagues that the subcommittee was concerned that the position of a community physician should not be filled by someone not qualified to hold it for more than a limited time. Once the acting up salary had been determined, Dr Sarginson said, it was not subject to any incremental progression. Improvements wanted by the negotiators included the same payments for membership of unit management teams as was being claimed for clinicians, and a fairer system of reimbursing trainees' travel expenses.

The major outstanding item, however, was private practice. The DHSS had agreed that whole time community physicians could earn up to 10% of NHS income from private practice. A maximum part time contract would not be available and so private practice would be limited to 10% unless the doctor could secure a part time appointment, and this would be at the employing authority's discretion. There would be a definition of what constituted private practice, but this would be more limited than had first been envisaged. The subcommittee had maintained that all current fees retained under the present terms and conditions of service should continue and should not count towards the 10%. That had been agreed verbally by the DHSS but there now seemed to be some difficulty. Dr Sarginson hoped that the matter could be resolved at the next negotiating meeting in July.

The remainder of the day's proceedings, which were chaired with firm good humour by Dr A W Macara, was largely devoted to the problems of trainees. Dr S J Watkins, chairman of the trainees' subcommittee, spoke of the aim to obtain fairer treatment for trainees' out of hours work, an aim that he feared might get lost in the review body's increasing concentration on junior hospital doctors' problems. The subcommittee had put in a claim for a similar system to that of the hospital doctors, and a satisfactory independent report by the Office of Manpower Economics on community medicine trainees' working hours "strongly supported" this claim, he maintained. Turning to manpower, he said that he wanted proper planning in the specialty and his subcommittee had won a victory in obtaining a meeting of the community medicine manpower advisory committee.

Recruitment a "continuing worry"

Recruitment in the specialty is a continuing worry, and Dr Eileen Wain, a community physician from Yorkshire, had no difficulty in convincing her audience that a "radical review" was necessary of the funding available for recruitment. Most regions, she said, did not fund a sufficiently high establishment for registrar posts, and the resulting shortage of trained staff would continue well into the 1990s.

Before this—and in the face of some opposition—Dr Wain had already successfully persuaded the conference to deplore "the first appointment to community physician posts" of doctors who were not members of the Faculty of Community Medicine and not accredited by the Joint Committee for Higher Medical Training. "Being short handed," she declared, "is no excuse for appointing inadequately trained individuals, and those who do so are no credit to community medicine." A succinct and appropriate sentiment on which to conclude this report on the conference of community medicine.

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