COMMUNITY MEDICINE CONFERENCE

Community physicians' important place in management

Dr A W Macara, chairman of the conference, flanked, on his right by the secretary of the CCCMCH, Mr John Hopkins, and on his left by his successor, Dr Stephen Horsley.

Many doctors in community medicine are still reeling from the effects of the Griffiths proposals on National Health Service management, and doctors in community health are still aggrieved that little progress has been made in producing a satisfactory career structure for them. These two points came across forcibly at the annual conference of community medicine and community health on 14 June. Even so the chairman of the Central Committee for Community Medicine and Community Health, Dr David Miles, sounded a more optimistic note in his brief opening address, describing the Acheson inquiry into the future of public health as a "positive step."

The meeting overwhelmingly supported Dr Lindsey Davies, who proposed that the district management group of each health authority should include a chief medical adviser who was a community physician and who should be a member of the management group regardless of other functions. In many districts, she said, there was no community physician at the management table; he might be there as a unit general manager but that put him in an impossible position. The health authority's main task was to recognise and serve the needs of its population so the public needed a skilled advocate to ask questions and suggest alternative answers.

Having established that, the meeting went on to reaffirm the necessity for community medicine to retain its coordinating role in infectious disease control and environmental health.

Freedom of speech

Several speakers had alarming stories to tell about community physicians who had suffered from speaking their minds. Before 1974 medical officers of health had security of tenure and could speak out freely and give often unpalatable advice to their local authority employers. The meeting heard of one community physician who had been reprimanded for writing privately to his member of parliament about child health services in his district. The letter was leaked and he was told that in future such action would be a disciplinary matter. In Wales another doctor had been disciplined for speaking against local policy. He had criticised on television the centralisation of hospital services.

Dr Joan Black maintained that community health doctors also suffered. Nowadays the doctor had an administrative and a managerial and an advisory role, and as such had to communicate with the health authority and outside agencies, including the social services departments and the education authorities. It seemed to her that the criteria for successful management was how much money could be saved and how many cuts could be made. That brought doctors into conflict with management.

So the meeting resolved that doctors in community medicine and community health needed to have freedom of speech.

Spread of AIDS

The conference was worried about the spread of the acquired immune deficiency syndrome (AIDS) and requested the government to set aside adequate resources to curb the disease before it reached epidemic proportions. If AIDS spread through the heterosexual communities, Dr Edmund Jessop said, the NHS would face a task for which it was not prepared. Specialist infectious disease wards would need to be set up and maintained and preventive measures introduced.

In Oxford, Dr Alex Gatherer reported, it was not possible to use earmarked money to appoint a specialist adviser in health education and other preventive measures for AIDS, but fortunately the city council had come forward with support.

The meeting turned down a motion (*a*) to make AIDS a notifiable disease; (*b*) to make sufferers from AIDS subject to compulsory treatment where appropriate; and (*c*) to make job discrimination against sufferers of AIDS illegal to obviate the fear of being tested.

The chairman of council, Dr John Marks, told the representatives that (*b*) was covered by regulations and that (*c*) would be a breach of a patient's civil rights. As regards (*a*), was there any value in making AIDS notifiable? It was normally spread by intimate bodily contact and there was no evidence that it was spread by coughing or sneezing or washing facilities. So the infected person presented no everyday public health problem. The DHSS maintained that if AIDS was made notifiable it reduced the number of people who would come forward for testing.

Dr A W McIntosh agreed that compulsory notification would be counterproductive. Part (*b*) was unnecessary as there were already powers of detention available, and these had been tested in one part of the country. Education would be much more effective than any form of compulsion. Compulsion to try to eliminate job discrimination would have the reverse effect, making people more resistant to having a carrier in the workplace.

Dr A W Macara, a senior lecturer in community medicine, was in the chair for the last time when the annual conference of community medicine and community health met in BMA House on 14 June. The conference elected Dr Stephen Horsley to succeed him and Dr Eileen Wain as deputy chairman. On 21 June we published a summary of the conference, résumés of the reports from the chairman of the negotiating subcommittee, Dr John Sarginson, and the chairman of the community health doctors subcommittee, Dr Kathleen Dalzell, and some of the conference's decisions (p 1689).

Growth of NHS private practice regretted

Private practice is a subject that provokes sharp debate and the trainees subcommittee hold strong views on the subject, putting forward a motion regretting "the continued growth of private medical practice within the NHS." Dr K G Kelleher, a senior registrar in community medicine, who opened the short debate, declared that health and health care were basic rights and people needed to be free to choose. Private health care meant that the person had to have money to be able to make a choice. The three million unemployed in this country had no choice.

The motion was contrary to the contracts of general practitioners and consultants, Dr Harvey

Gordon reminded him, and also conflicted with the BMA's policy. If private practice was being conducted improperly there were agreed rules for dealing with that and it was up to community physicians and district medical officers to see that the rules were upheld. The motion was "an absolute disaster."

Dr A L J Williams wished that there was a growth of private practice in the NHS because it brought in money. His district had only nine private beds but they brought in welcome income. A computer tomography scanner had been bought by public subscription and income from private patients would help to maintain it.

Forcefully supporting the motion, which was carried, Dr Gabriel Scally said that the representatives were at the meeting to put forward the views of the craft and not of the BMA. Their views should reflect the interests of community medicine and community health and the interests of the population. In his view there was a fundamental contradiction in private medical practice being conducted in the NHS.

Renewed plea for community health consultants

The meeting called for a career grade post of consultant status for senior clinical medical officers. Dr Patricia Anderson wanted discussions with the appropriate bodies to achieve this. This was agreed, though Dr Kathleen Dalzell pointed out that as long ago as 1982 the community health doctors subcommittee had formulated proposals for a career structure headed by a consultant status community health doctor.

Dr Jane Seymour believed that the senior clinical medical officers had seen their position eroded while more and more responsibility was heaped on them. They had more administrative responsibilities as the number of community medicine colleagues had declined. They were called on to train medical students, general practitioner trainees, health visitors, and senior registrars. Yet when they had applied for recognition of their services some had been refused accreditation while others had not applied because they were unsure of the requirements. The meeting agreed with Dr Seymour that there should be recognition of consultant community paediatric status for senior clinical medical officers.

With the surplus of doctors in training in some popular specialties doctors are seeking to switch into community medicine and community health. Dr Stephen Watkins persuaded the meeting to add as a rider "it is urgent and important to correct the misleading idea that the MRCP alone is an appropriate qualification for a consultant appointment in the community child health services or that time expired senior registrars are usually the best appointees to such vacancies." Senior medical officers were being told that they were not eligible for consultant community paediatric posts, he declared, because they did not have the MRCP. At the same time they were asked to take on senior registrars so that these doctors could apply for the posts. This was "one of the most vicious and appalling pieces of professional skullduggery ever to have been practised in the BMA."

Dr Harvey Gordon pointed out that in the real world a higher qualification was necessary to get a consultant post. If the MRCP was not the appropriate qualification what was?

Dr Loraine Lawrence did not deny that the MRCP was important, but it was not the only qualification needed to be a community paediatrician or a specialist in child health. Senior registrars were being told to apply for the posts and that they would pick up the experience as they went along. They should obtain the necessary practical experience before they applied. Dr Patricia Anderson pointed out that paediatric senior registrars could not have accreditation for the community aspects of their work unless they had spent the appropriate number of years gaining that community experience, but it was the whim of the appointments committees that they appointed senior registrars without experience.

Clinical medical officers were not forgotten. The meeting passed without debate a motion deploring the lack of a proper career structure and recognised training programme for community health doctors and called on the BMA council to press for clarification of the present and future role of clinical medical officers.

Eighty trainees a year needed

There should be at least 80 new trainees a year recruited into community medicine, Dr K G Kelleher proposed. He called on the meeting to ask the BMA to support the provision of resources necessary to fund adequate numbers of trainee posts. For some time community medicine had been a shortage specialty but recently a higher number of high quality candidates had been entering the specialty. People were making community medicine their first choice but in some places the money was not available to fund trainee posts. In his view this showed "a lack of commitment by members of the specialty at the top."

The motion was passed despite a plea from Dr J M Dunlop to establish posts of specialists in community medicine first. Otherwise, he said, community medicine would be in the same position as general surgery and general medicine were now, with too many trainees chasing too few consultant posts.

But there were a large number of community medicine vacancies, Dr Gabriel Scally told him. His department of community medicine had five or six vacant posts. He drew attention to the age structure. There was going to be a substantial number of retirements in the next 10 years and it was vital to have trained doctors to step into those positions. Eighty posts a year was a reasonable, rational target for the medium term.

The conference . . .

- deplored the lack of funding for preventive medicine, which the motion described as "better and cheaper than cure."
- agreed that in the light of experience of the present NHS management arrangements a review by the medical profession should take place during the session 1986-7.
- called on the Secretary of State for Social Services to insist that regional health authorities should retain the substance as well as the form of the senior staff contracts which they hold and should cease their widespread attempts at devolution by stealth.
- called on the DHSS to review the procedure for investigating complaints concerning clinical competence of consultants.
- declared that senior clinical medical officers and clinical medical officers had an important function to perform in the integration of the future child health service in the community and should have an adequate career structure, including the recognition of consultant community paediatric status for senior clinical medical officers.
- supported a positive health education programme for schools incorporating alcohol and drug misuse that would have a positive effect on mental health in later life.
- believed that the BMA should allocate sufficient funds to ensure that the findings of the board of science's report, *The Long Term Medical and Environmental Consequences of Nuclear War*, were made readily available to the general public.
- considered community nurses to be an essential part of the primary health care team.

Taking the vote on one of the motions.

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