government to have failed to increase taxation on cigarettes in the 1987 budget, Dr Peter Tiplady said, and his motion from Northern RCCMCH urged the government to increase taxation in each budget so as to increase retail prices relative to 1986 levels. Consumption, he said, could be reduced by fiscal measures.

Dr Gabriel Scally agreed that it was a scandal that the tax on cigarettes had not been increased. To buy votes in the short term would be done at the expense of more deaths in the long term. The cost of the tobacco industry in Northern Ireland was more than £100 million a year. Twenty times as much was spent on the industry in the form of capital grants by the government as was spent on antismoking health education.

The motion was carried.

Separation of two crafts opposed

The association of community medicine with community health caused confusion according to Dr I J Robbe, a senior registrar in community medicine in Oxford, and he proposed that consideration should be given to their separation.

The essence of the confusion was that they had different objectives. Community health doctors were outside the hospital and oriented towards the individual. The objectives of community medicine were related to the health of the whole population inside and outside the hospital. The processes by which the two groups achieved their objectives were also different. The BMA should explore the organisational implications of a separation. Neither group had anything to fear, both were independent specialties with their own credibility and status. But at present there was an anachronism and illogicality about the joint craft committee.

The proposal had come from the trainees in the Oxford region, Dr Alex Gatherer explained, and had been passed unanimously by the regional committee. He did not think that the problems facing the medical profession were going to be solved if the present divisive craft structure continued. He hoped that full consideration could be given to the specialties having their own recognised position.

From the central trainees subcommittee Dr J R Wilkinson vigorously opposed the idea because he believed that there was strong commonality between community health and community medicine.

Dr Peter Grime warned that to pass the motion would mean throwing the baby out with the bath water. He agreed that at times there was confusion but the more appropriate answer might be to change the name of community medicine to, say, public health.

In Wales the problem was overcome, Dr A L J Williams said, by calling the central committee the Welsh Committee for Community Medical Services.

Dr Gabriel Scally suggested that the motion should be carried as a reference because it recognised the reality of the position. If the motion was passed, reference or not, Dr Stuart Horner pointed out, the conference was implying assent. The central committee did not need prodding to think about these issues. A suggestion from Dr Noel Olsen that the committee should produce different options before next year's conference was supported "in spirit" by Dr A W Macara, who believed that there would have to be major changes in the craft committee structure.

Reminding his audience that the proposal for separation always came from community physicians, Dr David Miles said that the two groups had common origins and common links in prevention. It would be selfish of community physicians to separate. If they did the community health doctors would probably retain their own committee in the BMA; community physicians would probably not.

Dr Lindsay Davies, district medical officer for south Derbyshire, reported to the conference on her first year as chairman of the negotiating subcommittee. Little progress had been made but she hoped that a forthcoming joint negotiating meeting with the department would result in satisfactory arrangements for community physicians as general managers.

If the motion was rejected he would take it that the conference did not want the matter discussed during the coming year. He doubted whether his committee would have much influence on changing the whole of the BMA's structure.

Insufficient support for Oxford's proposals led to the motion being defeated.

Using existing information to combat inequalities

Statistics on deprivation collected by local authorities for the Department of the Environment to help in allocating resources should be put to greater use by the NHS in order to reduce inequalities in health. This request for better use of the existing information was put by Dr Peter Grime from North Western RCCMCH. To provide the most efficient and effective delivery of health care health authorities needed more accurate information about social deprivation. The Department of the Environment was provided with information on unemployment, overcrowding, single parent households, pensioners living alone, households lacking basic amenities, population changes, and ethnic origin. The wealth of information available had, Dr Grime said, a real relevance to the findings of the Black report on inequalities in health. He referred to the work already done through the General Medical Services Committee using Jarman scores on deprivation to identify underprivileged areas in relation to primary care, and several local and health authorities were mapping ward boundaries to show variations in deprivation.

Dr Peter Gardner suggested that the motion should say that community physicians should make greater use of statistics because it was what they should be doing all the time. It was widely acknowledged that deprivation had a major effect on health, the CCCMCH chairman said, and he endorsed the motion, which was carried.

The conference . . .

- believed that individual performance review of doctors in community medicine and community health should be carried out by appropriately qualified medical staff and called on the CCCMCH to set up an appropriate framework within which such a review of community medicine and community health staff would be undertaken.
- resolved that a comprehensive record for each child, as proposed by the Child Health forum, was impractical and that the forum should seek other ways of improving communication within the child health services.
- noted with great concern that certain district health authorities were engaged in cutting their community family planning services.
- called on the government to set up an efficient mechanism for ensuring that there was coordination of the activities of the various monitoring agencies involved in dealing with nuclear incidents.
- instructed the CCCMCH negotiating subcommittee to ensure that there was a functional community medicine presence at the most senior level of management in every health authority and that the traditional professional relationship between community physicians and community health doctors in the health authority structure continued.
- believed that the medical examination of a child as defined by the Children and Young Persons Act who was believed to be the victim of sexual abuse should not take place in a police station but in an appropriate environment such as a paediatric ward. The child should be examined by a doctor trained and experienced in child sexual abuse and whenever possible there should be a facility to choose a female doctor. The number of examinations should be kept to a minimum.
- believed that the resources for the prevention and early detection of children sexually abused, which might include long term therapy for the victims, were inadequate and that additional resources should be made available in each district for what was believed to be a widespread problem.

Correction

Annual hospital conferences

In the caption to the picture of the hospital junior staff conference (20 June, p 1624) we called the secretary of the HJSC Mr Chris Hopkins instead of Mr Chris Hartley. We apologise for this error.