

For Debate . . .

Clinical medical officers in a child health service

K WHITMORE, M BAX, SHELAGH TYRRELL

British Medical Journal, 1979, 1, 242-245

Professor Court has emphasised the positive response of the Government to his committee's recommendations for an integrated child health service.¹ But it is the contradiction at the centre of the Government's proposals, to which he has also drawn attention,² that prompts us to be less sanguine about the Government's real intentions. The Department's circular on the Court Report³ is littered with phrases that have potential appeal but may be no more than a repetition of appeasing platitudes. Though it boldly announced "the Government's acceptance of the overall philosophy of the Court Report," it retreated behind an abortive reiteration of the committee's underlying philosophy when it came to showing authorities where to start a review of their child health services.

If the Government has accepted the philosophy and spirit of the report and the "objectives which should determine the future development of health services for children" then what is required is (and we quote from chapter 5 of the report, to which the circular made special reference):

(1) A child-centred service "in which the professional staff are adequately trained and experienced in the special needs of children" (5.4). That is, paediatric competence.

(2) "One service which follows the child's development from the early preschool years, through school and adolescence" (5.10) and is "able to provide families with a single identifiable source to which they can turn for skilled advice and where necessary treatment" (5.12). That is, continuity of care.

Paragraph 5.15 amplified this concept. "An integrated service must include at every level both developmental and educational medicine, as well as the treatment of acute illness. . . . There is no place for developmental medicine which does not see the child also in educational terms. There is also no place for preventive or advisory services which are wholly divorced from treatment services. All trained doctors who are involved in the clinical care of children must be empowered to treat as well as to ascertain, diagnose, and advise. Our argument rests on the nature of current health problems." It might also have been said to rest on the need of parents for services that are "readily available . . . and easy to use" (5.9).

(3) A service which is adequate to reach every child and "must . . . accept a responsibility for taking services to these families who need help, but who have difficulty in using existing services. This in turn means that there must be effective means of defining the child population and greater emphasis on services being territorially planned and organised" (5.16). That is, health cover for all children.

These are the specific objectives which should be defined, for they are cornerstones in the task of remodelling the child health services. They should also be noted by the profession because the rejection of the cardinal recommendations of the Court Committee exposes clinical medical officers (CMOs) once again to an uncertain fate. While we would agree that local circumstances must influence the rate at which integration is achieved from place to place, the nature and extent of such integration depends considerably on national decisions as to the future of CMOs as a group.

The Secretary of State has announced³ that the Health Departments are putting proposals to the profession for the long-term future of the CMOs and "the professional training needs of all three groups of doctors working in child health services." Both steps are welcome but we have grave misgivings about how they are being taken.

The CMOs' future is seen primarily in the context of the child health services and as a matter of concern to the medical profession as a whole. Yet this future is being negotiated only with those who represent community medicine, not one of whom is a child health specialist. Furthermore, no CMOs are present at these discussions as of right. The Department has chosen to overlook both its acknowledgment that "the majority of medical officers employed by local authorities work primarily as clinicians (and therefore do not practise community medicine as defined in paragraph 2),"* and its acceptance of the view of the Hunter working party that doctors engaged full time in Health Service administration (that is, specialists in community medicine) "should form a group distinct from those engaged in clinical practice."⁴ CMOs are now clinicians in the NHS, notwithstanding their anomalous interim status as subordinate staff in an alien discipline with neither the hallmarks nor status of their fellow clinicians in general practice and hospitals—as defined in the context of the reorganisation of the NHS in 1974.⁵ They cannot feel confident that specialists in community medicine are sympathetic to their predicament or determined to resolve it to their satisfaction.

The Department's approach to the training bodies is equally disconcerting. Mandatory training of clinical medical officers is overdue and necessary for their ultimate recognition as equals of principals in general practice and consultants in hospitals. It is now widely accepted that every doctor ought to have received specialist training if he is required to exercise a substantial measure of independent clinical judgment.⁶ We are grateful to the Council for Postgraduate Medical Education for including CMOs on their working party. But the council's terms of reference were restricted to considering only those elements in the CMOs' training in child health which CMOs, GPs, and consultant paediatricians might have in common. But how can such a common core be identified in the training of these three groups of doctors when one group has no recognisable training at all? What is the sense of considering any aspect of the CMOs' training when their full function, for which a specialist training is required, is still being debated? Or so we hope. Indeed, there are ominous signs—not least the joint reference to CMOs as

Thomas Coram Research Unit, London WC1N 1AZ

K WHITMORE, MRCS, DCH, research paediatrician

M BAX, BM, BCH, community paediatrician

Kensington, Chelsea and Westminster AHA, London W2

SHELAGH TYRRELL, BM, DCH, principal medical officer

*Paragraph 2 of Health Service Circular (Interim Series) No 13, 1974.

community health doctors—that the object of the Department's negotiations with the Central Council for Community Medicine is to consolidate the status quo and establish a permanent training and career structure for CMOs in community medicine. That really would be a blatant betrayal of the spirit of the Court recommendations.

Three outstanding issues

Proposals for the future of CMOs in the child health services need to be formulated first. This should be done by a working party which is no less representative of the medical profession than the one which has prematurely considered limited aspects of the CMOs' training and which includes spokesmen for the 2000 to 3000 CMOs—an estimate based on table F11 in the Court Report (volume 2).

There are three outstanding issues to be resolved. Firstly, CMOs, as clinicians in the NHS, should be entitled to provide treatment. Much treatment is undertaken by CMOs but the arbitrary restriction on their authority to prescribe free medical treatment for either internal or external use is inconvenient for the patients they see. It is also quite unwarranted, given the safeguards of competence based on training and the dictates of medical ethics. Perhaps it is an overstatement to describe this as an issue since the Government has accepted the objectives in chapter 5 of the Court Report. But no reference has been made to it in an official statement. The detailed arrangements need to be worked out but there should be no serious obstacles once the professional relationship between trained CMOs and clinicians in general practice and hospitals has been clarified.

Secondly, there is the job of CMOs. They have been regarded and employed as generic clinicians who practise so-called "preventive" health care; they are not supposed to undertake treatment and are available to staff community health services for children and adults alike. Some people would like CMOs to continue to be maids of all preventive work and even jacks of all gaps. In his address to the Annual Conference of Community Medicine, the chairman of the Central Committee for Community Medicine, with which the Department is negotiating the future of the CMOs, called on his colleagues to think of a way to "organise and maintain an effective group of community health doctors concerned with a wide variety of clinical interests embracing child health but not confined to it [lest] we find that we have handed over our future for someone else to determine."⁷ This view was championed in 1974 by the BMA's Public Health Committee.⁸ The arguments were specious and unconvincing then and are largely irrelevant in 1978 but nowhere have we read or heard of any justification for exhuming this outmoded concept.

Moreover, it is incompatible with the principles of paediatric competence and continuity of health care which should govern the future pattern of our health services for children. Nowadays all doctors need to specialise. Today's generic CMOs will need in future to restrict their area of clinical practice. To specialise exclusively in preventive care of patients of all ages is no longer an option because it does not meet children's needs. Furthermore, medical knowledge has advanced to a point when it is no longer possible for one doctor to be as competent as the public have a right to expect in every aspect of individual preventive health care from infant feeding, through the management of maternal stress and the health problems of inner city residents, to the care of the elderly. It is doubtful whether doctors not working full time in such a wide sphere could maintain sufficient competence, and two out of five CMOs work part time or sessions.

The alternative would be for CMOs to specialise in the comprehensive health care of either children or a particular group of adults. This is already the trend, with approximately 54% working only in the child health services and 6% solely concerned with either family planning or geriatrics. Most CMOs favour such specialisation⁹ and it should be formally adopted as a matter of policy. This would provide a rational basis for the training of CMOs and the integration of preventive and therapeutic care with hospital and community services. A sizable minority of these doctors would like to continue their present function but in planning for the future the needs of clients must take precedence of the preferences of individual practitioners. The best interests of children (and probably of adults) can no longer be served by generic CMOs.

The third issue is closely related to the previous one: the professional identity of CMOs. In future they must continue to work largely in the community and more closely with GPs and consultants, particularly if they are to be more concerned than now in the treatment of children. But working more closely with other clinicians is not the same as sharing with them a sense of professional identity that stems

from common membership of a small group of like-minded clinicians with a day-to-day professional relationship. This cannot be provided by attachment to the staff of an area health authority (AHA). It can be provided only by close association with one or other of the existing groups of clinicians or by the establishment of a new and separate group of clinicians who work in the community.

The newly formed Association of Clinical Medical Officers recently sent a questionnaire to as many CMOs as it could to obtain their views on the present position and on their future clinical responsibilities and status. Four-fifths of them were dissatisfied with their present organisation and status. They were asked to put in order of preference the three clinical groups with whom they might be associated. Of the dissatisfied doctors 18% wanted as their first choice to work from general practice as a member of a primary health care team; 34% would prefer to join with consultant paediatricians and work as a member of a combined district paediatric and child health service; and 41% were in favour of organising themselves as a third group of community clinicians, independent of general practitioners, consultant paediatricians, and community physicians.

Working in a primary health care team

Continuity of health care during the preschool and early school years could be ensured for most children registered with a group practice if CMOs who were school doctors worked as members of the group practice. In rural areas this pattern of organisation could be as effective as the participation of selected general practitioners in educational medicine in local primary schools.¹⁰ But it has serious limitations for the continuity of health care of secondary school children and would be difficult to apply in densely populated urban areas where the need for more comprehensive health care is most urgent. It could not ensure that comprehensive health care reached all children, for general practice does not at present accept any obligations to offer health care to those who do not seek it, nor does it show any sign of restricting its services to geographically defined populations.¹¹

Though attractive to many CMOs, this alternative is now only of academic interest. In rejecting the concept of the general practitioner paediatrician general practice has turned its back on this route to integration and also on age specialisation. This must not preclude every effort being made to find other ways for CMOs and JPs to work more closely. The Royal College of General Practitioners would also welcome this¹² and with mutual goodwill it could be achieved. Perhaps some form of attachment of CMOs who practise developmental and educational medicine would be the best way. Attachment, however, offers no solution to the problem of the CMOs' professional identity.

Working as a separate group of clinicians

Most CMOs who have expressed an opinion say that they will not tolerate a subordinate status "on the staff of" and "under the operational control of" specialists in community medicine.⁵ It is unlikely (were they to be given an opportunity to comment) that they would be any more receptive to the alternative prospect that community medicine specialists have to offer: that they continue to be on the staff of the community physicians; that their career grade as clinicians should be senior medical officer; and that the grade of CMO should be a combined training grade for both specialists in community medicine and for senior medical officers, as well as a basic grade for doctors who wish to remain clinicians in preventive medicine but do not seek to become senior MOs or fail to achieve this grade.

In this way community physicians would retain their control of CMOs and maintain the traditional avenue for recruitment to their own specialty. But once again the interests of the CMOs would be relegated. The chairman of the CCCM has expressed fears for "our future," but to whom does he refer: CMOs or community physicians? Does he really speak for both? Specialists in community medicine still seem unable to comprehend that clinicians working in community health services "... form a group distinct from ..." specialists in communal health and health service administration. They need a different training for what is a different career, and we see no good reason why CMOs should be regarded as the principal or most appropriate source of recruitment for community physicians. It would probably benefit the whole administrative structure of the NHS if such recruitment were to be more widely based.

The proposal for the future status of CMOs is objectionable on two further counts. In no other section of the NHS is there such a rag-bag

grade as "clinical medical officer." There should be a separate training grade and then career grades, and no doctor should be employed in a post for which he or she fails, for whatever reason, to acquire the necessary expertise. The readiness of health authorities to employ CMOs in their preschool and school health services who are manifestly incompetent for the work has been near disastrous for these services. Above all, however, for CMOs to continue their present professional association with community physicians would be to perpetuate a tripartite clinical health service for children.

In our view, therefore, CMOs have no option but to withdraw from their present affiliation with community medicine. To become a separate group of community physicians would not mean that they would, even if they could (and they cannot), work independently of specialists in community medicine or independently of doctors working in primary health care and hospital services. The preventive child health services could easily continue to function as they do now. It is not necessary for the CMOs to be on the staff of community medicine specialists in order to staff the services these specialists administer. Hospital consultants are independent in this respect, as are the many hundreds of GPs who practise education medicine in local education authority schools. While there are obvious reasons why CMOs should not be manacled to community medicine a totally independent status would not be particularly beneficial for the child health services or for the doctors. It would contribute nothing towards continuity in the health care of children or to co-operation and better communication with GPs and hospital staff. And, like the CCCM's proposal, it would perpetuate a tripartite clinical service.

Comprehensive district child health service

The third alternative would be for CMOs who at present work in community child health services to join with the doctors working in the paediatric department of the district general hospital to form a comprehensive district child health service. They would be appointed by AHAs to specified posts, defined in terms of the responsibilities these would carry, the sessions they would need to undertake in health service clinics and maybe hospital clinics, and the schools they would be required to attend. They would be members of the district paediatric (cogwheel) division and they would establish a close working relationship with the present hospital-based paediatric consultant and registrar. Some of them would participate in the development and running of the district handicap team.

Through their sessions in schools and clinics outside the hospital they would retain some responsibility for the individual health care of geographically determined populations of children, which is important in ensuring health cover for all children. They would still need the administrative backup that AHAs already provide. As appropriately qualified members of such a comprehensive service their occasional participation in the therapeutic care of children in the district might more readily be arranged with primary health care teams. Part-time attachment to a group practice would still be possible and desirable, reciprocating the appointment of some GPs to clinical assistant posts in the district general hospital.

Bogeys to be refuted

There is nothing new in this suggestion for a district child health service. There was regret that it was not adopted in 1974.¹³ Scotland advocated such a pattern of child health services in 1973¹⁴ and is still waiting (for the outcome of "Court") to implement it. Time and events have ripened the concept and it would be folly for this country to discard it again. The pros and cons of this pattern have not been spelt out in recent years but the Public Health Committee of the BMA saw two disadvantages which need to be refuted, because they are bogeys which persist today.

The first of these is the obsessional fear that hospital paediatricians would take over the preventive child health services, which would then be swamped to the point of virtual disappearance. There are, however, three times as many CMOs as consultant paediatricians. Their imminent specialist training, together with a new-found confidence in themselves as a result of the Government's and the professions' recognition of the importance of the preventive child health services, will ensure that they are not swamped. Furthermore, there is no evidence

that paediatricians as a whole have any desire, which is a pity, to be concerned with routine health surveillance of children. And if it is a sense of professional identity that CMOs seek, they would do well to ponder on the alternative proposal that they be "formally absorbed into community medicine."¹⁵ CMOs, who provide personal health services to children and often have a DCH, have a greater affinity with paediatrics than with population health and health service administration. Even so, we do not see the present position as a choice between two evils, nor as a takeover or a process of absorption. It would be a desirable amalgamation with mutual benefits.

Such an amalgamation would do much to break down the artificial barrier between preventive and therapeutic services erected and maintained by the tripartite organisation of the NHS. It would help to dispose of the myth that hospital paediatricians are neither interested nor concerned with health promotion, help them to see children in educational as well as developmental terms, and facilitate their greater participation in the services outside the hospital. For many CMOs an amalgamation would satisfy their need to be associated with a group of like-minded clinicians, and the group would be based on the district rather than the area and thus be smaller and less dispersed. Furthermore, such a change would be rational in terms of training, for in the early stages the training of consultant paediatricians and of CMOs would have much in common, with therapeutic and preventive content for both courses. Only at senior registrar grade would the apprenticeship and training diverge significantly.

The second disadvantage is that it might lead to a permanent, whole-time subconsultant grade. This has been another bogey long bedevilling discussion about the future of CMOs. But as such a grade is universally disliked and totally unacceptable to CMOs it is now an irrelevance. There still remains the underlying problem for which the notion of a subconsultant grade was an unimaginative and futile solution. This derives from the fact that CMOs are now clinicians in the NHS whereas the NHS was neither designated in 1946 nor modified in 1974 to accommodate them. It is a problem that becomes more urgent as the time draws near when all CMOs will have received specialist training. After three or four years' clinical training no doctors in their right mind are going to opt for a status inferior to that of their clinical colleagues in the NHS. GPs are now recognised as specialists in primary care and while their specialty is different from that of hospital consultants their status as clinicians is not regarded as being subconsultant. Reorganisation and training point to the inescapable need for clinical medical officers to be registered as specialists, with a distinctive clinical function complementary to that of a principal in general practice and a hospital consultant and inferior to neither.

On completion of their specialist training doctors working principally in Health Service clinics and schools should be known as "community paediatricians." This would make clear to the public that these doctors are specialists in the district child health services. At the same time it would recognise that their primary interest would be in the health of children at home and in school, in contrast to the primary task of the consultant paediatrician in the care of children at the hospital. Designation as some kind of "medical officer" would be wholly inappropriate for their modern image.

In arguing for a comprehensive child health service we are not campaigning for alternative 24-hour therapeutic and preventive services in competition with the services provided by GPs. Nor do we seek to exclude GPs with a special interest in child health from the district paediatric division. We see the community paediatrician as supplementing health surveillance of children in a district; providing treatment where this is indicated and convenient, through their arrangements with or their attachment to general practices; advising the staff of various institutions for children in the district—for example, schools and day nurseries—and, with their nursing staff, supervising the health of the attending children; and co-operating with GPs and the district handicap team in the long-term medical

care of handicapped children. As doctors specialising in certain aspects of the clinical health care of children it seems logical that they be affiliated with other doctors in the district who specialise in other aspects of child health care.

It has been argued that the loss of operational control of CMOs and their participation in a district rather than an area child health service would undermine the function and executive responsibility of the specialists in community medicine vis à vis local education authorities. Regrettably, the Government has chosen not to review the responsibilities of these specialists because there are significant anomalies in their present task.¹⁶ But even as currently defined a district child health service would enhance rather than diminish their function. In addition, an experienced community paediatrician could effectively maintain liaison between the district and the area specialist (child health) without the need for creating yet another management post in child health services at district level.¹⁴

Some CMOs have wondered whether instead of a national pattern the organisation of child health services in different areas should be flexible; after all, the Department favours a varying pattern for integration. The danger in this laissez-faire approach is a continuing drift towards more fragmentation of child health services and increasing discontinuity in the provision of health care during the preschool and school years, to which a boost has unfortunately been given by the Department's encouragement to GPs only to play an increasing part in the preschool preventive health services. National guidelines are essential in the form of decisions at national level on the crucial issues to which we have referred if a rational training is to be designed for CMOs and if, as Professor Court has urged, the preschool and school health services are to be strengthened.

While we believe that in future all CMOs must specialise we realise that not all will want to do so in child health care. The future of most CMOs, however, is inextricably bound up with the future of the child health services and they could become

members of a district service. Nevertheless, the pattern is appropriate for those who opt for other specialties. The obstetric and gynaecological services, for example, need to have doctors providing the community element in an integrated district service and so do the geriatric services.

References

- ¹ *Fit for the Future: Report of the Committee on Child Health Services*, Cmnd 6684. London, HMSO, 1976.
- ² Court, S D M, *Lancet*, 1978, **1**, 653.
- ³ DHSS, *Health Services Development: Court Report on Child Health Services*, Health Circular HC(78)5. London, DHSS, 1972.
- ⁴ *Report of the Working Party on Medical Administrators*. London, HMSO, 1972.
- ⁵ *Management Arrangements for the Reorganised National Health Service*. London, HMSO, 1972.
- ⁶ *Report of the Committee of Inquiry into the Regulation of the Medical Profession*, Cmnd 6018. London, HMSO, 1975.
- ⁷ *British Medical Journal*, 1978, **2**, 376.
- ⁸ BMA, *Report of a Special Working Party on Public Health Clinical Medical Officers*. London, BMA, 1974.
- ⁹ *Lancet*, 1978, **2**, 851.
- ¹⁰ DES, *The Health of the School Child, 1964 and 1965: Report of the Chief Medical Officer of the Department of Education and Science*. London, HMSO, 1966.
- ¹¹ Richardson, I M, Howie, J G R, and Dingwall-Fordyce, I, *Health Bulletin*, 1975, vol XXXIII, No 4, 156.
- ¹² RCGP, *Report of the College on the Report of the Child Health Services Committee*. London, RCGP, 1978.
- ¹³ *British Medical Journal*, 1974, **1**, 348.
- ¹⁴ SHHD, *Towards an Integrated Child Health Service: Report of a Working Party on Child Health Services*. Edinburgh, HMSO, 1973.
- ¹⁵ Alberman, E D, Morris, J N, and Pharoah, P O D, *Lancet*, 1977, **2**, 393.
- ¹⁶ DHSS, *Operation and Development of Services (including school health services)*, NHS Reorganisation Circular HRC (74)5. London, DHSS, 1974.

(Accepted 13 October 1978)

A Modern Epidemic

Road accidents and legal sanctions

BY A SPECIAL CORRESPONDENT

British Medical Journal, 1979, **1**, 245-247

Willett tells of a motorist who on being stopped by a policeman after nearly hitting a pedestrian on a crossing reacted with "Mind your own bloody business" and "I'll show you," repeatedly regretting that the police had nothing better to do.¹ He was fined £3 with 28 days to pay for this offence. The unpleasantness and the meagre end-result of so many cases combine to give the police a discouraging job, and inconsistencies in the outcome of cases is helpful neither to the police nor to the public. Although accidents clearly are not always associated with traffic offences, penalties for offences may play an important part in road safety.

Penalties and their credibility

Penalties for traffic offences, like any others, should both discourage the individual concerned from repeating the offence

and deter the community in general. To be effective they need to be prompt, inevitable, consistent, and appropriate to the individual case.² Too often they are none of these things.

An immediate fine, however minor, may have more meaning for the offender and therefore more educative effect than one that follows weeks later; should not Britain, like several other countries, introduce on-the-spot fines by the police for the lesser offences,² which would also simplify administrative and legal procedures? Common complaints about the existing system of penalties, which range from endorsement of the driving licence and fines to disqualification and imprisonment, are that they are inconsistent—between different courts and different offenders—and often too mild to be truly deterrent. A driver, for instance, may be quite prepared to risk a fine of up to £10³ for the convenience of parking in a dangerous place. Of the fines for driving after drinking and speed limit offences in 1976, the largest numbers were of £51-£100 and £11-£20 respectively, but many were less.

The Magistrates' Association has recently issued new guidance on penalties for road traffic offences—both maximum figures