disability and distress inpatients suffered was also unaffected. The duration of all monitored clinical signs was unchanged. . . . Medical opinion on inpatients' progress was not altered by AMS." "... admission screening had no impact on the speed with which treatment was begun." It was found that 25% more AMS patients than controls had a consultation for a second clinical opinion. Costing showed that AMS increased hospital expenditure by 5% and increased laboratory costs by 64%. This was partly because the doctors who had the benefit of AMS subsequently asked for more tests on their patients. Altogether AMS increased investigations by 78%. The doctors who did not get AMS results asked for only one-third of the tests that their colleagues subjected to AMS did. As is the way in scientific papers, the authors underplay their conclusions by saying that it would seem "unreasonable to advocate the introduction of this kind of hospital multiphasic screening procedure into the current teaching hospital framework. It is hoped that these findings will now foster future work on the evaluation of discretionary investigation."

I like that understatement and appreciate it because I know two of the authors, but it should be screamed from the housetops. It has enormous relevance everywhere in the developed world. It shows a most rare common-sense scepticism in the very people who might be expected to build empires, yet they look at part of that empire and say it is of no use for this purpose. And not only

is it no use: it seems to generate peculiar anxious behaviour in the doctors actually at the bedside. The AMS seems to have made them unsure, so that they needed further bolstering from the laboratory to treat their own anxiety. And they consulted colleagues more often. All of us at the bedside know the feeling—the wanting to explain everything and not miss anything. The more information you have the more you want, but it may have no relevance for the patient.

Of course, the trial took about two to three years and it entailed much hard work but the outcome was well worthwhile. It stopped the advance of some potential nonsense. So much in medicine today needs this kind of investigation. In many areas we are in a self-perpetuating roundelay, churning out the old refrains, and not knowing how to stop them. What we need so badly are a few brakes firmly applied to both old and new projects which may be trivial, teetering, and not of the least value, either in non-financial or financial terms. But it takes courage to look at our practices and say that they are useless and even unproductive. So hurrah for the IMVS, for they have shown the way!

Reference

Durbridge, T C, *et al*, *Medical Journal of Australia*, 1976, 1, 703.

What I would say to the Royal Commission

Community medicine attitudes

N S GALBRAITH

British Medical Journal, 1976, 2, 805-806

One of the main problems of the reorganised NHS is the allocation of resources between prevention and the more immediate and pressing needs of cure and care. Medicine had little influence on the health of the population until this generation, but, despite this, the NHS has been designed as a service for the sick, particularly for the acute sick and particularly for their hospital treatment and care. Furthermore, much modern curative medicine has been so successful that the public now expects medicine to find a "cure" for every problem. It is partly these unrealistic expectations and partly the sickness orientation of the NHS that are leading us in what is likely to be a vain quest for health by developing more and more advanced hospital care provided by more and more highly trained medical and technical staff.

The recent document, *Prevention and Health; Everybody's Business*,¹ has pointed out the need for more emphasis on prevention, but such a change of emphasis needs a change of attitude, both medical and lay, as well as a reallocation of

resources. The starting point would seem to be, therefore, education: on the value and limitations of medical care; on the use of medical services; and on the prospects for prevention. This document is a welcome beginning, which I hope the Royal Commission will wish to see extended by a greatly increased commitment to education for health.

Community medicine

Community medicine has a specific responsibility for the health of the population, and for preventing disease, as well as for planning services for the sick and handicapped and is, therefore, in a key position to study and evaluate the distribution of resources.

In the metamorphosis from medical officers of health to community physicians, however, the doctors working in the specialty lost the administrative and statistical support they need to carry out their work. Furthermore, they acquired management tasks in the new NHS which have eclipsed their preventive tasks, so much so that the specialty is now seen as "management" and has been included by the DHSS in the management standstill and threatened with a 5-10% reduction in staffing. There can be little future for prevention if the main practitioners are working full time in management, if their support is limited to secretarial staff, and if their establishment is frozen and likely to be reduced. The Royal Commission should review the organisation of community medicine.

Department of Community Medicine, City and East London Area Health Authority (Teaching), Addison House, 32-43 Chart St, London N1 6EF

N S GALBRAITH, MB, FFCM, area medical officer

Medical managers are necessary, but giving the managers additional tasks of epidemiology (as applied to the prevention of disease and to health care planning) has, in practice, led to the neglect of epidemiology. Theoretically, combining the epidemiologist and manager in one job should be an effective way of bringing epidemiological influence into the health services, but experience of the first 2½ years of the reorganised Health Service has not shown this to be so. I suggest, therefore, that the Royal Commission should consider two distinct types of post in community medicine: managerial, and epidemiological. The former would be made up of the existing regional and area medical officers and district community physicians; and the latter would include the specialists in community medicine who have received such labels as "information," "health care planning," and "environmental health." Whether these epidemiologists are based at region, area, or district is not important so long as they provide support for the medical managers and their teams at all levels. To provide the effective support needed, the epidemiologists must not work isolated in their regions, areas, or districts, but should be co-ordinated nationally and given the statistical, sociological, administrative, and clerical back-up necessary for their work.

Health information

At present we are surrounded by masses of data and volumes of statistics, but they produce little information which enables us to make rational use of our resources. With a nationally co-ordinated epidemiological service there would be more hope of providing detailed comparable data, more reliable statistics, and improved information. The Royal Commission should consider, therefore, bringing together statistics, social science, information and epidemiology into a nationally co-ordinated service.

An example of the need for such national co-ordination is the current activity in all regions to determine a more equitable distribution of resources according to need between their constituent areas. Is it really necessary for this same task to be undertaken separately in the 14 regions? Will all the multi-district areas have to repeat it again to allocate resources to their districts?

Resource allocation

Two aspects of resource allocation of particular concern to London teaching areas are already causing considerable problems: the allocation of resources for teaching, and the allocation of resources among the geographically small area health authorities in London (with boundaries that have no meaning in health care).

The allocation of resources for teaching has been complicated by teaching students outside the university hospitals, both in other hospitals in the area or region and in primary care and the community. The secondment of students away from the university hospital in this way will not cost less, but will, rather, increase the cost of teaching because of the additional service expense in extending the teaching in previously non-teaching parts of the NHS. Should not the staffing levels, for example, in community medicine in teaching areas be increased to take into account the teaching commitments of community physicians?

The second problem in London is that small geographical areas with artificial boundaries lead to patient flows from one area to another, particularly for hospital care, and this tends to invalidate any formula for allocating resources on the basis of population. The Royal Commission should consider whether the hospitals in Greater London should be financed as a whole, rather than separately in the artificial areas and districts; whereas the primary care and other community services could be financed on the basis of district or borough populations.

Such a suggestion would seem to be contrary to the philosophy of the integration of health services, but it need not necessarily be so and is mooted to show that the special problems in London may need special solutions.

The administrative structure

Difficulties have been created for community medicine in the reorganised NHS, not only by the confusion of management and epidemiology, but also by the management structure, which has divided community medicine into tiers. A method needs to be found by which community physicians could be deployed according to their skills rather than according to district or area boundaries. One way of doing this is to create for each area a single service department of community medicine, whose members are deployed as district community physicians or specialists in community medicine, but all of whom have responsibilities throughout the area as well as responsibilities to teams.

The recent standstill on management with a possible 5-10% cut seems illogical. A much more constructive approach would be to eliminate one of the tiers. Certainly if the regions and areas were combined to form something like 40 areas, as suggested by Mr Kenneth Robinson in the first Green Paper, these would be an ideal size on which to base departments of community medicine comprising medical managers and epidemiologists.

In examining the management structure the Royal Commission should consider the possibility of reducing the plethora of committees, community health councils, joint consultative committees, and the multitude of advisory committees. It might be possible to use elected local authorities to provide the community voice in the health services, and to associate the area health authorities more closely with local authorities, thus avoiding the need for joint consultative committees. The elimination of a tier of management would at the same time remove one set of advisory committees, and if general practitioners could become part of "cog-wheel" divisions in the districts, it would be possible to obviate the need for a district medical committee, the "cog-wheel" medical executive advising the district management team.

Perhaps the Royal Commission should consider a more flexible and experimental approach to the management of the health services, and encourage area health authorities to become more closely associated with local authorities, so that differing patterns of joint local authority area health authority management could develop in different areas according to their local circumstances.

Team management, an essential part of the reorganised NHS administrative structure, has shown itself to be an expensive and frequently ineffective way of reaching decisions. If the concept of a chief medical executive is still not acceptable, perhaps the Royal Commission could devote attention to the modification of the team idea so that there is more individual responsibility and less team responsibility.

Five minutes as a witness

Given five minutes as a witness to the Royal Commission, I should like to bring to their attention the need not only to talk about health and the prevention of disease but to do something about it: educate for health, organise epidemiologists, sociologists, and statisticians more effectively in a nationally co-ordinated service; and allocate more of the limited national resources to health.

Reference

- 1 *Prevention and Health; Everybody's Business*, London, DHSS, 1976.