From the Council

Community health doctors' report endorsed

Mr A H Grabham chaired the Council meeting on 4 March. The report of the Joint Working Party on Community Health Doctors was endorsed. Several recommendations on the organisation of the ARM were approved. It was agreed to seek a meeting with the Secretary of State to emphasise the need for improved manpower and facilities to secure the safe delivery and early care of all babies. A proposal to approach deans of medical schools and regional postgraduate deans to consider the provision of further teaching and educational programmes relevant to professional self-assessment was approved. The Council turned down, however, a recommendation that the Board of Science should set up a working party on the use of computers in the medical profession.

Mr Grabham told the Council that since the last meeting oral evidence had been given to the Review Body for the 1981 review on 13 and 23 January. Both were useful meetings; general principles had been discussed as well as the immediate pay review. The chairman welcomed Dr Derek Buchanan to his first meeting as BMA Scottish Secretary. The Secretary of State had replied (21 February, p 671) to the BMA's letter to him setting out several of the resolutions of the 1980 ARM. He had referred to the studies that the DHSS were undertaking of the way health care was financed in other countries. The BMA, the chairman said, was not taking part in these inquiries; the Executive Committee was still considering proposals for alternative methods of financing. When the examination was complete a report would be made to the Council. Dr J A Hicklin said that he was concerned at the emphasis on voluntary fund raising by health authorities. It was wrong, he said, to use Health Service staff, who were paid out of taxation, to compete for voluntarily subscribed funds: this would result in needy, vulnerable sections of society losing out.

The Chairman drew attention to the recently announced membership of the Health Education Council. The BMA's nominee had not been appointed. Dr David Williams pointed out that the only representative of general practice was a senior lecturer in a university department. Mr Grabham said that he intended to write to Mr Patrick Jenkin about the BMA's disquiet. Dr J S Horner, chairman, Central Committee for Community Medicine, said that his committee had put forward four nominees and none had been accepted. He had already written to the Secretary of State on behalf of his committee.

- *BMA budget savings approved*
- *ARM proceedings*
- *Perinatal and neonatal mortality*
- *Audit*

Community health doctors

The report of the Joint Working Party on Community Health Doctors (4 October 1980, p 955), chaired by Dr A A Clark, had been considered by the craft committees and endorsed by the Executive Committee. In welcoming the report the committee had noted that the changing and developing state of community paediatrics would be one in which it was hoped that general practitioners would play a greater part. It had decided that where prevention overlapped treatment any such treatment should be carried out only in full consultation with the general practitioner or the hospital consultant concerned. The Executive Committee also believed that those doctors in post as senior clinical medical officers were likely to remain but thought that in future such appointments would be made only on a personal basis and should come within the overall manpower control machinery.

The working party's report had concluded that clinical integration would best be achieved by a suitable alteration in the training of the community health doctors so that at the end of three years' training, having attained the grade of clinical medical officer, they had several options open to them:

To undergo further educational training and experience in the field to achieve the status of senior clinical medical officer.

To remain as a clinical medical officer—this might apply particularly to part timers.

To undergo a year's traineeship in general practice and then apply to become a principal in general practice.

To undergo a further four years in higher medical training in paediatrics and then be eligible to apply for a consultant post. Such doctors would be expected during their training to obtain a higher qualification appropriate to the specialty of paediatrics.

It was pointed out at the Council meeting that "a suitable alteration" would now have to take account of the regulations for mandatory vocational training in general practice.

The final conclusion of the report was: "The decision to opt either to be a principal in general practice or a consultant in paediatrics could be taken also after reaching the status of senior clinical medical officer." The Council endorsed the Executive Committee's recommendation to add the following sentences: "Such doctors will choose for themselves whether to enter general or hospital practice, or to remain within the grade. It is noted that the training period for clinical medical officers and senior clinical medical officers may be varied in the light of further discussions."

Savings on BMA budget for 1981

At its last meeting (17 January, p 245) the Council had resolved: "That in order to achieve a saving of £79 000 in 1981, the staff of the Association be reduced either by redundancies, natural wastage, or early retirement (whether voluntary or compulsory) at the discretion of the Secretary in consultation with the Finance and General Purposes Committee, unless after full discussion with the staff alternative savings are identified which are acceptable to the Finance and General Purposes Committee." The Treasurer, Dr J E Miller, reported that the Secretary had held discussions with the Official Staff Committee, with APEX (representing the Executive and Clerical Staff), and with senior managers of the Association. A series of suggested savings had been identified and submitted to the Finance and General Purposes Committee for consideration. These included a delay in filling some vacant posts, together with one redundancy and two voluntary early retirements. The total package would produce a saving in 1981 of £80 000. The Secretary had agreed to review the need to fill every vacancy that arose in the future, and the committee would receive regular reports of the Association's staffing position.

The viability of the BMA, Dr Miller said, required a serious examination of long-term policies on expenditure. The largest cost was staff; in 1981 the bill would reach £3m. Either the subscription had to be increased to an unacceptable level or staff had to be reduced; this could mean a reduction in services. The present solution was a short-term one to produce a surplus in 1981.

The Secretary reported that the budget allowed for the appointment of a provincial medical secretary in north-west England and it was intended to fill the post on 1 January 1982. (The previous appointee had withdrawn on personal grounds.) Dr John Havard said that he was aware of the lack of medical cover in the north and he hoped to do something about the matter on a temporary basis.

The chairman of the Northern Ireland Council, Dr C J H Logan, pointed out that there had not been a medical secretary in Northern Ireland for several years and it was difficult for the existing staff to balance more work with more economies.

The Welsh Council had recommended that an appropriate interval should elapse before the post of Welsh Secretary was readvertised with the proviso that the matter be subject to review at each meeting of the Welsh Council. This was agreed.

ARM proceedings

The 1980 ARM had resolved: "That no present action be taken to reduce the size of the Representative Body, but that efforts be made over the next few years to reduce the length of the Annual Representative Meeting, but without prejudice to the business content of the meeting." The Organisation Committee had consulted previous chairmen of the RB, members of the ARM Agenda Committee, and other organisations such as the RCN, NALGO, National Union of Teachers, and Institution of Professional Civil Servants. It had decided that in general the arrangements for the conduct of the ARM were satisfactory and that it should concentrate on minor adjustments rather than major changes.

After a long debate the Council endorsed the following recommendations:

(1) That, after the publication of the ARM Agenda, the acceptance of amendments (or riders) shall be at the discretion of the Chairman of the RB, after consultation with the Agenda Committee, and that only in exceptional circumstances shall amendments submitted during the course of the meeting be accepted.

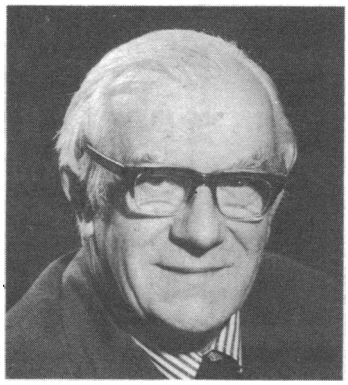
(2) That, as an experiment, a ballot of representatives be conducted at the ARM 1981 during the first morning of the meeting, to identify those motions relating to items not dealt with in the Annual Report of Council which representatives consider should be given priority.

(3) That the constitution of the ARM Agenda Committee be amended from six members (with four deputy members) to eight members (with two deputy members), of whom at least two shall not be candidates for election to the Council or committees with delegated authority or existing members of those bodies at the time of the first meeting of the Council after the ARM.

(4) That two associate members, nominated by divisions, be invited to attend the ARM 1981 as observers.

(5) That the following minority groups each be invited to appoint a representative to attend the ARM 1981: advisers to the pharmaceutical industry, Association of Police Surgeons, prison medical officers, and Civil Service medical officers.

Gold medal



The Council agreed unanimously to award the Gold Medal of the Association to Sir John Stallworthy, FRCS, FRCOG, for his outstanding services to the BMA and to the profession. Sir John has been chairman of the Board of Science and Education since 1976. The medal will be presented to him at the Adjourned AGM in Brighton in July.

Briefly . . .

● The Council approved a revised report on ethics committees for clinical research. The revised constitution, which will include a member of the public and wider medical representation, will be discussed with the Joint Consultants Committee and the Royal College of General Practitioners.

● It will be recommended to the Representative Body that the associate membership subscription should be increased to £9 a year from the start of the next academic year—namely, 1 October 1981. It was reported that there were now over 6000 associate members of the BMA.

● The BMA's Certificate of Commendation has been awarded to Dr Henry Blair of the Waltham Forest Division.

● The Council endorsed the Board of Science and Education's comments on the Criminal Law Revision Committee's working paper on the law relating to and penalties for sexual offences. The chairman of the board, Sir John Stallworthy, agreed to incorporate some comments from the Central Ethical Committee and the suggestions made by members of Council.

● A recommendation from the Board of Science that information on alcohol-related problems as it applies to the community and to the medical profession should be disseminated was adopted.

● The Council turned down a proposal that the Board of Science and Education should set up a working party on the use of computers in the medical profession. It was pointed out that the GMSC had commissioned the Scicon Report, which had cost £24 000, and that a Government NHS computer working party was producing guidelines.

● The Charities Committee has recommended that the 150th anniversary of the BMA in 1982 should be used to promote an appeal for medical charities using facilities already available to the Association.

● A proposal from the Private Practice Committee that BMA members should be invited to submit their names for inclusion on a list of doctors interested in medicolegal work was turned down. It was pointed out that the BMA was about to reissue its booklet *Medical Evidence in Courts of Law*; the recommendation was not compatible with guidance in the booklet.

● With certain modifications the Association's recommended fees for category D services will be increased from 1 April 1981 by 15%. The Private Practice Committee has decided that the fees for completion of cremation certificates (forms B and C) should remain unaltered until April 1982.

● The Council appointed Dr G M Mitchell, department of pharmacology, Cardiff, to the Permanent Committee on Manpower as the member whose major concern was the interest of non-NHS doctors. He replaces Dr J L Kearns, chairman of the Occupational Health Committee, who has resigned. Dr Mitchell will also represent Welsh interests on the committee.

Several speakers were concerned about the acceptance of amendments to ARM motions. Dr J A Hicklin and Dr Michael Rees said that divisions would have their right of amendment removed and that that was a blow against democracy. But no rights were being withdrawn, Dr Jane Richards pointed out; all amendments would be considered more carefully. The Chairman of the RB, Dr E B Lewis, said that the representatives wanted to deal with fewer motions and to deal with them properly. He hoped, for example, that the new procedure would emasculate amendments that were thinly disguised direct negatives. Dr Simon Jenkins thought that the best way of maintaining the democracy of the divisions was to curtail the manipulations of the medico-politicians, who took the opportunity to put up last-minute amendments that completely altered the motions of divisions.

Constitution of Council

Dr Mary White had presented a paper to the Organisation Committee in which she had pointed out that the four members of Council elected by the Representative Body had tended to be experienced medicopoliticians. The RB did not wish to lose their expertise nor did it want them to retire immediately from medico-politics. She had recommended that the former chairmen of Council and of the RB and the Treasurer should be co-opted to Council on an annual basis but for a maximum of three years. At present, the Chairman of Council has an ex-officio seat on Council for one year after his retirement. This would leave the four seats to be filled by younger members of the RB. The Organisation Committee had sympathised with this proposal but thought that there should be a limit of one year and had so recommended. An amendment by Dr M Hamid Husain and Dr Gyels Riddle that the one year should be extended to two years was defeated. Dr R A Keable-Elliott opposed the suggestion. The BMA was living beyond its means and the Council was already too large. It could not go to the RB and claim that there was no money to appoint staff in the periphery and yet want to appoint two extra members to the Council.

The proposal was carried by 18 votes to 16.

Medical advisory and representative machinery

The Organisation Committee had considered the Chief Medical Officer's working party report on medical advisory and representative machinery at district level in the reorganised NHS (17 January, p 239). One of the suggestions in the CMO's report was the discontinuance of the district medical committee (DMC). The committee had proposed that with the demise of the DMC different branches of the profession would need to discuss major issues and BMA divisions would be in a position to fill that function.

The recommendation implied, Dr R B L Ridge declared, that the Council had accepted the proposal to get rid of DMCs, yet the report had not been discussed. There had to be a job for divisions, whether or not there was a DMC. The recommendation should be referred back, according to Dr G E Crawford. It was a backward step. In many parts of the country there was a lack of conterminosity, Dr John Ball pointed out, and the recommendation would just repeat what the reorganisation was trying to avoid. Dr David Williams told the Council that in Wales it had been decided to retain the DMC. The recommendation was referred back.

Vice-president

The Council decided unanimously to recommend to the Annual Representative Body that Dr Harry Fidler, chairman of the Private Practice Committee from 1972 to 1980, should be elected a Vice-president of the BMA for his services to the Association.

Perinatal and neonatal mortality

The Council endorsed the following motion proposed by Dr J A Ford and Dr W J Appleyard:

"That an early meeting be sought with the Secretary of State to discuss the recommendations of the Social Services Committee on Perinatal and Neonatal Mortality with particular emphasis on medical manpower, nursing staff, and the facilities required for the safe delivery and early care of all babies."

Maternity services affected different crafts, Dr Ford said, and he could speak only for neonatal paediatrics. Advanced technology meant that more sophisticated care could be given to babies, particularly those with a low birth weight. But staffing and resources had not matched these advances: units were understaffed and underfinanced. Most consultants in neonatal medicine were singlehanded and working with one or two juniors. Referral units often had to turn babies away. He thought that the BMA should be seen to be taking an active interest in pressing for improved resources. All the craft committees were looking at the Short Report on Perinatal and Neonatal Mortality, the Chairman said, and their comments would be referred to the Executive Committee. He supported the motion.

Select Committee on Medical Education

The Hospital Junior Staff Committee, Mr Derek Machin announced, had asked for a separate meeting with the Parliamentary Select Committee that was looking at medical education. His committee could not fully endorse the evidence that had been submitted by the BMA (21 February, p 666). Its particular concern was the proposal to introduce a part-time grade broadly comparable with the hospital practitioner grade and open to all suitably trained doctors. Junior staff, Mr Machin said, were aware of the need for solidarity and were not wholly opposed to the hospital practitioner grade mark II. But they were worried that until the hospital staffing structure had been sorted out such a grade would become a subconsultant grade. The HJSC chairman, Dr Michael Rees, had objected to the inclusion of the recommendation when the evidence had been circulated to craft committee chairmen for approval. The introduction of a second part-time grade was the policy of the Representative Body, Dr E B Lewis told the Council.

In addition to the evidence from the BMA as a whole the select committee had received papers from the General Medical Services Committee, the Central Committee for Hospital Medical Services, the Central Committee for Community Medicine, and the Medical Academic Staff Committee, as well as from the HJSC.

The BMA was to give evidence to the select committee on 11 March, when the deputation would be the Chairman of Council; the chairman of the Permanent Committee on Manpower, Dr C J Wells; the chairmen of the GMSC, CCHMS, CCCM, and HJSC; a representative of MASC; and the BMA Secretary.

Dr Michael Wilson hoped that the deputation would draw the select committee's attention to those recommendations in the Council working party's report on manpower (19 May 1979, p 1635) that had been approved by the Council. This report had been sent to the select committee. Dr Maurice Burrows reported that the select committee had been visiting different parts of the country collecting evidence and seemed to have narrowed its remit to the examination of hospital career structure and postgraduate medical education.

Medical audit

The Board of Science and Education reported to the Council that it was continuing to review methods of audit and was keeping a watching brief on the progress made by the craft committees and other organisations. The board believed that the profession should continue to develop interest in self-audit with the emphasis on assessment of quality of care and individual standards. It was realised that this would be a long process, which should be achieved through continuing education, beginning at undergraduate level to encourage acceptance of the concept of audit, and continued through training programmes and postgraduate medical activity and monitored throughout. The board had recommended "that an approach be made to deans of medical schools and regional postgraduate deans to consider the provision of further teaching and educational programmes relevant to professional self-assessment."

The recommendation was carried, though Dr John Ball and Dr David Williams were unhappy about endorsing something over which the BMA would have no control. Dr

(*continued on page 923*)

The small change in the higher costs of hospital activity projected for London reflects the estimated extra cost of labour and other services in the metropolis and the comparative stability of the number of cases to be treated in London itself in the LHPC projections. (This constancy of case numbers implies a fall in London hospital beds since duration of stay is projected to fall.)

The rise in teaching costs projected may seem puzzling at first glance because of the planned changes in medical teaching activity in the next eight years. It arises because the effect of the proposed acute bed plan will be to increase the case loads of the teaching hospitals as a whole. This higher case load, when combined with the estimated higher cost per case of teaching hospitals, yields the projected increase in costs. Both this and the London cost adjustment should be viewed with caution, as the effects of higher case loads and falling durations of stay may well change the cost increase that occurs in London and in teaching hospitals.

The implication is that, based on a crude set of calculations, the cost of the proposed plan for acute hospital inpatient services in the Thames regions in 1988 will not be appreciably lower in real terms than in 1977.

Discussion

Certain reservations must be borne in mind in interpreting these results. Firstly, the assumption that 1977 costs are meaningful as a basis for calculating 1988 costs is questionable. The pace of technological change and its consequences, even over an eight-year period, are problematical. For example, a particular therapeutic advance could change patterns of demand, as has occurred with the growth of surgical joint replacement. Secondly, the technological input to existing types of case may change. While in industry, and potentially in some of the hotel and technical support services in hospitals, technology has produced labour-replacing equipment of growing sophistication, in much of medicine new capital has increased labour inputs by creating new skills that are intended to augment existing medical practice rather than replace it. Similarly, the growth of technical manpower in the NHS shows the effects of increased complexity in medicine.

Any tendency to underestimate 1988 treatment costs, arguably the more plausible effect of technical change, will increase the cost of meeting the 1988 plans. Hotel costs may also rise faster than prices in general, at least where they remain labour intensive. (Labour intensity leads to more rapid cost increases if the pace of wage increases is set by industries with more capital per worker and more scope for increases in productivity. Higher wages will then be claimed in the labour-intensive sector or must be paid to prevent loss of workers to other sectors.)

Conclusions on costs cannot be readily drawn from the available evidence. A comparison of cost estimates for 1976-7 with those derived for 1971-2 in an earlier study[3] indicates rising hotel costs and falling treatment costs. This is counter to expectations though may partly reflect the attribution of some portion of the cost of routine treatment practices to the hotel cost category. Certainly, we did not feel sufficiently confident of one set of comparisons to develop a further set of cost figures for 1988 incorporating any such cost trends.

Conclusions

A first approximation of the cost of acute inpatient services in the Thames regions, planned by the LHPC for 1988, suggests that appreciable revenue savings will not accrue in real terms. Thus the suggestion that the proposed rationalisation of the acute sector will free resources for other sectors is not confirmed by the available and undeniably limited evidence. In consequence, and since the Thames regions are currently funded above their RAWP (Resource Allocation Working Party) target budgets, any growth in the non-acute sectors of the health services of south-east England may well have to rest on the minimal growth of the total budget if plans for the acute sector are realised. Alternatively, if average duration of stay continues to fall and acute bed provision does not contract to the planned level the so-called priority sectors may be further constrained by the acute sector.

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Reprints from GHW, West Midlands Regional Health Authority, Management Services Division, 326 High Street, Harborne, Birmingham B17 9PX.

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(*Accepted 15 January 1981*)

From the Council—*continued from page 919*

Williams wanted people to be encouraged to participate locally rather than being coerced. The recommendation placed too much emphasis on education; he thought audit should be more of a service activity. LMCs and RCGP faculties were being encouraged to take initiatives locally on audit in general practice, Dr R A A R Lawrence told the Council (7 March, p 839).

The President, Sir John Walton, is dean of Newcastle Medical School and chairman of the GMC's Education Committee. It would be wrong, he said, for general practitioners to have a monopoly of self-audit of their work. The recommendation meant that educational bodies at large should be encouraged to pay more attention to continuing education, and that, he said, was something everyone could support.

Confidentiality of medical information

The Central Ethical Committee had considered the Council of Europe Convention for the Protection of Individuals with regard to Automatic Data Processing of Personal Data, and the proposed draft recommendations by the European Committee on Legal Co-operation on regulations for automated medical data banks. The committee had welcomed both documents as their contents were in agreement with much of the evidence that the BMA had given to the Younger Committee on Privacy (1972) and to the Lindop Committee on Data Protection (1978). Seven western European nations had already signed the convention, and the CEC was dismayed that the UK Government had no intention of enacting enabling legislation within the present Parliamentary programme. The Council agreed to impress on the Government the urgent need for data protection legislation in the medical field and to give maximum publicity to the matter.

Correction

Milage payments for hospital doctors

In the article by Michael Lowe (28 February, p 755) we said that the Scottish circular, NHS 1980 (PCS) 48, was operative from 20 December 1980. In fact, the arrangements in Scotland are effective from 1 April 1980 as in England and Wales. In table I the third figure in the first column (for cars up to 1000 cc over 9000 miles) should read 6·9p and not 6·0p.