TALKING POINT

Alternatives for community physicians

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Five years after the reorganised NHS created community physicians many are still struggling to make an impact on the Service and to acquire a new identity. Over 40 community physicians and a few consultants and GPs were surveyed during 1978 to assess community physicians' functions and future prospects.

Community physicians were created by fusing the jobs of medical officers of health and medical officers of pre-1974 regional hospital boards. The fusion was stimulated by reorganisation itself and by the Todd and Hunter Reports.^{1 2} The Hunter committee saw the community physician as having a critical role in achieving the major objectives of reorganisation. Describing his function the Faculty of Community Medicine emphasised this objective.³ The community physician has potentially an important part to play in the NHS, but will that potential be realised?

Survey

I interviewed 70 NHS employees, primarily community physicians and those concerned in education or research related to community medicine (see table). I covered 12 of the 14 NHS regions in England, and interviewed people in Edinburgh and Glasgow.

Breakdown of people interviewed

Community physicians	28
Administrative level	
District*	8
Area	9
Region	7
DHSS	4
Other posts	5
Education and research in community medicine	37
Community physicians	17
Other posts	20

*Includes a few consultants and GPs on district management teams, for instance.

Since 1974 the community physician has had to face major problems including defining his function, the character of training, the number and quality of doctors, and the perceived deficiencies in organisational structure.

Nearly all the interviewees thought that the community physician's job was too broad and vaguely defined. He has to work as an epidemiologist, an administrator, and an environmental health expert. The epidemiology includes health planning activities, assessment of needs or community diagnosis, the development of tools and information for resource allocation decisions, and evaluating the effectiveness of current medical procedures and practices. This function is critical to establishing his contribution to the NHS and to his acceptance by consultants in acute clinical services. At present there is a definite lack of acceptance, a sense of distrust, and an ignorance of the community physician's purpose. He fails as an epidemiologist

because of the overwhelming proportion of time spent on administrative duties. Some community physicians estimated that they spent 75% of their working time in committee meetings. It is questionable whether a job so predominantly administrative needs a trained doctor.

There is a problem of intellectual, organisational, and functional isolation. The community physician is seen as neither a clinician, an administrator, nor an epidemiologist. While charged with the responsibility of participating in the internal decision-making machinery of the NHS he does so as an outsider, looking in, unable to reach the heart of the matter.

Training

Though epidemiology should be a major subject in the training curricula, these should also include business management, human relations, organisational behaviour, NHS structure and operation, political science, finance, committee procedures, and planning. Both the MSc and consortia or modular training programmes are needed but some people are dissatisfied with them. There are inadequate opportunities for experienced clinicians to move into community physician training. There were also complaints about the low quality of practical or service training experience.

It is important for community physicians to continue to be concerned with clinical practice. The amount of clinical background recommended varied considerably from completion of basic medical training to continued clinical activity.

In April 1978 119 of the 696 community medicine posts in England remained unfilled. Many of the people interviewed were worried about this and could foresee no early improvement. Even in the face of this shortage quality remains the critical issue. The quality of this new discipline has been damaged or hampered by the image of posts being filled largely by past medical officers of health who were inadequately prepared. Clinicians have questioned the validity of establishing this supposedly new job when they see the "old" MOH appointed to service positions. The new specialty, however, was created at a time of organisational upheaval and severe financial constraints in the NHS, an atmosphere which exposed the community physician as the "whipping boy." But whether the problem rests in the organisation of the NHS or is inherent in the nature of the community physician's function, up to now quality has been inadequate. The community physician has not been sufficiently innovative, his identity remains vague and unassertive, and relations with clinicians have been poor.

The study showed almost universal agreement that there is one tier too many in the NHS structure. Districts and areas should be consolidated in some way. The elimination of areas was preferred. Such a consolidation would allow regrouping of community physician manpower to use it more productively. There is uncertainty about who takes executive leadership in the NHS. It is difficult for the community physician to be an effective leader with no power (other than that of persuasion) in his dealings with clinicians and other members of the management team. It was also pointed out that to do their job properly community physicians needed more administrative and staff support.

Future

The people I interviewed recommended changes in one or more of three areas: clarification of the community physician's responsibilities, change in emphasis or focus of training programmes, and alterations in NHS organisation. Proposed modifications ranged from enhancement of quality of current performance, through extensive redeployment of manpower, to complete abolition of the present post and its replacement with a more workable alternative.

EPIDEMIOLOGIST

Many people thought that community physicians should become exclusively epidemiologists. This would mean establishing a close working relationship with clinicians. The clinician would have to see the community physician as someone to whom he could turn when faced with a problem in efficiency or organisation of services, assessment of efficacy of treatment, determination of patient needs for services available from clinicians, evaluation of current practices with a view towards improvement rather than criticism. Clinicians must see the community physician as working *for* them, rather than *against* them and for management. This means that data collection and analysis must be quick and results must be practical, relevant, and digestible for clinicians. The community physician/epidemiologist should develop data to support productive working relationships between social and medical services. Similar evidence should be developed for appropriate co-operative relationships between general practitioners and consultants. The improvement and maintenance of information systems would be firmly in the community physician's office.

This "exclusive epidemiologist" proposal would need accompanying changes in some other positions in the NHS. All administrative responsibility must be diverted to non-physician administrators. The community physician must give up all committees except those related to epidemiological issues. Environmental health duties or "proper officer" functions must be performed by someone else. That someone else might be called an "assistant community physician" or a "medical officer of environmental health." "Proper officer" training and appointment would be completely different from that of the community physician/epidemiologist.

ABOLITION

If community physicians were abolished their job would be performed by a combination of epidemiologists without medical training, non-physician administrators, and clinicians (GPs and consultants) employed in an advisory capacity as needed. This proposal was not the most frequently heard but was prevalent enough to be mentioned. "If community physicians were abolished tomorrow, what would happen? Nothing. If I were an administrator and needed a sacrificial lamb to get clinicians moving, I would slaughter community medicine." This speaker and others see a need for high-quality business leaders, managers, and organisers. Clinicians would be consulted when clinical questions were raised. Such an approach would mean a short future for community physicians.

CLINICIANS AS COMMUNITY PHYSICIANS

Some people thought that community physicians should be chosen exclusively from the ranks of respected clinicians. Ten to 20 years of clinical experience might be appropriate. Such positions would be well rewarded financially, probably at a level higher than the appointed clinician's remuneration. The individual would be elected by peers for an indefinite term or one of substantial duration. He would have the advantage of a long-standing relationship with clinical colleagues and of being

elected. Adequate time with full financial compensation should be given for intensive training either full time or, possibly preferably, part time while maintaining partial clinical activity.

MULTIPLE SUBSPECIALISTS

The current fragmentation which almost tears the community physician apart cries out for healing integration or formalisation of the fragments through subspecialisation. The three basic subspecialists required would be: epidemiologist, community medicine generalist/administrator, "proper officer" (environmental health, infectious disease control). This alternative would require several fundamental changes. Firstly, distinct service posts in these three subspecialties would be created. Responsibilities in such posts would be clearly defined to eliminate overlap. Secondly, partially or totally separate training programmes would be developed for these three subspecialists. Thirdly, community medicine manpower resources would be consolidated to some organisational level of the NHS so that all three subspecialists could be jointly assigned to that level. This step would probably require elimination of one or more tiers.

GENERALIST AND SPECIALIST

This proposal is based on the two designations: specialist in community medicine (SCM) and district community physician (DCP). Most community physicians would divide their time between both functions. They would serve as generalist/administrators, akin to the district community physician, for a small geographical unit. This unit may be the district or a newly delineated sector matching other divisions in social services, housing, and so on. Additionally, the community physician would serve as a consultant specialist in community medicine in his discipline or particular interest (for example, child health, information systems, etc) for a considerably larger geographical division of the NHS—for example, region. The community physician would then be aware of local problems while at the same time benefit from the challenge and esteem of special expertise. The problem of isolation would be remedied without sacrificing close touch with day-to-day problems in the NHS. Probably a select few senior community physicians would serve in purely administrative jobs at region or DHSS level under this scheme.

RESOURCE ALLOCATOR

This proposal represents a drastic departure from fundamental management philosophies in the NHS but is common in successful private industries throughout the world. The community physician would not adhere to the principle of consensus management. He would be granted full power and authority for resource allocation decisions in a predetermined geographical division. This would require expertise in epidemiology, assessment of needs, political process, systems analysis, finance, and human relations. This proposal ought to ease the brake on innovation, lower barriers to co-operation between community physician and clinicians, help recruitment, and restore morale.

Conclusion

This study does not pretend to be an unbiased assessment of the current state of community medicine. It sampled opinion from among the most prominent and respected members of the discipline as well as those of other crafts. The picture painted is rather dark and dim, though glimmers and flashes of optimism do shine through. So far there has been little opportunity for developing community medicine. But long-term opportunities

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Occupational physicians

BMA's new recommended pay scales

The BMA has published its recommended 1979 salary scales for occupational physicians in the fourth addendum to "The Occupational Physician." The scales have been increased to reflect the Review Body's recommendations for NHS hospital doctors. An appendix gives the fully up-to-date scales to be achieved by 1980 and in the preamble the Association comments:

Whole-time salaries

The recommended whole-time salary scales are regarded by the Association as suitable for those enjoying pensionable or superannuable appointments, and where no pension or superannuation scheme is in operation the salary should be increased accordingly. Furthermore, the figures constitute the minimum scale which the Association regards as satisfying the levels of responsibility commensurate with each grade, and they should be exceeded where qualifications, levels of service, or special circumstances warrant it.

In its Eighth Report in 1978 the Review Body agreed to the profession's request to relate the basic salary for junior hospital doctors to a 40-hour working week. These salary scales had previously been seen by the Review Body as containing an unspecified element in respect of hours worked in excess of 40 per week. In preparing scales for those occupational physicians whose salaries are based upon those of the training grades in the hospital service, the Association has taken into account the fact that by preserving such a link in the past occupational physicians in these grades were implicitly assumed to be available for duty for hours in excess of 40 per week. It was therefore considered appropriate to enhance the basic salaries recommended for junior hospital doctors by an amount which would reflect the nature of this commitment when applying these scales to occupational physicians. It was considered that the appropriate amount should be that which would be received by a hospital junior doctor were he available for duty for one night per week and one weekend per month on average. This amount is, therefore, equivalent to a 1-in-4 rota, payable at those rates appropriate to availability rather than actual duty—namely, "B" UMTs. Amounts con-

sistent with this approach have therefore been incorporated at the appropriate scale points.

Occupational physicians in more senior grades retain their link with hospital consultants and therefore until such time as there is a change in the contract of NHS consultants their commitment will remain open-ended and their salary scales will reflect this fact.

The recommended whole-time salary scales as from 1 April 1979 will be:

Occupational physician (senior registrar): Initially at least £7258 per annum, rising by five annual increments to at least £9233 per annum.

Occupational physician: Initially at least £8444 per annum where the appointee is relatively inexperienced. A commensurately higher salary should be paid to a doctor of greater experience in occupational health or other medical employment. The scale would rise by six annual increments to at least £13 646 per annum.

Senior occupational physician: Initially at least £12 000 per annum rising by four annual increments to at least £15 292 per annum.

Chief occupational physician, or director of occupational medical services: Commencing minimum at least £17 956 per annum.

The scale for occupational physicians (senior registrars) is designed to cover inter alia those undergoing the higher professional training in terms of a training scheme recommended by the Joint Committee on Higher Medical Training.

Part-time salaries

The Association recommends a minimum and maximum point at each level to allow the doctor's experience, qualifications, length of service, and level of responsibility to be taken into account when selecting a point within the range. Furthermore, these part-time ranges are recommended on the understanding that the doctor does not enjoy the benefit of paid leave, nor does he participate in the firm's superannuation scheme (the figures have been adjusted already to allow for the fact that individuals will have to make private arrangements in this respect). The ranges are based for periods in excess of an average of two hours per week on sessions of up to 3½ hours' duration. However, in special circumstances

where less than a full session is required recommended scales are given for periods of 0-1 hour and 1-2 hours.

Hours/sessions per week	Annual salary	
	Minimum £	Maximum £
0-1 hour	498	687
1-2 hours	939	1 299
1 session	1 326	1 836
2 sessions	2 376	3 288
3 sessions	3 423	4 740
4 sessions	4 473	6 192
5 sessions	5 523	7 647
6 sessions	6 627	9 174
7 sessions	7 734	10 704
8 sessions	8 838	12 234
9 sessions	9 942	13 761

July 1979

Fully up-to-date scales to be achieved by 1980

WHOLE-TIME ANNUAL SALARIES

Occupational physician (senior registrar): initially at least £7872, rising by five annual increments to at least £10 077.

Occupational physician: initially at least £9195, rising by six annual increments to at least £15 189.

Senior occupational physician: initially at least £13 329, rising by four annual increments to at least £17 049.

Chief occupational physician or director of occupational medical services: commencing salary at least £20 109.

PART-TIME SALARIES

Hours/sessions per week	Annual salary	
	Minimum £	Maximum £
0-1 hour	549	768
1-2 hours	1 035	1 449
1 session	1 464	2 046
2 sessions	2 622	3 666
3 sessions	3 780	5 286
4 sessions	4 938	6 906
5 sessions	6 096	8 526
6 sessions	7 314	10 230
7 sessions	8 532	11 937
8 sessions	9 750	13 641
9 sessions	10 968	15 345

Alternative for community physicians—continued

for demonstrating progress and positive contribution should not be taken for granted.

Several proposals for injecting vitality into the community physician's function have been offered. Energetic implementation of these proposals—or more likely those which grow out of discussions stimulated by these proposals—might move community medicine towards the pivotal position so needed in the NHS.

References

- 1 Royal Commission on Medical Education 1965-8, Report Cmnd 3569. London, HMSO, 1968.
- 2 Report of the Working Party on Medical Administration. London, HMSO, 1972.
- 3 Community Medicine and the Community Physician, Faculty of Community Medicine, July 1977.

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