SUPPLEMENT

TALKING POINT

Community medicine: a sense of direction

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Community medicine was introduced into the NHS as a medical specialty when the Service was reorganised in 1974. But the term "community medicine" first came into general use with the publication of the Report of the Royal Commission on Medical Education¹ in 1968, when it was described as "the specialty practised by epidemiologists and by administrators of medical services. . . . It is concerned not with the treatment of individual patients but with the broad questions of health and disease in, for example, particular geographical and occupational sections of the community and in the community at large. . . . It makes use of a variety of techniques and procedures which are not necessarily exclusive to it. Nevertheless, the functions of all doctors working in this field are closely related; there are no intrinsic differences in their requirements for basic training or in the techniques they employ."

The Royal Commission emphasised the importance of specialist training and practice in this branch of medicine, and soon after the report was published the Faculty of Community Medicine was formed by the royal colleges of physicians in the United Kingdom. Many of the commission's recommendations have been implemented, including the development of training schemes for new entrants. The practice of the specialty has been widely discussed and commented on. The Unit for the Study of Health Policy² has called for community physicians to renew their concern for preventive medicine. Acheson³ found a majority of trainees and recently appointed community physicians in favour of a contract with an option permitting the practice of clinical medicine part time. Commenting on the issue of clinical practice in community medicine, a leading article⁴ claimed, "The success of the specialty does not rest solely on skilful application of management, epidemiological, and other techniques learnt during the training courses."

Community physicians are facing formidable difficulties. Many were ill prepared for the tasks thrust on them after NHS reorganisation and the present system of NHS management, of which they are a part, is defective. They do not always enjoy the sympathy of their colleagues in other specialties and this may stem partly from a lack of understanding of what a community physician actually does.

In an attempt to overcome this a group of community physicians in Scotland has prepared the following working definition of the specialty:

The community medicine specialist is a registered medical practitioner who has a professional responsibility for the health of a

defined population or group, and whose primary task is the recognition and analysis of problems of health and health care and the planning and implementation of measures to prevent, contain, or overcome them. He collaborates with other community medicine specialists in the NHS, each contributing his own special skills, and may either engage in a full range of activities or concentrate on investigative or administrative work. Whatever his particular commitment, however, whether investigating problems or managing services, his overriding objective is the maintenance and improvement of the health of the community.

The community medicine specialist works closely with clinical colleagues in their groups and divisions in hospital and in the community to ensure the provision of comprehensive medical services; he supports their work through his understanding of and participation in the administrative arrangements of the NHS and by initiating alternative approaches to the provision of health care based on his knowledge of epidemiology and human behaviour. His work with other professional and administrative colleagues makes use of his knowledge of health and disease and of his understanding of clinical practice. To the general public he is the doctor who plans the provision of appropriate services and promotes measures to prevent disease, from whatever source it may arise.

This definition of the community physician's work fore-shadows an important function for doctors who recognise the responsibilities of medicine to the community as a whole. It forms the basis of the Scottish group's guidelines for training in the specialty.⁵ Though relatively few doctors choose a career in community medicine, those who do are generally of a high calibre, and it is important that they should be offered an appropriately challenging training, which is not easy in a specialty with such comprehensive aims. The guidelines prepared by the group aim to ensure that the community physician has the knowledge, skills, and attitudes appropriate to his responsibilities. At the end of his training he should be able to demonstrate the following:

Knowledge

A familiarity with the natural history, distribution, and determinants of disease, particularly of those diseases which are common or have a chronic or serious outcome.

An understanding of the opportunities for preventing, limiting, diagnosing, and managing disease in man.

A knowledge of the community in which he is working and particularly of its patterns of health and disease and of the range of health and social services available.

An understanding of the social behaviour and customs of the population and of its political and physical environment: a recognition of the effects of these on health and the use of health services.

An understanding of the organisation in which he works, its traditions, policies, personnel and procedures, and its relationships with other bodies.

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Familiarity with medicosocial legislation and its impact on his own organisation, the environment, and the population.

Skills

The ability to describe the state of health of a defined community and compare it with that of other communities.

The ability to identify specific features in the physical, social, and psychological environment which endanger the health of the community.

How to assess the effectiveness of the medical services provided to prevent, cure, or alleviate illness and disability.

How to assess the efficiency with which medical services are provided.

The ability to collect, organise, and present, in an appropriate form, information relevant to his tasks.

That he can prepare alternative plans for achieving realistic goals, identifying the criteria which make for optimum use of available resources.

The ability to use both formal and informal channels of communication, taking into account the potential for misunderstanding caused by his own or others' preconceptions or values, and recognising the need for feedback.

The ability to recognise, and react appropriately to, the wide range of individual and group behaviour he will meet in the course of his work.

Attitudes

A concern for the promotion of health and the prevention of disease.

The capacity to work with multiple—and sometimes incompatible—goals within a complex system directed towards the integration of health care services.

An acceptance of the possible conflict between his dual role as investigator of problems and supporter of existing services.

An awareness that ideal solutions rarely exist but that acceptable decisions can be made in most circumstances.

An acceptance of the slow process of testing ideas and implementing change in a large organisation.

Determination and ability to evaluate his own work critically.

A recognition of his own need for continuing education.

We believe these aims follow the direction set by the Royal Commission on Medical Education and supported by the Faculty of Community Medicine. If they are in doubt now is the time for them to be challenged. It would be wholly wrong to train a new generation of doctors for redundancy.

References

- 1 Royal Commission on Medical Education, *Report*, Cmnd 3569. London: HMSO, 1968.
- 2 Unit for the Study of Health Policy. *Rethinking Community Medicine: Towards a Renaissance in Public Health?* London, 1979.
- 3 Acheson ED. Clinical practice and community medicine. *Br Med J* 1979;ii:880-1.
- 4 Clinical practice and community medicine. *Br Med J* 1979;ii:817-8.
- 5 Scottish Council for Postgraduate Medical Education. *Learning and Teaching Community Medicine*. Edinburgh, 1979.

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BMA criticises Government's computer plans

The British Medical Association has warned that a Government computer plan previously criticised by doctors as failing to meet ethical standards of confidentiality is already out of date.

After a briefing by the BMA, the Joint Consultants' Committee at its meeting on 29 April told the Chief Medical Officer that the Government should think again about its computer plans. The Child Health Computing Committee (CHCC), supported by the Department of Health and Social Security, proposes to store details of all children from the date they were conceived up to school age together with other family details. The BMA's computer experts' view is that the computer hardware being used by the Child Health Computing Committee is now outdated. The Department has been told that the out-of-date equipment will prove to be more expensive in the long run, with service and maintenance costs far outweighing the costs of investing in up-to-date computer hardware, which should at the same time fulfil the ethical criteria laid down by the BMA. The report suggests that to spend money on the Government's planned programme by using the existing computers in 1980 must be considered a gross waste of public funds. The BMA does not believe that the DHSS will be able to devise a system using these computers which will guarantee confidentiality of medical information as set out in the three principles agreed between the BMA and the CHCC. These principles are:

(1) Identifiable information is to be regarded as held for the specific purpose of the con-

tinuing care of the patient and should not be used without appropriate authorisation or consent of the patient (parent or guardian in the case of a child) for any other purposes.

(2) Access to identifiable information held in medical records is to be confined to the author and to the person clinically responsible for the patient during the episode from which the data has been collected (or their successors) unless specifically authorised by the clinician in the clinical interest of the patient.

(3) An individual is not to be identifiable from data supplied for statistical or research purposes except when follow-up of the individual patient is a necessary part of the research (and either the patient has given informed prior consent or consent has been obtained from the chairman of an appropriate ethical committee).

Charges to NHS patients

When the chairman of the GMSC, Dr R A Keable-Elliott, met Dr Gerard Vaughan on 16 April the Minister agreed verbally that GPs could charge their NHS patients for issuing private prescriptions for "prophylactic" drugs which they needed when going abroad. This will require an amendment to the terms and conditions of service. The DHSS has not yet decided whether a fee may be charged for routine medical examinations requested by the patient or for referrals to private consultants.

BMA Notices

Medical Advisers in the Pharmaceutical Industry Group

The annual meeting of the Medical Advisers in the Pharmaceutical Industry Group will be held at 4 pm on Tuesday, 17 June 1980 at the Royal Society of Medicine, 1 Wimpole Street, London W1.

The constitution of the group committee provides for the retirement of one half of the members of the committee every other year. Four members of the existing committee will retire in June 1980 and nominations are invited to fill these seats. The nominator and the nominee must both be members of the group. The people elected will serve until June 1984. Retiring members of the committee are eligible for re-election. Nominations must be sent to the administrative secretary, Association of Medical Advisers in the Pharmaceutical Industry, 41 Queen's Gate, London SW7 5HU, to arrive not later than Wednesday, 21 May 1980. If more than the required number of nominations are received a ballot will be arranged.

Any member of the BMA who is a medical adviser in the pharmaceutical industry and who is not also a member of the AMAPI and who wishes to be included in the group should contact the administrative secretary at the above address.

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Secretary