TALKING POINT

The district community physician's task

A M B GOLDING

Ever since April 1974 I have been asked what I do. One of the troubles is that I do not carry a stethoscope or a little black bag.

The specialty of community medicine is new and it now has its own faculty, founded in 1972. But the faculty is only the recent recognition of a specialty which goes back to people like John Ryle who recognised the importance of the community. He pointed out¹ that high infant mortality and the causes of death such as pulmonary tuberculosis, syphilis, valvular heart disease, and gastric, uterine and skin cancer were more prevalent in the lower income groups. The all-causes mortality remains unfavourable to the underprivileged.

While the importance of some of these diseases have waned since 1948, the core of Ryle's argument remains: there is a higher morbidity and mortality among the underprivileged and if we are to make any major improvements in the community's health we must look at that community. The specialist in community medicine is concerned with the pattern of diseases in the community. His academic base is essentially epidemiology and the critical comparison of different forms of treatment—classically the randomised controlled trial. Community physicians are administrative doctors who do this type of work. They work in the DHSS, the region, the area, or the district.

Conception of the DCP

The district community physician's job was described in the Hunter Report of 1972. The aim of reorganisation in 1974 was to bring together the three branches of the Health Service, hospitals, general practitioners, and medical officers of health. The need to do this was set out in the Porritt Report,² a report produced by doctors. Not only should there be closer links between the three branches but the Health Service should also be more responsive to the health needs of the population rather than concentrating on the treatment of the sick individual.

The DCP was conceived against this background. Most were MOHs, but others were with regional hospital boards, and a few like myself had spent time working in the DHSS. The DCP functions mainly as one of the three doctors on the district management team, which manages the health services in the district on behalf of the area health authority. There are six members on each DMT—the administrator, finance officer, nurse, and three doctors. Two of the latter are the consultant and general practitioner, both elected by the district medical committee. So they are only on the DMT for a limited period, whereas the DCP is there for life. Also, they are only part time though many seem to put in long hours on committee work.

The DCP's job is to try to improve the health of his district by making better use of

the various parts of the Service—for example, the proper management of resources.

Management

In the past decisions on the mixture of facilities and services have been made without reference to population needs and with no information about those who do not use the services and yet may still need health care. The DCP has to make some assessment of need by looking at the population as a whole. He must look at the services which are needed but which have often lacked effective spokesmen, such as those for the mentally handicapped and the alcoholic. But it would also include acute diseases where there is a need to emphasise the less glamorous aspects—like rubella vaccination.

These examples will show why a medical community physician is needed. He has to be a doctor because he needs to be able to assess what is likely to be the most effective way of providing health care and he also has to be able to communicate with medical colleagues.

In our department at King's there are a variety of doctors with experience in general and hospital practice and this helps in understanding the problems of all branches of the Service.

Administration

There are two processes covered by administration and management—one is concerned with broad policy and where the organisation should be going, while the other deals with the execution of existing policy—that is, the internal functions and supporting services of the organisation. Unfortunately, the words administration and management are not used consistently. The DCP is concerned with both in the day-to-day running of the service—especially the community health service—and also with preparing policy. But the essential feature of the job is to collaborate with medical staff, non-medical administrators, nurses, and so forth, to develop a coherent district plan. The plan will be constantly changing but when any new proposals come up the decision to support or reject them should be based on whether they lead in the right general direction.

IMPROVED USE OF RESOURCES

Over the last year or so any developments have had to be paid for out of savings and while the King's District has been given insufficient money we need to make the best use of what resources we have.

Let me give some examples. In 1974, soon after reorganisation we closed three wards because of industrial action: one was reopened within a few months. But the other two remained closed because we believed that the money we had should be used to increase the level of staffing of the wards in use rather than

being spread over extra wards. For some years there had been a successful five-day gynaecological ward at King's: it had been one of the easiest wards to staff, caring for the many patients who did not need emergency admission and who could be discharged within five days. The nurses liked the ward because they had every weekend off. The patients liked it because each admission and discharge was planned in advance. So in place of one of the wards we had closed because of industrial action we opened a five-day ward for male surgical patients. It is too early to say how well this will work but so far it seems to have been as effective as is the gynaecological ward. Certainly the urology waiting list has been cut in half.

Another example of better use of resources has been the treatment of old people living alone with some minor injury which brings them to the casualty department. In the past many have been admitted for a night or two but the best place for them is at home. So the casualty staff now arrange for the district nurse to call on the patient within an hour or so of his return home. On the debit side this means that the district nursing system has to be available day and night.

BUDGETARY CONTROL

Consultants have been asked to keep their own budgets in an attempt to achieve the best use of resources. The x-ray department, for example, spends over £½ million a year and has requested an extra consultant, which the district supports. But though the region has on several occasions given approval to this request there is insufficient money to employ him. The radiologist in charge has now been told that if he can find sufficient savings from his department the funds will be transferred to finance the new consultant.

The district has to be certain that the savings are achieved, but with all diagnostic departments doctors often commission expensive tests which are unlikely to show anything of value for the patient's management. What sort of probability should there be that a test will help in caring for a patient before it can be justified? One criterion will be the risk to the patient of doing the particular test, but if there is virtually no risk, then what? Perhaps a one in 20 probability is acceptable for a cheap test but unjustified if it is expensive. These are difficult decisions but to pay for the advances needed—in this case a new consultant—something else has to go.

Community health services

I am also responsible for managing the former local authority clinics which were the responsibility of the MOH. In some areas this duty is carried out by the area doctors. There are 55 doctors, mostly working for a few sessions each, and equivalent to 20 whole-time staff. These include 24 general practitioners, 15 married women working part-time, and six

Based on a lecture given at the Postgraduate Centre, The Brook Hospital, Woolwich, on 20 November 1976.

other part-time staff (retired doctors, university lecturers, etc). In addition, there are now 10 whole-time doctors, one of whom is shared with the medical school. Eleven doctors are also employed as visiting medical officers to homes in the district: they act as GPs to residents who wish to go to them but in addition they are paid a small fee for general advice they give to the staff of the home in the management of general problems.

The district has two whole-time doctors preparing for the examination of the Faculty of Community Medicine. And a GP with no previous special experience of caring for the elderly was seconded to the geriatric department for training sessions so that he can run an over-60s clinic. These are two examples of how the district helps in the training of doctors.

Several community doctors in the district have honorary appointments in the medical school and all of those doing six sessions a week or more have a session with one of the hospital staff, either the paediatrician, geriatrician, or child psychiatrist, depending on their particular interest. These doctors have much to offer the hospital as well as much to learn.

Health care planning

Apart from the management of resources in the hospital and the management of a team of doctors working mainly outside, the core of the DCP's work is co-ordination and providing information for the health care planning teams. These have been slow to develop in the King's District, partly because there is not a large administrative machine and also because these teams should be seen to be useful and not waste the time of those who attend, including, of course, general practitioners.

The King's District is a deprived area, with overcrowding, lack of basic facilities like inside WCs and hot water in many homes, and many people in social classes IV and V. The Resource Allocation Working Party³ has suggested that the best way of relating this sort of information to health needs is to work out the standardised mortality ratio, the point being that poor social conditions are associated with an increase in morbidity and hence in the need for health resources whether by general practice or in hospital. These conditions also cause a higher mortality—and this is easier to measure. If the mortality for England is 1 then King's (in 1971) was 1.09.

In England and Wales the infant mortality in 1975 was 16, in the King's District 19, while the infant mortality for illegitimate babies in the King's District was 30, nearly double the national average for all births. The poor figures are not a slur on the hospital service for they reflect the environment in which the population lives and the need for additional resources.

FAMILY PLANNING

Since July 1975 there has been a free general practitioner family planning service. So the family planning HCPT decided that the number of clinics for ordinary family planning was sufficient. The team thought that a clinic was needed in one centre which did not have one and one of the less popular clinics was transferred from another centre. At the general practitioners' request a clinic for psychosexual counselling was set up in place of one of the other sessions. In this way minor changes were made, improving the service without raising the cost.

HEALTH CENTRES

Another health care planning team was set up to consider health centres. The district has one health centre—this opened in July 1976—and several others have been planned. But another one had to be abandoned because the GPs who had once shown interest had either retired or decided that they no longer wished to work in a health centre. Alternative ways of providing health centre facilities are now being examined.

If all the plans go through less than 15% of the GPs in the King's District would be working in health centres in 10 years time. But health centres do pose problems. They are expensive and take a long time to build. The HCPT has recently looked at this because some people believe that the whole health centre concept may be wrong. But GPs should be encouraged to work in premises which are adequate for other professional staff who may need to see the patient immediately after—or possibly before—he sees the GP. Thus there should be facilities for health visitors, district nurses, and secretarial staff.

I think we need to maintain a clinical service similar to that formerly run by medical officers of health. Such a service provides a means of supplementing the work of the GP for it is unreasonable to expect every GP to be a wide ranging expert in family planning, infant welfare, behavioural problems in adolescence,

screening of well women, and the problems of the elderly. In some practices partners may specialise so that the whole spectrum is covered, but certainly in Inner London an alternative service is wanted despite its complex relations with GPs—another headache for the DCP.

Conclusion

DCPs are often seen as part of the chaos which seems to have descended on the Health Service with reorganisation. But change of this sort was inevitably traumatic. The aim of reorganisation was not to continue exactly as before and it will take time to adjust. The DCP has an important task in assisting the advance of the health services in his district. Whether he is up to the task is a different question.

References

- ¹ Ryle, J A, *Changing disciplines: lectures on the history, method, and motives of social pathology*. Oxford, Oxford University Press, 1948.
- ² *A Review of the Medical Services in Great Britain* (Porritt Report). London, Social Asay, 1962.
- ³ DHSS, *Sharing Resources for Health in England: Report of the Resource Allocation Working Party*. London, HMSO, 1976.

King's College Hospital, London SE5 9RS

A M B GOLDING, MB, MFCM, district community physician

Association Notices

Full-time Medical Teachers and Research Workers Committee

Nominations are invited for the full-time non-professorial vacancies on the Full-time Medical Teachers and Research Workers Committee of the Association for the session 1977-8. The vacancies are to be filled on a regional basis, as follows in the table:

All members of the Association who hold a full-time non-professorial appointment at a university in the appropriate region are eligible to nominate and vote in one of these

elections. Retiring members are eligible for re-election.

Nomination forms for the elections may be obtained from me at BMA House, Tavistock Square, London WC1H 9JP, and must be returned *not later than Monday, 25 April 1977*, preferably by recorded delivery. In the event of a contest, voting papers will be issued.

E GREY-TURNER
Secretary

Region	Medical school(s)	No of representatives
(1) ENGLAND		
Northern	Newcastle upon Tyne	1
Trent	Sheffield	}
	Nottingham	
	Leicester	1
East Anglia	Cambridge	}
North-west Thames	Charing Cross	
	Middlesex	1
	St Mary's	}
North-east Thames	Westminster	
	Royal Free	}
	St Bartholomew's	
	The London	1
South-east Thames	University College	}
	Guy's	
	King's College	1
	St Thomas's	}
South-west Thames	St George's	
Wessex	Southampton	1
Oxford	Oxford	1
South-western	Bristol	1
West Midlands	Birmingham	1
Mersey	Liverpool	1
North-western	Manchester	1
(2) SCOTLAND		1
(3) WALES		1
(4) NORTHERN IRELAND		1
Total		17