and remedial professions. The circular, based on a statement by the DHSS's Standing Medical Advisory Committee, was to be commended to health authorities. The chairman thought that the SMAC was an advisory body and he objected to the sentence that "... therapists have a duty to advise, and even on occasion the right not to treat, if by reason of their knowledge and experience they feel that what has been prescribed is inappropriate or hazardous." A member of the BMA Council, Dr J A Hicklin, had pointed out, in a letter to the secretary of the JCC, that in asking for treatment by a therapist, the doctor was clearly asking for the help of another trained professional and the professions of medicine and the various therapies differed. The therapist had the duty and consequently a right to decline to perform any therapy which his or her professional training and experience suggested was actively harmful to the patient. Equally, the doctor who was responsible for the patient had the right to instruct the therapist not to carry out certain forms of treatment which he believed harmful to the patient. The matter was put on the agenda for the meeting with the CMO.

The new chairman of the Scottish CHMS, Mr J Kyle, a consultant surgeon from Aberdeen.

Health Services Board

The Health Services Board had recently issued two documents to area health authorities,

Mr D E Bolt, a deputy on the board, told the JCC. One referred to the closure of consulting room facilities for private patients in NHS hospitals by 30 September, subject to a provision that in cases of exceptional hardship an extension might be agreed. The other referred to the next group of pay-beds to be phased out after the first 1000. The next phase was supposed to take place within six months of the Act becoming law, though, in response to a request from the board, the Secretary of State had given two months' extension. Because of the time limit, the board had used as a basis for identifying the next block of pay-beds the same criteria used in identifying the first 1000. This was at variance with the requirements of the Health Services Act and the BMA had already protested to the chairman of the board (9 April, p 879).

So far as common waiting lists were concerned, evidence had been submitted to the board which had agreed to meet representatives of the profession on 25 April. The committee appointed the following members to meet the board: the chairman, Professor J G Robson, Dr M M Burrows, Mr A H Grabham, and Mr J Kyle.

TALKING POINT

Future staffing in community medicine

KEITH YOUNG

Recruitment to community medicine will have to more than double if the present position is to be maintained. Alternatively, a different structure requiring fewer posts could be adopted. At present (table I) there are 603 community physicians in post under the age of 65 and 59 trainees in registrar or senior registrar posts. To forecast future staffing prospects it is assumed that men and women will retire at 65 and 60 respectively and that recruitment will remain at its present level.

TABLE I—Age and sex structure of community medicine staffing*

Age group	Career grades		Training grades	
	M	F	M	F
>30	0	0	12	3
30-34	15	1	6	11
35-39	22	9	8	3
40-49	183	40	7	7
50-59	176	76	0	2
60-64	69	12	0	0
Total	465	138	33	26

*Source: DHSS, *Community Health Service Medical Staff, England and Wales, National Tables*. DHSS Statistics Division, November 1976.

Expected death rates are based on the Registrar General's figures on occupational mortality (see table II and figure). Thus, with 600 retirements and 81 expected deaths by the end of the century, replaced by only 295 new appointments, the total number in post would drop by 385 (63.8%) in 25 years to 217.

TABLE II—Deaths and retirement in community medicine*

Age group	Year					
	1975	1980	1985	1990	1995	2000
30-34	16	15	15	15	15	15
35-39	31	33	32	32	32	32
40-49	223	161	96	97	96	97
50-59	252	231	230	175	112	113
60-64	81	78	79	84	90	37
Total	603	518	427	356	281	217
Total retirements and deaths		144	150	130	134	123

*Source: Registrar General's *Decennial Supplement, England and Wales, 1961, Occupational Mortality Tables*. London, HMSO, 1971.

In addition to the number of occupied posts in community medicine, there are said to be 100 unfilled funded posts in England and Wales and additional posts that have not been funded, approved, or even put forward because of the recruitment difficulties. If the total of 600 community physicians in post is to be maintained the number of trainees required would be more than double the present number. But is there any evidence that 600, let alone 700, community physicians are needed to staff the NHS?

Structure of community medicine

The structure of most clinical disciplines evolves in response to a natural demand. For example, in the last 20 years, geriatric medicine

has grown and chest medicine declined. Community medicine, however, was created artificially to match the reorganised NHS with regional and area medical officers and district community physicians created to fit into the administrative structure. Some of the specialist appointments were created not only to fit in with the structure but also to allay the anxieties of local authorities at the loss of their

Number of community physicians in post at September 1975 and forecast at five-year intervals until 2000.*

*Source: Registrar General's *Decennial Supplement, England and Wales 1961, Occupational Mortality Tables*. London, HMSO, 1971.

health departments—for example specialists in child health, environmental health, and for social services liaison.

Other specialist posts were created in epidemiology, medical information, and service planning—all relevant to community medicine. Finally, in large districts the conflict of jobs of the DCP¹ has led to the appointment of what sounds like a deputy or second DCP under the unfortunate title: "specialist in community medicine for district support." Unfortunately, these posts were designated specialist despite the absence of sufficient people trained to the required level.²

DEFINITION OF SPECIALTY

The functions of community medicine have been defined by several committees³⁻⁵ and now by the Faculty of Community Medicine.⁶

"Community medicine is that branch of medicine which deals with populations or groups rather than individual patients. In the context of a national system of medical care, it therefore comprises those doctors who try to measure accurately the needs of the population both sick and well.

"It requires to bring to the study special knowledge of the principles of epidemiology, of the organisation and evaluation of medical care systems, of the medical aspects of the administration of health services, and of the techniques of health education and rehabilitation which are comprised within the field of social and preventive medicine.

"Community medicine thus brings together within the one discipline those who are presently engaged in the practice of public health, in the administration of the health services whether in hospital, local authority, or central government, in relevant research, and those responsible for undergraduate and post-graduate education in the university departments of social medicine."

Community medicine stands or falls on its ability to demonstrate its usefulness in exercising these professional skills and not on its direct contribution to administration or management, in which it would be competing with professional administrators whose training should equip them better for the task. I do not suggest that management and administration are not part of a community physician's task but in many cases they have become a major part. Even clinical consultants take part in administration, the amount varying greatly, being high in geriatrics and low in general surgery.

CHANGED CIRCUMSTANCES

Doctors have practised community medicine for many years, mainly as medical officers of health or as administrative medical officers of regional hospital boards. The former's job was gradually eroded by changed circumstances, including a progressive loss of health functions in local government. Before reorganisation some were doing little community medicine and, unsupported by administrative staff of any quality, spent their time administering their departments. When regional hospital boards were set up administrative medical officers found themselves forced into whole-time administration simply because there was a dearth of professional administrators who had any knowledge of hospitals.

There is also some misunderstanding about the administrative content of community

medicine.^{7,8} Epidemiology, medical statistics, information services, and the control of environmental health are not administration in the ordinary sense of the word but medical professional activities. But, in an area with three districts, inevitably four community physicians, the AMO, and three DCPs spend much time on management,⁸ as members of management teams.

Alternative structure

In general medicine in the United Kingdom most district hospital services have several general physicians each with a special interest—for example, cardiology. There are also specialist cardiologists who practise in special centres, serving their colleagues in the surrounding districts. Community medicine might be better practised on a similar pattern, with a group of community physicians practising in each area, as a division, each member of which would have a special interest.⁹ The offices of AMO and DCP would be abolished and the elected chairman of the division serve on the management teams, as do the clinical members. The appointment of specialists, on the analogy with clinical practice, would be confined to regional units and academic departments. If the specialty were reorganised as suggested, only the chairman of the division would be greatly concerned with administration, saving the time of as much as a whole-time equivalent, or 16% in an area staffed by six community physicians.

ONE TO 100 000

In some clinical specialties it is possible to calculate how many consultants are required for a given population, though the needs may vary greatly with local circumstances. No such calculations have been attempted for community medicine, but experience in Warwickshire suggests that it might be a ratio of one community physician per 100 000 population, with variations to meet local needs. The most frequent criticisms made about the reorganised service are about multidistrict areas. Though rival claims for redundancy are made for both region and area, most people would agree that only two levels of administration are required: planning and operational ones. If all areas were single district—that is, operational—it would be easier to solve the problems in community medicine. Unless the present system is rationalised, this branch of medicine may be one of the first casualties of reorganisation.

I wish to thank Mr David Fildes, BSc, for statistical help and advice.

References

- Griew, A R, *et al*, *British Medical Journal*, 1976, **2**, 435.
- Knox, E G, Morris, J N, and Holland, W W, *Lancet*, 1972, **2**, 696.
- Royal College of Physicians, *Report of the Committee on Medical Administration*. London, RCP, 1966.
- Royal Commission on Medical Education 1965-8, *Report*, Cmnd 3569. London, HMSO, 1968.
- DHSS, *Report of the Working Party on Medical Administrators*. London, HMSO, 1972.
- Faculty of Community Medicine, *Standing Orders*, 1972.
- Horne, J S, *British Medical Journal*, 1976, **2**, 829.
- Griew, A R, *Health and Social Service Journal*, 1977, **86**, 155.
- Galbraith, N S, *British Medical Journal*, 1976, **2**, 805.

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Association Notices

Venereologists' Group Committee

Nominations are hereby invited from members of the Venereologists' Group for four vacancies on its group committee for 1977-81. The vacancies are caused by the retirement every two years of one half of the members of the group committee, who are eligible for re-election.

Nomination forms are obtainable from the undersigned and must be returned not later than *Thursday, 30 June 1977*. In the event of a contest arising, voting papers will be issued at a later date to members of the group.

Both the candidate for election and the person making the nomination must be members of the group.

E GREY-TURNER
Secretary

Diary of Central Meetings

	MAY
2 Mon	New Consultant Contract Working Party (CCHMS), 2 pm.
5 Thurs	Central Committee for Hospital Medical Services, 10 am.
6 Fri	Central Committee for Community Medicine, 10 am.
11 Wed	BMA Council Executive, 10 am.
18 Wed	Negotiating Subcommittee (CCHMS), 10 am.
19 Thurs	General Medical Services Committee, 10 am.

Division Meetings to be Held

Members proposing to attend meetings marked * are asked to notify in advance the honorary secretary concerned.

- Blackpool**—At Victoria Hospital, Wednesday, 4 May, 8.15 pm, agm.
- East Cumbria**—At Penrith New Hospital, Thursday, 5 May, 8 pm, general meeting.
- Furness**—At the Coot, Urswick, Friday, 6 May, 7.30 for 8 pm, annual spring dance.* (Guests are welcome.)
- Halifax**—At Royal Halifax Infirmary, Wednesday, 4 May, 8 pm, agm, and consideration of Annual Report of Council.
- North and Mid Staffordshire**—At Medical Institute, Stoke on Trent, Wednesday, 4 May, 8.15 pm, agm.
- South Bedfordshire**—At Hendon District Hospital, Thursday, 5 May, 8 pm, first meeting of BMA NT Regional Council.
- Blackburn**—At Montague Health Centre, Tuesday, 3 May, 7.45 pm, agm.
- Dartford, Gravesend, and Medway**—At St Bartholomew's Hospital, Rochester, Tuesday, 3 May, 8.30 pm, general meeting.
- Halifax**—At Royal Halifax Infirmary, Wednesday, 4 May, agm.
- Ipswich**—At St Clement's Hospital, Wednesday, 4 May, 8 pm, meeting to consider Annual Report of Council and motions for ARM.
- Isle of Wight**—At St Mary's Hospital, Newport, Thursday, 5 May, 8.30 pm, meeting to discuss Annual Report of Council.
- Lancaster**—At Postgraduate Medical Centre, Thursday, 3 May, 8 pm, general meeting.
- Manchester**—At Boyd House, Tuesday, 3 May, 8 pm, ordinary general meeting.
- Mid-Northumberland**—At Ashington General Hospital, Wednesday, 4 May, 7.30 pm, agm.
- Northampton District**—At Cripps Postgraduate Medical Centre, Wednesday, 4 May, 7.30 pm, sherry reception followed by ordinary meeting.
- Oxford**—At Radcliffe Infirmary, Wednesday, 4 May, 8.30 pm, business meeting.
- Redbridge and Stratford**—At King George Hospital, Tuesday, 3 May, 8 pm, general meeting.
- South Middlesex**—At Ashford Hospital, Monday, 2 May, 8.30 pm, business meeting.
- Rotherham**—At Brecon Hotel, Monday, 2 May, 7.30 for 8 pm, dinner,* 9.15 pm, agm.
- West Derbyshire**—At Newhaven Inn, near Hartington, Wednesday, 4 May, 8 for 8.30 pm, agm.*
- Wigan**—At The Owls, Standish, Friday, 6 May, 7.30 for 8 pm, dinner.*
- York**—At York District Hospital, Wednesday, 4 May, 8 for 8.15 pm.