TALKING POINT

District medical committee in suspended animation

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In 1974 the Mid-Surrey District inherited an active and strong medical executive committee (MEC), which included a general practitioner division. The MEC was formed in April 1970 in accordance with the First Report of the Joint Working Party, *Organisation of Medical Work in Hospitals*.¹ Before Cogwheel a medical advisory committee existed, which was inaugurated intact as a medical staff committee in 1970 and in 1974 was reconstituted as a district medical staff committee. The last meets annually but may be called at other times if necessary. All consultants may attend, including the district community physician (DCP) and representatives of the cottage hospital general practitioner staff. Six representatives of the junior medical staff are also invited. The chairman of the MEC is elected by that body and views are exchanged about the MEC's work during the previous year.

The medical officer of health was a member of the MEC and with his disappearance a place was offered to the DCP. The formation of the district medical committee (DMC) was initiated by the local BMA division and it met with the same frequency, on the same evening, and with the same chairman and secretary as the MEC.

The most suitable meeting time for family doctors was late evening, when the MEC had finished. Moreover, consultants did not wish to turn out on another evening for a committee. Agenda items for the DMC were as suggested in the "Grey Book" (*Management Arrangements for the Reorganised National Health Service*, 1972)² but were mainly about hospital matters, which had inevitably been discussed a few hours before by the MEC; thus whatever initial enthusiasm there had been for the new committee quickly waned.

Little merit in DMC?

At the outset, few could see the merit of the DMC, as the MEC had already successfully co-ordinated and presented the views of various medical disciplines. Well-attended general practitioner division meetings stemmed from the fact that the district has three cottage hospitals where GPs have a close relationship with consultants and they have evolved a local system of care that includes investigations, surgical operations, and rehabilitation. The GP division's role was to integrate cottage hospitals' services with the main general hospital, and, as it included all GPs in its membership, debates occasionally, and inevitably, spilled over into primary care topics. The almost equal numbers of hospital and family doctors on the DMC was novel, but

discussions between them around a table was old hat. The popularity of the DMC diminished, overshadowed as it was by the established MEC.

In a paper delivered to a *BMJ* conference at Chichester Dr R G S Brown,³ of the Institute of Health Studies at the University of Hull, reported that problems had arisen through the juxtaposition of the district medical committee and the Cogwheel structure. It seemed difficult for the MEC and the DMC both to work effectively, he said, and one or other tended to become an electoral college, either to select consultants for the DMC or to appoint clinical members to the district management team.

The case for the DMC to settle important questions was strong, since it gave general practitioners a chance to influence hospital priorities affecting their patients and vice versa. But a DMC tended to become overloaded if it had to deal with too much detailed hospital business and in conclusion Dr Brown said that the answer seemed to lie in delegating as much executive authority as possible to the divisions and, preferably, to an equivalent body on the primary care side. In the reported discussion at the Chichester conference,⁴ Dr Brown hits the nail squarely on the head when he is quoted as saying that no two committees should be doing the same thing. In his district the DMC was strong and the MEC was weak, and it was difficult to see the two bodies co-existing; one or other should go.

Initial stage

As I was the only permanent member of the DMC I felt a life-giving transfusion was necessary and as early as September 1974 I contacted the DHSS to ask if the DMC and the MEC could merge. In a personal communication⁵ the Department advised me that the

New model for the medical advisory system.

DMC was not a statutory body and that the model constitution (HRC74(9))⁶ could be amended to meet the views of local doctors. But a cautionary note was added to the effect

that the Cogwheel structure and the DMC had different functions as described in the Third Report of the Joint Working Party, *Organisation of Medical Work in Hospitals* (1974).⁷

By this time seven health care planning teams were being formed. These were on child health services, services for the elderly, disabled and rehabilitation services, maternity and gynaecology services, services for the mentally ill, services for the mentally handicapped, and primary care and preventive services.

These teams have a wide multidisciplinary membership as appropriate—for instance, hospital and community nurses, social workers, voluntary organisation workers, and a finance officer—and report directly to the DMT; but the views of the consultative bodies described below are required before implementing new policy. All the planning teams' views are collated annually by a district planning working party (I am the chairman) and the DMT seeks the opinions of the following consultative bodies concerning the planning working party's report—community health council, joint consultative committee (representing all staff), and the medical advisory committees.

Some doctors considered that these teams duplicated the work of the MEC and there was overt opposition—for example, from the psychiatric division—to the new health care planning team for services for the mentally ill.

Planning by MEC division rejected

In a draft paper to members of the district management team I suggested a scheme whereby the task of the health care planning teams could be taken on by MEC divisions, while divisional membership could be widened to include a bigger proportion of non-medical personnel. Nevertheless, it was forcibly put to me by non-medical members of the DMT that the MEC divisions could never become truly multidisciplinary as they would always be dominated by doctors. It would be quite impossible for consensus to be reached in the DMT should my suggestions be accepted by medical staff and formally put to the management team for the planning system to be changed. I did not proceed with this idea.

The DMC then discussed a possible merger with the MEC, but the suggestion did not find favour, mainly because GPs who had equal representation with consultants did not approve of a new committee where GP representation was much diminished. So the proposal was dropped. But several months later, stimulated by the two clinical members of the DMT, I prepared a second report

suggesting that the DMC could be abolished if the following amendments to the MEC constitution were accepted:

(a) GP membership to be increased from one to four, so that each cottage hospital area and the chairman of the division would be on the main committee.

(b) A community health services division to be added to the divisional structure. Soon after NHS reorganisation, community health services staff had begun to meet as a division, though it was not recognised in the Cogwheel structure. Creation of a new division would carry with it the right of membership of the chairman to the MEC but the DCP was already a member, and the proposals would result in MEC membership increase of at least three. The new committee might be called the district medical advisory committee. The GP member of the DMT could then be elected by the GP division and the consultant by the rest of the new district committee—its GPs and the DCP not taking part in the election.

These proposals were turned down by the DMC. Consultants thought that the MEC was already large enough and the new proposals would make it unwieldy and less effective. The view could be summed up by the question: Why should the MEC's efficiency deteriorate to aid an ailing DMC? General practitioners agreed.

Let it be thought that all my ideas were aimed at dissolution of the DMC, I should mention that I also proposed that DMC meetings should be on a different night from the MEC so that items would not necessarily be forestalled by the latter committee. This, too, was turned down, as was the suggestion that one of the DMT secretariat should service the committee.

Final stage

By now health care planning teams had got into their stride and in 1976 the DMC was busy examining their proposals. Chairmen of health care planning teams were invited to DMC meetings and members began to feel that they were considering worthwhile topics and using their time effectively. Two factors, however, militated against the improving morale of DMC members. Firstly, most of the planning teams' topics had been aired at the MEC as most were to do with the hospital service; but perhaps more important was the severe limitation in financial resources which affected most of the plans, making their fruition seem unlikely in the foreseeable future.

Matters came to a head once again in early 1977, when the administration put a paper on the future of the cottage hospitals before the DMC. The DMT had always looked upon the DMC as the district's medical advisory committee, though this interpretation was frequently resisted by the consultant member of the team. Consultant members always insisted that hospital matters were for the MEC to deliberate on, while the DMC dealt with general health problems. The difficulty with that belief was that there was hardly a problem considered by the DMC that did not have implications for the hospital service. To present a submission to the area health authority about the next major phase of the rebuilding of the district general hospital a decision about the future of the cottage hospitals was needed fairly quickly to fit in with

the planning cycle. The DMC, with its nearly equal numbers of family and hospital doctors, was considered to be the right forum for this type of discussion. In any case, the MEC, through its divisions, would need several weeks to come to a united view. Medical staff fiercely resisted the idea that the DMC should make such a decision, insisting that the MEC must brief the hospital representatives first, and inevitably the DMC would then have a rubber stamping role only. These events spurred me to present yet another—and, from my point of view, final—report about medical advisory committees. By this time the third chairman of the DMC had been installed and its membership was much altered.

There appeared to be two constraints to any change. Firstly, adequate representation of all medical staff was necessary and, secondly, the MEC should remain unchanged. The figure illustrates the suggested model whereby three separate committees with cross-representation would advise the DMT. By these means each medical member of the DMT would have a back-up committee to advise him. The general practitioner committee would be the existing Cogwheel division. This GP committee would then have a dual role of a Cogwheel division and provide advice on general medical services to the DMT. The MEC and the community health services committee would advise the DMT about hospital and community health matters, respectively. If he wished, each chairman or his nominee could attend the other two committees, and chairmen would receive all three committee agendas. In the event, it was the DCP, as chairman of the community health services committee, who frequently exercised this prerogative. Though I was a member of 25 committees and had no desire to acquire more, regular attendance at the MEC and occasional attendance at the GP division was necessary to fulfil my planning role.

In the unlikely event of one committee taking exception to the advice given to the DMT by another there would be direct access to the DMT by any other committee via its DMT member. Very rarely, representatives of the three committees would need to meet, and I proposed that a "DMC style" group could be formed—say, by four members of the GP committee, four members of the MEC, one from the community health services committee, plus the DCP. The GP committee would elect the GP member of the DMT and hospital consultants would elect their member.

In contrast to my previous proposals the latest ones received unanimous assent. Two further proposals were amended. I envisaged that the acceptance of the new model would result in the abolition of the DMC, but an ingenious amendment was carried in the DMC to suspend its activities and delegate them to the three new committees described. This obviated "constitutional problems." After three years the arrangements would be reviewed, but any of the chairmen of the three committees could call a DMC-style meeting and from there steps could be taken to reconvene the DMC proper. I also thought that the health care planning team for primary care might be abolished and its job taken over by a joint meeting of the general practitioner and community health services committees, but this was not supported.

The resolutions of the DMC were later approved by the GP division, the MEC, and the community health services committee, and finally accepted by the DMT. During the

ensuing months the new system worked well with minimal duplication of agenda items between the three committees.

So, after just three years, a pre-1974 tripartite advisory system has been set up in this district and, at present, all concerned view it favourably.

I wish to thank the clinician members of the district management team for their helpful advice—Dr P F Goddard and Dr A C Trevan. I am grateful to Miss Barbara Hancock, MEC Secretary, for information concerning pre-1974 events.

References

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French for doctors

In conjunction with the Institut Français du Royaume-Uni, the BMA is offering a French course for doctors who wish to practise in a French-speaking country or speak French on holiday. The 20-week course, which will start on 13 January 1978, will be at two levels. Level 1 is intended for students with "O" level French; it will use an audiovisual method based on medical material. Each session will last two hours from 6 to 8 pm. Level 2 will cater for students who can express themselves in French. Each session will last one and a half hours and students will study and discuss texts of general medical interest.

Though intended primarily for BMA members, non-members and medical students are invited to apply for the course. The numbers must reach a minimum of 12 students at each level and the maximum number per class will be 20. Classes will be held on Thursday evenings at the French Institute, 14 Cromwell Place, London SW7. Fees are £20 for level 1 and £18 for level 2. Miss Christine Leonard, British Medical Association, BMA House, Tavistock Square, London WC1H 9JP (01-387 4499), will supply registration forms.