so that in the end he would take a pay cut. It seems grossly unfair that such doctors would lose the £4 a week due to them under the next pay policy.

"Our employer, the Department of Health, under the guise of the pay policy, is asking us to accept proposals, however well wrapped up, whereby the great majority of junior doctors would take a salary cut. No union could accept such proposals."

TALKING POINT

Facing too many ways? Community medicine at district level

A R GRIEW, J P HUTCHBY, A K SPENCE, M C T WILKES

The performance of community medicine at district level will determine the success of the specialty. This is borne out by the role envisaged for the district in the management structure of the NHS¹ (the "Grey Book") and its planning system.² The concept of the district, "a population served by community health services supported by the specialist services of a district general hospital," is not new. The Porritt Committee³ said that, "in each area general hospital there should be a comprehensive department of social health closely linked with the other specialist branches."

We think that a start should be made to test "the hypothesis of the district community physician,"⁴ examining our experiences in the light of the role specification in the "Grey Book."

Role analysis

We work in a four district area and have analysed our role and responsibilities.

MEMBERS OF THE DISTRICT MANAGEMENT TEAM

The success of the DMT depends largely on developing satisfactory relations between the DCP and key members of the team. Because of the district administrator's role in providing general administrative co-ordination for the DMT, the relationship between him and the DCP is the most important of the various intra-team relationships. Preparation by a chief officer group is necessary if the DMT is to carry out its work effectively, and for each of us this means a weekly meeting in addition to the formal DMT meetings.

There are also meetings with the AHA and "think-tank" meetings on team development. This is a result of a DHSS-sponsored organisational development project carried out in the area with the help of the Industrial Training Service.

CO-ORDINATING RESPONSIBILITY FOR OPERATIONAL HEALTH SERVICE PLANNING

We try to identify opportunities to improve the operational health care services to enable the best patient care to be provided with the resources available. We all think that this has been a major part of our work, though, as a result of the management philosophy introduced with reorganisation, important parts of it are, rightly, carried out on a group basis.

Since December 1974 we have set up health care planning teams and related working parties for the following services: elderly, children, mentally ill, mentally handicapped, physically handicapped and young chronic sick, expectant and nursing mothers, family planning, and casualty services.

Apart from our membership of the DMT, we consider health care planning team work to be our most important function because it is unlikely to be tackled as successfully by other disciplines. The team structure provides a clear multidisciplinary channel through which identified improvements in services can be incorporated in the NHS planning system and the necessary adjustments made to improve the effectiveness of existing services. The DCP acts as chairman of all planning teams in two districts, in one out of three in the third, and in three out of seven in the fourth. Even when not chairman, he is

HJSC Executive recommends continuation of industrial action

At its meeting on 7 August, the HJSC executive recommended that existing regional industrial action should continue and that an emergency meeting of the full HJSC should be convened on 19 August to consider the call from various regions for the escalation of industrial action.

heavily concerned in co-ordinating the activities of the other members of the health care planning teams and their subgroups.

A major factor is the quality and availability of administrative support to service the teams. Another constraint is the large number of other standing committees (including local government) which the DCP has to attend.

A detailed survey of health care planning team members' views is being carried out in one district⁵ and 41 out of 50 members who have replied so far have said that they think the work of their team likely to bring about an improvement in the way the relevant service operates. Half also consider that the team will bring necessary additional resources into the service which otherwise might not occur.

Another task is to co-ordinate preventive services in the district, including operational control of attached clinical community health doctors. The policy of this AHA is that services should be managed at district level wherever possible and appropriate. This policy has been valuable in ensuring the integration of operational health care services, particularly those for school and preschool children.

The extent to which the DCPs are asked to advise consultants and general practitioners is a measure of the degree of understanding and acceptance of the role of community medicine by our clinical colleagues. This is particularly so with hospital staff, since, though the pre-reorganisation MOH had frequent requests for advice from GPs, this was less commonly sought from hospitals, except where the MOH was a member of a cogwheel division or where joint planning arrangements between hospital and local authorities had been developed.⁶

"Proper officer" functions for the local authority

While many of the routine and non-medical aspects of environmental health control have rightly passed to the newly established chief environmental health officers' departments, community medicine still has a part to play, particularly in controlling notifiable disease and in relation to the medical aspects of environmental health. Though two of us have a particular interest in this branch of the DCP's work, we all think that it fits uneasily into the general pattern of our responsibilities. The main reason for this is that most of our time is taken up with multidisciplinary group work, and it is difficult, for example, to justify abandoning a meeting with consultant and other key staff, often convened by the DCP on a major health issue, to deal with an urgent, time-consuming, but more limited environmental health problem. We cover nine environmental health district committees. A joint liaison committee on environmental health, initiated by the area medical officer, includes staff from area, districts, the veterinary services, the water authorities, and the county council.

The control of infectious diseases requires a close working relationship with GPs. The DCP must have sufficient community medicine support if a damaging clash of responsibilities (with consequent failure to achieve the principal stated aims of community medicine in the new NHS) is to be avoided. Without such support there is a real danger that excessive attention to infectious disease and environmental health matters may prejudice the planning of operational health care services, which we believe to be the community physician's paramount role. The problem is being met in this area by the appointment of a specialist in community medicine to provide district support in the environmental health field in two of the four districts, and by the help of a senior medical officer in a third. Such provision should be made nationally since its lack is a big gap in the manpower plans for community medicine put forward at reorganisation.

Subject to these reservations we are all convinced of two things. Firstly, that the opportunities arising from NHS reorganisation and the role of community medicine can and will be grasped in the context of a multidistrict area. Secondly, that our main aim of facilitating the improvement of relevant operational health care services at district can be achieved.

Discussion

In industry care used to be taken to distinguish between "line" and "staff" roles. The "line" workers are controlled by the managing director, and their function is production. "Staff" are the advisers—research and development, marketing and after-sales service. They have their own, looser, hierarchy but cannot attain the topmost tiers of the executive and still remain "staff." The lack of this distinction is the hope and the peril of the DCP. The hope lies in the ability to bring ideas and advice based on researched information directly to the executive (the DMT). The peril lies in the possibility of too much work on too many fronts, with the danger that the two roles of adviser and executive may engender suspicion from other NHS staff—not least our medical peers.

In a multidistrict area the views and personalities of individuals are too influential in determining the extent of area specialist

support for districts. More direct support should be available as a matter of national policy. The second problem will be resolved only when clinical colleagues realise the depth of their own participation in decision-making and can accept the DCP for what he is: another doctor in the range of diagnostic specialists but one who studies the whole population rather than the individual patient.

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Hereford and Worcester Area Health Authority

A R GRIEW, MB, MSC, district community physician
J P HUTCHBY, MB, DPH, district community physician
A K SPENCE, MB, DPH, district community physician
M C T WILKES, MB, DPH, district community physician

Junior clinical academic staff New salary structure agreed

At a meeting of the Clinical Academic Staff Salaries Consultative Group on 6 August the following agreement was reached on a new salary structure for junior clinical academic staff.

(1) Junior clinical academic staff are obliged to perform such duties as may be required from time to time and, in common with all university teachers, have no fixed hours of duty.

(2) It has been recognised that following PIB Report No 98 (Cmd 3866) clinical academic staff remuneration should be broadly comparable to that paid to their counterparts in the National Health Service.

(3) The principle has been accepted by successive governments and has been held to include an extra duty allowance payment scheme for junior clinical academic staff, broadly comparable but not identical to that operating in the NHS.

(4) At the time this was agreed it was also accepted that the extra duty allowance scheme would continue until agreement was reached on a new scheme bringing about broad comparability with the "new contract" for junior hospital doctors in the NHS.

(5) For this purpose an amendment of the existing scheme is necessary to determine the categories of duties over and above which units of medical time payments can be made.

The following scheme has been agreed by the consultative group for implementation as soon as practicable and not later than 1 October 1976.

(a) The academic duties of a clinical university teacher include all duties performed by him in connection with his responsibility for teaching, research, administration, and patient care, subject to what is said below in 5(b), whenever, wherever, and for however long a period such duties are performed. Consistent with maintaining the principles in paragraphs 2 and 3 above the basic salary of junior clinical academic staff payable in respect of their academic duties shall be regarded as comparable to the basic salary payments of their counterparts in the NHS. Such duties shall not rank for extra payments.

(b) The extra duties of clinical university teachers consist of duties and responsibilities arising directly and solely from residence in a hospital, or having to pay visits to a hospital on a duty rota, or being on call with liability to recall to a hospital,

and any other extra duties that shall be required for the continuity of medical care or well being of the patient. Such extra duties shall be identical to their NHS counterpart. Extra duties shall be remunerated on the strict application of A and B units of medical time in concurrence with the present form of the NHS agreement.

(c) In no case shall any extra duties under these arrangements attract additional payment that would not have attracted additional remuneration under the NHS scheme.

The University Grants Committee has agreed that the scheme will be implemented as soon as possible and in any case not later than 1 October 1976. Junior clinical academic staff employed by universities and the Medical Research Council will be eligible for this new method of remuneration. Other clinical research fellows should inquire of their present or prospective employing authority whether they will be included in the new system.

Family planning payments for clinical academic staff

Mr J P Carswell, the Secretary of the University Grants Committee, said at a meeting of the Clinical Academic Staff Salaries Consultative Group on 6 August that as the money for family planning payments was not University Grants Committee money they did not feel able to make recommendations as to how it should be paid. It was the view of the UGC that this was a matter for individual universities to decide.

The chairman of the Full Time Medical Teachers and Research Workers Committee of the BMA, Professor J P Quilliam, has accepted this view and invites local groups of doctors to contact the BMA Secretariat if they experience difficulty with their local negotiations.