TALKING POINT

Community medicine: where are we going?

J STUART HORNER

*They seek him here, they seek him there,
These doctors seek him everywhere.
Is he their friend or someone to shun,
That damn'd community physician?*

It should surprise no one that there has recently been renewed interest in the community physician and his place in the reorganised National Health Service. The new specialty lays much stress on the need for evaluation in health services and there is a natural concern among doctors to know more of what, if anything, is being achieved. Two years is a reasonable period for any group of doctors to confirm or deny that they have a useful contribution to make to the work of their colleagues. Moreover, two years is approximately the period of time lag during which old stationery is replaced by new style headings without the need for overprinting and the community physician's name and office is appearing on written documents. The medical profession has also been anxiously watching this new bureaucratic animal (the reorganised NHS), trying to determine how it works, and how its functions can be influenced.

Doctors' contributions

The prototype envisaged three ways in which doctors might make an effective contribution in the revised structure and the first of these, the medical advisory machinery, on which the profession had lavished such devoted and loving care is already demonstrating its inability to influence events. One community physician has pointed out that an application for a senior registrar post may have to be considered by no less than 14 medical committees and in many areas and regions the medical advisory committees meet infrequently and in some cases not at all. Few area medical committees can claim the 30 meetings of my own area with 400 items discussed, but then few have appointed area medical officers as their secretaries, and so guaranteed themselves access to all important events in the management structure. The community physician has a service role towards his colleagues and should undertake this throughout the cogwheel machinery. Clinical colleagues do not help themselves by keeping the community physician at a respectful distance.

The second area was the participation of the clinicians in the management process but the first two years have merely emphasised their relative ineffectiveness and the difficulties associated with such an imaginative concept. The need to maintain clinical skills, inability to attend all meetings necessitating the use of deputies, and the need to ascertain the views of colleagues are only some of the difficulties faced by the clinical members of the team. Projected into an administrative job by colleagues who would prefer to get on with clinical practice they find themselves constrained by the need for team consensus and unable to speak with the authority of a consensus view of their medical colleagues. So, inevitably there is increased interest in the third avenue into the management organisation—the community physician.

Meaning of the title

Efforts to try and understand the work of the community physician are seriously handicapped by a misunderstanding of his title. If a community nurse works outside the hospital surely the community physician is by analogy exclusively concerned with the problems outside the hospital service. Many come to their posts with no recent

hospital experience and it has been all too easy to misinterpret their desire for information and their wish to be helpful in the hospital service as unwarrantable intrusion. The work of the community physician embraces health services wherever they are provided and at present he has probably a greater contribution to make in the hospital than outside it. His perspective, however, must always be that of all the people in the geographical area that he serves, whether it be the catchment area of the local district general hospital or the artificial boundaries created by regions and many areas. A patient does not cease to be a member of a community merely because he occupies a hospital bed, and it is that total community which the community physician is expected to serve. No greater mistake could be made than to equate him with so-called community services outside hospital or to assume that he is the medical officer of health with a change of name.

Community physician and the management team

One of the principal functions of the community physician is to serve on the management team, either at district, area, or regional level. It is through such membership that most community physicians exercise a continuing management function, and it is important to consider the contribution which the community physician should make to the team. The effectiveness of management teams clearly varies like boards of directors, and the analogy may be an apt one. The administrator is the works manager, being concerned mainly with the operation of the plant and the services required to enable the professional staff to function effectively. Some administrators seem to have aspirations to become managing directors and this tends to cause tension and friction within management teams which are unhelpful and unnecessary. The treasurer is the financial director and may either take the view that his task is to control the rest of the management team from unwise spending or, alternatively, the far more helpful attitude of making what the rest of the team wish to accomplish financially possible. The nursing officer is appropriately cast as the personnel director as she controls the largest group of staff.

The clinical members seem to be the early precursors of worker/directors and, like them, may have difficulty in deciding what is their principal responsibility. Most see themselves as having a representative function in respect of doctors, but it is almost impossible to be concerned with management and not to participate in it, so that at times the clinical members find themselves agreeing to decisions which their clinical colleagues will later challenge.

By this analogy the community physician is the research and development director. He is charged with the responsibility for producing new ideas for the team and for challenging existing methods of work. In periods of economic difficulty it is usually the research division which suffers the greatest economies and the community physician has suffered several handicaps in trying to implement this function.

HEALTH CARE PLANNING TEAMS

Originally it was envisaged that the community physician would generate his ideas through the "shop floor" by ensuring that those directly concerned with patient care took part in health care planning teams. Over the first two years there have been increasing doubts about the value of such teams. It has been alleged that 14 drafts of a circular on health care planning teams were produced by the DHSS before the unequal struggle was abandoned and a much shorter circular (HC(76)18) finally issued merely exhorting districts to "review their planning arrangements." Moreover, the community physician having surrendered—with varying degrees of willingness—his managerial responsibilities for nursing staff and environmental health staff

finds that other colleagues on the management team are less willing to concede to him the tasks which he was supposed to inherit. In a sense, many community physicians were fortunate in having had a "dress rehearsal" during the Seebohm reorganisation, but it has certainly added to the difficulties of the community physician that he has had to fight, not always successfully, to take over tasks which were originally thought to be essential to his role.

Moreover, administrators, themselves unclear about the function of the community physician, have failed to appreciate his need for adequate supportive staff so that the research director often finds himself doing the work of the office boy because there is no office boy to undertake such minor functions on his behalf. If no help is given for the routine tasks which must be undertaken the community physician finds himself so committed with such tasks that he is unable to undertake those responsibilities which can only be developed by his distinctive knowledge and expertise. Finally, the community physician finds that the health information system he was due to inherit at the time of reorganisation is at best embryonic and in many cases non-existent. After many hours of labour he may be able to produce some approximate statistical information upon which to base his planning forecasts and when he presents this to his clinical colleagues in triumph he is likely to be told that he has merely succeeded in proving the obvious.

Assessment of need and evaluation of services

The principal tasks of all community physicians are the assessment of health needs of communities and the evaluation of health services provided for those communities. Few community physicians would claim that much progress has been made in this area. In fairness it must be conceded that the technical problems are immense. Although epidemiology has made great advances in the prevention of non-infectious disease, the application of the available research studies to the service requirement in an identifiable local community raises major difficulties. Firstly, the population base must be defined and the shortsighted decision to base health districts on hospital catchment populations rather than on definable administrative units has meant that many populations have to be estimates. While much care has been taken in determining such estimates it would not be uncharitable to describe them as little more than intelligent guesses and not a suitable starting point for statistical analyses. The cancellation of the 1976 Census, while no doubt essential on economic grounds, means that projected populations upon which most of the health care planning for the remainder of this century will be based, will become increasingly unreliable and it will now be the middle 1980s before there can be any means by which current assumptions about the age structure of populations can be tested. Indicators of need have hardly begun to be developed and, while some sophistication in the analysis of mortality data can now be achieved, the Health Service is primarily concerned with morbidity data where a major breakthrough in the development of indices is still awaited. Evaluation of services is still at its most elementary with hospital activity analysis not even beginning to justify the faith which the Department has placed in it. Many clinicians are completely disenchanted with its output to such an extent that they do not even look at the tables which are produced. With the computer producing lengths of stay for men in gynaecology wards, who can blame them?

ECONOMIC RETRENCHMENT

The new specialty of community medicine always accepted that it was destined to develop in fairly barren soil but few could have foreseen that it would also have to contend with the weedkiller of economic retrenchment. Thus, even those community physicians who are prepared to tackle the enormous basic problems, still find themselves faced with insuperable difficulties. There are insufficient established posts in community medicine to allow adequate time to be allocated to this work. Community medicine is the only group which shows a net reduction in staff numbers since reorganisation, and the profession's request that the Department's policy in the clinical specialties of appointing two consultants in each specialty to each district should be applied in community medicine has so far not been met. Moreover, one in six of existing posts remains vacant. Lack of administrative support has already been discussed but the community physician's task is to interpret data not to collect and record it, and for these latter skills administrative support is required. Specialist statistical support is also required but not only is this not provided at district level as many would consider to be necessary, but effective statistical units

have not been developed either at area level or even at regional level, presumably because of resource constraints.

COMPUTERS

There is an increasing sense of disillusionment with computer data processing. Originally thought to mark the beginning of a new era in organised medicine, doctors are increasingly concerned about aspects of confidentiality which are hardly allayed by suggestions that the profession is old fashioned in these matters. Many find the existing NHS computer system inadequate, even for the minimal payroll demands made upon it and suggestions that service applications might be considered in the immediately foreseeable future are laughable. Many cling tenaciously to previous local authority computer systems which in some areas have been shown to be effective and appropriate to local needs. New national computer systems appear but even computer programmers doubt their applicability, quite apart from community physicians. Thus the era of the community physician analysing inexhaustible data on the computer terminal in his office remains as remote as ever and its delayed arrival limits both his own understanding of his position and the contribution which he can make.

Perhaps most depressingly of all the cross fertility with the burgeoning academic departments of community medicine and also with the DHSS heralded with such hope after the Report of the Committee on Medical Administrators—obstinately refuses to develop. The specialty has always been handicapped because service needs and academic interests have tended to pursue divergent paths and, while there has been an increased recognition of the essential unity of the specialty, little progress has been made in resolving its basic technical problems. Hopes that the Faculty of Community Medicine and the provision of specific training posts within the service would assist in this process have not materialised: a depressingly large number of community physicians seem to feel that the faculty is too academically based and insufficiently sensitive to their immediate problems particularly at district level. Moreover, though the training programme is beginning to meet its present targets many feel that those targets were far too modest. Furthermore progress made in creating training posts in some regions, often where the need for consultant appointments is greatest, has been too slow. It has yet to be seen what effect the freezing of community medicine posts¹ will have upon the recruitment of suitable candidates in a specialty which does not always attract its fair share of the most able doctors.

Preventive services

The community physician has a specific responsibility to maintain and encourage the preventive services. Indeed, many have been gratified by the welcome conversion of the DHSS to the concept that such a policy may have economic as well as other advantages. Many who were prepared to support Sir George Godber's conclusion that the separation of preventive medicine from the mainstream of curative medicine was harmful were nevertheless anxious that the proposed integration in one direction might only result in a dangerous fragmentation in another. The community physician now finds himself only with an advisory role in environmental health, the managerial responsibilities for which have now rightly passed to another emerging professional group. He is left with direct responsibility only for infectious disease control, where in any case the steady reduction in clinical practitioners is causing increasing concern. If infectious disease continues at its present relatively low level these changes are probably justified, but if the country ever again faces a resurgence of infectious disease it will find both our clinical and preventive barriers totally ineffective against the consequences.

HEALTH EDUCATION

Health education is an excellent example of the difficulties which the community physician now faces in the prevention of disease. Not only must the community physician argue the priorities for health education against the persistent clamour of curative services but he must also attempt to gain priority for such services in competition with administrative needs as well. In an attempt to control administrative costs a freeze in money terms has been imposed on all grades of staff "not offering a service to patients." Perhaps the definition should have been "hospital patients" since in the hospital dominated re-

organised NHS health education officer posts have been included in such a freeze, notwithstanding the fact that most health education practitioners spent most of their time teaching schoolchildren, mothers in clinics, and middle-aged groups for whom the control of smoking and the improvement of diet is an urgent necessity. Any person who seeks help from the NHS is surely a "patient" and the inclusion of health education officers in an administrative control exercise illustrates the yawning gap between precept and practice when the DHSS considers the problems of prevention.

POPULATION SCREENING

Population screening is an emotive and controversial subject but many have suggested that this is likely to be the next step forward in preventive services. Although "proof" is rarely required before a new curative service is introduced, screening techniques are expected to prove themselves conclusively before recommendation, thus the community physician finds his opportunities for preventive initiative seriously limited by current administrative arrangement, restriction of essential staff, and doubts about professional validity.

Misunderstood specialty

The need for consensus has destroyed the opportunities for the entrepreneur and the specialty of community medicine is denied the opportunity of making the contribution to medicine of which it is capable. So is it surprising that the Secretary of State—like his civil servants and regional administrators—considers that the specialty is composed of administrators who happen to have a medical qualification and whose numbers must be firmly controlled?

References

- ¹ *British Medical Journal*, 1976, 2, 432.

Croydon Area Health Authority

J STUART HORNER, FFCM, DPH, area medical officer

General Medical Services Committee

The Chairman has told the Secretary of State that GPs should be paid extra for extra work.

The GMSC will recommend to the Council that the RCGP Council be invited to send a representative to the committee.

The committee is to tell the CMO that the GMC should examine in appropriate cases the linguistic knowledge of doctors from other Member States in the EEC who come to practise here.

At the start of his oral report at the meeting on 16 September the chairman, Dr R A Keable-Elliott, reminded the meeting that one of the points in the "crisis of confidence" statement (24 July, p 250), which had been subsequently discussed at a meeting with the Prime Minister (31 July, p 310), was that additional work in general practice should attract additional remuneration. The chairman had since written to the Secretary of State about it. He had also written about trainee GPs who suffered a loss in remuneration when leaving their hospital training posts because of the improved pay negotiated for hospital junior staff. Another matter raised had been the direct payment of ancillary staff—the negotiators had suggested that this should be increased to 80%. The DHSS had suggested, however, that the pay policy prevented any alteration but it was seeking advice from the Treasury and the Department of Employment.

It was the negotiators' duty, the chairman pointed out, to raise with the Review Body the position of GPs who had received a nil award because of the pay policy. This and the other matters already discussed with the DHSS would be considered at the meeting of the Joint Evidence Committee on 30 September.

Dr Keable-Elliott congratulated the hospital junior staff negotiators on the successful outcome of their dispute with the Government over annual and study leave.

Turning to the Royal Commission on the NHS the chairman thought that the BMA could not submit its evidence without a Special Representative Meeting. Though local medical committees were being consulted about the GMS Committee's evidence it might also prove necessary to call a Special Conference of LMCs or at least a special meeting of the committee.

At a recent negotiating meeting the DHSS had been given the GMSC's views on the consultative document on priorities. The negotiators had criticised "consultation" documents which turned into policy documents and the DHSS had agreed to report on how the Government intended to deal with comments on what seemed to be a definitive document. Other items dis-

cussed had been the transfer of patients on the contraceptive list to an incoming partner and the question of renewed claims for contraceptive services before the end of the first 12 months. Draft circulars on these matters were awaited.

The chairman reported that the DHSS had at last produced draft circulars clarifying that members of district medical committees and other bodies set up by health authorities—including regional postgraduate education committees and their GP subcommittees—could receive the same allowances and compensation for loss of remunerative time as members of regional and area advisory committees. The negotiating team had approved the circulars.

Criticism of the medical profession

In his report the chairman had referred to the "unhelpful" report produced by two members of the Bow Group on the Health Service. Both in their twenties and with no experience of medicine they had suggested, among other things, that general practice should be abolished and primary care provided by auxiliaries. Dr J Noble thought that the profession had been attacked enough—it was not only the Bow Group, Dr Beric Wright had also made disparaging remarks about the profession at the meeting of the British Association. GPs were still the most popular people in society and they ought to publicise what they did. It seemed to be an open season for denigrating GPs, observed Dr W G A Riddle, and he wanted the BMA Council to remind all branches of the profession not to criticise each other.

Co-option to the GMSC

The General Purposes Subcommittee had prepared a memorandum on co-option of members to the main committee. At present the Hospital Junior Staffs Committee, the SHMOs Group, and the BDA send observers with no voting rights, while the representatives of the Central Committee for Hospital Medical Services, the Central Committee for Community Medicine, and the Private Practice Committee are full voting members. The subcommittee had, therefore, recommended: "That it be recommended to the Council that the status of 'non voting member' be accorded to the representatives on the committee of the CCHMS, CCCM, HJSC, PPC, SHMOs