Some progress had been made, Mr D E Bolt explained, though originally the Department and the GMC had been told that an assessment scheme was no substitute for a proper clinical test. Dr E B Lewis was concerned about the responsibility for patient care when a person who had marginally passed or failed TRAB was taken into a team for a month. Sir Rodney Smith said that the candidate should neither have passed nor failed until he had taken both parts, and it was pointed out that Sir John Richardson had agreed and wanted TRAB results announced annually.

The group which met the DHSS and the GMC will prepare a further paper on the matter for the interim JCC.

Part-time training

At an earlier meeting the JCC had decided to collect information from constituent bodies about part-time training for doctors with

The JCC made a presentation to Dr David Gullick, who has been deputy secretary of the JCC for three years.

JCC supports call for independent inquiry

Committee resolution

The Joint Consultants Committee meeting today at the Royal College of Physicians of Edinburgh received a report concerning the suspension of a consultant psychiatrist, Dr Terence Lawlor, by his employing authority, the South-west Thames Regional Health Authority, under threat of industrial action, after Dr Lawlor had sought an inquiry into unexplained injuries to patients.

The Joint Consultants Committee unanimously and strongly supported the call for an inquiry under section 70 of the 1946 National Health Service Act, in order that the facts may be as fully established as possible in a matter of considerable public concern.

domestic responsibilities. This had been in connection with the Department's document "Women in medicine." For the Royal College of Obstetricians and Gynaecologists, Mr Raymond Booth said his college had accepted the concept of part-time training. Provided that candidates completed the training they were allowed to sit the examinations.

Sir Rodney Smith said that the Royal College of Surgeons would consider the matter but no one had come up with a scheme to train a surgeon except on a full-time basis. The committee was told that the DHSS wanted advice on the matter and the meeting agreed that a working party should be set up after consultation with the CCHMS and the colleges.

Clinical psychologists

A draft circular on the role of psychologists in the Health Service had been discussed re-

cently between JCC and DHSS representatives. There were about 500 clinical psychologists at present, Mr A H Grabham told the committee, and they wanted to become "free-standing" and not be under the supervision of a medically qualified consultant. One sentence that the CCHMS and the Royal College of Psychiatrists would like to see removed from the circular was that "psychology should not be regarded as an adjunct to any other profession." The JCC representatives had also objected to the suggestions that there should be direct provision of therapy and that GPs should refer patients directly to a clinical psychologist. Furthermore, they disliked the concept of a multidisciplinary team with everyone agreeing to the team's policy—a solution meant to reconcile the two principles of the consultant carrying ultimate responsibility and the psychologist being freestanding. There was general agreement in the JCC with the objections Mr Grabham had mentioned, particularly about the multidisciplinary management of patients.

TALKING POINT

Is there a future for community medicine?

D H STONE

The "grey book"¹ stated that the district community physician would be engaged in four main spheres of activity: "(a) co-ordinating the formulation of plans for the operational health services; (b) advising his clinical colleagues as a specialist in community medicine; (c) co-ordinating the preventive services; and (d) carrying out various functions for local authorities."

When the NHS was reorganised in April 1974 the resilience of the new specialty was put to immediate test. The administrative upheaval was immense; jobs, institutions, and boundaries were suddenly dissolved, created, redefined or realigned, often simultaneously.

Six months later Donaldson undertook a postal study of the 154 district community physicians in post. The response rate was 84%.²

When asked to describe the main opportunities of their new posts, 65% mentioned the "integration of services," followed closely by "rational planning" (61%). There was less consensus on the main problems of "roles in general" (48%), "lack of medical support" (32%), "relationships between area and district" (30%), and "difficulties with medical colleagues" (23%). The study also showed that much of the time was spent attending meetings (over 80%

spent more than 10 hours per week in meetings and over 48% more than 15 hours). Most complained of a lack of supporting NHS administrative staff.

So the DCP, having risen to the challenge of "integration," faced real difficulties of identification and communication, particularly with clinicians, and I suspect that many of them continue to face difficulties in relating the medical, as opposed to the administrative, functions as defined by the faculty, to the reality of their work. Since those medical functions (as defined by the Faculty of Community Medicine) to the reality of their work. Since those medical functions cannot

be fulfilled by clinical activity, the DCP must rely on the resources of epidemiology and preventive medicine, disciplines in which academic credentials are of the highest order. Yet herein lies the problem. He is a practitioner, not an academic. With clinical outlets denied him only administrative channels remain. Inevitably, this induces frustration, anxiety, and loss of confidence, all of which serve to undermine the adoption of a secure professional identity.

Crisis of professional identity

The concept of the population as a patient is an abstract one. But, as Garraway pointed out, the aims of community medicine and clinical medicine are identical—to promote and maintain the health of the community by the control and prevention of disease.³ The clinician makes his contribution by attacking illness in individuals, the community physician by relating his knowledge of disease to groups or populations.

Social medicine has a tradition of integrating the concepts of prevention, cure, and care. Indeed, the creation of the specialty of community medicine was widely regarded as practical expression of this previously theoretical unity.⁴ The unfortunate maintenance of a rigid barrier between the functions of clinical and community doctors may thus be regarded as both a threat to the professional identity of the community physician and as a denial of the fundamentally holistic view of social medicine from the time of Hippocrates.

The responsibility for the creation of this dualism must rest largely with the professional philosophy, as embodied in its definition, of the Faculty of Community Medicine: "Community medicine is that branch of medicine which deals with populations or groups rather than individuals." The definition explicitly excludes individual patient contact from the activities considered appropriate for a community physician. The clinician, by contrast, regards the individual patient as his prime responsibility. Therein lie the seeds of "goal conflict" of which Garraway warned in 1972.

Prospects for change

This gloomy analysis is not intended to undermine the admirable aims of the faculty nor to persuade it to abandon its definition but merely to highlight some of the practical shortcomings of the latter.

What are the prospects of resolving the dilemma? Two related courses of action should be urgently considered. Firstly, the definition might be altered: "Community medicine is that branch of medicine which deals with populations or groups *as well as* individuals."

Alternatively, a less drastic, though consequently less effective, modification would be to use the definition in the Scottish report *Doctors in an Integrated Health Service*:⁵ "Put at its simplest, community medicine is concerned with... health and disease in populations." This would mean a major reassessment of the legitimate content of the community physician's work. Stated bluntly, there is no logical reason why a community physician should not participate actively in the clinical management of individual patients without compromising his wider responsibilities to the community as a whole. Many

DCPs have the qualifications and enthusiasm for such work, the nature of which would be determined by individual interests. For example, the community physician (or specialist in community medicine) interested in primary care would maintain his general practice skills and experience by applying them, albeit in a part-time capacity. Child welfare and family planning clinics, rehabilitation units, and certain hospital specialties such as paediatrics, geriatrics, and psychiatry, all offer potentially fruitful milieus for the community-oriented doctor. Indeed, it is salutary to consider the pioneering spirit of some hospital based clinicians who have already advanced the cause of "dehospitalisation" through the development of local community services.

As well as providing the community with often sorely needed clinical assistance the clinically orientated community physicians would be likely to reap benefits both in terms of personal professional satisfaction and for the specialty as a whole. There would be several advantages—promotion of professional credibility, enhancement of job satisfaction, maintenance of professional competence, and, probably most important, encouragement of recruitment.

PROMOTION OF PROFESSIONAL CREDIBILITY

The notion of individual patient care is intrinsic to the concept of medicine, which need not be compromised in any way by the notion of "community medicine." The population consists of individuals and the idea of "the medical care of the population" is a meaningless abstraction without reference to the individuals of which it is composed.

Community medicine, as constituted at present, has tended to become isolated from clinical medicine, which has reciprocated by withdrawing, or muting, its support for the new specialists. The restoration of contacts with clinical practice is more likely to win friendship and good will than conscientious attendances at interminable cogwheel committees.

ENHANCEMENT OF JOB SATISFACTION

A commitment, however limited, to clinical practice would provide a welcome diversion from sustained administrative routine.

Clinical activity is in itself rewarding for many doctors, who may view with regret the relinquishment of hard-won diagnostic and therapeutic skills.

MAINTENANCE OF PROFESSIONAL COMPETENCE

A medical problem perceived at a population level lacks the quality of the doctor-patient meeting, which may bestow unexpected insights into the nature of the problem.

A working acquaintance with the daily frustrations, limitations, and opportunities of clinical practice can stimulate epidemiological hypotheses, discourage irrelevant or impractical research, and facilitate administrative policy making.

The community physician, in the course of duty, is likely to become concerned with problems relating to individual patients and their clinical management. The confidence and competence of his approach to such problems

In brief . . .

Parliamentary criticism of NHS financial control

The House of Commons Committee of Public Accounts has just published its report on the session 1975-6 (HMSO £5.30). Several aspects of NHS spending have been critically examined, including catering, the experimental computer programme, and the procedures for the closure of hospitals. The committee, which is chaired by Mr Edward du Cann, has also studied the financial control of expenditure on the Health Service.

On this subject the report comments: "We have been disturbed by the need to report critically in successive years after our examination of the accounting officers of the DHSS, and we will again emphasise the importance of effective methods of financial control, and of according the highest priority on behalf of the taxpayer, to obtaining value for money in the NHS."

Supplements for some consultants

A consultant on the first point of the incremental scale (£8322 pa) may ask for an individual assessment of his income to be made if he considers that his total income from all public sources, such as London weighting, family planning, and lectures, is less than £8500 pa. This arrangement is set out in an advance letter ((MD)11/76) to employing authorities. The consultant will be paid a partial supplement equal to the amount by which the total income falls short of £8500 backdated to 1 April 1976 or the date of his advancement to the first incremental point of the scale, whichever is the later.

Functioning of the CCHMS

The CCHMS's executive subcommittee thinks that it is time to review the constitution of the CCHMS, its subcommittees, and regional committees and the way in which the whole machinery works. This review will be undertaken by a small working party chaired by Dr M M Burrows, a consultant anaesthetist from Liverpool and a member of the CCHMS's Executive Subcommittee.

Family planning in hospitals

An October circular from the DHSS (HC(PC)(76)20) sets out formally "the arrangements to be made for the organisation of family planning work undertaken by medical staff in the course of their employment in the hospital service." Contraception, vasectomy, and female sterilisation other than on medical grounds have not normally been part of the service provided at hospitals. Each area health authority now has responsibility for providing comprehensive family planning services in its area. HSC(IS)32 gave advice on the development of services in England.

must reflect his current clinical participation and awareness.

ENCOURAGEMENT OF RECRUITS

The existence of a clinical component within community medicine will extend its attractions to potential recruits of high quality at both undergraduate and postgraduate levels.

A clinical component would provide a more interesting and appropriate setting for the teaching of the specialty to undergraduates, who frequently express—to the chagrin of their teachers—doubt as to its “relevance” to clinical medicine.

Conclusions and future prospects

The community physician has undergone a long undergraduate course, an arduous period of hospital residency, and a varying experience of postregistration training, usually in clinical medicine or general practice. His career expectations are likely to be realistic in that the administrative orientation of community medicine will scarcely surprise him, though he may feel justly aggrieved that his clinical skills must lie dormant. He may have overestimated the opportunities for applying medical skills of any kind, whether preventive or therapeutic, and he may have underestimated the scale of routine administrative demands, which have pre-empted the development of a satisfying professional role. He may now be experiencing an increasing anxiety that community medicine's hard-won status cannot be maintained in the face of declining morale, lack of clinical and administrative support, and economic stringency.

The threat to the future of community medicine appears to arise from two sources, external and internal. Because of the country's economic plight no branch of public service can adopt a complacent attitude towards its future. Public spending will be reduced and politicians tend to sacrifice first those services whose demise would make least impact on the public consciousness. Community medicine is not exempt from such hazards.

The internal threat is more subtle. The amalgamation of medical administration, public health, and epidemiology has left rough edges. If practitioners of such diverse, though related, fields can submerge their interests and orientations then the future must be bright.

On the other hand, if ideological confusion persists the prospects look bleak. Only a full-scale, uninhibited professional debate can divert the new specialty from its present self-destructive course.

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H=hospital doctor; G=general practitioner; C=community medicine