The Origins of the Faculty of Public Health Medicine

(formerly the Faculty of Community Medicine)
By Michael D Warren

With forewords by Wilfrid Harding CBE and James McEwen

FACULTY OF PUBLIC HEALTH MEDICINE
of the Royal Colleges of Physicians of the United Kingdom
FACULTY OF PUBLIC HEALTH MEDICINE
THE ORIGINS OF THE FACULTY OF PUBLIC HEALTH MEDICINE  
(FORMERLY THE FACULTY OF COMMUNITY MEDICINE)  
of the  
ROYAL COLLEGES OF PHYSICIANS OF THE  
UNITED KINGDOM  

by  

MICHAEL D WARREN  

With forewords by  

WILFRID HARDING  
and  
JAMES McEWEN
**Key to Illustration** (Photograph by R. Lawrence, Marlow, Bucks)

**Members of the Board with the Presidents of the Royal Colleges of Physicians on 15 March 1972.**

(Reading from left to right and from the back row to the front)
T Anderson, H Yellowlees (later Sir Henry), WJ McGinness, AJ Essex-Cater
CR Lowe, WW Holland, JD Kershaw, TA Ramsay and RHM Stewart.

J Halliday Croom (President of the Royal College of Physicians of Edinburgh), Sir John Brotherston, TMcL Galloway (Registrar),
MD Warren (Academic Registrar), FJ Fowler (Treasurer), W Edgar,
GD Forwell and EM McGirr (President of the Royal College of Physicians and Surgeons of Glasgow).

Lord Rosenheim (President of the Royal College of Physicians of London),
JR Preston, Maud P Menzies, AL, Cochrane (President) and WG Harding
(Vice-President). JF Kirk was absent.
DEDICATED TO THE FOUNDING FATHERS

Professor J.N. Morris, CBE
Initiator and Chairman of the Working Party

Lord Rosenheim, KBE
Chairman of the Joint Committee of the
Royal Colleges of Physicians

Dr. W.G. Harding, CBE
Chairman of the Provisional Board
I am delighted to write a few words for this new edition of *The Genesis*, particularly at a time when the Faculty is looking to its future roles and structure, and when there is such development in public health. Wilfrid Harding, in the foreword to the first edition, alluded to the importance of such an account and to the authority that this account has.

It is very helpful to be reminded of the origins of our Faculty, and to recognise a vision and enthusiasm of all those who were involved, both directly and indirectly in community medicine at that time. While we are obviously particularly aware of the rapid changes that are taking place at present, with respect to professionalism, practice and the public health function, change is not new and indeed our Faculty was founded at a time of very considerable change and great optimism.

I would urge all members of the Faculty to read or re-read this excellent account of our early days, provided with such clarity and insight by Michael Warren, our first Academic Registrar. There is now the opportunity to read it either in traditional printed format or on the Faculty’s website. I believe that we will all be assisted in our thinking about the present and future function of the Faculty, if we are more familiar with the history and the issues that have influenced our development. Just as then, the issues surrounding our Faculty today involve government, other professional bodies and the diverse views of those working within our own area. While there have been great changes since the early 1970s, many of the underlying concerns are similar, and I would suggest that we need the same commitment to the future as those responsible for establishing our Faculty.
Professor James McEwen

President
Faculty of Public Health Medicine
From time to time I have been asked about the origin of the Faculty of Community Medicine (now the Faculty of Public Health Medicine). I was strongly tempted to write it up myself, but found I was too closely involved to be able to do so objectively. I am delighted that I can refer enquirers to this meticulous account written by my friend Michael Warren. His report describes clearly and concisely the turmoil of political and organisational changes during the period in which the Faculty was created and their influence on its formation and subsequent development. Drawing on original papers, he has set out the progress and set-backs of the negotiations not only between the representatives of the bodies concerned with what became
“community medicine”, but also between them and the three Royal Colleges of Physicians. Michael Warren has contributed what will be an essential source for those who are interested in the history of the Faculty, of public health medicine and of its link with the Royal Colleges (for the Faculty is the first and only faculty of the three Colleges). It is with admiration and gratitude that I commend this book to Fellows and Members of the Faculty and to many others.

Wilfrid Harding

Chairman of the Provisional Council,
Vice-President (1972-5) and President (1975-8),
Faculty of Community Medicine
ACKNOWLEDGEMENTS

Many people have helped me, but first and foremost I must thank Wilfrid Harding who has been a partner in this endeavour. He continually advised me, gave me access to his unique collection of papers relating to the formation of the Faculty, assisted in many other ways and has kindly contributed the foreword.

Wilfrid Harding and Michael Tibbs identified the references to the formation of the Faculty in the minutes of the Council meetings and of the Comitia of the Royal College of Physicians of London and the minutes of the Joint Committee of the Royal Colleges of Physicians. George Forwell did the same in respect of the minutes of the Royal Colleges in Scotland.

Wilfrid Harding (member of the Working Party and chairman of the Provisional Board), Jerry Morris and Sir Richard Doll (chairman and member of the Working Party respectively), Maud Menzies and Mac Stewart (members of the Working Party and the Provisional Board), Sir Henry Yellowlees (observer on the Working Party and the Provisional Board), George Forwell and Walter Holland (members of the Provisional Board), and Michael Tibbs (secretary of the Joint Committee of the Royal Colleges of Physicians and of the Provisional Board) commented on a draft of this document.

Tom Ramsay, Dame Rosemary Rue and Mac Stewart gave me their recollections of the meetings of the Senior Administrative Medical Officers, and Mac Stewart sent Wilfrid Harding copies of notes he had recorded after such meetings.
Ian Leck supplied copies of the minutes of the annual general meetings of the Society for Social Medicine and of the meetings of the Society's Committee. Alwyn Smith and George Knox discussed their recollections of the anxieties of the Society and of the Heads of Departments during the negotiations for the formation of the Faculty.

Colin Brough, Iain Macdonald, Jimmy Macgregor, James Mercer and George Venters recalled details about the meetings of the Scottish Association of Medical Administrators and other matters relating to medical administration in Scotland.

Peter Gardner helped with references relating to the Society of Medical Officers of Health and JS Wilson lent copies of the minutes of its Scottish Branch. Michael Garraway and Andrew Curran provided substantial information about the development of teaching in public health and social medicine in the medical schools of Edinburgh and Glasgow respectively.

Librarians and archivists gave considerable help, in particular Julia Sheppard (Wellcome Institute for the History of Medicine, Contemporary Medical Archives Centre), Mary Gibson (London School of Hygiene and Tropical Medicine), Emily Naish (British Medical Association), Sue Cover (Kent Postgraduate Medical Centre at Canterbury), GM Furlong (University College London), Patricia Methven (King's College, London), Mike Barfoot (Edinburgh University Library, Special Collections) and Edith Revesz (Department of Health, Records Management).

David London gave permission to quote from the various minutes of the Royal College of Physicians of London. I thank all of the above, and to this list I must add Jean Robertson for her considerable help in many ways from within the Faculty, and Penny Gwynne, Tracey Johnson, Simon Latham, Linda McDonnell, Jackie Newton and Joan Warren for help in preparing the draft for publication.

Finally I must record my gratitude and indebtedness to the Society of Public Health for its generous grant to the Centre for Health Services Studies (Director, Professor Michael Calnan) which has enabled this report to be published.

MICHAEL WARREN
November, 1996

2 Bridge Down,
Bridge,
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WG Harding's Papers contain the minutes of the Working Party and drafts of the proposal to set up the Faculty, minutes of the Provisional Council/Board, and many letters and copies of letters. There is some overlap with documents at the Faculty (see below).

MD Warren's Papers contain minutes and letters relating to the Society for Social Medicine and papers about the development of the examination for the membership of the Faculty and of specialist training in community medicine. His engagement diaries give dates of some informal as well as formal meetings. There is overlap with the papers of the Society for Social Medicine and with the Faculty's archives.

***

British Medical Association archives have a copy of A History of the Medical Superintendents' Society by AD Morris (typescript document).

Edinburgh University Library, Special Collections has the papers of the Scottish Association of Medical Administrators.

Faculty of Community Medicine has a file of "Early Papers until the end of 1970" and another file of some of the papers of Dr F Fowler (member of the Working Party and Provisional Council/Board, and the first Treasurer of the Faculty). It has complete runs of The Faculty Newsletter, News-sheets, The Public Health Physician, Community Medicine and The Journal of Public Health Medicine.

General Medical Council has a complete set of the minutes of the meetings of the Council and its Committees.

London School of Hygiene and Tropical Medicine Library has full sets of Public Health, The Medical Officer and Transactions of the Epidemiological Society.

Royal College of Physicians of Edinburgh - Minutes of the Council.

Royal College of Physicians and Surgeons of Glasgow - Minutes of the Council.
Royal College of Physicians of London - Minutes of Council, Abstracts of Comitia, and the minutes of the meetings of the Joint Committee of the Royal Colleges of Physicians.

Royal Society of Medicine has complete runs of the *British Medical Journal*, *The Lancet* and *Public Health*.

Society of Medical Officers of Health - The main collection of its papers is at the Wellcome Unit for the History of Medicine, Oxford. Dr TS Wilson has the records of the Scottish Branch of the Society.

Society for Social Medicine papers are at the Wellcome Institute (see below).


Wellcome Institute for the History of Medicine, Contemporary Medical Archives Centre has the papers of the Society for Social Medicine and of the County Medical Officers Association.
INTRODUCTION

As the historian CV Wedgwood remarked “those who know the end of the story can never know what it was like at the beginning”. For those who were not there at the beginning this chronicle records the activities which resulted in March 1972 in the creation of the Faculty of Community Medicine (now the Faculty of Public Health Medicine) by the Royal Colleges of Physicians of Edinburgh and London and the Royal College of Physicians and Surgeons of Glasgow. Conscious of Chesterfield’s observation that “a man who has been concerned in a transaction will not write it fairly; and a man who has not, cannot”, reliance has been placed in the main on documentary material with the emphasis on what was important at the time. Something of the contemporary scene and of the aspirations, doubts, possibilities and decisions involved in the negotiations for and the establishment of the Faculty are presented, but neither an historical analysis nor an evaluation of the role of community medicine has been attempted.

The narrative is divided into three parts. Part I describes briefly the development of the activities and responsibilities of the medical practitioners in public health, in the administration of hospital services and in related teaching and research, the changing responsibilities of local and central government for health services, and the changing organisation of postgraduate medical education. Part II describes the establishment of the Faculty, and Part III its early efforts to develop the specialty.

The creation of the Faculty resulted from many forces and for the sake of clarity the progress of some components and issues are treated separately from other contemporaneous events. So that the reader can see the historical sequence of events these are listed chronologically on pages 99-103. To avoid repetition of titles, honours and posts held of people named in the text these details are given on pages 104-112.
PART I

THE BACKGROUND

“The task has always been the same: To promote health by preventing illness and curing it”. Sigerist¹

Preliminary informal discussions about forming a corporate body concerned with the medical specialties of public health, medical administration and social and preventive medicine began in 1967 (see Part II). Prior to these discussions the Society of Medical Officers of Health had explored the possibility of changing its name and constitution so that it could become a College with functions similar to those of other medical colleges, but this idea was abandoned when the possibility of a faculty was broached².

The five years of discussions and negotiations for the Faculty coincided with a period of reform of central and local government and of the National Health Service³, and of the formalisation of arrangements for the training of clinical specialists in the hospital services⁴. These activities, which are outlined below, impinged upon the creation of the Faculty and influenced the content and setting of the practice of community medicine.

LOCAL GOVERNMENT AND HEALTH SERVICES

The Initial Role of Medical Officers of Health

From the beginning medical officers of health were expected to ensure that "the local sanitary authority may be duly informed of such influences as are acting against the healthiness of the population of his district, and of such steps as medical science can advise for their removal; secondly, to execute such special functions as may devolve upon him by the statute under which he is appointed; and, thirdly, to contribute to that general stock of knowledge with regard to the sanitary condition of the people and to the preventable causes of sickness and mortality which, when collected, methodized, and reported to Parliament by the General Board of Health, may guide the Legislature in the extension and amendment of sanitary law”⁵.

Until the end of the nineteenth century medical officers of health were mainly concerned with environmental sanitation, housing, food inspection and control of infectious diseases, including towards the end of the century the administration of isolation hospitals and the clinical care of the patients therein⁶. The populations and geographical areas of the local authorities varied considerably, as did the time and effort given by medical officers of health to their public health duties. By the end of the century there were 1,771 medical officers of health submitting annual reports to the Local Government Board⁷. Many of the
doctors appointed to the smaller urban and the rural districts were general practitioners who were also poor law doctors and who lacked any special knowledge about public health matters. They provided nothing more in the way of a medical officer of health than a "scrap of time" for a "small fee of a few guineas coming with instructions not to be meddlesome". All medical officers of health were subject to dismissal with the agreement of the Local Government Board (and this was usually forthcoming) and to some the non-renewal of their annual contracts for which the employer did not have to give any explanation.

Simon, the first (chief) medical officer at central government level, sought a scientific approach to public health practice. "The first function", he wrote, "which the department had to fulfil was the function of EXACT STUDY ... The Medical Department had to develop a scientific basis for the progress of sanitary law and administration ... We had to aim at stamping on public hygiene a character of greater exactitude than it had hitherto had". Simon's precepts were not being achieved country-wide nor even, in the last two decades of the century, at the Local Government Board.

**Personal Health Services 1900 -1929**

By the beginning of the 20th century the apparatus had been established for dealing with the insanitary aspects of the environment, and it had achieved considerable success. However social surveys and the report of an Interdepartmental Committee on Physical Deterioration in 1904 drew attention to the importance of personal health care in promoting health and preventing disease, to the links between poverty and poor housing and ill health, and to the lack of adequate curative and long-term medical care for the "poorer classes".

During the first 25 years of this century new services were developed in response to these findings. These included midwifery services, school medical services, services for mentally handicapped people, maternity and child welfare services, tuberculosis services and health education services. Often legislation in regard to the provision of new services was based on the experience of forward-looking authorities, who through various means had already developed services akin to those proposed in the acts.

These developments were welcomed by most medical officers of health although apparently they did not change the public image of the MOH, as the editor of Public Health lamented in 1909: "The recent development of public health administration is but little realised by the general public, which still regards the medical officer of health as chiefly concerned with the supervision of drains". This was a perception which continued to be held for very many more years - even after the MOH had become responsible for a far wider range of services than he had been in 1909.

**Municipal and Voluntary General Hospitals**
In 1929 the councils of counties and county boroughs were given powers to provide general hospitals and they became responsible for the administration of the domiciliary medical care of people receiving welfare financial assistance. The abolition of the Boards of Guardians, effected by the Local Government Act\(^20\), not only transferred poor law functions to the counties and county boroughs, but also transferred to these bodies a vast system of hospitals and institutions in which chronically sick people, frail elderly and acutely ill people were cared for and treated. The Act left much discretionary power in the hands of the local authority; some, such as the London, Surrey, and Middlesex County Councils and Manchester, began the development and up-grading of general hospitals, others were slow to introduce change. An important effect of the Act was the union under the direction of the medical officer of health of preventive and curative medical services\(^21\).

Sir George Newman, the chief medical officer at the Ministry of Health at that time, referred in his annual report to the great opportunities available to local authorities to improve their expanded services. "The position demands," he wrote, "of every Medical Officer of Health concerned a careful study and survey of the whole medical situation of his area"\(^22\).

However, not all medical officers of health were enthusiastic about the increase in their duties. For example the county medical officer of Lancashire said in 1929: "I hope there is no danger that the curative work now imposed upon us will take the time and energy which ought to be given to preventive work. The most important part of our work should still be the promotion of the science of healthy living, which includes adequate housing accommodation,"
proper nutrition, the dissemination of a knowledge of hygiene and health education, and the best means of preventing disease\textsuperscript{23}.

Six years later, and speaking with the experience of carrying out the new duties, the county medical officer of Somerset repeated the warning that there was a "pre-existing and ever-pressing tendency to deflect too much time to curative and remedial work and away from preventive work.... Personally, I do not suggest that we have taken the wrong turning but rather that while we have our feet well set on the broad road of preventive medicine, we are being induced and officially directed to squander our energies by incursions into side roads which, while occasionally profitable and sometimes interesting, prevent progress to our real goal being other than deplorably slow.... One urgent need is adequate scientific controls in our work and that means an adequate staff.... It will be obvious that I do not hold the view that medical officers of health are but passive instruments to carry out policies initiated in Parliament or Whitehall under the direction of their respective authorities. They have this to do but I believe their special training and wide experience entitles them to, and should compel them to, survey the whole sphere of preventive medicine and to express their views and to exert their influence in making the practice of public health more scientific in outlook and more effective in operation\textsuperscript{24}. Similar doubts and thoughts were to be expressed following the re-organisation of the National Health Service in 1974, two years after the foundation of the Faculty.

Throughout the 1930s the main providers of acute general hospital services were the voluntary hospitals. These were independent institutions funded (usually inadequately) through endowments, donations, various contributory schemes and payments from patients, with unpaid visiting senior medical staff who were represented on the governing bodies and committees through a medical staff committee. In contrast the municipal general hospitals were funded by public money (which due to the current financial crisis was being cut back), had salaried medical staff and a hierarchical staff structure with a medical superintendent at the apex exercising clinical supervision throughout the hospital and responsible for its general administration. These differences in ethos and the unreformed structure of local government were significant factors in deciding a structure for the National Health Service which was largely independent of local government and hence of the medical officer of health.

In 1935 the British Hospitals Association appointed a commission to consider the present and future positions of the voluntary hospitals in the light of their financial plight and the development of the municipal hospitals. The Commission recommended, in 1937, that the country be divided into regions with the formation in each region of a Voluntary Hospital Regional Council with a Central Council to co-ordinate the work of the regional councils, and that the State and local authorities should provide grants to the voluntary hospitals\textsuperscript{25}. No action was taken in regard to these and other recommendations of the Commission before the 1939-45 War started and the emergency hospital (later medical) service was introduced and with it regional planning of hospital services\textsuperscript{26}.

Towards a National Health Service
In 1944 the Government proposed the development of a national health service by the creation of new joint authorities, usually combinations of county and county borough councils. These authorities would be charged with preparing plans for health services in their areas and be responsible for the provision of hospital and consultant services by directly providing the services and through contractual arrangements with voluntary hospitals and other joint authorities. The proposals would have extended the responsibilities of medical officers of health of the major local authorities, which, as can now be seen, were at their
zenith at that time. The proposal to link the development of a national health service with local government was supported by the Society of Medical Officers of Health\textsuperscript{28}, but was strongly opposed by the Medical Planning Commission, a body set up by the British Medical Association in 1940 consisting of 73 members nominated by 11 organisations including the Royal Colleges and the Society of Medical Officers of Health\textsuperscript{29}. The Commission favoured the provision of hospital services on a regional basis, perhaps linked to reformed local government authorities, a view shared by the previous and current chief medical officers at the Ministry of Health\textsuperscript{30}.

**THE NATIONAL HEALTH SERVICE**

Despite the proposals in the 1944 White Paper, the Labour Government which took office in 1946 decided against local government authorities, either individually or in combination, being responsible for the administration of the hospital, specialist or the general practitioner services. Reasons given for this were the antagonism of the medical profession and of the representatives of the voluntary hospitals, the inappropriate structure of local government including the dichotomy between county boroughs and the surrounding counties and the large variations in the sizes of populations and resources between authorities\textsuperscript{31}.

The National Health Service Acts 1946 and 1947\textsuperscript{32} created what became known as the tripartite structure with the hospitals (except teaching hospitals in England and Wales) and specialist services under regional hospital boards composed of appointed (not elected) members, the general practitioner, dental and pharmaceutical services under local executive councils with the general practitioners remaining independent contractors, and a package of personal preventive and domiciliary support services under local health authorities (county and county borough councils with some additions in Scotland, and from 1964 London borough councils). The local health authorities became responsible for the provision of health centres (except in Scotland where the central department had this responsibility), maternity and child welfare clinics, health visiting, domiciliary midwifery, home nursing, and domestic ("home") help services, vaccination and immunisation and a broad remit for "prevention of illness, care and after-care", and in England and Wales for ambulances\textsuperscript{33}.

In 1951, three years after the start of the National Health Service, the responsibilities of the Ministry of Health for local government including environmental public health and housing were transferred to a new Ministry of Local Government and Planning (later the Ministry of Housing and Local Government).

**Co-ordination of Prevention and After-care with Clinical Practice**

The 1944 White Paper and the National Health Service Acts foresaw health centres provided by local authorities as major features of the proposed national health service\textsuperscript{34}. These centres were to provide accommodation for general medical and dental services, personal preventive medical services, consultant sessions and certain diagnostic services, local midwives, health visitors and home nurses, and a pharmacy. General practitioners would be in regular contact
with consultants and would take on most of the clinical work of the local authority's assistant medical officers. The centres would be the key co-ordinating places for the three parts of the health service\(^{35}\).

However six months before the start of the National Health Service the Ministry of Health informed the local authorities that because of building difficulties and the need for further investigation of the best kinds and purposes of health centres no general programme of development was appropriate and only schemes of particular urgency would be considered\(^{36}\). Due to this directive, the costs of building the centres and the continuing suspicions of general practitioners of coming under any sort of control of the local authorities (the British Medical Association wanted the centres to come under the regional authorities\(^{37}\)) only a few centres were built along the lines originally envisaged\(^{38}\). What had been expected to provide a major coordinating function between the divisions of the NHS did not materialise. Nor did general practice take on the bulk of the clinical work of the assistant medical officers as had been widely recommended and anticipated\(^{39}\).

Collaboration between general practice and the services provided by the local health authorities was developed in some areas by the attachment of health visitors and other nursing staff to general practices\(^{40}\). The role of the medical officer of health became somewhat peripheral to the major activities (and expenditure) of the NHS, although he remained in a pivotal position within local government in regard to the environmental functions of the authority - a situation that was reversed when the NHS was reorganised in 1974.

**Reactions of Medical Officers of Health**

As had happened before at times of change in the duties and responsibilities of medical officers of health their opinions about the changes were mixed. Some became pessimistic about their future. In its evidence to the Guillebaud Committee in 1954 the Society of Medical Officers of Health stated that the local health authorities' services had suffered so much in status and prestige under the National Health Service that their medical staff had greatly degenerated both in quantity and quality, and that they felt there was no real future for them in the local authority field\(^{41}\). Others foresaw their future as medical administrators responsible not only for the local authorities' services but also as coordinators of the preventive and curative services\(^{42}\). In contrast yet others saw the lessening of their administrative commitments as providing an opportunity for extending preventive and health promotional activities and to this end the Scottish Health Services Council issued in 1951 a report entitled "What Local Authorities Can Do To Promote Health and Prevent Disease\(^{43}\)."

**Senior Administrative Medical Officers**
In England and Wales the posts of medical superintendents gradually disappeared after the introduction of the NHS, those in the mental hospitals being the last to go. In Scotland the posts continued for longer. By transferring the hospital services to regional hospital boards a new cadre of regional medical administrative officers was formed.

The work of each regional hospital board (RHB) was carried out by a permanent full-time staff headed by a small number of senior medical, administrative and other professional staff. The Secretary of the Board was responsible for the conduct of the Board's business management including general supervision of the finance, supply and the staff of the Board. The Senior Administrative Medical Officer (SAMO) was adviser to the Board on the planning, organisation and staffing of the hospital and specialist services, and was the chief medical spokesman to the Board. There was ambiguity as to whether the Secretary or the SAMO was the overall chief executive to the region. Official guidance emphasised team work, but, especially where the chairman's authority was weak, conflict arose among the chief officers. The avoidance of hierarchy became a recipe for anarchy in certain boards.

The medical division, headed by the SAMO, usually included a deputy (or a nominated senior medical officer to act in the absence of the SAMO), senior and assistant medical officers. The division's functions were to assess demographic, epidemiological and clinical information and relate this to trends and developments in clinical practice and to management and financial
resources; to provide personal links between medical committees of the hospitals and groups and of individual clinicians and the Board; to assist the Board with its negotiations with the Ministry of Health and in implementing national policies; to promote sound medical and paramedical manpower education and training policies; and, later, to sponsor operational research.

The first appointments to the posts of SAMO were made between August and October 1947. In England and Wales seven of the fourteen appointments were of doctors from the public health service; three from medical superintendent posts, two came from the Ministry of Health, one from the colonial medical service and one from general practice and subsequent administrative experience in the Army. In Scotland the backgrounds of the first appointments were similarly distributed; two came from public health and one each from a medical superintendent post, central government and the India Office.

Tenth Anniversary

The tenth anniversary of the National Health Service in 1958 was the occasion for a number of reviews of its progress and achievements. An American economist, writing in the British Medical Journal, considered that on the whole "the British attitude seems to be one of restrained optimism". A leading article in the Journal was not so sanguine. It agreed that from the point of view of the public the health service had been a success, but went on: "the end of the first decade of a social revolution finds the profession in no mood for jubilation". It announced that the BMA together with others would set up a committee to review the health services.

The problems then facing the NHS were the rising costs of the service (which had been looked at two years before), its elaborate administrative structure and the lack of integrated planning. Many medical officers of health were pessimistic about their roles and the future of their work despite authoritative reassurances about the value of their contribution - a sure sign that morale was low.

Porritt Report

The committee foreshadowed in the British Medical Journal was set up, under the chairmanship of Sir Arthur (later Lord) Porritt, during the following autumn by the British Medical Association, the Royal Colleges of England and Scotland, the College of General Practitioners and the Society of Medical Officers of Health. The Committee was to "review the provision of medical services to the public, and their organisation, in the light of ten years' experience of the NHS, and to make recommendations". The 45 members of the committee although nominated by their sponsoring body were not official representatives. The Report, published in 1962, recommended one administrative unit (area health board) for each appropriate area, with a medically qualified administrator as the chief officer to each board. All existing health services and their employees would be brought into the new system with the exception of the teaching hospitals. Regional hospital boards would be abolished but area health boards would combine to create regional planning
committees to deal with services which could only be planned economically over a wide area. Each area health board would have four subsidiary councils responsible to it for the day-to-day administration of

(1) the general medical, dental, pharmaceutical and supplementary ophthalmic services, (2) hospital and specialist services, (3) preventive and social health services, and (4) occupational health services.
The Porritt Report received a mixed reception and did not lead to any immediate change in Government opinion or action. Sir George Godber, chief medical officer at the Ministry of Health when the report was published, has subsequently stated that he did not support suggestions for the unification of the administration of the Service at that time. In 1984, he said: "By the 1960s it had become common medical rhetoric to condemn the tripartite administration of the NHS and nowhere more stridently than in the profession's own Porritt Report. I have never subscribed to that. There were three components each with its own problems of change and advance. It would have been a calamity if the family practitioner and preventive services had been subordinated and largely forgotten by new authorities overwhelmed by the size and complexity of hospital and specialist problems".

The major significance of the Porritt report was that it presented the first collective deliberation of the medical profession on the future of health care since 1942 and was the first formal sign that the profession was in favour of reorganising the National Health Service.

**Ten-year Plans**

The general optimism about the future of the NHS was reflected in the publication in 1962 of plans for the development of the hospital services and buildings over the next ten years and a year later plans for developing the community health and welfare services. The plans showed a concern for comprehensive medium-term planning. They were ambitious and required considerable capital expenditure. They were widely welcomed but only partially implemented in the succeeding years, not least because of national financial difficulties in 1966-67.

**REORGANISATION OF LOCAL GOVERNMENT 1957-1975**

Despite the official cool reactions to the proposals of the Porritt Committee the reorganisation of the NHS became a dominant concern of the second half of the 1960s. Part of the pressure for the reorganisation arose from changes taking place in local government.

**Local Government Reorganisation**

The disparity between the populations and resources of individual counties and county boroughs, the distribution of functions between the two tiers of authorities in the counties, and the concentration of major institutions (e.g. universities, technical colleges and hospitals) in the county boroughs had long been sources of dispute and criticism. A Royal Commission on local government in London was set up in 1957 and reported in 1960. As a result in 1965 the
London County Council (LCC), Middlesex County Council and the county boroughs of Croydon, East Ham and of West Ham were abolished and together with parts of Kent and Essex were replaced by the Greater London Council (GLC) and London Boroughs. The London boroughs were responsible for local health authority services (except ambulance services which came under the GLC), social services, environmental health services and the outer London boroughs for education services. Education services in the inner London boroughs (previously the area of the LCC) came under a special body, the Inner London Education Authority, with the medical officers of health of the local boroughs acting as principal school medical officers.

Local government in the rest of England was reviewed by another Royal Commission which reported in 1969. The majority of the Commissioners recommended a one-tier system of 58 unitary authorities responsible for all local government services outside the three conurbations around Birmingham, Liverpool and Manchester for which a modified "Greater London" model was proposed. The Commissioners foresaw local government continuing to be responsible for the local health authority services as "local authorities' health services are important to local government both in their own right and because of their relationship to the welfare and other services." Furthermore they considered that their recommendations made it possible for the proposed authorities to take charge of the NHS thus bringing about the unification of the health services already proposed by the Government (Robinson's Green Paper, see later), keeping the health services in close relationship with social services and introducing democratic control of the NHS. The Commissioners stated that they were "utterly opposed to the transfer from local government of the range of personal social services with which the Seebohm Committee was concerned".

A separate Royal Commission reported in 1969 on local government in Scotland. The Commissioners recommended a two-tier structure consisting of seven regional authorities based on an amalgamation of existing counties, and thirty seven district authorities. The regional authorities would be responsible for water, sewerage, drainage, education, social work, and housing and the districts for environmental health. The Commissioners listed the arguments for and against a local government-administered health service but did not make any recommendations on the matter, passing the decision back to central government.

In February 1970 the Government issued a White Paper on the reform of local government in England in which it accepted the need for far-reaching changes and of the broad strategy set out in the report of the Royal Commission. The White Paper reiterated the Government's intention to unify the NHS along the lines set out in Crossman's Green Paper (see later) and stated that the Government did not consider the transfer of responsibility for the NHS to local government to be practicable, but agreed with the Commissioners that the health services reorganisation should take account of the areas of the new major local authorities.

The change of Government in June 1970 was followed by changes in the proposals for the reform of local government as well as in the reorganisation of the NHS. A further White Paper suggested a two-tier system throughout the country with the creation of six metropolitan counties and thirty eight county councils and an undetermined number of metropolitan and other districts. The status of county borough which the larger cities and a few smaller ones had was to be abolished. Responsibility for social services and for education was to be with the metropolitan districts and the counties, and that for environmental health to be with the districts. Personal health services were to be transferred to the new health authorities.
No radical changes were put forward to the proposals of the Royal Commission on local government in Scotland\textsuperscript{65}. Legislation embodying the reforms was passed in 1972 and 1973\textsuperscript{66} and came into effect in England in 1974 and in Scotland in 1975.

**Personal Social Services**

Before the Royal Commission on Local Government in England had completed its inquiry, the report of another committee had made recommendations which, if accepted, would change substantially the responsibilities of some departments of county and county borough departments. The Committee, set up in 1965, a year before the Royal Commission began its work, was asked to review the local authority personal social services. The chairman of the Committee was Frederick (later Sir) Seebohm. There were ten members among whom the only medical member was Professor JN Morris, then the director of the Medical Research Council's Social Medicine Research Unit based at the London Hospital Medical School.

In its report in 1968 the Seebohm Committee recommended that all staff concerned with any aspect of personal social care should be brought together into new social services departments within the major local authorities\textsuperscript{67}. The staff concerned included those working with deprived children, delinquent children, child offenders, family breakdown, homeless people, mentally or physically disabled people and aged people. The Committee recognised that its proposals would have serious consequences for the local authority health departments. It stated:

"We have given much thought to the consequences of our proposals for local authority health departments. Our recommendations would remove half their staff and a substantial part of their budget, contacts and interests. Moreover, our proposals would involve loss of services for the social care of the mentally ill which has been one of the main growing points of local authority health departments. Some medical officers of health are eager to develop social work by their health visitors as part of their programmes in "prevention, care and after-care". We are unable to support this policy. Other medical officers of health wish to provide social workers to cooperate with local general practitioners. We welcome the idea in principle though we think these workers should be provided through the social service department.

"The critical question is whether the local authority health and school health department which remains after our proposed changes could be a viable working unit. The answer has serious implications for the local community and for the National Health Service; we consider them here from the point of view of the social service department.

"Our proposals affecting local authority health departments have done no more, we believe, than bring into the open weaknesses that have been present in them at least since 1948. These departments have been much engaged in work which we think is more likely to develop in the social service department. It has been questioned whether in the long run some of their other functions will remain their responsibility. Meanwhile, major new tasks of community
medicine are being left undone; thus little use is being made of modern epidemiology to provide an intelligence system relevant to local needs in health and health services. Demand for leadership and organisation in the promotion of health and in preventive medicine continues to grow, and it would be tragic if the vital contribution of the local health department to these was weakened even temporarily. However, the widening character of "prevention" now demands the joint effort of all the medical services - and of the other social services; as described already for the care and treatment, the medical officer of health has had neither the authority nor the resources to cope with these new requirements.

"We therefore welcomed the announcement by the Minister of Health in November 1967 that his department was to conduct an enquiry into the structure of the National Health Service. In dealing with the future of local medical services such an enquiry must pay particular attention to the medical officer of health - the community physician - and his team\textsuperscript{68}.

In Scotland there was no committee of inquiry. Three experts were appointed to work with the civil servants in drafting a White Paper which was published in 1966 and set out proposals for the reform of the personal social services\textsuperscript{69}.

In Scotland the proposals in the White Paper were incorporated in legislation in 1968\textsuperscript{70} and in England legislation reflecting the recommendations of the Seebohm Committee was passed in 1970\textsuperscript{71}. New social services departments were formed in 1971 and reorganised in 1974 in accordance with the new local government structure.
In 1967, the year before the publication of the Seebohm Report and of the first Green Paper on reorganising the NHS, the Ministry of Health gave evidence to the Royal Commission on Local Government. The Ministry favoured a smaller number of larger unitary authorities combining the surrounding country area with the towns; the integration of environmental health, communicable disease control and housing functions held by district councils with the preventive and personal health and welfare functions held by county councils; and that all functions requiring a medical officer of health should be at the same tier of local government. The Ministry announced its intention to transfer responsibility for the ambulance services to the regional hospital boards regardless of changes in the pattern of local government, a point referred to indirectly in the Seebohm Report. At this time the Ministry did not envisage the transfer of the personal health services provided by local government to the NHS; indeed part of its case for unitary authorities was "the importance of the links between the personal health and welfare services and child-care and education on the one hand and housing and environmental health on the other". A year later this view had changed, and there followed a succession of proposals for the reorganisation of the NHS reflecting points made in the discussions and the opinions of different ministers and different governments.

Robinson's Green Paper 1968

The first proposals put forward by the Ministry of Health to reorganise the NHS were published as a "Green Paper" in July 1968, the same month as the publication of the report of the Seebohm Committee. The Paper was produced by a small high-powered team in the Ministry of Health working more or less full-time on planning the reorganisation. The team continued its work until the passage of the Reorganisation Act in 1973. Between 1968 and 1970 Brian Abel-Smith, a close colleague of RM Titmuss, was a special adviser to the Secretary of State for Social Services and was much involved in the planning. The Paper set out briefly the need for change and proposed the replacement of the tripartite division of the administration of the health services by 40 to 50 area boards in England and Wales, responsible directly to the Minister, and combining the responsibilities of the regional hospital boards, the hospital management committees, local authorities' personal health services and the executive councils. There was to be no regional tier, and the teaching hospitals were to lose their own boards of governors and come under the management of the area boards. The Paper stated: "A highly dispersed administration appears less well fitted to achieve the objectives with the resources available than would be a smaller number of strongly staffed management authorities". The relationship between the public health functions of the new health authorities and those of local government authorities was left to be clarified when discussions about the future structure of local government were taken. However, it was envisaged that the medical officers of health would "extend their role as community physicians and specialists in community medicine".

Crossman's Green Paper 1970
Within a few months of the publication of Robinson's Green Paper the Ministry of Health was amalgamated with the Ministry of Social Security to form the Department of Health and Social Security (DHSS) under Richard Crossman, who had been appointed in the preceding March to a new post of Secretary of State in charge of social services. In February 1970 Crossman's Green Paper was published. It took account of some of the criticisms of the previous proposals and of the Government's decisions on the future structure of local government in England. The NHS would not be administered by local government but by area health authorities directly responsible to DHSS as in the first Green Paper. The number and boundaries of the area health authorities would match those of the new local authorities. At the regional level there would be advisory (but not administrative) planning councils. In the larger areas there would be local district committees.

The area health authorities were to administer the hospital and specialist services (including those provided by the teaching hospitals), the family practitioner services, the services provided by the local health authorities (including ambulance services, health centres, clinics and provision for prevention, care and after-care), and the school health services. Special mention was made of the Boards’ responsibilities for “epidemiological work (general surveillance of the health of the community)”. The tasks of community physicians were briefly outlined and it was stated that a detailed study of the scope and nature of their work in the reorganised service would be made. The four main tasks identified for the community physician were to develop the quantity and quality of information about health needs and the working of the area health services; to act as adviser on the health services to the area health authority; to advise the local authority on the health aspects of all of its services and particularly to give a lead in health education; and to perform the public health duties of the present medical officer of health. Environmental health services and the public (later environmental) health inspectorate were to remain with the local government authorities.

**Proposals for Changes in Scotland, Wales and Northern Ireland**

Separate Green Papers were published setting out proposals for the health services in Scotland in 1968, in Northern Ireland in 1969 and in Wales in 1970. Much of the main detail in these documents was similar to that in the English Green Papers except that no regional tier was suggested, and in Northern Ireland combined boards for health and personal social services with separate committees and directors for each service were proposed.

**Joseph's Consultative Document 1971**

After the Conservative Party won the election in June 1970 Sir Keith Joseph succeeded Richard Crossman as Secretary of State for Social Services. In 1971 a "Consultative Document" was issued to interested parties only and comments were sought within three months. A major difference from the preceding Green Paper was the giving of executive functions to the regional health authorities. These authorities would be responsible, in addition to their general
planning functions, for allocating resources to the area health authorities, co-ordinating their activities and monitoring their performances. As before the area health authorities would be coterminous with the new local authorities, and the personal health services of the previous local authorities would be incorporated into the functions of the new area health authorities. Consumers' views would be voiced through community health councils at district level. The setting up of two special studies was announced in the Document, one was to look at management arrangements for the reorganised service and the other at collaboration between area health authorities and the local government authorities.

**The White Paper 1972**

A year later, after the new social services departments had been set up and the Government had published its plans for the reform of the structure of local government and within a month after the inaugural meeting of the Faculty of Community Medicine, more detailed proposals for the reorganisation of the NHS were given in White Papers. The new administrative structure below DHSS would consist in England of 14 regional health authorities, 90 area
health authorities coterminous with the new local government authorities, and 207 districts. Each tier had a team of officers which included a community physician, but only the top two tiers had boards of appointed members. The teaching hospitals became responsible directly to the regional health authorities. As regards community medicine, environmental health and occupational health the White Paper stated:

"Unification will bring together into one service medical administrators now working in the public health services and those in the hospital service. Their functions will continue to be carried out after reorganisation and doctors from both these spheres will have a central part in the planning and management of the unified service, in the Department, in the regions and in the areas and districts.

"As specialists in what is now recognised within the profession as community medicine, their concern will be with assessing need for health services, evaluating the effectiveness of existing services and planning the best use of health resources. Equally, they will concern themselves with developing preventive health services, with the links between health and the local authority personal social, public health and education services, and with providing the medical advice and help which local authorities will need for the administration of those and other services.

"Their skills will complement those of other health service administrators and of the clinicians. These groups will together form a partnership in management of the new service.

"Environmental health will continue to be a function of local government. This term includes measures for preventing the spread of communicable disease (other than routine immunisation, some epidemiological investigations and treatment); powers relating to food safety and hygiene, port health, and the diseases of animals in so far as they affect human health; the public health aspects of environmental services; and the enforcement of requirements about environmental conditions at work places. These environmental hygiene responsibilities will be vested in the district local authorities. The local authorities will be encouraged to seek the advice, and indeed the services, of medical staff employed by the health authorities, though statutory responsibility will rest on the local authorities, not the health authorities."

**Enactment**

Legislation to implement the reorganisation of the NHS along the lines set out in the Scottish and English white papers and the equivalent for Wales was passed in 1972 and 1973, and the date for the start of the reorganised services was set for April 1st 1974 - the same date as the reformed local government structure was to become operational in England and Wales.

**Anxiety among Medical Officers of Health**
It had become obvious from the mid-sixties that it was unlikely that medical officers of health would continue for much longer to be officers of local government departments. As the various reports, green papers, consultative documents and white papers were published so uncertainty about the future roles and careers of medical staff in public health departments increased. Recognising this Sir George Godber wrote, in 1971, a "Chief Medical Officer Letter" to all medical officers of health of the local health authorities⁸. In this letter he acknowledged the difficulties and anxieties being experienced, and after reviewing the current position in the discussions about reorganisation, he wrote:
"I am writing to you and to other senior doctors in the Public Health Service because I want you to know that I am fully aware of the difficulties you are meeting in anticipating what re-organisation of local government and the health services mean for the services you are running at present. I appreciate that it is not easy to keep essential services running efficiently during a protracted period of uncertainty and still less to maintain the momentum of development. The fact that the service is not only being maintained but that it is advancing is a tribute to all in the Public Health Service. Although the next three years are a period of uncertainty for the individual public health doctor, the long term future for public health, community medicine or medical administration - whichever title we choose - is brighter than it has ever been."

Towards the end of 1970 it became apparent that whatever the future pattern of health service administration and the role of the medical administrator within it would be, there was an urgent need to provide a reorientation programme for medical administrators then in post. In January 1972 arrangements for multi-professional courses on management of integrated health care and for special courses for medical administrators were published, and these were later arranged.

**Appointments to the New Authorities**

Following the legislation to implement the reorganisation of the NHS all the medical administrative staff in the public health departments and at regional hospital boards had to apply for posts in the re-structured service. Each candidate could apply for a post in up to five regions and five areas. The candidate was interviewed by a special panel separately for each post and only after all the interviews were completed for all the posts was he/she offered an appointment. The same procedures applied to other senior officers of the authorities. In England there were about 17,000 applications from 3000 candidates for all of the 766 senior posts with regional and area health authorities. During this period the medical officers were expected to continue their present duties and to attend appropriate re-orientation courses and planning meetings. The whole process caused considerable anxiety and extensive upheaval to a large number of individuals and their families. Many experienced staff left the service at that time.

**Career Structure and Remuneration**

An important decision in regard to the career structure in community medicine was taken in 1973 when the Review Body on Doctors' and Dentists' Remuneration endorsed the decision of the Royal Colleges of Physicians to regard community medicine as a specialty in its own right concerned with broad questions of health and disease in the community at large, and on a par with all other specialties. The Review Body recommended the establishment of a single career grade for the specialty which should be broadly equivalent to that of consultant and carry a similar salary scale. Regional and area medical officers should have salary scales based on that of the career grade with additional supplements in recognition of their positions as "heads of teams of
community medicine specialists". The Review Body agreed that "specialists in community medicine at all levels should, as a matter of principle, be eligible for distinction awards in each category from the outset". But it went on to say "In practice it is most unlikely that A plus or A awards will be given for some years, as time is needed for distinction, and particularly outstanding distinction, to be demonstrated in a new specialty". This statement showed a lack of understanding of the emergence of the "new" specialty which was not shared by the chairman of the Distinction Awards Committee (see page 78).

"Management Arrangements"

In 1971, at the time of the publication of Joseph's Consultative Document, the Department of Health and Social Security set up an "expert study" under the guidance of a large steering committee chaired by Sir Philip Rogers, the Department's Permanent Secretary. The Group reported in 1972; its Report entitled "Management Arrangements for the Reorganised National Health Service" became known as "The Grey Book" from the colour of its cover. The report set out in detail for the English health authorities, the roles of the senior officers and of the members of the authorities, and the membership and functions of the main committees and of the planning teams. The Group rejected the idea of chief executives and introduced multi-disciplinary management teams, with "decision by consensus" (that is any one member could frustrate decisions agreed by the other members). A community physician was a member of each management team. The roles prescribed in the Grey Book for regional and area medical officers and for the district community physician are given in appendix I. The prescribed roles were heavily weighted towards the management needs of the NHS.

The area medical officers were expected to continue to supervise the work transferred from the former local health authorities including the work of the community child health services and the school health services but not the ambulance services. District community physicians were to advise the local authorities on matters relating to environmental health and the control of communicable diseases for which purpose they (or colleagues) were appointed as "proper officers" to the authorities. In the first round of appointments some of the responsibilities for collaboration with departments in local government were allocated to specially designated posts in community medicine (e.g. "child health" and "social services"). Further advice was given about collaboration between the NHS and local government in the reports of a working party which examined this issue.

The Start of the Reorganised Health Service

In February 1974 a general election returned a minority government under Harold Wilson which announced that the arrangements for the reorganisation of the NHS and local government to take place on April 1st would not be changed. They were noted without enthusiasm by the British Medical Journal which headlined its leading article "No Fanfares for 1 April". The leading article in The Lancet was equally unenthusiastic remarking that "the problems facing the incoming teams are just the same as those which faced and so often defeated the outgoing ones - namely, integration, management, money, and
democratic participation... The biggest problem of all, and the oldest, will be money, yet there is nothing that districts, areas and regions can do about the global sum, depending as they do on allocations from above... for the time being it seems to have missed the opportunity to allocate resources with regard to need rather than precedent".

The consequences of the country's economic problems rapidly led to disillusion and disruption among employees in the health service. In June, less than three months after the start of the reorganised health service, The Lancet published a leading article headed "Bleak Times". It stated: "The nation's economic woes are sharply reflected in the disruption undertaken and contemplated by unhappy and angry members of the NHS... There is no denying that parts of the structure have collapsed - in that things for which the NHS and the social services were established are now tardily and incompletely achieved. As the gales of inflation threaten to blow away even more of its vital fabric, the NHS stands in worse peril today than in any of the recurrent storms which have beset it since 1948".

Later in the year the presidents and deans of the Royal Colleges and Faculties published a statement about the financial crisis within the NHS concluding: "The Presidents and Deans unanimously urge the Government to recognise, and to remedy to the best of its ability, the serious under-financing from which the NHS is suffering. If standards were to be allowed to decline further, this would be condemned by the Colleges and Faculties, by the profession at large, and by the public".

This financial crisis started discussions on priorities within the NHS and their relation to the clinical freedom of doctors. Questions that were discussed in the leading medical journals included: Should there be a restricted list of drugs prescribable on the NHS? Are all clinico-pathological investigations necessary? Can cost be audited? Should there be criteria for introducing technical advances into NHS practice? Can centres of academic excellence be afforded within the NHS? Where is the customers' voice in determining medico-economic priorities? What information do doctors need? Could the number of hospital beds be reduced by a third? Could more patients be treated at home if the general practitioners had more support? Can the community cope with patients discharged earlier from hospitals? and, Could nurses initially see some of the patients attending general practices and do some of their follow-up consultations?

Such was the situation into which the new community physicians were thrust as they sought to continue, enhance and extend the best of the achievements of their predecessors.

TEACHING, TRAINING AND RESEARCH
Concurrently with the establishment and later with the reorganisation of the National Health Service there were changes and developments in the curriculum for undergraduate medical students and in the requirements for postgraduate diplomas in public health. These changes contributed to the responsibility for the teaching of public health and of preventive and social medicine passing from medical officers of health to full-time University teachers.

Social Medicine

In 1938 the teaching of hygiene and public health (as the courses of lectures were usually called) was undertaken by senior medical staff in central or local government in ten of the twelve London schools, and by staff from the London School of Hygiene and Tropical Medicine in the other two. None of the undergraduate schools in London had provided postgraduate courses leading to a diploma in public health since the start of a full-time course in 1929 at the London School of Hygiene and Tropical Medicine (LSHTM)\textsuperscript{102}.

In the provincial cities the commonest arrangement was for the local medical officer of health to be appointed a part-time professor in the university and be concerned with the teaching of the medical students and the organisation of part-time courses leading to a diploma in public health. This was the situation in five of the seven provincial schools in England, in the other two schools the local medical officer of health in one and the local county medical officer in the other were the heads of the departments but not professors. In Wales the local medical officer of health of Cardiff was also the professor. In Scotland the head of the department was a full-time academic appointment in Edinburgh and Glasgow, and in the other two schools it was the local medical officer of health, one with the title of professor\textsuperscript{103}.

In 1939 a Committee for the Study of Social Medicine was set up from University College Hospital, London, which included Rosenheim, D'Arcy Hart, Morris and Titmuss as members\textsuperscript{104}.
In the Harveian Oration at the Royal College of Physicians of London in 1942 Sir E Farquhar Buzzard (Regius Professor of Medicine at Oxford and one of the first Governing Trustees of the Nuffield Provincial Hospitals Trust, and the first chairman of the Trust's Medical Advisory Committee) referred to the importance of the contributions of "social medicine" in the reconstruction of medical education and practice. He stressed the need to improve the teaching and suggested that there was "room, perhaps, for a larger and more varied panel of teachers and a reconsideration of their responsibilities".

Similar calls for improvements in the teaching of hygiene, public health and preventive medicine had been made by eminent doctors during the preceding thirty five years. Later in 1942 Farquhar Buzzard enlarged on his concept of social medicine and its place in the reorganisation of the health services and Jameson (Chief Medical Officer at the Ministry of Health) took as the title for his Harveian Oration "War and the Advancement of Social Medicine".

Reports from the Royal College of Physicians of London

In 1942 the Royal College of Physicians of London set up a committee "to consider the subject of social and preventive medicine and to make recommendations for its development". The Committee consisted of ten members in addition to the President and Registrar of the College. The first chairman of the Committee was JC Spence (professor of child health at Newcastle, later Sir James) who was succeeded in the chair by AA Moncrieff (later Sir Alan and Nuffield professor of child health at London). Other members were AWM Ellis (later Sir Arthur and regius professor of medicine at Oxford), PM D'Arcy Hart (member of the scientific staff of the Medical Research Council), AJ Lewis (later Sir Aubrey and professor of psychiatry at London), Janet Vaughan (Principal of Somerville College, Oxford and later Dame Janet), Major Greenwood (professor of epidemiology and vital statistics at LSHTM), JM Mackintosh (professor of social medicine at Glasgow and soon to be professor of public health at LSHTM), JA Charles (medical officer of health at Newcastle and soon to be deputy chief medical officer at the Ministry of Health, later chief medical officer and Sir John) and WA Daley (medical officer of health, London County Council and later Sir Alan).

The Committee issued an interim report in October 1943. It attempted to define and restrict the "almost unlimited" scope of "this important but ill-defined field". It stated that "the coupling of social and preventive medicine is not a mere tactical expedient to avoid the difficulties of definition. Preventive medicine has already acquired recognition as an established branch of medicine, whereas social medicine represents a relatively novel point of view. Preventive medicine under the title of public health or hygiene is already in the curriculum. Social medicine is concerned with the social environment and with heredity in so far as they affect health and well-being. Preventive medicine is more executive in outlook and comprises the design and direction of measures for the preservation of health and the prevention of disease".

The Report reviewed the changes in the teaching of public health and preventive medicine, discussed reasons for the lack of its development in the curriculum, and concluded that, given the existing arrangements for teaching, "it was not surprising that the student sees public health as one of the most incomprehensible and elusive subjects of the curriculum".
The Committee recommended that every medical school should establish a department of social and preventive medicine which should organise a course to replace the present teaching in public health. The course should be based on the relevant sciences and should continue throughout the three clinical years. The professors to be appointed to the new departments should be medically qualified, have had some clinical experience, training in research and familiarity with public health activities through formal training and/or experience in public health work.

Definitions of Social Medicine

The Committee of the Royal College of Physicians referred to the imprecision of definitions of "social medicine" and this continued to be a hindrance to the development of the subject in medical schools. In 1943, the year of the Committee's report, Ryle was appointed professor of social medicine (the first in England) at Oxford and Director of the new Institute of Social Medicine supported by a grant from the Nuffield Provincial Hospitals Trust. Prior to his appointment Ryle had defined social medicine as follows: "Social medicine is clinical medicine activated in its aetiological inquiries by social conscience as well as scientific interest, and having as its main purpose the education of professional and lay thought and the direction of legislation on behalf of national health and efficiency." Later Ryle enlarged upon his concept of the subject: "If clinical medicine is a comprehensive term... social medicine is even more so. It embraces, on the one hand, the whole of the activities of the public health administration and of the remedial and allied social services, and, on the other hand, the special disciplines necessary for the advancement of knowledge relating to sickness and health in the community". In time the definition of social medicine became limited to the last part of Ryle's definition.

Inter-Departmental Committee on Medical Schools (Goodenough) 1944

Meanwhile in March 1942 an Inter-Departmental Committee on Medical Schools was set up by the Government to review the organisation of medical teaching and its relation to universities and hospitals in England, Wales and Scotland. The chairman was Sir William Goodenough (chairman of the Nuffield Provincial Hospitals Trust 1940-1951) and among the other nine members were Jameson and Janet Vaughan who was a member of the Royal College of Physicians' Committee on social and preventive medicine. The Goodenough Committee reported in 1944.

The Committee attached considerable importance to the study and teaching of "social medicine" but, like others at that time, had difficulty in defining the term. The Report stated: "There is no generally accepted definition of social medicine and it is unnecessary for us to attempt to frame a comprehensive statement. As used by us the term includes the more restricted, though very important, subject of disease prevention. It also signifies a particular conception of medicine; a conception that regards the promotion of health as a primary duty of any doctor, that pays heed to a man's social environment and hereditary as they affect health, and that recognises that personal problems of health and sickness have communal as well as individual aspects."
The recommendations of the Committee in regard to the teaching of social medicine reflected those of the first report of the Committee of the Royal College of Physicians. The Committee recommended that the foundations of the subject should be laid during the pre-clinical years with the promotion and maintenance of mental and physical health being related to the study of normal structure and function. Throughout the clinical period the social and preventive aspects of disease and of patients' illnesses should be demonstrated and students should be enabled to carry out personal investigations of social and industrial conditions and should receive instruction on the communal and administrative responsibilities for disease prevention, on the history of preventive medicine and the evolution of medical and social services.

The Committee reviewed the appointments of the teachers and concluded that teachers in the joint appointments with public health departments were usually unable on account of their heavy administrative duties to devote sufficient time or attention to the medical school. The Committee recommended that there should be in each medical school someone on the staff "whose principal interest and responsibility is the furtherance of teaching and research in social medicine, and who is free to devote a considerable amount of time to the performance of this task".

**Teaching in Social and Preventive Medicine**

In Scotland changes in the undergraduate teaching of public health started before the London College's Committee and the Goodenough Committee had been appointed. In 1940 JM Mackintosh moved from his post as chief medical officer at the Scottish Department of Health to become professor of public health and social medicine at Glasgow. In 1944 FAE Crew was appointed professor, with a similar title, at Edinburgh. In his inaugural lecture Crew stated that "social medicine is medical science in relation to groups of human beings. It is not circumscribed by what has come to be known as preventive medicine since it is not merely concerned with the prevention and elimination of sickness, but it is concerned also and especially with the study of all social agencies which promote or impair the fullest realisation of biologically and socially valuable human capacities. It includes the application to problems of health and disease of sociological concepts and methods".

In 1945 the Nuffield Provincial Hospitals Trust helped to fund a chair of social medicine at Birmingham to which T McKeown was appointed. Some of the other provincial schools also appointed full-time professors of social and preventive medicine. In London joint lectureships with the London School of Hygiene and Tropical Medicine were established at Guy's Hospital and at the Royal Free Hospital Schools of Medicine.

**Further Reports from the Royal College of Physicians 1953 and 1966.**
During 1951-52 the Royal College of Physicians' Committee on Social and Preventive Medicine reviewed the progress made since its earlier report in 1943 and the report of the Goodenough Committee the year after. The College's Committee found that there had been expansion and changes in the content of the teaching in the provincial schools in England and Wales but were disappointed with the situation in the London schools, and considered that in schools without whole-time professors there was a lack of research in the departments. The general policy in the London schools was that social medicine should be integrated with the clinical subjects and with pathology, and not be presented as a special subject. The Committee drew attention to the special arrangements at Guy's and the Royal Free medical schools where the joint appointments with the London School of Hygiene and Tropical Medicine had been made, and study groups, tutorial classes and case conferences had been introduced.124

The development of departments of preventive and social medicine was not helped by the General Medical Council's revision of its Recommendations for the medical curriculum in 1957. The separate section on the subject in the 1947 Recommendations was replaced by less specific guidance given as "Notes" to the section on medicine and surgery125.

In 1966 the Royal College of Physicians of London issued a further report from its Committee on Social and Preventive Medicine126. The membership of the Committee had changed and now included Rosenheim, Doll, Godber, McKeown and Morris. The Committee had requested information from each medical school and supplemented the results from this approach with data from a parallel inquiry carried out by the Society for Social Medicine. The findings in regard to staffing and the amount of teaching time allotted are shown in table 1. The Committee commented: "Many medical schools in the UK have responded to the recommendation of the 1943 report that they should establish a well-staffed department of social medicine. The objective has not been realised in most London schools and has been only partially realised in some provincial schools, five of which have only a part-time head of department". The reason for their disaffection with part-time direction of a department continued to be that it rarely led to research that would justify the full development of the department.

Reports from the General Medical Council and the Royal Commission on Medical Education

A year later the General Medical Council revised its Recommendations taking account of changes that were already occurring. It advised that students should be instructed in the community aspects of medicine, epidemiology, organisation of medical care, disease prevention and health promotion127.

In 1968 the Royal Commission on Medical Education (Todd Report) repeated the earlier recommendations that each medical school should have a department of preventive and social medicine (now termed community medicine), and suggested that each department should have sections dealing with epidemiology, statistics and computers, preventive medicine and rehabilitation. It went on to say that from the educational point of view the department of community medicine should have an influence throughout the undergraduate medical period. "The department could offer instruction during the pre-clinical stage in the broader aspects of community health and in the means of providing medical care, with reference to problems both in this country and in other parts of the
world. In this way the department might well provide a bridge between the social and behavioural sciences, statistics and population genetics on the one hand and the clinical aspects of epidemiology and medical care on the other.128.

By 1972 the change to full-time academic heads of departments of social and preventive medicine (or related title) had occurred in almost all the medical schools. In three of the twelve London schools there were full-time professors and in only two did the local medical officer of health organise the teaching. In the provinces eight of the departments were headed by full-time professors, one by a senior lecturer and three by the local medical officer of health each with a part-time appointment as professor. In Wales and Scotland all the departments were headed by full-time professors129. Dominant components of the teaching by the staff in departments of social and preventive medicine were epidemiology and the study of the medical needs of society, including the assessment of the nature and extent of medical problems, the evaluation of social influences on the health of the community, the structure and appraisal of the efficiency of existing services, and the estimation of future trends and needs130. A continuing difficulty was the shortage of funding for academic and research posts in the departments131.

SPECIALIST EDUCATION AND TRAINING IN PUBLIC HEALTH

In addition to the changes in the service and teaching responsibilities of medical officers of health and their medical staff and the creation of the separate cohorts of regional administrative medical officers and full-time teachers there were changes in the specialist postgraduate education and training of doctors entering public health service. Some of these changes were in response to long-standing pressures unconnected with the changes in legislation and the structure of the health services.
Pressure for Specialist Training

In 1855, eight years after the appointment of the first medical officer of health, a leading article in The Lancet recommended that "each Medical Officer of Health ought to be well versed in vital statistics and hygiene, a well educated and practical physician, and acquainted with at least the general principles of chemical and physical science; above all he should possess sufficient logical acumen to enable him rightly to distinguish the post hoc from the propter hoc, and enough judgement to decide between coincidences and consequences"\(^{132}\).

Introduction of Diplomas in Public Health

In 1871 Trinity College, Dublin, offered the first university certificate in state medicine by examination. The College did not provide any courses or other instruction and restricted entrance to the examination to its own graduates. The examination consisted of 9 papers, one each on law, engineering, pathology, vital and sanitary statistics, chemistry, meteorology, medical jurisprudence including hygiene, hygiene (as a separate subject), and a paper set by the regius professor of physic concerned mainly with epidemiology and public health philosophy. Edinburgh University established a B.Sc. degree in 1874 under the directorship of D Maclagan, professor of medical jurisprudence. Cambridge, which had recognised state medicine and sanitary science as subjects for its MD in 1868, introduced a certificate examination in sanitary science and state medicine in 1875. Gradually other universities introduced certificates covering a similar range of subjects as for the Trinity College's examination but with fewer papers\(^{133}\). The Royal College of Physicians of London agreed to establish a special examination in hygiene and state medicine in 1883. Four years later the name was changed to a Diploma in Public Health and the examination became the responsibility of the Conjoint Board. Neither the College nor the Board provided instruction for the Diploma\(^{134}\).

The General Medical Council and the Diploma in Public Health

In 1868 the General Medical Council appointed a committee "to report on the steps proper to be taken, if any, for granting Diplomas or Certificates of Proficiency in State Medicine, and for recording the same in the Medical Register, due regard being had to the interests of existing Health Officers in several parts of the kingdom"\(^{135}\). The intention of the Council to introduce regulations for the recognition of the diplomas was resisted initially by the Royal Colleges of Physicians of London\(^{136}\) and Edinburgh. In 1870 the Edinburgh College wrote to the GMC expressing serious doubt about creating examinations for medical men "in branches of study belonging to another profession, as so far removed from ordinary medical practice as engineering science, as recommended by some, or the construction of actuarial tables and formulae, as suggested by others"\(^{137}\).

It was not until over 20 years later, in 1889, that the Council in accordance with the Medical Act of 1886\(^{138}\), provided guidance. The Council required that for diplomas to deserve recognition they had to "have been granted under such conditions of education and examination as to ensure (in the judgement of the Council) the possession of a distinctively high proficiency, scientific and practical, in all branches of study which concern the Public Health". The candidates had to have been qualified in medicine for at least one year and it was recommended that they should have attended, after qualification, for practical
instruction in a laboratory for six months, and should have "practically studied the duties of out-door sanitary work under the medical officer of health of a county or large urban district" for six months.\(^{139}\)

Meanwhile the requirement for a medical officer of health to hold an additional registered qualification in public health had become law as far as appointments to counties, larger districts or combinations of districts and (later) the London boroughs were concerned.\(^{140}\) However disquiet developed about the effectiveness of the recommendations of the GMC in establishing uniform standards between the approved examining bodies and about the quality of the training offered.\(^{141}\)

The Resolutions and Rules of the General Medical Council became substantially more detailed when they were revised in 1910. For the first time the Council set out the subjects to be studied, the minimum number of hours to be spent on laboratory work (150 hours), and the minimum number of days of practical instruction under the personal supervision of a medical officer of health (60 days spread over 6 months) and for attendance at an infectious disease hospital (twice weekly for three months). The period of practical instruction could be reduced to 30 days spread over three months if the candidate had "attended a course or courses of instruction in sanitary law, vital statistics, epidemiology, school hygiene and other subjects bearing on public health administration given by a teacher or teachers in the department of public health of a recognised medical school."\(^{142}\)

As the duties of medical officers of health increased to include personal child health and maternity services so teachers found the "Rules" becoming a restraint to the appropriate development of courses for the diploma. Kenwood (Professor of Hygiene at University College, London and Medical Officer of Health, Stoke Newington) set out the criticisms in the Milroy Lectures to the Royal College of Physicians in 1918 as follows: "The training courses provided for the DPH are still adapted to the production of a person fitted for the post of medical officer of health after the fashion of the time when public health administration was much younger than it is. They embrace a study of many sciences and crafts and are designed to secure a detailed technical proficiency in these. That is to say, the present training suggests that a medical officer of health is less required to advise, as a medical man, upon all the complex matters which affect the public health and to take administrative charge of a wide range of public health work than to act as a sanitary engineer, a chemist, a bacteriologist, and even a lawyer. His present training overlaps that of the clerk, the engineer, the sanitary inspector and the public analyst; and much of the technical detail of this overlapping knowledge could be omitted with great advantage to his fuller training in other respects. ...The medical officer of health, as the responsible adviser of the local authority, is looked to for general advice and detailed suggestions for the prevention of any mortality which can be brought under administrative control, and it is necessary that he should be mentally trained to weigh and sift evidence and to form a sound and independent judgement of the relative value of administrative measures. He should be educated for these purposes, as well as carefully trained in the actual executive work which devolves upon him. ...This points to the necessity for him to devote more attention to his function as an administrator and propagandist, and to the social factors which in such great measure dominate the public health situation, and for him to leave to an increasing extent the technical work of sanitation, etc. to his staff." Kenwood wanted a reduction in the time spent on bacteriology, chemistry, sanitary engineering and sanitary law and more time in practical training.
Diplomas in Public Health  1920-1940

Notwithstanding Kenwood's criticisms, the General Medical Council in revising its Rules in 1922 retained much of the requirements relating to sanitary science and law, and, for the first time, introduced minimum periods of time required for the class-room study of each of the major subjects\textsuperscript{144}.

These prescriptive and detailed Rules were only slightly modified in 1930\textsuperscript{145} and did not reflect the enlarged role of the medical officers of health of the major authorities resulting from the 1929 Act (see page 3). Not surprisingly criticism of the Rules continued, and to these was added another source of dissatisfaction - that of the disparity of duties between
junior and senior members of the medical staff in public health departments. Savage, whose presidential address to the Society of Medical Officers of Health in 1935 has already been mentioned, referred to the "undoubted dissatisfaction" which existed among some of the new entrants to the public health services and attributed this in part to the fact that "the actual duties of the junior member seem to bear little relationship to the larger problems of public health which he studied for in the DPH. Particularly in counties and the very large towns the work is mainly routine school medical inspections and attendance at infant welfare clinics". He recommended the inclusion of the study of administration and management in the training "instead of as at present acquiring this knowledge by the method of trial and error", and that "every junior member should carry out some definite investigation bearing on our work, both for the sake of his own development and as a contribution to the stock of facts upon which a fresh signpost of achievement is erected".

These observations from a senior member of the specialty in 1935 have been confirmed by a student at that time. Sir George Godber in his Duncan Lecture at Liverpool in 1984 stated: "When I took the DPH in 1936 it was a statutory requirement for a MOH, but after that, one had to spend at least a year or two doing routine clinic work with school children and mothers and babies in a way far less constructive than preventive paediatrics is today. It did, however, give a period for re-orientation from the nine months course in which so much time was spent on sanitary law and bacteriology and chemistry of water and milk."

Teaching for post-graduate students in public health was discussed at a well-attended meeting of the Society of Medical Officers of Health in 1936. Four questions were raised that were to continue to be discussed for the next thirty years. These were: (1) Should DPH courses or their equivalents be primarily "educational" or should they be a period of technical preparation for a particular job? (2) Should there be special courses in child health and in tuberculosis (for example) or should all subjects be covered on one generalist course? (3) Should part of the training be involvement in full-time or equivalent part-time employment in public health departments? and (4) How were students to be financially supported while attending DPH courses?

Reform of the DPH in 1947 to 1960

The Goodenough Committee made two major recommendations about training for all clinical specialists. First the minimum period of postgraduate training and experience should be four to five years after full-registration; and second the salaries attaching to the various appointments held by specialist trainees should be such that there was no need for them to seek other sources of income. In regard to public health the Committee stated: "The standard applied to medical specialists in public health should be comparable to that applied to specialist physicians and surgeons, and the prescribed period of training and experience should be of approximately the same length. It should include the holding of posts as senior house officers with the object of adding to the trainee's general and clinical experience; attendance at a course of instruction and a period of service as an assistant to one or more whole-time medical officers of health. The course of instruction must be planned and carried out by institutions that have staff and facilities of university standard. The examination for the diploma in public health should be conducted only by the universities providing the training... It will be necessary for the universities generally to raise the standard of the post-graduate training which they provide in preventive medicine. Broadly speaking, the leading post-graduate schools in, say, the United
States of America, are better equipped, better staffed and more fully organised both for post-graduate teaching and research, than their British counterparts, with the notable exception of the London School of Hygiene and Tropical Medicine\textsuperscript{150}. The Committee made no special mention about research in preventive medicine and public health. An editorial in "Public Health" welcomed the recommendations to lengthen the training for doctors entering careers in public health and to make the standards of training and qualification comparable to those of other specialists\textsuperscript{151}.

Two years later the Public Health Committee of the GMC, chaired by Sir Wilson Jameson, who had been a member of the Goodenough Committee, reviewed its Resolutions and Rules about the DPH\textsuperscript{152}. Despite the good intentions of the revision of the Rules in 1946 the changes did not meet the current needs or the broadening concepts of public health and social medicine. Furthermore they were outdated to a certain extent by the changes introduced by the National Health Service Act with the clinical responsibility for tuberculosis and infectious diseases passing to consultants employed by the regional hospital boards and the gradual disappearance of the posts of medical superintendents in England and Wales. The Rules were revised again in 1955 and 1960\textsuperscript{153}, but many of the weaknesses persisted.

**Mounting Criticism of Specialist Training in Public Health**

The GMC's Rules for the DPH had the effect of over-emphasising examinations at the cost of providing sufficient opportunity for in-depth study, developing habits of precise enquiry and experiential learning. As the number of subjects in the prescribed syllabus increased so, inevitably, did the approach to some become superficial. Criticisms continued\textsuperscript{154} along the lines of those expressed in the 1930s, and similar comments were made about courses in other countries\textsuperscript{155}.

**Students Attending DPH Courses and Their Financial Support**

Each year between 1935 and 1960, except during the 1940s, about 200 students attended courses for the DPH at 13 universities and 1 institute in the UK (see table 2). Over half of the students were at the London School of Hygiene and Tropical Medicine or the Royal Institute of Public Health and Hygiene in London both of which attracted many students from overseas. During the 1950s the overseas students found parts of the courses irrelevant and some of their needs not met. The introduction of an elective in tropical public health at the LSHTM did not suffice so the School introduced in 1962 a nine-month course for a new Diploma in Tropical Public Health.

During much of this time only 10 to 20 per cent of students at the School were women. About 90 per cent of the male students were aged 30 years or more and therefore had substantial experience in one or more fields of medicine\textsuperscript{156} (see table 3). The majority of the students in London and Edinburgh were not
intending to follow careers in the British public health services, and this had been the case at the London School of Hygiene and Tropical Medicine since the start of the DPH course\textsuperscript{157}.

A particularly important issue was the financial support of students during their attendance on DPH courses. Since the start of the NHS the specialist training of clinicians had been combined with salaried posts in the hospital service or as assistants in general practice. No similar arrangements were generally available to doctors employed in local government.

Some students from overseas and those in the British Defence Services were paid their normal salaries by their employers while studying for the diploma. Other overseas students were on various grants provided by the World Health Organisation, the British Council or other government or international agencies. A major problem for British students intending a career in the public health services was the need to pay the fees for the course and to support themselves and their families. During the 1950s and 1960s some public health departments provided help. The commonest form of such help was for the aspiring student to be given a
contract to work for the local authority, usually in the child welfare clinics and school health service, for three years during which he or she would attend a DPH course either part-time over two years (usually at the nearest university) or full-time for nine months. The total salary would be the sum of the normal pay for the time the doctor actually worked for the authority spread evenly over the three years. Some authorities required the doctors to do evening clinics, to work on alternate Saturday mornings and to forego half of their holiday entitlement during the time they were on the DPH course. Over half of the counties (including Kent, Middlesex and Surrey) and of the county boroughs had no arrangements (see table 4). These authorities were, apparently content to poach staff from those authorities which supported training. Needless to say this situation was becoming unacceptable both to intending trainees and to the minority of authorities who had schemes to support them. In 1954 the Society of Medical Officers of Health suggested that there should be a central agency supported by a precept on all local authorities and responsible for remunerating students on DPH courses, but this was not achieved.

**Medical Administration/Management**

In the late 1950s and during the 1960s there was a growing demand for more instruction in medical administration to be given on special courses and as part of DPH courses. Pressure for this came from the regional medical administrative staff and from various national health organisations through the World Health Organisation. The matter was also the subject of a series of meetings of the Teaching Group of the Society of Medical Officers of Health between 1959 and 1962 and of a special committee of the Royal College of Physicians of London which reported in 1966.

While these discussions were going on courses in medical administration were introduced in Edinburgh (Professor Brotherston) and in London at the London School of Hygiene and Tropical Medicine (Professor Walton), and a new course was being planned in Manchester (Professor Brockington). In Edinburgh a course leading to a Diploma in Medical Services Administration (DMSA) was designed in 1958-59 with the interest and financial help of the World Health Organisation. The Diploma was open to medical and non-medical university graduates. The orientation was to hospital administration within the context of community services and needs, and with emphasis on the planning and evaluation of all health services.

The London course in medical administration, introduced in 1959, did not lead to a diploma. It was arranged at the request of the English senior administrative medical officers of the regional hospital boards for their trainees and assistant medical officers. The course lasted two months and dealt with aspects of business administration (with speakers from Ashridge College and leading industrial firms) as well as the administration, structure and functions of central, regional and local government and of health service institutions. The number on each course varied up to a maximum of twelve.

At Manchester the plans were to adapt the DPH course in order to lay more stress on administration and on the concerns of regional hospital boards and executive councils. The DPH course was a two-year part-time course which allowed for concurrent in-post experience which could be with public health or hospital authorities or rotating between them.
In 1966 the deputy registrar of the General Medical Council wrote to universities, teaching institutes and other bodies informing them that the Council was revising its current (1955) Rules and would welcome their views. He stated that the Committee on Public Health of the Council (chaired by JHF Brotherston) had noted the decline in the number of candidates for
the diploma in public health and in the number of institutions offering courses. At the same time a growing number of doctors, apart from those in public health services, were engaged in various aspects of "community medicine", for whom a common element of postgraduate training might be appropriate.

**Evidence Given to the GMC's Committee and the Royal Commission on Medical Education**

There was substantial agreement in the evidence given to the Committee and to the Royal Commission on Medical Education that structured programmes were required for training novices in all fields of medical administration, and that programmes should consist of academic components and periods of supervised field experience where the trainees were given some responsibility. The subjects to be studied by all trainees should include statistics, epidemiology, social sciences, organisation of health, medical care and related services, and management. Some research experience, which may be involvement in the systematic investigation of a practical problem, should form part of the training programmes. Views differed as to the duration of training, but there was agreement that it should be not less than two years and not more than four. The trainees should receive salaries during secondment for training equal to those of equivalent clinical grades.

The Ministry of Health in its evidence to the Royal Commission\(^{168}\) referred to the "urgent need to remould the training for medical administrators and for doctors in the various fields of public administration in the hospital and local authority services, in government departments and in medical schools". The evidence did not go into any details about the nature of such training.

The Society of Medical Officers of Health, which had set up a special committee in 1962 under the chairmanship of RC Wofinden to advise on the future pattern of training, stated in its evidence to the Committee of the General Medical Council that there should be a new two-year course for medical administrators in regional boards, central government departments and in senior posts in public health departments and that the DPH should be continued for the "bulk of doctors who join the British Public Health Service" and for overseas students. The Society gave evidence along similar lines to the Royal Commission. In presenting oral evidence to a group of the Royal Commissioners the Society's representatives pressed for community medicine or public health to be recognised as a specialty in accordance with any recommendations which the Commission might make in regard to the clinical specialties. The representatives were asked about the possibility of the Society forming or joining a College, not as a training institute but as a body concerned with maintaining professional standards. The question of the name of the specialty was also raised, the questioner considering that "medical administration" was unattractive\(^{169}\).

The evidence given by the British Medical Association\(^{170}\) was similar to that of the Society of Medical Officers of Health in that it suggested the continuation of the DPH as a one-year course (with certain modifications) registrable with the General Medical Council and required by statute for the post of medical officer of health. An optional higher qualification should be introduced for those aspiring to senior posts in medical administration which could be taken either immediately after obtaining the DPH or later on in the doctor's career.
The Committee on Medical Administration of the Royal College of Physicians of London gave evidence to the GMC's Committee on behalf of the College setting out briefly the recommendations of its report which summarised the situation facing it as follows: "Although the number of medical administrators is small compared with that of their clinical colleagues, their importance is great, and the challenge which the NHS presents for studies in community care and medical planning emphasises the need to recruit able young graduates."
into medical administration and to provide a sound training comparable with that in other specialties. Training which matches these needs is not at present available". It stated that "the medical administrator practises medicine in relation to populations and groups. He must be aware of and able to follow the advances and changes in the various specialist branches of medicine and organise their application for the benefit of the community under his charge. He must advise the authorities about the planning and organisation of the health and medical services, and must have some knowledge of epidemiology, statistics and measurement applied to medicine, medical sociology, and of the theory and practice of administration and government. The computer should be an everyday tool of the modern medical administrator. As in other branches of medicine, he should be able to spend some part of his time on research". The training should be based at a centre where all the disciplines involved in the training were available and where research was being carried out.

The Committee considered that the London School of Hygiene and Tropical Medicine was the natural home for such a centre given its collaboration with the London School of Economics (for social policy, management studies and health economics) and with Bedford College (for medical sociology).

The Committee recommended that the proposed training should be for all medical administrators whatever field they might first enter. The training should "lead to a qualification that will come to be rated among the higher postgraduate medical qualifications", and there should be training posts in all fields of medical administration comparable with those in other specialties. The Committee hoped "that in future senior medical administrators will be more clearly equated with consultants, and that their work will be better understood by the young graduate who at present has little knowledge of the scope of medical administration".

The Society for Social Medicine expressed in its evidence to the GMC's Committee172 similar recommendations to those of the Royal College. The Society was "strongly of the opinion that there should be a common basic post-graduate training for all prospective medical administrators in this country whatever the field in which they will eventually work - local authority, hospital, industry or central government department", and felt "that it is essential for the proper development of post-graduate education in public health that a system of training posts should be organised". The main subjects in the common basic course would be epidemiology, statistics, behavioural sciences, preventive medicine and organisation and administration of health services, and throughout the course "emphasis should be placed on work done by the students themselves designed to demonstrate the inter-relation of the several disciplines and their relevance to community medicine". The Society saw little reason for the continuance of the statutory requirement for medical officers of health to hold a specific diploma, but if this was to continue then the regulations of the Council should be such as to recognise the proposed new courses for this purpose.

**Recommendations of the General Medical Council 1967**

In 1967 the General Medical Council issued new recommendations as to diplomas in public health and similar qualifications173. The Council accepted that its supervision of the diploma should continue "for the time being" and recognised that the changes in the duties of the medical officer of health required radical changes in training. The Council agreed that postgraduate training was requisite for doctors engaged in any of the different branches of community medicine
and considered that the DPH (or its replacement) should be regarded as the academic core of longer schemes of training which should include periods of vocational training.

The new "Recommendations", which replaced the previous "Rules", allowed a substantial measure of freedom in arranging the curriculum for the course for the diploma or degree, which the Council recommended should extend over one academic year of whole-time study or the equivalent of part-time study. The content of the course should include the following subjects:

"(a) The quantitative sciences appropriate to the study of community health, including medical statistics and epidemiology;
(b) The behavioural sciences as applied to community health; the scientific study of human behaviour, including the health education of the public and the psychological and social factors in community organisation and in health services utilisation;
(c) Genetic and environmental (including micro-biological) factors in health and disease; methods of prevention and control as applied to physical and mental disease; and
(d) Health services organisation, including the ascertainment of the health needs of the population; the provision, deployment and evaluation of health services; the economics, staffing and utilisation of health services and the principles of administration and management."

The new recommendations were generally welcomed, although some questioned whether there was still a need for the Council to be so involved in the examinations for this one specialty.

Report of the Royal Commission on Medical Education

The Report of the Royal Commission on Medical Education was published a few months after the issue of the Recommendations of the General Medical Council. In many respects the Commission's Report re-iterated many of the points made in the Council's document and came to similar conclusions about training courses and programmes. The core subjects of the academic part of the training should be epidemiology, statistics, medical sociology, operational research and the organisation of medical care. The training should include planned experience in training posts and provide opportunities for gaining some research experience. The Commissioners regretted the tendency for teachers and research workers in community medicine to pursue their interests separately from the practitioners of the specialty. There was a great need, the Report stated, for a professional body to bring together all the interests, academic and service, and have the strength to undertake the assessments needed during specialist training.

New Courses and the Development of Training in Public Health
While the Committee of the General Medical Council and the Royal Commission were deliberating changes were being introduced into DPH courses at some universities.

At the Annual Symposium of the Society of Medical Officers of Health in 1965 Morrison enlarged on his concepts behind the amalgamation of the DPH and DMSA courses in Edinburgh176. He warned against falling into the "practical man" fallacy (the practical man being one who continues to make the mistakes of his predecessors except that he does so rather more efficiently) and argued that sharp distinctions between preventive and curative medicine were out of date, not least in the challenges posed by the chronic diseases in the developed countries. He thought that medical officers of health would not become over-lords of the medical care services of hospitals and general practice. Morrison saw the future practice of public health being based on epidemiology with the medical officer of health becoming a practitioner of social medicine concerned with the health of communities. His tasks would be the traditional ones of investigator, educator and innovator. He would concentrate on acquiring knowledge about factors affecting health and disease in his community and about the effectiveness of local health and related services. When the data had been collected and analysed his educational and persuasive powers and his organisational knowledge and experience would be exercised in suggesting and monitoring changes and experimental trials of innovative services.

These views were in accord with those of many academic staff, but were opposed by some doctors in public health and hospital medical administration who wanted to extend, or at least retain, "broad authority" over health and related services177.

At Edinburgh the new course leading to a diploma in social medicine began in 1966, bringing together elements from the previous DPH and DMSA courses. The new course was seen as the first step in the training of community medicine specialists and aimed to provide the skills for investigating the state of health of a community and the working of health services. For a small number of postgraduate students attendance at the course formed the first year of a three-year training scheme in medical administration sponsored by the Scottish regional hospital boards in collaboration with the Scottish Home and Health Department. During the second year these students carried out supervised research work and in the third year gained practical experience of medical administrative work178.

At Manchester the traditional two-year part-time course was retained and its content re-arranged into four distinct themes - epidemiology and medical statistics; behavioural sciences in relation to medicine; principles of health service management; and medical advances and the health services - so that doctors not wishing to obtain the DPH could study one theme by attending one half-day per week. During the days that the diploma students were not engaged in their academic studies they could be employed in appropriate posts in hospital administration or public health, engaged in supervised research at an approved centre or undertake a comprehensive study of health services management. In regard to the last two options difficulties remained about the financial support of the doctors during their training179.

At the London School of Hygiene and Tropical Medicine Morris introduced a new two-year full-time MSc (Social Medicine) degree which aimed to provide the academic component of the training for doctors wishing to specialise in community medicine and follow careers in public health, medical administration or in teaching and research. The first course began in October 1969. During the second year of the course each student gained experience and expertise in
applying epidemiological and operational research skills to the planning, evaluation and management of health services, working under the supervision of an approved preceptor\textsuperscript{180}. Initially some of the British students were supported by bursaries made available by the Department of Health and Social Security through the regional hospital boards.

\textbf{POSTGRADUATE EDUCATION AND SPECIALIST TRAINING}

\textbf{Development of Training for Hospital Specialists}

During the 1960s training in all the clinical specialties was formalised within the medical staff structure of the NHS, with the formulation of the programmes and the maintenance of standards being the responsibility of the respective Colleges and Faculties. The impetus for change began at a conference organised at Christ Church, Oxford, in December 1961 by the Nuffield Provincial Hospitals Trust and chaired by Sir George Pickering\textsuperscript{181}. This followed a
report earlier in the year on the medical staffing structure of the hospital service which had expressed concern over the imbalance between training and service needs and the quality of training available in some posts.

The Christ Church Conference, attended by representatives from all the main educational and health service bodies (except the public health services), agreed that arrangements should be made to enable all doctors to have postgraduate education not only while they occupied training posts in hospital but also as a continuing discipline throughout their careers; that there should be a strong regional committee for postgraduate education in each region, convened by a postgraduate dean appointed by the appropriate university; and that a consultant should be nominated by the regional committee as clinical tutor in each hospital group where facilities including at least a seminar room and a library should be available.

In 1964 the Ministry of Health accepted that the cost of postgraduate and continuing education was a proper charge on NHS funds. This concession did not apply to doctors in public health who were employees of local government authorities, but it did apply to the medical staff at regional hospital boards' headquarters.

Also in 1964 the Royal College of Physicians of London published recommendations for training in each of the medical specialties under its aegis, and two years later the College of Pathologists did likewise. The Royal College of Surgeons and the Royal College of Obstetricians and Gynaecologists had longstanding regulations concerning training. The regulation of the requirements for postgraduate diplomas in public health remained with the General Medical Council, but the Council was not concerned with formulating or supervising training programmes.

In 1966 there was another national conference, this time at the Royal College of Physicians of London, where it was agreed that there should be a central committee on postgraduate medical education. Such a committee, the Central Committee for Postgraduate Medical Education, was formed the next year supported by a grant from the Nuffield Provincial Hospitals Trust. In Scotland the Postgraduate Medical Association had been formed in 1962, also supported by the Trust.

These events occurred before or during the deliberations of the Royal Commission on Medical Education. In its Report the Royal Commission endorsed the developments and recommended that postgraduate medical education should be extended so as to provide systematic progress from basic qualification to the appropriate level of career competence and to maintain that competence thereafter. Such training should be required for doctors entering any field of practice, including general practice and community medicine. The general pattern recommended by the Royal Commission for professional training consisted of an intern year (corresponding broadly to the pre-registration year) followed by three years of general professional training embracing the senior house officer and registrar grades, then a period of advanced training varying in length in different specialties, and intermittent continuing education throughout his/her career.

Council for Postgraduate Medical Education in England and Wales
In 1970 the Central Committee for Postgraduate Medical Education in effect became the official Council for Postgraduate Medical Education in England and Wales, working in conjunction with Joint Higher Training Committees set up by the Colleges and Faculties, and the Regional Postgraduate Committees. The Joint Higher Training Committees set up Specialty Advisory Committees to advise on and oversee training standards for each of the specialties.

At the time of the formation of the Council neither the Society of Medical Officers of Health nor the Society for Social Medicine were represented on it or on any Higher Training Committee. Following the creation of the Faculty of Community Medicine in 1972 and the reorganisation of the NHS in 1974 specialist training in community medicine came within the remit of the Joint Committee for Higher Medical Training and of the Council and ceased to be the concern of the General Medical Council (see page 73).

DEFINING THE ROLE OF THE COMMUNITY PHYSICIAN

"Community Medicine"

The first use of the term "community medicine" in an English journal was by Gordon in 1955 who defined it as "that branch of social medicine which deals with matters relating not to individuals but to groups". A year later McGavran, Dean of the School of Public Health, North Carolina, wrote about "the concept of public health as the scientific diagnosis and treatment of community health needs and status". In 1959 in the annual report of the Chief Medical Officer at the Ministry of Health the term "community physician" was used in reference to the role of the medical officer of health. During the 1960s both terms were increasingly used. The Royal Commission on Medical Education defined "community medicine" as an inclusive term embracing the practice of public health and medical administration and teaching and research in social medicine. The Seebohm Committee used "community physician" without defining the term and this title was used in Crossman's Green Paper and the subsequent White Paper on reorganising the health service. The Society for Social Medicine used the term in its evidence to the General Medical Council's Committee but the Society of Medical Officers of Health referred to "public health" and "medical administration".

"Tomorrow's Community Physician"

The first detailed exposition of the possible responsibilities of a community physician was given by Morris in the Delamar Lecture at the Johns Hopkins University School of Hygiene and Public Health in 1969. Morris presented a visionary view of the role. He stated that public health practice should be based firmly on the principles of epidemiology. He saw the community physician as epidemiologist, community counsellor and administrator of local medical
services, as a professional man and a public servant taking on and extending "the traditional tasks of the medical officer of health as teacher, watchdog, and troubleshooter...In promoting the people's health, the community physician must be directly concerned with the mass problems of today and be able to draw on the community's resources to deal with these, not be limited to the categories of need or service that history happens to have deposited in his office".

Morris foresaw a rewarding and exciting future: "The community physician thus will be able to play his part in reducing suffering and in improving the quality of life. It is our good fortune to be able in this field to combine medicine and social science in public service. I appeal in particular to young physicians to join us. The opportunities have never been greater to give their best, use all they know, and find fulfilment in service to the people and to their profession". Some answered his call, but difficulties continued in establishing an appropriate setting from which to carry out the functions described by Morris.
The Work of the Community Physician

During 1970 and 1971 a number of medical officers of health of counties and county boroughs set out their perceptions of the work of the proposed community physicians. There was general agreement that they would take on the long-standing responsibility for assessing the health needs of "the community" - that is of the population residing in an administratively defined locality; they would advance preventive medicine in close collaboration with the clinical services; they would be the link between the health service and the local government authorities acting as adviser to the environmental health services, school health services and the social services of the latter; and they would participate in the administration of the hospital and family practitioner services by advising on long-term planning, the integration of preventive and curative medicine, the evaluation of the effectiveness of services and the deployment of resources. Their underlying specialist skills were seen as being epidemiology and administrative theory and practice.

An area where there was substantial disagreement was whether there should be distinct differences between medical administrators on the one hand and epidemiologists on the other, all-be-it that both groups would come within the term "community medicine". This difference of opinion extended to arguments about consultant status. The Central Committee for Hospital Medical Services of the British Medical Association was not prepared to concede consultant status to doctors engaged in medical administration mainly on the ground that they were part of a hierarchical structure, but the Committee was prepared to concede the status to advisers and teachers in applied epidemiology.

Working Party on Medical Administrators (Hunter) 1970-1972

A Government Working Party was set up in the wake of Crossman's Green Paper "to define the scope of the work of medical administrators at regional, area and district levels in a reorganised health service (later broadened to "the health services"), and to indicate how training and re-training for such doctors could be provided". The chairman was Dr RB Hunter and members of the Working Party included three professors B Abel-Smith, EG Knox and JN Morris; three medical officers of health, JJA Reid, W Edgar and HWS Francis; three senior administrative medical officers at regional hospital boards, WJE McKee, JA Oddie and KRD Porter; two members from central government departments, RT Bevan and H Yellowlees; three clinicians, who were a consultant pathologist, a professor of investigative medicine and a general practitioner; the Secretary of the King Edward's Hospital Fund for London; and an Assistant Secretary at the Department of Health and Social Security.

Evidence Presented to the Working Party

Much of the evidence presented to the Hunter Working Party reflected that given to the Royal Commission on Medical Education on the subject of specialist training in community medicine. Exceptions were that the Society of Medical Officers of Health and the British Medical Association now supported
the proposal for a single career structure and common basic specialist training for medical administrators and others in community medicine as recommended previously by the Society for Social Medicine and accepted by the Royal Commission. The Society of Medical Officers of Health advised that a "Faculty of Community Medicine attached to the Royal Colleges would be an appropriate body" to be responsible for maintaining standards of training and for establishing criteria for specialist registration. The proposed formation of a Faculty was also welcomed by the Public Health Committee of the British Medical Association in its evidence.

**Report of the Working Party**

The Report of the Working Party was published in June 1972²⁰⁵, three months after the inauguration of the Faculty of Community Medicine. The Working Party saw "a vital and continuing task for doctors working full-time in health service administration... Their value is primarily in the skill and knowledge they contribute as specialists in community medicine". The functions of such specialists suggested in the Report reflected the evidence given by the medical professional bodies. The functions were listed as:

i. assessment of need for health services;
ii. planning of services to meet needs;
iii. promotion of health, including health education;
iv. measuring the effectiveness of health care services and promoting improvements;
v. promotion of research and development into health care services;
vi. integration of health services and their co-ordination with other services, particularly the relevant services provided by local government; and
vii. provision of medical advice and services to other bodies, including local government authorities responsible for environmental hygiene and the control of communicable disease.

The development of health information systems will be an essential pre-requisite to the performance of many of these functions”.

The Report foresaw posts of chief administrative medical officers to region and area health authorities who would be members of a team of chief officers responsible for advising their authorities and would be in charge of a group of specialists in community medicine.

The Report recommended that the basic remuneration of doctors in the career grade of the specialty should equate with that of consultants, including the eligibility for distinction awards, and that the appointments procedures for community medicine specialists should, as far as possible, be similar to those for consultants²⁰⁶.
The Times in an editorial considered that "so far as they go, the general principles (of the Hunter Report) are reasonable enough", and pointed out that the Working Party had been "in the unenviable position of reviewing the functions of medical administrators without knowing the managerial structure in which they will be expected to operate". The editorial concluded that the crucial question was "Will enough doctors of the standing necessary to carry weight with their colleagues be attracted to medical administration? This is not a question which can be left to the long-term because the functions of particular jobs will be settled in the short-term. Yet unless medical administrators are sufficiently respected in the different branches of the profession they will not be able to act as the kind of link between the health authority and clinicians which the Working Party wants".

**Developments in Scotland**

In Scotland the future role of community medicine was examined alongside changes proposed in the organisation of clinical work within the NHS. In December 1969 the Secretary of State for Scotland appointed a joint working party, with the chief medical officer (JHF Brotherston) as chairman, to consider the organisation of medical work in the proposed reorganised national health service. The Working Party set up three sub-groups one of which was concerned with community and preventive medicine. The Working Party did not take
formal evidence, but the sub-groups had informal discussions with individuals with expertise in various fields. The report of the Working Party, published in 1971\textsuperscript{208}, was based on the findings of the sub-groups but the views expressed in it were those of the Working Party.

The Report contained a chapter on the contribution of community medicine\textsuperscript{209}, a specialty which it stated "is concerned with the study of health and disease in populations. The function of the specialist in community medicine is to investigate and assess the needs of the population so that priorities may be established for the promotion of health, the prevention of disease and the provision of medical care. The specialty is also concerned with coordinating medical expertise so that policies which are in accord with medical need can be presented to the central department, area health authorities, and those responsible for the management of services below area level." The Working Party emphasised that the specialist in community medicine would not erode the position of clinicians in management, who, indeed, should be encouraged to take a greater interest and be more involved in policy-making and decision-taking in the health service.

The Working Party envisaged that in each area health authority the chief administrative medical officer of the authority would coordinate the activities of the specialists in community medicine, each of whom might have an interest in a special field over the whole area and/or have a more general responsibility in a particular district of the area. The control of communicable diseases should be a responsibility shared between the area authorities, the local government authorities and the national Communicable Disease Centre which had already been established in Scotland. The clinical activities of the local authorities' doctors should become part of the appropriate clinical organisations within each area health authority.

The training of specialists in community medicine outlined by the Working Party included academic instruction in "epidemiology, statistics, medical sociology, operational research in the organisation of medical care, and management and personnel administration". This should be combined with planned experience in training posts which could be weighted in one or other direction according to the probable future field of work of the individual, and with an opportunity for some research experience. The Working Party suggested that some service posts at senior house officer and registrar levels should be established and based on academic departments. Further details about the development of community medicine were given in 1973 in a subsequent report of the sub-group itself\textsuperscript{210}.

CONCLUSION
It is noticeable that while Morris in his paper "Tomorrow's Community Physician" stressed the basic investigative, analytical and advocatory roles of specialists in community medicine and their concern in promoting health and controlling disease in the population, the "Management Arrangements" (see page 15) emphasised the planning and management roles. The Scottish reports showed how the skills, set out by Morris, should be utilised in a broad and practical way balancing concern with medical care planning with that of the health promotion and prevention activities.

The major tasks facing the new Faculty in 1972 were to develop the contribution of community medicine not only to the management of health services but also to improving the health of the population; and to assume responsibility for setting criteria and standards for the training for the specialty and for their subsequent supervision. All this was to be achieved
within a scenario of change and financial restrictions in the NHS, change in the structure of all specialist training, and change in the work (and for some in their residence) of the senior people in the specialty.

PART II

NEGOTIATION AND INAUGURATION

EARLY DISCUSSIONS AND MEETINGS

In April 1968 while the discussions about the re-structuring of local government and the reorganisation of the health services described in Part I were taking place, the Royal Commission on Medical Education published its report. It stated that: "In community medicine there is a great need for a professional body which can bring together all the interests, academic and service, and which has the support and strength to undertake the assessment needed during and at the end of general professional training".

Morris, who was at that time a member of the Seebohm Committee, had become very concerned about the impact on the public health services of the likely recommendations of the Committee (see page 9). Between 1966 and 1968 he had numerous informal confidential discussions with individual medical officers of health, senior administrative medical officers, colleagues in academic departments and research units, senior government officials, the Dean of the London School of Hygiene and Tropical Medicine, and others. He found there was considerable support for the idea of creating a single body. Morris also discussed possibilities with his friend and one-time colleague Professor RM Titmuss who was a member of the Royal Commission on Medical Education, and with Sir Max (later Lord) Rosenheim, President of the Royal College of Physicians of London, 1966-1972. Rosenheim suggested associating the development with the Royal Colleges of Physicians. Morris had reservations about this. His conception was of an independent body as he was concerned about the links of community medicine with the interests of other colleges and specialties such as the general practitioners, paediatricians, obstetricians and psychiatrists as well as the physicians. Morris saw the need for a strong and independent voice for public health in medicine and in providing an input into health and social policies, but he realised that at that time the idea of a free-standing college of public health lacked sufficient support for its realisation.

On March 6, a month or so before the report of the Royal Commission was published, a selected group of people, invited by Morris, dined at the London School of Hygiene and Tropical Medicine and discussed the possibility of forming a college of community (or social) medicine.

On the 29th of April Morris wrote to the chairmen of the Council of the Society of Medical Officers of Health, of the meeting of the senior administrative medical officers (SAMOs), of the committee of the Society for Social Medicine and of the Scottish Association of Medical Administrators, and to the
chief medical officers of the Ministry of Health and the Scottish Home and Health Department inviting them (or their representatives) to a meeting on June 28th at the London School of Hygiene and Tropical Medicine to consider the recommendation of the Royal Commission quoted above.

Harding, chairman of the Council of the Society of Medical Officers of Health 1966-1971 and medical officer of health of the London Borough of Camden 1965-1974, was one of the medical officers of health involved in the informal discussions with Morris. Through his appointment on the staff of University College Hospital Harding was a colleague of Rosenheim, and through his membership of the Board of Management of the London School of Hygiene and Tropical Medicine was involved in developments there. Harding had numerous informal discussions about "possible developments" with colleagues in the Society, with Rosenheim and with others ⁹. He strongly supported Rosenheim's suggestion that the "development" should be linked to the Royal Colleges of Physicians ¹⁰.

The meeting arranged for June 28 had to be postponed until October 18 due to industrial action on the railways and holidays. For the meeting the Society of Medical Officers of Health nominated Harding, Wofinden (President of the Society 1968-69) and Lycett (chairman of the Public Health Committee of the BMA). Revans (chairman of the meeting of SAMOs) and Stewart were nominated by the SAMOs' group, Duncan was the nominee of the Scottish Association of Medical Administrators, and Doll, Case and McKeown were the nominees of the Society for Social Medicine. (For titles and appointments of people mentioned in the text see pages 104-112)

In July Alwyn Smith wrote ¹¹ to the secretary of the Society for Social Medicine requesting that the Society's nominees to the meeting should include a person who could represent the views of the heads of academic departments of social medicine ¹², as neither Doll nor Case were involved in organising specialist training courses in public health or medical administration and Morris as convenor would not be in a position to urge forward the views of one group. This question of the representation of academic departments was raised again later on (see page 57).

On 12th September Revans wrote to Harding about the forthcoming meeting at the School of Hygiene expressing a wish to discuss "a more direct association" with the medical officers of health ¹³. Later in the month Revans and Stewart met with Harding and Wofinden. It was felt that arguments between SAMOs and MOsH should be avoided in the forthcoming discussions. The SAMOs considered that the interests of community and administrative medicine could best be safeguarded by a Faculty of the Royal Colleges of Physicians. The MOsH emphasised that at the forthcoming meeting they could only speak as individuals and stressed that in any future arrangement the interests of present members of the Society would have to be safeguarded ¹⁴.

At this time the meetings and discussions about a possible faculty (or college) were confidential, but the need for change in training and recruitment in public health and medical administration was being discussed. Wofinden referred in his Presidential Address to the Society of Medical Officers of Health in 1968 to the changes which were already under way in the training courses for the specialty (see pages 28 and 29) and commented that they would have a "profound influence" on future practice. He saw the statement of the Royal Commission about the need for a professional body as a challenge to the Society. "For years," he said, "the Society has considered from time to time the problem of its own future - what its title should be, how it could achieve Royal Collegiate
status and whether it should seek to merge with one or other national organisations operating in the public health field. Indeed, these matters have again been under active consideration during the past two years but, so far, with no satisfactory outcome.” He saw the statement of the Royal Commission as strengthening the hands of the Society’s negotiators and went on to say; “but the practical problems to be overcome will be immense. No professional body can be really strong unless it has not only well-qualified and experienced members but also material resources - a proper headquarters and a strong secretariat. This needs money ... Nevertheless, the Society has to consider with which national organisations, within or close to our field, it should discuss this very important suggestion of the Todd Report” 15.

Two major events affecting the future structure of the health and personal social services occurred before the representatives met at the School of Hygiene in October. These were the publication of the report of the Seebohm Committee on the personal social services and of the first Green Paper about the reorganisation of the National Health Service referred to in Part 1.
First Meeting of the Informal Group (for explanation of the various bodies involved see appendix 2)

The meeting proposed by Morris eventually took place on the 18th October at the London School of Hygiene and Tropical Medicine, under the chairmanship of the dean of the School, ETC Spooner, who had been a member of the Royal College of Physicians' Committee on Medical Administration and, with Wofinden, had represented England at the WHO Inter-Regional Conference of Directors of Schools of Public Health. In addition to those already referred to as nominees to the meeting Sir George Godber (chief medical officer at the Ministry of Health), J Smith (representing Brotherston, chief medical officer, Scottish Home and Health Department), and Warren were present.

Doll sent a note of the substance of the meeting to the secretary of the Society for Social Medicine. He wrote: "It was unanimously agreed that the subjects covered by the Societies represented at the meeting formed an academic unity and that there was an urgent need for some professional body to take responsibility for laying down training schedules and maintaining professional standards in the subject. It was also unanimously agreed that it would be undesirable to set up an independent organisation to do this if it were possible to arrange for one to be set up under the aegis of the Colleges of Physicians.

"There was evidence that the Colleges were becoming more flexible in their attitude to specialists within medicine and that the English and Scottish Colleges were moving towards organisational unity. It was agreed, again unanimously, that the first objective should be to try to negotiate for a faculty of social and preventive medicine (no decision was taken about its name) to be organised under the aegis of the Royal Colleges of Physicians. It was recognised that there might be difficulty in achieving this and two difficulties in particular were mentioned: (a) The fact that a substantial number of non-medicals were responsible for much of the work in departments of preventive and social medicine, in public health departments and in regional hospital boards, and that the organisation of a purely medical professional body in the subject might have repercussions on the relationships between medicals and non-medicals concerned in the subject; and (b) That the academic status of a large number of the present members of the Society of Medical Officers of Health was low, so far as social and preventive medicine was concerned; that any faculty that was set up within the Colleges would have to be eclectic in its choice of founder members; and that the exclusion of a large number of doctors now working in the field of public health would have repercussions within the Society of Medical Officers of Health. It was agreed, however, that neither of these difficulties should be regarded as insuperable. In particular, the character of the work carried out by medical officers of health was changing and would change even more in the future and it might be that many of the doctors now in the Society of Medical Officers of Health would look to having professional contacts with clinical societies in the future, rather than with an academic grouping of doctors in preventive and social medicine."

The question was raised about the futures of the Societies involved in the discussions should a new professional body be formed. No decision was taken, but Doll saw no reason why the societies should not continue.

Statement of Intent
A point that Doll did not record was that McKeown and Wofinden agreed to produce a paper for future discussion by the group. Within days of the meeting McKeown sent a draft entitled "A Note on the Proposal to Establish a Professional Organisation concerned with Social or Community Medicine" to Wofinden who consulted Harding. After consultations a revised document was sent to each of the people who had attended the meeting in October¹⁹ (appendix 3). The document made five recommendations as follows:

(1) The proposal to establish a professional organisation concerned with social or community medicine deserves serious consideration.
(2) The first possibility to be explored would be an organisation within the framework of the existing Colleges.
(3) The new organisation should be concerned with vocational training and assessment rather than other professional interests, at least until local and regional services have been modified on the lines suggested in the Green Paper.
(4) The vocational training and assessment should be designed to meet the needs of those engaged in the teaching and practice of community medicine but not necessarily others - statisticians, medical sociologists, epidemiologists etc. - working in social medicine but not directly concerned with administration.
(5) Vocational requirements should not be applied so rigidly as to exclude the contribution to research, teaching and practice of administration by occasional gifted people who have not met formal requirements."

**Coordinated Reaction of the Three Royal Colleges**

Meanwhile informal discussions had continued. In particular Rosenheim had separate talks with Morris, Doll (who had recently been appointed Regius Professor of Medicine at Oxford) and Harding. On 21 February 1969 Rosenheim took the opportunity at a meeting of the presidents and representatives of the Edinburgh and London Royal Colleges of Physicians and of the Glasgow Royal College of Physicians and Surgeons to tell the Scottish Colleges about the meeting in October and his ongoing informal discussions. The Scottish Colleges informed him that they had received a letter from the Scottish Association of Medical Administrators seeking affiliation with them²⁰. In telling Morris of these developments Rosenheim wrote, "All three Colleges expressed great interest in maintaining close contact with the exponents of Community Medicine (or Social Medicine, or Epidemiology) and hope that some way might be found of preventing this important discipline from separating itself from General Medicine". Rosenheim went on to invite Morris with a few others to meet the presidents and representatives of the three Royal Colleges on 1 May to discuss "how best our Colleges could help your aspirations", and continued, "We have no clear solution to offer but would like to hear your needs and views"²¹.

In regard to the request from the Scottish Association of Medical Administrators the President of the Edinburgh College reported to its Council that the three Royal Colleges had agreed that there should be a UK policy in responding to requests from societies and associations representing one or other component of community medicine, and that an exploratory meeting had been suggested for the three colleges to meet a group of people concerned with community
medicine. The Edinburgh College Council resolved to send representatives to such a meeting. Similar action was taken by the Council of the Glasgow College who invited the Scottish Association of Medical Administrators and the Scottish Branch of the Society of Medical Officers of Health to nominate representatives to join the College's representatives at the proposed meeting.

Further Meeting of the Informal Group

Morris's informal group met again on 26 February 1969. It was accepted that their discussions should continue to be confidential and it was emphasised that the members of the group had no mandate from their organisations to commit their members to any definitive course of action. The aim of the group to set up a professional body was confirmed, and it was agreed that, if possible, such a body should be a "Faculty of Social or Community Medicine" within
the existing Colleges. The difficulties that would arise from seeking to include in the Faculty those without medical qualifications and those mainly concerned with clinical work in public health departments were discussed and it was concluded that membership (other than exceptional honorary membership) of the proposed Faculty would be limited to medically qualified people working in the broad field of community medicine. The Faculty would be concerned with vocational training and assessment of postgraduate students; with the advancement of knowledge of the subject; and with standards of practice.

Two important issues remained to be considered. The first referred to the name of the Faculty and specialty. While the Todd Commission had defined community medicine fairly succinctly it was pointed out that the term was still much used for describing modern general practice; that the term social medicine had led to confusion in the past and still had its detractors; and that public health was still seen by many as concerned mainly with environmental sanitation and the control of infectious diseases and was used in the title of the public health inspectors (previously sanitary inspectors). The second issue was the effects that the creation of the Faculty might have on existing organisations and their members.

Meeting with the Royal Colleges

The meeting proposed by the Royal Colleges was held at the London College on 1 May with Rosenheim in the chair. In addition to the representatives of the Colleges it was attended by senior people from the London School of Hygiene and Tropical Medicine, the Society of Medical Officers of Health and its Scottish Branch, the Senior Administrative Medical Officers in England and Wales, the Society for Social Medicine, and the Scottish Association of Medical Administrators, and observers from the Department of Health and Social Security and the Scottish Home and Health Department.

Morris introduced the discussion and emphasised that it was unofficial and exploratory. The meeting agreed that there was a need for a Faculty of Community Medicine to be set up under the auspices of the three Royal Colleges and that its membership would embrace those engaged in community medicine and epidemiology and could include those without a medical qualification. Membership would not necessarily be by examination alone. The Faculty would be responsible for setting its own standards and organising its own examinations and training programmes (appendix 4).

Following this informal meeting the next step was to seek the approval in principle of the governing bodies of the Royal Colleges. On 13 May Halliday Croom informed the Council of the Edinburgh College that it had been agreed to set up a working party to study closer relations between the Royal Colleges and representatives of community medicine. On the same day the Council of the Glasgow College approved that their representatives should continue discussions.

The President of the London College reported at some length to Comitia at its May meeting about the proposal to set up a Faculty of Community Medicine. He stated that "it would be a tragedy if those engaged in social or community medicine broke away from the main body of medicine". He foresaw that there would be protracted discussions before a suitable structure could be hammered out, and mentioned that one of the problems was that some of those engaged in
social medicine were not medically qualified. Fletcher asked whether some sort of inter-collegiate arrangement going beyond the Colleges of Physicians would be more appropriate as the interests of community medicine did not relate solely to those of the colleges of physicians. The President, while appreciating the point, felt that negotiations would be difficult enough as they were. Comitia approved the setting up of a working party in conjunction with the Scottish colleges 28.

At the June meeting of the Joint Committee of the three Royal Colleges it was agreed that each college would appoint two members to a working party which would meet during the following September to discuss details of setting up the Faculty 29.

One or Two Working Parties?

In writing to inform Morris of this decision Rosenheim expressed the hope that those engaged in the disciplines of "social medicine might also set up a working party so that in the autumn the two working parties might meet and exchange views" 30. A clue to what seemed to be a change in procedure from having a single working party under the auspices of the Colleges to having two working parties is contained in the statement of the President of the Glasgow College to its Council meeting in July 31. Reporting on the meeting of the Joint Committee he expressed the view that the initiative for the formation of a Faculty should come from members and fellows of the Colleges who were active in the field and not from the Royal Colleges.

Morris and Harding were disappointed with this apparent change, and Morris arranged for the informal group to meet in September at the London School of Hygiene and Tropical Medicine 32. The meeting, chaired by the Dean of the School, was attended by Morris, Harding, Doll, Revans, McGinness, Brotherston and Yellowlees. It accepted reluctantly that there would have to be two working parties and agreed that the working party representing the interests of community medicine should be composed of three representatives from the Society of Medical Officers of Health (one to be from the Scottish Branch), two from the Society for Social Medicine, one or two nominated by the senior administrative medical officers in England and Wales and one representing the Scottish Association of Medical Administrators, with one observer from the Department of Health and Social Security and one from the Scottish Home and Health Department. It was also decided that there would be two observers from the London School of Hygiene and Tropical Medicine but this was later dropped 33.

Prior to the meeting Doll told Harding privately that he was concerned that McKeown was insistent on bringing in non-medical people en-masse from the start. Harding responded by pointing out that he would find it very difficult to argue to doctors working in public health that some of them would not be eligible for membership from the start of the proposed faculty while non-medical people might be 34.

Following the meeting in September Harding, Morris and others of the informal group wrote to the secretaries of the four organisations and to Drs Brotherston and Yellowlees. The letter set out the position in regard to forming a Faculty of the three Royal Colleges and invited the organisations to nominate delegates (and deputies) as members of an official Working Party which it was hoped would meet in October 35(appendix 5).
Informing the Constituent Organisations

Until the receipt of this letter the nominees on the informal group had only been able to discuss developments informally and confidentially with a few senior colleagues in their respective organisations. In September 1969 it became necessary to seek the approval of the organisations to nominate representatives on the Working Party. Both the meeting of the senior administrative medical officers and the Scottish Association of Medical Administrators being small groups had no anxieties about the general trends of the discussions and decisions which had taken place. Stewart and Fowler with Ramsay as deputy were nominated by the SAMOs, and McGinness with Mercer as deputy were nominated by the Scottish Association. The situation was different in regard to the other two organisations, both of which had substantial concerns about the repercussions of the creation of the Faculty upon groups of their members.

Society of Medical Officers of Health

Harding had kept Wofinden, Lycett and a few others informed about developments and the invitation to him to attend the meeting in September at the London School. He reported formally to the Society's Council meeting, of which he was chairman, in October. It was agreed that he and Wofinden would be the Society's representatives on the Working Party with Ludkin and Pearson as their deputies. Menzies reported to the Council of the Scottish Branch of the Society and to the Working Party on community medicine which had been previously set up. At the meeting of the Council of the Branch Menzies was nominated as its representative on the Working Party for the proposed faculty, but concern was expressed about the proposed exclusion from membership of the faculty of the clinical medical officers.

An event, open to all members of the Society and others, which carried pointers to the future, was its eighth annual symposium. This was held in May 1969 at the Royal College of Physicians of London with sessions chaired by Wofinden, Harding and Brotherston. All used the term "community medicine" and argued the need for change. Harding announced that the Society had asked the Secretary of State for an enquiry into the future of the "community physician". The first session was addressed by Rosenheim on the unity of medical services. Later Reid remarked that "I believe it to be particularly significant that we were addressed by the President of the Royal College of Physicians and I also think it significant that we met in this College. This College has in fact had an interest in preventive and organisational aspects of medicine for many years, but this lapsed until comparatively recently, when it has been revived again".

The concern of many people present at the symposium was not about a proposed faculty, about which few would have known anything at all, but about the future of public health in the light of the Government's declared policy to unify the National Health Service. Brotherston addressed these anxieties in his characteristically positive way in opening a discussion on the future of the public health doctor. "What public health doctor and what public health are we talking about?", he asked, "Are we even asking about the future of a named and historic office called 'medical officer of health'? ... Are we talking about a
restricted field of specialist practice - for example, within an area health board, perhaps as adviser on epidemiological control, on environmental controls, or on liaison with social work services and so on? Or are we talking perhaps about something very much bigger, and if so what is this bigger thing?” He suggested that public health "is that discipline of medicine which is concerned with the total needs of the community, and with the deployment of resources to meet these needs". He then referred to the recommendations of the Royal Commission on Medical Education which had "put a kind of time-bomb into our proceedings, with its recommendation about specialist status ...The specialist registered public health doctor, who is claiming the same consideration as other specialists, will have to meet similar standards of recruitment, training, assessment and so on, and also job specification in terms of content, skills, sophistication and the like" 45.

Society for Social Medicine

Following the meeting on May 1 between representatives of community medicine with the presidents of the Royal Colleges, the Committee of the Society for Social Medicine decided that the proposal for a Faculty should be discussed at the next annual general meeting. Each member of the Society was sent a copy of the note of the meeting on 1 May 46 (appendix 4). At the Annual General Meeting on September 19, held in conjunction with its Scientific Meeting, subsequent developments and the invitation to appoint representatives to the Working Party were reported. The meeting elected Morris and Doll as its representatives with McKeown and Lowe as their deputies 47. In accepting nomination as a reserve representative McKeown emphasised that no decisions committing the Society to any change in its policy should be taken until the whole Society had had the opportunity to examine the proposals in detail. He also stated that in the event of his own views differing from those of Morris he would report accordingly to the Committee of the Society 48.

THE WORKING PARTY: OCTOBER 1969 - NOVEMBER 1970

The first meeting of the Working Party was held at the London School of Hygiene and Tropical Medicine on 14 October 1969 49. It was attended by Morris, Brotherston, Doll, Fowler, Harding, McGinness, Pearson, Ramsay, Spooner and Shaw (see appendix 6 for a list of the membership of the Working Party). Morris was elected chairman and Pearson honorary secretary, thus becoming a co-opted member. The Society of Medical Officers of Health agreed to provide secretarial help and the Society's secretary, Miss PF Cashman, attended all succeeding meetings. Later the Nuffield Provincial Hospitals Trust made a grant to cover secretarial and travelling expenses 50, so an offer from the Society for Social Medicine to contribute to the expenses did not have to be taken up.

The role of the Working Party was to:

(1) Draw up plans for the formation of a Faculty of Community Medicine within the Royal Colleges of Physicians of Edinburgh and London and the Royal College of Physicians and Surgeons of Glasgow.
Morris, Pearson and Fowler were asked to prepare a paper on the objectives, membership and constitution of the proposed Faculty for discussion at subsequent meetings. It was agreed to work towards the establishment of the Faculty early in 1971 (i.e. some 18 months ahead).

In regard to the second function set out above Morris wrote on behalf of the Working Party to JOF Davies, secretary of the Central Committee for Postgraduate Medical Education, and to the chief medical officers of England and Wales, of Scotland and of Northern Ireland. The responses were generally sympathetic, stating that the interests of community medicine would be borne in mind but that the Working Party could not be treated as formally representing community medicine before the Faculty was established. The matter was taken up again by the Provisional Council in 1971 (see page 61).

Four days after the first meeting of the Working Party the text of Morris's Delamar lecture given at the Johns Hopkins University School of Hygiene and Public Health the previous April was published in The Lancet (see page 31).

"The Proposal"

The Working Party met again on 6 November with Morris, Doll, Fowler, Stewart, Harding, Pearson, Menzies, McGinness, Yellowlees and Brotherston present. The first draft of the document (later referred to as "The Proposal") was discussed. Key points in the document were:

1. The organisations involved in the discussions did not consider it appropriate to amalgamate. They agreed that a new body should be set up, and that thereafter each organisation could consider its own future.
2. The objectives of the Faculty would be to promote and develop high standards in vocational training and the practice of community medicine, and represent the specialty on appropriate professional and educational bodies.
3. In the first instance membership would be limited to medical practitioners registered in the United Kingdom. At a later date, by agreement with the Royal Colleges, consideration would be given to the admission to membership of non-medical colleagues practising, teaching or researching in the field of community medicine.
4. On the formation of the Faculty and for a period limited to one year registered medical practitioners with experience in one or other field of community medicine practice and with an acceptable higher degree or diploma would be entitled to apply for membership. Thereafter admission to
membership would be limited to registered medical practitioners who had attained an appropriate academic standard either by passing an examination approved by the Council of the Faculty or have published outstanding work in community medicine which is acceptable to the Council.

(5) The Council would elect to its Fellowship members who in its opinion had reached a particularly high professional standing in the field of community medicine.

(6) The Faculty would function as a professionally independent body within the three Royal Colleges. It would be governed by a Council composed of fellows and members representative of the regions and various other groups together with its appropriate officers and representatives of the Royal Colleges.

Second Meeting of the Working Party

As well as considering "The Proposal", the Working Party at its second meeting discussed a memorandum submitted by Doll, and concerned mainly with criteria for membership and the examination. Initial membership, he suggested, should be at the invitation of the Royal Colleges and should include all the present members and fellows of the Colleges who held appropriate posts in public health, medical administration, social medicine and epidemiology, and other suitably qualified individuals. Doll proposed that the examination for membership should be in two parts - a general examination in the principles of medical care, public health, epidemiology and medical statistics and a second part consisting of specialist papers and viva voce examinations in one of the above subjects chosen by the candidate. He suggested that Part 1 of the MRCP (UK) should exempt from Part 1 of the MFCM, hence enabling physicians with special knowledge of one or other of the subjects direct entry to Part 2. He also suggested that the Faculty should have one class of members, and that members should be eligible for election to the Fellowship of one of the Royal Colleges by the normal route of that College on the initial nomination of the Faculty.

The Working Party agreed that there should be only one class of membership and that eligibility for election to a fellowship of one of the Royal Colleges should be discussed at a later meeting. It agreed that initial membership of the Faculty should be determined by rank rather than qualifications and should be equivalent to specialist recognition. It was accepted that the Faculty would function as a self-governing body within the Royal Colleges. An invitation from Rosenheim for representatives of the Working Party to meet with the Presidents and representatives of the Colleges during the following January (1970) was accepted.
Eligibility for Initial Membership and Name of the Faculty

At its third meeting the Working Party discussed possible criteria for the admission of members during the first two years after the formation of the Faculty, and the question of the election of members of the Faculty to fellowships of the Royal Colleges. These discussions were continued at its next meeting together with certain constitutional issues. Harding reported on informal discussions he had had with the Director of Army Health who had expressed an interest in the Faculty. It was agreed that a meeting should be arranged with representatives of the medical services of the Royal Navy, Army and the Royal Air Force. In regard to doctors in the occupational health services the views of the Royal Colleges would have to be sought. At a previous meeting the Working Party had decided that there would have to be a Provisional Council and it was now decided that this should be set up by the Royal Colleges in consultation with the organisations represented on the Working Party. The name of the Faculty was also discussed, it being felt by some members of the Working Party that the term "community medicine" was being used increasingly by general practitioners and others to refer to the practice of clinical medicine outside hospitals.

Further Points for Discussion with the Royal Colleges

At the fifth meeting of the Working Party, with Brotherston in the chair in the absence of Morris, it was agreed that an amended draft of "The Proposal" should be sent to the Royal Colleges prior to their meeting with representatives of the Working Party. It was also agreed that some additional points should be raised which were not included in "The Proposal". These were the election of members of the Faculty to fellowships of the Royal Colleges and thereby to membership of their ruling bodies, the titles of the Faculty's Officers, the need for the Provisional Council of the Faculty to have powers to admit to membership some applicants who, although eligible by the seniority of their appointment and their experience, lacked a "relevant qualification", the proposed discussions with the Armed Services, and the views of the Colleges about the inclusion of members of occupational health services.

Objectives of the Faculty

The fifth draft of "The Proposal" contained many of the points of the first. The objectives of the Faculty would be to promote high standards in the practice of community medicine; advance knowledge in the field; raise and maintain the educational standards of specialist training and take an active part in continuing education; and seek appropriate recognition and representation as the professional organisation responsible for standards in the training and practice of community medicine.
Criteria for Election to Membership

The draft proposed that after a period of two years admission to membership of the Faculty would be limited to registered medical practitioners who had passed an examination of the academic standing of the MRCP (UK) and which had been approved by the Council of the Faculty, and to others, at the discretion of the Council, who were deemed to have made distinguished contributions to community medicine. During the first two years after the founding of the Faculty registered medical practitioners practising in the UK who had a relevant postgraduate qualification, had had five years experience in community medicine and had been promoted above the basic grade would be eligible for election to membership without examination. At a later date, and with the agreement of the Royal Colleges, consideration would be given to the eligibility for membership of the Faculty of non-medical colleagues practising, teaching or researching in the field of community medicine.
Constitution

Details to be incorporated into the constitution of the Faculty were set out in "The Proposal" and it was stated that the Royal Colleges would need to appoint a Provisional Council after consultation with the four constituent organisations. A very significant difference between the first and fifth drafts was the omission in the latter of any reference to "fellows" of the Faculty. Another difference was that the period for the admission of foundation members was extended from the one year mentioned in the first draft to two years. The reference to later consideration being given to the admission to membership of non-medical practitioners in community medicine was included in all drafts. An important statement the purport of which is in every draft was that the organisations concerned in the discussions were agreed that a new body "should be formed, without prejudice to their own continued individual existence". In almost every respect the fifth draft of "The Proposal" was similar to the ninth draft which is reproduced in appendix 7.

Reporting Back

At the meeting of the Joint Committee of the Royal Colleges of Physicians on 1 November 1969 Rosenheim reported that a Working Party of those interested in the creation of a Faculty had been formed and hoped to be able to put proposals to the Colleges in the new year. It was agreed that JGM Hamilton and AW Wright (Edinburgh), RB Wright and EM McGirr (Glasgow) and Rosenheim and Dame Albertine Winner (London) should meet representatives of the Working Party to discuss their proposals on 12 January 197061.

During November 1969 Harding reported in general terms on the progress of the discussions to the Council of the Society of Medical Officers of Health. Although formal discussions with the Colleges had not yet commenced he assured the Council that there was much interest and support from them62. The Scottish Branch was similarly kept informed by its representative on the Working Party.

Ramsay reported in confidence on the first meeting of the Working Party to the meeting of the Senior Administrative Medical Officers in October 196963.

Morris and Doll reported, also in confidence, to the Committee of the Society for Social Medicine, which decided that its chairman (H Campbell, who had succeeded Case) should inform all members of the Society about the general position. In his letter Campbell64 reported the setting up of the Working Party and the Society's connection with it. He wrote "that there are many problems to be discussed and solved to reach a compromise between the various interests concerned, but the main objectives are:

1. To establish a constitution for the proposed Faculty.
2. To establish criteria for membership both at the beginning and subsequently.
3. To establish a framework for the training and registering of doctors to be included on a future specialist register.
He assured members that no decisions would be taken which committed the Society to a change in policy until the whole Society had had the opportunity to examine the proposals in detail and he went on to state that there would be an Extraordinary General Meeting of the Society on 4 June 1970, by when it was hoped that more details would be available.

At a later meeting of the Society's Committee Doll reported that there were problems in the use of the term "community medicine" as this was increasingly identified with general practice. The following names, in order of preference, were suggested - social medicine,
Meeting with the Representatives of the Royal Colleges

Copies of "The Proposal" were sent to the presidents of the three Royal Colleges of Physicians at the end of 1969 and on 5 January 1970 Morris wrote to each president setting out the additional issues that the Working Party wanted to discuss at the forthcoming meeting. He received prompt replies from the presidents of the London and Edinburgh Colleges. Rosenheim wrote: "I think the points you raise are very important. I was going to raise the question of the election of members of the Faculty to the MRCP (UK), but if we can skip the Membership and just elect members of the Faculty to the Fellowship, this might equally meet the situation. I am sure that there is a desire in all three Colleges to do what they can to help the proposed Faculty." However the President of the Edinburgh College was very doubtful about the proposal for direct election of members of the Faculty to the fellowship of the College. He wrote: "It is my belief that such a provision would not be possible under our Edinburgh Charter... At the moment therefore our Charter and Laws do not seem to give us much room for manoeuvre, and although laws can be altered, changes in the Charter are a very different matter. However I will consult our Clerk on the point since clearly what you have in mind is a procedure whereby all the Members of the proposed Faculty would at least be eligible for a Fellowship of a College." The meeting between the representatives of the Working Party and the Royal Colleges took place on 12 January 1970. A week later Morris reported briefly in writing to the members of the Working Party and suggested that they should meet on 5 February. He informed the members that the Colleges considered that the question of including occupational medicine within the ambit of the Faculty should be left to the Provisional Council to decide.

At the end of January Harding and Pearson up-dated the Council of the Society of Medical Officers of Health. They reported that the proposals had been approved in principle by the representatives of the Royal Colleges and that the formation of a Joint Working Party was expected shortly.

At the meeting of the Working Party on 5 February various relatively minor changes were agreed to "The Proposal" in the light of the discussions at the meeting with the representatives of the Royal Colleges. Morris reported that the Colleges were discussing their problems in relation to changes in their charters and bye-laws with particular reference to the election of members of the proposed Faculty to their fellowships. The Working Party agreed that Morris and Harding should have informal discussions with representatives of the three Armed Services. It was expected that there would be another meeting with the representatives of the Royal Colleges at the end of the month and after that each Royal College would discuss the proposals at their Comitia or equivalent meetings in April. Unless there were unforeseen difficulties members of the constituent organisations would be fully consulted and their agreement sought. The Working Party nominated Morris, Doll, Fowler, Harding, McGinness, Pearson and Yellowlees as their representatives on the anticipated joint working party with the Royal Colleges.
A final matter referred to at the February meeting of the Working Party was the receipt of a letter from a group of professors of social medicine in the Midlands which questioned the adequacy of the representation of academic departments of social medicine on the Working
Party and raised doubts about the use of the term community medicine. A reply was sent suggesting that the Society for Social Medicine adequately represented the academic departments and that the term "population medicine" suggested in the letter was undesirable, not least because it would probably be abbreviated to "pop medicine".

The Joint Committee of the three Royal Colleges met on the same day as the Working Party and welcomed the draft proposals. The Committee suggested some verbal improvements, that the Faculty's chief officers should be called Dean and Vice-Dean rather than President and Vice-President, and that the Faculty's Council should meet regularly in Edinburgh and Glasgow as well as in London. In reporting this to Morris Rosenheim concluded his letter: "May I take it that it ("The Proposal") has the general approval of the four bodies mentioned on the first page? I think all is going well but we cannot rush it.".

The penultimate sentence of Rosenheim's letter, quoted above, caused concern to Harding. He felt that, perhaps, he should table at the next meeting of the Council of the Society of Medical Officers of Health, due on February 27, a copy, or at least a summary, of "The Proposal". In the event Harding tabled a statement of the position mentioning the meeting with the representatives of the Royal Colleges on 12 January, the proposal to set up a Joint Working Party, and the intention for each of the Colleges to raise the principle of the formation of the Faculty (the first in any of the three Colleges) before their governing bodies in April. His memorandum set out the criteria for membership of the Faculty as stated in "The Proposal" and summarised the proposals regarding the constitution of the proposed Faculty. Mention was also made of the grant from the Nuffield Provincial Hospitals Trust towards the secretarial expenses involved by the Society. The memorandum was marked "Strictly Confidential and Personal to Members of Council" and its confidential nature was emphasised in the text. The reason for strict confidentiality at this stage was to avoid embarrassing the Royal Colleges by premature disclosure of details before their governing bodies had had an opportunity to consider them.

The implications of the question in Rosenheim's letter were not pursued at that time by the other three organisations on the Working Party. It would appear that both the Senior Administrative Medical Officers and the Scottish Association of Medical Administrators were content with the assumption made. The Society for Social Medicine had already arranged a meeting for all its members to be held in June and meanwhile did not consider that it had committed itself to supporting the formation of the Faculty (see below).

In replying to Rosenheim's letter Morris emphasised that the four constituent organisations had not yet ratified the proposals and that they intended to do this after the general principles had been approved by the Royal Colleges. He also mentioned three issues that were to give rise later to disappointment and disagreement. These were the aim of the Faculty to have a single-tier membership with the members eligible for election to a fellowship of one of the Royal Colleges, the admission of non-medical specialists, and the title of the Faculty.

Approval of the Royal Colleges
In introducing the proposals to establish a Faculty of Community Medicine the President of the London College told Comitia that "he regarded this as an extremely important step since it was the first faculty that the Colleges had proposed to set up and it would deal with the extremely important subject of community medicine which loomed ever larger and to which great attention must be paid by all who worked in hospitals... Community medicine was going to become increasingly important and he hoped that by establishing the Faculty the body of medicine would retain within it those practising community medicine".
Doll, speaking as a member of the Working Party, paid tribute to the encouragement that the College had given to the proposals and referred to the possibility that a different title for the Faculty might be chosen later. He said "Comitia would appreciate that no subject took up more time than discussion of a name and they were all well aware of the unattractiveness of some aspects of the term community medicine. It had been used to get the project off the ground and to avoid sterile discussion". At the end of the discussion Comitia approved in principle the formation of the Faculty.

The Edinburgh College warmly welcomed the proposals and suggested only a modification to the membership clause to allow experience in more than one field of community medicine to count towards the total of the five years required. This had, in fact, been the intention of the Working Party. The Council of the Glasgow College referred the proposals to a full meeting of the College to be held in June.

The Edinburgh College warmly welcomed the proposals and suggested only a modification to the membership clause to allow experience in more than one field of community medicine to count towards the total of the five years required. This had, in fact, been the intention of the Working Party. The Council of the Glasgow College referred the proposals to a full meeting of the College to be held in June.

The Hunter Working Party and the Local Authority Social Services Act

At this time discussions about the reform and unification of the parts of the National Health Service were coming to decisions. In March 1970 in replying to a debate in the House of Commons on the future structure of the National Health Service (Crossman's Green Paper, see page 11) Dr J Dunwoody, Joint Under-Secretary of State at the Department of Health and Social Security, referred to the future role of "community physicians", a term which he said "was increasingly bandied about in professional circles, which no one has yet defined to everyone's satisfaction". He announced that the Government had set up a working party under the chairmanship of Professor RB Hunter to consider the functions and training of "medical administrators". The Hunter Working Party met for the first time in April and then on a further 36 times during the next two years. Morris and Yellowlees who were members of the Working Party considering the proposed Faculty were also members of the Hunter Working Party (see page 32).

The Secretary of State for Scotland, in December 1969, appointed a joint working party chaired by Brotherston to consider the organisation of medical work in the reorganised health service. Brotherston's working party invited a sub-group to advise on the organisation and contribution of community medicine (see page 33).

At the end of May the Local Authority Social Services Act became law and preparations began to form the new departments of social services within the local government authorities in England and Wales. Action had already been taken in Scotland. This involved the transfer of staff and duties from the departments of medical officers of health to the new departments involving additional administrative work and disruption of staff to say nothing of the loss of responsibility for work which had been a focus of special interest and development of many medical officers of health and their senior staff.

Name of the Faculty
At the meeting of the Faculty Working Party in May 1970 two recurring issues were discussed. At the request of the Committee of the Society for Social Medicine Doll raised again the use of the term community medicine. The Working Party also had before it a copy of a letter sent by Professor Alwyn Smith on behalf of the Heads of Departments Group to the Registrar or Secretary of each of the Royal Colleges, objecting to the title "community medicine", and expressing the desire of the Group to present their views about the formation of the Faculty directly to the Colleges. The Group preferred the term "social medicine", with "social and preventive medicine" or "social medicine and public health" as second and third
choices. The Working Party "unanimously agreed that the original title "community medicine", selected after long and detailed discussion, was the most fitting: (a) because the Todd Report proposed the formation of an organisation like the Faculty and employed the term "community medicine" and this wording was supported in the Green Paper; and (b) because in creating a new amalgam of interests it was preferable that its name should be new and not already established as referring to any one of these interests".

**Election to Fellowship of a Royal College of Physicians**

The Working Party also considered the issue of the direct election of a member of the Faculty to a fellowship of one of the Royal Colleges of Physicians, without preliminary election to the membership of the College. It was decided to suggest to the proposed Joint Working Party that "the Council of the Faculty, having defined criteria recognised to conform with those of the Royal Colleges, should nominate annually agreed numbers of members for election to Fellowships. Meanwhile, it was hoped that it would also be possible for an initial number to be nominated by the Provisional Council to mark the inauguration of the Faculty. It was appreciated that the Edinburgh College, in which there was no direct election to Fellowship, might require entry through a formal Membership".

**Extraordinary General Meeting of the Society for Social Medicine held on 4 June 1970.**

Fifty-six members, 31 from London, attended the Extraordinary General Meeting of the Society for Social Medicine held in June at the Royal Society of Medicine to discuss the formation of the Faculty. Of those attending six were statisticians or social scientists, all the others were medically qualified.

Morris discussed some of the points in "The Proposal", a copy of which had been sent to every member of the Society. The Faculty, he said, would provide an excellent opportunity to re-unite the various branches of the profession working in public health, academic social medicine and medical administration. Because of the conflicting interests among the different bodies constituting the Working Party it had been necessary to compromise, and one such point was the name of the Faculty. He and Doll had no doubt that the best name was Social Medicine, but they had not been able to convince their colleagues.

Knowelden, Morrison and Alice Stewart agreed with the general outline of the proposals, although Morrison disliked the term Community Medicine.

Opposition to the proposals was expressed by Margot Jefferys and Alwyn Smith. Jefferys considered the exclusion of social scientists would be divisive and reflect adversely on their status in departments of social medicine; that the association of the Faculty with the Royal Colleges of Physicians would shift the emphasis of social medicine away from population studies of medical care towards clinical epidemiology; that the medical members in favour of the Faculty were influenced by the prestige of the Colleges; and that the establishment of the Faculty would alter the function of the Society for Social Medicine. She also...
Smith's main objections to the proposals referred to the educational role of the proposed Faculty. The main responsibility for education, he said, should lie with the universities not with the Faculty. He considered that the university departments of social medicine should have much stronger representation on the Working Party and on the Provisional Council.

Cochrane felt that the objections to the formation of the Faculty were unrealistic. There had been semantic difficulties in naming the subject for the past 25 years, he said, and the fears of interference with the responsibilities of universities for undergraduate and postgraduate teaching were unfounded; his friends who were professors of medicine had no difficulty in maintaining their own standards in teaching and research in academic medicine.

The meeting accepted "The Proposal" with some textual amendments, thanked their representatives on the Working Party, and agreed that they should continue to serve "at least until the Annual General Meeting on 24 September 1970".

**Survey of Members of the Society for Social Medicine**

At the Extraordinary General Meeting of the Society for Social Medicine the results of the survey of members of the Society about the formation of a faculty were presented. The survey had been carried out by Jefferys and Cartwright following the decisions taken at the Annual General Meeting in 1969 and before members had seen a copy of "The Proposal". Of the 214 listed members 198 (93%) responded, of whom 75% were medically qualified, 82% were male, and the same proportion (82%) worked in university departments or research units. Sixty-seven per cent of the respondents supported the formation of a faculty, 46% preferred community medicine as its name and 8% preferred social medicine; and 75% (76% of the medically qualified respondents) favoured the inclusion of non-medical specialists in the faculty's membership if the faculty set training requirements for them and 60% if it did not. If the non-medical specialists were not included as members of the faculty, then only 44% (47% of the medically qualified) favoured the creation of a faculty.

**Meeting of the Joint Working Party on 16 July 1970**

The meeting between the representatives of the Working Party and of the Royal Colleges took place at the London College on 16 July 1970, following a meeting of the Joint Committee of the Colleges on the same day. The Joint Working Party agreed that the Provisional Council of the proposed Faculty should consist of 6 members nominated by the Royal Colleges (2 from each College), 7 by the Society of Medical Officers of Health (to include Scottish and Welsh representatives), 4 by the Society for Social Medicine, 3 by the meeting of the Senior Administrative Medical Officers and 2 by the Scottish Association of Medical Administrators, with one observer from the Department of Health and Social Security and one from the Scottish Home and Health Department. The Provisional Council would elect its own chairman, secretary and treasurer from among its appointed members and would be based in the
first instance in the London College. It would be responsible for its own finance and for drawing up the constitution and legal status of the Faculty in conjunction with the secretaries of the Royal Colleges.

In regard to election to the fellowship to one of the Royal Colleges it was intimated that members of the Faculty would be eligible for election to membership of a College without examination via the present bye-laws (which would be generously applied) and later in the ordinary way to fellowship. Entrance to the Faculty by examination would need to be seen by the Royal Colleges to be on a par with the MRCP (UK) before common membership facilities could be considered. Rosenheim suggested that this might be a matter of 7 to 10 years. The representatives of the Working Party expressed serious disappointment at what they felt was a major change on the part of the Royal Colleges, certainly as far as London was concerned. Rosenheim expressed regret if there had been any misunderstanding and said that the matter in any case was not important because so many of those involved were already fellows or members of one or other Royal College. This was disputed by the members of the Working Party. The question of a two-tier system of members and fellows within the Faculty was raised and referred to the Provisional Council, the Colleges having no objection to such a scheme90.

Subsequently the representatives of the Working Party agreed to report to the constituent bodies the views of the Royal Colleges about election to their fellowship and to recommend them to appoint members of the Provisional Council subject to further consideration of the decision of the Colleges about their fellowship.

The disagreement about the equivalence of the membership of the Faculty and the MRCP (UK) became a major issue and led to the first meeting of the Provisional Council being postponed from October 1970, as had been agreed at the Joint Working Party, to February 1971.

Further Debate about Election to Fellowship of a Royal College

Shortly after the meeting between the representatives of the Working Party and of the Royal Colleges Harding reported the situation to the General Purposes Committee of the Society of Medical Officers of Health. The Committee decided to recommend to the Council of the Society that negotiations on the formation of the Faculty should proceed, and that in the meantime, and without prejudice to the Council's decision, it agreed to nominate as members of the Provisional Council Edgar, Galloway, Harding, Preston, and Pearson91.

In the September issue of Public Health an editorial reviewed the progress being made with the formation of the Faculty92. It doubted whether the Society of Medical Officers of Health could have created a College of Preventive Medicine when the matter had been discussed previously, and was certain that it could not do so by itself at the present time. It therefore advised those in public health to support the efforts being made to create the Faculty and to secure that membership of the Faculty would rank equally with the membership of the Royal Colleges. The editorial foresaw continuing "tough negotiations" which must ensure parity of esteem of specialists in community medicine among other specialists. "If the establishment of a Faculty", it said, "should be on terms which,
in effect, said to community medicine 'you are accepted as only a junior partner and must prove yourself before you receive equal status' then community medicine as a discipline or a cause would be left behind at the start of the race and would labour under a handicap for many years to come".

Morris met Rosenheim on 14 August and emphasised the importance that the Working Party attached to the provision of direct election of members of the Faculty to fellowships of the Royal Colleges. Nominees for college fellowship, he argued, would often be leaders in the profession and senior in the specialty so that career progression through a College membership would be inappropriate at this stage. He also remarked that enthusiasm for the Faculty did not appear to be uniform among the three Royal Colleges and perhaps some re-thinking was necessary93.

The Working Party met again on 17 September and expressed "grave disappointment" at the outcome of the discussions with the Royal Colleges and of Morris's later meeting with Rosenheim94. It decided that the proposals of the Colleges could not be recommended to its constituent organisations, nor could it recommend proceeding with the appointment of representatives to the Provisional Council. Each member of the Working Party agreed to report to his organisation only that "negotiations were at an extremely delicate stage". Morris and Harding discussed the matter again with Rosenheim on 23 September, and he agreed that the Colleges would review the situation and he would write to Morris stating how far the Colleges could go to meet the wishes of the Working Party95.

The Annual General Meeting of the Society for Social Medicine was held on 24 September, the day after Morris and Harding had met Rosenheim. Morris reported to the meeting that little progress had been made in the negotiations since the Extraordinary General Meeting in
June due to the intervening holidays, and that current discussions had reached a stage dealing with delicate confidential matters. Jefferys questioned the need to withhold these matters from the Society, but Doll supported Morris and said that the matters were not related to problems which had been raised in June. The meeting agreed that there should be a further extraordinary general meeting after the Working Party had met and when the confidential matters could be discussed. Doll resigned as one of the Society's representatives on the Working Party due to the pressures of his other commitments. Morris and Lowe, with McKeown and Cochrane as their deputies, were elected to represent the Society on the Working Party and on the Provisional Council, if the latter was set up.

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The Council of the Edinburgh College at its meeting in September nominated its President and Forwell to represent it on the proposed Provisional Council and at about the same time the Glasgow College nominated its President and Anderson as its representatives.

Rosenheim reported his discussions with Morris and Harding to the October meeting of the Council of the London College and said that he hoped that those proposing a Faculty would not break away and set up their own college. At the meeting of Comitia in the same month the matter was discussed at length. Rosenheim stated that a serious hitch had developed. Members of the Working Party of the various societies concerned with Community Medicine hoped that the Colleges would be able to elect Members of the Faculty directly into their Fellowship. All three Colleges, however, could at present time only elect Fellows from among their own Members.... While agreeing to be as forthcoming as possible and while each College was most anxious to see the Faculty established and Community Medicine retained in the field of general medicine, it would be wrong, at this time, to seek to change the College's present arrangements. If, in the next few years, after the Faculty had been established, it became evident that the new examination for the Membership of the Faculty was of the same high standard as that of the present Membership Examination, Comitia might reconsider the matter.

The President read out a letter from Doll who wrote "The present proposals have given me some anxiety as, if we were to put them into effect many people both inside and outside community medicine would get the impression that membership of the Faculty was equivalent to some of the pre-existing diplomas and appreciably inferior in status to membership of the Royal Colleges of the United Kingdom. This, I believe, would start us off on a weak basis, cause dissension between the academic practitioners of social medicine and their other colleagues, and be deleterious to the development of the subject. It is, in my view most important for the membership of the Faculty to be, and to be seen to be, regarded as equivalent to the MRCP (UK) from the beginning. I can appreciate that the College may have some qualms about this, but we who are interested in the subject are looking to the Colleges to ensure that this need is recognised". Doll suggested as a compromise that there might be a more limited initial election to membership of the Faculty, or "an alternative, and to me a less satisfactory but much easier solution, would be for the Faculty to have two tiers of Members and Fellows of its own. This I fear, would mean that the life of the Faculty would be largely independent of that of the Colleges and the integration that we were hoping to obtain might never come about".

After considerable debate, Comitia agreed by a very large majority that at the present time, not ruling out some possible change in the future, the College did not see its way to suggesting an alteration of Bye-Laws, regulations or Charter in order to allow the direct election of fellows from Members of the proposed Faculty of Community Medicine.
After the meeting Rosenheim wrote to Morris re-assuring him that the Royal Colleges were "very anxious to see the Faculty of Community Medicine launched", but that the Colleges could not accept members of the Faculty as the equivalent of their members until the examination for the Faculty "has been established and recognised as being of a difficulty corresponding to that of the Membership" (see appendix 8).

**Final Meeting of the Working Party**

The Working Party met on 17 November with Lowe attending in the place of Doll. Morris reported at length on his meetings with the President of the London College and on the content of the latter's letters. The meeting recorded disappointment at the lack of progress on the question of College fellowship and noted with concern that no mention had been made of any facilities of the colleges being made available to members of the Faculty. Nevertheless it was agreed that much had been achieved and that a positive step forward must be taken if the goodwill of the three Colleges was not to be lost and the whole enterprise jeopardised. In these circumstances the Working Party agreed to the setting up of a Provisional Council leaving negotiations on the outstanding matters to be continued by the new body. The Working Party was dissolved and Morris informed Rosenheim that the way was now clear for the formation of the Provisional Council (see appendix 9).

At the meeting of the Joint Committee of the Royal Colleges on 20 November the presidents confirmed their stance on the issue of election to college fellowship and agreed to call the first meeting of the Provisional Council in February 1971 on the lines previously agreed.

The decision to set up the Provisional Council and the disappointment of the members of the Working Party over the fellowship issue were reported to the Council of the Society of Medical Officers of Health by Harding at the meeting on 27 November. At about the same time the conclusions of the Working Party and its winding up were reported to the meeting of the Senior Administrative Medical Officers and to the Scottish Association of Medical Administrators.

**Concerns of the Society for Social Medicine**

Morris informed the Committee of the Society for Social Medicine that the negotiations had proved extremely difficult and was able to explain that the "hitch" referred to at the Annual General Meeting was over the question of the election of members of the proposed Faculty directly to fellowships of one of the Royal Colleges, thus putting the Faculty's membership on a par with the Colleges' membership. The Colleges had rejected this. The other negotiators, he said, were willing to accept the situation so the Society had to decide either to give way or boycott the subsequent development of the Faculty. He considered
that the Committee had no choice but to put the issue to all members of the Society. The Committee agreed and an Extraordinary General Meeting was arranged.

The Extraordinary General Meeting, with Knox in the chair, was held on 30 January 1971 at St Thomas's Hospital Medical School. Fifty-three of the 218 members of the Society were present. Morris and Doll summarised the negotiations with particular attention to the inability (or unwillingness) of the Royal Colleges to accept members of the Faculty for direct election to their fellowships. He pointed out that the Colleges were ruled by their Fellows. There was a danger, he said, of the new Faculty becoming a minor enclave in the mighty Colleges and thereby losing a lot of independence to the Colleges without obtaining compensating power to influence their decisions and policy.

Boddy, Fletcher (FRCP) and Meade (MRCP) suggested that the Colleges' position was not unrealistic as they could be expected to take a cautious attitude to an influx of new members. Donald Acheson proposed that the Faculty should develop its own requirements for fellowship, and thereby recognise merit independently of the Colleges. In answer to the
suggestion that there should be a separate college of community medicine, Morris, Doll and Lowe all thought it was extremely unlikely that the other constituent bodies would agree as they were anxious to get on and form the Provisional Council.

Lowe questioned the relationship of the Faculty to academic departments which, he stressed, should have adequate say in the planning of courses and maintenance of standards. He suggested that the meeting should consider what benefit social medicine as a subject and the Society itself would gain from entry into the Faculty on the proposed terms. He did not mention that from the start of negotiations it had been agreed that the proposal was not to amalgamate various societies and associations, but to create a new body without prejudice to existing organisations, (see page 44). Rose pointed out that the avenues of entry into social medicine were very varied and that, in his opinion, it would be impossible to devise a single examination that could fairly assess the merits of all applicants for membership.

Donald Reid and Cochrane spoke firmly against going into the Faculty, but Doll pointed out that specialist registration was coming and that it was imperative that the Society should be involved in this. Campbell and Backett agreed with Doll and advocated sending representatives to the Provisional Council. McKeown proposed that the Society should not send members to the Provisional Council but that the Society's negotiators should keep in touch directly with the Royal Colleges.

Forty-six of the members present voted to reject the current terms offered. Fifty-two voted in favour of the Society continuing to negotiate with the Royal Colleges, and it was agreed that Morris, Lowe, McKeown and Cochrane would be the Society's representatives in such negotiations.

Knox, as chairman of the Committee of the Society, wrote to Rosenheim expressing concern about the lack of parity between membership of the Faculty and membership of the College. He asked for a meeting between the President and representatives of the Society "to find an acceptable alternative approach", and went on to say that "the Society is unable to participate in a Provisional Council which has the implementation of the present proposals as its basis" (see appendix 10).

Rosenheim and Harding were surprised and disconcerted at the response from the Society for Social Medicine. Rosenheim responded to Knox's letter by inviting representatives of the Society to meet representatives of the Royal Colleges on the morning before the first meeting of the Provisional Council. At that meeting with the Colleges' representatives the Society's nominees asked to attend the meeting of the Provisional Council as observers. This was not acceptable to the Provisional Council. However at its meeting the Provisional Council regretted that the Society had not felt able for its nominees to attend as members, hoped that this would soon be changed and agreed that meanwhile the Society could send observers.

Subsequently Rosenheim wrote to Knox saying that the Colleges "really felt that the important thing was to get a Faculty established without too much worry about status" and that suggestions about the possibility of a two-tier Faculty which would include a fellowship had been made to the Society's representatives. He concluded his letter: "It would be the greatest pity if the academic side of community medicine was not represented in the Faculty and I do
hope that your Society will review the situation again and that after discussions with the Executive Committee (of the Provisional Council) you may feel able to discuss the situation once more with your members”.

The Society's negotiators met with some members of the Society's Committee on 23 February and on 4 March, but unfortunately not all members were present on both occasions and Morris was unable to attend the second meeting. At the first meeting Morris reported on the
negotiators' meeting with the presidents of the Royal Colleges and a letter from Anderson was discussed. The letter criticised the Society's stance as being confused and emphasised that the concern of the Society's representatives should be about the place of teaching, training and research in the new subject of community medicine. During the discussion some of the anxieties of members became more apparent. These included the relationship between membership of the Faculty and specialist registration with the General Medical Council (a possibility then being discussed in relation to all specialties). The worry was that if membership of the Faculty was only by examination then those who entered social medicine through clinical medicine and research in academic departments of social medicine might be excluded from specialist registration. Linked to this was the doubt of some senior members of the Society (eg Rose and McKeown) whether it was possible to create a pattern of training which could embrace the range of people coming together under the term of community medicine. Anderson, who attended the second meeting, said there was plenty of scope for discussion on these issues within the Executive Committee of the Provisional Council, but McKeown doubted that the Provisional Council would ever see eye to eye with the academic viewpoint.

On 10 March Knox, Cochrane and McKeown, as representatives of the Society met with members of the Executive Committee of the Provisional Council (which included Anderson). The Society had sent a memorandum setting out its main reservations which were concerned with election to fellowships of the Royal Colleges, and the admission to membership of the Faculty and its relationship to specialist training and registration. The Society's representatives also wanted to re-open discussions on the name of the Faculty, criteria for the admission of the initial members and the admission of non-medical scientists.

At the meeting Harding (chairman of the Provisional Council and of its Executive Committee) gave an account of the negotiations leading to the formation of the Provisional Council and emphasised that places remained available for nominees of the Society on the Council, and that the replacement of the Working Party by the Provisional Council did not imply that all major issues were settled. On the contrary, he said, almost all details of policy and implementation remained to be discussed and decided. However it was made clear that each member of the Provisional Council would be regarded as a member in his or her own right and would not be answerable to any society of which he or she was a member. Harding, supported by members of the Executive Committee, assured the Society's representatives that it was the Council's intention that there should be flexibility in admitting to the membership of the Faculty those who for various reasons had not taken a "relevant" examination earlier in their careers but were recognised as specialists in one of the fields of community medicine.

The Society's representatives were re-assured on many of the points about which they had been concerned and recommended that the Society should nominate members to join the Provisional Council. The Society's Committee met on 16 April with only the three officers (Knox, Alderson and Campbell) and three members (Cartwright, Cochrane and Warren) present and they agreed to proceed with a postal ballot of all members. Harding was so informed.

The members of the Society voted overwhelmingly in favour of participating in the Provisional Council (95 in favour and 5 against) and the election of the Society's nominees was then carried out. While this was taking place the previously appointed representatives were asked to attend the meetings of the Provisional Council as observers, but only Cochrane was able to do this and he was invited by Harding to join the Executive Committee. Morris asked to be excused from nomination as one of the nominees of the Society as his commitments at the London School of Hygiene and Tropical Medicine were increasing.
and he felt he had done his "fair share in getting the Faculty off the ground". The result of the ballot was that Cochrane, Heasman, Holland and Lowe were elected to serve on the
Provincial Council\textsuperscript{21}, and all, except Holland, were able to attend the meeting of the Council on 23 July\textsuperscript{22}. The whole matter was reported to and accepted by members attending the Annual General Meeting of the Society in September 1971\textsuperscript{23}.

Throughout the period of negotiations with the Society the three Royal Colleges and the original constituent bodies were kept informed\textsuperscript{24}. At the meeting of the Joint Committee of the Royal Colleges in June Rosenheim welcomed the information that the Society for Social Medicine had agreed to take its places on the Provisional Council\textsuperscript{25}.

**Heads of Academic Departments of Social Medicine Group**

While the talks were going on between the Provisional Council and the Society for Social Medicine the heads of academic departments of social medicine and directors of related research units established a formal body for the purpose of safe-guarding and promoting the interests of their departments and units particularly in relation to their responsibilities for the undergraduate and postgraduate education of doctors and for research in social and preventive medicine and in public health\textsuperscript{26}. Although members of the Heads of Departments Group were also members of the Society for Social Medicine, the Group had felt from the early days in the development of the proposal for a Faculty that it should be involved in the process. In April 1971 the Group asked the Provisional Council to invite it to nominate two of its members first as observers and then as members of the Council\textsuperscript{27}.

Pemberton (chairman of the Group) wrote later to Harding expressing the view of the Group that the academic departments should have representation separate from that of the Society for Social Medicine on the Provisional Council and, particularly, on the Education Committee as members of the Group would be mainly responsible for the education and training of future practitioners of community medicine\textsuperscript{28}. Harding replied that the Provisional Council had already decided that at least three heads of academic departments would have places on the Council, excluding the president and vice-president, and that the Council would be mindful of the need for adequate representation on the Education Committee\textsuperscript{29}. In a later letter he emphasised that the Faculty must be an integrated body and not a collection of representatives from various organisations, and that the academic aspects of the Faculty's work must be covered by proper expertise\textsuperscript{30}.

**THE PROVISIONAL COUNCIL/BOARD: FEBRUARY 1971 - NOVEMBER 1972**

The Provisional Council (later Board) met six times between February 1971 and January 1972\textsuperscript{31}. Its main tasks were to draw up a constitution and bye-laws for the proposed Faculty, recommend a list of foundation members to the Royal Colleges, outline proposals for the future entry of members and set up arrangements for continuing financial support and administration. The members of the Provisional Council were those nominated by the constituent bodies
although as already described, the nominees of the Society for Social Medicine did not attend the first two meetings. The list of members is given in appendix 11. At its first meeting on 19 February 1971 Harding was elected chairman and an Executive Committee was formed132.

Announcement of the Formation of the Faculty

It had been intended that there would be some publicity about the formation of the Faculty immediately after the first meeting of the Provisional Council, but following the reservations of the Society for Social Medicine this was postponed133. A press statement was eventually issued on behalf of the three Royal Colleges on 14 May, and abstracts of it were printed in the British Medical Journal, The Lancet and The Medical Officer134. The statement in The Lancet was as follows:

"The Royal Colleges of Physicians of the United Kingdom have agreed to found a joint Faculty of Community Medicine. The provisional council, which includes the presidents of the three colleges, has met twice under the chairmanship of Dr Wilfrid Harding; its executive committee has met several times to consider by-laws and administration. A provisional education committee has also been set up. It is hoped that the provisional Faculty will be in position later in the year to receive applications from those wishing to become founder members."

A week later a leading article in the British Medical Journal welcomed the creation of the Faculty and the emergence of the community physician135. "Without a medical man," it said, "committed to the measurement, planning and development of all services for the prevention and treatment of disease in each administrative area an integrated health service cannot be achieved." It went on to hope that the Faculty would help the community physician to be recognised from the outset as a medical specialist working alongside his clinical colleagues.

Administration and Finance

The meetings of the Provisional Council and of its Executive Committee were held at the London College's premises where, in due course, an office was provided. An approach was made to the Nuffield Provincial Hospitals Trust for a grant of £8000 to cover initial costs (mainly office expenses and travelling costs incurred by members attending council and committee meetings) but the Trust felt unable to make such a grant136. The London College offered to support the work of the Provisional Council until it obtained other funds and could derive income from the subscriptions of members of the Faculty. The Scottish Colleges agreed to pay the expenses of their representatives attending meetings137. Later the London College made generous arrangements for the temporary accommodation of the staff and for Council (later Board) and Committee meetings within its premises138.
The Secretary of the London College, Michael Tibbs, acted as Secretary to the Provisional Council and of the Faculty itself for its first few weeks. His contribution to the creation and launching of the Faculty was immense - and he did all this while, in addition to his post at the College, he was also Secretary of the Joint Committee of the Royal Colleges of Physicians and of the Joint Committee on Higher Medical Training.

The detailed work of the Provisional Council was carried out by its Executive Committee. At its meeting in May the Provisional Council set up a provisional Education Committee with Anderson as convenor, and the Council asked the Executive Committee to consider setting up an Accreditation Committee.

Defence Services

From the early days of the Working Party Harding had informally kept the directorates of the medical services of the Royal Navy, Army and Royal Air Force informed about the development of the Faculty, and this he continued to do. Members of the Services practising community medicine were eligible for initial election without examination to the membership of the Faculty, but a formal link was not made with the Services until after the establishment of the Faculty when the Defence Services Medical Services nominated a member of the Faculty’s Education Committee.
**Occupational Medicine**

The Todd Commission had recommended that "doctors who wish to specialise in occupational medicine should have a full course of training for community medicine. Occupational medicine would be an elective subject in the academic course and the planned experience would be appropriately adapted"\(^{141}\). However neither the initial approaches (see page 36) nor the Working Party included specialists in occupational medicine. The Working Party sought the advice of the Joint Committee of the Royal Colleges\(^{142}\) who suggested that the matter be left for the Provisional Council to decide\(^{143}\). Meanwhile representatives of occupational medicine approached the Royal Colleges with a request that a Faculty of Occupational Medicine should be formed. The Royal Colleges were cautious about this proposal and set up a small group to meet the representatives\(^{144}\).

Discussions were held between the Faculty and representatives of occupational medicine. The view of the Faculty, as Harding wrote later, was that the basic concept of community medicine was as the practice of medicine relating to populations or groups rather than to individual patients. Within that concept occupational health physicians were included among the Faculty's foundation fellows and members. What the Faculty felt it could not do, and did not do in relation to clinical medical officers in the public health services, was to accept clinical occupational medicine as part of community medicine\(^{145}\).

[In 1978 a Faculty of Occupational Medicine was founded within the London College with an agreement that observers from one Faculty would attend meetings of the Board of the other Faculty.]

**Constitution and Standing Orders**

A major task of the Provisional Council was the drawing up of the Constitution and Standing Orders of the proposed Faculty. Much of the detailed work was done by Harding, Tibbs and the Executive Committee of the Council. Field Fisher and Co., the firm of solicitors used by the London College, was appointed by the Faculty as its solicitors. Mr John A Nelson-Jones did the work on behalf of the Company.

The Provisional Council agreed that the Faculty should have control of its own funds and be registered as a charity. At the same meeting it was decided that there should be a two-tier structure of fellows and members with equal voting rights (unlike the parent Colleges) in the election of the Council of the Faculty\(^{146}\).

At its meeting in May the Provisional Council accepted the recommendations of the Executive Committee that members of the Council should be elected by postal vote; that the annual general meetings should rotate London, Edinburgh, London, Glasgow, London, Edinburgh, etc. and be held in the respective College; that the officers of the Faculty should be the President, Vice-President, Registrar, Treasurer and Academic Registrar; that the President and Vice-President should be fellows and be elected annually at the annual general meeting; that the other three officers should be appointed by the Council; that there
should be a minimum of three "academics" on the Council at any one time (the term "academic" proved difficult to define); that the Council should appoint annually members, who could be fellows or members of the Faculty, to form Finance and General Purposes, Education, and Scientific Meetings Committees; and that the Council should appoint the examiners "who should normally be fellows of the Faculty".

Considerable progress was made with the drafting of the Standing Orders at the meeting of the Executive Committee at the end of June when Nelson-Jones attended. It was accepted that the term Board should be used instead of Council, and Standing Orders instead of Bye-Laws,
Changes in the Bye-Laws of the Royal Colleges

The creation of the Faculty by the three Royal Colleges necessitated amendments to their Bye-Laws. An early draft of the Faculty's Bye-Laws (later Standing Orders) was discussed at the meeting of the Joint Committee of the Colleges in June 1971, when the Colleges agreed to begin the necessary formalities to amend their own bye-laws. The President of the London College reported to Comitia in July and the Registrar gave formal notice of the intended changes to the bye-laws to provide for the College to found Faculties and Joint Faculties. During the same month the Councils of the Edinburgh and Glasgow Colleges began the procedures to alter their regulations and bye-laws.

Accreditation

"The Proposal", on the basis of which the Royal Colleges set up the Provisional Council, stated that for a period of two years in the first instance, registered medical practitioners practising in the United Kingdom and fulfilling the following conditions would be eligible for consideration by the Provisional Council of the Faculty for immediate election to Membership without examination. They should:

(a) hold an appropriate higher postgraduate qualification,
(b) have had five years experience in community medicine, and
(c) have been promoted above the basic grade in the relevant field of community medicine.

This statement gave a broad indication of intent, but while excluding all non-medical specialists and medical specialists practising abroad, it left open definitions of the boundaries of community medicine and of appropriate postgraduate qualifications. A foot-note in the original document defined "above the basic grade" as applied in the local authority health services, regional hospital boards, central government departments, university departments and research...
units. A major difficulty in defining the boundaries of community medicine was to decide what aspects of preventive medicine came within community medicine. The distinction was drawn between population programmes of prevention which came within community medicine and the carrying out of health surveillance and preventive measures on individuals which did not. There were also difficulties in the field of clinical epidemiology, where judgements had to be made of the experience of the applicant and the amount of time devoted to epidemiology. The Provisional Council was very conscious of the need for a rigorous process of selection of foundation members. Not only was this essential in establishing the definition and status of the new composite speciality, but also it was necessary in order to fulfil the assurances which the negotiators had given to the Royal Colleges.

At its meeting on 26 May 1971 the Executive Committee agreed that applications for membership of the Faculty should be invited and that the invitation should stay open for two years. The Committee appointed an Accreditation Committee with Galloway as convenor, and Harding, Anderson, McGinness, Fowler and Yellowlees as members. The remit of the Accreditation Committee was to produce a detailed statement of the standards of vocational training required to be accepted for membership and to draft an application form which would elicit the information relevant to this.

In practice all applications were checked first by Patricia King (assistant secretary) and doubtful ones were referred to Tibbs before Galloway went through them all in detail. Lists of "probably accept", "reject" and "doubtful" were drawn up and presented to the Accreditation Committee. Members of the Committee, or the Committee as a whole, were permitted to consult in confidence with other people about individual cases. Applications over which there was doubt had to be discussed by the whole Committee and reasons for rejecting an applicant had to be minuted. The final responsibility for rejecting an applicant lay with the Provisional Council which had authority to over-rule decisions of the Committee. The Executive Committee agreed that there should be no limit to the number of people who might be selected for membership154.

In October 1971 a letter signed by the Presidents of the three Royal Colleges was published in the British Medical Journal and The Lancet. The letter set out the background to the formation of the Faculty within the structure of the three Colleges and drew attention to an invitation, printed in the advertisement columns of each journal, for those eligible to apply for foundation membership of the Faculty155. The invitation repeated the criteria for membership quoted above and added: "Other medical practitioners of comparable qualifications and/or experience who are engaged in the practice of Community Medicine, including those engaged in relevant research and those who have made notable contributions to Community Medicine may also apply". It added that there would be an admission fee of £25 and an annual subscription in the region of £20 per annum in the first instance156.

By the end of the year, slightly less than three months from the publication of the invitation to apply for membership, 1,400 applications had been received, of which about 800 had been dealt with or were still under consideration157. At the inauguration of the Faculty 900 members were elected, of whom 144 were elected fellows158.

**Specialist Training**
The initial request of the Working Party to be involved in the new procedures and monitoring of specialist training was met with the response that the position would be considered when the Faculty was established (see page 43). The Council for Postgraduate Medical Education in England and Wales was set up at the end of 1970, continuing the work of the preceding Central Committee. When the Council was formed community medicine was not in the list of specialities for which training programmes should be laid down. During 1970 representatives of the Royal Colleges of Physicians, of the Association of Professorial Heads of Departments of Medicine and Paediatrics, and of various specialists associations (but not including the Society of Medical Officers of Health or the Society for Social Medicine) agreed to form a Joint Committee, supported by Specialist Advisory Committees. The Joint Committee (to be called the Joint Committee on Higher Medical Training or JCHMT) was to provide authoritative training programmes, arrange to visit and approve posts suitable for training, and, if required, provide certificates of completed specialist training. The first full meeting of the Joint Committee took place in February 1971, the month during which the Provisional Council of the Faculty first met. The relationship between the JCHMT and the Council for Postgraduate Medical Education was that the Council received and discussed the training programmes submitted by the Joint Committees (medicine, surgery, obstetrics and
gynaecology, dentistry, etc) and commented on any programme that seemed seriously out of step. In brief the procedure was that a speciality training programme would be developed by the relevant specialist advisory committee, agreed by the JCHMT and reported to the Council for Postgraduate Medical Education.

Shortly after the first meeting of the Provisional Council of the Faculty Harding wrote to Dame Albertine Winner (Linacre Fellow of the Royal College of Physicians of London) urging that community medicine should be recognised as one of the medical specialities even before the Faculty was established. Dame Albertine replied that the Royal Colleges had agreed that the Faculty would be responsible for appointing a specialist advisory committee on community medicine. Later the Provisional Board was asked to nominate four members to be the Faculty’s representatives on the Specialist Advisory Committee, to which two members of the JCHMT would be added. Although the Specialist Advisory Committee would be ineffective nationally until the Faculty was formed, it was suggested that it should proceed to prepare a training programme. Subsequently the JCHMT agreed that the Faculty itself would act as the specialist advisory committee within the ambit of the JCHMT. This was a significant step in the recognition of community medicine as a medical specialty and had implications about the pattern of training for the specialty.

Membership Examination and Training Programmes

The discussions and correspondence with the Council for Postgraduate Medical Education and the JCHMT were concerned with the development and approval of specialist training programmes. The introduction of an examination for membership of the Faculty was another, although related, issue. The Education Committee of the Provisional Board first met in May 1971 with Anderson as convenor, and Kershaw, Kirk, Harding, Holland, Lowe, Menzies and Ramsay as members. The Committee had two major tasks - to outline the role and structure of such a committee as part of the constitution and standing orders of the Faculty, and to indicate the content and procedure for the membership examination and for specialist training. A further concern of the Committee was the requirement to advise on the re-orientation of doctors in the public health services and in the regional hospital boards in preparation for their new roles in the reorganised national health service. Only a few medical administrators at that time had had any direct experience of the problems of providing total health care for a defined community.

A draft report from the Education Committee was discussed at the final meeting of the Provisional Board attended by Warren who had been appointed to be the academic registrar. It was agreed that the report with some amendments should be presented as a memorandum for discussion to the Inaugural Meeting.

The Memorandum recognised that the assessment of candidates for membership must cater for entrants with special interests in different aspects of community medicine, for those who had already achieved distinction in a clinical speciality and wanted to move into community medicine and for those who had already made significant contributions bearing on community medicine. The Memorandum recommended that for younger candidates passing the membership examination should signify the completion of the preliminary period of training, preceding a period during which the skills and knowledge are


applied under supervision in the field, and that the period of planned training must be seen as the initial stage of a clearly defined career structure. A variety of patterns of preliminary training should be available such as a period of approved service appointments interspersed with short academic courses taken at different centres, a full-time academic course leading to a M.Sc. degree or its equivalent, or attachment to an academic department of social or community medicine.

The core subjects of the academic components of the training should be epidemiology, statistics, social sciences in relation to community medicine, and management. An indication of the content of these subjects was given in an appendix to the memorandum. It was suggested that the examination for membership should be divided into two parts. The primary examination, concerned with the core subjects, could be by means of papers and/or oral examinations. The second part should be designed to enable the candidate to concentrate on one or more subjects such as health services administration, health services research, information services and management techniques, the epidemiology of communicable diseases, and the epidemiology of non-communicable diseases. The presentation of a dissertation or a series of papers on one or other of these subjects together with an oral examination could form the basis of assessment. The Memorandum emphasised that any system of education and training and its assessment procedures needed continuous appraisal and adaptation to changes in knowledge and practice.

**Election and Appointment of Officers**

At the meeting of the Provisional Board on 25 January 1972 Yellowlees took the chair for the discussion about the appointment of the initial officers\(^{70}\). Standing Orders required nominations to be submitted to the Inaugural Meeting for the President and Vice-President, and for the Provisional Board to appoint the other three officers. Informal discussions had resulted in agreement that the first president should be a distinguished professor, and preferably one who had participated in the formation of the Faculty; Harding wholeheartedly agreed, although some members of the Board felt he was the obvious choice. Morris was pressed to be nominated by several of those involved, but felt his commitments prevented this. For the same reason Doll, who was approached informally, felt he had to decline. The Board unanimously supported the nominations of Cochrane as President and of Harding as Vice-President for election at the Inaugural Meeting. The Board appointed Galloway as Registrar, Fowler as Treasurer and Warren as Academic Registrar. The three Royal Colleges subsequently appointed the members of the first Board of the Faculty who were to serve until the first Annual General Meeting.

**INAUGURAL MEETING**

The Inaugural Meeting was held at the London College on 15 March 1972 with Lord Rosenheim in the chair\(^{71}\) (see appendix 12 and illustration). In warmly greeting those present Rosenheim said: "I am confident that this Faculty will bring together and weld together all those who work in the field of Community
Medicine and that the Faculty will work most intimately with the three Colleges. We look forward to a close association with the Faculty and on behalf of the three Colleges I say to you all ‘welcome’”. The meeting then elected the President and Vice-President, and business began under the chairmanship of Cochrane.

Galloway briefly described the accreditation procedure and announced that the initial membership of the Faculty was about 900 and that many applications were still being received.

Anderson presented the Memorandum on education and training to the meeting. He stressed that it was a declaration of intent to be seen and commented on by members, heads of academic departments of community medicine and colleagues in other special areas of medicine. He invited representatives of the Heads of Departments Group to discuss the Memorandum and future documents relating to training and assessment with the Education Committee or its representatives. He drew attention to the statement in the Memorandum that
the acquisition of the membership marked the end of the preliminary period of training, and, like the MRCP enabled the person to proceed to a variety of specialist training programmes.

Fowler discussed the financial prospects of the Faculty. The hospitality of the London College had allowed the Faculty to start with very modest initial expenses, but the Faculty would need separate premises, the costs of which together with that of additional staff, it would have to meet in full. He was hopeful that the Charity Commissioners would approve the registration of the Faculty as a charity. He announced that the three Royal Colleges had agreed for some of their facilities to be made available to members and fellows of the Faculty.

The meeting concluded with the President thanking the three Royal Colleges, and especially Lord Rosenheim for "his determination, imagination, patience and skill without which the difficult confinement would never have been brought to term". The meeting was followed by a reception in the London College, which was attended by a number of dignitaries including the Secretary of State for Social Services Sir Keith Joseph and Lady Joseph.

PART III

COMPLETING THE BEGINNING

MEMBERSHIP, MANAGEMENT, AND LIAISON

At a short meeting of the Board of the Faculty held before the Inaugural Meeting on 15 March it was agreed to elect the Presidents of the three Royal Colleges of Physicians, Lord Rosenheim, Dr J Halliday Croom and Professor EM McGirr, Fellows of the Faculty under Standing Order 10b which referred to the election of distinguished persons holding a medical qualification to the fellowship (as distinct from honorary fellowship). No more than four such elections were permitted per year. Less than nine months later, on 2 December 1972, the Faculty was greatly saddened by the death of Lord Rosenheim who had by his patience, diplomacy and concern for the development of community medicine contributed so much to its formation.

Getting Down to Business

The first meeting of the Board to be held after the inauguration of the Faculty had to be postponed from April to May for the same reason that had caused the postponement of the first meeting of the informal group convened by Morris, namely industrial action on the railways. The postponement had the advantage that Paul Luke, who had taken up his post as the first full-time secretary of the Faculty on 1 May, was able to attend the meeting at which the Board got down
to the business of getting the Faculty going. In the interim the officers, with the continuing help of Michael Tibbs, had dealt with a large number of applications for foundation membership, developed further details of the membership examination and training programmes and dealt with many other matters.

At the Board Meeting on 11 May various items relating to banking and trustee matters were regularised. An important decision concerned the office of vice-president. Under the standing orders the vice-president could deputise as a member of any committee in the absence of the president, but was not an ex-officio member of all committees. The Board agreed that Harding, as Vice-President, should be an ex-officio member of all committees of which he was not an elected member. The Board also agreed that the members of the Executive Committee of the Provisional Board should be elected as the members of the Finance and General Purposes Committee and that Harding should chair this committee. The Board went on to appoint Anderson chairman of the Education Committee and the members of the previous committee as the members of the new one. Similarly Galloway was appointed chairman of the Accreditation Committee with the re-election of its previous members. Holland was appointed chairman of the Scientific Meetings Committee (a new committee). (Membership of the committees is shown in appendix 13, and a list of the officers of the Faculty up to 1995 is shown in appendix 14).

At the Board meeting the President spoke of the need for close liaison with members in the regions and raised the possibility of appointing regional advisers along the lines of such appointments made recently by the London College. This matter was referred to the Finance and General Purposes Committee, which was also asked to arrange for a Newsletter to be produced and sent to all members in the autumn.
Foundation Membership

Applications for Foundation Membership had to be received by the Faculty by 1 December 1973 so that they could be considered before the election of such members ceased on 15 March 1974. At the Annual General Meeting of the Faculty, held in Edinburgh on that date, the Registrar announced that there had been more than 3000 applications for membership of which 2073 had been accepted. It had been estimated that a membership of 2000 would be reached in five years; in the event that figure was surpassed in less than half that time.

Committees in Scotland, Wales and Northern Ireland

As the legislation and administration of the National Health Service in Scotland, Wales and Northern Ireland is separate from that in England the Faculty set up committees to consider and deal with matters relating solely to each country's particular circumstances and to give their views on matters common to all the countries including England. The Scottish Affairs Committee was set up in 1972, initially with the President as chairman and Anderson as deputy chairman. The Welsh Affairs Committee first met in March 1974 with P Alwyn-Smith as convenor. In Northern Ireland the arrangements were different. The Northern Ireland Council for Postgraduate Medical Education set up a specialty committee, chaired by JMcATaggart, concerned with all matters relating to community medicine in the Province and this committee liaised closely with the Faculty.

Regional Advisers

In addition to the arrangements for developing the Faculty's influence and serving its members in Scotland, Wales and Northern Ireland the Faculty, in 1973, appointed a regional adviser in each of the health service's regions in England. As had been suggested by the President these appointments were along the lines of the London College's advisers. Each adviser was the Faculty's representative on the regional postgraduate medical education committee. Each had wide-ranging responsibilities as a two-way link between the Faculty and its central and peripheral activities, and each had special obligations to doctors in training for career posts in community medicine. At the first conference for the Faculty advisers, held in November 1973, the duties of the advisers and the recommendations of the Education Committee about training programmes were presented and discussed in detail.

Newsletter
The Board of the Faculty was very conscious of the need to keep in touch with the members and fellows not only in order to inform them of decisions taken in their name but also to hear their views about issues under discussion by the Board. Regional meetings organised by the advisers and the annual general meetings of the Faculty were essential avenues for these purposes. In addition a Faculty Newsletter was started. The first number was published in January 1973 and contained a letter from the President, progress reports from the Registrar and the Academic Registrar, an outline of the proposals for the examination for membership and of the training programmes (see below), comments on two recent government reports, a list of members of the Board and its committees and a diary of future meetings. The Newsletter, edited first by Warren and then by Macara, was published periodically until 1978.

"Community Medicine"

In 1979 the first number of the Faculty's journal was published, edited by Wild and Williams. This journal contained a section under the heading of "Notes and News" which replaced the Newsletter. This section appeared in each number until the end of 1985 when the Oxford University Press took over publication from John Wright and Sons.

Library Facilities

The Faculty Board decided that it would not attempt to set up a library. Instead agreement was obtained for members and fellows of the Faculty and students of community medicine to use for reference purposes, at the librarian's discretion, the excellent library at the London School of Hygiene and Tropical Medicine. As a supplement to this the Faculty published a list of books and periodicals which illustrated the scope and range of the practice of community medicine. A limited number of the listed books and periodicals were recommended to be available in the libraries of all postgraduate medical centres and medical schools.

Liaison
In addition to creating mechanisms for two-way flows of information and ideas between the central administration of the Faculty and its members and fellows, formal and informal links were developed with various organisations. The Faculty was represented on the council of each of the three Royal Colleges, and each College was represented on the Board of the Faculty. The President of the Faculty became a member of the Conference of Presidents and Deans of the Royal Colleges and Faculties in England and Wales, and Anderson (with Forwell as deputy) represented the Faculty on the Scottish Conference14. The Faculty was one of the three bodies which formed the Community Medicine Consultative Committee, of which Harding was chairman for a time; the other two bodies were the British Medical Association's Central Committee for Community Medicine and the Department of Health and Social Services. Discussions continued with the Society of Community Medicine (previously the Society of Medical Officers of Health) about issues common to both organisations, and introductory meetings were held with representatives of the Defence Services, the British Paediatric Association, British Geriatrics Society, Royal College of General Practitioners, Royal College of Psychiatrists, Society of Occupational Medicine, Medical Women's Federation and the Directors of Social Services among others15.

**Premises**

After the formation of the Provisional Council (see page 57) the Faculty had the use of rooms in the London College. As its activities increased so more staff and space were required, Paul Luke being joined by Jean Robertson at the end of September 1974. At the same time the work of the College itself increased to the extent that it required the use of the rooms occupied by the Faculty. In June 1979 the Faculty moved to temporary accommodation in the basement of the Royal Institute of Public Health and Hygiene in Portland Place. In 1980 the Faculty launched an appeal to its fellows and members for funds to provide permanent accommodation, hopefully within the precincts of the London College and for enhancing the Faculty's activities in the field of prevention16. The target for the appeal, which was masterminded by Harding, was £250,000. Half this sum was achieved by the end of January 1982. The Phoenix Assurance Company, as part of its bicentenary celebration, donated £40,000 to the appeal for the internal furnishings of the premises. For this donation the Faculty was indebted to Lord Richardson, an honorary fellow, who introduced the Faculty to the Company17. At the Annual General Meeting in 1984 Harding reported that the Appeal had passed its target18. Less than eighteen months later, in November 1985, the Faculty's offices moved into 4 St Andrew's Place which was formally "opened" by the Queen on 11 June 1986.

**Arms of the Faculty and the President's Badge**

The President, Vice-President and Secretary of the Faculty first met the Norroy and Ulster King of Arms in June 1972, and during subsequent discussions the design of the Arms gradually took shape. The Arms were "granted and assigned" to the Faculty on 28 May 1974. Separate action was necessary for the Arms to be valid in Scotland and this was done by the Letters Patent dated 21 February 1975. The Arms are formally described as follows:
"Sable in front of an annulet between three Ancient Crowns two in chief and one in base or a Rod of Aesculapius Argent."

In heraldic terms the Annulet means a community or group; the Rod of Aesculapius represents medicine; and the Three Ancient Crowns indicate the three Royal Colleges of Physicians. The Faculty colours are black and yellow (gold)\(^9\).

The President's Badge was given to the Faculty by the three Royal Colleges. The Badge was presented to Harding, who had succeeded Cochrane as President, on 26 June 1975 at a dinner at the London College\(^9\).

**EDUCATION AND TRAINING**

**Continuing Education**

An important objective of the Faculty is to nourish the continuing education of its members and fellows. As a part of this activity the Board of the Faculty at its first meeting after the Inauguration set up a Scientific Meetings Committee with Holland as chairman. The Committee met for the first time in June 1972 and the first scientific meeting, organised by Heasman, was held the following November in Edinburgh concerned with health services research and intelligence units\(^21\). The following March there was a joint meeting with the Society for Social Medicine on epidemiological methods in the practice of community medicine. In March 1974 the Faculty took part for the first time in an international conference. It collaborated with the King's Fund College, London, in organising a five-day residential seminar for teachers of public health and health services administration in Europe, USA and Canada.

**The "Hunter" Courses**

The major activities in continuing education in community medicine during the first few years of the Faculty's existence were the courses funded by the Department of Health and Social Security, the Welsh Office and the Scottish Home and Health Department. These were designed to ease the transition into new posts in the reorganised health service of doctors in public health and hospital services administration, as had been recommended by the Interim Report of the Hunter Working Party\(^22\). The arrangements for the courses in England and Wales were published in January 1972\(^23\). The courses, each of which lasted between three and five weeks, were based at the Extension Training Centre of the London School of Hygiene and Tropical Medicine, the Department of Social Medicine at Manchester University and at the Welsh National School of Medicine in Cardiff\(^24\). In Scotland the arrangements were different. The Scottish Council for Postgraduate Medical Education initiated in 1971 a programme of re-orientation in community medicine based on four components\(^25\):
(1) A series of one week courses in association with the university departments of social and preventive medicine in Scotland, with the intention that each medical officer should attend three such courses.
(2) Local working parties comprised of the prospective community medicine specialists in the proposed areas of the larger health boards.
(3) Series of newsletters and discussion papers sent to each medical officer.
(4) Occasional regional and national conferences.

The topics discussed on the university-based courses were advances in epidemiology, medical information services, preventive medicine, health services management and social administration. These reflected concepts and material presented in the new MSc (Social Medicine) and similar revised degree and diploma courses (see page 28).

The Faculty was kept informed and consulted about these courses. Much of their content was relevant to the Faculty's discussions about its membership examination and future training programmes. The Faculty itself did not organise any of the "Hunter" courses.

**Membership Examination**

Morris's Working Party had assured the three Royal Colleges that the standard and rigour of the examination for the membership of the proposed Faculty would be of the same order as for the Colleges' membership (see appendices 7 & 8). In academic terms this meant that the new examination would be at the level required for a master's degree rather than for a diploma. The Education Committee of the Provisional Council in its memorandum distributed at the Inaugural Meeting had recommended that the examination for the younger candidates should be seen as marking the end of the preliminary period of training. The examination was to be only one part of a training programme. No dissenting comment was made about these decisions about the standard to be achieved and the place of the examination within a programme of specialist training; such proposals had been advocated for the training of public health medical officers since 1920 (see page 22).

The task facing the Education Committee was to decide the details of the syllabus, the procedures for the examination and the requirements for the in-service training programmes. In doing this in 1972, two years before the reorganisation of the NHS, the Committee had to make assumptions about the education and training needs of the future practitioners, teachers and researchers in community medicine. This created some difficulties but also helped to avoid placing too much emphasis in the examination requirements on the vocational aspects of practice in one or other field within the specialty.
The Education Committee decided that the examination should be in two parts. Part I should test the candidate's knowledge and understanding of the basic subjects and Part II the ability of the candidate to apply these to one or more aspects of the practice of community medicine. The examination for Part I should consist of written papers and for Part II the assessment of a written report or reports of a study, investigation or activity chosen by the candidate together with an oral examination on their contents and related matters. During the spring of 1973 the Board appointed an Examination Committee with the President as chairman and, later, R Acheson as examination secretary (assistant academic registrar).

**Part I - The Basic Subjects**

The first syllabus for Part I contained four main subject areas: Epidemiology; Statistics; Social Sciences in Relation to Community Medicine; and, Principles of Administration and Management. The details under these headings reflected changes already being introduced.
in the relevant new degrees and diplomas and which in turn had been recommended as the core subjects by the General Medical Council, the Royal Commission on Medical Education and the Hunter and Brotherston Working Parties. In deciding on this syllabus the Education Committee had discussions with representatives of the Heads of Departments of Social and Community Medicine Group and other organisations including the Joint Committee on Higher Medical Education and the Council for Postgraduate Medical Education in England and Wales.

Model examination papers were published during the summer of 1974, and the first examination was held the following November. Twenty two candidates entered the examination of whom twelve passed.

Exemptions

The Education and Examination Committees were concerned about the position of people who had begun careers in community medicine but who had not reached a stage which fulfilled the requirements for foundation membership - that is those who were halfway there. In order to meet the special circumstances of these people the Board agreed a regulation giving exemption from Part I of the examination to candidates who had, or would have, a registrable qualification in public health, state medicine or social medicine before the end of 1973. This regulation applied only to the first examination.

Candidates who had passed degrees or diplomas given by universities in which the subjects required to be studied for Part I had been assessed at a level and in a manner acceptable to the Examination Committee could be granted exemption from Part I by the Committee. Every course and examination coming within this latter regulation had to be reviewed by the Examination Committee every second year. The degrees accepted for exemption by the Committee were those given at London University (London School of Hygiene and Tropical Medicine) and at Edinburgh, Glasgow, Manchester and Nottingham universities. This form of exemption ceased in 1979 and from that date only special applications from individuals could be considered for exemption from any part of the examination.

Criticisms of the Syllabus

The syllabus was criticised from two points of view. Some considered that there was insufficient emphasis on environmental medicine including the control of communicable diseases, and some considered that there was too much emphasis on epidemiology and too little on management - a point of long-standing dispute.

In regard to the first of these, the intention of the Education Committee (and later of the Examination Committee) was to avoid including specific vocational elements in the preliminary period of training in order to avoid overloading the syllabus with subjects (or aspects of the practice of community medicine) that
would be relevant to only some of the trainees. The Committee wanted to move away from requiring some knowledge of a large number of subjects (as had occurred with the syllabus for the DPH in the past) to setting a syllabus that provided the opportunity for in-depth study of basic concepts and skills. This approach had been advocated by Kenwood in 1920 (see page 22). Additional knowledge needed for practice in any special field of community medicine was expected to be acquired during higher specialist training after completion of the preliminary period. In this way, it was hoped, the diverse needs of trainees could be met within one general pattern of training.
Brotherston has discussed the controversy that arose about the emphasis placed on epidemiology by the Faculty in its first syllabus. "There are several issues", he wrote, "in this debate. Are community medicine and epidemiology interchangeable terms? Is administration a necessary responsibility of community medicine? Is epidemiology a monopoly of community medicine? ... Epidemiology is a prime diagnostic tool to identify problems and needs but community medicine has a therapeutic responsibility to go beyond diagnosis to achieve action for improvement. This necessitates administrative action. Administration is not just a bad word to describe bureaucratic excesses in the health service; it involves procedures which are necessary to solve problems, to shift resources, and to carry through changes which are shown to be necessary by epidemiological investigation. Community medicine must acknowledge its share of responsibility for administration... Is this mission easy to discharge? Of course not, but who ever said that community medicine was an easy pitch?"

**Preparation for Part I of the Membership Examination**

The Faculty did not require candidates for its examination to have attended a prescribed course. This was a move away from the requirements of the General Medical Council in regard to the DPH and a move towards the practice of the Royal Colleges. In the past the General Medical Council had approved institutions and their examinations (a function which the Faculty assumed for an interim period in respect of exemptions as already described). With this exception the Faculty set its own examinations and appointed the examiners.

Although not required by the Faculty to attend any courses, candidates were advised to do so. The arrangements available for the preparation for Part I and the academic component of the training varied. Full-time and part-time courses were available at the London School of Hygiene and Tropical Medicine (full-time for two years or part-time equivalent), and at Bristol, Liverpool, Manchester, Nottingham, Cardiff, Edinburgh and Glasgow medical schools lasting one year full-time or the equivalent where part-time attendance was available.

The Todd Report and later the Hunter Report suggested that there would be advantages, both to doctors in training and to service and academic authorities, in developing arrangements for formal academic study spread over a number of modular courses, which in all would be the equivalent of full-time study for one academic year. McKeown and Doll took the initiative in setting up the first such consortium approach. Their programme started in 1973 and was offered jointly by the universities of Birmingham, Bristol, Exeter, Oxford, Reading, Southampton and the Welsh National School of Medicine in collaboration with the five regional hospital boards (later authorities) in which the universities were located. The first co-ordinator was McKeown who was succeeded by Whitfield. Each module lasted two weeks. Attendance required the majority of trainees being away from home for four nights each week of the modules. The Thames consortium was the second to be set up. It was based in London and co-ordinated by Weddell. The participating medical schools were St Thomas's, Guy's, Middlesex and St Mary's with contributions from the Royal Army Medical College and the universities of Kent and Surrey. A third consortium was formed in the north and east midlands under the leadership of Knowelden. It included contributions from the medical schools at Leeds, Leicester, Liverpool, Manchester, Newcastle, Nottingham, Sheffield and Belfast.
There were strengths and weaknesses in each of the arrangements for introducing the academic bases of community medicine. Full-time courses protect the trainees from day-to-day pressures arising within a service post and so provide a valuable opportunity for study and reflection; but in doing this they remove the trainee from the practice of his specialty and make the integration of theory and practice more difficult. Furthermore some trainees want to "get on with the job" and have no wish to return to the lecture room. Part-time courses overcome some of these difficulties but it is necessary to control the demands of the service on the trainees. The modular courses organised by a consortium of departments enable trainees to keep in touch with service work and provide periods of full-time study. However, much effort is required to co-ordinate the teaching on the modules to avoid overlap, repetition and gaps. Attendance at modules in different universities can disrupt personal and family life, and some trainees found that periods of two weeks are too short to be able to settle down to in-depth study.

**Part II of the Membership Examination**

The second part of the examination caused unintended difficulties to some candidates. The objective of the Examination Committee was "to test the ability of the candidate to apply the content of the basic subjects to one or more aspects of community medicine ... and to enable the candidate to display specialist skills". As Bacon wrote "Reading maketh a full man; conference a ready man; and writing an exact man".

The subject(s) of the report for Part II was chosen by the candidate and to prevent a candidate pursuing a "non-starter" had to be approved by an examiner. Each candidate was recommended to have a "tutor" who, at that time, was usually in a university department, and, where appropriate, a "preceptor" based within the part of the health service where the study was to be carried out. As an interim measure material which had been accepted for another degree and/or published could be submitted. In 1975 the Faculty issued guidance for candidates for Part II, particularly in regard to the choice of the tutor and the content of the report.

Candidates were advised that their reports should set out the methods and techniques used in their studies, contain a critical review of relevant literature and currently accepted knowledge, and should incorporate and analyse new data (or previously collected data) so that new insights and understandings are revealed and/or fresh proposals are brought forward. Candidates were advised that commentary on data without analysis was insufficient.

At a series of meetings with members and trainees in different places in the UK the academic registrar enlarged on these details. He saw the work for Part II of the examination as the core of a series of tutorials during which the tutor encouraged and guided the trainee to consolidate, apply and extend knowledge obtained during preparation for Part I, to analyse and use his/her experience, and to develop the investigative and analytical skills required in the tasks of planning, organising and evaluating health services including the promotion of health and the prevention of disease. Chosen subjects could be a position paper reviewing available data and relevant literature and relating these to a general or local problem; a disciplined enquiry carried out for the purposes of planning or evaluation, and concerned with what is happening and what should happen; the introduction of change such as the provision of a new service or the
withdrawal of an established service; or a research project. The choice would depend on the needs of the service, interests of the candidate, the collaboration likely to be available and the time available. The project or projects chosen should be circumscribed addressing a clearly defined question to which an answer seems possible within a reasonable time.

Too often the trainee saw Part II as a time-consuming "ivory tower exercise" or a chore divorced from his/her day-to-day practice. This arose partly from the previous scarcity of using quantitative skills in the organisation and management of health services combined with the lack of experience of many administrative medical officers in tutoring, and partly because the intended tutors, preceptors and examiners within the health service were more than fully occupied in immediate administrative decisions. Sometimes there was the imperative "I don't want it good. I want it Tuesday". Consequently there was a disproportionate involvement of academic staff, not yet closely associated with colleagues in the NHS, in helping and advising the trainees and hence the growth of the idea that Part II was a one-off academic exercise. To quote Brotherston again "Discontent was aroused among trainees by the contrast of the theory and theoretical specifications of community medicine and the humdrum and unimaginative administrative pre-occupations which they sometimes discovered in practice". Nevertheless many trainees produced excellent reports, some of which formed the basis of papers published in refereed journals and some of which have been presented to meetings of the Faculty and of the Epidemiological Section of the Royal Society of Medicine.

Credit is due to the trainees during the first few years of the Faculty's existence who, despite the difficulties, achieved high standards in the examination and through their publications and practice demonstrated that community medicine was of equal status with other medical specialties.

Training Programmes for Registrars and Senior Registrars

The Todd Report recommended that all doctors should attend a period of up to three years of "general professional training" following completion of the pre-registration year, on the satisfactory completion of which each doctor would be expected to seek an appointment providing "further professional training" varying in length according to the field chosen. These recommendations were not adopted in detail in that early specialist training became part of Todd's general professional training and this was followed by a period of higher specialist training.

In 1973 the Government set out in detail the responsibility of the NHS to "pay for the professional postgraduate training for any of its doctors". The transfer in 1974 of public health doctors from local government to the NHS brought payment for their postgraduate training and their salaries during such training into line with those of other doctors, and so resolved what had been a long-standing hindrance to the recruitment and training of doctors in public health (see pages 24).

In November 1974 the Faculty, in its capacity as the appropriate Specialist Advisory Committee on the Joint Committee on Higher Medical Training (JCHMT) set out its recommendations for "Early Specialist Training" and "Higher Specialist Training". The minimum period required of general
professional training and early specialist training was three years made up of at least one and preferably two years of clinical training and the completion of Part I of the examination. Higher specialist training was to last three years during which it was expected that Part II of the examination would be completed around the end of the first year. During higher specialist training it was recommended that trainees (later senior registrars) should take on increasingly important responsibilities. During this period it was expected that some trainees would develop their special interests in one or more of the fields of practice of community medicine, but this was not to be to the exclusion of all other fields. These special fields included medical administration, planning for health services (including capital building, use of resources and medical staffing), child health, special care groups (social services), health information, epidemiology, health education, communicable disease control, environmental health, teaching and research.

The essential element in higher medical training was that trainees should have increasing responsibility for service (or academic) activities and should discuss their experience with their trainers. There should be opportunities for the trainees to attend short courses and special attachments (e.g. communicable disease control). They should have links with the nearby university department of community medicine and contribute to teaching and have facilities for research. Senior trainees in university departments were expected to gain experience in service work within the NHS. In 1975 the DHSS issued a circular giving guidance on collaboration between academic departments of social and community medicine and NHS authorities, and on the awarding of honorary NHS contracts to medically qualified academic staff in the specialty. At first there were difficulties in persuading some trainers in the NHS to hand over responsibilities to trainees, in getting agreement for trainees to attend meetings of the officers, and in the provision of secretarial help and office space for the trainees.

Approval of Training Posts

An essential feature in the organisation of training programmes was the approval by the JCHMT of the training posts. In order to avoid disadvantaging trainees during the period of change in the training for the specialty and during the run-up to and aftermath of the reorganisation of the NHS the Faculty agreed that time spent by trainees in current posts and on courses would count as part of the recommended period of specialist training. By 1976 it was possible for the Faculty to announce without detriment to trainees that "only trainees occupying a designated senior registrar post with a properly structured programme of training should apply for enrolment" with the JCHMT.

The procedure for the approval of training posts was set out by the Faculty in the memorandum on specialist training already referred to. Points that the inspecting visitors were to check were that the programme was structured and had been agreed with the trainee; that the trainer or tutor had adequate time available for the supervision of and discussion with the trainee; that adequate secretarial help and back-up facilities were available for the trainee; and that there was evidence of innovation and development in the provision of services within the authority in which the training post was situated.
Restructuring of the Education Committee

Following the setting up of the Examination Committee the Board of the Faculty in 1974 changed the membership structure of the Education Committee so as to ensure representation of the various interests concerned with the development and oversight of training posts.

The new Committee ensured that there were representatives from England, Scotland, Wales and Northern Ireland, from academic departments, the NHS and Defence Services, and observers from the UK Conference of Postgraduate Deans, DHSS and trainees. It continued as the Specialist Advisory Committee to the JCHMT; it was the first such committee to have trainees attending its meetings.

Advisory Committee on Training for Community Medicine

The Hunter Report advocated as a matter of urgency that the recently formed Council for Postgraduate Medical Education in England and Wales should establish a body to advise and stimulate action, oversee progress and ensure cooperation between the various agencies concerned in developing training programmes in community medicine. In November 1972 Sir George Godber, then the chief medical officer at DHSS, asked the Council to set up an Advisory Committee on Training for Community Medicine to function until the Faculty was able to become responsible for the supervision of training. Hunter was appointed chairman of the Committee (hence the sobriquet "the Little Hunter Committee") and Harding, Galloway and Warren the representatives of the Faculty on the Committee. The first meeting of the Committee was held on 1 December 1972. The Committee was informed about and discussed the setting up of the consortia and recommended their funding to DHSS. It was also informed about the Faculty's decisions about its membership examination and training programmes; but here there was an overlap of responsibility as the Faculty had been accepted as the Specialist Advisory Committee to the JCHMT, which also reported to the Council. The Hunter Advisory Committee was wound up after its meeting on 22 November 1974. There was no equivalent to the Hunter Advisory Committee in Scotland where the JCHMT reported to the Scottish Council for Postgraduate Medical Education.

General Medical Council

An issue that had to be considered by the Education Committee was the continuing duty of the General Medical Council to approve courses and examinations for diplomas in public health (or the equivalent). The possession of an approved diploma was required by law for holders of posts of medical officer of health. With the cessation of such posts after the reorganisation of the NHS this requirement became irrelevant. The President of the Faculty and the Academic Registrar attended a meeting of the Public Health Committee of the Council on 21 June 1972 and informed the Committee that the Faculty saw no long-term place for the DPH in postgraduate training in community medicine once its examination for membership was established, and that the Faculty was against the
continuation of a statutory requirement for holders of specified posts in the NHS to have a particular postgraduate qualification. The involvement of the General Medical Council in monitoring DPH courses and examinations ceased in 1974.

A different issue of concern to the Faculty was its desire that its membership should be registrable with the Council. Through the good offices of Harding (then President of the Faculty) and Sir John Richardson (President of the Council) this was achieved in 1974 - sooner than might have been expected.

Reviews of the Examination and Training Programmes

With the examination and the training programmes established it soon became apparent that the Faculty should organise periodic meetings to hear about the experience of trainees and trainers. The Scientific Meetings Committee organised a meeting in Cardiff in July 1974 which discussed postgraduate training for the specialist in community medicine\textsuperscript{58}. The setting up and operation of the Midlands and the Thames consortia were discussed. Lowe outlined the need for some trainees to have further expertise in what he termed the sub-specialties of community medicine particularly in planning and manpower activities and in environmental medicine which he felt was receiving too little attention. McKeown suggested that community medicine should be regarded as analogous to clinical medicine with each sub-specialty requiring different training programmes (eg. as for paediatrics, cardiology, neurology, etc.). The comments from trainees were mainly of detail and included the need to establish a close relationship with a personal tutor; for the Faculty to define more clearly what the examinees were expected to know; avoidance of repetition and overlap in the material presented at different modules; and the introduction of some academic stimulation between the modules. On the whole it was felt that the new courses were progressing satisfactorily.

In June 1975 the Scottish Affairs Committee organised a meeting in conjunction with the Annual General Meeting of the Faculty\textsuperscript{59}. In the first session on training Zealley, speaking on behalf of a group of trainees saw three major needs: 1) The avoidance of rigidity in the training requirements, 2) the involvement of trainees in planning their programmes, and 3) a network of counsellors and advisers.

The work for Part II of the examination, she advised, should be relevant to the health care needs of the area, and realistic not least in that the methods employed should be capable of
repeated application throughout the candidate's subsequent career. There was still a gulf, she reported, between the in-service training and academic community medicine.

A major theme at the second session was the development of local Faculty activities. Innes, the opening speaker, said that "the Faculty had rightly given a high priority to setting examination standards and facilitating the education and training of entrants to the specialty. Foundation members could, however, be excused if they felt they had derived little benefit so far from the Faculty". In response the Registrar of the Faculty pointed out that the call for more peripheral activity could not be answered without greater resources. In reply to the question "What should we be getting out of the Faculty?", he would ask, "What should we be putting in?"

In March 1976 the opportunity was taken by the Faculty to invite a group of trainees to meet the president and academic registrar informally at the London College.  Much of the discussion was about the trainees' anxieties following the Government's announcement of its proposals to reduce "management costs" in the NHS (see below) and the possible repercussions on the career prospects of the trainees. The comments of the trainees about the examination and training were similar to those expressed at the meetings in Cardiff and Glasgow with the additional point that there should be stronger representation of the views of trainees at Board and Committee meetings. Prior to the London meeting with the trainees the Board of the Faculty had accepted the need to organise a national meeting to be attended by trainees, tutors, teachers, Faculty advisers and members of the Examination and Education Committees. The meeting was held in Sheffield in January 1977. Current difficulties in preparing for the examination, the form of the examination and problems of trainees and trainers were discussed. This meeting was the first of a series of annual meetings devoted to training.

**Review of the Examination**

At the meeting of the Examination Committee in May 1976 a sub-committee was set up, with Morrison as chairman and Knox and Lane as members, to review all aspects of the membership examination. Morrison gave an interim report at the meeting in Sheffield, and a final written report, which included an appendix on examination methods written by Lowe, was presented to the Examination Committee in May 1977. The Report recommended that Part I of the examination should be divided into two parts, the first consisting of a 1 hour multiple choice question paper and two other papers designed to test knowledge and understanding and the second part to consist of one 3-hour paper and an oral to test reasoning and original thought. Little change was suggested for Part II of the existing examination except for recommending that more emphasis should be put on the option of submitting two or three reports on small projects.

An analysis of the results of the first examinations found that about half of the candidates passed Part I on each occasion (once two-thirds passed) and that there had been little difference in the mean marks obtained for each paper which was around 50 per cent. Of the 99 candidates who had entered for Part II of the examination 47 had been approved, 21 referred back for amendment and 31 had been failed. A proportion of those who failed Part II had been exempted from Part I under the interim regulation and had submitted their DPH dissertations despite having been advised that these were unlikely to be suitable unless
they contained some investigative work and analysis. The review concluded by recalling an observation made by Charles Colton (1780-1832), one time vicar of Kew, wine merchant and bankrupt, "Examinations are formidable even to the best prepared, for the greatest fool may ask more than the wisest man can answer".

"Learning and Teaching Community Medicine"

In 1979 the Scottish Council for Postgraduate Medical Education published a guide for trainees, trainers and regional specialty advisers, much of it drafted by Zealley, setting out the role of the community medicine specialist (the term used in Scotland in place of community physician) and the knowledge, skills and attitudes required for its practice. The guide stressed the need to relate theory to practice and gave examples of how trainers could help trainees to do this. It included suggestions for a revised syllabus for the examination and a list of topics to which each trainee should be introduced early on in his/her training post and another list to be covered later in training. The guide stressed the importance of trainers informing the trainee about local organisational and procedural matters and his/her role and responsibilities within the organisation.

"Specialist Training in Community Medicine"

The Education Committee in 1980, under the leadership of Knowelden who had succeeded Warren as academic registrar in 1977, began a thorough review of the Faculty's requirements and guidelines for its examination and training programmes. The result was the publication two years later of the handbook "Specialist Training in Community Medicine". As Knowelden wrote in the foreword: "In response to criticisms the Faculty has made a number of changes to different aspects of the training programme, in the curriculum, in examination procedures and in the organisation of training. These changes have occurred at different times and have perhaps led to the temptation to think of training programmes as a set of distinct activities ... The Education Committee feels that the time has come to restate the aims, objectives and methods of the training programme as a whole, setting out its parts and emphasising their common purpose ... Inevitably there will be further changes, better solutions to the current problems as well as adaptations to new circumstances". He paid tribute to the Scottish Report from which, he said, the Committee had borrowed heavily.

The knowledge required for the membership examination was set out in more detail than previously. The new headings for the syllabus for Part I of the examination were Population (its structure and dynamics); Methods of enquiry used in community medicine (surveys and statistical analysis of data); Factors affecting health (heredity, environment and nutrition); Principles of disease control (prevention, cure and care); Health, human behaviour and social policy (the individual in society and the origins and development of health and social services); and Management of health and social services (nature of management, organisations, management roles and functions, planning and resource allocation and the economist's approach). Previous statements about the preparation and assessment of submissions for Part II were brought together and more emphasis given to the submission of multiple reports. The handbook set out the responsibilities of trainers and trainees and included material about the content and planning of in-service material along the lines of the Scottish
Report. For the first time there was a detailed statement about ad hominem training for doctors with substantial experience in another specialty.

CAREER POSTS

A matter of considerable concern to members of the Faculty in 1972 and to those in training in community medicine was the uncertainty about the status and conditions of service of posts in the specialty in the reorganised health service. The Hunter Working Party recommended that the appointments procedures for specialists in community medicine should be "as far as possible similar to those for consultants. Although there may be need for there to be stronger representation of the employing authority than in the case of clinicians, it will be equally important to ensure adequate representation of professional interests". The Report suggested that the main grade for doctors who complete specialist training should be "comparable in status to the clinical grade of consultant ... and one facet of this should be that their basic remuneration should equate broadly with that of consultants ... (and be) eligible for distinction awards in addition to their basic pay".

The Faculty did not participate in negotiations over pay and conditions of service of doctors in community medicine. That function was carried out by the British Medical Association advised by its Public Health Committee chaired by Lycett. However without entering into negotiations on these matters the Faculty in commenting on the Hunter Report in 1972 strongly supported the view that consultants in community medicine should be treated equally to all other consultants in the NHS including eligibility for distinction awards. The President followed this up three months later with a letter to the Chief Medical Officer stating that the Faculty "consider it a matter of some urgency that the status of community physicians should receive the official recognition suggested by the Hunter Report". In July of the following year the Review Body on Doctors' and Dentists' Remuneration reported on the matter and recommended "a single career grade for the specialty, which should be broadly equivalent to that of consultant and carry a similar salary scale" and that specialists in community medicine should, as a matter of principle, be eligible for distinction awards in each category from the outset (see page 14). The President of the Faculty reported this to the Annual General Meeting in Edinburgh in 1974.

Distinction Awards

The Distinction Awards Committee set up a special Community Medicine Sub-Committee chaired by Sir David Trench, vice-chairman of the main committee, to advise the main committee on awards. The Sub-Committee sought advice from the Faculty. To be recommended for an award by the Sub-Committee the community physician had to have shown more than an average effort or contribution beyond that expected as part of his or her contract with the NHS. Hard work and outstanding service to the NHS could alone be sufficient for recognition, particularly at the C or B level. Seniority and mere length of service were not in themselves grounds for an award. Contributions that were particularly looked for were in improving services, training and teaching
During 1974, the first year in which community physicians became eligible for awards, one A+, two A, four B and nine C awards were allocated to community physicians\(^7\). By the end of 1978 one community physician had an A+ award, eleven had A awards, twenty one B awards and sixty one C awards. Altogether 13.5 per cent of all community physicians had an award compared to 35.4 per cent of all consultants and honorary consultants\(^8\). By 1981 the proportion of community physicians with an award had risen to 21.7 per cent\(^9\).

**Appointments Procedures**

As well as having responsibility for setting and supervising standards of specialist education and training the Faculty had responsibilities for maintaining high standards of practice in the specialty. One part of this was the Faculty's advice to the Distinction Awards Committee, another was through its involvement in advising authorities about the suitability of candidates for posts in the specialty. Fellows of the Faculty, whose posts were not affected by the reorganisation of the NHS had been non-voting assessors in the initial appointments of regional and area medical officers and district community physicians and their equivalents in Scotland during 1973-4 (see page 14). After the "appointed day" (1 April 1974) membership of the Advisory Appointments Committees had to include both lay and medically qualified members with the medically qualified in the majority, and those working in the field of community medicine in a majority among the medical members. This had not been the case for appointments of senior doctors by local government authorities. The Faculty became
responsible for the nomination of members representing community medicine on the appointments advisory committees.

Harding and Galloway were particularly involved in this activity, and guidance was given to the Faculty's assessors on the committees. This emphasised that:

(a) They are custodians of the Faculty's honour and that of the Royal Colleges of Physicians of which it forms a part.
(b) The reputation of the specialty - locally, nationally, and perchance, internationally - rests in their hands.
(c) They have a responsibility to ensure that justice is done, and to satisfy candidates that this is so.
(d) In the final analysis, the quality of health services will depend upon their decisions.

**Review of Management Costs in the NHS**

During 1976 the reports of an enquiry by the chairmen of the regional health authorities and of the Resource Allocation Working Party were published. The chairmen's report recommended a clarification of the roles of the regions and of the Department of Health and Social Security, with a strengthening of the former and a reduction in detailed operational decisions by the latter. The other report recommended that the money available to the NHS should be distributed to regions and areas in accordance with a formula which took into account the size and age and sex structure of the population, and the morbidity in the communities concerned and was adjusted for cross-boundary flows of patients. A similar report was published in Scotland.

A consequence of these reports was what became known as "The Review of Management Costs", an exercise designed to contain the costs of the administration of the NHS. To the surprise and embarrassment of members of the Faculty, community medicine posts were included as part of the review. The basic philosophy on which the Faculty was founded, as Harding, the then President, pointed out, was the concept of community medicine as a medical discipline and not as a tool of management. Furthermore the Faculty in conjunction with the British Medical Association and the DHSS had only recently set up manpower planning and appointments procedures similar to and connected with those operating in clinical medicine. Harding took the issue up with the DHSS and together with Horner and Grey-Turner (representing the BMA) met Dr D Owen the Minister of Health. The day after the meeting Owen sent the representatives a conciliatory letter in which he expressed his belief in "the importance of community medicine as a medical discipline", accepted that the consultative arrangements between his Department and representatives of community medicine should be reviewed and invited the representatives to discuss the situation again with him later in the year.

At the same time that there was anxiety about the implications of the management costs review doubts were being expressed about the role of community medicine in the reorganised NHS. Dominant among these was the practicality of combining the epidemiological, investigative and evaluative functions with those of management and the apparent reduction of emphasis on prevention and environmental health that had followed the cessation of the posts of medical
officers of health. The first point was discussed by Yerby (Professor of Health Services Administration at Harvard University) in his report to the US Department of Health, Education and Welfare following a visit to the UK in 1975 to study the development of community medicine. He wrote: "It appears unlikely that community physicians can function effectively as community epidemiologists and medical managers at the same time..."
Fundamental issues such as the appropriateness, efficacy and effectiveness of services provided by the NHS and the rationale for the present allocation of resources within the NHS deserve to be continually assessed with the aid of rigorous analysis. Community physicians should have a central role in this process. To be able to do so they will need to be relieved of a number of coordinating and liaison relationships which were assigned to them in an effort to compensate for, or overcome, certain anomalies created by the reorganisation”.

The second point was discussed at length in a report from a study group convened by the Unit for the Study of Health Policy in the Department of Community Medicine at Guy's Hospital Medical School85. The Group considered that "perhaps the most important result of the reorganisation of the NHS has been to focus the attention of community medicine on the organisation of treatment and care services (medical administration) at the expense of tackling the wider environment (public health)... There currently exists no "public watchdog" (comparable to the medical officer of health created in the 19th century) whose raison d'être is the prevention of illness and the promotion of health".

The differing views and doubts about the role of community medicine and hence of the careers of community physicians were the subject of articles and letters in the medical journals86. The Faculty responded by issuing and widely distributing in 1977 a brief statement on the role of community medicine87; organising, a year later, a conference on education, training and manpower which was attended by the chief medical officers of England and Wales and the chairman of the Council for Postgraduate Medical Education88; and joining with the Central Committee for Community Medicine of the BMA in a working party which reviewed the current state of community medicine89.

In 1978 DHSS and the Welsh Office set up, at the suggestion of the Manpower Advisory Committee (Community Medicine), a Joint Working Party to report on recruitment to community medicine89. The anxiety about recruitment stemmed from the shortage of suitable applicants for posts, particularly in the West Midlands and North West of England89, and from the disproportionate number of community physicians aged between 50 and 59 years (table 5). Between 1975 and 1977 the total number of senior registrars and registrars increased by around 20 each year, but the increase between 1977 and 1979 was only of the order of 10 (table 6). After the Joint Working Party had reported DHSS issued a memorandum92 suggesting that authorities should consider the establishment of more part-time posts, create joint academic and NHS posts and encourage the recruitment of suitable doctors from other specialties. The Department asked authorities to take the opportunity of the forthcoming re-structuring of the NHS92 to dispense with the sub-specialty labelling of community medicine posts94. The memorandum emphasised that community physicians should have adequate administrative, professional and clerical support and stated that specialists in community medicine and their personal secretaries were to be excluded from the management costs exercise.

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"The task has always been the same: to promote health by preventing illness and curing it."
APPENDIX 1.

ROLE SPECIFICATIONS

REGIONAL MEDICAL OFFICER

General Characteristics

The Regional Medical Officer will be a member of the Regional Team of Officers (RTO) and will advise the Regional Health Authority (RHA), both as a member of the team and as an independent source of medical advice. He will be engaged in five main spheres of activity: (a) coordinating the formulation of advice to the RHA on policies and plans for the operational health-care services; (b) co-ordinating the briefing stage of major capital building projects; (c) monitoring and co-ordinating Area performance; (d) co-ordinating research, postgraduate education, etc.; and (e) providing personnel services for consultants and senior registrars.

Principal Responsibilities

1. Co-ordinates policy formulation and planning (as a member of the Regional Team of Officers)
   1.1 Maintains an inventory of the health-care needs of the Region as a whole, based both on locally-identified needs and on special regional studies.
   1.2 Co-ordinates the formulation of regional policies related to the development of the operational health-care services of the Region including the distribution of medical specialties and the deployment of medical manpower, and scheduling of major capital building projects.
   1.3 Co-ordinates the work of any multi-disciplinary Regional health-care planning teams established to review services directed towards specific groups of needs.
   1.4 Draws up planning guidelines on Regional health-care policies and priorities for each AHA, and communicates these guidelines to Area Medical Officers.
   1.5 Reviews and challenges AHA plans and budgets for the operational health-care services in relation to the agreed guidelines.
   1.6 Provides specialist planning assistance for AMOs including helping them to support DCPs and District health-care planning teams.
   1.7 Advises the RHA on how to use its medical advisory machinery and ensures that the Regional Medical Advisory Committee is appropriately involved in the planning process.
1.8  Reviews and modifies as necessary arrangements for overlap between AHAs, and the distribution of Regional and sub-Regional specialties.
1.9  Reviews the extent to which collaboration is taking place between AHAs and their matching local authorities.

2.  Briefs project teams on capital projects
2.1  Provides medical advice to project teams concerned with capital building projects.
2.2  Co-ordinates the briefing stage of major capital building projects dependent on the operational policies for medical services.

3.  Monitors and co-ordinates AHAs
3.1  Reviews information and reports on AHA performance.
3.2  Monitors and co-ordinates the performance of Area Teams of Officers, particularly in relation to the operational health-care services and the functions of the AMOs.
3.3  Assists in the design and implementation of Regional information and monitoring systems.

4.  Co-ordinates various Regional services
4.1  Co-ordinates the work of the Director of the Regional Blood Transfusion Service.
4.2  Manages the work of the Regional Scientific Officer and the Regional Pharmaceutical Officer.
4.3  Co-ordinates the development of postgraduate medical education, in conjunction with the postgraduate committee and dean.
4.4  Assists in determining priorities for the use of RHA funds available for health-care research, and co-ordinates community medicine research in liaison with the departments of social medicine and of general practice of associated medical schools.

5.  Provides personnel services
5.1  Provides the necessary personnel services for Regionally employed consultants and senior registrars.

**Working Relationships**

Accountable to: Regional Health Authority.
Manages: Regional specialists in community medicine; attached administrative staff; regional scientific officer; and regional pharmaceutical officer.
Monitors and co-ordinates: Area medical officers; and director of regional blood transfusion service.
Monitors: Regional ambulance officer (medical aspects only).

**AREA MEDICAL OFFICER**

**General Characteristics**
The Area Medical Officer will be a member of the Area Team of Officers and will advise the Area Health Authority (AHA), both as a member of the team and as an independent source of medical advice. He will be engaged in five main spheres of activity: (a) co-ordinating the formulation of advice to the AHA.
on policies and plans for the operational health-care services; (b) co-ordinating the formulation of joint service plans with the matching local authority; (c) co-ordinating preventive-care services throughout the Area; (d) monitoring and co-ordinating District performance; and (e) carrying out various functions for the matching local authorities.

**Principal Responsibilities**

1. Co-ordinates policy formulation and planning (as a member of the Area Team of Officers)
   1.1 Keeps under review the health-care needs of the population of the Area as a whole and initiates special studies and research.
   1.2 Recommends appropriate Area operational health-care policies, after review of both national and Regional policy initiatives, policy proposals submitted by Districts Management Teams and by matching local authority.
   1.3 Draws up planning guidelines on Area operational health-care policies and priorities for District Management Teams.
   1.4 Reviews and challenges District plans and budgets for the operational health-care services.
   1.5 Provides specialist planning assistance and support to the District Community Physician, the District health-care planning teams and the District Management Team.
   1.6 Ensures the provision of adequate advice on medical aspects of plans for capital projects.
   1.7 Advises the AHA on how to use its medical advisory machinery effectively (convening specialist advisory groups as required, in consultation with the Medical Advisory Committee).

2. Joint planning functions with local authority
   The Area Medical Officer will be a member of the officer team of the joint consultative committees. He will:
   2.1 Co-ordinate the formulation of joint plans for the operational health-care services, in conjunction with the Area Nursing Officer and chief officers of the local authority.
   2.2 Carry out special analysis and research for the joint consultative committees.
   2.3 See that the policies and plans for the operational health-care services agreed by the joint consultative committees are properly taken account of by District Management Teams.

3. Co-ordinates preventive and other services
   3.1 Plans and manages the work of subordinate medical officers based at Area engaged in clinical work for infants and pre-school children, the school health services and other forms of screening.
   3.2 Co-ordinates all aspects of health services for children including speech therapy throughout the Area.
   3.3 Plans and provides health education and chiropody programmes for the population of the Area.
   3.4 Co-ordinates the dental and pharmaceutical services within the overall health services of the Area.
   3.5 Co-ordinates the planning of the scientific services.

4. Monitors and co-ordinates District performance
4.1 Reviews information, reports on and monitors and co-ordinates the performance of DMTs, particularly in relation to the operational health-care services and the function of the District Community Physician.

4.2 Assists in the design and implementation of improved information for monitoring.

5. Functions in relation to local authority

5.1 Likely to be invited to act, in certain areas only, as proper officer for environmental health to relevant local authorities.

5.2 Likely to be invited to act as medical adviser to the local authority in relation to personal social services and school health.

6. Provides personnel services

In an Area Health Authority (Teaching) provides the necessary personnel functions for consultants and senior registrars.

**Working Relationships**

Accountable to: Area Health Authority and the local authority for the performance of functions relating to them.

Manages: Area specialists in community medicine; clinical medical officers, attached administrative staff; health education officer; area chiropodist; and area speech therapist.

Monitors and co-ordinates: District community physician(s); area dental officer; and area pharmaceutical officer.

Monitors: Area ambulance officer (medical aspects only).

Monitored and co-ordinated by: Regional medical officer.
DISTRICT COMMUNITY PHYSICIAN

General Characteristics
The District Community Physician will be a member of the District Management Team (DMT) and will be engaged in four main spheres of activity: (a) co-ordinating the formulation of plans for the operational health care 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.

Principal Responsibilities
1. Co-ordinates service planning
   1.1 Continuously assesses the community's need for health care and maintains a health profile of the District.
   1.2 Keeps under review the provision of services within the District and identifies gaps in relation to need.
   1.3 Identifies opportunities to improve medical services, so as to provide the best patient care with the resources available.
   1.4 Co-ordinates the various health-care planning teams, so as to ensure that sound proposals for change are prepared for the DMT within the guidelines established by it.
   1.5 Organises or conducts special studies for the DMT in relation to the operational health-care services.
   1.6 Maintains a general surveillance of the implementation of improvement projects, with particular reference to the assessment of the effectiveness of changes in service organisation or methods.
   1.7 Works closely with the District Medical Committee and its divisions in drawing up plans for medical services.

2. Advises his colleagues as a specialist
   Stimulates the process of integration, by advising his consultant and general practitioner colleagues in his capacity as a specialist in community medicine. Makes available his knowledge of the needs of the District and his expertise in the organisation of health-care and epidemiological techniques.

3. Co-ordinates various preventive services
   3.1 Controls the work of clinical medical officers attached to him by the Area Medical Officer to provide preventive services, including vaccination and immunisation, and screening.
   3.2 Plans and co-ordinates the work of medical officers in school health services where this responsibility is assigned to him by the Area Medical Officer.
   3.3 Arranges for the provision of some preventive services by general practitioners, either in their own premises or in AHA clinics.
   3.4 Arranges, when appropriate, for consultant sessions in preventive clinics throughout the District.
3.5 Ensures that the health education programmes, managed by the Area Medical Officer, are co-ordinated with the general preventive services of the District.

4. Functions in relation to the local authority
   4.1 In certain Districts he is likely to be invited to act as the proper officer on environmental health matters to a local government district authority. He will be accountable to the local authority when he is acting as their proper officer on environmental health.
   4.2 Carries out certain functions assigned to him by the Area Medical Officer in relation to the local authority's retained responsibilities for school health.

**Working Relationships**
Accountable to: Area Health Authority; responsible to the Area Medical Officer for functions assigned to him.
Manages: Attached clinical medical officers, and attached administrative staff.
Monitored and co-ordinated by: Area Medical Officer.


Note: The role specifications refer only to arrangements in England.

APPENDIX 2.

GUIDE TO THE MAIN ORGANISATIONS, WORKING PARTIES AND COMMITTEES

Central Council (Committee 1967-70) for Postgraduate Medical Education in England and Wales exercised general oversight of postgraduate medical education and training. Its first secretary was JOF Davies.

Heads of Departments of Social Medicine Group was formed formally in 1971, having met together informally in preceding years. Its purpose was to promote the interests of the academic departments and research units and their personnel particularly in relation to undergraduate and postgraduate education and research in social and preventive medicine and in public health.

Informal Group was a small group of people interested in exploring the possibility of forming a professional body bringing together medical practitioners in the public health services, in the administration of hospital services and in academic departments and research units in social medicine. JN Morris convened the first meeting in 1968. The work of the Group led to the formation of the Working Party in 1969 (see below).

Joint Committee of the Royal Colleges of Physicians was a small committee composed of the Presidents of the three Royal Colleges of Physicians in the UK and a few representatives from each College. It was concerned with all matters common to the Colleges.

Joint Committee on Higher Medical Training was formed by the Royal Colleges of Physicians, the Association of Professorial Heads of Departments of Medicine and of Paediatrics and the relevant Specialist Associations to coordinate recommendations on training programmes in the various medical specialties. Its first full meeting was held in 1971 when representatives from the newly formed Specialist Advisory Committees (see below) were present.

Joint Working Party was composed of representatives from the Royal Colleges of Physicians and the Working Party concerned with the proposal for a Faculty of Community Medicine (see below).

Provisional Council/Board of the Faculty of Community Medicine was set up towards the end of 1970 by the Royal Colleges of Physicians. It met for the first time in 1971 and continued until the inauguration of the Faculty in 1972. Its chairman was WG Harding.

Scottish Association of Medical Administrators was formed in 1954 and contained medical superintendents and other medical administrators (but not those in public health services) among its members.
Scottish Council for Postgraduate Medical Education was the Scottish equivalent of the Council for England and Wales (see above).

Senior Administrative Medical Officers Group The SAMOS of the regional hospital boards in England and Wales had no formal association but met monthly to discuss common problems.

Society of Medical Officers of Health was founded in 1856 as the Metropolitan Association of Medical Officers of Health. Its membership included medical and dental practitioners practising "public health" and not only medical officers of health. The Society was governed by a Council whose chairman during the time of the formation of the Faculty was Dr WG Harding. Scottish affairs were dealt with by the Council of the Scottish Branch of the Society, which was chaired by Dr Maud Menzies.

Society for Social Medicine was formed in 1956 with the object of advancing academic social medicine through research. Initially membership was restricted to people who had published research papers within the broad field of social medicine.

Specialist Advisory Committees advised the Joint Committee on Higher Medical Education on training programmes for their specialty (see above).

Working Party (Official Working Party) took over from the Informal Group (see above) the negotiation of the proposal for a Faculty of Community Medicine within the three Royal Colleges. Its chairman was JN Morris. It met from October 1969 until November 1970 when the Colleges set up the Provisional Council (see above).

APPENDIX 3.

A NOTE ON THE PROPOSAL TO ESTABLISH A PROFESSIONAL ORGANISATION CONCERNED WITH SOCIAL OR COMMUNITY MEDICINE
(As Amended November 1968)

1) The Todd Report (para.138) stated: "there is great need for a professional body which can bring together all the interests, academic and service, and which has the support and strength to undertake the assessment needed during and at the end of professional training." This proposal is in accord with two trends: one towards unification of regional and local health services, as reflected in the Green Paper; the other towards recognition of the common interests of medical administration and epidemiology in the contemporary interpretation of social medicine.

2) The Green Paper, like the earlier Porritt Report, recommends unification of local medical services. It proposes (para.20) "that there should be a single authority in each area and that these area authorities should replace and undertake the functions of the Executive Councils, Regional Hospital Boards, Boards of Governors and Hospital Management Committees and ... should be responsible for some important functions now in the hands of the present local authorities." The number of Area Boards is estimated tentatively at about forty or fifty, in which case the mean size of population served would be about a million or a million and a quarter. Each Board would have a Chief Medical Officer. Within an area, services would be administered
at district level by (among others) community physicians. With this pattern of area and district services, several hundred physicians would be concerned largely or wholly with administration of unified medical services. Others would be needed, for example in Central Government Departments and in industry.

3) Some ambiguities of interpretation of social medicine (with which the term community medicine appears to be roughly synonymous) have been removed by recognition that the discipline is concerned with the themes of epidemiology and the study of the medical needs of society. This is the interpretation in evidence from the Society for Social Medicine to the Royal Commission on Medical Education, a paper from the Royal College of Physicians and a Report by the Society of Medical Officers of Health. The interpretation is accepted in the Todd Report (para.133), which also states (para.137) that the core subjects in the professional education and training of the specialist in community medicine are epidemiology, statistics, medical sociology, operational research and the organisation of medical care and administration (or management).

4) Since administrative developments and academic experience both point in the same direction, the proposal to establish a professional body clearly merits examination. It raises two questions: Should there be a professional body? And if so, how should it be established? It will be easier, if less logical, to consider the second question first.

5) It would seem most undesirable to have a separate institution, for example on the model of the College of Pathologists. To this approach there is the general objection to creation of a different institution for every discipline, and the specific objection that it would be particularly undesirable to separate the subject which includes preventive medicine from the rest of medicine. If this view is taken, the first possibility to be explored would be an organisation within the framework of the existing Colleges.

6) The organisation envisaged in the Todd Report would be concerned both with vocational training and assessment and with more general academic and service interests. Training and assessment are at present largely in the universities although the Sheldon Report has welcomed the initiative of the Society of Medical Officers of Health in providing training courses in developmental paediatrics. It would probably be agreed that responsibility for their supervision could, with advantage, be assigned to a professional body. However, the service and other interests are largely in the hands of other bodies and their rapid transfer to a new organisation might create considerable difficulties. They would be most formidable for the Society of Medical Officers of Health, perhaps somewhat less difficult for the Society for Social Medicine and the Association of Senior Administrative Medical Officers.

7) For this reason it may be desirable for the new organisation to be concerned in the first place with vocational training and assessment, leaving the other interests with the existing professional bodies, and to consider the reshaping of the professional organisations when local medical services are recast on the lines recommended in the Green Paper.
8) This still leaves unanswered the large question whether there is enough in common in the work of all those engaged in social or community medicine to make it desirable to introduce a common vocational training. There are two problems, which at this stage can be stated but probably not entirely resolved: one concerns the route of entry to medical administration; the other concerns differences in the work done in academic and administrative social medicine.

9) With one reservation, the common training and assessment seems reasonable for those whose work will be wholly or largely in community medicine. The reservation concerns the possibility of accepting people who have not had the formal training but have demonstrated exceptional gifts. The issue is probably most acute in the most exacting posts. Would an exceptional candidate be unacceptable as C.M.O. because he had not completed formal training early in his career? This question underlines the unique requirements of administration at the highest level, where personal qualities may outweigh other considerations. It also differentiates administration from most other professions. A surgeon, engineer or architect could not be appointed to senior posts without the relevant basic experience. But large industries look for the most capable executive, without fussing unduly about formal requirements. If training for medical administration is specified more precisely than in the past, it seems desirable to make some provision for occasional exceptions.

10) A common training for academics and others working in social medicine also raises problems. A pathologist in an academic department and one in a regional hospital could, at a pinch, do each other's jobs. This is not true in social medicine; the academic statistician, epidemiologist or medical sociologist - to consider three of the groups referred to in the Todd Report - could not replace doctors in hospital administration or public health. Nor would it be in their own or anyone's interest that they should be able to do so, and it would be quite undesirable to modify their training to this end. There are of course academics who teach medical administration, and for them the common vocational training would appear to be suitable. But again provision should be made for the occasional exception who, while lacking formal preparation, might make an essential contribution to research and teaching in an academic department.

11) If it is decided to introduce a scheme of vocational training, assessment and registration for community physicians, it should be equivalent in standard and duration to that of other specialists.

12) These suggestions already go beyond the points agreed at the last informal meeting, and for the purpose of focusing discussion they are taken further in the following recommendations.

**Recommendations**

1) The proposal to establish a professional organisation concerned with social or community medicine deserves serious examination.
2) The first possibility to be explored would be an organisation within the framework of the existing Colleges.

3) The new organisation should be concerned with vocational training and assessment rather than other professional interests, at least until local and regional services have been modified on the lines suggested in the Green Paper.

4) The vocational training and assessment should be designed to meet the needs of those engaged in the teaching or practice of community medicine but not necessarily others - statisticians, medical sociologists, epidemiologists etc - working in social medicine but not directly concerned with administration.

5) Vocational requirements should not be applied so rigidly as to exclude the contribution to research, teaching and practice of administration by occasional gifted people who have not met formal requirements.

****

(This memorandum was drafted by T McKeown and RC Wofinden)
APPENDIX 4.
ROYAL COLLEGE OF PHYSICIANS OF LONDON

SUMMARY OF A DISCUSSION HELD ON 1 MAY 1969 TO CONSIDER SETTING UP A FACULTY OF COMMUNITY MEDICINE

Present

Royal College of Physicians of London
Sir Max Rosenheim (President, and chairman of the meeting)
Dr JF Stokes Mr GMG Tibbs (Secretary)

Royal College of Physicians of Edinburgh
Dr JGM Hamilton (Vice President) Dr HM MacLeod (Registrar)

Royal College of Physicians and Surgeons of Glasgow
Mr RB Wright (President) Dr EM McGirr
Dr JH Hutchison Dr TJ Thomson (Secretary)

London School of Hygiene and Tropical Medicine
Dr ETC Spooner (Dean) Prof. JN Morris

Society for Social Medicine
Prof. RAM Case (Chairman) Dr WRS Doll Prof. T McKeown

Senior Administrative Medical Officers
Dr J Revans Dr RHM Stewart

Society of Medical Officers of Health
Dr WG Harding (Chairman of Council) Prof. RC Wofinden

Scottish Branch of the Society of Medical Officers of Health
Dr Maud Menzies (President of the Branch)

Scottish Association of Medical Administrators
Dr WJ McGinness (Chairman) Dr AH Duncan

Department of Health and Social Security
Dr H Yellowlees (Deputy Chief Medical Officer)
Dr Spooner opened the discussion by thanking the Chairman and all present for giving their time that afternoon. The discussion which would take place was an unofficial one between a group of friends with a common interest.

Professor Morris then outlined a possible basis for the discussion which followed. The Chairman summarised the discussion as follows:

1. It was agreed that there was a need for a Faculty of Community Medicine which could be set up under the auspices of the three Royal Colleges of Physicians with its own Chairman and Council which would include representatives from the three Royal Colleges.
2. The Faculty would embrace those engaged in the discipline of Community Medicine and Epidemiology.
3. Membership would include both those qualified in medicine, and also non-medical experts who play an increasingly important part in medicine.
4. Entry would not necessarily be by examination alone, but the Faculty would be responsible for setting its standards, and organising its own examinations and training programmes.
5. The Faculty would be responsible, through the three Royal Colleges, to the General Medical Council.

The first step would be to seek the approval of the Fellows of the three Royal Colleges of Physicians to the setting up of a working party to look into the formation of a Faculty of Community Medicine. The Colleges would then invite the various interested bodies to appoint representatives to the working party. The Department of Health and Social Security and the Scottish Home and Health Department would be invited to send observers. The formation of the working party could also be advertised in medical journals.

APPENDIX 5.

LETTER TO SECRETARIES OF INTERESTED ORGANISATIONS

LONDON SCHOOL OF HYGIENE AND TROPICAL MEDICINE

CONFIDENTIAL 9th September 1969
Dear Secretary,

Proposed Faculty of Community Medicine

During the last eighteen months an informal group has been considering the establishment of "a professional body which can bring together all the interests, academic and service" of community medicine (Todd Report, para 138). In the course of the discussions it emerged that the Royal Colleges of Physicians of London, Edinburgh and Glasgow would welcome the formation of a "Faculty" within them for this purpose. Meanwhile, the proposals for specialist registration and developments in postgraduate medical education have increased the importance of the proposed Faculty and the urgency of getting it established. The Royal Colleges of Physicians have now set up a working party as their own first step and they suggest that those engaged in the disciplines of community medicine do likewise.

As participants in the informal group we now propose that an official Working Party be formed, consisting of representatives, one or two as they wish, of the Society of Medical Officers of Health, Society for Social Medicine, Scottish Association of Medical Administrators and the Senior Administrative Medical Officers. In addition, we suggest that Dr Yellowlees and Dr Brotherston be invited to join as observers from DHSS and the Scottish Home and Health Department and that the Working Party has powers to co-opt.

Members of the Working Party should be prepared to put in the necessary time; a lot of work will have to be done in drafting proposals for the functions and constitution of a Faculty (or any other organisation). Delegates will also have to be in close touch with their "constituency". For this reason it is suggested that each member of the W.P. has an officially designated Deputy.

In order to speed things up we have arranged for the first meeting of the new Working Party to be held on Tuesday, October 14th, at the London School of Hygiene and Tropical Medicine, starting at 10.30 a.m., and continuing if necessary into the afternoon.

Yours sincerely, WG Harding, WRS Doll, WJ McGinness, J Revans and JN Morris.
APPENDIX 6.

MEMBERS AND DEPUTIES OF THE WORKING PARTY

The Society of Medical Officers of Health
Dr WG Harding (Deputy Dr S Ludkin)
Professor RC Wofinden (Deputy Professor RCM Pearson, later Dr TMcL Galloway)

The Society for Social Medicine
Professor R Doll (Deputy Professor CR Lowe)
Professor JN Morris (Deputy Professor T McKeown)

Senior Administrative Medical Officers
Dr FJ Fowler (Deputy for either, Dr TA Ramsay)
Dr RHM Stewart

The Scottish Association of Medical Administrators
Dr W McGinness (Deputy Dr JCG Mercer)

Scottish Branch of the Society of Medical Officers of Health
Dr Maud Menzies (Deputy Dr JL Gilloran)

Department of Health and Social Security
Dr H Yellowlees (Observer) (Deputy Dr RM Shaw)

Scottish Home and Health Department
Dr JHF Brotherston (Observer)

The Working Party met nine times (14 October, 6 and 20 November, 4 and 19 December 1969, and 5 February, 21 May, 17 September and 17 November 1970.

Professor JN Morris was elected chairman, and Professor RCM Pearson secretary. Dr ETC Spooner was coopted as a member of the Working Party.

APPENDIX 7.

FINAL DRAFT OF "THE PROPOSAL" DRAWN UP BY THE WORKING PARTY
Preamble

1. Community medicine is concerned with the study and application of the principles of epidemiology, social and preventive medicine, organisation of medical care, and administration of health services. Medical practitioners of Community Medicine currently engaged in the practice of public health, in teaching and research in social medicine, in medical administration of health services and in central government have, for some years, felt the need to identify their specialty more clearly and for closer cooperation between them.

2. The Report of the Royal Commission on Medical Education (1965-68) recommended that an organisation be formed which would further the training of those practising or about to practise in the field of Community Medicine: "In community medicine there is a great need for a professional body which can bring together all the interests, academic and service, and which has the support and strength to undertake the assessment needed during and at the end of general professional training" (Para.138).

3. After informal discussions beginning late in 1967 the following organisations set up an official Working Party which met first on 14th October 1969, to prepare a plan
for the formation of a Faculty of Community Medicine within the Royal Colleges of Physicians of London, Edinburgh and Glasgow:

Society of Medical Officers of Health, and its Scottish Branch; Senior Administrative Medical Officers of the Regional Hospital Boards in England and of the Welsh Hospital Board; Society for Social Medicine; and Scottish Association of Medical Administrators; with Observers from the Department of Health and Social Security and the Scottish Home and Health Department.

These organisations have agreed that a new body with clearly defined objectives should be formed, without prejudice to their own continued individual existence.

**Objectives of a Faculty of Community Medicine**

1. The Faculty would promote high standards in the practice of Community Medicine.
2. The Faculty would promote advancement of knowledge in its field.
3. The Faculty would seek to raise and maintain the educational standards of those medically qualified wishing to enter the specialty of Community Medicine and would itself take an active part in their continuing education.
4. The Faculty would seek recognition as the professional organisation responsible for Community Medicine under current proposals for Specialist Registration.
5. The Faculty would seek representation on the Central Councils and Regional Committees for Postgraduate Medical Education when these are set up.

**Membership of the Faculty**

It is the aim of the Faculty that the academic standard of its Membership should equate with the membership of the Royal Colleges of Physicians of the United Kingdom. With this in mind:

1. After standards of vocational training have been established and agreed with the Royal Colleges of Physicians, admission to Membership would be limited to registered medical practitioners who have attained an appropriate academic standard by passing an examination (approved by the Council of the Faculty and acceptable to the Royal Colleges of Physicians) and to others, at the discretion of the Council, who are deemed to have made distinguished contributions to Community Medicine.
2. For a period of two years in the first instance, registered medical practitioners practising in the United Kingdom and fulfilling the following conditions would be eligible for consideration by the Provisional Council of the Faculty for immediate election to Membership without examination. They should:
   (a)  hold an appropriate higher postgraduate qualification,
   (b)  have had five years experience in Community Medicine, and
(c) have been promoted above the basic grade in the relevant field of Community Medicine. This would be taken to mean medical practitioners holding, or who have held, an appointment in one of the following categories:

(i) above the grade of a medical officer in a local authority’s public health department, or
(ii) as lecturer or above in a university department of social medicine (or equivalent), or
(iii) as principal assistant senior administrative medical officer or above in a regional hospital board, or
(iv) as senior medical officer or above in a central government department.

3. During these two years, at the discretion of the Provisional Council of the Faculty, other medical practitioners of comparable qualifications and experience who are engaged in the practice of Community Medicine, including those engaged in relevant
research and those who have made notable contributions to Community Medicine, would also be eligible for immediate election.

4. At a later date, and by agreement with the Royal Colleges, consideration would be given to the eligibility of non-medical colleagues practising, teaching, or conducting research in the field of Community Medicine.

**Constitution of the Faculty**

1. The Faculty would function as a self-governing body within the Royal Colleges of Physicians, sharing in their efforts for the advancement of medicine. It would consult and collaborate with the Royal Colleges on all appropriate matters in the field on Community Medicine.

2. The Faculty would elect and be governed by a Council of members of the Faculty together with appropriate honorary officers of the Faculty and with representatives of the three Royal Colleges.

3. The Faculty would elect honorary officers as required. The senior of these would serve for a period of three years but might be re-elected for a further term in the same office after a gap.

4. With the object of establishing the closest collaboration, the Council of the Faculty would nominate annually one of its Members to serve as its representative to each of the three Royal Colleges. The Royal Colleges would each nominate a representative to serve on the Council of the Faculty.

5. The Council would be advised by a Finance and General Purposes, a Training and a Research Committee, and any other committee which it might from time to time wish to constitute.

6. The Council would appoint a Secretariat.

7. The Council would make arrangements to provide suitable headquarters.

8. The Council would fix any subscription for membership or other dues.

9. The Council would have the power to invest money, seek grants, and promote research, etc.

10. The Council would report annually to the Faculty members and to the Royal Colleges.

11. Meetings of the Council would be held in London, and in Edinburgh and Glasgow.

12. The Royal Colleges would be asked to appoint a Provisional Council after consultation with the four constituent organisations.

**APPENDIX 8.**

**LETTER FROM LORD ROSENHEIM TO PROFESSOR JN MORRIS**

ROYAL COLLEGE OF PHYSICIANS
10th November 1970

Dear Jerry,

I am sorry not to have written to you before but as you were present at Comitia I thought that you would probably have the necessary ammunition for your working party.

The situation following Comitia can be simply stated: it is that the College is very anxious to see the Faculty of Community Medicine launched, and I know that the other two Colleges are as well. Our College will, as I have told you, be generous in making members of the Faculty Members of the London College under the special bye-law 117, and it is possible on special occasions to accelerate the election of a Member to Fellowship under bye-law 39(c). I do most sincerely hope that your working party will feel able to continue to organise the Faculty within the Colleges and hope to get good news from you following the meeting of your working party on the 17th November. We are having a meeting of the three Colleges in Edinburgh on Saturday 21st, and any information you can let me have before that would be welcome.

I am sorry if you feel that I or the College is being difficult but I really could not hope that our Members, let alone our Fellows, could accept members of the Faculty of Community Medicine as the equivalent of Members of the College until the examination for the Faculty has been established and recognised as being of a difficulty corresponding to that of Membership, but the proposed Faculty certainly has the goodwill and good wishes of the three Colleges.

Yours sincerely, Max

APPENDIX 9.

LETTER FROM JN MORRIS TO LORD ROSENHEIM

LONDON SCHOOL OF HYGIENE AND TROPICAL MEDICINE

17th November 1970

Dear Max,
Proposed Faculty of Community Medicine

I am happy to report that the members of our Working Party today agreed to recommend to their constituent bodies that a Provisional Council be set up forthwith. Of course some important matters remain to be settled, but we believe that this can best be done within the Provisional Council. Constituent bodies that have not yet appointed representatives to sit on the P.C. have been asked to do so at their next meetings.

We hope that this information will be of assistance to your colleagues and yourself on the 21st. And I once again assure you of our profound appreciation of the goodwill and interest of the Royal Colleges - and our own determination to build a Faculty within them.

Yours sincerely,         Jerry.

APPENDIX 10.

LETTER FROM EG KNOX TO LORD ROSENHEIM

DEPARTMENT OF SOCIAL MEDICINE, THE MEDICAL SCHOOL, BIRMINGHAM

3rd February 1971

Dear Lord Rosenheim,

The Society for Social Medicine held a general meeting on Saturday 20th January to discuss the proposals for a Faculty of Community Medicine within the Royal Colleges. Because the Working Party had agreed to keep the negotiations confidential this was the first occasion on which the members of the Society had heard the full proposals. They were disturbed to learn that the Royal Colleges may be proceeding to the setting up of the Provisional Council. The Society heard from its representatives, Professors Doll, Lowe and Morris, the full account of the negotiations which have taken place and of the proposals now under consideration. Members were particularly concerned about the effects on the academic departments of acceptance of a professional qualification lower than that in other specialties. Here it may be useful to mention that six members of the Society for Social Medicine are Fellows of the Royal Society and of the 162 Medical Members nearly half are already Fellows (39) or Members (41) of the Royal Colleges. After a full discussion of this and related issues it was decided by an overwhelming majority that the present proposals are not acceptable.

It follows from this that the Society is unable to participate in a provisional Council which has the implementation of the present proposals as its basis. However the Society does wish to continue discussion with the Royal Colleges in the hope that it may be possible to find an acceptable alternative approach.
It has therefore appointed five of its members, including its former Working Party representatives, to represent it in future discussions. These representatives would welcome an early meeting with you.

Yours sincerely,  EG Knox

**APPENDIX 11.**

**MEMBERS OF THE PROVISIONAL COUNCIL/BOARD**

Royal College of Physicians of London  
Lord Rosenheim (President)  Sir Kenneth Robson (Registrar)  

Royal College of Physicians, Edinburgh  
Dr J Halliday Croom (President)  Dr GD Forwell  

Royal College of Physicians and Surgeons, Glasgow  
Dr EM McGirr (President)  Professor T Anderson  

Society of Medical Officers of Health  
Dr WG Harding (President and Chairman of Council)  Dr AJ Essex-Cater  
Dr W Edgar  Dr TMcL Galloway  Dr J Kershaw  
Dr Maud P Menzies (Scottish Branch)  Dr JR Preston  

Senior Administrative Medical Officers  
Dr FJ Fowler  Dr TA Ramsay  Dr RHM Stewart  

Scottish Association of Medical Administrators  
Dr JF Kirk  Dr WJ McGinness  

Government Observers  
Dr JHF Brotherston (SHHD)  Dr H Yellowlees (DHSS)  

Joined later by Society for Social Medicine  
Professor AL Cochrane  Dr MA Heasman  Professor WW Holland  
Professor CR Lowe  
Secretary  
Mr GMG Tibbs
Dr WG Harding was elected chairman. The Council/Board met six times on 19 February, 5 May, 23 July (joined by the Society for Social Medicine members), 25 November and 30 December 1971 and 25 January 1972 (Joined by Professor MD Warren).

APPENDIX 12

PAPERS FOR THE FIRST MEETING OF THE FACULTY OF COMMUNITY MEDICINE

15 March 1972

JOINT FACULTY OF COMMUNITY MEDICINE

In accordance with the resolution adopted by the Royal College of Physicians of London on Thursday, 27th January 1972, a resolution adopted by the Royal College of Physicians of Edinburgh on Thursday, 3 February 1972 and a resolution adopted by the Royal College of Physicians and Surgeons of Glasgow on Monday, 7th February 1972 I have been instructed to convene the first meeting of the Faculty of Community Medicine on Wednesday, 15th March 1972.

The meeting will take place at 3.30 p.m. at 11 St Andrew's Place, Regent's Park, London NW1 4LE (The Royal College of Physicians of London).

G.M.G. Tibbs (Secretary).

AGENDA

1. Welcome by Presidents of Colleges.
2. To receive the Colleges' appointments to the Board. (List attached).
3. To receive lists of Fellows and Members. (These will be available at the meeting).
4. To elect a President.
5. To elect a Vice-President.
6. To receive the Board's appointment of:
   Registrar
   Academic Registrar
Treasurer

7. To receive the Standing Orders.
   Draft Standing Orders have already been circulated. Amendments have had to be made, most of them following representation from the Charity Commission. The three Royal Colleges have now approved the Standing Orders and delegated to the Faculty all powers necessary to enable it to conduct its affairs in accordance with its Standing Orders. (Copies will be available at the meeting).

8. Report from the Chairman of the Accreditation Committee.
9. Report from the Chairman of the Education Committee.
10. Report from the Treasurer about financial prospects and facilities in the Colleges.
11. Conclusion by the President of the Faculty.

APPOINTMENTS TO THE BOARD

The three Royal Colleges have under their Laws and Bye-Laws and in accordance with Standing Order 21 (Draft Standing Order 18) appointed the following as the first members of the Board of the Faculty of Community Medicine, to serve as such until the first Annual General Meeting of the Faculty.
The Colleges have each appointed a representative to serve on the Board:

Royal College of Physicians of Edinburgh  Dr GD Forwell
Royal College of Physicians & Surgeons of Glasgow  Prof. T Anderson
Royal College of Physicians of London  Lord Rosenheim

Subsequently Professor MD Warren was elected by the Board as Academic Registrar and in this capacity has become a member of the Board.

APPENDIX 13.

OFFICERS AND COMMITTEE MEMBERS OF THE FACULTY OF COMMUNITY MEDICINE 1972

Officers

AL Cochrane (President)
WG Harding (Vice-President)  TMeL Galloway (Registrar)
MD Warren (Academic Registrar)  FJ Fowler (Treasurer)
Note: The officers were ex-officio members of the committees below

The Board

See list in appendix 12

Finance and General Purposes Committee

WG Harding (chairman)
T Anderson, GD Forwell, WJ McGinness, Lord Rosenheim, H Yellowlees

Accreditation

TMcL Galloway (chairman)
T Anderson, MA Heasman, WJ McGinness, H Yellowlees

Education Committee

T Anderson (chairman)
JL Gilloran, WW Holland, JD Kershaw, JF Kirk, CR Lowe, MP Menzies, TA Ramsay

Fellowship Committee

AL Cochrane (chairman)
WW Holland, JD Kershaw, JF Kirk, TA Ramsay

Scientific Meetings Committee

WW Holland (chairman)
AJ Essex-Cater, A Gatherer, MA Heasman, EG Knox, R Rue,
V Springett, WE Waters

Scottish Affairs Committee

AL Cochrane (chairman)
T Anderson (convener and vice-chairman), Sir John Brotherston, GD Forwell
APPENDIX 14

FACULTY OF COMMUNITY (PUBLIC HEALTH) MEDICINE

OFFICERS 1972-1995

Presidents
1975-78  WG Harding  1989-92  WW Holland

Vice Presidents
1972-75  WG Harding  1986-89  RM Acheson
1975-77  TA Ramsay  1989-92  JM O'Brien
1977-79  TMcL Galloway  1992-95  RK Griffiths
1979-83  GD Duncan  1995-00  M Clarke
1983-86  GD Forwell  2000-  S Griffiths

Registrars
1972-77  TMcL Galloway  1988-91  AL Bussey
1981-85  HE Mair  1995-97  M Reynolds
1985-88  JM O'Brien  1997-  K Williams

Academic Registrars
1972-77  MD Warren  1989-94  DL Miller
Treasurers
1972-77  FJ Fowler  1986-90  S Hagard
1977-79  GD Duncan  1990-95  J Dunlop
1979-84  AW Macara  1995-99  J Dunlop
1984-86  JA Scott  1999-  P Donnelly

Secretaries
1972  GMG Tibbs (part-time)  1982-89  M Spence
1998-  P Scourfield

CHRONOLOGY OF EVENTS

1929  Local Government Act.
1930  General Medical Council extended the Rules for Diplomas in Public Health. Council of the British Medical Association published recommendations for "A General Medical Service for the Nation".
1935  Oxford Joint Board for Hospital Planning set up, supported by WR Morris (later Lord Nuffield).
1937  Report on "The British Health Services" published by PEP (Political and Economic Planning) set out the uneven distribution and gaps in the services available from the National Health Insurance scheme, the voluntary hospitals, charities, and local government. Final Report of the Voluntary Hospitals Commission (Sankey Report) considered that the future prospects for the voluntary hospitals were not favourable, and proposed, among other matters, that regional hospital planning councils should be formed.
1940  Nuffield Provincial Hospitals Trust founded.
1942  Interim Report of the Medical Planning Commission of the British Medical Association favoured the organisation of all hospital and other medical, health and allied services on a regional basis, with the integration of preventive and curative services and the fusion of...
public health with other forms of practice. "Social Insurance and Allied Services" (the Beveridge Report) recommended that there should be comprehensive health services available to all members of the community.

1943 The Committee on Post-War Hospital Problems in Scotland (Hetherington Report) recommended the establishment of five advisory regional councils to assess hospital needs and prepare schemes for the development of hospital services in their regions. Royal College of Physicians of London published its first report on Social and Preventive Medicine. JA Ryle appointed Professor of Social Medicine and Director of the Institute of Social Medicine at Oxford, supported by the Nuffield Provincial Hospitals Trust.

1944 Coalition Government published a white paper "A National Health Service". Report of the Inter-Departmental Committee on Medical Schools (Goodenough Report).

1945 Nuffield Provincial Hospitals Trust funded a chair of social medicine at Birmingham University to which T McKeown was appointed.

1946 National Health Service Act (for England and Wales).
General Medical Council revised the Rules for Diplomas in Public Health and introduced a preliminary Certificate examination.

1947 National Health Service (Scotland) Act.
Royal College of Surgeons of England formed the Faculty of Dental Surgery, the first faculty of a medical royal college.

1948 Start of the National Health Service, July 5.
World Health Organisation established. Medical Research Council set up the Social Medicine Research Unit at the Central Middlesex Hospital with JN Morris as Director and RM Titmuss as deputy director. Royal College of Surgeons of England formed the Faculty of Anaesthetists.

1950 The Medical Act introduced the pre-registration year.

1951 Creation of the Ministry of Local Government and Planning (later Housing and Local Government). Scottish Health Services Council's report "What Local Authorities Can Do To Promote Health and Prevent Disease".

1952 College (later Royal) of General Practitioners founded.

1953 Committee of Enquiry into the Cost of the National Health Service appointed in May. Second Report of the Committee of the Royal College of Physicians of London on Social and Preventive Medicine published.


1959 Mental Health Act. The Medical Services Review Committee (chairman Sir Arthur Porritt) set up. Public Health Officers Regulations set out the duties, qualifications and procedures for the appointment and dismissal of medical officers of health and public health inspectors. Diploma in Medical Services Administration introduced by Edinburgh University. Short course in medical administration started at the London School of Hygiene and Tropical Medicine.

1960 Mental Health (Scotland) Act.


1964 Ministry of Health started direct funding of health services research. Royal College of Physicians of London reported on consultant training.

1965 Royal Commission on Medical Education (Todd Commission) appointed in August. Committee on Local Authority and Allied Personal Social Services (Seebohm Committee) set up in December. Health Services Research and Intelligence Unit established in Scotland.

1967 White Paper on Local Government in Wales published. The Central Committee for Postgraduate Medical Education in England and Wales set up in March. General Medical Council replaced its "Rules" for diplomas in public health by "Recommendations" in April. JN Morris took up his appointment as professor of community health at the London School of Hygiene and Tropical Medicine in October and began the development of a new two-year degree for the M.Sc (Social Medicine). Publication by the Nuffield Provincial Hospitals Trust of "Vocational Training in Medicine" which included a report on the training of doctors for the administration of hospital and public health services. In November the Minister of Health announced a review of the structure of the National Health Service.

1968 March: At an informal dinner, organised by the Dean and Morris at the London School of Hygiene and Tropical Medicine the possibility of forming a college representative of community medicine was discussed. April: The Royal Commission on Medical Education (Todd) reported. July: The Committee on Local Authority and Allied Personal Services (Seebohm) reported. National Health Service. The Administrative Structure of the Medical and Related Services in England and Wales (Robinson's Green Paper) published. October: An Informal Group of persons nominated by the Society of Medical Officers of Health, the Society for Social Medicine, the Senior Administrative Medical Officers Group, the Scottish Association of Administrative Medical Officers, the Ministry of Health and the Scottish Home and Health Department met to explore the possibility of creating a single professional body for doctors in public health, medical administration and related academic departments. November: Ministries of Health and of Social Security amalgamated to form the Department of Health and Social Security. December: Social Work (Scotland) Act. "Administrative Reorganisation of the Scottish Health Services" (Scottish Green Paper) published.

1969 February: Scottish Association of Medical Administrators sought affiliation with the Royal College of Physicians and Surgeons of Glasgow. Possibility of forming a Faculty raised with the Royal Colleges of Physicians of London, Edinburgh and Glasgow. May: Representatives of the Informal Group met the presidents of the Royal Colleges of Physicians. June: Royal Commissions on Local Government in England (Redcliffe-Maud) and in Scotland (Wheatley) reported. October: Working Party set up with JN Morris as chairman. First MSc (Social Medicine) course started at the London School of Hygiene and Tropical Medicine. December: Joint Working Party on Doctors in an Integrated Health Service (chairman JHF Brotherston) appointed by the Scottish Home and Health Department.

1970 February: "The Future Structure of the National Health Service" (Crossman's Green Paper) and "Local Government Reform in England" (White Paper) published. Standing Royal Commission on Environmental Pollution appointed.
April: "The Reorganisation of the Health Service in Wales" (Green Paper) published.
May: Local Authority Social Services Act.
June: Extraordinary General Meeting of the Society for Social Medicine called to discuss the proposal for a Faculty of Community Medicine.
November: Last meeting of the Working Party on the proposal to create a Faculty of the three Royal Colleges agreed that a Provisional Council be set up.
December: Council for Postgraduate Medical Education in England and Wales replaced the Central Committee which had been set up in March 1967.

1971 January: At an Extraordinary General Meeting of the Society for Social Medicine the majority of members present rejected the current proposals for the Provisional Council of the proposed Faculty, but wished to continue negotiating with the Royal Colleges.
The three Royal Colleges discussed a proposal to create a Faculty of Occupational Medicine.
May: "National Health Service Reorganisation" (Joseph's Consultative Document) published.
May: First meeting of the Provisional Education Committee of the proposed Faculty (chairman T Anderson). Nominees of the Society for Social Medicine did not attend.
May: First meeting of the Provisional Education Committee of the proposed Faculty (chairman T Anderson).
The proposal of the three Royal Colleges to found a joint Faculty of Community Medicine and the formation of the Provisional Council were announced in the British Medical Journal and The Lancet.
July: "Reorganisation of the Scottish Health Services" (White Paper), and "National Health Service Reorganisation in Wales" (Consultative Document) published. Joint Working Party on Doctors in an Integrated Health Service (in Scotland) reported. Nominees of the Society for Social Medicine attended the meeting of the Provisional Board as full members of the Board. The Provisional Accreditation Committee was set up.

1972 January: Final draft of the Faculty's Standing Orders approved by the Joint Committee of the three Royal Colleges and the Provisional Board agreed nominations for the first honorary officers of the Faculty. Government published arrangements for reorientation courses for senior staff in the public health and hospital services.
March: Inaugural Meeting of the Faculty of Community Medicine at the Royal College of Physicians of London.
May: Paul Luke started as the first full-time secretary of the Faculty. Working Party on Medical Administrators (Hunter) reported.
June: First meeting of the Scientific Meetings Committee (chairman WW Holland).
July: First meeting of the Scottish Affairs Committee (convener T Anderson).
September: "Management Arrangements for the Reorganised National Health Service" (Grey Book) published. Academic Registrar of the Faculty attended meetings of the Joint Committee for Higher Medical Training and the Council for Postgraduate Medical Education for the first time as a member.
November: First Scientific Meeting of the Faculty.
December: Death of Lord Rosenheim. Hunter Advisory Committee met for the first time.

1973
First "Faculty Newsletter" published; it contained a memorandum on the syllabus for the membership examination and proposals for higher specialist training.
March: First Annual General Meeting of the Faculty; membership consisted of over 1400 members and 200 fellows; Sir Austin Bradford Hill was elected as the first Honorary Fellow.
June: First meeting of the Examination Committee.
July: National Health Service (Reorganisation) Act. Supplement to the third report of the Review Body on Doctors' and Dentists' Remuneration recommended that salaries for community physicians should be comparable to those of the consultant grade and that community physicians should be eligible for distinction awards. Report of the Working Party on Collaboration between the National Health Service and Local Government published. "Community Medicine in Scotland" (Gilloran) published. National Health Service Staff Commission appointed to oversee appointments to the reorganised National Health Service.
October: Local Government (Scotland) Act. Regulations for the Faculty's Membership Examination published.
December: National financial crisis - "the gravest situation since the end of the war".
During 1973 Henry Yellowlees succeeded Sir George Godber as Chief Medical Officer at the Department of Health and Social Security; and the Midlands and South West Consortium was established.

1974
March: First meeting of the Welsh Affairs Committee (chairman P Alwyn-Smith).
Membership of the Faculty exceeded 2000.
April: The start of the re-structured health services and local government authorities with the consequential cessation of posts of medical officers of health and the introduction of community physicians and specialists in community medicine.
May: Coat of Arms granted to the Faculty.
November: First meeting of the Faculty's regional advisers.
First examination for the Membership of the Faculty held.
Last meeting of the Hunter Advisory Committee.

1975
June: Presentation of the Faculty’s Presidential Badge by the President of the Royal College of Physicians of London on behalf of the three Royal Colleges.
October: Prime Minister announced his intention to appoint a Royal Commission to examine the National Health Service.

1976
February: "Prevention and Health: Everybody's Business" published.
March: "Priorities for Health and Social Services in England" and "The Way Ahead" (Scotland) published.
April: Cash limits on public expenditure introduced.
May: The report of the Regional Chairmen's Enquiry into the Relation between DHSS and the Regional Health Authorities published. This led to the review of management costs. Royal Commission on the National Health Service appointed (chairman Sir Alec Merrison).
December: “Fit for the Future”, report of the Committee on Child Health Services (SDM Court) published

1977
January: First meeting of community medicine trainees, tutors and examiners held in Sheffield.
April: The Department of Health and Social Security appointed a Research Working Group (chairman Sir Douglas Black: JN Morris a member) to examine inequalities in health status.
May: First meeting of the Prevention and Health Committee of the Faculty (chairman JN Morris).
July: First meeting of the Joint Working Party set up by the Central Committee for Community Medicine, with the participation of the Faculty of Community Medicine and the Society of Community Medicine to review the state of community medicine (chairman GD Duncan).

September: "Scottish Health Authorities Revenue Equalisation" (SHARE) published.
December: "Prevention and Health" (White Paper) published by the Departments of Health and Social Security and of Education and Science, the Scottish Home and Health Department and the Welsh Office.

1978

November: The Department of Health and Social Security and the Welsh Office set up a Joint Working Party on Recruitment to Community Medicine.

1979

June: Faculty's offices moved to temporary accommodation in the premises of the Royal Institute of Public Health and Hygiene, Portland Place.
July: Royal Commission on the National Health Service reported.
September: "Learning and Teaching: Community Medicine" published by the Scottish Council for Postgraduate Medical Education.
December: Department of Health and Social Security published "Patients First" which contained a proposal to remove the area tier of the administrative structure of the National Health Service.

1980

During the year the Faculty launched an appeal for funds for permanent accommodation and for enhancing the Faculty's activities in the field of prevention.

Towards the end of the year the Health Services Act was passed which led to the abolition of the area tier in 1982.

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In November 1985 the Faculty's offices moved to 4 St Andrews Place in the precincts of the Royal College of Physicians of London.

Sir John Brotherston, who was President when the appeal for funds for premises was launched, died in the preceding May.
Abel-Smith, Brian, Professor of Social Administration, London School of Economics and Visiting Professor, London School of Hygiene and Tropical Medicine. Joint author of "The Cost of the National Health Service in England and Wales", prepared for the Guillebaud Committee 1956. Special Adviser to the Secretary of State, Department of Health and Social Security 1968-70. Member of the Hunter Working Party 1970-72.

Acheson, E. Donald (later Sir Donald), Professor of Clinical Epidemiology 1968-83 and Foundation Dean of Southampton University Medical School 1968-78. Member of the Wessex Regional Hospital Board 1968-74 and of the Hampshire Area Health Authority (T) 1974-78. Later Chief Medical Officer, Department of Health and Social Security, Department of Education and Science and the Home Office. Member of the Committee of the Society for Social Medicine 1968-71.

Acheson, Roy M., Professor of Epidemiology, Yale University, USA 1964-72. Director of the Extension Training Centre, London School of Hygiene and Tropical Medicine and Professor of Health Service Studies, London University 1972-76. Later Professor of Community Medicine, University of Cambridge 1976-88. Member of the Board of the Faculty 1974-84, Secretary to the Examination Committee 1974-77 and Vice-President of the Faculty 1986-89.

Alderson, Michael R., Professor of Information Science, Southampton University 1970-75; subsequently Professor of Epidemiology, Institute of Cancer Research, London University. Later Chief Medical Statistician, OPCS. Honorary Secretary of the Society for Social Medicine 1970-73.

Alwyn-Smith, Peter, Senior Administrative Medical Officer, Welsh Hospital Board, later Principal Medical Officer, Welsh Board. First chairman of the Welsh Affairs Committee of the Faculty.

Anderson, Thomas, (later CBE), Henry Mechan Professor of Public Health 1964-71, formerly Professor of Infectious Diseases 1959-64, Glasgow University. Member of the Provisional Board and Board, Chairman of the Education Committee, Vice-Chairman and later Chairman of the Scottish Affairs Committee of the Faculty; Faculty representative on the Conference of Royal Colleges and Faculties in Scotland. Member of the Porritt Committee 1958-62. Member of the Scottish Home and Health Department Joint Working Party on Doctors in an Integrated Health Service and of the sub-group on Community Medicine 1969-73.

Backett, E. Maurice, Professor of Community Health, Nottingham University 1967-81. Chairman of the Committee of the Society for Social Medicine 1963-64.


Boddy, F. Andrew, Senior Lecturer, Department of Epidemiology and Preventive Medicine, Glasgow University. National Course Organiser (Community Medicine), Scottish Council for Postgraduate Medical Education. Observer on the Community Medicine Sub-Group of the Scottish Home and Health Department’s Joint Working Party on Doctors in an Integrated Health Service.

Brockington, C. Fraser, Professor of Social and Preventive Medicine, Manchester University 1951-64, previously County Medical Officer of West Riding of Yorkshire. Member of the Council of the Society of Medical Officers of Health 1944-66, and President of its Teaching Group 1957-60. Author of “A Short History of Public Health” (1956 and 1966), “World Health” (1958 and 1975) and “Public Health in the Nineteenth Century” (1965).

Burn, J.Lance, Medical Officer of Health, Salford. Member of the Committee of the Society for Social Medicine 1968-71.
Buzzard, Sir E. Farquhar, Regius Professor of Medicine, Oxford University 1928-45. Governing Trustee of the Nuffield Provincial Hospitals Trust 1940-45; First Chairman of the Trust's Medical Advisory Committee.
Campbell, Hubert, Professor of Medical Statistics, Welsh National School of Medicine, Cardiff. Chairman of the Committee of the Society for Social Medicine 1969-70.
Cartwright, Ann, Research Director, Medical Care Research Unit, Institute of Community Studies, London; later Director, Institute for Social Studies in Medical Care. Member of the Committee of the Society for Social Medicine 1969-72.
Case, R.A.M., Professor of Social Medicine, Chester Beatty Research Institute, Royal Cancer Hospital, London. Member of the Informal Group and Working Party for the proposed Faculty. Chairman of the Committee of the Society for Social Medicine 1968-69.
Chalke, H.D., (OBE Mil), Medical Officer of Health, Camberwell. President of the Society of Medical Officers of Health 1957-58. Member of the Porritt Committee.
Charles, Sir John, Chief Medical Officer, Ministry of Health, Ministry of Education and the Home Office 1950-60; previously Deputy Chief Medical Officer 1944-50, and Medical Officer of Health Newcastle-upon-Tyne 1932-44. Member of the Royal College of Physicians' Committee on Social and Preventive Medicine 1942-43 and 1951-53.
Clayton, Sir Stanley, Professor and Consultant Obstetrician and Gynaecologist, King's College Hospital, London. President of the Royal College of Obstetricians and Gynaecologists 1972-75. Chairman of the Advisory Committee on Distinction Awards 1976-84.
Cochrane, Archie L., (later CBE), David Davies Professor of Chest Diseases and Director of the MRC Epidemiology Unit, Welsh National School of Medicine, Cardiff. Member of the Provisional Board of the Faculty and the first President. Author of "Effectiveness and Efficiency", 1972.
Crew, F.A.E., Professor of Public Health and Social Medicine, Edinburgh University 1944-55; previously Buchanan Professor of Animal Genetics, Edinburgh University.
Crofton, John, (later Sir John), Professor of Respiratory Diseases and Tuberculosis, University of Edinburgh. President of the Royal College of Physicians of Edinburgh 1973-76.
Croom, J Halliday (later Sir John), Physician, Royal Infirmary, Edinburgh. President of the Royal College of Physicians of Edinburgh 1970-73. Member of the Provisional Board of the Faculty.
Davies, J.B. Meredith, Director of Personal Health and Social Services, 1969-71, later Director of Social Services, City of Liverpool 1971-81. Previously Deputy Medical Officer of Health, Liverpool. Honorary Secretary of the Teaching Group, Society of Medical Officers of Health, and President of the Group 1972-73; Member of the Council (1967-73) and of the Special Committee on the Future of the Society of Medical Officers of Health 1964-66.

Davies, J.O.F. (later CBE), Secretary of the Central Committee (later Council) for Postgraduate Medical Education in England and Wales; previously Senior Administrative Medical Officer, Oxford Regional Hospital Board. Member of the Nuffield Provincial Hospitals Trust's Working Party on Vocational Training for Administration of Hospital and Public Health Services 1966-67.

Doll, W.R.S. (later Sir Richard, FRS and CH), Regius Professor of Medicine, Oxford University; previously Director of the MRC Statistical Research Unit, University College Medical School, London. Member of the Informal Group and Working Party of the proposed Faculty. Member of the Steering Committee of the Society for Social Medicine 1956. Member of the Royal College of Physicians (London) Committee on Social and Preventive Medicine 1966. Chairman of the Committee of the Society for Social Medicine 1967-68. Councillor Royal College of Physicians of London 1970-73. Vice-President Royal Society 1970-71. Member of the Standing Royal Commission on Environmental Pollution 1973-79.

Donaldson, R.J., (later OBE), Medical Officer of Health, Teeside; from 1972 Director of Studies, Extension Training Centre, London School of Hygiene and Tropical Medicine. Member of the Nuffield Provincial Hospitals Trust's Working Party on Vocational Training for Administration of Hospital and Public Health Services 1966-67. Member of the Joint Working Party (BMA/FCM) on The State of Community Medicine 1977-79.
Draper, Peter, Director of the Unit for Study of Health Policy, Department of Community Medicine, Guy's Hospital Medical School.

Duncan, A.H., Group Medical Superintendent, Special Hospitals Group, Aberdeen; later Principal Medical Adviser for Health Services, Livingston. Member of the Informal Group of the proposed Faculty, nominated by the Scottish Association of Medical Administrators.

Duncan, George D., Senior Administrative Medical Officer, East Anglian Regional Hospital Board; later Regional Medical Officer, East Anglian Regional Health Authority. Treasurer of the Faculty 1977-79 and Vice-President 1979-83. Chairman of the Joint Working Party (BMA/FCM) on The State of Community Medicine 1977-79.

Edgar, William (later OBE), Medical Officer of Health, Northampton County Borough; later District Community Physician, West Berkshire Health District. Member of the first Board of the Faculty. Member of the Hunter Working Party 1970-72. Member of Council and Treasurer, Society of Medical Officers of Health.

Essex-Cater, A.J., Medical Officer of Health, Monmouthshire County Council; later Medical Officer of Health, States of Jersey. Member of the first Board of the Faculty.


Forwell, George D. (later OBE), Senior Administrative Medical Officer, East Regional Hospital Board (Scotland); later Chief Administrative Medical Officer, Greater Glasgow Health Board. Member of the Provisional and first Board of the Faculty; Chairman of the Scottish Affairs Committee; Faculty Representative on the Conference of Royal Colleges and Faculties in Scotland; Vice-President of the Faculty 1983-86. Member of the Nuffield Provincial Hospitals Trust's Working Party on Vocational Training for the Administration of Hospital and Public Health Services 1966-67.

Fowler, Frank (later CBE), Senior Administrative Medical Officer, North West Metropolitan Regional Hospital Board; later Regional Medical Officer, Yorkshire Regional Health Authority. Member of the Provisional Board of the Faculty, and the first Treasurer 1972-77.

Francis, Huw W.S., Deputy County Medical Officer, West Riding of Yorkshire; later Senior Lecturer in Community Medicine, Manchester University. Member of the Hunter Working Party 1970-72.

Galloway, Thomas McL., County Medical Officer, West Sussex; later Area Medical Officer, Hampshire Area Health Authority (Teaching). Member of the Provisional Board of the Faculty, first Registrar 1972-77, and Vice-President 1977-79. Member of the Joint Working Party (BMA/FCM) on The State of Community Medicine 1977-79.

Gatherer, Alexander, Medical Officer of Health, Reading County Borough; later District Medical Officer, Oxford Health Authority.

Gilloran, James L., Medical Officer of Health, Edinburgh. Member of the Scottish Home and Health Department's Joint Working Party on Doctors in an Integrated Health Service, and Chairman of the Sub-Group on Community Medicine (1971-73). Member of the Scottish Council
for Postgraduate Medical Education. Member of the Committee of the Society of Medical Officers of Health on the Future of the Society 1964-66, and President of the Society 1972-73.

**Godber, Sir George** Chief Medical Officer, Ministry of Health (later the Department of Health and Social Security), Department of Education and the Home Office. Councillor of the Royal College of Physicians of London 1951-53 and 1958-60; Member of the College's Committee on Social and Preventive Medicine 1965-66.

**Goodenough, Sir William,** Director of Mercantile and General Reinsurance Co.Ltd., and other companies. Chairman of the Nuffield Provincial Hospitals Trust 1940-51. Chairman of the Inter-Departmental Committee on Medical Schools 1942-44.

**Gordon, Israel,** Medical Officer of Health, Redbridge. Member of the Council of the Society of Medical Officers of Health 1967-72.

**Grey-Turner, Elston** (MC, later CBE), Deputy Secretary, British Medical Association; later Secretary.

**Grundy, Frederick,** Mansel Talbot Professor of Preventive Medicine, Welsh National School of Medicine, Cardiff 1949-61; previously Medical Officer of Health, Luton. Later Assistant Director General of the World Health Organisation. Member of the Committee on Social and Preventive Medicine of the Royal College of Physicians of London 1951-53.

Harding, Wilfrid G. (later CBE), Medical Officer of Health, London Borough of Camden and Principal School Medical Officer, Inner London Education Authority; later Area Medical Officer Camden and Islington Area Health Authority. Honorary Consultant in Community Medicine, University College Hospital. Member of the Informal Group, of the Working Party and Chairman of the Provisional Board of the Faculty; first Vice-President of the Faculty and first Chairman of the Finance and General Purposes Committee; President of the Faculty 1975-78. Chairman of the Council of the Society of Medical Officers of Health 1966-71 and President of the Society 1971-72. Member of the Department of Health and Social Security's Working Party on Collaboration between the National Health Service and Local Government 1971-73.

Hart, P.M.D'Arcy (CBE), Consultant Physician, University College Hospital 1934-37; Member of the Scientific Staff of the MRC 1937-48; Director of the MRC Tuberculosis Research Unit 1948-65. Member of the Royal College of Physicians' Committee on Social and Preventive Medicine 1942-43.

Heasman, Michael A., Co-Director, Scottish Health Services Research & Intelligence Unit; later Director of Information Services Division, Scottish Health Services Common Agency. Member of the first Board of the Faculty. Assessor on the Community Medicine Sub-Group of the Scottish Home and Health Department's Joint Committee on Doctors in an Integrated Health Service 1971-73.

Hill, Sir Austin Bradford (CBE, FRS), Professor of Medical Statistics, London School of Hygiene and Tropical Medicine and Honorary Director of the Medical Research Council's Statistical Research Unit 1946-61. Honorary FRCP, and the first Honorary Fellow of the Faculty of Community Medicine 1973.

Holland, Walter W., (later CBE), Professor of Clinical Epidemiology and Social Medicine, St Thomas's Hospital Medical School. Member of the Provisional Board and of the first Board of the Faculty; Member of the Education Committee and first Chairman of the Scientific Meetings Committee of the Faculty; President of the Faculty 1989-92. Member of the Nuffield Provincial Hospitals Trust's Committee on Vocational Training for the Administration of Hospital and Public Health Services 1966-67. Member of the Committee of the Society for Social Medicine 1970-73. Member of the Department of Health and Social Security's Working Party on Collaboration between the National Health Service and Local Government 1971-73. Joint editor of “The Oxford Textbook of Public Health” 1985, 2nd Ed. 1991.

Horner, J. Stuart, Deputy Medical Officer of Health, Croydon; later Area Medical Officer, Croydon Area Health Authority. Chairman of the Central Committee for Community Medicine and Community Health 1974-84. Member of the Joint Working Party (BMA/FCM) on The State of Community Medicine 1977-79.

Hughes, H.L.Glyn (CBE, DSO, MC), Senior Administrative Medical Officer, South East Metropolitan Regional Hospital Board 1948-59. Member of the Porritt Committee 1958-62.

Hunter, R.B. (later Lord), Vice-Chancellor of Birmingham University 1968-81; previously Professor of Therapeutics and Dean of the Medical Faculty, Dundee University. Chairman of the Medical Sub-Committee of the University Grants Committee 1966-68. Chairman of the Department of Health and Social Security's Working Party on Medical Administrators 1970-72 and of the Advisory Committee for Training in Community Medicine of the Council for Postgraduate Medical Education in England and Wales 1972-74.
Jameson, Sir Wilson W., Chief Medical Officer, Ministry of Health, Ministry of Education and the Home Office, 1940-50; previously Professor of Public Health and Dean, London School of Hygiene and Tropical Medicine. Member of the Goodenough Committee 1942-44.

Jefferys, Margot, Reader (later Professor) of Medical Sociology, Bedford College, London University; previously Senior Lecturer in the Department of Public Health, London School of Hygiene and Tropical Medicine.

Jessop, W.J.E., Professor of Social Medicine, Trinity College, Dublin 1956-75. Member of the Steering Committee which formed the Society for Social Medicine 1956.

Kenwood, H.R., (CMG, FRSE), Chadwick Professor of Hygiene at University College, London University 1904-24, and Medical Officer of Health, Stoke Newington and Bedford County Council.

Kershaw, J.D., Medical Officer of Health, Colchester 1946-70. Member of the Provisional Board, the first Board and the Education Committee of the Faculty. Member of the Committee on Social and Preventive Medicine of the Royal College of Physicians of London 1951-53. President of the Society of Medical Officers of Health 1956-57 and Member of the Committee on the Future of the Society 1964-66.

Kirk, J.F., Medical Superintendent, Stobhill Hospital, Glasgow. Member of the Provisional Board, the first Board and the Education Committee of the Faculty.


Lane, Anthony J., Deputy Senior Administrative Medical Officer, South West Metropolitan Regional Hospital Board 1970-71; Senior Administrative Medical Officer, Manchester Regional Hospital Board 1971-74 and then Regional Medical Officer North West Regional Health Authority. Member of the Education Committee of the Faculty 1973-1978.

Logan, Robert F.L., Professor of Organisation of Medical Care, London School of Hygiene and Tropical Medicine, London University.

Lowe, C. Ronald, (later CBE) Professor of Social and Occupational Medicine, Welsh National School of Medicine, Cardiff. Member of the Provisional Board, the first Board and the Education Committee of the Faculty. Joint author of “An Introduction to Social Medicine” 1966 and 1974. Medical Adviser to the Department of Employment (Welsh Office) 1964-72.

Ludkin, Stanley, (OBE), County Medical Officer, Durham County Council. Substitute member on the Working Party for the Faculty. Member of the Committee on Management Arrangements for the Reorganised National Health Service 1971-72.

Luke, Paul, first full-time Secretary of the Faculty; retired in 1982.

Lycett, Christopher D.L., County Medical Officer, Wiltshire County Council; later Area Medical Officer, Wiltshire Area Health Authority. Chairman of the Public Health Committee of the British Medical Association. Member of the Council of the Society of Medical Officers of Health 1963-68.

Macara, Alexander, Senior Lecturer in Public Health, Bristol University. Second editor of the Faculty Newsletter; Treasurer of the Faculty 1979-84. Member of the Joint Committee (BMA/FCM) on The State of Community Medicine 1977-1979.

Mackintosh, James M., Professor of Public Health, London School of Hygiene and Tropical Medicine 1944-1956; previously Professor of Public Health and Social Medicine, Glasgow University 1941-44, and Chief Medical Officer, Scotland 1937-41. Member of the Committee on Social and Preventive Medicine of the Royal College of Physicians of London 1942-43 and 1951-53.

MacLennan, Sir Hector, Consultant Surgeon, Glasgow Royal Maternity and Women's Hospital 1934-71. Chairman of the Distinction Awards Committee 1971-76.

McGinness, W.J., Medical Superintendent, Royal Infirmary, Perth. Member of the Working Party, Provisional Board and first Board of the Faculty. Chairman of the Scottish Association of Medical Administrators.

McGirr, E. McC., (later CBE), Muirhead Professor of Medicine, Glasgow University. President of the Royal College of Physicians and Surgeons of Glasgow 1970-72. Member of the Provisional Board of the Faculty. Chairman of the Scottish Council for Postgraduate Medical Education.
McKee, W.J.E., Senior Administrative Medical Officer, Liverpool Regional Hospital Board; later Regional Medical Officer, Mersey Regional Health Authority and subsequently of Wessex Regional Health Authority. Member of the Hunter Working Party 1970-72.


McLachlan, Gordon, (later CBE), Secretary, Nuffield Provincial Hospitals Trust 1955-86.

Mair, Helen, (later OBE), Medical Officer of Health, Gillingham Borough Council; later District Community Physician, Medway Health Authority. Registrar of the Faculty 1981-85. Member of the Council of the Society of Medical Officers of Health.

Meade, Thomas W., (later CBE, FRS), Senior Lecturer, Department of Community Health, London School of Hygiene and Tropical Medicine 1968-70; Director, MRC Epidemiology and Medical Care Unit, Northwick Park Hospital, Harrow.

Menzies, Maud, Principal School Medical Officer, Glasgow; later Specialist in Community Medicine (Maternity and Child Health), Greater Glasgow Health Board. Member of the Working Party, Provisional Board, and the first Board of the Faculty. President of the Scottish Branch of the Society of Medical Officers of Health.
Mercer, J.C.G., Medical Superintendent, Boards of Management for East and West Fife Hospitals. Substitute member of the Working Party for the Faculty. Member of the Community Medicine Sub-Group of the Joint Committee on Doctors in an Integrated Health Service of the Scottish Home and Health Department.


Morris, J.N., (later CBE), Professor of Community Health, London School of Hygiene and Tropical Medicine, and Director of the MRC Social Medicine Research Unit. Convener of the Informal Group and Chairman of the Working Party for the Faculty. First Chairman of the Prevention and Health Committee of the Faculty. Member of the Committee on Social and Preventive Medicine 1965-66 and Councillor 1966-68, Royal College of Physicians of London. Member of the Seebohm Committee 1965-68. Member of the Hunter Working Party 1970-72. Author of “Uses of Epidemiology” (1957, 1964 and 1975) and of “Tomorrow's Community Physician” 1969.

Morrison, S.L., Professor of Public Health (later Community Medicine), Edinburgh University, 1964-75; later Professorial Fellow and Director, Centre for Medical Research, Sussex University, and Specialist in Community Medicine, East Sussex Area Health Authority. Member of the Community Medicine Sub-Group of the Joint Working Party on Doctors in an Integrated Health Service of the Scottish Home and Health Department.

Nelson-Jones, J.A., Solicitor with Field Fisher & Co., adviser on drawing up the constitution of the Faculty.

Newhouse, Molly, Senior Lecturer in Occupational Medicine, London School of Hygiene and Tropical Medicine. Honorary Secretary of the Society for Social Medicine 1966-70.


Owen, David (later Lord), Minister of Health 1974-76.

Parish, C., Postgraduate Dean, Faculty of Clinical Medicine, Cambridge University; previously Consultant Thoracic Surgeon, Cambridge. Member of the reformed Education Committee of the Faculty. Member of the Joint Working Group on Recruitment to Community Medicine of the Department of Health and Social Security 1978-80.

Pearson, R.C.M., Visiting Professor of Health Services Administration, London School of Hygiene and Tropical Medicine; previously Medical Officer of Health, Newcastle-upon-Tyne. Secretary of the Working Party for the Faculty 1969-70. Chairman of the Committee of the Society of Medical Officers of Health on the Future of the Society of 1964-66; President of the Society 1967-68.

Pemberton, John, Professor of Preventive and Social Medicine, Queen's University, Belfast. Member of the Steering Group which formed the Society for Social Medicine 1956. Chairman, Heads of Departments of Social Medicine.

Porter, Keith R.D., (MBE), Senior Administrative Medical Officer, South East Metropolitan Regional Hospital Board; later Regional Medical Officer, South East Thames Regional Health Authority. Member of the Hunter Working Party 1970-72.

Preston, J.R., Medical Officer of Health, Sutton Coldfield; later District Community Physician, North Birmingham Health District. Member of the first Board of the Faculty. Member of the Council of the Society of Medical Officers of Health. Member of the Working Party of the Department of Health and Social Security on Collaboration between the National Health Service and Local Government 1971-73.

Ramsay, T.A., Senior Administrative Medical Officer, North East Metropolitan Regional Hospital Board; later Postgraduate Dean, Aberdeen University 1972-76 and then Regional Medical Officer, West Midlands Regional Health Authority. Member of the Provisional Board, first Board and Education Committee of the Faculty; Vice-President of the Faculty 1975-77.

Reid, Donald D., Professor of Epidemiology, London School of Hygiene and Tropical Medicine 1959-77.

Reid, J.J.A., (later Sir John), County Medical Officer, Buckinghamshire County Council; later Deputy Chief Medical Officer, Department of Health and Social Security 1972-77, then Chief Medical Officer, Scottish Home and Health Department. Member of the Committee of the Society of Medical Officers
Management of the London School of Hygiene and Tropical Medicine. President of the British Medical Association 1992-3.

Revans, John (CBE), (later Sir John), Senior Administrative Medical Officer, Wessex Regional Hospital Board; later Regional Medical Officer, Wessex Regional Health Authority. Member of the Medical Consultative Committee of the Nuffield Provincial Hospitals Trust 1961-76. Member of the Committee of the Royal College of Physicians of London on Medical Administration 1965-66.


Robertson, Jean, (later  MBE), Assistant Secretary of the Faculty 1973-1996.

Robson, Sir Kenneth, Consultant Physician, St Georges Hospital and Brompton Hospital, London. Registrar of the Royal College of Physicians of London 1961-75.

Rose, Geoffrey (later CBE), Professor of Epidemiology and Consultant Physician, St. Mary's Hospital, London; later Professor of Epidemiology, London School of Hygiene and Tropical Medicine.

Rosenheim, Sir Max (later Lord), Professor of Medicine and Consultant Physician, University College Hospital, London. President of the Royal College of Physicians of London 1966-72. Member of the Provisional Board and the first Board of the Faculty. Member of the Committee of the Royal College of Physicians of London on Social and Preventive Medicine 1965-66.

Ryle, J.A., Professor of Social Medicine and Director of the Institute of Social Medicine, Oxford University 1943-50; previously Regius Professor of Physic, Cambridge University and Consultant Physician at Guy's Hospital, London.

Savage, Sir William, County Medical Officer, Somerset County Council during the 1930s. President of the Society of Medical Officers of Health 1935-36.

Seabohm, Frederick, (later Lord), Chairman of Barclay's Bank International; Deputy Chairman of Barclay's Bank. Chairman of Joseph Rowntree Memorial Trust. Chairman of the Committee on Local Authority and Allied Personal Social Services 1965-68.

Smith, E. Alwyn, (later CBE), Professor of Social and Preventive Medicine (later Community Medicine), Manchester University. President of the Faculty 1981-86. Honorary Secretary of the Heads of Departments of Social Medicine c.1971.

Spooner, E.T.C. (CMG), Dean, London School of Hygiene and Tropical Medicine 1960-70; previously Professor of Bacteriology and Immunology at the School. Chaired the first meeting of the Informal Group 1968, which led to the Working Party concerned with the Faculty. Member of the Committee of the Royal College of Physicians of London on Medical Administration 1965-66.

Stewart, Alice, Reader in Social Medicine, Oxford University. Member of the Steering Group which founded the Society for Social Medicine in 1956.

Stewart, R.H.M., Senior Administrative Medical Officer, Newcastle Regional Hospital Board. Member of the Working Party, the Provisional and the first Board of the Faculty.


Taggart, James McA., Medical Officer of Health, Belfast; later Chief Administrative Medical Officer, Eastern Health and Social Services Board, Northern Ireland. First Chairman of the Community Medicine Specialty Committee of the N. Ireland Council for Postgraduate Medical Education.

Taylor, Stephen J.L., (later Lord), M.P. 1945-50. Medical Director of the Harlow Industrial Health Service. President and Vice-Chancellor, Memorial University, Newfoundland 1967-73.

Tibbs, G.Michael G., (later OBE), Secretary of the Royal College of Physicians of London 1968-86 and of the Joint Colleges' Committee, the Joint Committee on Higher Medical Training, the Provisional Board of the Faculty, and initially of its first Board.

Tilley, J.B. (OBE), County Medical Officer of Northumberland County Council. Member of the Porritt Committee, resigned November 1960. President of the Society of Medical Officers of Health 1966-67.

Titmuss, Richard M., (later CBE), Professor of Social Administration, London School of Economics. Author, with B Abel-Smith (see above) of the special report commissioned by the Committee on The
Cost of the National Health Service in England and Wales 1956. Member of the Royal Commission on Medical Education 1965-68.


Townsend, G.W. (CBE), County Medical Officer, Buckinghamshire, retired 1967. President of the Society of Medical Officers of Health 1960-61. Member of the Porritt Committee, resigned January 1962.

Trench, Sir David, Vice-Chairman of the Advisory Committee on Distinction Awards 1972-79. Chairman of Dorset Area Health Authority 1973-82. Governor of Hong Kong 1964-71.


Warren, Michael D., Reader in Public Health, London School of Hygiene and Tropical Medicine 1967-71; later Professor of Social Medicine and Director of the Health Services Research Unit, Kent University. First Academic Registrar of the Faculty. Member of the Council of the Society of Medical Officers of Health 1967-72 and secretary of its Committee on The Future of the Society 1964-66; Treasurer (later Vice-President) of the Teaching Group and President of the Research Group of the Society. Member of the Committee of the Society for Social Medicine 1969-72. Member of the Department of Health and Social Security’s Group on Recruitment to Community Medicine 1978-80. Joint Editor of the British Journal of Preventive and Social Medicine 1969-72.
Weddell, Jean M., Senior Lecturer in Community Medicine, St.Thomas's Hospital Medical School, London. First Coordinator of the Thames Consortium.

Whitfield, A.G.W. (CBE), Director of the Board of Graduate Studies and Emeritus Professor of Medicine, Birmingham University. Second Coordinator of the Midlands and South West Consortium.

Wild, David, Deputy Medical Officer of Health, West Sussex County Council; later Area Medical Officer, West Sussex Area Health Authority. Joint Editor of Community Medicine 1978-84.

Williams, Brian T, Senior Medical Officer (Adult Health), Northamptonshire County Council, later Specialist in Community Medicine (Information and Research), Trent Regional Health Authority. Joint Editor of Community Medicine 1978-85.

Winner, Dame Albertine, Linacre Fellow, Royal College of Physicians of London; previously Deputy Chief Medical Officer, Ministry of Health.


Wright, A.W., Consultant Physician, Bangour Hospital. Member of the Council of the Royal College of Physicians of Edinburgh 1970-74. Member of the General Medical Council.

Wright, Robert B., (OBE, DSO, later Sir), Senior Surgeon, Southern General Hospital, Glasgow. President of the Royal College of Physician and Surgeons of Glasgow 1968-70.


Yerby, Alfonso S., Professor of Health Services Administration, School of Public Health, Harvard University, USA.

Zealley, Helen, Medical Registrar, Wellcome Laboratory, Edinburgh; later Specialist in Community Medicine, Lothian Health Board and medical officer to the Scottish Coordinating Committee for Community Medicine Training. Drafted substantial parts of “Learning and Teaching Community Medicine” published by the Scottish Council for Postgraduate Medical Education 1979. Member of the
NOTES AND REFERENCES

PART 1


2. The Society of Medical Officers of Health (now the Society of Public Health) grew out of the Metropolitan Association of Medical Officers of Health which was founded in 1856 (WS Walton, *The History of the Society of Medical Officers of Health 1856-1956. Public Health* 1956; 69: 160-226; and IS Macdonald, *The Society of Medical Officers of Health: A Scottish Centenary. Public Health* 1992; 106: 335-342). Membership, which was by election, gradually widened to be open to all doctors and dentists working in the field of public health, including the clinical medical officers working in the fields of maternity and child welfare and the school health services. In 1958 a proposal to change the name of the Society to "The College of Social and Preventive Medicine" was unacceptable to the Board of Trade. In 1966 a special committee (RCM Pearson (chairman) with JL Gilloran, JD Kershaw, JB Meredith Davies, JJA Reid and MD Warren) set up by the General Purposes Committee of the Society recommended that the Society should be re-constituted as a College. Discussions were started but the proposal was abandoned when negotiations began about the formation of a Faculty of the Royal Colleges. See Anon, *The Society of Medical Officers of Health - Past, Present and Future. Public Health*. 1972; 86: 27-42; *Notes and News. The Lancet* 1967; i: 168. See note 5, Part II


5. W Cowper, General Board of Health, Election and Duties of Medical Officers of Health. *The Lancet* 1855; 636-7. see also Metropolis (Local Management) Act 1855 (18 & 19 Vict. c.120), sect.132.

6. Public Health Act 1875 (38 & 39 Vict. c.55); Public Health (London) Act 1891 (54 & 55 Vict. c.76); Public Health (Scotland) Act 1897 (60 & 61 Vict. c.38); and, Isolation Hospitals Act 1893 (56 & 57 Vict. c.68).


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480. Sir Wilson was chief medical officer 1940-50 and formerly dean and professor of public health at the London School of Hygiene and Tropical Medicine.


32. National Health Service Act 1946 (9 & 10 Geo.VI c.81); and National Health Service (Scotland) Act 1947 (10 & 11 Geo.VI c.27).

33. Detailed guidance to the services to be provided by the local health authorities was given in Ministry of Health Circular 118/47.


35. MacNalty, note 30, pp. 52-54; and, Society of Medical Officers of Health, note 28. For a description of the pivotal role envisaged for health centres in the planning of the National Health Service see Honigsbaum, note 31. The Central Health Services Council appointed a committee in 1948 to recommend the lines on which health centres should be developed. The final report of the committee (chairman Fred Messer) was published in the *Annual Report of the Council for 1950.* London, HMSO, 1951.

36. Pater, note 29, p. 149.
PART I


44. AD Morris, *A History of the Medical Superintendents Society*. Mimeograph document produced by the Medical Superintendents Society, London, 1974, p. 2 (copy in the BMA archives.); Pater, note 29, p. 174. See also A Correspondent, Preface to Hospital Administration. *The Lancet* 1950; ii: 450-452 (the "Correspondent" was S Taylor, later Lord Taylor); Central Health Services Council, *Report of the Committee on the Internal Administration of Hospitals* (Chairman AF Bradbeer). London, HMSO, 1954. Membership of the Committee included four doctors who were or had been medical superintendents. The BMA, Medical Superintendents Society and the Senior Administrative Medical Officers, but not the Society of Medical Officers of Health, gave evidence to the Committee. The situation in Scotland was reviewed in the *Report of the Sub-Committee of the Standing Advisory Committee on Hospital and Specialist Services* (chairman Sir George Henderson). Edinburgh, HMSO, 1957.
45. National Health Service Act 1946, note 32, Sect.11.
46. C Webster, note 41, p. 288.
50. Leading Article, Ten Years, ibid, 33-34.
51. Ministry of Health and the Scottish Department, *Report of the Committee of Enquiry into the Cost of the National Health Service* (Cmnd 9663) (CW Guillebaud). London, HMSO, 1956. The Committee consisted of five members; the chairman was a Cambridge economist, other members were a Glasgow chemist, a senior trade union official, a former permanent secretary to the Ministry of Health and an industrialist.


60. Ibid., pp. 92-93.


62. Ibid., pp. 127-130.


66. Local Government Act 1972 (Eliz.II c.70); Local Government (Scotland) Act 1973 (Eliz.II c.65).

67. *Report of the Committee on Local Authority and Allied Personal Social Services* (Cmd 3703) (Chairman F (later Sir Frederick) Seebohm). London, HMSO, 1968, paras. 30 and 31. Appendix F sets out the structure and scope of the personal social services that the Committee was considering. See also Phoebe Hall, *Reforming the Welfare. The Politics of Change in the Personal Social Services*. London, Heinemann, 1976, appendix 2 reproduces the memorandum on the need for an enquiry into social work services.


70. Social Work (Scotland) Act 1968 (16 & 17 Eliz.II c.49).

71. Local Authority Social Services Act 1970 (Eliz.II c.42).


73. Ibid., paras. 26, 24 and 30.

74. See note 3.


77. Leading Article, The Secretary of State's Special Adviser. *The Lancet* 1978; i: 287-288. B Abel-Smith was professor of social administration at the London School of Economics and visiting professor at the London School of Hygiene and Tropical Medicine.

PART I

79. Anthony Howard (editor), *The Crossman Diaries. Condensed Version*. London, Methuen Paperbacks Ltd., 1979, pp. 476-480 and 538; B Pimlott, *Harold Wilson*. London, Harper-Collins Publishers, 1992, pp. 334-337. Richard Titmuss and Brian Abel-Smith were sceptical about the merger of the Ministries of Health and Social Security, not least because of the different mores of the staff of the two ministries - a repeat of the doubts and arguments of John Simon when the medical department and poor law board were brought together in 1871 to form the Local Government Board (see note 10, ch.15). The new Department of Health and Social Security was split into the Department of Health and the Department of Social Security in 1988, each headed by a Secretary of State with a seat in the Cabinet.


81. Ibid., paras. 36 and 49-52.


86. English White Paper, note 85, paras. 141, 142, 144, and 25.

87. National Health Service (Scotland) Act 1972 (20 & 21 Eliz.II c.58); National Health Service Reorganisation Act 1973 (Eliz.II c.32).


95. Ibid., Role Specifications A1, A2 and A3, pp. 122-127.


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100. Presidents and Deans of the Royal Colleges and Faculties, NHS Finances: Royal Colleges' Statement. *British Medical Journal* 1974; 4: 237. Representatives from the British Medical Association, British Dental Association, Joint Consultants' Committee, Royal College of Nursing and the Royal College of Midwives also issued a statement (*British Medical Journal* 1974; 4: 297-300) after meeting the Prime Minister.


104. JN Morris, personal communication to MDW.


111. Ibid., p. 6.

112. Ibid., pp. 13-17, 20-21 and 31.

113. McLachlan, note 5, p. 175.
118. Ibid., p. 167.
119. Ibid., pp. 168-173.
120. AP Curran, personal communication to MDW, dated 20.5.94.
123 See Annual Reports of the London School of Hygiene and Tropical Medicine.
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138. Medical Act 1886 (49 & 50 Vict.c.48), Section 21, viz.: "Every registered medical practitioner to whom a diploma for proficiency in sanitary science, public health, or state medicine, has after examination been granted by any college or faculty of physicians or surgeons or university in the United Kingdom, or by any such bodies acting in combination, shall, if such diploma appears to the Privy Council or to the General Council to deserve recognition in the medical register, be entitled on payment of such fee as the General Council may appoint, to have such diploma entered in the said register, in addition to any other diploma or diplomas in respect of which he is registered". The DPH was the first and only specialist diploma for which the General Medical Council prescribed regulations. Given the statutory powers of medical superintendents of mental hospitals to detain people there was pressure for the Council to take similar responsibility for the DPM.


140. Local Government Act 1888 (51 & 52 Vict. c.41), Section 18; Local Government (Scotland) Act 1889 (52 & 53 Vict. c.50); and, Public Health (London) Act 1891 (54 & 55 Vict. c.76), Section 108


143. Kenwood, note 107.
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146. Savage, note 24.
147. Godber, note 55.
150. Ibid., pp. 34 (paras.13 & 14) and 219 (para.38).
156. London School of Hygiene and Tropical Medicine, Department of Public Health, internal papers; *Report on the Work of the School for 1966-67*, pp. 80-81.
158. Society of Medical Officers of Health, unpublished internal paper (MDW papers).
159. Ibid.
160. Nuffield Provincial Hospitals Trust, The Administration of Hospital and Public Health Services, in *Vocational Training in Medicine*. London, Nuffield Provincial Hospitals Trust, 1967. Chairman of the Working Party was CH Stuart-Harris, the members were JOF Davies, RJ Donaldson, GD Forwell, WW Holland, JJA Reid, SR Whittaker and H Yellowlees.

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163. Royal College of Physicians of London, Report of the Committee on Medical Administration. London, Royal College of Physicians, 1966. JHF Brotherston, J Revans and ETC Spooner were members of the committee.


166. CF Brockington, Training for Public Health and Medical Administration. The Medical Officer 1963; 110: 7-11.

167. General Medical Council, letter, dated 1 April 1966, from MR Draper, Deputy Registrar.

168. Ministry of Health, Evidence to the Royal Commission on Medical Education. MH 149.338 B/M63/4/B.


171. Royal College of Physicians, note 163.
172. Society for Social Medicine, *Evidence to the General Medical Council’s Special Committee on Public Health 24 October 1966* (MDW papers). J Knowelden, R Lowe and MD Warren gave oral evidence to the Committee.


175. Royal Commission on Medical Education, note 128, paras 133-144.


177. Leading Article, The Specialty of Medical Administration, *The Lancet* 1965; i: 1206-1207. This was followed by a number of letters - SL Morrison, p.1329; G Scoular, p.1393; CW Dixon, ii: p.35; I Gordon, pp.35-36; SCA Clifford,p.79; M Susser, p.130; and, FR Reeves, p.187. The issue was discussed in *The Medical Officer* 1965; 114: 123-124 and 131.
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183. Ministry of Health Circular HM(64) 69.
191. G McLachlan (editor), note 4; Robin Dowie, Postgraduate Medical Education and Training. The System in England and Wales. London, King Edward's Hospital Fund for London, 1987. Dowie describes the complex system of postgraduate training including the requirements of the Colleges and Faculties; manpower needs for specialists; financing of training; and the special concerns of women doctors and doctors from overseas.
195. Royal Commission on Medical Education, note 128, paras.133-144.
199. Society of Social Medicine, note 172; General Medical Council, note 173; and, Society of Medical Officers of Health, note 169.
203. Hunter Report, note 47.
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206. Ibid., paras. 126 and 125.
209. Ibid., The Contribution of Community Medicine, chapter VI, pp. 31-40.

BIBLIOGRAPHY


**PART 2**

2. Personal discussion between JN Morris, WG Harding and MDW, 26 October 1994; and letter from JN Morris to MDW dated 30 December 1995.
3. Appointments diary of MDW; letter from JN Morris to WG Harding, dated 11 March 1968, referred to "real progress" having been made at "the dinner the other night" (WGH papers).
4. Letter from JN Morris to WG Harding, Chairman of Council, Society of Medical Officers of Health, dated 29th April 1968 (WGH papers).
5. The Society of Medical Officers of Health, see Part 1, note 2. In 1965 there were about 2300 doctors employed full-time by local government authorities in England about half of whom carried out only clinical duties. In addition there were about a further 1000 doctors employed part-time in clinical duties and about 2000 general practitioners employed on a sessional basis. The majority of the full-time staff and some of the others were members of the Society of Medical Officers of Health. For a description of the work and attributes of the doctors employed in public health services in England see MD Warren and Jane Cooper, Medical Officer of Health: The Job, the Man and the Career. *The Medical Officer* 1966; 116: 41-50, and Local Government Medical Staff. *The Medical Officer* 1967; 118: 185-192. For details of medical staff in the Scottish local authorities see J Riddell, Scottish Local Authorities. *Health Bulletin (Edinburgh)* 1962; 20: 72-75; and TS Wilson, Scottish Local Health Authorities - Medical Staffing. *Health Bulletin (Edinburgh)* 1966; 24: 81-84. The Society of
Medical Officers of Health represented the largest group of doctors likely to become the foundation members of any new professional body. WG Harding was chairman of the Council of the Society (its governing body) from 1966 to 1971, and President of the Society 1971-72. The interests of members in Scotland were the concern of the Scottish Branch of the Society, the members of which elected the Branch Council and the chairman, who at the relevant time was Maud Menzies. In 1973 the name of the Society was changed to the Society of Community Medicine and in 1989 to the Society of Public Health.

6. The doctors working on the staff of the senior administrative medical officers of the regional hospital boards had no formal association. The senior administrative medical officers (SAMOs) of the 15 regional hospital boards in England and Wales met privately, usually at the offices of the Nuffield Provincial Hospitals Trust, prior to their monthly meeting with the chief medical officer at the Ministry of Health (personal letter to WG Harding from RHM Stewart dated 27 June 1993). See also K Porter, The Role of the SAMO. Health Trends 1972; 4: 16-17. In the late 1960s there were 113 medical officers in addition to the 15 SAMOs on the headquarters staff of the boards (Department of Health and Social Security, Report of the Working Party on Medical Administration (Hunter Report). London, HMSO, 1972 p. 56). The "officers" of the SAMOs' meetings in 1969 were J Revans (chairman), RHM Stewart (vice-chairman) and TA Ramsay (secretary).

7. In 1956 a group of academics in social medicine departments formed an independent British Scientific Society of Preventive and Social Medicine which soon became the Society for Social Medicine. The Steering Committee consisted of JHF Brotherston, R Doll, WJE Jessop, T McKeown, J Pemberton and Alice Stewart. The main object of the Society was to advance academic social medicine primarily through research. Initially membership was restricted to people who had published research papers within the broad field of social medicine. Later membership was open to any person engaged in research or teaching in social medicine. From its beginning there were members from England, Wales, Scotland, Northern Ireland and Eire. In 1964 there were 150 members of which 23 were non-medical, 7 were employed in public health departments and 2 in regional hospital boards (Society for Social Medicine, Origin of the Society for Social Medicine. Undated cyclostyled document; Society for Social Medicine, Constitution and Bye Laws as Amended. SSM, 1964; Society for Social Medicine, List of Members. SSM, 1964). By 1994 the total membership was just over 1000 (Society for Social Medicine, Honorary Secretary's Report for Year Ending 31 August 1994. SSM, Cyclostyled document, 1994). The governing body of the Society was its Committee composed of the chairman of the Society, the secretary and the treasurer elected at the annual general meeting and six other members each elected to serve for three years. The chairmen during the period of formation of the Faculty were R Doll, RAM Case, H Campbell and EG Knox and the secretaries were ML Newhouse and M Alderson.
8. The Scottish Association of Medical Administrators was formed in 1954. Its membership included the SAMOs of the Scottish regional hospital boards, medical superintendents and other medical administrators within the National Health Service, Defence Services and the Scottish Home and Health Department. In 1968 there were almost 100 members and in that year the Council of the Association formed a Working Party (JP Wall, J Kirk and HA Raeburn) to investigate the possibilities of affiliation with one of the Scottish Royal Colleges (Papers of the Scottish Association of Medical Administrators, Edinburgh University Library, Special Collections Department).


11. Letter from Alwyn Smith to Molly Newhouse (Wellcome CMAC).

12. At this time the Heads of Departments Group had not been formally instituted.


18. Notes on the meeting on the 18 October 1968 made by WG Harding (WGH papers).

19. WG Harding, letter to RC Wofinden dated 28 October 1968; T McKeown, A Note on the Proposal to Establish a Professional Organization Concerned with Social or Community Medicine, First Draft, October 1968; RC Wofinden, letter to Professor T McKeown dated 8 November; and a second draft of "The Note on ..." from T McKeown, November 1968 (WGH papers).


21. Sir Max Rosenheim, letter to JN Morris dated 24 February 1969 (WGH papers); Joint Committee of the Royal Colleges of Physicians, Minutes of the meeting held on 21 February 1969.


23. Royal College of Physicians and Surgeons of Glasgow, Minutes of the Council meeting held on 8 April 1969 (GF notes).
24. RC Wofinden, Proposal to Establish a Professional Organisation concerned with Social or Community Medicine, revised draft of "The Note ..." following the meeting held on 26 February, reference RCW/VJD dated 18 March 1969 (WGH papers).
25. Sir Max Rosenheim, President of the Royal College of Physicians of London, Summary of a discussion to consider the setting up of a Faculty of Community Medicine held on 1 May 1969 (Society of Social Medicine Papers, Wellcome CMAC).
26. Royal College of Physicians of Edinburgh, Minutes of the Council meeting held on 13 May 1969 (GF notes).
27. Royal College of Physicians and Surgeons of Glasgow, Minutes of the Council meeting held on 13 May 1969 (GF notes).
29. Joint Committee of the Royal Colleges of Physicians, Minutes of the meeting held in June 1969.
31. Royal College of Physicians and Surgeons of Glasgow, Minutes of the Council meeting held on 8 July 1969 (GF notes).

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32. JN Morris, letter to Brotherston, Doll, Harding, McGinness, Revans, Spooner and Yellowlees dated 11 July 1969 (WGH papers); WG Harding, letter to RC Wofinden dated 9 July 1969 which was written after a telephone conversation between Morris and Harding (WGH papers).
34. Harding, ibid.
35. WG Harding, WRS Doll, WJ McGinness, J Revans and JN Morris, letter to the secretaries of the Society of Medical Officers of Health, the Society for Social Medicine, the Senior Administrative Medical Officers group, and the Scottish Association of Medical Administrators, and to the Dean of the London School of Hygiene and Tropical Medicine, Brotherston and Yellowlees dated 9 September 1969 (WGH papers).
36. RHM Stewart, Extract from Notes of the Meetings of the Senior Administrative Medical Officers dated 27 June 1993, sent to WG Harding (WGH papers); C Brough letter to MDW dated 12 February 1995 (MDW papers).
37. WG Harding, letter to Dorothy F Egan dated 14 July 1969 (WGH papers).
39. Scottish Branch of the Society of Medical Officers of Health, Minutes of the Council meeting held on 11 October 1969; Minutes of the meeting of the Working Party on Community Medicine held on 16 September 1969.


44. JJA Reid, The Unity of Medical Services - Discussion. *Public Health* 1969; 83: 268-269.


46. Rosenheim, note 25.

47. Society for Social Medicine, Minutes of the 13th Annual General Meeting held on 19 September 1969 (MDW papers).

48. T McKeown, letter to M Newhouse dated 23 September 1969 (Wellcome CMAC); Society for Social Medicine, Minutes of Committee Meeting held on 23 October 1969 (MDW papers).

49. Working Party, Minutes of the first meeting held on 14 October 1969 (WGH papers).

50. RCM Pearson retired from the post of Medical Officer of Health for Newcastle-upon-Tyne and was appointed Visiting Professor of Health Services Administration at the London School of Hygiene and Tropical Medicine in 1969. On becoming secretary of the Working Party Pearson was replaced by TMcL Galloway as deputy to RC Wofinden.


52. Working Party, Minutes of meetings held on 6 and 20 November 1969 (WGH papers).


54. Working Party, Proposed Faculty of Community Medicine, first draft dated 30 October 1969 (WGH papers).

55. R Doll, Faculty of Community Medicine. Undated memorandum submitted to the meeting of the Working Party held on 6 November 1969 (WGH papers).

56. Working Party, Minutes of the meeting held on 6 November 1969 (WGH papers).

57. Working Party, Minutes of the meeting held on 20 November 1969 WGH papers.

58. Working Party, Minutes of the meeting held on 4 December 1969 (WGH papers).

59. Working Party, Minutes of the meeting held on 20 December 1969 (WGH papers).


61. Joint Committee of the Royal Colleges of Physicians, Minutes of the meeting held on 1 November 1969.
63. Stewart, note 36.
64. Society for Social Medicine, Minutes of the 49th Meeting of the Committee held on 11 December 1969; H Campbell, letter to all members of the Society for Social Medicine, undated, sent out during January 1970 (Wellcome, CMAC).
65. Society for Social Medicine, Minutes of the 50th Meeting of the Committee held on 20 February 1970 (Wellcome, CMAC).
66. JN Morris, letter addressed to the Presidents of the Royal Colleges of Physicians dated 5 January 1970 (Faculty archives).
67. Sir Max Rosenheim, letter to JN Morris, dated 7 January 1970 (Faculty archives).
68. C Clayson, letter to JN Morris dated 7 January 1970 (Faculty archives).
69. JN Morris, letter to all members and observers of the Working Party, and their deputies, headed "Proposed Faculty of Community Medicine" dated 19 January 1970 (Faculty archives).
71. Working Party, Minutes of the meeting held on 5 February 1970 (WGH papers).
72. Joint Committee of the Royal Colleges of Physicians, Minutes of the meeting held on 5 February 1970.
73. Sir Max Rosenheim, letter to JN Morris dated 11 February 1970 (Faculty archives).
74. WG Harding, letter to RC Wofinden dated 20 February 1970 (WGH papers).
75. Society of Medical Officers of Health, "A Faculty of Community Medicine", memorandum tabled at the Council Meeting held on 27 February 1970 by WG Harding, chairman of Council (WGH papers).
76. JN Morris, letter to Sir Max Rosenheim dated 2 March 1970 (Faculty archives).
78. Working Party, Minutes of the meeting held in 21 May 1970 (WGH papers).
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84. A Smith, letter to the Registrar of the Royal College of Physicians of London dated 6 May 1970 (WGH papers). This letter surprised Morris and Doll, neither of whom had previous knowledge of it. Doll considered resigning from the Working Party (ML Newhouse, letter to H Campbell, chairman of the Committee of the Society for Social Medicine dated 21 May 1970 (Wellcome CMAC)).

85. Working Party, Minutes of the meeting held on 21 May 1970 (WGH papers). For details about the origin of the title "community physician" see HWS Francis, *Faculty Newsletter* 1976; 3, no.1: 55-57, and no.2: 44-45. The Lancet welcomed the name, *The Lancet* 1971; ii:418. WG Harding has stated "I liked Community Medicine, because it clearly expressed our primary responsibility to the community rather than to the individual" (letter to JM O'Brien, President of the Faculty of Public Health Medicine dated 31 May 1993 (MDW papers)).

86. Working Party, note 85.

87. Society for Social Medicine, Minutes of the Extraordinary General Meeting held on 4 June 1970 at the Royal Society of Medicine (Wellcome CMAC).
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88. Society for Social Medicine, Results of a Survey of Members about their Views on the Possible Formation of a Faculty of Community Medicine/Social Medicine/Public Health. Ibid.
89. Joint Committee of the Royal Colleges of Physicians, Minutes of the meeting held on 16 July 1970.
90. RCM Pearson and JN Morris, Proposed Faculty of Community Medicine, Notes on the Meeting of the Joint Working Party held on 16 July 1970 at the Royal College of Physicians of London, attached to the agenda for the meeting of the Working Party on 17 September (WGH papers). Morris, Harding, Fowler, McGinness, Pearson and Yellowlees represented the Working Party and Sir Max Rosenheim and Sir Kenneth Robson represented the London College, C Clayson, J Halliday-Croom and AW Wright the Edinburgh College, and RB Wright and EM McGirr the Glasgow College, with GMG Tibbs as secretary to the meeting.
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93. JN Morris, Note by Chairman about his meeting with Lord Rosenheim on 14 August 1970, dated 31 August 1970 (WGH papers).
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96. Society for Social Medicine, Minutes of the 14th Annual General Meeting held on 24 September 1970; Minutes of the 52nd Committee Meeting held on 23 September 1970 (Wellcome CMAC).
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107. Society for Social Medicine, Minutes of the Extraordinary General Meeting held on 30 January 1971.
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111. Lord Rosenheim, letter to EG Knox dated 19 February 1971 (WGH papers).
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113. EG Knox, letter to WG Harding dated 9 March 1971 enclosing a copy of the memorandum (WGH papers).
114. Provisional Council, Minutes of the Executive Committee Meeting held on 10 March 1971 (WGH papers); Society for Social Medicine, Notes on the Meeting held on 10 March 1971 (MDW papers).
115. EG Knox, letter to MR Alderson dated 7 April 1971 (MDW papers).
116. Society for Social Medicine, Minutes of the Committee Meeting held on 16 April 1971 (Wellcome CMAC).
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117. MR Alderson, letter to WG Harding dated 22 April 1971 (WGH papers).
118. Society for Social Medicine, Minutes of the 56th Committee Meeting held on 11 June 1971 (Wellcome CMAC).
119. WG Harding, letter to AL Cochrane dated 14 May 1971 (WGH papers).
120. JN Morris, letter to MR Alderson dated 6 May 1971 (Wellcome CMAC).
121. MR Alderson, letter to WG Harding dated 1 July 1971 (WGH papers).
122. Provisional Board, Minutes of the meeting held on 23 July 1971.
123. Society for Social Medicine, Minutes of the 15th Annual General Meeting held on 9 September 1971 (Wellcome CMAC).
125. Joint Committee of the Royal Colleges of Physicians, Minutes of the meeting held in June 1971.
126. A Smith, letter to the Secretary of the Provisional Council of the Faculty of Community Medicine dated 23 April 1971 (WGH papers).
127. Ibid.
129. WG Harding, letter to J Pemberton dated 12 May 1971 (WGH papers).
130. WG Harding, letter to J Pemberton dated 9 June 1971 (WGH papers).
131. The dates of the meetings were 19 February, 5 May, 23 July, 25 November and 30 December during 1971 and 25 January 1972.
132. Provisional Council Minutes, for members of the Executive Committee see note 110.
133. Lord Rosenheim letter to M Ware (editor of the British Medical Journal) dated 19 February 1971 (WGH papers).
137. Provisional Board, Minutes of the meeting held on 23 July 1971.
138. ND Compston (Treasurer, Royal College of Physicians of London), letter to WG Harding dated 22 November 1971 (WGH papers).
139. Provisional Council, Minutes of the meeting held on 5 May 1971.
Representatives of the three Royal Colleges met representatives of occupational medicine on 18 February 1971 (GF notes) and subsequently set up a joint collegiate working party (Joint Committee of the Royal Colleges of Physicians, Minutes of the Meeting held in March 1971).

WG Harding, letter to JJA Reid (at the Department of Health and Social Security) dated 9 May 1975.

Faculty of Community Medicine, *Standing Orders*. Hayes, Harrison and Sons Ltd., 1972. Minor amendments were incorporated in this printed version

Provisional Board, Minutes of the meeting held on 25 November 1971.

Joint Committee of the Royal Colleges of Physicians, Minutes of the meeting held in June 1971. For the changes in the Colleges' Bye-laws see note 149.
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153. Royal College of Physicians of Edinburgh and the Royal College of Physicians and Surgeons of Glasgow, Minutes of their Councils' meetings held on 13 July 1971 (GF notes).
154. Provincial Council, Minutes of the Executive Committee meeting held on 16 May 1971 (WGH papers).
156. Faculty of Community Medicine of the Royal Colleges of Physicians of the United Kingdom. British Medical Journal 1971, 9 October, (advertisement); The Lancet 1971, 9 October, 16 (advertisement).
157. Provisional Board, Minutes of the meeting held on 30 December 1971.
162. WG Harding, letter to Dame Albertine Winner dated 17 March 1971 (WGH papers).
163. Dame Albertine Winner, letter to WG Harding dated 29 March 1971 (WGH papers).
165. Provisional Board, Minutes of the meeting held on 25 November 1971.
166. Provisional Council, report of the meeting of the Education Committee held on 26 May 1971 (WGH papers).
168. Faculty of Community Medicine, Report of the meeting of the Acting Board held on 11 February 1972.
169. Faculty of Community Medicine, Memorandum on Education and Training, distributed at the Inaugural Meeting held on 15 March 1972 (WGH papers).
170. Provisional Board, Minutes of the meeting held on 25 January 1972. Later Paul Luke was appointed full-time Secretary of the Faculty and started on 1 May 1972.
171. Faculty of Community Medicine, Report of the Inaugural Meeting, note 158.
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1. Faculty of Community Medicine, Minutes of the meeting of the Board held on 15 March 1972.
2. Faculty of Community Medicine, Minutes of the meeting of the Board held on 11 May 1972.
3. TML Galloway, Registrar's Annual Report. Faculty Newsletter 1974; 1: No.4, 10.
5. P Alwyn-Smith, The Faculty in Wales. Faculty Newsletter 1973; 1: No.4, 30.
7. Faculty of Community Medicine, note 2.
11. From 1986 until the end of 1989 "Notes and News" was printed informally on yellow sheets of A4 paper. Since 1990 the material has been included in The Public Health Physician, which is sent only to fellows, members and trainee members of the Faculty. In 1990 the name of the Faculty's journal was changed to The Journal of Public Health Medicine.
12. Library, London School of Hygiene and Tropical Medicine. Faculty Newsletter 1975; 2: No.1, 17.
14. For a list of representatives of the Faculty on the councils and committees of other organisations see Faculty Newsletter 1973; 1: No.2, 29-30.
15. AL Cochrane, President's Letter. Faculty Newsletter 1973; 1: 2-5. For dates of various liaison meetings see Meetings and Social Events Diary in various numbers of the Faculty Newsletter.
19. Faculty of Community Medicine, Arms of the Faculty of Community Medicine. *Faculty Newsletter* 1975; 2: No.1, inside front cover; and *Community Medicine* 1981; 3: 281.


24. For a description of the courses at the Extension Training Centre at the London School of Hygiene and Tropical Medicine see RM Acheson, Basic and Continuing Education of Community Physicians. *Health Trends* 1975; 7: 53-57.


27. Faculty of Community Medicine, A Memorandum from the Education Sub-Committee to the Provisional Board, 1972.


29. Faculty of Community Medicine, Regulations for the Examination for the Diploma of Membership of the Faculty of Community Medicine. *Faculty Newsletter* 1974; 1: No.3, 19-27.

30. Faculty of Community Medicine, Model Examination for the Diploma of Membership. *Faculty Newsletter* 1974; 1: No.4, 16-22.


35. Faculty of Community Medicine, Specialist Training in Community Medicine, November 1974. *Faculty Newsletter* 1975; 2: No.1, 55-68.
39. Faculty of Community Medicine, Regulations for the Examination, note 29.
40. Faculty of Community Medicine, Diploma for the Membership of the Faculty, Notes and Procedures for Part II. *Faculty Newsletter* 1975; 2: No.2, 67-76.
42. Sir John Brotherston, note 34.
44. Todd Report, note 36, p. 69, para. 144.
45. Sir John Brotherston, note 34.
46. MD Warren, Report on the Membership Examination. *Faculty Newsletter* 1977; 4: No.1, 16-22. A copy of each successful submission for Part II of the membership examination is retained and can be read at the Faculty office.
50. MD Warren, note 38.

52. Faculty of Community Medicine, Announcement - Specialist Training. *Faculty Newsletter* 1974; 1: No.3, 28.

53. Faculty of Community Medicine, Enrolment of Trainees. *Faculty Newsletter* 1976; 3: No.1, 62-63.

54. Faculty of Community Medicine, note 35.


56. Council for Postgraduate Medical Training in England and Wales, Minutes of the meeting of the Advisory Committee on Training for Community Medicine held on 1 December 1972. The members of the Committee were RB Hunter (chairman); WG Harding, T McL Galloway and MD Warren (Faculty of Community Medicine); ACP Campbell, Sir Richard Doll and J Pemberton (Committee of Vice-Chancellors and Principals); JJA Reid (Department of Health and Social Security); IB Sutherland (Administrative Medical Officers of Regional Hospital Boards); DG Cullington (Society of Medical Officers of Health); JB Lynch (Advisory Committee of Postgraduate Deans); MA Wilson (Advisory Committee on General Practice); BW Meade (National Association of Clinical Tutors); CR Lowe (Society for Social Medicine); and GA Phalp (King's Fund for London). For a brief account of the work of the Committee see Council for Postgraduate Medical and Dental Education, *An Account of the Work of the Council 1971-75* (JOF Davies). London, CPME, 1975, pp. 34-36.

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59. Faculty of Community Medicine, Specialist Training and Faculty Development in Scotland. *Faculty Newsletter* 1975; 2: No.2, 29-39.


62. Faculty of Community Medicine, Report of the Sub-Committee (chairman SL Morrison) of the Examination Committee, Minutes of the meeting of the Examination Committee held on 23 May 1977.

63. MD Warren, note 46.

64. Scottish Council for Postgraduate Medical Education, *Learning and Teaching Community Medicine*. Edinburgh, SCPME, 1979. A substantial part of the document was drafted by Helen Zealley.
65. Faculty of Community Medicine, *Specialist Training in Community Medicine*. London, FCM, 1982. Parts of the document were drafted by MD Warren.


70. AL Cochrane, Letter to Sir George Godber dated 12 October 1972 (WGH papers).


72. AL Cochrane, President's Report to the Annual General Meeting held in Edinburgh on 15 March 1974. *Faculty Newsletter* 1974; 1: No.4, 5.

73. WG Harding, Letter from the President. *Faculty Newsletter* 1976; 3: No.1, 3-5.


79. T McL Galloway, Guidelines for Faculty Assessors on Advisory Appointments Committees. Undated cyclostyled memorandum distributed by the Faculty of Community Medicine in 1974 (MDW papers).


82. WG Harding, From the President. *Faculty Newsletter* 1976; 3: No.2, 2-3.

83. D Owen (Minister of Health), letter to WG Harding. *Faculty Newsletter* 1976; 3: 3-4.

84. AS Yerby, *Community Medicine in England and Scotland: DHEW Publication No (NIH)* 76-
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85. Unit for the Study of Health Policy, Department of Community Medicine, Guy's Hospital Medical School, *Rethinking Community Medicine: Towards a Renaissance in Public Health?* London, Unit for the Study of Health Policy, 1979, pp 39 and 76-77. Members of the Study Group were R Alderslade, Debbie Bartley, Jackie Chambers, J Dennis, P Draper, Jenny Griffiths, H Knight, Helen Mair, J Partridge, Jennie Popay and Helen Zealley.


87. Faculty of Community Medicine, Community Medicine and the Community Physician. *Faculty Newsletter* 1977; 4: No.1, 84-86.


94. Between 1974 and 1982 some posts for specialists in community medicine were limited to special responsibilities and were so labelled. These included child health, social services support, information and research, and building (on the staff of a regional health authority). For descriptions of such posts see British Medical Association, *Supplementary Memorandum of Evidence to the Review Body on Doctors' and Dentists' Remuneration on Community Medicine*, May 1973, and advertisements for such posts in the *British Medical Journal* and *The Lancet*.

GF notes = Abstracts and notes from George Forwell  
WGH papers = Wilfrid Harding's papers  
MDW papers = Michael Warren's papers  
Wellcome CMAC = Wellcome Contemporary Medical Archives Centre


**TABLE 1**

**DEPARTMENTS OF SOCIAL MEDICINE IN THE UNITED KINGDOM 1965**

<table>
<thead>
<tr>
<th></th>
<th>Number of Departments</th>
<th>Hours of instruction offered</th>
<th>Number giving DPH course</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of medical</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>schools</td>
<td>F/T head</td>
<td>P/T head and</td>
</tr>
<tr>
<td>London</td>
<td>12</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Oxford and</td>
<td>2</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>Cambridge</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>English Provinces</td>
<td>7</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Wales</td>
<td>1</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Scotland</td>
<td>4</td>
<td>4</td>
<td>-</td>
</tr>
<tr>
<td>Northern Ireland</td>
<td>1</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>TOTAL</td>
<td>27</td>
<td>13</td>
<td>5</td>
</tr>
</tbody>
</table>

F/T= Full-time  
(a) London DPH course provided at the London School of Hygiene and Tropical Medicine  
P/T= Part-time  
(b) Cambridge had no clinical students

<table>
<thead>
<tr>
<th>University or Institute</th>
<th>1935-6</th>
<th>1938-9</th>
<th>1955-6</th>
<th>1958-9</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birmingham</td>
<td>N/A</td>
<td>N/A</td>
<td>No Course</td>
<td>No Course</td>
</tr>
<tr>
<td>Bristol</td>
<td>N/A</td>
<td>N/A</td>
<td>9 (3)</td>
<td>7 (6)</td>
</tr>
<tr>
<td>Durham/Newcastle</td>
<td>10</td>
<td>10</td>
<td>8 (8)</td>
<td>15 (12)</td>
</tr>
<tr>
<td>Leeds</td>
<td>10</td>
<td>5</td>
<td>12 (N/A)</td>
<td>15 (15)</td>
</tr>
<tr>
<td>Liverpool</td>
<td>13</td>
<td>12</td>
<td>20 (18)</td>
<td>19 (14)</td>
</tr>
<tr>
<td>Manchester</td>
<td>12</td>
<td>20</td>
<td>15 (15)</td>
<td>13 (13)</td>
</tr>
<tr>
<td>LSH &amp; TM</td>
<td>39</td>
<td>44</td>
<td>68 (N/A)</td>
<td>64 (14)</td>
</tr>
<tr>
<td>RIPH &amp; H</td>
<td>46</td>
<td>30</td>
<td>36 (21)</td>
<td>42 (22)</td>
</tr>
<tr>
<td>Welsh National</td>
<td>7</td>
<td>10</td>
<td>No Course</td>
<td>11 (11)</td>
</tr>
<tr>
<td>Aberdeen</td>
<td>6</td>
<td>17</td>
<td>5 (4)</td>
<td>2 (1)</td>
</tr>
<tr>
<td>Edinburgh</td>
<td>9</td>
<td>21</td>
<td>20 (8)</td>
<td>16 (4)</td>
</tr>
<tr>
<td>Glasgow</td>
<td>15</td>
<td>39</td>
<td>15 (15)</td>
<td>13 (11)</td>
</tr>
<tr>
<td>St Andrews/Dundee</td>
<td>2</td>
<td>7</td>
<td>7 (N/A)</td>
<td>9 (5)</td>
</tr>
<tr>
<td>Belfast</td>
<td>12</td>
<td>22</td>
<td>7 (5)</td>
<td>No Course</td>
</tr>
</tbody>
</table>

* Number intending to join in the UK public health service is shown in brackets

N/A = Figures not available  
LSH & TM = London School of Hygiene and Tropical Medicine  
RIPH&H = Royal Institute of Public Health and Hygiene

Source: Figures collected by the BMA in 1959, unpublished.
### TABLE 3

**ANALYSIS OF STUDENTS ON DPH COURSES 1959-1964**  
**LONDON SCHOOL OF HYGIENE AND TROPICAL MEDICINE**

<table>
<thead>
<tr>
<th>Students</th>
<th>1959-60</th>
<th>1961-62</th>
<th>1963-4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total all students:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Males</td>
<td>51</td>
<td>55</td>
<td>38</td>
</tr>
<tr>
<td>Females</td>
<td>13</td>
<td>5</td>
<td>17</td>
</tr>
<tr>
<td>TOTAL</td>
<td>64</td>
<td>60</td>
<td>55</td>
</tr>
<tr>
<td>Males: aged under 30</td>
<td>9</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>aged 30-39</td>
<td>34</td>
<td>39</td>
<td>21</td>
</tr>
<tr>
<td>aged 40 or over</td>
<td>8</td>
<td>12</td>
<td>10</td>
</tr>
<tr>
<td><strong>From the UK:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In PH or unattached</td>
<td>17</td>
<td>12</td>
<td>20</td>
</tr>
<tr>
<td>In Defence Services</td>
<td>10</td>
<td>8</td>
<td>6</td>
</tr>
<tr>
<td>Working Overseas</td>
<td>10</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>37</td>
<td>29</td>
<td>35</td>
</tr>
<tr>
<td><strong>From other nations:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asian</td>
<td>13</td>
<td>12</td>
<td>10</td>
</tr>
<tr>
<td>Continental European</td>
<td>9</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>African</td>
<td>1</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td>American (USA &amp; South)</td>
<td>4</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Australian</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>27</td>
<td>31</td>
<td>20</td>
</tr>
</tbody>
</table>

Source: Department of Public Health, London School of Hygiene and Tropical Medicine, unpublished papers.

### TABLE 4

**FINANCIAL SUPPORT AVAILABLE FROM LOCAL AUTHORITIES FOR MEDICAL OFFICERS TO ATTEND DPH COURSES 1962**

<table>
<thead>
<tr>
<th>Arrangement</th>
<th>Counties</th>
<th>County Boroughs</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>No arrangement</td>
<td>38</td>
<td>47</td>
<td></td>
</tr>
<tr>
<td>Leave with full pay</td>
<td>7</td>
<td>7</td>
<td>Usually for local part-time courses</td>
</tr>
<tr>
<td>Leave with reduced pay</td>
<td>8</td>
<td>14</td>
<td>Usually a 3 year contract</td>
</tr>
<tr>
<td>Leave with no pay</td>
<td>9</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>No information given</td>
<td>-</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>62</strong></td>
<td><strong>83</strong></td>
<td></td>
</tr>
</tbody>
</table>

TABLE 5

NUMBER AND PROPORTION OF CONSULTANTS IN THREE AGE GROUPS: ENGLAND & WALES 1978

<table>
<thead>
<tr>
<th>Age Groups in Years</th>
<th>All Ages</th>
<th>Age Groups in Years</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>40-49</td>
<td>50-59</td>
<td>60-64</td>
</tr>
<tr>
<td>All Consultants</td>
<td>11,640</td>
<td>4221</td>
<td>3595</td>
</tr>
<tr>
<td>Per Cent</td>
<td>100</td>
<td>36</td>
<td>31</td>
</tr>
<tr>
<td>Community Physicians</td>
<td>603</td>
<td>174</td>
<td>290</td>
</tr>
<tr>
<td>Per Cent</td>
<td>100</td>
<td>29</td>
<td>48</td>
</tr>
</tbody>
</table>


TABLE 6

NUMBER OF SPECIALISTS, TRAINEES AND POSTS IN COMMUNITY MEDICINE IN ENGLAND AND WALES 1975-1979

<table>
<thead>
<tr>
<th>Year</th>
<th>Community Physicians (1)</th>
<th>Trainees (2)</th>
<th>Posts</th>
</tr>
</thead>
<tbody>
<tr>
<td>1975</td>
<td>607</td>
<td>59</td>
<td>693</td>
</tr>
<tr>
<td>1976</td>
<td>610</td>
<td>76</td>
<td>738</td>
</tr>
<tr>
<td>1977</td>
<td>617</td>
<td>95</td>
<td>738</td>
</tr>
<tr>
<td>1978</td>
<td>603</td>
<td>104</td>
<td>734</td>
</tr>
<tr>
<td>1979</td>
<td>587</td>
<td>116</td>
<td>732</td>
</tr>
</tbody>
</table>

(1) Permanent appointments in the grades of regional medical officer, area medical officer, district community physician, specialist in community medicine and doctors on special salary scales.

(2) Senior registrars and registrars.

Sources: DHSS, Recruitment to Community Medicine, Part III, note 90, appendix 4.