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NO 6163 BRITISH MEDICAL JOURNAL 1979 VOLUME 1 573-640
BRITISH MEDICAL ASSOCIATION TAVISTOCK SQUARE LONDON WC1H 9JR
ASTM CODEN: BMJOAE 1 (6163) 573-640 (1979)
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We may return unduly long letters to the author for shortening so that we can offer readers as wide a selection as possible. We receive so many letters each week that we have to omit some of them. Letters must be signed personally by all their authors. We cannot acknowledge their receipt unless a stamped addressed envelope or an international reply coupon is enclosed.

Clinical medical officers in a child health service

SIR,—This urgent matter drags on, and those concerned will welcome the cogent article from Dr K Whitmore and others (27 January, p 242). It offers a way forward from the uncertainty in which the clinical medical officers have been left since the Government[1] rejected the solution proposed by the Child Health Services Committee.[2] I shall not comment on the content of their proposals, with which I am in substantial agreement, but focus on the professional principles on which any lasting solution must be based.

The clinical medical officers are clinicians, and the majority who work with children and their families paediatricians. They need two things: a career structure in whose planning they are fully involved; and training programmes, initially shared with paediatricians and general practice, which will increase their paediatric competence and raise professional status and esteem. The concept of the "generic community doctor" will not meet the needs of children today, ignores the specialist component in all medical practice, does not lend itself to rational training, and is professionally disparaging and unacceptable. Equally, the view that clinical medical officers are part of community medicine denies the present concept of that discipline as "the specialty concerned not with the treatment of individual patients, but with broad questions of health and disease in different sections of the community and in the country at large."

Yet, if the guarded statements which have emerged are true, the DHSS is conducting its conversations almost exclusively with community medicine. When I was president of the British Paediatric Association, the Faculty of Community Medicine made it clear that they wanted no further responsibility for clinicians working in the child health and school health services and implied that these were the responsibility of paediatrics. This was understandable in the light of their definition of community medicine; and the rapid demise of the Society of Community Medicine showed that they meant what they said. Yet the Central Committee for Community Medicine of the British Medical Association now proposes the reintroduction of a "clinical section," and wishes to maintain this as a "managed service" under the area medical officer and the specialist in community medicine (child health). This would establish the present tripartite service more firmly than ever and make a mockery of the Government's commitment to integration. In the meantime the clinical medical officers still wait for an acceptable career structure and training programme.

The Council for Postgraduate Medical Education is examining the training, with a member of the Association of Clinical Medical Officers on the working party: on the design of an acceptable career structure (which in a logical approach would have preceded programmes of training) the Department remains silent. I hope this indicates second thoughts. An acceptable career structure for an integrated service can be designed only by those who are genuinely involved—primarily the Association of Clinical Medical Officers, with representation from the British Paediatric Association, the Royal College of General Practitioners, the General Medical Services Committee of the British Medical Association, and the Association of Specialists in Community Medicine (Child Health).