Journal of Public Health Medicine

Vol. 19, No. 1, pp. 93–105
Printed in Great Britain

The Creation of the Faculty of Community Medicine (now the Faculty of Public Health Medicine) of the Royal Colleges of Physicians of the United Kingdom

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Summary

The National Health Service Act 1946 transferred responsibility for the non-voluntary hospitals and certain clinical services from the public health departments of counties and county boroughs to new regional hospital boards, thereby substantially reducing the functions of their medical officers of health and creating a separate cadre of doctors concerned with the planning and management of hospital and specialist services. At around the same time there was pressure to develop in each medical school a department of social and preventive medicine with full-time staff involved in research work. Reviewing the situation 20 years later, the Royal Commission on Medical Education recommended that doctors in public health, medical administration or related teaching and research should form a single professional body concerned with the assessment of specialist training for and standards of practice in 'community medicine'. Immediately after the publication of the Commission's Report in 1968, J. N. Morris invited leaders in the three strands of activities to meet and discuss the proposal. A series of informal meetings led to the setting up, in 1969, of a Working Party (chairman, J. N. Morris) which negotiated with the Royal Colleges of Physicians of Edinburgh, Glasgow and London for them to create a faculty of community medicine. In November 1970 the Colleges set up a Provisional Council (chairman, W. G. Harding), later Board, and the Faculty formally came into existence on 15 March 1972. The key decisions and some of the complications and hitches encountered in achieving this radical outcome are described in this paper.

Keywords: community medicine, public health, medical administration, social medicine

Background

Introduction

'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.' So said the Royal Commissioners in their report on medical education in April 1968.[1] Just one month short of four years later, on 15 March 1972, the Faculty of Community Medicine came into existence. Two questions arise from these events: Why were 'all the interests' separate in 1968? And, how did the Faculty emerge so quickly to take on the tasks outlined by the Royal Commissioners?

Changes in health services provided by local government

The National Health Service Act 1946 assigned many of the responsibilities of medical officers of health (MOsH) of county boroughs and county councils to the newly created regional hospital boards (RHBs) with a new cadre of senior administrative medical officers (SAMOs) and their medical staff. The transferred responsibilities included the municipal general hospitals (responsibility for which had been given to local authorities under the Local Government Act 1929), infectious diseases (isolation) hospitals, maternity hospitals and the tuberculosis and venereal disease services.[2]

In 1946 the views of MOsH about the transfer of hospitals were divided, as had been the case in 1930 when MOsH took over the municipal and county general hospitals. Sir George Newman, chief medical officer at the Ministry of Health, referred in his annual report for 1928 to the great opportunities becoming available to local authorities to improve their extended 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.'[3] However, not all MOsH were enthusiastic about the increase in their duties. 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

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preventive work.'[4] 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'.[5] In tune with this observation, some MOsH saw the changes introduced in 1948 as providing an opportunity for extending their preventive and health promotional activities and in coordinating preventive and curative services.[6] However, a few years later, in giving evidence to a government enquiry into the cost of the National Health Service (NHS), the Society of Medical Officers of Health stated that the local health authorities' services had suffered so much in status and prestige under the NHS that their medical staff had greatly degenerated both in quantity and quality, and that they felt there was no real future for them in local government.[7] Pessimism among many MOsH and poor recruitment of medical staff persisted despite some outstanding developments in collaboration with general practice and in services for mentally handicapped people (to use the term of the time), disabled people and frail, elderly and often isolated people,[8] services which were later transferred to local social services departments. Some MOsH saw the future in combining the three branches of the NHS within a reformed local government structure,[9] others considered that the health service should be unified outside local government.[10]

At the time of the twentieth anniversary of the NHS in 1968 the debate was no longer about whether there should be changes in the structure of the NHS and the duties and location of MOsH, it was about the detail of the changes. Change was seen as inevitable.[11] In July 1968 the Seebohm Committee on the future of the personal social services, of which Professor J. N. Morris (Professor of Community Health and Director of the MRC Social Medicine Unit at the London School of Hygiene and Tropical Medicine) was a member, reported.[12] It foresaw that a consequence of its proposals to set up social services departments within local government would be a substantial reduction in the staff, budgets and interests of local health departments. 'The critical question', the Report stated, 'is whether the local health and school health department which remains after our proposed changes could be a viable working unit... 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 since 1948... 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.'[13] Earlier in the year, the Royal Commission on Medical Education had reported and had recommended a formal structure for the training of consultants in all the specialties, including community medicine.[14] In 1969 the Royal Commissions on Local Government in England and in Scotland reported recommending widespread changes.[15]

In the same month that the Seebohm Committee reported the Ministry of Health issued a 'Green Paper', which was followed by another in 1970 and a 'Consultative Document' in 1971. All these documents proposed changes in the structure and management of the NHS.[16] Similar papers were published in regard to the NHS in Scotland, Wales and Northern Ireland. This intensive period of reviews, reports and consultations led eventually to the creation of social services departments in local government in 1971, and in 1974 to the reorganization of the NHS and of local government.[17]

The office of medical officer of health within local government ceased to exist in 1974, two years after the creation of the Faculty. New posts of regional and area medical officers and of district community physicians in England and of chief administrative medical officers and specialists in community medicine in Scotland were set up. In England their duties were outlined in detail, with the emphasis on management functions,[18] but they were stated more broadly in Scotland.[19] All who were to become the new men and women in community medicine had to apply for new posts within the reorganized service and prepare to take on new tasks and responsibilities.[20] The Faculty was created during this period of radical change.

Medical administration and the hospital services

The SAMOs and their staff were concerned with the planning, organization and medical staffing of the hospital and specialist services.[21] Half of the first SAMOs appointed were doctors from the public health service.[22] By 1960 the SAMOs were experiencing difficulty in recruiting their medical staff at regional headquarters, and there was no pattern of training or postgraduate qualification in medical administration other than the courses for the DPH.[23]

Teaching and research

The third group whose work was to be embraced within the new specialty was the doctors working in academic departments and research units in the medical schools and universities. Until the 1950s teaching public health to medical students was most commonly done by the local (or nearby) MOH or a senior member of his department. In 1938 in five of the seven provincial medical schools in England and in the Welsh school the local MOH was also the professor of public health or had a similar title; in the other two English provincial schools and in Aberdeen and Dundee the local MOH was head of the department of public health in the medical school but was not a professor. Most of the departments, at that time, ran courses for a postgraduate diploma in public health in addition to teaching the undergraduate students.

In ten of the twelve London medical schools courses of lectures in 'hygiene and public health' were given by senior medical staff, none with the title of professor, from central or local government. At the other two, staff from the London School of Hygiene and Tropical Medicine, the only school in London to offer a university diploma course, gave the

lectures.[24] In Edinburgh and in Glasgow there was a full-time professor of public health.[25]

From the beginning of the twentieth century there was concern (except, apparently, among senior staff in the medical schools) about the quality and quantity of the teaching of public health. In 1907 a leading article in *The Lancet* deplored the lack of support given to the subject in some of the medical schools and the lack of coordination of public health teaching with other subjects. It recommended the appointment of lecturers who have 'made a study of preventive medicine rather than of administration and law'.[26] These points were repeated by Jameson in 1928, just after his appointment as the first professor of public health at the newly opened London School of Hygiene and Tropical Medicine,[27] and by Sir George Newman in 1931.[28]

Social and preventive medicine

In 1939 a Committee for the Study of Social Medicine was set up at University College Hospital, London, which included among its members J. N. Morris, R. M. Titmuss, M. Rosenheim and P. M. D'Arcy Hart.[29] Three years later the Royal College of Physicians of London set up a committee, with D'Arcy Hart as a member, to 'consider the subject of social and preventive medicine and to make recommendations for its development'. The Committee's report in 1943 recommended that every medical school should establish a department of social and preventive medicine with a full-time professor and should undertake research.[30] These recommendations were endorsed a year later by the report of the influential committee on medical schools chaired by Sir William Goodenough. This Committee considered that teachers holding 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.[31]

The events envisaged by these committees gradually occurred, although in reviewing the situation in 1953 the re-convened committee of the Royal College, while finding that there had been expansion and changes in the content of teaching in most of the provincial schools, was disappointed with the situation in London. The Committee considered that there was little, if any, research carried out in departments which were not headed by a whole-time professor;[32] a view it repeated in a further report in 1966 after reviewing the findings of an inquiry carried out by the Society for Social Medicine and its own investigations.[33]

Specialist education and training[34]

Not only was there long-standing concern about the teaching of public health to undergraduate medical students, but also there was dissatisfaction about the training for doctors entering careers in public health. In 1889 the General Medical Council (GMC) for the first time set out its requirements for the registration of diplomas in public health, the holding of such diplomas having been made obligatory in the preceding year for appointment to the post of MOH of a county, large district or combination of districts.[35] The GMC set guidelines but did not set a national examination; it approved courses and examinations provided by universities and other institutions and examining bodies. Within a few years it was felt that the requirements of the GMC were failing to establish uniform standards of examination or of the quality of training offered.[36] The GMC responded by adding considerable detail to the curriculum it required to be taught.[37] However, despite periodic reviews and adjustments, the required curriculum did not adequately reflect changes in practice, and too often it became a restraint on the development of courses and an irritation to the students.[38]

The 'Rules' of the GMC had the effect of over-emphasizing the examination at the cost of a lack of in-depth study, the development of habits of precise enquiry and of experiential learning. Not all of the blame can be attributed to the GMC's requirements, for similar criticisms were made during the 1950s and early 1960s about public health courses in Europe and the United States.[39] There were three recurring themes in these criticisms: insufficient attention to public health–medical administration; lack of the use of statistical and epidemiological data in planning, management and evaluation; and the lack of supervised field experience in public health practice analogous to the clinical experience gained by trainees in other specialties.

In the United Kingdom special courses on medical administration were introduced in Edinburgh and London,[40] and in the mid-1960s new courses replaced the DPH courses at Edinburgh, London and Manchester, which introduced an additional year (or the equivalent) of supervised experiential learning for all the students in London and for some in the other two universities.[41] Both the Royal Commission on Medical Education and the GMC endorsed these developments.[42]

The Royal Commission recommended a general structure for postgraduate medical education and training with a central body to exercise oversight and ensure that effective professional training schemes existed for each specialty in each region and that the schemes were effectively assessed. It recommended that training for community medicine should come within the national scheme;[43] this led to the recommendation about the need for a professional body quoted at the beginning of this paper. A central body, the Central Committee for Postgraduate Medical Education, had been formed in 1967 on the lines later to be recommended by the Royal Commission. The Central Committee became in effect the Central Council in 1970 and worked in conjunction with the Joint Higher Specialist Training Committees set up by the Colleges, Faculties and specialty associations, and with the regional training deans and training committees.[44] On its formation the Faculty of Community Medicine became part of the Joint Committee on Higher Medical Training (JCHMT) and was recognized as the Specialty Advisory Committee (SAC) on training in community medicine.

Bringing the specialist training for community medicine within the arrangements supported by the NHS resolved another long-standing obstacle to recruitment to the specialty.

Until the changes introduced by the reorganization of the NHS in 1974 there was no national system for financially supporting postgraduate students attending basic public health courses. Some students from overseas and from the British Defence Services were paid their normal salaries while studying, and some had grants from various international agencies. The commonest sources of help available to British students intending a career in the public health services were various appointments, usually limited to three years, working in local authority child health clinics and the school health service. During such an appointment the person attended a DPH course, either full time or part time, and was paid a salary composed of the total of the normal rate for the time the doctor actually worked for the authority paid evenly over the three years. Not all authorities had such schemes or their equivalent, and those without such schemes 'poached' the trained doctors from the authorities with the schemes. This thoroughly unsatisfactory situation was partially alleviated when the Department of Health and Social Security (DHSS) and the Scottish Home and Health Department (SHHD) introduced in the late 1960s bursaries and fellowships for some students attending the new courses in London and Edinburgh.

Defining community medicine

The term 'community medicine' was used in the reports of the Royal Commission on Medical Education and of the Seebohm Committee. The Royal Commission did not define the term but stated that 'in the sense we use the term, community medicine is the specialty practised by epidemiologists and by administrators of medical services... and by the staffs of the corresponding academic departments. It is concerned not with the treatment of individual patients but with the broad questions of health and disease....'[45]

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 Medical School of Hygiene and Public Health in 1969. Morris presented a visionary view of the role based firmly on the principles of epidemiology. He saw the community physician as epidemiologist, community counsellor and administrator of local medical and health 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 troublemaker... 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 services that history happens to have deposited in his office.'[46]

Negotiations

Early discussions

During 1966 Morris had numerous informal discussions with individual MOsH, SAMOs, colleagues in academic departments and research units, senior government officers and others. He found considerable support for the idea of creating a single body which would provide a strong and independent voice for public health in medicine and an input into health and social policies. Sir Max (later Lord) Rosenheim (Professor of Medicine, University College, London, and President of the Royal College of Physicians of London 1966–1972) suggested in discussions with Morris that any development along these lines might be associated with the Royal Colleges. Morris had reservations about this idea because of the inevitable constraints that would be entailed, although he realized that at that time a proposal for a free-standing college of public health would not attract sufficient support for its realization.[47] Another leading person among those with whom Morris had informal discussions was Dr W. G. Harding (then the MOH of the London Borough of Camden and chairman of the Council of the Society of Medical Officers of Health), who, in turn, discussed 'possible developments' with colleagues in the Society and with Rosenheim. Harding strongly supported the suggestion that the development should be linked to the Royal Colleges, largely because this would put community medicine on a level equivalent to that of the clinical specialties.[48]

Immediately after the publication of the report of the Royal Commission on Medical Education, in April 1968, Morris wrote to the chairmen of the Council of the Society of MOsH,[49] of the meeting of the SAMOs,[50] of the Committee of the Society for Social Medicine (SSM)[51] and of the Scottish Association of Medical Administrators (SAMA)[52] and the chief medical officers of the Ministry of Health and the Scottish Home and Health Department inviting them or their representatives to a meeting at the London School of Hygiene and Tropical Medicine to consider the recommendation of the Royal Commission quoted at the beginning of this paper.

For various reasons the meeting did not take place until October. At the meeting, chaired by Dr E. T. C. Spooner (Dean of the School), it was unanimously agreed that the subjects basic to the work of the members of the groups present formed an academic unity; that there was an urgent need for a single professional body to take responsibility for formulating training schedules and maintaining standards in the specialty; and that, if possible, such a body should be set up under the aegis of the Royal Colleges of Physicians.[53] Three issues remained unresolved. These were the name of the proposed body and specialty; the exclusion of clinical medical officers in the public health services and of non-medical scientists within the foundation membership of the proposed body; and the effects that the creation of the new body might have on existing organizations and their memberships.

After further meetings of the informal group and meetings between individuals, in particular Morris, Rosenheim, Harding and Professor W. R. S. Doll (Regius Professor of Medicine at Oxford University), a document setting out the proposals of the group was agreed at a meeting in February 1969.[54]

Formal involvement of the Royal Colleges of Physicians

During the same month Rosenheim took the opportunity of a joint meeting between the presidents of the Royal Colleges of Physicians to tell the other two presidents and their colleagues of his informal contacts with Morris's group and with individual members of it. The Scottish Colleges informed him that they had received a request from the SAMA for it to be affiliated to their Colleges. Subsequently, Rosenheim invited Morris and a few of his colleagues to meet the presidents and representatives of the three Royal Colleges to discuss 'how best our Colleges could help your aspirations'.[55] The meeting took place on 1 May, when possibilities were explored informally. Rosenheim reported at some length to Comitia of the London College. He said 'it would be a tragedy if those engaged in social or community medicine broke away from the main body of medicine'. Comitia approved the setting up of a working party in conjunction with the Scottish Colleges.[56] The presidents of the Scottish Colleges reported to their respective Councils. At the June meeting of the Joint Committee of the Colleges it was agreed that each College would appoint two members to a working party which would meet the following September to discuss details of setting up a Faculty.[57] The Scottish Colleges agreed to defer any decision about affiliating the SAMA, but would ensure that representatives of the Association would be involved in the proposed discussions.

The working party representing 'community medicine'

When informing Morris of the decision of the Joint Committee, 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 [1969] the two working parties might meet and exchange views'.[58] Morris and Harding were disappointed with the suggestion of a separate working party for those representing community medicine, having expected that there would be only one working party with representatives from the Colleges and from community medicine. At a meeting of Morris's Informal Group it was reluctantly accepted that there would have to be two working parties.[59] A letter was sent over the signatures of Harding, Morris and others to the secretaries of the bodies represented on the Informal Group and to the chief medical officers. The letter set out the position in regard to forming a faculty of the three Royal Colleges and invited the organizations to nominate delegates and deputies to form an official working party. It was accepted that the nominees would not have authority to commit their organizations to any final decisions about the proposals.[60]

The Working Party elected Morris as chairman. It met nine times between October 1969 and November 1970.[61] Its task was to add detail to the outline proposal which the informal group had drawn up. At its first meeting it was decided that it would be inappropriate for the organizations involved to amalgamate. A new body should be formed without prejudice to the future of existing bodies.

Issues debated at length at various meetings were the criteria for foundation membership of the proposed faculty; admission of members who were not medically qualified; whether there should be two classes of membership (members and fellows); relationships with the Royal Colleges, including the election of members of the Faculty to fellowships of the Colleges; and the name of the Faculty and the specialty.

The final draft of a document, referred to as 'The Proposal', set out the views of the Working Party on the main points. The Proposal stated that 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 organization responsible for standards in the training and practice of community medicine.

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 United Kingdom 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.

The Faculty was to function as a professionally independent body within the three Royal Colleges, governed by a Council which would contain a representative from each College.

Meetings with the Royal Colleges

A copy of 'The Proposal' was sent to the President of each of the Colleges at the end of 1969. Early in January 1970 Morris wrote to each president setting out some additional issues that the Working Party wanted to discuss at the forthcoming meeting with them. The issues included the election of members of the Faculty directly to fellowships of the Royal Colleges, thereby accepting the equivalence of the membership of the Faculty to the MRCP (UK) and enabling members of the Faculty to participate in the meetings of the Colleges' decision-making machinery. Another issue was the need for the Provisional Council of the Faculty to have powers to admit to foundation membership some applicants who, although

eligible by seniority of their appointment and their experience, lacked a 'relevant' postgraduate qualification.[62]

Representatives of the Working Party met the representatives of the Royal Colleges later in January. The Proposal was approved in principle with only some minor amendments. The Colleges' representatives stated that they would look at the question of direct election to their fellowships in relation to their Charters and by-laws. The Joint Committee of the three Royal Colleges met in February, approved the decisions of their representatives and subsequently each College sought the formal agreement of its governing body.

There was a further meeting between the representatives of the Working Party and the Colleges in July, when agreement was reached about the constitution and powers of the Provisional Council of the Faculty which would be set up by the Colleges. In regard to the election of members of the Faculty to College fellowships the Colleges intimated that members of the Faculty would be eligible for election to membership of a College without examination via the present by-laws, which would be generously applied, and then in the ordinary way proceed to election to fellowship. The Colleges' representatives stated that membership of 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 procedures could be considered. Rosenheim suggested that this might be a matter of 7–10 years. The representatives of the Working Party expressed serious disappointment at what they felt was a major change on the part of the Colleges, certainly as far as the London College was concerned. The question of a two-tier system of members and fellows within the Faculty was raised and referred to the Provisional Council.[63]

The disagreement about the equivalence of the proposed MFCM and the established MRCP (UK) became a major issue between the two parties. Morris met Rosenheim on 14 August and emphasized the importance that the Working Party attached to the issue. Nominees for a college fellowship, he pointed out, 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.

The Working Party met in September and expressed grave disappointment over the matter. It decided that the proposals from the Colleges could not be recommended to its constituent organizations, nor could it recommend them proceeding with the appointment of representatives on the Provisional Council. Later in September Morris and Harding persuaded Rosenheim to ask the Colleges to review the situation.

The matter was discussed at length at the October meeting of Comitia of the London College. The meeting agreed by a very large majority that the College could not see its way to altering its Charter and by-laws to permit the direct election of members of the Faculty to its fellowship until the Faculty's membership examination had been established and seen to be as demanding and rigorous as the MRCP (UK).[64] The Edinburgh and Glasgow Colleges also reaffirmed their positions. (In 1985, 15 years later, after completing the necessary amendments to their Charters and by-laws the Colleges directly elected members of the Faculty to their fellowship.)

The Working Party met for the last time in November 1970. It agreed, notwithstanding its disappointment with the decisions of the Colleges, to go ahead with the setting up of a Provisional Council, leaving further negotiations on outstanding matters to be continued by the new body.[65]

Concerns of the Society for Social Medicine

Until the governing bodies of the Royal Colleges had approved the proposals for a joint faculty, members of the Working Party were only able to report back to their nominating bodies in general terms. During the discussions about election to a college fellowship, members of the Working Party agreed to report to their organization only that 'negotiations were at an extremely delicate stage'. The Committee of the SSM decided at its meeting in December 1969 that it should inform all members of the Society about the general position and assure them that no commitments in regard to establishing a faculty would be made until the whole Society had had an opportunity to examine the proposals in detail at an Extraordinary General Meeting (EGM) which would be held in June 1970.[66] At that meeting 'The Proposal', copies of which had been sent out with the agenda, was approved. There were objections from some members about the proposed name (community medicine), the exclusion of scientists without a medical qualification (particularly statisticians and social scientists) from membership, and the replacement of approved university degrees and diplomas by the Faculty's membership examination as the recognized gateway to the specialty.

At the EGM the results of a survey of members' opinions about the proposed faculty were presented. The survey had been carried out before members had seen a copy of The Proposal. Of the 214 members of the Society, 198 (93 per cent) responded, of whom 75 per cent were medically qualified, 82 per cent were male and the same proportion worked in university departments or research units. Sixty-seven per cent of the respondents supported the formation of a faculty, 46 per cent preferred community medicine as its name and 38 per cent preferred social medicine. Seventy-five per cent favoured the inclusion of non-medical scientists in the faculty's membership provided the faculty set training requirements for them, and 60 per cent if this was not done.[67]

The proposal to create a faculty was considered again by the members of the Society at its Annual General Meeting (AGM) the following September, the day after Morris and Harding had met Rosenheim about the fellowship issue. Morris reported to the Society that, owing to holidays, little progress had been made since the meeting in June and, in accordance with the decision of the Working Party, he said that discussions were now mainly concerned with confidential matters. The AGM called for a further meeting to be held when the nature and

content of the confidential matters could be discussed.[68] After the AGM Doll resigned as one of the Society's nominees on the Working Party.

At a further EGM, in January 1971 and attended by 53 members of the Society, Morris summarized the negotiations that had taken place and, in particular, the issue of direct election to a College fellowship. He pointed out that the Colleges were ruled by their fellows so that there was a danger of the new faculty losing independence to the Colleges without obtaining compensating power to influence their decisions and policy. The question of forming a separate college was raised, but Morris, Doll and Lowe thought that it was extremely unlikely that the other organizations would agree as they were anxious to get on and form the Provisional Council. Members present voted to reject the current terms offered and to seek to negotiate directly with the Colleges.[69]

Professor E. G. Knox (Professor of Social Medicine, University of Birmingham), who had replaced Professor H. Campbell (Professor of Medical Statistics, Welsh National School of Medicine) as chairman of the Committee of the Society, wrote to Rosenheim asking him to meet representatives of the Society and stating that meanwhile the Society was unable to participate in a 'Provisional Council which has the implementation of present proposals as its basis'.

Rosenheim and Harding were surprised and disconcerted at this request from the Society. Rosenheim replied that he and representatives from the Royal Colleges would meet representatives from the Society on the morning before the first meeting of the Provisional Council arranged for 19 February. After the meeting, at which the Colleges' representatives reiterated their position, Rosenheim wrote to Knox concluding his letter that '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.'[70]

The Society's representatives reported back to its Committee and in discussion further doubts were expressed about a possible link between membership of the Faculty and specialist registration so that those who entered social medicine through clinical medicine and research (i.e. through MRCP and Ph.D.) instead of through membership of the Faculty might be excluded from specialist registration. Related to this was the doubt of some senior academic members of the Society as to whether it was possible to create a pattern of training which could embrace the range of people coming together under the umbrella of community medicine. Professor T. Anderson (Professor of Public Health, Glasgow University), a member of the Society's Committee and representative of the Glasgow Royal College on the Provincial Council, considered the Society's stance was confused and counter-productive, and thought that the issues could and should be discussed within the Executive Committee of the Provisional Council of the Faculty.[71]

In March, Knox, Cochrane and McKeown, from the Society, met members of the Executive Committee. Before the meeting Knox sent a memorandum[72] to the chairman of the Provisional Council (Harding) setting out the reservations of the Society and adding that the Society wished to reopen discussions on the name of the Faculty, the criteria for foundation membership and the admission of scientists without a medical qualification to membership. At the meeting, Harding emphasized that places remained available for nominees of the Society on the Provisional Council and that the replacement of the Working Party by the Provisional Council did not imply that all the major issues were settled. He reassured the Society's representatives on a number of points; but he stressed that each member of the Provisional Council was regarded as a member in his or her own right and was not answerable to the nominating body.[73]

Subsequently, the Committee of the Society agreed to recommend the nomination of members to the Provisional Council and arranged for a postal ballot on the issue of all the members of the Society. The result was that 95 per cent of the members voting were in favour of the Committee's recommendation.[74] Morris asked to be excused from nomination to the Council as his commitments were increasing and he felt that he had done 'his fair share in getting the Faculty off the ground'.[75] The Committee's decision was endorsed at the next AGM.[76]

Name of the specialty and Faculty

The suitability of the term 'community medicine' as the name of the specialty and of the proposed Faculty was periodically questioned on the grounds that the term was increasingly used to refer to general practice or primary medical care. At one stage, the Society for Social Medicine proposed the term 'population medicine' but this was dismissed as it would soon have become shortened to 'pop medicine'. 'Medical administration' was favoured by some, and was implied in the title of a report on the specialty published a few months after the inauguration of the Faculty,[77] but this term was unacceptable as it conveyed nothing of the activities of preventive medicine and the promotion of the health of the community. 'Social medicine' was favoured by a group representing the heads of academic departments and research units,[78] but the term had led to confusion in the past and still had its detractors. It was generally agreed that 'public health' should be avoided in the title as it was identified closely with one of the groups involved (the Society of MOsH) and was associated particularly with the work of the public health inspectors (previously called sanitary inspectors and later environmental health officers). 'Community medicine' had been used by the Royal Commission in proposing the formation of a professional body, and eventually this term was accepted by the Working Party as a compromise which avoided close identification with any one of its constituent bodies.[79] (In 1989 the name of the specialty and the Faculty was changed to 'public health medicine'.)

Scientists without a medical qualification

Another recurring issue in the negotiations was the inclusion in the membership of the proposed Faculty of scientists specializing in subjects related to practice, teaching and research in community medicine, such as statisticians, epidemiologists, medical sociologists, economists and scientists concerned with social policies. Morris's Informal Group accepted, but with reluctance on the part of some members, that difficulties would arise if it was proposed to include members without a medical qualification, except for the election to honorary membership of those who had made outstanding contributions to the subject or its practice. Despite returning to this matter from time to time the decision was not changed by the Working Party or the Provisional Council.

Provisional Council[80]

The first meeting of the Provisional Council was held in February 1971. Harding was elected chairman and at the next meeting in May he was elected chairman of the Executive Committee. The representatives of the SSM did not attend either of the first two meetings of the Council although they had been invited to attend the second meeting as observers. The main tasks of the Council (the name was later changed to the Board) were to draw up a constitution for the proposed Faculty, set up arrangements for the Faculty's continuing financial support and administration, recommend a list of foundation members to the Royal Colleges, and outline proposals for the future entry of members by examination.

The London College initially funded the work of the Provisional Council and provided accommodation for its meetings and those of its committees and, later, for staff. G. M. G. Tibbs (Secretary of the London College) was Secretary of the Provisional Council, and of the Faculty during its first few weeks.

Accreditation

The Executive Committee appointed an Accreditation Committee in May 1971 with Dr T. McL. Galloway [County Medical Officer, West Sussex, later Area Medical Officer, Hampshire AHA(T)] as chairman. The Committee produced detailed criteria for the election of applicants to foundation membership, reviewed all applications and made recommendations to the Council about their suitability for election.

In October 1971 the Presidents of the three Royal Colleges announced the proposal to form the Faculty[81] and applications for foundation membership were invited.[82] The criteria for membership were similar to those which had been agreed by the Colleges and the Working Party (see above), but added to these was the statement that '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'.

By the end of 1971, 1400 applications had been received. At the inauguration of the Faculty in March 1972 about 900 foundation members were elected, of whom 144 were elected as fellows. Foundation membership remained available until December 1973, by which time more than 3000 applications had been received, of which 2073 were accepted.

Membership examination and training programmes

The Provisional Council appointed an Education Committee in May 1971 with Anderson as chairman. The committee had three major tasks:

1. to indicate the content of and procedures for the examination for membership of the Faculty, bearing in mind the undertakings made to the Colleges about its standards and the varying career interests of likely applicants;
2. to develop programmes of specialist training acceptable to the Joint Committee on Higher Medical Training and the Council for Postgraduate Medical Education;
3. to advise the Department of Health and Social Security and others on the preparation of doctors in public health and medical administration for their new roles within the proposed reorganized NHS.

The Education Committee prepared a memorandum which was circulated for comment to members attending the Faculty's Inaugural Meeting. The core subjects of the examination, it stated, should be epidemiology, statistics, social sciences in relation to community medicine, and management. It was suggested that the examination should be divided into two parts. The first part would be concerned with the core subjects and could be by means of papers and oral examination. The second part should be designed to allow a candidate to concentrate on one or more of the subjects included within community medicine. The presentation of a report or a series of shorter reports together with an oral examination could form the basis of assessment. For younger candidates, passing the membership examination should signify the completion of the preliminary period of training, and this should be followed by a period during which the skills and knowledge are applied under supervision. The memorandum emphasized that any system of education and training and its assessment needed continuous appraisal and adaptation to developments and changes.[83]

(The first examination was held in November 1974 and in the same month the Faculty, in its role as the appropriate Specialist Advisory Committee of the JCHMT, set out its recommendations for 'Early specialist training and higher specialist training'.[84])

Inaugural meeting

The Faculty was inaugurated by the three Royal Colleges of Physicians at the London College on 15 March 1972 with Lord Rosenheim in the chair. The foundation fellows and members were elected; A. L. Cochrane and W. G. Harding were elected

as President and Vice-President, and T. McL. Galloway, M. D. Warren and F. J. Fowler were appointed as Registrar, Academic Registrar and Treasurer, respectively. Lord Rosenheim, Dr J. Halliday Croom and Professor E. M. McGirr (presidents of the Royal Colleges) were elected fellows of the Faculty.[85] The meeting was followed by a reception in the London College which was attended by the Secretary of State for Social Services, Sir Keith Joseph.

The mission (to use a currently fashionable word) of the new Faculty was to develop, through education, training and the maintenance of standards of practice, the contribution of community medicine to improving the health of the population and to the management of health services. In the words of a directive sent to medical officers of health over 100 years previously, their duties were to inform the authorities '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.'[86]

All this was to be achieved within a scenario of restructuring the NHS (which was experiencing increasing financial restrictions), change in the organization of specialist medical training, and change in the content of the work (and for some in the residence) of the senior people in the specialty.

This paper is based on a fuller account of the events leading up to the recommendation for a professional body, of the negotiations for the Faculty and of some of the main activities in establishing its reputation. The full account contains transcripts of some of the major documents relating to the creation of the Faculty. Copies of the full account, entitled *The genesis of the Faculty of Community Medicine*, published by the Centre for Health Services Studies, University of Kent, Canterbury CT2 7NF, are available (price £10, including postage and packing) from the Centre.

Acknowledgements

I am very grateful to Dr G. D. Forwell, CBE, Dr W. G. Harding, CBE, and Professor J. N. Morris, CBE, for their helpful comments on a draft of this paper; to the registrar and secretaries of the Royal Colleges of Physicians for the permission to refer to the minutes of council and comitia meetings; and to Penny Gwynne for her secretarial help.

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50 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, before 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). In the late 1960s there were 113 medical officers in addition to the 15 SAMOs on the headquarters staff of the boards. The 'officers' of the SAMOs' meetings in 1969 were J Revans (chairman), RHM Stewart (vice-chairman) and TA Ramsay (secretary).

51 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 whom 23 were non-medical, seven were employed in public health departments and two in regional hospital boards. 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

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Accepted on 2 October 1996