Michael O'Brien and colleagues is not unique to England.[1] On behalf of the Scottish affairs committee of the Faculty of Public Health Medicine we examined the future role of public health medicine in communicable diseases and environmental health in Scotland.[2] Our remit was to produce a document that the specialty could use as a basis for discussion with other interested bodies. The work had some urgency as the "market" in health care is just beginning to take effect in Scotland and radical changes (reform of local government and the creation of the Scottish Environmental Protection Agency) are being proposed, which may influence the ability of our coworkers in local government to support such activities.

The problems highlighted were virtually identical with those in England apart from those associated with notifiable diseases. In Scotland notification is to the chief administrative medical officer of the health board. The Scottish schedule of diseases has been modified recently and is paralleled by the system of reportable infections based on voluntary reporting by laboratories. Our report also noted the need to enhance skill in the surveillance of environmental hazards. To control both infections and environmental hazards it is important to establish a system with sufficient staff to promote skill and prevent isolation without losing valuable local knowledge and relationships. Several options for the future were identified and three highlighted as meriting further examination —namely, modification of the status quo, a Scottish communicable disease control and environmental health agency, and a Scottish public health (all functions) agency.

We believe that the present system requires modification to avoid confusion over responsibilities and powers, to ensure national standards for surveillance and control of environmental and infectious hazards, and to make resourcing explicit. The possible requirement for legislation to facilitate these changes must not be a reason for inaction. All professional groups with an interest in the public health aspects of infection and environmental hazards must enter into dialogue urgently to produce a model that will serve the nation into the twenty first century.

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Misfits in the new NHS

EDITOR,—J Michael O'Brien and colleagues' pleas for a system designed to cope with communicable diseases rather than with a "market" are important.[1] Unfortunately, they are unlikely to find favour with a government that wants district health authorities to be led by a new breed of chairman and non-executive members specifically chosen for their skills in purchasing.[2] Furthermore, unlike with surgery, there is little customer demand for control of communicable disease—until there is an outbreak of some infection.

Legislation alone is unlikely to be the answer to effective control of communicable diseases as laws need to take account of harmonisation of procedures for controlling infection and hygiene measures in the European Community. Recent legislation concerning the inspection of food entering the United Kingdom from other countries in the European Community has complicated rather than simplified the work of environmental health officers. Countries in the European Community that lack systems for controlling communicable disease comparable to those in the United Kingdom are more likely to persuade the United Kingdom to change its system than to introduce one for their own citizens.

O'Brien and colleagues' suggestion that there should be a nationally managed service for controlling communicable disease will help settle the quandary in which consultants in communicable disease find themselves. They do not fit neatly into either the commissioner or provider role. They have no one to commission services from, and they provide a service based more in the community than in hospitals. Ideologues in the health service are irritated by this quandary and, rather than accept that in any system there are anomalies, may prefer to abolish the post of consultant in communicable disease, tempting fate even further.

Together with legislation and new systems should come leadership from consultants entrusted with controlling communicable disease: they should show solidarity with their colleagues, set standards for their work, and ensure that there is public access to their knowledge and services. They could learn the skills of marketing tycoons and create a demand for their services by making clear their success in preventing the spread of infection in the community.

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Compulsory removal powers inappropriate

EDITOR,—J Michael O'Brien and colleagues provide a succinct analysis of the current problems associated with the control of communicable diseases.[1] I support the recommendations that the authors make to ensure that our duty is effectively discharged. In addition, I would like to see an end to the powers given to the medical officer of health (now the consultant in communicable disease control) under section 47 of the National Assistance Act (1948) to enable compulsory removal of a person who fulfils certain criteria from his or her home to suitable accommodation.

The problems with section 47 have been well documented[2,3]; it is the view of many consultants in communicable disease control that we have neither the skills nor the training to assess properly the patients for whom all other efforts have failed and compulsory removal is considered to be the last resort. The number of times the act is implemented may be small, but this does not reflect the number of referrals, some of which necessitate lengthy discussion with many different agencies and visits to the person concerned. Geriatricians and psychiatrists are, I suggest, much better placed to carry out these assessments.

I share the authors' concern about the establishment of mainly part time posts for communicable disease control and agree that the specialty continues to be marginalised by health authorities. This is becoming even more of a problem with the strong emphasis currently placed on purchasing and on districts' responses to *The Health of the Nation*. Welcome opportunities are afforded by both, but with the relatively small numbers of staff in public health departments the workload of consultants in communicable disease control is increasing at the expense of communicable disease control.

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Tuberculosis screening falls foul of reforms

EDITOR,—One important infectious disease not mentioned in J Michael O'Brien and colleagues' article on the control of communicable disease in England[1] is tuberculosis, which is currently increasing in many countries, including Britain.

My experience of a problem arising as a result of the reorganisation of the NHS may be of interest. Two weeks ago a chest clinic at which I screened contacts of patients with tuberculosis was closed. Three quarters of the patients seen at that clinic came from a relatively small area of Liverpool close to trust hospital A. Despite specific overtures by the purchasers to move the screening clinic to this hospital after closure of the chest clinic the hospital decided not to contract for these services. Trust hospital B has agreed to provide a clinic for these services in principle. This hospital, however, is almost 5 km—and at least two bus journeys—from the greatest concentration of potential patients and contacts. Thus a high proportion of contacts and patients will probably default.

At the moment negotiations are under way between purchasers and other potential sites for the clinic. But the ability of a trust hospital to remain aloof from the clinical requirements of the community in which it is based—which it is perfectly free to do since the recent reorganisation of the NHS—has left purchasers and community alike with a potential problem that should never have arisen.

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Departments of microbiology are central to control of infection

EDITOR,—J Michael O'Brien and colleagues' article on the control of communicable disease in England[1] is a valuable attempt to arouse medical and managerial interest in a subject that receives great political and public attention only when things go wrong and outbreaks occur. Between these high profile events the current unsatisfactory situation is allowed to continue, seemingly because the health service is distracted by more pressing problems.

Two attempts have been made to improve control of infection in the community. In the first, proposals for reforming the laws on communicable disease are being considered. This has proved to be a slow process since no single agency is responsible for applying these laws. In the second, the post of consultant for communicable disease control has been created in response to the Acheson report,[2]