Editorial

WHITHER PREVENTIVE MEDICINE ?

All family doctors must feel proud that so many of the aims for which the College was founded have already been achieved. Undergraduates are being taken into general practice and shown wha goes on there, and many postgraduate courses of a kind suited to the general practitioner are being organized. These benefits to the doctor are passed on to the patient, and we may hope that, in the not too distant future, the country will gain in health and well-being. But our work must not stop here. We must continue to direct our efforts to the prevention of disease and accident. That prevention of disease has to be practised in the environment of the people is evident enough. The term " public health " is significant; *Medizinischen Polizey* of Frank, expressing the all-pervading intrusion of prevention into the homes and lives of the people is even more descriptive.

It is worth while to consider how the public health is cared for in the National Health Service. The science of preventive medicine is relatively young, though from the earliest recorded times we hear of prevention being practised. The ritual to prevent the entrance of evil spirits into the home is an example. The wearing of amulets is a practice which was common in all ages and even in this age of technology is not entirely laid aside. Means to keep away plague and pestilence directed to the assumed causes have always exercised the minds of men. Scientific preventive medicine dates, however, from the time of Lind (1748) who first established the actual cause of scurvy and pointed to the means of eradication, and Baker (1762) who demonstrated the presence of lead in Devonshire cider, and clearly showed that this metal was the cause of the colic from which cider-drinkers commonly suffered. In the early nineteenth century the work of Howard on prisons and Chadwick amongst the " labouring poor " brought to light the need for improvements in sanitation and personal hygiene. The occurrence of Asiatic cholera in 1831—32 underlined the need, and the work of Snow and Budd made it essential that the care of the public health should be placed in the hands of those best qualified to look after it. Enlightened local authorities appointed medical officers of health—Andrew Duncan by Liverpool in 1847, and John Simon by the City of London in 1848—and soon (1848) the appointment of medical officers of health was authorized, although these appointments did not become obligatory until 1869. Though these men came from all branches of the profession, the majority had been private

practitioners and, in spite of the instructions of the local board of health that they should be whole-time officers, they often continued in practice, working for a purely nominal salary.[1] The laws of sanitary science had not been formulated, there were no courses of instructions to initiate them into their duties, yet they had the advantage of moving amongst the people, knowing their hardships, weaknesses, and diseases. It was they who developed the speciality of public health and taught a generation of sanitary engineers and surveyors how safely to improve and develop cities, towns and villages. The appointment, under powers granted by the Local Government Act of 1872, of sanitary inspectors was followed in 1875 by the foundation by Chadwick of the Royal Sanitary Institute and trained health inspectors were soon giving valuable aid to the medical officers of health.

The battle for healthier living was hard fought and the attack was directed not to the individual, but to the local community—to the authorities who administered the towns and villages. Chadwick in his first draft of instructions laid down that " the general duties of the officer of health shall in no case comprehend treatment for the cure or alleviation of disease." Only slowly, as improvement was gained, were fresh duties allotted to the medical officer. At the turn of the century attention was first directed from the community in its environment to the individual in the community. There were many causes for this. The waning popularity of the miasmatic theory of infection, and the recognition of the germ theory of disease with the consequent realization that people spread diseases; the awakening of the public conscience after the recruitment for the Boer War had dramatically revealed the low physical standards of the young manhood of the country; and the increasing interest in local government all contributed; and—most important—the vision and energy of those great moulders of the nation's sanitary conscience—Newsholne and Newman. Thus, over the last fifty years we have had a series of enactments directing medical supervision and care to the medical staff of the local authority. The Education Act of 1907 set up the school medical service; the Public Health (Tuberculosis) Regulations of 1912, the Mental Deficiency Act of 1913, and the Maternity and Child Welfare Act of 1918 all brought patients of the family doctor under the wing of the medical officer of health. The resentment felt by the general practitioner was summed up in a " Report on Encroachment on the Sphere of Private Practice," published by the British Medical Association in 1929.

The coming of the comprehensive National Health Service in 1948 brought the practitioner into a service in which the great

majority of his patients were able to consult him for all their ailments at no cost to themselves. Logically, the family doctor should welcome every measure devised to keep his patients fit, and most do so. Many feel that the preservation of the health of the people, being in their interest, should be directed by them. They see the medical officer of health in charge of a number of the ancillary services with which they, the family advisers on health and disease have to work. They see the larger, impersonal, local-authority clinics serving tea, biscuits, hygiene and therapy impartially to all-comers. The district nurse, the midwife and the health visitor, the duly authorized officer and the home-help have all to work for two masters. It is surprising that disagreement does not occur more often. Dr. G. RAMAGE recently discussed at length the problems involved and came to the conclusion that general practitioners could quite well carry out the medical work of the preventive services.[2] There has never been any real doubt of this; they are today undertaking antenatal and welfare clinic work, and increasing its value by their unique knowledge of the family and the home.

The problem is far greater than just who does various clinics. If it be granted that the essential part of the health service is the maintenance of health, then surely preventive medicine must be in the forefront. To pay lip-service to the general practitioners that he is in the front line in the fight against disease, without placing him in the van of the preventive services is illogical. There is only one satisfactory answer. The old concept of the health officer as a sanitarian is obsolete. Since 1948 when his responsibility for the isolation and municipal hospitals and the orthopaedic services was taken away from him, he has been left with half the work, and no clear direction as to where his main duties lie. The general practitioner, anxious enough in his own interest to practise prevention, has no guide. He has no voice in the direction of the services which should be an integral part of his daily work. He is not even directly responsible for the nurses who help to treat his patients.

The answer is clear, but it will require courageous action to achieve. The medical officer and his whole department should be removed entirely from the local authority and placed under the executive council. The medical officer of health would then become adviser in preventive medicine to the executive council; be responsible to it for the nursing, health visiting and mental health departments of general practice. The executive council would be responsible to the education authority for the health of the school children. The medical officer would still be able to act as adviser on health problems to the local authority who might be bound by statute to consult the executive council in certain matters involving

housing and the distribution of food. After-care would become the responsibility of the general practitioner. The ambulance services would pass to the control of the hospitals to and from which they carry patients.

Medical officers would find themselves better placed to practise preventive and social medicine, and many would welcome the release from the cramped atmosphere of local government. Their remuneration would cease to be compared with that of local government officials, and their status and prestige would benefit. The first reaction of the local authorities to the threat of losing their " doctors " would doubtless be one of dismay, but the loss would be accompanied by relief from the responsibility for services such as the ambulance over which they have no control, financial or otherwise. Local authorities have strong representation on the executive councils, and their accumulated experience and wisdom would not be lost. The inequalities between the richer and the poorer, the progressive and the reactionary local authorities would cease.

These changes, revolutionary as they may appear, would bring preventive medicine into line with modern medical thinking. In a paper on " Reducing the Load on Hospitals by Preventive Measures and Home Care " SIR ALLEN DALEY wrote, " Every country should examine its hospital statistics to ascertain the extent to which its hospital beds are occupied by people suffering from disease or injuries for which preventive measures are known and have somewhere been applied with success."[3] In 1954—55 the cost of the National Health Service was £478,000,000, of which £278,000,000 or 58 per cent. was spent on hospitals and £53,000,000 or 11 per cent on family doctors providing home care. If we wish to reduce this heavy load we must not only enquire into the known methods for the prevention of preventable disease, but we must also review the organization through which these measures may be applied. The necessary reforms may be difficult to effect, but when the well-being of the nation is concerned they must not be shirked on that account.

REFERENCES

[1] Brockington, C. Fraser. *Med. Officer*, 1956, **96**, 327.
[2] Ramage, Gerald. *Med. Officer*, 1957, **97**, 31.
[3] Daley Sir Allen. *Med. Officer*, 1957, **98**, 65.