MEDICAL CARE IN THE COMMUNITY. THE FUTURE ROLE OF THE MEDICAL OFFICER OF HEALTH*

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THE FUTURE work of medical officers of health is intimately bound up with two problems, only one of which also applies to doctors working in other branches of the National Health Service. This common problem is the whole question of the organization of medical care, while the other comprises all the difficulties and uncertainties facing local government, with its irrational structure and variable standards of service. It is however, with the first of these subjects that this paper will deal, for, as far as local government is concerned, all that can be done is to trust that the work of the Royal Commission will be followed by legislative action leading to more effective, and presumably larger, units at the local health authority level.

The medical officer of health has two broad tasks, namely the prevention of illness and, where prevention has failed, the organization, in conjunction with general practitioners and hospital staff, of domiciliary care (Reid 1964). It may be conceded that there need not, in theory, be a special branch of the medical profession concerned primarily with prevention, and it is encouraging to note the increasing general acceptance of the fact that prevention and cure can no longer be regarded as separate processes. The two are interdependent, as is emphasized by the growing interest, not merely in primary, but also in secondary and tertiary prevention. It is still, however, necessary to have a section of the profession with special interest in preventive medicine and this state of affairs will continue throughout the foreseeable future.

Prevention of disease

Health education is a vital part of preventive medicine, and the medical officer of health has a particular duty to develop and co-ordinate it. The importance of the subject is emphasized by the

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current pattern of mortality and of morbidity, as health education, in the widest sense of that term, offers the main approach to the attempted control of such problems as cardiovascular disease, cancer, bronchitis, accidents and certain forms of mental disorder. The medical officer of health, with his specialist health education staff, must facilitate the work of doctors, health visitors, nurses and others in presenting facts about health to a fairly receptive, but still all too often grossly misinformed, public. This calls for a planned approach, using sophisticated methods which can hold their own against the expertise of commercial advertising, which is not infrequently devoted to the encouragement of ways of life which are incompatible with good health.

Family doctors have always played a role, albeit sometimes an unwitting one, in health education, particularly at the individual level, and it is to be hoped that this will increase with the attachment of public health staff to general practices. Health education also has its part to play in another aspect of preventive medicine with which the medical officer of health is concerned in conjunction with his colleagues in general practice and in the hospital service. This is the screening of populations, or of selected groups, for various diseases in order to detect morbid processes at an early stage in their development when they are, presumably, more readily reversible or treatable. At our present stage of knowledge, screening for diseases is far from supplying the ultimate solution to health problems, and it is becoming apparent that the process all too often serves to pose far more questions than it answers.

It seems likely that the future in this field lies, first, in establishing or confirming the epidemiological picture of disease for which screening can be carried out, and then in applying this knowledge. This, in turn, may mean that the general practitioner will have the task of identifying individuals who are at risk, while the hospital service will be responsible for the actual screening mechanism, the process of confirmatory diagnosis and, in many cases, the initiation of treatment. The medical officer of health, on the other hand, will probably be involved in educating appropriate sections of the public about the desirability of being screened, in providing the administrative machinery for dealing with those at risk, and, in co-operation with his colleagues in general practice and in hospital, in supplying appropriate aftercare arrangements. This last point is important because, particularly in the case of chronic disease, it is essential that screening should not degenerate, as has tended to happen in the United States of America, into an isolated exercise, with inadequate investigation and aftercare for those whose screening tests are positive. The ability to follow screening processes to their logical

conclusions should be a corollary of our national system of organized medical care.

Domiciliary care

On turning to the organization of domiciliary care, it must again be accepted that this is a concept which cannot stand on its own, as domiciliary and hospital care have a reciprocal relationship. The medical officer of health, by the way in which he deploys the services under his control, can have a profound effect on hospital medicine and on general practice and, hence, on the overall pattern of medical care.

On looking at the relationship between the medical officer of health and general practice, it must first be emphasized that variability of arrangements and of standards in the latter are even greater than those which exist between different local health authorities. There is, however, no scope for the continuation of historical rivalries between these two branches of medicine, for these relate to a bygone age, and the only test which should now be applied to any situation ought to be who can best supply the most effective service to the public. On this principle, it is appropriate that various activities traditionally associated with public health should, in the long term, pass mainly into the hands of family doctors, leaving a smaller number of more specialized public health staff to concentrate on particular problems, such as those of the educational needs of handicapped children. It should be clearly understood, however, that this must be conditional upon these general practitioners having received appropriate undergraduate and postgraduate training, as they certainly have no prescriptive right to undertake work for which they have not been adequately prepared. It is, incidentally, to be hoped that the general practitioners' entitlement to fees for providing certain essentially preventive services will encourage them to assume even wider responsibilities towards their patients than has hitherto been the case.

The trend towards attachment of health visitors and nursing teams to general practices is to be welcomed, and brings clear advantages to them and to the public. The practical difficulties which sometimes arise, however, in arranging the attachment of an organized group of health visitors or nurses to a collection of disparate and often ungrouped general practices must be recognized for, to be logical, it would be simpler to incorporate general practitioners into the more ordered structure of health visiting and district nursing. The process should remain one of attachment of local health authority personnel to general practices and not of their detachment from public health, for it is imperative that attached staff should be saved from the type of professional isolation which has hitherto been typical of much of general practice. It is also

worth bearing in mind that the attachment of public health staff to ungrouped general practices may involve the destruction of well-organized health visiting and nursing teams, often with degrees of specialization and delegation amongst their members, and it must be hoped that the trend towards group practice will progress rapidly so that this danger is averted.

Perhaps the greatest advantage of attachment schemes is that they allow a full interchange of information between the personnel concerned, and it is vital that such schemes should include substantial interavailability of records, as is already commonly the practice in antenatal care. Public health personnel are no less capable of maintaining confidentiality than are general practitioners, and it is to be suspected that the plea of secrecy which is sometimes raised as an objection to any form of linkage may be a sign either of insecurity or of a desire to keep secret an unsatisfactory system of records. The importance of interchange of information lies in the fact that it is a prerequisite of increased selectivity of work on the part of general practitioners and attached public health staff, and selectivity is essential throughout the whole of medicine if the best use is to be made of limited resources of skilled manpower, and if services are to be effectively deployed.

One of the principal future tasks of the medical officer of health must be to ensure that full advantage is taken of epidemiological knowledge in order to attain selectivity, so that medical and paramedical effort is directed into appropriate channels, and not squandered in an overlapping manner as a result of the perpetuation of systems of general practice and of public health appropriate to the sociomedical *milieu* of many decades ago. The increased selectivity which can come about in the work of general practitioners and public health staff as a result of schemes of attachment is striking. Doctors are notoriously bad delegators, but they must master the art and must also overcome the widespread, and mistaken, belief that good organization is in some mysterious way incompatible with good doctoring. The rapprochement between general practice and public health should help to change these attitudes and should, in time, lead to the development of closely integrated community medical services, often based on health centres.

Hospitals

Similarly close links must be fostered between the medical officer of health and the hospital service, and it is encouraging to note the growing awareness amongst hospital staff of the importance of social and community factors in the causation of disease, and of the necessity for paying due regard to such factors if treatment is to prove successful. Current signs of the rediscovery of the community

by hospitals, and particularly by the London teaching hospitals, is one of the most significant features of present-day medicine in Britain.

The medical officer of health must constantly ensure, in conjunction with his hospital colleagues, that the balance between their respective services is being adjusted in the light of current needs and that they are not merely continuing along lines hallowed by tradition. There is, for example, need to look closely at patterns of hospital inpatient care in the fields of midwifery, surgery and psychiatry, as many patients can be returned to the community at an earlier stage than has been traditional, and a policy of co-ordinated hospital and community care may not merely make the best use of limited and expensive hospital resources, but may well be more acceptable to the patients themselves. In attaining such co-ordinated policies, it is also necessary to look at various groups of personnel, such as midwives and medical or psychiatric social workers, and to decide in each case whether they should be employed primarily by the hospital, by the local health authority, or on some kind of joint basis. Interavailability of staff should become the rule rather than the exception, and it is, incidentally, greatly to be hoped that, in the field of social work, any re-organization of the services supplied by local authorities will not discourage joint schemes of this kind, for they can play a significant role not merely in providing adequate and continuing care for patients, but also in helping to keep hospital staff in touch with the community.

The medical officer of health and his team should not be strangers to their local hospitals, but should act as links between them and the community which they serve. Relevant sociomedical information on hospital outpatients and inpatients would thus be readily available and, once again, this is more easily ensured where public health personnel are attached to general practices. Similarly, before patients are discharged from hospitals, positive steps should be taken to ensure that aftercare is immediately supplied where necessary, and this process will be encouraged if the medical officer of health has a physical presence, in the form of a small department in every major hospital, to serve as a focal point for the work of the various members of his staff who contribute to the care or aftercare of hospital patients. In addition, as district general hospitals are becoming the local centres round which all forms of medical care are grouped and on which continuing professional education for doctors and other members of the health services are based, the medical officer of health cannot be fully effective unless he takes an active interest in their work and plays a part in influencing their policies. This should also help to ensure that, in future, hospitals

do not again become as remote from the community as they were in the recent past and as some, unfortunately, still remain.

Organization of medical care

The picture of the medical officer of health which this paper has attempted to present is not of someone sitting in majestic isolation in a town or county hall, but rather of a medical administrator with an interest both in general practice and in hospital medicine, and in control of services which can be used flexibly to meet current needs in the field of medical care. He has the responsibility of trying to measure the health needs of his community, and then of evaluating how these are being met by the various medical services. This work will often be carried out in conjunction with family and hospital doctors, and its object is to enable patterns of care to be adjusted to meet changing situations. It is necessary to assess priorities, for the spending on sociomedical services is potentially infinite, and it is therefore important that these priorities should be based, as far as possible, on a careful assessment of the factors involved. This calls for research at local, as well as at regional and national levels, and there is need for a much closer linkage between university departments of public health and social medicine and local health authorities.

The medical officer of health is in the process of evolving into a medical administrator with wide interests, and is increasingly willing to delegate to others various traditional pursuits which do not call for a background of medical education. In the long run, two things must come about. In the first place, if local health authorities are to retain their functions in a reformed system of local government, they must be large enough, and with sufficient resources, to enable them to attract, and to justify retaining, the services of skilled medical administrators of the requisite calibre. Secondly, these medical officers of health, who will be considerably fewer in number than at present, must be appropriately trained for their widening responsibilities in the organization of medical care, and this training should be of a generic type common to them and to all other groups of medical administrators. A country which spends over a thousand million pounds per annum on its health services requires an adequate supply of highly trained medical administrators if the development of these facilities is to progress in a rational way and not as a result of decisions which are the administrative equivalents of clinical impressions.

In the meantime, there is much to be done, and there is little or nothing which cannot be attained within the existing framework of health services in this country (Reid 1965). Area health boards are a concept which may be worthy of trial on some suitable experi-

mental basis, but they must not come to be regarded as the only means by which progress can be made and, hence, as an excuse for inactivity. Our National Health Service is slowly tending towards functional, if not administrative, unity and both the rigidity of the hospital service and the anarchic state of general practice are changing. Public health has always been an organized service, but organization can have a fossilizing effect, with the result that the service was, at one stage, in danger of becoming preoccupied with the perpetuation of traditional pursuits, usually carried out in isolation and all to often without regard to their continuing relevance to modern medicine. This phase has passed, and the public health service is beginning to come into its own as a means of rendering general practice and hospital medicine more effective and, in conjunction with them, of evolving a more genuinely comprehensive system of medical care.

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Mortality of bereavement. W. DEWI REES, M.B., B.S., M.R.C.G.P. and SYLVIA G. NUTKINS, B.SC. *Brit. med. J.* 1967. **4**, 13.

A survey over a six-year period in a semi-rural area in Wales shows that bereavement produces a definite increased mortality in bereaved close relatives. In the first year of bereavement there is a sevenfold increase in deaths among bereaved close relatives, as compared with age and sex matched controls. Widows and widowers have a higher mortality rate than other close relatives (children, sibs). There is also a higher mortality rate among the bereaved when the primary death occurs in hospital or at 'other sites' than at home (sudden death in the street etc).

Families in flats. D. M. FANNING, *O.B.E.*, M.B., B.S., D.P.H. *Brit. med. J.* 1967. **4**, 382.

Wing-Commander Fanning, an R.A.F. medical officer, compares two groups of service families living in Germany. Social status and amenities were comparable, the only difference being that one group lived in flats, one group in houses. All had been allocated to their dwelling-place on a random basis. The families living in flats had a definitely greater morbidity (+ 57 per cent). The greatest differences were in respiratory infections in young women and children, and in neurotic/psychomatic disorders in women. Possible reasons for this are discussed.