In and Out of Medicine

Two faces of planning

When the holidays are over and summer has come to an end the remoter shores of Argyll seem a strange place to find an Englishwoman who is both a doctor and an architect, but that is where Ruth Cammock has come to rest. She has had a house near Lochgilphead since 1971, but until July 1978 used it only for breaks from work; she expected to spend her days until retirement at the City and East London Area Health Authority as specialist in community medicine for planning and primary care—a prospect that didn't particularly excite her. One day, however, a colleague showed her an advertisement for district medical officer for Argyll and Bute (an area that includes many islands and covers 3000 square miles with a population of only 65 000). She knew western Scotland well, had experience in local authority work both as an architect and as a doctor, and, perhaps most important, loved Argyll and already had a house there. She applied and was accepted.

Dr Cammock always enjoyed drawing and painting and would like to have trained as an architect when she left school, but her academic father thought otherwise and was determined that his daughter should have a secure career. At that time architecture was (and still is) even more of a man's profession than medicine; women had little chance of promotion in private practices or being offered partnerships. Medicine was a better bet for a woman and, in any case, it was wartime so there was little call for building. Thus Ruth Cammock became a doctor: she has found no discrimination against women in the medical profession but does know women who have not made the grade in architecture because of their sex. She qualified at University College Hospital in 1945, did a bit of everything in hospital jobs up to paediatric registrar level, and spent seven years in Newcastle upon Tyne. She enjoyed research more than clinical work and was happy to work within the orbit of Sir James Spence in his unit in Newcastle. She married there and eventually moved with her husband to the Midlands, where he took up general practice. He had been a historian and changed horses after the war: after Ruth had done a variety of part-time clinic jobs and two years long-term general practice locums she decided that it was her turn to change careers.

Ruth Cammock

Dr Cammock admits that without a stable financial background (her husband was well off and there was no need for her to work) she would have been unable to take on six years' more training. By this time she was about 40, but found that her new life as a student in Nottingham rejuvenated her; she began to think and read with a younger generation and her medical training helped her too. She thinks that if she had stayed on in medicine she would have stagnated. Changing careers in middle life is an excellent idea, she thinks, and she found it salutary to look at medicine from the outside and see just how arrogant doctors can be. Now she has colleagues and friends of her own age who are doctors, and younger ones who are architects. After qualification her medical knowledge was put to advantage because she worked for three years for the Nottingham County architects' department on the CLASP system (Consortium of Local Authorities Special Programmes, which was originally applied to schools) when it started being applied to hospitals and health centres. From 1968 onwards health centres became the vogue, but Dr Cammock realised that an architect's approach to a client's needs was entirely different from a doctor's—and the architects had no idea what questions they should be asking GPs. Because of her experience in hospital, in local authority clinics, and in general practice, she was uniquely placed to use all her experience to advantage. Design, however, was her chief love and as she rose to the position of senior architect she knew that soon she would become an administrator.

No woman can be professionally qualified twice over without having a clear mind and a determination to make the best of her abilities, so Ruth Cammock went to see the chief architect at the Ministry of Health to ask him for ideas on how she could best be employed. He suggested the Medical Architecture Research Unit at the Polytechnic of North London, an organisation that was supported by research grants. The studies of health centre buildings now in use which she did there[1-3] were the most useful work that she has ever done, and she thinks that the unit makes a real contribution towards solving the problems of Health-Service building and bringing together the two professions. An example of the thought that Dr Cammock put into her designing is that she remembered that some doctors in health centres are left-handed (see figure). Sadly, only those who could survive a hand-to-mouth existence from DHSS grants, or who had private means, could afford to work there; many people who might otherwise have done much for this unit were unable to abandon the security of other jobs. Dr Cammock did this valuable work on a part-time basis and commuted from Nottingham for two days a week.

One of the supposed difficulties for a woman architect is controlling site meetings, but the authority she had gained as a doctor helped her here (not to mention stitching up drunks on a Saturday night), and she was immensely flattered when the men on the site of a fire station she had designed played a practical joke on her that they usually played only on men. But her happy days as an architect were drawing to a close and, when her marriage ended in divorce in 1975, she had to choose a job that would give her some sort of security with a pension at the end of it. After careful thought she reluctantly opted for medicine and went to work full-time for the City and East London AHA. (Even so, she continued her connection with MARU until she left London.) For some time she regretted this decision, but it has enabled her to get her present job which, although it combines administration and medicine (the two things she hoped to avoid), has turned out well.

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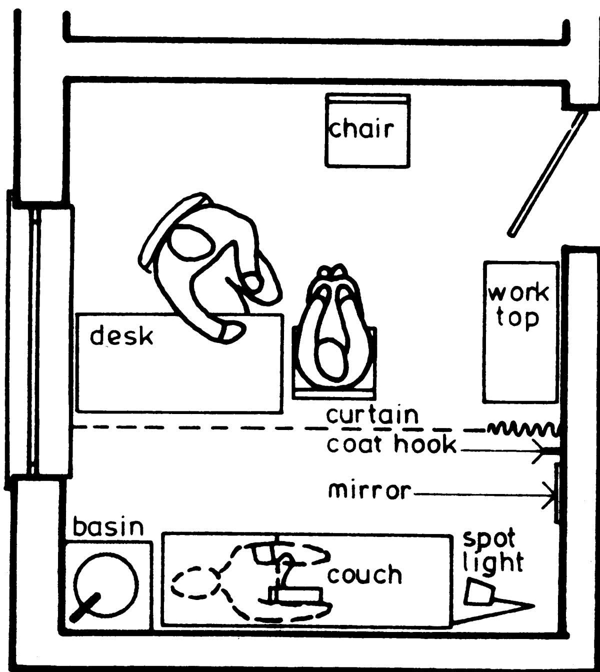

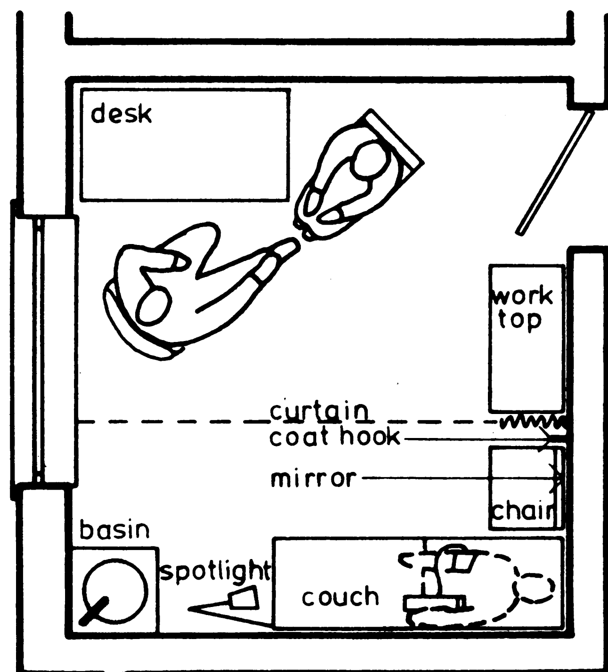

Individual clinical room (for left-handed doctor on the left, and right-handed doctor on the right) in a health centre.

Ruth Cammock may have found it rejuvenating to change from medicine to architecture, but there is little doubt that she has again shed a few years and probably stimulated her colleagues in Argyll by her enthusiasm for the challenges of her new life. As district medical officer she is the only doctor (and the only architect) in a management team of four and most of the plans for Health-Service buildings end up on her desk for comment and ideas; her knowledge of architecture has been much more useful than she expected.

She visits her district extensively by car or boat (the only train service is in Oban). She is flexible and a great believer in teamwork and integration of services: a good example of how one team works is on Tiree, where there is a GP and an occupational therapist, but a physiotherapist visits the island only about twice a year; the solution they have found is for the physiotherapist (who is employed by a different authority) to teach the GP and the occupational therapist how to treat patients in the gaps between visits. Dr Cammock hopes to introduce a mass radiography survey in Islay, where there are still cases of tuberculosis among the island's 4000 inhabitants; elsewhere there is too much measles and too little immunisation, so she is planning to cope with this, too; she has many problems connected with the increasing number of old people who retire to her district from Glasgow and other towns. She says she is always learning new things—refreshing for someone of 57—and the more she sees the more she becomes interested in her work and she doubts whether she will retire in three years. She has a varied and stimulating life and is flexible enough to take on anything that comes along. She even enjoyed a course in industrial relations recently: COHSE and NUPE have had militants in Lochgilphead (with little success).

In the end, things have turned out well for Ruth Cammock, and Argyll and Bute are lucky to have someone who cares about them so much (she was very flattered when a neighbour remarked, "You're not an incomer, you're one of us"). She is contented to slow down her pace to fit the more leisurely ways of the people of Argyll, is proud to have been elected to the committee of the Natural History and Antiquarian Society of mid-Argyll (she is interested in archaeology), is a keen sailor and gardener (a bad year for vegetables), has a circle of good friends, and looks forward to drawing and painting again when she retires. She lives in one of the most beautiful parts of Britain, a land of lochs, hills, and mists, but it is an area that needs someone like her to look after its medical services ("outwith the nurses"), which still leave much to be desired; if anyone is to bring those services up to the standard of the rest of the country it will be Dr Ruth Cammock.

The photograph of Dr Cammock is reproduced by courtesy of Medical Practitioner Affairs Ltd.

References

[1] *Health Centres: Reception, Waiting & Patient Call.* London, DHSS, HMSO, 1973.
[2] *Utilisation of Consulting Suites in Health Centres.* London, MARU, 1977.
[3] *Utilisation of Treatment Suites in Health Centres and Group Practices.* London, MARU, 1979.

A man with an inoperable aneurysm of the anterior communicating artery had a subarachnoid haemorrhage. He recovered with conservative treatment and now feels well. Should he be advised not to drive?

It is a pity the questioner did not give the age of this patient as I think this would influence the way one interpreted the law. The requirements of a driving licence state that the applicant should report any incidence of unconsciousness whatever the cause. The reason for this is chiefly to detect people who may be driving with epilepsy. The rule here states that after any unconscious attack due to epilepsy the patient should not drive for three years. After this initial period if they have an attack at night there should be one further year free of attacks. If they have a further attack during the day, the period is another three years. This man has had an attack of unconsciousness, and in the natural history of the disease from which he is suffering he could have another. I believe that he should be handled as an epileptic. It would be perfectly fair, however, for this patient to write himself to the driving licence authorities explaining truthfully what has happened. They would almost certainly appoint an assessor for this problem, and the patient would have to abide by this assessment. If this patient came to me I would say that he should stop driving for three years in the first instance. If there was no suggestion of any further leaks or bleeds from this aneurysm I would reconsider the matter as if the patient had epilepsy. There would be differing opinions over this problem, but the real point is that it should be managed within the bounds of what the law thinks about it. So, the driving licence authorities should really have the last say.

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