Impressions of Cogwheel

The Medical Officer of Health

FROM A SPECIAL CORRESPONDENT

British Medical Journal, 1972, 4, 166–167

The first Cogwheel report[1] referred specifically to "liaison activities with other divisions and with other departments and committees within the hospital group, with general practitioners and with medical officers of health" as an important part of the medical division's duties. By the time of the second report,[2] in 1972, out of 107 groups for which information was available only 11 had formal medical officer of health representatives; five of these were associated with psychiatric divisions, five with obstetric and gynaecological divisions, and one with a paediatric division. Of course, many other hospital groups do have close but informal liaison with their local medical officers of health. Nevertheless, even with the White Paper on national health service reorganization[3] now stating that "unification will bring together into one service medical administrators now working in the public health services and those in the hospital service," these links with Cogwheel are probably not yet good enough.

Dr. Umfraville,* regards N.H.S. reorganization,[3] the Cogwheel reports,[1 2] the Salmon report[4] on senior nursing structure, and the Seebohm report[5] on local authority and allied personal social services as all related parts of the whole health scene—even if, as he says, it seems that this is being divided into "disease services" in the N.H.S. and "health services," which are to remain outside.

A Single Agency, or Not?

In his foreword to the White Paper, Sir Keith Joseph says "no doubt arguments will continue about the theoretical advantages of making both health and social services the responsibility of a single agency. But the formidable practical difficulties, which have been fully argued elsewhere rule this out as a realistic solution." Dr. Umfraville thinks that despite Sir Keith's guarantees and the existence of community health councils the patients will suffer from the continued gap between the N.H.S. and local authorities. In his area, for example, the new social services area officers are not to be situated in health centres, though accommodation for social workers will be provided. Community health services are committed to an organization based on general practice and therefore will be separate from the area organization of social services.

Dr. Umfraville works in an urban area of 250,000 people supplied by numerous old small hospitals which are shortly to be replaced by a district general hospital. The local hospital consultants have a group medical advisory council to which Dr. Umfraville, but no general practitioners, belong. The consultants also belong to their individual hospital committees. The area is still in its pre-Cogwheel pristine state, and hence Dr. Umfraville regards this as a good opportunity to look at the two ways Cogwheel can be introduced in the new area in 1974. In the first of these community medicine could be brought into Cogwheel by having a division of community medicine which would include the medical and non-medical members of the health services concerned with child health, domiciliary midwifery, family planning and cytology, geriatrics, psychiatry (especially child psychiatry), and rehabilitation in the community. This division would have the advantage of a specific representative on the medical executive committee of the local district general hospital when it is ready and if a Cogwheel structure is decided upon.

Linking the Domiciliary Services

Nevertheless, Dr. Umfraville favours a second alternative: linking the domiciliary services with the relevant hospital services, thus bringing Cogwheel into the community. In this way the appropriate hospital-based divisions would therefore organize the work and workers concerned with the respective domiciliary and hospital services and provide truly continuing care.

For years the paediatrician has in Dr. Umfraville's area done sessions in the local authority premises, and at present Dr. Umfraville is also trying to obtain a geriatrician with sessions outside the hospital. On the other hand, one of the psychiatrists who works in the community has no hospital beds at all. Specific responsibilities and enough sessions for hospital-based consultants outside the hospitals would, he thinks, recreate the great understanding of the community which general practitioners who became hospital consultants before the health service had. The community G.P.s could hardly attend all the hospital divisions often enough, so they must have a division of their own, but again this could easily be incorporated into the coming changes. Indeed, in this area Dr. Umfraville has a high proportion of elderly G.P.s and he is concerned that recruitment should be adequate—for example, by starting to design and build health centres, so that young doctors are not discouraged by doing surgeries in little terrace houses with no ancillary services.

Dr. Umfraville would like to encourage the G.P.s (whose decision it is) to include in the health centres space for reading and records, for research, and for social services personnel. Indeed, he is convinced that the local authority area offices for social services should be located in the health centres, but this is probably not to be. Even so, it will be possible to locate the "health services," including nurses, health visitors, and midwives at health centres, because these will be employed by the area health authority. Dr. Umfraville already works closely with his chief nursing officer and her staff of area nursing officers and senior nursing officers (including district nurses, health visitors, and midwives), who look after about 60 district nurses, 80 health visitors, and 10 district midwives. This pattern of organization, he thinks has improved the service in the last year, but he would like there to be a career step for nurses specializing in clinical problems such as home care of diabetics, patients with colostomies, and neurological disorders.

* The name is a pseudonym.

Value of Attachment Schemes

Dr. Umfraville values the G.P. attachment system as a very useful path of communication. If, for example, an immunization programme is not going well the chief nursing officer can call in her nurses and tell them so and they can then subtly influence the doctors with whom they work. Another valuable link would be the involvement of G.P.s in maternity and nursing units with the local authority providing the nursing staff and the hospital service providing the hotel and hostel service. Co-ordination among the 100 or so G.P.s on a divisional basis could also lead to organized night and weekend rotas and eliminate the use of deputizing services.

Dr. Umfraville's ideas about bringing Cogwheel into the community are in keeping with the concept of the "specialist in community medicine" which the recent Report of the Working Party of Medical Administrators under the chairmanship of Dr. R. B. Hunter advocated.[6] The medical officer of health would cease to "manage" domiciliary midwifery, psychiatry, and other conditions which were in fact much better understood by obstetricians, psychiatrists, and other hospital-based specialists. Instead, he would be able to concentrate on the epidemiological and organizational aspects of health care for which he had been trained: on running a health data unit, collecting and presenting health information to, for example, the district medical teams which would appear in 1974, and to the Cogwheel medical executive committee.

Even so, Hunter had missed the opportunity, Dr. Umfraville thought, of dividing M.O.H.'s into two specialties—medical administrators and epidemiologists. Instead, all medical officers of health were to be converted into managers and epidemiology could be done either as a part-time activity of the community physician or full-time as an underling in the area or regional health offices. In 1974 a medical officer of health would acquire not only a new area committee but also two new employers—the area and regional authorities—whereas now he was a boss himself within the local authority. Dr. Umfraville did not regard it as likely that the specialist in community medicine would be treated as a consultant supplying a service as pathologists and radiologists do, but as a "dogsbody" untangling patients caught between the social service departments, the general practitioners, and the hospital; or "unblocking" hospital beds occupied by patients with social problems.

Nevertheless, the changes produced by the implementation of the Cogwheel, Seebohm, Hunter, and the 1974 reorganization could allow the experienced medical officer of health to develop a new and rewarding role for himself. For many, however, the changes will mean divided loyalties, and more direction—Dr. Umfraville was adamant that, whatever the protestations, the district, area, and regional structure could not avoid becoming hierarchical.

References

1 *First Report of the Joint Working Party on the Organization of Medical Work in Hospitals.* London, H.M.S.O., 1967.
2 *Second Report of the Joint Working Party on the Organization of Medical Working in Hospitals.* London, H.M.S.O., 1972.
3 *National Health Service Reoganization: England.* London, H.M.S.O., 1972.
4 *Report of the Committee on Senior Nursing Staff Structure.* London, H.M.S.O., 1966.
5 *The Committee on Local Authority and Allied Personal Social Services 1965-8, Report,* Cmnd. 3703. London, H.M.S.O., 1968.
6 *Report of the Working Party on Medical Administration.* London, H.M.S.O., 1972.

Today's Drugs

With the help of expert contributors we print in this section notes on drugs in common use

Drugs in Infertility

British Medical Journal, 1972, 4, 167–170

Now that ovulation can be induced artificially great changes have occurred in the management of infertility. There is now a need to identify patients with defective ovulation so that suitable ones may be chosen for treatment.

Preliminary Investigation

Before any drug therapy is contemplated it is essential to have a full history from both partners, with particular reference to infertility. In most clinics this is usually obtained from the wife initially: general physical examination with special emphasis on pelvic assessment is followed by taking a biopsy specimen of premenstrual endometrium. Tests of tubal patency performed are mostly insufflation and hysterosalpingogram, though laparoscopy and dye instillation is sometimes more appropriate. At the initial visit the patient is carefully instructed to record her basal temperature and asked to bring the graph with her at every visit. By the time the other investigations have been completed, her chart will include records of several cycles and variation between cycles can be assessed. Finally, a specimen of seminal fluid from the husband is also analysed.

Absence of ovulation may be diagnosed by a monophasic temperature record, even in the presence of menstruation. It is supported by a failure to find secretory endometrium on biopsy and the presence of poor cervical mucus. There may be a history of oligomenorrhoea that may indicate at the first visit the subsequent need for induction of ovulation, but the preliminary investigation must still be completed.

Ovulation may now be induced. The drugs are expensive and the courses of treatment protracted, involving frequent attendances at the clinic, so there should be no other bar to pregnancy. The patient's need for treatment of the infertility must be established and her full co-operation must be ensured by fully discussing all the factors relevant to the use of these "fertility drugs."

These patients are initially treated with clomiphene citrate, possibly after measuring basal oestrogen excretion beforehand, since higher values of this may indicate the possibility of successful induction of ovulation.[1] The co-existence of amenorrhoea presents a more complex problem. In addition to the above assessment, there must be a more elaborate investigation to exclude any organic process that requires treatment before the infertility is dealt with. The following investigations are performed in patients with amenorrhoea or in any patient before she is started on gonadotrophin therapy: measurements of