

Letters to a Young Doctor

Community physician's tasks

PHILIP RHODES

Every large organisation needs administration to attempt to co-ordinate its activities. The National Health Service is the largest employer of labour in the United Kingdom and ranks among the major enterprises in the world for numbers of staff and amount of money spent. Doctors may be bitter and scathing about bureaucracy and red tape in the running of the Health Service, but it is essential whether they like it or not. Few specialists realise that it takes an average number of 13 support staff for each of them—nurses, physiotherapists, occupational therapists, laboratory officers, scientists, porters, maids, cooks, cleaners, boilermen, laundresses, and several others. For the doctor to do his work all of these people need to be co-ordinated, and that cannot happen simply by guess and by God. People are needed to get the machine together and keep it running. It is irrational to think otherwise.

Administration is as essential to the running of the Health Service as the doctors and nurses are. Only when an enterprise is very small can one do without identified administrators, and only then is the administrative function hidden because a doctor may cope with it in his spare time. Staff still have to be hired and fired, have their duties arranged, and be paid, and drugs and equipment have to be ordered, linen washed, and buildings repaired and decorated.

As professional administration develops doctors are needed to work with them and help them, just as they are needed in medical education and basic medical sciences. Though they do not necessarily run the show they are important members of the teams that do. Doctors who do not think much about their place in the scheme of things may resent the fact that they are not "cock of the walk." When the environment is restricted to purely clinical work the doctor's word is law. When the enterprise is bigger than that doctors find that they must work with people other than doctors and professionals such as nurses. This is a new and sometimes irksome dimension, which must be understood by all doctors now for none of them works in isolation, however much one may wish that one did.

Doctors as administrators

Inevitably, some doctors have specialised in administration and these are the community physicians. They are the voice of medicine in the administrative system. They work at a difficult interface between clinical medicine and the social environment in which it functions and has its being. It is a measure of the general blindness of the profession in its vision of its place in society that there is a serious shortage of community physicians

and that their work is not understood and is even held in some degree of contempt by their clinical colleagues.

Community medicine evolved from public health. Medical officers of health used to be appointed to work for local authorities and advise them on the environment in such matters as housing, sanitation, water supply, food hygiene, and the control of epidemics. They had a clinical role in supervising domiciliary midwifery, child health clinics, and health visiting. They were said to deal with the population as a patient, and this still defines community medicine.

In addition, there were always doctors concerned with the running of the Health Service in the previous Ministry of Health and later the Department of Health and Social Security. They ranged from the older medical superintendents of hospitals through to the administrative medical officers of various grades of the regional hospital boards, which were set up by the National Health Service Act of 1946. The intention was to try to bring the medical profession under a unified system, but this failed. The result was three groups—hospitals, general practitioners, and public health.

The reorganisation of the Health Service in 1974 again attempted to unite the three branches. Again it failed, since hospitals came under regional, area, and district authorities. These authorities needed administrative doctors to help and advise them. They came partly from what was the field of public health, where administrative experience was part of work day to day, and a few clinicians joined their ranks. The general practitioners tended to remain separate since they were still independent contractors with their local family practitioner committees. The local authorities had to get their medical advice from community physicians (as they were now called), who were employed by regional, area, and district health authorities. These local authorities, however, still had to maintain some clinical services in midwifery, family planning, school health, mental handicap, and for the aged, keeping control of some community clinical medical officers for these services. These are, relatively speaking, rather cut off from the remainder of the Health Service and are often forgotten by those in the hospitals and general practices.

Their work

Community physicians are employed by NHS authorities, now at region and district only since area authorities were abolished last year. They are concerned with the administration of all parts of the service except clinical community medicine, which is the responsibility of local authorities. They are much concerned with finance and other resources—such as manpower in medicine, planning hospital building, siting various services, planning for services as the need for them changes—thus generally looking to the future as well as at the present.

Their tools are epidemiology and statistics, sociology and psychology. They must take a very wide view in their analyses of problems arising now and of possible future problems. Their

University of Southampton, Southampton

PHILIP RHODES, MB, FRCS, professor of postgraduate medical education, and dean of graduate medicine for the Wessex region

information comes from national and other statistics, and they have to keep an eye on the social context in which the health services work. This means being au fait with the national and local political scene, assessing the forces at work in medicine and outside it, and analysing the strengths and weaknesses, bigotry and partisanship of their colleagues and the laymen and administrators with whom they have to co-operate.

The job can be fascinating. Just as in clinical medicine, problems are presented in many ways. Different kinds of information must be collected and analysed until the problem can be defined, as in a diagnosis. Methods of solving the problem must be sought, just as in treatment. Coming to a solution is, however, more difficult than in clinical medicine, since it requires persuading others who can take effective action. This includes colleagues in clinical medicine, lay administrators, and members of regional and district health authorities. This is done by writing reports and attending meetings and committees to present analyses, opinions, and arguments for and against possible solutions. This may be the major part of the work, but there are also responsibilities during epidemics, for example, and for port and airport health. There is specialisation too in community medicine—such as information services, manpower, and building. The information services are especially useful in attempting to work out the effectiveness of procedures, including clinical ones, and this will become more important as audit of clinical procedures becomes more common.

There is much to be done in community medicine and a great deal of research work is an inevitable part of it. Many academic departments in universities do research into all aspects of the workings of the Health Service and also into the epidemiology of disease. The major recent triumph here was showing the relations of cigarette smoking to several disorders. Other causes of disease in the community traceable to the environment may well be found by epidemiological research.

Community medicine has been dealt with at some length since it is so often misunderstood, yet it ought to attract some of the best intelligence in medicine because it is vital now and for the future. Moreover, it is relatively easy to enter now. There is a faculty of community medicine in the Royal College of Physicians. Entry to consultancy is by appropriate experience and passing a two-part examination for the membership of the faculty (MFCM). Information about community medicine examinations should be sought from the faculty, since regulations may change. In each region there is an adviser in community medicine, who may be traced by contacting the postgraduate dean for the region or through publications from his department. Similarly, the dean can find appropriate advice for you should you wish to go into clinical community medicine with a local authority. This may be a useful career for some women who may wish to work only part-time (see a later article).

In the next article I shall conclude the discussion of other careers in medicine.

Does wood, and in particular mahogany, commonly cause allergic reaction?

Certain woods cause allergic contact dermatitis, others are irritant to the skin and mucous membranes, and some have both properties. Some woods cause allergic rhinitis and bronchial asthma. Such reactions are probably not very common but they may still be under-diagnosed.¹ Only a few of the allergens have been chemically identified. Most are quinones and catechols. The key to the investigation of suspected cases is the correct botanical identification of the woods concerned.² Woods are not always what they are said to be. Mahogany is a good example. True mahogany originally came from South America (*Swietenia*) but today is mostly replaced by African mahogany (*Khaya*). Though both can sensitise the skin *Khaya* appears to do so more readily. But another type of wood, makoré, is also called African mahogany but is botanically quite distinct, and this irritates both skin and mucous membranes.—R J G RYCROFT, consultant dermatologist, London.

¹ Hausen BM. *Woods injurious to human health. A manual.* Berlin: Walter de Gruyter, 1981:4.

² Cronin E. *Contact dermatitis.* Edinburgh: Churchill Livingstone, 1980:551.

What proportion of pregnancies are spontaneously aborted?

Take a theoretical group of 100 fertile couples trying to achieve a pregnancy. If intercourse is frequent¹ and appropriately timed about 85 of the women will conceive in the first month. (This is a widely accepted estimate² but is difficult to prove.) Fifteen of these fertilised ova will fail to implant, and of the 70 that do start to implant, around half will be lost.³ (These figures are based partly on numbers of abnormal fertilised ova found in specimens taken at hysterectomy.) Chorionic gonadotrophin will be detectable in the urine of 36 women before the next period is due, but only 24 of them will miss a period. (These are more reliable figures, based on the observations of a recent British study.⁴) Three or four of these 24 women will miscarry. (The miscarriage rate² among women who know that they are pregnant is somewhere between 10% and 30%.) Only a very small proportion (relatively speaking) will lose their baby after the first trimester of pregnancy. The end result is a fecundability rate of around 20%

among couples trying to start a family—roughly the rate that has been observed in several demographic studies.¹ Thus the proportion of pregnancies lost after conception is 76%, but figures such as this are based in part on theoretical estimates.³ Direct observation,⁴ however, has shown that 43% of pregnancies are lost after chorionic gonadotrophin is detectable. The discrepancy between these two figures may be attributed to losses soon after fertilisation. The reasons for the high wastage rates are thought to be mainly to do with the fetus: 80% of aborted fetuses have chromosomal or other abnormalities,¹ and possibly some of the remaining 20% have abnormalities undetectable by present methods.—JAMES OWEN DRIFE, senior lecturer in obstetrics and gynaecology, Leicester.

¹ Short RV. When a conception fails to become a pregnancy. *Ciba Foundation Symposium 64.* Amsterdam: Excerpta Medica, 1979:377-94.

² Schlesselman JJ. How does one assess the risk of abnormalities from human in vitro fertilization? *Am J Obstet Gynecol* 1979;135:135-48.

³ Roberts CJ, Lowe CR. Where have all the conceptions gone? *Lancet* 1975;ii:498-9.

⁴ Miller JF, Williamson E, Glue J, Gordon YB, Grudzinskas JG, Sykes A. Fetal loss after implantation: a prospective study. *Lancet* 1980;ii:554-6.

Does meat sold for human consumption contain antibiotics, and if so is the level permitted likely to produce a reaction in people allergic to, say, penicillin?

Meat and all bulked milk are regularly monitored for antibiotic residues. Cooling in cold storage may influence the amounts. Both sensitisation after repeated exposure as well as the triggering of a reaction in a previously sensitised patient are possible. Tenderisers, colorants, and preservatives in meats may cause allergic problems in man. Anabolics are also a potential hazard so that a Joint FAO/WHO Committee on Food Additives reviews the possibility of establishing "acceptable daily intakes" for residues in man. Unfortunately, regulations are made but enforcement in many countries is far from adequate. Some of these problems are further detailed.¹⁻³—A W FRANKLAND, consulting allergist, London.

¹ Olson JC, Sanders AC. Penicillin in milk and milk products: some regulatory and public health considerations. *Journal of Milk Food Technology* 1975;38:630-3.

² National Academy of Sciences. *The effects on human health of subtherapeutic use of antimicrobials in animal feed.* Washington DC: NAS, 1980:301-16.

³ O'Brien JJ, et al. Effect of cooking and cold storage on biologically active antibiotic residues in meat. *Journal of Hygiene* 1981;87:511-23.