Career focus

Public health is good for you

The skills learnt during training in public health are increasingly recognised as useful in the clinical mainstream. Sam Gibbs and Nandu Thalange tell you how

We were, for a time, public health chaps. We stepped off the conveyor belt of our clinical training to spend time on the other side of the fence grappling with the broader determinants of health and disease and getting a feel for the medical arm of NHS management. We feel we are better people for having done it and would warmly recommend the experience to anyone interested in doing the same.

The Anglia public health training scheme offers two fellowships in public health and epidemiology every year. These fellowships allow specialist registrars from any specialty to spend six months or a year working in a department of public health medicine. The projects undertaken, and the skills and experience gained, can be tailored for the particular interests and needs of individuals but are likely to include some of the following broad areas: epidemiology and statistics; contracting, budgeting and prioritisation; guideline development; service review; audit, quality and clinical governance; health needs assessment; and the promotion of a knowledge based service.

What is public health?

This is a question that haunts even those within the confines of public health. One of the hallmarks of the specialty seems to be a constant search for self definition and clear objectives.

It is now known that public health is not just about drains but is, in fact, a little like a religion, a whole way of life.¹ In essence it is the application of medical principles to populations rather than individuals. The practice of public health therefore involves not only promoting health and preventing disease (as if that were not enough) but also maximising the benefits of clinical services.

Increasingly, the importance of coordinating the efforts of all those whose work affects the health of the public (in the

Some of the public health projects we were involved with

Epidemiology and statistics

- Secular trends in skin cancer
- Childhood diabetes

Communicable disease control

- Head lice guidelines
- Scabies guidelines

Health service management

- Alcohol services business plan
- Review of skin cancer services

Policy implementation

- White paper steering group
- PCG development

Promoting knowledge based service

- Cochrane review of wart treatments
- Screening for neonatal hearing

Quality

- Guideline development for oral surgery
- Quality specification for renal replacement therapy

broadest sense) is being stressed.² This is particularly evident in recent government papers on health policy—such as *Saving Lives: Our Healthier Nation*, published in 1999. Among much else, this white paper includes the concept of a local, multidisciplinary public health strategy—the health improvement programme. Training in public health for doctors involved in clinical services could therefore be seen as a part of this process of encouraging joint working between different “camps.”

As with general medicine, there are elements of public health that could easily comprise whole specialties in their own right. As doctors coming to public health from other clinical specialties, we followed advice to focus on a limited number of areas within the discipline so as not to become overwhelmed. Negotiating the cultural change from clinical doctoring to public health medicine was somewhat bewildering initially. Suddenly there were no clinics, ward rounds, or even patients, and acres of time stretched out ahead needing to be filled with useful activity. The pattern of

work in public health is largely project based and does not yield quick, palpable results in the way that our clinical training had taught us to expect. In order to survive this, an adjustment towards longer time scales was needed, as well as disciplined time management and perseverance. With time, we gained considerable knowledge of the particular issues that were the focus of our projects and acquired the skills needed to develop them and bring them to fruition.

What public health covers Ill or not ill

Epidemiology is the basic science of public health. Measuring incidence, prevalence, and all those other things gives an accurate picture of a particular disease in the population and provides invaluable information for developing prevention and control strategies and planning services. Seeking out, handling, and interpreting data are fundamental skills in public health.

Bugs, antibiotics, and collective hysteria

Communicable disease control has a central position in public health and involves the surveil-

lance of communicable diseases locally and globally as well as the management of outbreaks within the catchment area. Dealing with outbreaks requires diplomacy and “media management skills,” as public perceptions and reactions (be they to meningitis or head lice) are often out of proportion to the reality of the situation.

Managing the muddle

Health service management is probably one of the essential areas for a visiting fellow to get involved in while in public health. Death by meetings can ensue, but there is no real short cut to finding out what makes the cogs go round and how change can be brought about, if at all. Here one can gain exhaustive experience of the politics and psychodynamics of committee work. Not everyone’s cup of tea, but it should definitely be tasted.

The men from the ministry

Related to health service management is the knotty problem of implementing government policy, which is also an integral part of what public health doctors do. During our first weeks in post, our desks seemed to be progressively smothered with papers: memos, minutes, circulars, rectangulars, reports, green papers, white papers, sweet papers. It was difficult to keep up, and suddenly, brutally, we had gained an insight into the horrifying complexity of the NHS.

What’s the evidence for that?

Systematic reviews, as with varnish, tend to do just what it says on the tin—review the evidence for interventions in health care in a systematic way. Doing one of these is a very good way of developing a number of key skills, and such an exercise can be carried out during an attachment in public health. Skills acquired include exhaustive literature searching, assessing the methodological quality and validity of clinical trials, and the statistical mechanics of pooling data and meta-analysis.

Never mind the quality, feel the width—no more

Quality and consistency of quality of service are emerging hot topics for public health doctors and clinicians alike, requiring close collaboration. This is one area where a clinician working in public health can make a valuable contribution, and where skills learned will prove invaluable later on working in the brave new world of clinical governance. There is a dearth of people working within trusts who can help to “translate” research into practice, and in one NHS region health managers have gone so far as to appoint medical care epidemiologists to promote clinical effectiveness in hospitals.³

The benefits

Firstly, we enjoyed ourselves. This was a creative break from clinical work, a refreshing change (certainly not a rest), and an opportunity to stand back and think about the practice of medicine in a much broader framework. It was a tremendous privilege to have time to really think through specific issues and work on particular problems in the health service. This kind of time is simply not available when coping with day to day clinical work. We feel there is a strong case for every doctor having the opportunity to develop

this broader perspective at some stage in his or her postgraduate training.

Secondly, we feel that we have grown and developed, professionally and personally, during our time in public health. We now have some appreciation of the scale and complexity of the NHS and a better understanding of the difficulties of managing such an organisation. Also, we have been stretched and challenged in the course of the various projects we worked on and have developed particular skills that will be invaluable in our chosen career paths.

Thirdly, the health service can only benefit from having clinicians who have some understanding of public health issues, especially now that it is recognised that the public health function concerns us all. The benefits should be felt both ways. Clinicians with experience in public health are likely to be less blinkered about their own small corner of the medical universe and have a grasp of the concept of the greater good. Public health doctors will be able to develop closer, more fruitful relationships with clinical medicine by having trainees from clinical specialties in their midst. Vive la difference, go forth and cross-fertilise!

In short, we have a sneaking suspicion that you're not really

complete until you've done something like this. Although there are some examples of public health training for clinicians,⁴ we feel there should be more opportunities for “ordinary” doctors to gain experience in public health. More departments of public health medicine should consider offering such fellowships, and clinicians in training should think about what could be gained by such a venture. Why not try it? Public health is good for you.

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1 Palmer S. From public health to the health of the public. *BMJ* 1998;347:550-1.

2 Calman KC. *Chief medical officer's project to strengthen the public health function*. London: Department of Health, 1998.

3 Hill P. Public health in hospitals: change agents for clinical governance. *Public Health Forum* 1998;2(2):4.

4 Mason B, Udenze C, Clarke M. General professional training in public health medicine—the Leicester senior house officer scheme. *J Public Health Med* 1994;16:310-3.

5 Brenner H, Money P, Quinn R. General practice vocational training and public health medicine: a novel collaboration. *Fam Pract* 1994;11:171-5.

6 Boyer MH. A decade's experience at Tufts with a four year combined curriculum in medicine and public health. *Acad Med* 1997;72:269-75.

Briefing

● The NHS assumes its consultants will retire aged 65, but a recent report suggests that only a minority may in fact do so. A survey of all consultants in a single trust in *Employing medical and dental staff* reported that half intended to retire before the maximum age. The Department of Health bases its workforce predictions on overall “wastage rates” from census data and estimates that the consultant workforce shrinks at about 6% each year. Although it is unwise to extrapolate too much from a single small trust with onerous rotas and little middle grade cover, the survey makes it easy to see how localised workforce problems can easily become acute.

Employing medical and dental staff. Chamberlain Dunn Associates, 0181 334 4500 or from mail@chamberdunn.co.uk

● Although the perceived threat of a bad reference is generally considered to be one of the most powerful normative forces in medicine, recent research suggests that in fact the problem is the reverse. In the United States all applications for residency programmes are accompanied by a Dean's letter which should reflect overall performance in medical school. When researchers compared actual medical school records with more than 500 of the deans' letters they found that more than a third suppressed relevant negative information such as failing an exam or a clinical firm.

● Career focus's recent move within the eBMJ means that you can post rapid responses to articles. For instance, Bobby Farsides points out that Macnair was wrong to say that St Christopher's Hospice is appointing an ethicist, though it is in the process of developing its ethical committee. (<http://www.bmj.com/cgi/eletter/s/319/7214/S2-7214>)

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