Bad Food Guide

The Medical Officer of Health for the City of Westminster calls attention once again to the serious defect in the law which actually helps unhygienic catering establishments to come into being. The report says, “A local authority is unable to prevent a person opening an unsatisfactory catering business. There is no legal requirement to obtain prior approval of the premises by the local authority.” Therefore, it is not until the restaurant or other catering business is functioning that the premises can be inspected and the requirements of the Food Hygiene Regulations applied. It is time that this was put right, as more and more unsatisfactory food businesses are springing up all over the country. Public health inspectors are aware of this but are unable to give sufficient supervision because of limited staff and the many other duties they are required to perform. A system of prior approval and registration would undoubtedly lead to much more effective control and safer eating out for the public.

It is only necessary to consider what has happened to that most British of catering establishments—the fish and chip shop—to realize the need for stricter legislation. In recent years all sorts of exotic dishes have been added in some establishments to the once limited bill of fare. These dishes are often prepared in a kitchen which is overcrowded and whose equipment is old, some of which would seem to have been discarded from domestic use and not even designed for commercial purposes. Large catering pack cans have more than once been seen in use as cooking pots. A good example is quoted in the Chief Medical Officer’s latest annual report.13 Thirteen people developed violent sickness after eating fried rice from a restaurant. The causal organism was the aerobic spore-bearing Bacillus cereus. It is likely that the outgrowth from B. cereus spores with toxin production occurred in the stock lot of boiled rice kept at kitchen temperature over several days, and used for preparing the fried rice when ordered by customers.

Cases and outbreaks of food-poisoning cases are grossly under-reported, though it is a notifiable disease. This laxity is the more regrettable as it is only by prompt notification that the disease can be satisfactorily investigated. The principal causual organisms are various Salmonella serotypes, Staphylococcus aureus, and Clostridium welchii.

The number of fatal food-poisoning cases in 1971 was 48, which suggests the need to give more attention to the epidemiology and control of this group of readily preventable illnesses. The prior approval and registration of all food premises would initially place a heavy burden on public health inspectors, but in the long term it would make their supervisory duties much easier. However, doctors must also take more seriously their responsibility to notify promptly all patients whom they see and consider to be suffering from food-poisoning, as it is only in this way that unhygienic catering establishments can be promptly traced and inspected.

A Look at Practice Organization

With the ink barely dry on his second Cogwheel report on medical work in hospitals4 Sir George Godber is now to chair a joint working party which will look at general practice organization. The last time that a Whitehall mandarin was involved in studying the practical workings of general practice was in 1964. Then Sir Bruce Fraser, Permanent Secretary to the Ministry of Health, chaired a working party which had been set up to try to ward off the worsening manpower and money crisis. As an administrative attempt to solve an essentially political problem it was doomed to failure though its reports were of help in the subsequent discussions on the family doctors’ charter.

The new inquiry, which will consider “the various patterns of organization in general practice, the ways in which they may evolve in a changing situation, and the range of advantages to patients which may result,” takes place against a less tempestuous background though the forthcoming upheaval of the N.H.S. is bound to influence its outcome.

To those patients and doctors firmly wedded to the “personal family doctor” the idea of sharing the patient’s care with other doctors—let alone other health workers—and working from large outpatient-like premises is unpalatable. They may perhaps be tempted to say “I told you so” at stories of patients having to wait several days to see a doctor—or pleading with a practice secretary for a visit from the doctor—or rarely seeing their own doctor—or confronted at midnight by a strange doctor from a deputizing service. It is hardly surprising, however, that the changing pattern of practice organization—more and larger groups, health centres, appointment systems, attached ancillary staff, rotas, and deputizing services—has had some untoward side effects. In any case the archetypal family doctor was to a quite considerable extent an ideal.

The many reports on general practice in recent years have aimed to graft the best of the old onto new ideas for caring for patients in the community. The latest study is essentially in this mould for it will measure the success and probe the weaknesses of the amalgam of old and new. Sir George will be joined by six general practitioners from the General Medical Services Committee and four from the Royal College of General Practitioners, along with four Departmental officials and one outside lay member. Despite its strong professional base many doctors may groan at the thought of yet another inquiry, but they will probably be wrong. At least Sir George

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