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THE STATUS OF THE MEDICAL OFFICER OF HEALTH IN RELATION TO THE MINISTRY OF HEALTH,*

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THIS is a somewhat difficult question to introduce, by reason of the fact that whatever one has to say upon it is always open to the criticism that one's view is prejudiced owing to self interest. I will, however, try to treat the subject from a wholly detached point of view—that is, from the point of view of what is best in the public interest.

Everyone is agreed that the unification, the control under one body, of matters affecting the health of the people, is essential in the public interest. There should be an immediate end of a system whereby seven or eight different Government Departments deal with matters affecting the health of the community. With such a system there must be overlapping, and there must be over-staffing and consequent increase of expense.

If unification is necessary at the centre, it is equally necessary at the periphery, and for the same reasons. There should be one body locally to deal with all questions affecting the public health.

In passing, may I say that, at any rate the predominant nucleus of that local body dealing with health questions should be the existing Health Committees of Corporations, because, in the first place, public money will have to be spent, and, therefore, must be spent by people over whom the ratepayers have some control; and in the second place because these Committees have already had large experience in these matters. These remarks apply only to the larger authorities, County Boroughs and County Councils. There cannot be the same

effective administration in the smaller urban and rural district authorities, for various reasons, and in this direction there is need for reform.

Now it is obvious that for each local authority there should be some person appointed to advise, supervise, control, and co-ordinate all agencies having for their object the improvement of public health.

The British Medical Association, in a deputation to Lord Rhondda, have advised that there should be two such advisors, that the existing medical officers of health should advise upon, and supervise what they call preventive work, and that a Clinical Administrative Officer be appointed to supervise and organize all clinical work undertaken by local authorities.

Why two people are suggested to do cognate work is not explained; but there is a widespread feeling in the medical profession (and this is supposedly the reason) that medical officers of health are out of touch with practical clinical medicine.

Indeed, medical practitioners have inferentially left it to be understood by the layman, and many laymen do, as a fact, understand, that medical officers of health are different from other doctors. It should be very clearly stated, and re-stated, that a medical officer of health goes through exactly the same course of study as any other doctor. He has, in most instances, held appointments in clinical hospitals, but afterwards he has specialised in infectious diseases (just in the same way as other doctors specialize in the treatment of eye and ear diseases) and has, in addition, taken a special course of study in public health over and above that necessary to become qualified to practise medicine.

Now this inference that the medical officer of health is out of touch with clinical medicine is not true. Let us examine the facts. The medical officer of health has organized and is now intimately associated with the work

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in connection with Tuberculosis, Venereal Diseases, Child Welfare, Fever Hospitals, School Medical Inspection, etc. In all but the larger County Boroughs he is in charge of the Fever Hospital and treats the patients therein. In the smaller County Boroughs, in addition to the fever hospital work, he actually does the clinical work in one, or possibly two, of the above-named departments. He either acts as school medical officer and medical officer of health, or acts as medical officer of health and presides at the child welfare centre, or combines medical officer of health, school medical officer, and medical officer of the child welfare centre, and so on. It must not be forgotten, too, that the etiology of infectious fevers has had during the last few years largely to be re-written, mainly owing to the observations of the medical superintendents of fever hospitals, who, as has just been stated, are almost invariably medical officers of health.

Even if the inference were true that medical officers of health are out of touch with clinical medicine, would not the same argument be applicable in a few years to the clinical administrative officer suggested by the British Medical Association? As a matter of fact, clinical officers will be employed more and more by public bodies, and the medical officer of health will, therefore, be more and more in touch with clinical matters, since he will be in touch with these clinical officers, who should be on his staff. Moreover, the appointment of two administrative heads is the very negation of the principle of unification for which we are contending. There can be but one administrative head, if only to obtain the following advantages:—

(1) To prevent friction and, therefore, inefficiency and overlapping. If the two suggested co-equal heads disagree there is bound to be inefficiency and overlapping, since there will be no conference between the two, each will "gang his own gait" and do his own work with his own staff.

(2) To promote economy: (a) the number of persons necessary to be employed will be fewer and, therefore, salaries to be paid will be less; (b) the number of institutions required will possibly be fewer. Let me illustrate by example.

Suppose two heads, one dealing with clinical and the other with preventive medicine (so called), as suggested by the British Medical Association, one is at once faced with the

question, "Which disease is preventable and which is not?" How, therefore, are their respective spheres to be defined? Possible friction at once. Again, almost inevitably certain enquiries will have to be made at the homes under each heading. There will thus be home visits from the preventive side and home visits from the clinical side, which, added to the already large number of home visits from other different departments, will result in further chaos, further expense, and further opportunities for friction. With but one head, he would see that one visitor only collected all the information necessary for his department from one house.

Take another example. School clinics are for children of school age, say, between 5 and 14 years. A child aged 4 years requires treatment, but is refused such treatment at the school clinic because it does not attend school. If there were one co-ordinating head for the whole system, it is obvious that this difficulty would easily be overcome, whereas with two heads each might be ignorant of the desires of the other, and each, unknown to one another, might be arranging for an institution in which certain work was to be done, whereas with one head one institution might be made to serve the two objects.

If, as the British Medical Association suggests, it is necessary to have a clinical administrative officer for the clinical work undertaken by corporations, should this clinical officer be a physician or a surgeon? Some of the work undertaken by corporations will be surgical and some medical, and if the medical officer of health, although a qualified medical man, is, inferentially (according to the British Medical Association) not a suitable person to administer clinical work, on presumably similar grounds a physician is not a suitable person to administer surgical work, nor is a surgeon to administer medical work. Logically, therefore, there should be three administrators—the medical officer of health, the surgical administrator, and the medical administrator. Obviously the proposition is absurd, and it is difficult to understand how such a proposal could have been approved by the Council of the British Medical Association.

Medical officers of health should be the local representatives of the Ministry of Health, and just as happens now in many businesses with branches all over the country, once a year, or as often as necessary, the local managers and the heads of the firm meet

together and discuss the business of the firm, how it can be improved in various directions having regard to local circumstances, and so on, so in like manner should there be a meeting of medical officers of health with the Ministry of Health once a year, in order that the Ministry may be kept fully informed of public health opinion all over the country, and also of the local difficulties. By this means the governing central authority would not, as so often happens now, lag behind public opinion. The Government could be informed first-hand of the needs of the country, and that the country was ripe for legislation in certain directions. Moreover, recalcitrant local authorities could be kept up to the mark, and—dare I breathe it here?—too conservative medical officers of health also could be brought up to the scratch. Before this meeting took place, returns on certain questions might be asked for from local authorities, and the Ministry could form from the answers to these an opinion as to the amount of work done in any particular locality in any given direction, and could ask for explanations if they do not consider the amount of work done or its quality up to the standard.

Further, it is inexpedient that the details of administrative measures should all be settled at the centre. Local conditions vary so much. It does not make for efficiency that every little item of expenditure should be criticised by the Government Department. The policy should be laid down, and principles settled by, the Ministry of Public Health, and the details of any scheme should, very largely, be worked out locally.

To sum up the conclusions at which I have arrived—

1. That unification of control in public health matters is necessary at the centre.

2. That, if necessary, at the centre, it is also equally necessary at the periphery, for reasons stated; and

3. If unification is obtained at the centre and at the periphery, it equally follows that there should be unification in administration, and this can only be obtained by having one head. Who that head should be, I will only indicate by saying that the person who has already organised tuberculosis work, maternity centre and child welfare work, school medical officer's work, venereal disease work, and the ordinary work of a public health department, is clearly the man to be entrusted with any organization required for future developments in medical

work, rather than that another man with no experience whatever should be appointed to organize work precisely similar to that already undertaken by the medical officer of health.

SYPHILIS AND TUBERCULOSIS IN U.S.A.

FOR the purpose of determining the frequency with which syphilis is associated with tuberculosis and to direct those found luetic to general dispensaries for treatment of that condition, thereby possibly improving their tuberculous state, Wassermann blood tests were made on 175 tuberculous patients at Corlears Tuberculosis Clinic. The findings are classified as follows:—

Wassermann Tests: Cases with four plus reaction, 12; with three plus reaction, 2; with one plus reaction, 7; with negative reaction, 154; total, 175.

Fifty-two of the patients had tubercle bacilli in their sputum; of these five gave a strongly positive Wassermann reaction.

One hundred and sixteen patients had no tubercle bacilli in their sputum; of these, fifteen gave a positive Wassermann reaction, the cases being about equally divided among four plus, three plus, and one plus reactions.

Subsequent clinical findings confirmed the diagnosis of syphilis in all cases that gave a strongly positive Wassermann reaction, and in some of those that were reported weakly positive. So far as could be learned, the beginning of the luetic affection invariably preceded that of the clinically associated tuberculosis. All of the positive Wassermann cases were referred to general dispensaries for observation of their syphilitic condition and for anti-syphilitic treatment. As many with active pulmonary lesions and negative sputum gave a positive Wassermann reaction, with and without clinical evidence of syphilis, the possibility of pulmonary syphilis was not lost sight of, later developments proving, in at least two instances, the probable existence of that condition. The effect of the anti-syphilitic treatment upon the tuberculous process in the luetic cases has, thus far, been encouraging. These findings are corroborative of results obtained by other observers, and again emphasize the need of a more general use of the Wassermann test in tuberculous patients.

PLAGUE.—Plague has insidiously spread itself to almost every country in the world; there is hardly one, some of whose towns or ports have not been affected during some period of the year.—*Prof. E. W. Hope, M.D., Annual Report 1916, Medical Officer of Health to the Port Sanitary Authority, Liverpool.*