THE ROLE OF THE MEDICAL HEALTH OFFICER IN BRITISH COLUMBIA

by

DALE RAYMOND LOEWEN, M.D.
Queen's University, 1966

A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF THE
REQUIREMENTS FOR THE DEGREE OF
MASTER OF SCIENCE

in

THE FACULTY OF GRADUATE STUDIES

Department of Health Care and
Epidemiology

We accept this thesis as conforming to
required standard

THE UNIVERSITY OF BRITISH COLUMBIA
January, 1979

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Department of HEALTH CARE AND EPIDEMIOLOGY

The University of British Columbia
2075 Wesbrook Place
Vancouver, Canada
V6T 1W5

Date ~~October, 1978~~
February 1979

ABSTRACT

The role of the Medical Health Officer (M.H.O.) in British Columbia is explored in this thesis, looking for consensus on the "job description."

The evaluation of this brand of community physician is examined in a literature review which considers his function in the three countries of Britain, the United States and Canada. Some associated discussions of community health services in these countries is evident. Education of the Medical Health Officer is also explored as a necessary component in assuming this role description. The diversity of roles as engendered in the Canadian provinces is related to the legal and administrative position of the British Columbia Medical Health Officer. The study generally examines the level of consensus that has existed internationally and nationally on the role of the Medical Health Officer and specifically the level of consensus amongst British Columbia Medical Health Officers.

A survey questionnaire was mailed to all provincial, regional and city Medical Health Officers in British Columbia to elucidate their opinions and ideas on what the job description entails and what they feel it should be. The response rate overall was seventeen out of twenty or eighty-five percent.

Selection, education and experience of Medical Health Officers in British Columbia is examined in detail. Attitudes about the position and how it relates to the rest of the medical community are felt to be important aspects to integration of community medicine with the rest of medicine in general. The role description is divided mainly into Administration (Health Unit Director role) and Direct Services (Community Physician) role. The Health Officer

(legislated officer role) is outlined as it occurs in British Columbia but this area is not pursued in detail because it could form the substance of a complete study in itself.

The results indicated a lack of consensus on the role of the Medical Health Officer. In British Columbia the variable role is found to be more a function of personal preference and regional needs than a common set of procedures and practices.

History revealed a constant reorganization and re-evaluation of Medical Health Officer functions accelerated by rapid technical, political and social changes.

The need for a clearer role is questioned. The Medical Health Officer is felt to be a generalist, hopefully with the versatility to direct the "conflicting goals" of health systems into some kind of organizational sense. His broad outlook is felt to be an asset in this regard.

Five main recommendations resulted from the study with respect to the British Columbia Medical Health Officer. These were:

1. re-evaluation of the educational program, periodically;
2. elimination of the marginally useful administrative functions of the Medical Health Officer by expansion of the Office Supervisor role;
3. re-evaluation of the selection process for British Columbia Medical Health Officers;
4. establishment of closer formal liaison with "clinical medicine" via the BCMA to eliminate traditional barriers between the two

groups and to expand the role of community medicine and;

5. requirements that assure new Medical Health Officers will obtain the F.R.C.P. qualifications to maintain equality and credibility with the clinical physicians.

Finally, it is felt that there will be ongoing evaluation and assessment of the Medical Health Officer role without consensus ever being achievable or even desirable. This is not felt to alter his contribution to health systems.

The question, "What level of consensus is there among British Columbia Medical Health Officers about their role?" has been answered. There is none.

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CHAPTER I

INTRODUCTION

There is a considerable difference of opinion about the role of the Medical Health Officer. Different points of view have been expressed about what Medical Health Officers should be doing and how they should fit into the overall system of health care.

Regional needs, culture, personal preferences and a host of "parochial" pressures shape and determine the Medical Health Officers' role and act as forces which oppose the development of a common role.

The issue then, is whether regional demands dictate the role or whether a common set of procedures and practices transends regional boundaries, and serve as the basic components of a common role.

As a first step in determining whether functions transcend boundaries or are dictated by them, we must look at what Medical Health Officers are doing and how they view their functions. This will give us some valuable insights even if it doesn't answer the question on whether a common role for Medical Health Officers can emerge.

Has the role of the Medical Health Officer ever been defined clearly? What level of consensus is there among British Columbia Medical Health Officers about their role?

This thesis will examine the level of consensus that has existed internationally and nationally. Specifically this research will explore the level of consensus amongst British Columbia Medical Health Officers on their role.

The literature review looks at Public Health (Community Medicine) and the Medical Health Officer from their development in Britain, the United States, Canada and British Columbia. Questionnaire data from British Columbia Medical

Health Officers is collected and analysed and finally conclusions and recommendations are drawn based on the literature and on consensus about the role of the Medical Health Officer in British Columbia.

CHAPTER II

LITERATURE REVIEW

In this Chapter we will be examining the beginnings of the Medical Health Officer as public health evolved from private practice in Britain. The spread of public health, now referred to as community medicine, from Britain to the United States and Canada is explored and compared. The role of the Medical Health Officer as it emerges in these countries is contrasted looking for similarities and consensus on the job description.

The provinces within Canada are compared with the same idea in mind and finally the legal and administrative position of the British Columbia Medical Health Officer is discussed.

1. Medicine and Public Health

Public health has existed since the beginning of medicine in some varying form. The mainstream of medicine involved the historical clinical physician, whose background stretched to earliest of written records. He was individual oriented and patient oriented. The Hippocratic Oath itself, stressed that the physician (an individual) should live in partnership with the physician (an individual) who taught him the art, and the whole flavour of the oath is that of a relationship between the individual physician and his patient. For thousands of years the individual has been coming to the individual doctor saying: "It hurts here", and asking to be helped.[1]

In much of this traditional medicine, the physician didn't see the patient unless he was sick. The well man didn't consult a physician, but the family doctor frequently saw family members in good health, thereby involving himself

in preventive medicine and obtaining insights which would help him when these individuals became sick. Public health, or protection from and prevention of disease in the community required state involvement and eventually separated from private practice or the mainstream.

Community Medicine, the application of scientific and medical knowledge to the protection and improvement of the health of the group - calls for organization, a conscious effort by authority. Some form of organization of public health has also existed in most societies from the earliest times, eg. the state doctors of Egypt and Rome, the medieval leprosaria, sanitary inspectors of Arabian cities and regulation of brothels. This has always, until recently, been limited by the lack of technical knowledge and hampered by an inadequate appreciation of the value of health and a lack of social understanding. Certainly, there was an almost complete lack of organization for community health services. It has always played a secondary role to the mainstream and consensus on this role has been lacking.

2. Organization of Public Health

Is there international or national agreement on the organization of public health? Public health organization has had to await the enlightened self interest of those who are capable of getting things done, so it has been practiced when it seemed to lead not only to "new pastures" but to more pleasant pastures. Thus, the rich in England played a more active part in sanitary reform, once they were convinced that the diseases of squalor might endanger their own lives, as well as those of the poor.

The beginnings in Europe were near the end of the eighteenth century, reflecting varying ideologies of the many peoples. Johann Peter Frank (1745-1821)

wrote about social medicine as a police measure - an expression of the autocracy he lived under. His ideas on hygiene in the classroom, and poverty as a cause of illness were way ahead of his time but did little to reflect present day concern for 'participation by the people, local government or doing things with people in tune with their culture.'(2)

In Britain, Chadwick's (1800-1890) circulation of vital fluids, from pure water to purified sewage, protected water courses, pipes, drains and sewers intact and inviolate, return after purification to the soil - has been as momentous for man's progress as Harvey's discovery of the circulation of the blood. If he were alive now he would still find nine-tenths of the world suffering the torments of intestinal infestations from which Europe and the New World, in following his teachings, have escaped. Not only his sanitation, but the use of local government in public health administration and the use of the Medical Health Officer as a specialist advisor gave rise to far reaching effects.(15) The appointment of the Medical Health Officer soon became compulsory and their tenure of office protected.

Throughout Europe, North America and the British Dominions the general plan of organization followed. However, while Europe gathered its administrative forces at the centre and attacked the problem of how to get the sick treated, England and the New World got down to Chadwick's sanitation with the responsibility firmly placed upon the shoulders of the local citizens.

The influence of England on America was striking. The Shattuck report, (1850) might easily have been written by Chadwick. Shattuck followed the English report in most of its main recommendations, including that for full time Medical Health Officers specially trained and qualified in public health and

independent of private practice. Despite the report, however, the concept of a well-organized health department, supervised by a whole-time Medical Health Officer, was not widely applied in the United States until the 1920's.

The Canadian experience has followed a similar pattern to the United States, and earlier Britain, in the establishment of health units. In British Columbia, which became a province in 1871, the first Medical Health Officer was appointed in 1892 because of a smallpox epidemic. The first health unit began in Saanich in 1921. In 1951, G.R.F. Elliot speaking on the evolving role, stated that "the health unit must have a broad approach to social and economic problems and must learn to understand and attack medical care, poor housing, mental hygiene, accidents and others."(16)

The development of local health units has been, to all appearances, quite haphazard everywhere.(2) In England, they began in 1831 and the country was covered in 1875. In the United States, the span was from 1793, in Baltimore, until the 1920's. Few things, indeed, are so striking as variations in development of public health amongst countries. Denmark began gratuitous treatment of Venereal Disease for all patients in 1790 - Britain didn't until 1916. Britain concentrated on sanitation in 1848 - France hardly appreciated it until 1902.

Also, the extent of power wielded by the Medical Health Officer has been strikingly different, within different countries and often within the same country. (W.H.O. '75). The Health Commissioner in a United States city governed on the managerial system, making and executing his own laws, but generally liable to removal by political whim, will have enjoyed a very different daily round of life from that of a nominated official in a European country. The

British Medical Officer of Health, whose duty it was to discover everything in his area prejudicial to the health of the people was virtually independent of control from the centre and yet the servant of a locally elected council with its own chairman. In Canada there is a similarity to Britain but the Medical Health Officer is not totally at the mercy of any local body because of provincial control. There is variation here amongst the provinces and, as we will see, the roles are changing contingent on provincial governments, not local sources of power.

In machinery and content, public health - the basic institution created and maintained by society to preserve the life and health of the people - is, in Europe and North America, a many splendored garment. (W.H.O. '75). Recent developments in comprehensive medical care have tended to hasten the development of a common pattern. Most of the countries which began their public health in the nineteenth century movement are once again in the throes of revolutionary thinking towards the newer goal of social medicine, which involves public health in curative medicine and vice versa. The concept of good public health now demands a full medical service, at home and in hospital, available to every citizen irrespective of the ability to pay. Britain, Australia, New Zealand and Canada are engaged more deeply in operating schemes of medical care, financed by the State or insurance, according to taste. These have resulted in increasing emphasis on the hospital, a phenomenon which every country has experienced to some degree. The future in Europe and North America may well become a fight to prevent the hospital from taking control.

On the creation of a Public Health or Community Medicine health structure, the World Health Organization (W.H.O. '75) has come out with four concepts

concerning the permanent framework.

i. Unification of preventive and curative medicine.

ii. The need for unity or control, where one governing body of the community needing the service co-ordinates all measures of prevention, care and restoration under one health service, is stressed. (W.H.O. '52)

iii. There is a need for local government with legal backing for autonomy of action. Problems, when this isn't in effect have been evident in underdeveloped countries.

iv. Finally, it has been stated that "primacy of preventive medicine is to be maintained by having health minded rather than disease minded people responsible for overall planning and the direction and allocation of community resources." (14)

Where the hospital has been included in the administration, this offers the best opportunity of preventing hospitals from becoming autonomous with uncontrolled vested interests in curative medicine. It is the Medical Health Officer, rather than the Hospital Officer, that should plan.

"Public health in Europe and North America is a many splendoured garment. Power wielded by the Medical Health Officer between different countries and in the same country has been strikingly different. The development of local Health Units has been quite haphazard everywhere." These statements from the preceding discussion indicate lack of agreement on the organization of public health and on the power base of the Medical Health Officer.

Reunification of Clinical Medicine and Public Health

To further confuse this lack of agreement, today public health and clinical medicine are moving together again. In some parts of the world they have already joined, in others they are still apart.[1] There has been an uneveness of the advance towards the acceptance of medicine as a social science, and of medical and hospital care as an essential agent in public health. While Scandinavian doctors have accepted a co-operative role from the nineteenth century onwards, the professions in England, the United States of America and France have fought rearguard actions to avoid what they consider to be an infringement of their liberties.[2]

In 1920, the Dawson Committee said in Britain, commenting on the need to unify preventive and curative medicine: "Preventive and curative medicine cannot be separated on any sound principle, and in any scheme, medical services must be brought together in close co-ordination. They must likewise be brought within the sphere of the general practitioner whose activities should embrace communal as well as individual medicine."[3]

The most important expression, of this linkage, is in relation to the work of the general practitioner, where medical care, based on the family unit, can go hand in hand with health promotion, prophylaxis, health education, rehabilitation and "stimulation of local interest in public health."[2]

The barriers between clinical medicine and public health, between medical health officers and medical care administrators are crumbling. Teamwork of all clinical practice and of that with the social services is required. Public health needs clinical medicine - clinical medicine needs a community. The present structure of health services reflects history and politics, sectional

pressures, sheer inertia, and it has to catch up now with changes in the patterns of disease, service and care. In promoting the public health, the community physician (medical health officer) must be directly concerned with the mass problems of today and be able to draw from the community's resources to deal with these, not be limited to the need of services that history happens to have deposited in his office.[4]

"By far the most important trend influencing the future role of the local health department and medical health officer in Canada is the increasing realization that society will no longer tolerate the old fashioned division between prevention (local health department) and treatment (hospital and health professionals). This split is said to be a waste of time, effort and money."[5]

More recently in the United States of America it has been stated that the private sector of medical care has demonstrated serious inadequacies in coping with such difficulties as maldistribution of services,[6] quality control[7] and cost containment.[8]

A survey of local health departments and their directors in 1977,[9] established that official public health agencies are far too extensive to be consistently overlooked in the development of the nation's health policies. The United States has in place an unevenly operative public infrastructure of community and personal health services - understaffed, underfunded and widely ignored. The possible benefits that might derive from correcting these neglects needs close attention.

Reorganization of the British National Health Service in April 1974 brought about the creation of community medicine as a service specialty.[10]

In 1967 Sir George Godber had stated, "It will be lamentable to the future

of social medicine and gravely limiting to the development of our services if the present generation of administrative doctors does not seize the opportunity now opening before it, of providing in every district the "community physician" who will promote the organization of medical care in all its curative and preventive aspects and in large areas the essentially medical part of better administration."[11] A Working Party on Medical Administrators in March 1970 resulted in the emergence of "Community Medicine" from a union of the Report on Medical Education (Todd Report)[12], the Report of a Working Party on Medical Administrators (Hunter Report)[13] and the reorganized National Health Service. (N.H.S.)

Public health has attracted new interest and is moving closer to the mainstream of medicine again but it seems this has not yet resulted in a clearer role.

3. The Role of the Medical Health Officer

We will now examine more specifically the Medical Health Officer attempting to find consensus on his functions.

a. Britain

The evolving role of the Medical Health Officer can best be seen by looking, initially, at the British Experience. The Medical Health Officer owes his conception to the formidable genius Chadwick.[15] The reason, or principal reason, in his mind, for the birth of the Medical Health Officer was not humanitarian but economic, because it would make sense in the effective ordering of the public health system. He felt disease was a waste of human resources.

W.H. Duncan was the first Medical Health Officer appointed, in January 1847 but it was the appointment of Simon in London the following year which gave the office the stamp of authority. He set a standard of responsible and impartial comment, on matters of public health, which won him much respect. He recognized

the value of vital statistics.

In 1855, reform of local government in London allowed the appointment of forty-eight medical officers. By 1857, the Lancet calculated upwards of fifteen-thousand sanitary nuisances had been removed. "They caught all kinds of stench, and snares and all sorts of nuisance."

However, it was not until 1872, by legislation, that Medical Health Officers were appointed to 1400 other areas in the country. The Public Health Act of 1875 marked the high water mark of environmental sanitation as a nationally complete system of health. Although carried along by its own momentum for many years, towards the end of the century the sanitary idea began to be overtaken by a new concept, that of the individual and his personal needs.

The great feats of sanitation had been accompanied by a substantial decline in the death rate and especially that part due to infectious diseases. The Medical Health Officer had no time for complacency. The infant mortality rate remained obstinately high. It became clear that environmental control wasn't enough and that services directed towards the needs of vulnerable groups were necessary.

By the beginning of this century, a rudimentary health visiting and child welfare clinic service was gradually being introduced to improve infant care. The 1902 Midwives Act laid the foundation for the regulation and control of midwifery with a view to reducing maternal mortality. It was not until the 1930's that the Maternal & Child Health services under the Medical Health Officer reached full development.

G. Bernard Shaw wrote to Sykes, Medical Health Officer for St. Pancras, in 1903, about concern for lack of involvement of the Medical Health Officer in

schools. Sykes was a knowledgeable Medical Health Officer and had written "State remedies cannot be applied in advance of public opinion, and this is slow to move. The education of a vast community is perhaps the most difficult task to fall to sanitarians. Persuading the unscientific mind to reason logically, even after possession of the facts, is not a light task. To rouse it to take action, even when convinced, and to overcome prejudice, requires a prodigious effort."[17] Probably, this is a very sound statement on the difficulties of health education.

Sykes responded to Shaw with a comprehensive job description for the Medical Health Officer in schools and encouraged Medical Health Officers to be involved in examination of school children. The school medical service was introduced in 1907.

The first World War highlighted two grave sickness problems - venereal disease and tuberculosis. Legislation and brisk organization facilitated the rapid development by public health departments of venereal disease clinic service. A whole new service with staff and sanitoria beds was developed for tuberculosis. As knowledge of infectious disease increased so did notification, immunization, isolation and disinfection.

By the 1930's, the Medical Health Officer was in control of a wide range of personal and environmental health services closely woven together. Prevention, diagnosis, treatment and rehabilitation - all came within his compass but prevention was uppermost in his mind. (Wolfinden)[15]. The principles of social medicine were put into daily practice - housing and health, socialwork and tuberculosis, management of handicapped children in special schools, as well as the previously mentioned development.

Following the second World War new duties were added - provision of ambulances, health centres, home care and nursing, health education, and increased immunization responsibilities. Mental health services developed following the British Mental Health Act of 1959.

The U.K. Social Services Act of 1970 swallowed up mental health services, home help, childrens work and services for the children and the aged. The cleavage is perpetuated today.

The Medical Health Officer in Britain, had a great deal of legislative power and responsibility. While purporting to be a specialist in preventive medicine he was a generalist. (Wolfinden 1974).

The N.H.S., in 1974, resulted in the disappearance of the classical Medical Health Officer. He and his heirs are now labelled "community physicians" - some are employed in a medical administrative capacity at regional, area and district levels but as members of multiprofessional teams. Others are epidemiologists and other medical advisors of district councils on environmental health matters and social and educational services.

The issue of role and identity, under this new system, continues to be one of the major problems that faces the specialty.(18) About one-hundred out of the seven hundred consultant grade posts in the specialty have a major managerial duty. The other six-hundred should play an advisory rather than an executive role. They should practice the art of epidemiology and contribute towards the setting of objectives at each level of the service, measuring and evaluating need, demand and outcome. Epidemiology and medical statistics should be the basic components of community medicine.(19) Community medicine specialists contribute to the health of population groups in a very direct way. The fact that their

efforts in prevention, planning and evaluation have not yet received the attention they deserve can be attributed largely to difficulties arising from reorganization and change of role.[18]

In considering the new public health, Morris looks at the evolution of the community physician as epidemiologist, administrator of local medical services, community counsellor, professional man and public servant. The traditional tasks of the Medical Health Officer as teacher, watchdog, and troublemaker, in health, are being renewed and he will have new duties in the provision of services as an integral resource of health protection. One of his main tools will be knowledge, a contribution to social policy at every level. He will be able to combine social science and medicine.

In 1906 the society of Medical Health Officers believed that the day of the Medical Health Officer would soon be over.[26] It really was only the end of the beginning. A similar idea surfaced in the 1940's. However, there continued then and now to be new needs resulting in an evolving role for the Medical Health Officer and his continued existence under whatever title or label.

Clearly, there has never been consensus as to what the role of the Medical Health Officer is in Britain. There has been constant re-evaluation and reorganization of the job description.

Education of the Medical Health Officer in U.K.

This confusion has been engendered into the educational process as well. The original Medical Health Officers in the U.K. were simply qualified physicians, but as the field progressed a need for extra training was recognized. The first Diploma in Public Health (D.P.H.) began in Dublin in 1871 followed by

Cambridge in 1875.[25] In 1888 a Medical Health Officer surveying a population greater than fifty-thousand population was required to have the D.P.H. qualification, which took about a year to obtain. By 1922 in Britain, every Medical Health Officer had to be so qualified. The qualification contained as much of the various elements required in public health practice and administration as could be fit into a one year period. The course of the role changed.

Community medicine represents a progressive combined development of medical administration and public health. As with any other discipline the subject matter is continuously changing.[27] A doctor planning a career in community medicine should obtain a varied clinical experience, preferably both in hospital and in general practice, before starting specific training. This method retains flexibility in early training in case trainees should feel that the specialty had less of an appeal than felt initially.

The Lancet disagrees with Heath & Perry's emphasis on full time attendance at a university course.[18][27] Many doctors training for other specialties have to combine the service and academic aspects of the job, and indeed separation of these is one of the major criticisms that has been levelled against community medicine in the past. The Lancet also disagrees with their suggestion of creation of a subspecialist grade. The Lancet felt that only by giving proper place to epidemiology can community medicine attract the best young minds, and only this discipline can reveal the impact of the specialty on health.

Tomorrow's community physician in the U.K. will continue to administer local health services but can only succeed by building an effective intelligence system.[28] Local epidemiology should be the frame for clinical practice and teamwork, provide tools for management and improvement of services and more analysis

and trials. After twenty years one of the sadder disappointments of the N.H.S. is the poverty at the local level of its learning resources. Without knowledge there can be no planning to "realize an image of the future" - no rationality. The unique contribution of the community physician, and his passport to community leadership, will be the information system he creates.(4)

Times have changed and complexities increased. In order to preserve a balance of resources and service allocation between community and hospital care, when the latter is often said to be the more intense and dramatic of the two functions, it was suggested that a diplomatic and highly trained doctor who has a knowledge of both functional parts, is required.(29) He would be a medical practitioner either with experience in primary care or hospitals who had subsequently undertaken an MSc or fellowship in medical administration and sociology. Such a person would have a stake in the future health service administration, which must cover and balance the whole spectrum of hospital and community care and co-ordinate the field multi-disciplinary teams. He would be possessor of a combined discipline. His training and apprenticeship more than any other, would likely enable him to encompass the whole spectrum of community and patient care, as co-ordinator and facilitator. The other "caring" professions such as nurses, social workers and physiotherapists still generally deal with more limited and specialized areas of human function and behaviour.

Now, at least community medicine is recognized as a specialty in its own right. There has been continuous reassessment, re-evaluation, reorganization, and change in the educational process. In training the Medical Health Officer the obvious lack of consensus in the organization of public health and the role of the Medical Health Officer has been carried into the educational model.

b. United States

In the United States this confusion has been carried a step further. Examination of the role of the Medical Health Officer (Miller & Albers)[22] indicates that registered nurses with a masters degree in public health in many cases have more training and experience than physicians to function effectively in this role. It is suggested that, given current physician shortages, the change in scope of public health practice, and the use of other professionals capable of fulfilling this role, the selection of physicians as local health officers should be viewed as only one of several alternatives.

The earliest documented instance of the use of a non-medical person as a local health officer occurred in 1873 in New Jersey.[23] A recent unpublished survey of current practices among states, with regard to the use of non-physicians as Medical Health Officers indicates that twenty-five states now use such personnel, while twenty-five states still require by law or policy that a Medical Health Officer be a licenced physician. The inability of many communities to recruit physicians to fill Medical Health Officer positions is an obvious stimulus toward the use of other qualified personnel.[24]

Education of the Medical Health Officer in the United States

Nearly two-thirds of all health officers in the United States have an M.P.H. (or similar) degree. About 23% have both an M.D. and M.P.H. (or similar) degree; about 9% have a bachelor degree, or no degree at all.

The highest proportion of health officers who are physicians is found in the Pacific and South Atlantic regions (96.6% and 88.2% respectively). Only about 25% of health officers in the Mid Atlantic and New England regions are physicians. About one-half of the health officers in the South Atlantic and

Pacific regions have M.P.H. or similar degrees.[9]

The growth and development of state and local health agencies will depend largely upon the knowledge, skills and attitudes of their professional staff.[31] Public Health Administrators should inform schools of public health about what knowledge they want trainees to acquire and what skills and attitudes they want developed. Faculty members should encourage this. Schools of public health have a responsibility to be among the leaders in developing attitudes towards patterns of program changes in community health. Course content along problem centered lines should recognize that administrative organization and management in community health require the joint efforts of generalists and specialists in the medical and social sciences.

In performing his duties, the Medical Health Officer (physician) needs a deep understanding of human nature as well as formal training in administration and the health sciences. Leadership ability is essential.[32]

It's important that Medical Health Officers have a broad educational background as well as training in medicine and public health. A variety of advanced programs are available to train a competent specialist in this field. Recognition of this competence through certification by the American Board of Preventive Medicine is desirable. Residency training and a degree in public health or preventive medicine, to reach this end, is suggested. A sustained effort toward continuing education throughout the life of the professional is also essential.

The diveristy and number of occupational titles in which we find graduates of schools of public health is so great that no single-core curriculum can hope to prepare individuals adequately for practice in the field.[33] Public Health en-

compasses direct medical care, the setting of standards for clinical and institutional practice, the organization and administration of a variety of community health programs and a multitude of other programs. At the same time the setting for the practice of public health has changed.

Kinney proposes redefining public health in the United States as a discipline concerned with adequate functioning of the individual in the political, social and physical environment in which conditions place him at a point in time. To him it is a matter of applied "human ecology." Brotherston stated that public health tends to be detatched from the mainstream of clinical medicine and the hospital. Community medicine should act as a central focal point for the growth of "human ecology."[34]

Medical Health Officers in the United States today are more likely to find themselves involved in political manipulation than biostatistical manipulation; more likely to be called to exercise their knowledge of solid logic than of solid wastes; and far more likely to be confronted by the problem of the epidemiology of dissent than of diphtheria.[33]

A unique feature among students in public health programs is maturity and experience. Kinney feels that few of the schools take advantage of the opportunity to have these students with specialized skills participate in the program rather that sit as passive recipients. Students should teach as well as learn, where the real world of experience and the world of theory can interact in such a way as to produce deeper understanding and greater commitment to a health philosophy based on individual dignity and societal good.

His final recommendations stress ceasing to educate nine month wonders - "pseudo - epidemiologio - biostatistio - environmento - administratologists" and to concentrate on the masters level students on an ecological perspective and a philosophical base for the practice of public health. Curricula should be restricted to make maximum use of student experience and skills. Bring the community into the school through entry level training and career ladder programs in the various public health content areas.

Finally, (Mytinger, R.E.) emphasized the importance of attempting to recruit recent, well qualified graduates into public health and of providing them with opportunities for advanced public health training.[55] He found, in a study, that the best general predictors of attitudes related to innovativeness were rank in medical school graduating class and degrees held beyond the bachelor level.

In the United States the extent of diversification in defining the Medical Health Officer common role has been carried beyond the physician who traditionally has filled the role. They include other related professionals. The educational process is more confused again and admits its limitation in preparing the individual for the field and an inability to develop a core curriculum. There isn't a hint of consensus on the role of the Medical Health Officer in the United States which extends to indecision on who he should be.

c. Canada

The term Medical Health Officer still exists in Canada and has not been obliterated by change as in Britain. Attempting to predict the role of the Medical Health Officer might be described either as peering at a very murky crystal ball, or perhaps better looking at a kaleidoscope which never stops turning

and produces an ever changing picture. Prevention is far from the relatively simple matter it used to be, either primary or secondary. Changing behaviour (lifestyle) is a very difficult area indeed. Unfortunately, there are very few well-proven methods of health education which can be readily and inexpensively applied in the community.

Schwenger[5] envisages two main roles:

I. The Medical Health Officer can concentrate on the role described by Morris.[4] This should satisfy the more medically oriented Medical Health Officer who will have additional clinical, epidemiological and statistical training. This role has been described essentially as assessor (watchdog), monitor (troublemaker), and counsellor (teacher) or,

II. The Medical Health Officer can concentrate on the co-ordination of health services or even co-ordination of health and social services. He feels it is unrealistic to expect the Medical Health Officer to do both jobs. More M.D.'s will be filling the job of community doctor and a smaller number will find the task of senior administrator to their liking. Medical schools should be prepared to train both types.

MacIntosh states "Medical Health Officers do not have a defined role. They do not have one general function which is recognized by all, both within the corps of Medical Health Officers, within the ranks of the medical profession, by their employees and by the public at large, as the function at which they should aim to be good. Therefore they have no recognizable occupational goal." He also sees a gradual fading away of the Medical Health Officer as an obsolescent species.[53]

Education of Medical Health Officers in Canada

In a 1960 questionnaire study concerning revision of the D.P.H. course in Toronto, Le Riche contrasted several hundred public health programs.[36]

He also found out what Toronto graduates thought of the curriculum for the D.P.H. and brought about considerable changes including the introduction of optional subjects.[37] A D.P.H. revision committee was instituted in 1969 and exchanged views on the future role of the D.P.H. course. There was some difficulty in arriving at consensus on future changes, i.e., whether or not to include non-physicians in the D.P.H. or to move towards an American type all-purpose M.P.H.[21] Perhaps too much was being crammed into a nine months course?

In 1975, however, Schwenger states that the D.P.H. was to be transformed into an M.P.H. which would be open to all health professionals.[5] Administration of existing local health agencies would no longer be the exclusive perogative of the physician but the posts would be open to competition among managers having a variety of backgrounds. Teamwork would include respect for the professional autonomy of fellow health workers with leadership and charisma, not exclusive to the M.D. alone.

The top level of qualification in Canada is the F.R.C.P. in public health, or more recently in community medicine. In 1972, Anderson found that of one-hundred and thirty-three of these specialists, 38% were in Ontario, and 29% in B.C. However, 48% of all specialists who had obtained the certificate by examination (not honorary) were in B.C. Certification was clearly related to career development in that single province where salary differentials and promotion favor the holder of the F.R.C.P. Elsewhere, the certificate was regarded merely

as a mark of excellence or clinical competence.[38] This situation remains similar today in B.C.

The specialty training requirements set out by the Royal College of Physicians and Surgeons of Canada (February 1978) for community medicine state the physician must have a basic knowledge of epidemiology and biostatistics, as well as an appropriate understanding of the principles of the social sciences and of administration. The candidate is expected to develop a field of concentration from one of these five areas: public health, administration of health services, maternal and child health, epidemiology or clinical preventive medicine. There are set out two streams of training requirements of four years each to reach this end.

The University of British Columbia offers an MSc (health services planning) which fulfills the above requirements, in its public health option, for physicians. The program is interdisciplinary in approach and may be a good indication of where education of the Medical Health Officer in Canada is going but there is some uncertainty among the leaders as to whether this type of training is the desirable route for the Medical Health Officer. There are a variety of routes one can pursue to become F.R.C.P. eligible, including credit for a year in "any" clinical specialty or credit for two years in a family practice residency. These numerous combinations of training certainly illustrate a lack of agreement on a common training route for the Medical Health Officer.

The situation in Canada, in general, is perhaps only slightly less confusing than that in the United States on the role of the Medical Health Officer.

5. Provincial Variations in Public Health and Medical Health Officer Roles

We can now examine the major regions of Canada, attempting to find a common

denominator. A letter was written to the other provinces, besides B.C., to review public health organization and Medical Health Officer descriptions across the country. There was response from all areas, except Prince Edward Island and Nova Scotia, and these are summarized here where information was given.

Newfoundland employs one full-time Medical Health Officer. A second Medical Health Officer is employed by the International Grenfell Association to look after public health programs in Newfoundland and coastal Labrador.

Public health programs are administered centrally from St. Johns and the Medical Health Officer is occupied with administration of the provincial immunization program, communicable disease control and epidemiology. Medical support is provided by the Medical Health Officer to public health nurses, health inspectors and the division of Nutrition and Health Education throughout the province.

Also employed are four full-time Child Health Officers, (physicians with pediatric qualifications or experience). Two are located in St. Johns, one in central Newfoundland and one in the west. They are occupied mainly with preschool and school health assessments and with providing support to public health nurses in these areas.

The provincial objective is to organize four health regions and to staff each with a Medical Health Officer, Child Health Officer, Nutritionist and Health Education person. Emphasis would be placed on immunization, child health and health promotion. The Medical Health Officer would be responsible for information systems for his region and for planning programs to meet the needs.(41)

New Brunswick has five regional health districts directed by Medical Health Officers employed by the province. No discussion of the role of the Medical

Health Officer was available but program activities of the units included maternal & child health, communicable disease control, public health nursing and inspection, home care, nutrition, long term care, occupational therapy, health education, radiation and T.B. control.[42]

There was no information from Prince Edward Island but this province is in the process of revamping its Health Care System placing the responsibility of health care on the public as well as health professionals and physicians. The emphasis will be on health promotion and illness prevention and health education to encourage individuals to take more responsibility for their health.[50] This is in the form of an experiment as laid out in a "Discussion Paper" and would obviously result in a magnified role for the community physician, (Medical Health Officer) if implemented.

Quebec sent a substantial document, in French. In 1973 this document was developed in tune with the Castonguay Report recommending the integration of public health with the general regime of distribution of health and social services, including hospitals and community health centres. It was felt that public health was suffering under two separate regimes of community care and hospital care. Also, with the development of community health centres the whole thing should be pulled together. The plan would be implemented in 31 hospitals in 12 regional districts. It was decided to enlarge responsibilities of the hospitals to house the division of community health. This department would play a major role in the co-ordination of health and social services in community health centres, hospitals and public health, thus bringing together all areas of prevention and treatment. In previous years, with separation, resource allocation to public health had suffered.

The department of community health housed in the hospitals would be responsible for the development of preventive services for the local community health centres, for development of physician and mental health programs reflecting the needs of the particular population, control of accidents and epidemics and to participate in health studies and to counsel the board of directors of the hospital and region on health matters.

The community health division would be under the direction of a physician (Medical Health Officer) trained in medicine, epidemiology and administration. It would be desirable that the department of community health would be affiliated with a department of social and preventive medicine of a university. The Medical Health Officer would be responsible for the programs mentioned in the previous paragraph and leadership in co-ordinating and administering the preventive and curative health needs of the community. This is the route Quebec has been following.(43)

The province of Ontario sent some guidelines respecting the Medical Health Officer. No details on job description were available. In general terms, they stated the function of the Medical Health Officer as the executive officer of the Board of Health. He is responsible for promotion and protection of the health of the public, for keeping the board informed on health subjects, for implementing policies and directives of the board and for effective management of health unit or health department activities.(44)

Amalgamation of the departments of Health and Welfare occurred in Manitoba, in 1970. When this happened, the Medical Health Officer became a medical public health consultant to the public health nurses, social workers and other staff.

The province is divided into eight regions with a regional director in

charge and the Medical Health Officer is no longer chief executive officer of the units but acts as a consultant with some direct duties. In his role description, he is described as a medical resource to the region and consultant in public health and health care, participating as a member of the regional management executive group. He is to play an active resource role in planning, delivery and monitoring of community health programs of the department and community. He will report to a regional director on a day to day basis but will be responsible and accountable for program standards and professional competence to the executive director of Public Health Services. Under general and specific responsiblities there are 27 points listed which cover virtually every area of community medicine and which stress the consultant and direct services role rather than any administrative tasks. These appear to be the responsibility of the regional director.(45) Quebec, Alberta and Manitoba have included mental health and social services in their community medicine programs.

Saskatchewan has a decentralized delivery system for public health programs whereby the province is divided into ten regions, each with its own Medical Health Officer and staff of health professionals. Local participation is encouraged through regional health boards which are advisory to the Ministry of Health. Regina, Saskatoon and the North have autonomous health programs relying heavily on provincial standards.

They have had some problems in recruiting physicians to fill the Medical Health Officer positions. No role descriptions were available but the position here is again a combination of administrative and direct service functions. There have been several administrative studies done internally to try to improve the delivery system for public health programs.

Alberta enclosed a working paper on job descriptions for Medical Health Officers and a position paper on the future of the Medical Health Officer in Alberta as a community physician.[47][48] It was stressed that the Alberta Medical Health Officers were opposed to many parts of the papers.[49]

Dr. Schnee, an Alberta public health physician, submitted policy papers to serve as a focus for discussions between the division of local health services and health units, with the object of jointly establishing a policy for the future role of Medical Health Officers in Alberta.

He felt that new challenges had emerged in public health, chronic and lifestyle diseases, the aged, alternatives to high institutional costs and co-ordination of the multiplicity of health and health related social services in the community. These have replaced emphasis on communicable diseases, food and water, and sanitation and maternal & child health which are under better control. With the changes arises a related change in the emphasis of the role of the Medical Health Officer in maintaining and promoting community health.

The traditional roles of the Medical Health Officer were legislated, medical and management.

The medical role of the Medical Health Officer is indivudal and community with the community role taking precedence. The Public Health Act and regulations prescribe the Medical Health Officers "officer role." (This is the case in all provinces). He felt there was no evidence to suggest that such powers be given to someone else. The management role is described as exercising the authority and performing the duties of the board with respect to the administration of the health unit.

The roles to be expanded by future Medical Health Officers would be those of community health consultant, community health services co-ordinator, health researcher and planner.

With an increased role of the Medical Health Officer in direct services or a community health role, a reduced administrative role in the health unit would be expected. Schnee proposed that all administration be delegated to an administrator and that health unit management committees be formed with the Medical Health Officer as medical director, the administrator as executive director and the nursing supervisor as nursing director.

A full-time Medical Health Officer should serve a population of 80,000 - 120,000. Full-time people should be shared rather than encouraging part-time Medical Health Officers. Rank ordered preference from most preferred credentials for a Medical Health Officer would be:

1. certification
2. masters level
3. diploma
4. M.D., without additional training

Also recommended was a program of in-service education, emphasizing planning, statistics, epidemiology, economics, community organization and community health and social service co-ordination.

The comprehensive "job description" of the Medical Health Officer includes the eight primary roles of Director, including input to administration, public relations, and personnel management; Officer, with enforcement and application of legislation; Epidemiologist/Statistician; Educator; Consultant to health unit staff and community; Co-ordinator - health unit services; Clinician; Researcher/

Planner - for health unit, community and department. Goals could be stated in each area and measured by the criteria of fulfillment of these goals.

Schnee lists four categories of Medical Health Officer:

I. Director - full-time Medical Health Officer acting as health unit director and community physician.

II. Medical Director - full-time Medical Health Officer acting as medical director or health unit and community physician. In this case leadership responsibilities go to an executive director.

III. Consultant - no management role but only officer and consultant roles. The other functions would be taken over by other professionals.

IV. Part-time Medical Health Officer.

Current Medical Health Officers in Saskatchewan and Alberta fulfill, to some extent, most of the responsibilities delineated in category I which may be the most desirable. Category 4 is the most undesirable. The categories leave considerable leeway in delivering public health services. There is no consensus as to a common role in this instance or in the case of the other provinces. Considerable variation exists across the country.

6. Legal and Administrative Position of the Medical Health Officer in the British Columbia Public Health Service

British Columbia is composed of 18 health unit districts with a Medical Health Officer in all but two, (January 1979) who fulfills an administrative and service function, in delivery of community health services. Mental health and social services are administered separately from community health programs. There are also four city and one regional units which are autonomous but rely heavily on provincial standards and legislation for their program as well. Their Medical

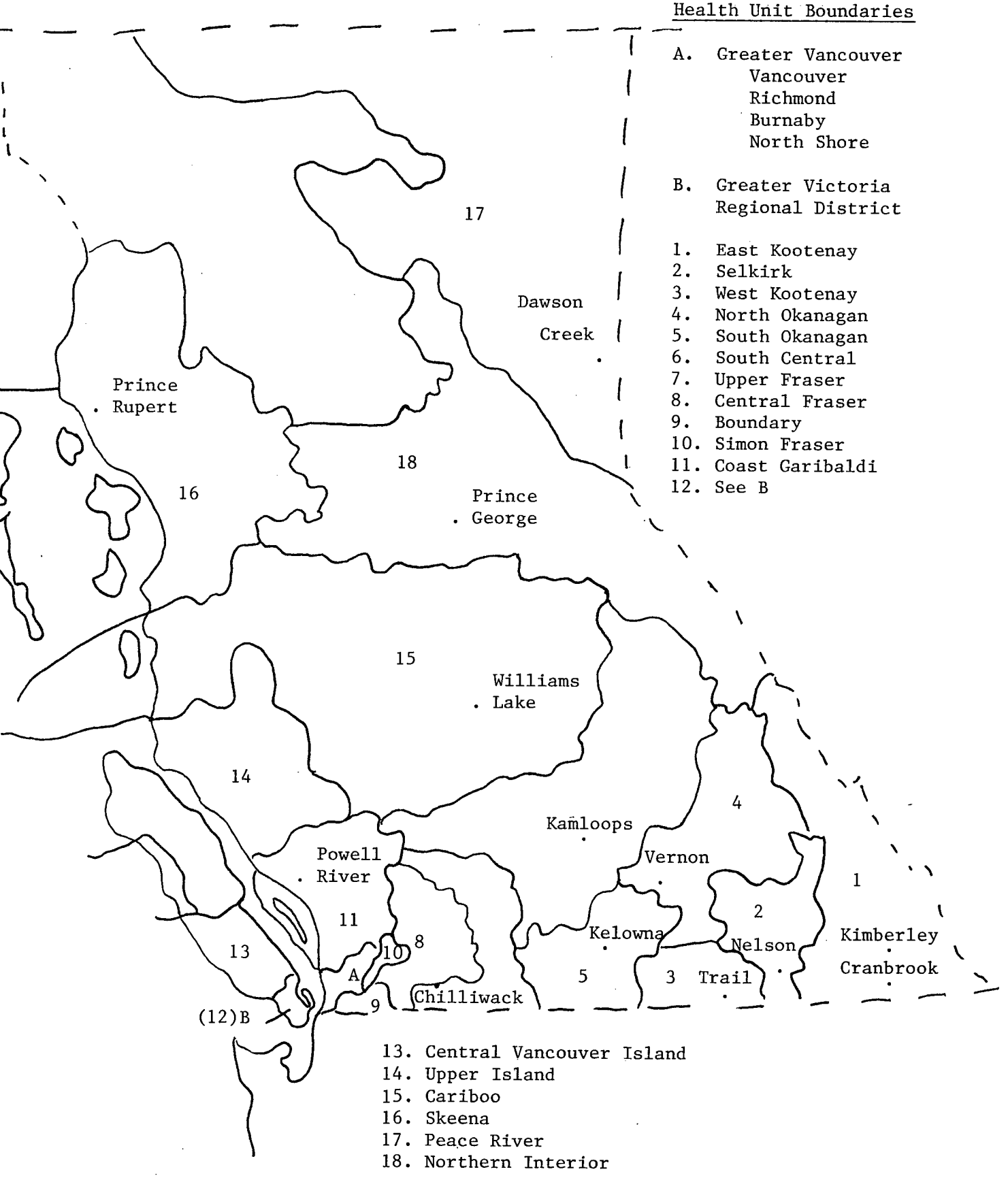
Health Officers meet every six months, with provincial Medical Health Officers, to discuss mutual problems and programs of interest.

The top official in community programs is at the Assistant Deputy Ministerial level. Both he and his assistant are selected from among the Health Officer staff. The Deputy Minister of Health in British Columbia is usually a physician.

The Health Unit areas are mapped (see page 33) and each unit has several programs. The Medical Health Officer is responsible for all programs.

Public Health Nursing is headed by a Nursing Supervisor with senior nurses in various sub-offices. These nurses are involved in a wide variety of programs including the major ones of home care and long term care. The new long term care program has more autonomy than the others, having its own administrator in each health unit, but this person also comes under the Medical Health Officer. Public Health Nurses are also involved in school health programs, V.D. and birth control, child and adult health conferences, all immunizations, pre-natal and post-natal training and counselling, health education, and a generally wide variety of health unit functions to the community. They are generalists and are assisted in their duties by other registered nurses.

Public health inspection is headed in each health unit by a a Chief Public Health Inspector who comes under the Medical Health Officer. A Medical Health Officer is appointed by government to be the chief health and sanitary official for the municipality or union of municipalities to which he is appointed and he has all powers and authority possessed by any Health Officer under the Health Act.(51) In Health Inspection, the Medical Health Officer usually delegates responsibility of looking after the health and safety of the community environment


Health Unit Boundaries
A. Greater Vancouver
Vancouver
Richmond
Burnaby
North Shore
B. Greater Victoria
Regional District
1. East Kootenay
2. Selkirk
3. West Kootenay
4. North Okanagan
5. South Okanagan
6. South Central
7. Upper Fraser
8. Central Fraser
9. Boundary
10. Simon Fraser
11. Coast Garibaldi
12. See B
13. Central Vancouver Island
14. Upper Island
15. Cariboo
16. Skeena
17. Peace River
18. Northern Interior
Dawson Creek
Prince Rupert
Prince George
Williams Lake
Kamloops
Vernon
Kelowna
Nelson
Kimberley
Cranbrook
Trail
Powell River
Chilliwack
(12)B

to Health Inspectors.

Other departments in health units providing preventive health services to the community are dental hygiene, nutrition, speech and hearing, environmental engineering, physiotherapy and health education. There is an office Supervisor in each Health Unit who manages the clerical staff for all these departments. Staff in each Health Unit can vary from 50-130 individuals.

Local Boards of Health in each municipality are the Council of the municipality but a municipality may by law join with other municipalities to establish a Union Board of Health on which each municipality is represented by school trustees and/or Council members. A member of a Regional District council may also be on the Union Board. The Union Board exercises co-ordinating, supervisory, advisory and consultative functions in the administration of health services in the area within its jurisdiction, but has no legislative power. The Medical Health Officer is secretary on the Union Board and most Health Units have these boards which belong collectively to the Associated Boards of Health of British Columbia.

Medical Health Officers in British Columbia legally need only to be duly qualified practitioners but all presently have further training in public health. Municipal councils usually accept provincial appointment of Medical Health Officers who are responsible for duties under the Municipal Act as well as Health Act. In the case where Regional Districts are responsible for administration of Health Services the Medical Health Officer assumes duties under this Act as well. In British Columbia, as elsewhere, Medical Health Officers are given certain powers under the Health Act for control and abatement of nuisances which may constitute health hazards, for control of communicable diseases and for

inspection of facilities and institutions giving service to the public and where health hazards can develop. He has legal authority (legislated officer role) to see that the provincial regulations in these areas are adhered to pursuant to the Health Act of British Columbia.(51)

The legislated Officer Role is a legal one and is one of consensus, as defined in the Health Act. Much of this role is delegated to other staff, e.g., Public Health Inspector. This area forms a relatively small part of Administration and Direct Services. It is not explored in detail here and, in fact, could form the substance of a separate study.

CHAPTER III

METHOD

A survey questionnaire was mailed to all Medical Health Officers in British Columbia, to establish levels of consensus on their role description. There were twenty individuals involved in this survey, including fifteen provincial Medical Health Officers, four city Medical Health Officers (Vancouver, Richmond, North and West Vancouver and Burnaby) and one regional Medical Health Officer (Victoria and Southern Vancouver Island). The latter five Medical Health Officers run autonomous health programs which rely considerably on provincial standards.

There were sixty-five questions in the survey, which was divided into seven sections. These seven sections were designed to elicit information on several areas concerned with role description of the Medical Health Officer. The sections referred to were:

1. Personal Experience and Educational Background
2. Attitudes towards the Medical Health Officer Role
3. Workload and Setting
4. Administration
5. Direct Services
6. Relations with the Medical Community
7. New Directions

Explanations of the contents preceded each section.

Also included with the questionnaire was a request for a one week "time budget" (see Appendix). The Medical Health Officers were asked to keep a record of their activities during any week and to classify them as to Direct Services or Administration and whether they were very useful, useful or marginally

useful, in their opinion.

The questionnaire employed the 'double ballot' method of return whereby anonymity could be maintained. The document could be placed within a blank envelope within an addressed envelope, on its return. This would allow one to determine which health units had not responded and needed reminders. An optional space was provided for signatures.

The survey was mailed on April 28, 1978 and a reminder was given at 'Health Officers Council' on May 11, 1978. A third reminder, by way of a personal telephone call to each non-respondent, was given on May 28, 1978.

The final day for receiving questionnaires and time budgets was June 15, 1978. Following this results were examined, referenced, tabulated, cross tabulated and compared with literature review findings where appropriate. Conclusions were drawn based upon the level of consensus among British Columbia Medical Health Officers about their role description.

CHAPTER IV

ANALYSIS OF DATA

In this chapter, an effort will be made to examine the levels of consensus among British Columbia Medical Health Officers and to determine the extent to which this may be used to define a common role.

1. Description of Population

The population under study in this case are twenty Medical Health Officers in the province of British Columbia. Seventeen responded to the questionnaire. Four of these work in the large urban areas of Victoria, Vancouver, Burnaby and Richmond. The remainder are distributed throughout the province.

Tables I, II, and III describe the age distribution, year of graduation for M.D. or equivalent and level of qualification of British Columbia Medical Health Officers.

TABLE I - AGE DISTRIBUTION OF B.C. M.H.O.s

60+	50-59	40-49	30-39
3	5	5	3

TABLE II - YEAR OF GRADUATION

1940-1949	1950-1959	1960-1969
5	5	6

TABLE III - LEVEL OF QUALIFICATION

DPH	MSc	Attempting FRCP	FRCP
15	2	4	4

Twelve of seventeen received their undergraduate training outside Canada. One qualified in British Columbia. Four received a DPH from the U.K. and eleven received a DPH from Toronto; two pursued the MSc route at the University of British Columbia.

2. Levels of Consensus

In the following discussion we will examine the levels of consensus among the Medical Health Officers by concentrating on:

a. Allocation of Effort

b. Preparation for Medical Health Officer roles

c. Role of the Medical Health Officer in the total medical community

d. Attitude about Work and Setting

e. New Directions in Services

a. Allocation of Effort

One measure of consensus among Medical Health Officers would be the similarities between the actual time they spend in administration and direct services. Another measure would be the similarities in attitude towards the kinds of services they should deliver.

Perhaps the most critical issue surrounding the question of whether a role exists has to do with whether the Medical Health Officer is primarily an administrator with a peripheral role in direct services or whether he is primarily a community physician (provider of services) with only a peripheral role in administration.

Tables IV, V and VI offer insights as to what Medical Health Officers regard as essential administrative and direct service functions and how they allocate their time to administration and direct services.

TABLE IV - M.H.O.'S DIVISION OF LABOUR WITH RESPECT TO PERCENT OF TIME ALLOCATED TO ADMINISTRATION

% TIME	NUMBER OF M.H.O.'S
0 - 10	
11 - 20	1
21 - 30	
31 - 40	1
41 - 50	4
51 - 60	3
61 - 70	4
71 - 80	
81 - 90	
91 - 100	4

TABLE V - ESSENTIAL ADMINISTRATIVE FUNCTIONS AS LISTED BY RESPONDENTS

Essential Administrative Functions	No. of Positive Respondents
Program Planning & Implementation	8
Meetings - Senior Staff Conferences	4
Reports for Union Board of Health	3
Evaluation of Program Outcomes	3
Leadership	3
Discussion of Staff Problems	3
Orientation of New Senior Staff	2
Delegation Duties	2
Ministerial Problems - Public Complaints	2
Decision Making	2
Medical Correspondence Between Health Unit & Physician & Hospital	2
Studying Relevant Information & New Directions	2
Negotiating Resources	1
Administrative Circulars	1
Budget	1

TABLE VI - ESSENTIAL DIRECT SERVICES AS LISTED BY RESPONDENTS

Essential Direct Services	No. of Positive M.H.O.'s
Consultation to Hospitals & Physicians	12
Consultation to Municipalities, Regional Districts and Groups Therein	7
V.D. and T.B.	5
Comm. Disease Control	5
Problem Solving for Staff	4
Advice to Public	4
Family Planning	3
Nutrition	2
Research	2
Media Statements	2
Environmental Programs	2
Comm. Care Facilities	2
Medical Consult. - Aid to Handicapped	2
Home Care	1
Epidemiology	1
Maternal & Child Health	1

Tables VII, VIII and IX explore marginally useful administrative functions, use of extra time (if available) by Medical Health Officers and those functions which Medical Health Officers regard as lay administrative ones.

TABLE VII - MARGINALLY USEFUL ADMINISTRATIVE FUNCTIONS - THOSE FUNCTIONS WHICH MEDICAL HEALTH OFFICERS WOULD PREFER TO DELEGATE TO SOMEONE ELSE

Marginally Useful Administrative Functions	No. of Positive Respondents
Buildings & Space	8
Personnel Matters	7
Office Supervision	5
Government Cars	4
Equipment & Supplies	4
Signing Cheques & Reports & Forms	3
Answering Routine Letters	2
Low Order Planning	1
Union Business	1
Using Telpak	1
Meetings With Middle Management	1

TABLE VIII - HOW MEDICAL HEALTH OFFICERS WOULD USE EXTRA TIME IF IT WERE AVAILABLE

Use of Extra Time	No. Of Positive Respondents
Reading Journals & Education Upgrading	5
Program Planning	5
Meeting With Other Physicians and Community Groups	3
Field Research	3
Appraisal of Community Needs & Priorities	3
Pilot & Special Projects	2
Health Education	2
Clinical Work	2
Epidemiology	2
Writing Articles For Publication	2
Staff Education	1
Program Evaluation	1
Golf & Contemplation	1

TABLE IX - LAY ADMINISTRATIVE FUNCTIONS - THOSE FUNCTIONS WHICH COULD BE DELEGATED TO A LAY ADMINISTRATOR

Buildings	Communication
Cars	Expanded Office Supervision
Personnel Matters	Co-ordination
Signing of Routine Documents	Health Education
Meetings	Media Releases
Budget	Research Projects Evaluation
Office Administration	Equipment & Supplies

The following principal findings emerge from the preceding tables and the information on the allocation of effort by the province's Medical Health Officers.

i. In terms of the gross allocation of time it is clear that no practical consensus is evident from the percent time spent in administrative areas as opposed to direct services. Eleven of the seventeen respondents spend between forty to seventy percent of time in administration. However, one allocates less than twenty percent of time to administration, while four

allocate greater than ninety percent of time in this manner.

ii. There is little agreement with regards to areas the Medical Health Officer believes to be essential administrative functions. There was also no consensus with respect to marginally useful administrative functions.

iii. There were two apparent areas of consensus in the direct services role. Twelve out of fifteen believed consultation to physicians and hospitals is necessary. (Two out of seventeen didn't understand the question.) Also, twelve out of fifteen believe they weren't performing marginally useful direct services.

iv. There is no consensus about what constitutes lay administrative functions, but those listed correspond closely with the list of marginally useful administrative functions. Ten to fifteen percent of time on the average is spent performing these functions. Twelve out of seventeen felt any lay administrator should have a supportive and subordinate role to the Medical Health Officer while eleven felt they would lose effectiveness if they totally relinquished the administrative role. Thirteen felt they could use extra administrative help.

b. Preparation for Medical Health Officer Role

Another measure of agreement would concern the method of preparing an individual to be a Medical Health Officer. The role itself and the educational approach are closely related. Consensus in one generally would indicate consensus in the other because of dependency between the two variables.

Tables X, XI and XII rate the various areas of training with respect to adequacy, relevancy and deficiencies.

TABLE X - RATING OF AREAS OF TRAINING

Area of Training	Rating by Number of M.H.O.'s				
	Excellent	Good	Fair	Poor	Total
Administration	0	7	7	3	
Epidemiology	2	6	7	2	
Env. Engineering	2	9	3	3	
Microbiology	6	7	1	3	
Research & Planning	2	2	8	5	
Preventive Medicine	1	12	3	1	
Public Health	3	7	5	2	
Int. Health	1	3	6	7	
Health Economics	1	1	8	7	
Social Medicine	0	6	7	4	
Occ. Health	1	4	7	5	
Mat. & Child Health	0	9	6	2	
Lab. Procedures	2	7	5	3	
	21	80	73	47	= 243
Percentage	9%	36%	33%	22%	= 100%

TABLE XI - RELEVANCY TO JOBS OF AREAS OF TRAINING

Area of Training	Relevancy to Their Jobs By Number of M.H.O.'s		
	Directly Relevant	Marginally Rel.	Not Rel.
Administration	16	1	
Epidemiology	15	2	
Env. Engineering	13	4	
Microbiology	14	3	
Research & Planning	11	4	2
Preventive Medicine	15	2	
Public Health	17		
Int. Health	4	11	1
Health Economics	1	13	3
Social Medicine	10	7	
Occ. Health	7	9	1
Mat. & Child Health	13	4	
Lab Procedures	6	11	

TABLE XII - DEFICIENT AREAS OF TRAINING

Deficient Area Of Training	Rated By Number of M.H.O.'s
Epidemiology	8
Administration	6
P.R. & Politics & Health Educ.	3
Social Medicine	2
Microbiology	2
Occ. Health	1
Health Economics	1
Medicolegal	1
Env. Engineering	1
Resident Training	1

Tables XIII and XIV relate previous experience in other fields by Medical Health Officers and what they consider relevant experience for the Medical Health Officer.

TABLE XIII - PREVIOUS EXPERIENCE RECOMMENDED FOR COMMUNITY MEDICINE WITH AVERAGE NUMBER OF YEARS RECOMMENDED

Fields	No. of Respondents Recommending	Average No. of Years of Experience Recommended
General Practice	15	2.5
Pediatrics	4	2.2
Internal Medicine	7	1.8
Psychiatry	1	0.5

TABLE XIV - EXPERIENCE IN OTHER FIELDS BY CURRENT M.H.O.'s

Field	No. of Respondents	Average No. Of Years Experience
General Practice	12	6.4
Internal Medicine	3	2.5
Surgery	2	3.5
Dermatology	2	4
Tropical Medicine	1	10
Occ. Medicine	1	5 (part-time)
Emergency	1	1
Anesthesia & Pediatrics	1	5

The following principal findings emerge from the tables and the information on preparation for the Medical Health Officer role.

i. There is no consensus on the rating of areas of training.

ii. There is consensus about relevancy to the job of areas of training. Public health, administration, epidemiology, preventive medicine, microbiology, maternal and child health and environmental engineering

are considered the most relevant areas. Health Ecomonics was deemed the least relevant area.

iii. No agreement emerged on deficient areas of training although epidemiology and administration were those most commonly mentioned.

iv. Fifteen out of seventeen recommended Medical Health Officers have a background of general practice for 2 - 3 years. Twelve of this group had such a background.

v. Ten out of thirteen felt the F.R.C.P. should be obtained; four were undecided. There was no agreement on how to obtain the F.R.C.P.

c. Role of the Medical Health Officer in the Total Medical Community

In this section we will be examining the degree of consensus amongst Medical Health Officers in relations between themselves and the medical community at large. We will be looking at ways each believe they can use the other more effectively and where there are areas of interference.

Tables XVI and XVII query how clinicians could use Medical Health Officers more effectively, where the health unit might be interfering with clinicians and how the Medical Health Officer might be used more effectively by clinicians.

TABLE XV - AREAS OF CLINICAL PRACTICE THAT COULD BE DEALT WITH IN THE HEALTH UNIT

Areas for Health Unit	No. of Positive Respondents
All Immunizations	7
All V.D. Treatment & Control	4
Home Care	3
Family Planning	3
Nutrition	2
Well Baby Care	2
Reporting of Food Poisoning	1
Communicable Diseases	2
Alcohol Problems	1
Long Term Care	1
Speech Therapy & Audiology	1
Smoking Cessation & Lifestyles	1

TABLE XVI - WHAT M.H.O.'S THINK CLINICIANS REGARD AS AREAS OF INTERFERENCE BY THE HEALTH UNIT

Areas of Interference	No. of Positive Respondents
Maternal & Child Care Advice	8
Nutrition & Counselling	2
Release of Biologicals & Lab. Services	2
Communicable Disease	2
Rheumatic Fever Program	1
Home & Long Term Care	1
Accidental Poisoning	1
Patient Referral	1
Implications of Medical Competence	1
Vaccinations	1

TABLE XVII - HOW M.H.O.'S THINK CLINICIANS COULD USE THE M.H.O. MORE EFFECTIVELY

Ways To Use The M.H.O. More Effectively	No. of Positive Respondents
Reporting & Consultation About Comm. Diseases	8
Epidemiology Resource	2
Advice on T.B. & B.C.	2
Integration of Health Services	2
Health Care Planning	1
Bed Utilization Committee	1
Hypertension Followup	1
Nutrition Counselling	1
Occupational Health Problems	1
Social & Family Problems	1
Vital Statistics	1
Research	1
By Treating Him As An Equal Even Though He Isn't "Saving Lives"	1

Findings

i. The study indicated some agreement (thirteen out of seventeen) on the question that there were areas in clinical practice that should be dealt with in the health unit, but Table XV indicates no consensus on the specific areas.

ii. Thirteen out of seventeen claimed that clinicians could use the Medical Health Officer more effectively but Table XVIII illustrates little agreement as to how.

iii. There was no agreement on whether clinicians regard the health unit as interfering with their practice and no consensus as to specific areas of conflict.

iv. There was no consensus as to whether community medicine and the Medical Health Officer are too detatched from the mainstream of

clinical medicine and the hospital.

v. Fifteen out of seventeen felt that the clinical people regarded Medical Health Officers and health units in a favourable manner.

d. Attitudes About Work and Setting

All seventeen Medical Health Officers claimed they were satisfied with their jobs, would not wish to change positions and found the work challenging and productive. Fifteen felt there was considerable freedom and autonomy in defining their own "role description."

There was no agreement on whether they spend most of their time doing what they believed was necessary in the community. Thirteen out of seventeen felt they would not welcome more direction from Health Officer's Council (twice annual meeting) in defining their role.

e. New Directions in Service

In this section consensus on judgements about future roles might give some idea about where the Medical Health Officer in British Columbia is going.

Only seven Medical Health Officers felt there were services in which he should play an increasing role. This is not consensus. Thirteen out of seventeen Medical Health Officers felt there were current programs in need of review.

Tables XVIII and XIX deal with health unit programs in need of review and diseases needing more attention by Medical Health Officers.

TABLE XVIII - HEALTH UNIT PROGRAMS IN NEED OF CRITICAL REVIEW

Programs In Need Of Critical Review	M.H.O.'S
School Health	7
Immunization	4
Maternal & Child Health	4
Prenatal Classes	3
Health Education	3
All Of Them	2
Communicable Disease	1
Lab. & Epid. Services	1
Telpak	1
Rheumatic Fever	1
Poison Control	1
Relations With Mental Health	1
Role of Union Board of Health	1
P.H.N. (nursing)	1
Environmental Health	1
Research	1
Administration of Health Department	1
Office Administration	1

TABLE XIX - DISEASES MERITING MORE ATTENTION BY M.H.O.'S AND THOSE WITH FEASIBLE PROGRAMS TO ATTACK THEM

Diseases Meriting More Attention From M.H.O.'s & Health Units	M.H.O.'S	Feasible Programs By No. of M.H.O.'s
Endocrine, Nutritional & Metabolic Disorders	10	8
Infectious & Parasitic Diseases	9	8
Neoplasms	8	6
Congenital & Perinatal	7	5
Hypertension & Hematological Disorders	6	6
Pregnancy, Child Birth, Puerperium	6	4
Circulatory, Resp. Digestive and G - U	5	2
Neurological Disorders	2	0
Environmental Diseases	2	0
Industrial Accidents	2	2
Highway Accidents	2	1
Geriatrics	1	1

Findings

The last three questions of the survey on which this section is based were answered poorly. Three left them all out and six left out the last question.

i. There is no agreement on what programs are in need of review.

ii. Diseases meriting greater attention were specifically listed but there wasn't agreement on them, even then, or on feasible programs to attack the specific diseases.

iii. Seven Medical Health Officers only listed ten different services in which the Medical Health Officer should play an increasing role. There is no consensus about where the Medical Health Officer is going.

3. Levels of Consensus Among Sub Groups

This discussion will be limited to attempting to find agreement amongst sub groups of the population of study in an attempt to find consensus.

NEED FOR F.R.C.P. IN COMMUNITY MEDICINE

TABLE XX - NEED FOR F.R.C.P. IN COMMUNITY MEDICINE AS DEPENDENT ON INDIVIDUAL LEVEL ACHIEVED

Community Medicine	M.H.O.'s Having F.R.C.P.	Working On F.R.C.P.	No F.R.C.P
Need for retaining F.R.C.P.	9	1	
No need for retaining F.R.C.P.	1		2
Undecided	1	2	1

Findings

Nine out of eleven Medical Health Officers having the F.R.C.P. felt it

should be retained. None of three not having the F.R.C.P. or working on it felt it should be retained as a requirement for the Medical Health Officers.

All who felt that it should be retained thought it was necessary to retain credibility and status with other physicians. Several mentioned the additional financial rewards from the additional qualification. This is rational behaviour in economic terms and consistent with the report of Anderson, D.O. in 1972.

There was no consensus on the best route to obtaining the F.R.C.P.

Selection of Medical Health Officers

Candidates are selected mainly on the basis of assessment and interviews with the assistant deputy minister and his assistant. There was no consensus as to whether this approach was satisfactory. However, three Medical Health Officers were not satisfied with this approach. These three only, are involved in their health units with residency training of Medical Health Officers and are on the faculty at the University of British Columbia. They felt a screening committee should be involved, represented in addition by field Medical Health Officers and other faculty at the University of British Columbia.

The previous two cross tabulations illustrated some consensus in the areas discussed. Several other attempts at cross tabulation, on the basis of age of Medical Health Officers, education of Medical Health Officers, geographic location and size of health unit, place of training and background experience were employed looking for agreement in various areas. No common patterns were elicited other than those mentioned.

Little consensus was illustrated in this data on definition of a common Medical Health Officer role.

CHAPTER V

SUMMARY AND RECOMMENDATIONS

In this study we have examined the literature of the countries of Britain, the United States and Canada looking for consensus on the role of the Medical Health Officer. The Canadian provinces have been looked at and the British Columbia Medical Health Officer examined in detail. Little agreement has emerged on the role of the Medical Health Officer.

Since there is not agreement, should a policy clarifying the role he developed or should the British Columbia Medical Health Officer carry on as he has?

He was found to be satisfied with the job, which he regards as challenging and productive and, in general, feels he is fulfilling the needs of the community he serves. Considerable freedom was described in defining his own role and he preferred not to have this tampered with by direction from the collective group of Medical Health Officers.

There is not any desire in the group to develop a policy clarifying the role. Job satisfaction and personal freedom, possibly dependent on each other here are essential components to efficient and effective job functioning. The freedom is inhibiting development of a common role but one can hardly argue in favour of such a role if the needs of the community are being fulfilled under a diversity of roles. The freedom is also individualizing the role and moulding it in terms of perceived cultural and regional needs and demands.

The likelihood of a clearer role emerging in the 1980's is remote. History to date has revealed a constant reorganization and re-evaluation of functions. This is accelerated by rapid technical, social and political changes. The Medical Health Officer is involved with too many areas of the social milieu to be

forced into a clearer paradigm.

I would say that a clearer role in the field is not really necessary or desirable at this time. Regional needs and personal preferences dictate the job description within the context of services provided by the province and the services the Medical Health Officer might administer in addition to these. The personal freedom does leave more room for goal oriented innovation.

I would disagree with Ian MacIntosh who states Medical Health Officers have "no recognizable occupational goal and will fade away as an obsolescent species."[52][53] In being a generalist, each Medical Health Officer will pick from the "pool" the required tools to fit his own personal goals in tune with regional needs, culture and tradition. There are conflicting goals in Health and this is perhaps more clearly engendered in Community Health and the making of a Medical Health Officer. The general knowledge necessary in all his working areas for understanding and planning strategy should be the goals of his training and experience. This can mould an efficient and effective planner who can direct these "conflicting goals" into some kind of organizational sense. A generalist is necessary for this, not another stereotyped specialist.

Several areas where possible improvement could occur emerged.

1. Elimination of the marginally useful administrative functions (10-15% of time) by expansion of the Office Supervisor role.

It was revealed that the British Columbia Medical Health Officer wants a lay administrator in a supportive role to perform the marginally useful administrative functions. He does not feel he would function as effectively if he totally relinquished his administrative role to someone else. This is in opposition to Schwenger who feels that two roles should evolve to fulfill either

an administrative or a direct service role.

The British Columbia Medical Health Officer is being trained to perform the majority of administrative tasks he wishes to retain and I would recommend this to continue.

A lay administrator would have to be shared amongst three or more health units to absorb the marginally useful administrative jobs here and to remain busy. To maintain local personal contact and to be more closely allied to these tasks I would suggest expansion of the role of the Office Supervisor rather than creation of a new sophisticated lay administrator job description.

2. Re-evaluation of the public health educational program, periodically, to improve deficient areas such as epidemiology and administration, at present and to diminish training in marginally relevant areas such as health economics.

One of the weakest areas in the University of British Columbia MSc program is one of the most important, as stressed by Heath and Parry, Morris and the Lancet. There is presently one introductory course in epidemiology in the public health option which, by itself, is simply too limited to give the Medical Health Officer the epidemiological training that the above writers feel is necessary. I would agree that another more detailed course is needed. Morris has stated that the success of tomorrow's community physicians will depend on an effective intelligence system built up using epidemiologic tools. Fifteen out of seventeen Medical Health Officers felt that epidemiology was directly relevant to their positions while only eight rated their training as good or better.

Administration was felt to be directly relevant by sixteen Medical Health Officers and Health Economics marginally relevant by the same number. The University of British Columbia course has three units of economics and half of this

for epidemiology. Administrative training is at least as limited. Increased emphasis on epidemiology and administration and decreased emphasis on health economics is recommended.

3. Re-evaluation of the selection process for Medical Health Officers to include the University of British Columbia faculty and field Medical Health Officers as well as the health department, in screening candidates.

This is suggested because of the opinion of the only three Medical Health Officers directly involved in residency training who support the concept.

4. Establishment of closer formal liaison with "clinical medicine" by Medical Health Officers, probably via the British Columbia Medical Association to expand the role of "community physician" and further deteriorate traditional barriers between the two physician groups, which have inhibited progress in community medicine.

Medical Health Officers feel they are regarded favourably by the medical community, at large. There was a feeling that the health unit and the Medical Health Officer could be used more effectively by the clinical people but there was divided opinion on how to accomplish this.

It would be reasonable to assume that there should be closer liaison between Medical Health Officers and clinical physicians to enhance the breakdown of traditional barriers between the two groups. This is supported by Morris, Schwenger and British Columbia Medical Health Officers. At the present time, there are only local contacts between Medical Health Officers and practitioners and some mutual projects through the B.C.M.A. Mutual formal discussions to delineate areas of responsibility, to determine the mechanism for using each other

more effectively and to improve organization of areas that can be dealt with more efficiently and effectively in the health unit and clinical practice are necessary. For example, the costs of such things as "well baby care" in clinical practice are astronomical. Can this be done solely in the health unit by Public Health Nurses with appropriate referral to clinicians?

Surely this attitude of "favourable regard with only occasional interference" of clinicians towards Medical Health Officers is conducive to mutual discussions and clarification of individual areas of practice. The traditional barriers revolving around interferences by "government physicians in the realm of the private practitioner" have limited the Medical Health Officer and I believe the incentive lies with him to attack them at this more favourable time. He has everything to gain in expanding his role of "community physician", especially if these barriers are lessening. MacIntosh, in the U.K., elucidated the nature of this split which he felt was greatest in the fifty years following the turn of the century.

The fee for service private practitioner however does stand to lose income if some of his functions are assumed by the health unit. One might expect that opposition to any Medical Health Officer interference would be greatest in heavily doctored areas where the supply of physicians exeeds demand for services. At the other extreme where demand exceeds supply of services, relief of some services by health units might be welcomed by private physicians. Total resolution of this problem isn't likely until all physicians are salaried. This topic could form the substance of further study.

Requirements that new Medical Health Officers obtain the F.R.C.P. qualifications to maintain credibility and equality with their clinical peers, thus

facilitating mutual pursuits.

Nine of eleven having the F.R.C.P. felt it should be retained to retain credibility and status with other physicians. I believe it would obviously facilitate dialogue between the groups, particularly with specialist clinical physicians. It is a universally accepted qualification in this country amongst physicians.

In conclusion the Medical Health Officer in British Columbia can be a key person in the planning and delivery of Health Services. Department priorities and public opinion have played a part in the course of this role but he has had much freedom to define his own direction. Someone is always needed who can look at the whole complex of health services and pull it together in an organizational sense. This is the crux of the Medical Health Officer. He will remain the "enforcer" of the Health Act and he will keep his "clinical eye" sharpened with his knowledge of such things as communicable diseases and environmental toxins.

He can still see the "forest", in most cases, always to be his greatest asset and hopefully he will never lose himself in the "trees" as have so many of his clinical colleagues.

He will continue to do his own thing, re-evaluating and reorganizing his role from time to time. He has not, to date, reached consensus on this role and it is unlikely that he ever will. It is also unlikely, in my opinion, that this will alter his valuable ongoing contributions to Health Systems.

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APPENDIX

MEDICAL HEALTH OFFICER QUESTIONNAIRE

Please note:

The enclosed questionnaire has been designed to solicit information from you, in an attempt to clarify the current situation. Much work has gone into it to minimize the time needed to answer it. The "double ballot" method of return can be used to maintain anonymity by placing the questionnaire within a blank envelope and placing this within an addressed envelope. I will receive the blank envelope from the secretary who can check who has responded.

An optional space is provided at the end of the questionnaire if you wish to give your name.

TO: All Medical Health Officers in B.C.

RE: The "Role of the Medical Health Officer (M.H.O.) in B.C."

As you know, despite the growing concern with the role of the M.H.O. in Canada, there is little information on the topic.

In light of this, I have decided to do a thesis on "The Role of the M.H.O. in B.C." as a part of the requirements for the MSc. (health services planning).

I am hoping this information may be of some future use in terms of selection, education, orginization of functions, delineation of "job description" and definition of the M.H.O.

As you will discover in the questionnaire I am looking at individual backgrounds and examining the job description in terms of attitudes concerning direct services and administration.

Also I will be reviewing the literature in order to examine what the role of the M.H.O. elsewhere, and will attempt to correlate this with the data here.

As usual with these projects, the time element is important. I am attempting to do most of this work prior to assuming my duties as M.H.O. in the Cariboo on July 1st, 1978. An answer within the next two to three weeks would be most helpful in allowing me to get this together within the time frame.

Thank you for your consideration and for any help you can give.

Yours sincerely,

QUESTIONNAIRE

A. Personal Experience and Educational Background

An individual's background, training and experience usually have a strong bearing on how he approaches his work. Therefore, in this section, we would like to obtain some information on these factors.

1. Your age..... ( ) 30-39 ( ) 40-49 ( ) 50-59 ( ) 60+
2. Where did you receive your M.D. or equivalent?
   ( ) British Columbia.
   ( ) Canada, other than B.C. Specify.....
   ( ) Outside Canada. Specify.....
3. In what year did you graduate? ( ) ( ) ( ) ( )
4. Where did you receive your training in Community Medicine? (Public Health and Preventive Medicine)
   ( ) British Columbia.
   ( ) Canada, other than B.C. Specify.....
   ( ) Outside Canada. Specify.....
5. What is your level of qualification in Community Medicine?
   ( ) D.P.H., or equivalent.
   ( ) M.P.H., MSc., or equivalent.
   ( ) F.R.C.P.
   ( ) Other. Specify.....
6. Are you still working on further qualifications in this field?
   ( ) Yes ( ) No
7. If yes, please specify.....

8. How many years of experience did you have in Community Medicine prior to becoming an M.H.O. in B.C.?

( ) ( ) Years

9. How many years of experience have you had as an M.H.O. in B.C.?

( ) ( ) Years .... as an M.H.O. outside B.C. ( ) ( ) Years

10. How many years of experience have you had in other fields of medicine?

( ) ( ) Years

Specify fields and years .....

11. Could you indicate roughly how many years, in total, you expect to practice as an M.H.O.?

( ) ( ) Years ( ) No

B. Attitude Towards The Medical Health Officer Role

In this section we would like to obtain your views about your present role, and to indicate how you feel about the current approaches for recruiting M.H.O. candidates and for training them. This will give some indication about the present function of the M.H.O.

12. Pick the statement which best describes the way you feel towards your present field as an M.H.O.

a. ( ) I am satisfied and would not want to change fields.

b. ( ) I am not really satisfied but have not attempted to change fields.

c. ( ) I am not satisfied and have attempted to change fields.

If you selected 12a., please go on to question 16.

If you selected b. or c., please continue.....

13. Why are you not satisfied?

14. If you were starting over again to choose a career, which of the following statements comes closest to indicating your choice?

( ) I would choose community medicine but in another area besides being an M.H.O.

( ) I would not choose community medicine.

( ) I don't know.

15. If you did not choose community medicine, can you indicate what you might have chosen?

16. Generally speaking, how would you rate the adequacy of your training and educational program for the position of M.H.O.?

( ) Excellent ( ) Good ( ) Fair ( ) Poor ( ) Undecided

17. With respect to each particular area of training that you received how would you rate?

	Excellent	Good	Fair	Poor	Undecided
Administration					
Epidemiology					
Environmental Engineering					
Microbiology					
Research & Planning					
Preventive Medicine					
Public Health					
International Health					
Health Economics					
Social Medicine					
Occupational Health					
Maternal & Child Health					
Laboratory Procedures					
Other (Specify).....					

18. Please rate your areas of training in terms of their relevance to your present position.

	Directly Relevant	Marginally Relevant	Not Relevant
Administration			
Epidemiology			
Microbiology			
Environmental Engineering			
Research & Planning			
Preventive Medicine			
Public Health			
International Health			
Health Economics			
Social Medicine			
Occupational Health			
Maternal & Child Health			
Laboratory Procedures			
Other (Specify).....			

19. In your opinion, did your training program not include some areas you needed and what were they?

20. In the light of your training and work experience, is the present approach for selecting prospective M.H.O.'s, producing candidates who, you feel, have the kinds of backgrounds and personal qualifications for fulfilling this role?

( ) Yes ( ) No ( ) Undecided

21. Are you satisfied with the current methods of recruiting candidates?

( ) Yes ( ) No ( ) Undecided

If your answer is "Yes" or "Undecided" please go to question #24.

If your answer is "No", please continue.

22. Why are you not satisfied?

23. How would you ammend the present method?

( ) Don't know.

( ) Specify.....

24. Do you feel that applicants should be trained or experienced in other fields of medicine?

( ) Yes ( ) No ( ) Undecided

25. If you answered "Yes", could you indicate what you think are the relevant fields and recommended minimum number of years experience required in any one of them?

26. Recognizing the F.R.C.P. as the full specialty qualification in community medicine, which approach would you recommend for achieving it?

( ) D.P.H. & assistant director (Trainee).

( ) M.P.H. or MSc. & assistant director (Trainee).

( ) Other (specify).....

( ) Undecided

27. In your view, is there a need for a clinical specialty, or F.R.C.P., at all, in this field?

( ) Yes ( ) No ( ) Undecided

28. If "Yes", could you indicate why?

C. Workload & Setting

We would like to find out about a typical week and what you feel about its relevance to the community. This section will reveal some ideas about your job effectiveness.

29. Given that the set workload is 37 hours, how many hours do you work in a typical week.

( ) ( ) Hours

30. Generally speaking, do you find the work challenging and productive?

( ) Yes ( ) No ( ) Undecided

31. What kind of freedom do you have in defining your own "job description?"

( ) Considerable ( ) Limited ( ) None

32. Would you welcome more direction, in defining your role, from Health Officers' Council?

( ) Yes ( ) No ( ) Undecided

33. If "Yes", in what areas would you find direction most useful?

34. Pick the following statement which is most characteristic of how you feel your time is spent fulfilling the needs of the community in community medicine?

( ) Most of my time is spent doing what I believe needs to be done in the community.

( ) Fifty to seventy percent of my time is spent doing what I believe needs to be done in the community.

( ) Some of my time is spent doing what I believe needs to be done in the community.

( ) Seldom is any of my time spent doing what I believe needs to be done in the community.

D. Administration

Here we will explore administrative tasks and their importance to you in fulfilling your role in the community.

35. What approximate percentage of time do you spend in

Administration ( ) ( ) %

Direct Services ( ) ( ) %

100 %

36. In your view, what are the essential administrative functions for you?

37. Are you currently performing any administrative functions which you feel are marginally important?

( ) Yes ( ) No ( ) Undecided

38. If "Yes", what are these functions and what percentage of total time do you spend doing them? (approximately) (Please ensure your estimate is realistic in terms of your estimate in question #5).

38. (continued)

Marginally Relevant Administrative Tasks	Percentage of Time

39. If you had extra time what would you do with it?

40. Pick the statement which best represents your view about the time you spend in administration.

( ) I am totally satisfied with the amount of time spent in administration.

( ) I am reasonably satisfied.

( ) I am somewhat dissatisfied.

( ) I am very dissatisfied.

41. Although M.H.O.s are now totally responsible for administering their unit, some in the field believe that there may be a place in the health unit for a "lay administrator"; others disagree.

Do you feel there is room for one in your unit?

( ) Yes ( ) No ( ) Undecided

If you answered "No" or "Undecided", proceed to question #44.

If you answered "Yes", please continue...

42. What administrative or other functions do you feel they could assume?....

43. Pick the statement which best represents your opinion about the role of a "lay administrator" in relation to yourself.

( ) Supportive & Subordinate role.

( ) Division of labour/Division of control.

( ) Superior and directing role.

44. Can the M.H.O. function equally effectively if he relinquishes his position as administrator of the health unit?

( ) Yes ( ) No

E. Direct Services

The approaches which the M.H.O. takes in meeting the needs of their particular communities will vary depending on the location and size of the area. We will examine these services and how you feel about their worth in terms of your position.

45. In your opinion, what are the essential "direct services" functions you fulfill?

46. Are you currently performing any "direct service" functions which you feel are marginally important?

( ) Yes ( ) No ( ) Undecided

47. If "Yes", what are these functions and what percent of total time (approximately) do you spend doing them?

48. Do you feel that it is worth the time and effort for the M.H.O.s to gain further expertise in particular areas, (eg. epidemiology) so they might act as resource people for each other and others in the province?

( ) Yes ( ) No ( ) Undecided

F. Relations With The Medical Community

One area which is obviously curcial for the M.H.O. is the quality of their relationship with their colleagues in the medical community. In this section we will pursue your general views about how the M.H.O. should relate to the medical community, and vise-versa.

49. Do you feel that community medicine and the M.H.O. are too detached from the mainstream of clinical medicine and the hospital?

( ) Yes ( ) No ( ) Undecided

50. In your view, are there areas presently dealt with in clinical practice which should be dealt with in the health unit?

( ) Yes ( ) No ( ) Undecided

51. If "Yes", what are these areas?

52. Do you think the "Clinicians" regard the health unit as interfering with some areas of their practice?

( ) Frequently ( ) Occasionally ( ) Seldom ( ) Never

53. What are these areas of interference, if any?

54. How do you feel the "Clinicians" regard your function with respect to them and the community at large?

( ) Very Favourably ( ) Favourably ( ) Not Favourably

55. Could "Clinicians", in your view, use the M.H.O. more effectively?

( ) Yes ( ) No ( ) Undecided

56. If "Yes", could you indicate in what possible ways?

G. New Directions

In this, the final section, we would like to determine your views about changes in the role of the M.H.O.s in community medicine. We would like your opinions on the need of reviewing some of the current direct service programs, and we would like to know if any areas of direct services need expanding.

57. Do you consider the M.H.O. a health planner and researcher?

( ) Yes ( ) No ( ) Undecided

58. If "Yes", is he being trained effectively for this role?

( ) Yes ( ) No ( ) Undecided

59. Are there any direct services in which you feel the M.H.O. should play a greater role?

( ) Yes ( ) No ( ) Undecided

60. If "Yes", what are these services and how can he play a role?

61. In your opinion, are there any current programs which are in need of critical review?

( ) Yes ( ) No ( ) Undecided

62. If "Yes", what are these programs?

63. In the following list, are there any diseases which, in your opinion, merit greater attention from health units and M.H.O.s? (Please circle the diseases which merit greater attention).

1. Infections and parasitic diseases.
2. Neoplasms.
3. Endocrine, nutritional and metabolic diseases.
4. Hypertension and hematologic disorders.
5. Neurologic disorders.
6. Circulatory, respiratory, digestive and G-U problems.
7. Pregnancy, child birth and puerperium.

63. (continued)

8. Skin and musculo skeletal disorders.

9. Congenital and perinatal disorders.

10. Other (Specify).....

64. Are there any feasible programs which you are not now using that could be effective in preventing these diseases? (Please indicate which of those diseases which you have chosen have feasible preventive programs, by circling the appropriate number).

Disease

1. 2. 3. 4. 5. 6. 7. 8. 9. 10.

65. Could you describe these programs briefly?

Thank you for participating in this questionnaire and I hope you will participate in the time budget study.

Name: (Optional) _____

TIME STUDY

DAY _____

TIME	ACTIVITY	RATED
8:30-9:00		
9:00-9:30		
9:30-10:00		
10:00-10:30		
10:30-11:00		
11:00-11:30		
11:30-12:00		
12:00-1:00		
1:00-1:30		
1:30-2:00		
2:00-2:30		
2:30-3:00		
3:00-3:30		
3:30-4:00		
4:00-4:30		
4:30-5:00		
5:00-5:30		