Doctors can be prone to getting lost in their own Petri dish. This is by nature and nurture. Attention to detail and perfectionism must be natural attributes of anyone who makes it through the rigours of medical school. Then as a junior doctor daily faces overwhelming demand at work, he learns to focus evermore closely on the task in hand. Beyond this, diligent study is required to pass exams and learn to treat patients in narrower and narrower fields of medicine. It is no wonder we all have tunnel vision.

In the stiler moments of a junior doctor’s frenzied work, does wonder about the bigger picture, about where plans and strategies are made and monitored, about how efficacious his work actually is. This far downstream a strategy feels like wishful thinking.

Thus, I was delighted to start my second year as a doctor with a Public Health placement, miles away from bleep and wards. This was a chance not only to step out of my hamster wheel for a while, but also to see the wider world that commissions it and all the much bigger wheels.

During my four months with a Public Health team in a deprived area of Merseyside, I was struck first by the unfamiliar language: ‘commissioning’, ‘modelling’, ‘scoping it out’, the concept of whether or not one has ‘capacity’, that a project is always ‘around’ a subject, never ‘about’. One email I needed to have translated by a Public Health colleague, and one meeting I came away from with no idea what was discussed! But when the dust settled, I began to see healthcare from an entirely different vantage point, one of objectivity and strategy, evidence-based service planning, the consideration of a patient’s community and local facilities.

As for whether the speciality adds anything to clinical medicine, do I need, in 2011, to defend evidence-based medicine? Must I speak out for cost-effective strategy in service planning? Surely we have seen the benefits of immunization and screening programmes? Is not it elementary that promoting health and practising prevention are better than fighting the battle of ill health downstream? And do doctors not long for sensible, evidence-based management behind their teams, and a sensible, evidence-based plan behind their management?

Indisputably, the speciality is essential to clinical medicine and the health of the nation, but is it for doctors to learn and practise the science and art of Public Health? What is taught in medical schools?

I think for this we must consider medical education of any speciality under two domains: learning and practising the principles and tools of a speciality, and practising as a specialist.

The principles and tools of Public Health can be learnt, and are taught in medical schools. You cannot get a medical degree in the UK without having critically appraised an article, worked with statistics, considered the aetiology and epidemiology of each disease, appreciated the value of screening programmes and smoking cessation services, learnt how to protect the public and staff in the event of a TB case, practised asking and advising patients about their alcohol intake or sexual health discerningly but without inciting discord or mistrust.

After graduation, a doctor cannot practise for long without simultaneously using these Public Health tools, whether by referring to local services, encouraging immunization and breast-feeding, undertaking audits or treating contacts of a meningitis case.

Further on in a doctor’s career, he will become more familiar with other aspects of Public Health, those of funding, service commissioning, regulatory bodies, etc. These things are admittedly poorly taught in medical schools, and junior doctors come to decry this omission from their education.

It is true, though, that currently none of the above is learnt or practised under the banner of ‘Public Health’, so medics will answer that they know nothing of the speciality.
But as Public Health principles and tools are weaved through every field of medicine, it has, in fact, been taught them by stealth, and they engage with them daily.

However, there is a world of difference between practising the principles and tools of a speciality, and practising as a specialist.

A surgeon might feel competent to practise some principles of endocrinology by prescribing dextrose for his hypoglycaemic patient, but he does not seek to practise endocrinology as a specialist. There is a whole world of endocrinology that the surgeon cannot possibly take on.

Likewise, a doctor should practise the tools and principles of Public Health in his work, but he cannot practise Public Health as a specialist unless he take up the speciality and be trained in it. There is a whole world of Public Health that a doctor cannot possibly undertake while running a clinic.

In conclusion, we need cardiologists to be cardiologists, General Practitioners to be General Practitioners, nurses to be nurses, and Public Health specialists to be Public Health specialists, and each must practise their speciality well while recognizing the incalculable contribution of the other.

So, doctors, return to your Petri dish and learn its wisdom well! Learn, teach and practise the principles of public health in your speciality, and praise the skill of the Public Health professionals in the defence and treatment of your population’s health. Long may they live!