

From PhD to Public Health Doctor..... (Extended Network Article)

Dr Catherine Heffernan is a graduate of Green College (now Green Templeton), University of Oxford, where she obtained a D.Phil. in Sociology in 2002. Following the completion of her doctoral thesis on sexually transmitted infections and sexual behaviours, she spent three years working as a post-doctoral researcher into Motor Neurone Disease, neurological disorders and sexual health at the Department of Public Health, University of Oxford. She has also lectured and tutored on sociology, social policy, public health and research methodologies. She is a Fellow of the Royal Statistical Society.

In 2005 she joined the higher specialist training programme in public health, which is overseen by the Faculty of Public Health, open to both medical doctors and those from other public health disciplines. She qualified in 2009 and now works as a Consultant in Children's Public Health at NHS Hounslow & Hounslow Borough. Here she writes about her working day and working life:

My day kicks off at 9.30 with coffee and 100 emails. My PA hurries by, handing me my diary for the day. There is nearly always a last-minute meeting added. Today is no exception. There has been an Ecoli outbreak at a school, so there is an emergency teleconference at 11am. I am also quickly briefed on the protocol for taking the Deputy Mayor around our new breast screening unit - etiquette instructions have arrived from the Mayor's office.

I check the agenda and minutes for the Breastfeeding and Immunisation Steering Committee that I chair and set up dates for the Sexual Health Strategy Board and the Healthy Weight Healthy Lives Board, two other partnership boards that I also chair. I glance at the time. I am responsible for meeting three Primary Care Trust targets on health and have to meet with the performance team to update them on teenage pregnancy in the borough and the possible effects the recent local authority cuts are likely to have on delivery of this target.

The 100 emails are now 110. Most are queries needing immediate responses and decision making, fire fighting, as we call it. Maternity A&E attendances have increased suddenly in the local hospital. This means increased costs but it is not clear if this increased demand is due to poor provision of urgent care or some other factor. I am asked what we're doing about it. There is a consultation document on the effects of the NHS White Paper on children and young people which requires input. Alcohol Awareness Week is approaching and the communications team want to know what we will do to promote it. The local radio station wants to interview me at 5pm on the rise in child poverty in London. The Children and Young People's Needs Assessment is due a refresh and I am to oversee the Primary Care Trust's submission. One of the community paediatricians reports a rise in asthma; I must check if this is a real effect and if so, develop a patient care pathway. There is a query about decommissioning the dermatology service. I comment on this, demonstrating cost-effectiveness and impact upon patients' outcomes.

I look at my diary again. I have a new public health registrar starting today and I've just signed up to supervise a GP registrar in November. Plus there is that period of time I have set aside this afternoon for writing the funding proposal to do some public health research.

This is a typical morning for a public health doctor in the NHS. The difference is I'm a sociologist.

I graduated in the mid-1990s with a BA in English Literature and Sociology. My final-year dissertation focused on the reasons why women did not breastfeed despite knowing the benefits. I was immediately hooked on medical sociology. I decided then and there to become a medical sociologist, but I was only 20 years old and unsure about where to go to do my doctorate. Instead, I embarked on an MSc in Science Communication. Essentially, this was a degree in journalism but it equipped me with the skills to effectively absorb scientific jargon and then communicate it to a lay audience. (This was also put to good use in later years when undertaking systematic reviews of treatments and interventions in a large number of diseases).

In 1997, I did another masters degree at Trinity College Dublin in applied social research and the following year, I applied and was accepted to Green College, University of Oxford, for my D.Phil. in Sociology. I spent a wonderful four years at the Department of Sociology in Oxford, studying under Professor Anthony Heath, whilst working away on a thesis entitled 'STIs, Sex and the Irish'. During this time I attended various BSA conferences, airing working papers and I even spent a stint as Features Editor for *Network*.

Then in 2002, I was posed with a dilemma. Despite being enticed into management consultancy, I really wanted to remain in sociology. The sociology department at Oxford was at the time in its infancy, and as a burgeoning medical sociologist I was encouraged to move to the more established Department of Primary Care and Public Health, where the other medical sociologists were based.

There I accepted a post-doctoral post working with Professor Crispin Jenkinson and Professor Ray Fitzpatrick on developing national guidelines for the care of patients with motor neurone disease. I also had the opportunity to continue developing my quantitative sociological skills and branched out into measuring outcomes and developing health status instruments. I busied myself with teaching and examining duties, obtaining a lectureship in health and disease, and preparing myself to apply for that all important lecturer post. Everything was falling into place.

Then I got married and faced a home truth. Oxford was and still is expensive to live in. As academics, my husband and I found it almost impossible to get a home within our budget. Obtaining permanent job contracts was also an issue. Had I been the next Foucault, I probably wouldn't have worried, but there always seemed to be hundreds of competitors for posts and funding whom I believed were better than me. I remember one night thinking about whether I would be able to give my children the upbringing they deserved. I didn't want to be in a position to have to say to my future son that he couldn't join the football team because I couldn't afford the kit.

Luckily, a chance encounter with a former NHS manager at a garden party changed everything. Although public health is a medical specialty, non-medics who are suitably qualified can apply to the post-graduate programme and train to become consultants. The training programme also contains academic positions - a chance to get that elusive lectureship, I thought. I joined the programme run by the Oxford Deanery in February 2005 and a year later moved to the Yorkshire and Humber Deanery.

It was a fantastic experience. Like other registrars, you rotated to different training locations but instead of hospitals you moved between primary care trusts, the Health Protection Agency, the Department of Health, academia, hospitals, local authorities and public health observatories. There is a portfolio of competencies to fulfil and there are the dreaded Faculty of Public Health exams, known as Part A and OSPHE (a form of role-playing oral exam). The programme is four to five years, depending on whether you need to do a Masters in Public Health or not. The salary is good – it is a percentage of a consultant's salary plus 20 per cent for doing on-call for health protection duties. This works out between £40,000 and £50,000. Consultants in public health start on around £65,000 plus three per cent on-call (and London weighting if applicable). Any additional teaching or other duties are paid for separately. The medics – known as consultants in public health medicine – start on roughly £10,000 more but both medics and non-medics do exactly the same job. Non-medics are also entitled to be paid as clinical lecturers if they decide to become academics.

The training programme provides you with a lot of freedom to develop your own work interests. I learned that I thrived on the hustle and bustle of NHS life and absolutely adored developing strategies and policies at the Department of Health. I didn't abandon my academic roots completely. As a registrar, I got an honorary lectureship at University of Leeds and contributed to the teaching of medical students and dabbled in a little research. As a consultant, I'm going to take an honorary senior lectureship and have built into my work-plan to do a substantive piece of research next year. However, I found that my sociological background was invaluable to my day-to-day work. It really is a fantastic grounding for public health.

Firstly, there is health intelligence. All my statistical and social research methodology training means that I can interpret any health trend, read any epidemiological report, conduct and commission valid evaluation and audits and measure outcomes and users' perspectives. Secondly, service redesign is a huge component of public health work and being able to develop service models based on evidence requires the skills of a social researcher. I am totally confident that if a paper exists, I will find it and be able to critically appraise it. People need to know what works and the years spent doing literature reviews means that I can quickly put together an argument on the effectiveness of interventions. Thirdly, partnership working is crucial to improving health and wellbeing and reducing health inequalities.

Sociology gives you the understanding of different cultures including those of organisations. Without knowing it, I readily apply the theories to my work and feel that I can bring anyone even dissenting voices to the table. Sociology also equips you with an understanding of the barriers to good health on micro-, meso- and macro-levels including the impact of social structure as well as environment. This is crucial when working with local authorities, which have the responsibility to improve housing, transport and education, reduce crime and social inequalities and so improve quality of life.

Perhaps most crucially, public health is a 'whole systems' approach. We look at the big picture, the health and well-being of populations. For instance, if you change something, what will happen to people now and what will happen in the future? You need an understanding of lay-persons' perspectives, effects of social class on use of public services, doctor-patient relationships, medicalisation, social-constructivism, deviance, stigma, effects of age, gender and ethnicity, social causes of disease, social capital, changes in family, among others. You need an understanding of sociology.

Since March 2010, I have been working in Hounslow, West London. I am jointly appointed between the local authority and the NHS and I am the Consultant in Children's Public Health. I deal with all health and well-being issues pertaining to the 0-19 year old age group, although I am the lead for maternal health, sexual health and obesity for adults as well. I have a portfolio of work that changes over time, depending upon the priorities. I often liken it to being like Gordon Ramsay in 'Ramsay's Kitchen Nightmares' or Mary Portas in 'Mary Queen of Shops' or even the 'Hotel Inspector' on Channel 5. There is a service that's not delivering or it doesn't suit its customers' needs. The public health consultant comes in, evaluates it, checks out the evidence and best practice elsewhere, talks to the frontline staff and the consumers and putting this together, revamps the service. He or she returns after some time to check on the service to see if it is still operating efficiently.

Sometimes the job is like Location Location or Place in the Sun. Someone comes to you with a need (for example, there may be a group of people with a disease who need looking after). You have a budget and instead of finding the house to suit this need, you are finding or adapting a service to meet the health need. Other times, we're like the 10 Years Younger programme or Jamie Oliver, giving populations makeovers by tackling poverty and unemployment, encouraging healthy changes in lifestyles and promoting healthier eating and living. Then there are lots of strategies to write, not forgetting our role in protecting the population from the spread of communicable diseases and chemical incidents. The job is busy, chaotic at times but never ever boring.

If you are interested in finding out more about getting into public health, please check out my website www.drcath.net, which aims to promote a wider public understanding of public health work.