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# Correspondence

## Make it boring: letter to the *Journal of Public Health*

Sir,

We enjoyed reading your recent editorial 'Making it boring'.[1] Your thesis is an interesting one—that standardization and repetition can achieve quality improvement in public health practice. This thesis is drawn on findings by Judge *et al*. showing that hospitals which frequently perform hip and knee replacements achieve better clinical outcomes.[2] In addition to workload volume, comparisons have been made between doctors and airline pilots to highlight the benefits of standardization within the healthcare setting.[3] Applying these lessons to public health is certainly a challenge.

Repetition is not a prominent feature of public health practice, largely because it sees itself as a 'generalist speciality'. Frequent reorganization and fragmentation of public health organizations are additional threats to repetition; public health practitioners, increasingly isolated in small and under-resourced departments, are expected to cover a bewildering range of areas from child immunization to funding decisions for novel cancer treatments. While there have been a number of innovations to promote standardization of practice, these have largely been through synthesis of research evidence such as the York Centre for Reviews and Dissemination.[4] While previous studies have shown that uptake of guidelines is often poor in clinical settings,[5] we are not aware that the effectiveness of evidence reviews within public health practice has been measured.

As implied by Jessop and Judge, successful repetition and standardization in other areas of medical practice have largely been achieved through increasing subspecialization. In modern medicine, the General Physician has all but disappeared, and General Practitioners increasingly rely on hospital specialists for expert advice. Within public health, there are a few examples of a movement towards specialization. The clearest example of this is the area of health protection, which has been taken out of general public health departments and established as its own specialist agency—the Health Protection Agency.[6] Public Health Observatories are further examples where expertise in health intelligence has been concentrated into specialist units.[7] In both examples, standardization and repetition of practice are much more feasible, but their effectiveness relies heavily on maintaining close relationships with local public health departments.

Until now, the Faculty of Public Health has firmly resisted subspecialization. The present curriculum for Consultant-level training prescribed by the Faculty of Public Health requires trainees to gain some understanding or experience of almost every aspect of the public health universe: in short, more value is placed on breadth than depth of knowledge. While this itself does not create a barrier to specialization, once qualified as a Consultant, it can be difficult to justify formal specialist training in areas such as epidemiology or health promotion. Interestingly, the Specialist Voluntary Register has chosen to adopt a different approach by promoting 'defined specialists' in a range of areas such as health intelligence and health promotion.

While public health will always require a mixture of generalist and specialist practitioners, it may be time to recognize that as professionals, we cannot gain and maintain a high level of competence in all areas of public health practice. If standardization and repetition are indeed a recipe to improve quality, we need to recognize the value of specialization.

## References

1 Jessop EG. Make it boring. *J Public Health* 2006;**28(2)**:87.

2 Judge A, Chard J, Learmonth I *et al*. The effects of surgical volumes and training centre status on outcomes following total joint replacement: analysis of the Hospital Episode Statistics for England. *J Public Health* 2006;**28(2)**:116–24.

3 Helmreich RL. On error management: lessons from aviation. *BMJ* 2000;**320**:781–85.

4 Centre for Reviews and Dissemination. http://www.york.ac.uk/inst/crd/ (30 July 2006, date last accessed).

5 Haines A, Donald A. Looking forward: getting research findings into practice: making better use of research findings. *BMJ* 1998;**317(7150)**:72–5.

6 Agency HP. http://www.hpa.org.uk (30 July 2006, date last accessed).

7 Association of Public Health Observatories. http://www.apho.org.uk (30 July 2006, date last accessed).

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## Mobile phones and driving: a follow-up

Sirs,

A law banning the use of mobile phones whilst driving was passed in the UK and went into effect on 1 December 2003.[1] A study demonstrated that within 10 weeks of enforcement of the new law, mobile phone usage while driving fell from 1.85 to 0.97% across three different sites around Birmingham.[2] A correspondence[3] in response to this study referred to a similar study conducted in New York, in which although the same sort of post-legislation drop was reported, the figures were then found to return to pre-legislation levels within a year.[4] Thus, as a follow-up to the study conducted in Birmingham, we aim to assess the longer-term impact of the legislation 2 years on from its implementation.

To ensure continuity, we replicated all contexts used by Johal *et al.* in our study. The same three sites were used: a traffic-light T-junction (A), a pedestrian crossing (B) and a roundabout (C). Samples were taken on four consecutive Tuesday evenings between 17:00 and 18:00 hours in October. The results are shown in Table 1—the table also shows the results from the previous study, 10 weeks before and 10 weeks after the legislation was enforced.

Our new data show statistically significant rises in the rate of mobile phone usage at two of the three sites since the previous study. The overall rate of mobile phone usage from this data is 1.63%, demonstrating an increase of mobile phone usage back to nearly pre-legislation levels. This is very much in keeping with the results of the New York study of 2004[4] as well as with anecdotal evidence within the UK itself.[5] The apparently anomalous findings in relation to site B are most likely to be explained by the introduction of another road safety measure, speed cameras, a few hundred yards before the observation point, after the original survey. This may well have resulted in drivers' feeling the need to behave better in other respects concerning road safety.

As mentioned by Paul Pilkington in his correspondence to the initial study, the reasons for the decreasing compliance could be 2-fold. Firstly, after a brief period of compliance, drivers are judging the risk of 'getting caught' as minimal and hence returned to using mobile phones whilst driving due to lack of enforcement of the law. Secondly with publicity of the risks of using mobile phones whilst driving diminishing so soon after the legislation, people are forgetting or down-playing these risks and dangers.

Without the fear of being prosecuted, this law has been shown previously[4] and on this occasion to be ineffective. Calls for greater enforcement of this law and improved publicity and education are hence the required course of action. We may also benefit from new measures proposed in the UK Road Safety Bill (yet to be passed) seeking to increase the penalty for using a mobile phone while driving from £30 to £60 plus three penalty points.[6] The idea of 'on-the-spot' fines may also act as a deterrent. It is evident that although the current legislation has certain level of potency, it is very much short-lived and is hence in need of such measures to reduce mobile phone usage whilst driving.

## Contribution of authors

T.M. thought of the idea. K.H., J.A., A.M. and A.A. carried out the observations and wrote the first draft. K.H. wrote the final draft. K.H., J.A., A.M. and A.A. hold the raw data, to which T.M. has access.

**Table 1** Table showing the rates of mobile phone usage whilst driving across 3 different sites (A, B and C) in Birmingham over a period of 2 years

| | *Site* | | | | | |
|---|---|---|---|---|---|---|
| | *A* | | *B* | | *C* | |
| Mobile phone use | Y | N | Y | N | Y | N |
| Before (September–October 2003) | 54 | 3390 | 119 | 3852 | 60 | 5092 |
| After (February–March 2004) | 22 | 3479 | 61 | 4017 | 30 | 3997 |
| Now (September–October 2005) | 59 | 4065 | 49 | 2569 | 31 | 1903 |
| RR (now/before) (95% CI) | 0.91 (0.63–1.32) | | 0.62 (0.45–0.87) | | 1.38 (0.90–2.12) | |
| RR (now/after) (95% CI) | 2.28 (1.40–3.71) | | 1.25 (0.86–1.82) | | 2.15 (1.31–3.54) | |

Site A, traffic-light T-junction; site B, pedestrian crossing; site C, roundabout.