

PUBLIC HEALTH IN THE 1980s AND 1990s: DECLINE AND RISE?

The transcript of a Witness Seminar held by the Wellcome Trust Centre for the History of Medicine at UCL, London, on 12 October 2004

Edited by V Berridge, D A Christie and E M Tansey

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WITNESS SEMINARS: MEETINGS AND PUBLICATIONS¹

In 1990 the Wellcome Trust created a History of Twentieth Century Medicine Group, associated with the Academic Unit of the Wellcome Institute for the History of Medicine, to bring together clinicians, scientists, historians and others interested in contemporary medical history. Among a number of other initiatives the format of Witness Seminars, used by the Institute of Contemporary British History to address issues of recent political history, was adopted, to promote interaction between these different groups, to emphasize the potential benefits of working jointly, and to encourage the creation and deposit of archival sources for present and future use. In June 1999 the Governors of the Wellcome Trust decided that it would be appropriate for the Academic Unit to enjoy a more formal academic affiliation and turned the Unit into the Wellcome Trust Centre for the History of Medicine at UCL from 1 October 2000. The Wellcome Trust continues to fund the Witness Seminar programme via its support for the Wellcome Trust Centre.

The Witness Seminar is a particularly specialized form of oral history, where several people associated with a particular set of circumstances or events are invited to come together to discuss, debate, and agree or disagree about their memories. To date, the History of Twentieth Century Medicine Group has held more than 40 such meetings, most of which have been published, as listed on pages xv–xix.

Subjects are usually proposed by, or through, members of the Programme Committee of the Group, which includes professional historians of medicine, practising scientists and clinicians, and once an appropriate topic has been agreed, suitable participants are identified and invited. This inevitably leads to further contacts, and more suggestions of people to invite. As the organization of the meeting progresses, a flexible outline plan for the meeting is devised, usually with assistance from the meeting's chairman, and some participants are invited to 'start the ball rolling' on particular themes, by speaking for a short period to initiate and stimulate further discussion.

¹ The following text also appears in the 'Introduction' to recent volumes of *Wellcome Witnesses to Twentieth Century Medicine* published by the Wellcome Trust and the Wellcome Trust Centre for the History of Medicine at UCL.

Each meeting is fully recorded, the tapes are transcribed and the unedited transcript is immediately sent to every participant. Each is asked to check his or her own contributions and to provide brief biographical details. The editors turn the transcript into readable text, and participants' minor corrections and comments are incorporated into that text, while biographical and bibliographical details are added as footnotes, as are more substantial comments and additional material provided by participants. The final scripts are then sent to every contributor, accompanied by forms assigning copyright to the Wellcome Trust.² Copies of all additional correspondence received during the editorial process are deposited with the records of each meeting in Archives and Manuscripts, Wellcome Library, London.

As with all our meetings, we hope that even if the precise details of some of the technical sections are not clear to the non-specialist, the sense and significance of the events will be understandable. Our aim is for the volumes that emerge from these meetings to inform those with a general interest in the history of modern medicine and medical science; to provide historians with new insights, fresh material for study, and further themes for research; and to emphasize to the participants that events of the recent past, of their own working lives, are of proper and necessary concern to historians.

**Members of the Programme Committee of the
History of Twentieth Century Medicine Group, 2005–06**

Dr Tilli Tansey – Reader in History of Modern Medical Sciences, Wellcome Trust Centre for the History of Medicine at UCL (WTCHM), and Chair

Sir Christopher Booth – WTCHM, former Director, Clinical Research Centre, Northwick Park Hospital, London

Dr Robert Bud – Principal Curator of Medicine and Manager of Electronic Content, Science Museum, London

Dr Daphne Christie – Senior Research Assistant, WTCHM, and Organizing Secretary

Dr John Ford – Retired General Practitioner, Tonbridge

Professor Mark Jackson – Centre for Medical History, Exeter

Professor Ian McDonald – WTCHM, former Professor of Neurology, Institute of Neurology, London

Dr Helga Satzinger – Reader in History of Twentieth Century Biomedicine, WTCHM

Professor Lawrence Weaver – Professor of Child Health, University of Glasgow, and Consultant Paediatrician in the Royal Hospital for Sick Children, Glasgow

² Sir Iain Chalmers authorizes the Wellcome Trust to publish his work and to report or reproduce it in any form or media, including offprints, provided that it is understood that the Wellcome Trust's right to do so is nonexclusive.

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‘Public Health in the 1980s and 1990s: Decline and rise?’ was suggested as a suitable topic for a Witness Seminar by Dr Niki Ellis, who assisted us in planning the meeting. We are very grateful to her for her input. We are particularly grateful to Professor Virginia Berridge for writing the Introduction to these published proceedings, and also for her excellent chairing of the occasion. Our additional thanks go to Dr Sally Sheard (Liverpool University) for her help with the organization of the meeting and during the preparation of this publication; and Dr Martin Gorsky, who read an earlier draft of the transcript and offered helpful comments and advice. We also thank Professors John Ashton and Virginia Berridge for additional help with photographs, and Professors Virginia Berridge, Susanne MacGregor, Drs Niki Ellis, Anne Hardy, Ornella Moscucci and participants for their help with the reconstruction of a small missing section of the recording (pages 25–37).

As with all our meetings, we depend a great deal on our colleagues at the Wellcome Trust to ensure their smooth running: the Audiovisual Department, and the Medical Photographic Library and Mrs Tracy Tillotson of the Wellcome Library; Mr Akio Morishima, who has supervised the design and production of this volume; our indexer, Ms Cath Topliff; our readers, Ms Lucy Moore, Ms Fiona Plowman, Mrs Lois Reynolds and Mr Simon Reynolds. Mrs Jaqui Carter is our transcriber, and Mrs Wendy Kutner and Mrs Lois Reynolds assist us in running the meetings. Finally we thank the Wellcome Trust for supporting this programme.

Tilli Tansey

Daphne Christie

Wellcome Trust Centre for the History of Medicine at UCL

HISTORY OF TWENTIETH CENTURY MEDICINE WITNESS SEMINARS, 1993–2006

- 1993 Monoclonal antibodies**
Organizers: Dr E M Tansey and Dr Peter Catterall
- 1994 The early history of renal transplantation**
Organizer: Dr Stephen Lock
- Pneumoconiosis of coal workers**
Organizer: Dr E M Tansey
- 1995 Self and non-self: A history of autoimmunity**
Organizers: Sir Christopher Booth and Dr E M Tansey
- Ashes to ashes: The history of smoking and health**
Organizers: Dr Stephen Lock and Dr E M Tansey
- Oral contraceptives**
Organizers: Dr Lara Marks and Dr E M Tansey
- Endogenous opiates**
Organizer: Dr E M Tansey
- 1996 Committee on Safety of Drugs**
Organizers: Dr Stephen Lock and Dr E M Tansey
- Making the body more transparent: The impact of nuclear
 magnetic resonance and magnetic resonance imaging**
Organizer: Sir Christopher Booth
- 1997 Research in general practice**
Organizers: Dr Ian Tait and Dr E M Tansey
- Drugs in psychiatric practice**
Organizers: Dr David Healy and Dr E M Tansey
- The MRC Common Cold Unit**
Organizers: Dr David Tyrrell and Dr E M Tansey
- The first heart transplant in the UK**
Organizer: Professor Tom Treasure

- 1998 Haemophilia: Recent history of clinical management**
Organizers: Professor Christine Lee and Dr E M Tansey
- Obstetric ultrasound: Historical perspectives**
Organizers: Dr Malcolm Nicolson, Mr John Fleming and Dr E M Tansey
- Post penicillin antibiotics**
Organizers: Dr Robert Bud and Dr E M Tansey
- Clinical research in Britain, 1950–1980**
Organizers: Dr David Gordon and Dr E M Tansey
- 1999 Intestinal absorption**
Organizers: Sir Christopher Booth and Dr E M Tansey
- The MRC Epidemiology Unit (South Wales)**
Organizers: Dr Andy Ness and Dr E M Tansey
- Neonatal intensive care**
Organizers: Professor Osmund Reynolds and Dr E M Tansey
- British contributions to medicine in Africa after the Second World War**
Organizers: Dr Mary Dobson, Dr Maureen Malowany, Dr Gordon Cook and Dr E M Tansey
- 2000 Childhood asthma, and beyond**
Organizers: Dr Chris O’Callaghan and Dr Daphne Christie
- Peptic ulcer: Rise and fall**
Organizers: Sir Christopher Booth, Professor Roy Pounder and Dr E M Tansey
- Maternal care**
Organizers: Dr Irvine Loudon and Dr Daphne Christie
- 2001 Leukaemia**
Organizers: Professor Sir David Weatherall, Professor John Goldman, Sir Christopher Booth and Dr Daphne Christie
- The MRC Applied Psychology Unit**
Organizers: Dr Geoff Bunn and Dr Daphne Christie

- Genetic testing**
Organizers: Professor Doris Zallen and Dr Daphne Christie
- Foot and mouth disease: The 1967 outbreak and its aftermath**
Organizers: Dr Abigail Woods, Dr Daphne Christie and Dr David Aickin
- 2002 **Environmental toxicology: The legacy of *Silent Spring***
Organizers: Dr Robert Flanagan and Dr Daphne Christie
- Cystic fibrosis**
Organizers: Dr James Littlewood and Dr Daphne Christie
- Innovation in pain management**
Organizers: Professor David Clark and Dr Daphne Christie
- 2003 **Thrombolysis**
Organizers: Mr Robert Arnott and Dr Daphne Christie
- Beyond the asylum: Anti-psychiatry and care in the community**
Organizers: Dr Mark Jackson and Dr Daphne Christie
- The Rhesus factor and disease prevention**
Organizers: Professor Doris Zallen and Dr Daphne Christie
- Platelets in thrombosis and other disorders**
Organizers: Professor Gustav Born and Dr Daphne Christie
- 2004 **Short-course chemotherapy for tuberculosis**
Organizers: Dr Owen McCarthy and Dr Daphne Christie
- Prenatal corticosteroids for reducing morbidity and mortality associated with preterm birth**
Organizers: Sir Iain Chalmers and Dr Daphne Christie
- Public health in the 1980s and 1990s: Decline and rise?**
Organizers: Professor Virginia Berridge, Dr Niki Ellis and Dr Daphne Christie
- 2005 **The history of cholesterol, atherosclerosis and coronary disease, 1950–2000**
Organizers: Professor Michael Oliver and Dr Daphne Christie
- Development of physics applied to medicine in the UK, 1945–90**
Organizers: Professor John Clifton and Dr Daphne Christie

2006 The early development of total hip replacement

Advisers: Dr Krishna Kunzru and Dr Francis Neary

The discovery, use and impact of platinum salts as chemotherapy agents for cancer

Advisers: Professor Paul Andrews and Dr Anthony Woods

Medical ethics education in Britain, 1963–93

Adviser: Dr Michael Barr

Superbugs and superdrugs: The history of MRSA

Adviser: Professor Gordon Stewart

PUBLISHED MEETINGS

'...Few books are so intellectually stimulating or uplifting'

Journal of the Royal Society of Medicine (1999) **92**: 206–8,
review of vols 1 and 2

*'...This is oral history at its best...all the volumes make compulsive reading...
they are, primarily, important historical records'*

British Medical Journal (2002) **325**: 1119, review of the series

Technology transfer in Britain: The case of monoclonal antibodies

Self and non-self: A history of autoimmunity

Endogenous opiates

The Committee on Safety of Drugs

In: Tansey E M, Catterall P P, Christie D A, Willhoft S V, Reynolds L A. (eds) (1997) *Wellcome Witnesses to Twentieth Century Medicine*. Volume 1. London: The Wellcome Trust, 135pp. ISBN 1 869835 79 4

Making the human body transparent: The impact of NMR and MRI

Research in general practice

Drugs in psychiatric practice

The MRC Common Cold Unit

In: Tansey E M, Christie D A, Reynolds L A. (eds) (1998) *Wellcome Witnesses to Twentieth Century Medicine*. Volume 2. London: The Wellcome Trust, 282pp. ISBN 1 869835 39 5

Early heart transplant surgery in the UK

In: Tansey E M, Reynolds L A. (eds) (1999) *Wellcome Witnesses to Twentieth Century Medicine*. Volume 3. London: The Wellcome Trust, 72pp. ISBN 1 841290 07 6

Haemophilia: Recent history of clinical management

In: Tansey E M, Christie D A. (eds) (1999) *Wellcome Witnesses to Twentieth Century Medicine*. Volume 4. London: The Wellcome Trust, 90pp. ISBN 1 841290 08 4

Looking at the unborn: Historical aspects of obstetric ultrasound

In: Tansey E M, Christie D A. (eds) (2000) *Wellcome Witnesses to Twentieth Century Medicine*. Volume 5. London: The Wellcome Trust, 80pp. ISBN 1 841290 11 4

Post penicillin antibiotics: From acceptance to resistance?

In: Tansey E M, Reynolds L A. (eds) (2000) *Wellcome Witnesses to Twentieth Century Medicine*. Volume 6. London: The Wellcome Trust, 71pp.
ISBN 1 841290 12 2

Clinical research in Britain, 1950–1980

In: Reynolds L A, Tansey E M. (eds) (2000) *Wellcome Witnesses to Twentieth Century Medicine*. Volume 7. London: The Wellcome Trust, 74pp.
ISBN 1 841290 16 5

Intestinal absorption

In: Christie D A, Tansey E M. (eds) (2000) *Wellcome Witnesses to Twentieth Century Medicine*. Volume 8. London: The Wellcome Trust, 81pp.
ISBN 1 841290 17 3

Neonatal intensive care

In: Christie D A, Tansey E M. (eds) (2001) *Wellcome Witnesses to Twentieth Century Medicine*. Volume 9. London: The Wellcome Trust Centre for the History of Medicine at UCL, 84pp. ISBN 0 854840 76 1

British contributions to medical research and education in Africa after the Second World War

In: Reynolds L A, Tansey E M. (eds) (2001) *Wellcome Witnesses to Twentieth Century Medicine*. Volume 10. London: The Wellcome Trust Centre for the History of Medicine at UCL, 93pp. ISBN 0 854840 77 X

Childhood asthma and beyond

In: Reynolds L A, Tansey E M. (eds) (2001) *Wellcome Witnesses to Twentieth Century Medicine*. Volume 11. London: The Wellcome Trust Centre for the History of Medicine at UCL, 74pp. ISBN 0 854840 78 8

Maternal care

In: Christie D A, Tansey E M. (eds) (2001) *Wellcome Witnesses to Twentieth Century Medicine*. Volume 12. London: The Wellcome Trust Centre for the History of Medicine at UCL, 88pp. ISBN 0 854840 79 6

Population-based research in south Wales: The MRC Pneumoconiosis Research Unit and the MRC Epidemiology Unit

In: Ness A R, Reynolds L A, Tansey E M. (eds) (2002) *Wellcome Witnesses to Twentieth Century Medicine*. Volume 13. London: The Wellcome Trust Centre for the History of Medicine at UCL, 74pp. ISBN 0 854840 81 8

Peptic ulcer: Rise and fall

In: Christie D A, Tansey E M. (eds) (2002) *Wellcome Witnesses to Twentieth Century Medicine*. Volume 14. London: The Wellcome Trust Centre for the History of Medicine at UCL, 143pp. ISBN 0 85484 84 2

Leukaemia

In: Christie D A, Tansey E M. (eds) (2003) *Wellcome Witnesses to Twentieth Century Medicine*. Volume 15. London: The Wellcome Trust Centre for the History of Medicine at UCL, 86pp. ISBN 0 85484 087 7

The MRC Applied Psychology Unit

In: Reynolds L A, Tansey E M. (eds) (2003) *Wellcome Witnesses to Twentieth Century Medicine*. Volume 16. London: The Wellcome Trust Centre for the History of Medicine at UCL, 94pp. ISBN 0 85484 088 5

Genetic testing

In: Christie D A, Tansey E M. (eds) (2003) *Wellcome Witnesses to Twentieth Century Medicine*. Volume 17. London: The Wellcome Trust Centre for the History of Medicine at UCL, 130pp. ISBN 0 85484 094 X

Foot and mouth disease: The 1967 outbreak and its aftermath

In: Reynolds L A, Tansey E M. (eds) (2003) *Wellcome Witnesses to Twentieth Century Medicine*. Volume 18. London: The Wellcome Trust Centre for the History of Medicine at UCL, 114pp. ISBN 0 85484 096 6

Environmental toxicology: The legacy of *Silent Spring*

In: Christie D A, Tansey E M. (eds) (2004) *Wellcome Witnesses to Twentieth Century Medicine*. Volume 19. London: The Wellcome Trust Centre for the History of Medicine at UCL, 132pp. ISBN 0 85484 091 5

Cystic fibrosis

In: Christie D A, Tansey E M. (eds) (2004) *Wellcome Witnesses to Twentieth Century Medicine*. Volume 20. London: The Wellcome Trust Centre for the History of Medicine at UCL, 120pp. ISBN 0 85484 086 9

Innovation in pain management

In: Reynolds L A, Tansey E M. (eds) (2004) *Wellcome Witnesses to Twentieth Century Medicine*. Volume 21. London: The Wellcome Trust Centre for the History of Medicine at UCL, 125pp. ISBN 0 85484 097 4

The Rhesus factor and disease prevention

In: Zallen D T, Christie D A, Tansey E M. (eds) (2004) *Wellcome Witnesses to Twentieth Century Medicine*. Volume 22. London: The Wellcome Trust Centre for the History of Medicine at UCL, 98pp. ISBN 0 85484 099 0

The recent history of platelets in thrombosis and other disorders

In: Reynolds L A, Tansey E M. (eds) (2005) *Wellcome Witnesses to Twentieth Century Medicine*. Volume 23. London: The Wellcome Trust Centre for the History of Medicine at UCL, 186pp. ISBN 0 85484 103 2

Short-course chemotherapy for tuberculosis

In: Christie D A, Tansey E M. (eds) (2005) *Wellcome Witnesses to Twentieth Century Medicine*. Volume 24. London: The Wellcome Trust Centre for the History of Medicine at UCL, 120pp. ISBN 0 85484 104 0

Prenatal corticosteroids for reducing morbidity and mortality after preterm birth

In: Reynolds L A, Tansey E M. (eds) (2005) *Wellcome Witnesses to Twentieth Century Medicine*. Volume 25. London: The Wellcome Trust Centre for the History of Medicine at UCL, 154pp. ISBN 0 85484 102 4

Public health in the 1980s and 1990s: Decline and rise?

In: Berridge V, Christie D A, Tansey E M. (eds) (2006) *Wellcome Witnesses to Twentieth Century Medicine*. Volume 26. London: The Wellcome Trust Centre for the History of Medicine at UCL. This volume. ISBN 0 85484 106 7

Fifty years of cholesterol, atherosclerosis and coronary disease, 1950–2000

In: Reynolds L A, Tansey E M. (eds) (2006) *Wellcome Witnesses to Twentieth Century Medicine*. Volume 27. London: The Wellcome Trust Centre for the History of Medicine at UCL. In press.

The development of physics applied to medicine in the UK, 1945–90

In: Christie D A, Tansey E M. (eds) (2006) *Wellcome Witnesses to Twentieth Century Medicine*. Volume 28. The Wellcome Trust Centre for the History of Medicine at UCL. In press.

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All volumes are freely available online at www.ucl.ac.uk/histmed following the links to Publications/Wellcome Witnesses.

Copies of volumes 21–26 can be ordered from www.amazon.co.uk; www.amazon.com; and all good booksellers for £6/\$10 plus postage.

Other publications

Technology transfer in Britain: The case of monoclonal antibodies

In: Tansey E M, Catterall P P. (1993) *Contemporary Record* 9: 409–44.

Monoclonal antibodies: A witness seminar on contemporary medical history

In: Tansey E M, Catterall P P. (1994) *Medical History* 38: 322–7.

Chronic pulmonary disease in South Wales coalmines: An eye-witness account of the MRC surveys (1937–42)

In: P D'Arcy Hart, edited and annotated by E M Tansey. (1998) *Social History of Medicine* 11: 459–68.

Ashes to Ashes – The history of smoking and health

In: Lock S P, Reynolds L A, Tansey E M. (eds) (1998) Amsterdam: Rodopi BV, 228pp. ISBN 90420 0396 0 (Hfl 125) (hardback). Reprinted 2003.

Witnessing medical history. An interview with Dr Rosemary Biggs

Professor Christine Lee and Dr Charles Rizza (interviewers). (1998) *Haemophilia* 4: 769–77.

Witnessing the Witnesses: Pitfalls and potentials of the Witness Seminar in twentieth century medicine

By E M Tansey. In: Doel R, Soderqvist T. (eds) (2006) *Writing Recent Science: The historiography of contemporary science, technology and medicine*. London: Routledge.

INTRODUCTION

This Witness Seminar on the recent history of public health and health promotion in the UK began with a suggestion by Dr Niki Ellis that the Wellcome Trust's History of Twentieth Century Medicine Group might consider running a seminar on the post-war history of public health. After discussion and advice from Dr Sally Sheard of Liverpool University and from myself, the brief was narrowed to the developments of the last 20 years. This is a period which has been less discussed by historians and participants, and which offered, so it seemed to all of us, the possibility of gaining insights while memories were still fresh.

The preface to those decades was the reorganization of the public health profession in the post-war years. The Medical Officer of Health's (MoH) 'empire' of social workers, baby clinics, municipal hospitals and sanitary inspectors had been widely expected to form the backbone of an integrated National Health Service (NHS). But this did not happen: the NHS emerged as a hospital-dominated, tripartite service in which local government health services were a subsidiary partner. Health service reorganization in 1974 and the creation of autonomous social services departments in the local authorities in the wake of the Seebohm Report, saw public health doctors relocated out of local government and into the NHS as consultants in what came to be known as 'community medicine'. Ironically, the language of community was adopted just as medically qualified public health professionals severed their relationships with local communities. Instead their role was defined in relation to medical specialities within the health service. The formation of the Faculty of Community Medicine in 1972 and its rejection of non-medical membership epitomized these changes.

These developments have been widely discussed, both by participants and historians.¹ The relocation of public health out of local government and into health services led to a period of demoralization, and reduced power and influence. This Witness Seminar opened in the aftermath. We planned to discuss what we saw as four key developments over the following 20 years:

- The impact of the 1988 Acheson Report on public health medicine on a demoralized profession.
- The role of new ideas about health promotion imported from the international scene.

¹ Lewis (1986); Porter (ed.) (1997); Warren (1997); Berridge and Taylor (eds) (2005); Sheard and Donaldson (2005).

- The rise of ‘evidence-based medicine’ and health services research, and their impact on public health.
- The movement for multidisciplinary public health (MDPH) as a new avenue for public health from the 1990s.

In the first section of the seminar, participants vividly described the confusion and demoralization of public health in the late 1970s and 1980s. Walter Holland alluded to the difficulties faced by service practitioners who had aspirations far greater than they could fulfil and who served a number of different masters. Geoffrey Rivett and Rod Griffiths gave us their perception of the people who went in to public health – ‘a wildly variable bunch of folks’ (page 7). Shirley Goodwin, as a health visitor, had started as part of the MoH’s local government empire, but found that he just dropped out of view after 1974. John Ashton described the same process in Liverpool, where the City Council had had over 5000 public health staff in the 1950s, a power base which disappeared over this 20-year period. David Blane drew attention (page 14) to the dispiriting role of community physicians in closing down hospitals in London in this period.² Some public health people began to see inequalities as an issue, but, in the wake of the Black Report,³ and with a new Conservative Government, such work was out of favour in official circles.

The report of the 1988 Acheson Committee thus marked a ‘new beginning’ for public health: it reasserted a positive role for the profession. Sir Donald Acheson’s recollections of its genesis underline the support received from the then Secretary of State, Norman Fowler. The committee’s consideration of the role of public health – as it came to be renamed – also arose from other imperatives. There was the need to define the role of public health within health services in relation to the new role of the general manager, as advanced by the Griffiths Report. The Hunter Report, another report on administration, had seen public health doctors as health service managers, and some disputed this. The seminar made clear the connections between health service changes in the 1980s and the redefinition of the role of public health.⁴ The new role, as outlined in the Acheson Report,

² See, for example, Korman and Glennerster (1989).

³ Black Report (1980).

⁴ This connection also emerged from discussion at another Witness Seminar, on the history of multidisciplinary public health, organized by David Evans at the University of the West of England in November 2005. The participants commented that the introduction of the internal market in healthcare required skills which medically qualified public health practitioners did not have and so hastened the reorientation of the profession.

continued to focus on hospitals, in part because local government had no interest in public health. And the role of infectious diseases was also important. Some infections were hospital focused – the Stanley Royd Hospital outbreak, for example – but the impact of HIV/AIDS and BSE was also significant (page 18). The Farley infant food epidemic in 1985 was a less well-known impetus to the renaissance (pages 19–20).

Behind the scenes of the formal professional activities and central government policy-making, there emerged what Ann Taket (page 16) called ‘public health around the edges’. This was what came to be called the ‘new public health’ and participants remembered the formation of the Public Health Alliance: people coming from community development, health education, and other groups, such as radical statistics and the radical health visitors. This was an outgrowth of the radical critique of medicine of the 1960s and 1970s, an involvement in issues such as inequalities that had no place in the mainstream political agenda of the 1980s. Alongside ‘new public health’ was ‘health promotion’, whose influence began at the international level and flowed down into different countries in the 1980s. Ann Taket remembered the excitement and the tensions at the World Health Organization’s (WHO) European Regional office in Copenhagen in the 1980s (pages 29–32). The Alma Ata Declaration in 1978 was followed by the WHO’s ‘Health for All by the Year 2000’ policy. The driving force in Copenhagen was Ilona Kickbusch, unusual for being both a sociologist and a woman in a key public health post. Her dynamic programme on health promotion outlined the principles of community action which came to different countries through major developments such as the Healthy Cities initiative. The migration of ideas and people was a feature of this period, with a distinctive European dimension emergent in health promotion and new public health. John Ashton remembered that he was sent by Jerry Morris to visit Finland to talk about the Black Report and while he was there visited the Karelia project that used community engagement in innovative ways (page 32). In Liverpool this internationalism formed the backdrop to the initiation of needle exchanges to deal with the threat of the spread of HIV among drug users – an initiative which later found its way into national harm-reduction policies on drugs. The Health Education Council was a seedbed for these initiatives. Jeff French remembered the tensions between the largely non-medical health promotion people and the largely medical ‘new public health’ contingent (pages 36–37).

Analysts of public health have identified the ongoing tension between ‘activist’ and ‘technician–manager’ roles. The third section of the seminar dealt with

the latter, the rise of evidence-based medicine and health services research (EBM and HSR) as another dimension of the reorientation of public health in the 1980s. Nick Black (pages 38–42) made it clear that this arose from the radical critique of medicine and the type of ‘underground’ radicalism of the 1980s, whose mentors had been Thomas McKeown and Archie Cochrane. Public health practitioners and academics sought to make health services and medical care more effective; this was their view of the core remit of public health. Influences here came from research by people like Klim McPherson and others on variations in health; and from North American and northern European examples. They were determined to bridge the gap between service practitioners and academic public health. Community health councils were one way of remedying the ‘democratic deficit’ in the NHS and exerting political influence at the local level where public health had lost ground after 1974. Public health people seem to have used the councils as allies.

A key force in this public health tendency was the work of the National Perinatal Epidemiology Unit in Oxford, which subsequently became the Cochrane Collaboration. Sir Iain Chalmers, its former Director (pages 44–7) remembered his training in the MSc in social medicine course run by Jerry Morris at the London School of Hygiene and Tropical Medicine, and the key role played by the Society for Social Medicine, in providing a supportive and crucially multidisciplinary environment. The medical sociology section of the British Sociological Association was another influence, a network of social science/public health researchers. Such multidisciplinary tendencies reached a peak during the 1980s and 1990s with the NHS Research and Development Initiative – although the rise of the randomized controlled trial was also central to the evidence-based movement.

This multidisciplinaryity had not been accommodated at its formation by the Faculty of Community Medicine (later the Faculty of Public Health Medicine and, more recently, the Faculty of Public Health), which had excluded non-medical personnel from membership. The movement for the MDPH characterized the 1990s and was a clear outgrowth of some of the tendencies already discussed in the seminar. Klim McPherson, as a public health statistician who had been excluded from the Faculty, was one of the leaders of the movement and a founder of MDPH Forum. Other contributors also spoke of groups excluded from public health. Tim Carter (pages 58–9) cited the environmental health officers, who stayed in local government after 1974; and the speciality of occupational health, which had pursued a parallel but separate path to

the formal public health occupation. Jeff French remembered the Society of Health Education and Health Promotion Officers with a large membership in the 1980s: there was an ancestry too in the patient–activist groups, in the consumer movement, and in radical feminism and obstetrics (page 68). There was a sense of what Carter called a ranking of ‘gentlemen and players’, although French thought most people worked together well at ground level even before the MDPH.

What comes across from the last session of this Witness Seminar is a preoccupation with occupational positioning. Shirley Goodwin’s memento of her year as one of the first non-medical students on the MSc at LSHTM in 1992–3 draws the same conclusions. She told her fellow public health students: ‘Who cares about your role, it’s what you do that matters...’ (page 60). What public health practitioners actually do and how this has changed over time can be tracked through the transcript of this seminar. But a sense of public health practice is stronger for the earlier years, the demoralized years of the 1970s and early 1980s and the seedbed of the later 1980s, than it is for the earlier 21st century, when some of the radical ideas have come to fruition. The role of researchers and of academic public health is more prominent in the last section. Maybe this is natural enough; but maybe recent practice is also the subject for another seminar.

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PUBLIC HEALTH IN THE 1980s AND 1990s: DECLINE AND RISE?

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Edited by V Berridge, D A Christie and E M Tansey

PUBLIC HEALTH IN THE 1980s AND 1990s: DECLINE AND RISE?

Participants

Professor Sir Donald Acheson	Professor Stanley Gelbier
Professor John Ashton	Professor Alan Glynn
Professor Virginia Berridge (Chair)	Ms Shirley Goodwin
Professor Nick Black	Professor Rod Griffiths
Professor David Blane	Professor Walter Holland
Dr Tim Carter	Professor Klim McPherson
Sir Iain Chalmers	Dr Ornella Moscucci
Dr Aileen Clarke	Dr Geoffrey Rivett
Dr June Crown	Professor Alwyn Smith
Dr Jeff French	Professor Ann Taket

Among those attending the meeting: Dr Niki Ellis, Dr Anne Hardy, Professor Susanne MacGregor, Dr Ronnie Pollock

Apologies include: Dr Sheila Adam, Dr Michael Ashley-Miller, Professor Mel Bartley, Sir Kenneth Calman, Professor John Catford, Professor George Davey Smith, Professor Sir Liam Donaldson, Dr Spencer Hagard, Professor David Hunter, Professor Jane Lewis, Dr Kelly Loughlin, Professor James McEwen, Dr David McQueen, Professor Don Nutbeam, Mr John Wyn Owen, Dr Richard Parrish, Dr Stephen Peckham, Dr David Player, Dame Rosemary Rue[†], Dr Sally Sheard

[†]Died 24 December 2004

Professor Virginia Berridge: I would like to welcome you to today's Witness Seminar and as everyone will know the subject is a quite recent one: public health in the last 20 years. It has been a period of change, one that we characterize in our theme for today as a period of decline and then rise – somebody who wrote a letter back to us said, 'You should say decline again at the end.'¹ But certainly we might have added, 'reorientation' and 'redefinition'. The backdrop that will be known to everyone in the room is the reorganization of the National Health Service (NHS) in the early 1970s and the relocation of the local government-based Medical Officer of Health (MoH) into the NHS as a community physician, and renaming public health as community medicine. Now that change has been much discussed and written about² and in some analyses it has been seen as a wrong turning. When planning this seminar, we decided that our focus would start slightly later, with a period of more optimism in public health. So we are starting with the changes of the 1980s,³ when public health medicine has revived and changed its name back to public health again. We want to look at what those changes in the past 20 years have actually meant. How has the remit of public health changed? What has it taken on board? What has it not done? Have there been tensions in public health between its technician/managerial role, and its activist role? How has it responded to the rise of chronic disease and the newly revived threat of infectious disease and so on? So, there are lots of different themes emerging from those past 20 years.

The afternoon is divided into four sections, on which we want to spend roughly equal amounts of time: about an hour on each. Firstly, the changes in community medicine in the 1980s, and the impact of the Acheson Report⁴ at the end of the

¹ In a letter from Professor Walter Holland to Dr Daphne Christie, 28 June 2004. All correspondence, documents and tapes from the meeting will be deposited in Archives and Manuscripts, Wellcome Library, London.

² See, for example, Francis (1981); Kember and Macpherson (1994); Webster (1998 a and b).

³ For an overview of the 1974 and after changes see Introduction, pages xxi–xxv.

⁴ Acheson Report (1988). Professor Virginia Berridge wrote: 'The Acheson Committee was appointed by the Secretary of State for Social Services on 21 January 1986 with the following terms of reference: To consider the development of the public health function, including the control of communicable diseases and the speciality of community medicine, following the introduction of general management into the Hospital and Community Health Services, and recognizing a continued need for improvements in effectiveness and efficiency; and to make recommendations as soon as possible, and no later than December 1986.' Note on draft transcript, 16 December 2005. Sir Donald Acheson wrote: 'Norman Fowler insisted on the word "development" being inserted after "future" in the top of my inquiry to ensure a positive approach to public health.' Note on draft transcript, 25 January 2006. See page 20.

decade on the revival of public health. The second theme looks at developments taking place outside the UK in the 1980s: the rise of health promotion at the international level, and its influence nationally. After tea we are going to turn to another aspect of public health and its recent history, public health and the rise of evidence-based medicine and health services research. And, finally, to a recent area of great discussion and debate, the era of multidisciplinary public health (MDPH). So you can see from those themes that we have characterized public health, not just in a medical sense or in terms of the politics of the Faculty of Public Health,⁵ but we want to take the widest possible view of what it comprised in that period.

For each of those themes we have asked two or three people to speak for a short period to ‘start the ball rolling’ with some reminiscences and comments. The aim is to try to get at the stories behind the formal events. Everyone knows what happened when, but we don’t quite know how it happened and who was involved and how.

I noticed in reading the historical section of the Wanless Report⁶ recently, that it jumps from the 19th century right through the late 1990s in its historical chapter, apart from a little bit about the WHO [World Health Organization], so we hope in this session we will be able to fill in some of that history.

Having said that, I will turn to our first theme, which is public health in the 1980s, and we wanted to start by looking at what things were like before the

⁵ This is discussed later in the Seminar. The Faculty of Community Medicine was established in 1972 as a result of a recommendation of the Royal Commission on Medical Education (1965–8) ‘The Todd Report’. It is a joint Faculty of the three Royal Colleges of Physicians of the UK (London, Edinburgh and Glasgow). The Faculty of Community Medicine changed its name to Faculty of Public Health Medicine in December 1989 after the publication of the Acheson Report. It became the Faculty of Public Health (dropping ‘Medicine’) in 2003. See notes 16 and 81.

⁶ Professor Virginia Berridge wrote: ‘Derek Wanless, former Chief Executive of NatWest, was asked by the Prime Minister, the Chancellor and the Secretary of State for Health in April 2003, to provide an update of the challenges in implementing the “fully engaged” scenario set out in his previous report on long-term health trends, published in 2002 [Wanless Report (2002)]. This further report was published in 2004, *Securing Good Health for the Whole Population* [Wanless Report (2004)]. The 2004 review focused particularly on prevention and the wider determinants of health in England and on the cost-effectiveness of action which could be taken to improve the health of the whole population and to reduce health inequalities. See www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4074426&chk=c4gJvj (visited 16 December 2005).’ Note on draft transcript, 16 December 2005.

changes at the end of the decade. What was it like in community medicine at that point? We have asked Professor Walter Holland if he would like to lead off with a few thoughts on that.

Professor Walter Holland: I think I will have to go back to a little earlier in years to discuss the way in which the term ‘community medicine’ began to be used.⁷ I think that it really goes back to the discussion of the unification of the three parts of the health service: local authority services, general practice services and hospital services; and the Todd Royal Commission on Medical Education;⁸ and various other bodies. It was the Todd Commission in particular that suggested that there was a gross deficiency in the educational and research capabilities in public health and those doing population medicine. As a result, they suggested that the three parts should come together and that it should change its name. There was a great deal of discussion as to what name should be used and the *British Medical Journal* columns were rife with letters from Alice Stewart⁹ and others proposing ‘public health’, ‘community medicine’, ‘population medicine’, ‘epidemiology’, and so on.¹⁰ The resultant compromise of ‘community medicine’ was agreed by the major parties that were involved in the foundation of the Faculty of Community Medicine. However, the term ‘community medicine’ led to a great deal of confusion for practitioners, particularly those who had been in service positions, for they were ill prepared for taking on the duties they were expected to perform. There were a variety of educational initiatives, such as the further education centre – I can’t remember the precise names¹¹ – at the London School of Hygiene and Tropical Medicine (LSHTM), and other courses in Manchester and other centres, to prepare practitioners to take on the tasks that they would have to perform.¹² I experienced those as a member of a DMT (district management team), where I was a member, not only for my skills in epidemiology and public health, but representing the medical school [St Thomas’]. It was a large district, West Lambeth as it was then known, and the district community physician had a completely unenviable task of coping

⁷ For a history see Lewis (1986); Webster (1988, 1996, 1998 a and b).

⁸ The Todd Report. Royal Commission on Medical Education (1968).

⁹ See biographical note for Dr Alice Stewart on page 90; See also Dry (2004).

¹⁰ See Baggott (2000, 2004); Webster (2001); Hunter (2003).

¹¹ See note 12 below.

¹² The work of this Centre, the Centre for Extension Training in Community Medicine, is discussed in Berridge and Taylor (eds) (2005): 35–7. See also www.lshtm.ac.uk/history (visited 16 December 2005).

with this area, supported only by a secretary with nobody else there to help him. There was great confusion among the general practitioners, the hospital clinicians, nurses and managers, as to what a community physician actually was. They confused it with providing services in the community, not concerned with actually providing health services for populations. They thought he should be there to make sure that ‘Mrs Bloggs’ was rehoused and things like that, which was part of his task, but only one very small aspect.

So there was great confusion. I gave a presidential talk, at the Royal Society of Medicine, some time in 1982,¹³ in which I put forward the suggestion that we should return to the term ‘public health’, which would be a far clearer term for practitioners who were performing the job. However, it didn’t meet with any acclaim at all, and was completely ignored until the Acheson Report, which really put the subject on the map by defining very clearly what public health was about and suggested that that term should be used.¹⁴ That was accepted by the Faculty of Community Medicine, as it then was, at the end of Rosemary Rue’s era as President in 1989.¹⁵ I followed her as President and the name was formally adopted by the Faculty.¹⁶

Your other question is, ‘What was life like?’ I think that life was extremely difficult for service practitioners, it was much easier for academics. They were trying to serve a variety of different masters with few, if any, resources to do this. This was increasingly difficult because they had been educated and had aspirations that were actually far greater than they could possibly fulfil. There were people like John Ashton¹⁷ who had gone through the MSc course¹⁸ and had great aspirations, but were unable to perform these tasks adequately when they were in service posts. In addition to that, they were subject to continuous reorganization. First of all there was the reorganization in 1980–2 from district

¹³ Holland (1982); See also Holland and Stewart (1998).

¹⁴ See note 4.

¹⁵ Dame Rosemary Rue was President of the Faculty from 1986 to 1989. See biographical note on page 88.

¹⁶ The Faculty of Community Medicine changed its name to the Faculty of Public Health Medicine in December 1989. See note 5 and Professor Michael Warren’s account of the formative years of the Faculty [Warren (1997)], later re-published by the Faculty in 2000 [Warren (2000)].

¹⁷ Professor John Ashton was present at the meeting. See biographical note on page 81.

¹⁸ Community Medicine at the London School of Hygiene and Tropical Medicine (LSHTM). Details can be found in Berridge and Taylor (eds) (2005) and Warren (1997).

management team to district health authority, and then there was the Griffiths Report,¹⁹ and so on. They were as badly off at that time to my mind, as they have been in recent years, in terms of continually having to cope with new organizations and to develop new relationships. I am open to comments.

Berridge: Thank you very much, Walter. You have painted a rather disturbing picture of that period. Does anyone else have recollections of that period, perhaps as a service practitioner or otherwise involved in the 1980s?

Dr Geoffrey Rivett: I had the experience of being an outside, untrained observer of the 1974 National Health Service reorganization. I came into the Department of Health from general practice, quite untouched by public health. I was given the task of looking after first one, then two, then four of the London Regional Health Authorities.²⁰ It was a good vantage point. Having to go round the Thames regions my natural contact point at district level was the DCP (District Community Physician). What a wildly variable bunch of folks the DCPs were, in their desires, their wishes and their competences. There was one guy, not far from here, who said that it was not his view that he should be sweeping cholera from the streets of St Pancras; you also got the managers *manqué*; and people who never succeeded in getting the time of day from the consultant staff.

Professor Rod Griffiths: I became a trainee of sorts in 1978 and got a DPH [director of public health] job in 1982. There were two other trainees in the West Midlands at the same time as me, and there wasn't anybody, a trainer, who had actually done the Faculty's exams, because they had all acquired their way in, as it were, on the 'grandfather clause'.²¹ So we trained ourselves, essentially. Between us, and networking with other trainees in the rest of the country, we figured out what it was that we had to do and trained ourselves to do it. When

¹⁹Professor Walter Holland wrote: 'The Griffiths Report was published in 1983 [NHS Management Inquiry Report (Griffiths Report) (1983)]. It recommended that general managers should be appointed at all levels in the NHS to provide leadership, introduce a continual search for change and cost improvement, motivate staff and develop a more dynamic management approach. The Report also proposed that a health services supervisory board and an NHS management board be established within the Department of Health and Social Security and that the chairman of the management board should be appointed from outside the health service and civil service.' Note to Dr Daphne Christie, 26 October 2005. See Baggott (2004).

²⁰Dr Geoffrey Rivett wrote: 'Specifically the North-East Thames, North-West Thames, South-East Thames and South-West Thames Regional Health Authorities.' Note on draft transcript, 25 October 2005.

²¹Professor Rod Griffiths wrote: 'When the Faculty was first set up there was a mechanism to make people members on the basis of their previous qualifications and experience, this was known as "the grandfather clause". I have no idea where the name came from.' E-mail to Dr Daphne Christie, 13 December 2005.

I became DPH in central Birmingham, there were five districts in Birmingham. One had no DPH, one had someone who had the Faculty qualifications, and the other two had DPHs who didn't have the Faculty's qualifications, one having failed Part I four times and the other having failed it twice.

So I was the only person in Birmingham who actually had done the training, which made it quite interesting. We think we are thin on the ground now, but we were very thin on the ground then. Also, we had Edwina Currie for a Chairman,²² which meant that we were being thrown an awful lot of political ambitions at the same time as trying to establish what the speciality was. And, as Walter [Holland] said, there were confusions around what community medicine was. Some people thought it was communist medicine – I heard that said a number of times. For me it included both tasks: to make a dent in the NHS so that you could secure money, and to build up relationships with people like local authorities or voluntary bodies, or primary care for that matter, and both meant that we were really pretty stretched simply because there was far too much to do and not enough people to do it. What happened next, in terms of the Acheson Committee and the things that led up to it, is for later on. But Stanley Royd [Hospital]²³ was clearly an accident waiting to happen, given how thin the speciality was stretched.

Berridge: Would you like to say a bit about Stanley Royd or the impact that had?

Griffiths: It is still a riveting read; if anybody hasn't read the Report recently, they ought to, because it is a good indication of the kind of risks that you run when you have got a system that's too stretched with unclear responsibilities. Don't read it if you are about to be catered for by somebody else; it's not good if you are staying in a hotel or something like that, because you can frighten yourself. The Stafford Report, on what happened with the Legionnaire's disease,²⁴ is

²² Edwina Currie was Chairman of Birmingham City Council Social Services Committee, from 1970 to 1980, and Chairman of the Central Birmingham Health Authority, from 1981 to 1983.

²³ This refers to the Stanley Royd Hospital outbreak of salmonellosis. The Stanley Royd Inquiry. See Department of Health and Social Security (1986). Professor Virginia Berridge wrote: 'The role of public health in communicable disease control had been undermined by reorganization and also the focus on chronic disease: and there was also a confusion of responsibilities within the NHS. This is referred to in the Acheson Report.' Note on draft transcript, 16 December 2005. See Acheson Report (1988): 42–54.

²⁴ See note 23. Sir Donald Acheson wrote: 'The outbreaks of infectious disease in Stanley Royd and Stafford with their morbidity and fatalities were unacceptable to Ministers because they occurred in institutions owned and run by HMG. They led to a highly critical public inquiry.' Note on draft transcript, 25 January 2006.

also important. Together these two reports were the ostensible reason for the establishment of the Acheson Committee. In each of the reorganizations that I have been through – and I have been through a lot – I don't think anybody has ever done any risk analysis asking, 'Are we making it safer or not?' They have all been driven by some ground theory, with a lot of emphasis on the upside and virtually no analysis of the possible downside. We have frequently seen the public health consequences arising from them. The disruptions of the health service reorganizations, in 1974 and 1982, led to a considerable reduction in staffing in public health, mostly the result of large numbers of early retirement and a reduction in training I think, that made an incident like that at Stanley Royd possible, which could have happened in a number of places. I think the recent changes through shifting the balance of power reorganization is part of the reason why sexually transmitted infections are out of control, because nobody had actually thought about how we would keep an eye on them through all this chaos, and the answer is that it is very difficult. You can find other examples of where the disruption to public health is just an accidental side-effect of reorganizations and no one's thought through the consequences, we have to pick up the pieces afterwards. We are very slow in doing it.

Ms Shirley Goodwin: I am a public health specialist, as we now call ourselves, in a primary care trust in West London. In the 1980s I was a practising health visitor, also in West London, and I am trying to remember the extent to which I felt that the pursuit of my frontline public health practice had anything to do with the district community physician, or whatever we were calling him, or indeed ever met or knew anything about, mostly it was him at that stage. At that time our main relationships and debates were about the interface with general practice, because for years there had been a struggle between the public health approach that traditionally my profession had used, which was working with neighbourhoods and communities on a geographical basis, relating to people's problems and issues at estate and street level. On the other hand, it was much more convenient, and for various other reasons that we won't go into, which Geoffrey [Rivett] understands in relation to later developments around fund-holding for example,²⁵ it became much more expedient for people like myself and other health visitors to work attached to general practice. I am old enough to have been employed originally as a health visitor by the London Borough of Ealing, and my boss at that time was the Medical Officer of Health (Dr Ian

²⁵ See biographical note for Dr Geoffrey Rivett on page 88; Webster (2001).

Seppelt). My pay came half from education and half from health.²⁶ Then, of course, in 1974 we moved over and I lost sight of the wonderful figure of Dr Ian Seppelt, who I think continued to be whatever they called him after 1974, but just dropped out of view and stopped being an inspiring figure for the frontline workforce, people like myself. So I think that's an interesting sideline on the issue, from the point of view of people who were also engaged in public health practice, that such a figure had just disappeared from our view altogether.

During the mid- to late 1980s I was working for the Health Visitors' Association at national level. I was the General Secretary for six years in that decade, and I was also involved as Chair of the Steering Group, originally of the Public Health Alliance.²⁷ Thinking back, how many times did public health physicians circulate in my orbit? Not very often. Public health dentists, yes – I can think of going to meetings with Aubrey Sheiham. I can think of academics like Alex Scott-Samuel, for example, and Peter Draper.²⁸ Those little brown-paper-covered tracts that Peter Draper produced out of Guy's Hospital, the Health Policy Unit, were my bible as a health visitor and later as a trade union official.²⁹ The WHO had far more impact on the way I was thinking through its publications,

²⁶ Ms Shirley Goodwin wrote: 'NHS community health services were part of public health and welfare, and at the time provided by local authorities. In Ealing, half the funding for the health visiting service came via the London Borough of Ealing Health and Welfare Committee, and half via its Education Committee, in recognition that health visitors were also school nurses. It was not until later that the two roles were separated. I do not know whether local authorities received the money from the two different government departments.' E-mail to Dr Daphne Christie, 1 November 2005. Dr Martin Gorsky wrote: 'Historically (i.e. pre-NHS) it was certainly the case that the school medical service budget was supported by Treasury education grants. For details of arrangements after 1948 see Harris (1995).' Note on draft transcript, 24 November 2005.

²⁷ Ms Shirley Goodwin wrote: The Public Health Alliance grew out of a coalition of organizations (including local and health authorities, professional organizations, trade unions, voluntary and community organizations, and individuals such as policy analysts, practitioners, academics) which began meeting in the mid-1980s initially at the Health Education Council and later at the Health Visitors' Association, and was formally launched in 1987. In 1999 it merged with the Association of Public Health to form the United Kingdom Public Health Association.' E-mail to Dr Daphne Christie, 1 November 2005. See The UK Public Health Alliance website www.ukpha.org.uk/ (visited 9 November 2005). See also Public Health Alliance (1995); Goodwin (2005).

²⁸ Alex Scott-Samuel and Peter Draper helped establish the Public Health Alliance (now the UK Public Health Association) in 1986. See biographical note on pages 88–9. See also Draper (ed.) (1991); Draper and Crombie (1995).

²⁹ Draper (ed.) (1991).

such as the Alma Ata Declaration,³⁰ and also some of the work of the voluntary organizations like the National Childbirth Trust.³¹ On my way here I heard Rod's [Griffiths] excellent contribution on the radio at lunchtime today on *You and Yours* when he was asked to comment on the public's suggestion of what ought to be in the White Paper.³² It is interesting that people continue to raise breastfeeding and nutrition, a live issue then in the 1980s. Nothing really seems to have changed in the intervening years, but it was the work of organizations like the La Leche League, the National Childbirth Trust, WHO Europe through Marsden Wagner³³ and other people, who pushed some of these debates on a lot further than they might otherwise have gone. I think it is fair to say that the progress of those debates owed little, if anything, to public health medicine at that time.

Holland: May I just comment? People seem to forget that as a result of each reorganization, public health medical officers had to reapply for a job. In the selection of an individual to be appointed I can think of several cases where the clinicians and local authorities ganged up to make quite sure that those who were good and were able to ask questions were not appointed and only second-rate appointments were made. It should also be remembered that at that time left-wing local authority members of appointment committees would caucus to decide on their choice of candidate for the job.³⁴ That led to a great loss of individuals who would have been able to train better and perhaps more quickly than doing it on your own, as Rod [Griffiths] has described. As a survivor of six reorganizations, I have to say it must be awful to have to reapply for your job on more than one occasion.

³⁰ World Health Organization/UNICEF (1978): 11–24.

³¹ See Christie and Tansey (eds) (2001). Freely available online at www.ucl.ac.uk/histmed following the links to Publications/Wellcome Witnesses.

³² See BBC Radio 4 *You and Yours* website www.bbc.co.uk/radio4/youandyours/ (visited 7 December 2005). Ms Shirley Goodwin wrote: 'The White Paper about which the chairman of the FPH was speaking on 12 October 2004 was, of course, the one everyone was expecting at the time – about public health including a smoking ban [Department of Health (2004)].' E-mail to Dr Daphne Christie, 1 November 2005.

³³ Ms Shirley Goodwin wrote: 'Marsden Wagner was a paediatric epidemiologist employed as the World Health Organization Regional Director for Maternal and Child Health in Europe in the 1970s and 1980s.' Note on draft transcript, 10 June 2005.

³⁴ Professor Walter Holland wrote: 'I served on a large number of advisory appointment committees as the "statutory" academic (and one of the few around).' Letter to Dr Daphne Christie, 8 June 2005.

Dr Aileen Clarke: I came into public health in 1987 and at that time it was still very much a minority-appeal subject. In North London, four of us applied for four jobs, and all four of us were appointed. Since then public health has become much more popular, but this constant ongoing process of reorganization is a destructive feature.

Professor John Ashton: I wanted to point out that the loss of capacity and the loss of coherence were two fundamental reference points in 1974. For example, the Public Health Department in Liverpool City Council in the 1950s had over 5000 staff. We are talking about health visitors, nurses, social workers, environmental health, food hygiene and so on. It was huge. We have just heard a hint about the issue of the fragmentation that occurred after 1974 from the health visiting perspective, but this happened to the social workers and the environmental health officers, and the other people as well, so the fragmentation was just immense.

I came into it in 1976. I had always intended to go into public health from when I was still at medical school ten years before. I used to get the prospectus from the LSHTM every year and look at it and think: 'I am going to do social medicine one day'. But when I arrived it was nothing like I had expected. By and large the academics had retreated into epidemiology and the service people had found themselves already doing management, and I had thought before that public health was much more than that. Walter [Holland] was wrong, I didn't actually work in service initially, I was in academia for 17 years, trying to work across to service with my honorary sessions, because that was the only way I could create space to do what I thought needed to be done. I will talk a little bit about that later.

I wanted to talk about the calibre of people coming in at that time. I can remember being on a selection committee when I was a senior lecturer at the London School (LSHTM), and we had over 30 applicants for a number of training places, most of those applications were thrown in the bin. They were people who had been diverted from their clinical careers because they were not up to it, often told by the postgraduate Dean that the thing they should be doing was public health, because they weren't going to make it in whatever they were doing. One might be left with a small number of people to interview who might be suitable. Then in the remaining groups, there were one or two who had a religious motivation. There were quite a number with political motivation, who had strong critical views, and at the time there would be a few who had some managerial system they were interested in developing. That's just a thumbnail sketch.³⁵

³⁵ Further details can be found in Berridge and Taylor (eds) (2005).

Professor Stanley Gelbier: I think that 1974 was the making of dental public health. The dentists' big advantage in 1974 was that not only did one of their number become the Area Dental Officer for each area health authority, the leading dental public health figure, the adviser of the health authority etc., which brought the various branches of the profession together, but he also had one advantage that virtually no other member of the public health team had at that time. When I was appointed Area Dental Officer in Lambeth, Southwark and Lewisham, I had 30 clinics that I managed, a staff of roughly 100 people, and my medical colleagues always used to say to me, 'It's all right for you. If you get up in the middle of the night to read the results of a survey you have done, you can actually do something about it, without going to many, many committees'. I think that was a lesson that maybe other branches of public health never cottoned on to. There was always the separate Area Medical Officer, or District Community Physician, who could talk a lot, but unless he could bring his clinical colleagues along with him, he could actually do nothing in practical terms.

Professor Klim McPherson: I would like to ask Shirley about something of which I know absolutely nothing. What kind of training was there in public health? Was their training appropriate, in your view?

Goodwin: You are asking me to remember something I started in 1967, because I did an unusual course when I trained as a health visitor and a nurse, I did a combined course, so I trained as a nurse, a district nurse and a health visitor in one course, which began in 1967, at the Hammersmith Hospital and what was then the Battersea College of Advanced Technology³⁶ and continued for four years with a final two terms of health visiting at the University of Guildford in 1971. From what I can recall, we had a range of lectures on the subjects you might expect: control of infectious disease, housing, environmental issues, from people including Medical Officers of Health at the time, a lot of academic nutritionists, microbiologists and people like that. It was adequate training for what we were required to do as health visitors at the time.

In the 1970s, health visiting practice, was, I think, more public health oriented in terms of housing conditions, environment, than it was a decade later at the end of the 1980s. I had a much less direct association with health visiting, by which time the emphasis had moved, I think irrevocably, towards checking child

³⁶ Now part of the University of Surrey, Guildford. See http://portal.surrey.ac.uk/portal/page?_pageid=764,128643&_dad=portal&_schema=PORTAL (visited 22 September 2005).

health, the sorts of things that GPs wanted health visitors to do to relieve them of ‘heart-sink’ and other sorts of insistent patients.³⁷ The emphasis in training was much less on the use of a public health approach. I think in the years since then attempts have been made to bring back the public health skills and understanding, but that has been very patchy. I am involved in a programme across North-West London at the moment, based on a training needs analysis we have done of environmental health officers and health visitors in the area. We have found that most of them feel that they lack most of the skills they need to operate a public health population approach. I had a reasonably adequate training 30 or 40 years ago, but I am not sure whether they would have one now that would allow them to operate in the way that some of us might hope and expect that they would.

Professor Alwyn Smith: As a professor of public health I would just like to say briefly that I was frequently asked to be an external examiner on health visitor courses and I was always extremely impressed with the students’ grasp of public health issues and with the public health content of the courses they had taken. I found it a very encouraging experience to be involved in health visiting in that peripheral way as an external examiner.

Professor David Blane: I don’t know how general my experience was, but I think it’s worth bearing in mind that the period we are talking about, in London at least, was the time when we were going from a region with 150-plus hospitals down to something more like 40 hospitals; the era of the closure of the small hospital. Often the community physician was the fall guy locally for this often very unpopular decision. When I first went to work in West London in the mid-1970s, I found scrawled on bridges and walls, ‘Singer must go’ and after a while I asked, ‘Who is Singer?’ It turned out he was the Public Health Physician who was closing the local hospital.³⁸ It must have been the one time since Ibsen’s day,³⁹ that public health in Britain had achieved that sort of notoriety. That was one-half of the picture; and, certainly in London, it would be an important part of the context to bear in mind.

³⁷ See, for example, Tansey and Reynolds (1998): 129.

³⁸ His first name is not known to Professor David Blane. Note on draft transcript, 27 October 2005. See Korman and Glennerster (1989).

³⁹ Henrik Ibsen (1828–1906). See, for example, *Ghosts* (1881), *An Enemy of the People* (1882, 1977) and http://en.wikipedia.org/wiki/Henrik_Ibsen#List_of_Works (visited 15 December 2005); see also Ibsen (1964).

The other half of the picture in my area of interest, which is health inequalities, was that during this period it was the kiss of death to be involved in research in this area. I remember being told by a senior civil servant that it was absolutely naive to expect that someone like Peter Townsend⁴⁰ would get funding for any further research in the area of health inequalities in the 1980s. Most of the work that was done then was done by people like John Fox and Peter Goldblatt at City University,⁴¹ who were very much going against the grain, and whose careers suffered – they left academic work and went back into the Civil Service to escape the fallout for not using the LS [Longitudinal Study] in the way the Government wanted.⁴² It was a period where there was very important scientific advance in some areas, often at some personal cost against the dominant influences, but at the same time the local hospitals were being closed. So it was a mixed picture.

Dr June Crown: Going back to the very early days, I was part of the second cohort of the MSc students at the LSHTM in 1972,⁴³ which then took two years. I emerged on this brave new world in 1974, and went straight into a consultant job. Because the whole thing was terribly prescriptive, every area had to have a consultant in childcare: social services, information and planning, and they were all medical jobs by definition. People who had come from the Medical Officer of Health's departments in local authorities were obviously highly experienced in the childcare and the social services side of things, but not with information and planning. Anybody who could actually wave an MSc was seen to understand about this, which was really quite an educational experience. One of the difficulties certainly was the responsibility for managing mainly hospital services and developing plans for hospital closures, and establishing some sort of credibility with colleagues in other disciplines and clinical colleagues. When Area Health Authorities disappeared in 1981 I came to a job across the road from here in Bloomsbury Health Authority, at University College Hospital. I

⁴⁰ Professor Peter Townsend, well-known writer and campaigner on the concept and definition of poverty, was one of the original members of the Black Committee. See Berridge and Blume (eds) (2003); www.bris.ac.uk/poverty/Background_files/Peter%20Townsend%20Interview%20about%20research.pdf (visited 10 February 2006).

⁴¹ Dr Peter Goldblatt was Chief Medical Statistician for England and Wales, Office for National Statistics. See biographical note for Professor John Fox on page 83. See also Berridge and Blume (eds) (2003).

⁴² For further details on the Longitudinal Study (then the OPCS Office of Population Censuses and Surveys, now the ONS Office for National Statistics) see the ONS Office for National Statistics website at www.statistics.gov.uk/about/data/methodology/specific/population/LS/process/default.asp (visited 9 December 2005).

⁴³ For a discussion see Berridge and Taylor (eds) (2005): 26–32. See also www.lshtm.ac.uk/history (visited 16 December 2005).

think the most useful thing was that the then district offices were located in the private patients' wing and I had my office in what had been a private patient's room with a little window on the door. Consultants going up and down the stairs saw that I was in my office at 8.00 a.m. They didn't know what on earth I was doing there, but at least they realized that I was there doing something, and gradually popped in and had cups of coffee. It was at that sort of level, and by reading things like the *Journal of Orthopaedics* so that you could actually say something sensible to clinicians over a cup of coffee, that you gradually got other messages home.

Professor Ann Taket: Listening to these contributions and speaking not as a public health specialist but as someone who has touched on public health at a number of points of her career, I want to offer a small picture of how I saw life in the Department of Community Medicine in Tower Hamlets where I found myself from 1986 onwards for a number of years, for three sessions a week. With no public health training I found myself in a department of community medicine and was required, among other things, to supervise the projects of public health physicians in training. That was totally fascinating and I think the picture I want to offer was that some of those trainees did manage to reconnect with what I would call the old or the old/new public health agenda and found themselves going out, and doing projects that were strongly based in action research, in community development, tackling health inequalities in the area where there was no shortage of problems like that. But when I look at the department of community medicine as a whole, the Director of Public Health, Dr Jean Richards, and her consultant colleagues were tied up with crises: for example, when plague pits were opened on the Isle of Dogs;^{43a} with the infectious disease agenda; with assessing medical requests for rehousing – not that rehousing could be provided – but they still had to be assessed. However, below that layer there were opportunities to do some very interesting pieces of work that I think connect to a rather different public health agenda than others have talked about today and I would be very interested to hear whether that sort of public health 'around the edges' was going on in other places as well.

^{43a} Dr Jean Richards wrote: 'I am sure I never came across any mention of plague pits on the Isle of Dogs while I was in Tower Hamlets. We had to deal with lead poisoning in children who had been playing on the site of a car battery breaking yard there however. We also dealt with some exhumations of many hundreds of bodies from the crypts of two Hawksmoor Churches, Christ Church Spitalfields and St Annes Limehouse. At Spitalfields we found bodies with intact skin on which smallpox vesicles were still clearly seen.' Edited e-mail to Dr Daphne Christie, 3 February 2006.

Ashton: A vignette from the tail-end of the old ‘public health’: I returned to Liverpool at the end of 1982, two years too late to stop the new Professor of Public Health [Professor Peter Pharoah]⁴⁴ evacuating the Liverpool School of Hygiene to set up shop in the new medical school, to be nearer to the clinicians. The School of Hygiene, which was nearly 100 years old, had the County Analyst in it, the health visitor training, social work training, the Museum of Public Health, all these fantastic resources, and it was just abandoned.⁴⁵ The health visitor training continued for a few years after that, purely because Andrew Semple,⁴⁶ the last Medical Officer of Health in Liverpool and who was retired, carried on running the training of the health visitors, after being together with Meredith Davies.⁴⁷ He was also a public health doctor but had been the first Director of Social Services in Liverpool and was a good friend and colleague of Andrew Semple, and Tom Hobday, another public health doctor, Senior Lecturer in the University, but Conservative councillor and Chair of the Health Committee in Liverpool. They had all of the health committees stitched up between them and very effectively too. They carried on training the health visitors for a few years, but when they could no longer do it, the Health Authority stopped funding the health visitor training and it just faded away. The community physician at the time spent most of her time, as far as I could see, in the company of the clinicians, so that the traditional linkages fell. I had to persuade her to see that it was an interesting idea to provide a plaque on the house of the first Medical Officer of Health in the country [William Henry Duncan],⁴⁸ and to have her photograph taken outside it. I had to persuade her that it was an interesting and a good idea.

Berridge: I wonder if at this stage we could perhaps turn to the changes at the end of the 1980s. There will be time for other people to come back and comment on the Acheson Report, its formation and its impact. Perhaps we could start by asking Sir Donald Acheson to say a few words on that.

⁴⁴ See biographical note for Professor Peter Pharoah on page 88.

⁴⁵ See Ashton (1984); Power (1999).

⁴⁶ For biographical note see page 89.

⁴⁷ Meredith Davies DPH FFPH (b. 1920) was the Director of Social Services, City of Liverpool, from 1971 to 1981 and received the Duncan Medal, in 1988, for services to public health in Liverpool, from 1953 to 1971.

⁴⁸ Dr William Duncan was appointed Medical Officer of Health for Liverpool on 1 January 1847. For biographical note see page 83. See Frazer (1997); Laxton (2000): 59–88. See also www.whitebeertravels.co.uk/liverpool.html (visited 9 December 2005).

Sir Donald Acheson: Would you mind if I said a few words on some other things as well? The danger might be that I could become a talking pen.

I was Chair of the Hampshire Area Health Authority when the disaster – the 1974 reorganization – occurred and I remember that well, but I think that has been dealt with.⁴⁹ In September 1983 I left the periphery, was released from the unsatisfactory situation there and was invited to become Chief Medical Officer (CMO) and on 1 October found myself sitting in the hot seat vacated by Sir Henry Yellowlees [in Whitehall].⁵⁰ Briefing me on the basis of his experience, I think you will find this interesting, Henry predicted that 80 per cent of my time would be involved with the NHS and the Minister's relationships with the British Medical Association (BMA), 10 per cent would relate to the wider health issues, including smoking, alcohol, etc., and 10 per cent to represent the UK at WHO and other global organizations.

Apart from the diseases of childhood and vaccination for them, infectious disease was not, as I remember, mentioned at all. In the eight years that followed, infectious diseases dominated my work and thereby led to a renaissance in public health in some ways – the infections, not me. Of the infections that I dealt with in the period 1983–91 the most important were HIV/AIDS and BSE [bovine spongiform encephalopathy], both of which had not previously been described and carried with them the fear of the unknown and, in the case of the former, stigma. To develop an appropriate response to HIV/AIDS, Norman Fowler, the then Secretary of State for Health, a remarkable man, and I visited New York, San Francisco, Amsterdam and Geneva.⁵¹ That aspect of public health that dealt with sexually transmitted infection was renewed by a substantial increase in public funds and an influx of high-quality recruits to this speciality. But the renaissance of public health had other roots.

Within a few weeks of my arrival in Whitehall in 1983, a calamitous outbreak of salmonellosis occurred in a mental hospital in Yorkshire.⁵² The fact that this had happened in Stanley Royd Hospital, an institution under Government management within the NHS, and with several hundred cases and more than 50 fatalities created a scandal and the setting up of a public inquiry that identified serious deficiencies in public health organization. That's the first

⁴⁹ See Introduction (pages xxi–xxv) and page 3.

⁵⁰ See biographical note on page 91.

⁵¹ See Berridge (1996); Sheard and Donaldson (2005).

⁵² See note 23. Department of Health and Social Security (1986).

public inquiry. I don't believe anybody has looked at it. If that weren't enough to bring the importance of public health in to every house in the land, an outbreak of legionellosis occurred in a newly constructed hospital in Stafford, again resulting in many fatalities, which underlined the point once again. There was a second public inquiry that was extremely critical of public health, and again I don't think anyone's ever looked at it.

After these two tragedies came a recommendation in 1986 to set up an inquiry into the future of the public health function under my chairmanship with instructions to see that not only the future development of communicable diseases, but the speciality of community medicine following the introduction of general management into the health services should be studied. It would include a broad and fundamental examination of the role of public health doctors after the implementation of the 1983 Griffiths Report into the management of the NHS.

That's another key issue that needs to be looked at: how the Griffiths Report worked and what it did? [Sir] Roy Griffiths had been a Chief Executive of Sainsbury's and was appointed by the Prime Minister herself [later Baroness Thatcher] to introduce some sort of order, as she put it, into the NHS and stop it being a centralized, Soviet-like organization as she saw it, and to get better value for public money. As far as the NHS was concerned, there was to be reorganization centrally, regionally and locally, also to set up a system of committees with financial functions, estates functions, personnel functions and a clinical function with a general manager as the chief executive. Roy [Griffiths] and I differed as to whether or not there should also be a public health function. I thought there should be, and he thought that would be very threatening to the general manager, and in the end the Secretary of State, Norman Fowler, agreed with me that there should be a public health function, and unfortunately shortly afterwards, Roy died. I hope I didn't actually kill him, but I didn't do him any good, I will tell you that. Not deliberately, but he did not like the idea of a public health function.

One further outbreak of infectious disease helped sustain the momentum for the revival of public health. This was the Farley infant food epidemic, in which a number of babies became ill and died throughout Britain.⁵³ It turned out that

⁵³ An outbreak of *Salmonella ealing* infections in November and December 1985. All the infected infants had been fed with a dried-milk product from one manufacturer, Farley's. Despite intensive efforts to isolate *S. ealing* from packets of the product it was found only in four of 267 sealed packets. The source of infection was traced to the factory spray-drier, which had a hole in its inner lining, allowing powder to escape and return from contaminated insulation material. The factory was eventually closed. See Rowe *et al.* (1987).

the common factor was an infant food infected with *Salmonella ealing*, but this seemed unlikely as this had only been found in seagull droppings, so there was great scepticism. But then, in the end, the mystery was solved, because the bacterium was found in the water tank in the Farley infant food factory and the tank had been contaminated by seagull droppings. I was seen as someone who against the odds had got it right; a bit of luck. When the inquiry *Public Health in England* was established by Norman Fowler in January 1986 it may be for that reason that I was asked to chair it. Be that as it may, it was Norman Fowler who gave it political weight.

Here is a little story that hasn't been in the papers. When I put the first draft of the agenda to him, he said, 'Not a committee into the future of the public health function, a committee into the future *development* of the public health function.' He would accept nothing that was not positive and strategic, because the prior title might have been negative and suggest there shouldn't be a public health function. He said, 'A report within 12 months, if you please.' He got it. What came out of it was a small central unit to monitor health nationally, and a director of public health in every district and region responsible for monitoring health and advising the authority on how it should be improved. It was expected that this director should work in close cooperation with the local authority, not always easy because the boundaries were often different. Although managerially accountable to the general manager,⁵⁴ the director of public health would have direct access to the authority if necessary and in the final resort, to the Minister. So that was satisfactory.

Professor Alan Glynn: Donald Acheson's reference to infectious diseases gives me the opportunity to remind you that all this public health work, particularly with infectious diseases, depends on the laboratory work, and particularly for those Donald mentioned: HIV obviously, the Staffordshire legionellosis and, the 'baby flu', the *S. ealing* one, were all essentially based on laboratory work which was then taken up and the data used to track down the source epidemiologically.⁵⁵

⁵⁴ See note 19. See also Baggott (2004).

⁵⁵ See Rowe *et al.* (1987) and note 53. Professor Alan Glynn wrote: 'The epidemic was only discovered because someone at Colindale noticed that they were finding an unusually large number of specimens of *Salmonella ealing*. The actual patients were so spread out in time and over the country that they had never been connected in anyone's mind. Once an investigation was started it discovered the source in Farley's infant food. The moral is that you do need central reference laboratories.' Letter to Dr Daphne Christie, 4 January 2006.

Acheson: Absolutely, an outstanding contribution.

Glynn: Can I add that since that time, the Public Health Laboratory Service which was the main strand of that work, plus, of course, all the work in the NHS pathology labs, has now been fragmented and destroyed by the unenlightened successors of Sir Donald as CMO.⁵⁶

Rivett: I would just like to talk about that very brief year or so: the post-Griffiths, pre-Acheson Report. [Sir Roy] Griffiths made the managers pre-eminent. Community physicians, public health physicians, whatever, were really an endangered species under Griffiths. Travelling the regions, as was my remit, one came across many situations where the community physicians were going to be pushed to the margins of the organization. Under Griffiths it was possible to have a widely differing form of management structure. One theme, which often ran through the new management structure, was to get doctors out of top-tier positions, where they might challenge the chief executive's authority. There was also a will to reduce the power of the nurses. I have very strong feelings about the legacy Roy Griffiths left to the health service by marginalizing professionals: good in parts would be an optimistic statement.⁵⁷

Goodwin: Again I want to cast another light on the period leading up to Acheson and beyond, because there was something else happening, I think, which perhaps is an underlying aspect to what was happening to public health at that time. The Public Health Alliance Steering Group started to meet in a room at the soon to be doomed Health Education Council.⁵⁸ Some of the people associated with it at the time were in that room. By 1987 we had a formal Steering Group calling itself the 'Public Health Alliance'.⁵⁹ It brought together a lot of interests, according to Richard Smith,⁶⁰ some of whom were a smattering of doctors at the meetings, but a lot of the people there were from community development,

⁵⁶ For a history see Williams (1985). Professor Virginia Berridge wrote: 'Professor Glynn's comments refer to the establishment of the Health Protection Agency.' Note on draft transcript, 16 December 2006.

⁵⁷ Sir Donald Acheson wrote: 'That is exactly what I feared Griffiths would do. Happily I nipped it in the bud.' Note on draft transcript, 4 November 2005.

⁵⁸ The Health Education Council (HEC) replaced the Central Council for Health Education (CCHE) in 1968–9. See Berridge and Loughlin (2005).

⁵⁹ See note 27.

⁶⁰ Professor Richard Smith was the Editor of the *British Medical Journal (BMJ)* and Chief Executive of the *BMJ* Publishing group. See biographical note on page 89.

health education, health promotion, radical statistics, some were radical health visitors, people from a lot of groups that had started in the early 1980s who saw a focus for all the things that were slipping away, being suppressed, such as work on inequalities and community development. I remember going to see a senior civil servant in the Department of Health sometime during this period, to talk about community development, and he said, 'Ha, when my Minister hears those words, he sees women walking down Whitehall burning their bras'. That was typical of the attitude towards anything to do with health promotion, community development, at the time.

By this time some of this – the demise of the public health physician – gave strength to a non-medical, much more social, model of public health development,⁶¹ which was calling itself the 'new public health'. I suppose that if public health physicians hadn't been as weak as they were, perhaps the Public Health Alliance (PHA) wouldn't have had the impetus to start and to get the support it did in its early years. It was on the platform of the Public Health Alliance's response to the Acheson Report that we inaugurated ourselves formally at a meeting at the House of Commons, and our response said there should be a public health commission and a public health minister, all the things I notice that the Tories are saying in this week's *Health Service Journal*, in their manifesto for the future of public health.⁶² It was on that occasion that we had the opportunity in the PHA to start lobbying for them. So Acheson had some unintended side-effects, I think, which were altogether positive for public health in its wider sense at that time.

Berridge: I know, Rod Griffiths, that you were a member of the Acheson Committee. I don't know if you would like to make some comment.

Griffiths: I was reflecting on the fact that after Roy Griffiths's Report I started boycotting Sainsbury's and that has done them in. At the time they were ahead of Tesco's. I have only ever boycotted two things in my life: one was South Africa over apartheid, and the other was Sainsbury's and I am pretty careful about using it as a tool. It's obviously desperately powerful.

I was reflecting on what Shirley [Goodwin] said about the Public Health Commission. I think most of the ideas that have ever been around were all

⁶¹ Ms Shirley Goodwin wrote: 'The reference here is to the *social* model of health (as against the medical model).' Note on draft transcript, 10 June 2005.

⁶² See the *Health Service Journal* website at www.hsj.co.uk/ (visited 15 December 2005). See also Mooney (2004).

presented to the Acheson Committee by various enthusiasts. Some never saw the light of day outside the Committee. There was someone who wanted the speciality named ‘demiatics’, from the Greek for *demos*, population. That didn’t catch on. I do wonder what would have happened to the Report if we had announced that it was to be called demiatics instead of public health. We settled on public health because it had some kind of international currency and we thought it was better understood by anyone that needed to understand – the media, the general public, the rest of the medical profession – certainly better than community medicine.

Acheson: One reason, which I have only just discovered, why Griffiths was so paranoid about public health doctors was the Hunter Report⁶³ into what responsibilities a public health doctor should have, and it was that a public health doctor was an administrator–doctor, which I think is quite wrong. But at the same time this description was seen by Griffiths to threaten the general manager. In any history of this period people should look again at the Hunter Report, not only at those two public inquiries I mentioned earlier, which I think have never been reviewed. I don’t know what Hunter’s brief was, perhaps somebody here was on it?

Griffiths: It was one of the clutch of reports around about the same time as the 1974 reorganization, wasn’t it? Just going on about the impact of Roy Griffiths’s Report and the circumstances, here I was, I think, the youngest member of the Acheson Committee. I think I was put on it so that they could say there was somebody young. What Roy Griffiths failed to think through, because he didn’t spend very long on it – no doubt he was very gifted as a manager of Sainsbury’s – was the lack of development of the managerial cadre in the NHS. There just weren’t enough people around of the calibre and vision qualified to be Chief Executives and what happened was that a lot of people were appointed, in my view, who were quite paranoid about their position, because they probably knew that anybody who was any good could see through them. So they tended to settle scores via people, and got to be very good at manipulating power, rather than in leading. I always show students pictures of Nelson Mandela and pictures of the man who used to run East Germany, hands up if anyone can remember; he was very good at using power, although he was hopeless at leadership. Once he was in jail no one took any notice of him. When Mandela was in jail people took a lot of notice of him, they are different kinds of models. The model of general management you got in the health service was not a leadership model.

⁶³ Hunter Report (1972); www.fph.org.uk/policy_communication/downloads/publications/Origins_of_the_Faculty.pdf (visited 10 February 2006).

For public health, which is about ideas, vision and collective action, the two models couldn't be further apart. In a sense, those of us who survived in public health, in the service, had to learn how to work alongside that power-driven, rather hierarchical model, and to work out how to insert ideas into it so that it actually tried to do some of the right things. To some extent that meant we also had to learn to play their game, so we had to find ways of saving money and purchasing, or whatever other means were invented afterwards, to get any of the money. We had to take a pretty hard look at public health tools – epidemiology, statistics, and so forth – to unpick what the health service did. I think the interesting thing that the Acheson Report did was to say that there were a collection of things, going back to the formation of the Faculty and what Walter [Holland] said about bringing together the three strands.⁶⁴ It wasn't a daft idea that we should invest in training enough people. It established a target workforce number that we figured out by trying to guess how many districts there would be in the future plus a lot of other things, and that guesswork has never been made public. There is just the figure, 15.8 consultants in public health medicine per million population, but nobody knows what it was based on.^{64a} It has not been possible to work forwards from that, so when some new function comes along, or something is reorganized, you can't go back to the Acheson arithmetic and say therefore that means two extra or two fewer people, or whatever. It's probably just as well nobody knew how we estimated the number, but nevertheless it's a weakness of the Report. But it did mean that money was invested in training, and so when some of the other reorganizations hit – although there was this continuing problem of the retirement of senior people, who got proper pension packages – we had more trainees come through. So we have never actually got back to workforce levels as low as those prior to Acheson, there are some parts of the country where the shortage of trained people is downright scary to me.

That was what it felt like, and it was fuelled, if you like, by agencies like the Health Education Council, that funded a whole series of new academic departments, they kicked those off; they established the national training scheme, they were promotional officers. So they helped to put in to place some of the academic infrastructure needed to take this reorganization forward. There was a big flowering of philosophical papers, not just in this country, but internationally, defining health promotion. There certainly was a clash, I think, of ideologies with what was called public health, although as we all know that's a debate that can rumble

⁶⁴ See discussion and notes on page 5.

^{64a} Acheson Report (1988): 39.

on, and where the overlaps and different desires are still to be resolved. One of my long-held beliefs is that we actively run away from this debate, it's too difficult for us, we don't want to think it out and be ridiculed about what the ideological basis of public health is, because that exposes us to political critique from both the left and the right. Historically, 80 per cent of the time we have spent so far looks at this question through the lens of the professions, be it public health, health promotion, or whatever, some of which is largely irrelevant. During this time there is a history around industry in public health, things like the 'scare industry' developing. Remember bran? Bran as dietary fibre was discovered at this time.⁶⁵ The leisure industry was born, as was the big farmer. These were the issues that impacted on public health. The actual health of the public – lifestyles, the leisure industry, the yawning gap in health inequalities, unemployment, strikes, jogging, aerobics – these had a big impact on public health. As did non-governmental organizations that haven't been mentioned much: the role of family planning, Action on Smoking and Health (ASH), the environmental movement, Greenpeace, these are the big public health histories as I see it.⁶⁶ To focus on public health specialists or health promotion specialists is largely irrelevant, as far as I am concerned.

In terms of what fuelled health promotion at that time, Acheson did a lot of good work, but also just practical things, like special funding was a big boost for HIV, drugs, smoking and so on. But there was also an ideological drive behind the 1980s, early 1990s, the Conservative drive around 'look after yourself'; 'let's save some money', 'let's take some pressure off the NHS by getting people to look after themselves now in old age', optimistic in a sense. I think we have done lots and lots that we can do, but it is slightly depressing to see those arguments coming back again in the run-up to the White Paper about personal responsibility in an opportunity society, and also again taking some pressure off the NHS. I am sounding very negative, aren't I? Those arguments go round and come round. One of the challenges as we look forward rather than back, I think, is to have the courage to get those philosophical debates out on the table.⁶⁷

⁶⁵ In the early 1970s interest grew in the relation between diet and health, and it was suggested that the risk of death from ischaemic heart disease might be reduced by a high intake of dietary fibre or by a vegetarian diet. Burkitt (1973); Burr and Sweetnam (1982). See also www.cuisinenet.com/digest/breakfast/cereal.shtml (visited 5 October 2005).

⁶⁶ See, for example, *Health Which?*, the Consumers' Association publication launched in 1988 (discontinued June 2004); Lyall (2004).

⁶⁷ A small section is missing from the recording here (pages 25–37) and has been reconstructed with the help of participants and notes taken at the meeting by Professors Virginia Berridge, Susanne MacGregor and Drs Niki Ellis, Anne Hardy and Ornella Moscucci.

McPherson:⁶⁸ I always wanted to work in public health, but definitely didn't want to do medicine. I had hoped that professional opportunities for leadership in public health would arise but sadly the FCM (Faculty of Community Medicine) [subsequently the FPHM (Faculty of Public Health Medicine)] prevented any such aspiration becoming a reality.

Ashton:⁶⁹ Returning to Rod's [Griffiths] comments on capacity building for Public Health.⁷⁰ Immediately prior to signing up for the social medicine MSc course at the London School of Hygiene, I worked as a lecturer in primary care (mental health) in the community-based health centre linked to the new medical school in Southampton. The notion of specialoid GPs (now coming back as gypsies – GPs with a special interest) was another of Thomas McKeown's ideas;⁷¹ one that Donald Acheson had incorporated into his blueprint for the new school. I was attracted to working there because it offered a rational, population-based approach. I later learned of other examples, beginning with Peckham in the 1930s,⁷² but spreading to South Africa where Sidney Kark developed the concept and took it along with his team to Jerusalem when the apartheid laws drove them out of South Africa.⁷³ Leon Epstein is the current carrier of the flame, and of course Julian Tudor Hart was on to the same thing in Glyncoed [West Glamorgan].⁷⁴

When I attended the MSc at the LSHTM it was still a two-year course based on the US model, as June Crown has already mentioned.⁷⁵ This was made possible by generous funding from Sir George Godber as CMO,⁷⁶ which ended when he retired in 1973.

⁶⁸ Reconstructed piece by Professor Klim McPherson, 21 June 2005.

⁶⁹ Reconstructed piece by Professor John Ashton, 4 July 2005.

⁷⁰ See pages 7–8.

⁷¹ See note 117 and biographical note on page 87.

⁷² The Peckham Health Centre was opened in 1926 by George Scott Williamson and Innes Pearse. It closed in 1930 and reopened in 1935, continuing to operate until 1950. It involved the local community in the delivery of primary healthcare, and placed emphasis on positive health and management of pregnancy and infant care. See Ashton (1977); Abel-Smith (1981): 97; Lewis and Brookes (1983).

⁷³ See Kark and Kark (1999); Preston-Whyte and Jinabhai (1999); Brown and Fee (2002).

⁷⁴ See Ness *et al.* (eds) (2002): 69.

⁷⁵ See page 15.

⁷⁶ See biographical note on page 84.

I have to confess to being the author of an editorial in the *British Medical Journal*, which criticized the Acheson Report on its appearance for not embracing multidisciplinary public health – ‘two cheers for the Acheson Report’.⁷⁷

Smith:⁷⁸ The upheavals of 1974 often seem gloomy in other people’s recollections, but I remember them as a time of exciting challenges that were confronted by service public health doctors as well as academics with courage and a sense of opportunity. I had gone to the Chair in Manchester in 1968 to be warmly welcomed both by service public health colleagues and by clinical colleagues in the medical school. I inherited an excellent department with first-rate courses at both undergraduate and postgraduate levels developed by my predecessor, [Professor] Fraser Brockington.⁷⁹ He had been a distinguished Medical Officer of Health before his appointment to the Manchester Chair and the department had good relations with Medical Officers of Health in Manchester, Lancashire and the neighbouring county boroughs. I particularly remember Dr Lance Burn in Salford, Dr Jim Hilditch in Wigan and Dr Stanley Gawne in Lancashire.

We ran a series of special courses to prepare people for the changes of 1974⁸⁰ and I was greatly impressed by the professional and personal qualities of those who attended them. The 1974 reorganization of the NHS more or less coincided with the creation and establishment of the Faculty of Community Medicine and these were exciting, if challenging, times.⁸¹

Dr Tim Carter:⁸² The focus has been on big outbreaks and their effects. As the HSE⁸³ (Health and Safety Executive) was the enforcement authority concerned

⁷⁷ Ashton (1988 a).

⁷⁸ Reconstructed piece by Professor Alwyn Smith, 6 June 2005.

⁷⁹ Professor John Ashton wrote: ‘Nobody who has been a Professor of Public Health at Manchester has ever died.’ Note on draft transcript, 4 July 2005. Professor Colin Fraser Brockington (1903–2004) was Professor of Social and Preventive Medicine, Manchester University, from 1951 to 1964, Emeritus since 1964. See Brockington (1956); Acheson (2004).

⁸⁰ The 1974 reorganization of the NHS. See Walter Holland’s earlier comments on pages 5 and 11, and the Introduction.

⁸¹ The Faculty of Community Medicine (the Faculty of Public Health Medicine in 1989) brought together academic bodies such as the LSHTM, community health doctors and organizations such as the Public Health Laboratory Service. See note 16. See also Porter (ed.) (1997).

⁸² Reconstructed piece by Dr Tim Carter, 6 June 2005.

⁸³ See www.hse.gov.uk/index.htm (visited 30 September 2005).

with outbreaks of Legionnaire's disease, I chaired the interdepartmental committee on the subject. The committee had quite rapidly arrived at a set of recommendations with the support of the public health and infectious disease specialists in the Department of Health. The draft was circulated widely and the NHS comments were all about the cost of plumbing modifications in hospitals. Extensive redrafting was the consequence and this weakened the original recommendations as well as delaying its publication for over a year.⁸⁴ This is an example of the unresolved tensions then influencing disease prevention and of the equivocal attitudes to prevention within the state healthcare system.

Holland:⁸⁵ There have been several comments about the role of Sir Roy Griffiths.⁸⁶ I probably knew him better than anyone else here – and, therefore, would like to make a few remarks. Roy was an active member of the Schools Council and Deputy Chairman of the Finance Committee of my medical school, St Thomas'. I was a member of both as well. Throughout his time as adviser to Mrs [later Baroness] Thatcher⁸⁷ he always discussed matters with members of the staff in St Thomas'. While he was considering his report on management, a senior surgeon (Barry Jackson), a senior physician (Brian Creamer), a professor of general practice (David Morrell)⁸⁸ and I met him regularly once a month together with the civil servant responsible for the administration of the inquiry (Cliff Graham). Griffiths had a high regard for public health as a discipline and was very supportive on the development of public health research. The major recommendations of this report were directed at the organization of the Department of Health – but the senior civil servants within the Department of Health were able to 'spin' this so that most concern was at district and regional level. He was not active in public health at these levels, but he was scathing about some public health practitioners. In his recommendation about public health he always envisaged that the Director of Public Health (DPH) would be accountable to the District/Regional General Manager (D/RGM) and be a member of the management team. The DPH was to have independent access to the health authority in the same way as the CMO could go straight to the

⁸⁴ See Joint Health and Safety Executive and Department of Health Working Group on Legionellosis. Department of Health (1992).

⁸⁵ Reconstructed piece by Professor Walter Holland, 8 June 2005.

⁸⁶ For biographical note see page 85.

⁸⁷ The Conservative Prime Minister from 1979 to 1990.

⁸⁸ For biographical notes see pages 86 (Jackson), 82 (Creamer) and 87 (Morrell).

Secretary of State. The D/RGM would be medically qualified and could be a public health person – but would have to compete for the post with nurses and professional managers. Griffiths originally did not consider that nurses should be chief officers. There is one further point that I would like to make. The early 1980s were not only a period of doom and gloom. The medical entrants to public health at that time were of a far higher calibre than the entrants in the 1960s. The establishment of the MSc programmes and the Faculty ensured that they were far better trained, and far more acceptable to other medical staff. It is correct that the structure within which they practised was far narrower and more precarious, but it had been hoped that with better entrants more possibilities could be created.

Taket:⁸⁹ At the end of 1983 I had an exciting opportunity for secondment, arising out of my role in the Civil Service, to work as a consultant in the Epidemiology and Information Support Unit at the WHO's European Regional Office in Copenhagen. My initial role was technical editing of two books, one of which took me right into the exciting domain of the new health promotion.⁹⁰ *Measurement of Levels of Health*, edited by Johannes Ipsen, Jan Kostrzewski and Walter Holland, a joint publication between the WHO and the International Epidemiological Association was published in 1979.⁹¹ One of the books I was working on was intended as a follow-up to this volume, focusing on the measurement of improvements in health, or positive health. When I arrived in Copenhagen, I found a very mixed collection of chapters, and elsewhere in the office a newly instituted and very dynamic programme on health promotion, under the control of Ilona Kickbusch.⁹² The roots of the programme can be traced back to the declaration of Alma Ata, and the WHO's ensuing 'Health for All' (HFA) policy. 1980 saw the re-orientation of regional programme in Europe towards HFA, and the arrival of Ilona as Regional Officer for Health Education. She led a reassessment of health education activities, putting an emphasis on prevention, promotion and support. In 1981, a regional programme for 'health education and lifestyles' was presented to the regional committee and approved by member states, followed in 1983 by 'lifestyles' forming the focus of technical

⁸⁹ Reconstructed piece by Professor Ann Taket, 27 July 2005.

⁹⁰ Bui-Dang-Ha-Doan *et al.* (eds) (1986); Abelin *et al.* (1987).

⁹¹ Holland *et al.* (1979).

⁹² The Regional Officer for Health Education, World Health Organization. See biographical note on page 86 and Kickbusch (1997).

discussions at the regional committee meeting in Madrid.⁹³ Following this, the programme of the Health Education Unit was divided into four: lay, community and alternative healthcare (non-professional healthcare) [note the identification of alternative with non-professional here!]; public education and information for health; health promotion; and smoking.

The Health Education Unit was notable for being led by a sociologist, rather than a medical doctor (and a woman as well!).

The health promotion programme in the European Regional Office of WHO was started in 1984 and its relationship with other programmes in the office was characterized by several features: tensions between technician and activist polarities in public health; a re-surfacing of an older model of public health; and tensions between medical and non-medical worldviews.

These tensions can be exemplified by the book I was working on: it was becoming increasingly apparent that to do justice to the issue of measuring improvement in health, a very explicit account was needed to be taken of the new developments in the conceptualization of health promotion. Two highly contrasting meetings in Copenhagen were held in July 1984: a working group on health promotion concepts and principles; and an editorial board meeting for the book. The two groups met only briefly in a party. For me, new to the debates on health promotion, it felt like watching two worlds collide.⁹⁴

By the time *Measurement in Health Promotion and Protection* was published,⁹⁵ the 'new' discipline of health promotion was firmly in place, both in the book's title and in its contents, through prominence in the foreword provided by Jo Asvall (then Regional Director of WHO in Europe), and the inclusion of the report from the working group meeting on concepts and principles of health promotion as the final chapter.

Throughout my time in the regional office, and in visits thereafter in the mid-1980s, I was struck by its operation as a crucible of interesting new ideas, with

⁹³ See, for example, Kickbusch (1983, 1986).

⁹⁴ The tensions within public health and health promotion; between medical and non-medical; and between activist and technician manager roles are discussed in the Introduction, pages xxi–xxv.

⁹⁵ Abelin *et al.* (1987). Professor Walter Holland wrote: 'It might be worth noting that this book was a follow-on from Holland *et al.* (1979). This latter book was a joint publication between WHO and the International Epidemiological Association (IEA), because the latter recognized that a complementary book looking at health rather than disease was needed. Vera Carstairs, a sociologist in Edinburgh, was asked by the IEA and WHO to take on this task.' Note to Dr Daphne Christie, 26 October 2005.



Figure 1: Some of the original Healthy Cities Steering Group at the first conference in Lisbon in 1986, including from right: Trevor Hancock, Len Duhl and Ilona Kickbusch.



Figure 2: Professor John Ashton at the World Health Organization Healthy Cities Symposium, Hungary, 1989.



Figure 3: Healthy Cities, Dubrovnik, in 1999 just before the war in former Yugoslavia.

a procession of people passing through, giving seminars etc., and some of these ideas caught the attention of the office to the extent of becoming programmes or policy. One particularly striking example was a seminar by Len Duhl in August 1985 at which he presented many of the ideas that were later to take shape in the Healthy Cities programme.⁹⁶

Goodwin:⁹⁷ Essentially, a Tory government found the existence of the Health Education Council (HEC) and, indeed, health promotion, to be uncomfortable. As a new secretary of state appointee to the Council in 1981, I recall frequent challenges to policies and programmes from the DHSS ‘minder’, Raymond Petch, provoking me on one occasion to ask why the Department did not just turn the HEC into a leaflet-producing function, run from an office in Elephant and Castle, Alexander Fleming House, marked Room H.

Ashton:⁹⁸ Coming into public health in 1976, I had been frustrated by the amount of talking and the small amount of action on the ‘New Public Health Agenda’. While at the LSHTM, I had had the opportunity to visit Finland representing Jerry Morris, to speak about the recently published Black Report,⁹⁹ and I took the opportunity to visit the Karelia Project, which was causing waves around the world in terms of how community engagement could impact on public health.¹⁰⁰

Returning to Liverpool at the end of 1982, I was determined to put some of these lessons into action and established a regional health promotion group within the Mersey Regional Health Authority. I was fortunate to have increasing support from the Chairman, Sir Donald Wilson, and the Chief Executive, [Sir] Duncan Nicholl, who later went on to become Chief Executive of the National Health Service; and early on to recruit the imaginative and entrepreneurial

⁹⁶ See, for example, Hancock and Duhl (1986). See also Duhl (1986).

⁹⁷ Reconstructed piece by Ms Shirley Goodwin, 1 November 2005.

⁹⁸ Reconstructed piece by Professor John Ashton, 4 July 2005.

⁹⁹ Black Report (1980) (revised editions, Penguin 1982, 1988 and 1992).

¹⁰⁰ The Karelia Project began in 1972 as a project to prevent cardiovascular disease among residents of eastern Finland. The Finnish Heart Association coordinated the initial discussions, which included community representatives, national experts and several representatives of the World Health Organization (WHO). This is discussed in a Witness Seminar ‘Fifty Years of Cholesterol, Atherosclerosis and Coronary Disease in the UK, 1950–2000’, held on 8 March 2005 [See Reynolds and Tansey (2006)].



Figure 4: Professor Jerry Morris in 1978. © The London School of Hygiene and Tropical Medicine Archive.



Figure 5: Black Report Witness Seminar at the LSHTM, in March 1999. Front row, left to right: Professor John Fox, Professor Jerry Morris, Sir Douglas Black, Professor Peter Townsend, Professor Arthur Buller; Back row, left to right: Dr Elizabeth Shore, Professor Margaret Whitehead, Dr David Player; Jill Turner.

Howard Seymour as the country's first Regional Health Promotion Officer.¹⁰¹ At the time I produced the first regional public health report (ever, to my knowledge) in England: *Health in Mersey*,¹⁰² which was extensively marketed through conferences and roadshows establishing 12 regional health priorities, which were then used as the basis for programmes and initiatives seeking to implement new public health principles by the year 2000 derived from the Alma Ata Declaration and the World Health Organization's strategy of *Health for All*.¹⁰³

An early major initiative was the attempt to reduce teenage pregnancy levels in Liverpool as a pilot project for the Health Education Council. This drew heavily on the Swedish experience, which, in turn, had derived its philosophy from Karelia.¹⁰⁴ Despite considerable groundwork and the support of all the relevant sectors on Merseyside, including the Roman Catholic Church, the Health Education Council got cold feet and did not proceed with the project. However, the impact of this work can be seen today in the multi-agency agenda that was established at that time, and has been pursued ever since; Liverpool's teenage pregnancy rate has come down by over 20 per cent, contrasting sharply with most other northern urban areas.

The real opportunity to put the new public health on the map came with the arrival of heroin and HIV/AIDS. We brought the San Francisco Director of Public Health, Dr Glen Margo, over to Liverpool to run workshops to set an agenda for action. This he did with incredible drive over a two-week period, exposing several hundred people to the facts, the realities, the urgency and the practical way forward. This led to the establishment of the first large-scale syringe exchange programme in the country some months before the Minister of Health authorized pilots of this approach. The International Garden Festival at Liverpool in 1984 provided the opportunity to develop the first large-scale public health promotion initiative, incorporating a static health fair with personal fitness training and personalized lifestyle advice to thousands of the 4.5 million visitors to the Garden Festival during a five-month period: Health promotion was incorporated into and grounded in many aspects of the festival

¹⁰¹ Howard Seymour was the Regional Health Promotion Officer with the Mersey Regional Health Authority based in Liverpool. See Ashton and Seymour (1985, 1988).

¹⁰² Ashton (1984).

¹⁰³ World Health Organization (1981); WHO (Europe) (1985). See also note 30.

¹⁰⁴ See note 100.

from nutrition advice in allotment gardens to agitprop drama on health themes located around the festival site, and in poetry, music and health events.

The outcome of this work was an invitation from Dr Ilona Kickbusch¹⁰⁵ to coordinate the Healthy Cities Project for the World Health Organization in Copenhagen.¹⁰⁶ They began with a planning meeting in Copenhagen on 9–10 January 1986, and the first conference in Lisbon two months later [see Figure 1]. The full story of the politics of this has yet to be written. Ilona took an early decision to bypass national level departments of health and to work directly with the chosen cities – something that unleashed an enormous amount of energy. However, there was a tension between the World Health Organization's desire to make this a tightly-managed project with a small number of cities and performance measures, and the reality in which hundreds of cities around the world became galvanized by the idea of being part of the new urban public health movement based on the Alma Ata principles. Early on, Jerry Morris pointed out to me that Healthy Cities was really the Health of Towns Association of the 1840s revisited, as indeed, in some ways, it was.¹⁰⁷ That Association achieved major success in obtaining Parliamentary action for public health in England between 1842 when it began its work following the publication of the Chadwick Report on the sanitary conditions of the labouring classes in England,¹⁰⁸ and 1848 when the first Public Health Act was put on to the statute book.

These lessons, in which we learnt how to line up all the ducks in a row, to get all the stakeholders on board with community engagement, have stood us in good stead ever since, with the three public health White Papers, 'Health Action Zones', 'Healthy Living Centres', and the welter of other 'area-based initiatives'.

The most recent example of this has been the use of Stan Glantz,¹⁰⁹ the guru of tobacco control in California, to play the same role that Glen Margo had

¹⁰⁵ For biographical note see page 86.

¹⁰⁶ See resource for the WHO Healthy Cities Project, Ashton (1988 a and b); Ashton and Knight (1990).

¹⁰⁷ Professor Virginia Berridge wrote: 'We held a conference on the Health of Towns at the LSHTM in 2004 on this theme because of this comment.' E-mail to Dr Daphne Christie, 5 September 2005. See LSHTM (2004). See also www.lshtm.ac.uk/history/healthoftowns.html (visited 16 September 2005).

¹⁰⁸ Chadwick (1842–3).

¹⁰⁹ See Glantz *et al.* (eds) (1996). See also <http://ark.cdlib.org/ark:/13030/ft8489p25j/> (visited 16 September 2005).

20 years earlier with HIV/AIDS.¹¹⁰ Two weeks of workshops with Glantz and 400–500 activists from health services, local authorities and other sectors in the North-West has led to Liverpool's introducing its own Tobacco Control Act at the House of Lords; and the towns and cities of the region competing with each other to be the first to be smoke free.

Crown:¹¹¹ Around this time the World Health Organization published *Health for All by the Year 2000*.¹¹² Bloomsbury Health Authority managed a district that was very hospital dominated (University College Hospital, the Middlesex, three postgraduate groups of hospitals, National Temperance, St Pancras, Royal London Homeopathic, and Elizabeth Garrett Anderson). The authority agreed to adopt the 'Health for All' principles as the basis for its annual plans and each department across the district had to include at least one item on its plan that would contribute to 'Health for All'. This came as a surprise to many, including the World Health Organization which had not expected such a concrete response at local level. However, it proved a remarkably cohesive initiative and inspired unexpected groups (finance, operating theatre teams, accident and emergency) to develop innovative schemes. It helped to identify the public health department as central to the district's activities and gained considerable public support as well as providing a platform for senior administrative staff.

Dr Jeff French:¹¹³ I have found much of the discussion so far to have been dominated by the belief that public health doctors and public health medicine were in some way the driving intellectual and practical driving force for health improvement during the 1980s and 1990s. I find this a curious but not unfamiliar partial retelling of history. I stand here wearing two hats. One hat is that of a practicing health promotion practitioner and the other as a public health historian. From a practitioner perspective, the 1980s and 1990s were a liberating and exciting time when the health promotion paradigm with its focus on empowerment and personal development began to challenge the dominant public health approach characterized by a patronizing and patriarchal medical establishment. Rather than being based on a detached descriptive mindset characterized by epidemiology, health promotion and the many hundreds of

¹¹⁰ See, for example, Krieger and Glen (eds) (1994).

¹¹¹ Reconstructed piece by Dr June Crown, 24 August 2005.

¹¹² World Health Organization (1981).

¹¹³ Reconstructed piece by Dr Jeff French, 6 December 2005.

health promotion officers, who were recruited and trained at that time, were action oriented.

Health promotion officers quickly began to dominate the intellectual literature of that time and were increasingly gaining a reputation for being the people who really made things happen. Health promotion was a subversive new paradigm which was fuelled and supported theoretically by the WHO and practically in England by the HEC through targeted funding and training support. Many new health promotion departments were established in the NHS and local authorities and a great deal of support was given to the department to recruit high-calibre staff and to train them. The flowering of health promotion in the UK and internationally, however, began to create a reaction from within the public health establishment. They first attempted to encompass health promotion as a sub discipline within public health and then by the deliberate subversion of the health promotion paradigm as set out in the Ottawa charter into the 'new public health'.¹¹⁴ The 'new public health' actually being the 'old public health' counter-revolutionary reaction of the public health establishment to health promotion's theoretical and practical challenge to their professional and theoretical domination. Using this classic professional protectionist tactic public health temporarily suppressed the essentially liberal philosophic challenge posed by health promotion to collective paternalistic public health medicine. This hidden history of ideological and practice between health promotion and public health is a defining feature of attempts to improve health during the 1980s and 1990s and the decline of public health over that time.

Glynn: Taking a much more narrow viewpoint than the last speaker, the most effective and, at the time, very exciting promotion of public health for all types of people, was the big drive against AIDS, pushed by Donald Acheson and the then Secretary of State, Norman Fowler, who did extremely good work, which probably needs to be repeated now, in spite of some clearly obstructive efforts from above by Mrs [later Baroness] Thatcher and Lord Hailsham.¹¹⁵ It is not to say that all their [Acheson and Fowler] work was quite right, as I can remember at least two subcommittees on which I sat, where the prevailing view of the membership of the committee was against the prevailing view of the Government on various things like testing for HIV and the vaccine for

¹¹⁴ See the Ottawa Charter for Health Promotion website at www.who.int/hpr/NPH/docs/ottawa_charter_hp.pdf (visited 20 December 2005).

¹¹⁵ See, for example, Berridge (1996).

German measles.¹¹⁶ These were clearly suppressed by hidden forces behind the Chairman, but on the whole the AIDS programme was fantastic in terms of health promotion.

Berridge: Sir Donald, I wondered if you wanted to comment on the discussion or on the role of the WHO, as you saw it?

Acheson: I think the role of WHO was wonderfully stimulating. The greatest privilege of being CMO is that you represent the UK not only at regional level but also at the WHO Geneva meetings where you can see the real perspective of global health. It really is an astonishing thing to see and I think that the fascinating thing about it was that the work had nothing to do with health services, it might be 1 per cent, but 99 per cent with prevention, health promotion, risk factors, smoking, whatever you care to mention. It's profoundly stimulating for Chief Medical Officers to have that opportunity.

Berridge: We are now into the last half of the meeting, and we will look at two other aspects of more recent public health, the first one being the way in which something called evidence-based medicine, health services research, developed from public health interests, out of social medicine. Something that was also an international movement with developments in Canada and elsewhere, which impacted on the British scene. To start the ball rolling on that, perhaps Nick Black would like to say a few words.

Professor Nick Black: I have been fascinated by the session before tea because I feel that the prevailing view of the health services in this context seems at best a distraction. I am somebody who came into public health because I was interested in health services and that interest started as a medical student under the influence of Tom McKeown, who lectured me at Birmingham as a student in about 1972.¹¹⁷ He was a breath of fresh air, because for the first time here was somebody who was a serious intellect, but more to the point seemed to be saying things that had some resemblance to the real world, compared with many

¹¹⁶ Professor Virginia Berridge wrote: 'One of these two committees was the surveillance subgroup of the Expert Advisory Group on AIDS (EAGA) chaired by Dr (later Sir) Joseph Smith, Director of the Public Health Laboratory Service. This began its discussion of anonymous screening in 1987. For the politics of this committee, see Berridge (1996): 211–5.' Note on draft transcript, 16 December 2005.

¹¹⁷ See biographical note on page 87. See McKeown (1976), for his criticism of the conventional wisdom that medical services and therapies contributed to improvement in life expectation in the 19th century. McKeown's argument was that nutrition and rising living standards rather than medical technology had had the decisive impact on the decline of mortality.

clinical tutors and teachers, particularly about the effectiveness of medicine and of healthcare in general. So I say this because the comments I am going to make are personal.

My motivation for coming into the realm of public health was because I bought into, and continue to buy into, Tom McKeown's scepticism. Later came slightly more radical views with Ivan Illich and others as to the medical edifice that I was now part of, being sucked into and trained for.¹¹⁸ There was a lot wrong with it. I think I am probably both an optimist and an iconoclast, so it also appealed to me in that sense. Having done some clinical medicine and enjoyed it, I made the decision to move across into public health in 1978. My reason for doing that, I will be quite honest about it, wasn't an undying belief in prevention and health promotion. I recognized that those were incredibly important issues but that wasn't my personal interest. My personal interest was that we have got to get to grips with medical care. I came in to public health in 1978 because that was the only route from clinical medicine. You could not get into what we would now call health services research – it goes under lots of other titles, medical care research, and so on. That was the only way to pursue a career in public health.

When I think of health services research (HSR) before 1980, I would say that the scene in Britain was patchy. There were some notable players: there was Walter's [Holland] HSR Unit at St Thomas'; there was the Medical Care Research Unit in Sheffield and so on. There were a few places, but nothing like what was to come. The main factors in the early 1980s in this area are about four or five key influences. One was the work on variations, of which Klim [McPherson] in this country was a key exponent. This links to the second main influence, from Canada and the USA, of Jack Wennberg, of Bob Brook and others.¹¹⁹ From a personal point of view, I think one of the most influential events in my career was when Klim and I went to a meeting in Copenhagen,¹²⁰ which at the time I thought, 'This is just going to be one of lots'. With hindsight, of course, it was a unique moment because it actually brought together in one room, for the one

¹¹⁸ See biographical note on page 86. See also Scott-Samuel (2003); <http://webs.lanet.com/aeolusaero/Articles/Mayday%20Cafe--Apr%2004--Ivan%20Illich.htm> (visited 5 October 2005) and www.infed.org/thinkers/et-illic.htm (visited 5 October 2005); Illich (1974, 1977).

¹¹⁹ For a discussion on the North American influence on evidence-based medicine see Daly (2005).

¹²⁰ Professor Nick Black wrote: 'The Copenhagen Collaborating Centre (1986).' Note on draft transcript, 27 October 2005.

time ever as far as I am aware (unless I didn't get invited to other occasions), all the key players in the field looking at variations in processes and outcomes in healthcare from across the world, essentially North America and northern Europe. It was incredibly stimulating and exciting and I think probably most of my career since then came from those 48 hours.

Something that hasn't been talked about much so far was the relationship between academic public health and the NHS or public health practice. I was slightly appalled at the divide between the rigorous science, which I saw in Oxford at this time in the academic public health arena and Oxford was and remains exceptional, and what I saw going on in the NHS in terms of public health. It was like two different worlds. Science and scientific evidence did not enter into what I saw going on in terms of running the health authority. That seemed bizarre to me and also I didn't want to have anything to do with that unless that gap was bridged. It seemed to me also that the variations work and the science around that was the perfect way of doing it, although there were some early attempts with performance indicators and so on from the Department of Health.

While that was true of personal health services, I think it was also true of prevention. I am interested in earlier comments about the Health Education Council.¹²¹ I don't think we have *samizdat* publications any more in public health, but there was a very exciting period in the early 1980s when public health was much more political. I can remember all sorts of exciting fringe events with people like Alwyn [Smith] at the meeting of the Society for Social Medicine, which seems to have all but disappeared, at least from within the public health community.¹²² One *samizdat* publication, by Wendy Farrant and Jill Russell, was fantastic, and if you have never seen it, you ought to.¹²³ It couldn't be published, because it was an observational study by two sociologists of policy making in the Health Education Council on coronary heart disease prevention, where the policies were not informed by the evidence at all, actually completely counter to the evidence. They showed this with a lovely piece of qualitative research, and as it wasn't allowed to be published, it got circulated among the younger,

¹²¹ See, for example, page 21 and note 58.

¹²² See Leck (1996); Porter (ed.) (1997). See also Pemberton (2002).

¹²³ Between 1981 and 1985 Wendy Farrant worked at the Institute of Education, London, and wrote a booklet on the politics of health information with Jill Russell, which provided a critical analysis of Government-sponsored health education. See Farrant and Russell (1986).

more radical public health folk, as I was then – certainly younger, and I think probably more radical. So the issue of the academic contribution (essentially science driven) and public health practice wasn't just about health services, it was also about health promotion.

The other reason why I was keen to go into health services was that I looked at the world and thought, 'Well, where is all the power and the money?' It was in the hands of the clinicians and the large hospitals. So from a public health point of view, unless we could get a grip on that and take these groups on, then how could the resources that we need for the wider public health agenda be freed up? And simply one of the justifications (that we will be coming to in the last session) to having doctors in public health, because I think it is still a lot easier for doctors to take on other medical powers than non-medics, whether we like it or not. It doesn't mean it's impossible for others.

The final influence around that time was the lack of foot soldiers compared with hundreds of Medical Officers of Health. By the time I came in 1978, the Medical Officer of Health had become, in my case, an area medical officer without all the troops. Yet there were troops, a group who haven't been mentioned so far today, the public and particularly the community health councils.¹²⁴ Perhaps we were lucky in Oxford, we had a superb secretary of the community health council, Tom Richardson, who was also a very active Labour politician and as such knew how to work the system. I got thick with him and talked about it and thought, 'Well, surely what we should be doing in public health is to form much closer alliances with the public, because if we are doing one thing in public health surely it is about making the system accountable to the public, whether it's health services or whether it's other policies with sectors that influence health.' So that was another thread and an alliance with the public. Again, our role was to provide them with rigorous evidence so that we could work together.

So that's where I would see the origins of evidence-based this, that and the other. Those were the roots of it as far as I was concerned. Then of course, around 1990 two strong trends emerged, though related. One became the Cochrane Collaboration.¹²⁵ I was involved in a small part with Iain [Chalmers] to begin with, which I feel incredibly lucky that I was in the right place at the right time, and that was the launch of the NHS Research and Development strategy. I look back with fondness but also with some sadness, on the five years

¹²⁴ See Klein and Lewis (1976); See also note 140.

¹²⁵ See Iain Chalmers' contribution on pages 43–8.

working with Mike Peckham¹²⁶ from around 1991 to 1996, because while I still think NHS R&D is doing a lot in terms of health services research, with much the strongest ministerial support that the NHS research programme has ever received, through Stephen Dorrell,¹²⁷ unfortunately, ministerial support has sadly and somewhat ironically declined, even to the extent of cuts in the budget under the previous Secretary of State [Alan Milburn]. Those two threads brought in scientific evidence, not to determine policy but to influence policy.

Rivett: I will plunge in to say that most ideas have almost certainly been about the place 50 years before we implemented them. If you take immunization: diphtheria immunization started in the late 1940s on the basis of good evidence that if you immunize children against diphtheria, fewer die. Whether that's evidence-based medicine I don't know, but it certainly is practice, based on evidence. Local authorities got into this field early on with immunization schemes, often computer-based as in the case of Tom Galloway, in West Sussex.¹²⁸ So that is an example of public health evidence having an effect on practice. Then the Department of Health got in on the act and immunization became a national programme affecting the practice of every GP in the country. Similarly with cervical cytology, though perhaps the evidence wasn't quite so good. When the 1990 GP contract was introduced we had great pleasure in saying that there was a WHO target immunization level, presumably evidence based, with targets that raised the immunization level fairly rapidly. At least with immunization, we have a good example of evidence affecting clinical practice on a national basis.

Ashton: I thought Nick's [Black] point was really interesting. One weakness has been the disappearance of funding for public health research and development. So the argument in favour of a strong research and development base for the clinical end, to enable the other stuff to happen, has not really materialized, because the people at the clinical end don't understand the broader picture. But I think it's quite persuasive, it is a bit like sending our children to a Church of England primary school in order to inoculate them against religion and the

¹²⁶ See biographical note on page 87.

¹²⁷ The Rt Hon Stephen Dorrell was Secretary of State for Health (1995–7), and Shadow Secretary of State for Education and Employment (1997–8).

¹²⁸ In 1962 Tom Galloway, Medical Officer of Health for West Sussex, pioneered a new approach to the organization of immunization programmes. The local authority computer was programmed to use the information collected by health visitors, who called to see newborn infants, to summon them to clinics or to their GP's surgery at the appropriate age. A rapid rise in the immunization rate was achieved and other local authorities soon adopted the system. See Anon (1968).

argument for getting the children into a church school. If you don't send them to the church school they are not going to get religion from anybody.¹²⁹ The first observatory we set up in Liverpool tried to bridge the academic and the service world. I think that's generally been recognized to be quite a good idea, but they have still not realized their potential.¹³⁰ I conclude that the notion of a community physician is probably a good idea and we could probably do with more community physicians, but that they are really GPs who do some public health as well, or they're community nurses, or others who do public health as well on the Tudor Hart model.¹³¹ That's not the same as the public health practitioner. We have two public health doctors in the North-West based in acute trusts, one being Melanie Maxwell at the Arrow Park in the Wirral, who is doing a really good job. This was something that [Sir] Liam Donaldson was very keen on when he was in the North-East and he funded six. There is a confusion about people who are called community physicians, who were neither in the community nor physicians, when we might need community physicians, which is different.

Berridge: Iain Chalmers, would you like to say something about evidence-based medicine?

Sir Iain Chalmers: Well, I have a public apology to make first of all, because I was sent a letter asking me if I would speak for five minutes or so at this session. I didn't read it properly with the consequence that I only learned this expectation of me just before the meeting started.

Like Nick, I am going to give a rather personal reflection. I also started off as a clinician, interested in maternal and child health. As you couldn't do maternal and child health in this country, I went to the Gaza Strip for two years where I

¹²⁹ Professor John Ashton wrote: 'So the church schools should be preferentially taking the children of heathens when, of course, they take the religious children of the middle classes who are using them as free private schools.' Note on draft transcript, 4 July 2005.

¹³⁰ Professor Virginia Berridge wrote: 'The concept of the observatory, derived from the historical notion of the "panopticon", became important in public health in the 1990s when observatories were set up to gather data (usually epidemiological) that could be used to advocate change.' Note on draft transcript, 16 December 2005.

¹³¹ Julian Tudor Hart suggested that general practice should perform the public health function. He envisaged a 'new kind of doctor' who would not only care for the individual needs of patients but would also look beyond the walls of the health centre. This would involve considering the health not only of those who do attend, but also the health of those who do not attend. He also saw an important role for the doctor to be involved in the local area and its wider health needs. See Hart (1988); Ness *et al.* (2002): 37.

worked in maternal and child health for the United Nations Relief and Works Agency for Palestinian Refugees. It wasn't until I came back to England and attended a course at the Institute for Child Health, to which Patrick Hamilton was contributing, that I became aware of two terms: 'epidemiology', which had never crossed my consciousness previously, and 'randomized-controlled trials' (RCTs).¹³² I hadn't heard of either of those things until six years after I had been given a 'licence to kill' by London University.

I went ahead and trained in obstetrics, motivated particularly by the preventive aspects of the speciality. When an opportunity arose to obtain a Department of Health bursary to study at the LSHTM and the LSE [London School of Economics] on a two-year MSc course in social medicine run by Jerry Morris, I took it up. The course was a most wonderful learning experience. I was there between 1973 and 1975, so it was on the cusp of the 1974 NHS reorganization. We weren't taught much about infectious diseases, nor about RCTs. But that said, it was a wonderful first year of education at the LSHTM. I know I am not the only person who is deeply indebted to Jerry Morris and his colleagues for having designed that course so well.¹³³

For the second year, I had to do a project. My project had been prompted by an epidemic of neonatal jaundice in Cardiff. This seemed to be associated with developments in obstetric practice, in particular the greater use of induction of labour. People were saying, '38 weeks is the same as 42 weeks, so why not think in terms of daylight obstetrics and get everyone induced as soon as they get to 38 weeks?' With the support of a couple of obstetricians who had very different approaches to obstetric practice, I did some research evaluating obstetric practice. This came to the notice of an obstetrician, Melville Kerr, and a sociologist, Meg [Margaret] Stacey. Melville was Professor of Obstetrics in Edinburgh; Meg was Professor of Sociology in Warwick.¹³⁴ They were organizing a seminar on obstetrics and sociology. I was given the chance to present my findings there. As a result of this I was invited not long after to establish the National Perinatal Epidemiology Unit.¹³⁵ After my appointment as Director, I was offered an

¹³² See biographical note for Patrick Hamilton on page 85.

¹³³ See Chalmers (2001); See also Berridge and Taylor (eds) (2005); www.icbh.ac.uk/icbh/witness/socialmedicine/index.html (visited 22 November 2005).

¹³⁴ See biographical note on page 90. See also Stacey (1972); Stacey (1976): 194.

¹³⁵ The National Perinatal Epidemiology Unit (NPEU) was set up in 1978 by the Department of Health. See the NPEU website at www.npeu.ox.ac.uk/npeu_home.php (visited 8 November 2005).

honorary NHS Consultant contract as a community physician. And someone thought that, in the light of this, it would be appropriate if I applied to the Faculty of Community Medicine for membership. The exam at the end of the first year for the MSc degree counted as Part I of the Faculty's membership requirements. I had to submit my MSc dissertation in consideration of Part II. This dissertation was rejected unanimously by the examiners. I had been cavorting with clinicians and investigating an epidemic happening within a hospital. In essence, I had been doing clinical epidemiology, which was frowned on by the founders of the Faculty. In spite of the fact that I was director of a health services research unit, there was no way in which the Faculty could overrule the decision of my two examiners.

Those of us who are interested in the contributions of the health services to the health of the public have sometimes felt rejected by people who think that we are traitors to real public health for talking to clinicians and taking an interest in clinical practice. Eventually I was allowed to join the Faculty.

The 1970s were an immensely exciting time. Nick [Black] has already given you some idea of that. Iconoclasm was really in, with Cochrane, McKeown and Illich as its basis. There was the Radical Statistics Health Group, of which I was one of the founder members.¹³⁶ Alison Macfarlane has kept that group alive and kicking for a long time. Klim McPherson was also involved in it. We did a report entitled 'Whose priorities?' in response to a Government report.¹³⁷ We produced a report for the Royal Commission on the NHS called 'In Defence of the NHS'.¹³⁸ I was down in Wales at the time, and some of us started a local South Wales branch of the Socialist Medical Association,¹³⁹ and together with the Welsh TUC, we organized a meeting in Llandrindod Wells. I produced a wonderful paper, called 'Democracy in the National Health Service', in which

¹³⁶The inaugural meeting of the Radical Statistics Health Group was held in January 1974. See Macfarlane (1999), www.radstats.org.uk/no071/article4.htm (visited 24 November 2005); Kerrison and Macfarlane (eds) (2000).

¹³⁷Radical Statistics Health Group (1976). Reprinted in full: Radical Statistics Health Group (1978).

¹³⁸Radical Statistics Health Group (1977). Pamphlet, submitted as evidence to the Royal Commission on the NHS and then reprinted as: Radical Statistics Health Group (1980).

¹³⁹The Socialist Medical Association (SMA), founded in 1930, was a medical-political group whose members recognized the close relation between poverty and ill health, and the importance of political decisions to change these conditions. For a history, see Stewart (1999).

I tried to struggle with the new idea of community health councils.¹⁴⁰ My paper went down like a lead balloon. It was completely useless. I still don't know how to communicate effectively about democracy in the NHS.

The reference group for people like Nick and me was and is the Society for Social Medicine.¹⁴¹ The Society provides a wonderful environment; it's very supportive and multidisciplinary. The people who come to mind as members of the founder generation of the Society include Archie Cochrane, Walter Holland, Margot Jefferys, Ann Cartwright, Alan Snaith, Michael Warren, George Godber and John Brotherston. They were very important influences on the way that people like us were thinking, and they sometimes came to the annual meetings of the Society. And then there were the somewhat younger people like Klim and Nick and me, and Sally McIntyre, Phil Strong, Sheila Adam, [the late] David Bainton, Ian Baker, Aubrey Sheiham, Robert West, Angela Coulter and Ian Russell. In the wider community there were people like Jean Robinson, who had been Chairman of the Patients' Association, and Sheila Kitzinger, who had had a very important influence in making people think about maternity services.¹⁴² Some people didn't go to the Society for Social Medicine, because the annual meeting was usually followed by the annual meeting of the British Sociological Association. Some of the medical sociologists, like Hilary Graham, Meg Stacey, Joyce Leeson and Alwyn Smith, used to go on to that meeting. Now, if you ask these people whether they were part of public health, many of them would say 'yes' without any ambiguity. For example, the unit, the NPEU [National Perinatal Epidemiology Unit], that I worked in at the time had on its staff Ann Oakley,¹⁴³ initially a qualitative sociologist, but who used quantitative methods too, Alison Macfarlane, a statistician, Miranda Mugford, a health economist, Jo Garcia, another social scientist, Adrian Grant, who, because he is

¹⁴⁰ Unpublished manuscript. Sir Iain Chalmers provided a copy of the manuscript, dated 30 October 1976, which will be deposited along with other documents and tapes from the meeting in Archives and Manuscripts, Wellcome Library, London. See Klein and Lewis (1976).

¹⁴¹ Pemberton (2002). See also Pemberton (1998); Porter (ed.) (1997). See the Society for Social Medicine website at www.socsocmed.org.uk (visited 8 November 2005).

¹⁴² For biographical notes see page 88 (Robinson) and 86 (Kitzinger). See also Christie and Tansey (2001): 8–9, 18, 19, 29, 33, 44–48, 79; and 46, 61–64. Freely available online at www.ucl.ac.uk/histmed following the links to Publications/Wellcome Witnesses.

¹⁴³ Professor Ann Oakley was Director of the Social Science Research Unit, Institute of Education, University of London, from 1990. See Tansey and Christie (2000): 10 and 11. Freely available online at www.ucl.ac.uk/histmed following the links to Publications/Wellcome Witnesses.

medically qualified you would probably now call a clinical epidemiologist, and Diana Elborne, another statistician.

One of the good things to come out of this multidisciplinary mixing is epitomized in a book that Ann Oakley published in 1990 called *Experiments in Knowing*.¹⁴⁴ It attacked paradigm wars, the way that people slag others off for using research methods with which they are unfamiliar. Ann's book asks why people couldn't see that taking a variety of different perspectives on a phenomenon gives a richer understanding of it.

To get back to the defence of my and Nick's interest in health services: Bunker, Frazier and Mosteller have made one of the few serious attempts to try to work out what proportion of the increase in life expectancy over the last 50 years, and in life free of major morbidity, can be attributed to health services improvement.¹⁴⁵ They estimate that between one-third and one-half of the increase in life expectancy over the last 50 years is due to what has happened in health services, and an extra five years of life free of major morbidity. That's an important estimate to bear in mind in the post-genomic era. People keep on promising us that we are on the edge of a revolution in the effectiveness of healthcare. They have to beat a very good existing record. I will be surprised if over the next 50 years, post-genomic medicine can take credit for half of the increase in life expectancy.

I want to celebrate the type of work on the health of the public that I value by referring to someone who has a paper in this week's *Lancet*.¹⁴⁶ Ian Roberts is a public health doctor at the LSHTM. Some time ago, he wrote a *British Medical Journal* editorial suggesting that Ken Livingstone should be regarded as a public health hero, for what he has done to reduce traffic in central London. That's only part of what makes Ian an exemplary public health doctor. He is very interested in public health interventions to reduce injuries and trauma. But he is also interested in interventions to mitigate the effects of trauma. In this week's *Lancet* he and his colleagues report the most multinational randomized controlled trial that I have ever seen (the participating countries range from Albania to Vietnam).¹⁴⁷ The study concerned the use of steroids for people

¹⁴⁴ Oakley (2000).

¹⁴⁵ See, for example, Bunker *et al.* (1994).

¹⁴⁶ See Roberts *et al.* (2004). See also Roberts (2003).

¹⁴⁷ Roberts *et al.* (2004).

who have acute traumatic brain injury. The idea for the study came from a systematic review of the existing evidence. That review left uncertainty about the effects of steroids. The trial showed that people who have been using steroids over the past 30 years have actually been inadvertently killing their patients. A previous systematic review done by Ian Roberts and his colleagues suggested that human albumin solution used for resuscitation might do harm, and failed to uncover any good evidence that it was doing any good. That prompted a clinical trial, done in Australia and New Zealand, which has shown that we have been wasting millions of pounds on an expensive intervention which is no better for resuscitation than salt water. Ian's [Roberts] work – ranging from Ken Livingstone being hailed as a public health hero, to the evaluation of intensive care for an important cause of morbidity and mortality worldwide – should be taken as an example of the open-mindedness and the broad church which public health needs to foster.

Berridge: Would anyone like to comment on that? You talked about the role of sociologists and palliative research. I don't know if there's anyone who would like to say something about that.

Griffiths: Just for this speech – I am President of the Faculty [of Public Health]; I think Iain [Chalmers] is dead right. I do think there needs to be a 'broad church', we do need to have everybody in.¹⁴⁸ There is a series of proposals being kicked around at the moment which should be on the website this week if we are lucky. It's been through the Board provisionally already, which I think will help to open things up more. I do think it's important that we have a framework of standards and qualifications, but it needs to be organized in such a way that everybody can pitch in and that we can cope with the widest range of relevant careers and still be part of the same family. I am not trusted by anybody, because I have been an academic, have been in the service and have messed around with hospitals and all the rest of it, so nobody knows where I am coming from. But I have spent quite a lot of my life trying to get money out of acute services by putting them on the spot, to see whether or not they would ever get value

¹⁴⁸ Professor Stanley Gelbier wrote: 'Dentists also wondered why they were not accepted as part of the wider community or public health fraternity. They too were excluded from the new Faculty. Dental members of the Society of Medical Officers of Health had played a role in exerting pressure and formulating ideas for the Faculty. They were thus disappointed to learn that [they] could not become members. A deputation from the Society's dental group consisting of Alan French, Stanley Gelbier and Ian Maddick went to see Professor Archie Cochrane and Dr Wilfrid Harding to explain their disappointment. Cochrane said "Dentists join? Over my dead body. If we are not careful the sociologists will also want to join the Faculty".' Letter to Dr Daphne Christie, 14 June 2005.

for money, because I wanted the money for other things, and equally I have spent time trying to persuade people with local authorities and so forth. It is terribly difficult. We haven't the time to argue with each other, we are one big family, with the tensions that families have. Let's be facing outwards, because we need all these different kinds of workers, from the sociology right across. In the three years I am at the Faculty I promise to keep trying to make it as wide as possible.

Berridge: Ann Taket, I wondered if you wanted to say something about the role of qualitative research in all of this?

Taket: Well, here's one I haven't prepared earlier, not that I prepared the others very much. I think I was really pleased and noted down the reference to the book *Experiments in Knowing*,¹⁴⁹ because I have never read it, but it sounds like one I ought to be citing to justify my position. All of the interesting questions in public health usually require a judicious combination of quantitative and qualitative research. Unfortunately, that is still not reflected in the funding, or ease of funding, that we see for mixed method designs. Again to keep it personal, I can reflect on the past year, where we have had three designs for randomized controlled trials (RCTs), plus a qualitative enquiry, all were turned down because the funder explained to us quite tactfully that they really only wanted an RCT, which told me some but, I think, not the entire story. So although I don't want us to engage in paradigm wars, there is a need for some judicious lobbying of funding bodies to fund good quality qualitative research alongside the quantitative research, and to fund them separately as well. The situation has got better, but I still don't think it's quite where it needs to be.

Ashton: Perhaps the personalization of this kind of discussion is really a reflection of the breakdown of the system. In the postwar period medicine itself became much more reductionist and public health became reductionist too, and in losing its contact with all the other areas of action – the environmental, social areas and so on – it retreated into this more narrow paradigm. Trying to reconnect the different parts of the family, in Rod's [Griffiths] terms, or the enterprise, is really very much what we should be doing now. But we do need to understand how that system broke down and what kind of system would support the coherence of public health. Not mentioned so far was the initiative in place in the 1970s and 1980s out of Johns Hopkins, in which Kerr

¹⁴⁹ Oakley (2000).

White was instrumental in creating, along with Geoffrey Rose,¹⁵⁰ which led to a couple of books.¹⁵¹ One of them is *Healing the Schism: Epidemiology, medicine, and the community's health*,¹⁵² in which White argued that public health and epidemiology should drive the curriculum in the medical school and that there should be an intelligence unit in the Dean's suite of every medical school, so that the curriculum was able to be dynamic and respond to the changing health needs of the population. Whereas, we know that medical curricula tend to be at least one generation out of date. Part of that initiative put clinicians through the LSHTM and other schools, who returned as clinicians with an epidemiological perspective. There have been things around which have tried to address some of these issues, but again the strategy is piecemeal, and we need to try to join them up.¹⁵³

Berridge: I think we are drifting towards our final theme: multidisciplinary public health. People have started to talk about that already, but this has been one of the struggles, the areas of debate of the last ten years or so. We have a couple of people who are going to start the ball rolling. Perhaps I could ask Klim McPherson to talk about his own experiences in this area.

McPherson: A number of people suggested that I ought to succumb to my normal mode of communication, which apparently is to rant. I will try not to rant if I possibly can, because I have done enough of that. I ought really to thank the various recipients of my ranting over the years for eventually listening to what I had to say, because they have been very tolerant, and because sometimes I have been extremely rude to some of them, for which I apologize. A lot of this is an issue, and I think it's a real issue, having to do with the question of 'what is public health?' This has been my main thread: is public health a medical speciality, or is it multidisciplinary, or is it just a speciality among which there are lots of disciplines? There are many arguments taking place along those lines, and my abiding concern has been to enable and encourage, to make it easy for bright graduates coming out of universities to say, 'Yes, public health is for me'.

¹⁵⁰ See biographical note on page 88 and Rose (1981, 1992).

¹⁵¹ See, for example, Fee (1987).

¹⁵² White (1991).

¹⁵³ Professor John Ashton wrote: 'My starting the first observatory in Liverpool was one piece of this jigsaw.' Note on draft transcript, 4 July 2005. See note 130.

That's not quite what happened to me, because I don't think I knew what public health was when I was a kid. As you know I came from a family that was completely replete with doctors in every single direction; about 14 of them, my parents, my wife, my daughter, everybody I know is a doctor.¹⁵⁴ Anyway, when I was a kid I didn't want to be a doctor, I really didn't, I thought that's not for me. Anyway, I was brilliant at maths and physics, but wasn't very good at biology, and was terrible at chemistry. So I just had to sort it out for myself, and my attempts at sorting it out for myself is what I am going to talk to you about now.

Essentially, what it boiled down to was that I went into public health because I didn't know what to do, but it had to be in health. I got a job at the LSHTM, a very junior statistical assistant person and that was brilliant, but I learnt a lot from my various colleagues, and I liked it. I liked the idea of doing that sort of analysis on those sorts of problems and the whole thing was very exciting to me. So I moved along, as one does, doing what one can in various ways, and trying to address the questions that are central to the core of public health. What does matter for health? And clearly there is the case that we have had a clear spectrum of that from Nick and Iain [Chalmers]. It was always clear to me, anyway, in the last several decades that health services have a major contribution to make to health. Not least because over those years, due to the influence of people like Archie Cochrane and Iain and others, we all worried about which treatment works and which doesn't: that is partly to do with people like me, statisticians, giving some yardstick against which you can measure the success of these sorts of things.

But the question really is what works in public health? I worked for the Medical Research Council, doing mainly clinical research and it was great and I loved it, and then an opportunity arose to go to Oxford. I didn't think I stood a chance in hell of getting it, but I applied all the same, and got it and thought, 'Well, OK, I will get stuck into more public community-based things, public health things,' as opposed to clinical things, which was what I was involved with at Northwick Park.

It struck me, gradually, to ask, 'What am I doing here?' Among a group of people who claim to be the leaders of public health, they eschew clinical medicine, yet they are the leaders of public health, and they don't seem to know much about the sorts of things that I know about. And I was meant, nonetheless, to be a

¹⁵⁴ See note 148.

‘support’ person to them all. There is a massive issue about the various insecurities that we all have in this question, in particular that public health doctors in the early days had with respect to their clinical colleagues. So everybody was very insecure, and I think the Faculty of Public Health,¹⁵⁵ the Faculty of Community Medicine, was quite an insecure institution, and it liked to think that it had a special role in public health and it emphasized that special role *ad nauseum*, and as a consequence of that, it was very exclusive, very secretive and, in my view, extremely elitist.

I thought that this was crazy: is it the case that you can only do public health if you are a doctor? No, that seemed to be silly to me, and it seemed to be silly to anyone you talked to. There were many manifestations of the various kinds of insecurities that took hold of the genesis of the Faculty of Public Health, which got on my nerves, not to put too fine a point on it. I tried to address this with respective Presidents of the Faculty. The example I have already given – not being allowed to go to conferences, not knowing about anything, never even knowing where the Faculty of Public Health Medicine was geographically – and yet I was told to teach cohort after cohort of people on the modular course who were training to be public health doctors. We gave a good course, and I think we livened them up in some sense. And so it seemed to me odd that there was no obvious connection.

Somebody wrote to me from the Faculty and told me that I was going to be the examiner in statistics for the next three years. I said, ‘I am not, I won’t do it’, and he asked why not. I said, ‘Because I don’t think your organization has much to do with what I do, it is very secretive, it is very elitist, it has no connection with me whatsoever, how can you have the cheek to write to me and say I am going to commit even more time to this enterprise for which I have little respect?’ They were completely shocked, having thought it would be a privilege and an honour for me to be part of their enterprise as an examiner, and I had refused. So that led to the question, ‘Well, what is this Faculty, and if it is doing anything positive, why can’t we be in it together and do it together, because after all we all have something to contribute’. So poor Alwyn [Smith], poor old June [Crown], and many other people, had me harassing them at various stages in their lives, urging them ‘to get real’, to open up and be equal; to get some aspect of the work we are doing, not walled off, secretive and elitist. Alwyn decided the solution was to make me the Scientific Adviser to the Faculty.

¹⁵⁵ See notes 5, 8 and 16.

I became the Scientific Adviser to the Faculty, which meant, I suppose, that I was a non-medical scientific adviser, with the onerous duty of advising the Faculty about issues to do with public health that might not be entirely medical. It was a slightly obscure job, but a nice job, I quite liked it. We had a little committee and we did all sorts of things. When Walter [Holland] became President, he said, 'I know what you are going to do as Scientific Adviser to the Faculty, you are going to write lots of papers about this and that', and so he gave me a list of papers to write for the Faculty. I said, 'Wait a minute, Walter, there's got to be a little bit of give and take here. I am not going to sit here and work my guts out for this Faculty unless it actually brings down some of the barriers.' In the end with John Fox, and many others, something called the Multidisciplinary Public Health Forum was created. Many people from different arenas came together to create this Forum whose objectives were to make access to public health much more egalitarian, much less elitist and much less discipline based. The Faculty decided that they would concede and make us members of the Faculty by allowing us to become Honorary Members and be on the register – I don't think we could vote, and we certainly weren't allowed to stand for anything, and we didn't have any influence – but we were expected to sit on various committees and to pay money. So we then had the Honorary Members' Committee created by the Faculty, and the first Chair was John Fox. We used to meet and discuss how to make things better with respect to the organization of the specialist professional entity of public health. Eventually the Honorary Members' Committee, of which I became the next Chair, were given seats on the Board and on the Executive of the Faculty. It was quite an education.

I don't know why I gave up so much time, but anyway I did. We would sit on these Board meetings, and every now and then I would have a little scream and a rant and they would say, 'Oh, go away', and every now and again I said something that was listened to, it was sensible, they said, 'Fine we will do something'. So it was quite an extraordinary experience. I learnt a lot, anyway. It was the first time that I began to understand what the Faculty was all about. But of course that has all subsequently changed, the inertia was then created and the sense of the general argument about the point of this disciplinary barrier in public health was understood, and then eventually, of course as you know, the Faculty decided that they would open the whole thing up and remove every reference to anything medical from the statutes. We now can become Fellows and indeed stand for office, because I did so the other month, and have some influence on the Faculty. I think that's great. It's a necessary part of enabling people who want to come out of university and say, 'I want to do public health' to feel that there

will be open, not closed doors, and I think that it is very important to have open doors. After all, when I started in this business you couldn't even do an MSc in public health or epidemiology, apart from, I imagine, in Alwyn's department in Manchester, without being a doctor, and that again seemed crazy. So in a nutshell that's how it all came about, and for me it has been a great lesson.

The question I have, though, remains germane: if somebody comes to me now, having done sociology or economics or maths or statistics or history or whatever, and says I really want to do public health, I would still have some problems saying, 'Yes, go for it', because I think we have got a long way to go, actually, but, of course, go for it – if you have got thick skin, are really determined, and don't mind half the salary and don't mind none of the connections that happen within public health at the moment normally for doctors: honorary contracts with the health service, very good connections with the health services which I don't have. I just went to the CMO [Sir Liam Donaldson] to ask, 'How about making honorary contracts for non-doctors in the health service routine? And he has written a very sympathetic letter saying, 'Yes, very good idea, why not, why don't we do it, let's get some move on it', and it's only a matter of changing custom and practice. I don't think you have to change anything else. That might happen as well, so you get some easy connection between the health service and academia, that's very important in principle, not only because of disciplinary matters, it's very important to have some connection between academic public health and the practice of public health which is well oiled and easier than it is now, because there's an increasing divide between the practice of public health, as has been alluded to many times, and what goes on in academic departments, which really should not be there, they should be joined up. So that's my experience, and I am glad it has happened, and I am glad that people listened in the end, and again I apologize for being rude to those to whom I was rude.

Smith: I remember Klim's approach, and it's really a very long time since I was President of the Faculty [from 1981 to 1986]. I felt he made a very good case. I thought what on earth could I do to accommodate his legitimate point of view. And I thought, 'Well, we will get him in, in some way, for a start', because I felt that once he got in he would do what in fact he has done. We set up this scientific advisory group with Klim, and there was Steven Rose, you probably remember who the others were – I am afraid I am an old man and I can't remember names. There were a whole lot of people. Having created this committee we had to devise a realistic and worthwhile role for it, and I don't think we were altogether quite successful in that. Things have changed, and will

go on changing, and I think it's important that they should. In North America, public health is a multidisciplinary activity, and some of the most distinguished people in American public health are certainly not doctors. I remember many years ago working with people like Sam Shapiro and Paul Densen,¹⁵⁶ being on WHO committees with these people, major figures in world public health, neither medically qualified, and it simply was irrelevant. I think that is how it has got to be. Of course, deep paranoia and vested interest based on this paranoia exist and have to be dealt with, and frankly I am not quite sure how to go about doing it, but it will be done.

Crown: It may come as a surprise to many of you to learn that most of the time Klim and I were on the same side in this argument, and certainly from my own professional background it has always seemed entirely obvious that public health is a multidisciplinary activity. In my department, throughout the years when one could access the money for it, we always had people from a variety of disciplines, for example a psychologist and an economist. I think ours was the first NHS Department of Public Health that had an economist.¹⁵⁷ Peter West left after a year and wrote a memorable article entitled 'Sometimes I sits and thinks'.¹⁵⁸ He departed not because he wasn't getting on well with people but because he had reached the conclusion that all the decisions in the NHS were political and there was no point in having evidence. That probably has an element of truth. He did all the work on the new hospital (UCH) that is going up now.¹⁵⁹ But I came into the thick of this debate through my involvement with the Faculty, with the sense, rather as Alwyn said, that it's obvious, let's just get on with it.

¹⁵⁶ Sam Shapiro (died 30 December 2000) was Professor Emeritus of Health Policy and Management in the Johns Hopkins Bloomberg School of Public Health, Baltimore, Maryland; Paul Densen was the Deputy Commissioner of Health in New York City (1959–). Telephone call from Professor Alwyn Smith to Dr Daphne Christie, 21 October 2005.

¹⁵⁷ Peter West wrote: 'It is more accurate to say that I was one of a small number of economists at the time working for health authorities.' E-mail to Dr Daphne Christie, 13 December 2005.

¹⁵⁸ Peter West wrote: 'I am fairly certain that this was published in the forerunner of the *Health Service Journal* but have not been able to locate a copy.' E-mail to Dr Daphne Christie, 6 January 2006. Further searches have been unsuccessful.

¹⁵⁹ Peter West wrote: 'Far from doing all the work on the new hospital, I raised a number of concerns about affordability but it was clear that long-term affordability was not seen as an issue. Breakeven this year is one rule for the NHS but getting investment, on any terms and without worrying about the long-term costs, was another rule for managers. It was part of the way the game was and is played.' E-mail to Dr Daphne Christie, 13 December 2005.

Because I was coming to this Witness Seminar, I went to the Faculty office last week and went through some documents. As Walter said at the outset, in 1972 when the Faculty was first set up, the sort of kindred spirits who were involved – Archie Cochrane, Wilfrid Harding, Jerry Morris – had no doubt whatsoever that they wanted a multidisciplinary faculty,¹⁶⁰ but they were using the medical Royal Colleges' model and in association with colleges, and some of the words used in these documents are quite intriguing. They went for the medical faculty members first, because that bit was easy. Having done that in 1972, there's this marvellous line I found last week that I hadn't seen before which said, 'And then in 1974 there was a distraction', a wonderful underestimate of what was happening in the NHS reorganization. But there's no doubt that that was the intention and the Faculty does move slowly. The 'distraction' in 1974, as we have heard today, certainly did give a very different spin on things, and was very prescriptive. My sense was that the Faculty got itself terribly overwhelmed by trying to keep community medicine, as it then was, on a par with other disciplines in medicine. As a Faculty of three medical Royal Colleges, that was obviously hugely important, and it was dependent on the parent colleges at that time, and I think it probably was very difficult for people then to do anything other than fight for this element of parity. That came up again when I was President of the Faculty in 1995.

At the outset of my Presidency, the Academy of Medical Royal Colleges was being established. There was a fight then to keep the Faculty within the Academy of Medical Royal Colleges, so the tension hasn't entirely gone away. But this business is about maintaining not just the parity in salaries, although I am sure that was hugely important to people, but also in issues around training and professional standards.

Those were very big issues, while the work agenda was overwhelming for those people who had come from a quite different world, often having left their multidisciplinary colleagues behind in local authorities or other agencies. One of the sad things, perhaps, at the time was that there wasn't enough pressure from the academic departments which were still wholly multidisciplinary. I think perhaps some of them saw the Faculty as a sort of an NHS trade union for the people working in the service. At that time, the Faculty conferences were almost entirely for medical people in service posts, and not very well attended.

¹⁶⁰ Dr Martin Gorsky wrote: 'This section appears to contradict the earlier note about dentists (see note 148).' Note on draft transcript, 24 November 2005. This is the nature of historical evidence. See, for example, Porter (ed.) (1997); Warren (1997); Berridge (2001); Berridge and Taylor (eds) (2005).

If you really wanted to meet kindred spirits, find out what was going on in the proper public health, you went to the Society for Social Medicine,¹⁶¹ you didn't go to the Faculty conference. Klim may have thought the Faculty conferences were absolutely gripping, but I can tell you, having been to both, the Society for Social Medicine was much more fun.

But eventually, as you heard, we got to the position, which at the time seemed fairly major progress, of the Honorary Members, who were neither honorary, because they had to pay a subscription, nor were they members, because they didn't have any of the other rights of the members. It always seemed to me that the hurdle for those people was pretty high, because the requirements were rigorous and demanding, and were rigidly adhered to by the assessors. Honorary members were required to have had ten years' experience in a public health department, five years in a career post, and to have made a significant contribution to public health. I have to say, that it probably would have been hard to have the size of Faculty membership even that we had in those days, if those criteria had been applied to everybody who became a member.

It sounds terribly disloyal, because I am a great supporter of the Faculty, I think it's done a lot of good work, but I think that at that time it was perhaps working much more slowly, much more rigidly, than it could. But there was also an element of 'not frightening the horses', because going faster might have totally exploded the whole thing and that probably would have been a price too high for everybody. But throughout the 1990s there was progress, there were many of us, people like Rod Griffiths and John Ashton who are here today, each trying in their own way to get this embedded in a way that was going to be good. We consulted on widening membership. One of my most painful moments was having to give the results of this consultation to the Multidisciplinary Public Health Forum. There certainly has been quite a lot of protectionism at the time, because, as we have heard today, people had been through three or four or five reorganizations, had to reapply for their own jobs and had coped with the introduction of general management. There was concern that, 'If the general manager can get somebody to do my job at half the price, what happens to me?' There was also at that time a phase when there was quite a lot of difficulty in self-confidence and of people actually identifying the role of public health and specifically of doctors in public health.

¹⁶¹ See notes 122 and 141.

At about the same time, there was a survey that I think Rod [Griffiths] may well want to talk about. It aimed to develop a database of everyone working in public health.¹⁶² We didn't know where all these people were, and I think we found over a thousand people who responded by all the different routes that we tried. This was very powerful in helping us to have the evidence base to take forward 'widening membership' of the Faculty. We have now achieved membership for all practitioners' training programmes, and progression to Fellowship. From my point of view, I think that is as it should be and it's just a pity that they had the 'distraction' in 1974 and didn't get to it then.

Carter: It's interesting what people don't talk about. I haven't heard environmental health officers mentioned once this afternoon, yet perhaps they do more practical, old-fashioned public health than anybody else. I haven't heard the work place talked about, yet there are immense parallels in terms of prevention and risk management at work with those in the general community. It's quite interesting what public health now doesn't seem to be involved in, and I have watched this from an occupational health perspective, I have watched the parallel antics of two medical faculties in occupational medicine and public health, busy playing the game of walking round the lamp-post with the other faculty and with College of Physicians docs to see who can lift their leg highest, if that is not sexist. The medical game has been played, but the parallel is not being considered very effectively.

I remember early on when I was very new to the field, the two faculties being set up and this distinction, occupational medicine with a clinical emphasis. 'Oh no, we can't have anything to do with that', from public health, which saw itself as administrative, and somehow purer and more different because of it. And I think this is perhaps beyond witness, but a huge opportunity was missed, by not bringing prevention together and thinking about the different disciplines in prevention and how they could work more effectively together. I think that those who define problems somehow see themselves as gentlemen, with those who solve them, like environmental health officers (EHOs) and health and safety advisers, as the players. I am not sure if any EHOs have been invited here this afternoon, it's quite interesting whom you invite to talk.¹⁶³ Those who

¹⁶² See page 64. Ms Shirley Goodwin wrote: 'As a public health specialist I have received several questionnaires from the Faculty of Public Health and various researchers over the past few years.' E-mail to Dr Daphne Christie, 10 December 2005.

¹⁶³ Apologies are listed on page 2.

go out and solve problems in the field in terms of the environment are not here. But I think this is quite an important perspective on this seminar, that it somehow intuitively looks at a professional group rather than looking at an area of preventive activity and what are the problems in it, what are the resources in it and how they can better be used and maybe used in a quite novel way. So it [i.e., public health] is back to the empowerment of populations, back to a lot of things about technologies as well as back to the epidemiology and back to the medical academies.

Berridge: In fact we did invite two people from environmental health, but I don't think they are here [No].

Goodwin: I was on the first course at the LSHTM that admitted non-medics to the Master's degree. This happened because by about 1990 I had been working in effect in public health all my professional life but I didn't have a formal training or any recognition of that fact, and I was trying to find a way of training in public health. Diana Walford¹⁶⁴ was the deputy CMO at the time. Some statement was issued by the Department as part of everything that came out in the early 1990s, I forget what it was now, and it mentioned multidisciplinary public health, and people being able to train. I wrote to her to ask if she could please tell me how to train then, because there had been no way for me to enter a training programme. I got a polite letter back saying, 'Oh dear', but not much more than that. At that point Geoffrey Rivett, who has just left the meeting, rang me up and asked if I would come to do some work for the Department of Health on GP fund-holding and community nursing, as I seem to recall, but I got no money to train. Eventually I managed to round up enough funding from various sources and applied to do the epidemiology Master's degree because at that time the public health medicine one was not open to non-medics. While I was going through the process of applying and being accepted on to that course, somebody on the other epidemiology course, I won't say who it was, said, 'You don't want to do that epidemiology, they are all head-bangers, wait another few months and you can come on the public health medicine Master's which shortly will be open to non-medics'. So that's what I did, I wanted to do the full-time Master's degree there. That was 1992–3, and at that time the vast majority on the course were medics of course, but there were a handful of nurses and other people from health promotion, community development, one or two other people who had come on the course that year.

¹⁶⁴ See biographical note on pages 90–91.

There are one or two stories I think I should tell. The thing the School did at that time, I don't know if they still do, but we all went on a couple of days away to Tunbridge Wells to do team-building, to get to know each other, which was very much the vogue at that time, wasn't it? I remember sitting on the coach next to a medic (I won't say the name), and I said, 'Well...what made you decide to do this course?' And he said, 'Well, Shirley, I was sitting there with my hand on this baby's head, and I gave a tug, I got covered in blood and I thought there must be a better way of earning a living'. I know what he is doing now, because I see his name every now and then, he's a consultant in communicable disease control (CCDC), somewhere in the Home Counties, works for the Health Protection Agency now, of course. I was also told that most of the people on the course were 'retreads', and this turned out to be partly true, in that there were a lot of people who were taking what seemed to me a very much-deserved escape from hospital medicine, people who had recently been working very hard as junior hospital doctors, in general practice, sometimes in clinical medicine, one or two consultants, and you know I could see that they were simply exhausted. For some of them it was a relief. 'What shall I do? Anything to get out of this.' But there were nevertheless among that lot a significant, I think it was still a significant, minority of people – Nick (Black) was there so he would corroborate or not – who were truly devoted and had opted to do public health medicine quite deliberately because that's what they wanted to do, and they were committed to it.

I had some very interesting experiences during that year, and one of them was to go into an optional session one afternoon which was part of a series simply on public health medicine, it wasn't one of the modules we had to do for the exam, it was optional. I can remember sitting in the lecture theatre with about 40 or 50 people, all medics, and they were moaning and whingeing just like a crowd of health visitors about their lack of role, that they were generalists, and nobody valued them. I said, 'Do you realize you sound exactly like the people I have been working with for the last 20 years? They say exactly the same things, use the same words, agonize endlessly about their role. Who cares about your role, it's what you do that matters, not this notional idea of having some formal identity'. But I do believe that having served health visitors for a very long time, being a generalist of the preventive kind carries with it an occupational hazard, if you like, of feeling a lack of identity and of constantly seeking a role and wanting to be assured that there will always be a job for you, whoever else is allowed to join in some of the things that you actually do, and I think that's something that public health generalists share.

I was very apprehensive, as I was 45 when I started the course, at my lack of recent formal education. I had done my degree as a health visitor in the evenings, 15, 20 years before, three nights a week, so I hadn't done any statistics or anything for a very long time. I was really anxious about that, I was a three times 'O' level maths failure in any case. But I managed to get through and I found that my much wider managerial, political and professional understanding of how systems work and of public health issues more than compensated for my lack of short-term memory, for example, managing to retain the reading of a paper from one night to the next day's seminar. You know how quickly those things disappear when you find it hard. And I was able to get through. The problem then for me, however, having done the Master's, was what could I do, how would I be employed? I was recruited by Maureen Dalziel,¹⁶⁵ who at that time was the first doctor to become a general manager, a public health doctor as well as a GP, and at that point she was setting up Hillingdon Health Agency, which was that creature that appeared briefly in the early 1990s where family health service authorities cohabited with district health authorities, and of course they created health authorities in about 1995, if I recall, from those hybrids. And she was setting up one of these not realizing I was doing the Master's degree when my name got mentioned, and she said, 'Come and work for me. I am setting this all up'. So I ended up commissioning, purchasing, you know the very early years of the internal market, where I found that we were working in a largely knowledge-free environment in terms of how to operate, because it was so new. Some of the evidence-base from the work of people like Nick [Black] was coming into play there, but much of the time the decisions that were made were led by finance, rather than by evidence, and everybody was learning as well, including GPs of course, who were learning how to be fund-holders. For a while I led a locality with 60 GPs in 15 practices. I managed half-a-dozen big hospital contracts, including that of my *alma mater*, which was a nightmare and I think still is for the people who try to manage it. I didn't ever get a chance in those immediate years following the completion of my Master's to consolidate and enter any sort of training programme. So it wasn't until 1998, when my current boss, Hilary Pickles, DPH, persuaded me to work in her department on the newly created Health Improvement Programme, HIMP, which was part of New Labour's modernization of the health service, when we were once again allowed to use words beginning with 'P', like planning, poverty, and partnership and so on,

¹⁶⁵ See biographical note on page 83.

and so that's how I got into public health. A couple of years later I became an honorary member of the Faculty.

For me the main benefit of the Faculty was, and remains, the fact that I had a continuing professional development process to be a part of. I had felt a bit loose for a number of years. I had no professional body to relate to. I was no longer on the nursing or health visiting register, because I couldn't satisfy the requirement, and although I retained my membership of those bodies, I felt as if I was hanging loose, there was nowhere for me to be, there was no home for me as a public health professional. And the Faculty has felt increasingly much more like that home, although there are still significant barriers to my day-to-day involvement in the Faculty, which are partly my own, because I have too many other things to do to seek actively a role on a committee, for example. I certainly value going to the Faculty conferences, receiving its newsletters and so on, and also the recent move, I gather, to allow people like me to be put up to be Fellows, which is a welcome honour at this stage in the game.

I think from where I am now and for people like me, public health truly does now feel multidisciplinary. Perhaps one of the main things that made that happen, apart from the Faculty's developments, was the severe shortage of public health physicians, which has led to the need to allow non-medics to be appointed as public health specialists, and indeed Directors of Public Health. It feels a bit as if that's the reason why they are being appointed because there aren't enough doctors out there. I think it's a false argument. That is not the right reason for that having happened for myself, personally, but I still do have a debate with my medical colleagues about the extent to which somebody like me, or perhaps more so to somebody who doesn't have any clinical background, can actually perform all the duties of a Director of Public Health to the necessary standard. I certainly don't think I could, however much more training I had, and I am not sure that many of the other people I see occupying those roles increasingly, could actually discharge the functions that are expected of a Director of Public Health as we have known and loved them.

Ashton: I want to make two or three quick points. I think Klim was a prophet and I hope some of us were supporting him. The important message is that the criticism that Wanless made about the lack of fitness for purpose of public health is partly because we lost ten years fighting over this issue and not building capacity. That's been a tragedy. During this Labour Government from 1997 we haven't had the right numbers of people in the right places to do the job, to be able to respond to what's been on offer. There have been all sorts of people who

have colluded with that. Alwyn talks about the Professor of Public Health at Manchester, Professor Brockington.¹⁶⁶ The British Medical Association has never been right on this issue. They have always said that we shouldn't be training more people because there weren't going to be enough jobs, and we have always known that there weren't enough people to do the jobs that were there. And so we are in a mess because of that and because people were bloody-minded and difficult. When the Faculty changed its name from community medicine to public health medicine in 1989, there was a big debate, and many of us wanted it to be called the Faculty of Public Health, but we lost. Some people dug in their heels and wanted public health medicine, and the evidence that Klim cites is there for people to see. The wonderful MSc at the London School [LSHTM], which several of us here did, had weaknesses, it didn't prepare you to go out and change the world, maybe it should have, but it didn't. It was a great experience, but you couldn't get a Master's if you weren't a doctor. David Lawrence,¹⁶⁷ who was in our group, got a diploma out of it, he wasn't allowed to get a Master's degree out of it. When I restarted the postgraduate programme at Liverpool it was open to all-comers from the beginning and that was 15 years ago. We were in a position then with shifting the balance of power to appoint people from a range of backgrounds, who were prepared for those jobs. In the North-West, out of 40 Directors of Public Health, 18 or 19 are not doctors, and the lack of a level playing field, the way the tripartite thing is operating, is there for the people to see. Again there is more being required of the non-medical people in terms of the ten competencies than is being required of the medical people in terms of the ten competencies, who may well be very poor with their community development understanding, with their knowledge of local government, and such like, but what people want to talk about is infectious diseases, which any non-medical person who is a Director of Public Health in the North-West has had the full opportunity to skill up in those areas. It isn't a level playing field yet, there are jobs being advertised all the time, which will mean that Directors of Public Health without a medical background are not getting paid the same as those with a medical background. On the other hand, on Klim's finer points, the Director of the North-West Public Health Observatory who is not a doctor, has an honorary contract, and gets paid an extra supplement for fulfilling that. That's because I am in control of those conditions. We need to get the Government to set up a system that ensures a level playing field.

¹⁶⁶ See page 27 and note 79.

¹⁶⁷ Dr David Lawrence is Honorary Senior Lecturer in Health Services Research at the LSHTM.

Griffiths: Can I pick up on several things? The point about EHOs, which is from the Acheson Report. Mike Eastman was the EHO on the Acheson Committee and his remit, from his profession I think, was to say, 'We are all right, hands off, we don't want the doctors back'. Mike is a friend of mine and I have always thought he was a great guy. He was very effective at making that particular pitch, and in effect we lost the opportunity on the Acheson Committee to look broadly at that aspect, because the local authority view was, 'We're all right, hands off, it's the health service that's in a mess'. They were able to sustain that right message throughout. It's a good thing that we work with them, and have kept those doors open.

A point on the survey we did: When I became Professor in Birmingham I was working with a number of people who were not doctors – it had never occurred to me to ask who was a doctor and who was not. When I became a RDPH [Regional Director of Public Health], I was parachuted in to help sort out messes. I continued that relationship, and found that we were supporting a lot of people in district departments around the region who said, 'We haven't got anywhere else to go for inspiration and help' or whatever, which raised the question of how many are there? There must be others in other parts of the country. I just funded Lilian Sommerville to do a survey, not a brilliant survey, as we wrote to everybody that we could think of asking if they knew anybody who fits this bill, who thinks they are in public health, and soon, a rolling sample emerged. We were slagged off for not conducting the survey using a good method, but we did find 1000-plus people. We then thought we ought to get them together as their survey responses said they were without support. We contacted those who had replied and invited the first 150 that said yes to a conference in Birmingham. I paid for that conference out of the RDPH's budget, which was quite big in those days.¹⁶⁸ We did it again the following year, and said we would run another conference the third year. At the second conference people decided it was such fun that they should set up a multidisciplinary public health forum and once that organization was created I stopped paying for the conferences. But up until then we paid for it, because the money was there. It was quite astonishing that no one had done anything to find these people before, to provide them with careers. If you looked at the half-life of jobs, the length of time before half the people in a job have left it, looking backwards, it was less than two years. So these people were in jobs which were essentially training jobs, and yet here were people who were trying to make a career.

¹⁶⁸ Each Regional Health Authority received an allocation of money according to the size of its population. See, for example, West Midlands Regional Health Authority (1991). See also Warren (1997).

We also funded a booklet on what careers could be in public health, mapping out a number of trajectories. The great thing was that people like Klim responded. There was obviously a club of us who had been roused out by Klim and it's really good that we still continue together after this. I think it shows the value of subdata. Mike O'Brien, when he was President of the Faculty, said we should open the doors, and he got kicked in the head quite a lot for it, and then June [Crown] had to pick up the pieces. It's never been easy, because of some of the things that John said, there are people who are thinking, 'What's in it for me?' 'What's in it for us?' is a much better question and we now have a very powerful group of people. We should all keep our eye on the bigger picture.

Chalmers: It is a shame that Tim Carter has just left, because I wanted to make a space in the transcript for Walter Holland to contribute something that would be appropriate in the light of the question that Tim raised about occupational medicine (see page 58). Before the meeting I was trying to understand from Walter what might have been behind the apparent antipathy among founders of the Faculty to people like me who had consorted with clinicians. He said that the Faculty had faced three problems.¹⁶⁹ One was that there were Clinical Medical

¹⁶⁹ Professor Walter Holland wrote: 'There were some problems in deciding on who was eligible to apply for foundation membership of the Faculty: (1) All founder groups – Medical Officers of Health (MoH), administrative medical officers and academics agreed that eligibility for exemption from an examination would be dependent on grade – I believe MoH needed to be at SMO (senior medical officer) grade or higher, academic senior lecturers or higher. Individuals of lower grades could apply and were considered by a committee and the foundation board individually on the basis of their skills, responsibilities and experience. Clinical Medical Officers employed in public health, who did well-baby clinics, routine medical examinations, school medicals etc., were not eligible automatically because (a) their main responsibilities were clinical and (b) they had no training or experience in the population aspects of this work. They could appeal. (c) We were anxious not to "poach" from the Royal College of Physicians (RCP) which was "interested" in this group; (2) We wanted to incorporate occupational medicine, but apart from some, such as Professor Richard Schilling [died 30 September 1997], Dr Raffle (of London Transport), Dr David Slattery and Professor Corbett McDonald, who did not wish to be part of community medicine and considered themselves to be clinicians rather than "population doctors". They wanted to be closer to the RCP (or the Royal College of General Practitioners). This was because the majority were part-time occupational doctors and spent most of their time as GPs or hospital doctors; (3) The RCP accepted that the Faculty could have non-medical Members and Fellows. The Faculty, and this was largely led by the MoH, was reluctant to have non-medics at the start in order to establish their credibility with the RCP. Already, at the start, there were some non-medics as Honorary Fellows, for example Sir Austin Bradford Hill; and (4) Some of the founder committee thought they had a commitment from Sir Max Rosenheim that members of the Faculty (medicine and non-medicine) would automatically become, in due course, Fellows of the College. However, this was not in his gift – and the College did not agree to this. They did agree that a number of Members and Fellows of the Faculty could be made Members/Fellows of the College without examination by a new set of by-laws. This would not be automatic, but individuals nominated by the Faculty would be considered on their individual merit.' Letter to Dr Daphne Christie, 8 June 2005.

Officers, who had been employed by local authorities to do child health clinics and so on, and the Faculty didn't really want them as part of what it was trying to do. Yet there was obviously a feeling among some of the Clinical Medical Officers that they ought to be part of this new enterprise. Walter said there were two different people associated with occupational medicine. People like Richard Schilling, who were at the public health-end of occupational medicine, and others who were general practitioners who did occupational medicine on a contract basis. The latter apparently wanted nothing to do with the Faculty. So within that community there appear to have been divided opinions. And then the third issue mentioned by Walter was that Max Rosenheim, President of the Royal College of Physicians at the time,¹⁷⁰ had made a verbal promise that people without medical degrees would be acceptable members of the Faculty from the point of view of the Colleges of Physicians. Someone appears to have reneged on that undertaking. I am repeating, at secondhand as best as I can remember, what Walter said. But in the light of the issue that Tim raised (page 58), it is going to be important to try to get Walter to give you a proper version of what I have just said.

Griffiths: At that time about one-third of the members were non-medical, which, given the number of retired members and so forth that we have got, shows us the huge progress that has been made in the last few years.

Smith: I may possibly be the only Foundation Fellow of the Faculty here¹⁷¹ and I remember the agonizing discussions that surrounded the foundation of the Faculty in the first place. Some people, I believe Tom McKeown was one, and I certainly backed him, thought that the simplest thing to do would be to amalgamate the existing Society of Medical Officers of Health¹⁷² with the Society for Social Medicine. That was ruled out totally by the main negotiators on the grounds that the Society for Social Medicine was heavily influenced by non-medical people. Another very important aspect was that the Faculty was created as a faculty of three different Royal Colleges of Physicians, in London, Edinburgh and Glasgow, and everything had to be negotiated with those three,

¹⁷⁰ Baron Rosenheim KBE FRCP FRS (1908–72) was President of the Royal College of Physicians, London, from 1966 to 1972. See Pickering (1974).

¹⁷¹ Professor Walter Holland wrote: 'Acheson and I were Founder Fellows, as well as Alwyn Smith. I was a member of the founding committee of the Faculty (see note 16).' Letter to Dr Daphne Christie, 26 October 2005.

¹⁷² See Engineer (2001).

and a lot of compromises had to be made in order to ensure that all three Royal Colleges of Physicians would accept this new Faculty. A tribute needs to be paid, in my view, to Wilfrid Harding, who steered this whole thing through, mainly because of his close friendship with Max Rosenheim, who was then the President of the Royal College of Physicians of London.¹⁷³ It was agreed that this was for doctors, that they had to be people who might otherwise have been members of one of the other Royal Colleges, or the College of Physicians. It is actually quite important, though, to make quite an interesting point: all the other colleges are for doctors quite specifically – physicians, surgeons, and obstetricians and gynaecologists, for example – not colleges of a subject. Whereas the Faculty as it started was for a subject, community medicine, and that was a very important break with tradition. It was very important, when it was getting started, that it was accepted by the parent colleges of which it was a faculty, and a lot of academics, Tom McKeown was one of them, could see no point in it. He said, ‘We are all Fellows of the Royal College of Physicians anyway’, and of course that wasn’t true, we weren’t all Fellows of the Royal College of Physicians; he was, but most of us were not. It was a difficult time to start.

Once it started, it developed pretty encouragingly. The pioneering role of the Royal College of Pathologists is quite interesting, because they were the first of the Medical Royal Colleges to accept non-medically qualified people as full members in 1962. Many non-medically qualified bacteriologists were taken into the Royal College of Pathologists, creating a precedent within the college system that has been very valuable.

French: May I make a couple of quick observations about health promotion officers and health education officers as an occupational group? I was the Chair of the Society of Health Education and Health Promotion Officers back in the 1980s.¹⁷⁴ At its height there were about 1500 people, a big part of the public health workforce and hardly mentioned here today. Two interesting things about multidisciplinary working: first, that the society was multidisciplinary from the beginning; second, the health promotion officers came from a range of professional groups. Within my department, we had a nurse, a doctor, a

¹⁷³ See note 170. Dr Wilfrid Harding was Chairman of the Provisional Council, Vice-President (1972–5) and President (1975–8), of the Faculty of Community Medicine. See biographical note on page 85.

¹⁷⁴ The Society was formed in 1982 with the aim of advancing health education and promotion. See the Society of Health Education and Health Promotion Specialists website at www.hj-web.co.uk/sheps/ (visited 12 November 2005).

social worker, a dentist, an RAF pilot, a broad spectrum of backgrounds. One of the key votes that that society took back in the 1980s was to move towards a professional status via some kind of mandatory registration. That was hotly contested and the vote came down against it. Part of the rationale was that they saw the edifice of setting up a professional registration system, even with all the benefits, the quality assurance that it provides, as something that was ‘anti’ the philosophy of health promotion, and would exclude those from a broader disciplinary base, and those entering from a variety of different levels, whether members with no academic professional qualifications, through to those with several postgraduate qualifications. I think that hotly-contested debate during the 1980s led to the demise of that group, having committed occupational suicide by not accepting professional registration and not carving out some territory that they could call their own. Now we have a multidisciplinary public health with many active members of that new movement. However, multidisciplinary public health work is not new at all. I can remember in the 1970s, 1980s, 1990s, where the actual occupations that we have been talking about – in local government and the NHS voluntary sector – have been working in a multidisciplinary way on the ground, despite these occupational barriers. There have been many thousands of worthwhile, innovative, effective projects; these people have worked together despite their occupational boundaries. A lot of the debate has concerned that process of moving towards an occupational status, in terms of multidisciplinary public health, the work on the ground has, in a sense, not been unduly affected by not having that in place during the 1980s and 1990s.

Dr Ornella Moscucci: I would like to pick up on three things that have emerged from Nick Black’s and Iain Chalmers’ earlier contributions. The first was Nick’s point about the 1970s – how certain public health people saw one key strategic development, the formation of an alliance with the public in order to enhance the status of public health, to divert much-needed resources away from hospital medicine. The second point is the political radicality at that time. We have heard names like Ivan Illich, the father of the critics of modern medicine, and other names to conjure with, like Jean Robinson, Sheila Kitzinger, Ann Oakley, Alison Macfarlane and so on. The third is how research in obstetrics provided a focus for people with an interest in public health and evidence-based medicine who were involved in a critique of hospital medicine. The question is to what extent were public health people capitalizing on the wave of feminist discontent with maternity care in order to advance their status? And, what was the role played by obstetrics in establishing evidence-based medicine at that time?

Black: Thinking back to the period of 1978–82, which for me certainly involved sociology in general as an influence and at that period, feminist sociology was the most energetic area. I think it would need more thought. It is a very interesting question, and I recognize why you are asking it. I can see a connection there. It's more immediately Iain's area, because he was working in obstetrics, and I wasn't.

Chalmers: I don't think that the women we worked with were necessarily feminists. In the early 1970s there was a revolt by many women against what they saw as inhuman maternity services, and the practices within them.¹⁷⁵ Few of them would have regarded themselves as having been motivated by feminist considerations. Having said that, I agree that it was very important that the feminist movement was growing at the same time. But the reason that the National Perinatal Epidemiology Unit had women on its advisory committee right from the beginning was basically from considerations of 'self-defence'. We felt that we would actually do the wrong things if we didn't get input from people who were in touch with the women using the maternity services, and who knew about the concerns they were expressing. So it wasn't from some sort of politically correct position that we engaged users of the maternity services. It simply seemed common sense to do so.

Griffiths: I was on a community health council from the date they were set up in 1974 until I got a DPH job in 1982, and I was Chairman of the National Association for two years and had been Vice-Chairman for two years before that. It is hard to convey the energy of the consumer movement in those days and the excitement of being able to get into areas that we had no access to before. And although I think the feminist end of that was very important, so was what MIND [National Association for Mental Health] were doing – they were called MENCAP then, I don't know the correct name. So were those in the disability movement, RADAR (Royal Association for Disability and Rehabilitation) I think it was. There were patient groups, based mostly around chronic disease such as diabetes and Parkinson's disease where patients were really more expert than the doctors and gradually doctors were beginning to recognize that. There was a change in that period where some of these strident groups started to work with the doctors, or rather the doctors started to work with the various strident groups, producing some very powerful alliances. I remember piloting through stuff to ensure that patients had access to their own notes. I was considered to

¹⁷⁵ Chalmers (1976).

be completely mad and I was told off by the British Medical Association, but it seemed very obvious that you would get better medicine if it was more open. I think the feminist movement was important, because it had a lot of energy and again in an obvious area of medicine to start on. But the other organizations were very important as well. Later, as we gradually got better at stopping people dying of things like heart attacks, more diseases have been converted into chronic diseases with their own patient groups. It's matured as a movement, but was a great deal of high energy in those days, and very exciting to be around.

Berridge: I think on that exciting and interesting note, it's probably the time to finish and move on to a drink. Before we do I'd like to thank everyone who has contributed this afternoon. It has been an extraordinarily rich and exciting Witness Seminar with many new insights emerging. I would like to thank everyone who has contributed and particularly those who started the ball rolling in the various areas. I would also like to thank Daphne Christie and Wendy Kutner for all the work that they have put into organizing the seminar, which I think has really paid off; and my coorganizer, Niki Ellis. I also would like to mention Sally Sheard,¹⁷⁶ who helped with some of the early organization and suggestion of names, who unfortunately could not be with us this afternoon. Thanks to those of you who have attended and we look forward to the contributors' comments on the transcript.

Christie: On behalf of the History of Twentieth Century Medicine Group I would like to thank you very much for participating in the meeting this afternoon, and also to thank Virginia for her excellent chairing of this occasion. Please join us now for a drink.

¹⁷⁶ For biographical note see page 89.

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Professor Sir Donald Acheson

KBE FRCP FFPH FFOM FRCS
FRCOG HonFRSM (b. 1926)
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Professor John Ashton

CBE (b. 1947) has been Regional
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Professor Nick Black

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* Contributors are asked to supply details; other entries are compiled from conventional biographical sources.

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FRCP FFOM (b. 1944) worked on the prevention of occupational disease, first in the petrochemical industry and from 1983 to 1997 as Medical Director for the Health and Safety Executive. He was actively involved in the professional bodies concerned with occupational medicine and health and safety for most of this period. He has been a part-time Chief Medical Adviser, Department for Transport, since 1999 while developing his expertise as a medical historian.

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Dr Aileen Clarke

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at Bart's and the London School of Medicine and Dentistry, in east London and a reader in health services research. She originally trained in medicine at the University of Oxford and was inspired by the work of Professor Sir Richard Doll and others. She became a GP in east London before moving to academic public health. She worked as Course Director for the MSc in public health at the LSHTM from 1996 to 2003, training successive cohorts of new recruits in the underlying knowledge and skills of public health.

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FRCP (1926–2005) was Consulting Physician at St Thomas' Hospital, London, 1991 (Physician, from 1959 to 1991), Senior Lecturer in Medicine, United Medical and Dental Schools (St Thomas') from 1959 to 1991, Honorary Consultant in Gastroenterology to the Army, from 1970 to 1990, and Dean, St Thomas' Hospital, London. See Thompson (2005).

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and District Medical Officer, Bloomsbury. She has acted as an adviser to the World Health Organization since 1980 and was President of the Faculty of Public Health from 1995 to 1998.

Dr Maureen Dalziel

MD FPPH FFRSA (b. 1952) was Director of Public Health North Thames Regional Office NHS Executive (1995–8), Director of the National Coordinating Centre for Service Delivery and Organ Research and Development (1999–2001), Chief Executive, Human Fertilization and Embryology Authority (2001–02), and has been Director of Health Consultancy Ltd since 2004. She has been Honorary Senior Lecturer in Public Health Medicine, LSHTM, since 2000.

Sir Liam Donaldson

Kt FRCP FRCPE FRCSE FFPH FRCGP (b. 1949) has been Chief Medical Officer, Department of Health, since 1988. He was Director of Public Health, Northern Regional Health Authority, from 1986 to 1992, and then Regional General Manager and Director of Public Health, Northern and Yorkshire Regional Health Authorities, later Regional Director, Director of Public Health, Northern and Yorkshire NHS Executive, from 1994 to 1998. He has been

Honorary Professor of Applied Epidemiology, University of Newcastle upon Tyne, since 1989.

Dr William Henry Duncan

(1805–63) was Liverpool's first Medical Officer of Health, appointed on 1 January 1847. He started his professional career as a GP working in two practices in Liverpool. As a key member of the Health of Towns Association in Liverpool (established 1845) he helped in creating Liverpool's first Sanitary Act in 1846. See Laxton (2000).

Professor John Fox

(b. 1946) was statistician at the Employment–Medical Advisory Service (1970–75) and then the Medical Statistics Division of the Office of Population Censuses and Surveys (OPCS) until 1979. He was Professor of Social Statistics at City University, London, from 1980 to 1988, where he established the Social Statistics Research Unit. He returned to OPCS in 1988 as the UK Chief Medical Statistician and in 1990 was appointed Visiting Professor at the LSHTM. In 1996 he became Director of the Census, Population and Health Group and in 1999 he moved to the Department of Health as Director of Statistics. He is Vice-Chair of the Economic and Social Research Council's Research Resource Board.

Dr Jeff French

(b. 1955) was Director of Marketing and Communications, Health Development Agency, London, in June 2000, and is now Director of the National Social Marketing Centre for Excellence, National Consumer Council, London.

Professor Stanley Gelbier

HonFFPH FDS DDPH (b. 1935) was Area Dental Officer in Lambeth, Southwark and Lewisham (1974–80), Senior Lecturer and later Professor of Dental Public Health (1980–2002), Head of the Division of Oral Health Services Research at King's College London (1998–2000) and Honorary Consultant in dental public health to a number of health authorities (1983–2002). He is a past President of the British Association for the Study of Community Dentistry and past Chairman of the Specialist Advisory Committee in Dental Public Health (1980–2). He was the first dentist to gain an Honorary Fellowship from the Faculty of Public Health and was awarded the Tomes Medal by the British Dental Association in 2002.

Professor Alan Glynn

FRCP FRCPATH (b. 1923) qualified at University College Hospital, London. He trained in clinical medicine but after two years as

a senior registrar at St Mary's Hospital, London, converted to bacteriology and became Professor there in 1971 and Head of the Department of Bacteriology in 1974. In 1980 he was appointed Director of the Central Public Health Laboratory at Colindale, London, until his retirement in 1988.

Sir George Godber

KCB GCB DPH HonFRCS HonFRCGP HonFRSM FRCPsych FFCM (b. 1908) was Deputy Chief Medical Officer, Ministry of Health (1950–60), Chief Medical Officer, Department of Health and Social Security, Department of Education and Science, and Home Office (1960–73) and Chairman of the Health Education Council (1976–8).

Ms Shirley Goodwin

RGN RHV FFPH (b. 1947) qualified as a health visitor in 1971; practised for 12 years in west London before becoming Chief Executive of the Health Visitors' Association (1983–9) and was appointed as the first chair of the Public Health Alliance Steering Group in 1986, and the first Vice-Chair of the UK Public Health Association in 1999. She worked as a public health specialist at Hillingdon Primary Care Trust and retired in October 2005.

Professor Rod Griffiths

CBE FFPH FRCP (b. 1945) has been Professor of Public Health Practice, University of Birmingham, since 1990, and Regional Director of Public Health, West Midlands, Department of Health (formerly West Midlands Regional Health Authority), since 1993. He was a member of the CMO's Inquiry into the Public Health Function (Acheson Committee) from 1986 to 1988 and has been President of the Faculty of Public Health, London, since 2004.

Sir Roy Griffiths

Kt FCIS FIGD HonFCGI (1926–94) was Deputy Chairman of the National Health Service Policy Board, 1989–, and Adviser to the Government on the National Health Service, 1986–. He was Chairman of the Management Inquiry of the NHS, 1983 (the 'Griffiths Report'), a member of the Health Services Supervisory Board (1983–9), and Deputy Chairman of the NHS Management Board (1986–9).

Professor Patrick Hamilton

FFCM FRCP (1934–88) was Senior Lecturer, Department of Medical Statistics and Epidemiology, LSHTM, from 1967 to 1974; Director, Pan American Health Organization/WHO Caribbean Epidemiology Centre,

Trinidad, from 1975 to 1982; and Professor of Community Health, University of London, from 1982. See Black and Skinner (1989).

Dr Wilfrid Harding

CBE FRCP FFCM DPH (b. 1915) was Medical Officer of Health for the London Borough of Camden from 1965 to 1974, Honorary Consultant in Community Medicine, University College Hospital, London, from 1971 to 1979, and Chairman of the Provisional Council, Vice-President (1972–5) and President (1975–8) of the Faculty of Community Medicine.

Professor Walter Holland

CBE MD FRCGP FRCP Path FRCP FFPH (b. 1929) qualified at St Thomas' Hospital Medical School, London, in 1954. After training in medicine and epidemiology at St Thomas', the LSHTM and Johns Hopkins University, Baltimore, USA, he returned to St Thomas' in 1962, retiring in 1994, having founded the Department of Clinical Epidemiology and Social Medicine (later Public Health Medicine), and served as the Honorary Director of the Social Medicine and Health Services Research Unit. He was President of the International Epidemiological Association (1987–90), and of the Faculty of Public Health Medicine

(1989–92). He served on a variety of hospital, district, regional and Department of Health committees between 1964 and 1997.

Dr Ivan Illich

(1926–2002) obtained a PhD in history at the University of Salzburg and went to New York, NY, USA in 1951, where he served as assistant pastor in an Irish–Puerto Rican parish. From 1956 to 1960 he was assigned as Vice-Rector to the Catholic University of Puerto Rico, where he organized an intensive training centre for American priests in Latin American culture. Illich was co-founder of the Center for Intercultural Documentation (CIDOC) in Cuernavaca, Mexico, and from 1964 he directed research seminars on institutional alternatives in a technological society, with a special focus on Latin America. Known for his critique of modernization and the corrupting impact of institutions, his concerns dealt with deschooling, learning webs and the disabling effect of professions. See Smith (2001); Scott-Samuel (2003).

Sir Barry Jackson

FRCS FRCP HonFRACS (b. 1936) was Sergeant Surgeon to Her Majesty the Queen from 1991 to 2001, Consultant Surgeon at St Thomas' Hospital, London, from

1973 to 2001 and at King Edward VII Hospital for Officers, from 1983 to 2002. He was President of the Royal Society of Medicine from 2002 to 2004.

Dr Ilona Kickbusch

(b. 1950) has held posts with the World Health Organization (WHO)(1980–8) and was Professor and Head of the Division of Global Health Department of Epidemiology and Public Health at the Yale University School of Medicine (1998–2004). Since 2004 she has been Senior Adviser on Millennium Development Goals at the Pan American Health Organization. She initiated the Ottawa Charter for Health Promotion, launched the WHO Healthy Cities Project, and founded *Health Promotion International*.

Ms Sheila Kitzinger

(b. 1929) was the Course Team Chairman in the Open University from 1981 to 1983 and received the Writers' Fellowship Award from the Rockefeller Foundation in 1988. She was a member of the editorial board of the Midwives Information and Resource Service, the National Childbirth Trust, and was Chairperson, Foundation for Women's Health Research and Development, from 1985 to 1987.

Professor Thomas McKeown
FRCP HonFFCM HonFACP (1912–88) was Professor of Social Medicine from 1945 to 1977, and Pro-Vice-Chancellor from 1974 to 1977 at the University of Birmingham. See also *The Life and Work of Thomas McKeown*, 20–21 September 2002, University of Birmingham, UK. International Conference. Organized jointly by the Centre and the Department of Public Health and Epidemiology, University of Birmingham. See McKeown (1988).

Professor Klim McPherson
FFPH FMedSci (b. 1941) is Professor of Public Health Epidemiology at the University of Oxford. From 1990 he was Professor of Public Health Epidemiology at the LSHTM until 2001 and MRC Senior Scientist and Deputy Director of the MRC HSRC in the Department of Social Medicine at the University of Bristol from 2001 to 2003. He has been the Chair of the European Public Health Association, the Society for Social Medicine and the British Breast Group and is a Fellow of the Academy of Medical Sciences.

Professor David Morrell
OBE FRCP FRCGP (b. 1929) was Wolfson Professor of General Practice, United Medical and

Dental Schools of Guy's and St Thomas' Hospitals, London, from 1974 to 1993, Emeritus from 1993. He was President of the British Medical Association from 1994 to 1995.

Professor Jeremy (Jerry) Morris
CBE HonFRSM FRCP (b. 1910) was Director of the MRC Social Medicine Unit from 1948 to 1975, Professor of Social Medicine at the London Hospital from 1959 to 1967, Professor of Public Health, University of London, at the LSHTM from 1967 to 1978, and Emeritus Professor, from 1978.

Dr Ornella Moscucci
(b. 1954) is a historian with a special interest in the history of obstetrics and gynaecology. Since 1999 she has been a member of the History Group at the London School of Hygiene and Tropical Medicine, now Lecturer. She has been a member of the Executive Committee of the Society for the Social History of Medicine since 2004.

Professor Sir Michael Peckham
CBE FRCP FRCS FRCR FRCPATH FMedSci (b. 1935) was Director of Research and Development at the Department of Health from 1991 to 1995, and has been Founder and Director of the School of Public Policy, UCL, from 1996 to 2000.

Professor Peter Pharoah
FRCP FRCPCH FFPHM
(b. 1934) was Professor of Public Health (formerly of Community Health), University of Liverpool, from 1979 to 1997, now Emeritus.

Dr Geoffrey Rivett
FRCGP (b. 1932) entered general practice in 1962 and joined the Department of Health in 1972. He worked in the fields of computers in the National Health Service, rationalization of London health services, and the development of general practice. Now retired, he writes about the history of the NHS [King's Fund and www.nhshistory.net (visited 29 July 2005)]. See Rivett (1986, 1998).

Professor Jean Robinson
was Chair of the Patients' Association from 1973 to 1975, Honorary Research Officer, at the Association for Improvements in the Maternity Services from 1989, and Visiting Professor, School of Health Sciences, University of Ulster since 1997. See Robinson (1974).

Professor Geoffrey Arthur Rose
CBE FRCP FRCGP FFPH
(1926–93) was Professor of Epidemiology, St Mary's Hospital Medical School, London (1970–7), LSHTM (1977–91), and Honorary Consultant

Physician, St Mary's Hospital (1964–91), Emeritus Professor from 1991. See Meade (1994).

Dame Rosemary Rue
DBE CBE FRCP FFPH FRCPSych FRCGP FRCS (1928–2004) was a general practitioner from 1952 to 1958, worked in the Public Health Service from 1958 to 1965, and in 1972 she became one of the founders of the Faculty of Community Health (the Faculty of Public Health from 1989), and was President from 1986 to 1989. She was awarded the Jenner Medal of the Royal Society of Health. See Rue (1987); Richmond (2005).

Dr Alex Scott-Samuel
(b. 1947) graduated in medicine at the University of Liverpool in 1971, and took his Master's in public health in 1976. From 1978 to 1994 he was Consultant in Public Health with Liverpool Health Authority. Since 1994 he has been Senior Lecturer in Public Health at the University of Liverpool, where he directs IMPACT, Liverpool Public Health Observatory and EQUAL, the Equity in Health Research and Development Unit. His chief research interests are in health impact assessment, health politics and policy, and health inequalities. He leads the health promotion

module on the Liverpool Master's in Public Health course. From 1979 to 1985 he was founding Editor of the journal *Radical Community Medicine* (now *Critical Public Health*). Together with Peter Draper, he established the Public Health Alliance (now the UK Public Health Association) in 1986. In 2003 he co-founded the Politics of Health Group, and he is Vice-Chair of the Pioneer Health Foundation.

Professor Andrew Semple

CBE FFCM (b. 1912) was Professor of Community and Environmental Health (formerly of Public Health), University of Liverpool, from 1953 to 1977, later Professor Emeritus.

Dr Sally Sheard

(b. 1965) holds a half-time senior lectureship, jointly between the Department of Public Health and the School of History at the University of Liverpool. Her research interests include the development of public health and health services in Britain in the 19th and 20th centuries; the development of medical authority, especially the interface between experts and politicians and she has completed a joint research project with Professor Sir Liam Donaldson on the development of the role of the Chief Medical Officer, 1855–

1998. See, for example, Sheard and Power (eds) (2000); Sheard and Donaldson (2005).

Professor Alwyn Smith

CBE FRCP FFPH FRCGP (b. 1925) qualified at the University of Birmingham after wartime service in the Royal Marines. After academic posts in Birmingham, Dundee, Edinburgh and Glasgow he was appointed Professor of Social and Preventive Medicine at Manchester in 1968, later, Professor of Community Medicine and finally Professor of Epidemiology. He was President of the Faculty of Community Medicine from 1981 to 1986.

Professor Richard Smith

(b. 1952) was the Editor of the *British Medical Journal (BMJ)* and chief executive of the *BMJ* Publishing Group. He worked for the journal for 25 years, from 1979 to 2004, of which the last 13 was as Editor. He resigned in 2004 at the age of 52 to work for the UnitedHealth Group; he is the chief executive of UnitedHealth Europe. He is also on the Board of Directors of the Public Library of Science and the Governing Council of St George's, University of London and a Professor at the London School of Hygiene and Tropical Medicine.

Professor Margaret (Meg) Stacey FRSM (1922–2004) was Professor of Sociology at the University of Warwick, from 1974 to 1989, later Emeritus Professor. She was Director of the Medical Sociology Research Centre, University College of Swansea, from 1972 to 1974, and Chair of the British Sociological Association, from 1977 to 1979, later President, from 1981 to 1983. See Murcott (2004).

Dr Alice Stewart

FRCP (1906–2002) worked on MRC-funded projects for Dr Leslie Witts during the war, including a study of pneumoconiosis, 1945–6, became a lecturer in the Nuffield Department of Social Medicine at the University of Oxford in 1946, a reader in 1949 and the head of the Social Medicine Unit until her retirement in 1974. Her work on radiation risks and childhood cancer put her at odds with the medical establishment. With the statistician, George Kneale, she established in 1953 what became the Oxford Survey of Childhood Cancer, one result was that pregnant women were no longer sent for X-rays. In 1974 she started her collaboration with Thomas Mancuso on the health of nuclear workers in the USA, which led to congressional investigations in 1978–9. She was awarded the Livelihood Award, the alternative

Nobel, in 1986, the Ramazzini Prize for Epidemiology in 1992, and was one of the founders of the *British Journal of Industrial Medicine*. See Greene (1999); Anon. (2002).

Professor Ann Taket

(b. 1954) worked with the Department of Health's Operational Research Unit from 1979 to 1986, seconded as a consultant to the European Regional Office of the WHO from 1983 to 1984. From 1986 to 1994 she was a lecturer and senior lecturer in health and healthcare, a joint appointment between Department of Geography, Queen Mary and Westfield College, and the Department of Epidemiology and Medical Statistics, London Hospital Medical College, University of London, including three sessions a week in Tower Hamlets in the Department of Community Medicine. Since 1994 she has been Professor of Primary Health Care at London South Bank University.

Dr Diana Walford

CBE (b. 1944) became Director of the Public Health Laboratory Service in 1993 from her post as Deputy Chief Medical Officer for England and Director of Healthcare on the NHS Management Executive. After joining the

Department of Health and Social Security in 1976 to work on the safety of medicines, she held a series of senior posts, including one with responsibility for undergraduate and postgraduate medical education and training. In 1986–7 she spent a sabbatical year doing a MSc in epidemiology at the London School of Hygiene and Tropical Medicine. Subsequently, she was appointed to the School's Court of Governors and continues to serve on its Board of Management.

Professor Michael Warren

FRCP HonFFPH (b. 1923) has been Emeritus Professor of Social Medicine, University of Kent, since 1983. He was Professor of Community Health, University of London (1978–80), Director of Health Services Research Unit and Professor of Social Medicine, University of Kent (1971–83), the Chairman of the Society of Social Medicine (1982–3), and joint Editor of the *British Journal of Preventive and Social Medicine* (1969–72).

Sir Henry Yellowlees

KCB HonFRCP HonFRCPsych FFCM FRCS (b. 1919) was Chief Medical Officer at the Department of Health and Social Security, the Department of Education and Science and the Home Office from 1973 to 1983. He had been at the

North-West Metropolitan Regional Hospital Board from 1959, when seconded to the Ministry of Health as Principal Medical Officer in 1963, then Deputy Chief Medical Officer to Sir George Godber in 1967, and the second Chief Medical Officer from 1972 until Godber's retirement in 1973.

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