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“There was no plan!” - The origins and development of multidisciplinary public health in the UK

Report of the witness seminar held at the University of the West of England on Monday 7 November 2005

Edited by David Evans
Teri Knight

University of the West of England, Bristol 2006
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Acknowledgements

We are very grateful to the Wellcome Trust for funding this witness seminar. Judy Orme did a superb job chairing the seminar, with particular skill in moving our conversations on so that we managed to cover the whole agenda for the day. Our thanks as well to Emma Griffin for her essential administrative support for the day, and to Leigh Taylor and her team of transcribers for producing the transcript - despite the multiple voices and poor sound quality of some of the recording. Jane Wathen kindly designed the cover and typeset the text. Finally, our deepest thanks to all the participants for their insightful contributions, both those who attended and those unable to attend who kindly supplied material which we have appended.
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Introduction
David Evans and Teri Knight

The last twenty years have seen a sea change in professional roles and boundaries in the practice of specialist public health in the UK (see Chronology p. 91). In the 1970s and 1980s specialist public health was wholly medically dominated. All senior public health posts in the National Health Service (NHS) were restricted to those with a medical qualification, usually to members of the Faculty of Community Medicine (McPherson et al., 1997; Evans, 2003). Public health workers from disciplines other than medicine were restricted to 'support' roles (Somervaille & Griffiths, 1995; Smith & Davies, 1997). Even those with high levels of skill and expertise in core public health disciplines such as epidemiology and health promotion, fairly quickly experienced a glass ceiling in terms of their career development. From the late 1980s and early 1990s an increasing number of such workers began to question and challenge the professional boundaries which excluded them from senior public health roles. Although progress felt slow and difficult at first, within a decade, a number of quite significant changes were in process. The Faculty of Public Health Medicine gradually opened its examinations and membership to those from disciplines other than medicine. Then senior NHS public health posts were similarly opened to public health specialists from other disciplines. Today, there are a number of directors of public health and specialists in public health working in the NHS from a variety of non-medical disciplines, a situation hardly conceivable in the 1980s.

How and why did this change come about? This paper reports on a witness seminar designed to make sense of this rapid and arguably radical shift in professional boundaries. The seminar brought together key players to document and discuss the origins, context, and development of multidisciplinary public health in the UK. We were particularly concerned to give voice to those activists whose often lonely work ‘banging on the door’ and creating ‘do-it-yourself’ careers, has to date been little documented or analysed. The creation and development of the Multidisciplinary Public Health Forum in the mid 1990s was a key moment in the development of multidisciplinary public health and several of the founding members were able to contribute to the seminar.

Before discussing the seminar in more detail, it is important to briefly describe the historical context and the current state of the literature on the development of multidisciplinary public health. There has been relatively little discussion of the emergence of multidisciplinary public health in the UK within the wider historical and policy commentary on developments in public health. For example, Lewis' (1986; 1991) otherwise seminal work on the history of public health medicine in the twentieth century does not discuss the development of multidisciplinary public health. Partly this is due to the relatively recent surfacing of multidisciplinary public health into the policy arena. But this only partially accounts for the silence. As Jefferys (1997) and Warren (2000) illustrate, there were tensions as long ago as the late 1960s and early 1970s, around the establishment of the Faculty of Community Medicine with quite heated debates as to whether membership would be restricted to registered medical practitioners or include others such as social scientists from within the Society for Social Medicine. Once the Faculty was established, however, these tensions generally simmered under the surface and were not explicitly written
about until the mid 1990s when the policy debate re-emerged.

Public health policy documents of the 1980s and early 1990s did not often refer to multidisciplinary public health. A key document of the period, the report of the Acheson inquiry into public health (Secretary of State for Social Services, 1988), did refer to public health as a ‘multidisciplinary endeavour’ but its discussion was essentially limited to the role of multidisciplinary training and clearly conceived of other disciplines as limited to a support role to public health medicine. Other key public health documents such as The Health of the Nation (Secretary of State for Health, 1992) and the Abrams Report (Department of Health, 1993) did not mention multidisciplinary public health at all.

The first significant publication specifically focused on multidisciplinary public health was the report of a survey on the training and career development needs of public health professionals (Somervaille & Griffiths, 1995). This report demonstrated the extent of the ‘problem’ – the large number of those working in public health from disciplines other than medicine who felt undervalued and disenfranchised, and acted as a catalyst for much of the subsequent activity described in the witness seminar. There followed a steady stream of publications over the next decade, largely or wholly, on the development of multidisciplinary public health (McPherson et al, 1997; Smith & Davies, 1997; Levenson et al, 1997; 1999; Cornish & Knight, 2000; Evans and Dowling, 2002; Evans, 2003; 2005; Williamson, 2004; Abbott et al, 2005; Griffiths et al, 2005). Most recently (and published subsequent to our witness seminar), the report of a Wellcome Trust witness seminar on public health in the 1980s and 1990s (Berridge et al, 2006) provides a small number of other first hand stories of the development of multidisciplinary public health complementary to the accounts reported here.

At the same time as these research reports and policy commentaries, a number of short articles and letters appeared in the professional press from the advocates and opponents of the development of multidisciplinary public health. Many of these exchanges took place in the letters pages of the British Medical Journal, and a noteworthy example appeared in that journal’s occasional series of ‘For and against’ debates (McPherson et al, 2001).

A national policy commitment towards the development of multidisciplinary public health was first articulated after the election of the new Labour government in May 1997. A first expression of the newly emergent policy appeared in the interim report of the Chief Medical Officer’s (CMO) project to strengthen the public health function in England (Department of Health, 1998). This was followed by a much stronger statement in the White Paper Saving Lives (Secretary of State for Health, 1999). At the same time, the policy was given practical effect with the first central guidance that senior public health posts in England (Primary Care Trust (PCT) public health leads) could be filled by non-medical professionals (Department of Health, 1999). The following year saw a forceful statement from the Secretary of State for Health (Milburn, 2000) decrying ‘lazy thinking and occupational protectionism’ and calling for NHS public health to embrace more multidisciplinary leadership. The pace of policy statements continued with further support for multidisciplinary public health from the House of Commons Select Committee on Health (2001), the final report from the CMO project (Department of Health, 2001a) and
further Department of Health guidance on *Shifting the Balance of Power* (Department of Health, 2001b; 2001c). The latter was a particularly significant milestone, leading in 2002 to the appointments of the first cadre of directors of public health from backgrounds other than medicine in English PCTs (Evans, 2005). Wider UK public policy also supported the development of multidisciplinary public health. The two reports carried out by Derek Wanless for the Treasury (Wanless 2002; 2004), in particular the second report offered support to many of the multidisciplinary public health movement’s challenges to the status quo. Wanless criticised the lack of public health strategy, insufficient leadership, the capacity of PCTs in England to deliver and judged the public health workforce as not fit for purpose. Wanless called for a refocusing of public health energy away from the NHS as a sickness service towards addressing key lifestyle and environmental risks.

This high profile change in public health leadership opportunities was underpinned by a decade of often hidden activism by the advocates of multidisciplinary public health. As this witness seminar demonstrates, change began in different arenas over varying timescales and occurred due to a number of people challenging and pushing at different doors. The accounts given here demonstrate the initiative, courage and opportunism of these activists. “There was no plan” as one participant emphatically commented to general agreement, but real movement came when these individuals networked and came together. A plan did emerge, ‘bottom-up’, from a very different way of working which achieved considerable change. Key moments included the establishment of the Multidisciplinary Public Health Forum, the *Feasibility Study of the Case for National Standards for Specialist Practice in Public Health* (Lessof et al, 1999), the opening up of public health training schemes and the Faculty of Public Health Medicine examinations and membership, and the establishment of the Voluntary Register for Public Health Specialists. Change was not of course linear or continuous. As seminar participants discuss, some wider policy changes such as the introduction of the NHS internal market in the 1990s had both facilitative effects (e.g. increased need for epidemiology skills) and negative impacts (e.g. marginalisation of health promotion within provider Trusts).

Although the Multidisciplinary Public Health Forum worked across the UK, many of the developments were initiated in England with Wales and Scotland somewhat behind (NHS Education for Scotland, 2003). The situation in Northern Ireland was somewhat different due to the ‘all Ireland’ nature of public health development, and was not covered in this seminar.

Although significant policy change has been very recent, the seeds of change go back further. One of the purposes of this witness seminar was to identify those seeds, describe and document why and how change occurred and to look at the implications for the future development of multidisciplinary public health.

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1 In June 2006 David Hunter commented that “There are two important omissions from the report: (1) Scotland and Northern Ireland get scarcely a mention and yet developments there have been distinctive. The history of the short-lived Public Health Institute of Scotland and the review leading up to its establishment are pertinent to the issues addressed by the witness seminar. On Northern Ireland it’s worth mentioning the recent public health function review (Department of Health, Social Services and Public Safety, 2004) which makes reference to multidisciplinary working, skills and training. (2) There is no mention of the Coalition for Public Health Action formed a year ago via a concordat signed by the five major stakeholders: UKPHA, Faculty of Public Health, Chartered Institute of Environmental Health, Royal Society of Health and Royal Institute of Public Health.”
This witness seminar was initiated during a conference dinner conversation by two participants in the development of multidisciplinary public health. David Evans was one of the first UK directors of public health from a background other than medicine. Teri Knight was a founding member of the Multidisciplinary Public Health Forum. During the 2005 UK Public Health Association (UKPHA) conference dinner they reflected on the radical changes in multidisciplinary public health over the last decade and that the history of those changes had not yet been written, in particular, the role played by the Multidisciplinary Public Health Forum. It was also recognised that policy in this area is still developing quickly and that a historical analysis can offer insights to inform current and future policy. From that conversation a proposal was drafted and submitted to the Wellcome Trust for funding. The Wellcome Trust kindly agreed to support a witness seminar on the history of multidisciplinary public health.

The witness seminar is a well recognised form of oral history, where people associated with a particular historical event or process are invited to come together to collectively recount, discuss and record their memories. A number of witness seminars have been conducted by the Wellcome Trust History of Twentieth Century Medicine Group² and the Centre for Contemporary British History³ among others. Recent witness seminars exploring aspects of the history of UK public health have addressed the Black Report (Berridge & Blume, 2003) and public health in the 1980s and 1990s (Berridge et al, 2006). It is recognised that the accounts participants give are based on their memories, often of events that occurred some years before. Thus there will inevitably be some disagreements on facts and interpretation and some recollections may be factually inaccurate. And as David Hunter reminded us, in a comment on the draft transcript, there is always a danger of those present seeking to rewrite history. But such challenges are, in our view, more than counterbalanced by the richness and insights of the accounts presented here and the reader must make their own judgement of competing accounts. The witness seminar is an opportunity to reclaim an important historical moment and make sense of it in the light of multiple accounts from different perspectives.

Invitations were made to 41 key players in the development of multidisciplinary public health. These included all the founding members of the Multidisciplinary Public Health Forum, the current and former presidents of the Faculty of Public Health (Medicine), selected regional directors of public health and PCT directors of public health, those involved in developing the Voluntary Register for Public Health Specialists, some of the first cohort of non-medical trainees and those we called ‘refuseniks’ who, although working in public health from backgrounds other than medicine, rejected some or all of the core aims of specialist status and registration. Much of our recruitment was through ‘snowballing’ those we personally knew or were known to initial invitees. Inevitably there was some selection bias in those invited, and response bias in those who attended. 18 of those invited attended and 17 sent apologies. Some key voices were not present at the seminar (for example presidents of the Faculty of Public Health (Medicine), representatives of the UK health departments) or under-represented (refuseniks, the UK outside England). Some of these voices have been included in the post-seminar

² www.ucl.ac.uk/histmed
³ www.icbh.ac.uk/
additional comments presented here⁴, though we recognise that despite our best efforts, other perspectives remain absent, particularly from the UK outside of England⁵.

The seminar took place on 7 November 2005 and was structured around seven sessions:

- The historical context for the rise of multidisciplinary public health.
- Where did change come from? Experiences of those from backgrounds other than medicine working in public health prior to the opening up of career structures in the mid 1990s.
- Education and training. The opening up of the Masters in Public Health to non-medical applicants. The opening of the NHS public health training scheme. The Competency Framework and the Voluntary Register.
- The role of the Faculty of Public Health (Medicine).
- The role of the Department of Health and other UK health departments.
- Lessons from history for future policy.

Each session was introduced by one participant who had been previously asked to informally reflect on the topic and open the discussion in no more than five minutes. The floor was then open to other participants to reflect and tell their stories. The discussion was audio-taped and fully transcribed. The transcripts were corrected by the editors, some minor irrelevant discussion deleted and minor grammatical changes made before being checked by participants.

We recognised that although this seminar addressed a number of important questions, there are others that time and an already wide agenda, did not allow us to explore. Thus although there is much useful discussion of tensions between public health medicine and other disciplines, other tensions such as those between public health in the NHS and local government, or between NHS and academic public health, are only briefly if at all touched upon. As Peter Farley usefully reminded us on several occasions, the discussion too often focused on England and did not sufficiently explore developments in the other UK jurisdictions. Similarly, there is much more to be said about the complex inter-connections between the development of health promotion and multidisciplinary public health, with the contribution of health promotion to the ‘new public health’ critical, but its position within multidisciplinary public health still problematic and unresolved⁶. Finally, there are critical debates in the field about the fundamental importance of the changes described here and the extent to which they demonstrate a significant resolution of previous inequalities in professional opportunities, or whether they represent merely a slight widening of a continuing elitist ‘medical model’ of

⁴ Additional comments by those unable to attend and further reflections by participants are listed in alphabetical order starting on page 62.

⁵ In July 2006 Phil Mackie submitted a list of policy documents which chart the development of public health in the other UK nations. These have been included in this report as an annex to his additional comments on page 81.

⁶ In June 2006 Jenny Griffiths commented that some progress is now being made. A report commissioned by the Department of Health and Welsh Assembly Government was published in July 2005 (Shaping the Future of Public Health: Promoting Health in the NHS) and, at the time of writing in 2006, some of its recommendations are being taken forward by the Royal Society of Health, the Faculty of Public Health and the UK Voluntary Register for Public Health Specialists working in partnership with each other and with other public health organisations.
public health practice. We recognise that this witness seminar report is a contribution to a number of ongoing debates and welcome further inquiries into these important issues.

\[\text{footnote}{\text{Most of the contributors to this seminar took the view that the changes described here reflect significant progress for multidisciplinary public health, but for alternative views see David Hunter's comments on pages 76-77 below and Evans (2003).}}\]
Participants

Virginia Berridge
Yvonne Cornish
Ros Dunkley
David Evans
Peter Farley
Shirley Goodwin
Ian Gray
Jenny Griffiths
Ruth Hutt
Teri Knight
Tessa Lindfield
Klim McPherson
Judy Orme
Paul Pilkington
Jane Royle
Paul Scourfield
Michael Shepherd
Fiona Sim
Robert West
Jenny Wright

Apologies

Sheila Adam
Lee Adams
Lynn Crooks
June Crown
John Fox
Jeff French
Selena Gray
Rod Griffiths
Sian Griffiths
David Hunter
Phil Mackie
Jim McEwen
Aislinn O'Dwyer
Maggie Rae
Mala Rao
David Seal
Lillian Somervaille

Please see page 54 for biographical notes.
Transcript
Edited by David Evans and Teri Knight

Judy Orme: Welcome everybody. I would like to begin by asking Teri Knight and David Evans, who have organised this seminar, just to say a few words about how we come to be here today, leading on to the aims of the seminar.

Teri Knight: Thank you Judy. David and I were talking with Shirley Goodwin, at the UK Public Health Association Conference Dinner in March 2005, about a Wellcome oral history seminar on public health in the 1980s and 1990s, which she had participated in. We talked about how important it was for these things to be documented to reveal the history of important developments. A few glasses of wine later, we’d agreed to try and pull something together which would lead on from this, covering the emergence of multidisciplinary public health.

David Evans: It started there indeed. I’d been thinking about doing something like this and it was a very serendipitous meeting because Teri had been wanting to try and celebrate the achievements of the Multidisciplinary Public Health Forum and I’d actually started doing interviews with a few key individuals as part of a very small scale research project around this. Suddenly we thought, well actually, there’s an opportunity to bring a lot of voices together. We put in a bid to the Wellcome Trust asking for a small grant to fund people’s travel and the lunch, transcription of tapes and so on and they were very kind and gave us that grant.

In terms of the aims, there were three things we wanted. To bring the key people together so we could actually do the second thing, which is to document the origins, context and development of the rise of multidisciplinary public health in the UK. We also wanted to create a space for some critical analysis and reflection, both today and also, in some future collaborative writing we all might want to do.

Judy Orme: Thank you that’s very helpful. So the way we’re going to structure this is that we’re going to move through the series of questions that you have on the programme. First of all, looking at the historical context through eyes of multidisciplinary public health and asking the question, ‘Where did the change come from?’ Then asking a question: ‘How did the change begin?’ That should take us up to lunch time and then after lunch we’re going to focus a bit more on education and training and on the roles played by the role of Faculty of Public Health Medicine, Department of Health in England and other UK health departments. In the final part of the day we’ll think about the lessons from this history for future policy and finish with discussion about the documentation process and how we want to end up in terms of seminar reports from this event.

We’re going to move through these areas for discussion by having a very short five minute or so introduction from somebody around each of these areas and then open it up to discussion after that. Can I hand over to David then to introduce the first section, the historical context for the rise of multidisciplinary public health?

David Evans: Thanks, Judy. I am going to introduce this very briefly with three observations which hopefully will be a useful context for the rest of our discussion. The first is that I think there’s been relatively little historical research on the professions of public health in the UK in the latter half of the twentieth century. I haven’t done a systematic literature review on this, but in terms of what I’ve managed to collect, other than the work of

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8 Berridge et al (2006)
of Jane Lewis which I’ll mention in a moment, what I’ve had are a number of tantalising glimpses. For example there’s a very interesting book that Dorothy Porter edited⁹, on social medicine and medical sociology, and there’s a chapter in there by Margot Jefferys in which she talks about the origins of the Faculty of, as it then was, Community Medicine, and the debates which went on then around whether or not the Faculty of Community Medicine was going to be multidisciplinary. In the end the decision at that point was that it was going to be a membership restricted to medical doctors. The report on the Wellcome witness seminar on public health in the 1980s and 1990s,¹⁰ which hasn’t been published yet, will also give us some glimpses, but my fundamental point is that I think this area has been really under-developed in terms of historical research.

To my knowledge the most substantial historical work has been that of Jane Lewis, in her book What Price Community Medicine?, published in 1986¹¹. There are a few other articles and chapters that she wrote in the late 1980s up to 1991,¹² which focussed on the history of public health medicine in the twentieth century and I think that is really important context. What she tells is a story, starting with a shift in 1974 from the public health function in local government with medical officers of health managing quite large units with health visitors and environmental health people and so on, to the role of the community physician in the NHS which was, I think she suggested, a shift from a kind of managerial role to an ill-defined advisor or co-ordinator role, and then lots of changes to that role with the general management reforms of the mid 1980s. That’s a really important context, but her work really doesn’t engage with the role of other disciplines within public health, so I think that’s an important place to start. I think one of the key things that she does is to identify what she calls a continuing identity crisis and a central paradox in public health medicine. I just want to read you a key quote from a 1991 chapter of hers¹³, “if public health is about the health of people, then much more is involved than medicine ... Yet any such widening of public health’s focus threatened to weaken an already weak speciality further.” I think the tension was between the NHS public health function focussing on health care and the service-side, as opposed to the ‘new public health’ which focussed on the inequalities agenda and the wider determinants of health. She sees that as a fundamental tension and paradox in public health medicine and I think that that’s a useful tension to identify in terms of the development of multidisciplinary public health.

The third thing I wanted to point out was that the first Acheson Report in 1988 on the future of public health function¹⁴ is, I think, a key moment in the history of multidisciplinary public health. I re-read that report recently and it’s quite interesting in that it’s got a rhetorical commitment to multidisciplinary public health but doesn’t actually operationalise that. It seems to me that you could actually do quite a useful discourse analysis of that document, because there are a huge number of assumptions around the role of medicine and the role of other disciplines. So, although there are a number of rhetorical statements about the importance of multidisciplinarity, actually the assumptions are that public health is led by doctors and other disciplines, other

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⁹ Porter (1997)  
¹¹ Lewis (1986)  
¹² Lewis (1987; 1991)  
¹³ Lewis (1991, p. 197)  
¹⁴ Secretary of State for Social Services (1988)
professions, are in support roles. I think it’s notable that one of the key recommendations which was actioned out of that report was the re-naming of the speciality from Community Medicine, to Public Health Medicine, at the same time that it’s saying that multidisciplinarity is key. I think that the report really captures a lot of the tensions around 1990 and the beginnings of some of the things we’re going to talk about. So in summary, my view is that we have an NHS public health service, which until at least the mid 1990s was dominated by public health medicine. There were fundamental tensions within the wider health system about the role of public health medicine within the health service and also hidden tensions about the role of other professions. That debate, until at least the mid 1990’s, was hidden rather than taking place in a very public way.\footnote{In June 2006 David Hunter commented: “I’m surprised there is no mention in this historical account of Holland & Stewart’s (1998) review of public health. Holland and Stewart, inter alia, bemoan the change of name from public health to social and preventive medicine and then officially to community medicine. They claim the multiplicity of names created confusion and demoralisation within the speciality. Their chapter on where now for public health would seem especially relevant for this exercise.”}

**Judy Orme**: Thank you David. Can I open the discussion out now for people to make comments, ask questions, give their views?

**Ian Gray**: I don’t think the tensions were hidden if you worked in local government under a medical officer of health. I think the tensions were very obvious in those authorities where the MOH carried total responsibility for public health without having a detailed understanding of the areas, and in some cases without even an interest, in what they were representing. A classic experience for me was the MOH making decisions on whether premises in a slum clearance area were fit or unfit and would be condemned and pulled down, not having visited any of the properties in that area and relying totally on the local authority staff to give the real evidence. I think there was a real tension there.

**Klim McPherson**: I think similarly in academic public health, which is where I started, the tensions were manifest. When I started my career there was no ambiguity about the role that people like me should fulfil, that was, strictly as a support staff role. There were clearly two tiers of seniority but not of competence. Folk who were doctors, whether or not they understood the issues at all, had very secure jobs, much better training, much better accreditation, much better futures. Many others didn’t have tenured jobs and were clearly there to serve the interests of the dominant profession. I think the tensions were manifest but what was interesting about those tensions was that it was very accepted. It was only when you began to get a little more senior and interested in your own career, as opposed to doing a good job doing what you were doing, that the tensions became something that had to be dealt with.

**David Evans**: I wasn’t trying at all to say that the tensions weren’t manifest for those people who were involved in them. What I meant was that in both the history that has been written and in terms of the policy documents that emerged, it was hidden. I think in terms of the lived experience they were very real.

**Klim McPherson**: I think it’s interesting that it was thought that a weak speciality was frightened of becoming weaker as a consequence of opening itself up. I think that’s clearly a dominant theme throughout the whole of the development of multidisciplinary public health. It needs to be properly explored because I think it’s still dominant. I believe it wouldn’t be made weaker, but stronger.
Robert West: We have in the history that the Faculty was thinking in terms of being multidisciplinary from the outset because several of the founding fathers were members of the Society for Social Medicine and so on. Yes, the discussion was there, but I don’t think they tried terribly hard and I think they did perceive that the way to get credibility was to get attached to the Royal Colleges and that meant being medical. As Klim said, those of us who were around at the time were expected to be supporting the officer’s move into a new club.

Yvonne Cornish: I came into public health just after the Acheson Report of 1988 was published and I think it was actually written into the circular that implemented it, that there would be a director of public health, supported by a multidisciplinary team. I came in as a researcher working under the director of public health. Where I worked the director of public health built this supporting team, a nice multidisciplinary really good and vibrant department, but it was very much a hierarchical department. Trainees came in and we helped them develop and they moved on and up. Then we said, “hang on, what’s happening to us?” and started to think “there’s a bit of inequality going on here”. That led us, where I was working down on the south coast, to start discovering other people in the same sort of situation and we started to build our own networks in parallel to the networks trainees and the other professionals had which we were excluded from. In the South East, around Sussex and Kent, we built quite an ad hoc network and then I later discovered a similar network in the West Midlands, which is where Lillian Somervaille and I initially made contact. Suddenly we realised these little networks were building up spontaneously, because I think there was a real shortage in public health capacity at that point in the NHS, and so people were drawing in non-medics to boost their capacity. But then there was no career structure, there was no training, there was no way of progression and there were no kind of professional networks for us to become part of.

Shirley Goodwin: I started ‘health visiting’ in 1971 and I was employed by the London Borough of Ealing and I was part of the Department of Health and Welfare, which was headed by the medical officer of health, who was also the deputy town clerk. Now I was a lowly health visitor and I don’t remember anything much about him other than that he was a vaguely inspiring figurehead for us. He was in charge of everything, social workers, of course they weren’t called social workers they were called child care officers, and various other kinds of welfare officers and of course public health inspectors. There was a very dynamic woman who had been a health visitor, Nancy Zinkin, who had persuaded Dr Ian Seppelt the MOH that she should be a health education officer. She was a fantastic woman in many ways and I reckon that most of the public health that went on, other than the technical public health, was probably under her influence because she was working to a social model of health and pushing that line of thinking. As a new health visitor that’s the area that I picked up on. I didn’t look to medical leadership in any way whatsoever. In fact medics, mainly in the person of GPs, were more an opposing force to a lot of things that we wanted to do. I remember something else that was going on in the seventies, there was a whole alternative movement in health, which wasn’t called ‘public health’, it was called ‘community health’. There were community health ground level organisations such as the Albany Project, which people like me looked to, for the model of how we should be working. That was the direct line that led
to things like Alma Ata\textsuperscript{16} and Health for All\textsuperscript{17}.

**Jenny Griffiths:** My introduction to what I now call public health was actually through health promotion. In terms of the paradigm for this part of the seminar, it's whether we see it as the medics 'opening up' and acknowledging the contribution of others, or whether we see it over as the development of several parallel professions. Environmental health is absolutely crucial, health visiting as well and I would say also health promotion. If you go back to the history of health promotion you've got 'Health for All'\textsuperscript{17} being launched by the World Health Organisation in 1977 you've got 'Alma Ata' in 1978\textsuperscript{16} and you've got the Ottawa Charter\textsuperscript{18} in 1986, for me the most important defining moment for health promotion in public health in my working lifetime. And then you've got the theory base being built up by a wide range of highly respected academics in the 1980s - Adams, Caplan and Catford and all the rest of those luminaries in the field. Parallel to this was the development of health promotion, from its emergence as a profession, to its virtual eclipse in the last few years and its hopeful re-establishment now as a discipline within multidisciplinary public health. A lot of the underlying concepts of health promotion have been brought into the ten key areas of public health. So we're seeing it becoming mainstreamed as a contribution now along with community development, community empowerment, and those sorts of ideas. I think it's very important to document that and to document what was happening in health visiting and in environmental health at the same time and not just to see it from the point of view of medics. There was very little contact really between medical public health and these other areas and where there was, it was largely full of tension.

**Peter Farley:** I support Jenny's analysis, but there was also another player that I don't think we can afford to forget, that came immediately before health promotion, and that was health education. Education was part of the more holistic locally driven, local government-led function, but it also had its own national support. There was the Health Education Council and before that there was the Central Council for Health Education. So there was that whole tradition which is very well described in a book by Ian Sutherland on the history of the Health Education Council.\textsuperscript{19} I think it was called *Health Education, Half a Policy* or something like that. He takes the story up to the abolition of the Health Education Council and the instigation of the Health Education Authority which was a different animal again, but which must still have been effective because they kept getting rid of the chief executives as they got into difficult territory, like sugar.

**Ian Gray:** I want to mention another stream of activity in the seventies, the big campaign groups who were identifying the health consequences of environmental issues, such as Greenpeace, Friends of the Earth. There was also a group I joined called ‘British Scientists for Social Responsibility’, I don’t suppose that one's still going! But these were having an effect, not just in forming populist opinion but in terms of influence, for example, on the Royal Commission on Environmental Pollution\textsuperscript{20} that actually brought about law on all kinds of things.

\textsuperscript{16} WHO (1978)  
\textsuperscript{17} WHO (1981)  
\textsuperscript{18} WHO (1986)  
\textsuperscript{19} Sutherland (1987)  
\textsuperscript{20} Royal Commission on Environmental Pollution (1971)
Mike Shepherd: I started in 1987. I think why I was employed was because there was this huge information technology revolution going on and certainly within Bristol there were no skills available within public health, or community medicine as it was then. So the first day I came into work I was faced with two computers, kind of dusty, which had never actually been set up and a printer sitting between them that nobody had any idea of how to use. So my first job was to establish information technology within public health in the South West. There were other people, David Prothero in Southmead and Paul Ewings in Somerset in particular, who were doing similar things, adding data analysis and research into community medicine. So what was happening was that the doctors were recognising that actually they didn't know everything and they needed some skills from somewhere else. It was very hierarchical even then. We started developing networks and questioning why we weren't invited to the regional community medicine meetings. I think it was because they were about identifying how the medics could get the skills they needed to take things forward and to stay up-to-date with IT and information development.

Judy Orme: Thank you, I think that does move us very clearly into the next question which is, ‘Where did the change come from?’ Teri would you like to say a few words to introduce us into this section?

Teri Knight: David and I felt that change perhaps built up from lots of individual beginnings and has persuaded me to start us off with my personal story. So my personal beginning is with my studies in Human Biology, at Oxford ‘Poly’, from where I graduated in 1983. I’d taken as part of that degree a module called ‘The Health of Man’, which, looking back on it now, was basically like an ‘introduction to public health’ course. I thought it was fascinating. At the same time I was Secretary to the Biology Society and one of my duties was to engage an external evening speaker every term. As part of my work for an assignment for this module ‘The Health of Man’ I’d read a paper by a chap called Richard Doll about ‘prospects for prevention’. I thought it was a fantastic paper – it held me spellbound. That was a major milestone in my life; sitting there in the library I thought “this is what I want to do with my life”. I looked at the small print on the paper and realised that this chap worked just down the hill at the University. So I rang him up and said, “look, we need an evening speaker, will you come and give us a talk about this prevention stuff?” And great man that he was, he agreed. He came and gave us a brilliant talk to a packed lecture theatre. I hadn’t realised he was rather well known! Anyway, another of my duties as Secretary was to take the speaker out for a meal afterwards. So we went to a pub, I put his pint down in front of him, drew up a stool and said “Can I have a job? I want to work with you, I’ll do anything, any job, but please can I come and work in your group?” So that’s what I did and I worked on gastric cancer with a lovely person called David Forman and graduated from Green College in 1988 with a PhD. As a foundation for a career in public health I couldn’t have had a better beginning.

The Cancer Epidemiology Unit we worked in was next door to the Community Medicine Department and during my time there I was privileged to work with many well-known respected public health researchers and epidemiologists. People came from all over the world to work there or give talks and although my field was gastric cancer it was impossible not to learn something about the whole breadth of public health research. I’d like to just take this opportunity to pay tribute to Richard Doll,
sadly no longer with us. He was always a great supporter of multidisciplinary public health. He always took time to encourage and support me in my personal career and I think he also played a part in the widening of public health. After my PhD I took on two post-doctoral research contracts of three years each, one working on heart disease in Bradford, a bit of a contrast to Oxford, but a great experience and then one working back again on gastric cancer at Keele University. By then I’d done over ten years of research in public health and so I decided that it was about time I tackled the difficult bit, putting all the research into practice and working out how to actually prevent ill health. I moved to North Staffordshire Health Authority, to lead their ‘Coronary Heart Disease Prevention’ programme. It was during this period that I first encountered the ‘closed door’. I was working alongside public health medicine colleagues but I suddenly realised that a recognised career in public health was not open to me. Not because of lack of ability or potential, but simply because I didn’t have a medical degree. I wasn’t even allowed to sit the Faculty exams to prove my point. I felt very much like a second class citizen, never to be allowed in the first class compartment even though I had the money to buy the ticket. I felt the system wasn’t fair and didn’t best serve public health because it didn’t recognise and use effectively all the skills and experiences available. Public health is clearly a multidisciplinary team function, I couldn’t see how anyone could argue differently. It made me very angry and as ‘knocking on the door’ hadn’t worked it was obvious that I’d have to dig underneath it. I cast about looking for where the next step was going to be and decided to study for a part-time Masters in Public Health at Birmingham University, the first year that it opened as a multidisciplinary course.

I was lucky enough to be funded for this and given some study leave and graduated in 1996. Around the same time I joined the Association for Public Health and stood up at my first Annual General Meeting and asked "Was the APH going to lead the way in challenging the inequity in public health careers?" As is often the case when you put your head above the parapet, they said “Yes, we should, would you like to do it?” So I set up an APH working group and we wrote a discussion paper and I did a little tour and spoke at different workshops and APH and other meetings. I found many allies, some that are around the table here, but also had to face the wrath of those who were just totally opposed to the concept. About that time I met Lillian Somervaille and became involved with the Multidisciplinary Public Health Forum, but that’s where we are going in the next session, so I’ll finish here so we can hear about other personal beginnings.

**Judy Orme:** Thank you Teri. Are there any other contributions, views or perspectives on where change came from?

**Shirley Goodwin:** Well, here’s a little more personal history. In 1990, which was the beginning of the internal market, Diana Walford, who was one of the Deputy Chief Medical Officers at the time, made a speech and in it, talked about the importance of multidisciplinarity. Now at that time I’d just finished working at the Health Visitors Association full time as its Director/Chief Executive/General Secretary and was hoping to do a Masters degree in something relevant to consolidate my public health background. I couldn’t apply to the public health medicine masters degree at the London School of Hygiene because it was ‘closed’ to non-medics at that time, so I applied for a place on the Epidemiology Masters. I was dissuaded by Martin
McKee, who was running the Public Health one. He said “come on Shirley, you don’t want to do that, come on the public health masters which will start admitting non-medically qualified people at the 1992 intake.” I then went back to Dr Walford, and wrote a letter to her asking her to elaborate on the commitment she had made in her speech, pointing out that there was not a route for someone like me to get onto a public health training programme nor any funding, even if it was now possible to do the master’s degree. And she wrote a sort of ‘oh yes, sorry’ letter back. I was then invited to do some work for them [the NHS Management Executive] on community nursing and GP fund-holding. After that I applied to every source I could think of until I got funded. I managed to get money from various sources including the Women’s Unit at the Department of Health – they had set up a bursary scheme, particularly for nurses but also other disciplines and I started the Masters in Public Health in the first year that they took non-medics. I had to do the course as an independent student, so to do my policy dissertation I had to make up a fictional health authority because I wasn’t employed by one! But once I’d finished the course I’d nowhere to go. Then, fortunately, somebody rang me and said come and work for us – and that’s what I did, working as a ‘commissioner’, not doing public health. To this day I have never been able to complete any training in public health. By the time I came back into public health in a full time post, which was 1998, I had missed the boat in many ways. Although I was regarded by my colleagues as equivalent to them, termed a ‘Senior Public Health Specialist’ by my Director of Public Health, I didn’t actually have quite a lot of the skills and knowledge that I would have needed to actually operate as one. The job title was more a courtesy than a real evaluation of what I could bring. I had done the Masters degree, but I had never been able to consolidate the work. If I hadn’t been so close to retirement I would have certainly gone for the ‘Voluntary Register’ route, but it came just a bit too late for me.

Judy Orme: Thank you, two very interesting stories. Any other views or contributions?

Mike Shepherd: It’s very hard to credit ‘Thatcherism’ with anything positive, but I think the building of the internal market was really quite important in raising the profile of multidisciplinary public health, because when ‘purchasing’ started, what were to become health authorities were really small organisations and there was the director of public health, maybe a couple of registrars, perhaps one other consultant, a commissioner and me. Suddenly we were part of the ‘top team’ and that actually contributed significantly to raising the importance of the other contributions. Personally, I had been extremely influenced by doing an MSc in Public Policy. I couldn’t do a Masters in Public Health. It was 1990 when I finished, I’d just written a thesis on community development and the contribution to public health and so being able to sit around a table discussing such issues with the medics and a couple of commissioners was very important in establishing public health at that level.

Shirley Goodwin: Can I come back in with an anecdote related to this? Some of the work that Michael did was quite important to me when I moved back into the health service in 1993 as a commissioner. I was commissioning community health services under someone who knew nothing about community nursing at all. I had just done the Masters and learnt about the work of Nick Black and Phil Strong and people like that and this stimulated me into thinking about ‘how do you purchase,
how do you commission, what is it about?” “What do you actually put in the contract to commission health visiting?” It’s not going to be numbers of visits, that’s the stuff we criticized Korner\(^\text{21}\) for. We’re trying to commission outcomes, measure volume in health terms – the sort of work you [Mike] were doing at the time identifying families with special needs, using the existing data collection processes. I was trying to make the connection between what they were already putting into their systems and the staff, to form a measure I could use that didn’t just deal with numerical quantitative aspects of what they were doing, but also some of the more qualitative stuff as well. So I agree with you, some of the challenges that the internal market threw at us, forced us to think about what we were trying to do, it actually forced us into public health mode.

**Robert West:** Klim, Teri and Shirley all pointed out really very clearly, that pressure for change came from the disenfranchised working within public health. The Society for Social Medicine held a meeting in Canterbury around 1976 on careers for people that were supporting research and public health. It didn’t really get anywhere, but it became clear that a lot of the competent people felt that a way of getting tenure, getting promotion and responsibility was to hop into management. This was, in some ways, jumping over the shoulders of the doctors, because the doctors were sort of ‘senior’ scientists, but the people who were really making the decisions were the managers.

**Peter Farley:** I think one of the key parts of the landscape we haven’t mentioned, that maybe we ought to acknowledge, was the ‘Black Report\(^\text{22}\), which probably was one of those things that had more influence by not being published than by actually being published. I’ve still got my typescript copy. For me, it was an inspiration, because it was very clear that you could not address the issues just using the medical model.

**Yvonne Cornish:** I just wanted to add something about where change came from. It seemed to me that it was going on at a number of levels simultaneously. There was this kind of ‘bottom up’ thing going on as departments opened up, and I think you’re right, it was the reforms of the market that actually drove a lot of that opening up. Those departments needed skills around health needs assessment and information which they didn’t have, so they started bringing in people like sociologists, people with information management skills and so on. I’d come in with a degree in Sociology and just completed a Masters at the University of Bristol in gender and social policy. I’d discovered Victorian public health in some of the stuff I’d done in my degree and then I saw a job in it and fell into it accidentally as a lot of us have done. We became a discontented bunch and we started talking to each other and networking and grumbling and realising there were all these barriers. But there was change going on.

After I left the health authority in Brighton I was very fortunate to get a job working for fourteen regional directors of public health. It was a brilliant job. I worked in it for three years and I was initially managed by somebody called Malcolm Forsythe and then later, by Sheila Adam, which was a stunning experience. I’m sorry she’s not here today. It was my job

\(^{21}\) Korner returns from health authorities and trusts cover almost all aspect of a trust’s performance and include details of population morbidity as well as service activity and staffing levels. They are aggregated datasets named after the Chair of the steering group set up to review NHS data collection in England, in 1980.

\(^{22}\) Department of Health and Social Security (1980)
to act as ‘intelligence officer’ for all fourteen regional directors of public health. I had to go round and visit them all, to familiarise myself with what they were doing. It gave me an opportunity to tell them about what I wanted out of public health. I had a real ‘bee in my bonnet’ at that time about the inequality within the profession and lack of opportunity. I can remember visiting Michael O’Brien who was then in Cambridge and was the President of the Faculty and we had a discussion about what could be done. Then I moved to North Thames to Sheila Adam’s department, still doing the same job. Suddenly this questionnaire appeared on my desk from someone called Dr Lillian Somervaille, who I assumed to be a specialist registrar, asking about my training and post. I contacted Lillian and found out that she’d been asked to do this piece of work by Rod Griffiths, on behalf of the Faculty, so something was clearly going on in the Faculty at the time. Later on I worked with June Crown at the South East Public Health Institute and she was President of the Faculty at the time and so I was able to constantly get the message across to her. So it seems to me that there were a number of us all trying to get the same message across in lots of different places and ways. There was a sort of change in the ‘zeitgeist’ almost and the number of people in this group grew and grew and people were influencing wherever they could. But it was a message that was increasingly beginning to be heard wasn’t it? So it seems to me that it was very much kind of ‘top down’ as well as ‘bottom up’, people at the ‘top’ were picking up the message and running with it.

Ian Gray: I think there’s a need for a time-line on this. A key document for me was The Nation’s Health\textsuperscript{23}, Bobbie Jacobson’s report, which clearly identified that the medical profession couldn’t do it alone. It was very much a document for the medics really but those of us outside medicine, even trade unions, started to grow an agenda as a result of it. It was followed by The Health of the Nation\textsuperscript{24} and then by Our Healthier Nation\textsuperscript{25}. Having an explosive government agenda for public health meant that those of us in local authorities were able to map what we were already doing against that and have it valued and we were doing some very significant things. I worked in Hackney, where the inequalities agenda was a very important agenda, a health agenda but also a political agenda - it was about welfare rights, it was about education campaigns, housing tenure and so on. All these agendas had health consequences and benefits. Sian Griffiths was the Director of Public Health then and she was very receptive to this idea that we were all working together. What she was able to do, I don’t think it was the fact that she was a doctor, I think it was just her personality, was to raid the joint finance arrangements, which in most areas were absolutely owned by the Director of Social Services in conspiracy with the Director of Public Health. She challenged that and from that we got a fully developed joint structure for public health and primary care and that meant there was money. There had never been money before and at last there was a table you could go to, to discuss money for projects. So that was really important.

David Evans: I just want to pick up some of the discussion we had a moment ago around the impact of the internal market reforms around 1990-91. I was working in a health promotion unit at that time. Before the internal market reforms came in we were loosely associated with the

\textsuperscript{23} Jacobson et al (1991)
\textsuperscript{24} Secretary of State for Health (1992)
\textsuperscript{25} Secretary of State for Health (1999)
public health department and did quite a lot of joint work with them. When the internal market came in the clear view was that the place to be for health promotion and public health was with the purchaser, that if we were placed within a Trust or Provider unit we would be really marginalised there. But that’s what happened and it was a very disempowering experience for those of us working in health promotion because our manager, who was line managed by the Director of Public Health, went into the purchaser organisation and the rest of us were put in a large teaching hospital Trust in a very small community unit. Immediately we had our very small budget slashed by about 20%. By then I wanted to advance my career and I went for promotion in another health authority where I was doing HIV sexual health work. The HIV post was in public health in the health authority rather than health promotion in the provider unit and that was when I really started to understand some of the tensions and contradictions. I was initially managed by the director of public health but he wanted me to be physically located with and managed by the health promotion manager. I fought that quite hard but that was what actually happened to me and my compromise was that although I was physically located there I would continue to be managed by the director of public health, but in fact I never saw him, didn’t get proper support, supervision, professional development and so on. Then there was another re-organisation and there were lots of big meetings of all the public health departments around the county taking part and I realised I didn’t have a voice in them. I wasn’t quite as courageous as Teri and some of the other people around the table and I opted out and went off to a university research post because I could see that people like me had no status and no voice within these re-organisations. So I think the internal market was very important. For some people it opened up new avenues but for others it was a process of real marginalisation.

**Judy Orme:** Jenny, did you want to say something?

**Jenny Griffiths:** Yes, two entirely different points, one rewinding way back to the 1970s, which is when I started work in the Unit for the Study of Health Policy under the leadership of Peter Draper. There was a report on rethinking community medicine, which I was involved in at the time as a research assistant, which certainly shaped the rest of my life. The report provided a very important intellectual base, underneath what was then community medicine, opening that up to the determinants of health and economics. I just wanted to log that on the timeline really because it’s still cited in the literature even though it’s nearly 30 years old now. Then going forward to the 1990s, I wanted to pick up the debate about the importance of the development of purchasing, commissioning and the internal market. I became General Manager of Oxfordshire Family Health Services Authority in Oxford in 1989. We set out to have an impact on public health from our primary care base, which is those days was quite new, and to really use the new GP contract to achieve that. There was some very important work going on which has developed ever since. My other point was that purchasing/commissioning was a brand new idea. It bred a generation of chief executives and managers, who, for the first time in the history of the NHS, took population health seriously, rather than just focusing on provision of treatment and care services for

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[26] Unit for the Study of Health Policy (1979)
individuals. Although the development of commissioning was very varied and although it was, I agree with David, very damaging for many in health promotion, overall I think when you look back to those years, they were very fundamental in positioning public health and health promotion centre stage within the NHS and in educating and developing a cohort of managers and chief executives who really understood what population health was all about. It also led to my involvement in supporting the development of multidisciplinary public health, because it seemed a seamless process to me, that if population health was important to health authorities, then it required the contribution of a wide range of disciplines. That seemed common sense to me coming from the outside with no baggage.

Klim McPherson: All my relatives were doctors, every last one of them, therefore the last thing I wanted to do was medicine. I wanted to do public health, so I did maths and then I did a PhD at the London School of Hygiene and Tropical Medicine starting in 1967. I then got a job in the Medical Research Council at Northwick Park, then after that I went to Harvard for two years, which was completely traumatic for me, but seminal. We had weekly seminars on issues to do with healthcare provision and its variation and its utility and effectiveness and I became completely traumatised by the notion that medicine wasn’t entirely a science, that it was in many respects a rather badly and arbitrarily practiced art. It became a complete obsession for me. Anyway, when I came back I decided that, because of the hierarchy in clinical research, it wasn’t really for me. I thought the place to be was in public health, so I then applied for a job in Oxford as senior lecturer in medical statistics in public health. I thought I didn’t stand a chance in hell of getting it but I did.

Then I met Sheila Adam and Richard Doll and all the other folk. It was just at the time when the Faculty was starting off and public health medicine was beginning to consolidate itself as a specialty. They were very very anxious then that they should become a widely regarded, esteemed specialty. As some of the recorded history indicates, there was some discussion that the Faculty should be open. There were many people like Margot Jefferys, Ann Cartwright and others saying you can’t do this without it being an open specialty, but there was also a feeling that they ought to be widely regarded and esteemed and, to some, that meant being consolidated with the Royal College of Physicians, so they felt they couldn’t open the Faculty up because it was felt that that would weaken them. So they opened the Faculty of Public Health Medicine which was very very tightly controlled and ruled, but which was seen as being quite appropriate in the circumstances. I didn’t actually have a view about it because, frankly, I didn’t even know about it. It wasn’t much discussed in any sort of public sense. Occasionally you’d see the six people from your department who’d disappeared for four days and I’d think “well, where did they all go?” And then they’d come back and I’d say, “where’ve you been?” and they’d say “well, we’ve been to a conference”. I’d ask what conference they had been to and they’d say “oh, it’s called the Faculty of Public Health

27 In June 2006 David Hunter commented: “I have enormous respect for Jenny and usually agree with all she says, but I do not share this assessment. She may be reflecting her own experience which I suspect was not common. I was a non-executive director of Leeds Health Authority between 1990 and 1999 and I saw no evidence whatsoever that chief executives occupying strategic commissioning roles paid more attention to public health. Quite the reverse. The sad thing about this period surely was the lost opportunity for public health and the failure to seize the initiative. Even directors of public health lost their way at this time as they became locked into an essentially reductionist manageralist and clinical NHS agenda – a development noted with regret by Holland and Stewart (1998, p. 202).”
Medicine, it wouldn’t interest you.” I began to think, “well, they all went to this conference, which is all about what I do, and yet I know nothing about it”. I’d raise this with the right person and ask if I could go and they’d say “No! It’s very poor, its very bad quality Klim, its very boring Klim, you wouldn’t want to go to it Klim.” So I was made to feel foolish about making an issue about it, so I didn’t make much of an issue about it.

But then gradually I began to understand where the power structures and the influence lay and where the contacts were and where networking took place and all the rest of it and I realised it was central to my core interest but that it was all happening somewhere else. I began to ask questions and then suddenly I got a letter from the Faculty saying that I was going to be the examiner in medical statistics. At the time I was busily training a lot of these people and it was quite clear to me that the level of competence they had to achieve in statistics was not very serious. I was teaching my kids as well and it was clear that the level of attainment was just not parallel. Anyway, I got this letter saying I had been appointed and the tone of the letter was, at last Klim we’re opening a door for you, here’s a privilege, here’s access to this august body that you’ve been wanting to join. I thought, wait on, that’s not the tone that’s appropriate here. I don’t want to be told its going to be an honour and a privilege to do this work, if you want to find somebody who wants to examine medical statistics, find somebody else. Proper involvement is proper involvement and I don’t want to be told I’m going to do it. They were completely shocked by the idea that I didn’t want to do it, they thought it was an honour and privilege. So discussions with Michael O’Brien and other people started taking place and I got slightly stroppy and said “it’s silly, why don’t we do something about it” and they said, “we want to do something about it” and there was a lot of support for this. The bottom line of course is that in the end you can’t resist the argument of multidisciplinarity in public health, it’s got to be multidisciplinary. The idea that there should be these ridiculous barriers and hierarchy is an anathema, to everyone and so they all said “yes, yes, but we’re constrained by our rules and our bylaws and all the rest of it”, as they indeed were. So they set up this thing called the Scientific Advisory Panel, which was meant to be an in-road to folk like me into the Panel. It had a lot of quite eminent people on it and we basically sat and discussed issues of science related to public health and public policy. It was constitutionally weak and sadly it didn’t do a great deal but it opened the door for further discussions about issues to do with honorary membership and all that.

Of course different presidents had totally different views. When Rosemary Rue, who was an extremely close friend of mine, became president, she summoned me up and said “come on Klim, what’s your agenda?” I said that my agenda was to make public health egalitarian and meritocratic and there shouldn’t be these silly barriers and people who want to do good work in public health should be able to do it without completely arbitrary barriers and she said, “I’m afraid that’s just not going to be possible.” I said “why not?” “Well,” she said “it’s very important that public health and health services, should be run by doctors, otherwise it’ll have no credibility. We’ve got to maintain that value.” I said, “well, that’s ridiculous, I have credibility and other people have credibility. It’s not something that’s bestowed upon one for what one does, and what one says and what one writes”. She said “sorry, it will not work, there’s no way the Faculty will ever do that.” Rosemary was a lovely person, no question about that, she was extremely formidable, but she was
completely stuck on this notion and it took time for subsequent presidents to actually make the changes that were required.

Still, I think a problem for the Faculty, because the Faculty has a constituency and the constituency is its members, is that in my field of academic public health, people join the Faculty because, they argue, without it they won’t get their honorary contracts and their merit award. But, they actually have very little interest in the Faculty because it doesn’t represent anything they want to do or think about. I think we’ve got an awfully long way to go to make public health egalitarian and meritocratic, because what public health really needs is a core organisation concerned about training, a core organisation concerned about advocacy and a core organisation concerned about public policy. All aspects of public policy. At the moment we haven’t got that because we’ve still got this intrinsic division. Of course the voluntary register is a massively important initiative, enabling people who want to do public health to qualify and accredit themselves in order to practice public health. But I think the other thing is that advocacy and public policy development is simply lacking as a consequence of the division that we’re stuck with because of history. I think something yet has to change an awful lot before we get a strong public health force in this country. At the moment it remains weak and it remains weak simply because it’s divided and the hearts and minds of many of the leaders in public health are not involved in this issue of developing public health. It’s quite clear that some of them don’t even understand what the issues are. Some say “Come on Klim, the Faculty’s open, come on, we’ve got the Voluntary Register, what are you complaining about, it’s all fine, we can just go on and do it.” No way, actually, because a lot of people aren’t interested in being part of the Faculty and its organisations because the Faculty, in their view, doesn’t take them seriously.

Judy Orme: Thank you Klim. You’ve raised issues that we will continue to debate this afternoon because we’re looking at the future. What we have done though is move into the next question about ‘How did change begin?’ I’d like to ask Teri and Yvonne just to talk about the origins and work of the Multidisciplinary Public Health Forum which you have already talked a little bit about.

Teri Knight: Yes, we had hoped Lillian Somervaille would be able to be here to talk about this but unfortunately she’s ill, so we’ll get her input later. I’ve written a timeline around the development of the Forum and I’ll begin with the survey that Lillian undertook in 1994. It was commissioned by the Faculty and supported by Rod Griffiths in the West Midlands and it was the first attempt to try and get information on who was out there doing multidisciplinary public health. It used a snowball cascade methodology, the ‘send it on to your mates’ sort of approach and it identified around 1500 people working out there in all sorts of different roles. It described a very chaotic, ad hoc, self-funded scene in terms of the training and education and development from these people. They had all different job titles, paid different salaries and were working in different places. It was a real catalyst because it gave you strength in thinking, you’re not alone - one of the things people identified in the survey was this sense of isolation they felt. It was a very important piece of work. At about the time the survey was finishing, Lillian pulled together a group of people that she’d come across, who were speaking out about this, to organise a workshop on multidisciplinary public health, to be held in Birmingham. She invited me, Klim, Amy Nicholas from the NHS Executive, John Fox and Yvonne
I remember Lillian travelling all over the UK to seek the views and experiences of people and to seed the development of multidisciplinary public health networks in those regions. That’s how we uncovered these informal networks that were already starting and it was an attempt to try to bring people together and give people the strength of having contact with others. We also wanted to get consensus and a shared approach to try and challenge the inequities that we’d been talking about. We produced reports from all these regional workshops and they fed back to a second conference in Birmingham that was held in April 1996.29 At this conference, the group that had organised the conference were mandated to form the ‘national core group’ of what was to be called the Multidisciplinary Public Health Forum and this was described as, and I quote, “a national group which will be built upon strong local networks and which will act as a catalyst of change”. The main objectives of the forum were agreed at that conference. The ‘national core group’ was charged with reporting back on progress the following year. John Fox became the Chair of the group and we called in people to act as representatives from all the regions and nations and set about working on the objectives. We held a third conference in Birmingham in April 199730 and the core group were charged with carrying on making progress but with an emphasis on trying to work more closely with other key public health bodies. So, towards the end of 1997, the Multidisciplinary Public Health Forum issued a joint statement of intent, between the Forum and the Royal Institute of Public Health and Hygiene, to work together on developing the framework for the development and accreditation of multidisciplinary public health professionals. In February 1998, that joint statement of intent was expanded to include the Faculty and the so-called ‘Tripartite Group’ was formed. This group focused on examining the whole issue of national standards and accreditation systems and it commissioned what we called the ‘feasibility study’, that Klim was involved in, funded by the NHS Executive.31 This study asked the question, “would it be possible to accredit multidisciplinary public health professionals?” And the answer was yes. So that really sparked off all the work that culminated in the development of the Voluntary Register for Public Health Specialists. During 1998 the Forum issued various position papers on the training, accreditation, development and ‘continuing professional development’ of multidisciplinary public health people. By then, the Tripartite group and the Voluntary Register had developed their own momentum and so the Multidisciplinary Public Health Forum focussed much more on supporting and further developing the regional and national networks. There was a lot of variability at that time. Some regions really took off and the networks there were very strong. In others, there was a lot more struggle. Things were also very variable around the UK nations, I’m sure Robert can tell stories of what was happening in Wales?

Klim McPherson: Can I tell a story about one of those meetings? I’ve forgotten which one it was, one of the regional directors of public health was talking about public health and how wide open it was and how everybody knew

Somervaille & Griffiths (1995)
Somervaille (1996)
Somervaille (1997)

Lessof et al (1999)
what their purpose was and that everybody who wasn’t a doctor knew they were in support roles, whereupon there was a great ‘kafuffle’ in the row behind me and Teri said, “you said what!” Of course the person speaking was just reflecting the Acheson 1988 report in which it said that everybody had a support role apart from doctors and she just quoted it out as the way people thought and Teri kind of exploded, it was wonderful!

**Teri Knight:** Yes, well, thanks for that memory Klim! My records kind of get a bit hazy around the beginning of 1999, I was on maternity leave, but there was a fourth national conference held in Bristol.³² Hopefully Lillian Somervaille and of course, Phil Mackie, who both chaired the Forum after John Fox, will be able to add more on what happened at that conference. My paper records go up to the early parts of 2002, 2003. We never actually officially ‘wound up’ the Forum, but it was felt that things were now happening, things were going on, the Forum was always supposed to have a finite life and so eventually we stopped meeting as a national core group although the regional networks continued. Perhaps Yvonne can add something on this?

**Yvonne Cornish:** I also ceased to be involved around that time, because I had a PhD to get finished and was a bit pre-occupied with that, but certainly I would agree with everything that Teri was saying. I think this regional variation was really really strong. Certainly in the South East we’d got quite a good network that I was able to go back to, and I know the West Midlands had had a good network. But when we tried to organise network meetings across the country it was surprising how difficult it was in some parts of the country to get people together. Progress was very very variable wasn’t it? How I got involved was that one of these questionnaires turned up on my desk and I thought “who’s this Dr Somervaille? I think she’s not asking the right questions” and I discovered this absolutely delightful woman who said “why don’t you come and talk to our network and tell us about your network”. So that’s what I did and we suddenly realised that there were all sorts of things going on, in the Society for Social Medicine, in the Association of Public Health, things were growing. So I think the Forum in a sense happened out of that and we kept bumping into the same people at conferences and up-dating each other with what happened at the last conference and the last meeting.

But there was a parallel process also going on in the Faculty, because at the time we were running regional workshops and organising another conference, there was a Faculty vote. I was then working at the South East Institute of Public Health and the director of that was June Crown, who at that point had just taken over as President of the Faculty. There was a Faculty vote on opening up membership as far as Part 1 was concerned and the membership voted against it and I can just remember that being reported back to that conference and everybody then saying “well what do we do next?” And we, the national core group, decided to just keep on going, reporting back to another conference on what we had done and saying “shall we stop?” and people kept saying “well no, we think you need

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³² In June 2006 Phil Mackie noted “I can confirm that Liam Donaldson was the keynote speaker at the 4th UK Multidisciplinary Public Health Forum meeting in Bristol. At the meeting Liam elaborated the definition of public health workforce. The 4th meeting was hosted by Gabriel Scally (South East Regional Director of Public Health) and was something of strange experience as by then the second CMO report was out, Saving Lives Our Healthier Nation had mentioned the “glass-ceiling” and the die was pretty much cast.” Yvonne Cornish commented independently at this time that “this meeting was held on 14 April 1999 in the Wills Hall, University of Bristol. Liam Donaldson spoke on ‘Developing the Public Health Function.’”
to do something else” and we kept coming away with another year’s work. Jenny Griffiths got very involved at one point and was brilliant at doing an action plan for us. That really helped us move forward because we’d always have these debates about how much to formalise this group. There was lots of tension about whether we became a separate organisation and further fragmented public health, or whether we tried to work through all the organisations we were part of. We kept coming back to not wanting to start another organisation, not wanting to further fragment public health by setting up another professional body, but trying to act through our existing organisations. So we had a lot of meetings with other organisations. With some there were great consequences, such as with the Royal Institute of Public Health and Hygiene, that was very successful, but there were one or two other groups that we got involved with who looked as though they were taking us forward and then they themselves imploded, which was quite sad because we wondered whether our negotiations with them had caused them to fail!

Klim McPherson: One important thing about that questionnaire which I remember very vividly, when it arrived on my desk from nowhere, was that one of the key questions in it, was, ‘is the Faculty of Public Health Medicine the kind of organisation you’d like to join?’ or words to that effect. To which the answer was ‘no’, but that wasn’t the expected answer, the expected answer was ‘yes’. So I took it up with Lillian and asked her “why do you ask this silly question, of course we don’t want to join the Faculty!” Lillian reassured me that the question was not so much about the Faculty as it then was but more about how it might become. The rest is history.

Paul Scourfield: It’s interesting really, the vote [to open up the Faculty] failed in 1996 and I’d always thought that my appointment to the Faculty was something to do with that vote. If you look round at people who’ve got my role in other colleges and faculties, they’re always ex-RAF, ex-Naval, retired and so the Faculty actually took quite a risk by recruiting me. I’d been a public health specialist for 12 years in two districts and listening to some of the other experiences, I think I’ve had quite an easy ride, because I was in a very progressive department that actually promoted me and enabled me to develop, and I was treated the same way as all of the trainees. In fact I ended up managing the trainees somehow. So I think the Faculty wished, after the vote had failed, to demonstrate that they had a commitment to multidisciplinary public health and they saw me as being part of that. So there was some good out of it, certainly on my part. But we actually had honorary members from 1991, Klim.

Klim McPherson: I was the first to join, I know that. At my age you can forget a decade!

Paul Scourfield: But going back to what you were saying Klim, I think there is still a long way to go but I do think there is a lot of foundation put in place now to enable us to go forward. It’s very difficult when you have a medically dominated organisation that has to rely on a ballot to change anything and with a weak speciality, or perceived weak speciality within the medical hierarchy, you’ve got a lot of frightened members out there. It took a lot of persuading, cajoling, convincing that this was the right way to go and I know Mike O’Brien had some difficulty with his presidency, June Crown continued that. So it’s taken a long time. If you go back to when the Faculty was actually started and you look through some of the early documentation and some of the meetings that took place, there was always an intention for the
Faculty to become a multidisciplinary organisation, and Michael Warren’s ‘genesis of the Faculty’ documents this quite well.\footnote{Warren (2000)} We have got the archive documents. It’s just taken 30 years and I wasn’t there then and I’m not sure if it was ‘sort out the medics and then we’ll move on’ or what the reasoning behind it was, but it’s taken a long, long time. We’re sort of there now, or part there, but there is still more to do.

Yvonne Cornish: But presumably it went off the agenda and came back again later, a bit like a lot of the other things we were talking about, the origins in the 1970s etc. I teach the history of public health and health promotion now and it seems to me that it keeps getting on the agenda and sliding off and people have to come and put it back on the agenda again.

Ian Gray: Why was it called the Faculty of Public Health Medicine then?

Paul Scourfield: It was Community Medicine originally.

Ian Gray: But it held on to the ‘medicine’? I’d like to read about alternative titles if there were any?

Judy Orme: Jane, you wanted to comment didn’t you?

Jane Royle: Yes I did want to come in, but I’m not sure if it’s now or later on the agenda where it comes in? The contribution I could make could also come under ‘education and training’. But I think one of the key catalysts for change linked with the Multidisciplinary Public Health Forum was around other education and training events. When I was working in the South West during 1998-2001 we ran inter-professional education and training events for public health specialists - they weren’t called that then, health promotion people, specialist registrars and consultants. We brought them together and started to do short courses and residential courses, which I think was very challenging. I would like that to be documented and to look at how that’s working now – are there still issues around different people coming to them?

Judy Orme: I think we will continue to debate that this afternoon.

David Evans: Just to quickly validate what Jane was saying, I think things like the South West residential school were important where you actually have a two day event and people stay overnight in the same place and have dinner in the evening. I think that as an outsider, my perception is that it happens a lot in medicine and those para-social, social/professional networks are actually really important in the construction of social identity and further professional networks and furthering people’s career, so I think the fact that you and others generated those sorts of networking social events, on an inter-professional basis, was actually important. It meant that rather than all the doctors sitting down in an evening talking together, people were sitting down in mixed tables and having complex discussions around professional identity and role. It was an important catalyst.

Jane Royle: Thank you, I’m happy to add more detail, more thought and explore what’s happening now.

Shirley Goodwin: There’s something that Jane said that reminded me of something else we haven’t really mentioned and that’s the role of the Public Health Alliance. The PHA was a collection of people who started meeting, I think in David Player’s office at the old Health Education Council, sometime in
the mid 1980s. It was a kind of ‘underground resistance’ movement keeping the flags of public health, community development, health education and promotion as they were then, alive, during the darkest years of Thatcherism. The PHA started in 1987 but its first big event was in the House of Commons on the back of Acheson’s publication in 1988. The PHA was very much ‘grass roots’, it was community organisations, bottom up, single issue protest, fringe groups, all of those, but also with a strong dose of medical practitioners who came from different backgrounds and public health practitioners and academic public health, public health dentistry and so on. It was a real mixture and there were always very dynamic tensions between those different elements in the organisation. When it started off and the discussions were going on almost in secret cellars, the tensions were creative enough and there was enough commitment to hold the whole thing in balance. Once the organisation became formally constituted and the first executive committee ended up with a lot of doctors on it, those people who had been the barefoot community, you know ground swell organisation, backed off and we lost some of the really good people that were in the consumer organisations and community organisations.

Then there was another debate after the ‘new Labour’ got in, about stopping this fragmentation of public health by at least talking to the Association for Public Health and this went on for a couple of years until about 1998 when progress was made and in 1999 the UKPHA was launched. One of the key things the UKPHA tried to do was to operate at a reasonable level by holding events and ‘piggy – backing’ on, as well as stimulating, events, formal, informal, training, educational, whatever, to try and create the organisation, not as a centralised one but as regional entities. And didn’t the Health Development Agency create regional posts around that time? And there were also the regional assemblies starting up, regional offices, so there were a lot of things going on from 1998 onwards which were increasing the likelihood that a lot of very different kinds of people who were working in the wider world of public health would have an opportunity to meet two or three times a year. In London there was the London Public Health Network run by Sue Atkinson’s office, the Regional Director of Public Health and literally anybody could go, it was such an important thing. I would always tell my voluntary sector colleagues who were working on energy efficiency or something and they would be really excited and delighted that anybody who called themselves a public health person was invited to go and they would have a good quality event in a good quality surrounding with a lunch provided and that it was completely free and informal networking. There would be what several hundred people there, although numbers varied. So that to me was when multidisciplinary public health actually felt real because there we all were all standing in a great big room with our plates of food and there was no distinction made between people. You could be an unpaid community worker from the Iraqi Women’s Association but you were taking part in a discussion with one of the people in the office of the Mayor. I can see Fiona remembering it all as well?

Fiona Sim: I set it up!

Judy Orme: Fiona, you wanted to come in anyway?

Fiona Sim: I was just going to pick up on the issue of public health and before that, community medicine, being a weak speciality. One thing that hasn’t come up
yet, is that the sparring partner of the Faculty is the BMA, the British Medical Association, which is a very powerful trade union for doctors. The reason I wanted to mention it is that within the BMA, community medicine and now probably public health, has always historically been a weak specialty. When I was first appointed to a consultant post, you didn’t have parity with clinical colleagues and my post was labelled as ‘specialist’. We were not allowed to be called consultants in the 1980s so we were specialists in community medicine, working alongside our consultant colleagues. The heads of departments were labelled district community physicians, medical officers, area medical officers and none of them actually had a consultant title. So there was probably quite a massive chip on the shoulder of many of the founding fathers of the Faculty about where they were in the pecking order, not only in regard to the Royal Colleges, but particularly I think, in regard to the trade union hierarchy. I found something which I thought I’d share with you now, from a paper that was written in March 1995, so really not that long ago. It was in a report called Manpower in Public Health Medicine, written by and for the public health committee of the BMA. I can tell you that to this day, it is still called the Committee for Public Health Medicine and Community Health. We didn’t agree with this just in case you are wondering. Predicting manpower requirements: bullet point 3 ... ‘some of the work of public health physicians might in future be done by non-medically trained people, but again the extent of this, and its effect on consultant numbers are unknown’.

Now the Faculty had a seat on that committee and it was usually occupied by the President if that person was courageous enough to attend. It’s just worth pointing out the balance within the public health medicine and the community medicine community between those people who really did want to forge relationships and those that didn’t. I suppose I’m really sounding defensive here, but most people did really wanted to forge ahead with truly multidisciplinary public health in the interests of public health but some were really very anxious and felt threatened as a tiny medical speciality. I think even now we know some of these are still functioning in the backwaters of some of the departments.

Jenny Griffiths: It’s an important point that.

Fiona Sim: If I could just add, it will come up later probably, but I think the absence of a trade union for public health specialists, certainly to the work that I’ve been doing over the last decade or so, has been terribly important in terms of the pace at which things have been able to move. I can only say I still have a sadness that despite my best protestations, some people seem to be still believing that professional representation is not necessary, which weakens their national negotiating position.

Klim McPherson: But you’ll be glad to learn I think I represent the Faculty on that committee now. I have yet to attend a meeting but I remain to be further educated.

Jenny Wright: I don't think we should lose sight of the Chief Medical Officer’s report, I think it was 1987, The Public Health Function which actually captured and described the workforce. Also, Saving Lives: Our Healthier Nation in 1999 which stated that there would be new posts of ‘specialist in public health’. I

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34 Committee for Public Health Medicine and Community Health (1995)
35 Secretary of State for Social Services (1988)
36 Secretary of State for Health (1999)
don’t know what the story is about how the wording actually got in, but it is important because all the other changes actually stemmed from that.

Shirley Goodwin: The other thing is that Saving Lives: Our Healthier Nation and the White Paper The New NHS, also floated the health improvement programme. That gave a huge boost to multidisciplinary public health I think. That's sadly gone now, overtaken by another commissioning, purchasing, financially led structure, but I think it was also really important.

Yvonne Cornish: In response to what Klim was saying, I did once, when I was working for the regional directors of public health, get invited along to that committee and taken to lunch and I never worked out why. It really was quite an archaic meeting. I think they were trying to forge links but I couldn’t see where I could make the connection. I also wanted to just emphasise that the regional directors of public health were incredibly useful. I think a large majority of them were signed up to this quite quickly. And I think they were very helpful in things like accessing training budgets and getting networks supported and getting training needs analyses done. I think the regional directors of public health did actually pick up the agenda and run with it. I’d just left working for them when I got summoned to a meeting of theirs by Graham Winyard to report on multidisciplinary public health and what the department ought to be doing about it. That’s when Amy Nicholas got involved with it. Amy had been sent along by Graham Winyard, as a Department of Health person, to work with us, infiltrate us, whatever. We were a wee bit wary of her at the beginning but she was a great ally and certainly opened up opportunities. Shortly after I left working for the regional directors of public health, I got called up to Quarry House in Leeds on two or three occasions, to talk to people about multidisciplinary public health and what was happening and what needed to happen. That was right up to around the time of the general election. I’m sure there were lots of other people doing similar things and it was around that time that the regional directors of public health went from being NHS into the Department of Health and they took some of that power in with them.

Peter Farley: I haven’t had to say this for so long, but it’s still true, the UK isn’t England and it does seem to me that listening to the accounts of the last few minutes, we do seem to have been missing something. There’s a lot of regional talk but there isn’t UK talk of the same quality. I’m not totally convinced as an observer from across Offa’s Dyke that there’s even necessarily terribly good English talk either, but that’s for you to say. So, one of the things I should like to put down as a marker, because it is slightly saddening, is that I don’t hear much currently from the Multidisciplinary Public Health Forum and I’m looking for the voices of all of us, at that UK level. The UK Public Health Association, the voice of the public health movement, seems to me to be mostly a conference organising business. Who is engaging across the countries and who is engaging with the government departments? Maybe we’ll come back to that later, but I just put that down as an observation.

37 Secretary of State for Health (1997)
**Teri Knight:** I have some empathy with what you’re saying but in fact the Multidisciplinary Public Health Forum was very very focused on making sure it was about UK, which is why when we started, the workshops were held across the regions in England and in Scotland and in Wales and in Northern Ireland. We worked really hard to try and keep those connections and networks going, but the earlier comments about variability applied very much to the nations and the links we had waxed and waned. Things were steaming ahead in some places and not in others; that has always been the case. But we tried very hard to be UK-wide.

**Yvonne Cornish:** Once we had four health strategies again, it became very very difficult and things happened in England that weren’t necessarily done the same way in the other UK nations.

**Teri Knight:** And of course the Voluntary Register stream of the work was very much a joint venture between England and Wales.

**Peter Farley:** I don’t dispute that at all, but things feel a bit weak at the minute.

**Teri Knight:** Of course the Forum doesn’t exist anymore and I think that what you’re making is an important point, because it suggests that the Forum was key in keeping a national/international perspective on things.

**Yvonne Cornish:** Yes, it is interesting if people feel that that’s gone, because we did try to maintain it, but it did become impossible with all different policies plus all the organisational changes, plus of course most of us were involved on voluntary basis, it wasn’t part of our job descriptions, so sustaining activity wasn’t easy.

**David Evans:** One of the things I think we need to reflect upon is that our memories are fallible and whenever you do this sort of oral history, we will get dates wrong and documents wrong and so on as Klim helpfully demonstrated earlier on.

**Klim McPherson:** At least being nearly 70 I have an excuse.

**David Evans:** You do have much more of an excuse than some of us and that’s not a problem. Several people have mentioned the importance of documenting timelines and documents and I think that that’s something it would be really useful to do, because there are several kind of subtleties in some of the time sequencing. I think Jenny mentioned the CMO’s report. Now that was actually commissioned, to my knowledge, 1997, it’s the ‘emerging findings’ document of 1998 which actually expressed the gist of it.\(^{39}\) Then there was this long delay until 2001 when a formal glossy document\(^{40}\) came out. To my external observation, that only appeared because of the House of Commons Health Select Committee Report on public health,\(^{41}\) which is another key document that we haven’t mentioned. It was really the government trying to demonstrate a response to some of the criticisms of the Select Committee. Actually just documenting some of those complex nuances is

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\(^{39}\) Department of Health (1998)  
\(^{40}\) Department of Health (2001a)  
\(^{41}\) House of Commons Select Committee on Health (2001)
something that I think would be quite useful.\(^{42}\)

**Judy Orme:** I’d like us now to move into the next part of the discussion, to look at education and training, the opening up of the masters in public health courses and of the NHS public health training schemes. Can I invite Klim to introduce this for us?

**Klim McPherson:** Thank you. I’ll start with what I’ve already mentioned. I did a PhD at the London School of Hygiene and Tropical Medicine in 1969, very prehistoric, and there was an MSc course in social medicine then and also one on epidemiology, demography and other relevant things. The courses on social medicine and epidemiology were not open to non-medics, that was in the 1960s. When I joined Oxford in 1976, there was a modular course, which was actually quite a successful way of training public health doctors, on which doctors went from one academic centre to another and spent two or three weeks in each and we all had to teach them aspects of public health. I really, really enjoyed that part of my life. In fact I hold myself responsible for training, among others, Graham Winyard and Sheila Adam, who were some of the first trainees on that course. So I knew Graham and Sheila when they were in short trousers as it were. Anyway, what was interesting about the modular course was just this ridiculous business that the modular course needed to be coordinated between Birmingham, Oxford and Southampton and several other places. Every time there was a meeting to co-ordinate it all the doctors in the departments went off to coordinate it, but some of the stuff we were teaching was a core part of the curriculum, but we were never invited to the meeting. Anyway, in 1990 I was appointed Professor of Public Health at the London School of Hygiene and Tropical Medicine and I arrived to discover I couldn’t do the MSc in epidemiology or the MSc in public health, which struck me as a little bit of a nonsense, so I raised it and the argument was that epidemiology was strictly for clinical medicine people and the course would completely collapse if it opened up because it got an awful lot of money from the regional health authorities who were sending their trainees to do it. But actually of course it didn’t collapse and the courses were opened up quite soon. But there had been several exceptions to those particular restrictions over the years. One or two per year or several years had got into the MSc in social medicine and been trained by it, but weren’t allowed to get the degree at the end of it, they got some sort of Diploma I think. There are several people roaming around the country now who were the only non-medics on these courses.

People were treated with such indignity, one such person actually came top of his class. The whole thing was absolutely ludicrous and staring people in the face. Geoffrey Rose, another charming guy, couldn’t understand the point of training non-doctors in epidemiology. It always reminded me, and I wrote about this in the Faculty journal once quite extensively, about Apartheid, the whole business of Apartheid is you couldn’t train people to do jobs they weren’t allowed to have so what was the point and that was the centre of the argument.

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\(^{42}\) In June 2006 David Hunter commented: “I think the genesis of the public health function review is important to document. It was set up by Ken Calman when he was CMO and then inherited by Liam Donaldson. While Ken was committed to the review and to strengthening the public health function in ways we in the wider public health would approve of and welcome, Liam had different priorities. He was not as far as I could discern at the time enthusiastic about the public health function review. For a start it wasn’t his initiative – he’d simply inherited it and it was nearing completion so it was beyond his influence. It was because some of us suspected his lack of enthusiasm and commitment that we used the lever of the Health Committee’s inquiry to put pressure on the Department of Health to publish the final report.”
There was no point in training these people to enable them to do jobs they couldn’t have. But of course all these barriers went after a couple of years, 1991 – 1992 I think and the MSc is now open to everybody. And then there arose issues of training in the NHS for aspiring public healthists and again they opened up. With very minimal, less generous funding, as I remember and the opportunities were not anything like as generous as the opportunities for medics in public health. Others who have gone through the system will know much more about it than I do. Maybe we can stop there, but essentially it has been a process of realising the aspirations of young kids who wanted to do public health and not putting barriers in their way which were completely ubiquitous when I started in this business.

Judy Orme: Okay, thank you, contributions around the area of education and training?

Robert West: I have clearly a massive amount of overlap with Klim, but some differences. Klim referred to the training scheme run in Birmingham, to which the medics went. Well that’s where I was regularly meeting Klim’s medic head of department. My medic head of department just wasn’t interested in this sort of thing and I was running the Cardiff contributions to the modules for something over ten years, so I was in that coordinating group. So this ‘wedge’ that we were building with some people has perhaps got slightly longer antecedents. On a personal and informal basis we let one or two people into our Cardiff modules that weren’t allowed there, as has already been alluded to. But slightly earlier than 1991-92, taking the initiative really from the Acheson Report that mentioned the word public health, we changed our MSc in epidemiology, which had been multidisciplinary for about five our six years. We completely re-designed the course in 1990 and called it an ‘MPH’ and it was multidisciplinary from the outset.

Shirley Goodwin: Just a few thoughts on my experiences of the first course admitting non-medics in 1992-93 in the London School of Hygiene and Tropical Medicine. First of all I think I was very frightened. I was 45 for one thing and a mature student and worried about how was I going to manage and anxious about keeping up with all these doctors. Then I discovered there was a huge range of ability within the ‘doctor’ contingent and also, surprising to me, widely varying levels of motivation towards public health. Quite a few of them were there because they were escaping from something else. The consultants, senior hospital doctors, GPs, were fleeing either massive workload or had a desire to stop working long enough to get pregnant. Some of the women, junior doctors, had been working terrible hours and had awful jobs, so they came to do the course and relaxed and got pregnant in the first term. That meant it took them time to get through the course. Then I discovered that my age and experience compensated for my lack of knowledge, skills and expertise in some areas that seemed to matter. So I didn’t do badly compared with the medics in terms of marks and so on. The third thing I observed was this shared occupational paranoia with my original profession. I went to a series of sessions on public health medicine and there was this lecture theatre full of all these doctors who sounded like a bunch of health visitors, they were all whingeing and moaning about someone trying to take their job away, that they were masters and mistresses of nothing, ‘jack of all trades’. I just thought, maybe that’s the problem, if you are part of a public health generalist discipline, you think you’re going to be got rid of, or that other people
want your job and you’re constantly trying to seek a role and identity in some form of generalisation of your role and carve out a niche which is secure. I think that’s partly where the resistance may have come from. There is this intrinsic fear in public health that nobody respects us, we don’t have anything to call our own and everyone’s got to protect what it is. That was another thing I was interested to see on that course.

**Judy Orme:** Any reflections from current public health trainees?

**Tessa Lindfield:** Firstly, an appreciation of how much work was done before we started on the training scheme and how easy we’ve had it. But also how much things have changed over the last five years, I was just writing a list of things that have changed since we started.

**Klim McPherson:** When was that?

**Tessa Lindfield:** 2000. When we first started we could only do Part **1**, we couldn’t do Part **2**, we couldn’t do ‘on call’, we didn’t do ‘RITA’ until we’d been in the position about six months. The **CCST** wasn’t talked about, that was decided fairly late on. We didn’t have training numbers and we didn’t have protected pay. Certainly in London all that’s changed in the last five years.

**Ruth Hutt:** We couldn’t be members of the Faculty actually, as trainee members we were excluded from that as well. There was a small group called the Association of Public Health Specialist Trainees. It was an ‘e’ group really, an informal network and it was how we worked out what was going on across the country. It’s been interesting that there’s been talk today about the NHS Public Health Training Scheme, implying that there was such a thing. In fact, there wasn’t, it was each individual region and deanery doing their own thing with whatever funding they had if they were engaged enough and not all deaneries were engaged enough, some refused to do it. London was quite ahead of the game in that I think from the outset they had a four year programme, others were shorter. They also had the vision to realise that Part 2 was likely to come on line. In other parts of the country there were people doing schemes that were a year, two years and then having to find their own funding to continue on training at that time.

**Yvonne Cornish:** And there’s a huge bit in between isn’t there? When I left working for the regional directors of public health I joined the South East Institute of Public Health. The consultant I was working with then, Yvonne Doyle, was responsible for continuing professional development for the doctors and she’d done a ‘needs assessment’. She thought it might be a good idea to do something similar for the non-medics in public health. So, she was quite happy for me to go round running group discussions in public health departments in health authorities in both South East Thames and South West Thames. So I just went round and started talking to people about their training and education needs, about the Multidisciplinary Public Health Forum, about some of the changes that were happening, telling them about Lillian’s survey and the first conference we’d had. Usually there was this whole sensitive issue of who to include and who not to include but in a sense we let people self-identify. What we found very much echoed what Lillian had found in her survey, that people didn’t have any formal training, that there

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43 Diploma and Part 1 examination of the Faculty of Public Health Medicine
44 Part 2 examination of the Faculty of Public Health Medicine
45 Record of In-training Assessment
46 Certificate of Completion of Specialist Training
47 Cornish (1996)
wasn’t much of a training budget. Nevertheless some people had managed to get onto an MSc, some people had directors of public health and consultants managing them who funded them, but they often ended up getting half their fees paid and having to find half of it for themselves. They found themselves then studying alongside the trainees on the training scheme, doing the same masters programmes, but not having any time allocated for it, not having any study leave, not having any book allowance, having to pay their own fees or half their own fees, not having a travel allowance. Often they’d end up having to do the day they were missing over the weekend. So there were incredible inequities, even once the courses were open.

I know at one point when Amy Nicholas arranged for me to go up to Quarry House to talk about training for multidisciplinary public health. Somebody said, “oh we don’t know what the training needs for these people are” and I said “but we do!” and handed her a copy of the report. Shortly after that I went to do a similar project in the West Midlands, Rod Griffiths was very good in supporting the work. Unfortunately the region I was in was undergoing re-organisation and so nothing much happened as a result of that report, but when Lillian and I reported back to Rod Griffiths at a meeting, the Workforce Development Confederation had just come into existence and we persuaded them to start funding staff. Then we developed a regional training strategy and then a bit after that, Pat Dark who was very influential in the South East region, also developed a regional strategy that ended up going across Kent, East Sussex, Hampshire, the Isle of Wight and up into the Oxford and Thames Valley area. Then Ros Dunkley came to see me because she was doing some similar work in Oxford at that point and we suddenly realised there was a lot of ad-hoc training needs analyses going on and every time people started saying, “oh we don’t know what to do about non-medical people”, we’d say yes, but there’s this project, there’s that project and they’re all saying the same thing about inequity of provision. I think that helped us argue for funding and to get the Workforce Development Confederations on board, although different regions took different approaches. In some regions they took the money and immediately funded a couple of trainees and I think that’s what they did in the South West region. In the South East we didn’t, we felt that we could only fund a couple of places that way, so we tried to pump prime a lot of other opportunities. So again, there was a real difference in regional approaches.

Paul Pilkington: I came into public health virtually from university where I’d studied geography and social sciences, but although I wanted to get into it, I didn’t see any career in it whatsoever. I did a year teaching, but I still wanted to get into public health and I was fortunate enough that during that year the South West training scheme was started and I got a place on it. It was only when I got placed and started on the scheme that I realised the historical context of it and it took a lot longer actually to realise how the process of the interview panel was set up and things like that. For example, the interview process was separate from the medical intake, and as far as I know, the Faculty weren’t involved in the recruitment process in that first year of the multidisciplinary scheme. There were only two of us recruited from backgrounds other than medicine and I think for the first year we felt quite isolated in a way. The good thing about the South West scheme though is that it was very integrated in terms of tutorials from the very beginning and that helped.

Cornish (1998)
Shirley Goodwin: What year was it Paul, you didn’t say?

Paul Pilkington: Sorry, it was 1999. The first year was in London doing a Masters so I didn’t really notice too much, but then coming back it felt fairly isolated, although we felt integrated in some ways. Part 2 wasn’t open and we had a 3-year contract instead of a 5-year and I think one of the important things that happened was this getting together of different trainees from other regions. We actually met in 1999 in Sheffield and we managed to get trainees from every region to this initial meeting. It was really interesting to actually discuss the differences between our training schemes, differences in length, terms and conditions. Some people weren’t even expected to do part 1. It was only through this group, which then really became an ‘e’ group, that we actually tried to promote joining a union as a specialist group. I think that was helpful although it’s not completely sorted, there’s still different unions involved.

Shirley Goodwin: Did you join a union then?

Paul Pilkington: Yes, Amicus.

Shirley Goodwin: I ran a trade union for some years at the Health Visitors Association. We went through lots of different discussions over the years before we ever thought to merge. I just wondered how you chose Amicus and whether you all went into it and whether some of you are still in your existing old disciplinary unions, because that was a real issue for nurses.

Paul Pilkington: From my perspective I was just aware that people were trying to persuade us to go into Amicus. I can’t remember why now.

Ruth Hutt: It was because we lobbied. We went round all the unions to see who was prepared to take us on. A lot of us did have professional memberships of other unions like the Royal College of Nursing and the RCM and most of us retained those memberships as well. We’ve tried to get Amicus to work with those other unions, but Amicus agreed to take us on. It’s really been ‘Agenda for Change’ that’s been a catalyst because we needed someone round the table to represent us and there wasn’t anyone.

Tessa Lindfield: It’s really only in the last six months, really late in the whole Agenda for Change process, that Amicus have come on board.

Paul Scourfield: I just wanted to go back to something Yvonne mentioned which is the variation with which training is being delivered regionally. I think it’s important to mention the English Department of Health Public Health Development Advisory Group that actually did bring people together who were aware of what was happening in their local patch, or what was not happening in their local patch, so they could actually compare it to what was happening elsewhere. I think that really helped standardise as much as it ever has the training and the opportunity for training throughout the UK.

Yvonne Cornish: Janet Baker started that off and I think it grew out of the CMO’s project on the public health function. That had ten working groups and one was an education group. I was co-opted onto that.

Paul Scourfield: Well that group really seemed to wake people up to either what they had got or what they hadn’t got and the Department were then able to try and

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34 Royal College of Midwives
50 Department of Health (2001a)
give guidance and funding to actually try and standardise it.

**Judy Orme:** Am I right in saying Northern Ireland still has not got public health training?

**Jane Royle:** I think it has because I’m a ‘specialist visitor’ and we’ve just done the paper visit.

**Peter Farley:** The position in Wales is not dissimilar to any of this, we’ve now for the first time had a completely open application process for specialist trainees which doesn’t discriminate, as far as possible, in any way between medics and non-medics. The first round was interviewed early this year and all the people appointed to the scheme were non-medics and I think we might have to think about the balance between the disciplines before too long.

**Ros Dunkley:** But there are other deaneries where I think that we still have remaining bias against selecting non-medical trainees. They may have overcome that in Wales, but it certainly hasn’t been overcome in some places.

**Shirley Goodwin:** Are there different pre-entry requirements in Wales? Because if they are required to have different histories, then that is discrimination and that is certainly the case in London and the South East.

**Ruth Hutt:** I think one of the big things in London particularly, is that now training is really the only route to get through, particularly if you decided to see how the portfolio thing would pan out and haven’t quite got it together yet, we’ve got really senior people applying for training posts who have got PhDs, who have got vast experience in public health. When you compare them to the medics who often haven’t had that length of experience, they will get through and it is difficult to manage that. Tessa and I were saying over lunch that we probably wouldn’t get onto training if we applied now, because we were people who had come in with very little public health experience. I had done a Masters at the London School of Hygiene and Tropical Medicine before I came into public health and there were specialist registrars at the time who were being paid full salaries to do it and I was working as an agency nurse on my weekends and doing nights to pay my way through it and I couldn’t believe people were being paid to study. It was just amazing to us that there they were just whining about how hard their lives were, and yet they were being paid to do this. I think that balance has changed a lot and maybe it will change again in the future. To my mind public health training was set up for people like us, who actually needed to be trained in public health, not people who had most of those skills already.

**Yvonne Cornish:** That was the whole point of the original ‘top-up training’. It was to capture those people who had been around in the system a long time and who had gained quite a large amount of experience, who already had quite a lot of relevant skills and education and knowledge but who had some gaps, for instance in areas like a communicable disease which previously they hadn’t been allowed to do. Teri and I did a project for the Faculty, didn’t we, where we actually looked at the issues around people proceeding to Part 2. One of the things we did as part of that was to do telephone interviews with all the regional training schemes and we locked into your organisation which was quite new then, the Association of Specialist Trainees, to find out the experience of trainees. Again, we found differences between the two–year schemes and the four-year schemes and those who were doing on-call and those who weren’t. There were also differences in recruitment criteria.
was on one of the interview panels where it was a case of, we’ve got this many posts, we’ve got this many applicants, we take the top ones and do it completely on merit. Other places had said we’re taking on six docs and we’ve got funding for two specialists and whatever the balance of skills they allocated it in that way.

**Ian Gray:** I just want to reinforce this business of protected pay and what a massive disincentive that is. In my profession I’ve known of people who have given up five figure salaries in order to do the exams. That’s a very substantial commitment and it’s not available to everyone, especially senior people who have developed their lifestyle. Part of the problem is that there isn’t, for many of those people working outside the NHS, a sponsoring department. It certainly isn’t the Department of Health. If you take the case of environmental health, they cover food, environment, local government and public health, there isn’t a single sponsoring department. Even the Office of the Deputy Prime Minister, which is responsible for environmental health within local government, would not accept that they were responsible, and I think that’s a big issue. When we do get onto talking about the future, then I think some ownership of the education and training responsibilities needs to be taken up.

**Judy Orme:** Fiona, do you want to respond to that?

**Fiona Sim:** I was going to say that when there was a big possibility, in terms of people’s aspiration to establish multidisciplinary health specialist training, there were a number of barriers. One was attitudes out there that everyone here is aware of and the other one was the funding issue. I think it was 2002 – 2003 roughly speaking, that two completely separate levies were merged in the health service. There was a medical and dental education levy and that money was controlled by deaneries and quite separate from that was something called NMET, which was a non-medical education training levy and for something like nearly fifty years it was a case of ‘never the twain shall meet’. So we had a real uphill struggle in terms of trying to develop training programmes from an NMET levy which was committed, fully committed for years to come, mainly with the pre-registration training. So my personal experience was of almost literally going round with a begging bowl to health authorities to encourage them to make a contribution. We didn’t really know how much to ask for so tried saying “how does £5,000 seem?” But most of them paid up thank goodness and that enabled us to get something off the ground. Then the workforce confederations came along and they were persuaded that actually this profession was for real and it was only really when the two levies came together and there was some recognition that public health could be a seen as an entity, that we could move forwards. Anyway before that happened I was in London and very fortunately I had a postgraduate dean who was willing to hear the case that public health should be a multidisciplinary entity. She was very keen on being involved in things that were new, progressive and the future and she said “yes alright then Fiona we’ll let you use some of your money for public health training”, which was only for specialist registrars, to put into the pot alongside the health authority money and a few pennies from the confederations and so on, in order to set up the programme. It was all done on little bits of funding from all over the place, so I suppose that if you didn’t have a hell of a lot of energy, it was very easy to say it was impossible. So there were only a few regions that did take the trouble to get off the starting blocks before it became easy
to do so. I think there’s still quite a lot of inequity around the country, in terms of who gets appointed and to what post and there’s still inequity in terms of conditions of service as we know. Hopefully that will begin to improve, but historically the way that it all came about was that there wasn’t a plan.

**Teri Knight:** Can we specifically record that, it could be the title for the report for this seminar!

**Judy Orme:** I’m just aware that we do want to have reflections around the emergence of the Competency Framework and Voluntary Register. Teri, do you want to start us off?

**Teri Knight:** Well I would just kick off with the feasibility study that Klim was involved in.\(^{51}\) That was the first major step along with the formation of the Tripartite Group which was just before that. That was the starting point really wasn’t it?

**Jenny Griffiths:** Yes. I have a note that Nicky Wilkins\(^ {52}\) prepared on the historical background which I can take you through. This starts at the point that Teri highlighted earlier, which was the three organisations, the Faculty of Public Health, the Royal Institute of Public Health and the Multidisciplinary Public Health Forum coming together and issuing a joint statement of intent in February 1998. What it doesn’t say here is when colleagues from the health departments in the four UK nations were co-opted onto the Tripartite group. I’m not sure when that actually took place, but it was very important.\(^ {53}\)

**Paul Scourfield:** It was something to do with the development of the national standards.

**Jenny Griffiths:** Right, so it was a bit later on. So the next stage according to this note is that an advisory group was set up and that was chaired by Ken Calman, former Chief Medical Officer, and brought in environmental health, nursing, medicine, health promotion and the Health Development Agency, the NHS Executive as it then was and other government departments. So a very wide ranging advisory group which obviously did a lot to get stakeholder confidence and involvement in the whole process. The feasibility study was October 1998 and sought to assess the case for national standards of specialist practice. It concluded that there was a demand for this from employers and employees. There was no point in having a Voluntary Register unless employers would support it. That project was supported by the Chief Medical Officer and then as Jenny Wright mentioned earlier, there was a crucial announcement in Saving Lives: Our Healthier Nation para 11.25, that a new post of specialist in public health was to be created.\(^ {54}\) Symbolically, that was of the utmost importance in terms of recognition of the status of colleagues from professions other than medicine. And then following on from that, Healthwork UK, who are now ‘Skills for Health’, were commissioned to develop national standards. That work was funded by the Qualifications and Curriculum Authority on behalf of all four nations.

**Fiona Sim:** It was jointly funded between the health departments and the QCA.

**Jenny Griffiths:** Right. From that came the project to develop, consult on and agree formally the ten key areas of public

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\(^{51}\) Lessof et al (1999)  
\(^{52}\) Former Chief Executive, Royal Institute of Public Health  
\(^{53}\) Fiona Sim added after the witness seminar “For information: the health department representatives were co-opted early on, but as observers, onto the Tripartite group, as far as I recall.”  
\(^{54}\) Secretary of State for Health (1999)
health practice which are the core of all the work that’s gone on since, because they brought together all the key contributions of public health from health protection to health promotion. The Tripartite Group then developed the business case in 2002 which was sent to the four UK health departments. Here I think it’s important to record the contribution of Philip Hunt because he did express very strong support for the development of a Voluntary Register at that stage. The business case must have been approved during 2002 because I was asked by the Tripartite Group, via Paul Scourfield I think, if I’d be interested in tendering for the work to set up the UK Voluntary Register for Public Health Specialists. We got on with that project remarkably quickly, looking back on it. There was a fantastic group of people on the Tripartite Group who had worked together effectively for a long time and we did virtually all of the work electronically, what the assessment process was going to be, what the constitution for the board was. Everything through to standing orders we did in a period of about three months. It was a fantastic opportunity for me and I thoroughly enjoyed it. So by March 2003, the public health minister Hazel Blears was able to say at the UKPHA Annual Public Health Forum in Cardiff, that the register was about to be launched with government backing. The inaugural meeting of the register joint board took place in May 2003 and the register then opened for generalists. Following on from that, I was commissioned to do the feasibility study into defined registration for different disciplines in different regions and we eventually came up with the framework we have now, which is everyone in public health being required to have the knowledge competencies and then specialising at a higher level in ‘shows how’ in different areas of expertise. Following that, through Jenny [Wright] and Ros [Dunkley], we’ve taken forward the implementation of that feasibility study. So that’s where we are now, with the UK Voluntary Register opening for defined registration in June 2006.

Jenny Wright: One of the drivers for the register in my recollection was *Shifting the Balance of Power* because it created director of public health posts in England which were open to either consultants or specialists, so we had to get on with the process. In terms of the competency framework that Ros and I worked on, we had to get a means of retrospective assessment by portfolio for generalist competencies in the ten key areas of public health. For that we had the Faculty’s 10 key areas, plus RITA, but we also had the Skills for Health standards to work with. The trick was to make it do-able for senior people in full time posts. Both were quite difficult tricks to pull off. It was patently obvious to Ros and I that people applying through that route, from background other than medicine, would need some help and we got some money and set up the first top-up scheme in the Thames Valley. Fortunately, that was picked up by the Department of Health in England and Ros has been providing support to other regions as well, so there’ll be others around the table who can talk about that process. I think if we hadn’t had a framework that was do-able and we hadn’t had the top-up scheme, plus the

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**Notes:**

55 Then Acting Minister for Public Health

56 Department of Health (2001b; 2001c)

57 Record of In-training Assessment
DNAC**, we wouldn’t have so many people able to get portfolios together.

**Robert West**: I wonder if we might go back briefly to the terminology of Tripartite agreement, because I think in writing up the whole of this it can be seen as a watershed. If you really think of the three legs of the stool, one organisation several hundred years old, the other organisation relatively young, 20-35 years old, have really got a strangle hold, as we’ve heard through most of this morning, on public health and public health medicine. The third leg of the stool was this bunch of mates. We hadn’t got a constitution, we hadn’t got anything written down really at all. And yet, as pointed out, things suddenly became crystallised from that point on. We’ve discussed the sort of work that was going on in the background, people like Fiona were working away, getting a wedge in there and knocking the wedge harder and something happened.

**Ros Dunkley**: I think we need to just reflect on the value of those ten key areas that we skated over. I think they actually transformed the notion of multidisciplinary public health training, because I think for the first time ever, we had a clarity about what it was we were actually trying to train people to do, what the competencies were. Although doctors had had public health medical training, I would still challenge them to know exactly what it was they were training in, or being trained to do, other than get through the examination process. So the ten key areas were particularly important because they were meaningful and relevant to just about every group that was looking at public health at the time.

**Peter Farley**: Not to dissent from any of that, but to make a couple of observations, perhaps pointing towards one of the later parts of the session, I think the whole thing now has to be done again for practitioners. I don’t think there’s any doubt about that and we need to bear that in mind I think as we move forward. I think it would be a great shame if movement having been as we described it, we were to suddenly start pulling the ladder up behind us. Secondly, I think the question of competency has been important exactly as was described and that’s probably one of the reasons why some parts of government have been so interested in this. Because it actually points towards the idea that something might actually be done as a result of training and change might actually be brought about. That’s the link therefore between the training agenda and the policy agenda. That the two might come together in order to make a difference. So, pivotal and key things and isn’t it great how several of the key players are here today to celebrate this.

**Ian Gray**: This is the bit of the agenda that brings me here really, because as interested as I am in the Voluntary Register, we’ve done that and there’s a limited number of people that would be able to go through that door. Equity is still the name of the game on that and there are endless criticisms of the availability and selectivity of top up training. We must get beyond the rhetoric. If we genuinely are saying these are open to everyone, then they are to be promoted and offered in a way that people can obtain them. When people are required to put down in their application what they don’t know about, it shouldn’t be so the interviewers can steer the whole interview around that area. On the practitioner side, I think the work starts from here actually. I wouldn’t be happy until professions like mine actually teach those practitioner competencies as part of their core curriculum. And so should architects and housing officers and

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**Development Needs Assessment Centre**
planners and a lot of other people. They should be identifying where they contribute to public health and what the competencies are that their professionals need. I’d like an NVQ\textsuperscript{59} approach where everybody, whatever their job is, can be developing NVQ standardised lists of competencies, so that eventually they can go work for a public health organisation and do the link to the Voluntary Register. So there’s an enormous amount to do there. We are all young enough to do it aren’t we?

Ros Dunkley: You jumped ahead slightly into the future, and I totally enjoyed what you were saying, but I do just want to raise the interesting point that you made about variable access to top up training. We’ve had very variable criteria used across the UK, for people doing top-up training. I think that because of this variability, some very experienced individuals have been denied access to top up and are inappropriately doing the full 5 year formal training programme, whereas in another region they would be doing one year top-up training. It’s important that we ensure that does not continue. One of the most important elements we found in top-up training programmes was about giving people a sense of value. We still have to spend so much energy saying to people, who have very very responsible roles gained entirely by their own abilities, “you’re doing a wonderful job, its fantastic what you are achieving.” We are reassuring these people that they are valuable and do have really significant contributions to make to public health. Whilst we’re still having to do that to one group of people i.e. non-medics and not having to do it to medics, we do not have equity.

Judy Orme: Jenny, do you want to say something?

\textbf{Jenny Griffiths:} Just a couple of supplementary points to emphasise other colleagues’ contributions. One was that from my memory of a lot of the discussions in the mid-1990s onwards, being able to break through the glass ceiling as it was called, for people from backgrounds other than medicine, to achieve a Director of Public Health post, was a really key driver. Certainly at the conferences that Teri was talking about, that was one of the key things. Obviously for a small group of people, but enabling that to happen is of huge historical importance and it could not have happened without the regulatory framework, so it’s important to record that. The other thing was that the competency framework, I quite agree with Ros, was absolutely pivotal. It’s proved remarkably robust and I think it’s so important because it does two things. It brings the scientific base of public health medicine with its epidemiological, research and development base, together with health promotion, which I imagine took a lot of negotiating at the time. To bring together those two parallel universes in one competency framework was a huge achievement of international significance. The second thing it does is to put a strong focus on management. It recognises that without very strong management competencies, public health will never achieve its full potential. So for me those two things have made this a powerful competency framework to work with.

\textbf{Judy Orme:} That’s very helpful. I’m just going to move this on, but I think we can pull some of this debate with us, to ask Paul, if there’s anything additional that you would like to say on the agenda here?

\textbf{Paul Scourfield:} Yes, I think there are some bits that are almost Faculty only parts of this that we’ve done. We’ve heard about our involvement in the

\textsuperscript{59} National Vocational Qualification
Tripartite Group, but from that we needed to put our own house in order really to keep pace with time as it was changing. The first thing we felt was necessary to do, which was really in 2000, was to open our Part 1 exam to people from all backgrounds. We always knew that this was only a stop-gap if you like and that the logical pathway would be to go onto open Part 2, but again, dealing with a reasonably concerned, mainly medical membership, we felt it was better to do it in chunks that they found palatable and we were likely to be more successful if we did that. Part 1 opened in 2000, Part 2 opened in 2001, so not a big gap, but it did mean for the first time that people could actually go through the whole course in exactly the same way as those coming from the medical scene. We have tried as a Faculty wherever possible to make sure that whatever we have done for a medical membership, we have made that equally open to people from other backgrounds. That’s included along the lines of AACS, we’ve done a lot of work with the English Department of Health on that to ensure that the same rigour was produced for people who were coming from those backgrounds, as it was for the doctor.

We introduced specialist regional advisors, people who were of standing within the profession who had proved themselves and were willing to do tremendous amounts of work on a voluntary basis, often travelling all over the country to sit on appointment panels. We had little authority to do that. Whilst appointments for medics are governed by statutory document, we didn’t have that statutory document to actually go through and get the AACS to comply with the terms that the Faculty were putting down. Fortunately, because we’ve developed a relationship with human resources departments in NHS bodies, we were able to persuade them that this was good practice. Certainly from the point of view of the Faculty, it was a professional standard setting issue for us, because we wanted to make sure people who were getting those jobs in fair and open competition were doing it on exactly the same footing. The other area I wanted to mention was the change in our membership. If we look back, even ten years ago, we were virtually 100% medically dominated. We’ve got about 3,000 members now and we’ve got about 2,000 of those as doctors and a 1,000 of them from backgrounds other than medicine, so we’re seeing the change. Five years into the training programmes we’re seeing more and more people coming through the educational training route in addition to ones that are coming from the Voluntary Register and you can see the balance slowly beginning to become level. That’s reflected in all areas of the Faculty, on membership of committees, people that are being elected to posts. So we’re actually beginning to see some benefit from what’s been quite a hard slog. Interestingly, talking about international importance of the competencies, even within this country, if you look at the other royal colleges and faculties, I think it’s the Faculty that has led the way in developing a multidisciplinary approach. The only one that comes anywhere near it, was the Royal College of Pathologists who took clinical scientists in. But they didn’t register them, just purely examined them and then threw them out. Clinical scientists are paid considerably less than their medical counter-parts within pathology. So whilst they were happy to take their exam fees, they didn’t do a lot more for them. We are now being asked as a really very small Faculty within the royal college system, for advice and guidance on how we’ve achieved this because all of the other specialties are now realising there is a need to extend their membership to actually get the skills.

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Advisory Appointments Committees
that they need to perform the tasks that are demanded of them. It’s a wry smile that comes across my face sometimes when it’s the surgeons ringing me up saying how do we do that. Similarly, internationally, I spent a lot of time recently working through some of exactly the same issues that we faced with the Australasian Faculty, who are embarking on a programme to make their college a multidisciplinary college. They are meeting exactly the same problems.

**Shirley Goodwin:** Isn’t that interesting, because when the Association for Public Health, and Public Health Alliance were looking at how we were going to develop after the merger in 1999, the Australian Public Health Association was one of the models that we used. Geof Rayner at the time was in close communication with the person who ran that organisation and a lot of the exchange was about how they had avoided having disciplinary sub-sections because that was felt to be divisive. It’s very interesting that the professional bodies suffer from the problem whereas the UK Public Health Association somehow had managed not to.

**Paul Scourfield:** Yes, I think that’s actually true of the Association, but the actual professional standards setting body in Australia has closed doors at the moment.

Just briefly moving on, whilst we don’t have an official terms and conditions role as a Faculty, we do have a very strong professional standards setting role and with ‘Agenda for Change’ we’ve worked very closely with the Department of Health to ensure that the pay scales are appropriate for people working at that level of professional standing, and with a degree of success that we hope is acceptable.

**Judy Orme:** Thank you, that was very helpful. We shouldn’t underestimate that.

**Jenny Wright:** There was an issue for a time in some PCTs in England where posts, open to both consultants in public health medicine and specialists in public health and using the same job descriptions and person specifications, were advertised with very different salary levels. If that had not been sorted out there could have been implications for what PCTs would be prepared to pay for public health professional posts and also the potential attractiveness of public health as a career opportunity for those from backgrounds other than medicine.

**Mike Shepherd:** That’s really important.

**Ian Gray:** I don’t like the way that’s put. You could see it the other way, that you would not get the calibre of non-medic that you really deserve. Let’s not denigrate those applicants, because people were applying for those posts regardless of the fact that they’d be sitting next to somebody earning thirty, forty thousand more than they would.

**Paul Scourfield:** It’s been a really difficult road to tread though, because we’ve had to be very careful that we weren’t seen, as a medical speciality, as setting a precedent, because it would have had a knock-on effect to the rest of the medical profession. I think there’s some work to go on that.

**Judy Orme:** I think that it is useful time for us to ask, Fiona, to reflect on the role of the English Department of Health and other UK health departments.

**Fiona Sim:** A lot of this has already been covered. I’ve made reference in my note here to the internal market which we talked about this morning, so I won’t go anymore into that. In 1997 the Government appointed its first Minister
for Public Health and that was Tessa Jowell. I think it was a really important milestone. We’ve covered The New NHS. Modern, Dependable.⁵¹ There was a health service circular in 1998, HSC 228, which recognised the role of other agencies in public health but gave lead responsibility for public health at local level to the health authority. Now that’s relevant because it sets the scene, but it’s quite late on. I haven’t gone back very far, I’ve gone back a decade or so. Somebody’s already mentioned Saving Lives: Our Healthier Nation⁶², that had lots of public health targets as we know. But it’s the first formal recognition that there was such as thing as a public health specialist from a background other than medicine.

David Evans: This is a key symbolic moment, do you know how that paragraph got into the white paper?

Fiona Sim: No, I wasn’t at the department then I’m afraid, so I’m going to be saying ‘no’ to most of these sort of questions.

Klim McPherson: There was a lot of lobbying of Tessa and people like that.

Fiona Sim: There was a lot of pressure coming from all different directions. This has been very much an evolution, hasn’t it? It would have been awful had it not been in there. It had to be in that white paper.

Jenny Griffiths: Yes it was the official recognition. It was very important.

Peter Farley: And because the English Department of Health did that, the rest of us had to follow. Because this was around the time of devolution, it’s highly unlikely that Wales and Northern Ireland, though maybe not Scotland, as they were then expected to evolve, would have had the capacity to arrive at the same point. So that triggered a tremendous amount of UK-wide stuff, even though strictly speaking you could argue it only applied to England.

Klim McPherson: Ken Calman⁶³ was very, very influential in this process. He was extremely supportive of the whole business.

Fiona Sim: His review came out the previous year and the second Chief Medical Officer review was 2001⁶⁴, so I’m sure he influenced it.

Jenny Griffiths: He was chairing the advisory group behind the setting up of the UK Voluntary Register for Public Health Specialists, which was an important role at the time.

Fiona Sim: We’ve mentioned the CMO review earlier today. This looked at multidisciplinary public health in three categories, which I don’t think we have talked much about. We’ve alluded to specialists and practitioners, but basically what the CMO was describing were three non-hierarchical categories. The small group of specialists which didn’t have to be doctors. Practitioners who are the ground workers, and the wider public health function, who can be anybody. And all of those can function within and outside the health service. I think that was really important; it was important for me working both in the health service and the department of health, to keep remembering and reminding other people, particularly in the department, that there’s an awful lot of public health that went on well outside the health service. And, if you were talking about developing the public health function, you

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⁵¹ Secretary of State for Health (1997)  
⁶² Secretary of State for Health (1999)  
⁶³ English Chief Medical Officer 1991-1998  
⁶⁴ Department of Health (2001a)
were talking about working across agencies and across government departments, which is challenging.

**Yvonne Cornish:** Those three categories of public health very much came out of the discussions in the sub groups, the working groups, that fed into the CMO’s Report. I was on the Education and Training one and I know we were talking about it but then discovered that in a couple of the other groups, people were coming up with exactly the same ideas.

**Fiona Sim:** I don’t think it has ever been formally documented but the CMO, a few months after the second report was published, made a speech, somebody might remember where the speech was. In this speech he created two additional sub-categories within the specialist category.\(^{65}\) One was the technical specialist and I think the example he gave was a soil scientist, somebody who was highly technically able in a very narrow piece of the health agenda. The other was the key influencer. People like head teachers, chief executives of local authorities and so on, who had clearly an interest without having any specialist knowledge of public health, but who were in a position to do a hell of a lot about health in their local or wider community.

**Klim McPherson:** Wasn’t it at a Faculty conference?

**Fiona Sim:** I don’t think it was. I would have remembered if it was. A speech in Bristol is in my mind, but which conference it was I don’t know. Then we’ve got Lord Hunt’s speech which I think was absolutely crucial. I couldn’t get to that one but I remember he said that the door was open to regulation of public health specialists and that he wanted to see a register within the foreseeable future. I’d also like to mention one thing that hasn’t come up yet today and that’s *Getting Ahead of the Curve*\(^{66}\), January 2002 which was a review and a strategy for health protection. And again, I think just England, is that right?

**Peter Farley:** No, it was England and Wales. I think we were told with the usual twenty-four hours notice.

**Fiona Sim:** It wasn’t UK-wide, which I think is important in this context. But in it, the CMO highlighted the need to develop the health protection function and there were several paragraphs in there about the fact that the health protection function is multidisciplinary. In terms of widening public health specialist posts to people from backgrounds other than medicine the stumbling block very often has been health protection. Far too often in my view, and this is not a department of health view, for completely fatuous reasons. Then, December 2001, Shifting the Balance of Power which was Alan Milburn’s great speech, when he announced that every primary care trust would have a director of public health and that they could come from backgrounds other than medicine.\(^{67}\) That came as a very crucial announcement. If you’re going to ask me how it got into the speech, I don’t know, sorry. But again it was an awful lot of lobbying for months or years beforehand.

**David Evans:** I’d say that one thing that pre-dated that was his speech at the London School of Economics in 2000,\(^{68}\) when he talked about taking public health out of the ghetto and ending lazy medical protectionism. He tied opening up public health careers with a much broader

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\(^{65}\) See footnote 31 on page 25 for comments on this speech.

\(^{66}\) Department of Health (2002)

\(^{67}\) In fact the announcement was made by the Acting Minister for Public Health Lord Hunt in his speech to the Faculty of Public Health Medicine in November 2001 – see Hunt (2001)

\(^{68}\) Milburn (2000)
vision of public health. Somebody had obviously got to him a bit before then as well.

**Fiona Sim:** We’ve already had a mention of this one - Hazel Blear’s speech as Minister of Public Health at the UKPHA Conference March 2003. 69

**Klim McPherson:** Which you wrote, didn’t you?

**Fiona Sim:** I wrote it, yes! She announced the establishment of the UK Voluntary Register which opened two months later. At a personal level I went into the Department a year earlier with my own personal objective to establish the register within a year of arriving, so I missed by a month. Other things to mention are things like ‘top-up training’, we’ve had mention of that already. I can’t remember the exact dates that we managed to achieve top-up training nationally. There had been a public health development fund going from the department to each of the regions and we decided to pick it up nationally on the basis that I was assured funding would be ring-fenced for the purpose if we did it that way. There were a lot of concerns about some regions somehow finding it a lot easier to identify substantial numbers of very eligible people and other regions finding it really difficult to identify any suitable people, which was really very worrying. At some point someone asked about public health jobs within the Department. At the time the Head of Public Health was Don Nutbean. I thought his appointment, a couple of years earlier, was a very good message that got sent out because he was somebody who had a health promotion background and a very strong academic background but who had been appointed to a very senior position.

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69 Blears (2003)

70 National Assembly for Wales (2001)
long. It does have an England and Wales dimension. We had to factor that very quickly into terms of the national public health service in Wales. But we’ve done it and there is an England and Wales dimension to the HPA. The sad thing I think is, and I maybe think I heard this in something somebody said earlier, maybe it was Klim, the sad thing I believe is that we haven’t got an equivalent to the HPA for other parts of the public health. So there’s the whole wider public health agenda, health improvement if you want to call it that for the sake of argument now, which is unrepresented and unsupported by a major player. And that I think that is a serious deficiency. As for the other thing that I do agree with Fiona about, you said, I think something like “there was no plan” or what was that lovely phrase you used?

Fiona Sim: There was no plan.

Peter Farley: There was no plan, there is no plan! And a lot of this depends entirely on good will and good vibes between all of us, as it does between organisations and professions and at a Government level, it’s no different really.

Robert West: Back to Fiona, did you say the date for ‘top-up training’ was November 2003? Because I think that this illustrates one of the subtleties, that while you were developing it, Wales jumped ahead with small monies from the Wales Centre for Health. We can check the dates, but it was silly money as we talked about this morning, I think it was five thousand, ten thousand and so on. At the time I was very disappointed because it wasn’t parity, it wasn’t proper training but it demonstrates the synchronicity. I’m pretty sure the idea was coming from Fiona and London, but I think that this is one of the things where Wales jumped the gun.

Fiona Sim: I think that there had been some regional funding through the public health development fund. May I say something anecdotally about ‘top-up training’? Some of you may remember before it was top-up training it was called fast track funds and some of us got into quite a lot of trouble, mostly as far as I recall with specialist registrars, who were extremely anxious that these upstarts were going to come in through the back door via the fast track. So the compromise term was top-up training because that didn’t imply anything untoward.

Judy Orme: OK. Thank you for all of that. I now want to look at the lessons from all that we’ve talked about in terms of future policy. And I’d like to ask Teri and David, do you want to kick us off here or do you want to just reflect?

Teri Knight: For me there are three key issues. One of themes which people kept coming back to in different ways was about the need for a strong public health force in the country to continue to carry this forward. That’s something I think maybe there’s some debate about, because not everyone may have the same point of view. And then the other issue that really hit home to me was that there is still inequity out there. And that is something that we really need to make sure is known and talked about and dealt with. And that’s across the nations and within England as well. My third bullet point is about not stopping here and not being exhausted by all the effort to date. We’ve got the Voluntary Register, but we’ve got to carry on working on the practitioners’ side of it and the linking into the competences of the core training of all the other professionals, the point that Ian made.

Judy Orme: Would other people like to summarise their thoughts, their
recommendations, their thinking from today?

**Jenny Wright:** We shouldn't underestimate the power of Agenda for Change and the potential there within the NHS, but it has to be capitalised upon. We now have a suite of profiles that start from new graduate right up to consultant, in a number of disciplines e.g. health information, health improvement and academic. But also there is an NHS career framework, can we make that into a public health career framework and then link that to competencies at different levels? And then training would fall out of that. It could embrace other agencies such as local government, it doesn’t have to stop at the health service. But there’s tremendous power there. Following on from Agenda for Change, people will be required to do the knowledge and skills framework as part of their development against competencies, so there is a mechanism for people to progress. So if all of that’s used appropriately, it’s not there at the moment, but the potential is there, it would sort out the practitioners.

**Ian Gray:** Klim said this morning that what we need is a quantum core organisation, that one of the weaknesses was that the organisations were divided around the agenda. I actually want to dispute that; I think the last thing we need is one core organisation. We need a coalition of organisations. I think our ambition should be that those who accredit training within the public health world are aligned around this agenda. I switch off. I’m very interested in local government and the way public health work is being devalued within local government. I’m very interested in the fact that the private sector does not yet see the value of this qualification, yet they’re employing national risk managers, who are all about, in the future particularly, developing their public health awareness about products and services, never mind their own workforce. We must think beyond the NHS and the only reason for mentioning Agenda for Change is that we want parity. I think that parity’s the issue. If people get to the level of excellence that gets them on the Voluntary Register, as a public health specialist, they ought to command a good salary wherever they work.

**Klim McPherson:** In so far as there’s an agenda to do with health improvement and its optimal implementation for populations in this country, then there needs to be some strong coalition which is pushing the agenda strongly, whether it’s one organisation or several, it doesn’t matter so long as it works. And I think that’s core. And also the other aspect to the agenda that Teri’s just outlined, it needs to be taken forward in an effective and acceptable way. At the moment we are slightly running out of organisations that are going to take on that responsibility. My view of course is that the existing organisations ought to do it, but ought to do it in a unified way, and my particular problem at the moment, which is I think a serious problem for public health, is to trying to interest the academics in public health, in becoming part of public health. At the moment they feel very much out of it. There are anthropologists, economists, sociologists or even medical statisticians working in academic departments, of whom there are a large number, who are de facto engaged in a public health research enterprise, who feel that public health is not what they do. And the reason they feel that public health is not what they do, is because public health is what they perceive the Faculty as doing, and the Faculty is not theirs, it’s not part of them.
It’s a doctor’s organisation which doesn’t worry too much about the complexities of the evidence base, and all that kind of stuff. Trying to involve those people in a unified public health enterprise is difficult, first of all because they’ve got to start thinking about all this portfolio stuff, and this Voluntary Register stuff, and then they’ve got to think about paying a lot of money to the Faculty if they want to join. I think public health will be all the weaker so long as those people don’t feel a part of public health. Somehow they’ve got to be embraced into the enterprise, it’s very difficult, but somehow that’s got to happen. I think the Faculty not only is going to have to change radically in terms of membership, it’s got to change radically in respect of it’s agenda and it’s strategy and actually embrace academic public health people in a way which hitherto it has not bothered to do.

Fiona Sim: There’s a name that hasn’t come up today, so I’ll throw him in, Derek Wanless. It didn’t really come out in either of his reports, but in working with him on the second report, it was very apparent that Derek found something that was totally irrational, how peculiarly we work across our disciplines, or basically fail to work across disciplines. If you read his report, he believes that the economic arguments are very important and found it unbelievable that health economists are really not central, that they don’t view themselves as central to the public health function, neither does the average jobbing public health person view the health economist as an essential colleague in many instances. I’m sure there are exceptions too.

Peter Farley: Several times, particularly this afternoon, we’ve mentioned the advisory group that Ken Calman chaired, following the development of standards and the Tripartite Group and so on. But we haven’t mentioned one of the ideas that he floated in that advisory group and that was the idea of a UK Institute of Public Health. Not necessarily a real organisation, it could be a virtual one. I think that the general view was that the time wasn’t right, but whenever will the time be right? But that might just be, with some thought and development, one way of bringing players together. It will take the pressure off any one, like the Faculty, having to embrace everybody. It will bring a whole wealth of players around the table. There’s a not dissimilar notion in Scotland, which the Scottish Executive actually funds, to bring key players and organisations together. I just think it might be an idea that would be worth exploring.

Shirley Goodwin: I was thinking when others were calling for, ‘we need a big organisation’, ‘we need to organise’, now that’s easy to say, but I think we’ve got members around this room who’ve tried in the past to do this. I mean you’re always up against the problem that you’ve got a set of needs, demands, requirements for an individual member which are around trade union issues, pay and conditions, which one organisation is providing. You’ve got another set of issues and needs around regulation, professional development, standards, examining etc, which another one is.

Then you’ve got the lobbying, policy stuff like Friends of the Earth or whatever. No one organisation can actually do all of those, so you’re always going to have a mixture of organisations. You’re never going to have the one mass movement for public health that we might think is the ideal. It simply cannot happen. I think it is worth looking at some of the other countries’ experiences. The American Public Health Association is actually quite influential, but it’s smaller numerically compared with the population of its country, although it’s seen to be a

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71 Wanless (2004)
72 Former English Chief Medical Officer
successful multidisciplinary public health movement type organisation. So I think to call for one body is unrealistic but we do have to find a way unifying the voices that are there for public health, but without throwing good money after bad trying to do something the UKPHA and in its previous form the PHA, have struggled with for years. They run on a wing and a prayer on Section 64 funding. They could go for the big money and become much bigger and better like some other organisations that we’ve seen, often the medical ones, but the UKPHA hasn’t wanted to do that. So it’s struggling on its tiny amount of money and its even smaller number of subscriptions. The Faculty has only got three thousand members. How many has the RCN got now? The CPHVA must have twenty odd thousand. So the Faculty is a tiny, tiny little player. Why do we invest it with so much importance? And what’s the Chartered Institute’s membership?

Ian Gray: Ten thousand.

Shirley Goodwin: You see! Let’s forget about one movement and just try and think about a core set of values and aspirations. Let’s not try to corral the scientists. It doesn’t matter that they don’t know they’re doing public health, does it? If they’re doing it, it’s OK as far as I’m concerned. It’s like people used to say to me “the health visitors don’t know that the area health authorities have gone years ago”. Well I don’t really mind actually! As long as they know what they’re doing. The reality is, for the patients and clients, it doesn’t really matter that they don’t know, as long as they’re getting the right service and they know what they’re doing and they’re doing it properly. So we must avoid this attempt to build an empire for public health. What matters is that it gets done and that we develop the infrastructure to see that it gets done. We may never, and we should probably never aspire to, create the one big all-singing all-dancing organisation, so don’t let that be an outcome of our thinking for the future because I think that’s a dead end.

Judy Orme: Thank you. Tessa?

Tessa Lindfield: Before I started public health training, I assumed part of the reason we were having a multidisciplinary public health workforce, is that we would work outside of the NHS. We would work with housing, we’d work with local authorities in a far more engaged way. And yet, having been through training, it trains you to work in the NHS pretty much and I think that’s a real shame and if there’s one big weakness of having created the public health training system, it’s that it excludes lots of people that make a massive contribution to public health, outside of health. As trainees we nominated Jamie Oliver this year for one the prizes, because when you look at impact, actually the impact of other things are so much greater than some of the impact of the things that we do in the NHS in public health.

Teri Knight: Just picking up on the point about the need for this strong force and coalition, of course during the last fifteen years that's been attempted twice. First of all SCOPH, the Standing Committee on Public Health which imploded. And then much more recently, the Common Agenda Group. I think we have to learn from the fact that they didn’t work.

Yvonne Cornish: Well the Common Agenda Group had a specific function,
didn’t it, which was to influence an incoming Government, and they did that. But SCOPH was a disaster, wasn’t it?

Teri Knight: I’m not saying it won’t work but it hasn’t worked in the past.

Shirley Goodwin: People put a huge amount of energy in and is it worth putting in energy to do something which may not be actually sustainable?

Yvonne Cornish: That’s why it was a debate we had endlessly within the Multidisciplinary Public Health Forum, wasn’t it? Whenever we got groups together there was this tension between people who wanted us to form another organisation or a single organisation and those of us who said, “look, just get on with it. Do what we’re doing through the organisations we already belong to”. We went for the second approach. We thought we’d end up spending all our time and energy building another empire. When we actually mapped it out we were all part of at least two or three other organisations and we just kept it firmly in our mind that what we needed to do was go back and keep influencing those organisations to talk to each other. I think that was part of what helped us to achieve what we achieved. Occasionally there were Forum meetings where we had as many people around the table as we’ve got here today, but quite often it was very small. But then people would pop up somewhere else in another organisation and influence that, and it was very much that kind of networking approach.

Teri Knight: What made change happen was individuals getting together, talking and just saying “let’s change it”. It wasn’t creating an organisation.

Shirley Goodwin: Maybe that’s a lesson from history. There are other names that haven’t been mentioned today, people who’ve been in some way, a hot point, a spark, a catalyst. I think that, if we want to come out with one recommendation today, it should be that wherever we have influence, in whatever field we operate, we must make sure that this kind of event, time out for people to get together to share our ideas about the past and future, happens. So that they can go off and continue to feed those lights which cumulatively represent the public health movement, but which individually may be little flickers in all sorts of unlikely places. And also so that we can inspire other people to come on into public health and to stay in public health. I find, at the end of my career, that that’s been a really important part of what I think I’m here to do, which is to seed people.

David Evans: Several of the last contributions make me think I need to return to what I started with which was Jane Lewis and some of the tensions and paradoxes that she identified in public health medicine in the twentieth century. I think one of the things which I’ve failed to do on this day, is to give voice to the ‘Refuseniks’. When I was a director of public health I was part of the group of Refuseniks. I hadn’t quite decided if I was going to totally refuse and not do the Voluntary Register and so on, but I had many hesitations and qualifications. I still have a concern around how we constructed this professional project of multidisciplinary public health and the way that we have replicated what I see as some of the exclusionary tendencies which existed in public health in the twentieth century. We’ve let some new people in the door, but we closed other doors. If we take particularly some of the points Ian was making earlier, it seems to me that if we’re going to make a reality of what Shirley was talking about, we’ve got to have an inclusive approach that really nurtures people in all sorts of different careers, to give people flexibility to move
back and forth between the NHS, local government, the voluntary sector, overseas, whatever, that values all their diverse experiences. The frameworks are great and the CMO’s framework of specialists, generalists, wider workforce, is great. But as soon as you impose those categories, you actually close off a lot of doors for people whose career histories and contributions don’t fit into those neatly labelled boxes. And that’s my real concern about what we’ve done is that there’s a huge amount of creativity and energy for change out there and that some of the structures we’ve set up, although great in terms of opening up one previous inequality may, actually close other doors for other people.

Paul Pilkington: What happened when the Faculty became more involved in the multidisciplinary training scheme is that suddenly the criteria for entry to the scheme ratcheted-up, so suddenly you needed four years postgraduate experience, whereas for me I needed two and I actually had only one but I got in anyway. I wouldn’t have got in now, certainly. I don’t think there’s any room now for someone who’s enthused at university level to then go into public health.

Shirley Goodwin: As David was speaking I was thinking of something that allows you to move about - international, national, local. That licence to do anything is at the moment delivered by a medical degree. A medical degree allows somebody to move in and out, up and down, round and about, across. Now what we need is an equivalent to that, which you might want to argue could in future be a public health degree, which would actually solve the problem we’re just hearing about. A public health degree wouldn’t necessarily create a discipline or a profession. It could be a public health degree like any other area of study, which gave people a number of options from which they could then proceed. But if people start those degrees anticipating that they’re going to be a vocational route, then we are just recreating the old model in another way. But I don’t think we should forget that that passport to move anywhere, do anything, which a medical degree gives you, is very powerful and important and we should try to deliver no less for people who work in a public health field.

Yvonne Cornish: Just getting back to that point about the three groups, I don’t see them as three groups of any kind of; they are three groups of roles and people ought to be able to move from one into the other and move across them. That’s what the whole thing about the competency framework is, that people ought to be able move closer into the centre and go out and take that expertise with them. They start to get seen as barriers with all this ‘are you a practitioner or are you a specialist?’ debate. You could be a practitioner in one point of your career and a specialist at another, presumably. I never saw them as separate beings that you then went up a career ladder in. But it can be interpreted as that.

Peter Farley: There’s still a lot of scope for sorting all this out, both locally, regionally and nationally. The Faculty has never asked the government departments, who pay for it, what they think about the changes in the training scheme. They’ve assumed that they will just roll it out. I’m not suggesting that there isn’t any reason why they shouldn’t, but as a matter of fact as far as I’m aware, they have never actually said, ‘we’re proposing these changes, we’ve done this consultation, would you like to talk about it?’ So the situation is still very fluid. I think that’s a point to be borne in mind because there is a great deal of scope one way and another through the register. There was provision, as I
understand it, within a reasonable period of when they were first done, for the original standards to be revisited. There is plenty of scope for these issues to be addressed. It's not a done deal and it's not a closed door.

**Jenny Griffiths:** I just wanted to stress that for me, however it’s done, we need to find a way, and it’s back to funding as it always is, to ensure that all those who are working in the public health community have access to structured organised learning and development and the opportunity to have that accredited. Many of us are saying this in different ways. I think at the moment you have some groups who have access to that funded infrastructure, or elements of it, and some who do not have access at all below specialist level. The health promotion staff I’ve done a lot of work with have their access largely restricted to specialist level learning and development opportunities only, which is probably only about five percent of the workforce. It's a lottery whether anything else is available for 95% if the workforce and that argument can be replicated over a number of other groups. Others like environmental health officers, I guess Ian, you’ve got accreditation but access to funding and development is probably patchy as well. But linking that position to the broad career framework that Jenny Wright was talking about earlier is a huge piece of work to be done. Because although the work we’ve done on the specialist level is of fundamental importance, as we’ve said all day, the vast majority of the workforce who actually get things done, actually deliver the goods out there, are working below specialist level in organisations that do not support their learning and development. I’ve just done a survey in the South East, for the specialised health promotion workforce and it’s clear from the outcome that the vast majority of those staff have had no structured access to learning and development opportunities and yet are holding responsible and important jobs delivering on key aspects of national policy. So to me the next big agenda is broadening this out to practitioners and senior practitioners. However we do it, that’s what’s got to be done.

**Paul Scourfield:** In an organisation like mine, that has come a long way with this, the priority is to align what we teach, with national standards and Voluntary Register requirements and people then know they’re on the right road, on the correct path.

**Jenny Griffiths:** That’s right and you create something that’s portable. As we’re all saying, it should not matter where you work, it should be a portable set of standards backed up by accreditation.

**Ros Dunkley:** I want to do a bit of reassuring David, because you were saying, “we are introducing exclusive systems” and “not thinking broadly enough” and also pick up on what Peter was saying about flexibility. The whole principle behind the defined specialist registration is that there are no barriers to any individual who is a public health specialist, no matter what their background. Whilst the defined route is still not carved in tablets of stone, we need to actually take that opportunity and reinforce everything about flexible assessment frameworks and flexible training. It’s a great opportunity.

**Judy Orme:** At this point I would like to say thank you for so much to everybody for being involved in this. Thank you especially to Teri and David for the hard work that has gone on around getting the money and making this happen, which has been absolutely brilliant. Thank you also to Emma Griffin who has done all
the background work, keeping us afloat here with everything that we’ve needed.

**Teri Knight:** And can we thank you, Judy, for chairing today.
Biographical Notes

Sheila Adam graduated from the University of Edinburgh in 1972, and completed postgraduate training in public health in Oxford. She was appointed as a consultant in Brent in 1981, and moved to North West Thames Regional Health Authority in 1983. From 1995 she worked within the Department of Health and joined North East London Strategic Health Authority as Director of Public Health in June 2002. From 1991 to 1996, she held the post of Visiting Professor at the London School of Hygiene and Tropical Medicine, and is currently a Professor at Queen Mary University, London. She has been an elected member of the board of the Faculty of Public Health Medicine, was a founding co-chair of the Association for Public Health, and is on the Board of the Voluntary Register for Public Health Specialists.

Virginia Berridge is Professor of History at the London School of Hygiene and Tropical Medicine and Head of the Centre for History in Public Health. She was appointed Senior Lecturer there in 1988 as co-director of the AIDS Social History Programme. She previously worked at the Institute of Historical Research, University of London (1979-88) and the Economic and Social Research Council (1986-87) and the Addiction Research Unit, Institute of Psychiatry, London (1974-79). She has co-edited witness seminars on the Black Report (Berridge & Blume, 2003) and public health in the 1980s and 1990s (Berridge et al, 2006).

Yvonne Cornish’s academic background is in sociology, social policy and health management. She came into public health in 1990, as a research assistant for the Director of Public Health in Brighton. Two years later, she moved to North West Thames to work for the Regional Directors of Public Health Group. After this, a change of direction led to the South East Institute of Public Health, where she undertook applied public health research and consultancy – much of which was around the development of multi-disciplinary public health. While she was working at SEIP, Yvonne helped to set up the Multidisciplinary Public Health Forum, and was a member of the national core group, as well as being a regional representative for the South East. She has taught public health as a Visiting Lecturer at City University and the University of Brighton, and is currently an External Examiner for the Masters in Public Health at Oxford Brookes University. Yvonne Cornish became an Honorary Member of the Faculty of Public Health in 1999, and was Specialist Visitor to the South West Regional Training Programme from 2001 – 2003. She gained her PhD in 2001, and currently works at the University of Greenwich.

June Crown has served as Area Medical Officer in Brent and Harrow, Director of Public Health in Bloomsbury (central London) and Director of the South East Institute of Public Health. She was President of the United Kingdom Faculty of Public Health Medicine from 1995 to 1998. She has frequently acted as a special advisor to the World Health Organisation and overseas Governments and has undertaken work related to health services reform in central and eastern Europe, most recently in Russia. She chaired the 1989 Department of Health review on nurse prescribing which led to the extension of prescribing rights to district nurses and health visitors, and subsequently the Review of the Prescribing, Supply and Administration of Medicines which has led to further extensions of prescribing rights to other health professionals in all settings. In
'retirement', she has been Chairman of Age Concern England from 1998 to 2002 and is now a Vice-President. She was appointed a Trustee of Help the Aged in 2003. She chairs the Inquiry into the Mental Health and Well-being of Older People which is being undertaken on behalf of the Mental Health Foundation and Age Concern England. She was appointed Vice-Chairman of the Governors of Brighton University in 2002 and represents the University on the Brighton and Sussex Medical School Joint Board.

**Ros Dunkley** is Director of Public Health Development in the Public Health Resource Unit, a not-for-profit NHS public health consultancy based in Oxford. Throughout the 15 years Ros has worked in public health, she has increasingly focused her energies and attention on strengthening the public health skills and expertise of the workforce. Currently she leads the Development Needs Assessment Centre, the Department of Health funded virtual centre for advise and support to people preparing for registration by portfolio assessment on the UK Voluntary Register, and works to the Department of Health’s Health Improvement Workforce Programme Board to support national policy on public health workforce development.

**David Evans** first graduated in history, before training as a general nurse, qualifying in 1986. Working as a health adviser in genitourinary medicine led to a move into health promotion on HIV/AIDS and sexual health. He moved to a research post at the Institute for Health Policy Studies, University of Southampton in 1993. In 1998 he returned to work in a health authority department of public health taking a strategic lead on health inequalities and other issues. In 2001 he passed the Faculty Diploma and Part 1 examination, and was seconded as a locum public health lead for Bristol North Primary Care Group. In 2002 he was appointed Director of Community Development and Public Health for Bristol North Primary Care Trust. In 2003 he moved to University of the West of England Bristol to take up the post of Reader in Applied Health Policy Research. He has published several articles on the development of multidisciplinary public health (Evans 2003; 2005; Evans & Dowling, 2002).

**Peter Farley** is currently Acting Head of the Public Health Protection Division in the Office of the Chief Medical Officer, Welsh Assembly Government. He first became involved in public health in the mid 1970’s when he developed a programme of personal, social and health education for the Devon comprehensive school where he was teaching. From there he joined the Schools and Health Education Councils’ Health Education 13-18 Project in 1977, where he later became Project Director. After a spell in the NHS as a District Health Promotion Officer he joined the newly founded Health Promotion Authority for Wales. In recent years he became involved in the work of the Tripartite group, the founding of the UK Voluntary Register for Public Health Specialists and the development and dissemination of National Occupational Standards.

**John Fox** was “a statistician who by good fortune spent most of his early career with people who valued good scientific work irrespective of where it came from.” John moved in government service through occupational health, to health inequalities (the Black Report) to academia where he established a multidisciplinary research unit. Finding the unit was on the edges of several relevant disciplines, he became an active member of a range of professional organisations including the Society for
Social Medicine, British Society for Population Studies, Royal Society of Medicine as well as the Royal Statistical Society. In 1988 he broke through his ‘glass ceiling’ by becoming the first non-medical Chief Medical Statistician in 170 years at the Office for Population Censuses and Surveys and 10\textsuperscript{th} in line to William Farr. In that role he enjoyed considerable support, initially from two Chief Medical Officers, Sir Donald Acheson, who was involved with his appointment and Sir Ken Calman who welcomed him to the Regional Directors of Public Health table. John is currently the Director of Business Development at the Information Centre for Health and Social Care.

Shirley Goodwin After qualifying in 1971, Shirley Goodwin practised as health visitor for 12 years in West London, then served as general secretary of the Health Visitors’ Association until 1989. She did her MSc Public Health Medicine at the London School of Hygiene and Tropical Medicine in 1992/93, the first year in which non-medically qualified students were admitted. Returning to the NHS in 1993 to work as a senior manager in commissioning for Hillingdon Health Authority, she moved back in to public health as a senior public health specialist in 1998, retiring from Hillingdon Primary Care Trust in October 2005.

Ian Gray is the Policy Officer for health development at the Chartered Institute of Environmental Health and a co-chair of Forum, the national NGO forum for public health and inequalities. A Chartered Environmental Health Practitioner and an Associate Member of the Trading Standards Institute, he worked for many years in the local authority sector managing both regulatory services and health improvement teams. In 2002 he led the joint project with the Health Development Agency which both critically examined current environmental health practice and set out the vision for future development: Environmental Health 2012 – A key partner in delivering the public health agenda. He was also a member of the Trading Standards Institute Task Group on Health that produced the report: Making the Connection - Trading Standards: Contributing to Public Health.

Jenny Griffiths was an NHS manager and former Health Authority Chief Executive and has previously managed public health and health promotion programmes. She now works independently and has undertaken recent work for the Department of Health and Welsh Assembly Government on specialised health promotion and the role of pharmacists in public health. She is an assessor with the UK Voluntary Register for Public Health Specialists, a Trustee of the UK Public Health Association, a Non-Executive Director of the National Institute of Health and Clinical Excellence. She also works in health care consultancy, mentoring and organisational development and is Independent Chair of Surrey Connexions Partnership for young people.

Selena Gray is Professor of Public Health, University of the West of England, Bristol (UWE). After training in medicine in Leeds she worked in paediatrics in the north of England and Saudi Arabia before undertaking a specialist registrar training programme in public health medicine in the South West Region. She then worked at the regional level primarily on the NHS Research and Development programme and then on setting up the South West Public Health Public Observatory before moving to UWE in 2002. As Deputy, and then Faculty Adviser, over the period when multidisciplinary training was introduced in the South West, she ensured that both training schemes were fully integrated from the start. She was an active
member of the Working Group on RITA from 1999-2001, which developed a much more explicit competency based framework for public health training, that could be used by trainees from any background. She continues her interest in education through a part time appointment as Deputy Postgraduate Dean in the Severn and Wessex Deanery.

Rod Griffiths has been President of the Faculty of Public Health since 2004, Professor of Public Health Practice, University of Birmingham since 1990, and was previously Regional Director of Public Health, West Midlands, Department of Health (formerly West Midlands Regional Health Authority) from 1993 – 2004. He was a member of the CMO's Inquiry into the Public Health Function (Acheson Committee) from 1986 to 1988. He was earlier a Director of Public Health for Central Birmingham Health Authority from 1982.

Sian Griffiths has held a number of positions on the Board of the Faculty of Public Health/Public Health Medicine/Community Medicine, including Board member, Treasurer, Vice President, Chair of International Committee and President - holding the latter title when the Faculty made the decision to drop the word ‘medicine’ from its title in recognition of its multidisciplinary status. She was the Chair of the Association of Public Health and co-founder of the UK Public Health Association when it merged the Association for Public Health with the Public Health Alliance to form the UK Public Health Association (UKPHA). In April 2004, he was elected Chair of the UKPHA. In 2000 he moved to Durham University and set up the Centre for Public Policy and Health in the Wolfson Research Institute. He is author of Public Health Policy (2003) and editor and co-author of a forthcoming book, Managing for Health (2007).

David Hunter completed his first degree in political science at Edinburgh University and went on to obtain a PhD in 1979. Reflecting an interest in the interface between academic inquiry and the formation and implementation of policy, many of his earlier posts, including those at the Outer Circle Policy Unit, Royal Institute of Public Administration and the King’s Fund Institute, sought to bridge the two worlds. In 1989, he was appointed Director of the Nuffield Institute for Health Service Studies at Leeds University. He broadened the remit of the Institute to include public health and social care. During this period, he became co-chair of the Association of Public Health with Sian Griffiths and presided over the coming together of the Association for Public Health with the Public Health Alliance to form the UK Public Health Association (UKPHA). In April 2004, he was elected Chair of the UKPHA. In 2000 he moved to Durham University and set up the Centre for Public Policy and Health in the Wolfson Research Institute. He is author of Public Health Policy (2003) and editor and co-author of a forthcoming book, Managing for Health (2007).

Ruth Hutt was one of the first four multidisciplinary public health trainees on the London specialist training programme. Through the course of training she worked for two former health authorities, the Health Protection Agency and the King’s Fund. She is currently a Locum Consultant in Public Health at a South London Primary Care Trust, and works part time at the King’s Fund as a Policy Research Fellow, with a particular interest in long term conditions, demand management and workforce issues. She has a clinical background in nursing and prior to undertaking public health training had trained in tropical medicine and completed an MSc the London School of Hygiene and Tropical Medicine.
Teri Knight  After a degree in human biology, Teri Knight went on to obtain a PhD in 1988 within the Cancer Epidemiology unit at Oxford University. This was followed by two post-doctoral research positions, working mainly on gastric disease and coronary heart disease, in Bradford and North Staffordshire. She then moved into public health practice, working as a senior manager in public health in North Staffordshire Health Authority. This was followed by a spell as an academic in the Health Services Management Centre at Birmingham University. The next move was into her current post as Consultant in Public Health at Solihull Primary Care Trust. She was a founder member of the Multidisciplinary Public Health Forum and served on the councils of both the Association for Public Health and the UK Public Health Association, being vice-chair of the latter from 2002-2005. Teri was admitted onto the UK Voluntary Register for Public Health Specialists in 2005.

Tessa Lindfield was one of the first four public health specialist trainees on the London, Kent, Surrey and Sussex training programme. She originally trained as a Speech and Language Therapist and worked as a clinician and operational manager in the UK and overseas before moving into public health. During her time on the training scheme she has worked across NHS, health protection and academic departments. Her particular interests are in disability and international public health and she is currently placed at the Department of International Development.

Phil Mackie is a practising public health specialist whose remit covers older people’s care, adult mental health care and physical and complex disability care. He has previously held service posts in the north of England, including a year spent as the Locality Director for an English primary care commissioning pilot. He is a former Chair of the National Co-ordinating Group of the Multidisciplinary Public Health Forum, a Councillor and Trustee of Royal Institute of Public Health and is the Deputy Convenor of the Scottish Affairs Committee of the Faculty of Public Health. In addition to his NHS work, he is Co-Editor in Chief of the journal Public Health. He currently teaches applied epidemiology at the University of Edinburgh and has previously held research appointments at the Universities of Newcastle-upon-Tyne, Durham and Huddersfield. Phil trained in psychology at Durham University and paediatric epidemiology at Newcastle Medical School.

Jim McEwen graduated in medicine from St Andrews University. Following academic posts in Dundee and Nottingham he was appointed as Chief Medical Officer to the Health Education Council. He then had a personal chair at King’s College School of Medicine and Dentistry before moving to be head of department of Public Health at the University of Glasgow. He was Academic Registrar and then President (1998-2001) of the Faculty of Public Health. Currently he is Chair of The UK Voluntary Register for Public Health Specialists (from 2003) and Emeritus Professor in Public Health.

Klim McPherson is Professor of Public Health at the University of Oxford. From 1990-2001 he was Professor of Public Health Epidemiology at the London School of Hygiene and Tropical Medicine, then from 2001-2003 he was Medical Research Council (MRC) Senior Scientist and Deputy Director of the MRC Health Services Research Collaboration at the University of Bristol. He was Chair of the Honorary Members Committee in the 1990's and sat, ex officio, on the Faculty Board and
Executive. He is co-author of the *Feasibility Study of the Case for National Standards for Specialist Practice in Public Health* (Lessof et al, 1999).

**Judy Orme** With a degree in Human Biology from the University of Surrey in 1973, Judy Orme became a Research Assistant in the Department of Child Health at the University of Bristol, working on a controlled trial of smoking in pregnancy amongst other smoking related research projects. Later she worked for the International Centre for Child Studies in Bristol, on the 1970 Birth Cohort with a particular interest in young people and risk taking behaviour. A move into a Senior Lecturer at the University of the West of England (UWE) followed her completion of the MSc Health Promotion in 1994. She became Programme Leader for the UWE MSc Public Health, the development of which she led in 2000. She is currently Reader in Public Health and Director of the Centre for Public Health Research at UWE and was awarded Membership through Distinction of the Faculty of Public Health in 2004.

**Paul Pilkington** became one of the first two trainees from a multidisciplinary background to be appointed to the South West Public Health Training Scheme in 1999. His background is in social sciences (geography), and he developed an interest in public health at undergraduate level. Before joining the training scheme he completed a Postgraduate Certificate in Education. His particular interests are in road safety and tobacco control. In 2004 he gained membership of the Faculty of Public Health. Currently he is seconded to the University of the West of England where he is lecturing and completing a PhD examining knowledge, attitudes and experiences of casino workers with regard to second hand smoke exposure.

**Mala Rao** is now the Head of Public Health Workforce and Capacity at the Department of Health. She was previously a Director of Public Health for many years. Throughout her career, Mala has been committed to developing multidisciplinary public health and to bringing public health teaching, research and practice closer together. She has been actively involved in Public Health training and education and was the Faculty of Public Health Adviser to North East Thames Region between 1991 and 1996. She has contributed for many years to undergraduate and postgraduate teaching, her closest connections being with Cambridge, and Essex University where she is Honorary Professor. She is a member of the editorial board of the journal Work Based Learning in Primary Care. She was a member of the Committee of Inquiry into *Radiation in MRC supported research in the 1950s and 1960s* and the Wellcome Public Health Sciences working group which published *Public Health Sciences – Challenges and Opportunities* in 2004. She was Joint Chair with the Chief Pharmaceutical Officer, of the *Choosing Health through Pharmacy* strategy published in April 2005. During 2004/2005, she was Chair of the project jointly commissioned with the Welsh Assembly, to strengthen the health promotion workforce in the NHS. The project report, *Shaping the Future of Public Health: Promoting Health in the NHS* was published in July 2005.

**Jane Royle** has worked in public health for 10 years. She was previously employed by the Wessex Institute for Health Research and Development, University of Southampton and was on secondment to the National Institute for Health and Clinical Excellence (NICE) as Implementation Adviser - South East and now works for INVOLVE - promoting public involvement in NHS, public health and social
care research as Research Programmes Liaison Manager. She has a background in health promotion and a PhD which focussed on quality assurance process and the implications for specialist health promotion services. She has been a South West and South East representative on the Multidisciplinary Public Health Forum. She was entered onto the UK Voluntary Register for Public Health Specialists in June 2006.

Paul Scourfield came to public health from a generic NHS background in senior management, and worked as a public health specialist for 12 years in both North West Anglia and Coventry Health Authorities. For the last 9 years, he has been operating in the role of Chief Executive of the Faculty of Public Health, and was an active member of the Tripartite Steering Group (the group which led to the development of the Voluntary Register) He is a Company Director and Company Secretary for the Voluntary Register. Paul is currently advising the Australasian Faculty of Public Health on the development of multidisciplinary public health in Australia.

Michael Shepherd After several years in social research, Mike Shepherd joined Bristol and Weston Health Authority in 1987 as a Statistician/ Information Coordinator in the Community Medicine Department. At the time he was one of very few non-medical professionals working in public health in the South West. Following the reorganisation in 1990, he stayed in Community Medicine/Public Health, working as a Policy Analyst and later Research and Development Manager. In 2000, he was made an honorary member of the Faculty of Public Health Medicine. He continued to contribute to public health policy and information until the reorganisation of 2002/03, when he left the NHS. He is now a Senior Research Fellow at Cardiff Institute for Society, Health and Ethics.

Fiona Sim trained as a GP, before discovering public health. Following senior posts in NHS public health and in medical education, including Director of Public Health, Trust Medical Director and associate Dean of postgraduate medical education, she spent two years at the Department of Health, responsible for delivery of national public health priorities, including tackling health inequalities and developing public health capacity. A former Faculty of Public Health Adviser and Director of Training. She is now an independent public health Consultant and part-time GP. Other current professional interests include: honorary senior lecturer, Univesity College London; joint editor of Public Health; Member, joint Board, UK Voluntary Register for Public Health Specialists; and General Medical Council Fitness to Practice panel member.

Lillian Somervaille has worked in public health for over 15 years with particular interests in public health intelligence and in the development of public health capacity and capability. She is now a freelance consultant. Lillian came into public health from a scientific background, having a biological degree, a PhD in physics and 6 years spent doing post doctoral research. Her first post in public health was as an epidemiologist supporting the West Midlands Regional Director of Public Health. This interest in health intelligence continued, finally resulting in Lillian becoming the Director of the West Midlands Public Health Observatory in 2001. Lillian’s involvement in national public health development began with the first survey of multidisciplinary public health in 1994 and the development of the Multidisciplinary Public Health Forum (MPHF) in 1996. As the then Chair of the MHPF, Lillian was a member of the
Tripartite group which established the UK Voluntary Register for Public Health Specialists and she remains Vice Chair on the Register’s Joint Board. Lillian has also been an active participant with the Faculty of Public Health (FPH) and has been a member of its Education Committee since 1997, a Faculty Visitor, and was elected as a General Board member in 2002. In 2003 the FPH awarded Lillian the Alwyn Smith prize for contributions to public health.

Robert West joined the Department of Social Medicine, Welsh National School of Medicine (later University of Wales College of Medicine (UWCM) in 1969. From 1975 - 1990 he taught on, and for many years led and managed, the Cardiff modules of the interregional training scheme for community (later public health) medicine. In 1990 he was co-founder of UWCM’s multidisciplinary Masters in Public Health, and led the core ‘epidemiology’ course until 2005. In 1991 he was made an Honorary Member of the Faculty of Public Health Medicine in its first year. In 2001 he became the first ex honorary member to become a Part 2 examiner, and is currently the only ex-honorary member OSPHE examiner. He joined the national co-ordinating group of the Multidisciplinary Public Health Forum (MPHF) from its outset, and organised and hosted a MPHF ‘fringe’ meeting at the annual Faculty meeting in Cardiff.

Jenny Wright is an accredited specialist in public health on the UK Voluntary Register for Public Health Specialists. She has worked in public health fields since the late 1980s and has been based in Oxford working first at regional level, then for a range of Thames Valley organisations. She is currently Director of the Public Health Resource Unit (PHRU), an NHS consultancy which undertakes a range of public health service, project and development work. She started her public health career as a social worker then became a health and social care researcher before entering health service planning. Her interests are in specialist service commissioning and multidisciplinary public health development. Jenny and PHRU have built a national reputation for specialist support, particularly associated with support to public health specialists seeking accreditation as specialists with the UK Voluntary Register. She led the teams which developed the frameworks for the current retrospective portfolio assessment for generalist/specialists and the coming accreditation of defined specialists. She was chair of the Faculty of Public Health’s Honorary Members Committee and subsequently Specialist Development Committee between 1999 and 2005 at a time of considerable change as it widened its membership to include non-medics.
Additional Comments

Sheila Adam
Submitted October 2005 prior to the witness seminar

I joined public health in 1975. At that point senior colleagues were still preoccupied with the 1974 reorganisation when public health moved from local government into the NHS, and were grieving the role, status and span of control of the Medical Officer of Health. I was struck by the fact that, although a broad range of academics were crucial to my training programme, they were not recognised as members of the public health community – this seemed both bizarre and unjust. During the late 1970s I worked in the academic department of public health in Oxford – with the exception of Klim McPherson and me, the medics were men and the women were non-medics – Klim and I occupied a kind of grey area, where we were joined by Phil Strong when he was appointed. At the same time I established the Trainee Members Committee of the Faculty of Community Medicine, which gave me a platform. I was the trainee representative on the Education Committee and the Meetings Committee, and on the back of this was elected to the Board.

Alwyn Smith was President from 1981 to 1986 (I think) and was supportive of the proposal that Faculty membership should be extended. However, other senior Faculty officers and members were not, and a compromise of honorary membership was reached. The focus on the Faculty downplayed the action that was also required from employers, and especially the NHS, which would recognise equivalence in employment as well as in professional terms. Skirmishing continued. Subsequent Presidents were less committed to the Faculty broadening its membership. When the Faculty changed its name from Community Medicine, the ballot was in favour of Public Health Medicine rather than Public Health. The requirement that the Director of Public Health should be medically qualified was retained until the late 1990s. The membership backed this reactionary stance and it was particularly disappointing that the younger members were among the most defensive.

The Birmingham event, organised by Rod Griffiths and Lillian Somervaille in 1995, was reminiscent of the early Sheffield training conferences, when the 1970s cohort of trainees negotiated their position with the post-1974 Faculty – if only because it was icy cold! To me this event seemed to be the turning point – Lillian’s survey demonstrated just how many people there were working, generally unrecognised and undervalued, in multidisciplinary public health. A head of steam for change was created, and then taken forward by the hard working Multidisciplinary Public Health Forum. My current involvement is as a Director of Public Health striving to support multidisciplinary equity in UK public health, and as a member of the Board of the Voluntary Register for Public Health Specialists.

Somervaille & Griffiths (1995)
Sheila Adam

Note added June 2006 after the witness seminar

There is some discussion in the report about the change in name of the Faculty. My recollection is that there was a vote between ‘Public Health Medicine’ and ‘Public Health’. Some of us lobbied very strongly for the latter, but I think there was a clear majority at that stage for the former.

In terms of other things that were happening, there was also the *Radical Community Medicine* journal, initially set up by a multidisciplinary group in the 1970’s, then run for a long time by Alex Scott-Samuel and handed over to John Gabbay in the 1990’s when, I think, it became *Critical Public Health*. 
June Crown
Submitted June 2006 after the witness seminar

I am delighted to contribute to this history of public health. Throughout my career I have always had a wide range of non-medical specialists in my departments, several of whom, such as Yvonne Cornish, have been very active in the campaign to widen Faculty membership. I think I was the first person to appoint an economist (Peter West) to an NHS public health department – an interesting experience, as he left after a year, though we remain good friends. He decided that decisions in the NHS were made for political reasons and that economic evidence on the options carried no weight. His experiences were subsequently published in the British Medical Journal. I was rather more successful with the statisticians, nurses, social scientists, psychologists and others whom I worked with over the years.

With this background, I could not support the arguments against widening Faculty membership. I was on record that I would have no problems in serving under a non-medical Director of Public Health and indeed would feel privileged to work under the leadership of many of my non-medical colleagues. I was confident that they would recognise the particular role and contributions of public health physicians, perhaps articulating this more clearly than some of the doctors. A totally non-medical department seemed an unlikely prospect. I was saddened at the protectionist attitudes of some people, though could understand how these could arise after painful restructurings that left many experienced colleagues feeling undervalued, unappreciated and extremely worried about their future employment. The pay structures operating then, with much higher salaries for doctors than the rest, coupled with the recognition that the specific expertise of some non-medical colleagues was greater than theirs, resulted in widespread lack of confidence in their roles and value to public health.

The worst moment of my Presidency came near the beginning, when I had to announce the results of the Faculty ballot on widening membership, to the Multidisciplinary Public Health Forum. I am still grateful to the many people at that meeting who understood my dilemma and treated me kindly!

Needless to say, I am delighted at the progress that has been made since those difficult days and am pleased that we are now in many respects showing the way to other disciplines.
John Fox  
Submitted June 2006 after the witness seminar  

This report reminds me of some very exciting times and great people, who came together in the 1990s, and worked largely on a voluntary basis. I feel very proud of what was achieved and to have played a role in helping change happen. Many of our colleagues harbour longstanding scars from how they were treated by those they worked with and how their opportunities were limited. Without this record, future generations working in public would not be able to understand the ‘glass ceilings’ that we were up against and how people felt. As I recall, the survey and conference that Rod Griffiths and Lillian Somervaille organised around the survey, led to a simple and measurable goal for the Multidisciplinary Public Health Forum, and that was, to see the first ‘non-medical’ Director of Public Health appointed.

I was sad not to be able to join the witness seminar but offer some brief observations on parts of the history that I was involved in.

The Faculty of Public Health Medicine and honorary members  
My main involvement began in 1991, when I was invited to join the Faculty as an honorary member and then to become the chairman of the Honorary Members Committee, a role I held until 1998. There was considerable suspicion as to the Faculty’s motives for recruiting honorary members and many highly distinguished people refused the offer of honorary membership. However, those that did join, provided an increasingly important voice and driving force for change within the Faculty. Klim McPherson was vice-chair and together we established a regular honorary members meeting that provided us with ammunition to support arguments both at the Board and Executive level. Changing an organisation takes time, skill and persistent commitment and although many offered support, I would like to single out the roles played by Jim McEwen, Sian Griffiths and Rod Griffiths, who, from early in my involvement, saw the way forward and effectively facilitated change through robust defence of the status quo by a significant group of fearful members.

Survey and Conference  
It is difficult to overstate the importance of the first survey of public health professionals. Information is power and we certainly used this survey to the full. I remember working with Rod Griffiths and Lillian Somervaille, to get a robust questionnaire – taking advice on the questions from Karen Dunnell (who, in becoming National Statistician has subsequently broken through a different ‘glass ceiling’) and working hard to get as wide a community of ‘non-medical’ public health people to reply as we could. At the first workshop, where the findings of the survey were presented, I recall clearly the strength of feeling expressed by a wide range of highly skilled and knowledgeable people who had spent years in social medicine and public health and even the resentment that was expressed at a survey that was describing them by what they weren’t. But most, I remember the energy and enthusiasm for doing something about the problem. It was that which fired a small group of us to volunteer to make sure that the survey was built upon and to consider how that should be done. The group was given a mandate to report back in 12 months and this helped us focus our activities.

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77 Somervaille & Griffiths (1995)
**Multidisciplinary Public Health Forum**

I recall hosting a meeting of this group in St Catherine’s House, after the first workshop, to which I also invited one or two senior supporters - Jenny Griffiths, Sheila Adam, Klim McPherson, Lilian Somervaille, Yvonne Cornish, Amy Nicholas, Teri Knight and others were there. We discussed lobbying around the report at different conferences such as the Association for Public Health and running regional workshops to bring the issue to wider attention. We planned to use these events to start to develop regional networks of people that could support each other and act as a local pressure group for change. We also had heated debate about whether we should form a new organisation (separate from the Faculty). We realised that we needed a better understanding of the different professional organisations with an interest in public health, what they were there for and how they were funded. The wonders of electronic filing (and Denise Tanner’s skilled support) allow me to illustrate the level of activity which followed and the degree to which this was shared by an ever-growing group; Annex A below, contains an agenda prepared by Teri Knight for a meeting of the Multidisciplinary Public Health Forum towards the end of 1998. It covers everything that was going on and our involvement in it and demonstrates the emphasis we placed on sharing the load, continuous project management (in a very light touch way) and wide communication and sharing, to build up momentum. It also adds a few more names to the list of active people who stood up and fought for change.

**Common Agenda Group and Public Health Forum Newsletter**

Another important meeting was an event hosted by the King’s Fund around 1995/1996 which brought together a number of senior people from public health organisations to discuss how the public health community should influence and lobby during the expected General Election in 1997. Klim McPherson and I represented the Multidisciplinary Public Health Forum. The main outcome was agreement among these different organisations to develop common themes for use by all and the establishment of a Common Agenda Group. However, one by-product of the meeting was the development of a shared publication that went to all members of participating public health organisations. With the support of Ian Wiley from the King’s Fund and a small editorial board including Donald Reid, Geof Rayner, Nicky Wilkins, Sue Jelly and Yvonne Cornish (with brilliant support from Denise Tanner) we established the Public Health Forum newsletter. We used this newsletter as a way of communicating our message quarterly to an audience of 5-10,000. Annex B illustrates this with an Editorial piece that Klim McPherson wrote for the December 1998 issue.

The newsletter was funded (not all costs) by subscriptions from professional organisations who distributed it to their members. The main subscribers were Public Health Alliance, Association for Public Health, Royal Institute for Public Health and Hygiene, Royal Society for Health, Society for Social Medicine, the Faculty and one or two others. It produced 12 issues before I needed to pass on the baton in 1999. I haven’t followed its history but there is remarkable resemblance to *Public Health News* which I receive today and which is supported by a similar church of collaborating organisations, but a better financial model as it provides space for job adverts for public health professionals.
Chief Medical Officer’s Project on
Strengthening the Public Health Function

Although my direct involvement with this was marginal, I do recognise the contributions that Janet Baker, representing the Multidisciplinary Public Health Forum, made to this and also the support for the Forum’s goals given by Amy Nicholas and Jenny Carpenter. I also was confident in the outcome of this work as a result of the encouragement that I had received both from Ken Calman and also from Liam Donaldson and the Chief Nursing Officer in the English Department of Health.
Annex A: Agenda for a Multidisciplinary Public Health Forum meeting in 1998

1. UPDATE ON PROGRESS WITH REGIONAL WORKSHOPS:

West Midlands: 9 dec. (Janet Baker)
South Thames: 26 Nov (Pat Dark)
N.Ireland: February (Jackie McCusker) + Pat Dark to co-facilitate
North West: Feb/March (Jan Hutchinson)
Northern and Yorkshire: 12th Jan. (Jean Brown)
South West: January (Siobhan McErlain)

KLIM - North West were one of the regions who asked for a co-facilitator from the NCG - could you do this? Please contact Jan directly regarding dates (01925 704000).

Lillian and I need to prepare a workshop pack for facilitators so that we have some consistency of outputs to feed into the national conference. The following format was agreed by earlier NCG meetings:

WORKSHOP FORMAT
1. Update on progress against MPHF objectives
2. Feedback on progress with: tripartite project
   scoping study
   follow-up survey of PHPs
   Careers in PH project
   CMOs project
3. Report on regional activity
4. Presentation of MPHF Core Policy Statements as developed at the NCG time out - reactions/discussion
5. Development of a regional action plan for moving forward with MPHF objectives

We therefore need to prepare a 'pack' for facilitators to enable them to run the workshop and give updates. Lillian and I are happy to co-ordinate this but we need your help with various bits - so here follows a 'to do' list which we hope you will agree to:

Outline one overhead acetate (I will produce) plus half page briefing notes on:

1. CMOs project: Janet Baker
2. Scoping Study: Klim
3. Follow-up survey of PHPs: Lillian
4. Careers Project: Yvonne
5. Tripartite project: Phil
6. FPHM Multidisciplinary group: Klim
7. FPHM diploma/part I: Lillian
8. Forum newsletter: John
9. Common Agenda Group: John
10. MPHF Core Policy statements: Phil

What we need is a brief statement on what each activity aims to achieve plus an update on where we are up to. Detailed findings from surveys etc are not required.

This way the workload gets shared out.

IN ORDER THAT I CAN PREPARE THE PACKS IN TIME FOR THE EARLIEST WORKSHOP - I NEED YOUR CONTRIBUTIONS BY MONDAY 9TH NOV. AT THE LATEST.

Please let me know if this is not possible and delegate the task to someone else.
2. CONFERENCE:
Siobhan is organising this and is in the process of contacting speakers and finding a venue.

Teri Knight
Progress on the Multidisciplinary Agenda
The best technical competence in public health in the UK is currently dispersed between the various disciplines and professions, academic and service departments that contribute to all of its aspects. A turning point in understanding this was the interim report of the outgoing CMO for England on Strengthening the Public Health Function.\textsuperscript{78} Public health is \textit{multidisciplinary} because it is about the health of populations and it is \textit{multisectoral} because potent determinants of health do not acknowledge health service boundaries. Yet within public health there is still a residual failure to acknowledge that it is as much about housing as it is about intensive care and that its core skills spring as much from medical sociology as from clinical medicine.

The Faculty of Public Health Medicine however, at its AGM, also recognised clearly the extent to which the determinants of peoples' health act well beyond its own domain. It is now striving for serious collaboration and for unity, on the basis of equivalence of public health contributions, by allowing any discipline to now enter for the Part 1 examination. The tripartite agreement between it, the Multi Disciplinary Public Health Forum, and the Royal Institute of Public Health and Hygiene recognises a clear and urgent programme for developing the training and accreditation agenda for public health practitioners of all kinds.

Firstly, with a grant from the NHS Executive, we have studied the feasibility of developing national standards for specialist public health practice, by identifying some of the core competencies and by attempting to measure where these skills are now and who practises them and who would benefit from knowing them.

We have detailed appropriate specialists skills\textsuperscript{79} in public health under the following ten headings: Measuring health status, disease surveillance and control, promoting health and wellbeing, evaluating health care, information management and research, advocacy, communication and co-ordination, intersectoral collaborative working, management and leadership and modelling the future of public health.

Since the demand for the recognition of skills such as these in public health is palpable the strategy must be, secondly, to seek ways to implement these (or agreed variations) as the core standards for professionals working together united in their commitment to proper training, career paths and professional development. It is axiomatic that anything less will impede the emergence of a truly coherent and effective public health agenda.

Clearly, complete recognition of the multidisciplinary, multisectoral nature of public health is core to the achievement of any kind of unity and this means routinely questioning claims for professional dominance by any single group. The structure of public health will have to consciously unite across all its diversity to demand the high political priority, and to provide the complex commensurate technical competence.

Klim McPherson
London School of Hygiene and Tropical Medicine

\textsuperscript{78} Department of Health (1998)
\textsuperscript{79} Lessof et al (1999)
One of the major drivers to the development of public health as a multidisciplinary speciality was the general debate about skill mix and roles within clinical medicine which spilled over into debates and attitudes within public health. Towards the end of the 1990s there were debates about what aspects of doctors work might be undertaken by other staff, both to increase efficiency and with a view to reduction (in theory at least) to reduce costs. This led to the development of extended roles of practitioners into areas previously defined as purely medical and the development of advanced practitioners within the nursing and allied health professionals, who in many cases took on a number of roles traditional done by doctors only. This included skills and tasks like history taking with nursing staff clerking patients rather than junior doctors; insertion of intra-venous drips, advice and chronic disease management, and even limited prescribing.

This desire to review skill mix within teams (often driven initially by a desire to save money) led to efforts to try to define explicitly the knowledge, skills and attitudes required to undertake a certain task or role. This occurred across the clinical fields, and led to challenging of boundaries of existing roles and responsibilities, with a more diverse range of staff undertaking roles and tasks that were more previously clearly seen as delineated to one group. This included not only nursing staff undertaking work that previously might have been done by doctors, but also the development of assistant practitioners, for example in the field of physiotherapy and speech therapy, providing a significant input to therapy albeit it under supervision.

As similar processes were undertaken for public health tasks and particular competencies identified, it became quite difficult to justify or explain in many cases exactly why one necessarily needed to have a medical degree and training to undertake particular roles - the important thing was whether individuals were able to demonstrate competency. As the boundaries were being challenged within clinical medicine generally, with impacts on the skill mix in clinical services, this acted as a driver for similar questions and challenges within the field of public health.

80 Royal College of Physicians of London and the Royal College of Nursing (1996)
81 Department of Health (2000)
Rod Griffiths
Submitted June 2006 after witness seminar

The first survey\textsuperscript{82} was done because I decided that it ought to be done and I persuaded Lillian Somervaille to do it, although she didn’t need much persuading. I was West Midlands Regional Director of Public Health at the time, but I became vice president of the Faculty about then so it was not difficult to get Faculty ‘cover’ for it, but we would have done it anyway. I paid for the survey out of the regional public health budget, so it was relatively easy to insist that we were going to do it anyway, very arrogant of us really. There were a number of people at the time who thought they could have done it better, they may well have been right. I wanted to be sure that we found as many of the NHS and local authority people that we could. I was worried that if we commissioned an academic department we would end up with a focus on academics. That may well have been wrong of us but at the time I felt that the real lost tribes were those in the NHS and local authorities. Why did I think that? I was on the Acheson committee in 1986 – 88.\textsuperscript{83} I tried quite hard to get something said about the importance of getting other skills into public health. My department in central Birmingham had a number of ‘non medical’ people in it and I remember a number of very gifted people who left because we were not able to offer them a career where they could end up in a senior position (if John Cubbon, now a lawyer and a loss to public health, ever reads this he will know what I mean). The idea was not welcomed by Acheson, I think I might have got one sentence into the report.

In 1990 I became the second professor in Birmingham and later head of department. Lillian was at that time part of the regional epidemiology unit. We found that from time to time individuals approached us because they were on their own in a public health department and wanted support. We launched a network across the region, I remember the first meeting was in Wolverhampton. When we launched the multidisciplinary Masters in Public Health in Birmingham the numbers of people contacting the network went up. Talking about this and planning the future of the network, Lillian and I (plus Janet Baker and Estelle Gilman), came to the conclusion that if there were this many people in the West Midlands there must be others in the rest of the country. By then I was Regional Director of Public Health and could produce the money, so we did the survey, based on a sort of snowball sample technique. In effect we started multiple snowballs by writing to every Director of Public Health, Head of Academic Department and Head of Environmental Health and asked them to pass the survey invitation letter to anyone who they thought fitted our description of a public health worker. Anyone who replied was asked to fill in a questionnaire and asked to recruit anyone else they knew. From the early feedback we knew that many of the respondents were very isolated and often unaware of others in the same position. It seemed obvious that we ought to get these people together so I mobilised the money to organise the first conference. I paid for the second one as well. My recollection is that the Multidisciplinary Public Health Forum was launched at the second one. After that they had to pay for the next conference themselves, the NHS had been reorganised, I had to apply for my job again and had become a civil servant, my ability to simply spend money on what I thought was a problem had gone.

\textsuperscript{82} Somervaille & Griffiths (1995)
\textsuperscript{83} Secretary of State for Social Services (1988)
I think from then on my role was as a subversive internal supporter within the Department of Health rather than an active role. I have enjoyed picking up the issue again as President of the Faculty over the last two years and further consolidating the position.
Sian Griffiths  
Submitted October 2005 prior to witness seminar

Sitting here in Hong Kong I am able to reflect on the huge and significant progress made by the public health professions in the UK to develop a multidisciplinary framework for education and professional standards. Where did we come from?

The situation here in Hong Kong is similar to the ‘dark ages’ in UK where the only way to become an accredited public health professional was through a medical degree. It was only doctors who could occupy board positions as senior public health advisers/directors of public health. In Hong Kong there is still a belief in the infallibility of doctors and doctor power rules OK. Medical protectionism extends to elitism and only Hong Kong trained doctors can occupy powerful positions with full registration. Thus, many colleagues with excellent skills in public health find doors closed to them, not least parity of position and pay.

Whilst these issues have not been entirely resolved in the UK there has at least been an attempt to shift the goal posts to a more equitable system. In the latest English public health white paper there is a section on workforce which reflects much of the work by the Faculty of Public Health (FPH) and UK Voluntary Register for Public Health Specialists Board over the last few years. The framework recognises some basic concepts including:

- Competency-based career pathways - underpinned by processes to set, assess and maintain explicit standards without professional boundaries
- Life long learning
- Ability to recruit from wide range of backgrounds

Perhaps one of the key messages is that all professions can have public health competencies at different levels woven into their fabric. Nursing is a good example. Many nurses will wish to continue their clinical careers but may also wish to acquire public health competence at a practitioner level. Some may wish to aspire to specialist status. They now have pathways to follow to achieve this aim. In the same way multidisciplinary should not imply a binary division between doctors and others. The medical contribution to public health should not be undervalued, and the possibility of the acquisition of competence at different levels in the new F1/F2 (foundation years) and ‘specialist’ training can be used to grow a greater understanding of public health in an influential group. The same can apply for the professions outside healthcare who can also join the skills escalator and move to levels appropriate for individual’s aspirations and competence.

The essential element of achieving standards of practice and professionalism is underpinned by the notion of equivalence which was one of the guiding principles of the work of the Faculty of Public Health. As a member of the FPH [Medicine] Board for many years I was party to the ups and downs of the debates which eventually enabled us to remove medicine from our title and to publish the ten areas of competence, later adopted by the ‘Skills for Health’ organisation, as well as the professional framework of Good Public Health Practice which mapped onto Good Medical Practice and provided professional standards for all specialists. The creation of the UK Voluntary Register for Public Health Specialists,
particularly viewed from afar, is a shared achievement all contributors should be proud of. Much of what we do is conditioned by the circumstances we find ourselves in. For me three domains of practice requiring different competencies in different specialisations including underpinning skills in informatics, ethics and academic competence across all of them, acts as a more unifying concept than job titles because it allows useful international translation. We will benefit hugely from the commitment, dedication, persistence and resilience of many of you meeting in Bristol as we start to move very slowly on some of the complex issues we face in moving towards a more multidisciplinary profession here on the other side of the world with its different structures, challenges and expectations. I hope you have a good day and congratulations on all the progress that has been made.
David Hunter  
Submitted June 2006 after the witness seminar

As an essentially academic observer of the public health scene, I am less sanguine about the prospects for multidisciplinary public health than others contributing to the witness seminar. I am in particular not yet persuaded that significant progress has been made to date to embrace public health in its widest sense and those who work in it and to accord it its rightful place in public policy. There is still a long way to go and much remains to be done and I fear, as one or two other commentators have noted, that all that has been achieved so far is perhaps little more than a replacement of one narrow elite (public health medicine) with another slightly larger elite (multidisciplinary public health). There may be some self-satisfaction in such an achievement but I believe it fails to take account of public health in its widest context and may in fact have contributed unwittingly and unintentionally to achieving less progress in this direction than might have been possible in the absence of such territorial or boundary skirmishes.

Public health is forever at a crossroads and it now finds itself at another with the government’s shift in public policy from the post-war welfare state view of enlightened government action to the market state where government withdraws and becomes a facilitator and regulator. Such a development carries major implications for the public health function and for the balance between government involvement in healthy public policy on the one hand and the role of the individual in determining their own lifestyles on the other. It is also clear that giving the lead role to NHS to pursue public health is not succeeding and that local government is becoming increasingly impatient and keen to assert its leadership for health role thereby potentially taking public health back to the pre-1974 era although with some significant differences. I am not opposed to such a move – it has much to commend it – but it is likely to result in further power struggles between public health medicine and the wider public health movement which will probably be to the detriment of public health policy certainly in the short term.

The three domains of public health remain, as the account of the seminar notes, potentially problematic for the multidisciplinary agenda. This affects not just the health protection domain but also the health service development and clinical governance/patient safety domain. In both of these, the assumed supremacy of the clinical role is often a barrier to progress. Such supremacy is not always stated but it remains an issue and a potential barrier to progress all the same. There is also much renewed talk of the importance of health care services in improving the public’s health. While true up to a point, is this move also an attempt by public health medicine to reassert its supremacy and pole position at precisely the time it perceives itself to be under threat? I think those in multidisciplinary public health at least have to ask themselves the question.

Furthermore, the very term ‘public health’ is now being reassessed in the context of the convergence, and possible merger, of the public health and sustainability agendas. In addition, notions of health improvement and social justice suggest that use of the term ‘public health’ may itself be part of the problem rather than the solution. What does this mean for multidisciplinary public health? On one interpretation, it might suggest victory, namely, that the battle for the wider public health has finally been won. On the other hand, the very size, scope and diffuseness of the agenda pose
considerable challenges for workforce development and training and representation.

For these and other reasons, there is no room for complacency in the multidisciplinary public health workforce. Many of the battles that it thought it might have won could well reassert themselves in new forms and have to be won again. And there are other new challenges ahead which require a strong multidisciplinary voice which remains somewhat fragile and weak.

Regardless of the very real and important issues around the Voluntary Register, accreditation, skills and competencies are larger and more deep-seated issues around notions of power and politics. Rudolf Virchow made the point that medicine is a social science and politics nothing more than medicine on a large scale. I think the remark applies especially to public health and it remains remarkably prescient.
Phil Mackie
Submitted in July 2006 after the witness seminar

I was sorry not to be able to attend the Bristol witness seminar. So, when I got the chance to submit some reflections and elaborate something of the history, I was happy to contribute with my reflections on the period 1990 to 2000, when I was involved in the multidisciplinary public health movement within England. The period from 2001 when I moved to work in Scotland, I have left for another time.

Between 1990 and 1995 I was – like so many who came into public health following the Acheson Report – somewhat isolated and rather preoccupied with trying to find my feet in an unstable NHS. My experience was tempered by working with a fantastic group of pragmatic public health doctors. Two episodes characterised my early public health training. The first arose from a paper I had written for the District Health Authority Board on the local perinatal mortality figures. The Director of Public Health read it and said, “So what do you want me to do? What is the public health action you are recommending?” The second episode concerned a retired District Medical Officer who was dealing with a delicate issue in orthopaedics. They asked me to go to the orthopaedic surgeons to discuss monitoring peri-operative survival. I was wary of being hung out to dry and said so. The response was, “Don’t worry. Act like a consultant and they will treat you as a consultant”. Soon I had firmly established myself as a “consultant” in my local patch. I was the public health lead in one of the locality purchasing pilots and was pretty much part of the regional public health landscape. Then I got this questionnaire from Lillian Somervaille and Rod Griffiths in late 1994 and had my consciousness raised.

In late 1994 and through 1995 I was an Acting Locality Director, whilst still covering my public health duties. In the midst of all this I got approached by Yvonne Cornish to organise a workshop in the Northern Region for non-medics working in public health. I must admit I was inclined to refuse until I was contacted by Mike O’Brien who impressed on me the importance of making things happen. Years later I discovered that it was Mike, amongst others, who had fingered me in the first place! So, the workshop happened with over 25 people I never knew existed, who shared experiences that made me realise how fortunate I had been in my public health career, and the Northern Network Group was established.

Soon after that I found myself being stopped on the stairs at the old Office of Population Censuses and Surveys building near Aldgate by John Fox (who I had never met before) and asked to join the National Co-ordinating Group (NCG) of the Multidisciplinary Public Health Forum (MPHF) as the Northern Regional representative. I cannot be absolutely sure, but I must have joined the NCG after the workshop but before the 2nd Birmingham Conference. My first impression of the NCG was of a group of people who all seemed incredibly well motivated, organised and somewhat daunting! I remember my early involvement as being one of listening and learning before building up my participation. Several people from the NCG at that time say that wasn’t how they experienced me getting involved ….
Anyway, the 2nd Birmingham Conference arrived and we were all stunned when the result of the Faculty vote on widening membership was shared by June Crown and Mike O’Brien. The sense of rejection and anger was palpable. I recall Mike

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84 Secretary of State for Social Services (1988)
O’Brien coming up to me over coffee. He took me to one side and said something along the lines of: “If I nominate you for honorary membership, will you accept it on the understanding you are to get involved with the Faculty and help them change from the inside?” I pointed out that I wasn’t really the sort of person who fitted the criteria for honorary membership. To which he replied: “Oh, I still have some influence, I think.” It was then that I realised how much this whole multidisciplinary thing meant to him.

After the 2nd Birmingham Conference, the NCG regrouped and started to get organised for the longer push. Whatever the Faculty has said, we were getting strong messages from various parts of the system that we should continue and look for other avenues and partners. Jenny Griffiths came on-board to help us with developing a more structured action plan that would allow progress in spite of the Faculty. I recall much of the time between the 2nd and 3rd Birmingham Conferences as focussing on the development of the action plan, strengthening regional and local networks – in which regard the Multidisciplinary Public Health Forum newsletter should be recognised – and establishing a broader base of support for our five aims from the departments of health and other public health organisations. The 3rd Birmingham Conference sought a formal mandate from the Forum to exist as an independent “network of networks” and for the action plan. It was there that the work on professionalising public health people from backgrounds other than medicine got the clearest thumbs up from the English department of health and the Royal Institute of Public Health (RIPH) arrived, stage left.

After the 3rd conference, the RIPH approached John Fox and suggested that – as the RIPH could provide both quality assurance systems and qualifications – they were ideal partners for the Forum. The NCG agreed to explore this and John Fox, Klim McPherson and I started discussing a possible bipartite agreement with the RIPH. At the same time, June Crown at the Faculty invited John (as Chair of the Honorary Members Committee), Klim McPherson, Lillian Somervaille and me to attend a meeting to discuss how best to support the honorary members in the Faculty after the vote against opening things up. I recall that both Jim McEwen and Stuart Dollan (as Registrar and Academic Registrar) were also there. In the pre-meeting, we agreed that we should simply listen to what they had to say and then offer to go away and think. When we got there, June immediately undermined all our plans by simply asking us what we needed and said that they had come to listen to us! The meeting concluded that whilst the Faculty officers needed to recognise the importance of the views of the membership, the Faculty should also look to how it could facilitate the developments being proposed. So the seed of the Tripartite Agreement was sown.

The agreement was negotiated and finalised not long after, but long enough for John Fox to step down from being Chair of the MPHF and for me to find myself replacing him. At the Faculty, Jim McEwen, who had replaced June Crown, and at the RIPH, its new Chairman of Council, Mike O’Brien, and the new RIPH Chief Executive – Nicky Wilkins – were all keen to make significant progress. I believe that the creation of the Tripartite Agreement in 1998 was the tipping point. It became the mechanism by which so much else could happen. So, it was under the banner of the Tripartite Group that the Feasibility Study85 was carried

85 Lessof et al (1999)
forward and the work started that led to the founding the UK Voluntary Register for Public Health Specialists.

From 1998 until Lillian took over from me as NCG Chair, my main aim for the NCG was to continue to provide a means of supporting developments on the ground. I was very conscious that the “regulatory” route was one that was still fraught with problems; so, I tried to encourage the NCG to keep meeting and sharing ideas and progress. This was the time when the NCG was pushing for the development of local training schemes through the Non-Medical Education and Training Levy (at which West Midlands, South East and London excelled) and trying to keep people enthused about local networks and keeping them engaged in the process. I recall at least two NCG away days in Birmingham, one of which was timed to coincide with the regional directors of public health meeting and the second to discuss the need for the NCG to consider if it could wind its operation up; but it was an uphill struggle. Constant reorganisations and simply supporting the work of the Tripartite Group started to take its toll on many people. Regional representatives changed as NCG members moved jobs or simply needed to focus on careers rather than professionalisation.

By 2000, the world was a very different place from 1990. The UK Voluntary Register was more than a gleam in the eyes of some, training schemes were in place in many parts of the UK and the Faculty was actively discussing widening membership again.

Not bad in a decade ….
Annex: Key Documents on Multidisciplinary Public Health in the UK Outside England

In Scotland:


In Wales:


In Northern Ireland:


Jim McEwen and Paul Scourfield  
Submitted June 2006 after the witness seminar

During the 1990’s there was regular debate at Faculty of Public Health Medicine board meetings and annual general meetings about “opening the membership”. The first step was the introduction of Honorary membership in 1991. While initially this was seen as positive, it later indicated the two-level approach that existed within the Faculty. Opening the membership fully, aroused considerable controversy and there was strongly held views on both sides of the argument. This process of change spanned three presidencies, Michael O’Brien, June Crown and Jim McEwen. At the first survey of the membership there was a majority against opening the membership and no proposal was brought to the AGM. Finally at the AGM in Scarborough in 2000 it was agreed following a written ballot that the membership should be opened.
Is public health a science or a mixture of sciences?
The principle and opportunities for multidisciplinarity in public health practice are (belatedly) accepted. This has partially existed for public health science for a longer period in academic departments. Both Our Healthier Nation and more recent documents from the English Department of Health, accept that principle irreversibly as core to the future of public health. The essential question for public health science now is a choice between a mixture of disciplines working, somewhat opportunistically, on specific public health problems or a core public health ‘stand alone’ entity, with public health specialists and practitioners, coming originally from diverse disciplines. The current consensus favours the former – the status quo in public health science.

Multidisciplinarity must, of course, be combined with some equality of opportunity to achieve the common objective and ownership of public health that must be based on a scientific consensus about actual achievement and credibility. There is a long way to go before that can become a reality. Public health is diverse and complex and the opportunities for several core disciplines to play a full role in developing the circumstances (both research and development) for maximising the health of communities are legion. But the success or otherwise of such opportunities depends to some extent on these circumstances – which are varied - and the particular disciplinary mix that can maximise the effect in each.

I would argue that a consolidated multidisciplinary approach, in which each discipline maintains its essential identity, works well in some instances but public health will suffer in the longer run. This is because a) the professional and academic arrangements are very far from egalitarian and b) addressing that effectively is not possible on a piecemeal ad hoc basis. c) Issues of identity in public health are on the one hand too closely associated with the lead current discipline (medicine) while therefore d) other disciplines do not readily identify with public health and hence e) ownership in an intellectual sense is both too concentrated and, outside this one arena, too diffuse.

For an individual the choice is theirs: either to decide to remain a disciplinary expert and exponent but essentially outside public health or to try to do the same inside public health. But that choice is unavailable for many, largely because the commitment that is required to establish a really egalitarian public health entity is still lacking. In other words the latter choice too often means some variation on professional subordination. It is difficult to know how that can really change in any meaningful way – given the existing vested interests.

The analogy that seems to suit is that of lawyers – who are a united profession but individuals choose what they want to do from a wide array of specialties and careers. Public health has a long way to go before that can happen. Look now at the Walport initiatives to build a stronger academic component in public health – available as always only to medical academics. It was of course intended to strengthen academic clinical medicine,

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* Secretary of State for Health (1999)

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but nobody bothered with the reality that public health is not clinical. This can’t go on – or can it?
Mala Rao
Submitted June 2006 after the witness seminar

My contribution to this discussion is slightly different, because my views and past experience are heavily influenced by my formative years in India, and my contribution to multidisciplinary public health development in the UK until recently has been, not at the national level, but largely as a ‘service based’ DPH.

My interest in public health started when I was a medical student in India in the mid 1970s. This was at the height of the smallpox eradication era, and India which became smallpox free during that period was engaged in an extraordinary effort to achieve this goal. I was aware that a number of newly qualified doctors were volunteering as junior epidemiologists, to support the WHO in this work, and tales of great courage and heroism were being reported as teams of doctors, pharmacists, nurses and drivers, for example, ventured into dangerous and remote areas to undertake case finding and mass vaccination programmes. What struck me then was how public health goals which were deemed virtually impossible by some pessimists, could be achieved by the organised effort of multidisciplinary teams consisting of people with different skills and a variety of backgrounds working together in serving a common purpose.

I subsequently started training in public health in England and was struck by some aspects of the public health system at that time in the UK. Firstly, some of the most influential public health activists I knew about in India were practising doctors, nutritionists, academics and social scientists. By contrast, here in the UK, only medically qualified people were allowed at that time into specialist training. Secondly, the system discouraged these individuals from practising as clinicians as well as public health specialists, and it was assumed that there would be a ceremonial laying down of the stethoscope when doctors started their training in public health! A third peculiarity was that in general, one could practise as a public health academic or a ‘service based’ consultant in public health, but not both!

I found all three features very constraining, and that they resulted in a unidisciplinary rather than a multidisciplinary model of public health. My first opportunity to address some of these issues arose when I was the Faculty Adviser to North East Thames between 1991 and 1996. I was able to persuade the Public Health Training Committee to support trainees who were interested in combining, for example, general practice and public health training and to recognise that this enriched our multidisciplinary base rather than detracting from it. It interests me that more recently, the discussions on ‘defined public health specialists’ has led some medically qualified colleagues who have been interested in redefining the value of medicine to public health, to conclude that combined clinical and public health practice fits well within the description of a ‘defined specialist’.

My second opportunity arose when I was Director of Public Health to South Essex Health Authority in the late 1990s. I had an excellent team including highly skilled colleagues from a very wide range of backgrounds and we learnt a great deal about everything from building social capital to newly emerging drugs, from each other. However, consultant posts were only open to medically qualified colleagues, so the best I could do at that time was to train and develop my non medical colleagues and appoint them to Associate Director level posts. I was therefore delighted when these efforts to
encourage greater equity at a health authority level came to the attention of those who were spearheading change at a national level, and Healthwork UK selected my directorate for their first multidisciplinary public health skills audit, to inform the planning of the UK Voluntary Register for Public Health Specialists. We were also identified as a good directorate to receive one of the first cohort of non-medical public health trainees, and I was delighted when this trainee recently completed her training programme.

My third concern is the continued disconnection between academic public health and practice. Although my career has mainly been in 'service based' public health, I have continued to teach and undertake research. However, this remains far from routine practice contrary to what I had always hoped. In reality there appears to be little in the way of enthusiasm or incentives to bring the two sides closer together. I feel strongly that we can only claim to be one multidisciplinary specialty when there is a more joined up approach to teaching research and practice, equity among public health academics irrespective of their backgrounds and greater recognition that a number of other academic disciplines in addition to traditional public health, form a crucial part of the multidisciplinary public health family.
Michael Shepherd
Submitted November 2005 after the witness seminar

Since the seminar, two related issues have kept occurring to me. One relates to what Klim McPherson said at the end of the meeting about the position of academic public health – I certainly agree that for those of us in academic posts related to public health now there seems no motivation to connect to the public health career structures being developed in the health service. Voluntary Registers or Parts 1 and 2 of the Faculty exams are certainly not a hot topic of discussion around CISHE – although we are all making a contribution to public health research and teaching.

It seems like a very similar argument will apply to many other occupational groups at the other end of the spectrum, people who are recognised as having a public health role and for whom a public health career may be a possible future. This group may include health visitors and community workers, but as public health develops other groups will also emerge. Exercise professionals and institutional caterers may be more recently recognised as public health practitioners but my experience – sample of two - is that even those with the skills do not see public health specialism within their career horizons. Granted, as Peter Farley commented there will be amendments to competencies, but I’m not sure that will alter the perception of public health from the perspective of the sports science or nutrition specialist.

As David Evans said, it may be that multidisciplinary public health, in working to break down barriers to careers in public health has created just another elitist professional structure that excludes important public health practitioners.

Bristol University now has a well established MSc in Exercise, Nutrition and Public Health run from their Department of Exercise and Health Sciences – so that the argument that there are not people capable of progressing to public health specialism probably does not hold. I think they (graduates from this MSc) may argue however that as with academic public health, there is not sufficient reason to jump through the Faculty’s hoops. It may be that vesting the ownership of the hoops within the medical profession is what has to change before public health can be truly multidisciplinary.

Cardiff Institute of Society, Health and Ethics
Lillian Somervaille
Submitted June 2006 after the witness seminar

I ‘came into’ public health in 1990 from a scientific research background with very little understanding of what public health was or what skills I would need to contribute to it. Having working in the field for a few years I thought I should have some sort of professional badge, so took the Faculty of Public Health Medicine (FPHM) Diploma in Epidemiology in 1993. Much to my surprise the possession of this badge did little in terms of professional acceptance and I began to realise how unidisciplinary public health actually was, when in fact it needed so obviously to be robustly multi-disciplinary.

Having been involved with a multidisciplinary network within the West Midlands region I was really keen to be asked to carry out a national survey of public health professionals – something I was assured would not take much time as ‘there could only be – tops – a couple of hundred out there’. Using a snowball method and lots of phone calls, over one thousand replies were returned. The survey showed a ‘rule of halves’ was in operation. Of those public health professionals who responded to the survey (all in active practice at various levels within organisations), only half had had any training at all to do their jobs. Of the half that had, only half had had any support to do it. This was so obviously unsustainable and inappropriate that the Multidisciplinary Public Health Forum (MPHF) began its journey as has been so eloquently described.

Over the following decade I continued to be involved with the development of multidisciplinary public health, with the MPHF and the Faculty of Public Health. The formation of the Tripartite Group, as has already been said, was pivotal and from it was born the UK Voluntary Register for Public Health Specialists (UKVRPHS).

One area that has not been captured in the report which I feel was important, is the advent of the FPHM ‘quality assurance’ visits to training programmes. When training schemes started to include multidisciplinary trainees in the late 1990s, there remained substantial differences in training programmes for specialists in public health across the English Deaneries, not to mention the lack of any opportunities then available in Wales, Scotland and Northern Ireland. For example, in one Deanery, trainees were appointed to a very foreshortened scheme and actively discouraged from taking the FPHM Part I examination.

To bring in some national quality standards, I argued for the FPHM Education Committee to extend its jurisdiction of external quality assurance (QA) visits to the specialist schemes (although at this time the FPHM had little validity in this arena). This external QA role is provided by a visiting team, then comprising a service visitor, an academic visitor and a trainee visitor, who meet with key individuals in each Deanery as well as full site visits. These visits are regarded with due seriousness as the visitors have the ultimate sanction of recommending training approval is withdrawn at any training location where there are serious and irresolvable problems.

Having obtained agreement to pilot this, I undertook the role of ‘pilot’ specialist visitor to both South West and North West training schemes in 2000 and, with the FPHM Director of Training, developed the necessary paperwork to include specialist trainees in routine visits. The FPHM then adopted the

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89 Somervaille & Griffiths (1995)
specialist visitor as an integral part of its visit programme, which has been hugely influential in ensuring fully integrated training schemes and equity of access to training opportunities for all trainees, as well as keeping issues of outstanding inequity on the agenda until resolved.

However, this system is now under threat as the visits will now be carried out in line with PMETB policy (an agenda driven by the needs of medical training), and any quality assurance of specialist training issues will have to be done informally. This would not be of such concern if we were sure that all training opportunities were completely equitable and that this was robust enough to survive future pressures.

Some have accused the development of multidisciplinary public health over the last 10 years as having produced ‘genetically modified public health doctors’. In one sense this is right in that the first task was to break the urban myth that only a medical background can equip you to undertake a general public health role, such as being a DPH. I still remember fondly having to physically restrain a colleague when it was said at a public meeting in the early 1990s that outside of public health medicine there were no public health professionals. So now we have directors of public health from a variety of backgrounds contributing substantially to the public health function in a generalist way. Although I never thought I would find myself saying this, the advent of regulation through the UKVRPHS coming on the scene, has been catalytic. In addition, with the opening of the ‘defined specialist’ pathway to specialist regulation on the UKVRPHS, we are seeing a liberation from the ‘straightjacket’ of generalist practice.

Within a very short space of time we are all now talking about people who practice public health at very senior levels in different ways, being part of the public health whole, and we have a way to formally ‘badge’ them as such. We need to enfold those practising now and look to the future as to the best ways to develop the public health specialists of the future, both general and defined.

As we have moved into this multidisciplinary public health world I feel that there have been a number of key developments that have made progress sustainable. I would count the integrated training schemes as one, the appointment of directors of public health from multidisciplinary backgrounds as another, together with the regulatory framework provided by the UKVRPHS. Whilst we should not take our eyes from any of these areas we should be looking hard at what remains underdeveloped. The pace of change has not been the same across the four UK countries at specialist level, nor at practitioner level. We need to ensure lessons are learned from where change has been achieved successfully, and we must look to the sustainable development of the practitioner workforce as a matter of urgency.

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89 Postgraduate Medical Education and Training Board
# Chronology

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<th>Year</th>
<th>Key Developments in Multi-disciplinary Public Health</th>
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<td>1970</td>
<td>Final draft of ‘The Proposal’ drawn up by the working party for the proposed ‘Faculty of Community Medicine’. Under ‘Membership of the Faculty – Item 4: “At a later date, and by agreement with the Royal Colleges, consideration would be given to the eligibility of non-medical colleagues practising, teaching, or conducting research in the field of Community Medicine.”</td>
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<td>1972</td>
<td>Establishment of Faculty of Community Medicine, with membership restricted to registered medical practitioners.</td>
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<td>1979</td>
<td>Unit for the Study of Health Policy (1979) report proposes consultant level ‘community health advisers’ from backgrounds other than medicine.</td>
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<td>1990</td>
<td>Establishment of multidisciplinary Masters in Public Health at Cardiff University.</td>
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<td>1991</td>
<td>Creation by the Faculty of Public Health Medicine of category of Honorary Members open to those in disciplines other than medicine.</td>
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<td>1992</td>
<td>Masters in Public Health at the London School of Hygiene and Tropical Medicine opened to disciplines other than medicine.</td>
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<td>1994</td>
<td>Survey of public health professionals (Somervaille &amp; Griffiths, 1995) identified over a 1,000 people from background other than medicine working in public health in the UK.</td>
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<td></td>
<td>‘Working group’ set up by Lillian Somervaille to organise a national seminar.</td>
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<td>1995</td>
<td>National seminar in Birmingham to explore career structures, training, accreditation and professional roles in multidisciplinary public health.</td>
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<td></td>
<td>‘Working group’ then organised workshops in English regions and UK nations to facilitate networking and to explore training, education and development needs.</td>
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<td>1996</td>
<td>Survey of members of Faculty of Public Health Medicine, a majority reject opening examinations and full membership to disciplines other than medicine.</td>
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<td></td>
<td>Second national conference, leading to establishment of the Multidisciplinary Public Health Forum with the existing ‘working group’ as the National Core Group working through regional and national networks.</td>
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<td>1997</td>
<td>Third national multidisciplinary public health conference in Birmingham.</td>
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<td></td>
<td>Joint ‘Statement of Intent’ from Multidisciplinary Public Health Forum and Royal Institute of Public Health, to work together on development of a framework for education, development and accreditation of multidisciplinary public health professionals.</td>
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*Chief Medical Officer’s Project to Strengthen the Public Health Function in England: A Report of Emerging Findings* (DH, 1988), expressed commitment to developing multi-disciplinary working.

Vote of Faculty of Public Health Medicine to open Part 1 examination and Diplomate membership to disciplines other than medicine.

Faculty of Public Health Medicine joins with the Multidisciplinary Public Health Forum and the Royal Institute of Public Health to form the Tripartite Group to work towards multidisciplinary accreditation.


NHS Executive PCT guidance (Department of Health, 1999) includes first specific advice on appointment of those from backgrounds other than medicine to senior NHS public health posts.

Fourth national multidisciplinary public health conference in Bristol.

First regional training schemes for non-medical specialists in public health.


2000  Secretary of State for Health speech includes call to ‘take public health out of the ghetto’ and end ‘lazy thinking and occupational protectionism’ (Milburn, 2000).

At the Faculty of Public Health Medicine AGM in Scarborough it was agreed, following a written ballot, that the membership should be opened to candidates from disciplines other than medicine.

Consultant-level specialist in public health posts open to disciplines other than medicine advertised by some health authorities.

2001  Faculty of Public Health Medicine Diploma and Part 1 examination opened to disciplines other than medicine.

Faculty of Public Health Medicine Annual Lecture by Health Minister Lord Hunt: “This generation of directors of public health will be from a variety of backgrounds not only medical. This reform offers an opportunity to make multidisciplinary public health a reality.”

2002  Faculty of Public Health Medicine Part 2 examination and full membership by examination opened to disciplines other than medicine.

Following publication of *Shifting the Balance of Power* (Department of Health, 2001b; c) in England, the Faculty of Public Health Medicine issued guidance to ensure that all “consultant” or “specialist” posts were subject to an advisory appointments committee (AAC) and each region was invited to nominate a “specialist advisor” to take on a similar role to that of Faculty Advisor.

Appointment of first UK directors of public health from backgrounds other than
medicine in primary care trusts.

2003  Establishment of UK Voluntary Register for Public Health Specialists with support from all four UK health departments. First registration through the portfolio assessment route.

Faculty of Public Health Medicine name changed to Faculty of Public Health.

2005  First trainee from a background other than medicine completes training through the Faculty of Public Health and the first registration through the training route on the UK Voluntary Register for Public Health Specialists.

2006  The Faculty of Public Health has in excess of 3000 members, with one third being from backgrounds other than medicine.
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<th>Full Form</th>
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<td>Advisory Appointments Committee</td>
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<td>APH</td>
<td>Association for Public Health</td>
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<td>BMA</td>
<td>British Medical Association</td>
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<tr>
<td>CCST</td>
<td>Certificate of Completion of Specialist Training</td>
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<td>CIEH</td>
<td>Chartered Institute of Environmental Health</td>
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<td>CMO</td>
<td>Chief Medical Officer</td>
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<td>CPHVA</td>
<td>Community Practitioners and Health Visitors Association</td>
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<td>DH</td>
<td>Department of Health</td>
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<td>DNAC</td>
<td>Development Needs Assessment Centre</td>
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<td>DPH</td>
<td>Director of Public Health</td>
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<td>FCM</td>
<td>Faculty of Community Medicine</td>
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<td>FPH</td>
<td>Faculty of Public Health</td>
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<td>FPHM</td>
<td>Faculty of Public Health Medicine</td>
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<td>MOH</td>
<td>Medical Officer of Health</td>
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<td>MPH</td>
<td>Masters in Public Health</td>
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<td>MPHF</td>
<td>Multidisciplinary Public Health Forum</td>
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<td>NHS</td>
<td>National Health Service</td>
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<td>NMET</td>
<td>Non-medical Education and Training Levy</td>
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<td>NVQ</td>
<td>National Vocational Qualification</td>
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<td>Part 1</td>
<td>Faculty of Public Health (Medicine) Diploma and Part 1 Examination</td>
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<tr>
<td>Part 2</td>
<td>Faculty of Public Health (Medicine) Part 2 Examination</td>
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<td>PCT</td>
<td>Primary Care Trust</td>
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<td>PHA</td>
<td>Public Health Alliance</td>
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<td>PMETB</td>
<td>Postgraduate Medical Education and Training Board</td>
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<td>QCA</td>
<td>Qualifications and Curriculum Authority</td>
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<td>RAF</td>
<td>Royal Air Force</td>
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<td>RCM</td>
<td>Royal College of Midwives</td>
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<td>RCN</td>
<td>Royal College of Nurses</td>
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<td>RDPH</td>
<td>Regional Director of Public Health</td>
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<td>RIPH</td>
<td>Royal Institute of Public Health</td>
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<td>RITA</td>
<td>Record of In-training Assessment</td>
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<td>RSH</td>
<td>Royal Society of Health</td>
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<td>SCOPH</td>
<td>Standing Committee on Public Health</td>
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<td>UKPHA</td>
<td>United Kingdom Public Health Association</td>
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<td>UKVRPHS</td>
<td>United Kingdom Voluntary Register for Public Health Specialists</td>
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<td>World Health Organisation</td>
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