The Creation of the Faculty of Public Health:
A personal reflection by Walter Holland

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This is a personal account of my experiences and views. A far more comprehensive document is available (1) which has some details of the minutes of meetings which took place. This was prepared by Prof Michael Warren, who was the first Academic Registrar of the Faculty.

To understand the reasons for the creation of the Faculty it is necessary to look back on public health activities before, during and after the Second World War . A full account of public health history is recounted by Holland and Stewart (2).

Public health in the 19th century

The main public health issues of the 19th century were sanitation, housing, infection, nutrition and the poor health and excess mortality of the population. Much legislation was introduced between 1848 and 1890 to improve these issues in order to improve health. Medical Officers of Health (MOH) were appointed to all Local Authorities. Their independence was ensured by law, and they did not falter in the exposure of the inadequate conditions, and how these could be corrected, in their Local Authority.

The work of the giants of the 19th century had established much improved environmental and living conditions including sanitation. Medical Officers of Health – first appointed to Liverpool in 1847 when Dr William Henry Duncan, a local physician, became the first MOH in the country, to London in 1848 and the whole country by 1872 – continued to grow gradually in influence and esteem. And early in the 20th century the specialty was beginning to free itself from the perception that it was concerned only with sewers and drains and had begun to present itself in a more positive light.

The 20th century issues

One of the most influential bodies in the early 20th century was the Royal Commission on the Poor Laws and the relief of distress. Beatrice Webb, the great social reformer, was one of its members. There was some dissension amongst the Commissioners and both Majority and Minority reports were published in 1909. Both agreed that general mixed workhouses should be replaced by separate institutions for the able-bodied, the sick, the elderly and children, that local administrations should be brought under more stringent central control, that outdoor relief should be administered more efficiently and that there should be better coordination of charitable aid. Both Reports were in favour of old age pensions and the state insurance scheme for sickness

and unemployment. The Inquiry had little immediate effect, an attempt to abolish or reform the Poor Law after the end of World War I lay dormant for some years.

Health care and public health after the First World War was something of a patchwork of ramshackle and uncoordinated services. Since 1848 administration of health had been under various authorities of limited effectiveness in terms of co-operation and coordination. The Local Government Board, in its later years, had become somewhat discredited as being inefficient and obstructive. John Simon, the first Local Government Board Medical Officer, considered that it had become inadequate in its supervision of sanitary conditions. A Ministry of Health was eventually established in 1919. This was a signal that public health was, at last, coming to the forefront of the political agenda during the post-war reconstruction.

The Ministry's first Chief Medical Officer, Sir George Newman, reiterated the need for simplification and unification of medical administration which the creation of the Ministry had made possible. The central concerns were (a) General sanitation, housing, epidemiology and infectious disease; (b) prevention and treatment of tuberculosis and venereal disease; (c) food control in respect of disease; (d) maternity and child welfare; and (e) health insurance and other public medical services.

The Local Government Act of 1929 associated preventive medicine firmly with curative medicine and paved the way for the final ending of the Poor Law. It separated health policy from "pauperism" and thus brought to fruition the integration of Poor Law and public health services, sought in vain by John Simon. It defined and augmented the position of the MOH and his staff as the "responsible and primary advisers" of each authority.

The Act also required health authorities to achieve and maintain" a reasonable standard of efficiency and progress in the discharge of their function relating to public health services". Secondly authorities were enjoined to ensure that the health and welfare of the inhabitants, or some of them, were not endangered by the action or inaction of the authority.

Public health and Poverty

A major issue for public health at this time was the relation between poverty and ill-health, epitomised by the work of the MOH for Stockton on Tees, GCM McGonigle (3)

MOHs, at local level, throughout the country, with only a few exceptions, were also achieving improvements in the health of their populations despite the very unfavourable economic conditions. But in the late 1930s dramatic advances in chemotherapy were bringing clinical medicine to the forefront. The emergence of effective therapeutic agents for the acute treatment of disease began to overshadow disease reduction through public health effort.

The Second World War brought on many changes that had an effect on population health such as improvements in nutrition. The introduction of the National Health Service in 1948 had a major impact on public health. The strength of the public health departments had been evident during the war when the personal authority of MOH's proved essential to the organisation of the emergency services for civil defence. Services for mothers, babies and school children had been greatly improved and broadened through the activities of public health departments, though with some friction with the general practitioners and not much help from paediatric or obstetric Hospitals.

Foundation of the NHS

The specialty had expected the NHS would be introduced as part of local government with an expected expansion of the service provided by local authorities. They were gravely disappointed. Seeds of antagonism between LA services and the voluntary hospitals had been present for some time, but public health, not for the first or last time, did not grasp political reality. It grossly underestimated the power of concentrated lobbying by the BMA, the Royal Colleges and the voluntary hospitals.

By contrast the physicians, and those concerned with medical education, became very interested in the concept of social or community medicine, as the specialty was to become called. Both the Goodenough Committee (4) and the Royal College of Physicians (5) emphasised the importance of the subject in the medical curriculum.

There was a wide variety of views about the separation of public health from the NHS and curative medicine. But one serious consequence was the diminution of recruitment into the specialty in both quality and quantity.

Seebohm Committee

In 1965 the Seebohm Committee on Local Authority and Allied Personal Social Services (6) was set up to consider the organisation and responsibilities of the local authority personal social services. Social workers were also anxious to emerge as a separate professional group not under public health control. Prof Jerry Morris was a member of this Committee.

When it reported, in 1968, it recommended the establishment of a unified social service department in each major local authority. This was welcomed by the social work profession, although not unexpectedly it was criticised by the MOHs on the grounds that it perpetuated the division between health and welfare services and residential care for the elderly, mentally ill and handicapped and lost another opportunity for integration. The Seebohm Committee proposals were accepted and implemented in 1970 - 71.

Environmental health

Another group anxious for its independence from public health supremacy at this time was environmental health and the Report of the Subcommittee examining this was published in 1972 (7) and was embodied in the National Health Service reorganisation Act 1973.

Medical education

Since the early years of the 20th century undergraduate medical education in public health was gradually diminishing in both quantity and quality. Public health was considered to be largely a postgraduate subject. Only a few medical schools - e.g. Cardiff, Edinburgh and Manchester - retained chairs in the subject, and these were often linked to the position of MOH of the City.

The required academic qualification for MOH was the Diploma in Public Health (DPH). Courses for this were provided at the London School of Hygiene and Tropical Medicine (LSHTM), the Royal Institute of Public Health, and several universities such as Manchester and Newcastle. The most prestigious of these was that at the London School (LSHTM). They were not considered challenging or of a high standard. I audited some of the course at the LSHTM, and was profoundly unimpressed.

Parallel to the academic departments of public health there was flourishing academic research, supported by the MRC, and several universities, including the LSHTM under the headings of epidemiology and social medicine. The latter term had been coined by John Ryle, who had a chair in the subject in Oxford. Workers in this field such as Austin Bradford Hill, Richard Doll, Archie Cochrane, Donald Reid, Jerry Morris, Tom McKeown and John Pemberton were of high renown both nationally and internationally.

The Robbins Committee (8) was established in 1961 to review the pattern and content of full-time higher education. It devoted a great deal of attention to medical education. A much fuller analysis of medical education was included in the Todd Commission report (9). This included Prof Richard Titmuss of the London School of Economics and Political Sciences (LSE), who was a friend of Prof Jerry Morris. Thus Morris was able to influence its references to public health in the same way as Titmuss was able to transmit his views on social work to Morris on the Seebohm committee.

The Todd report in discussing ‘training for public health, medical administration, social medicine and related fields…. Considered that there were sufficient elements in common for these to be treated as one specialty “which it referred to as community medicine’.

It noted that ‘recruitment of doctors to community medicine is unsatisfactory’ and that ‘there is a great need for a professional body which can bring together all the interests, academic and service, and which has the support and strength to undertake the assessment needed during and at the end of general professional training’ (10).

Community medicine

Morris first defined the role of community physician as the individual responsible for community diagnosis and as such for providing the information required for efficient and effective administration of health services. He was the Director of the MRC Social Medicine Research Unit at the London Hospital Medical School (11). In 1967 he was appointed Professor of Public Health Medicine at the LSHTM. He recognised the deficiencies of the DPH and started a two-year course for an MSc in Social Medicine in 1969/70. (The name was changed to Community Medicine in 1979/80.) As intended this attracted a much higher calibre of applicant than the DPH. Many of the initial graduates of this course became academics or held senior positions in the NHS, Department of Health and abroad.

Morris's initiative in the redefinition of the function of MOH's and the suggestions of the Todd Commission stimulated the change in the organisation, accreditation, and education in public health. From the service side this was led by Dr Wilfrid Harding, who was MOH of the London Borough of Camden, and a very senior figure in the Society of Medical Officers of Health. He was also a personal friend of Lord Rosenheim, President of the Royal College of Physicians and Professor of Medicine at University College, London. Change was also facilitated by the proposed changes in the structure of the NHS, which envisaged public health becoming part of the NHS (12). The roles that community medicine would play in the NHS was outlined in the Hunter report (13).

MOHs welcomed the idea of change to community medicine – but, as Lewis (14) noted, mainly because they understood that there would be a substantial rise in the status (and rewards) of the specialty.

Initial steps

Warren recounts the tortuous negotiations which took place to implement Morris and Harding's vision. To understand some of these it is important to understand the background that I have described. As his description of the meetings, deliberations and personalities involved is very comprehensive I will limit myself to describing some of the issues with which I was involved.

An important issue was the place and relation of academics to, and in, the proposed Faculty. Academics were almost all members of the Multidisciplinary Society of Social Medicine. Many had considerable renown, both nationally and internationally, largely because of their work in epidemiology, e.g. cancer of the lung (Hill and Doll), chronic respiratory disease (Reid), coronary heart disease (Morris) and tuberculosis (Alice Stewart). But relations between academe and service were minimal. My department at St Thomas's Hospital Medical School was one of the few to have working relations with service departments (Kent County Council, London Borough of Harrow). A major concern in the creation of the Faculty by the members of the Society for Social Medicine was the place of non-medical

members of the Society in the proposed Faculty. Prof McKeown, of Birmingham, was particularly concerned with this.

Membership of the Faculty

Unfortunately, because it was considered essential that we should be closely affiliated to the RCP, and because the majority of those affected by the initial negotiations were medically qualified, we were unable to achieve equal status for the medical and non-medical individuals. The provisional committee was able to ensure that its first honorary fellow was Austin Bradford Hill, a medical statistician. Achieving equivalence for non-medical graduates has taken many years, in spite of support for this from many members, particularly the academics. This difference between non-academics' and academics' in attitude was, unfortunately, common in many matters at the beginning of the Faculty. It has, gradually, disappeared.

Another major issue at the beginning was the equivalence of membership of the RCP and of the proposed Faculty. Morris and Harding, encouraged by Rosenheim, expected that members of the Faculty would be able to progress to Fellowship of the College, in the same way as members of the College. One of the senior physicians at St Thomas's Hospital was John Harman (father of Harriet). We used to meet at lunch at the time of the negotiations for the creation of the Faculty. He was also Senior Censor of the RCP.

One day, at lunch, we discussed the formation of the Faculty. He was in favour, but was concerned. He emphasised that the College President, Lord Rosenheim, was giving false encouragement to Morris and Harding. There was no chance that the Fellows of the College would approve equivalence. He felt that Comitia (the ruling body of the College) would reject such a proposal. He counselled that we should not press for this, but instead agree that the Faculty would put forward every year a number of senior people to be made Fellows (or members) of the College, without examination, under an existing ByeLaw (39c). He considered that they would agree to that and it would help in the establishment of the Faculty.

Although Morris and Harding were very disappointed, and against some vehement opposition that this would perpetuate second-class status, the realpolitik of the situation prevailed.

Tenure of the President

Another piece of advice from Harman was the tenure of the President. At that time (in the early 70s) PRCP's could serve for many annual terms (Presidents of the RCP are elected annually). Harman pointed out that it was difficult to get rid of a President, if he was elected annually, and gave examples how, in their later years, PRCPs, with long tenure, had outlived their "sell by date". We took his advice – and agreed on a three-year term of office.

Nomination of first President

Another interesting issue in the formation of the Faculty, not recorded by Warren, was the nomination of the first President. In discussions between many of those involved in the creation of the Faculty it had been considered that the first President should be a highly prestigious figure, with an international reputation. Richard Doll was considered an ideal candidate and had agreed to stand. At the last meeting of the Provisional Board, before the inaugural meeting in March 1972, Harding, the Chairman of the Provisional Board, before the coffee break, announced that he had received a letter from Doll withdrawing his candidature because of his workload as the new Regius Professor of Medicine at Oxford University. This was received with great consternation. Harding stated that we would discuss this after the coffee break as we had very little time to make other arrangements.

Part 2 Faculty

Several of us (I believe it was George Forwell, Tom Anderson, Archie Cochrane, Mike Heasman, Ron Lowe and Walter Holland) were extremely concerned by this turn of events. We thought that as this matter had been sprung on us at the last possible minute it was likely that the meeting would propose Harding as its nominee, as he had done so much to promote the creation of the Faculty and it would be difficult to oppose this nomination. We were very uncomfortable with this. Harding was not popular with academics or the Society for Social Medicine.

The five of us discussed the situation for about one minute (as far as I can recollect) and turned to Archie Cochrane and unanimously urged him to agree that we should, immediately after the coffee break, and before Harding as Chairman could start a discussion, put forward Archie Cochrane's name as the Provisional Board's nominee for first President. Archie did require persuasion, but agreed that we could do this. Harding was surprised, but it was accepted by the meeting and Harding became our second President.

Membership of the Faculty

Since the Faculty was to be responsible for the professional standards of its members it obviously had to set an appropriate examination. It was rapidly agreed that the Faculty would follow in the footsteps of its parent Colleges and would not accept exemption from this examination because candidates had relevant academic qualifications such as MD or Ph.D. Initially, for a period of 2 years, registered medical practitioners practising in the UK and fulfilling the following conditions would be eligible for consideration by the Provisional Council of the Faculty for immediate election to membership without examination:

(1) Appropriate higher postgraduate qualification
(2) Five years' experience in community medicine
(3) Promotion above the basic grade in the relevant field of community medicine

At the inauguration in March 1972 900 members were elected, of whom 144 were elected as Fellows.

Clinical Responsibilities

In admitting aspirants to the Faculty under the “grandfather” clause two groups posed problems. It was agreed that that the Faculty should be concerned with population medicine rather than individual medicine. Part of the concerns were historical – as described many of the first MOHs had been, and were, general practitioners.

It was, at the beginning, important that the Faculty should not be in competition with the RCGP, thus general practitioners with an interest in public health were not considered eligible. Clinical and Child Health Medical Officers posed particular problems. There were many exhaustive discussions about individual applicants from this group of practitioners. The question was always the balance between individual medical practice and population responsibility. There was little generation of goodwill between the proposed Faculty and this group.

Allied to this question was whether some academics with the label of Clinical Epidemiology, who often did have responsibility for individual patients, were eligible. Arguments were not as heated as with the Clinical Medical Officer group. There was little argument of their contribution to Epidemiology rather than patient care.

Occupational Medicine

It has often been asked why individuals from Occupational Medicine were not included in the Faculty. Many on the Provisional Board wished them to be included. Several very senior occupational physicians such as Prof Richard Schilling, of the LSHTM, Dr PAB Raffle (CMO of London Transport), Dr D Slattery (CMO of Rolls-Royce) and Prof C McDonald of the LSHTM were in favour of this, but the great majority of those in occupational medicine considered themselves to be clinicians rather than population doctors.

They were mostly general practitioners or hospital physicians with part-time responsibilities in occupational medicine. They wanted closer relations to the RCP rather than to one of its Faculties. Thus the Faculty of Occupational Medicine (FOM) was founded. We agreed to support this and established links between the Faculties for mutual endeavours.

Conclusion

Looking back on the foundation of the Faculty it is important to be aware that Public Health, after its 19th century achievements, has always had difficulties in establishing its role and esteem. The dramatic advances in treatment first of infective conditions and later of chronic conditions such as coronary heart disease have always, in the public mind, overshadowed the far more effective

public health measures such as vaccination ,or the identification of the hazards of smoking and its prevention, lack of exercise and diet in the control of disease. It is unfortunate that we have never been able to make our subject more “sexy”. But, in addition, we have, as a group, always been concerned with inequalities and alleviation of poverty, which has diminished our appeal to many politicians and powerful financial, commercial and industrial interests.

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