

History in Public Health: a New Development for History?

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Historians, by and large, operate among their own kind. Most professional historians work in departments which are discipline-based, although often with contacts and networks among a wider range of interests relevant to their research speciality. Medical and other health-related schools, where they draw on history, as in teaching, tend to look within their own ranks. The history of public health might well be the responsibility of a non-historical staff member with an interest in the subject. It is rare for historians, in the UK at least, to cross the boundary and to be located in a medical or public health setting.¹ This is the position of the history group at the London School of Hygiene and Tropical Medicine.² Operating across the boundaries in this way requires a complex balancing act of interests. This paper reflects on the history of public health and possibilities for future development both from the perspective of that unusual location, but personally from that of a research career which has partially been spent in other non-historical

1 Apart from the London School of Hygiene and Tropical Medicine (LSHTM) group, I could only think of Elizabeth Fee, formerly at John Hopkins. I am not including groups of medical historians who operate as separate departments, or historical demographers, who sometimes have a closer relationship. Nor am I including groups of medically qualified historical workers, as for example in the German history of medicine institutes, now under threat.

2 The group is primarily based on the 'Science speaks to Policy' programme, funded by the Wellcome Trust, and includes work on smoking, medical technology, nutrition policy and the postwar rise of media processes in facilitating the science/policy relationship. There is further work on community and hospital pharmacy in the twentieth century. It is located in the Department of Public Health and Policy at LSHTM, a department of around 150 staff from a variety of medical and social science backgrounds.

contexts elsewhere as well.³ I aim to consider three related but different areas of interest – public health history (by which I mean the current state of play of historical research in this and allied subjects) and history in public health (by which I mean the interest in and use of that history by non-historical practitioners and the role of historians in non- disciplinary settings). So I will first consider the current focus of historical interest within public health, and then offer some suggestions of how, in the British context, a more extensive ‘history in public health’ could develop. I will finally consider the role of historians in such developments.

The Historical Consciousness of Public Health

Nobody could accuse public health interests of lacking an interest in history. In recent years, new developments in public health policy have regularly been justified by reference to the past. Key policy documents, for example, the Acheson Report on the Public Health Function in 1988, used the history of public health as a subtext. For AIDS, the history of the liberal and non-punitive British response to sexually transmitted disease was cited as a model for the types of policy which should be adopted. AIDS was seen initially as a foretaste of the revival of epidemic disease against which public health had battled in the nineteenth century. Public health could again fulfil this role in the 1980s, so it was argued. AIDS was an ‘epidemic waiting to happen’ in many senses – but particularly for public health, which was potentially rejuvenated through its role in dealing with the new syndrome.⁴ The ‘new public health’ has justified its broader mandate in health matters through reference to the public health past. John Ashton’s paper in the BMJ, ‘Sanitarian becomes ecologist’, gives a flavour of that linkage.⁵ The concerns of nineteenth century public health have been drawn on for lessons in the response to health problems in the Third World today. Sir Donald Acheson, former Chief Medical Officer (MOH), remarked in a lecture, ‘If Chadwick were alive today, he would not have limited his attention exclusively to the health of British people. Chadwick would have taken a global view...’.⁶

3 I also worked at the beginning of my career at the Addiction Research Unit, Institute of Psychiatry, with a specific interest in drugs and their history.

4 For some discussion of this, see Virginia Berridge and Philip Strong, ‘AIDS and the Relevance of History’, *Social History of Medicine* 4:1 (1991), 129–138.

5 John Ashton, ‘Sanitarian becomes ecologist: the new environmental health’, *British Medical Journal*, 302 (1991), 189–90.

6 Sir Donald Acheson, ‘Edwin Chadwick and the world we live in’, Edwin Chadwick lecture, *Lancet* (15 December 1990), 1482–90.

The history of public health these spokespeople draw on here is the nineteenth century 'heroic age' of environmentalism and the battle against vested interests of dirt and disease. In the British context, they lament the demise of the local government-based Medical Officer of Health (MOH). The revival of annual local public health reports in the 1980s was a nod to the role of the MOH in the nineteenth century. The recent Labour government's greater focus on public health as an activity within central and local government has also led to a looking back as well as looking forward. The 1848 Public Health Act celebrated its 150th anniversary in 1998, accompanied by a rash of discussions about whether Britain needed a new piece of similar legislation.⁷

Among public health researchers, there is also historical consciousness. They acknowledge the history of nineteenth century epidemiology. Teaching exercises use those well-known maps of the areas round the Broad Street pump. It is the John Snow Society, which holds meetings on contemporary epidemiology with recourse to the John Snow pub in Soho afterwards. There is some acknowledgement of the role of controversy and the mutability of historical 'fact' through the demographic debates. Everyone knows Thomas McKeown's work and its historical basis, and Simon Szreter's modification of that thesis – to the advantage of public health – needs no introduction from historians.⁸ That classic debate in economic history, the standard of living debate, is integrated into the revived discussion on inequality through the newer field of anthropometric history. This area of economic history is one where past and present data perhaps most easily intermingle.⁹

The historical model most drawn on is the tradition of nineteenth century public health, the era of the broad environmental mandate. Seeing the past – or parts of it – as a 'golden age' is common; the invention of tradition, so historians have told us, is widespread. A speaker at the Liverpool public health history conference referred to 'a package-able and mythologised past'.¹⁰ In my experience, many public health researchers, if they used a public health history text, would turn to Rosen rather than

7 For several years now, the Chief Medical Officer's annual conference has invited a historian along. I attended in 1996, although there was no specific historical component on the agenda. In 1998, the discussion focussed on whether 1848 could be a model for a new overall Act, and Sally Sheard from Liverpool was called on for advice.

8 These comments are based on observation at LSHTM.

9 A historical conference just before the recent Public Health Forum on inequalities at LSHTM attracted a good number of main conference attendees. Amartya Sen's keynote address at the main forum effortlessly mingled historical and contemporary data, with reference to the work of historians such as Jay Winter.

10 Paul Laxton, speaking at the Liverpool conference 'Health in the City: a history of public health', September 1997.

more recent work.¹¹ History in public health has two main practical functions. At the policy level, it is a matter of the 'lesson of history', of historical 'facts' giving specific historical messages for the present, often implicitly justifying what current policy interests want to do. Among researchers, it is this – but also a matter of 'folk tales', the professional equivalent of family history, tracing origins back to people in the past, looking at current practice in terms of lineages, tracing the origins of 'what we do now' in the light of what people did in the past. This, of course, is common practice within medicalized areas, among which professional public health still has to be included. There is little recognition of the interplay of 'fact' and interpretation in history, with the exception of Szreter's reinterpretation, which, it could be argued, fits with public health's conception of its revived role. It is noticeable that the most sophisticated integration of history within public health is through the standard of living debate, where the historical 'data' is quantitative, historical epidemiology more akin to the conventions and techniques of contemporary public health research.¹²

Expanding Historical Consciousness in Public Health

Like the late Raphael Samuel, I think family history and the interest in heritage is potentially a 'good thing'; anything which brings people to a sense of their past should be encouraged. But the historical consciousness of history in public health could be developed further. It seems that the understandings of processes and ideological/policy change are less well integrated than historical quantitative data. In this section of the paper I will first discuss some themes which emerge from historians' work in this area which could be drawn on by public health practitioners and researchers, but which mostly are not. I will also suggest some areas of further research, which could be developed, drawing on my own experience as a contemporary historian in a public health location.

If we look at the potential public health historical 'tool kit' available, it is clear that the nineteenth century environmentalist period was more complex than the heroic accounts would allow.¹³ Concern was indeed for poverty and ill health, but this arose out of a particular set of economic and social ideals. Edwin Chadwick came to public health from his involvement in the reform of the Poor Law. In his view, ill health caused poverty and therefore reliance on poor relief. The connection was with

¹¹ Personal observation by author.

¹² This is also the case with the historical epidemiological approach of the 'Barker thesis' which has influenced epidemiologists with work on the foetal and early origins of disease.

¹³ This section of the paper draws on Virginia Berridge, 'Historical and policy approaches' in Margaret Thorogood and Yolande Coombes, eds., *Evaluating health promotion* (Oxford, 2000, in press).

economic efficiency and the securing of a functioning working population. Public health had its rationale in the human capital theories of the time. Nevertheless public health reform did serve as a surrogate in the nineteenth century for more general social reform. Christopher Hamlin's work stresses its role as an alternative to wider reform; and other research has stressed the importance of activity at the local level in securing those ends.¹⁴ This tension between central direction and local initiative marked much of later nineteenth century public health. In 1840s Liverpool, the local/central relationship was a symbiotic one, with public health officials in both locations using the tensions in the relationship to advance their own objectives.¹⁵ Eyler's recent study of Newsholme shows, through a study of his work as the MOH for Brighton, how much a determined local official could achieve by working within local political structures.¹⁶

It is important to recognise, too, how public health efforts were informed by fear. Towards the end of the century, fear was focussed on what was seen as the growth of a 'residuum', a race of degenerates, physically stunted and morally inferior. Public health historians are beginning to relate this larger ideological climate to the concern for environmental pollution in the late nineteenth century – fear of contamination, which found expression in imagery such as that of the fog shrouded East End – or in the concept of the opium den. The focus of pollution concern was both environmental and individual.¹⁷

But public health has also had a history since the nineteenth century. Public health historians such as Jane Lewis have drawn attention to broad stages in the development of public health, which were also delineated by early writers on public health.¹⁸ The era of environmental sanitation gave place at the end of the century to an emphasis on isolation and disinfection under the impact of germ theory. The individual patient became the locus of infection. Some historians have argued that

14 Christopher Hamlin, *Public Health and Social Justice in the Age of Chadwick, Britain, 1800–1854* (Cambridge, 1998). Hamlin spent several months in 1998 as Health Clark Lecturer in LSHTM, a valuable cross-fertilisation exercise. An in-house conference on history in public health, organised by the history group, brought discussion between current researchers and public health historians.

15 Gerard Kearns, 'Town hall and Whitehall. The roles of local and central government in sanitary reform. The Liverpool case, 1847–1863'. Paper given at the Liverpool conference 'Health in the City: a history of public health', September 1997.

16 John M. Eyler, *Sir Arthur Newsholme and State Medicine, 1885–1935* (Cambridge, 1997).

17 Bill Luckin, *Pollution and control: a social history of the Thames in the nineteenth century* (Bristol, 1986). See also Gareth Stedman Jones, *Outcast London. A study in the relationship between classes in Victorian Society* (Oxford, 1971).

18 For a good survey of this argument see Jane Lewis, 'The origin and development of public health in the U.K.' in Walter W. Holland et al., eds., *The Oxford Textbook of Public Health*. 2nd ed. (Oxford, 1991).

these theories gained such widespread acceptability quickly at the political level precisely because they provided such a circumscribed notion of appropriate intervention. Others argue that bacteriology had a less significant impact on the implementation of policy. Its importance lay in preparing the way for the rise of what has been called 'surveillance medicine'.¹⁹ The new public health of the twentieth century was indeed founded on the concept of 'personal prevention'. Stimulated by concerns about national efficiency and the 'deterioration of the race', the concern was with education and personal hygiene. After local government took over the old Poor Law hospitals in Britain in the interwar years, public health doctors turned their attention to running hospitals rather than to securing the health needs of the community. Historians have pointed to Britain's resultant slowness in adopting diphtheria immunisation, and to the failure to draw the health consequences of unemployment to government during the 1930s.²⁰

The establishment of the National Health Service (NHS) in 1948 saw public health marginalised when the nationalisation of the hospitals rather than public health in the local authorities formed the bedrock of the new system. The 'new vision' for public health in the 1960s was community medicine – the public health doctor as health strategist', but with the health service and the structures of clinical medicine rather than the local authority, using epidemiology and statistics for 'community diagnosis'. The new public health was to be the lynchpin of the reformed NHS, and doctors were to be advisers as well as managers. At the same time, the technical tools of epidemiology underpinned a new change in ideology to personal prevention, drawing on the turn of the century ideas, and the concept of individual lifestyle, epitomised in government prevention documents of the 1970s. Individual habits were identified, but examined via epidemiology at the population level. It was smoking, alcohol consumption, and eating which epitomised the new public health concerns. Fiscal and media strategies – taxation, mass media campaigns – underpinned the standard patterns of response established at this time. In practice the dual role for public health proved difficult to manage. After health service reorganisation in the 1980s, community medicine was sidelined and in some areas virtually disappeared. The coming of AIDS stimulated another revival. More recently, the Conservative government's Health of the Nation (1992) policy document and the unintended consequences of NHS reforms, which saw public health playing a central role in purchasing, seemed to mark another 'new beginning'. The advent of the Labour government in 1997 has seen a greater stress on public health.

19 Dorothy Porter, *Health, Civilization and the State. A History of Public Health from Ancient to Modern Times* (London, 1999). See also David Armstrong, *Political Anatomy of the Body. Medical Knowledge in Britain in the Twentieth Century*. (Cambridge, 1983).

20 Work by Webster and Weindling, surveyed in Lewis (1991), *Oxford Textbook*, *op. cit.*

For historians, this broad historical survey would be nothing new. We are reasonably familiar with the debates and the interpretations advanced by fellow workers. But it is not internalised as history in public health in the way in which the Chadwickian 'heroic' period is. Advising recently on the compilation of a brochure to mark the centenary of LSHTM, I was struck by how little of the interwar UK history of public health was known to practitioners. The recognition of the history of UK public health in particular seemed to end with the nineteenth century. Yet the School in the interwar years and after had been the location for important moves which helped structure postwar public health, not least statistical and epidemiological developments and the role of its staff in policy making. For example its Dean, Wilson Jamieson, was CMO in the Ministry of Health during the war. So certain dimensions of 'historical fact' are missing. But there is also a more fundamental problem. Change over time in the ideology, location and practice of public health are important dimensions of historians' analyses, but these are difficult concepts for contemporary practitioners. It is more difficult to integrate the conceptual side of historical research. The interplay of 'fact' and interpretation in history is barely recognised. There is an added complication in that the other social science disciplines, which are located within public health, are also often unaware of historical research and its conclusions.²¹ When one European public health journal ran a historical special issue, it drew on the work of sociologists rather than that of historians of public health.²² Nor do the contemporary policy discussions of public health appear to take much account of this historical mutability of the concept of public health. At the policy level, public health is used as some kind of universal absolute, without recognition of historical developments in ideology. One recent policy report on health promotion remarked in its summary, 'Health promotion and public health are intricately linked concepts which overlap considerably. Greater clarity is needed on how they relate to each other'.²³ These are important historically determined issues.

The Public Health Consciousness of Historians

There is also another way of looking at history in public health. It is easy to be patronisingly superior. Public health practice could expand its understanding of history and of the greater complexities of historical interpretation. But historians of

21 Here Armstrong's work would be used, but rarely a range of historical work. e.g. of Judy Green and Niki Thorogood's recent book *Analysing health policy: sociological approaches* (London, 1998).

22 This was the *European Journal of Public Health* 6:2 (1996).

23 *The future of the health promotion function*. Report on a consultation facilitated by the Health Education Authority, 1998.

public health can expand their boundaries, too. History in public health from another perspective, that of historians working in a public health location, opens the mind to fresh possibilities and to perspectives which might not be so apparent to a disciplinary-based historian. Here I will focus on three layers: the area of postwar history of public health in general, and within that framework the analysis of changing structures, practice and ideology, both at the central and local levels. As is perhaps obvious from the preceding section, public health has a postwar history which has so far attracted relatively little attention. Jane Lewis has written of the role of community medicine;²⁴ but there has also been public health as prevention, prevention not as an environmental issue, but as a matter of remedying defects in individual lifestyle. The rise of this style of thinking can be traced both internationally, as for example through the Lalonde report of 1974 and in individual country-based prevention documents, as in the U.K. The roots of this reorientation can be traced to the postwar shift in interest from epidemic to chronic disease, and to the rise of technical tools, most notably risk factor epidemiology.²⁵ Epitomized in the new 'scientific fact' of the link between smoking and lung cancer, this was a fundamental paradigm shift in scientific 'ways of knowing', substituting for biomedical notions of direct causation, epidemiological concepts of relative risk and statistical correlation. In statistics, biomedicine gave way to public health epidemiology. Risk factor epidemiology became the new public health/preventive discipline par excellence, associated with a host of health issues from alcohol and smoking through to diet and heart disease. This was the epitome of the surveillance society. A public health agenda emerged in the 1960s and 1970s which was based on this risk agenda, on individual avoidance of risk. It developed a strong economic dimension and a focus on education of the individual. Consequently, the role of health education assumed new significance together with the use and development of techniques of mass persuasion in the health area.

In the postwar years, it was the smoking issue which most clearly epitomised the reorientation of public health towards individual lifestyle. By the 1970s, anti-smoking interests had developed a policy agenda which focussed on economic arguments (price and tax rises, anti-industry) and on the media (advertising bans, mass media campaigns), sustained through the techniques and findings of epidemiology. In the 1980s the development of AIDS as an issue also epitomised the reorientation of public health around the concept of risk. AIDS was a syndrome initially defined solely through epidemiology and the concept of risk. It was an epidemiological syndrome par excellence; and it also exemplified the key tenets of the new public

²⁴ Jane Lewis, *What Price Community Medicine? The Philosophy, Practice and Politics of Public Health since 1919*. (Brighton, 1986).

²⁵ Virginia Berridge, *Health and Society in Britain since 1939*. Studies in Economic and Social History (Cambridge, 1999).

health, stressing individual behaviour modification and individual responsibility rather than any collective reaction.²⁶

This history of prevention and concepts of risk in policy-making is one where, as yet, relatively little primary research has been done. If we look in this postwar period at the role of formal public health structures, then the history of public health points to other public health issues meriting historical research. The central government location of public health has its 'heroic' roots in the nineteenth century – but its contemporary history should also be considered. Historically the location of public health in central government has been important, and central/local tension is an enduring theme. The role of public health within central government in more recent times also needs to be considered. AIDS seemed to advance the position of public health centrally, with the leading role played by the CMO. The production of *The Health of the Nation* document continued that tradition. But what did public health gain in central policy terms? The main beneficiaries of AIDS were ultimately the clinical specialties and genitourinary medicine above all. The CMO's involvement was seen by some as a diversion, with little public health involvement in other key health issues, such as health service reorganisation. Florin's work on health promotion and the GP contract in the early 1990s shows little involvement by formal public health interests or the CMO.²⁷ Internal changes in the Department of Health and the merging of medical and administrative strands may also have impacted on the work of that office, with the NHS Management Executive increasingly taking on a policy role. Other key policy areas in the 'new public health', such as illicit drugs, also have little formal public health involvement on the central expert committees and coordinating units. What public health really means within central government and policy making needs examination, not least the changing role of the CMO.

Structural issues remain important at other levels as well. Walter Holland, part of postwar public health history himself, recently noted in his history of public health parallels between the purchasing role of public health and the events of the 1930s, when public health doctors ended up running hospitals.²⁸ There are parallels also with the 1970s, with the technician-manager role in the reformed NHS and the enhanced role of epidemiological information. The essential duality of the rationale of formal public health has been the continuing thread, on the one hand, between disease

26 Virginia Berridge, 'Science and policy; the case of postwar smoking policy' in Stephen Lock, L. Reynolds and E. M. Tansey, eds. *Ashes to Ashes. The History of Smoking and Health* (Amsterdam, 1998). Virginia Berridge, *AIDS in the U.K. The Making of Policy, 1981–1994* (Oxford, 1996).

27 D. Florin, 'The role of public health medicine in national policy; a study of the policy for heart disease prevention by GPs in the U.K.', *Journal of Public Health Medicine*, in press.

28 Walter Holland, after dinner speech, The Liverpool conference 'Health in the City: a History of Public Health, September, 1997. See also W. Holland and S. Stewart, *The Rock Carling Fellowship, 1997. Public health: the vision and the challenge* (London, 1998).

prevention and health promotion, and on the other, between the planning and management of health services. This has been epitomised in the Janus face of the annual public health reports, uncertain of whether their rightful audience was health care purchasers or the public.²⁹ The leading role of public health in the new HIMPS (Health Improvement Programmes) may perhaps resolve some of these historically determined structural issues, but the historians' supposition would be that it might well continue them.

One twentieth century structural issue has not gone away. Historically the tension was between GPs and public health doctors for control of the same territory in the interwar years. In the postwar period, and especially since the 1970s, GPs have taken on many of the 'health promotion' activities – brief interventions, screening, health checks, advice on diet, alcohol and smoking, sexual health issues – which are considered to be part of the modern public health package. We now, in the 1990s, have a 'primary care led' NHS. The question may well be asked whether it is rather primary care which now carries out a considerable part of the traditional public health role. Recent moves in health service organisation have not clarified this issue. One doctor with experience in both camps commented, 'There's a lack of clarity about how functions divide between public health, the health authority and the Primary Care Groups. The interface needs to be sorted out...'.³⁰ It is the primary care groups rather than public health which have been given the community development role. The terrain remains unclear, with the advantage apparently to the general practitioner. This is a significant change from the early discussion of primary care in the 1960s, when, as Jane Lewis has reminded us, the term meant public health.³¹

The public health 'policy community' is both broader and more fragmented even than this issue implies. The 'players', both locally and in policy advisory terms, are a wider community than the formal public health model. The players within the various 'policy communities' which exist around the issues deemed to fall under the public health umbrella are often not public health personnel in a straightforward way – and they differ from each other. The smoking policy community, for example, is distinct from that for alcohol, or for drugs. Probation officers and psychiatrists carry out public health policies, too.

This blurring of the organisational boundaries has been accompanied by some interesting changes in the ideological and technical underpinning of what are broadly termed public health activities. Epidemiology as a technical tool has been under pressure, criticised from different directions. Its central tenets within public health, in

29 N. Fulop and M. McKee, 'What impact do annual public health reports have?' *Public Health*, 110 (1996), 307–311.

30 Personal communication, December 1998.

31 Jane Lewis. 'Making recent community and primary care policy', lecture given at LSHTM, 4 November 1997.

particular the focus on 'risk' to the whole population, are yielding to a greater emphasis in some areas on harm and 'high risk' groups. The conflict or tensions between these two approaches is currently exemplified in debates in the alcohol field.³² This has brought in its train a redefinition of the concept of risk. But there is also a new environmental dimension to public health which has led to further redefinition. The global environment is involved, but also a redefinition and expansion of risk at the level of the individual in society, the concept of the 'environmental citizen', a rational consumer protecting him or herself from environmental risks.³³ There is a new 'environmental individualism' demonstrated, for example, in the concept of passive smoking. This gives the epidemiological concept of risk an environmental dimension, but one still rooted in the control of individual behaviour, conceptualised with a strong moral tone.³⁴ Environmentalism at the level of the city or the locality has been expanded through the concept of 'community safety', which means essentially control of the individual in local smoke, drug- or alcohol-free spaces. Such spaces are also to be crime-free. The concept is applied not just to health behaviours but also to issues of public behaviour and of law and order, as in the recent UK Crime and Disorder Act. Issues of law, regulation and public health are being brought together at the local level, a development which again has its historical and especially late nineteenth century local antecedents. Issues of individual responsibility and of environmental pollution are brought together, coupled also with that 'threat of the underclass' (redefined as 'social exclusion') which was so important at the turn of the last century. We seem to be moving from a risk-based public health to one redefined around safety and harm.

History and Historians in Public Health

These comments derive from the perspective of a historian more familiar with UK public health and its recent history. Those working in other cultures and countries would obviously have different points to make, although some of the issues are cross-national. This section of my paper is in part a call for more research on recent history, but also in part an illustration of the perspectives and possible areas of research which

32 Griffith Edwards et al., *Alcohol Policy and the Public Good* (Oxford, 1994). For the revisionist approach, see M. Plant, E. Single and T. Stockwell, eds., *Alcohol. Minimising the harm. What works?* (London, 1997).

33 A. Petersen and D. Lupton, *The new public health: Health and self in an age of risk* (London, 1996).

34 Virginia Berridge, 'Passive smoking: policy speaks to science?', *Social Science and Medicine*, 49:9 (1999), 1183–95.

emerge through the interaction of historical understandings with contemporary events and players. In this final section of the paper, I will turn to the role of 'historians in public health'. That arena of interaction is quite distinct from the type of 'presentism' for which many historians have such distaste. History in public health can be presentist, simply reproducing the preconceptions of the present in its analysis of historical work. But it does not have to be so. It can be a tool of analysis, bringing a historical understanding to bear, not presentist, but aware of the present.

In developing a more nuanced analysis, it is important to be a historian in public health, in the anthropological sense, to be 'living among the tribe', to be a 'stranger and a friend'. Let me give some examples from my own work and that of colleagues at LSHTM which illustrate the variety of advantages this can bring. There are practical ones. At a recent LSHTM conference, I organised a witness seminar, a group 'oral history event' on the 1980 Black Report on inequalities and health, a notable piece of recent health history, in part because of its rejection by the Conservative government. Thinking of whom to invite, apart from the members of the committee, and gaining their agreement to speak on the record in public were greatly facilitated by two things. My location in the same unit in the School as one of the members of the committee, now an Emeritus professor, meant that he readily provided information and advice to a colleague. My connections with a fellow historian, who had twenty years earlier been scientific secretary to the committee, also provided valuable briefing and contacts. The duality of the location – in public health, but also in history – was what mattered. Research work done on the role of the science/policy relationship in the revised role for health promotion in the GP contract, which took place in the early 1990s, saw medical civil servants speaking to the researcher, a public health doctor, in a forthright way which would have been less likely with a non-medical historian. But the researcher also located her work in the history of postwar general practice and public health through historical supervision. Again the duality of the location was important. Research on hepatitis B and its history gained from its location in an institution where current research was also feeding into Department of Health decision making on current hepatitis B vaccine policy. Research on the media processes round the science/policy relationships gains from a ringside seat at current debates and the process of dissemination. A recent media flurry over the safety of the pill for those who took it before having children, in which an LSHTM colleague was the focus of attention, produced interesting insights into the ways in which scientific facts can harden through dissemination through a hierarchy of media outlets. In this case the BMJ produced a press release on a paper which had appeared in another journal, and the mainstream press and TV then took up the issue. These types of processes can be related to theoretical stances on the media diffusion of science.

It helps, too, if leading medical journalists are regularly around. This practical and methodological point is an important one. At the methodological level, 'living among

the tribe' offers many opportunities. It is easier to trace the changing role of the CMO, when current and former CMOs are in the institution. It helps an understanding of nutrition policy if key scientists who play important policy roles are around. Lunching regularly with a leading smoking researcher, involved in the area for over twenty years, can be more valuable as a mode of oral history than the formal interview which a disciplinary-based historian would set up. Conversations and observation at meetings, in the corridor, in seminars may find their way into the eventual historical analysis. This type of history in public health has to be carefully managed. A range of health and disciplinary balls must be kept in the air at any one time. Historians are not current health policy 'poodles' but rather insider/outside, detached, yet part of the scene. The ultimate result is never cause for self-satisfaction, and its mode of analysis is often outside the conventions both of formal history and formal public health.

Here are the research advantages which this location brings. But I started with another issue – how to make public health more aware of historical concepts and research. How to bring more sophisticated historical perspectives into public health's understanding of itself is not capable of any easy solution, not least because this type of history does not offer lessons or prescriptions for the future in a directly applicable sense. When I look at the diffusion into drug policy discussions of work I did on nineteenth century opium and on drug policy in the twentieth century, it is still the analysis of 'open availability' of drugs in the nineteenth century which attracts most attention. But there is a process of gradual diffusion of the other arguments and analyses, not least because I have remained in contact with the field. This leads me to conclude that there has to be a continuing reciprocity and interchange from both sides, and the seizing of the opportunities, not least teaching, offered by the location.³⁵ Dissemination is important to a wide variety of audiences. The historical interest within public health is long standing and is there to be built upon. All in all, history in public health is an exciting and demanding way of doing history and one whose potentialities should be more widely realised.

Acknowledgements

I am grateful for the support of the Wellcome Trust, which funds the history programme at LSHTM and other historical grants. My thanks are also due to Jenny Stanton whose careful editorial comments have greatly improved the paper, and to Deborah Curle for secretarial assistance.

³⁵ This paper has focussed on research rather than on the opportunities offered by teaching as a process of diffusion. See Virginia Berridge, 'Teaching history in a medical school', Wellcome History, 1997.