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**Dame Rosemary Rue DBE in interview with Dr Max Blythe  
Oxford, 27 November 1995, Interview II**

**Part One**

MB Dame Rosemary, at the end of our last interview we actually got you applying for a post in Hertfordshire, in the public health field, and I want to start at that particular time which was 1958. You were coming up from what had been a rather difficult time – a broken marriage, poliomyelitis – and you were moving forward, getting more confident on your feet. But I think you still had an operation or two to go, and you weren't greatly mobile. But you took on this rather, this brave move when Martin Doyle died to the Public Health Department in Hertfordshire.

RR Yes, it was called assistant county medical officer, that job, and it was in south-west Hertfordshire, which was Watford, Rickmansworth and surrounding, that sort of area. And it was maternity and child welfare, which used to be clinics; people will remember the old baby clinics, masses of immunisations and looking after baby feeding and development, child development up to school age, and then also visiting the schools. Now midwifery had stopped by then, the local authority personnel were not doing midwifery, which was just as well because I wasn't trained for that. And I got to know all the children from 0 to 14 in quite a big area in all their settings there – home, the clinic – all the children with problems, and of course a big range of normal children in schools. It's interesting for a doctor because you tend to see the abnormal during the medical training, and suddenly to have the opportunity to look at not hundreds, but thousands and thousands of normal children, it gives you a very good idea of what is normal. You know normal when you see it.

MB I get a marvellous feeling as well from all that you've said that you really felt at home in that, in that role right from the start.

RR Yes, I didn't expect to enjoy it, I was a bit worried about it, but I did enjoy it and started doing it. Sometimes of course it was a bit boring, but then aspects of all medicine can be boring once you get familiar.

MB Very quickly, I think, when we were discussing it, very quickly you brought hospital work, public health department work, the work in schools and some lingering work in the practice, all together.

RR Yes, I continued to help in the practice from which I had just retired on a once a month basis, because it was being run as a single-handed practice. So from then right up until in fact 1972 I did one weekend a month in the practice, and on call for it. So I kept up my interest in general practice. And I also undertook locums for lots of the other practices round about, so I got to know all the GPs and the primary healthcare teams, and the children in their sickness settings as it were as well as their

health settings. So I had a very good overview of the children's population in south-west Hertfordshire.

MB That's an incredible spectral view, wasn't it?

RR It was, it was wonderful. It was one of the most satisfying bits of organisation and clinical work that I've ever seen or done, because as well as that I developed a link with the paediatric department of the hospitals in Watford. There was an out-patients department in the Peace Memorial Hospital, and an inpatients department at Shrodells, and I gradually gained the confidence of all the GPs and the paediatricians and of course all the families. So I was in an absolutely pivotal position of integrating public health, primary care and specialist medicine.

MB And this was not common.

RR It was unique as far as I know.

MB Yes, absolutely. And Rosemary, just while we're talking about children and child health and child interests, you were a mum as well...

RR Oh yes.

MB ...living with your parents by now. And perhaps tell me where the boys had arrived in age and schooling, would you?

RR I think by 1958... Yes, I would have had one child of six and one of three so one was at infant school and one was at school.

MB So you lived within this extended family with parents, in Chorleywood?

RR Yes, that's right, yes.

MB So close to work, but still you must have felt on occasions a bit detached from a family you wanted to be with, because you really had to keep up quite a pressure in work.

RR Well, of course the stresses of trying to look after little children and work full-time... The job that I was doing was basically nine to five, school hours. So in that way it was better than the general practice job. But in other ways of course one had to keep going, times when they were ill or wanted you and one just had commitments, and as a medical mum one got used to it.

MB Rosemary, in the Hertfordshire public health department, what was the overall administration like? Who were you working for? What kind of a department was it?

RR Yes, the ... the county medical officer was someone called Dr Dunlop<sup>1</sup>. And the divisional medical officer, who was responsible for the whole range of public health in which I was not participating because I was doing the children only, he was

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<sup>1</sup> Dr James Liddell Dunlop.

someone called Dr Alcock<sup>2</sup>. And then there was quite a big group of us, mainly women doctors, working throughout the clinics. I think there were about five or six of us and we used to meet from time to time.

MB Was that a comfortable environment? I mean, was it very supportive? Because I know sooner or later you started to look for postgraduate training to go with what you were trying to do.

RR Yes, it was not supportive. The public health service, although it was quite good and quite efficiently organised... And I would say some of the lay people in it, some of the lay administrators were extremely good and efficient and caring. The, most of the doctors who were in it felt that in some way they had missed out on medicine. Public health services were very much regarded at that stage as a sort of dying branch of medical practice. And most of them were either working because they couldn't get other jobs because they were married women and they'd missed out on their postgraduate training, or they were more senior and they were distinctly worried about their future. So it was not a very happy time.

MB But you were seeking to know more and more, and you were finding that you could cope physically and you were seeking more and more to understand child health problems?

RR That's right. I began to have a vision of a comprehensive health service, in practice, as opposed to a health service that was divided into three sections. And I felt very much the need for postgraduate training in paediatrics and child health, so that I could get up to date with the work I was trying to do; assessing children and knowing more about modern caring methods. Medicine was advancing quite fast at that time. I also wanted to see whether I could walk well enough, actually move myself about well enough to walk about in hospital, and partly I did that through going to the hospital on an intermittent basis at Watford. But then I applied for a postgraduate training programme at Great Ormond Street, which was the Institute of Child Health at the University of London, which seemed to be the academic centre that was offering exactly what I needed. I went to see the divisional medical officer, and said that I wanted to do this course and could I have some sabbatical leave. I think it was in my mind at the time that I hoped I might be offered some financial assistance with the training, which was quite expensive. And the answer was that this was completely useless from their point of view. The only kind of postgraduate training that they supported as a matter of principle was the DPH [Diploma in Public Health] course, which was the old sort of sanitary oriented public health of the lay knowledge, and if I wanted to go I'd better resign. So, I thought it over and wrote my resignation the next day and went off to Great Ormond Street, paying for myself.

MB This was quite a financial hurdle.

RR Oh yes, because I really didn't have any money. I hadn't had much opportunity to earn much money by then, but I was living with my parents and they were supportive, they understood. I think they were keen to see me making a break

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<sup>2</sup> Dr William Alcock.

and trying commuting to London, and living in London part of the time and managing in London.

MB So at the age of thirty-two, still physically quite disabled, you had to cope with a London course?

RR Yes. I wanted to see whether I could actually walk enough, say, to do a ward round, and I found that I was improving all the time and in fact I could. I think at that stage I couldn't actually get on a bus or easily manage an underground train. So I had just to grab somebody to get on and off the trains and so on. But I did manage to commute from Chorleywood a lot of the time, and managed to stick out the course.

MB You went to the Institute of Child Health. Where was that based, where were you based at that time?

RR At Great Ormond Street.

MB At Great Ormond Street, yes.

RR ...and they did a Diploma in Child Health, which was recognised by the [Royal] College of Physicians. And I took that and passed that, and of course had aspirations at that time perhaps to do Membership of the [Royal] College of Physicians, which I would like to have done. But there was no way I could do the necessary residential medical jobs at the time. So instead of doing that, I went back to the Nuffield for another operation, in fact they piled several operations together in one admission, and emerged feeling ... really that was the end of my active surgical rehabilitation procedures.

MB So that was right at the end of the Diploma in Child Health course?

RR Yes, that must have been...

MB Rosemary, let me just keep you to that course a little, a little while, because it was important time for you. You did find it was the right course for you. I was going to ask two questions about it. One: what kind of people were alongside you doing that course?

RR They were mainly people who were trying to work up paediatrics and child health as part of their membership training. They were taking a bit of time out of adult medicine to do the paediatrics. There were also quite a lot of people from overseas, including the old commonwealth countries, who were still developing very active public health programmes in their countries, mainly focused on child health and development. And they were seeing the importance of this in a way which was being just rather overlooked in the UK at the time.

MB Was the, was the approach of the course itself, was it kind of two-phasic? Was it child health in a kind of social sense as well as child health in the sense that you would meet it in the kind of specialist divisions at Great Ormond Street?

RR Yes, it was very broad and there was quite a lot of specialist paediatrics, as practised in the clinical setting of Great Ormond Street, which of course ... well a lot of it was extremely new. I mean there was a lot of paediatrics surgery, there was the beginning of the unravelling of some of the genetic diseases before of course the more recent invention or discovery of the DNA basis for these diseases. But there was a lot of research going on. And a lot of the junior staff at Great Ormond Street who were of course the future paediatricians, they were very, very active in specialist paediatrics. We also went to Hammersmith Hospital where there was a big postgraduate department of neonatal care and learnt a great deal about the care of the neonates, which again was developing extremely fast under Professor Tizard<sup>3</sup> who later came to Oxford, and John Davis<sup>4</sup> who later went to Cambridge as professor. And then as well as that there was the international public health aspect of child health in social and international settings of poverty and epidemiology, and also the legal framework, and problems of children who were lacking in developmental progress physically or mentally. And this I was extremely interested in.

MB It sounds a terrifically exciting course.

RR It was very good.

MB I think on one occasion when we talked about it you said that you actually met occasional cases that you'd referred.

RR Well, that was interesting because of course it was the tertiary referral centre for, well, for the whole of England at least. And I did see patients that I had dealt with as it were in south-west Hertfordshire turning up there for super-specialist(?) diagnosis and care.

MB So that course justified all your, all your investment in it at that time.

RR Yes, yes. I was pleased about that.

MB And yes, you came away and you returned to, you returned to Hertfordshire into the same job in some curious way!

RR Well, I went back to Hertfordshire and said 'Well, now I've done what you didn't think was a good idea and I thought it was an extremely good idea and extremely useful. And I think I'm now better equipped to do the job which I was supposed to be doing beforehand.' And they said 'Well, as it so happens your old job is still available.' And so I was re-appointed and continued there, until 1965.

MB Right, so there were two or three years to go in that job. Did you advance along the same front, this integrational front? I'm thinking all the time of this hospital, this community, this public health division, bringing it all together.

RR Yes, it developed extremely well, because by now I had got links of course with Great Ormond Street, this tertiary referral centre, and so that completed the jigsaw of the comprehensive health service for children in my mind. And also I had

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<sup>3</sup> Professor Peter Tizard.

<sup>4</sup> John Allen Davis.

made contact again with the child psychiatric and child development services in London, and could link in that aspect of child development. So I was very well placed to help the children and their families.

MB How well you created a hub, and things were now reaching out and moving into other directions, joining it all together.

RR Yes, yes. It seemed to me a pattern that could well have been duplicated.

MB Exciting, and you're also doing the general practice...

RR Well, that was part of it in a way.

MB This was incredible. The same practice, Martin Doyle's practice going on as it were, post-Doyle. And did that still give you as much satisfaction?

RR Yes, of course. Because having updated my medical and clinical knowledge, although it was with children one did of course get aspects of medical developments which were a spin-off for adults and even geriatric medicine and the psychiatry that I was still interested in, and so I felt better at general practice as a result of that. And a lot of the patients in general practice are children after all.

MB Rosemary, what made you leave there? You'd got it all going at that stage, you were bringing a lot together.

RR Yes. Now, in 1965 I felt that I wanted more professional, personal development. My children were by then at school, and I was getting quite strong. I could, I could walk quite well. I could do almost anything. And I thought that maybe what I should do is try to move up the ladder in public health service so that I would have... I suppose I was thinking I would have a rather more powerful position in which to spread the knowledge and the practice and the patterns that I'd developed over a wider area, because I was still confined to a fairly small area and didn't have a great deal of influence, and no one was particularly interested in what I was doing. I thought maybe I could do a bit more on a wider scale. So I went to see the county medical officer of health who by then had changed, and was someone called Geoff Knight, and asked his advice about what the prospects were for promotion. I think with rather a heavy heart I felt I ought to do the DPH course, which was what I'd been expected to do some years before, or maybe that I should change direction and do my MRCP after all. I felt there was more scope professionally at that stage.

MB So this was a crossroads time, and various things could have happened.

RR Yes. I was actually wondering whether to become a paediatrician, to become a child psychiatrist, or to continue in the public health field. I think I didn't think that I was going back into general practice, partly because of the sort of organisational and financial background that one needed to break into general practice at that time. Anyway, I went with a fairly open mind thinking that through public health I would get my next advance, and asked Geoff Knight for some career guidance really. And he said, not exactly verbatim but more or less, he said 'Public health is finished, it's

all over. There is no power; there is no future here. If I were you I would get out of this business as quickly as you possibly can.’ So I was rather startled and said ‘Well, to where? You know, where does one go from here? You know my background, what do you think the opportunities are for me?’ And he said ‘Well, all the power at present and in the future is with the regional hospital boards. That’s the only place to be, that’s where I’m going as soon as I can go.’ Well I drove back from Hertford, thinking that’s very strange advice, and I was a bit shocked and a bit rattled. But in retrospect it was about the only career guidance I ever asked for or received, and it was extremely good advice. I thought on my way driving home that I didn’t really know what a regional hospital board was – I don’t think I was alone in the medical profession in being a bit vague about the way NHS was structured. But that was a Friday evening, it was the end of the week, and I turned to the back pages of the *BMJ* [British Medical Journal] and saw a job offered in the Oxford Regional Hospital Board, but the closing date the next morning, Saturday morning. So I wrote off an application for the job, and first thing the next morning I drove down to Oxford and posted it through the letterbox of the Regional Hospital Board buildings on the old Churchill site. I think I got there about 2pm by the time I had prepared this application and sorted out the children and made the drive, but I was, I thought, just in time. And on Monday I determined to do some research as to what a hospital board was, and maybe what I’d applied for. And I also rang up the hospital board, and because of the experience I had had and heard about and seen I said to a very, very nice elderly man who was in charge of personnel on the telephone, I said ‘I’ve put in an application. Have you received it, did it meet the deadline? And by the way do you think the board is likely to consider a woman applicant?’ Now, he was shocked that I should have asked that question, and it was the first time again that I have, I had ever heard anyone say with such warmth ‘Of course we would consider a woman. How could you possibly have thought that a modern open-minded organisation like this wouldn’t be delighted to have a woman applicant?’ And I thought well, that’s a very good sign, and I went back and did a little bit of research. Well, to cut a long story short, within about a week I had been offered the job and had accepted it. And so that’s how I made a very major career move.

MB Rosemary, what I was going to ask at this point, was Geoff Knights in diagnosing the need for you to think elsewhere ... what was he picking up in the Health Service at that time? Were the regional hospitals boards getting a lot more money, had they just started to get power, was there a capital investments scheme? What was happening?

RR Well, they were extremely strong, influential and powerful. They were spending the money; they were attracting not only the best clinical doctors into specialist and hospital medicine. I mean, general practice was a bit in the doldrums at the time. Public health seemed to be going down the drain. Of the three branches of the NHS, the hospital specialities seemed to be the growing point. And interestingly a few years later Geoff Knight himself became head of a, medical head of a region and fell into the same kind of job that he’d advised me to get a few years before, so he followed his own advice.

MB You came to Oxford for an interview, and had an interview with the regional medical officer?

RR It was then called a senior administrative medical officer, or SAMO. And the Oxford SAMO at that time was JOF – that’s JOF, initials – JOF Davies, and JOF was one the group of fairly charismatic individuals, the fourteen SAMOs, who ran these very forward-looking developing hospital boards at the time.

MB So England and Wales was criss-crossed by fourteen regional authorities.

RR Wales was... There were fourteen English, and Wales was separate.

MB And Wales had separate boards, yes. And so you were invited to come?

RR Yes, and I came within a month, joined a team. There was JOF, his deputy was someone called Tony Oddie<sup>5</sup>, who was a former Royal Naval surgeon...

MB And who became duly distinguished.

RR ...also [became] a SAMO, and whom I then succeeded eventually. There were about six of us in the medical department. And the region, as were two or three other regions, particularly the more successful regions, they were very much medically managed. JOF and Tony worked extremely hard; they knew what was going on every second of the day, twenty-four hours a day, 365 days a year. Hardly ever took leave or were out of touch; they were very, very conscientious. JOF had come from the Middlesex services, which had been very advanced, and he had a distinguished career in the old public health services which were integrated with the services; Middlesex County. And Tony had come from the services and found a niche in, after the war, in hospital administration.

MB So this was strong medical executive power, that was well handled. Serving a board of who? Who were the regional hospital board? Were these elected representatives from different regions, different areas?

RR There were some local authority nominees on the board. There were also doctors – there were hospital doctors, GPs and local authority doctors, that’s medical officers of health. There were lay people. And the chairman at the time that I joined was Dame Isabel Graham-Bryce. They were distinguished people in Oxford. The, some of the debates that took place, always in public of course, at the regional hospital board were attended by the public out of interest for the quality of the discussion about the health service, which was felt very much to be owned by the people of the area which was covered by the Oxford Region.

MB So there was a great deal of local pride and commitment and concern by this body.

RR Absolutely, and we had... Unusually for many regions we had strong liaison committees with public health and general practice, the other two arms of the service. And we also had a very open arrangement of communication with the medical advisory committees, the nursing advisory committees, and later we added the other

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<sup>5</sup> John Anthony Oddie.

health professions. So that it was a very integrated approach to health, much as I had sought and longed for when I had been in south-west Herts.

MB Yes. And it was a body responsible for hospitals right across the equivalent of four counties, and also the development of real regional specialities?

RR Yes, we were responsible for co-ordinating and developing the regional specialties, and postgraduate education which was formally invented at the beginning of the sixties, and the regional hospital board was the postgraduate education authority. We had responsibility of course for policy and planning and for expenditure of funds, and for also the general development of the organisation of the service as it was developing very fast. And there was quite a lot of sort of integration of clinical departments required – many of the clinical departments were very, very scattered and they needed bringing together.

MB Rosemary, when you actually got to the, to the hospital board, I don't think you found anything very much on your desk. Can we talk about those early days because that was a remarkable...?

RR Yes. It was, it was very strange. When I turned up in this office building, with very little briefing of course, I was amazed it was the first medical job I had ever done where I walked through the door and there ... a queue of a hundred or so people didn't immediately form behind me with very obvious needs. I felt some time, I felt for some time that I couldn't discover what my task was, and what my role was. And after a few days of this, which seemed like an eternity for someone who'd been used to busy medical practice, I approached Tony and JOF and said 'Just what am I supposed to do?' And they looked a bit puzzled and they said 'Well, there seems to be plenty of work.' And so I said 'Well, what?' And they said 'Well, what do you think you ought to do?' And I said 'Well I think for a start I'd better learn something about what you imagine I'm supposed to be doing and something about the region.' And JOF then organised for me a most wonderful personalised postgraduate medical programme in health services management and development. He just asked me to jot down the areas where I thought I was deficient – and they were numerous – and he would pick up the telephone and ring up the national expert in the topic and arranged for me to go and visit him and his department. And I spent, I would think, six to nine months simply going around seeing everybody who was anybody in the National Health Services at that time, and picking their brains, because they were friends of JOF. And they were, I think, slightly intrigued to have someone to train in this way, which they did.

MB So, somebody had opened the box of postgraduate education for free, and just said 'Feast on the best!'

RR Yes, absolutely.

MB For the first time, I mean it had been a struggle.

RR Yes, more or less the only opportunity, I think, that anyone had really given me since I'd been qualified, and I was terribly grateful for it but also of course progressively fascinated by it. And of course it helped tremendously with my

background reading, and I was able to go to the conferences and hear the topics discussed, and to meet for the first time with politicians and senior civil servants who were interested in directing this as it were from the Department of Health – it was Ministry of Health at that time – where JOF had been deputy medical officer of health recently. And it was just wonderful to have such insight into the NHS.

MB That must have been a period of intense learning. I mean, you must have worked quite hard in that period, reading and visiting everywhere. I mean, it just seems that you moved around and looked at a lot of things.

RR And then of course gradually picked up the ideas and trailed them as it were around the region, and around the advisory committees.

MB It has brought a lot back to Oxford.

RR Yes, yes, I hope so

MB And perhaps we could talk, Rosemary, at this stage about things that were happening in Oxford. Exciting things were happening; you'd got a new medical school happening.

RR Yes. We were selected... Because there was a big shortage of medical manpower at the time – and that was one of the biggest issues, that there weren't enough doctors to go around and staff the big developments that we wanted – two new medical schools were formed with two or three more to follow. And Oxford was one of the first, with Southampton. And we had a wonderful period, led by Sir Richard Doll of the university who was regius professor, going through a period of what I would call kingmaking – that is creating the University of Oxford clinical chairs, obtaining the funding for them. Well, I would say easily, I mean it couldn't have been quite so easy for some of the people who were actually involved with getting the funding, but it certainly came in. And we just appointed a whole clutch of new heads of teaching departments in the medical school, and the medical school developed from about, an intake of about twelve or twenty or something like that from those very early years up to the present day where it's just over a hundred.

MB Yes. And all those new appointments gave the colleges a headache in finding placements for new Fellows, I mean, just ... and led eventually I suppose to Green College happening, which we'll talk about later because you had an association there. But that, that must have been the most incredible time, so many appointments.

RR It was wonderful, everything was new. And of course for all the teaching appointments that were made and all the new academic clinical departments, there was a great surge of activity in the various specialities throughout the region, which reflected terribly well on the standards of care in the Oxford Region.

MB And money, I think that this was a time when money began to come on stream in a big way. Capital investment.

RR Yes, when I arrived at the Region someone called Enoch Powell had just pointed out to the nation that no one so far had thought that the NHS might need some

money, and to him really goes the political credit of setting up a capital programme for the NHS. And hospitals, which were all of course inherited from before the war, for the first time had a ten-year rolling programme of capital development. And with the shift in population, a lot of which had come to the Oxford Region, we were early on the scene and in fact opened, built and opened the first phase of the first new district general hospital which was part of the plan. And that was phase one of the Princess Margaret Hospital at Swindon, which was then in the Oxford Region.

MB So you built a hospital?

RR And we kept on building hospitals then, and...

MB I mean this was, this was an unexpected incredible opportunity. I mean nobody had been doing hospital building, money was unstrained.

RR Nobody had been doing it, so working out the best way of planning, putting together, building quickly hospitals with the materials available... And although we're talking about the 1960s there were still a shortage of steel for construction of sheet glass, of some of the engineering components, there was a still a world-wide shortage of some of these materials. So there was ... a certain amount of difficulty with the designers of the buildings. And we eventually developed the Oxford method of building, which was not so much a way of construction as a way of working out the logistics of departments and within departments of engineering with building components. So that we gradually ironed out the difficulties, developed a method of building which was subsequently marketed internationally which put together a hospital. For the first time we achieved a million-pound spend in a year on the Royal, on, not the Royal Berkshire, on the battle site in Reading with an Oxford method hospital<sup>6</sup>. And the subsequent sort of checkout, [by the] users, checkout and snagging(?) procedure, turned up the incredible result that they were well over 95% satisfied – they'd got no problems with the hospital when they moved into it. It was unusual for a modern building in the 1960s.

MB Rosemary, you played a part in that design exercise, getting hospitals built in a particular way.

RR Yes, it was concerned with the ... the medical input was concerned with the logistics, the relationship of key departments. The way in which departments actually worked to provide clinical care, that was the input that one made. One had colleagues who were architects, engineers, design teams; I'm not saying that I had anything to do with that, but it was a question of working out exactly how a modern hospital might work. And how to make allowances for likely future developments, because we of course we asked all these new young consultants that we'd got in Oxford how they saw the future of their specialty developing.

MB So this was an incredibly refining audit process. Really moving down and refining things with time, but with all this money. And there was money. I'm dwelling on that because I don't think people hear of money being available in such

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<sup>6</sup> Battle Hospital, Reading.

tides, in the present climate. With that money you came across medical manpower shortages.

RR Yes, the constraining factor in those days was medical manpower, and some of the other specialist health professions, some of the scientific engineering and specialist nursing professions, but particularly medical manpower. But it is not, I think, fully appreciated that in the early days of the NHS, certainly up until the seventies, the problem was to find enough good worked up schemes with staff available, with trained staff to carry them through, on which the money could be spent. There was always money for any good idea that could be worked up and staffed, not just theoretical, but where one could definitely say you could attract the staff, the trained staff to run it and make it work. And we of course were well out ahead in the Oxford Region; we just kept on putting forward scheme after scheme after scheme. And the money came pouring in, and the job was to spend it.

MB Rosemary, you look at that problem of medical manpower and you pioneer developments that were to help.

RR Yes, you're referring to the idea of bringing women fully into the practising workforce in medicine. When one looked at medical manpower it was clear that the women in the workforce were being wasted. That is, they were qualifying, maybe doing one or two jobs, and then they were simply not joining in the general development of the next stage which was postgraduate training for specialisation, whether that was hospital speciality, or whether it was NHS management or general practice as a, as a thoughtful modern development of primary care, but particularly of course for the hospital specialities. And the reason was that in those days the requirement for, often even for entering for the exams in hospital specialities, and a problem which I had confronted, was that one had to spend a couple of years living in hospital. And living in meant that you got perhaps one weekend off a year, not a week or a month but a year. And this all had to happen between the ages of about twenty-five and thirty-five. Now, the women in medicine were at the same time being taught in obstetrics that if they deferred having babies after the age of thirty they were at much greater risk. I mean, that was statistically so in those days. And therefore the women were facing a terrible dilemma. They were about 90% married, as were their sisters in other professions, and they wanted to have their babies, and they had to live in hospital in order to join the medical profession. So this incompatibility was just absurd and resulted in wastage. So I, partly because I had thought this through from my own experience and managed it somehow, I thought that if this period of postgraduate training could be taken more slowly on an extended basis so that it would fit in with the years of motherhood and coping with young children, that some of these women could be rescued and the problem of the medical workforce shortage could be partly overcome. So I went with a scheme, supported by JOF Davies, to the Regional Hospital Board and asked for money to support financially for women on this basis, during that financial year. The scheme was immediately supported by two people I remember very well: Dame Annis Gillie, who was a former president of the Royal College of General Practitioners and a well known woman doctor; and also Sir John Stallworthy who was on the board at the time, and had himself of course in Oxford seen the dilemmas of many of the married women doctors in Oxford, who he had delivered as professor of obstetrics, and seen that in achieving their motherhood they were being lost to medicine. What I did, I found four women out of quite a list

of people whom I just knew were in Oxford and wanted to get back into medicine, and asked them what they wanted to do, what specialities they wanted to train in. And I found a consultant with the qualifications for training within his department, the requirements for training, and asked, if this woman were to be paid for, whether he would train her on the same basis as the other junior doctors in the department but take twice as long over it so she was there for half the week, and the other half of the week she could be with her young children. She could cover half a week with a nanny. Remember that half a week meant three and a half days and nights. It's, oh I can't work it out in hours now, but I mean we are not talking about junior doctors coming down to a seventy hour week, we're talking in the hundreds of hours that had to be covered in a week for those jobs. And these women were snapped up, these first four, by people who said 'Well, yes, look at this young woman's, you know, qualifications and qualities. And compared with having nobody available within the department to have this woman for half the time would be a godsend.' And very soon, I mean within a matter of I would say a month of the first one being placed, I did have a little queue forming outside my door of consultants who were saying 'You know that young woman you found for Doctor X? Do you think you could find me one like her?' And by the end of the financial year I went to the Board and said that I had got not four, but forty something women in post under these arrangements, and hoped that the over-spend that I had incurred would be alright, would be rolled forward and supplemented for the next year. And in those days as I have explained the difficulty was to spend the money and particularly to buy doctors. So that was quite alright according to the rules, and the scheme, within about two or three years it went up to over a hundred. I mean, at one stage we got up to about a hundred and forty women under this scheme. And as far as I know, there were no women who were genuinely seeking a further training who were not able to be placed under the scheme from then onwards.

MB Did this become a national, this became a national move?

RR Oh yes, of course the ideas have been adopted, worked into the official guidance and funding policy, adopted by the BMA [British Medical Association] as policy, and by the Medical Women's Federation. All the people with medical manpower interests at heart, they have all participated. And it has now fallen into an absolutely standard form of agreement whereby not only women, but also men, have the right to, provided they have well-founded reasons, they have the right to request part or all of their training should be held on a less than whole time basis. And it complies now with EC(?) regulations and it's a fully established national scheme.

MB Rosemary, to put this in perspective, I mean in terms of the career prospects of many, many thousands of women over the generation we are talking about...

RR Yes. Very quickly.

MB ...it's never been the same.

RR That's right. It was very quickly taken up in the Oxford Region, and in the South-West Thames Region and in the Wessex Region. Some other regions were not so quick to grasp what could be done. Maybe they didn't have the shortages of

doctors, which was a very pressing issue in the south of England, but I mean eventually everyone joined.

MB Rosemary, when people look back on your career and judge it, I mean that must be one of the things that people remember most.

RR Yes, yes. And...

MB I mean, you must get people coming up and saying 'Thank you for this opportunity.'

RR Yes, it's very nice to meet women, younger than me nearly all of them, but women who spent perhaps a few years of frustration, suddenly hit upon the scheme and returned with a satisfying medical career. And of course the results were extremely good. We analysed the results from time to time, and there was a time when among the women on the scheme there were exactly the same number of higher degrees and diplomas as babies born, which I always thought was a rather nice statistic. So it certainly demonstrated that the women were keeping up.

MB Rosemary, we were talking about the sixties. Just before the sixties, the regional hospital, the regional hospital board had, rather had exciting work going on that we perhaps should refer to. Because if we're going to look at the continuity over forty years... Acheson's work was quite exciting, when you got here it must have had exciting results.

RR Yes, I inherited, eventually fully inherited a unique data set of linked medical records which a then May Reader in medicine at Oxford, one Donald Acheson – who afterwards became Sir Donald, the chief medical officer – started when he saw the possibility of relating hospital admissions with deaths, discharges and births, so that one could actually follow not just an individual's series of incidents related perhaps to one episode of disease, but one could actually follow a sort of life history of a disease in an individual, and in many individuals. And one could determine a sort of natural history, the epidemiology of disease as it presented and as it might relate to events of birth, and subsequent episodes of hospital care, and of course finally cause of death. Now, this Oxford Record Linkage Study was carried on through thick and thin, first by someone called John Baldwin and more recently by Michael Goldacre. And it has been a terrible trial to those people to keep this enormous data set going, but in fact with the modern computing technology it has now come into its own. And after all those years – that is, it's more than forty years old now – it is beginning to be a useful tool, and people use it internationally for research into the distant origins of disease and disease patterns.

MB A colossal data bank. Rosemary, we're talking of pioneering in the Oxford Region. It was a pioneering region. And we bring you back to the sixties, because Milton Keynes, was that, was that coming on stream in the sixties?

RR Yes, it was... I think it was announced in the very late sixties, towards the end of the sixties. And the very day that it was announced on the radio in the morning that an agreement had been reached by government to start a new city in Milton Keynes, which was slap in the middle of our region, Tony Oddie and I caught the 9.45 or

whatever it is to Paddington and went straight to the Permanent Secretary's office and asked to see the minister. And [we] said 'If we are going have a city in our region which is destined to be the biggest city in the region, we want a planned health care system in the city. Not superimposed on a sort of framework of buildings and transport, but absolutely integrated with the planning of the city.' And from that very first day we had a team. There was Tony and myself from the hospital board, there was Sir John Reid – who was then Dr John Reid – who was county medical officer from Buckinghamshire, with Dulcie Gooding from the county. And from the Milton Keynes Development Corporation there was Jock Campbell<sup>7</sup>, who was chairman of the Development Corporation for many years. And together we planned health services into the city, from day one.

MB What a unique experience. A new city. How many people...? Incredible.

RR It is unique.

MB What a challenge though.

RR No one had ever before, anywhere we could discover in the world, put a new city of that size of population into a place where there was no hospital, no specialist health service. So we had an absolutely clean slate, and we started by saying 'The most important thing is primary healthcare.' It was very interesting that these days all these years later people are talking about primary care being the foundation of the NHS. When we said this nobody really believed us – they just thought that we were just a little bit eccentric – but we did in fact put in primary health care with the supporting facility of a community hospital. We put in care for the elderly, community care for the elderly, and for the mentally ill and for the mentally disadvantaged, and we resisted for a very long time building and opening a hospital. We always said that a specialist hospital would not be viable in a green field situation until you'd got a hundred thousand people at least dependent upon it, and against a lot of resistance and a lot of campaigns saying that Milton Keynes wanted a hospital. We got Northampton, Aylesbury and to a certain extent Oxford and one or two hospitals further afield to support the population with specialist services, including out-patient services, until such time as in the year that the population topped a hundred thousand, we opened the doors with a fully functioning first phase of the district general hospital.

MB Rosemary, I want to take up two ideas there. Milton Keynes bridges us, yes, the late sixties right into the seventies, so we'll keep that as a theme with us. But this community hospital theme we got into, it wasn't a new development, and you were pioneering community hospitals in Oxford in the sixties. This was on the wave of further pioneering of the sixties.

RR Yes, it was part of our conviction... And I say ours, because JOF and Tony and I and all my colleagues and the people in the region, including very good general practitioners in this region, strongly felt that unless you had modern good general practice with modern facilities a specialist service couldn't manage on its own. I mean there was at the time a danger, you see, that general practice might have

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<sup>7</sup> Baron Campbell of Eskan, John ('Jock') Middleton Campbell.

disappeared. And the pattern of health care for the service might have been more as the American system with specialist services selected as it were by the patient who diagnosed what speciality he belonged to from the telephone directory, and referred himself as it were immediately directly to a specialist. Now we felt that the British general practice system was extremely valuable, and a minister called Kenneth Robinson, who perhaps you remember, rescued general practice with a new General Practice Charter<sup>8</sup>, which improved the financial and professional prospects of general practitioners considerably. And we immediately looked at general practice and the primary health care team, which was then, oh a mere thought in the back of a few people's minds, it really didn't exist. But the thought that all the people who worked in the community with the people who were sick and the people needing preventive care, the sort of people I'd been working with way back in Rickmansworth, that we could work out a new pattern for general practice and support it with a modern facility which we saw as what we called the community hospital... Now this was partly an answer to the question as to what was to happen to the multitude of small cottage hospitals scattered particularly around our rural region – we had a whole lot in the Cotswolds, and up the Thames Valley. Many of them were so-called war memorial hospitals; they were beloved by the people in each small locality. But what they really provided was a rather low key nursing care under general practitioner supervision. Some of them provided minor surgery. Some of them did major surgery, which we didn't think was quite right. But they weren't equipped in a modern way and they didn't really meet the needs of either the practitioners or the patients. So we had a million pounds from the Department of Health to research a programme. And we worked out first of all in theory that a ... a community hospital was not really viable as we saw it for the full range of what a GP ought to have at his finger tips as a facility unless you had a population, again of something like a hundred thousand, looking to it. Now many of these small hospitals only served about five thousand, and we felt that these needed to be a good deal bigger, that they needed to have no surgical procedures where general anaesthesia was required, that they should not deliver high-risk mothers. We did agree that some of them could have maternity departments for selected deliveries, that they should have access to diagnostic facilities, that they should have out-patient consultation facilities – a sort of enhancement of the domiciliary consultation in a setting with some diagnostic facilities available – that they should be serviced by pathology and CSSU(?), and should have high nursing standards with some nurse training and nurse management going on in the hospitals, and that they should provide for a certain range which we defined of cases, and that they should not go beyond these sort of bounds. Now, we worked, first of all with the pilot scheme in the old tuberculosis hospital near the practice of Sonning Common, which John Hasler was responsible for. And then we built two pilot hospitals – one in Wallingford and one in Witney – and we carefully researched the one in Wallingford and wrote about it. Now there was a lot of opposition to this, because it was at a time that there was difficulty with nurse staffing, and these hospitals were clearly going to take some nurses. And there was still a lot of conflict between specialist care of the elderly and the mentally ill, and the physically disabled, and primary care by GPs. But those that were established and put fully into effect worked extremely well. We felt that they needed at first a hundred beds to be viable, to offer a range of in-patient facilities, and one modified those figures as all lengths of stay came down, including even continuing care for the

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<sup>8</sup> General Practice Charter 1966.

elderly, reduced over the years. But even so these were quite big hospitals by most people's standards, and they had quite a lot of facilities. The small cottage hospitals, some of them were designated for expansion into community hospitals, and some of them were really designated for performing a certain range of the facilities, of the functions with the facilities that a community hospital should have. But I think the idea is still viable. And when we put a community hospital into Milton Keynes, even though only half of it was used for primary care, and half was immediately snapped up for specialist care, this was an area that was very hard to protect. I think many GPs and primary health care teams would still go with the idea of a community hospital.

MB Yes, a great, a great development when I first came to Oxford in the early 1970s. I mean this was just under way, I think, the Wallingford development. And this you had a major hand in. I mean this was, this was a lot of your concern for integration that you poured into that.

RR Again arising from my earlier experience, I think.

MB Yes, yes. And one of the things that I, just taking that theme of integration, there's another theme that we talked about before. That was the pyramid and the dominance of the patient in your pyramid of health. You were saying that many people have the view of a minister of state dominating a health field, and a pyramid coming down to patients at ground level. But you were saying that the health authority that you supported and worked for and poured all this energy into really did have the patient right on top of the pyramid.

RR That's right. If you turn the pyramid or the triangle upside down, and the secretary of state is at the bottom catching the really difficult national flack perhaps in the House of Commons, the people along the broad top of the triangle of the pyramid are of course the public. I mean, the people who are still fit and who might be sick, and the people who are sick, and the people who've been sick and need some continuing care. And the contact that we tried to make throughout the region with these people was also I imagine pioneering. We had to produce plans, you see, ten year forward plans which gradually became more integrated in that they began to be composed not just of building plans – which was the original hospital plan – but they became health services plans eventually. And they were fully costed, and they had a full manpower projection and audit following them through as the years went by. But originally we went to the public to say 'We are thinking of putting this that or the other in the plans' – and this particularly related to the community hospitals – 'what are your views about this?' And what we would do, we would hold public meetings, we would go to the pubs sometimes in the Cotswolds in the evenings, we'd put up a notice, we would go to village halls, we would go to bigger centres when there were bigger issues of course. And later it very often revolved around closures of hospitals or hospital premises which, where integration of departments was thought to be beneficial. But certainly in connection with the community hospital plan and the very local efforts we found that we just had to go as a regional team with our ideas and go directly and talk to the people. Now, some of the people from other disciplines and specialist disciplines of course in the medical profession were not used to confronting real live people *en masse* who were not patients as it were, who were sick in hospital. And in that way my general practice and public health experience came in very useful, because I didn't mind a bit talking to large crowds of people about their health needs.

And I felt I could parry their questions, which very often ended up of course with rather personal health problems being aired in public. This kind of thing frightened lay administrators, or people concerned with finance, and indeed some specialists. But it didn't deter me and my general practitioner colleagues. We could cope with that easily.

MB Rosemary, I'm getting a picture of that you felt a representative of a, of a region, very much a region that had the power to do things locally within its regional remit for the good of people that you were meeting and exchanging views with, and also communicating with the local representatives of. Now, that's very different from what we have today. And I just wanted to put that on the table, because things have changed a lot since then, and we might, we might go out reflecting on some of the changes. But we're still in the 1960s, all these kind of things happening. All these things happening and you're building hospitals. And one thing that came across to me that you'd said at some time when we, when we were talking in the summer was that if the hospital building had actually started earlier it may have gone off on all the wrong wavelengths, but starting at, it probably started at the right time as technological advances just allowed it to see where it should be going.

RR Yes, in retrospect it was partly fortunate that the building programme didn't get started sooner, because there was a lot of pressure immediately after the war to spend a great deal of money on TB sanatoria on lonely hillsides, and also of course in developing the large mental illness institutions well outside the towns, whereas all modern hospital planning has been put as close as possible to the centres of population. And of course TB was conquered, and that investment would have been a terrible waste.

MB And also if we're staying with the sixties, was there a change in the mental handicap, the caring for the mentally, the mentally ill in the later sixties?

RR Yes, this was rather interesting. The individuals who were then called the mentally handicapped – they're now called people with learning difficulties – those individuals, to start with they were institutionalised very much more than they are these days as a matter of just public and social policy. It was much more the way people felt about their family members, that they wanted them rather out of the way in institutions. But there was a great deal of voluntary work going on. Many people had developed small houses or units, thinking with the very best will in the world that it would be kinder and nicer usually for one or more of their own relatives or friends, and that they would make a small cluster of other individuals who had the same care needs around them in a moderately sized country house. And the family would look after not only their own individual member who was so handicapped, but several others as well. And there were a multitude of these small units which had been set up, probably during the thirties, forties, fifties, and they were in charge of people who had grown extremely old with the problem. And they were elderly people who had not been able to recruit sufficient volunteers or indeed any modern trained nurses to their aid. And these were very, very sad little clusters of what one can only call worrying neglect, and it was through no fault of these individuals who had started out and who had simply grown old unsupported with the problem. Now, there were those, there were a large number of them in the Oxford Region. And there were also a few very terrible large institutions, mainly in old ex-army hutted accommodation which had

been taken over in desperation at the end of the war, where large numbers – and I mean maybe a thousand at a time of these individuals – were really looked after in very, very poor conditions indeed. Now, there were several efforts to develop better services for this group. And in the Oxford Region we gave it very high priority, backed up I think more than twice after that with it being a national priority, so that by the early seventies we had actually achieved a total programme of closing all these small units and grouping together in hospitals, in hostels, and with what would now be called community care – you know, domiciliary supervision and respite care and those kind of day care facilities – all the individuals which we knew by name. And indeed the numbers who needed care had diminished because of other developments. And we had managed to have a plan for all these individuals, which was a fully integrated service with specialist psychiatric services with hospital trained nurses with proper diagnostic and treatment facilities. And the state of the art was not terribly well developed at this stage; remember the genetic work had not yet been done. But we also integrated that endeavour with the local authority services, the social services which were not all local authority at that time, and with primary health care so that GPs knew for which individuals they were responsible. And we had got some very good plans worked out. These days I think one would say that some of the hospitals services were even so more institutionalised than one would wish, but they were good modern clean premises with a lot of interest and involvement of the local community, and they were properly staffed. My nursing colleagues really were delighted when we were able to say we'd closed the last of these isolated small units, because they were such a worry. Nobody knew... Although in a 99% of them were being run as well as the individuals could possibly manage, the scope for disaster, for ignorance, for abuse, for really introverted ideas about for whose benefit these services were being run was so horrendous that we were delighted to get all these individuals into a service where there was a flow through with people with a modern training who could see what was going on, could act as eyes and ears for the service, to stop potential scandals and abuse. Well, we were delighted with that project, and I personally was rather sorry that priority was given to demolishing it all long before some of the next priorities had been dealt with. I would have left it to develop, myself.

MB Rosemary, that period – we're still in the sixties, a phenomenal time... Do you want a drink of water? I'm thinking of drinking water at this stage, it's very drying in here, are you alright? You're managing to do more talking than I am. What I'm, what I'm interested in in that period, you must have worked phenomenally hard to have so many files on a desk and still to have a family at home. Boys going to school about this time, I suspect away from home, but you building a home for their weekends and holidays in the Chilterns.

RR Yes, that's right. We lived in the Chiltern Hills, at a village called Bledlow, and we had lovely holidays together. I did take time off in August and had a holiday, which I'd not had quite so regularly in general practice. And they were at boarding school, so during the term I worked extremely hard and all night and weekends and so on. I tried to make a bit more time available during the holidays. And they feel they were neglected, I know they do, but it was the best I could work out to hold the job down. I liked doing my job. We all needed the money. I needed to make a success of the job to see us all through, and I just did the best I could.

MB You said at one time that you still felt poor at that stage in your career, that the money had to keep coming in, whatever.

RR Absolutely.

MB Just in the sixties, just tucked into the sixties, you began to get some national recognition as well. You were joining committees, and I think the Lane Committee came up in the late sixties and you became a member of that.

RR Yes, the Abortion Act of 1967 was a liberalising measure, which had a lot of opponents. And there was a lot of public discussion, and a committee was set up to look at the working of the '67 act under Mrs Justice Lane, Dame Elizabeth<sup>9</sup>. And I served on that as a fairly independently minded woman doctor. I think I had not worked directly in that field, I had never gone into print with any views about it, and I was appointed by the then minister I think just as someone who might have an informed but fairly independent view about this. And we were a very hard-working and quite long-serving committee. We took a lot of evidence; it gave me some insight into the ways such national committees worked. It gave me another chance to go all round the country looking at obstetrics and gynaecology departments throughout the UK. And eventually of course we were able to produce a unanimous report which stated that the act was serving the country well on the whole, there were one or two small qualifications which we recommended.<sup>10</sup> But people who were very surprised. I think they expected that that committee would produce a report with a lot of minority codicils and so on and that we would never reach agreement, but we did. On the committee was Dame Josephine Barnes, whom you know, who was a well known women obstetrician, my senior by a few years, who gave a very, very expert and learned input to the committee, and also a young professor, Alec Turnbull, who was then in Cardiff and who subsequently came to Oxford as professor of obstetrics. So I remember those two particularly well.

MB By the time you get into the 1970s – we're actually getting to the seventies Rosemary – you'd become a deputy, deputy SAMO. JOF Davies must have moved on and Tony Oddie taken his place, and you became a deputy to Tony, who you always related, well, you related well to them all of that team.

RR Yes, yes. We were a good team, and although there was an appointments procedure and there was competition, on each occasion as far as I remember I moved up. And no one was more surprised than me that I had a fairly rapid promotion. There was a promotional ladder in that kind of business, and people moved between the regional departments quite frequently. But I was able to obtain promotion within Oxford, which was lucky – I didn't need to move – and I became deputy to Tony Oddie.

MB Yes. So into the seventies we've got Milton Keynes going on, quite an exciting enterprise. We've got community hospitals beginning to take their part in the primary health care field. You've got women doctors on stream in a new way. The

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<sup>9</sup> The Lane Committee, chaired by Mrs Justice Lane, was set up in June 1971 with the primary purpose of reviewing the operation of the 1967 Abortion Act.

<sup>10</sup> Dame Elizabeth Lane, *Report of the Committee on the working of the Abortion Act*, London: HMSO, 1974.

1970s were really a time though of new health service arrangements, and the regional hospital boards gave rise to regional health authorities and area health authorities and district authorities. A very curious three-tier system, everything changed, but that must have been a fascinating time.

RR Yes. The wind of change was in the air, and the main theme was that the three branches of the health service which I had mentioned before needed integration. A theme with which of course I fully agreed. The reorganisation did not take place until 1974, but the run-up to it consisted of six years. So that was 1968 to 1974 of almost continuous discussion and argument and consideration of the potential planned reorganisation of the health service. It was a mammoth exercise, and it involved of course becoming not only attuned to the various political threads that were floating in the air at the time, but also the options for management, for management style, for management theory. There was a lot of influence coming at that time from America where management as a subject had been developed within universities and within large-scale industries and services. And we not only listened to all these people and read what they had to say, but we invited them to Oxford, and we began having all the doctors together with as many representatives of the other health professions and our associated colleagues as would come. We began having a very, very heavy programme of management training. We had a lot of help in the Strong Mackenzies(?), and they did a study in Oxford which was quite well known, and they subsequently had quite a lot of input into the reorganisation. But they were not the only management consultants that we used – there was also what is now the Oxford Business School, which was then a school of management studies, we had a good deal of help from them. And what we did, we had one weekend a month – that was Friday to Sunday afternoon, Friday night to Sunday afternoon – we spent on management. We started that I should think, I don't know, towards the end of the sixties when this reorganisation really got going. And we continued that right through the seventies and eighties, so that we had about ten management weekends a year for all those years. And we involved all the doctors in the region down to the grade of registrar, invited all the GPs in the region, all the public health doctors, representatives from all the nursing departments and as I say colleagues from other disciplines. So we really made a big effort to teach and study management, and particularly the idea of medical management.

MB Yes. So that went on for many years actually, that in-service training.

RR Yes, we never, we never stopped.

MB Rosemary, by 1973, just before that reorganisation comes in, I think you take over.

RR Yes. To my very great surprise Tony Oddie, who seemed to be absolutely made for the job and was working extremely hard, he just told me that he thought he'd stop and he would retire because he'd always wanted to be a painter. And so one day he just left and took up his paints and his easel, and was around in the Cotswolds for quite a long time painting the scenery and so on, and had nothing whatever more to do with the health service. A terrible loss of talent and energy and enterprise at a very crucial time. But, to my surprise I succeeded him as SAMO – this was still the old SAMO job. In 1972 I think I became SAMO. And it was just before that that I had

finally decided I must give up general practice, because what with doing these management weekends and a weekend in general practice and so on I was really...

MB Rosemary, that's a strand that we'd... Because it's so unlikely, it's a strand that we've not kept in focus, but it was there.

RR Yes. I was still doing general practice one weekend a month, yes, until 1970, I think.

MB Just hours and hours a week spent in regional planning and management, and then you go out each week and then you continue general practice. That's a colossal workload for anybody. How did you find that? I mean, did you just live with that? Were you composed inside, you didn't feel any pressure? Were you able to negotiate that well?

RR I just got used to it. I did a little less during the school holidays, I think. And eventually of course I realised I wasn't keeping up with general practice, I mean...

MB Changes must have been dramatic, especially in the prescribing area.

RR Yes, I couldn't do enough reading and see enough of what was going on. It wasn't fair to the patients to go on. I was still helping my successor in the practice in Hertfordshire, but it wasn't fair to the practice for me to go on.

MB But in terms of your perspectives that has been enormously helpful.

RR Of course. I loved it and it was very, very helpful.

MB When you arrive in the top job, can I... It is the top job, that must have been quite a surprise, because a few years earlier, I mean even in 1965, this is not even a decade later, you're in a top job that has enormous demands right across four counties?

RR Yes, it was extraordinary. I felt as surprised as you think I did. Yes!

MB Big things were happening... I mean, inevitably that reorganisation lots and lots of footling things, because all kinds of small administrative matters have got to be taken care of right across the areas and the whole range of general practice interest you still have. But there were also developments like the new John Radcliffe. A massive development of a new hospital in Oxford.

RR Yes, this was the new teaching hospital, and of course to support the clinical activities of all these professors we'd appointed and the intake of the medical students and the staff that was required for teaching purposes, and the big research departments of course developing around the academic departments. Now, we had always had a theory in planning hospitals in the Oxford Region that hospitals should be much smaller than the projections of many other places. We thought there should be fewer beds, that the actual area should be more compact. And we were very, very alarmed when we went for example to one or two of the new teaching hospitals which had been built ahead of the John Radcliffe. I think it was in Nottingham where the

circular corridor around the main ward block was a mile. Now, I talked to you about the problems of going on a ward round just physically, but if you can imagine the distances involved floor after floor with a mile long corridor... So Tony Oddie, who was responsible for planning the first phase of the John Radcliffe, which was the maternity phase if you remember, and influenced then the development of the main phase which most people think of as phase one, was determined to make this compact. And we had a lot of arguments with the Department of Health, the Ministry of Health – I can't remember when it became a department, I think by then it was a department of state – to spend the money on a smaller hospital. And there was a lot of medical opposition as well, saying, you know, we're not getting a big enough hospital. But of course many of these big hospitals that were built, they stayed half-empty for many, many years, whereas the John Radcliffe as it opened up went immediately into high activity, and I think people were grateful as a result.

MB An amazing development, and you took that on its way. Was that largely planned within the regional health authority with good correspondence with the area and with architects coming in, with you having an input all the time?

RR No. You see, while it, while it was being planned, it was planned by the board of governors who were completely separate from the region and accountable only to the Secretary of State. They were not ... this was one of the plans for integrating the health service, that the teaching hospitals and the learning hospitals as we like to call ourselves should be integrated. But the only skills and expertise in planning on this scale actually lay within the regional hospital board. So I don't think we were the only place where the medical planner was seconded to the board of governors to plan, and so it was one reason why I was deputising for Tony Oddie pretty strongly, because he was busy planning the teaching hospital.

MB As these hospitals came on stream in the seventies and hi-tech medicine began to really gain momentum – this was a decade of hi-tech medicine really moving into gear – there must have been massive thoughts, and planning needs around the equipment that you needed that was incredibly expensive and took time to bring on stream.

RR Yes, I don't know what the proportion today would be in a phase of a modern hospital, but certainly for most of those years, the proportion of the capital value of a hospital at the time of building was approaching 50% engineering and the other 50% of course was loosely called building. Now, that engineering included all the back up that was necessary. Not only for heating and ventilating the hospital and running the lifts and the security system and all those kind of things, but of course making provision for the development of the technical equipment which was going to be put in the hospitals. I mean, arranging to plan an operating theatre block or an intensive care unit or a radiology department, when last year's model was being completely superseded before the ink was dry on the plan, was very difficult. Not just for the medical planners to say what they were likely to want to install, but for the engineers who had to make provision in that fabric and structure of the building for what might occur. And of course computerisation was developing apace and the question of whether one had to have, you know, cooled and ventilated rooms attached to every unit or almost every bedside, or whether things were going to develop so that people might, absolute magic, even carry a little laptop computer around with them... I

remember it was envisaged, but no one really believed it. The pathology departments, and whether their output would consist of tons and tons of paper or whether the results could be sent on a screen around the region. It seems extraordinary that people were so sceptical about whether some of these developments would ever really happen, and there was a bit of a 'belt and braces' attitude to making provision for this. But what we did, we developed the scientific aspects of medicine within the region. We created a post, we were the first region to do so, of regional scientific officer, and we had an integrated regional plan for the investment of capital into major medical and scientific equipment throughout the region. Now, it doesn't sound very adventurous, but what it meant for example was that the community hospitals definitely wouldn't be extended to comprise an intensive care unit. The geriatric department, which was still lingering on an out-of-hospital site, would not be equipped to install an NMR imaging machine. We were prepared, and we had preventive measures, to stop us falling into the American trap of over-investment in rapidly outmoding technology on every street corner. And we had by agreement a budget which was spent every year according to priorities which people, I won't say they always absolutely agreed but they gave into it with a good grace knowing their turn would come and that it was the best use of resources.

MB Rosemary, this regional scientific officer, was that a step that took us into the eighties or was that late seventies?

RR It started I think in the late seventies.

MB Right.

RR Yes, perhaps even earlier we were thinking of it, and the role developed during the seventies.

MB I'm interested in the computerisation, and because I think one of the hospitals came on stream with total computerisation in that period, which was quite a new advance.

RR Yes, this was Milton Keynes. You see we opened it without any paper records other than the clinical records which of course mainly are still on papers and standard, but all the administrative and managerial procedures were fully computerised. And they worked from day one, and it was at the time, I don't know what the position is now but I wouldn't be surprised to know if it isn't still the only hospital that really, really works without paper in the administrative machinery.

MB Rosemary, what a pioneering decade. We are just about to change reels and to take a short break, but that gets us right through the 1970s. And when we come back and talk perhaps we can, we can look at the 1980s and how things continued to expand but to also to change quite dramatically.

RR Yes, righto. Thank you very much.

## Part Two

MB Dame Rosemary, as we move in this part of our conversation into the 1980s of your career, it's almost like Sibelius beginning to fade in some cool winds of change. It wasn't going to be the happiest time, and quite early in that, in that decade you moved out whilst a second phase of reorganisation was on. We might, we might talk about the second stage of health service reorganisation, and your move to the London School of Hygiene and Tropical Medicine.

RR Yes, I think I'd explained that the '74 reorganisation took six years of constant work to come about. And it wasn't exactly successful. The integration did take place but we got too much, we got too much management, too many tiers. It wasn't working very well. We did get consensus management and through teams, team management approach. And in the Oxford Region we thought, I think all of the team felt that our team was working quite well, but there were many places that it didn't work particularly well. And there were then more reorganisations of the reorganisation with decreasing time intervals and less thought going into each change as time went on. And this of course coincided with a change of government in 1979, and then a distinct draught in the financial weather as it affected the health service. We did in fact obtain continuously increasing funds, but prices were going up and the demands were going up. We knew we had this ageing population, and really no provision was being made for the additional better level of care that could be offered with modern medicine. So things did begin to get rather uncomfortable. We were able in Oxford to show that for years and years and years, with less cash per capita and with a changing population and a growing population, with the geographical changes of the population, we were getting more out of our resources than any other region. And we felt we were demonstrating that we were efficient and doing extremely well. We had management costs limited strictly to 4.5% for years and years and years, and we never wavered and we never overspent. The NHS as a whole never overspent. People don't realise that. They imagine the NHS as running away with the funds, but it has... Certainly all the time I was there as a department we were all always able to support the Secretary of State that he'd not overspent his funds on health, which was incredible. But they started another reorganisation, and I felt I'd had rather a lot of this. And I was more concerned in the early eighties about another issue which was coming to the fore, and that was that public health as a discipline, not only had it been swallowed up as it were in the '74 reorganisation, but it was being rather lost sight of. And there were, in my view, some dangers to groups of the population in the old terms of epidemics of infection. There were one or two quite nasty incidents. And there was also a danger that the concept of offering services which were not necessarily the treatment and care of illness and accidents but were actually preventive, and services that were good for the health of the population, they were steadily being overlooked. Primary care had come on alright but public health was being lost. So when it looked as though the premier chair in public health in the country – that's the one at the London School of Hygiene and Tropical Medicine – was threatened... I can't quite remember how it was negotiated or how it came about, but I formed a determination that if possible I would go and sit in that chair and protect it until someone with proper academic qualifications would come and revive it. And in fact that's what I did while my colleagues got on with the all too familiar task of yet another management reorganisation, which was just a waste of time or marking time as far as I was concerned. I went to that department and acted as

professor of community health for two years, the first year whole time, and I think helped to save the department and the discipline from being lost to the public.

MB Rosemary, did that... We were talking about the way in which that appointment came about not being altogether clear, but perhaps it had something to do with your close links with the faculty of community medicine<sup>11</sup>?

RR Yes, I suppose that is one route. I was at the time being put forward for president of the faculty. That didn't come off until the end of the eighties – I was president from I think '86, I think, so it was before that. But I had always supported the faculty, and there were one or two rather important enquires into public health during the eighties which I was able help.

MB So you felt very strongly behind that need to preserve public health as a discipline in British universities.

RR As a concept, and as ... yes, yes. It is still important, it is put forward as important by politicians and academics these days, but I think people don't realise that preserving the level and the standard of public health that we have in this country just requires constant vigilance. You can't let your gaze be averted from it for a moment or things go wrong.

MB Was your...? At the London School of Hygiene and Tropical Medicine, was that an interesting experience, or was it just a caretaker time? I'm trying to dissect that out.

RR Well, I was not able to do any original research, of course. In the time available I couldn't do that. There was a certain amount of reorganisation going on in the academic departments at the school itself. And the whole school, as with various academic institutions in the University of London from about that time, were feeling somewhat threatened. So the skills that I brought to the school were experience of the health service and of course the capability of teaching in that area quite a lot, and also...

MB Did you teach...

RR Oh yes, yes.

MB ...whilst you were there? You did courses in public health?

RR Yes. I had, I had in fact been teaching there for a bit, so maybe that's how I was known at the school. And also of course I was able to use my administrative and management skills to help put the department on a sort of safe footing for the future.

MB And your knowledge of government administration as well?

RR That helped.

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<sup>11</sup> Royal College of Physicians Faculty of Community Medicine (now Public Health Medicine).

MB Which leads me to, my next question was that, within the regional health authority orbit of your job, was there a good link always between yourself and department of health? I mean, did you find that you could, you could offer advice in a reasonable way and get good responses?

RR Well, looked at historically... I mean when I first became a SAMO of the Oxford Region and George Godber was still chief medical officer, and he and indeed his successor Henry Yellowlees, who were themselves public health people, they would be in contact with the SAMOs and equivalent I would say most of us most weeks, I mean every few days. And we certainly met on a very regular basis, and we did exchange information. Now that rather diminished over the years. And indeed, of course what happened during the eighties was that the medical input and the old medical management input to the NHS was in decline. And it was considerably superseded and overwhelmed by a multidisciplinary management approach which afterwards became dominated by a financial management approach – the question of resource allocation between the regions and within the regions, the accountability for the spend in ever more detail. The projection of costed strategic plans became more and more dominating rather than the development of health and medicine, the health of the population etc.

MB So one became preoccupied in a way through this, through this hierarchical pressure from the department, you became preoccupied with effectiveness and efficiency and cutting all excess out of any budget.

RR Yes, constantly demonstrating that ... funds available were being used efficiently and as far as we could, and this tended to come from the service side of course, effectively.

MB But it was a squeeze effectively rather than a, than a sort of exercise of efficiency.

RR Yes. A lot of monitoring, reviewing upwards, downwards. Interviews between chairmen and ministers, which I always had to brief. We became very conscious during the eighties of the increasing centralisation, and the health authority as it had become from the old hospital board was smaller and had become less and less accountable to the public. The opportunity for local initiative, even local piloting, local enterprise really very much subdued, it became extremely difficult. And a lot of rather unhelpful activities promulgated for political ends – waiting list initiatives... Constant reporting in order to answer political issues, which really were by the way.

MB So you had a lot of desk-bound exercises and a lot of, I suppose a lot of links with trade unions, and looking at where things were going within changing jobs descriptions. It must have been a time of just trying to hold things as well as you could. Not a time of enormous progress on the lines that you'd been pursuing in the seventies.

RR Well, that's right. The constant reorganisation and the after-effects on staff of constantly changing jobs, and staffing, and reviews of staffing levels and requirements for efficiency savings and so on, coupled with the national change in the attitudes towards the unions, really meant that the personnel function and the relationship with

the trade unions became an almost daily priority. I mean, whereas before I had my time considerably just how to get my head round and trying to find support for enterprising health issues, I found my time more and more spent arguing over, important to the individuals, but relatively minor points of procedure in relation to staffing throughout the region which were forced upon us by legislation and the sort of changes that we were required to make.

MB And not exercises keeping your interest particularly on course.

RR That's right.

MB I suppose that was daunting.

RR I didn't mind doing it, I mean I... It seemed we were all wasting an awful lot of time. I felt...

MB In some ways it was like taking India rubber and erasing so much of what you'd achieved.

RR Yes, I felt that we were not making forward progress – this was for several years in the eighties – we were trying to protect advances that were in the wings and successes that we had achieved. And a lot of us, and I think this was felt by the staff and their representatives throughout the region, that we spent an awful lot of time wasting each other's time for political purposes. And really I felt very strongly that a lot of people with a lot to contribute, the best years of their lives were being used in fairly trivial bureaucracy and administrative procedures forced upon us for really political ends.

MB Rosemary, you came down from the London School of Hygiene; we haven't put that into context really. You were there for two years, so you were back '82 to '84ish, and you were back then for four more years until you, you retired in '88.

RR Yes.

MB I'm just trying to think of those years, because obviously this changing wind continued right up to 1988, some of the things that you would have wished to advance didn't advance as quickly. Looking at some of the people you worked with in that period, because when you returned from the London School of Hygiene and Tropical Medicine you became the manager, the regional manager... Not the medical officer, you became manager as well, which was quite a daunting double role. So you're into management big.

RR Yes, I was the only regional medical officer who combined the role of regional general manager, so that when in the new NHS after that particular reorganisation – I think that was '82, I think – the, when the Department of Health met the managers of the NHS, instead of meeting as they had always met before health professionals, they met one health professional – that was me – and my colleagues. Now that gave a very different flavour to the relationship between the NHS, which started at the regions as it were, and the Department of Health. I didn't find it too difficult being a general manager for the Oxford Region, because the Oxford Region had always been

medically managed. I wasn't really doing anything new or different from what I had always done. We simply had to do it in a different way. The team between us and my internal management arrangements within the region were rather different. I had a very supportive chairman in Sir Gordon Roberts at that stage. He is retired now, but I mean he is one of the people who has made a wonderful contribution to the development of health services in the region, and indeed nationally because he of course would meet ministers and talk to them about things that were happening in our region, which I like to think was out in front. And I think they heard of the advances that we were making through him over many, many years.

MB So he was perceptive and sensitive and supportive, and good in liaison with the department.

RR Yes, yes. He was very committed to the NHS as a concept, and he saw at once when a scheme or a proposal had some value, or when it was superficial, so that he wouldn't let me waste my time any more than was absolutely necessary. I didn't run round in circles looking after his ideas; he helped me deal with the problems that we all had to face.

MB Who else around you in these years in this senior role, who else around you were the key figures who supported what you were about Rosemary? It might be nice to put people on the record, because I know you've built a team that was very, very supportive.

RR Yes. My nursing colleague Madeline Davis, and one of her predecessors, Irene James(?), going back quite a lot. I would say that the collaboration between the nurses and the doctors at top level in the Oxford Region was as good ... well, as good as I could make it. I always felt entirely comfortable with trying to help them for the interests of nursing. Nursing has got itself into a very difficult position over the years, it's beginning to surface a bit now, but it became extremely unpopular, poorly paid, lost in management terms, and they needed a lot of help. But of course the advice that nurses could offer throughout the service was absolutely crucial and I valued that tremendously. Then I would always have a lay administrator or manager in support. The one who worked with me until, well in recent years over some of these very difficult times, was someone called Donald Norton, who was quite a well-known figure in the region. And we always had a financial expert, originally I think called the regional treasurer then the regional finance officer, and then perhaps back again. Everyone's title changed so often. But the original regional treasurer who was there for many, many years from 1948 right up until the seventies almost was Charles Poole(?), who could've worked out the finances of the region on a back of an envelope in a pub. You know, he knew exactly where every penny was all the time. And of course he had younger successors. Oh, there were two or three after him, but I remember Charles Poole particularly well.

MB And you made good appointments with your regional scientific officer appointments?

RR Yes. My medical colleague was the first holder of that post, Ronnie Pollock, who succeeded me as regional medical officer. And he was a very long-term colleague, he came to the region in the sixties with me, and he really created the post

and went on with that. So he was someone who had done quite a lot of radiotherapy and was particularly interested in that aspect of medical equipment. And he'd also trained as a surgeon, and so equipment of operating theatres and intensive care and planning, for that he was particularly good. And he did one or two studies of pathology departments, was the first one really to put forward proposals for computerised pathology departments in new hospitals.

MB And also with your areas and districts that were around you over the years you must have built up good colleagues and relationships with the range of specialists.

RR Yes.

MB It must have been quite a, quite a web that you had in contact with your work.

RR Oh, absolutely, and of course we would meet regularly. Now, we had, at various times depending on the stage of the reorganisation we had areas and districts, and we had area medical officers and district general managers and district medical officers, and this network around the region. And of course the region itself changed, I mean we swapped Swindon and that part of Wiltshire for east Berkshire, which for us was rather an awkward swap because we'd just made an enormous capital investment in Swindon and it was just needed in east Berkshire, so we were in some ways not too happy about that. But anyway this big and, well not very big, it was one of the smaller regions, but geographically it was a big area, but covered by various people.

MB And that change took place in the 1974 shake-up of everything. That wasn't one...

RR Yes, and again... Yes, the change of the actual geographical boundaries, yes.

MB Rosemary, we get towards the end of your career in 1988. I'm just trying to work out, that you... It seems that you retired early.

RR I retired when I was sixty years old, which is what I had kind of promised myself, and it seemed quite convenient because there was yet another organisation, reorganisation pending. I didn't really like the look of it, and I thought if I were younger and had had to do it I could maybe do it quite well, and of course I'd have worked with it, but I didn't have to spend my last years doing yet another reorganisation. I was president of the faculty of what was then community medicine, now public health medicine, by then, and I had another year to serve after that. And I thought it would be very helpful to have one year without a full-time job to try and help the academic discipline as it were of public health medicine into the new era, and make sure that that was firmly lodged. I had given evidence in that capacity to the Acheson Report on public health services in England<sup>12</sup>, and again I worked on the ... the NHS health for all, health of the nation document, just about the time of the retirement. So I was still making an input, and then a year after I gave up being president of the faculty I was elected president of the BMA, and that put me back for another year into the forefront of medico-political interest and activities. And so I

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<sup>12</sup> *Public Health in England. The Report of the Committee of Inquiry into the Future Development of the Public Health Function.* (Acheson Report) London: HMSO, 1988.

was able to watch, in a very presidential role, rather from the sidelines, what was happening about the new reformed NHS.

MB Rosemary, two key questions, from those privileged side line positions. Did you remain with an unhappy picture of where things were going?

RR I didn't like the direction of the changes as they seemed to be in 1988. We are now talking in 1995, and there is some evidence of modification of some of those aims, but there were two things that particularly bothered me. One was a complete break in the relationship between the Secretary of State and the medical profession, which I saw as extremely ominous and a mistake. It might have been very, very rough and rowdy and difficult, might not even have been constructive, but the influence would have been there. The medical profession would have carried some of the responsibility for the way things went shortly afterwards. And the other direction which I didn't much like the look of was the introduction of competition on virtually a commercial basis, when I had spent my whole life trying to persuade people who were highly competitive by nature to give way and give in, and collaborate for as it were the greater good for the people who didn't have powerful advocates and money behind them. I'm talking about the disadvantaged of the population, the elderly and the mentally ill, who would never come out on top in a competitive situation. And I felt that much work that we had done persuading the powerful interests in medicine to give way in favour of what one has to call the less popular specialities and health interests, I thought it was a great mistake to have turned the clock back on that work. I mean, I can understand that a touch of healthy competition between like departments, and perhaps a discussion on a real issue as to who should take priority over who when there really is a comparison is to be made, but I didn't like the wholesale introduction of this as an ethos. And so I was, I was not liking it and I have not liked a good deal of what I have seen. I thought that the proposal to give the GPs funds to hold and to buy a service and to influence the services was an idea which had come up years and years ago in one of those management weekends I had talked about, and it was a very good idea and it needed very careful working out. It, of course it has worked in some places, and in some ways it is still not worked out. I feel it might come a cropper, I'm not quite sure what will develop there, but I was sorry to see that very hastily just introduced in a rather widespread way. I think it was not a good service to general practice. Some practices, some people have benefited, but it's not in the long-term the way to have done it.

MB Many of these things are not the way you would have done them, I suspect, but we're left with the order of things as it is. And here in 1995 as we record our interview, you're enjoying some retirement now, with a number of exciting interests and children long grown up and with grandchildren?

RR Grandchildren, grown up too, just about.

MB It must be a great, a great pleasure.

RR It's lovely – it's family life, which I hadn't seen so much of during my professional time.

MB And you have time for yourself...

RR Yes of course.

MB ...occasionally to play music and to listen to music.

RR Yes of course, yes, I try to.

MB And a great pleasure must have been to have been recognised in one of the honours lists and to receive a DBE.

RR Well, it's a wonderful personal pleasure of course to be recognised in that way. But it is on behalf of all my colleagues and the people in the region and other places where I have worked, and I hope also in relation to the public health discipline and the, just the major thrust and interest of my professional life that I've shared with so many people and couldn't possibly have done without people backing me and helping me, and a lot of the time doing the less interesting aspects of the work.

MB It just seemed, thinking back over journey we've taken, to be a light year away from those dark days in the early fifties when you were quite ill, and when you weren't quite sure how the future would open up.

RR Yes, that's right, yes.

MB Rosemary, thank you for talking me through those years.

RR Thank you.