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PROFESSOR SHEILA ADAM

Career summary:

Sheila grew up in Nottingham and undertook her medical training in Edinburgh before moving south to do a variety of junior doctor posts before joining the newly formed community medicine training scheme in Oxford. Her first consultant post was at Brent Health Authority before moving to North West Thames Regional Health Authority as consultant then RDPH. From there she moved to the Department of Health in 1995 as Head of Mental Health and NHS Community Care then Deputy Chief Medical Officer and Director of Policy. When Strategic Health Authorities were created in 2002 she moved to NE London as DPH. She was an elected member of the Board of the (then) Faculty of Community Medicine and the General Medical Council, co-founding chair of the Association for Public Health, and a member of the Board of the UK Voluntary Register for Public Health Specialists. She has also held the post of Visiting Professor at the London School of Hygiene and Tropical Medicine, and was an Honorary Professor in Public Health at Queen Mary, University of London.

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EDUCATION, FAMILY AND MEDICAL SCHOOL

Why did you enter medicine?

I was lucky, I was born in 1949 and so I was in the post-war generation. My father had always wanted a girl. I was the first girl and he was determined we would get an education. In fact, the week I was born he went to the high school to put my name down because he had heard that was what you were supposed to do. Of course that was not what you were supposed to do! But it was a sign of his determination. I was incredibly lucky. He always encouraged me. My mum was one of those very unconditional mums, so I got the best of both worlds really. I started off in a fee-paying primary school and then got a scholarship to the high school in Nottingham. I was always better at Maths than English so was seen as one for the science stream but did not like science very much. I was about 12 when I was watching TV, a programme called 'Your Life in their Hands' with rather dramatic TV footage of operations. I remember sitting absolutely mesmerised by this and thinking I would like to do that. I did not know any doctors. One of the reasons my father was so keen on education was because both my parents had left school at 14. There was nobody therefore to go and chat to. I just said I am going to be a doctor. Then, of course, everyone tried to talk me out of it, it would be very hard, a long training, and I probably wouldn't like it. And I did the classic, well the more you try and stop me, the more I am going to do it. I got myself into medical school.

Did you have any encouragement from school?

They weren't very keen. They thought girls should do things like teaching or nursing. I was never in the brightest group of my set. I wasn't 'Oxbridge'. They probably thought I wouldn't get the grades. I remember a career section in the school library with university brochures, and looking at them and not knowing what to make of them. At a careers session I said what I wanted to do and they said we don't know anything about this, which wasn't true

because other people did do medicine. Then a friend who was also applying for medical school said she had heard Edinburgh was quite good, and I could try there. On the UCCA form you were allowed six choices, and I put Edinburgh at the top. I didn't get any offers because I was a year younger than I should have been, so they put me on the waiting list. Then, when I got my results, I received an offer for Edinburgh. I went there still not really liking science – I had found it a bit boring at 'A' level. Of course that was at the point in medicine where you first did your pre-clinical, which were the basic sciences, then you did your clinical. So I didn't enjoy the pre-clinical time, I hated that but thought I would be OK when I got onto the clinical bit. But I didn't enjoy that either, I found myself thinking these poor people are ill, they have already been admitted and started on treatment, and now I am being sent along to practise taking a history and examining them. So I had all sorts of misgivings about it, but then the first day I walked onto the ward as a qualified doctor it was brilliant, I absolutely loved it. As a student I had picked out social medicine and did my elective in that, I was swept away by clinical medicine, how exciting it was.

Were there many women medical students when you were training?

It was about 25% women. 160 in the year so quite a lot of women. It was very 'boysy'. The thing I remember at University was the Scottish nationalism which was having a real flurry at the time (late 60s). I was fascinated. One of the things I remember, for English people if you went into medicine with 'A' levels rather than Scottish 'highers' you didn't have to do the first year. We were 'direct entrants to second year' and there was tension between the Scots and the English about this. I remember that more than any concerns about the gender imbalance. They tended to group women together anyway eg for anatomy with six people per body, so that was a good way of getting to know five other women quite quickly because you did anatomy every day.

EARLY MEDICAL JOBS

Did you do your house jobs in Edinburgh?

No, I left because the rota at that point in Edinburgh was two nights on, one night off, so you were on call two thirds of the time. I got married when I was a student and we decided we would write round to a whole load of district general hospitals because they were just at the point of really trying to recruit UK graduates, and one of the tactics was to provide junior doctors with a flat rather than a room. We looked at lots of booklets and wrote to the ones that looked as though they had quite nice flats, and said we will take the one that offers us both house jobs. So we went to Hull, which was great, I absolutely loved it. It was a really good place to do your first year. The nurses were fantastic. There was still the fishing industry and the oil industry was just starting. and a lot of the guys would disappear for a month at a time so the nurses would have their shifts organised so they worked really hard while the men were away and had weeks off when they were back. It gave it an intensity which was very good. My first day as a qualified doctor – I was doing surgery – I went on to the ward and the sister was on duty. She was very good but could be fierce, and looked me up and down. She had taken me round the patients and I was not sure what to do then except pottering about, and she said 'doctor could you come to the dressings room please?' I went into the room which was very much her empire, and she had a patient with a disgusting wound which she was dressing and she said I am just going to take this dressing off and I want you to tell me what to do with it. She took it off and I suddenly realised it was a test,

and I managed to say 'what would you usually do?'. She said, that's fine, I will do what I usually do. After that we got on really well! Then my husband wanted to do general practice and we went to Northampton. Mike got on to the GP scheme and I thought I would just turn up and they would have a job for me – I don't know what planet I was on! At the interview he said my wife wants to do obstetrics and paediatrics, but when we arrived they said well we haven't got a job for her, she didn't apply for anything. We have only got two (Senior House Officer) SHO jobs, one in radiotherapy, and one in Ear, Nose and Throat (ENT). I went to see the consultant radiotherapist and said that I wasn't very good at physics. At that time there were no computers and the planning for radiotherapy was really complicated, calculating the physics of the rays. I said I don't think I will be very good at that, and he said that was OK and they would teach me how to do palliative care, I would look after all the ward patients so it would be more like medicine than radiotherapy. And that was again a fantastic job. It was just as the hospice movement was starting but most units still weren't very good at teaching things like pain relief and I got quite good at that – and I seemed to be quite good with people who were dying. Oncology was just happening, chemotherapy protocols were coming in, so it was quite an exciting time. Then I decided I would get a paediatrics job and I worked in London for 18 months doing SHO jobs in paediatrics and (eventually) got Membership of the Royal College of Physicians. At this time I bumped into someone who was doing social medicine at the London School of Hygiene and I asked what was all that about, how do you get to do an MSc in social medicine? She explained and I thought that was not too bad.

TRAINING IN COMMUNITY MEDICINE

You were not committed to paediatrics?

I was enjoying it. I didn't want to give up clinical medicine but I decided you can't do everything in life and I felt social medicine would allow me to have greater impact – that was before I knew much about it! But I thought that was probably the direction I wanted to go in. I had got some way in paediatrics and had that to fall back on. So I applied to Oxford and got told they were not allowing people to do an MSc course because they were committed to using the Midlands and South West Consortium[1]. I thought I don't want to do the consortium model, I want to do an MSc. I still applied to Oxford but they would not let me do the MSc and so I ended up doing the consortium modular model. It was OK but I think I would have much preferred to do a full-time academic course certainly at that time. Basically getting into public health in 1975, if you could write your name you were offered a job! – it was quite filled up with people who had fallen foul of the 1974 reorganisation including people like those women who had gone down the child health route. The consortium when I did it – Graham Winyard was on it which was good, we met at the interview – had one or two other people who wanted to train in community medicine but several others who didn't really want to do what I understood by public health[2]. They had been sent because they hadn't been given Foundation Membership of the Faculty and if they were to get membership they would need to do the course and the exams[3]. They really struggled, they had got jobs whereas we were messing about as trainees. They had families to look after and they were some years away from doing full-time study and it was difficult going back. I felt that if I had done the MSc, I

[1] Group of universities providing formal public health education

[2] Graham Winyard, later Deputy CMO and Medical Director for NHS England

[3] Membership of the newly formed Faculty of Community Medicine on the basis of experience and qualifications not examinations

would perhaps have gained more from the other students including the international students. It just sounded much more interesting.

Were there many women on the Oxford training scheme?

Our groups was half and half. The consortium started in 1973, and Graham and I were registrars in 1975-77. I did my public health in-service training in Northamptonshire where there were five consultants. The two specialists in community medicine were women, so 40% of the consultant-grade public health physicians were women, higher than most specialties.

Was there any curriculum to follow?

The Part I membership curriculum was quite specific and we were very much taught that. The teaching was good on the whole, the modules were at Birmingham, Bristol, Cardiff, Exeter, Oxford and Southampton. The academic departments at that stage were probably more competent and confident than many people working in the NHS. This group had just undergone a major transition from local government into the NHS and they were all over the place. The in-service training was very variable. People were not sure what to give you to do. They tended to give you bits of data to analyse or a report to write, rather than giving you responsibility for an area. That was quite hard for them to do so you had to kind of make it up as you went along. As well as the modules, we had a tutor so Graham and I both had a tutor in the Oxford Department of Social and Community Medicine. Mine was a pure clinical epidemiologist and Graham's was an community physician who was very interested in anthropology, so Graham and I quickly worked out that we would do much better to have joint tutorials. We had tutorials weekly in term time and Graham and I would also meet the other Oxford-based trainees. There were always meetings going on in Oxford, so after tutorials we would go to the five o'clock seminars with Richard Doll and his acolytes[4]. Martin Vessey was also there, and there were many research programmes going on[5]. It was a high status department compared with a lot of other universities. I decided I would do some academic work – I was quite young, 27, and I thought if I just did three years more training I would be a consultant at 30 and that felt quite young. So I slowed it down and got a Medical Research Council (MRC) training fellowship. My project was to do something on the pill. I rapidly realised I wasn't going to get much satisfaction out of one project – I'm a butterfly! I could have done a PhD but I wanted to do several projects. I did two or three projects on the pill and on HRT, because that was Martin's interest and I was in his department. And some stuff on cancer. With one of the research assistants in Oxford I went round the country visiting all the units providing hormone replacement therapy (HRT), new on the market, to ask whether we could recruit their patients for a follow-up study. It was a great department to be in, and I was able to build lots of contacts and networks. It came in really useful after ten or 15 years, many of the people I knew as a research fellow ended up with a chair or in another senior academic post. So as a real amateur academic I could tap into all these people who vaguely remembered who I was. When you are in a service department many people are a bit in awe of academics and I could say well I could phone so and so and they really won't mind. I am not very good at networking at all - I hate it! - but that network was a slightly more honest network. It was just people your age doing the same sort of work you were doing

[4] Sir Richard Doll, epidemiologist and pioneer in linking smoking to a variety of diseases

[5] Martin Vessey, Professor of Social and Community Medicine with special interest in women's health and the safety of therapeutic drugs

and it stood me in really good stead. Then I finished my training with about 15 months service experience. I worked with Rosemary Rue at Oxford Regional Health Authority and that was very interesting[6]. Then I got my first consultant job in 1981 in Brent.

Did you work full time throughout?

Yes. Rosemary Rue was a fantastic supporter of women in medicine juggling work and home, but less so of someone like me who worked full time. She did do great stuff for women in medicine, but I think she thought I should be perfectly capable of sorting things out for myself. She was quite a force of nature. She was a person to watch in action. She never came in before ten o'clock in the morning – you can't imagine that now! – and she would always have a glass of sherry at about five o'clock. She would stay in the office till all hours – it was not that she did not work – but the sherry bottle would always come out at five! She did teach me this wonderful trick. At that time the RHA held the consultant contracts. Rosemary would not put up with poor performance or poor behaviour and she would summons any doctor who was causing problems. She had this very cluttered office, a nice room but very cluttered, and stuff on the table so they could not sit at the table. So she would sit them in this low armchair leaning slightly back. She would then give them a very full cup of tea. One day she said I could sit in on a tough conversation she was going to have. Afterwards she asked whether I had noticed what she had done, and of course I sort of had noticed but I hadn't realised it was deliberate, as I hadn't seen anyone behave like that before! She was a real operator.

FACULTY OF COMMUNITY MEDICINE ROLES

Had you already started getting involved with the Faculty as a trainee?

That started from 1977. What happened was that the Faculty organised a training conference in April 1977 and it was not a representative thing but each Region was invited to send one trainee. I didn't mind doing it so I went and it was very preliminary, one day and out of it came the idea that it would be really helpful for trainees to have some sort of network and maybe to have an annual training conference which would be partly about scientific papers and partly about improving training. Partly it was about recognising that quite a lot of trainees were having problems with their training partly because of the separation of academic and service practice, and partly because of the continuing consequences of the major reorganisation in 1974. Too many of the trainees were not having a great time and it was also quite difficult to recruit – I can't remember exactly but I think only a half to two thirds of training posts were filled. The Faculty Education Committee (John Knowelden was the academic registrar at this point) and the British Medical Association (BMA) felt it would be a good idea to get some people together and I did a survey of trainees following that to find out how many trainees there were, what they were doing, and a bit about career intentions. Then I think we did a better training conference in January 1978 and got a lot more trainees there, as well as a sprinkling of trainers, both service and academic[7]. Following that we started to say it would be good if each Region got their trainees together and the Regional representatives met, and the Faculty Trainee Members Committee came from there. I am bossy, organising meetings is straightforward really! I chaired the Trainee Members

[6] Dame Rosemary Rue, Regional Medical Officer and General Manager, later first female president of the Faculty of Public Health (Medicine)

[7] Professor John Knowelden, Chair of Preventive and Social Medicine, Sheffield University

Committee, and represented the trainees on the Faculty Education Committee. The other thing that was going on at the same time was that there were lots of special interest groups, area medical officers, district community physicians but also quite a lot of specialist consultant posts each of which had brackets – specialist in community medicine (child health), (social services), (information and planning), (medical manpower) and they started getting together as specialist groups. Spencer Hagard was particularly involved in saying we should have some sort of standing committee which brings together representatives of each of the special interest groups because in a way that was where a lot of the energy was[8]. What was actually going on was that a lot of the newly trained people were selected to go into the information and planning jobs because they saw those as the most interesting, and there was quite a lot of energy in that group of just qualified people testing out what they could and could not do and they were the ones most active in getting this group together. It sounds bureaucratic but it was actually a way of getting people together to talk about real life in public health. Conferences tended to be quite academic. The academic world was much more organised at that point and it was a way of trying to ginger up the Faculty, can you get to grips with the future of community medicine in the NHS as well as in universities – what we should be doing, some of the influencing work, rather than endlessly debating whatever it was the Faculty was endlessly debating.

Were you chair of the trainees committee and when did you get to the Board?

Yes. I stood for the Board in 1984, soon after I stopped being a trainee. The thing about the Board was it was rather dysfunctional. It was massive. It was one of those groups that sat down at a long, thin table. Interactions were difficult. Meetings were very formal. Again Spencer was part of getting the Board to create an Executive where the actual work got done. The trick was to get onto the Executive Committee which I did manage after a few years. I did two terms on the Board. About the same time I stood for the General Medical Council (GMC). I was pretty over-exposed at national representative level but it was a good learning curve and got you in on stuff you would never otherwise have known about. The Faculty was still pretty male. The Board, the Education Committee, the officers and the staff. When I got to the GMC it was even worse. It was before they made changes to the constitution. There were about 150 people on the GMC, around 10 were lay members, all the rest were doctors mostly nominated by the colleges and faculties and BMA, some elected. A quarter in total I suppose were women, probably less. The GMC had some clever tricks. I don't know how they did it but they always achieved the membership they wanted in the elections to the important committees. At every session you filled in a form to say which committees you would like to serve on and I never got on to the committees I wanted. I got onto one defining standards which was interesting but only for a year, education for a year, and the health committee for 2 years.

Did the Faculty meetings discuss women at all?

There was definitely discussions about training. One of the early things we did with the Department of Health who were worried that we were not recruiting to training posts was to build a model which said this is the workforce, this is when they are going to be retiring, what do you need to pour into the top of the pot to replace the people who are going to build the

[8] Dr Spencer Hagard, influential District Medical Officer, Cambridge then Chief Executive of the Health Education Authority

specialty. With that we allowed for maternity leave and part time working. But that was with a workforce modeller. It was a bit off the Faculty piste. I think it was always taken for granted this was a good specialty for women compared with having to be on-call in hospital and the flexibility of it – I got cross when people said I didn't have to work so many hours as them because I think I did, but I had more choice about when I worked, and I could do some work at home in the evenings and at weekends. If you were sharing child care responsibilities it was always recognised that public health was a good place to be and it went crazy a few years ago when the Deaneries got in terrible muddle with part time trainees and said part time trainees could be paid the same as full time trainees! There was nothing like that going on then. We had a bit of discussion – a bit of a discussion with myself probably! – about Rosemary Rue's retainer scheme for women doctors and how could we make that work in public health. I don't remember a lot of angst about why. When I looked round the table most people were men. We did mutter about that in the bar afterwards but I don't remember any discussion about how can we get more women elected to the Board or anything like that.

Did you continue your relationship with the Faculty into the 1980s?

I was on the Board between 1984 and 1990. Then in 1988 I was appointed to the Regional Director of Public Health (RDPH) post and I gradually dropped my national stuff at that point because I thought this was potentially a conflict of interest. More importantly I wanted to do the RDPH job properly and I would have more chance of doing that if I didn't spread myself too thinly. I think I also got a bit discouraged by the Faculty. You said things 20 times and they still did not happen. I had tried all my tricks like writing the minutes and doing lots of the follow up action. I did masses of writing saying we were going to do this and none of it happened. You get dispirited.

CONSULTANT POSTS

Was there much competition for the Brent post?

There were two of us. I had gone for a consultant job before that. In part my career was shaped by who I happened to be living with at the time! – and this person was into coronary heart disease prevention. North East Thames Regional Health Authority had set up a consultant post specifically for heart disease prevention. I thought that looked quite interesting – there were not many of those jobs, one or two, not many and by this time I was planning to move to London. The East End would be very interesting so I applied for that but I am pretty convinced it had been fixed for someone else partly because I was told beforehand that I wouldn't get it but also because afterwards the chair went out of her way to say I had done OK and I would get a job, and she didn't have to do that. So I didn't get too dispirited, the Brent job came up a month later and I got that in 1981. That was fun, in particular the opportunity to work closely with the LA in care group planning. I had just arrived in Brent as Brent and Harrow were created from an Area Health Authority as two District Health Authorities in 1982. One thing in starting in a completely new specialty is you have no idea of the past. There were all these traumatised people who had had jobs in local government and they had only been in the health service a few years. I had to piece it together from the Area Medical Officer in Northamptonshire. In local government he had had an army of people and great deference, none of this NHS consensus management

nonsense and a tiny department. Some of the Medical Officers of Health brought their huge LA desks with them. I could understand that.

After the job in Brent I moved to North West Thames Regional Health Authority. It was the most perfect job, three days a week for the care group specialties as they used to be known – mental health, older people, people with learning difficulties, children – and the other two days running the NW Thames public health training programme. At that point there wasn't anybody else doing this, so the Regional Medical Officer I worked for said look we are recruiting all these people, they are going to Districts where they are not being properly trained, they are leaving and fed up. The Faculty Advisor was doubtful about it because he felt that it was his job to look after the trainees, we didn't need a specialist in the Regional Health Authority so the RMO said well, you haven't got time to do it, she will work with you. The Faculty Advisor was very accommodating and we sorted it out. But that gave me a whole new area of influence. Rod Griffiths and I – West Midlands and North West Thames – were putting a lot of energy into recruitment and retention, appointing good people and improving the quality of the training programmes eg doing annual appraisal meetings for all the trainees in their training base[9]. If we weren't happy with the training provided, we would move the trainee, and quite quickly everyone took their training responsibilities much more seriously. My development focus shifted to this group rather than trying to influence national dinosaurs. That was lovely. I put my energy there in the mid to late 80s, then I became RDPH and that was all consuming.

What was the impact in the 1980s of the Griffiths changes?

Initially it went down very badly in public health. If you talked to people they said how much they hated consensus management but as soon as anything else was proposed they hated that even more. Very few public health people became chief execs and this rarely worked very well anyway. There certainly was a flurry of concern in the mid-1980s, but then people got on with it. I used to argue very strongly that the best job on the Board wasn't chief exec, but was DPH. A DPH did not have to do all the turgid stuff, but had considerable influence as a Board director, so you had the best of both worlds really. From the mid-80s the confidence of public health began to grow. Having done a bit of grappling with Griffiths it settled down and we could actually start to see there were other agendas. Commissioning brought a new lease of life for public health. It sounds funny to say that now. Some chief executives were absolutely up for commissioning for health. The combination of that and the fact that some of the most disaffected in public health had retired meant that we were recruiting some very good trainees, the multidisciplinary discussions started, suddenly there was a much better relationship between academe and service public health and there was much more respect across the two groups, and then commissioning provided a framework to put public health into practice. Griffiths did cause a lot of anxiety. I used to say to people, be chief exec if you want but better to find a good chief exec to work with, for me that was the ideal thing. I was incredibly lucky right through with the people I worked with, people who understood public health and who respected it. It pushed me quite hard to be a manager in the real world, to balance that with the advocacy role, and not just the fluffy pink public health cloud. I had to be able to read a balance sheet and I had to be able to challenge HR. There were a couple of really good chief execs I worked with and I know they would use me in difficult decisions as

[9] Professor Rod Griffiths, DMO in Birmingham then RDPH West Midlands

a conscience, and that is a brilliant place to be. I didn't have to bang on in a boring way, but knew that the public health view would be taken seriously and they would just check at the end of a discussion whether I was 'acceptably unhappy', that we were doing the best that we could do. As DPH you were influencing and retaining integrity as well.

REGIONAL DIRECTOR OF PUBLIC HEALTH

So you went from Brent, to the Region then to the RDPH post?

I was appointed to Brent in 1981, in 1983 I moved to the Region to that lovely 3 + 2 post, then from 1989 I was RDPH until 1995 when I moved to the Department of Health.

So you were RDPH at the time of the Acheson Report?[10]

That was all really helpful, people rated Donald Acheson, and he had a very good team advising him. It felt like he seized it - with most reports it doesn't happen like it is supposed to – but that coinciding with more people around, seeing the opportunities and actually people starting to make their own opportunities, they didn't need a report telling them what to do. They just did it.

Were you the only female RDPH?

When I started. It had just been Rosemary but she retired and then it was just me. Then Sian too.[11] That was it. Mostly men.

Was it unusual to have got to that level as a woman?

Those jobs had been men's jobs apart from Rosemary. For years they had been SAMOs (Senior Administrative Medical Officers) with the Regional Hospital Boards (until 1974). She had obviously been a legend in that time. Most of the women at the establishment of community medicine in 1974 had come from local authorities and there were very few working at Regional Hospital Board level – capital planning and medical manpower was not the sort of stuff that women necessarily gravitated towards and I think it was a bit of a boys' club. It certainly felt quite a boys' club when I became RDPH. They were very nice to me and I was good at asking for advice. One or two were very helpful because it was the sort of jobs where you came up against things you had never come up against before. I also had an open phone line to my predecessor if I got stuck on anything. But you don't want to go bothering people who have tried to retire. I could always ask the regional general managers I worked with, and I worked with a very good human resources director for the disciplinary stuff which was pretty taxing (RHAs held some consultant and junior doctor contracts). People like Mike O'Brien helped.[12] Bob Haward in Yorkshire. He always used to say how great it was to have Yorkshire Region rather than one of the quarters of London plus some home counties. He could do all sorts of things in Yorkshire that I could never do in North West Thames and he used to like talking about it. Sometimes I would say to him, I can't do what you are doing but tell me what you are doing about this and this and this, and he would just love to tell the stories. It worked fine. I became the secretary of the RDsPH group when

[10] Sir Donald Acheson, Chief Medical Officer produced a report on public health in England in 1988
[11] Professor Sian Griffiths, RDPH South West Thames RHA, later president of the Faculty of Public Health
[12] Dr Mike O'Brien, RDPH East Anglian Region

David Wild was chair and did the minutes and agenda which was quite good because it gives you influence over what is happening. I also managed the manager we appointed to support the RDPH group, she was part of my team. And I did also used to collect the money for leaving presents!

It must have been an exciting time to be RDPH?

It was probably my best job but six years was the right duration. People say that after about seven years you meet the same problem for the third time. On the other hand if you do a job for less than three years you haven't got into it properly. Quality was coming on the agenda. Although we did not have a direct role in commissioning, I was nevertheless very firm that I would organise all the DPH meetings in the Region – there were some of them who said why do the district DPHs have to meet with the Regional people? – we dealt with that. I chaired the meetings and we got useful stuff done. Of course a lot of the discussion was about commissioning so I kept up with that vicariously but in terms of what the RHA teams were doing we were focusing on clinical audit and the broader quality agenda. I had a big team on mental health because we had had problems with the closure of the long stay mental hospitals and so we had to put some serious quality work in around that. I had R&D, Pharmacy, I had scientists, health promotion staff including a specific team on HIV. I had about 100 people on my team and mostly people I had recruited and they had recruited, so it was a very fresh team and exciting. I think we did some good work. We did not call it medical audit, we called it clinical audit, it was multidisciplinary taking full account of the patients' views of their outcomes and not just those of the doctors' and nurses'. It did go much further into the quality agenda. We did some stuff on patient safety and risk, adverse events, near misses and all that sort of stuff. It was lovely. It was just luck that I was given the budget rather than someone else, luck that we happened to have good people around. Once you start to generate a buzz, people want to be part of it. It wouldn't necessarily be me who got the phone call but clinicians would bob up and say I would love to do that for a day a week, or I could free up a day a week, what could I do? I had 100 people but they weren't all full time. They were a diverse mix. It was a good team. The finance director and I got on really well as sometimes happens because we are the numerate people on the Board – we were the ones who could add up. Really good regional nurses who were collaborative rather than competitive. I had very good HR which is crucial and good general managers/chief execs.

MOVE TO DEPARTMENT OF HEALTH

You then went to the Department of Health?

I moved to the NHS Executive just as Regional Health Authorities morphed into Regional Offices in 1995. Alan Langlands who had been the Regional General Manger for North West Thames had moved to the Department as Chief Executive as the NHS Executive.[13] I also knew Alasdair Liddell very well and Alasdair and I set up the Association for Public Health, trying to bring public health and managers closer together. Alasdair was Director of Planning at the NHS Executive. He rang up one morning in the mid-1990s – it was at the time when there was a panic about severe mental health problems and people with psychosis attacking people on the street – and at the same time a lot of unhappiness about how badly people were cared for. Within the Department of Health there were mental health teams in four different

[13] Later chief executive of the NHS

places. They decided to create a new division to bring together all of mental health and Alasdair asked if I was interested in heading that up. I usually make decisions quite quickly but I really didn't know. I was quite anxious about being a civil servant and I loved being an RDPH but clearly the Regions were changing. After about 12 days wondering what I should do I woke up one morning and said I will take that job. It wasn't advertised but that did happen then, I moved on a secondment. If I were to do that again I would have insisted it was advertised. Part of the problem moving into the Department was that civil servants were very picky about due process. I had three branches doing mental health and a fourth branch doing community care, all quite complicated, not just about values and evidence, also about legislation and politics. The work on community care was about funding (the health v social care funding battle), about people with disabilities and older people, and a lot of work with voluntary organisations. It was really interesting and I had to get my head around mental health legislation which I had never done before, but I was not a good civil servant. I could not see why ministers had to make every single decision to the extent I could not even send a letter – I could send an unimportant letter – but with anything that might be sensitive I had to write a submission to the minister, these are the issues, I have drafted you a response or I have drafted a response from me, could you tell me if it is OK? They had all this jargon you had to use. I ended up with a yellow post-it note on my computer saying remember ministers! It was so different from the autonomy of an RDPH and took me a while to get used to it. I kept saying I can do that. I couldn't always see the political ramifications of things career civil servants could, to their finger-tips they got it. It was good for me and I did mostly enjoy it. I particularly enjoyed the national service frameworks, the first one was mental health. After a couple of years there was another reorganisation and I took on a wider brief including all health services. That is one thing about my career, it has been very much public health in the health service rather than infectious diseases, or well-being. I don't think I would have much liked local government. I did find the politicians annoying, so egotistical! So I did that for a bit then Graham (Winyard) who was deputy CMO (I was one layer below – I switched from working for Alasdair to working for Graham) left to be a Post-Graduate Dean. I applied for his job and I became Deputy Chief Medical Officer (DCMO). That was OK until both Alasdair Liddell and Alan Langlands left and then it wasn't OK. That was probably the most difficult decision for me because I hadn't understood that your career goes up only so far, and then suddenly it is going to go down. The world turned. I knew that I would get much greater pleasure and enjoyment from a job back in the NHS, but the perception would have been otherwise. I am competitive and I had to get my head round that.

BACK INTO THE NHS IN LONDON

Fortunately there was another big reorganisation with the establishment of Strategic Health Authorities. They had done the slotting in posts for the DsPH in London but there hadn't been anyone slotted into North East London. I knew the chief executive there really well. We had arranged to have supper and over supper she said this is such hard work, I haven't even got a DPH. And I said, I could do that. She didn't react at all. I thought she's a friend, she doesn't want it to get too complicated, maybe she has someone else in mind, maybe she doesn't think I would be the right person. I didn't say any more and after a week she rang me up and said she just realised she might have been a bit slow, was I serious? So I applied for the job and did it for four years. It was a good time, and included leading the health element of the bid for London to host the 2012 Games. Then NHS London was created in 2006 by

merging the five SHAs in London, and that was the first time I thought I was not really sure about this reorganisation. At all the previous ones I had been able to stand in front of an anxious team and say this is really hard and disruptive but it is worth it, trust me. This time I thought these people are going to get savaged – it's five into one and actually some of the really good things we did in NE London wouldn't work elsewhere, so I was not quite sure we really needed this reorganisation, very depressing. At that point I said I would like to retire slightly early, and got my letter saying I could. Then David Nicholson (who was running NHS London before he moved to be chief executive of the NHS and was replaced by Ruth Carnall) said would I stay on at NHS London until he appointed a substantive DPH? I said I would. That was a really difficult nine months at NHS London. In the end they still hadn't advertised the job and it was so unfair to the people hanging around hoping to get the job so I said to Ruth (Carnall) I had arranged to go on holiday for the first three weeks in May, I had expected when I signed up for the job from 1 July that by May you would have replaced me, and that perhaps I should hand over and go.[14] She said what did I want to do and I said I just wanted to go, everyone knows I am only here temporarily, I can't really do much and it is not good for other people and not good for me, so I retired at the end of April 2007.

REFLECTIONS FROM RETIREMENT

I have done some part-time work since but am not doing paid work at the moment and I probably won't. There are tons of things people need doing and when you have got time you can pick up with friends and relatives; when you are working flat out you sometimes have to pretend you haven't noticed. So there is a bit of that that goes on. I have three (step) grandchildren now so I have plenty to do. I am lucky – in the age cohort that got a pension. I worked with some wonderful people and I can look back on my career and see bits where we did make a difference. I think I just feel totally sad that, despite our optimism and commitment overall things got worse on my watch and there is a bit of me that wonders what I/we could have done differently. All those awful graphs – how did we let that happen? We said all the right things and worked hard but it is quite difficult to look back. Perhaps the best things I look back on are the people I was able to help – trainees or colleagues, complainants, people you collect and think maybe I can just be a bit of help to you and then you see them take off. I think that is probably where I got the greatest rewards. A lot of that is not exclusively for women. I think it is changing but through the1980s and 1990s mentoring was such a female thing. I usually had three or four women I was mentoring at a time which I loved. There was also some guys, the same sort of age, who I was also 'mentoring' but it wasn't called mentoring, that was a cissy thing, we would just have a drink together. Mentoring seems more acceptable now. Those are the things I enjoyed as much as anything.

How many models or support would you have had entering public health?

Rosemary Rue was, everybody would say that. People like Tom McKeown, Archie Cochrane and Richard Doll, those very big names.[15] You would say wow, I have met them; Richard Doll I have worked with. I think in those days it was the 'watch and learn' kind of role models. They weren't particularly the sort of people to say come along, it's going to be

[14] Dame Ruth Carnall, Chief Executive NHS London

[15] Thomas McKeown, Professor of Social Medicine, Birmingham University; Professor Archie Cochrane whose book on efficiency and effectiveness of therapeutic treatments led to the establishment of the UK Cochrane Centre and the International Cochrane Collaboration

interesting. It was all a bit spikier than that. Spencer (Hagard) was a big role model. He was a bit older than I was and got his consultant job in Cambridge just after I met him. Alwyn Smith was definitely a role model although much more intelligent than I will ever be.[16] And June Crown.[17] When I went to Brent June was working in Brent and Harrow. Frank Seymour, the RMO at the Region and Alan Langlands, the RGM. They are the key people. I do remember going to have a heart to heart with Donald Acheson at one point. He was incredibly sweet. In the 80s/90s I got very involved with prison health and did various things to try and improve that and he had a working group he chaired on prison health with his CMO hat on. I remember writing to him saying could I come and talk to him, I didn't know what my role should be as an RDPH with so many health problems caused by poor housing or homelessness in NW London. He didn't say anything practical but it was just being listened to, him saying any time I can help, but of course you only do it once, it would be abusive otherwise.

And public health as a career for women?

I suspect it is quite a good career for women because women are used to balancing lots of priorities which you really have to do in public health. It is not like going into an outpatient clinic for three and half hours and you do that forever. At risk of stereotyping, women are resilient, we handle adversity well, are often strong on complex partnerships and relationships. There is no such thing as a typical woman but if there is something more likely generally to be found in women than in men a lot of that is what plays well in public health. I think one of my weaknesses is that I don't have the killer instinct. I don't know in local government if you need more of a killer instinct than you needed in the health service, I think you might. That might be a bit off putting for 'traditional' women but then women are different now aren't they? And men are too, co-parenting is having a real impact. In my time I think women managed the inter-relationships better than men – they had more strings to their bow. Men had hierarchical stuff but were not so good at the rest. The things you were taught as a girl – I have just done the Woman's Hour Chore Wars questionnaire and I came out as a classic woman and that includes who in your household remembers birthdays. Actually you do that at work as well. What I used to get exasperated about was how people would not do appraisals and I think it is probably improving but part of it is that men will just not make the relationships. Doing appraisal you have to get close. I remember someone saying at work isn't it interesting that women remember your children's names; they remember the basics, how many children you have got, what age they are. Men just didn't. When life is tough at work thinking you have a boss who knows that you have to go early on a Thursday because you look after somebody does make a big difference. One of my theories about why people don't like doing appraisals is because appraisees don't like being criticised and so you come in with you are 95% wonderful but there is just one tiny thing I might mention and they come back at you with What! How dare you, you haven't even spoken to me in the last three months. I think that sort of sense that women are more glue than men! For me all bets are off on the local authority stuff and I don't have direct experience of that but reading the early experience it feels like 50% are surviving, 50% struggling. It's

[16] Alwyn Smith, Professor of Social and Preventive Medicine, University of Manchester
[17] Former female president of the Faculty of Public Health (Medicine)

predictable. The confident teams with good leadership, they are doing OK but those without a DPH how are they going to flourish?

Why has no one 'noticed' medical women in public health?

I think we did talk about it in the 70s. I was quite struck going to Northamptonshire in 1975 to find 40% of the consultants were women. Even then it was traditional, a female workforce but the board level posts were held by men. The women had come up the child and adult health pathways but were not at the top table. That was noticeable. Doing the consortium and finding this wodge of people who had got stranded in sort of semi-clinical, semi-management jobs who were neither fish nor fowl, we definitely talked about them. How miserable it was for them, there was not really a job they wanted to do. They had been clinic administrators. When I was running the public health training programme we used to joke that you could spot the women who thought this was a sinecure. They were trainees in A&E or surgery and suddenly developed this passion for public health. One or two genuinely had but most of them hadn't. It's a good job for people but it is only a good job for women if it is going to be good for public health. The continuing failure of women to make the top jobs was discussed. The DPH group in North West Thames in 1990 was predominantly though not exclusively male; there were two women in Hertfordshire but they were old school one had membership, the other had done abbreviated training and both came from local authority, child health work. But the women were starting to come through, and it's wonderful to see where some of the NW Thames trainees are now. Some slowed their careers to spend time with small children, but they have certainly caught up. It did seem to depend a lot on role models. If they weren't around it was difficult to imagine yourself doing strategic jobs. At the GMC the committee I was consistently put on was the health committee which was where we used to see the doctors who had health problems, like some ghastly outpatient clinic. All the time I was on the committee it was all men except for me and the guy who chaired it would begin the meeting with his gavel and say 'welcome gentlemen'. After three meetings I got fed up with this and sat next to him one time at lunch - most of the doctors we saw had alcohol problems and we would have drinks before lunch, wine with lunch then a brandy, then we would sit all afternoon!- and said I am not very happy at being referred to as a gentleman so from then onwards he would bang his gavel and say 'welcome gentleman and Dr Adam'! In public health there may be 50 hours of work to do but you don't need to do it between the hours of 8 and 6. You can reasonably work full time in public health and flex it a bit. May be more difficult in local authorities because they have evening meetings or maybe do the school run and then go to your meetings!

Thank you very much for your time