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PROFESSOR SIAN GRIFFITHS, OBE

Career Summary

Sian trained in medicine at Cambridge University and at King's in London. Following a brief period in the United States, she trained in public health medicine in the North-East London Deanery. Her first consultant post was in Hackney before moving to Oxford Regional Health Authority. She became Regional Director of Public Health for South-West Thames RHA before returning to Oxford as Director of Public Health for Oxfordshire Health Authority until her election as president of the Faculty of Public Health 2001-4. She then became professor of public health and director School of Public Health and Primary Care for the Chinese University of Hong Kong. Now retired and working part-time from the UK, she combines her international work with academic links and board work including as an Associate Board member for Public Health England.

Interview date: 13/10/14

EDUCATION, FAMILY AND ENTRY TO MEDICAL SCHOOL

Why did you go into medicine?

I didn't like school very much. I was sent to boarding school in Felixstowe where my mother had gone – it has now closed down! Then I moved in my last year - because my parents decided I was unhappy enough to be moved – to North London Collegiate so my school career was a bit chaotic.

Were you doing sciences at school?

I was doing History and English A levels then changed to sciences because I made a decision I wanted to be a doctor. When I went to Cambridge in 1970 I took social and political sciences as the second part of the Tripos. I really enjoyed the sociology. Then I took a year out, but not with any encouragemen. The Dean of the clinical school I was going to did not think it was a good idea but I put it to him I either got a place or I didn't as I was determined to look at other career options outside medicine, and he held the place for me. My Cambridge experiences led me to decide early on I was interested public health rather than clinical work. During my year out I was a social worker, a supply teacher, ran a playgroup and worked in a toy museum. Then I went back and finished my medicine at King's (College Medical School) followed by junior doctor posts then some community clinic work, got my Diploma of the Royal College of Obstetricians (DRCOG) and had my first child in 1979. I didn't have a clear career plan at that point and my husband got a job in America so we went to New York. I was pregnant at the time and my second child was born in New York. That was quite tricky because I wanted to work and I didn't want to work. After a few months I was given a job part-time in the lab he was working in. I did some science and wrote some papers, and lab work fitted well with my two small children.

When we decided we were coming back to UK, I applied for the public health training schemes from America in South East London and North East London.

MOVING INTO PUBLIC HEALTH TRAINING

What was the application process then?

The five year training scheme was an application process with an interview. The first year was an academic course - the MSc at the London School of Tropical Health and Hygiene, followed by training placements .

Did you know much about community medicine as it was then before you applied to do public health?

As a medical student I worked on teenage pregnancy in Brixton and in Cambridge I had been interested in alcoholism and vagrancy so community medicine was the obvious choice . I think there were bits I hadn't realised were quite so fundamental, such as infectious diseases and hospital management wasn't something I was particularly tuned into but I had a good year at the School of Hygiene, although it was quite hard with two small children as well as studying.

Did you do the course full time?

I did it full-time.

What was the balance of men and women when you were there?

It was a pretty good balance, split between UK and non-UK and the gender balance probably more men from non UK. But amongst the UK students it was about 50:50. I didn't think there were any gender issues. It didn't feel overwhelmingly male. The most overwhelmingly male experience was Cambridge. There were only three women's colleges at the time so *de facto* we were a minority.

Was there any prejudice?

Cambridge at the beginning of the seventies was a very radical place. I was an active radical student on demonstrations, sitting-in, part of the Women's Lib group when it started etc. A few of us set up alternative lectures at Cambridge as we felt the medical course lacked teaching about important social, political and ethical issues. I don't think they were specifically gender focused but about making change.

I took a year out because I didn't think medical school would be very interesting. In the end it turned out to be something that was well worth doing. I think I would never have been called a conventional medical student.

Were your clinical jobs in London?

Yes. I did obstetrics and gynae then after my first daughter was born I worked in community health clinics because it was more flexible. I made the decision to have my kids early and carry on working and see what happened. That felt right for me. I didn't wait to get a career, I wasn't very career focused. I was more 'Zen' about it!

And your public health training?

As a public health registrar I worked for Ken Grant in Hackney who was active with Medecins Sans Frontieres. He was the Director of Public Health, but kept going off to

Afghanistan and various other places. As senior registrar, I got asked to take on responsibilities. I can remember having to be part of the group which closed St Leonard's Hospital. The patients had to be moved out and I can remember one of member of staff of an NGO doing a community project for which I was accountable lying down in front of the ambulance and having to discipline her later. Hackney was a vibrant place to work and we were innovative doing what is now routine practice - such as patch-based care, using small area statistics to look at deprivation, trying to reorganise services to be more community focused - I am not sure we succeeded but we did at least try. We were visited as part of the Acheson Review of London - Sir Donald produced a seminal report on primary care and how to improve it in London.

Who was in Ken's team?

The team was only recently separated from local government at the time - 1982-83. We were in a shared building with the local authority in Hackney. The team had a stream of registrars and other good non-medical people includes nutritionists, health educators, statisticians amongst others. As a teaching department, we also had university responsibilities such as teaching and research.

FIRST CONSULTANT POSTS

Were you a consultant by then?

Yes. I got to be a consultant about four years after leaving the London School of Hygiene. I stayed in Hackney until we came to Oxford. My son was born in 1987. I took a maternity break, I did some filling in jobs, started looking to see what was around then I got a job at Oxford Regional Health Authority. We moved because my husband, Ian, got a job at the City Council and we thought it was better for the children to be in Oxford. My career was definitely not the driving force at the time.

What was your role at the RHA?

I was responsible for health promotion and worked on AIDs, breast cancer, drugs and alcohol. I also played a role in primary care developments. I wasn't there that long before I got recruited to London to be RDPH.

REGIONAL DIRECTOR OF PUBLIC HEALTH

Were you head hunted for that job?

I was head hunted for South West Thames which was a really tricky job. I did it for three years. It involved a huge amount of travelling. The family stayed in Oxford. We had baby sitters and nannies and Ian was really good about covering for the kids. He has always been really good about supporting me. He said, oh yes, you should do the job. Then along came another reorganisation which meant I would have had to look after the whole of South East England and living in Oxford that was just not possible. I just did not want to do it so I did not go for the new post. I applied for the Oxfordshire DPH job when Alex Gatherer retired. That job was very competitive so I was really pleased to get it and come back to Oxford at that point.

If we could just go back to the South West Thames job for a minute, how many women were around in the RHAs at that time?

At 40 I was the youngest and the other female RDPH at the time was Sheila Adam. I was recruited by Julia Cumberlege, now Baroness Cumberlege, who was RHA chair and she was very supportive.[1] I think, in retrospect, I did not really know what I was doing a lot of the time but how would you know? You could say that about so many things as you get older - "Oh I would have done it differently." I now understand so much more but it was a good learning opportunity. I worked with Chris Spry with whom I am still friends.[2] It was the right thing to do when I left to come back to Oxford because it was the right thing for the family. If I had been hugely ambitious I might have kept going at that level doing regional work but I didn't want to do that so I came back to Oxford to what was a lovely job.

DIRECTOR OF PUBLIC HEALTH, OXFORDSHIRE HEALTH AUTHORITY

What was your department at Oxfordshire Health Authority like?

I had a huge department. We did very well. I was able to get extra money - I have always been able to do that, get money from various places. I worked well with the County, I worked with the Non-Governmental Organisations (NGOs), I did a lot of partnership work with less focus on the acute hospital. I did, however, establish the Priorities Forum which was seen as innovative and the focus of my hospital based work. I worked with Nigel Crisp when he was CEO (of the Oxford Radcliffe Hospitals NHS Trust) and I did a lot of networking.[3] I tried to get my juniors to focus on certain things, be the expert in different things. But there were always tricky people as well! It was a good time and several people who worked with me went onto be DPHs. I tried to give them all opportunities. We had a very good support network. When we were managed together with East Anglia, there was a very good group of DPHs [all women on the Oxford side!] and we used to meet regularly for dinner and discussion . I think we felt quite influential at the time as a group. The DPHs in the Oxford grouping worked together on critical appraisal skills training established groups and programmes such as CASP and whole lot of things like that.[4] So I think it was actually a very creative time. We all felt we had the opportunity to do things. I would be surprised if any of the people I worked with then didn't feel that. It was actually a good time to be in local public health.

You made the leap from consultant to a strategic role; was it expected in public health that people would go beyond career grade?

I think so. There are always some people who choose to sit and always some who choose to move on. I don't think that is gender specific - I can think of a lot of male consultants who sat for a long time! It's about motivation and influence. I happened to meet a group of people who were interested in doing more. I never felt being a woman held me back. There were also some very tough female local councillors in Oxford city and county - articulate people

[1] Later Junior Health Minister and Conservative life peer
[2] NHS Chief Executive
[3] Later chief executive of the NHS
[4] Critical Appraisal Skills Programme training

who have significant life experience, people who wouldn't see being a woman as a block on their careers .[5] A lot of strong women around to support other women.

FACULTY OF PUBLIC HEALTH ROLES

You got involved in Faculty business early on too?

There was no North East Thames trainee on the Faculty Trainee Committee so I was co-opted. I can't remember we were a terribly active group but I was then asked onto the Meetings Sub-Committee and went on to Chair it . Then I was asked to be Treasurer. I was always asked, it wasn't that I was wanting to do it. I was learning a lot on the way. Then I was elected the vice-president and then the president in 2001.

What was the Faculty like then?

When I was initially on the Faculty it was as an observer and I didn't say anything because I didn't think observers said anything! Also, when I was younger I didn't used to speak in groups. I can't quite remember when the change happened. I was OK at the meetings committee as I got got older and more confident. And as a DPH I had to speak in public. I wasn't naturally good at it - I had to learn how to do it. I didn't feel confident. I think you need to give people confidence, you have to help them to do it. It wasn't part of the training at the time. Frada Eskin was very good to me when I was a trainee and she involved me in group development sessions.[6]

Were there any role models at the time?

When I was young Beulah Bewley was very good to me.[7] When I was a registrar in London she would get me to go to things. I was a great favourite of Paddy Donaldson's, Liam's father.[8] He used to get me back to talk to the registrars at the School of Hygiene. In my earlier career these people were very supportive of my development. I did have personal coaching when I was in Oxford - not so sure it was terribly helpful. I was also part of a learning set with Jo Ivey Bufford and Julia Neuberger.[9] That was quite good. The King's Fund used to run a lot of supportive meetings. I used to find those were good and the culture around the creation of the RHAs when people like Alasdair Liddell, Laurie McMahon, Sheila Adam were all part of the group that created the Association of Public Health which I then became co-chair of after Lord Hunt. I led the merger of the APH with the Public Health Association which Geoff Rayner was chair of and which became the UKPHA. We created the UKPHA at around the time I became President of FPH. I found that whole group of Alasdair, Laurie, Sheila, Sue Atkinson a very good group to be part of.[10]

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[5] Angela Coulter, national specialist in public involvement; Ann McPherson, GP who founded a database of patient experiences

[6] Public health physician who wrote extensively about management skills.

[7] Public health academic who promoted women's development in medicine

[8] Dr Paddy Donaldson, former Medical Officer of Health, Liam Donaldson former Chief Medical Officer for England

[9] American campaigner for women in medicine

[10] Alasdair Liddell, NHS manager and later Director of Planning at the Department of Health, Laurie McMahon, management consultant from the Office for Public Management, Sheila Adam, RDPH and later Deputy CMO, Sue Atkinson, RDPH

REFLECTIONS ON PUBLIC HEALTH

What do you think the impact has been of public health being located within the management tiers of the health service?

Public health has been affected by all the changes. Every time there is a reorganisation you get shifted into a different world. The biggest problem is you just get used to your role when it gets smashed to pieces again. If you put a lot into it you see a lot disappearing. My classic example would be the New Opportunities Fund programme of Healthy Living Centres which I chaired.[11] We had all the lottery money and massive programmes. We had an evaluation stream established so we would be able to answer the question of whether the investment would make any difference. Then government changed the name of the New Opportunities Fund to the Big Lottery, changed the Board - they asked us if we wanted to stay on it and I said no because I didn't think I could legitimate being in the NHS and the Big Lottery - and the evaluation stream disappeared. We have no evaluation of the millions of pounds that were spent. It wasn't because we didn't think about it, it was because we were disbanded. This constant change makes it difficult to hold on to the learning. I think people lose a lot with all the reorganisations, the corporate memory disappears. If you were a gynaecologist you would be working in the same trust probably for 20 to 25 years, you would know everybody, your life would be pretty stable. In public health you have to keep changing, changing. A bit of change does no harm but it is too much. The functions remain but we reinvent how to carry them out. For example, Ebola has shown the importance of the old role of Consultant in Communicable Disease Control (CCDC). However, it also demonstrated the new way of delivery within Public Health England, a significant global player. Before this, the Select Committee was criticising PHE for not having role, not knowing what it was doing. It is clear that PHE was playing a key global role in managing the Ebola crisis.

Did it nevertheless career-wise help you?

Career-wise change took me to different roles but it was also hard. When I was elected as President I remember, before I had even taken up the role, reading on the train about Alan Milburn's changes in Shifting the Balance of Care and thinking "oh my goodness that is going to change the whole of the demands on the public health workforce."[12] We, the Faculty, had suddenly to move into being proactive - to get the multidisciplinary DPH agenda on track because otherwise we were going to end up nowhere. I spent most of my presidency on "Shifting the Balance." I made a decision that it was more important to do that than worry about Oxfordshire. Which I think was the right decision but some people in Oxfordshire weren't so happy I wasn't focusing on their futures but it was the right thing to do when the whole profession needed to be rebalanced.

You balanced the presidency with your DPH role?

I was DPH but because there was so much to do with "Shifting the Balance," I said I wouldn't be DPH and let someone else take the role and I moved to the academic side because I knew I would need a lot of time to do this work. I would need to lobby, to work

[11] Established in 1998 to distribute funds from the National Lottery to health, education and environmental causes

[12] Labour Secretary of State for Health who introduced the health service reorganisation moving from health authorities to Primary Care Trusts (PCTs)

with Ministers, I needed to work with the senior civil servants. I needed to work with the Regions. I needed to work with all the people on the ground. I ended up doing that rather than staying in Oxfordshire. Then the severe acute respiratory syndrome (SARS) became a major influence. In 2003 in my role as President I had been in Hong Kong to build relationships with Hong Kong College of Community Medicine because they were taking the Faculty exams and I was in Hong Kong when SARS started, setting up a Memorandum of Understanding and other various global links.

MAJOR INTERNATIONAL ROLE

Just after I finished being President I got the call saying did I want to be Head of the School of Public Health in Hong Kong? My jobs were all a bit bitty, I was on a lot of committees and I had a portfolio career which I on reflection I felt was too early or it was too early to sit in meetings for the rest of my life. My daughters were then in their twenties, my son at senior school and Ian thought it was a good thing to do so they said go on Mum, see what it is like, we will all come and visit you which is what they did. I went there initially for a couple of years but ended up finishing full-time employment ten years later, although I am still an Emeritus Professor there. I think that was the right thing for me to do. It took me away from UK public health and into knowing China and the Far East. That was all great fun, very interesting. Not always easy but interesting. I had more prejudice about being a woman in China but I was always different because I was white, I was a white woman so therefore I was always different. I expected to be treated differently and I didn't have my first language for communications. It was quite a good role to play - you had to recognise it and use it.

You are still doing international work now?

Yes. I think if you were to say to me what were the highlights of being in Hong Kong I would say I had a free hand in the School of Public Health to build it up. I was able to use all my past experience. We built up the MPH programme, we started a BSc in public health, we changed the career pattern for public health. We also published quite a lot. We have just brought out a book on global public health in Asia. We also got lots of donations in. The school is quite robust now. The best thing I did was employ the past minister who had to stand down because of SARS and he worked with me and has taken over from me. I still work with my colleagues at CUHK. I retired the end of December and I have been back four or five times since. They come over here. The vice chancellor still employs me as his senior adviser for international academic development and as part of this I am building links with Oxford and Cambridge Universities and Imperial College, London for exchange students. In the UK I am an Advisory Board Member of PHE and I chair the Global Health Committee for PHE. I am also working with Health Care UK.[13] So what I am doing now is using my knowledge of Hong Kong and China and my knowledge of the UK to try and bridge the two. I am working with Lord Darzi at Imperial.[14] Usual stuff really!

China was really interesting. Lots of people came to see me in China. People knew I was there and they would say I am just passing through, can I come and talk the students? I never felt out of touch. My family were coming and going; Ian was coming and going. I was often back in England.

[13] Government organisation which helps UK healthcare providers to do more business overseas
[14] Eminent London surgeon who worked with the Labour Government to review the NHS in 2008

And the future?

Ebola has made a difference to Public Health England. It stabilised it and has given it a real role. Being on the Advisory Board I looked at the first four appointees they were all white, middle class ageing men. I wrote to the CE and said they seemed short of women on the board and to let me know if they were advertising. I continue to challenge. I continue to challenge the Vice Chancellor in Hong Kong about all the men in the university upper echelons and am pleased to see some shift in latest appointments!

WOMEN IN PUBLIC HEALTH

Women have done well in public health but not many get to the very top. Why do you think this is?

That is problematic. Unfortunately when you look at world leaders you will see the governance of men. It is changing in some countries - there are a lot more senior women in France. The States will look different if Hilary Clinton gets elected. Things are beginning to change but it is slow. I think some of this is to do with women and their confidence; some of it is those women who succeed thinking if I can do they can and not helping other women, there is an element of that. There is still not enough child friendliness in the workplace and women wanting to have a better quality of life and men not choosing to make the same compromises or allowances. The opportunities are there but it is 45 years since Germaine Greer's work, it is a long time.[15]

It is not that women are not DPsH. In the eighties there were a lot of women in public health . The selection process can militate against women. It is a tough job. It is very hard to keep going. You have to be very motivated, you have to have a lot of confidence to believe you can do yet another job, you get tired!

What are your reflections on public health as a career?

For me it has been great fun. Going to China and seeing Hong Kong has been fantastic. It has been very hard at times but I have had an amazing opportunity to see China and Asia and public health has allowed me to do it. Public health is recognised as important in China. You don't feel public health is second class. The importance of control of infectious disease, for example, is a major political concern . Public health is a key to opening lots of doors. A great career to have. But you do have to be flexible and quite robust when necessary. No room to be precious. It is political and with politics you take the rough with the smooth. I think it is never going to be straightforward.

Women generally have done well in public health, why is this?

Probably their ability to multi-task. You have three domains of practice at any one point in time as a DPH even in the current structure. You have to be able to hold it all together. You can't be excellent in just one. There needs to be a balance between specialists and generalists - as a DPH you have to take a broad perspective and be able to balance things. I think public health is a caring environment, which women contribute to. You also have to work with a broad group of people in local government, NGOs. I think women are probably more tuned into that. In general they have less ego. You can't have an ego in public health unless you

[15] "The Female Eunuch," published in 1970

want it bashed! I suggest those are some of the characteristics. In public health you get buffeted by the politicians, by the consultants in hospital putting you down, sometimes by the public, the press; you can be buffeted on all sides. You need to believe in yourself and what you do.

Why haven't people looked at women in public health?

I don't know. All the public health heroes are always men! Which is bizarre really. Sally Macintyre in Glasgow, Margaret Whitehead in Manchester, Margot Jeffreys in sociology contributed a lot to the early thinking but they are not so celebrated.[16] When it comes to the history of service public health I can't think of one of us who is celebrated, even the women RDsPH. People would say it is easier to be a consultant in public health than other medical specialties, it is less demanding, remarks like oh you are only a doctor in public health. But they are extremely complex roles, difficult to do well. Because of constant structural change the role may not have a clear identity and that may be part of the problem. You are not a regional director for 20 years, you retire at each reorganisation.

Thank you very much for your time

[16] Sally Macintyre, Professor of Social and Public Health Sciences, University of Glasgow; Margaret Whitehead, Professor of Public Health, University of Manchester; Margot Jeffries, Professor Medical Sociology, Bedford College, University of London