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**Dr John Burton in interview with Max Blythe
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MB Dr Burton, you've spent a life, really, closely associated with health education and your name is, in some ways, synonymous with it, when you look into the documents of your years with World Health and the Central Council for Health Education. Can I take you right back to the beginning? When did you first become aware of health education and that it might have something in it for you?

JB Oh well, I didn't call it health education! It was as a medical officer of an infantry battalion in North Africa. And it was quite obvious that the fellows that knew a bit about diarrhoea, about what to eat, what not to eat, about VD and all the rest of it, were better off than the ones who weren't. My battalion was the Second Battalion of the Sherwood Foresters, a regular battalion, so everybody knew everybody, and the *esprit de corps* was very strong indeed. So that certain ideas, if they were placed in the right places, went round the battalion, and if it wasn't something crazy were adopted. I mean, they were prepared to receive advice on... on diarrhoea and diseases, for instance. So I can't say they were as keen to accept advice on VD, but...

MB But that had to be given?

JB At least they knew and they looked after each other. There was a lot of mutual support, very much more than I'd ever encountered before. And I think this was the long tradition of... originally, a bunch of miners, Geordie miners, joined the Army in the Thirties because of no work and remained a group knowing each other in India, and finally coming back to fight the war.

MB Was that really the time that you became hooked on health education, then?

JB Well, you know, the real justification for it became obvious.

MB But you thought that would apply to civilian life, once you'd moved on from war-time?

JB Yes. And... well, the same thing happened because, to some extent, I was a prisoner-of-war in Germany, and here again nutritional questions became exceedingly important and making the best use of whatever one had became extremely important. But, anyway, I was not particularly interested in clinical medicine. I thought clinical medicine was a wonderful hobby but a lousy profession. I couldn't see myself going back into the sort of commercial practice that pervaded when I left England. So I decided for public health, and took a DPH [Diploma in Public Health] course when I got back to England. And in that course, the health education part was really rather pathetic.

MB What did they say? What did they say?

JB Well, it was a formal teaching idea on one side, and on the other side... you know, mother schools and things of that kind, and on the other side, expensive propaganda, neither of which I thought were going to have much effect. I had the privilege and the benefit of taking part in the Army Education Corps's activities and they taught me more about modern educational technique than anything. They had everything wrapped up. They had discussion groups, they had dramatic presentations, they had... everything, and beautifully done. But, you know, when the war was over, I didn't see any of this brilliance of the Army Education Corps seeping through the schools or anywhere else.

MB And you'd had a very sterile course at the London School ...[of Hygiene and Tropical Medicine].

JB Yes. That was very poor. But as nobody, you know, it wasn't... no questions much were asked about it in the exam. Nobody bothered much. Well, it really wasn't until I got a job with the borough of Willesden, as Deputy Medical Officer of Health, and joined Dr Sam Leff, and one day he said, 'What are we doing about health education? Produce me a report.' And I found that a lot was being done in the borough, by nurses and one or two of the doctors in the maternal and child health clinics. And Sam Leff was a very imaginative and go-ahead person, and we invented all sorts of things for improving, for instance, the uptake of cod-liver oil and orange juice, which was the great thing at the time. And I remember saying to Sam, 'Would you go and collect cod-liver oil and orange juice if you were a citizen of Willesden?' And he said, 'No. You say, going off to a clinic, and then having to get the stuff there?' I said, 'Well, let's change it. If you want people to do anything, the first and foremost thing is to make it easy to do it.' So we introduced cod-liver oil and orange juice into all the grocers' stores. And in each grocer's store, the Health Department had a little stall at the end, and the shop-keepers knew exactly how to use it because they put it as far away from the door as you could get, and the mums with their babies used to come along, go all through the shelves and buy things on the way, get the cod-liver oil and orange juice at the end and then go off. We put the consumption up from something like ...We put the consumption up in about a month from... I think it was round the thirty per cent, up to sixty-five per cent of the people who were entitled, taking it. And this was purely making it convenient to do it. We didn't lecture them, or talk to them...

MB Simple strategies, yes.

JB It just made it convenient and easy to do it. And I think an enormous amount of behavioural change can be introduced without any education at all, but by making whatever it is that you want done, easy to do. And because so many people know these things. They know all about... they know about cod-liver oil, they know about immunisation, but they're lazy, and or busy, very busy. I had this experience in Africa time and time again, where various foreign enterprises would introduce, for instance, free milk for nursing mothers... nursing mothers and babies. But when you saw how they introduced it, it was in a sort of clinic serving an area of ten, fifteen kilometres. And I remember saying to a Swedish doctor, 'Would you walk fifteen kilometres in order to drink a glass of milk?'

MB Not on!

JB Not on! But it had never occurred to him that these African women had nothing else to do except walk fifteen kilometres there and fifteen kilometres back to drink a glass of milk! And I said, 'But, I'm sorry, these women are exceedingly busy people; they're looking after the garden and all the rest of it. You have got to give them the milk in powder so they can take it away.' 'Oh, but they'll sell it on the black market.' 'Then,' I said, 'somebody else will drink it. Well, what are you worried about? It's not your headache.'

MB So very early on that related to your time at the World Health Organization.

JB Yes. Yes.

MB From very early on, you were looking at the ways in which you could facilitate public health by simple manoeuvres?

JB By simple manoeuvres. And even immunisation could be made a great deal easier by studying the times at which people were available, rather than the times at which it was convenient for a nurse or a doctor to be in the clinic, which was the planning procedure for most of the work – it was convenience for the nurses and the doctors. But looking at it entirely from the mother's point of view, you've got a completely different time-scale, or schedule. And this, again, made it easy for them to... easier for them to do it.

MB John, these kinds of problems still exist. Why do you think they happen so often? I mean, is there a great lack of concern for the public interest and the public viewpoint? I mean, is this why medicine fails so many times to attract public support?

JB Yes. Well, if you only look at the committees which are set up, they are all committees of professionals looking after their own professional comfort. They are said to be experts: they are not experts at all. They may be technical experts, but they're not experts in the sense that a woman in Acton has to survive with a family of four. She's the expert on how to survive with a family of four in Acton, they aren't. They can possibly have excellent technical suggestions to make, but when it comes to a public service, the major study should be on the people using the public service and they should be represented in any committee.

MB Was this something you took particular note of when you were in Willesden?

JB Yes.

MB Did it enhance the development of that kind of practice, looking at the public, and designing for the public need?

JB Yes.

MB And you were there for how long?

JB I was... well, I was fascinated, actually. I was fascinated with the way in which people were solving their problems under very difficult conditions. You see, Willesden was a strange borough in which the population fluctuated between about 500,000 in the night, and about five million in the day – an industrial area as big as Birmingham. We had to study where people shopped. Now, some – the gentry, in the middle of Willesden – used to shop in the West End, never used the local shops – and then everybody else used to use the local shops. So we had to... I remember making maps, detailed maps, of where people shopped.

MB With a view to being able to put...

JB Put services on.

MB ...people in contact with the right services.

JB Yes. Or distribution of leaflets, or something like this. You had to... you had to know this. And...

MB What was public health knowledge, in terms of the real public, not public health specialists, at that time? Were you appalled by what you found among both the aristocracy of Willesden and the ordinary people? Were you appalled at what you found out? Or were you...

JB Well, I'm never appalled. You know, human beings are human beings. They never appal me. They just... I find it very fascinating that they think that's the way to do it, and it's never occurred to them, possibly, for a better way of doing it. And it certainly never occurred to the officials, either, that there was a better way of doing it.

MB But in terms of what you found though, you can't have been all that happy, otherwise you wouldn't have pressed for...

JB Oh no, I wasn't happy at all. But I wouldn't say appalled was the right word, more interested and fascinated that... you know, other people do things so utterly differently from myself.

MB I'm going to move towards the next step in your career, which is moving towards a national brief in health education, which was to go to the Central Council for Health Education after Willesden. Obviously, that was a formative experience.

JB Oh, very.

MB But you moved to a national job, obviously feeling that the pressure was to get involved in health education at the national level, very quickly.

JB Yes. Well, there I was very interested in the work in Willesden, enjoyed it... the council, the battles in the council, and all the politicking and suchlike that went on. I found that very interesting, and it was the beginning of the National Health Service and all sorts of interesting things were going on. And...

MB Did that make a big difference? Did you feel that that made a big difference to the...

JB There was a great feeling of enthusiasm. And then we had the infection... what was it? I can't remember what it was called now, but it's still there, I think. The Communicable Diseases Research Centre was in our area. And I also had the fascinating experience of being the Medical Officer of two handicapped schools – mentally and physically handicapped children. That was all in the Willesden operation, again, which taught me an enormous amount about education, because you had a problem there and you had to find some way of communicating. And the teachers in the educationally problem... the educational problem schools – the physical or mental – were the cream... the absolute cream of the teaching profession. And one could learn an enormous amount from them as to how to deal with...

MB What was the secret of this cream? Were they better communicators? Did they have more time to give to people?

JB I think it was motivation, that they really wanted to help these kids, and specialised in... I remember the headmaster of the mentally handicapped school, the IQs were around about the eighties – nineties, so they weren't desperate cases, and he was a rough diamond. I can't remember his name anymore, but a wonderful man. And one day he said, 'Would you like to come to the speech day?' I said, 'Of course I would.' 'Well,' he said, 'Wednesday next, and we're having the speech day.' I turned up; standing in his office, I watched motor car after motor car arriving, and I turned to him and I said, 'Who are these people? Are they the governors?' 'Governors,' he said. 'No, they're old boys.' So I said, 'Well, how come? They look really prosperous! Far more prosperous than you or I!' And he said, 'Yes. Go and find out. Talk to them.' He talked... he barked, actually, he never talked. So I went outside and took... got into a little group who were discussing it, and gradually worked the conversation round until I said to one of them, 'Well, what did you do at this school? Did you...' 'Oh, a wonderful school. The best school in... wonderful school,' you see. And I said, 'Well, what did you learn? Did you learn to read and write?' 'Read and write,' he said, 'Good Lord no! We pay people to do that!' Now, this was the key to education, to my mind, was that this headmaster had inspired self-confidence. These chaps had no feelings about being educationally below average, or being dull and backward. There was none of that feeling at all. They were aggressive, and one or two of them were in the timber business, doing very well. I mean, having become proprietors of businesses. But, you know, reading and writing: good Lord, no! 'I pay people to do that!' They thought it was some menial task, like the kings of the Middle Ages, thought exactly the same. They had a scribe who did this menial task of reading and writing. But it taught me that the essence of what a teacher should communicate is self-confidence.

MB Right. John, having had that experience in Willesden, of lots of things: going from handicapped schools, looking at the politicking there, looking at the shops, looking at the patterns of life among the people there, you then went to a very unusual organisation, the Central Council for Health Education, and you arrived there in 1948/'49?

JB '49.

MB '49. To be there for virtually ten years.

JB Yes.

MB That was a big step from health education in Willesden and looking at things on the ground there, to looking at the national pattern. Was that daunting?

JB Well, it was quite a different... one had to learn a new approach. In Willesden, I could do a practical approach and get things done. But in the Central Council, that was the big question, where do you start? And with my colleagues, we used to discuss this very frequently. How do we create an atmosphere in which health education becomes a normal activity of a local authority? And, fortunately, we were all very much of the same opinion, that the work of the Central Council should stop doing propaganda and start doing education through training courses, through refresher courses, through various practical exercises, which were within our power to organise.

MB These were courses designed for medical personnel? For professionals, paramedics, teachers?

JB They were for teachers of schools, sanitary... health inspectors, nurses and doctors, in the public health service.

MB Right. And they were courses designed to give them method, or to give them means and method?

JB Means and method. We started by going to see the Medical Officer of Health, having studied his annual report. And, you know, looking at it, and saying, 'Well, how come that the infantile mortality in Billstock is twice what it is in such and such,' you know. He'd say, 'Oh, we're very worried about it.' Well, I said, you know, 'Are you short of staff?' And he would... we would gradually work through his annual report finding all the problem areas. Most of them came out to be what I call 'behavioural medicine', that in order to change them, or to improve them, some change in behaviour was required of the population. So, finally, after having discussed all these things, we'd have a... discuss the questions which arose out of his report. We would then discuss which were educational problems and which were service problems and suchlike. And I always found that they got fascinated. They never looked at their annual report as to whether the problem was an educational one or a service one, or a... what it was. And they got fascinated. And then we said, 'Well, you know, Central Council could lay on a three-day refresher course for your nurses,' or health inspectors, or whoever it was. Smoke abatement, you see, was a big thing at that time.

MB Was immunisation still a big thing?

JB Oh Lord, yes. Very big thing.

MB Food hygiene?

JB Food hygiene.

MB Were there any more? I'd like you to spell out what were the big things at that time.

JB The big things that I can remember at the time were children in hospital, and we worked with John Bowlby on that.

MB What was this children in hospital? I'm still not with you on that one.

JB Well, the children in hospital – visiting by parents. And John Bowlby developed this theory that much mental ill-health later on, particularly the sort of alienation syndrome of babies who had been in hospital, was due to the isolation, the lack of parental care. And the hospital regulations excluded parents, and when you asked them why: 'Because they're bringing infection into the hospital.' Well, our reply was, 'Well, okay, the parents may bring in infection, which we can deal with. You are creating mental problems, which we can't deal with. And which do you choose?'

MB So you really spearheaded that major development in making hospitals more open?

JB Oh, absolutely, yes. Yes. I think we were as responsible as anybody. There was a film and... which really broke people's hearts, and it was useful. Then there was natural childbirth. We worked with Grantly Dick-Reed and shoved him round the country, and all these mothers' clubs and suchlike started.

MB The main messages being again?

JB Oh, the main message was... it started in UCH [University College Hospital], and the main message was that relaxation and lack of fear were the best preventives of pain in childbirth. And Grantly Dick-Reed was a sort of God-like fatherly figure who the girls liked. Then breastfeeding, we were very keen on.

MB Was it largely bottle-feeding at that time?

JB Oh yes, it was all bottle-feeding by the clock in those days. And we worked with the fellow at the Woolwich Hospital, who had achieved a sixty-five or a seventy-five [per cent] – I can't remember offhand – breastfeeding rate at six months, among girls who were working in the Woolwich Arsenal.

MB Which is quite some achievement.

JB Oh, a fantastic achievement! And he was one of the pioneers of reviving breastfeeding, and now it's become all the rage, all the fashion. Even the World Health Organization suddenly recognised that women have breasts and milk was in the breasts and this was for children. And...

MB Despite the work of Boudon(?) in Paris, and ... the work of ...

JB Yes. Well, you see, it didn't come from that angle, it came because one of the major diseases in the world today is enteric disease among babies. It's the major cause of mortality. And this was largely due to bottle-feeding, that the facilities for bottle-

feeding need to be very good, not just good but very good, in order for it to be safe. And these conditions did not exist in an African village. And breastfeeding was dying out, still is dying out, or, at least, decreasing in much of Africa and Asia because of the propaganda from dried milk, powdered milk producers – Nestlé and Glaxo and all the rest of it. And...

MB But there was a problem you were having in Britain in 1949.

JB Yeah. Yeah.

MB 1950, the same problem. You felt that babies weren't getting a fair deal, as far as... as far as their feeds were concerned.

JB Well, we thought it was... there were about three counts. Sir Ronald MacKeith, who was a very good paediatrician at Barts, had a bee in his bonnet about breastfeeding, but his bee buzzed immunity, lack of getting too fat, returning your figure, and the bond between mother and child, the sensual bond between mother and child. So that he had three main reasons. And the difficulty was to show anything really dramatic in a fairly well off country like England. Where it becomes dramatic is when you remove the money and people... and the facilities, and the... which people take for granted. But even so...

MB But it was a major priority of yours, in Britain in 1949?

JB For us, it became a major, major problem and this was one of the things we introduced into the educational programme. Then... those were, shall we say, the maternal and child health issues that we took up. Then there was food hygiene. The food hygiene in England at that time was appalling.

MB By what standards? I mean, can you give me examples?

JB By any standards. It was... it was largely the result of government decisions. They did not want to issue building permits. The industry... eating out had increased enormously with people coming back after the war. The premises were bought up by anybody, and you finished up with inadequate capital having been invested in a restaurant, and the washing-up, particularly, was dangerous. It was washed up in a... in a sort of minestrone of bacteria which had collected over the day. There was no refrigeration, so custards and things lay about in the warm kitchen. And I went all over Soho looking at what really existed.

MB Oh, that must have been terrifying.

JB It was pretty nauseating. And to think that you might have been sitting upstairs, paying a large sum of money for this bacterial soup...

MB But, on the other side of the coin, there were infections, and people were found to be suffering from them.

JB Oh yes. There were outbreaks and this was a public health problem. But it wasn't ... it wasn't ... there was no possibility of a local authority dealing with it

because they couldn't get the building licence. The Ministry of Health...the Ministry of whatever it was – I think, Ministry of Health – would not bring pressure to bear to get building licences improved so that the restaurateur could improve his premises. And so we... although we mobilised the Press and everybody, and finally got invited to sit on the Ministry of Health Committee of Food Hygiene. And that was a funny experience, because their experts had produced one hundred and twenty-two regulations. I was sitting there smiling, and took these one hundred and twenty-two regulations, and with my secretary, we went round Soho, with a completely solemn face, saying to the restaurant owner, 'The Ministry of Health is contemplating introducing the following regulations,' you see. 'How do you think it would go?' Well, to start off with, they didn't speak English, they spoke Greek, or Yugoslav, or Turkish, or some damned thing! And my secretary was taking down, in shorthand, verbatim answers from these chaps! And it was obviously a complete joke. So, again, very solemnly, at the next committee meeting, I read out the answers that we'd got from the customers...

MB No more vast list of...

JB Well, it was so hilariously funny that I think it was the first time the Ministry of Health Committee had had a good laugh because we had them absolutely verbatim, and the remarks which the restaurateurs made were... were fulsome and fruity! 'Ruddy Ministry!' you see! And anyway, we reduced them to twenty which we thought were essential. And we took them back to the Ministry and finally, after a long argument, they were accepted. And we said, 'There's no earthly reason to produce them in English. The English are a minority of the consumers.' So they had to produce them – these regulations – in Greek, Italian, Yugoslav, etc, etc, Spanish and Portuguese and... So we did.

MB What were the main things you were actually saying to people in the food trade, at that time?

JB Oh, they were simple things, like washing your hands, the temperature at which the washing water had got to be, changing washing water. They were simple things.

MB But that was necessary at that time?

JB It was absolutely. It still is. And then there was a separate pamphlet if you had automatic washing-up machines, but they were very few.

MB But that was a major campaign?

JB That was a major campaign and I'd say we must have sold something like five or six million copies of the leaflet.

MB Apart from restaurants, you were involved in the whole range of shops that might be serving food, things like that?

JB Yeah. Well, we sold the leaflets to – in the various languages – to the Medical Officer of Health of the local authority.

MB So it would go to the towns all over the country.

JB He would distribute them as he thought fit.

MB Was that good campaigning? Was that good campaigning? Were they good leaflets?

JB They were illustrated by Fougasse. I don't know whether you remember Fougasse?

MB Yes, I do. Yes.

JB Well, we got him to illustrate them.

MB Foremost cartoonist of the day.

JB Yes, cartoons. But he had a wonderful sense of humour, and he felt strongly about food hygiene and he gave his services free and so they were illustrated by him.

MB Do you think a lot came out of that campaign? I mean, do you think present food handling standards came largely from that period?

JB I think so. But the main thing which happened was to the Ministry of Health. They couldn't stand the bashing they were getting from the Press and they started to issue licences.

MB That's where that came in?

JB Mmm.

MB So that was the early Fifties by then? That was the early Fifties?

JB Yeah.

MB And you were moving on into other areas, because if I can just take you into the Fifties now, because we've seen how things were, and the priorities in the late Forties. When you went into the Fifties, things were starting to change. New things were beginning to raise their heads.

JB Yeah.

MB You were coming into a very... a very unusual... quite a unique time. Smoking was going to be found to be dangerous.

JB Yes.

MB Fluoridation became an interesting topic of debate.

JB Yes. Yes.

MB I mean, this was a most fascinating time. What happened then? I mean, you were in charge by then, at the Central Council.

JB Yes. Well, we thought... we never had the idea that the Central Council was going to do the job. We regarded ourselves as a small educational group, who would nowadays be called a management school or something of this kind, consultancy school. But we considered our job to train the teachers and the health workers, and we were able to lay on about forty sessions a year. When I say a session, it would be a course... a session would be in a particular locality. It would consist of a course for health workers – that's doctors and nurses – a course for health inspectors, because their problems were different, and a course for teachers from the local schools, of all grades. And we'd send a team of three, four people; they would change locations, leading discussions etc, and bringing up problems. But, very rapidly, we came to the conclusion that our educational techniques were pretty out of date and needed revising, and so we started to invent new educational approaches. And one of them was the problem-solving approach... that we didn't give them any answers. We set a problem, a real live problem, taken out of their Medical Officer of Health report, but written-up in a way that didn't infer that it was Bolton or Ipswich, but still the problem was there. And we'd put it to the class, group, right at the beginning. They would divide themselves up into small groups, they'd divide that problem up. We would help them organise the thing, then... that would be dealing with subject matter. Then we'd have sessions on technique – how do you actually run a discussion? What goes wrong? How do you get the most out of it? And then how do you come to a conclusion? And how do you ensure or encourage something to happen?

MB So you were engineering the facilitators locally?

JB Yes.

MB All across Britain?

JB All across Britain.

MB But not into Scotland, I take it, because that is a separate...

JB No. There is a Scottish Council. We worked with the Scottish Council from time to time; we would invite each other, mutually.

MB Was that the main job, this facilitating? Was that the main job of the Council? I mean, going out and doing courses with...

JB Yeah.

MB ...with people who were capable – local teachers, local public health workers – who were capable of carrying the messages on downstream?

JB Yes. Well, you see, the argument was so obvious to me. Here you have GPs, you have public health staff – doctors and nurses. You have quite a lot of GPs who came to our meetings because they were just interested. I said, 'These... this group is seeing far more people than ever are seen by a poster, and they're seeing them

intimately. Therefore, it's these people we should concentrate on, rather than sticking up some slogan on a wall, which nobody even looks at.'

MB What were the main messages in the Fifties? I mean, they're going out to educate. What were the main messages? Were they very different? Were you still... you were obviously still dealing with immunisation into the Fifties, but the new problems of, as I say, of fluoridation and smoking and air pollution, they were all the bigger issues of the Fifties, am I right?

JB Yes. Mental health was a very important part of our activities. We had a programme running over about four or five years, and...

MB With a view to?

JB With a view to acquainting public health workers with preventive mental health work, detection of early cases of breakdown, what the schoolteacher could do, what the health visitor could do. There was a lot of incest and all sorts of things that raised problems, and the nurses quite often hadn't a clue what to do, hadn't the faintest idea what to do. Sex education, also; they were, you know, textbook... and not dealing with it as a real problem, but dealing with it as a theoretical problem.

MB [Cyril] Bibby used to say, 'Plumbing and not relationships.'

JB Exactly! Well, we were concentrating on the relationships, and we produced a whole series of filmstrips based on real life situations in which the story is told. A neighbour comes in and says, 'Well, Mrs Smith, if I was you...' where it stops.

MB Stops.

JB And the commentator says, 'Yes, well, we know what Mrs Jones would do. But if you were in her boots, what would you do?' And it's then thrown over to the discussion.

MB Thought provoking.

JB Well, it was dynamite. Why they don't go on doing it, I don't know. But it was dynamite.

MB But that worked, and that got...

JB By Jove! We had... at all levels, too. It didn't just work among clinic mothers. I demonstrated them at a congress of psychiatrists in... I think it was Brussels. We had the whole of that group talking, solving the problem of this girl who wanted to go out every night, and after twenty minutes, I said, 'You do appreciate that you haven't mentioned... you haven't used any technical term for twenty minutes.' They all looked horrified! They were all talking about their daughter! But it works like... it works... Well, it was based on the theory, at least, my theory, that emotion is far more important than intellect when it comes to action. With the intellect, you can rationalise anything, but when you're feeling something, you act, or you run away. There is a definite outcome. Now, formal education completely ignores the emotional dimension. You

don't ask children how do they feel about London being the capital of England. Why shouldn't it be St Albans? But you never pose educational problems with the emotional content behind it. Now, if you go to Northern Ireland, you see that nine-tenths of the problem is an emotional problem, used by politicians, used by everybody, and that the actual intellectual content of it is very small. I think you and I have all sat on committees, and is the decision taken logically, on logical intellectual arguments? No, it's taken because they don't want to offend the chairman, or something of this kind. So we were very, very much of the opinion that if you're going to do education which results in behaviour change, the emotional component must be present. Well, these filmstrips...

MB Got right there.

JB Got right... get right under the skin. And I'm just producing a new series for... perhaps for the WHO, on how to train their representatives in... all over the world.

MB John, can I just take you along because, as I say, our time is limited and, therefore, I'm not being unsympathetic, I'm just trying to meet a schedule in time and I don't want to lose some other things, because your career has been very full. I want to go on looking at what you did in the Fifties – and I do know something about it, to have that privilege – looking at the way in which you went out to the schools and you brought a new didactic approach to health education in that time. It seems to me, worrying to be in 1985, right now, and to see how little sex education, how little, for instance, the fluoridation education issue has... how little that's progressed. What went wrong in the Fifties or post the Fifties, to prevent what you'd set off going anywhere in the long term? Or perhaps I've got it wrong, perhaps it has gone somewhere.

JB Well, I think you... again, one's got to be... to do some research to find out what has happened. You see, again, twenty-five years ago, there was nowhere with a fluoridated water supply. Now, I don't know how many there are...

MB Not many.

JB But there are certainly some.

MB Mmm, some.

JB The same thing applies to smoking and lung cancer. Twenty-five years ago, nobody knew there was any connection. Now everybody knows, and a large number of people have adopted no smoking. You can't make it a penal offence to smoke and so it must finally be a voluntary behaviour which people adopt or don't adopt.

MB So, to some extent, you feel gratified that there has been the degree of progress that's...

JB Well, I don't regard health education as medication. It's something which may take two generations. If you take family planning, for instance, 1985 has seen the pill authorised for girls under sixteen. Marie Stopes was talking about this in 1900, and it's taken how long? I followed, for instance, the diphtheria immunisation. Diphtheria immunisation was discovered to be effective in Hamilton, Ontario, in 1924. It took

four or five years to cross the Atlantic. Then Allen Daley¹ and one or two other people took it up, they were Medical Officers of Health, they said, 'We must do something about it.' And they, this group, formed the Central Council for Health Education. That was founded in 1925, I think. And then, if you follow immunisation, it dwindled, it was voluntary, and I think you may have had to pay for it.

MB And it wasn't popular, initially?

JB And it dwindled along, gradually before the war, it rose to about thirty nine per cent of children immunised against diphtheria. Then the war came, and a whole psychological change took place; people, you know, wanted to do things. And the health visitors were... I think it was [Wilson] Jameson,² who was [Chief] Medical Officer of Health at the time, and he made a... he harangued the public health services to do something about it. And, literally, within two years, the curve had reached...

MB I think it was eighty per cent.

JB It was eighty per cent. Eighty-two per cent, I think. Well, I don't think that a harangue by Jameson would have done it, unless there had been this long preparatory phase. It's the same with smoking and lung cancer. I think there's a long preparatory phase where people hear about these things, and they give up and they don't give up, and they go back and forth, and... but the knowledge and the uncomfortable feeling is there. And if some other dramatic thing takes place, they might give it up. And you come across people all the time, who say, 'I gave it up last week,' or 'I gave it up two years ago,' and they've stuck to it. But it is a...you can't compel people to do it. So...

MB But you feel that, as a result of all the work of health education in your time and before this development of the Central Council and the move to national... to inform the public, has resulted in a public who is intrinsically more healthy than... from their own... from their own kind of lifestyle standpoint?

JB Yes. I think there's no doubt about it. If you look at the infantile mortality figures and the various other things of this kind, there has been a vast technical input, but the making use of that technical input is what I'm concerned with. And you can easily make the technical input and get no results at all, if people don't use it.

MB But I'm not getting the feeling that you are depressed in any way about it, you seem to be feeling that it's gone at a rate that you've felt happy about?

JB Well, I think it's at a rate which is normal in human society. There are so many things. I mean, how long did it take to get reading, writing and arithmetic going? It took the best part of forty years building the schools, founding the schools, getting the thing going. And any of these major human changes take place over a generation. If you take size of family: my mother came from a family of fifteen; she had four and I had two. Now, this is three generations. It took two... three generations for the family size to reach reproductive replacement. And you see this happening in Africa, India,

¹ Sir (William) Allen Daley (1887-1969) Medical Officer of Health, London County Council, 1939-1952.

² Sir (William) Wilson Jameson (1885-1962) Chief Medical Officer, Ministry of Health and Ministry of Education, 1940-1950.

everywhere, that the original family was, perhaps, ten, and if you go to Zambia or Malawi now, and you ask somebody what a normal family is, they'll say, 'Well, ten or twelve.' And they think it's absolutely normal. And when I say, 'Don't you think that's rather a lot?' the reply from the minister of health, who was a woman, was, 'We like children.' Inferring that 'you Europeans hate children and therefore you're all for this limitation, having as few as you possibly can'.

MB So they're still coming through 1066 on your scale applied to Europe.

JB Yes. Yes. They'll change. But, at the moment, there's no great need for them to change.

MB John, coming back to change, towards the end of the 1950s, you were going to change and move on to the World Health Organization.

JB Yes.

MB I don't want to miss that part. Were there any things that you thought you missed in the Fifties – very briefly – missed in terms of achieving in health education, when you were at the Centre and had the power to do something about it? Was there anything that you missed that you regret about that period?

JB No. I don't regret because it's not in my nature to regret.

MB Right. So you don't think any opportunities were missed?

JB No. I got rather fed up with the Council because they got an economical bee in their bonnet and the programmes I put forward were not accepted on economic grounds. The chairman, Alderman York, who was chairman of the Sheffield Health Committee, and I resigned together. He said he wasn't going to preside over a bunch of misers. And I said, 'Well, there's no point in my staying here. Get somebody else who's prepared to work your little economic miracles.'

MB And so you didn't feel the financial support was coming in from the field...

JB Well, this...

MB ...to cope with what you wanted to do?

JB ...as you well know, there was a lot of monkey business going on at the time, with various committees, which my impression was that these committees were designed to somehow get rid of the Central Council because the Central Council had been a constant thorn in the flesh of the Ministry of Health. It was independently financed by local authorities; it had no compunction about running a campaign which went directly in the opposite direction to the Ministry of Health. It was forming a very large group of troops, sympathetic troops, in the public health services of the local authorities, and my feeling is, you know, central government doesn't like this sort of thing. And so a whole lot of committees were appointed, to my great astonishment because I felt, at the time, the work that the Central Council is doing, is very popular, it's going very well and what is all this inquiry that's going on? Why is all this inquiry

going on? And, you know, both Alderman York and I got the impression that there was some monkey business.

MB But at the back of that, government, you felt, was not wanting to spend money on a central issue of health care?

JB Well, they didn't spend any money on it, anyway. But they were prepared to spend Treasury money if they'd get rid of us.

MB What were they going to spend Treasury money on?

JB On putting great big posters up.

MB Going backwards...

JB Going backwards as fast as they could.

MB So the government resented health education but preferred health propaganda?

JB Yeah. Well, that was something they could control and it would never say anything which wasn't government policy.

MB Did they believe that that would work, that sticking up posters would be enough? Do you think they believed that, or was that just convenient?

JB I think it was this constant battle between local and central government. You've got it going on now, as between the Greater London Authority and the boroughs. If you can scrap the Greater London Authority, the boroughs aren't strong enough to make life difficult for the Ministry of Health, whereas the Greater London Authority, even in my day, the LCC [London County Council] was a power on its own. And if we could get Sir Allen Daley, who was then Medical Officer of Health for London, to agree with us, and he generally did, we knew the LCC would come in behind the campaign, and the Ministry would be left...

MB Flapping.

JB ...flapping, because we had the money. You know, I mean, the LCC would put in a thousand pounds, which, in those days was a lot of money, or £10,000 if they thought it was a good idea.

MB And that wasn't a good idea so far as the Ministry was concerned.

JB No. We had it, acutely, over the food hygiene, where we were... you know, definitely insulted by the Ministry, and they adopted every tactic to get us not to conduct that campaign. But among the local authorities, it was very popular because they were being besieged by their café owners and wanted to do something, but because of national economy, the building licences were not a good idea.

MB So out of that unpleasant climate at the CCHE, your resignation comes forward and you go off to do things on a... on a world scale now. Willesden, then national, now to World Health Organization.

JB Yes. Well, it seemed...

MB Still health education?

JB Still health education. It seemed to me logical. I get to the stage in any job where I say, 'I've done this job. Now we need to move on.'

MB Did they ask you to go there, or did you...?

JB The World Health Organization invited me, yeah.

MB Because you'd been a consultant?

JB I'd been a consultant several times, on holidays and suchlike, dealing with trachoma in the south of Spain, and then numerous health education committees and meetings and reports and suchlike, for WHO, and finally, the European Office of WHO asked me to come and be a sort of semi-permanent consultant. I said, 'Er... well, yes ... for a bit.' And while I was doing that, I got an invitation from headquarters, to become a permanent staff member of WHO and UN and... the temptation was very great. So I up sticks and go to live in Geneva.

MB But your brief was worldwide.

JB Worldwide, yes.

MB Covering under-developed countries, in particular.

JB Everything. Everything. And we had meetings in Russia, Poland, in Europe, all the countries of Europe, one in London ...

MB When you look at the division, though, between the developed and the under-developed countries, there must be entirely different requirements in health education.

JB Well, there are, but not a difference in approach. I think, whether you're working in Manhattan or in Samoa, the approach is the same. You still need to find out about Manhattan and you still need to find out about Samoa. The approach is the same, and, you know, the idea that we understand Manhattan, or Willesden, or any of the places we have been talking about, is nonsense. You've got to understand them in relation to a health, to a particular health problem. And so you define what the problem is. The Americans are very keen on starting off by asking the population what problems they have. And I remember asking this question in Yugoslavia, and the answer was, 'We want the road repaired. We want a better supply of alcohol in the local village shop, and we want a decent health, a decent doctor in the village.' Well, okay, these were perfectly reasonable...

MB Aspirations.

JB Yes. But they don't correspond to an objective need. But with a good report from a Medical Officer of Health, or a survey, you can get objective needs. And then if you can marry the objective needs with the felt needs, you can say, 'Well, here is a problem which is both important, public health-wise, and important to the local people, let's tackle that one'. But then you have to find out, and you spend quite a long time talking to everybody... I remember, in that same job in Yugoslavia, the government had had a huge campaign for latrines, and the headman of the village said, yes, they had the best latrines in Yugoslavia. Would I come and see them? Well, there they all were, painted with flowers and geraniums outside, and I looked in and they'd obviously never been used! So I said, 'Well, those are very, very fine latrines you showed me.' 'Oh yes,' he said, 'They're the best in Yugoslavia.' And he said, 'People come all the way from America to see them.' Isn't that lovely! And these are all the visitors! 'Yes,' he says, 'They must be the best if people come all the way from America to see them.'

MB But never used?

JB Never used. No, you couldn't use anything as beautiful as that. And he had never... I mean, he had... he considered them, as many village people do, as symbols, you know, like the size of a church, or... or anything else. It's a symbol. And these latrines were a symbol of health.

MB And in the under-developed countries and less privileged countries, there must be hosts of anachronisms in similar contexts.

JB Yes.

MB But what do you do about that, though? How does World Health organise anything to combat that?

JB Well, again, the World Health operates through assisting the local government in planning something, in identifying the problem, planning how to deal with it, and training the staff, or getting the staff trained to do it. I mean, the staff training may involve local courses of the health staff, or it may involve sending people away on fellowships for a year or two, to study in a foreign country. And England used to receive quite a lot of fellows coming to the Health Education Diploma Course in London. So WHO has no means of compelling anybody to do anything.

MB It's an advisory body.

JB It's an advisory body to the government. But there is a bit of arm-twisting that can go on because at the Annual World Health Assembly, decisions are taken by all the country members, such as, for instance, the fight against malaria. You can't do it on a country-by-country basis. Smallpox, the eradication of smallpox couldn't have been done on a country-by-country basis, it had to be a worldwide decision. And then the representatives of WHO and the staff members of WHO can go to a government and say, 'Your government voted for this at the World Health Assembly, therefore you must do something about it.' And it was there... it was an astonishing achievement that smallpox, a devastating disease, was eradicated from the world in nine years. In an incredibly short period. You know, when you consider that you've got to get

vaccinators up to the top of the Himalayas and down into the jungles of Brazil and... it's an amazing achievement. And if nothing else, if WHO have never done anything else, the contribution which that made to the world, to the world health, in terms of eradicating smallpox, and economy, in terms of abolishing the need for any of the services connected with smallpox, has amply paid for the whole contribution of everybody since the beginning.

MB What about things like malaria, which is still a persistent problem?

JB Well, it's a...

MB Massive campaigns today, including health education?

JB My own feeling was that the health education was never properly done. We never managed to get hold of a substantial portion of the budget, nor a substantial portion of the plan of operations. A friend of mine who was at the receiving end, said it was like a bunch of six-shooters, of cowboys with their six-shooters, loosing the spray-guns off in all directions, but there was no understanding on the part of the people at all. And, on the whole, resistance, because they didn't like their houses being destroyed with this spray and many of them just plastered them up again, after the spraying... had left ... or painted over it.

MB Neutralising the effect.

JB Yeah. And I think it was these hell bent enthusiasts thinking that because they've got DDT, they had the answer. But many of us told them, time and time again, 'You haven't got the answer. You're dealing with a mosquito and a mosquito is much brighter than you are.' Here you've got to enlist the population on your side and use measures which appeal to them. Well, the measures which appeal to the population are things like larvaciding and... but spraying a house is anathema. So... and they, you know, they have all the same superstitions that if it kills mosquitoes, it's going to kill the children too, who touch the... And when they see the cats and the rats and the things dying because they've eaten the mosquitoes, the dead mosquitoes, then they think it's dangerous, thoroughly dangerous.

MB And this situation still persists?

JB Yes.

MB So there is this ignorance preventing progress.

JB Yes. And... but the ignorance, I must say, I'm on the side of the local inhabitants. I think it's the experts who are ignorant.

MB Unless you get more knowledge of what's happening on the ground...

JB Yeah. Well, they should know a great deal more about how people behave, what motivates them, what they're likely to do and not likely to do. Not say 'DDT is the most effective way of killing a mosquito, therefore we'll use DDT.' This is nonsense public health. And WHO fell for it.

MB John, one of the things that you have said, and I'd like to just come back to, you were saying that you don't think they invested enough money. Apart from ideas in the right direction, you felt that World Health Organization might not have invested enough money on the health education side of the job, to make it effective. Am I right in following that up?

JB Yes.

MB So, nationally, in Britain there was this. Is there an international starving of health education by central bodies failing to give it the funds it needs to overcome the first hurdle?

JB I think so. I think the majority of authorities are still bewitched by so-called experts, and they're all technical experts, they're not social experts. And so they pour the money out to technical experts and starve the social experts. It's going to be very interesting to see what they do with this new disease of AIDS. Here is a disease of behaviour. It's not only a disease of behaviour, it's a disease where they have no treatment or cure, or prevention. So the only single element about the disease is behaviour, that they could deal with. I'm perfectly sure you'll find ninety-five per cent of all the money is spent on technical investigations about immunity and all the rest of it – very necessary – and perhaps four or five per cent on the behavioural aspects of it. And that's it. And it's a beautiful example because it is the only aspect of AIDS about which anybody knows anything.

MB John, I'm going to ask two final questions that I think might be challenging, but are absolutely right to address to you. One, if you were in the position of wielding the money, you'd change it all round, I take it? Can I ask, what would you do immediately to change the situation in the next ten-year programme? What would be the first thing that you did? Away from the theory, but in actual practice, internationally, what would you do with the money if you had it?

JB I would insist on plans of operations containing a complete plan and evaluation scheme for the educational component. That will require money and... but it will also require training. And I think a lot of money should be spent on... working out training methods for technical experts, so that they become as interested in the behavioural problem...

MB The social context.

JB ...as they do in the technical problem. My main hobby-horse is...

MB So, in some ways, you wouldn't be terribly disturbed if people stopped doing health education for ten years and actually got trained and prepared for where they were going and ready to do the job?

JB Yes. But I think you need the pressure from both aims. I think you need the ultimate authority, or whoever it is, to say, 'Sorry, we do not pass your plan of operation. It does not take the local population into account. Take it away and re-do it.'

MB But all this design period could be in the ten-year period I'm thinking of, and one could be starting to get the dialogue going towards a new future.

JB Oh yes. Yes.

MB But health education permanently seems to be hung up on the wrong racks and can't get off to a new start.

JB Yes.

MB And that's what I'm thinking. You'd agree with that?

JB Yes. But you would need a very powerful and... a Medical Officer of Health who knew what he was doing. You could make all the silly mistakes if you weren't well versed in the matter. So I think the two sides of the coin are training and education, and I would include the Chief Medical Officer and his staff in the training process, because they've never looked at health situations, with giving the social component, or the behavioural component, the same importance as the biochemical, or the immunological, or whatever it is. And all these other technical aspects have waltzed away with the money and the wretched social aspects have been totally neglected.

MB Even coming back now to your time-scale, which is more generous than mine – I'm probably more impatient – but coming back to your time-scale, with health education moving along, achieving things, going along, do you feel that at the end of the day what is going to be needed, though, is for health education to become part of education proper?

JB Yes.

MB So that it's an automatic part of everybody's birthright to go through an educational process that talks about health.

JB Well, it's inconceivable to me that after Alexander Pope, some three hundred years ago, said, 'The proper study of mankind is man,' nobody's taken the slightest notice of it. In my day, sex was the sex life of the earthworm. Very interesting animals, earthworms, having...

MB I think they're going as far as rabbits or frogs now! But they've not moved on to humans.

JB Yes, well, it's strange that it is not a proper study. But one needs to find out why it is not a proper study. What are the prejudices that need dealing with? And...

MB This goes right back to your social anthropology, your observation at field level.

JB Yes. Observation at field level is the thing which has got to be... got to be reintroduced. And this is where I think the handing over of the Health Council to... the Central Council to the government, was a disaster. But they believed in Madison

Avenue, and I don't think it has any effect at all. It is rather like the poster... very rarely do they understand what the poster is meant to be saying. And this even more so when this goes on in countries which are unaccustomed to looking at pictures anyway. There you get a total misconstruction of what the picture is all about.

MB John, that's where we're going to have to leave it for now. But it's a depressing picture to feel that many of the pictures are not being seen. Many of the pictures don't have the right message. And many of the people producing the pictures have never actually looked at the real world. Is that what we're saying?

JB Yes. Yes. Or the people looking at the picture may get the exact opposite message. If I could just give you one example from India, where I asked a lot of people, what did they think of this poster about family planning? Now, here was a poster with a mother, father and two children, all dressed up, you know, in their Sunday... go to meeting clothes. And the next poster was a family of eight or nine bedraggled looking children. And I just said, 'Which would you choose?' They all chose the bedraggled ones. They said, 'These poor people have only got two children.'