Abstract This paper discusses the work of Raymond J. Donaldson, who served as Medical Officer of Health (MOH) on Teesside in the North-East of England, 1968–1974, and the professional strategy that he adopted during this period is characterized. It is shown that Donaldson effectively withdrew from areas where the local authority public health department and general practitioners offered the same services, and consciously sought the complete attachment of some grades of staff to general practice. This approach, which was based on the view that in the long term the local authority could not compete successfully with general practitioners, allowed him to develop other activities, notably in the area of action research. ‘Progressive realism’ will be suggested as a suitable description for Donaldson’s professional strategy during his time in Teesside.

Keywords: Medical Officer of Health, health centres, Teesside, screening

Introduction

This paper, like the one to which it forms a sequel, is about the past professional strategies employed by leading local authority public health professionals. In particular, it is concerned with the relationship between public health and primary care, explored through the career of Raymond J. Donaldson, MOH on Teesside in the North-East of England, 1968–1974. As pointed out in the previous paper, this is a topic of current interest in the light of recent moves to enhance the role of local authorities in public health, and to integrate public health and primary care in England and Wales.1

Donaldson, who became known as ‘Paddy’, was born in Northern Ireland and trained as a doctor at the University of Belfast, qualifying in 1943. He took a DPH in 1948 and served for a year as assistant MOH for the County Borough of Middlesbrough. After two deputy MOH posts he became MOH for Rotherham in 1955, where he remained until he moved to the newly created County Borough of Teesside in early 1968 (Ref. 2, Chapters 1 and 2). (It will also be of interest for readers to know that R. J. Donaldson is the father of Liam Donaldson, Chief Medical Officer at the Department of Health since 1998.)

As was pointed out in the paper to which this is a sequel, the abolition of MOH posts in 1974 has been regarded as partly due to the demoralization of MOsH and their failure to adapt to changing circumstances.3 One circumstance was the decline in the importance of the prevention and control of infectious diseases, which had been central to the original remit of MOsH. However, in the case of the ambitious MOH such as Donaldson, these changes could be a spur to creative thinking. By the early 1960s, Donaldson’s department at Rotherham was well known and well organized, but, as he explains in his memoir, he was beginning to have doubts about the future of his specialty: ‘by the early 1960s, the medical scene had begun to change and an age of disillusionment was beginning to emerge … In general, the belief was that the flickering flame of infectious diseases would soon be extinguished for good … the public health service seemed somewhat less important, and many doctors had come to regard it as a dull and dreary discipline’ (Ref. 2, p. 122). Donaldson links this feeling to a ‘search of a new challenge’, which led to his fame as a pioneer of the application of new technology to preventive medicine, in the form of innovative screening services.

The idea of screening for presymptomatic disease was not a new idea among MOsH. Arguably, it was largely an extension of the principle of the medical inspection of schoolchildren, a statutory responsibility of public health departments since the
early twentieth century. J. L. Burn, MOH for Salford, for example, embraced the idea in 1951. The screening programmes of the 1960s, however, were more technologically advanced. This was a period when the government’s stated objective was to invest heavily in building new hospitals where the most technologically modern facilities would be provided (Ref. 4, p. 27). In these circumstances, it is not surprising that some public health professionals who sought new roles should base their hopes on the deployment of technology. According to Donaldson, however, his initial foray into screening was inspired by the suggestion of an assistant, and a statement by Charles Best, one of the discoverers of insulin, who was touring Britain at the time. Best claimed that there were half a million undiagnosed diabetics in Britain. Donaldson’s screening service led to much press attention, national and international recognition, medical controversy, and questions in Parliament. By 1966, with the approval and co-operation of NHS staff and general practitioners (GPs), 5700 people took an average of five of 10 tests offered in an annual screening exercise. Rotherham’s room-sized computer (usually used for salaries and wages) was employed to assemble and analyse the results (Ref. 2, pp. 122–124). Despite this apparent success for local authority public health, however, by December 1967 Donaldson had concluded that the next stage in the development of screening should be ‘much more closely related to the family doctor service’. By this time he had accepted an appointment as chief MOH of the newly created County Borough of Teesside and was about to move there in January 1968.

Public health and general practitioners

Donaldson’s thinking about the future of screening signals a recognition of trends in ideas about modernization of Britain’s health services. Debates of the 1950s about how to integrate the roles of GPs and MOsH around family medicine gave way, in the 1960s, to attempts at the level of national policy to stimulate the development of general practice (Ref. 4, p. 42). In 1962, prefiguring the eventual fate of the MOH, the report of the Medical Services Review Committee suggested that ‘the preventive and personal health services can only be effectively integrated with the family doctor and hospital services by transferring them … to the area health boards’. In 1963, a sub-committee of the Standing Medical Advisory Committee saw the GP as pivotal in co-ordinating resources and combining prevention and treatment of disease. It emphasized the need for suitable premises and adequate equipment and ancillary staff for GPs. Co-operation with the public health service, it was suggested, would be best secured by the attachment of local authority nurses, midwives and health visitors to individual practices. In 1965, in ‘A charter for the family doctor’, the British Medical Association suggested changes in GPs’ pay and contracts, and in 1966, after the seventh report of the Review Body on Doctors’ and Dentists’ Remuneration was published, negotiations over GPs’ contracts were concluded. Changes introduced included the payment of 70 per cent of the salaries of ancillary staff and the reimbursement of the rents and rates of practice premises.

These pronouncements and changes tended to enhance the prospects of GPs and diminish those of MOsH. GPs were set to become ‘king pins in a hierarchy of dependent occupations’. However, the changes at least made the possibility of GPs’ surgeries being housed in local authority health centres more attractive, as they could now claim the necessary rent. This would allow MOsH a new opportunity to come to terms and cooperate with GPs. The construction of such centres was possible under the legislation that established the NHS, but few had been built, because of obstruction by doctors and their representatives, financial limitations, and especially a lack of leadership from the Ministry of Health. The situation was recognized by the MP for Middlesbrough, when he opened a maternity and child welfare centre in 1965. He deplored the fact that the centre did not incorporate local GPs: ‘With the tremendous advances in clinical medicine, it strikes me that doctors are rather expected to practise in an isolated … environment away from the available services. Part of the trouble is financial, but a great deal of it is a human problem of getting different kinds of professional people working together to provide the best possible service.’

In Stockton-on-Tees, however, a health centre had been opened in 1962 that provided a suite of rooms for a local practice. But there was no contact between the local authority staff and the GP who used the building. GPs felt they were in competition with local authority services, a competition that they were winning, so there was little reason to co-operate. Attendance at local authority clinics had been in decline since soon after the establishment of the NHS, when the same services became free from GPs.

An alternative approach to the integration of services was the attachment of local authority staff to group practices, as suggested by the Standing Medical Advisory Committee. This was pioneered in Oxford, where all the health visitors were attached to group practices between 1956 and 1965. The arrangement spread elsewhere, unevenly and to a limited extent. In Middlesbrough one problem was that health visitors worked in distinct areas but following slum clearance and the development of new estates, ‘every firm of doctors’ had patients in ‘every district of the town’. However, the new GP contract increased interest in the scheme. The new financial arrangements encouraged GPs to move into rented accommodation where space could be made available for the local authority staff. It was the recognition of the trend towards the concentration of services under GPs that was behind Donaldson’s view that the future of screening lay with them.

Donaldson on Teesside

Teesside County Borough was created from six smaller authorities: Middlesbrough, Stockton, Redcar, Eston, Billingham and Thornaby-on-Tees. A shadow authority was elected in 1967 in preparation for the take-over in April 1968. Competition for the
Donaldson was then selected from eight applicants. After he arrived on Teesside, Donaldson had three months to plan the new department, and one of his first goals was to establish good relations with the GPs. Immediately upon taking office he started discussions with them about attachment and health centres. As a result, the local Medical Committee for Teesside adopted a plan for the attachment of local authority nurses to GP practices. Donaldson explained in his first annual report: ‘The attitude is that we should co-operate fully with GPs. The Department should provide supporting services that are complementary not supplementary to general practitioners. As far as is possible the object should be to provide the service in the way that is most suitable and convenient for the individual general practitioner.’ Donaldson promised his staff would review the amount of ‘treatment’ they carried out with a view to withdrawal where the work could be provided by GPs. This strategy won Donaldson wide approval. One GP sums up the views expressed in nine interviews with Teesside GPs: ‘1969 was a take-off point; Paddy Donaldson who took over for Teesside really revolutionized practice – he just devolved the whole of public health into practice – I don’t know what he was left to do himself.’ This GP, however, may not have been aware of the new roles that Donaldson was in the process of developing, which will be discussed below.

The implementation of his plans depended upon Donaldson being able to assemble a team of like-minded senior staff. Some of the nursing officers ‘held a jaundiced view of GPs and regarded the need for co-operation as a low priority’, but many were near retiring age and with a little persuasion were happy to leave (Ref. 2, p. 149). By the time of writing his annual report for 1969, Donaldson was able to report that ‘virtually all the local authority nursing staff are now working in integrated teams with the family doctors to provide a modern concept of primary medical care’ (Ref. 22, preface). These changes anticipated the Green Papers on the Health Service of 1968 and 1970, which preceded the legislation implemented in 1974.23,24

Forward-looking group practices first received district nurses and midwives into their premises, to work solely with practice patients. The district nurses were given treatment rooms and were able to see patients in the surgery, reducing home visiting. They became very busy, carrying out more procedures than before attachment. The GPs found the practice could extend the services provided, and that face-to-face contact with nurses produced a better understanding of each other’s roles.25,26

Donaldson used district nurses and midwives to pave the way for the introduction of health visitors into practices. Doctors had long found the work of health visitors more contentious, because of the competition between the local authority clinics staffed by health visitors and their own services. Doctors resented health visitors especially when the advice they gave conflicted with their own. But the GPs on Teesside who accepted health visitors found they could be useful, not only because of their statutory contact with new-born babies. They could also help with the ‘handicapped’, ‘mentally ill’ and elderly people. Donaldson encouraged GPs and other staff to reflect upon what was happening by organizing two conferences entitled ‘Teach-In on Team Work’, which took place in the summer of 1970 in Stockton and Middlesbrough. However, there were signs of some residual tensions. One health visitor who spoke at the event suggested that health visitors rather than GPs could assume leadership of primary care teams.27

Alongside the attachment scheme, a programme of health centre building was instituted. Donaldson’s report for 1969 stated: ‘the principle of the long-term benefits of Health Centres should be allied to the concept of attached nursing and ancillary staff working in a team with the GP at its head’. He commented that the health centre opened in 1968 in Thornaby marked the new era of integrated care for Teesside (Ref. 22, pp. 20–21).

The Thornaby health centre, however, which had been planned before Teesside County Borough was created, was beset by problems: As one GP commented, the designers ‘didn’t seem to have much of a clue about general practice … There was not enough room for nine doctors. The building was inflexible – the population was planned to increase at Thornaby so the centre needed to expand. The examination rooms were too small and very stuffy during the summer.’28 There were additional problems. The centre housed two practices with a shared reception area and competition became intense. Many new patients would present themselves at the first reception desk that they came to, to the advantage of that practice. As the receptionist explained ‘There were a lot of capitation fees involved so … it was very strained’.29

Donaldson became determined that the new local authority-built centres would not repeat the same mistakes. He realized that if centres were designed primarily for the GPs rather than the local authority, the GPs would embrace them more enthusiastically. Even though the eventual fate of MOsH and local authority public health departments was effectively sealed by this time, these design problems were not obvious to the Department of Health and Social Security (DHSS – the successor to the Ministry of Health). Their 1970 design guide for health centres still gave most prominence to local authority public health space. Donaldson lobbied the DHSS to approve new designs that acknowledged the wishes of GPs, and accepted the priority accorded to the GP by the general public. The new centres also had separate areas for each group practice (Ref. 30; Ref. 31, p. 32).

At the same time as introducing the attachment schemes and the health centre programme, Donaldson established a research unit staffed by ‘young graduates with knowledge of research techniques and a sense of mission’. The research team grew to 16 members, some of whom were funded from outside sources. The work was intended to be ‘action research’, aimed at his own department, and was frequently linked to Donaldson’s broader strategy.30 The unit carried out, for example, projects concerned
with patient activity at health centres. One looked at the uses made of the health centre at Thornaby (Ref. 31, p. 21). These surveys were used to reinforce representations to the DHSS over health centre design.

When research into the use of the local authority infant welfare clinics on Teesside was conducted in 1971, it was found that a majority of mothers preferred to consult their GP rather than a clinic doctor or health visitor.12,23 (In contrast, Cartwright found from her research in 12 areas of England and Wales conducted during 1964 that attendance at GPs’ special clinics for young children was poor, even taking into account the fact that only 40 per cent of GPs held them.24) Such findings helped Donaldson in his programme of clinic closures but he nevertheless needed to employ stealth: ‘The introduction of health centres made infant welfare clinics redundant. With some alarm I had watched banner-carrying members of the public protesting at the closure of small hospitals and their functions being absorbed into a new hospital. To avoid a similar crisis with the surplus clinics, their maintenance was allowed to dwindle so that, for example, suddenly in the middle of winter, the heating would fail and mothers and children would be directed to the nearest health centre. Then the clinic was quietly closed with no fuss’ (Ref. 2, p. 167). In his 1969 report, Donaldson commented that the importance of the new Thornaby health centre lay in ‘the complete co-ordination under one roof of GP and local authority services’, but by that time the Thornaby GPs had already taken over most of the clinics formerly organized by local authority doctors – infant welfare, immunization, antenatal and cervical cytology (Ref. 22, p. 21). The pattern varied at different centres that were subsequently established, but besides the clinics just mentioned there were continuing local authority school health and dental, family planning and mental welfare services. And having successfully established the attachment schemes and the health centre building programme on Teesside, Donaldson hoped to re-engage with work on screening.

The 1966 screening clinic in Rotherham had been the subject of a study published by the DHSS in 1969. The conclusions, however, were not conducive to the further development of screening services along the lines that Donaldson had pioneered. One-third of the clients of the Rotherham clinic, it was revealed, did not even live in the borough. There were twice as many women as men. They tended to be of higher social class status and frequently attended because some symptom was worrying them – in which case the clinic served the purpose of an ordinary consultation rather than early detection. In short, the DHSS concluded the Rotherham scheme was costly and unproductive. Donaldson’s continuing aspirations regarding screening can be seen from a report in the local press in June 1969, when he was said to have ‘ideas to make full use of the advantages’ of health centres: ‘The centre would be equipped with machines called diagnostic aids which will be manned by nurses or even technicians. Each patient would be tested by them to see if, for example, their lungs are functioning properly, or their heart beats are regular, before they see their GP.’16 His annual report for 1971 envisaged that local authority staff would screen patients at health centres and provide patient profiles to save the doctor’s time and help with diagnosis. He suggested training of nurses in the techniques of ophthalmology and audiometry. Such tests were already offered by the school health services within the centres and could be extended to the practice population, a principle that was subsequently implemented, but only to a limited extent (Ref. 31, p. 31; Refs 37, 38).

Donaldson failed to fully convert his vision into practice for a number of reasons such as pressure on staff time and his own involvement in other activities. He became ‘Secretary of State Teaching Fellow’ and was charged with organizing courses that aimed to prepare health staff for the changes of 1974 (Ref. 2, pp. 181–182). Reflecting on his career in the closing paragraphs of his memoir there is a hint that he regretted a lost opportunity: ‘Looking back to the 1960s, I find it extraordinary that the colossal surge of enthusiasm for screening, exhibited by both the media and public, should subside so quickly and dramatically’ (Ref. 2, p. 213). In 1974, with his teaching and research experience, Donaldson was well placed to survive the upheaval, and took up an academic post at the London School of Hygiene and Tropical Medicine (Ref. 2, p. 187).

Discussion and conclusions

Returning to Welshman’s question ‘watchdog or lapdog?’39 referred to in the earlier paper, it might be suggested that from the point of view of the local authority public health service, Donaldson’s strategy could be characterized by the latter category, as he effectively gave up the struggle between MOsH and GPs, and collaborated with government plans for the future. There is some indication that some professional colleagues regarded him as ‘letting the side down’, effectively selling out and hastening the decline of local authority public health (Ref. 2, p. 167; Donaldson’s remarks on this point, however, are concerned solely with the ‘warm welcome’ he gave and the co-operation he established with the Director of Social Services when the new social work department was opened in 1971). On the other hand, it might be suggested that Donaldson’s work on screening was an attempt to introduce a new ‘watchdog’ role. However, the most appropriate conclusion from this study is that more subtle characterizations of strategies of MOsH are required. In contrast to MacQueen in Aberdeen, whose strategy was characterized in the earlier paper as ‘innovative traditionalism’, we suggest the forward-looking stance of Donaldson on Teesside in the late 1960s and early 1970s, a time when trends in national policy were unmistakable, might be termed ‘progressive realism’.
The cases of Donaldson and MacQueen show that, as Welshman suggested, 'local studies' can enrich our understanding of the activities and fate of the MOH. We, in turn, suggest that the next step should be a more comprehensive comparative study, examining a range of MOsH, focusing upon their biographies, careers, theory and practice, and their interactions with each other, local authorities, government departments and government policy, and the public. The current comparison also suggests that the characteristics of MOsH in England and Wales and in Scotland might be usefully included in any such study. Finally, although the empirical research methods of the historian should be the basis for such research, the potential for the deployment of sociological theory in the analysis of activities and strategies of MOsH should also be considered. Here, the five 'adaptation modes' defined by Merton — conformity, innovation, ritualism, retreatism and rebellion — would seem a promising starting point.40 (The authors thank Pamela Abbott for this suggestion.) From the point of view of current policies, which are encouraging the reintegration of local authority and NHS public health (see the brief introduction to Ref. 1), such historical-sociological explorations may provide both inspiration and warnings.

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27 Donaldson RJ. Teach-in on team work. Middlesbrough: Teesside Health Department, 1970: 12.
31 RMOHT for 1971.


38 Interview, December 1997, district nurse who moved into a health centre, born 1936.


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