Interview with Dame Rosemary Rue
Christopher Cook

Rosemary Rue grew up during the Second World War. Born in south London, like many children she was evacuated to the country during the Blitz (to Totnes in Devon) where at the age of 11 after a serious operation and year long bed-bound convalescence she began to think about a career in medicine. She returned to London and when the war was over began her medical training at the old Royal Free Hospital in Gray’s Inn Road, which had played a great role in encouraging women to take up careers in medicine.

The Beveridge Report and the coming of the NHS

Health and social services in Britain were about to change decisively. The Beveridge Report envisaged a new set of arrangements for the nation’s health and its welfare. ‘I remember very clearly the publication of the Beveridge Report, which was the beginning of the welfare state. And this report was in everybody’s hands—on the trains and in the buses. We had several copies at home; my relatives were all reading it. It was a phenomenal piece of government publication really and everyone was talking in quite substantially thoughtful terms about what might or could be done for the post war period.’

Rosemary Rue had already seen the poor living and working conditions in the inner city that could lead to poor health. It was ‘partly just from observation in south London. There were quite a few poor families around. But one of my aunts was keen on social work and she ran a Guide Company in Stepney. I went with her very often at weekends and also for summer camps and mixed with some of the girls with whom she was working through this Guide Company. And these girls, before I had even started doing my serious work at school, had left school and gone into the then ‘sweat shops’ of the rag trade in that part of London. … And I saw 14-year-old girls already ground down with industrial injuries. So I did have some idea—I saw where they worked, I saw their homes. And it was really my aunt who showed me how the other half lived. [When I decided to become a doctor] one knew that there would be a range of patients and that most of the patients one saw would not be even in our modest middle class circumstances, that they would be probably very disadvantaged compared with me. I was aware of that.’

The National Health Service came into existence on July 5th 1948 while Rosemary Rue was still training at the Royal Free Hospital. ‘What I remember very much was that … everyone outside the medical school was talking about it, everyone that I met socially at home and outside medicine said to me, ‘Well, what do you think of the forthcoming NHS?’ No one at medical school talked about it at all. Didn’t think it was, I suppose, any of our business although it was going to be the basis of our future careers. Eventually on the appointed day, the day the NHS came into being, I was doing an out-patient clinic with a rather stuffy consultant who completed the mornings’ out-patient patients and then stood up and announced in a very supercilious tone of voice, ‘Well, you’ll see there’s some papers.’ And there were, indeed, a few forms on his desk, which hadn’t been there before. He said, ‘This is the paperwork for the NHS which starts today. You better take a look at them, you’ll probably have to fill in some of these forms in the future. I will have nothing to do with it.’ And he stalked out and that was just about all the teaching I got on the NHS from the medical school at the time.’

‘I was angry, yes. I was cross with him; I was cross with the attitude. I was by then, as you’ll probably gather, developing a very rebellious streak about society and the medical profession and really wondering what kind of a life I had committed myself to if this was the attitude … And I didn’t get to the end of my training at the Royal Free. I think the final act of rebellion was my confrontation with the then Dean of the Royal Free Hospital.’

‘She was’ a woman and a very nice woman, a very competent woman, a very able woman, and quite good at being a very competent woman, and that is probably the kind of person I am. But when I went to her and said out of politeness that I was going to be married the next month and my name would be changing, etcetera, she just looked at me in absolute horror and said, ‘You can’t do that, you can’t be married and remain a student here.’ And I was so outraged that I walked straight out and got on the telephone to other medical schools, but particularly Oxford, to see where else I could go and continue my studies if I were married. And within a couple of days I had fixed up to go to Oxford and I just resigned. And resigned a very valuable scholarship at the Free just because I couldn’t really stand this extraordinary intolerance.’

‘[It was principally a bureaucratic decision] I think she was a woman and a very nice woman, a very competent woman, and that I was simply spelling out the rules that had probably been given to her by the Governing Body. At that time after all in the teaching
profession if a woman married she had to resign. There was no such thing as employment for married women. So … [Perhaps] the idea of having someone around who was married … was regarded as disruptive. Perhaps there was an element of anti-feminist thinking about it. There weren’t any married women in my year although there were some ex-service women who were older than me. But my intended future husband was an ex-serviceman. He was older than me; he’d been through 6 years as a fighter pilot. He’d been lucky to survive. He didn’t want to wait another 2 or 3 years; we’d got to the stage of wanting to get married. He couldn’t imagine how anyone could stop him marrying me! … And so I came to Oxford where I did a London degree externally from Oxford. I did one more clinical year in Oxford and that’s how I completed my training.

Clinical training at Cowley Road Hospital, Oxford

Then began the search for jobs. By now Rosemary had had her first child. ‘We got a house and live in help and a nanny and all the things you could easily get in those days to run the household. And I thought of myself as a married woman with a family starting—I didn’t think it would be the last one. And I thought somehow I’ve got to build a career around this. So I laid everything on and went off to get one of the hospital jobs, which were not essential in those days, but I thought that’s what I should do. And at the time of the changeover of the house officers, which happened then every 6 months, I went around the various firms in Oxford where I thought I might get a job—people who had known me and whom I was quite friendly with. And after about a couple of days of seeing people and talking about it I think someone tipped me off and it finally dawned on me that there was a policy of the Board of Governors at Oxford not to employ married women doctors. And … the fact that I had got a baby was an absolute handicap in spite of all the arrangements I had made.’

‘My God’, I thought, ‘I have hit it again, this blank wall about not accepting that a woman doctor, although she’s fully qualified, can actually do a job.’ And so I returned home from one of these interviews and went to the Cowley Road Hospital, which was part of United Oxford Hospitals and was slightly down the road, a bit out of the circuit, if you like. And I knew there the person who was running it, a chap called Dr Lionel Cosin and his number one, Dr Bedford. And they had got there under their control the old workhouse which contained all the, what I would call, the medical ‘failures’—the chronically ill, the terminally ill, the people for whom medicine had got nothing left to offer and whose social circumstances were also such that they couldn’t be at home. And here they were in the old workhouse, which through the NHS was being turned into a site for a speciality that was just being invented then, geriatrics—the care of the elderly.

‘And Lionel Cosin was very, very committed, a ruthless sort of person. Ruthless I would say in relation to his administrative blockages. He just cut through the red tape and worked for these people on every front. He worked for them medically, that is, he treated them somehow, which nobody else was prepared to do. He gave them the best treatment that he could think of and he also fought for them socially and within the profession. And he was achieving the most amazing results. He was getting patients who had been in bed for 5 years up and walking and even discharged. He was diagnosing patients who had been passed over, missed or perhaps been admitted with another diagnosis and since been neglected. And he and Dr Bedford, between them, were very good physicians, very good teachers. And, of course, the wealth of material in that hospital, if one can put it crudely from a doctor’s point of view, was staggering. And compared with what I’d been able to lay my hands on at the Royal Free medical wards, for example there were hundreds and hundreds of cases that I could study and care for. So I went there and said to Lionel, ‘What about a job with you? I live just across the road, I haven’t done a house job yet, could I come to you?’ I didn’t mention anything about being married or having a baby and he just said, ‘Oh rather, sign here’. Because people were not terribly keen on his work actually, it didn’t have much glamour and it wasn’t very popular.’

‘So I set about working there and got my experience with him. I was supposed to live in. Ostensibly I lived in a flat over the gatehouse at Cowley Road Hospital and shared it with one charming, very experienced Ceylonese doctor who after a few weeks suspected from the way I was going backwards and forwards, especially in the middle of the night, that either I had a lover or … But to give him full credit, this chap got it right. He challenged me over the rather formal breakfast we used to have together with servants waiting on us in the style of the day. And he said, ‘I believe you have a baby’ and, of course, he was dead right. I did have a baby and, furthermore, I was still breast-feeding the baby a bit. And so, he was an absolute brick this chap. He said, ‘Look this is an impossible life for you’, he said, ‘and I don’t know what your husband makes of it, if you’ve got one. But, you know, we must do something about this.’ And so he covered for me quite often in the evenings and through to about the small hours of the morning. And, meanwhile, I had trained my baby to be fed and played with mostly at night and to sleep during the day with the nanny… Anyway, for a while this went very well. This colleague of mine could get me in just one minute—I was just across the road, by telephone. So there wasn’t any difficulty and we didn’t have a lot of night work in those days. One tended to settle the patients down for the night and the nurses coped until the morning—that was rather the way of it.’

‘So I … got some experience and at the same time I was trying to go one afternoon a week to a very good course in psychiatry that Dr McInnes of the Warneford Hospital was running for GPs and other doctors. And so I was to a certain extent developing [an] interest in psychiatry. And, of course, it did go with the care of the elderly because a lot of the elderly patients were demented and a lot of them were frankly mentally
ill or handicapped and one had to deal with them in the Cowley Road Hospital. And … I was quite enjoying it when a former colleague, who knew me slightly from the Radcliffe Infirmary days turned up and was shocked to find that, well frankly, that I was sharing a flat with a black man. And he complained to the authorities that they shouldn’t allow a married woman with a child to be in residence with a black man. (I mean, the colour stigma was quite strong, you know.) … But, anyway he let the cat out of the bag that I was (a) married, (b) got a baby and (c) that he disapproved of my lifestyle, which was absolutely crazy. Anyway I was dismissed there and then. Just sacked on the spot for deception or whatever.

**General practice in the 1950s**

**Temple Cowley, Oxford and Sarratt, Hertfordshire**

The young Dr Rue’s career was rescued by a call from a Dr Firth, a GP with a practice in Temple Cowley, which in 1952 was the industrial end of Oxford and home to Morris Motors and to Pressed Steel. ‘I had met him at seminars for psychiatry with Dr McInnes [that I had been attending]. And I had also contacted him quite a lot in relation to his patients … who were in the Cowley Road Hospital. And he just rang me up and he said ‘I hear you’re out of a job. Would you like to come and work in our practice?’ Well, I mean, this was an absolute godsend because at the time it was very hard to get a foothold in general practice. It was very competitive. There were still these chaps who’d come out from the war who were desperate to get a practice. It was an assistantship, it wasn’t a partnership but that was perfectly OK in those days. And I think within about a week I had joined him.’

‘I was very struck by the [fact that here were] patients [in] a whole population working, more or less, in one industry. And many of them had actually come to Cowley during the Depression from Wales where they had been miners. And they had walked from Wales to come to the car factory when it was starting up before the war.’ Many of these in Temple Cowley developed diseases associated with having worked underground in coalmines, ‘pneumoconiosis of various kinds’ and so on. ‘Their current work … had quite different health problems. In both the Pressed Steel and the Morris Motors Works their problems were dermatological, that is they were dipping their hands and splashing their faces and arms and legs with all kinds of awful chemicals. Dips of various kinds for which they were unprotected. And if it had the right effect on the metal you can imagine what effect it had on some people’s skins. And the other thing they suffered from very much were respiratory … problems, which again was rather confused with this ex-mining disease. But this was from hours and hours in somewhere called ‘the paint shop’, where they used to plunge into this terrible atmosphere. And in spite of masks and ventilation, and really a very good works doctor who was there trying to deal with the environmental and industrial circumstances, the effect on them, not just on their lungs but on their morale too was terrible. They were working long, late shifts at speed in terrible circumstances—I really felt for some of these people in a fairly old fashioned industry.’

By and large Rosemary Rue developed a good working relationship with the Occupational Health doctor at Morris Motors, despite the medical ‘class system of the day’. ‘There were very strong divisions in clinical medicine—between hospital and general practice, which I managed to overcome because I’d been at the Radcliffe and the Radcliffe was always a very community oriented sort of hospital. But there were divisions also between general practice and public health and general practice and occupational health. Partly it was that there was this awful competitiveness for jobs and there was a bit of a feeling that people were perhaps making money in other aspects of medicine from the one you were working in but weren’t quite so worthy and, you know, better paid, etcetera, etcetera, and was it as competitive. But it wasn’t just that. It was also a certain cynicism about public health and occupational health. But I used to talk to this doctor and he had some nurses who could help look after some of the patients, especially the ones with skin diseases. And they could go to a clinic at the works. For it was, for its time, quite advanced in having good occupational health services. And sometimes the occupational doctor would get very cross with me because I had put someone off work and he’d say, ‘No, he’s fit for work.’ And we’d have that sort of argument. But mostly it was a good relationship.’

While working in general practice at Temple Cowley Rosemary Rue contracted poliomyelitis. The resulting handicap and the prospect of a long programme of corrective surgery all argued against continuing her medical career. But Rue was determined to work again.

‘I couldn’t walk. I was beginning to drive after a bit. I could drive a car but when I got anywhere I couldn’t walk more than a few steps with a lot of aids and crutches and callipers and that sort of thing. And I couldn’t, for example, carry a medical bag so I couldn’t see how I could possibly go back to general practice. And I couldn’t see how I could ever go into hospital medicine because if you’ve ever seen a hospital and seen the length of the corridors and the staircases and the rushing around one does in theatres. Even sitting down as an anaesthetist you still have to be about the place. I could not see that I could do it. And, of course, at that time another thing I was thinking a lot about was that rehabilitation was a very new specialty. People were not used to seeing disabled people about in everyday life. Sometimes I’d be taken in a car to a shop and I’d struggle across the pavement and a little crowd of interested onlookers would gather round. They would be curious and partly pitying but also disapproving that someone as badly disabled as that should not be seen on the streets. There were efforts to break this down by the rehabilitation experts because of the way wounded servicemen had had to face up to civilian life.’

In time Rosemary Rue found a job teaching biology and chemistry at a girls school. However, she continued to hope to be able to resume her career in general practice. ‘I saw one or
two ads for a general practice opening and again I went. And
one or two places that I went to, although I could park outside
the front door, I couldn’t get up the flight of steps into the
surgery. So I went home again and rang them up and said,
‘Sorry I didn’t turn up I’ve got another job.’ And after two or
three false starts like that … sort of feeling around what I could
do, I had the extraordinary good fortune to make contact with
a man with a practice adjoining where I was living with my
parents. He had had recently lost a leg through sarcoma and he
had got this rather rambling, partly rural, partly urban single-
handed practice and he couldn’t cope and needed some help.
And this chap was called Martin Doyle and he lived in the Hall
at Sarratt. And I went to Sarratt Hall, parked my car just out-
side the hedge of the front garden, sort of took my courage in my
hands and used only one prop and walked up the path through
the front door. I thought, ‘Well I’ve got here, I can get as far this,
you know, I wonder what the rest of the practice is like?’ And
Martin, who was hopping around on a pylon because he didn’t
find his artificial leg helped very much, said, ‘Oh good you can
walk better than me, we can manage this!’ And he was very
constructive and we ran the single-handed practice together
with the two of us with one leg each!

‘I did learn that I was quite a competent GP. And, further-
more I learnt a good deal about managing a practice because
[Martin Doyle] had absolutely no help at all. His wife, as was the
custom then, used to take all the calls and if I was on call my
mother took the calls. And, bless them, they never messed up
any of the patients. And the telephone operators, using an old
sort of wind the handle system in the country in those days, used
to know where the doctor was. And if patients called for the
doctor they’d say, ‘Well I think she’s over at Bovingdon’, or, ‘I
think she’s just on her way home to lunch’… And I felt I could
have done a lot with the practice. I mean it was a bad practice by
modern standards. The only thing that was good about it was
that Martin was a good, caring doctor who was loved by the
practice. And they found me a modern doctor. And I think that
Martin was a good, caring doctor who was loved by the
practice. And they found me a modern doctor. And I think that
women particularly were rather keen to have a woman in the
practice. And certainly if they were

There was a kind of informal integration of services between
the practice and these midwives and district nurses because ‘in
that rural area … everybody knew everybody else and they lived
in the district. But ‘there was a big divergence between hospital
medicine and general practice at the time. It was partly because
a hospital practice was developing rather rapidly and many
more doctors and indeed other staff, were coming into the
hospital service who didn’t know all the GPs personally as they
had in days before. So the sort of link between hospital and
general practice was widening, the link was less firm. Also post-
graduate education had not yet been invented. It didn’t really
come into its own until after the Christchurch Conference,
which I think was in 1961. And it wasn’t until nearly 1965 before
formal postgraduate education for specialties was considered,
let alone for general practice, which followed some years later.
So although there were possibilities for meeting people in the
hospital service, there was no joint training and development
going on in spite of rapidly developing advances in medicine and
the burgeoning of the pharmacy. An incredible number of new
drugs were coming thick and fast. For example, Martin said,
‘Oh goodness I’m going to stick to my original four drugs’, that
he’d always prescribed. Whereas I was collecting quite a lot of
drugs that I was familiar with but quite worried about using
because I wasn’t having the opportunity to talk about them to
specialists in the hospital who were watching developments.’

It was general practice that drove the delivery of health
services in the middle 1950s ‘in terms of dealing with the work-
load, the actual ills and problems of the population. I mean,
there wasn’t room yet in the obstetric services for women to
choose to have their babies in hospital. If you were a normal
woman with a normal pregnancy you expected to have your
baby at home looked after by a GP and a midwife. If you were
someone with a bit of a problem disease who needed hospital
care and the GP rang up, as I did on many occasion, the admitt-
ing officer would say, ‘How old is this person?’ and I would say,
‘Well, 62.’ ‘Oh we’re not taking any one over 60.’ I mean, so one
had to look after that patient at home. You had to say ‘Well
sorry old chap we’ve got to get on with this together’, you know
‘Let’s see if we can get one or two tests done.’ And I would be
floundering about trying to diagnose obscure cancers or some-
thing like that for which there was no care. And this is only 50
years ago. And then without having a proper confirmed diag-
nosis with just what I could manage to get through general prac-
tice, I would look after these people. And certainly if they were
already 80 and ill one just got on with it. There were just these
one or two places, like the Cowley Road Hospital that I have
described, and a place in Watford. But the patients wouldn’t go
there. I mean, you would say to a patient, you’d say even to a
young patient, ‘This illness is serious for you, it needs looking
after with modern medicine. It needs investigation, etcetera, I
would advise you to go into hospital.’ ‘No thank you doctor I
don’t want to go into that hospital, that’s where my mother
died.’ ‘Well, but it’s much modernized now, there are new
people, new doctors, new developments, new advances.’ ‘Oh no,
you can argue all you want doctor but I’ll stay here in this
cottage and I’ll be carried out feet first, thank you very much.
You look after me, I won’t blame you.’ And you would have
quite young people just dying because they would not go into
hospital. So, I mean, we were carrying the load.’

A career in public health

Oxford Regional Hospital Board and then Oxford
Regional Health Authority

When Martin Doyle died the practice went to the son of a friend
and Rosemary Rue moved on becoming first Assistant County
Medical Officer for Hertfordshire and then joined the Oxford Regional Hospital Board (RHB) as Assistant Senior Medical Officer. In Hertfordshire she had learnt the importance of properly integrated medical and social services, at Oxford she joined one of the most progressive of the RHBs which in the 1960s would offer her ample opportunity to apply this lesson.

‘There was something unique about Oxford] probably always from the time [the RHBs] were formed. Oxford was one of the first ones and it was also one of the smaller ones. And just about the time I arrived there Wessex had been formed, which was about the same size as Oxford. And East Anglia was the other small one. … The idea of the original Boards was that they should each have a teaching hospital centre. … Oxford had got a kind of a medical school at that stage and a teaching hospital though not very well developed. And Wessex was going to get Southampton so that was the plan there. And East Anglia, of course, had got Cambridge, which again like Oxford was just developing its medical school. But there was quite a friendly but useful rivalry between the regions and who could do what and who could be ahead of the game. And also who could grab the development money that was going. A lot of it was trying to get funds. And the Oxford and Wessex Regions were run by SAMOs—that’s Senior Administrative Medical Officers—who were the bosses in those days. And they were great friends and rivals. Jof Davies was my boss and John Revans was the Wessex SAMO and those two were really leading among the small regions and were said to have advantages over the big regions. I know that some of the big regions were doing very good work and developments, and so on, but the small regions were really out in the front. So it was good.’

‘The whole thing was enterprise, advance, entrepreneurial spirit, research also into health services, information and statistics. They were ahead with absolutely everything. And insofar as the regions were measured against each other Oxford always came out top. You know, things like maternal mortality and measurable indices and so on, were very good.’

The advantage about being small was perhaps that the SAMO could take a different sort of overview. It was possible to know much more about what was happening in the region than in one of the larger RHBs. ‘It was much more personal, yes. And certainly we knew all the consultants and most of the GPs and between us we knew an awful lot of the other staff in the hospitals and the community sector and so on. And we were just on friendly relationships with everyone.’

**New Hospital Building Programme**

**The Oxford Method**

In 1961 Enoch Powell, then Minister of Health in the Macmillan government had initiated Britain’s first major hospital building programme since well before the Second World War. ‘The hospital service hadn’t had any capital funds to spend on developing it’s buildings and equipment really since 1948. Enoch Powell spotted that you couldn’t run the service like this without any capital investment in modern terms. I mean places like Scandinavia were already on their second generation of post-war hospitals and modern equipment, and so on, and we were struggling along kind of celebrating the fact that our hospitals were 300 years old or whatever. And it was just ridiculous. Anyway the capital planning programme developed quite separately and we always bid for it separately from the revenue although, of course, if you had a capital plan coming to fruition you needed revenue to run it. But those two pockets of money were always rather separate. And we did get money first of all for the Swindon Hospital, the Princess Margaret Hospital.’

‘The planning really had to start from scratch with architects, engineers, nurses, people taken on for planning, to develop planning know-how—we called them project teams. And they explored what had been done in any other countries that were ahead of us and they developed ideas for the hospital, which started at Swindon and we tested that out. And then we needed hospitals all round the region very quickly because the region’s population was expanding faster than anywhere else. And we realized that each separate team didn’t need to, sort of, reinvent the wheel. And it was the Architects Department, at that time under someone called Jobson, and developed further under Archie Arschavir who succeeded as Regional Architect, who developed a sort of standard for all kinds of modules which went into any hospital anywhere. For example, if you imagine a hospital bed towards the wall, the bed goes up against the wall and on the wall in a ward there’s a certain amount of wiring, pegs, places to hang equipment and notices and that sort of thing. And people were redesigning this area over and over again. Doing it differently for every hospital. And what we said was it would be very good to design a set of panels, one for a general ward or main ward, one for an intensive care ward, one for a post-anaesthetic recovery bed space, and one for a children’s cot space. And whenever this cropped up in the future planning we could put this panel in. Well that quickly developed into a method of designing component parts of a hospital, a bit like a ‘Lego’ system that could be fitted together on any site and round any plan and it was known as the Oxford Method. And it looked to many people absolutely awful. I mean, it was straight, square, it was made of preformed components and the external appearance did not look up to scratch compared with the Victorian edifices that we were carefully conserving. But it did have advantages, for example, every area of floor had got the right sort of trunking in for electricity, drains, computer leads, everything we could think of for the future. And gradually that developed into a very quick method. We put up a million pounds worth of Oxford Method hospital in Reading in one year, which doesn’t sound much these days but that was the fastest build there had been of a public building. It was an achievement to spend a million pounds in a year, on a technical building—and remember that half the content of a hospital is engineering, so that all had to fit into it.’

As well as standardizing, for example, the panel behind the head of a bed the Oxford Method also factored into its
calculations such basic shared measurements as the space around beds, the length and width of corridors and simple solutions about what had to be next to what. ‘Very much so! And it meant that, for example, when we opened a new department built in this method there was almost no desnagging to be done. Do you know when people move into a new building they spend weeks complaining about what’s gone wrong and they make great lists of things. We got it down to almost nothing. And also the people knew what related to what, where they could turn round and get their hands washed, or whatever was required, just because they were familiar with the layout in each package.’

Two essential requirements were satisfied by this Oxford building system. New hospitals could be built fast and within agreed financial limits and their design was driven by patients needs. It was a ‘kit’ to which or from which you could add or subtract according to what was appropriate for a particular community. ‘Each newer development was a kind of improvement on the last. And, of course, if we did a completely new department we hadn’t done before we had to kind of rethink it. And we didn’t use the Oxford Method absolutely all the time everywhere because quite a lot of the work we had to do was development on site of old buildings and gutting and replac- ing—well you can imagine like any sort of building really. So really the key to the Oxford Method was flexibility.’

**Community hospitals**

That flexibility was also evident in another of the Oxford Region’s initiatives, the building of community hospitals. ‘We made a study of some of the small cottage hospitals around the region. (We’d got quite a lot in our region although some regions had hardly got any.) But we and Wessex and the Southwest all had got these cottage hospitals and they varied tremendously. Some of them were only about eight beds and almost no additional facilities to that at all. They were just like little nursing homes and they were taking a bit of revenue for very little purpose. And there was quite a move to close them down and, indeed, many of them were just shut. And although it was a matter of protest for the local communities all over the country many of them were closed. But we had a careful look at what we were doing with our cottage hospitals and again in a rather enterprising region that had attracted very good GPs, and so on, there were a lot of developments had taken place both physically and in terms of providing services in these hospitals. And we thought that the idea of a GP facility shared between several practices was a very good idea, particularly in a rural region where a lot of the available staff lived—and remember then as now and always the NHS shortage is always of staff. But a lot of the trained nurses, doctors for that matter, were living not in the centres where the hospitals were but out in the country and, and couldn’t get into the centres. I mean they didn’t have transport and there was no public transport, and so on. And so there was a sort of wastage of people who were prepared to work in the health service out in the country. And we were able to work out a design for a facility which was much bigger than most of the cottage hospitals and we actually planned and built some. And we built them with day hospitals and day care facilities and straight X-ray departments and with pathology delivery services linked to the main pathology labs. And we worked out that you really needed a population of about 50 000 before one was really viable and that involved several GP practices.’

‘We called them community hospitals and we had a whole theory to go with it. We started researching it as fully as we could. The research programme faltered, the money was withdrawn and various things happened but we were able to show that they were value for money, in our region, at any rate. Some of the other regions who were interested copied it but some of them now in our region still survive. And they’ve waxed and waned in popularity. I mean, a few years ago they were going to close a whole lot more, now they’re again the flavour of the month. And, you know, I still think that they’re a good facility if they’re regarded as a GP facility.’

‘They are very often combined with a meeting room for multidisciplinary meetings. I mean, our original idea was that the nursing staff of this facility—we didn’t much like the idea of calling it a hospital to start with, the nursing staff should be the same nursing staff who were working out on the district. That they should be the individuals who could say to a patient, ‘Now look you’re not getting on very well at home. Let me take you into my bed for two nights, we’ll sort you out and then I’ll bring you home again and continue looking after you at home.’ And that would make the whole thing, admission and discharge for such in-patient care as being offered very appropriate. It would save some long admissions, difficulties in discharge from general hospitals and so on.’

It might have been expected that hospital consultants and hospital nurses would have reservations about these new community hospitals that were beyond their traditional spheres of influence. But not at all. ‘The consultants were usually great supporters of the cottage hospitals, in our region at least. And they loved the community hospitals because we had space for specialist clinics there and they could get out of the District General Hospital for an hour or two, see a few patients, meet the GPs in what they really called old-fashioned medicine. So they liked it. And they also liked the idea that they’d got somewhere that their patients for whom they’d done all they could for but still needed some nursing care could go to a nursing resource that was still part of the system.’

‘The nurses were very happy with it because the nurses who worked in the community hospitals were, as I said, really the ones that couldn’t get to the main hospitals and were otherwise not working in nursing, so there was a lot of recovery of nurses from the community. And also they had good nursing skills for minor casualties. You know, a little bit of suturing, minor burns, a quick look at sprains and so on. Do you need an X-ray? No. ‘Do you need to go into the A&E department? No.’ The ability to call a GP or call an ambulance if required. But they could take quite a lot of responsibility and that was welcomed. It takes the load off the A&E departments.’
Planning health services for Milton Keynes from 1967

Possibly the greatest planning challenge that confronted Rosemary Rue and her colleagues in Oxford in the late 1960s and into 1970s was the creation of the first ever new town to be built in the United Kingdom on a green field site. Milton Keynes.

‘The announcement was made early in the morning, I forget which Minister it was but it was a Ministerial announcement that was made on the radio. I remember hearing it when I was still in bed. And they were going to have this enormous city … with over a quarter of a million people just for starters. And that was bigger than Oxford, bigger than Reading, bigger than anything we’d got. And they said where it was going to be centred on this village, and I knew that all we’d got out there was the remains of a cottage hospital and, I think, two villages with general practitioners (GPs). And they were saying that ‘And building is going to start, sort of, next week and that people are going to start pouring in. And it’s going to be people from London who need housing.’

‘Anyway, I got dressed and went to work. My immediate chief then was Tony Oddie, who I think by then probably was SAMO. I can’t remember which year I’m talking about but he succeeded Jof Davies. Anyway, he and I went straight up to the Department of Health and asked to see the Minister and said, ‘Look no one has mentioned anything about health in this great plan for all these houses and all these people.’ There was a certain amount of shamefacedness. I think Departments of State have never been very good at talking to each other anyway. And I think in those days we had a Housing Minister who thought in terms of, you know, two beds and a bathroom and kitchen. Anyway, we said right away, ‘We will need to develop a health service, this will have to be planned and we will actually need some capital and additional revenue to provide for these people.’ ‘And where did we propose this money was coming from?’ you see. And we said, ‘Well, if the people are coming from London and London is diminishing in population and Oxford is expanding in population. The London teaching hospitals are touting for custom because the population is going away and they are wondering if they can survive, if they’re actually viable, whereas our hospitals are pouring people out of the doors faster than anyone can work. We think the money ought to come from the London funding and you should get on and close down some of the services in London and let us develop them at Milton Keynes.’ Oh well, they’d think about that, meanwhile would we get on with it.’

‘So Tony Oddie and John Reid who was County Medical Officer for Buckinghamshire and I and a colleague of John’s, whom he appointed for the purpose, called Dulcie Gooding set to work with some GPs. (Some of the local GPs on this rural patch were very active and supportive and keen to do something about it.) And also with the consultants in the surrounding hospitals—Northampton and Stoke Mandeville were the two hospitals mainly affected by this. So we got together and started making a plan for a health service for this city. And we did it in conjunction with the Development Corporation. John Reid was a very good leader in all of this because we all agreed very early on that the first thing we’d got to provide was a GP Service and community-based service and get that together. And that was going to be based on health centres with some diagnostic facilities and so on. And we were also going to put in a community hospital, which we’d already developed elsewhere. It was a GP run hospital that was a small hospital which would take some in-patients, some minor casualties, small things, and offer a small support service. We also thought we should provide a mental health service because that was in a very bad state, very hard pressed in Buckinghamshire already and in Northamptonshire. And we knew that displaced populations bring with them quite a lot of mental health problems. So that was also a priority.’

‘We did go around and see what had happened in one or two other New Towns. I don’t think I went to Crawley at that time but I think Dulcie did. We certainly went to some of the other New Towns but nowhere ever had anybody put a New Town in a place where there wasn’t already some sort of a hospital and some sort of specialist service. It had not been done anywhere in the world as far as we could see. So we really were starting with a green field site. And we did eventually attract a cadre of GPs, psychiatrists and mental health workers and we also provided some care for the elderly, partly in the community hospital and partly in one or two other day care centres and so on. And we did, in fact, get a foundation of a primary care and public health service going.’

‘Now, the people who arrived, they’d come from London, they were used to the London teaching hospitals and they immediately said, ‘Where’s the hospital?’ They didn’t understand about going to see GPs and depending on primary care which all rural communities, of course, did understand. But these people from urban settings, and particularly London settings, were used to taking every problem to the Casualty department of the local London teaching hospital. Which was just the system we didn’t want to encourage, indeed, it’s not a good system as it is bad for patients. [It’s] costly [and] everything about it is unfortunate. So we were terribly unpopular. And the wretched RHB was not providing a hospital. Now we had said right from the beginning we couldn’t provide a hospital until we’d got a 100000 people at least on the patch and to make it viable and to make it reasonable to appoint the consultants and run the specialties. And we kept asking the Department, ‘Well, where’s, where’s the money for this? You know, when’s it coming? We still haven’t got any money.’ We were paying for all the primary care services. And, of course, a lot of spin-off to Northampton and Aylesbury. Paying for it all out of our existing revenue. We needed a million pounds to start the hospital off. A million pounds was spent over and over again on things like sports stadiums and swimming pools and golf courses and things by the Development Corporation—they got lots of money but we couldn’t get our money for the hospital. Anyway, eventually we
did. We saved some money out of our capital programme. We deferred developments for the Oxford Teaching Hospital and the Medical School in order to provide for Milton Keynes. And we did get about a million pounds worth of hospital on the site and we opened the first phase of the Milton Keynes District General Hospital in 1984 when we said, ‘Right, we are active, prepare to receive ambulances.’ And that had never been done before anywhere in the world. No one had ever started off a hospital with a full range of specialties and an A&E department from scratch, without building on something. And, of course, it was very trying because you couldn’t appoint these people very far ahead of opening. And then they didn’t know each other. And a lot of the safety and progress with patients through hospital departments is because the teams know each other. They know who’s who, they know who to talk to, who to send the patient to and who’s who in the operating theatre and so on. And they had a very short time to familiarize themselves with the buildings and each other.

‘Eventually they said, ‘Alright, we’re ready to go’, and we sort of blew the whistle and prayed there wouldn’t be a major emergency on that day. And it worked, straight off. Not only did it work immediately on day one successfully—no hang-ups, no snags at all—but it worked without any administrative paperwork. That was all computerized from day one. So we had no paper apart from the patients’ notes and GPs letters in that hospital from day one.’

‘The idea in Milton Keynes was that the health service really consisted of a primary care service supported, if you like, underneath by specialist services and, and all the diagnostic help that GPs can get from specialist departments. And then if the specialists get into difficulty there are super specialties, regional specialties, teaching hospital special interests and that sort of thing right at the bottom. And if things really get out of hand, I suppose somewhere down at the bottom in my image is the Secretary of State who’s said to carry the can for all of this. But most people start and draw the plan the other way up with the Secretary of State at the top and a sort of triangle going downwards until the wretched GPs and community nurses and the patients fetch up near the bottom of the heap. Well I always look at it the other way around and doing it at Milton Keynes was a demonstration that this worked.’

**Getting married women doctors with families back into the service**

One of the things that Rosemary Rue noticed during her time in Oxford was that there was a pool of trained doctors in the community who were simply not being used, women who had qualified, who had gone off to have families and who simply weren’t welcomed back into the profession. ‘I think it occurred to me clearly as soon as I got to Oxford and realized that one of the big problems that was on everybody’s agenda—in every specialty, at every Board meeting—was the shortage of doctors. … And the need for more doctors was evident and plans had been drawn up, ‘We need a hundred more of this, a hundred more of that’, in the way of medical staff in specialties as they were developing. And there wasn’t anywhere in sight that we could get these doctors. We were having a lot of overseas trained junior doctors and many of them were being promoted but at that time a lot of the overseas junior doctors actually wanted to go back to their own countries. Things gradually changed over the years and they wanted to stay a bit more than they did then. But originally they were a bit more inclined to go back or go on to the States. So that source, although it was over 60 per cent of the junior workforce, was not actually leading though to career doctors. And the same was happening in general practice. The GPs were getting overwhelmed with work and needing more colleagues, but they couldn’t get them. And I was aware just from talking to a few friends in Oxford that there were a few more women doctors who hadn’t done any work for years. I mean, often up to about 15 or 20 years. They had given up all hope of doing any work because they had experienced the problem that I had run into of obtaining a postgraduate education in a specialty of their choice or indeed any specialty. And this was now a requirement for doing any sort of a career job. And they simply couldn’t get on to the ladder of postgraduate education.’

‘The requirements at that time were that the early stages of postgraduate education would be residential, full-time, for about 2 years. And that meant that you got at that time one weekend off a month at most. All the rest of the time you had to live in the hospital and be on call night and day. Now all these women that I knew in Oxford were in their late 20s, 30, 40s, they had got young children, school age children. They all typically had married and started families and at that time they had the minimum of help in the home and there was no way they could simply abandon their families and live away from home for 2 years.’

‘So I went to the Board one day and asked for some money to experiment with getting some part-time attachments, paid attachments to specialty departments for married women doctors—that’s what we called it at the time—because they were the ones who were being discriminated against. And I was given enough money to experiment with four posts. And I found out a grade that these people could be paid at and appointed. I found doctors with good training capacity who’d been waiting, perhaps for years, for an opportunity to train another junior doctor (but because of the shortage they hadn’t got anybody), who were prepared to take these women on. Mostly we said, to start with, for about half-time. That was at least four sessions a week plus they had to give another day of really attending the appropriate educational courses and so on. So that was, that was nearly full-time by most people’s standards but by medical standards it was less than half-time. And then I asked the Royal Colleges involved if they would recognize this form of training. (I think we started in anaesthetics and paediatrics … and anaesthetics, particularly, was very successful to start with.)

‘What I did, I matched the women with their aspirations for a career, which I went over with them fairly carefully in terms of
a kind of career counselling advice. And what the options really were and what the training would be like and what the life would be like, etcetera.' And I quickly got four together and by the end of the year in fact I had got 40. Within 1 year. Matched in departments—not all in Oxford, many around the region—with consultants who were desperate for a bit more help in their departments. Good qualified trainers, teachers who’d got recognition at the College of whatever it was, surgeons or physicians, whatever the appropriate College might be. That if they kept a diary of the work done and the teaching done they could build up, rather like a modular system, over a longer period than was normally allowed until they’d got sufficient experience for the College to recognize it and say, 'Right, you can now qualify to take the higher exam and, you know, continue in, if you pass the exam, continue in the next stage.' And, and then I went back to the Board the next year and said that I’d rather overspent—the sort of thing you can’t do these days I understand. I’d overspent by a factor of 10 and they were absolutely delighted. And I think by the next year we’d got a hundred and it went up to a hundred and twenty and stabilized there within a couple of years—this is for the region—of part-time married women working on recognized programmes trying to get their exams and to qualify to be either consultants or at least career doctors. And much later we introduced some training in general practice along the same idea and some of them went to general practice.

'This was quite a revolution that people would actually regard these women as part of the workforce. And, of course, in the light of my own experience I could see all too clearly that they’d got a lot to offer. I mean, some of these women were very well qualified. They were already quite highly qualified, women with postgraduate diplomas and degrees but the minute they had got married they’d been forced to resign and they had spent years sort of loitering around wondering how they could retrieve their careers in the face of this acute shortage of doctors. So the scheme developed from there. I published the outcome of the first year or so in 1967. (I started in about late 1965, I suppose, and was ready to publish in 1967.) It didn’t amount to much of a paper but it was put in The Lancet and people were absolutely astonished and couldn’t see how it could be negotiated and how one could get the women and the trainers and the funding and the Royal College approval all together in time to make it worthwhile.'

‘One or two of them failed because perhaps they couldn’t pass their exams and then they were slotted in to something more suitable, you know, clinical assistantship or something on a long-term basis. But I persevered with each one of them until she’d got a career going and was back on the patch. And at one stage when I analysed it after a few years I noticed that we’d got a matching number of Higher Degrees and Diplomas to babies born to the women going through the scheme, which I felt was rather sweet.’

'[My local managers and the Department of Health] too were delighted that someone was solving part of the medical manpower shortage problem, making a contribution towards it. They thought it was a very good plan and after a few years, of course, they adopted it and variations of it and extensions of it in various ways. And it is now a national plan which is still there, it is still available but administratively I understand it still takes months and months and months for women to achieve a slot in a programme, a funded slot in a recognized training programme. The administrative difficulties are considerable and people despair of getting through it.'

**Establishing a Faculty of Public Health Medicine, subsequently the Faculty of of Public Health**

The Faculty of what is now Public Health came about as a result of the reorganization of health services proposed by government in 1974. Rosemary Rue was a founding member of the Faculty and its President from 1986 to 1989. ‘The idea was that not only were the three strands of the health service going to be integrated but the three strands of public health were going to be integrated, that is the academic departments of public health which varied very much, some of which were straight health services research, some social medicine, so called, and some concerned with public health like the academic department at the London School of Hygiene. They had a wide range of interests and they were all small and they were all threatened. And so all these academic departments and then all the people who’d been in the local authority public health service, that’s all the Medical Officers of Health and all their staff who were medical. And also the SAMOs and their staffs from the Boards together with one or two odd people around the NHS and associated departments. And lastly there was CDSC and one or two others such as the Public Health Services Laboratory and so on. And we coined the name Community Medicine in order to make a new name and the three Colleges of the United Kingdom agreed to set up a Faculty, which is a mechanism that the Royal Colleges have. And it was by agreement with these three branches of the discipline. Now I wasn’t active in the in the negotiations setting up the Faculty. I had a lot on my plate at the time doing the reorganization in Oxford. But I did become a founder Fellow and did the training programme, which was under their general auspices for their membership exams. And I was an examiner for them for some time as well.’

The new Faculty brought together in one body Public Health practitioners and scientists. Rosemary Rue would argue that this has helped to eliminate misunderstandings and to relieve previous tensions between these two branches of the profession. Once we’d all started seeing, as it were, that our young protégés were trained on the same programme and that they’d all got some common background that really did help to sort that out. As with medicine in general, if you want advice you have to look for the right person for advice on that aspect of the issue. I mean, personally I never thought that the academic side or the research side of public health issues was exactly the same discipline as the management of what you call operational services.
in the NHS. I mean, in some ways it’s like the argument as to whether medical management is separate from medicine if you’re at the top and you’ve got to run a department. I mean, is it a separate discipline or not? But I think on the whole the Faculty has managed to hang everything together through thick and thin—we’ve had some bad times … I would say up to about 80–90 per cent of the membership of the Faculty at any one time was having its jobs changed and threatened. You know, so that nobody knew where they were going to be, or what title they had or where they were going to be working, or in what capacity, or what they needed.’

‘And then of course, there had also been one or two public health events for which the Faculty and the discipline as a whole was seen not quite to have enough weight to deal with them. There was that terrible incident of infectious outbreak at the Stanley Royde Hospital. One wretched clinical doctor was completely overwhelmed by it. Couldn’t summon enough support quickly enough. It was a very nasty incident, which really showed that the whole network and support of public health in that part of Yorkshire, had sort of collapsed. And this really indicated that in spite of the Faculty being formed, the protection of the public’s health was not in place. It resulted in an enquiry and a report by Donald Acheson who really revived the status of public health as a discipline again and said ‘Look we’ve got to have people with this capability in every patch to deal with this sort of thing. It hasn’t gone away.’ For things like BSE or more recently SARS you need someone with public health responsibility. I mean it was Gro Harlem Brundtland the Director General of WHO who recently stopped SARS in its tracks globally. She was publicly health trained, you see. She was a public health doctor and she knew what to do on day one and got it done. I mean, I know there were one or two other people on the spot who also reacted but she did stop it.’

‘[The principles of Public Health that the Faculty is there to uphold are] about prevention, protection, the development of standards and progress towards health. So really prevention, protection and progress I would say. And prevention is understanding the basic infrastructure that a population needs to prevent it falling foul of all kinds of mishaps—not just infectious diseases but also accidents, suicide, you name it, anything that befalls groups together. Then protection means the ability to care for whole populations should there be an incident. I mean it could be an environmental incident like spillage of something toxic, or it could be infectious diseases, or it could be a modern catastrophe, as yet unknown public health endeavours to protect the public from the worst effects. And then progress and development is really looking ahead, looking at the information, the epidemiological trends and just seeing where we’re all going. For example, in recent weeks there’s been a lot of talk about the obesity of the population. Well that wasn’t on the agenda after the war when I entered public health but it is a big problem now.’