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History *in* health and health services: exploring the possibilities

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There is increasing interest in history within public health and health services. However, there are few historians and health professionals who have direct experience of collaboration, and the potential benefits are only just beginning to be appreciated. Historical skills - especially the methodologies involved in searching and interpreting a wide range of sources - can secure a much better understanding of the structure and function of health services, and be used as a means of raising public consciousness on the expectations and experiences of health and health care. This paper examines how historians have sought to become overt 'tools' in the public health 'tool-kit'. [1] It examines what exactly historians do that is of potential value to health policy makers and practitioners. It considers the relative ease of using history at different levels and in a variety of environments, and uses specific case studies to show the experience of historians: how they have been variously ignored, courted by different audiences. It concludes that a properly devised strategy is now required to consolidate history as an essential skill within the health profession team, and also within evidence-based analyses of contemporary health issues.

Further, if it is accepted that historical skills are valuable in contemporary health policy formation and service practice, who should be delivering them? How transferable or teachable are these skills? The recent trend towards ‘history *in* health’ has resulted in some interesting informal and *ad hoc* collaborations. However, to my knowledge, no historian to date has been employed full-time by a British health authority. They have usually been involved on a ‘need to know’ basis. But who makes the decision that such skills are needed in specific circumstances? The use of experts in policy formation is a long-established principle – but too often history is not recognised as expert knowledge, or else it is provided by existing health professional staff who feel that their amateur interest gives them confidence and authority to take this role on themselves. Arthur Newsholme, the Chief Medical Officer for England and Wales between 1908 and 1919, later recalled that there was:

an honest belief, common to many government departments, that technical advice is advice not to be given until called for by the secretariat who, it is assumed, are entirely competent to decide whether such advice is needed. Second, when such advice is on record, it is assumed that it can be safely reapplied in what are regarded by the secretariat as analogous circumstances. [2]

It begs the question, when do health professionals know (if ever) that they need historical expertise?

Uses and abuses of history

This section focuses on three uses of history which illustrate the strengths and weaknesses of this fluid discipline. I have categorised them for the purposes of this overview loosely as the ‘political’, ‘legal’ and ‘individual’. Historical skills are applied in different ways to obtain specific outcomes. Yet this variation in application has rarely benefited from overt recognition and discussion. When history is done well, these subliminal directives are appropriately managed and understood, by both the historians and their intended audience.

A good example of the 'political' use of the history of health is the work of Daniel Fox, one of the few who have consistently tried to straddle the historian/adviser role. His career has included positions in US state government and federal agencies, academic posts and since 1990 he has been President of the Milbank Memorial Fund, one of America's foremost health policy research funding bodies. His research output includes both historical monographs and contemporary policy texts. [3-5] Fox's confident integration of historical context into contemporary analyses results from the application of a rigorous historical methodology. For example, his 2001 article in the *American Journal of Public Health* uses a revised public health history to show the consistent, sustained centrality of law to public health policy. Fox's historical analysis provided a useful interjection in the contemporary debate over the role of lawyers in public health. [6] It is *politically* illuminating, in the sense that it uses history to expose the strengths and weaknesses of contemporary structures with the intention of informing future re-structuring.

My second category is the 'legal', which challenges the popular view that history *per se* is neutral, unbiased and incontrovertible. History is at its least controversial when presenting bare facts - dates of births, deaths and battles. But if we move along the chronological and thematic spectra we enter contested territory, in which there is a blurred boundary between fact and fiction, and it becomes more accurate to talk about 'histories' rather than 'a history' of a topic. Yet one of the core historical skills has always been the *selection* of material to support a particular view. In the last ten years it has been increasingly used in legal cases. In many national cultures, it is a short jump from the court room to the policy-making chamber. It is important therefore that the full potential impact of historical evidence given in this format and environment is appreciated.

A good example of the interplay between legal and political aspects of history can be seen in the work of Gerald Markowitz and David Rosner, historians of American occupational and environmental health. They demonstrated that the American chemical and lead industries have long had the knowledge that their production processes cause a range of health problems including cancers. [7] In legal cases, their knowledge of the historical context of industrial health issues meant that they were able to recognise the full value of documents and to situate them in a much wider (and

more damaging) framework than lawyers working alone may have achieved. The success of Markovitz and Rosner can be seen in the campaign launched by twenty of the biggest American chemical companies to discredit their work. They have been accused of engaging in unethical conduct for their exposure of the perversion of American health and safety legislation by industry pressure groups. [8]

Yet the Markowitz and Rosner episode is not unique. There is a growing market for the use of historians in medical legal cases, especially in the US. [9] There are now companies that specialise in providing consultant historians, although they often are more interested in securing the services of professionals who can easily tell a story to a lay jury, rather than being subject matter experts. [10] Indeed, discussion of the Markovitz/Rosner case itself has led to the exposure of quite how much historian/industry collaboration there has been in recent years. Robert Proctor, the first historian to testify against the tobacco industry, has examined the motivations and naivety of historians engaged in this potentially lucrative research. He highlighted the activities of Project Cosmic, operated by Philip Morris, to build an international network of scientists and historians to serve as its paid consultants and project investigators. [11]

In most of these legal cases, the historians have acted in good faith; they have not deliberately misled juries. Yet the way in which they have been directed by the companies to focus their research on issues that will support their cases has undoubtedly sometimes compromised historians' professional standards, and resulted in biased outcomes. As David Rothman puts it: 'when historians work as historians, they do wide-angle studies; when they are expert witnesses, they do telephoto studies, acting as advocates not as historians. The work might have integrity, but it is not following the canons of the craft. Historians working for the defence or for the plaintiffs are doing many things, but they are not acting as historians.' [12]

The third loose category for the use of history of medicine is 'individual'. By this I mean the application of historical skills and knowledge to the individual's health and welfare. The most obvious example of this is the doctor-patient relationship, which has been one of the driving forces behind the academic discipline of history of medicine for over two centuries. There is a particularly strong German tradition of integrating historical skills into the doctor-patient relationship, so that history

becomes an automatic part of doctors' working regimes. [13] Yet perhaps the phrase 'taking a patient's history' should be carefully examined. It is the doctor who is both taking and making the history *from* the patient – the patient's role is usually that of the passive supplier of medical facts for the doctor to interpret. But there is much in this historical evidence that the patient can be skilled to interpret, and this is one aspect of health that needs further consideration. I will return to this theme later in the paper.

By focusing on the *type* of history that is being produced – political, legal, personal, it is possible to see that historical skills can be applied in different ways that generate, consciously or not, different outcomes. Historians are well aware of the benefits and pitfalls of such nuanced practice, but the casual observer/patient/policy maker also needs to have this insight. History really becomes useful when these connections are made, but raising such awareness is problematic. One of the key determinants of success appears to be the level at which the historian is attempting to operate.

Spheres of influence

The tension between 'national' and 'local' has been a constant feature of health policy and practice, especially in Britain. Historically, it has determined the adoption or rejection of radical health service re-structuring exercises. For example, the creation of the National Health Service in 1948 was deliberately engineered to avoid the harmonisation of health authority and local authority boundaries: the rival power of local government to the centrality of the new 'National' Health Service compelled this disjuncture. The local-national perspective is also helpful for understanding issues of accessibility of historians to communities of policy makers, and accessibility of history for the practitioner and the public.

New research by Virginia Berridge has confirmed long-held suspicions that policy makers are selective in the history that they are willing to listen to and employ. The short-term institutional memory is exacerbated by frequent turnover of staff, ignorance of historical precedents for contemporary policy issues, and the political requirement to seem to be coming up with new solutions. [14] Health ministers are fond of exploiting history, but historians with relevant knowledge are rarely invited to

contribute to policy discussions. How familiar Newsholme would have found the early twenty-first century.

Part of the problem then, seems to be gaining the initial access for both history and historians to the key spheres of influence. This is most extreme at the national level, where Whitehall is now rigorously patrolled by special advisers. Historians need luck and/or personality to make it in this environment: the celebrity historian David Starkey gave a keynote speech at the 2006 NHS Confederation conference, but one of the organisers commented that ‘to some extent, he was there as entertainment’. [14]

When history isn't history: the issue of re-branding

At the national level then, there appears to be little scope for history to have a proactive role within health policy. Even when history is engaged, the initiative usually comes from the policymakers, not the historians. See for example the WHO-commissioned historical analysis of environmental control strategies for malaria. [15] The more proactive history that has also appeared in mainstream medical journals in recent years often seems thrive under guise of ‘long-term analysis’, such as the fifty-year review by Navarro and his colleagues of the impact of political traditions on changes in health. [16] This fascinating research project is explicitly marketed as ‘scientific’, to the extent that nowhere in the text is the word history used. This is perhaps a deliberate styling of historical research to capture the attention of a health professional audience, which requires publication in such journals. Overtly historical papers are routinely relegated to special issues, for example in the *British Medical Journal*, which often saves them for its Christmas issue. The branding of historical research is a critical issue if it is to be useful to policymakers. If we recognise their limitations in accessing knowledge, then strategies must be developed to by-pass such barriers until a time when historians can have their work valued for what it is.

In Britain, a group of historians have demonstrated that it is possible to take a more proactive position in the quest to engage with policy makers at the national level. The recent formation of the History and Policy website provides a resource of short historical context papers on contemporary policy issues across a wide range of

themes. [17] Its long-term mission is to act as a broker between academics and policy makers, and to provide an information service for the media. Health policy is one area which this initiative addresses, for example through Martin Gorsky's contextualisation of hospital governance and community involvement in health care, [18] and Simon Szreter's study of the economics of health and development of social capital. [19]

In addition to the problem of historians getting their message across to the intended audience, there is also the issue of their academic territory being annexed by other social scientists, especially sociologists. [20] While it is interesting to see what other disciplines make of this type of material, would it not be more useful to engage in direct debate with historians on how their respective interpretations differ? There is no reason why historians cannot also play this game, and develop their skills in ways which reflect the fashion for syntheses and evidence-bases. Yet there is a distinct historical methodology, which acknowledges that source material is more varied in terms of quality and quantity than that used in other social sciences: it cannot be shoe-horned into social research data sets. Critically, historical analysis is at its most useful when identifying and interpreting divergent views. The skill is in working with these, rather than aiming for a focus on 'areas of convergence' or 'consensus', which often seems to be the rationale for sociological research.

It is clear that at the national level there are ongoing difficulties for historians in gaining access to the policy-making environment, and also in controlling how their discipline is used. Is the situation any easier at the local level? To date, historian/health professional engagement in this arena has not been adequately acknowledged. However, my personal experience has shown that there are many ways in which history can be exploited. I will examine three key mechanisms here: the historian as expert adviser, the historian as health professional trainer, and the historian as community health facilitator.

The historian as expert adviser

In 2001 public concern that cancer deaths in one district of Liverpool were linked to a former hospital incinerator led to the commissioning of a detailed study by Liverpool Health Authority. However, as the incinerator had long since been demolished, and there were incomplete emission registers, I was asked to construct a ‘pollution and disease’ history. This invitation came through informal contacts at health authority, which has a long tradition of collaboration with the academic Department of Public Health at the University of Liverpool. With the assistance of Dr Andy Sewart (a former dioxins adviser to the Department of Health, and at the time an undergraduate medical student at Liverpool), I provided vital contextual information which strengthened a disparate set of secondary data analyses. We were able to establish confidence with the health authority through our discussions on historical methodology, for example how we would locate source materials, cope with incomplete or biased archives, and how oral history could be used.

The final report, which was subject to peer review, had a substantial historical component, and some of the key historical context was picked up at the press conference by local and national newspapers. [21] It demonstrated to the wider health professional community in Liverpool that there is an active and useful role for history within their organisations, and that with careful discussion of aims and objectives, historians can be integrated into project teams.

Another strategy for the historian as expert adviser is to exploit anniversary ‘triggers’ to engender debate about the current health experiences and the potential for future change. The 150th anniversary in 1997 of the appointment in Liverpool of Britain’s first public health officials provides a good example. A year-long programme of activities, which I directed, focused on the theme of how health has changed in response to a variety of initiatives. Funding from the NHS North West Regional Office was invested in some eye-catching campaigns and events, including a Royal Mail postage frank, an oral history project, school drama productions and a museum gallery entitled *Liverpool: a healthy place to live?* In addition to making Dr William Henry Duncan (Britain’s first Medical Officer of Health) a household name in Liverpool, this year of public health had an unexpected outcome – it raised awareness of just how little ‘health history’ health professionals knew.

The historian as health professional trainer

Out of the development of the 1997 museum gallery came a history component for the Liverpool Master of Public Health (MPH) course. Established in 1989, this attracts British and overseas students, many of whom are already well-progressed in their careers. One of the main curriculum themes is the British National Health Service. It became apparent that many students had no idea how it had been founded, why there were divisions between medical and environmental health services, or how frequently health services had been re-structured. A chronological course was constructed, to show how various health crises, from 1830s cholera to 1980s AIDS, had stimulated a range of government and voluntary responses. Liverpool inevitably looms large in these teaching sessions, given its pioneering role as the first British town to appoint a Medical Officer of Health. The students are taken on walks around the nineteenth century parts of the city to see the remnants of insanitary housing and other significant health landmarks. The sessions include vintage film clips and discussion of historical texts. The integration of history into the Liverpool MPH is also reinforced through the requirement that the students complete a 3,000 word assignment on a contemporary health service initiative, and discuss its historical context. The annual student evaluations of the course have consistently recognised that studying history has provided a welcome sense of perspective, particularly on the current round of health service re-structuring.

More recently, through contact with North West Primary Care Trusts, it was clear that there were opportunities to provide training for other health professionals in health history and its applications. A one-day course was developed with a fellow historian, John Welshman, Senior Lecturer in Public Health in the Institute for Health Research at Lancaster University. We called the course *Health, History, Horizons*, and deliberately structured it to appeal to a wide range of health professionals. It comprises of the following elements:

- An introductory small-group session using a question sheet to assess existing 'health history' knowledge, and to identify specific topics that participants were interested in.

- A presentation on the development of public health leadership, from MOH through to DPH.
- A vintage film session.
- A presentation on how health services have developed in local government and NHS context.
- Small group work on annual health reports, looking at a variety of formats from different periods and organisations to gain an insight into how communication styles have changed.

The diversity of professional backgrounds of those attending (including Directors of Public Health, health promotion specialists, local government policy officers and specialist trainees in Public Health) ensured fascinating discussions and a rich collective appreciation of how tenuous the current British health care structure is. The course has addressed issues which are at the heart of many of the changes in health services at the moment: what are the obligations now for public engagement in decision making? How is leadership provided on issues of risk assessment? Have we progressed from the paternalistic attitudes of earlier health professionals? How can we better use history to explore the concept of potential for change for health and health services in Britain?

The *Health, History, Horizons* training days have been successful in a number of ways. They have raised the awareness of health professionals of the existence of a rich historical resource, they illustrated the ease with which skills could be developed to exploit these resources ‘in-house’, and importantly, they also have drawn attention to the existence of health historians who are willing not only to teach health history, but also to act as consultants within health authorities. Following the training days John Welshman and I received a number of requests from North West PCTs to discuss how historians could become involved with specific health policy and practice issues.

The historian as community health facilitator

One of the most exciting initiatives I am currently involved with seeks to develop local health history. Halton and St Helens PCT has begun a project to engage its community in debates about health expectations and experiences. Research has identified that there is a skewed vision of health determinants, in which many people believe that their poor health is the result of ongoing environmental pollution from the local chemical industry.[22] This ‘urban myth’ persists, despite evidence to the contrary, and it is proving difficult for the local authorities to correct these long-held assumptions. This project will therefore attempt to give ownership of local health history back to the community. Volunteers have been trained in oral history techniques, and later this year will begin to conduct interviews with local residents. Historical analysis will be employed as a key ‘tool’ in enabling them to assess the transformation of their personal and community health.

As a historian, this is an ideal opportunity to exploit my professional skills: first, to provide an overview of developments in health and health care in the PCT region for the project team members. Second, through direct engagement with the local community: through the preparation of ‘how to do’ material on conducting family and local history (accessing birth and death information, interpreting historical documents); guiding the preparation of histories of local health care initiatives, and assisting with the production of multi-media exhibits for display in a variety of public spaces. This project is truly interdisciplinary and multi-functional, engaging with as many groups as possible, from schools to care homes. It aims to enhance social, IT and communication skills through a discussion of how the community’s health has changed over the last century. Done properly, it should mobilise collective action on contemporary health issues. It offers a more engaging, sympathetic style of history than the didacticism of the traditional ‘great men’ institutional or epidemiological approaches.

Shared health history, such as the intended outcomes from the Halton project, could also be assessed in terms of its impact on ‘social capital’ – that contested late twentieth century concept which broadly refers to resources that circulate between individuals and networks within defined geographical spaces. [23, 24] Oral history, in particular, has the ability to ‘root’ people within communities, and thus the potential to strengthen social capital. However, there might also be negative outcomes: in areas

that have witnessed substantial in-migration, the new arrivals may feel excluded by an attempt to base community identity on local history. Yet by locating and then *understanding* historical material that illuminates how a community has developed, it is possible to gain a more accurate interpretation of the importance of economic, political, social and medical factors and their inter-relationship. It is historians who are best equipped to guide interpretations that require sophisticated appreciations of change across both space and time.

The potential for change

These local case studies give some indication of the variety of ways in which historians can engage with health professionals and the public. They demonstrate that it is possible to nurture the right conditions for such relationships to be created and maintained. Key factors include establishing face-to-face contacts and exploiting existing networks. This is easier at the local level than at the national, but if the newly re-structured British Health Service is to learn from earlier incarnations, it must surely now find mechanisms to take local good practice and disseminate it nationally. It is also important that the type of history produced must also be right and ripe for policymakers to use. This does not mean abandoning historical methodologies, but perhaps a more careful production of written materials to include executive summaries, in a language that policymakers will understand.

The potential for such innovative work is huge. However the capacity of academic health historians to participate from their current positions is limited. University teaching and the relentless pressure to publish material that will be suitable for the Research Assessment Exercise means that such outreach projects have a lower priority than they perhaps should. Yet these are valuable opportunities for reinvigorating the contact and debate between academic and practical public health.

History is not a new 'tool' in the public health tool kit.[1] Many of the English Chief Medical Officers also wrote engaging histories, a demonstration of their intellectual integration of historical and contemporary issues.[25] They drew original conclusions from their historical analyses to inform future policy development. There is now also

a strong community of historians who have developed their own portfolios of ‘history-based-evidence’ to offer to health professional colleagues as proof of their usefulness and value. [26] See for example the work of Abigail Woods on the British Foot and Mouth outbreaks, who was able to provide the rapid historical contextualisation demanded at the height of 2002 crisis. [27] The real challenge now is to consolidate this transition from leisurely academic-based discussions into practical liaisons with health professionals, responding to real-time issues.

It is clear that there is a demand for the involvement of historians as experts in their own right, particularly at the local level. They are also required as trainers in the use of historical context in contemporary health service and public health environments, and to stimulate greater public engagement in the debate on how our health has changed. But we need to ensure that such initiatives are developed in an appropriate way, and driven by professional historians. Health historians also need to be responsive to the sorts of history that will be useful, and to demonstrate that they have an active interest in more recent events. [28] They must be there at the outset of new policy formation or crisis management – as part of the initial team. This in turn, demands that relationships with historians can be made easily. This is much more likely to succeed if history becomes an integral component of undergraduate medical education, Masters level public health courses and the curricula for public health professional examinations. [29,30] As Virginia Berridge has indicated, in previous collaborations with health professionals, historians have tended to focus on content rather than process. Yet knowledge alone does not lead to behaviour change. [31] A properly devised strategy is now required to establish history as an essential skill within the health profession team, and also within evidence-based analyses of contemporary health issues. To adopt the fashionable management jargon, it requires that historians are core members of ‘communities of practice’, both at local and national levels. [32]

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