

Living the fall and rise of public health in the NHS: John V Dyer and community medical leadership in Lancaster, 1968-92

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ABSTRACT

The recent appointment of Dr Christopher Chiswell as a public health medicine consultant in Morecambe Bay's acute sector reflects national policy commitments around integration and population health management. His career trajectory embodies this shift, coming from a background working in specialist trusts rather than conventional bastions of public health. This shift aligns with policy debates between historical public health and new population health, and the location of medical leadership. Using the past to illuminate enduring tensions in the present, this paper considers those involved in changing community medical leadership in Lancaster between 1968 and 1992 through the career of Dr John Dyer, arguably Morecambe Bay's first combined public health doctor.

INTRODUCTION

The appointment of Dr Christopher Chiswell as a consultant in public health medicine by the University Hospitals of Morecambe Bay NHS Foundation Trust in December 2023 reflects national policy commitments around integration and population health management within the acute sector.¹ Dr Chiswell's career trajectory embodies these new trends, specialising in public health outside its traditional primary care and local authority bastions, then working in specialist trusts in the West Midlands, having originally studied at Birmingham. Such trends form part of a wider shift from traditional public health and its historical environmental, epidemiological and educational concerns to population health management focused upon improving the outcomes of defined patient groups and reducing their social, medical and financial burdens on health services.²

Whilst articulated as new, such trends are embedded in the National Health Service (NHS). Public health has experienced a fall and rise in its fortunes, able to anchor its identity to emerging political and management concerns as part of a process of reinvention. Using the past to illuminate how such tensions endure in the present, this paper considers them through the life and career of Dr John Dyer, responsible for public health in Lancaster between 1968 and 1992, and arguably Morecambe Bay's first public health doctor.³ The paper provides a chronological account of Dyer's medical education, early appointments and experiences in Lancaster as recounted in an oral history interview for the North West Sound Archive in 2011.⁴ Archival documents are used to contextualise his reflections within wider policy developments, and explore their significance in relation to changing community medical leadership.

STEPPING INTO MEDICINE

John Vincent Dyer was born on 14 April 1930 in Whitehaven to schoolteacher parents. West Cumberland's declining economic prospects during the interwar years offered little but 'special problems to the civil servants and elected rulers'.^{5: 221} From a young age he was sent for his schooling to Enfield

Grammar School, London, where opportunities were greater and he could acquire the southern accent wanted by his parents.⁴ Shortly after the creation of the NHS in July 1948, he secured a place to study medicine at Middlesex Hospital Medical School. Unfortunately, details of this time are scant, with student records not surviving.⁶ Middlesex was one of the smaller historic London medical schools, although still carrying a reputation for excellence. It was undergoing a renaissance owing to new professorial appointments, demobilised doctors experienced beyond their years serving as registrars in firms and occupying the forefront of subspecialisation.⁷ The resulting London pedigree opened myriad career possibilities for Dyer by the time of his graduation in 1953.

Despite the doors open to Dyer, he 'soon drifted back up to the north' following a series of house jobs at hospitals in the south.⁴ Crucially, he chose junior appointments with Lancaster and Kendal Hospital Management Committee (HMC). His time was 'absolutely marvellous', especially working single-handed as the houseman covering all departments at Westmorland County Hospital (WCH), Kendal.⁴ This formed part of established practice within the small WCH,⁸ and pointed to longstanding workforce issues for the area in the early NHS.⁹ He was, however, soon made a 'conscript doctor' to complete his National Service.¹⁰ 'Life was very pleasant' stationed at Royal Air Force (RAF) Cardington, Bedfordshire, with abundant resources compared with Kendal. The time developed his interest in public health, managing recurrent infectious disease outbreaks at the base, and learning the ropes of medical administration. This was affirmed towards the end of his service through secondment to the Air Ministry.^{4, 11}



Figure 1: Dr John Dyer during National Service, c1955-57.

It was this enthusiasm which led to postgraduate study at the London School of Hygiene and Tropical Medicine (LSHTM), which he described as a 'mecca for public health'.⁴ The LSHTM maintained links to the capital's leading research institutes and public health departments for students, with elective opportunities in child health being highly prized as one of the few bastions of professional power in the NHS. Unlike Middlesex, rifts amongst the staff at LSHTM made the

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education experience less than ideal.¹² During Dyer's time two thirds of the students came from Commonwealth countries or remaining British colonies, reflecting the declining career prospects of public health within the NHS.^{12, 13} On completing the Diploma in Public Health in 1957 the LSHTM's Dean, Sir James Kilpatrick, told Dyer that he had the 'pick of the posts' available.⁴ This was magnified through his cumulative London contacts.

FOOTSTEPS INTO PUBLIC HEALTH

Predictably, Dyer first moved to Lancaster. He was appointed as Assistant Medical Officer for Health (MOH) for Health Division (HD) 2 of Lancashire County Council, one of seventeen for the county, comprising Lancaster, Morecambe, Carnforth and the surrounding rural areas with a population of around 110,000. Duties within the HD were organised functionally, with maternal and child health, mental health and the welfare of the elderly providing rare areas of growth.¹⁴ Supporting the administrative duties of the MOH, Dyer was exposed to the vagaries of council politics, particularly contentious ones surrounding housing where the Conservative majority favoured improvement over clearance.¹⁵ This exacerbated tensions between the district and county council, mirrored in the two hats worn by MOsH with district responsibilities for Lancaster and divisional ones for Lancashire. This preference went against national policy pushing demolition.¹⁶ Patrician politics and paternalism remained the order of the day in determining the horizons of public health in Lancaster.¹⁷

The first substantive public health appointment for Dyer came in Corby in 1959. One of Britain's post-war new towns in Northamptonshire, the vacant MOH position was suggested by LSHTM's Dean because, owing to its social artificiality, it presented new professional opportunities outside traditional public health.⁴ The influx of young families from a range of nationalities into stable employment, almost exclusively in steel, brought myriad social problems.⁴ Housing was being erected rather than demolished, with much of poor quality and owned by the steel companies, making Corby a company town.¹⁸ New public health strategies centred around industrial and residential clean air and smoke control coupled with noise abatement given shift work around the clock.¹⁹ He left given the stifling political control held by the Northamptonshire aristocracy over the county council, preventing spending and the pursuit of more progressive policies.⁴

Upon leaving Northamptonshire Dyer returned north to Lancashire, as MOH for Lancashire County Council HD 6 from 1962. This covered the areas surrounding Burnley with a population of around 90,000 but not the town itself, which was a separate County Borough Council.²⁰ Medical administration dominated his time in HD 6. He fostered closer working relations with acute hospital services. These were at a nadir through proposed closures of smaller facilities following the publication of the 1962 Hospital Plan.²¹ Improving relations was limited by professional and organisational boundaries, with attempts to move mental health provision from institutions to the community failing given they entailed transferring costs across NHS service frontiers.²² Dyer also chaired the 'problem family' committee for the area, the precursor of modern child protection, bringing together statutory and voluntary services involved with children to develop common actions.²³

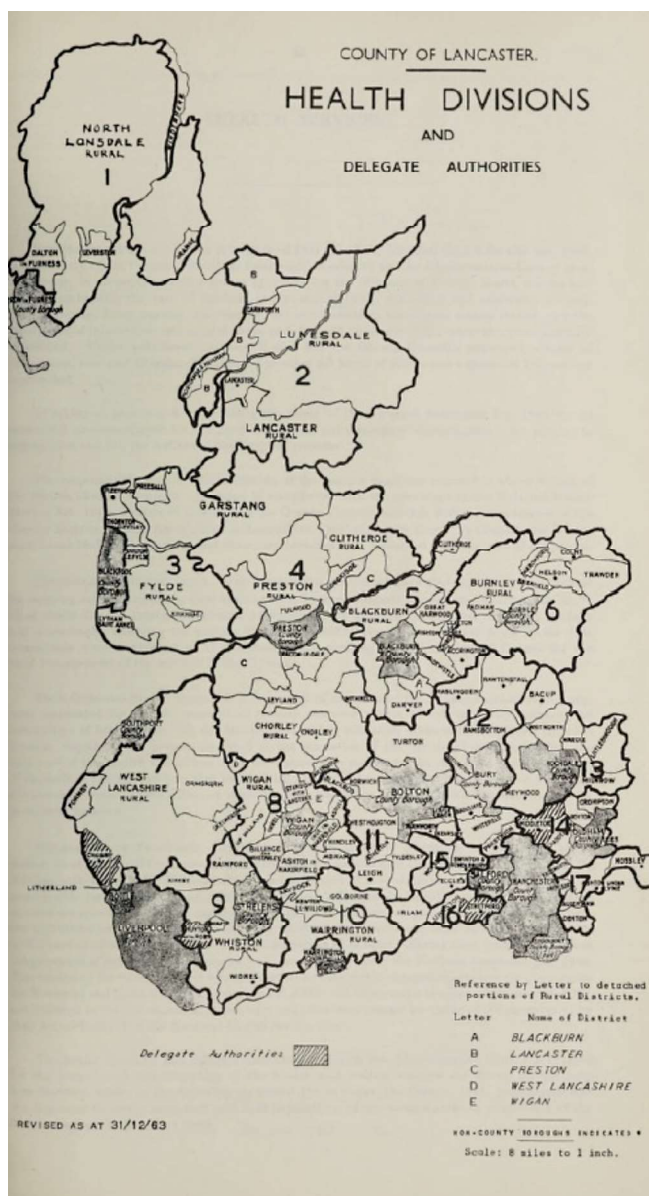


Figure 2: Map of Lancashire County Council Health Divisions, 1963.

Mirroring his time at Lancaster and Corby, politics also loomed large in shaping the horizons of public health strategies. Whilst having the support of the mayor and council, common to public health in Labour controlled areas,³ he was unable to secure a clean air zone owing to entrenched opposition from coal miners and organised labour concerned for their livelihoods.⁴ He was more successful in modernising sanitation in old properties with the removal of long-drop toilets common to the steep East Lancashire valleys, enabling water closets to be installed through generous use of improvement grants.²⁴ These same steep valleys contributed to more dramatic events and of one Dyer's most memorable accomplishments as MOH for HD 6: the council's accomplished response to the 1967 Barrowford floods.^{4, 21} Such moments exposed the importance of leadership, as much as competent medical administration, in successful public health.

STRIDENT MEDICAL OFFICER OF HEALTH

The unexpected death of Dr Robert W. Farquhar, MOH for Lancashire HD 2, in 1968 led to Dyer being 'headhunted' for the post by the County Medical Officer (CMO), Dr Stanley C. Gawne. He 'jumped at the chance' of a 'dream of a job' which had 'everything you could want from a public health point-of-view'. Unlike HD 6, there was 'no trouble getting trained staff', and he built a capable, large department in six years. These included Dr Bridie O. Wilson and Dr William R. Falconer, whom he recalled as reliable and enterprising deputies.^{4, 25}

²⁶ Such was the confidence in Dyer's leadership potential that Gawne's successor as CMO from 1969, Dr C Henry T Wade, leaned upon him to occupy the vacant HD 1 MOH position covering Ulverston, Lonsdale and the Furness Peninsula outside Barrow prior to the fated 1974 reorganisation.³

The first major reorganisation of the NHS in 1974 caused chaos for Morecambe Bay's health service geography.²⁷ This chaos was amplified in public health which 'had been building up since the beginning of the health service'.^{28: 219} Like 1948, professional status was once again reduced with the abolition of the MOH. Replacement Community Physician (CP) positions were fewer in number owing to planned coterminosity between reformed health authority and local government boundaries. CPs worked within new Area Health Authorities (AHAs), and District Management Teams (DMTs), sharing professional space with doctors in the acute hospital sector.¹³ Within the DMT decision-making was based around fashionable consensus management, with notional professional parity between administration, finance, nursing and clinical representatives. However, and crucially in the words of the official historian of the NHS Charles Webster, this repositioning meant community medicine became 'inevitably preoccupied with the general management of resources' as a result.^{29: 769} This slowly shifted their professional focus and understanding towards population health.

Whilst MOH from 1968 to 1974, Dyer managed uncertainty brought by these concurrent changes. Enacting the 1968 Seebohm Report meant social work responsibilities and resources abundant in his department were progressively stripped and passed to new combined Social Services Departments (SSDs).³⁰ This hampered existing policies in mid-development such as day nurseries and staffing in welfare homes for the elderly.³¹ Yet Dyer pushed forward with family planning services funded by his department – although provided by the Family Planning Association (FPA)³² – enabling progressive policies which expanded the number of clinics and eligibility for both unmarried women and those under 21.^{4, 33} Other, traditional, areas of environmental health remained. Periodic bouts of food poisoning in boarding houses and Pontin's holiday camp in Morecambe required careful investigation and action to sustain confidence in the tourism industry.³⁴ The isolation of contagious mariners in his capacity as MOH for the Port of Lancaster remained, although sexual rather than infectious diseases commanded greater attention with the decline of maritime traffic.^{4, 35}

MARCHING WITH COMMUNITY MEDICINE

Innovation carried into Dyer's time as CP for Lancaster DMT within Lancashire AHA from 1974 to 1982; a fact recognised and acknowledged by his superiors.⁴ The new DMT shared virtually identical boundaries with the old Lancashire County

Council HD 2, minimising otherwise chaotic consequences involved in transferring public health from local to health authorities. Here, Dyer was instrumental in establishing a child development centre.³⁶ During discussions concerning the future of Longlands Annexe in 1977, he pushed for its retention.³⁷ This was no mean feat given imperatives to economy with the introduction of cash limits from 1976. The centre, opened in 1979, was different to paediatric subspecialist ones focused on specific conditions which had emerged earlier elsewhere. The Lancaster centre unified a range of previously scattered, fragmented assessment and diagnostic facilities for children into a coherent multi-disciplinary one.⁴ With its traditional child health and new financial concerns, it also encapsulated the shift towards population health management.



Image 3: Dr John Dyer at his desk, c1980s.

Despite Dyer's personal involvement and pride in the venture,^{4, 38} its realisation was rooted in new, technocratic health care planning teams. Planning teams reflected national service priorities around the elderly, maternity, children, and mental health. These were also traditional domains of public health, and ones which Dyer had championed as MOH, and he held *ex officio* membership on each.³⁹ Beyond reactive developments such as the child development centre, planning occurred annually with nationally determined priorities issued through the Department of Health and Social Security's (DHSS's) guidance. Perennial delays to the guidance, its vague and opaque nature, and the wider context of cuts rendered the system deeply ineffective and easily circumvented by entrenched clinical interests.⁴⁰ Notwithstanding the occasional success, particularly attachment schemes for nurses and health visitors to GP practices,³⁷ interminable planning rounds consumed increasing amounts of time and energy without the desired results.

In 1982 AHAs were abolished and the DMT became a statutory District Health Authority (DHA) with a board of representative members alongside officials. The leadership requirements of the CP were transformed in 1985 with the implementation of the 1983 Griffiths Report,⁴¹ bringing private sector general management methods into the NHS. Clinical decisions were increasingly subordinated to executive authority and Dyer's capacity to exert influence diminished.⁴² However, the publication of the Acheson Report in 1988 reinvented the position, replacing CPs with Directors of Public

Health (DsPH).⁴³ This reinvention stemmed from several sources. Firstly, the lack of power around communicable diseases within the reformed NHS which became evident with several deadly, scandalous outbreaks, particularly in mental hospitals. Secondly, the emergence of new epidemic and transmissible diseases for largely defined patient populations, notably AIDS among homosexual men. Thirdly, political imperatives towards individual responsibility for health, engendering reinvigorated health promotion and education.⁴⁴ Crucially, population health management allowed traditional public health methods, especially epidemiology, to be reinvented by embracing models of fiscal efficacy.

Dyer and Lancaster were not immune to these developments. In 1981 he, along with the Public Health Laboratory Service (PHLS) and its Centre for Applied Microbiology and Research at Porton Down, Salisbury, traced and responded to an outbreak of legionnaires' disease from Heysham power station in 1981, the first recorded in an industrial setting in Britain.⁴⁵ Although AIDS had a mandated national reporting process, he was tasked with coordinating and leading the response, recalling the 'tremendous fear' and political uncertainty.⁴² Health promotion and education were significant too, especially in relation to childhood immunisation programmes. Although thankfully never realised, like all CPs Dyer was responsible for civil defence planning and preparedness for nuclear war which ebbed and flowed with the peaks and troughs of the Cold War.^{46, 47} Conversely, he remained alive to very traditional public health concerns. Those of contaminated milk abound in the history of the MOH.⁴⁸ In Lancaster brucellosis posed particular problems given the rural and tourist economies, and he successfully reduced incidence in the face of resistance from the National Farmers Unions (NFU).⁴ Traversing politics and interest groups remained an abiding feature both of Dyer's career, and the post-war public health profession.

Amidst a backdrop of further reforms constituting a continuous revolution in health,²⁸ Dyer remained in post as DPH for Lancaster from 1988 to 1992. After retirement he worked part-time for his replacement, Dr Nick Gent, until the merger of Lancaster with South Cumbria DHAs in 1994 to create Morecambe Bay Health Authority. This meant he was not DPH as new market reforms solidified population health management approaches. These occurred with the creation of an internal market in the NHS in 1991 through the separation of services into purchasers and providers. The DHA, as purchaser, used epidemiological statistics to ensure spending decisions obtained mandated health gains in certain disease categories outlined in the 1992 report *Health of the Nation*.⁴⁹ This ushered in the belated rise, after such a long fall, of public health which had been lived by Dyer in Lancaster over the previous twenty-five years.

CONCLUSION

The career of Dr John V Dyer shows how community medical leadership in the NHS in Lancaster has been exercised and constrained during its fall and belated rise. This resurgence occurred under the banner of new public health, where population health management focused attention on reducing the social, medical and financial burden of certain patient groups upon costly health services. Yet Dyer retained interest and experience in traditional public health concerns locally,

despite these being sidelined nationally. These were often unglamorous and mundane, but an essential part of maintaining the health of the community and economy alike. His education and background prior to 1968 here demonstrate the necessity of political diplomacy, as much as medical administration and public health, in achieving outcomes. However, the definition of such outcomes has narrowed with the integration of public health and acute services under managerial and financial logics. Whilst offering clarity, they have lost broader reach into experiences of communities and society. Crucially, these competing tensions – between national and local, patient and people, and efficacy and economy – continue to shape the parameters of public health and community medical leadership in the NHS across Morecambe Bay. Dyer's career offers myriad lessons on how these can be managed and negotiated, rather than reconciled, to achieve lasting results for both people and the profession.

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Mr Peter Dyer Associate Medical Director & Responsible Officer for UHMB has been awarded an O.B.E. in the Kings Birthday Honours list 2024.

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(a full list available on request)

ACCS (Acute Care Common Stem) trainees at University Hospitals of Morecambe Bay

Syed Bilgrami, Consultant Rheumatologist and TSTL Lead for ACCS UHMB

We are very humbled that we managed to host the first teaching day for ACCS (Acute Care Common Stem) trainees at University Hospitals of Morecambe Bay (UHMB) and hopefully we will be able to host regional teaching at the Royal Lancaster Infirmary in the future. We were overwhelmed with the response we had as this day was attended by ACCS trainees from the North West and Mersey regions as well as two FY2 doctors and some IMT and LED doctors as well. I am

pleased that all tutors were from UHMB except Catherine who was from Royal Bolton Hospital.

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