

CONFERENCE KEYNOTE ADDRESS

'HIDDEN FROM HISTORY'?: ORAL HISTORY AND THE HISTORY OF HEALTH POLICY

by Virginia Berridge

The oral history of health and medicine has focused primarily on 'history from below'; elites in science and medicine have also been studied through their life histories. But the role of networks of interests in the making of health policy has been largely neglected by oral historians, although not by other disciplines, who count interviewing among their tools of policy analysis. The agents of health policy making tend to be 'hidden from history', but should be important foci of our attention. We are otherwise in danger of losing sight of the operation of power and its structures in health history. More reflexive work on the methodology of such interviewing is needed. The oral history of health policy making presents some issues which are similar to history from below and some which are different, not least the greater power of the interviewee. To do such history should not mean taking the side of the powerful or writing 'advocacy history'. Historians should be careful not to become directly embroiled in present day policy. There is an inescapable tension between their interests and those of the policy elites they may study.

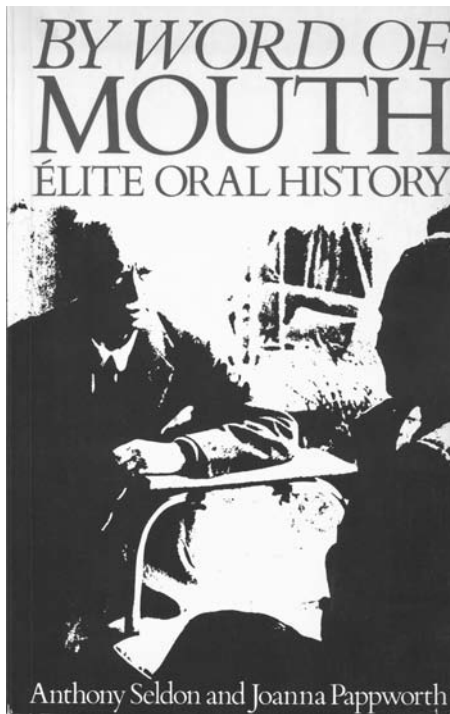
ABSTRACT

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Oral history as a specialist field had its origins in the desire to reconstruct the history of those who were 'hidden from history'. The 'life history' methodology and 'history from below' has dominated in the oral history field.¹ With some exceptions, this has also been the main utility of the approach within the study of health and medicine, and is demonstrated by major collections of oral history work and by the programme of the 2008 conference of the Oral History Society, timed to coincide with the sixtieth anniversary of the National Health Service

(NHS).² The role of elites in health and medicine has been less studied, although there are examples of projects which have studied health professionals. But the role of such elites in the making of health policy has been largely neglected in oral history. These agents of policy tend to be 'hidden from history', but should be important foci of our attention.

We have tended to neglect what, in other work, I have called the role of the 'policy community' in health policy.³ So elites in this context means not just studying the role of



doctors or politicians ; the meaning of the term incorporates the civil servants, the pressure groups, the professional bodies, as well as the politicians and others who go to make up the circuit of influence in a particular policy area. It can incorporate the views and activities of lower level bureaucrats as well as leaders, for such people are sometimes influential in policy formulation. By policy here is meant not formal programmes and plans of action but rather who and what influences the responses to particular issues, the operation of process and power through different layers of influence. Buse, Mays and Walt comment, ‘...policies may not arise from a single decision but could consist of bundles of decisions that lead to a broad course of action over time. And these decisions or actions may or may not be intended, defined or even recognised as policy’.⁴

THE DOMINANCE OF HISTORY FROM BELOW

The dominance of life history and history from below in the field of UK oral history is clear. The influence of History Workshop and the recovery of the history of the dispossessed spilled over into the health field. The pioneering work of Paul Thompson was important in both his published work and in the training courses which he ran for health historians with Rob Perks. The work of Roy Porter on the patient’s view is often also cited as key to the transition

to the health field, although his article on the subject was not specifically focused on oral history.⁵ *Oral History* itself as a journal provides evidence. When I checked, I found it almost exclusively focused over time on the ‘bottom up’ approach. A special issue in 2003 on the interview process made no mention of interviewing elites.⁶ That is understandable. Oral history is a key and often the only tool – as we all know – for getting at the history of those who do not leave written records. Some of my earlier work on using and dispensing opium in the early twentieth century, used oral history for this purpose – just as, in more recent times, Alex Mold and I have been interviewing members of the drug user movement with the same end in view.⁷ Oral history can often be used as a stand alone methodology, without reference to other sources.

HISTORY FROM ABOVE

This is not to say that ‘history from above’ has been neglected. In its early institutional incarnation in the UK in the 1960s and 1970s, oral history had a strand of ‘history from above’ exemplified by the work at the London School of Economics (LSE) of Anthony Seldon and others and by their writing on elite oral history.⁸ In research by historians with direct relevance to health, one can cite several instances of this type of work. The witness seminar is a particular variant of oral history and its advantages and disadvantages are discussed below. But there is no doubt that these gatherings provide much material about medical and scientific elites. The long series of witness seminars on contemporary medicine and science organised by Tilly Tansey and the team at the London Wellcome Centre provide a valuable resource for developments within science and medicine.⁹ The Royal College of Physicians (RCP)/Oxford Brookes University has a series of video interviews with key health and science personnel.¹⁰ Other projects in recent years have used interviews on general practice, on geriatrics and on other specialties.¹¹ The witness seminar series run from the Centre for Contemporary British History tends to focus on ‘high politics’. Their seminar on the 1967 Abortion Act which combines personal experience with policy insights is a rare example of a health topic in the series.¹² Another deals with the origins of the internal market in the NHS.¹³ There is also the strong tradition in the history of science – as opposed to specifically health and medicine – on interviewing those involved in key aspects of contemporary science. This has led to reflection on the biographical and oral history approach, in particular through work which has been edited and coordinated by Thomas

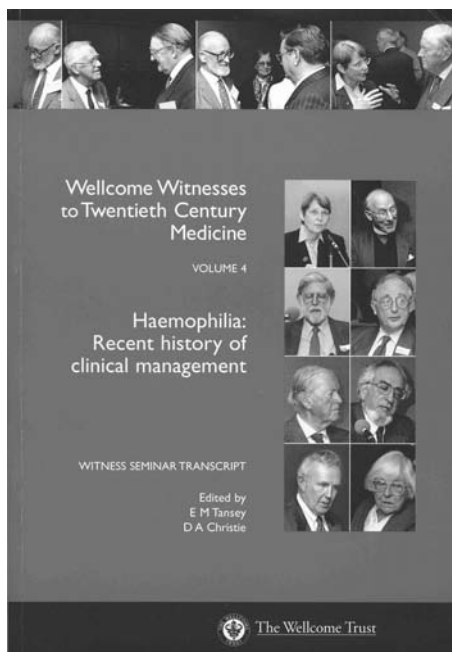
Soderqvist and Ronald Doel.¹⁴ Soraya de Chadarevian's paper on using interviews to write the history of science is one of the best and fullest discussions.¹⁵

So what is the problem? Where oral historians have dealt with what could broadly be called an elite within medicine, this work has tended to focus only on the role of scientific and medical professionals in their specific professional arenas. We do not see them operating – or rarely – within the corridors of power, nor examine how policy is made in the areas of health and medicine within which the specialty fits. The methodology is used less to study the history of health policy as a dynamic and the engines and networks of power. As I stated at the outset, we can study, through oral sources, the role of the 'policy community' in health policy. I have already commented that the players or actors in such circuits of influence will be varied and not all by any means will be health professionals. For illicit drugs, for example, that network of influence will be quite different from public health, from the formulation of policy on diet, or on HIV/AIDS.¹⁶ It was striking how little oral history work by historians dealing with NHS policy making was drawn on during the recent sixtieth anniversary celebrations, although there was plenty of published oral reminiscence in the media.¹⁷ And the NHS too is only one aspect of the broader field of health policy. There are many other aspects of health policy making outside service development.

THE WORK OF OTHER DISCIPLINES

Other disciplines have been interested in this arena. Political science is an obvious example. Back in the 1970s when oral history was also getting under way, there were a whole series of interview-based studies of Whitehall and civil servants – Gummatt's *Scientists in Whitehall* for example or Kogan and Henkel's research on the Department of Health and the Rothschild initiative – and, away from the health field, Hecla and Wildavsky's *The Private Government of Public Money*, studying the role of the Treasury.¹⁸ That interest has continued and one only needs to look through the pages of the relevant policy or political science journals nowadays to see how much recent oral history is going on.

My political science colleagues at the London School of Hygiene and Tropical Medicine (LSHTM) teach a course on health policy, process and power, where papers based on oral history, but not called such, regularly feature. To take just one example, Jenny Lewis wrote in an issue of *Social Science and Medicine* about networks of influence within Australian health policy and used interviews to do it.¹⁹ In the UK



the work of people like Stephen Harrison or Christopher Pollitt has been quite extensively interview based.²⁰ There is also work in other fields- for example Gillian Walford's book on *Researching the Powerful in Education*.²¹ For health, Rudolf Klein and Patricia Day, sometimes working with the US historian and policy analyst Daniel Fox, whose work also exemplifies some of this tendency, have studied health policy making as inside/outside observers: their contacts in health policy are utilised as background information.²² Anthropologists are now interested and there has been much discussion in the last decade about the 'anthropology of policy' and interviews as tools of the trade.²³ Wenzel Geissler's work on the relationships of science in Africa, on African 'trial communities' is using interviews as oral history.²⁴ Journalists too have long used interviews as a method and Nicholas Timmins' work is a prime example for welfare policy in general.²⁵

But even in those areas there is little discussion of the methodology. The social scientist Karen Duke, who studied the recent history of prison drugs policy a few years ago, pointed to what she termed '...a paucity of methodological and reflexive literature which explores how policy networks and the actors within those arenas are actually studied'.²⁶ She stressed the importance of 'switching the research gaze from the "objects" of policy to those who are in the powerful positions of "making" policy.' In saying this she echoes others who stress the importance of this type of work for the study of dominant power relations. Chadarevian, too,

points out that knowledge of the functioning of elites is as important for that study as research on the dispossessed.²⁷ How these elites operate within the policy field is more important still.

ISSUES IN DOING POLICY 'HISTORY FROM ABOVE'

Having argued in this way, I will turn next to look at some of the issues which beset the oral history of policy. Some are similar, others rather different to those for 'history from below'. I will speculate about future tendencies both in the study of health policy and more generally in oral history work in health.

My main areas of discussion are:

- Dilemmas of the interview and the witness seminar
- The active role of elite interviewees
- The position and role of the historian
- Future possibilities: documents and heritage?

DILEMMAS OF THE INTERVIEW AND THE WITNESS SEMINAR

Some issues in interviewing are different from the life history or history from below approach. For policy work, the researcher will not usually be collecting a life history. The dominance of the life history approach on training courses is less than helpful to junior historians wanting to develop the study of policy. One will often be simply interviewing a prominent person about their involvement in a particular set of events, not seeking out details of their background and where they were educated.²⁸ Another issue is whether or not to profess ignorance. This is not limited to policy history but has a particular resonance for that work. Eric Hobsbawm began his career as an oral historian, doing interviews with leading Fabians. In his commentary on writing the history of one's own times, he expressed the view that his interviews were of little use unless he already knew more than the interviewee – in which case it was rather pointless to do them.²⁹ That stance is debatable, but when one is interviewing powerful people, the issue of ignorance or knowledge has to be carefully negotiated. Maurice Kogan, well accustomed to research in the corridors of Whitehall, wrote about the 'ritual humiliation of the researcher'.³⁰ We have to pretend that we know less than we do in order to draw out the interviewee. But it is sometimes helpful to lay out real ignorance: to do interviews right at the start of research and to acknowledge that you know very little, that only the testimony of the person you are talking to, will help. It is then surprising what people will tell you. My initial research on HIV/AIDS policy making was informed by interviews conducted with the sociologist Phil

Strong. Professing ignorance was helped by the perceived emergency of the issue at that time, in the late 1980s.³¹

This interaction is complicated by issues of gender, age and status, which also affect life history work. When I did interviews jointly with Phil Strong, we always talked afterwards about who had made eye contact with whom. Some gay men talked to me and ignored him: while one female sociologist clearly wished I was out of the room. Sometimes being a woman interviewer helps and sometimes it does not. For health policy, being a health professional and a doctor clearly has advantages. Dominique Florin, a public health doctor, researched an MD thesis about the policy making process round the insertion of health promotion objectives into the general practitioner (GP) contract in 1990. As her supervisor, I noticed that not only did medical civil servants readily agree to be interviewed by her but they were more open with a fellow medic. The language of the interviews conveys very well the 'macho' culture of the medical civil service at that time. There was a camaraderie and fellow feeling which would have been absent with an historian. Here is a civil servant talking about how health promotion was inserted into the contract:

...health promotion was put in for the obvious reason, it is motherhood and apple pie. Nobody in the real world outside could criticise the Minister for saying we think health promotion is a good idea. Ministers would have to think carefully about their own profile in all of this, you don't go knocking a great institution like GPs without a lot of crap from outside, unless you are being seen to do something that patients would inevitably think was a good idea, more like health promotion.³²

And another example: 'Health promotion clinics were an invitation to print money.

This was the number one reason for 1993'.³³

Issues of status and profession matter. My colleague Susanne Macgregor, a well-known social policy specialist, who has researched the drug policy field for thirty years, is currently researching a history of British drug policy since the late 1970s. She finds that she gets access to civil servants who might not speak to a more junior researcher.³⁴ These interviewees are also aware of her work and sometimes the interview turns into a dialogue or discussion. Whether this is desirable is debatable. There has been much discussion in the oral history field about how the interviewee can become tainted by retelling the same story. But the interviewer can also be tainted.³⁵ Sometimes the interviewee

who knows the interviewer's past work will start to double guess the purpose of questioning. I have even had an interpretation I had published quoted back to me by an interviewee as his own interpretation of events. Interviewees can be too well read, too knowledgeable and too canny. I would suspect this is less the case for 'history from below'.

There is a power struggle in an interview between the interviewer and the interviewee, both of whom may have different objectives. This can be a mutually exploitative relationship, an issue which was discussed in the media in the wake of the Kelly/Gilligan affair at the time of the Iraq war. In my AIDS work I had a senior figure in the Medical Research Council (MRC) anxious to proffer his view of history, how the Council had dealt with HIV in the early days. Of course I accepted every word he said, but I knew from other sources that clinicians and researchers had been disgruntled with that early MRC response. This interview was important for its latent rather than its manifest content: of justification after time had passed. Getting beyond the official line is difficult and civil servants say that policy is for ministers to make although you know that they made it. Sometimes interviewing a lower level or 'outside' person who has been involved in events helps. The role of 'street level bureaucrats' in oral history of this type can be important.

Interviews can also change over time. What people say at one time and in one place can be quite different from what they say later on. Over the years, stories become set in an official history mode and the interviewee, particularly if eminent, develops a set public narrative which is difficult to dislodge. In recent work on smoking, I found that many people in the field had developed set stories because they had so often been interviewed and re-interviewed on the same topics. But in the archive of the pressure group Action on Smoking and Health (ASH) in the Wellcome library, I found a set of transcripts of interviews with key players conducted by an Australian journalist in the 1970s: these presented a different picture.³⁶ And an interview with Bradford Hill, one of the early researchers, who was interviewed less often, in the RCP video archive also presented a different view of the original research.³⁷

The setting and format can also make a difference. For doing policy oral history the witness seminar needs to be included within the oral history 'tool kit'. The results which can be obtained from this oral method can differ from that from individual oral history interviews. Sometimes one gets more from an interview, sometimes a witness seminar can be an excellent format. This is not always the case. For the

AIDS work, I interviewed a haemophilia consultant at length. I heard of the dilemmas which had confronted consultants as they tussled with whether to give their patients Factor VIII, the treatment for haemophilia made from pooled blood, in its British or American versions. They gave British and their patients were infected with HIV. But the rationale was the belief that voluntary systems were best for the blood supply: a belief which in this case turned out to be wrong. The US supply had been heat treated but heat treatment was at that stage regarded as a doubtful procedure because of an earlier series of infections with hepatitis B.³⁸ But at a subsequent witness seminar on haemophilia and changes in treatment, not a single participant – including the person I had interviewed – even mentioned HIV/AIDS. The public discussion which was considered suitable was about the undoubted advances made in treatment since the war, of which Factor VIII was one. The catastrophe of AIDS was for more private discussion.³⁹ It is of course unlikely now, with the passage of time and the compensation cases about infection that have been in train, whether even a private interview would be given. Other historians have told me of witness seminars where policy actors are unwilling to interact, despite the informality and confidentiality of the setting. One which brought together former Chief Medical Officers did not produce real interaction.

Sometimes the opposite can happen. A witness seminar can strike sparks and give material which would never come from an individual interview. At a witness seminar on the Black Report, the report on inequalities commissioned by a Labour government in the 1970s and subsequently presented to the incoming Conservative government in 1980, the panel were happily in reminiscence mode. The well-known story was how the Conservative government had blocked the report and failed to publish it properly. But other stories started to emerge through the interactions in this group exercise. The sociologist Peter Townsend talked about how he and the public health researcher Jerry Morris could not agree about the implications of the data and so the report was delayed. It was presented, not to the outgoing Labour government, but to the incoming Conservatives. And suddenly the two civil servants also taking part in the seminar, who had had responsibility for the enquiry into inequalities, showed their irritation with the researchers. Former chief scientist Sir Arthur Buller burst out to Sir Douglas Black: 'could you not have produced something earlier? You knew that the tide was turning and a Conservative government was likely to be elected. Poli-

tics is the art of the possible – couldn't you have taken that on board?' And Black replied, 'oh we are researchers and scientists and not politicians'.⁴⁰ That sort of exchange, which added a new dimension to the story, would never have been achieved through the individual interview format. And there is a further setting – which I call research standing by the sink or in the lunch queue – which is open to health historians in a health setting such as the London School of Hygiene and Tropical Medicine (LSHTM). The possibilities of such casual interaction in a public health setting are infinite and can be conveyed through the anonymous 'personal communication' route of citation.

THE ACTIVE ROLE OF ELITE INTERVIEWEES.

In elite oral history dealing with policy, the interviewee can have a powerful and sometimes baleful influence on the research. Oral history from below also has issues of power but they tend to be in the opposite direction, with the power of the interviewer dominant. For the style of interviewing I refer to here, the interviewee is not dependent on the interviewer for 'voice'. The sources can bite back. For example, the former chief inspector of drugs in the Home Office, Bing Spear, whom I had interviewed, took strong exception in his posthumously published book on British drug policy to what he saw as my interpretation of the 1920s changes in drug policy. It was a mistaken perception of my view and Spear was concerned to defend the Home Office position against attack, as he saw it. But it was difficult, not least because of his death, to 'bite back' in turn.⁴¹ In other instances, historians have been attacked through their methodology because they are said to have interviewed the wrong people or not interviewed the right ones. Actors in policy will have very definite views, dependent on their stance, on who one should, or should not interview.

Sometimes a journal editor will ask an oral source to referee a paper written on work which has involved that referee as a participant. When Jenny Stanton and I were editing a special issue of *Social Science and Medicine* on research and policy in the late 1990s a paper from one of our contributors was sent off to a reviewer who had been involved in events which had been written about by the contributor. This referee, we later discovered, had a strong objection to any research paper on the subject being published, in part because of their personal involvement. This can be a serious matter if one wants to publish outside the closed confines of the historical journals. I had the same experience with a leading medical journal, which chose a

referee who declared that the events I was analysing were 'well known' and nobody needed to know more about them. They were also contentious at the time I was writing and it might have been thought that the history, if published, could have raised awkward issues. Such involvement can lead to less serious results. A colleague developed false memory syndrome, claiming that he fully remembered me coming to interview him when I knew I had never done such an interview.

The problem is that 'actor' accounts have higher status in the field. The voice of the participant in policy unmediated by the historian has the status of 'truth'. Such reminiscence attains the status of the testimony of the elder of the tribe, which cannot be gainsayed. One can see this tendency more broadly in events such as the work of the Truth and Reconciliation Commission in South Africa. Shula Marks at a Royal Historical Society conference spoke of how historians and their interpretations based in part on oral history, had lost out to 'truth'.⁴² This tendency is not entirely limited to the testimony of elite actors in policy. In the drugs field the testimony of drug users has become an important dimension in recent years. And this can carry policy implications. For example, it was notable at a recent launch of the results of a potentially controversial trial of heroin injecting how the 'life histories' of drug users speaking from the platform were used to give colour and added weight to the potential policy case for this form of prescribing.⁴³ But this was 'history from below' which was firmly under the control of the organisers of the meeting. Sometimes, where elite interviews are concerned, it is just too difficult for policy actors to appreciate the mind set of historian researchers. Colleagues wanting to research policy development in health and applying for government funding were told they could look at it through interviews in the local areas, but not at the centre, in government, through interviews with civil servants. 'We don't need you to do that – we already know what happened there' was the attitude.

THE POSITION AND ROLE OF THE HISTORIAN

What should the role of the historian be in all of this? It is clear from the above discussion that there can be tensions between the researcher and the researched. We can be what Hammerley and Atkinson have called 'marginal natives'.⁴⁴ Kogan comments that what he calls a 'love affair' can develop between the interviewee and the interviewer.⁴⁵ My impression is that this relationship is common in the 'history from below' tendency in oral history, not least

because much work is done out of a keen desire to recover the detail of the past or to take the side of the dispossessed. But in the elite field too, the researcher can 'go native'. It is common for research on these recent events to

'take sides'. But my view is there cannot be an automatic payoff for the present from these interviews with the past. We cannot and should not become smoking activists or drug liberalisation advocates just because we are interviewing and analysing those policy actors. Clearly some interviewees strike more of a chord, are more sympathetic than others. The researcher has to 'withdraw into objectivity'. Historians have to maintain distance, although not all would agree; and the post modern tendency would argue that this is impossible.

In addition, there are often very different objectives for historical work and that of other colleagues who are mining the same terrain. My research on smoking is a case in point. My interviews were with public health and other health interests in smoking. I saw this area as representing and pioneering changes in the post war ideology of public health. My public health colleagues, on the other hand, were committed to research on smoking which also looked at the past, but within an activist, anti-industry model. They wanted to mine the past for material which would support present day health activist positions and arguments. This clash between the aims of historical oral history and current policy interests can cause tensions. One example occurred when I was researching AIDS policy. A paper on AIDS and the voluntary sector presented to a conference on AIDS caused uproar. My academic framework about the role of voluntarism and its change over time had a very immediate and different meaning to members of the audience. They had no patience with this analysis of voluntarism and the state. They saw early voluntary activity round HIV/AIDS as part of their own history, a form of activity which had then been coopted by the state. Insults rained down on my head for making academic something which was 'real' to them. But this event and that reaction was also data and a form of collective and unplanned oral history. Other historians have told me of how their studies and interpretations have been criticised by 'policy actors' who do not understand historians' mode of argument and see matters only in terms of 'taking sides'.⁴⁶ One has to be on one side or the other, in their view, and if the side is not the one they are on, then one has been 'duped'. These issues are common to contemporary history more generally but have a specific relevance where these studies are interview-based.

FUTURE POSSIBILITIES: DOCUMENTS AND HERITAGE?

Oral history of this sort is different too because it is generally not a 'stand alone' source or methodology in the way in which 'history from below' often is. The interviews should ideally be used in conjunction with other sources including those from government. The position here has changed in recent times. When we carried out the research on AIDS policy, primarily through interviews, this was because there were few other means of researching such a recent policy issue. There was no Open Government at first and no Freedom of Information. Now things are different-or are they? Committees often have their minutes on the web, as was the case with the Bovine Spongiform Encephalopathy (BSE) enquiry, and the whole expert committee arena has become more open. With recent research, using Freedom of Information procedures has been possible. But this only works if the department concerned has good recordkeeping practices. The Department of Health mostly does, but approaches to the Home Office have been less successful.⁴⁷ So documents are not automatically available and interviews can still provide what other sources cannot. In any case the interaction between the interview and the manuscript or email source is an important one. The move to electronic government records may ensure that the interview remains an important source.

Interviewing has also become more difficult because of the role of ethics committees in health institutions. Here the prime aim can be the protection of the interviewee at all costs. This is of course appropriate for interviewees who are relatively powerless but there can be misunderstanding of the nature of the interviewing and research process. Recently at LSHTM it was suggested that we might insert in our permission form a requirement that – if the interviewee did not want to be quoted, or the interview was to be used in any way, even for background – that we would expunge all memory that we had ever done the interview from our minds. This, I commented, would not be an easy task and the request was not repeated. But there is a fundamental difference here between the mind set of those used to survey research or the randomised, controlled trial, where privacy, anonymity and confidentiality are key issues and the population is the important unit – and those of us who do elite policy history interviews, where the specific role of the individual is important to the research analysis.

These requirements impact on the deposit of interviews and makes the interview less

visible. Again there is a difference from 'history from below'. In recent years, those life history interviews have begun to mesh with the field of 'public history' and have thus become public property, even entertainment or a form of 'family history'. The material is often deposited, available for re-use and even placed on websites in a way which would be unlikely in the policy research sphere. The re-use of interview material has been much discussed in both sociology and oral history in recent years.⁴⁸ Such re-usable data is currently available for health and medicine for example in the published witness seminars and also in the video interview series referred to above. This has advantages and disadvantages which have been rehearsed by other authors. In my experience, re-using elite interviews (such as the Oxford Brookes series) can be useful but it is never a complete substitute for doing an interview oneself. The Oxford/RCP series were often conducted by other elite members of the profession, who went down routes and asked questions of their interviewees not necessarily relevant to the interests of a policy researcher such as myself.

The ethical requirement for confidentiality has caused problems with funding organisations such as the Economic and Social Research Council (ESRC) who are now committed to an open access, data transfer and deposit model for interviews. There is a type of policy interview which it would be difficult to reuse or indeed deposit in an archive for open use. Indeed it is arguable that making interviews public property in this way would detract from their utility because such a process would make interviewees very wary about what they said if they knew it was for public consumption. To take one example, Sarah Mars' research on drugs policy in the 1980s and 1990s involved a series of interviews with medical practitioners who had prescribed to addicts in the 'private sector', a continuing area of controversy which could have had real personal implications for those who had agreed to be interviewed. ESRC at first asked for standard deposit, which we resisted, and this was also the case with recent research on drug user groups, which involved interviews with user activists.⁴⁹ This type of interview also has implications for the 'user involvement' model of research which has the support of funding agencies. User involvement implies a degree of powerlessness, not the sort of power which some policy interviewees might wish to assert over the interview.

Another development relates to my earlier

point about the powerful voice of the interviewee. This is the development of research by 'the field' in online archives – the tobacco industry for example – and a reverence for the status of 'the document'. This is a document which is usually unmediated by contextual appreciation and certainly not leavened by interviews with key participants in events. So alongside the 'rise of the truth' only to be obtained from key participants has also gone an opposite tendency – the revival of the document as a key source of truth. In either case the role of professional historians can be limited.

Interviews can be beset by difficulties which do not always affect the 'history from below' school, at least not in quite the same way. And for the future, this type of work may remain subservient to history from below. The availability of Heritage Lottery funding has increased the amount of work being done in that field and is likely to reinforce some of the tendencies I have talked about here – especially the dominance of the life history and oral history for public consumption. The enthusiasm for 'narrative' within medicine and the rise of medical humanities as a field may give further support to this tendency.

In this discussion, I have avoided much discussion of what elite policy interviews can add. Nor have I added to the lengthy discussions about the role of memory in oral history, or added a disquisition on 'how to do it'. But such interviews can be more than the collection of standardised anecdotes and can be triangulated against each other – as with my MRC ones – as well as with available documents. Choosing interviewees who have been bystanders and observers of events often achieves insights which are franker and more penetrating than with those who have been direct participants. But even the 'official history' standard accounts can be valuable as an insight into how those involved in policy make sense of events as time passes. Like all historical evidence they have to be assessed and evaluated. It is therefore important that oral history attempts to study the operation of power, not just the impact of power on those sections of society whom policy and power affects. To do so is not to take the side of the powerful or to advocate the cause of the advocates in controversial policy areas. Let us hope that this style of research is granted membership of the oral history field as a method for analysing recent policy history, and that we can appreciate the similarities, but also the differences, from the issues involved in traditional 'history from below'.

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11. Graham Smith, 'An oral history of general practice. 12, Reflections and the history of disappointment', *British Journal of General Practice*, vol 53, 2003, pp 420-1; Joanna Bornat, Leroi Henry and Parvati Raghuram, "'Don't mix race with the specialty": interviewing South Asian overseas trained geriatricians', *Oral History*, vol 37, no 1, 2009: pp 74-84; Griffith Edwards (ed), *Addictions. Personal Influences and Scientific Movements*, New Brunswick, New Jersey: Transaction Publishers, 1991.
12. Centre for Contemporary British History, 2002: 'The Abortion Act 1967', <http://icbh.ac.uk/icbh/witness/abortion/index.html>
13. Centre for Contemporary British History, 2002: 'The Origins and Establishment of the Internal Market in the NHS', <http://www.icbh.ac.uk/icbh/witness/nhs/index.html>
14. Thomas Soderqvist and Ronald Doel (eds), *The Historiography of Contemporary Science, Technology and Medicine. Writing Recent Science*, London and New York: Routledge, 2006; Thomas Soderqvist (ed), *The Historiography of Contemporary Science and Technology*, Amsterdam: Harwood Academic Publishers, 1997.
15. Soraya de Chadarevian, 'Using Interviews to write the History of Science', in Thomas Soderqvist (ed), *The Historiography of Contemporary Science and Technology*, Amsterdam: Harwood Academic Publishers, 1997, pp 51-70.
16. Chris Ham, *Health Policy in Britain. The Politics and Organisation of the National Health Service*, 5th edition, Basingstoke: Palgrave Macmillan, 2004, has written about the role of 'policy communities' and this term is widespread in the political science field.
17. This was also the case with the Oral History Society's 60th anniversary conference on the NHS in 2008, with the exception of a paper by Stephanie Snow on policy making at the local level, in Manchester. Martin Gorsky at the London School of Hygiene and Tropical Medicine organised a witness seminar in 2008 on the twenty-fifth anniversary of the Griffiths report on general management which is an exception to this comment on NHS history. This will be published online in 2010 in conjunction with a special issue of a journal. See also Nicholas Timmins, *Rejuvenate or retire? Views of the NHS at 60*, London: The Nuffield Trust, 2008.
18. Philip Gummett, *Scientists in Whitehall*, Manchester: Manchester University Press, 1980; Maurice Kogan and Mary Henkel, *Government and Research: The Rothschild Experiment in a Government Department*, London: Heinemann, 1983; Hugh Hecla and Aaron Wildavsky, *The private government of public money: community and policy inside British politics*, London: Macmillan, 1981.
19. Jenny Lewis, 'Being around and knowing the players: Networks of influence in health policy', *Social Science and Medicine*, vol 62, 2006, pp 2125-36.
20. Stephen Harrison, *Just Managing: Power and culture in the National Health Service*, Basingstoke: Macmillan, 1992. Christopher Pollitt, Stephen Harrison, David Hunter and G Marnoch, 'No Hiding Place: On the Discomforts of Researching the Contemporary Policy Process', *Journal of Social Policy*, vol 19, no 2, 1990, pp 169-90.
21. Gillian Walford, *Researching the Powerful in Education*, London: UCL Press, 1994.
22. Daniel Fox, Patricia Day, and Rudolf Klein, 'The Power of Professionalism: AIDS in Britain, Sweden and the United States', *Daedalus*, vol 118, 1990, pp 92-112.
23. C Shore and S Wright, *Anthropology of Policy. Critical Perspectives on Governance and Power*, London: Routledge, 1997.
24. Wenzel Geissler, personal communication, 2008. This work uses 'actor network' theory to look at the relationships between Western scientists and African workers in research and clinical trials.
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26. Karen Duke, 'Getting Beyond the 'Official Line': Reflections on Dilemmas of Access, Knowledge and Power in Researching Policy Networks', *Journal of Social Policy*, vol 31, 2002, pp 39-59.
27. Soraya de Chadarevian, 'Using Interviews to write the History of Science', in Thomas Soderqvist (ed), *The Historiography of Contemporary Science and Technology*, Amsterdam: Harwood Academic Publishers, 1997, p 53.
28. Sometimes newly trained researchers are determined to do things 'the right way' and so try to collect material which is irrelevant to their main topic, and which the interviewee may not have time to discuss.
29. Eric Hobsbawm, 'The present as history: writing the history of one's own time,' in David Bates, Jennifer Wallis and Jane Winters (eds), *The Creighton Century, 1907-2007*, London: Institute of Historical Research, 2009, pp 277-94.

- 30.** Maurice Kogan, 'Researching the powerful in education and elsewhere', in Gillian Walford (ed), *Researching the Powerful in Education*, London: UCL Press, 1994.
- 31.** Virginia Berridge, *AIDS in the UK. The Making of Policy, 1981-1994*, Oxford: Oxford University Press, 1996.
- 32.** Dominique Florin, 'How does science influence policy? Health promotion for coronary heart disease by general practitioners', MD thesis, University of London, 1997, p 55.
- 33.** Dominique Florin, 'How does science influence policy? Health promotion for coronary heart disease by general practitioners', MD thesis, University of London, 1997, p 59.
- 34.** Susanne Macgregor, Talk to LSHTM history group summer 2008.
- 35.** With some recent work carried out by Sarah Mars and Alex Mold, the researchers found that they had readier access to interviewees in the drugs field because they were working with the author of this paper. However, the access was sometimes based on a misunderstanding of the historical arguments in my work.
- 36.** These interviews are used in Virginia Berridge, *Marketing Health. Smoking and the Discourse of Public Health in Britain, 1945-2000*, Oxford: Oxford University Press, 2007.
- 37.** Austin Bradford Hill, interview with Max Blythe, Oxford Brookes/Royal College of Physicians video archive, 1990.
- 38.** This sequence of events is discussed more fully in Berridge, *AIDS in the UK*, pp 37-54.
- 39.** EM (Tilli) Tansey and Daphne Christie, *Haemophilia [text and electronic resource]: recent history of clinical management the transcript of a Witness Seminar held at the Wellcome Institute for the History of Medicine, London, on 10 February 1998* London: Wellcome Institute, 1999.
- 40.** Virginia Berridge and Stuart Blume (eds), *Poor Health. Social Inequality Before and After the Black Report*, London: Frank Cass, 2003, pp 147-8.
- 41.** Henry 'Bing' Spear, *Heroin Addiction, Care and Control, The British system, 1916-84*, London: Drugscope, 2002. Virginia Berridge, 'History and Twentieth-Century Drug Policy: Telling True Stories?', *Medical History*, vol 47 (4), 2003, pp 518 – 524.
- 42.** Shula Marks, 'The sources bite back; historians and their informants', paper given at the Royal Historical Society conference, 'The Responsibility of the Historian', 2002.
- 43.** Author's notes of launch of RIOTT trial (Randomised Injecting Opiate Treatment Trial), Royal College of Physicians, 15 September 2009.
- 44.** Martin Hammersley and Paul Atkinson, *Ethnography. Principles in Practice*, London: Routledge, 1983.
- 45.** Maurice Kogan, 'Researching the powerful in education and elsewhere', in Gillian Walford (ed), *Researching the Powerful in Education*, London: UCL Press, 1994.
- 46.** Linda Bryder, personal communication about research on the Cartwright enquiry into the Auckland Women's Hospital, 2008.
- 47.** This is discussed in Alex Mold and Virginia Berridge, *Voluntarism, Health and Society*, forthcoming 2010.
- 48.** The re-use of interviews has been much discussed in the sociological and oral history fields in recent years. See for example Niamh Moore, '(Re) using Qualitative data', *Sociological Research Online*, <http://www.socresonline.org.uk/12/3/1.htm>
- 49.** Sarah Mars, 'Peer Pressure and Imposed consensus: The Making of the 1984 Guidelines of Good Clinical Practice in the Treatment of Drug Misuse', in Virginia Berridge (ed), *Making Health Policy*, pp 149-182.