

The Medical Officer of Health in England and Wales, 1900–1974: watchdog or lapdog?

John Welshman

Abstract

The recent revival of interest in the potential of preventive medicine, reflected in its re-emergence as a medical specialism and in monitoring and campaigning activity at the local level, has been accompanied by growing interest in the history of public health. In particular, the work of the Medical Officers of Health (MOsH), the doctors appointed by many local authorities after 1850, has come under closer scrutiny. However, whereas historians have acknowledged that the MOsH played a key role in tackling environmental health and infectious disease in the second half of the nineteenth century, judgements have been less favourable for the period since 1900. It is alleged that the MOsH produced repetitive and complacent reports, delayed the introduction of immunization, and were seduced away from public health by hospital administration. Both they and their counterparts in the School Medical Service ignored wider threats to health such as malnutrition and unemployment, and campaigning on these issues was left to other individuals and pressure groups. Furthermore, it is argued that after the establishment of the National Health Service in 1948, MOsH failed to exploit the potential of health education, lagged behind thinking on social work, and were slow to develop services for 'community care'. According to this analysis, the demise of the MOH in the 1974 health service reorganization represented the logical culmination of trends in the previous 75 years. This paper examines the strengths and weaknesses of this interpretation, partly through a case-study based on the Midlands city of Leicester. It argues that, although some MOsH were complacent, all operated within the limitations of important local and national constraints, and that, given these restrictions on *their room for manoeuvre*, many were remarkably innovative and imaginative. The paper concludes that, until further research is undertaken, the charges levelled against these doctors remain largely unproven.

Keywords: Medical Officer of Health, public health, Leicester, Health Committee

Introduction

The increasing emphasis that politicians and policy-makers have placed on preventive medicine in the 1990s has been reflected among the academic community in growing interest in the history of public health. As is well known, from the mid-nineteenth century many towns and cities in England and Wales, concerned about the rise in infectious disease that

accompanied urbanization, appointed doctors who were called Medical Officers of Health (MOsH). Traditionally, these doctors have been regarded as the heroes of the battle for sanitary reform. Anne Hardy, for example, has concluded that the MOsH in nineteenth-century London 'spearheaded the Victorian struggle against infectious disease, and it was their initiative and their labours which led to the eventual eradication of the epidemic streets'.¹ Moreover, recent work that has increasingly questioned Thomas McKeown's thesis about the relationship between preventive medicine and Britain's mortality decline has also served to reinstate the MOH at the centre of the picture. Simon Szreter, for instance, has argued that intervention was of crucial significance, and has written of the reduction in the death rate that 'the role of a battling public health ideology, politics, and medicine, operating of necessity through local government, is more correctly seen as the principal causal agency involved'.² The performance of MOsH in the twentieth century has also attracted some favourable comment. Sir George Godber, for example, has argued that in the larger cities and more ambitious local authorities, these doctors played a key role in the decline of infectious disease and development of other community health services.³

Yet although the MOsH have been regarded as central figures in the battle against infectious disease in the nineteenth century, their work in the period after 1900 has generally received a bad press from historians. It has been suggested that MOsH neglected their true role as watchdogs of public health, produced complacent and repetitive reports, ignored malnutrition and unemployment, and failed to develop health education and 'community care' under the National Health Service. Charles Webster, for example, has written that 'to other doctors the MOH was an officious and bullying bureaucrat, presiding over an empire of clinics and institutions run along inhumane lines and delivering services of proportionately small benefit considering the costs involved'.⁴ Although this interpretation has been persuasive and influential, it has been based more on assertion than evidence, and raises other questions regarding the

The Wellcome Unit for the History of Medicine, 45–47 Banbury Road, Oxford OX2 6PE.

John Welshman, Research Assistant

© Oxford University Press 1997

role and status of the MOH. To what extent was the room for manoeuvre of MOsH limited locally and centrally by councillors and civil servants? Did the MOsH really ignore malnutrition and unemployment? Was it hospital administration that knocked public health off course in the 1930s? Do MOsH deserve the blame for the decline of preventive medicine under the National Health Service? This paper reassesses the work of MOsH in England and Wales between 1900 and 1974, and looks more carefully at their work through a local case-study based on the Midlands city of Leicester. It uses the issues of poverty and unemployment, infectious disease, nutrition, and hospital administration as test-cases, and also traces the work of MOsH after 1948. In this way it hopes to provide some insights into the achievements and failures of these much-maligned doctors.

Poverty and unemployment

One of the principal criticisms that is levelled at MOsH is that they ignored the impact of poverty and unemployment on health, particularly during the depression of the 1930s. More generally, it is suggested that they failed to tackle other vested interests, such as local industrialists and manufacturers, whose activities posed a threat to health.⁵ It should be noted at the outset that our local case-study is in many respects atypical, so that the conclusions drawn from it are of limited value for generalizing about local authorities in England and Wales as a whole. During the interwar period, Leicester's boot and shoe, hosiery, and light engineering industries generated high wages and prosperity, and did not create major problems of occupational health. The state of the city's housing was good compared with other urban centres of equivalent size, and even at the height of the depression, unemployment was relatively low. J. B. Priestley, for example, found on his *English journey* a dull but prosperous city where the Wolsey hosiery factory had 'the dumb secrecy and uncontrolled orderliness of a bee-hive or an ant-hill'.⁶ It was an impression backed up by social surveys which found that wages were high, and unemployment low and short term.^{7,8} Furthermore, the city had been one of the first to appoint part-time MOsH in the mid-nineteenth century, and there was evidence in the early twentieth century of a consensus among local Liberal and Labour councillors about the importance of health services. Thus it was not surprising that when the post of MOH for this progressive County Borough was advertised, it attracted a large number of applications.

The new MOH appointed in 1900, Dr Killick Millard, took a strongly moral stance on some problems of health care, and also flirted with fashionable eugenic theories. In the late 1920s and early 1930s, for example, his views about the 'submerged tenth' underlay his support for a birth control clinic, his approval of marriage certificates, and his opposition to slum clearance. Even so, although eugenics was an important current in provincial intellectual life, it had limited influence on health

policy, and Millard's earlier reports had demonstrated an interest in occupational health and compassionate approach to poverty. He was aware that mortality from pulmonary tuberculosis was particularly high in the boot and shoe trade, and he was interested in health inequalities, both in terms of the city's different wards, and with respect to Leicester and other urban centres of similar size. In his report for 1909, for example, he wrote of the wards with the highest birth and death rates that 'both are entirely working-class districts in a very old part near the centre of the town. There is much poverty, the bread-winners in very many cases being casual labourers'.⁹ Moreover, although statistics indicated that the health of the city's inhabitants was improving, Millard did not become complacent. In 1924, for example, he wrote that the striking variations in the infant mortality rates for individual wards indicated that 'in spite of the great reduction which has been effected in infant mortality great room for further improvement still remains in certain parts of the city'. More generally, he noted the correlation between birth and death rates and infant mortality, observing that 'at the top of the social scale people live longer, have smaller families, and such children as are born have a much better chance of surviving. At the bottom of the social scale the reverse holds good'.¹⁰

Although unemployment in Leicester was low and largely short term even at the height of the depression, Millard noted in 1932 that many men and women had been out of work, admitting that 'to some extent, no doubt, their health has been adversely affected in consequence'.¹¹ This concern about the impact of wider environmental factors upon health was also apparent in the case of pulmonary tuberculosis. In the 1890s, discussions about tuberculosis had been obstructed by the belief that the disease was hereditary and prevalent among a social residuum, but by the 1920s there was a greater recognition that poor housing was an important factor. In 1923, for instance, a doctor responsible for tuberculosis patients wrote that 'if permanent benefit is to be maintained after sanatorium treatment it is essential for each patient to have a suitable home to return to'.¹² Moreover, the slum clearance schemes of the early 1930s, although delayed by Millard's belief in improvement rather than clearance areas, reflected the increasing stress placed on the importance of good housing. Surveys indicated that the new housing estates had fewer deaths and new cases, and better recovery rates, and in 1936 Dr Kenneth Macdonald, who had succeeded Millard as MOH the previous year, wrote that 'good housing is, and in the future, even more will be, the greatest factor in the campaign against this disease'.¹³ In this field and others, Macdonald was in tune with wider movements in social thought that anticipated the creation of universal health services after the Second World War. More generally, although the city's MOsH occasionally exhibited strong moral views on issues such as overcrowding and flirted with eugenics, they also appreciated the impact on health of particular industries, poverty, housing, and unemployment.

Infectious disease

MOsH have been accused of ignoring poverty and unemployment, and of neglecting their responsibilities with regard to infectious disease. Although the monitoring of infectious disease was one of the key functions of MOsH, it has been suggested that they were slow to adopt immunization against diphtheria in the 1930s, even though trials in the USA and Canada had demonstrated the efficacy of this method.¹⁴ In the nineteenth century, Leicester had been a well-known centre of the anti-vaccination movement, and in his previous posts in Birmingham and Burton-on-Trent, Millard had gained a national reputation on account of his unorthodox views. In 1901, for example, he had argued that the isolation of scarlet fever cases in hospital was ineffective, as mortality had fallen in towns that had not adopted this method.¹⁵ In the case of smallpox, Millard also claimed that the importance of vaccination and the dangers of the disease had been exaggerated, and the drawbacks and objections underestimated.¹⁶ Given this background, it was not surprising that Millard was slow to introduce immunization, even though diphtheria posed a serious threat to child health in Leicester, with 34 deaths and 429 cases in 1924 alone. Millard recognized that immunization was efficient and effective, but he claimed that it was difficult to secure parental consent, and wrote in 1927 that ‘inoculation against diphtheria must still be regarded as of doubtful value so far as the general population is concerned’.¹⁷ Even after reading the Medical Research Council’s reports on US and Canadian trials, Millard did not encourage his Health Committee to adopt immunization against diphtheria.

Yet although Millard dragged his feet on the issue of diphtheria immunization, his successor took a completely different approach, and quickly made up for lost time. Macdonald had also monitored current research, but he interpreted the findings differently, and concluded in 1935 that immunization ‘has now passed the stage of experiment and is a public health measure of the greatest value’.¹⁸ From March 1937 the local Health Committee paid a general practitioner and health visitor to immunize children in infant welfare centres and at school clinics, and to provide health education in the form of lectures and leaflets.¹⁹ The pace of the local immunization and health education campaigns accelerated during the Second World War, so much so that Macdonald could write in 1949 that ‘diphtheria is no longer a public health problem – a proud, but justifiable boast’.²⁰ Thus, arguably, the Ministry of Health was responsible for the delay in introducing immunization, as it was slow to communicate research findings to MOsH at the local level. In Leicester the idiosyncratic views held by the local MOH delayed the diphtheria campaign, but after 1935 immunization was adopted quickly by his successor. The timing and ways in which new medical techniques were adopted were the result of a complex mixture of personal and administrative factors. Ironically, it was largely the success of

MOsH in tackling infectious disease that would later lead some to argue that public health had become redundant as a medical specialism.

Nutrition

Although infectious disease was integral to public health, after 1900 local authorities were increasingly preoccupied with the development of personal health services. Among these new responsibilities was the provision of orange juice and cod-liver-oil for expectant mothers and infants, and school meals and milk for schoolchildren. In the interwar period, nutrition became a controversial issue, as new scientific research on vitamins threatened to undermine existing methods of assessing malnutrition, and local authorities in depressed areas were unable to provide adequate numbers of school meals. By the late 1930s, academics such as John Boyd Orr and pressure groups such as the Children’s Minimum Council had effectively shattered the earlier complacency about nutrition, preparing the way for more generous provision during the Second World War. Some doctors working in depressed areas had also taken a radical stance on the issue of nutrition.²¹ However, historians have argued that these MOsH were the exception rather than the rule, and that complacency was more common. It has been suggested that, in general, the MOsH emphasized ignorance rather than poverty, produced optimistic reports telling the Ministry of Health what it wanted to hear, and were content to leave the real campaigning on malnutrition to other pressure groups and individuals.^{22,23} Charles Webster, for example, has written of the depression that ‘the public health mechanism failed to respond appropriately, and showed itself incapable of resisting political pressures for falsification of the evidence relating to ill-health and malnutrition’.²⁴ Clearly, there is much evidence to support these criticisms. In all local authorities, MOsH and School Medical Officers (SMOs) clung stubbornly to methods, such as medical inspections, that provided an inaccurate assessment of the degree of malnutrition among schoolchildren. Moreover, doctors working in depressed areas often found that, owing to low rates, the local authorities that employed them were unable to expand their provision of school meals and milk.

However, our local case-study indicates that some local doctors took a more enlightened approach, both to the assessment of nutrition, and to the provision of school meals and milk. When Macdonald became Leicester’s MOH and SMO in 1935, he demonstrated an awareness of the latest research, and had a sophisticated grasp of methods of assessing malnutrition in schoolchildren. In 1936, for example, he wrote that the ‘newer knowledge of nutrition’ had revealed that along with malnutrition, rickets and scurvy, ‘there is a vast amount of sub-clinical malnutrition, involving lowered health, lessened resistance to disease and a failure of the organism to develop to its full potentiality’. Macdonald argued that SMOs should dispense with the concept of the ‘average’, suggesting instead

that 'what we need to work to are optimum standards, and these we simply do not possess at present'.²⁵ He took steps to disseminate the results of current research on nutrition, by distributing copies of the first report of the Advisory Committee on Nutrition to teachers, and by writing in his annual report that 'a matter of the greatest importance is the nutrition of mothers and their young children'.²⁶ Macdonald also recognized that advances in nutrition had implications for school medical inspections. In 1938 he wrote that the concept of a 'normal' child would have to be modified, he experimented with haemoglobin tests, and he now admitted of malnutrition that 'no satisfactory physical or clinical assessment of it can yet be made'.²⁷ What was particularly striking was that Macdonald and his staff managed to keep up with the latest research, including the important statistical survey published by Robin Huws Jones in 1938.²⁸

The growing scepticism about methods of assessing malnutrition was accompanied by improved provision for mothers, infants, and schoolchildren. In 1937 Leicester increased the amount of milk, cod-liver-oil, and orange juice supplied through the Maternity and Child Welfare centres, and also adopted more generous means-testing. In the earlier period, the city had provided relatively few school meals, possibly because wages were high, or perhaps because school feeding was delegated to voluntary organizations. However, in the 1930s, the sophisticated grasp of research on nutrition that Macdonald displayed was followed by an expansion of school meals and milk. As in other local authorities, more children had access to school milk, so that by 1933, for example, 43 per cent of pupils were receiving a third of a pint a day. In fact, it was the Board of Education's civil servants who told the local Education Committee that it should use medical examinations to control access to school meals and milk, and central rather than local government that sought to limit expansion. The local authority conducted a comprehensive survey of the nutrition of its schoolchildren in June 1936, and in 1938 Macdonald noted of malnutrition in the city's special schools that the issue 'is one of the biggest and most fundamental questions with which our civilisation is faced'.²⁹ During the Second World War, the provision of school meals and milk was further expanded; in 1943, for example, the local authority served 869 322 meals, and by February 1944, 81 per cent of the children were drinking school milk.³⁰ It was perhaps not so surprising that a prosperous local authority was able to increase its provision of school meals and milk. What was particularly interesting, in light of the accusations made against public health doctors, was that the local MOH was so open-minded and well-informed about nutritional research and food policy.

Hospital administration

If historians have argued that MOsH ignored the issue of malnutrition in the 1930s, they have also suggested that the general emphasis on personal health services after 1900 served

to distract these doctors from their real calling as watchdogs of public health. In particular, it is suggested that MOsH became preoccupied with the expansion of clinics, and, after the 1929 Local Government Act allowed the larger County Boroughs to appropriate former Poor Law infirmaries, with the rival attractions of hospital administration. According to this argument, the remit of the MOH gradually changed from prevention to treatment, and it was partly for this reason that public health as a medical specialism lost its distinctive identity and philosophy.³¹ Charles Webster, for example, has written of the early 1950s that 'during the interwar period the MOsH had wearied of their traditional public health activities and they had progressively been seduced into hospital administration. Deprived of this role, they found no alternative worth contemplating'.³² Thus it has been suggested that the interest in clinics and hospital administration in the 1930s, and the associated failure to evolve a coherent philosophy for public health, left MOsH vulnerable to the restructuring of health services that accompanied the birth of the National Health Service.

It is undeniable that hospital administration was a novel and important aspect of public health provision in the 1930s. As is well known, the London County Council and many of the larger provincial County Boroughs used the provisions of the 1929 Act to appropriate former Poor Law institutions and redevelop them as municipal hospitals. In Leicester, for example, the Health Committee took over the North Evington Poor Law infirmary and renamed it the City General Hospital. With 16 large wards and 545 beds, the North Evington Poor Law infirmary had been one of the most advanced institutions of its kind. Now the local authority decanted the chronic cases into the workhouse, restricted admissions to acute cases, and appointed doctors from the Royal Infirmary, the voluntary hospital, to part-time consultant posts. With these changes and the opening of new orthopaedic wards, the Health Committee was able to claim with some justification that it had created a showpiece municipal hospital, and the City General developed further during the Second World War as part of the Emergency Hospital Service. Hospital administration certainly did add to the prestige of the MOH, and indeed Macdonald made this theme the subject of his address to the 1935 Royal Congress of Public Health.

Even so, hospital administration was not an entirely new responsibility for the MOsH who worked in the larger local authorities. In Leicester, for instance, the fever hospital had been an important aspect of public health provision in the 1880s, and the local isolation hospital and sanatorium remained central to the treatment of infectious diseases such as tuberculosis. In any case, the day-to-day running of the City General was in the hands of its Medical Superintendent, and it was he rather than the MOH who compiled the annual reports. Although Macdonald was keen to improve the City General, he realized that these changes in turn created additional problems, and was forced to appoint a new doctor to look after the

growing numbers of chronic sick in the workhouse. Moreover, plans that proposed to add 450 beds to the City General were opposed by the local Council and the Ministry of Health, and had not come to fruition by the outbreak of the Second World War.³³ Therefore, although the acquisition of the City General hospital certainly added to the empire of the local MOH, it does not appear that hospital administration distracted him from his interest in wider issues such as poverty, malnutrition, and housing. More generally, there is a contradiction in the argument that it was hospital administration that moved MOsH away from public health. Only the wealthier local authorities were able to appropriate former Poor Law institutions, and this ‘distraction’ did not exist in many of the depressed areas whose MOsH have come under especial criticism. The perceived remit of the MOH may have gradually altered in the 1930s from prevention to treatment, but there seems little hard evidence that it was the expansion of municipal hospitals that caused this change of direction.

The MOH and the National Health Service

If historians have alleged that public health doctors were complacent and disorientated in the 1930s, they have also been critical of the performance of MOsH in the early years of the National Health Service. Jane Lewis, for example, has argued that MOsH now looked back to the interwar period as a kind of golden age, and that in the 1960s their specialism came under additional pressure from social work on the one hand, and general practice on the other. She has suggested that MOsH ‘were on the whole unable to articulate any sound principle for their involvement in welfare work’, and failed therefore to notice the influential arguments of social scientists regarding the changing nature of social services. In part, this explains why the MOsH lost out in the Seeborn report (1968), and became ‘community physicians’ following the 1974 health service reorganization.³⁴ The official history of the National Health Service largely confirms this interpretation. Its author has argued that in the 1950s MOsH neglected health promotion, made slow progress on cigarette smoking and health, and did not implement water fluoridation.³⁵ Furthermore, in the following decade, public health doctors were slow to develop ‘community care’ services for the elderly and other vulnerable groups.³⁶ In many respects this is an accurate account of what happened to MOsH after 1948. Certainly, the hospitals and clinics previously administered by them were taken over by Regional Hospital Boards, health centres were not built on a widespread scale in the 1950s, and the focus was on hospitals rather than preventive medicine. In the 1960s, MOsH were further undermined by the revival of general practice, and the growing confidence of social work, and by 1974 had effectively lost their identity.

However, before and after the creation of the National Health Service, the MOsH in our local case-study did not perform as one might expect. In the months preceding the

‘appointed day’, for example, Macdonald performed a crucial leadership role in trying to rally colleagues despondent about the future of preventive medicine. In October 1947, Macdonald admitted that MOsH were ‘passing through times of great difficulty, of reorientation and of severe testing’, but he argued that they still had a role providing care and after-care, building welfare services, compiling statistics, and organizing health education.³⁷ Elsewhere, Macdonald reiterated that local health departments still had much scope, preventive medicine had been strengthened by the new discipline of social medicine, and concluded that recent changes left MOsH with ‘a much wider field of enquiry’.³⁸ In a paper delivered in July 1948, Macdonald noted the potential of health centres, welfare, the care of the elderly, statistics, health education and food hygiene, and he wrote that ‘I feel that there is no real need for discouragement or real regret’.³⁹ Finally, in another paper published that year, Macdonald again noted the potential of the Act’s Section 28 and asked: ‘Given the necessary vision and imagination, could any preventive power be wider?’⁴⁰ Therefore Macdonald performed a crucial role in trying to get MOsH to appreciate the potential of public health under the National Health Service. Although some public health doctors were depressed and demoralized by changes in their remit, others showed impressive qualities of resilience, leadership, and imagination.

Although MOsH have been accused of neglecting health education, this was an important aspect of provision in Leicester in the 1950s. In 1945, Macdonald had written that in the future his department should ‘teach the people the way of health’, and he became particularly interested in this field, serving as chairman of the Central Council for Health Education in 1948–1949.⁴¹ With his encouragement, Leicester’s Health Committee established a health education department, appointed staff, and promoted activities that included exhibitions, films, lectures, leaflets, and posters. Some of these featured the cartoon character of ‘Dr Fosse’, indicating that health education was often rather paternalistic in this period. Even so, educational materials tackled important contemporary health issues such as diphtheria immunization and dental health, and exhibitions on the health of the feet were sponsored by local shoe manufacturers. The MOH was aware of the dangers of cigarette smoking, writing in 1956 that ‘it cannot be too often emphasised that there is a definite and proved connection between cancer of the lung and smoking’, and it was local councillors who opposed water fluoridation.⁴² Undoubtedly, more could have been done in the 1950s in terms of health promotion. However, on issues such as cigarette smoking, it is clear that the Ministry of Health, under pressure from the Treasury, was slow to take action, and that the Central Council for Health Education remained a weak body.⁴³ Therefore it is arguable that the failure to develop health education was caused by a lack of leadership in Whitehall, and hampered by provincial political pressures, whereas MOsH such as Macdonald made valiant efforts to encourage health promotion at the local level.

Papers in public health journals were often rather superficial, but research sponsored by MOsH occasionally had an important impact at the national level. One example of this was a survey of unmarried mothers in Leicester, published in 1956. In the interwar years, provision for unmarried mothers had been left to voluntary organizations and to the Church of England, and it was only when illegitimacy increased in the early 1940s that the Ministry of Health encouraged local authorities to take action. In Leicester, the local authority became more involved with unmarried mothers, and in the mid-1950s, carried out a survey of the illegitimate children born in 1949–1955. This found that of the 240 mothers whose marital status at conception was known, 141 were single, 64 married, and 35 widowed or divorced. Five years later, 30 per cent of the mothers were married, 40 per cent were living with the father of the child, and 40 per cent remained single, and in most cases the children were being satisfactorily looked after.⁴⁴ The case-study of Leicester reappeared thinly disguised as 'Midboro' in an important study published in 1960. This emphasized that only 15 per cent of the illegitimate children in the sample had been born to teenage girls, and over half the fathers, who were mainly friends or fiancées of the mothers, were skilled workers. The author wrote that the unmarried mother 'has to face loneliness, shock, financial difficulties, her parents' attitudes, often social ostracism'.⁴⁵ Thus the research carried out under Macdonald's supervision was important in challenging the stereotype of the young, teenage, unmarried mother, and in paving the way for more liberal attitudes in the 1960s.

Although 'community care' came to occupy an important place in policy rhetoric from the mid-1950s, exhortations from the Ministry of Health were not matched by improved provision on the ground, and little of substance had been achieved by 1974. Nevertheless, it is less clear whether the failure to build new institutions for the mentally ill and 'handicapped' and to expand domiciliary services for the elderly was really the fault of local MOsH. In Leicester, for instance, Macdonald's successor, Dr John Moss, campaigned for better mental health services, and had a compassionate concern for the plight of the elderly. He was enthusiastic about the potential of the 1959 Mental Health Act, drew up an ambitious ten-year plan for health and welfare services, and opened new institutions that included hostels, training centres, day centres, and social clubs. Despite this progress, Moss did not become complacent, admitting in 1969 that 'costly hospital admission and treatment is being undermined by the inability of the local authority services to maintain adequate support for the patient on his return to the community'.⁴⁶ The MOH also placed greater emphasis on domiciliary services for the elderly, stressing the value of health visitors, district nurses, and home helps, and the services provided by voluntary organizations. Again, he did not simply list achievements, but wrote in his annual report for 1968 that 'it is seldom appreciated what contribution loneliness plays in the development of the insidious process of self neglect, malnutrition, hypothermia and suicide in old people'.⁴⁷

He pointed out that many old people still lived in houses lacking bathrooms and hot water, and he argued that greater resources should be devoted to domiciliary services. Thus the Leicester case-study suggests that the failure of local authorities to improve these services may not have been through lack of effort on the part of their MOsH, but because central government was not seriously committed to 'community care' in this period.

Conclusions

Clearly, there is some substance for the allegation that between 1900 and 1974, MOsH in England and Wales ignored poverty and unemployment, delayed immunization, neglected malnutrition, were seduced by hospital administration, and performed poorly in the early years of the National Health Service. Particularly in depressed areas, where low rates meant that local authorities could only make part-time appointments, MOsH produced repetitive reports and failed to investigate threats to local health. For the period as a whole their salaried status as employees of local government meant that they occupied a lowly position, particularly in comparison with general practitioners. Nevertheless, although some of these features were evident in our local case-study, the evidence does not support the charges that have been levelled at MOsH in general. Although Millard flirted with eugenics and opposed slum clearance, these aspects of his approach to health policy did not prevent him from taking a serious interest in the impact of poverty, occupational health, and unemployment. Moreover, after 1935, Macdonald quickly took action on diphtheria immunization, demonstrated an impressive grasp of current research on nutrition, and seized the potential of housing reform. As we have seen, the local authority appropriated a former Poor Law infirmary as a municipal hospital, but there was little evidence that hospital administration distracted the MOH from his traditional tasks. With his distaste for eugenics, and his progressive ideas, Macdonald was in tune with more radical plans that anticipated the creation of universal health services, and in the late 1940s he also performed a crucial leadership role in pointing out the continuing potential of public health. In Leicester, the postwar period was marked by an emphasis on health education, innovative research on issues such as unmarried motherhood, and by some progress in the area of 'community care'. Whereas local services could undoubtedly have been improved upon, many of the weaknesses in provision were the result of wider administrative and structural factors.

As was noted earlier, it is arguable that our local case-study is an atypical case, from which it is only possible to draw general conclusions of limited value. It is not surprising that services were more highly developed in the larger, wealthier County Boroughs, and indeed Leicester was among the local authorities that Sir George Godber singled out for special praise. Rather, the evidence should alert us to a number of wider issues that deserve further investigation. The allegations against

MOsH have proceeded largely by assertion, and much research remains to be done at the local level. Currently, we know little about how far the education and training of the MOH, and the Diploma in Public Health, equipped him for dealing with practical day-to-day problems. In some areas of public health, as we have seen, MOsH did campaign for better services, but their room for manoeuvre was limited, in town halls and committee rooms, by the concerns of individual councillors, and within the corridors of Whitehall by civil servants in central government departments. The relationship between MOsH and local councillors, with 'the man from the Ministry', with other members of local medical elites, and with the general public all require further examination. There are some signs that research at the local level is beginning to produce a more subtle, accurate, and complex picture of the work of individual public health doctors.⁴⁸ However, until other studies of this kind have been completed, and until further evidence of guilt is forthcoming, the case against MOsH in general remains unproven. Whether guilty or innocent, the recent revival of public health, both as a medical specialism and local government responsibility, suggests the work of MOsH before 1974 is of more than antiquarian interest.

Acknowledgements

John Welshman would like to thank the Wellcome Trust for funding the project 'Public Health in Twentieth Century Leicester' on which this paper is based (Project Grant 038059/Z/93), and his former colleagues at the University of Leicester for their support. However, the views expressed are those of the author alone and not of the funding body.

References

- Hardy A. *The epidemic streets: infectious disease and the rise of preventive medicine, 1856–1900*. Oxford: Clarendon Press, 1993: 293–294.
- Szreter S. The importance of social intervention in Britain's mortality decline c.1850–1914: a re-interpretation of the role of public health. *Social Hist Med* 1988; **1**(1): 1–38.
- Godber G. Medical officers of health and health services. *Community Med* 1986; **8**(1): 1–14.
- Webster C. Medical officers of health – for the record. *Radical Commun Med* 1986; 10–14.
- Lewis J. *What price community medicine? The philosophy, practice and politics of public health since 1919*. Brighton: Wheatsheaf, 1986: 30–49.
- Priestley JB. *English journey*. Harmondsworth: Penguin, 1933 (1977 edn: 126).
- Fogarty MP. *Prospects of the industrial areas of Great Britain*. London: Methuen, 1945: 300–302.
- Pilgrim Trust. *Men without work*. Cambridge: Cambridge University Press, 1938: 28–31.
- Report of the MOH, 1909*. Leicester: Leicester Sanitary Committee, 1910: 25.
- Report of the MOH, 1924*. Leicester: Leicester Health Committee, 1925: 6–9.
- Report of the MOH, 1932*. Leicester: Leicester Health Committee, 1933: 48.
- Report of the MOH, 1923*. Leicester: Leicester Sanitary Committee, 1924: 52.
- Report of the MOH, 1936*. Leicester: Leicester Health Committee, 1937: 60.
- Lewis J. The prevention of diphtheria in Canada and Britain 1914–1945. *J Social Hist* 1986; **20**(1): 163–176.
- Millard CK. The influence of hospital isolation in scarlet fever: an appeal to statistics. *Public Hlth* 1901; 462–503.
- Millard CK. *The vaccination question in the light of modern experience: an appeal for reconsideration*. London: H.K. Lewis, 1914.
- Report of the MOH, 1927*. Leicester: Leicester Health Committee, 1928: 20.
- Report of the MOH, 1935*. Leicester: Leicester Health Committee, 1936: 83.
- Report of the MOH, 1937*. Leicester: Leicester Health Committee, 1938: 21–23.
- Report of the MOH, 1949*. Leicester: Leicester Health Committee, 1950: 6.
- M'Gonigle GCM, Kirby J. *Poverty and public health*. London: Gollancz, 1936.
- Lewis J. *The politics of motherhood: child and maternal welfare in England 1900–1939*. London: Croom Helm, 1980: 18, 220.
- Lewis J. *What price community medicine?* 30–33.
- Webster C. Conflict and consensus: explaining the British Health Service. *Twentieth Century Br Hist* 1990; **1**(2): 115.
- Report of the SMO, 1936*. Leicester: Leicester Education Committee, 1937: 22.
- Report of the MOH, 1937*. Leicester: Leicester Health Committee, 1938: 157.
- Report of the SMO, 1938*. Leicester: Leicester Education Committee, 1939: 10, 104–112.
- Huws Jones R. Physical indices and clinical assessments of the nutrition of schoolchildren. *J R Statist Soc* 1938; **101**: 1–52.
- Report of the SMO, 1938*. Leicester: Leicester Education Committee, 1939: 16–18.
- Report of the SMO, 1943*. Leicester: Leicester Education Committee, 1944: 28.

- 31 Lewis J. *What price community medicine?* 17.
- 32 Webster C. *Medical officers of health*, 12.
- 33 *Report of the MOH, 1936*. Leicester: Leicester Health Committee, 1937: 113–121.
- 34 Lewis J. *What price community medicine?* 49–126.
- 35 Webster C. *The health services since the war: Vol. 1: Problems of health care: the National Health Service before 1957*. London: HMSO, 1988: 395.
- 36 Webster C. *The health services since the war: Vol. 2: Government and health care: the British National Health Service 1958–1979*. London: TSO, 1996: 109–126.
- 37 Macdonald EK. The challenge of section 28. *Public Hlth* 1947; **61**: 37–38.
- 38 Macdonald EK. The N.H.S. Act 1946, and the public health service. *Medical Officer* 1947; **77**: 251–253.
- 39 Macdonald EK. The fragments that remain. *Medical Officer* 1948; **80**: 185–187.
- 40 Macdonald EK. A new era in public health? *Health Educ J* 1948; **6**: 146–149.
- 41 *Report of the MOH, 1945*. Leicester: Leicester Health Committee, 1946: xi–xii.
- 42 *Report of the MOH, 1956*. Leicester: Leicester Health Committee, 1957: 3.
- 43 Webster C. Tobacco smoking addiction: a challenge to the National Health Service. *Br J Addiction* 1984; **79**: 7–16.
- 44 Macdonald EK. Follow-up of illegitimate children. *Medical Officer* 1956; **96**: 361–365.
- 45 Wimperis V. *The unmarried mother and her child*. London: Allen & Unwin, 1960: 51–73.
- 46 *Report of the MOH, 1969*. Leicester: Leicester Health Committee, 1970: 5.
- 47 *Report of the MOH, 1968*. Leicester: Leicester Health Committee, 1969: 45.
- 48 McLaurin S. *The housewives' champion: Dr G. C. M. M'Gonigle, Medical Officer of Health for Stockton-on-Tees from 1924 to 1939*. Hartlepool: Printability, 1997.

Accepted on 8 July 1997