

Problems of practising public health in Westmorland: John A. Guy as County Medical Officer, 1946-70

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ABSTRACT

The Covid-19 pandemic constituted an unprecedented public health crisis for the National Health Service (NHS) since its inception in 1948. The crisis exposed the fragmented nature of health services, the centralisation of decision-making, and the weakened position of the Director of Public Health (DPH) to provide essential local leadership. This position reflects years of uncertainty along with a pyrrhic 'return' to local government for public health in 2013. Using the career of Westmorland County Medical Officer (CMO) John A. Guy, this paper offers a historical examination of the problems of practicing public health in local government until its absorption into reformed NHS structures in 1974. The case study reflects upon the shape of current community health services in Lancashire and South Cumbria, the ambiguous place of local public health in a nationalised service, and the ability of individual leadership to overcome structural constraints.

INTRODUCTION

The Covid-19 pandemic constituted an unprecedented public health crisis for the National Health Service (NHS) since its inception in 1948. Despite significant localised outbreaks during the 1957 and 1968 influenza pandemics, pressures on health services and the government response were slight in comparison.¹ Both were dwarfed by the scale of the earlier 1918-19 influenza pandemic. The crises unleashed since 2020 have had several consequences for the NHS. First, it exposed the fragmented nature of health services and their organisation following decades of reforms. Second, the ensuing centralisation within both government and the Department of Health and Social Care (DHSC) exacerbated fragmentation, limiting the potential of local public health initiative. Third, it demonstrated the weakened position of the Director of Public Health (DPH) as the champion of local public health for communities in providing local leadership.² In the hour of greatest need, public health services were found wanting.³

The failure of public health is not an indictment of DsPH either individually or collectively. Rather, it reflects historic marginalisation within the NHS that has privileged acute hospital services, embedded professional uncertainty, and 'returning' in 2013 to its philosophical home in local government following its departure in 1974.⁴ Since its 'return', the position of public health has only worsened. Left with a range of residual functions and limited resources, placed in competition with other local authority services, and subject to relentless austerity, DsPH have increasingly become a 'protected species'.⁵ Ultimately, this leaves the problems of practising public health as using influence, networks, and individual expertise to counteract the constraints of systemic pressures.

Such problems would be immediately recognisable to those who first practiced public health under the newly nationalised health services in 1948. At the height of their power in the interwar period, Medical Officers of Health (MOsH) were significant figures in local authorities. They were, as I have discussed elsewhere, an 'omnicompetent servant' with extensive powers, resources, and status.⁶ However, at

the inception of the NHS they were 'reduced to a dispirited rump' in the view of Charles Webster, the official historian of the NHS.⁷ Nationalisation left them bereft of powers and demoralised as a profession. Accordingly, post-war MOsH were equally forced to rely on the same individual strategies to practice public health within the NHS as their contemporary counterparts.^{8,9}

Using the career of Westmorland County Medical Officer (CMO) John A. Guy as an example, this paper offers a historical examination of the problems of practicing public health in local government until its absorption into NHS structures in 1974. Drawing upon the annual reports of Guy whilst CMO, the papers of other local welfare state organisations, and obituaries from the *British Medical Journal*, I offer three sets of reflections. First, upon how historic decisions in Westmorland continue to shape current community health services in Lancashire and South Cumbria. Second, on the enduring ambiguity of local public health in a national service. Third, on the ability of individual leadership to overcome structural constraints.

THE RISE OF THE 'OMNICOMPETENT SERVANT'

The rise of the MOH as an 'omnicompetent servant' was slow but inexorable following their creation with the 1848 Public Health Act. Their rise was inextricable from the public health consequences of urbanisation, industrialisation and population expansion that characterised the Victorian era. Although the first MOH had been appointed for the City of Liverpool in 1847, serving as a blueprint for the 1848 Act, it was the 1856 appointment of an MOH for London that heralded their ascent.^{10,11} With successive Public Health Acts throughout the nineteenth century MOsH obtained growing responsibilities. These included: the provision of clean running water; removing and treating sewage; the demolition of housing declared unfit for human habitation; the testing of impure food for impurities, adulteration, and contamination; inspecting the conditions of livestock and the manufacture of produce; immunisation; curbing the spread of epidemics; the collection of epidemiological data; and much more besides. By 1900 local authority public health departments were the envy of the medical profession and a central building block of Victorian local urban government.¹²

From 1900 until the outbreak of war in 1939, the purview of MOsH increased. Moral panics surrounding the unfitness of recruits for the Boer and First World Wars propelled maternity and child welfare up the agenda. Here, MOsH expanded into schools with routine inspections for children, the municipalisation of health visiting formerly run by voluntary organisations, health education, and the provision of free milk and school meals.^{13,14} They were also given new powers for housing and slum clearance to provide 'homes fit for heroes' after 1918 although these were never fully realised in post-war austerity. These were inflected with the fashionable philosophy of eugenics that pervaded the public health profession.^{15,16} It was, however, the 1929 Local Government Act that provided public health with its zenith.¹⁷ This municipalised workhouses and public institutions previously run by parishes and poor law guardians, bringing them under the control of MOsH.¹⁸

During the Second World War they acted as key medical administrators of the Emergency Medical Services (EMS) under civil defence auspices.¹⁹ As an 'omnicompetent servant' their trajectory remained ascendent and knew few bounds prior to the creation of the NHS.

Their rising star, combined with involvement in hospital administration from 1929, caused antagonism with others in the medical profession. Hospital consultants who trained and worked in the elite private, voluntary and teaching hospitals resented the encroachment and could not countenance subordination to MOsH when reform loomed. This informed the decision to nationalise hospital services in 1948 rather than municipalise them, as some in the Labour Government demanded. Equally, GPs feared that public health would undermine the financial viability of their practice and supplant their role as the family doctor. This removed the prospect of a salaried primary care service from the negotiation table by the BMA (British Medical Association).²⁰ The culmination of these jealousies produced an outcome in 1948 which went 'against the natural trend of events' of the continued ascendancy of public health according to Webster.²¹ As I have noted previously, these professional divisions were mirrored in the tripartite division of the NHS.²²

Ultimately, MOsH were the major losers in the creation of the NHS and the welfare state. Hospital nationalisation removed a central source of their power whilst the concurrent creation of social services and housing programmes impinged upon other traditional responsibilities. Given the heights from which they rapidly fell, there was little wonder that public health practitioners were 'reduced to a dispirited rump', as Webster notes, under the NHS.⁷

PUBLIC HEALTH IN MORECAMBE BAY

Whilst the NHS created new organisational arrangements in 1948, public health remained anchored in the Victorian structures of local government that were virtually unchanged since 1889. Within these, power centred on towns and cities which – as county boroughs – possessed a greater ability to raise funds, recruit staff, and push active rather than permissive public health policies. County councils were far weaker, with power residing in urban and rural district councils below them. Between these were municipal boroughs. These had some of the powers of county boroughs, but still sat within the administrative territories of county councils. The wide variation in size, population and resources across councils produced stark discrepancies in powers.²³

Given their greater resources, urbanisation and population concentration, county boroughs served as the principal career route for MOsH before and after 1948. This impacted Barrow-in-Furness, which had a succession of MOsH using it as a rung on a ladder to a larger authority. This began after the death of A. Robb Forrest who served from 1939 until his death in June 1948. His successor, George G. Dickie (1948-50), left for a post as CMO in his native Aberdeenshire.²⁴ James MacLachan (1950-55) departed for Sunderland. I. D. M. Nelson (1955-62) was appointed as MOH for Gosport. D. J. Roberts (1963-68) ascended the career ladder to Salford. Arthur W. Hay (1968-74) bucked this trend, arriving towards the end of his career, having served for a decade as MOH for Whitley Bay. This turnover in senior leadership reduced the ability to develop professional or political networks and

further eroded the place of public health in the local NHS for the town, despite some innovation around policies for elderly people caught between hospital and local authority residential care.^{25, 26}

The reverse situation existed for the portions of Lancashire County Council in Morecambe Bay after 1948. Despite this disadvantage compared with urban areas, Lancashire was pioneering in public health administration, using the passage of the 1948 Local Government Act to strengthen its grip over urban and rural districts. The CMO delegated considerable authority to 17 Divisional Medical Officers (DMOs), each of which – apart from Lancaster, and Morecambe and Heysham, being municipal boroughs – served the rural hinterland of a county borough.²⁷ DMOs also became MOsH for all the constituent urban and rural districts within the area, removing historic conflicts of interests between such localities and the county council.

The hinterland of Barrow, part of the historic county of Lancashire comprising Health Division 1, stretched from Dalton-in-Furness to Coniston and Grange-over-Sands. Following the unexpected death of Archibald Todd in 1949, J. L. Wild (1950-70) took on the DMO mantle.²⁸ Despite a lengthy and stable tenure, Wild was unsuccessful. He struggled to recruit staff, obtain resources, or build networks across the NHS, leaving him responsible for delivering as well as organising services.²⁹ Lancaster as the epicentre of Health Division 2 was similarly placed. After the brief tenures of A. R. Graham (1946-49), who left for a succession of posts in London, and James A. Tomb (1950-52), who retired after an extensive career as an assistant MOH in Lancashire, the position was occupied by Robert W. Farquhar (1952-68).³⁰ Like so many Morecambe Bay MOsH, Farquhar died in post. The glowing obituary provided by Lancashire CMO Stanley C. Gawne was a testament to Farquhar's achievements: working tirelessly for the town with voluntary organisations, nationalised hospital bureaucracies, and the medical profession.³¹

The man who replaced Farquhar can arguably claim to be the first public health leader for Morecambe Bay. John V. Dyer served as DMO for Lancashire Health Division 2 (1968-74) having worked as a junior doctor at both Lancaster and Kendal, and with a stint in the public health department during the 1950s under his belt. However, concurrent NHS and local government reforms under review since the mid-1960s renewed professional uncertainty in public health.³² With Morecambe Bay struggling to recruit doctors in general, let alone MOsH, Dyer agreed to be DMO for Health Division 1. He subsequently became the District Medical Officer for Lancaster Health District (1974-82) and Health Authority (1982-90).³³ Indeed, such was Dyer's commitment that his successor as DPH, R. Nick Gent, praised his 'impressive' contribution to the development of Lancaster's health and health services, along with inspiring his own route into the profession.³⁴ Clearly not all MOsH were part of Webster's 'dispirited rump'.⁷

JOHN A GUY AS COUNTY MEDICAL OFFICER FOR WESTMORLAND

John Allan Guy was appointed as the first full-time CMO for Westmorland shortly before the NHS in 1946. The CMO role dated to 1911, although his predecessors were appointed either part-time or divided the role between the north and

south of the county. Originally from Leeds, Guy was raised and educated in Edinburgh, qualifying from the medical school in 1930. After a series of junior roles at hospitals and in general practice, he obtained his first public health role as Assistant CMO for Staffordshire in 1936. From there he became Deputy MOH for Barrow-in-Furness in 1939, forming part of the response to the May Blitz which targeted the town's vital shipyards in 1941. Afterwards he served in the Royal Army Medical Corps from 1942 to 1946.^{35, 36} During this time he completed his MD thesis on maternity and child health, reflecting his immersion in the classical philosophies of the 'omnicompetent servant' at their interwar zenith.

The situation in which Guy found himself in 1946 offered both constraints and opportunities in practicing public health.

Constraints abounded. The rural, agricultural, and sparse population of Westmorland was juxtaposed with the urban conditions which characterised the Victorian MOH. The political character of the local authority was significant. The county was a fiefdom of the Conservatives who were parsimonious in public health spending when compared with their Labour counterparts, particularly in the textile towns of Lancashire to the south.^{18, 37} Guy was outflanked by the growth of social and welfare services. His newly appointed – and, unusually, university-trained – social worker, Phyllis Thurman was in post for less than three months before resigning in 1948, having been appointed as Westmorland's first Children's Officer.^{38, 39} Services for homeless families and the elderly were run by a separate Welfare Officer, leaving Guy with few institutional resources.

Despite this, there were opportunities. Foremost was the comparably minor status of municipal hospitals in the county before 1948. Westmorland County Hospital was the largest, but the loss was small in comparison to towns and cities.⁴⁰ Ambulances, a minor function before 1939, expanded beyond recognition with wartime civil defence, and Guy inherited a fleet of vehicles able to bridge the gap between a static rural population and newly nationalised health services.³⁹ Whilst Lancashire serviced a large and sprawling population of just over two million in 1948, Westmorland in contrast had 66,700.^{39, 41} The county town, Kendal, was a municipal rather than county borough, which provided administrative unity. There was no need for a system of DMOs overseeing Health Districts for Westmorland, and the county was – at least from an administrative point-of-view – compact with close lines of authority to urban and rural district medical officers. Indeed, Frank T. Madge's lengthy tenure as MOH for the combined county districts from 1946 to 1974 was a key point of continuity in contrast to the fortunes of Barrow.⁴² Ultimately, how these relationships were handled hinged upon Guy's leadership.

PRACTISING PUBLIC HEALTH IN WESTMORLAND

There is a clear legacy from Guy's tenure on the shape of current services. In 1948 the former county District Nursing Association and its staff were nationalised, providing Guy with a sizeable staff of 33 domiciliary midwives who doubled as district nurses. The service 'flourished' during those early years with incentives of housing, transport, and promotion.⁴³ A combination of local conditions and national policy eroded gains. The availability of ambulances and a desire from mothers for hospital confinement led the number of maternity cases to decline from a peak of 228 in 1949 to 110 in 1963.^{43, 44} By 1967 the service was 'unviable', and the large and highly trained workforce was either retrained in health visiting or

relocated into hospitals.⁴⁵ The acceleration of this trend was due to government maternity policy. The 1959 Cranbrook Report created a target of 70% for hospitalisation within a decade which was increased to 100% with the 1970 Peel Report.⁴⁶ The national withdrawal of community services undermined Guy's local investment and removed a feasible alternative for the local population from the table by the time of hospital and maternity rationalisation a decade later.

Public health occupied an ambiguous place under the 'classic' NHS which defined Guy's tenure. It served as a permeable boundary between statutory and voluntary services, belying the fiction of universal services provided free at the point of delivery. A mixed economy of care remained. Whilst domiciliary midwifery initially flourished, other community services did not. Guy struggled to recruit health visitors for his ambitious vision for maternity and child welfare. Undeterred, the 'introvert who loved children' opened clinics across the county through the goodwill of the British Legion, St John Ambulance, churches, working men's clubs and the British Red Cross.^{41, 44, 48} The limited financial support rarely covered costs and was on an honorary, not contractual, basis. Although attendance from locals ebbed and flowed, and specialist care was not always available – with Guy's wife Angharad, a pioneering doctor in her own right, undertaking routine clinic work on returning to work in the 1960s⁴⁹ – these clinics constituted for many in Westmorland the reality of the new nationalised health service.

By 1953 Guy declared that the home help service – modern day social care – was 'one of the most vital parts' of the NHS, limited only by 'financial stringency'. A far cry from the marketisation of the present. Financial stringency was evident as costs were met from local rates rather than general taxation, and means testing was kept as a source of income generation based on the ability to pay.⁵⁰ The service existed since 1918 to help expectant and new mothers with domestic work, but professional and public hesitancy limited its growth.^{51, 52} After 1945 it grew exponentially, caring mainly for the elderly and infirm in their own homes. Guy struggled with two difficulties. First, high employment rates in Westmorland made the arduous work an unattractive proposition. Second, the paucity of vehicles in a rural county posed a significant barrier. However, Guy recruited help on a case-by-case basis from neighbours, families, and communities.⁵⁰ It was an innovative form of traditionalism rooted in the values held by his generation of MOsH. Although this ultimately inhibited the professionalisation of the service, it was a pragmatic solution which reduced the numbers moving into expensive and oversubscribed residential accommodation.

The problems of practising public health in Westmorland led Guy to develop a spectrum of strategies, although these struggled against constraints of powers and policies beyond his control. These same dilemmas existed for his successor H. Peter Ferrer (1971-74) who briefly held the post before public health moved into the NHS in 1974. He developed new knowledge exchange partnerships with the Operational Research Department of the fledgling University of Lancaster to reconstruct the county's community nursing.⁵³ Yet, like his predecessor, he praised the 'voluntary societies who form an essential part of the life and services' of Westmorland's public health.⁵⁴ On the cusp of MOsH becoming a 'protected species' in 1974, let alone 2013, Ferrer and a new generation of public health professionals needed to reinvent these same strategies and remake networks as Area and District Medical Officers under the reorganised NHS.

CONCLUSION

The story of public health under the NHS has largely been one of persistent decline since 1948. There are a few isolated exceptions. Chief Medical Officer Donald Acheson reinvented the MOH as the DPH in 1988 to rejuvenate the profession.⁵⁵ Concurrently, maverick John Ashton was in the vanguard of the new public health movement creating contemporary philosophies and practices.⁵⁶ Notwithstanding these and others, the DPH remains a shadow of the interwar MOH. They shifted from being a 'watchdog' of the public health to a 'lapdog' in the view of historian John Welshman.¹⁷ Webster's view of MOsH being 'a dispirited rump' seems to capture the overarching process of residualising public health further within the NHS over time, rather than capturing the experiences of 1948 alone.⁷

Despite the narrative of decline and a context of constraint, the experience of Guy as a public health professional shaping solutions to the particular problems of practising public health in Westmorland, offers a series of historical reflections for the present. First, the current shape of health services in Lancashire and South Cumbria have been moulded by the past. Maternity and child welfare were historic public health concerns which

have remained despite their move into community and hospital services. This accumulation of changes has influenced the current service landscape beyond the horizons of historic public health alone. Second, the ambiguous place of local public health in a nationalised service has been compounded by the uncertainty around place. A renewed emphasis on its primacy and the potential for individual strategies to rebuild or reconstruct alternatives creates a new space for DsPH, despite the barriers constructed against them. Third, the potential of individual leadership to overcome structural constraint requires an understanding of context. Although Westmorland and Morecambe Bay did not reflect the same urban public health problems imaged by their Victorian forerunners, some local MOsH were able to work with the grain of place rather than against it, comprising more than a 'dispirited rump'. With uncertainty comes opportunity, and if the history of public health tells us that anything, it is that uncertainty is the one certainty regarding the place of public health in the NHS.

REFERENCES

(a full list available on request)

Book review

With the End in Mind

By Dr Kathryn Mannix. William Collins; 2017

Review by Jacob McSweeney, 4th Year Medical Student, Lancaster University

Dr Kathryn Mannix's Sunday Times bestseller, "With the End in Mind", lifts the veil on the frequently avoided topic of death and dying. Walking readers through her stories as a palliative care doctor, Mannix explores common themes present not only at the bedside of dying patients, but also those found within the networks surrounding them.

My fears of the unknowns of death led me to pick up Mannix's book. The lessons shared within changed my entire perception of death and dying, allowing me to put down this book feeling comforted with a new found acceptance of the inevitable. I had never expected a book about dying to have such a profound effect on the way that I live today. I now find myself having frequent conversations about death and dying with those around me, using Mannix's teachings to reintroduce our abandoned relationship with death.

Throughout Mannix's writing, she invites us to consider our end-of-life plans and teaches the reader how to discuss these with family and friends. What is important to us? Who do we want with us at the end? And where do we want to die? Alongside her teachings, Mannix leaves us with a letter template to aid in opening conversations about death and dying with those important to us, offering the first stepping stone to support us in further exploration of our fate.

The gifts of knowledge acquired through Mannix's own experience are delivered to us throughout a series of patient interactions. Through these stories, we are brought to witness a plethora of different encounters. From emergency department deaths and premature unexpected turns to hospice weddings and final goodbyes, Mannix shows us death in all lights and settings with her experienced and compassionate commentary.

Despite its common place in daily life, Mannix recognises that due to modern medicine and hospital-based care, most are yet to understand what dying looks like. She describes "the process of dying is recognisable. There are clear stages, a predictable sequence of events. In the generations before dying was hijacked into hospitals, the process was common knowledge...". To unpack this reality, Mannix offers the reader a story of a young man, fearful of his mother's approaching death. She details how this son has difficulty understanding his mother's current state, desperately questioning the medical care being provided, concerned it is hastening his mother's end. The pivotal moment of this story highlights nothing less than the importance and sheer wonder of sound communication. Mannix invites us into the conversations between a senior nurse and the struggling son. We witness the calm and reassuring approach, as she delicately yet unambiguously details the changes in breathing this family can expect to see. Without divulging too much of this conversation, I will share that the major lesson I have taken from it, is that offering any small level of certainty or understanding through education in these precious moments can be powerful medicine in itself.

Mannix continually illustrates how a carefully struck dynamic between medical interventions and conscientiously constructed conversations can relieve not only the symptoms and worries of the patient, but also the complex relations surrounding them. Mannix's wisely placed patient stories, found along the journey she takes us on, create a personable and touching recommendation for how we can hold power over how we choose to live and die.

As a detailed guide to death and dying, filled with the compassionate, empathetic, and wise take of Dr Kathryn Mannix, I encourage all those curious, or even apprehensive, of death and its complex conversations to join Dr Mannix through her memoirs and rediscover the forgotten knowledge of dying.

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