Professional strategies of Medical Officers of Health in the post-war period – 1: ‘innovative traditionalism’: the case of Dr Ian MacQueen, MOH for Aberdeen 1952–1974, a ‘bull-dog’ with the ‘hide of a rhinoceros’

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Summary
Recent policies concerning the enhancement of preventive medicine and health improvement have raised important questions about leadership in public health and have emphasized the roles that can be played by local authorities. In this light, it is worth exploring the activities undertaken by local authority Medical Officers of Health (MOsH), until their posts were abolished in 1974. The process leading to 1974 has often been blamed, at least partly, on the complacency, lack of imagination and demoralization of MOsH. However, when John Welshman asked the question ‘watchdog or lapdog?’ of the MOH, in a paper published in 1997, he concluded there was little justification for the latter label. This paper considers the career of Ian MacQueen, Aberdeen’s last MOH, who is well known for the criticisms of his handling of the Aberdeen typhoid outbreak in 1964, which appeared in the report of an official enquiry. He was deemed to have made excessive use of the media and to have turned the outbreak into an event approaching a national crisis. However, in the context of MacQueen’s 32 year career in Aberdeen, his use of the media during the typhoid outbreak was no aberration. Rather, it was characteristic of his determination to maintain an important role for the MOH within the NHS-era health services. There is therefore continuity between MacQueen’s strategy and the ambitions of many MOsH before the NHS, who hoped for a unified health service with themselves occupying a leading role. MacQueen’s actions during the typhoid outbreak also reflected his innovative activities in the field of health education, and his interest in the media for that purpose. In conclusion, MacQueen provides an example of an MOH who cannot be charged with complacency and resignation to a declining role: rather, his strategy of ‘innovative traditionalism’ sought to protect and extend his department’s services.

Keywords: Medical Officer of Health, health education, health visitors, Aberdeen typhoid outbreak

Introduction
On the abolition of Medical Officers of Health (MOsH) in 1974, posts in community medicine were created within the NHS (whose occupants were later entitled ‘Directors of Public Health’), and debates about the role and standing of the new specialty began even before the transition. The debates have continued ever since, and have often included analysis of, or assumptions about, the former role of MOsH (e.g. Refs 1–4). The second report of the House of Commons Select Committee on Health recorded in 2001, for example: ‘One of the issues raised in evidence to us was the vagueness of the Director of Public Health’s remit and the lack of direct power he or she could bring to their job. Our impression is that a good deal was lost with the transfer of the public health function from local government in 1974’ (Ref. 5, para. 155).

The British Medical Association had claimed that Directors of Public Health were acting in an ‘entrepreneurial way’, but the Select Committee rejected this view. According to the Select Committee, the Directors were not generally ‘providing the necessary leadership in the public health field’ (Ref. 5, para. 157).

There have even been explicit calls to ‘bring back the MOH’ in recent years. However, the response of the Department of Health for England and Wales to the Select Committee offers no such simple solution. It is clear that the Director of Public Health’s role is expected to change in future, but also that much depends upon the implementation of the new Primary Care Trusts, which are responsible for general practice and related services. Primary Care Trust Boards will include a member appointed to lead a ‘public health team’. This will undertake ‘work of improving health and reducing inequalities’ by ‘integrating public health into primary care’ and also ‘working
in partnership with local authorities and other agencies’. A speech by the Health Minister, Lord Hunt, given to the Faculty of Public Health Medicine on 13 November 2001, provides further insight into the way these policies will be implemented. See http://www.fphm.org.uk/)

In Scotland, Directors of Public Health received less critical treatment in Review of the public health function, published in December 1998, where the emphasis was upon the development of Health Boards as ‘Public Health Organisations’. In contrast to England, there seems to be less emphasis upon Primary Health Care Trusts’ public health functions at present. As regards the role of Local Authorities, however, the Scottish Executive has recently stated that they ‘want to see Local Authorities develop their role as public health organisations’ and that they will ‘remove barriers to closer working between NHS Boards and Local Authorities to improve public health’. Existing examples of such NHS–Local Authority collaboration include the ‘Health Action Zones’ in England and Wales, and the ‘Health Improvement Programmes’ in Scotland. The latter will be soon be superseded by ‘Local Health Plans’. These initiatives aim primarily to address problems of health inequalities, highlighted by the Black report in 1980, which have gained a much higher profile of questions about the status of the MOsH in the twentieth century, but Jane Lewis raised a number of issues facing MOsH were exacerbated by the declining importance of infectious diseases, the control of which had been central to the raison d’être of MOsH. In addition, while social work divisions of health departments expanded during the period, in 1970 in Scotland and in 1971 in England and Wales, separate social work departments were established and directors of social services were appointed.

In this journal in 1997, John Welshman posed the question of whether the MOH should be regarded as ‘watchdog or lapdog?’ in a paper on the role of the MOH 1900–1974. In his recent book Municipal medicine: public health in twentieth-century Britain, he asks, similarly, whether the MOH was a ‘villain or hero?’ (Ref. 16, pp. 443–450). This was not a question about the influence of MOsH upon disease, but was rather focused upon professional strategies. Were the MOsH complacent and unimaginative, and responsible for their own fate, or did they valiantly seek to maintain and develop public health, so their demise was more due to other circumstances? Taking the example of Leicester as a case study, Welshman showed that after 1948 the MOsH developed new work in health education, the care of unmarried mothers, mental health services and other areas. He concluded that, far from lack of initiative on the part of the MOsH, it was factors outside their control that proved decisive.

Welshman admitted, however, that Leicester may have been a special case and argued that further local studies will produce a ‘more subtle, accurate and complex picture’ (Ref. 16, p. 34). This paper, on the work of Dr Ian MacQueen in Aberdeen, and a further paper on public health on Teesside, NE England, are examples of such studies.

Ian MacQueen: early career, and work in Aberdeen 1952–1963

Ian Alexis Gordon MacQueen was born in Kirknewton near Edinburgh in 1909, the son of a schoolmaster. He completed an MB ChB in Edinburgh in 1937 and a diploma in public health in 1939. He held junior posts at hospitals in Edinburgh, and in the early 1940s became assistant MOH at Barnsley in North Yorkshire. He then became one of the youngest MOsH in Britain in August 1943 when appointed MOH for Mansfield near Nottingham. During his 4 years in Mansfield he extended the health service of the town and according to a local newspaper ‘endeared him[self] to the community at large’ because of his commitment to the health of the people. He then returned to Edinburgh in 1947 and spent 5 years in central government, as a medical officer at the Department of Health for Scotland, responsible for liaising with local authority health departments. During this period he obtained his MD from Edinburgh University. However, he later commented that he was always unsuited to the ‘ivory towers’ of Edinburgh. When the chance came to return to local government he moved to Aberdeen on the retirement of Dr Harry Rae in 1952 (Ref. 19, p. v).

In 1951 the Department of Health for Scotland’s Standing Advisory Committee on Local Authority Services issued What local authorities can do to promote health and prevent disease,
and encouraged health professionals and elected representatives to study it. MacQueen made it the subject for the introduction to his first annual report as MOH for Aberdeen. He quoted a paragraph that stated that it was a main duty of an MOH to ‘study all factors affecting the health of the community, and – without neglecting the remaining – to apply to other health problems the epidemiological and other methods which yielded such striking results in reducing infections’ (Ref. 20, p. viii).

This statement encapsulated the feeling that much of the original role of the MOsH was obsolete and that they faced the challenge of reinventing themselves. MacQueen made it the occasion for emphasizing the need for him to be provided with information about the occurrence of disease and the discharge of patients from hospital, so he might develop a full role in co-ordinating services.

An important aspect of MacQueen’s bid to place his department at the centre of the health services was the collaboration that he hoped would be established between the department’s health visitors, and hospital staff and general practitioners (GPs). However, although the benefits of health visitors in after-care were soon realized in hospital circles, GPs were sceptical as to their value. MacQueen urged health visitors to communicate directly with GPs about patients’ problems that they encountered, but when the health visitors did so, GPs demanded a memorandum on health visitors’ qualifications and functions. In this MacQueen alluded to suspicions among GPs that health visitors were encroaching upon their own territory. He commented that it would be ‘useful if the doctor and health visitor each realised that the other was a highly trained professional person’.21

In contrast to his early remarks about the role of the MOH in the co-ordination of local authority, GP and hospital services, by the end of the 1950s MacQueen had become more concerned with ‘team work’ among his own staff.22 In 1960, he compared the local authority public health department to a cricket team and the MOH to the captain. It was the captain’s responsibility to decide the order of bowling, allowing successive bowlers to ‘place the field’ including the captain himself. The opposition, however, was not simply disease and its causes. The ‘team concept’, MacQueen argued, would provide ‘security’ for the public health team ‘in a world of empire builders’. He remarked that ‘as long as the team stands together and fights together, it is invincible, because no empire-builders can suddenly create a rival team’, alluding to a variety of possible threats to the integrity of public health departments.23

MacQueen’s concern to preserve and extend his own local authority public health empire reflected a traditional concern of MOsH, but he was fully aware of changing circumstances and the need for innovation and a new style of leadership. By 1960 he had reached the conclusion that, in view of social and demographic changes, there were a number of new key challenges for public health. These lay in developing health education and the preservation of mental health, the care of the elderly, the after-care of those discharged from hospital, and the prevention of non-infectious conditions such as home accidents.24 Two years later, looking back at what he had achieved during his first 10 years in Aberdeen, he claimed that significant advances had been made in all these fields. But work in the field of infectious diseases had also continued to be important. New immunization, and prevention and screening techniques (for TB) had been introduced (Ref. 24, p. 165).

Much of the new work depended upon the expansion of the numbers and roles of health visitors. Their statutory roles had been enhanced by the NHS (Scotland) Act, and the Department of Health for Scotland was prepared to support an expansion in their number. In Aberdeen, the establishment for health visitors was increased from 46 to 65 before MacQueen’s arrival and reached 85 in 1954, a higher density than for any other Scottish city and close to MacQueen’s target of 89.25,26 Nevertheless, there were frequently more than 20 vacancies for health visitors in Aberdeen and MacQueen blamed the poor salaries and career structure.27 MacQueen was also an advocate for male health visitors, and in 1961 Aberdeen became the first city in Britain to admit men to a full-time course at their Health Visitor Training School.28

MacQueen had begun a study of home accidents by the time of his first annual report and later received a Nuffield Provincial Hospitals Trust grant for research in this area.29 Health visitors played a key role in the research and in an associated home safety campaign. MacQueen was invited to prepare a report on home accidents for the World Health Organization and claimed the campaign in Aberdeen led to a reduction in home accidents by more than a third (Ref. 19, p. x; Refs 30, 31).

In his 1953 report, MacQueen described health education as ‘the most important portion of the local health authority’s work’. At this time health education was delivered through the day-to-day activities of his staff but in 1956 a new campaign was launched, dubbed by the press the ‘thousand salvo blitz on disease’. A thousand health education talks were to be given per year, mainly by the health visitors, but this figure was soon exceeded. A health education unit was established and MacQueen proudly boasted about the recognition that Aberdeen’s health education work had achieved. In the early 1960s he began to move beyond individual and group teaching and to show an interest in the potential of newspapers, television, and radio (Ref. 19, p. xvi; Ref. 24, p. 7; Refs 30–32).

In some areas, for example maternal and infant welfare and immunization, local authority health departments were in competition with GPs. In Aberdeen, however, MacQueen’s health visitors helped to ensure that the municipal services remained well utilized. Between 1952 and 1962 there was a significant increase in the number of clients attending antenatal clinics, and in the case of postnatal clinics there was only a slight decline. As for the proportion of primary injections for diphtheria carried out by local authority doctors (taken as an index of the use made of the municipal immunization services), this increased from 64 to 67 per cent (Ref. 20, pp. 27, 41; Ref. 24, pp. 41, 70).

One possible solution to the problems of health visitor–GP
communication and competition was to attach health visitors to group general practices, as was being pioneered elsewhere, notably Oxford. In Aberdeen, the first experimental attachment of a health visitor to a group practice in Scotland was established in 1959. However, further developments in this area were slow partly because of staff shortages and partly because MacQueen was inclined to claim that ‘health visitors could do a lot of the work that doctors did’. Understandably, that ‘didn’t go down too well’ with the GPs.

MacQueen’s enthusiasm for health education, the existence of his large and dedicated team of health visitors, and his difficult relationship with GPs, all proved of consequence in his handling of the typhoid outbreak of 1964, to which we will now turn.

The typhoid outbreak, 1964

The typhoid outbreak began in the middle of May 1964 and by the end of the month the source was traced to corned beef that had been sold in slices at the cold meat counter of a supermarket. There was eventually a total of nearly 500 cases, but it became possible to sound the ‘all clear’ after about a month. The outbreak allowed MacQueen an opportunity to return to an original role of MOsH in infectious disease control. However, because the local authority’s infectious diseases hospital and laboratory had been handed over to the NHS, he was unable to exert such direct control as had been possible for former MOsH. The management of the outbreak therefore depended more upon communication and co-operation between different branches of the health services than would have previously been the case. Unfortunately, MacQueen’s previous overriding concern with protecting and extending the role of the public health team had not created the conditions for this effective communication and co-operation to be rapidly established.

MacQueen deployed his health visitors in contact tracing and taking samples for analysis, which led to the swift identification of the source of the outbreak. But his lack of communication with GPs, the regional laboratory, and the hospitals, especially during the early stages of the outbreak, was criticized both locally and in the report of the official enquiry into the outbreak (the Milne report), which appeared in December 1964.

The Milne report also attacked MacQueen’s media strategy, commenting that during his press conferences ‘a number of dramatic statements were made in order to encourage the citizens of Aberdeen to obey those edicts of hygienic practice which Dr MacQueen felt to be essential’. One result, ‘which affected not only Aberdeen and to a lesser extent the rest of Scotland, and had repercussions internationally, was to give the outbreak … the status of a national disaster’ (Ref. 35, p. 69). The report suggested that a daily press statement rather than press conferences would have been sufficient to achieve the health education objectives. This view, however, was not that of The Medical Officer, which at the height of the outbreak alluded to MacQueen’s achievements in the field of health education and reported: ‘Dr MacQueen has been holding daily press conferences during most of the course of the epidemic with the result that this has probably been the best “covered” outbreak of its kind…. it is fortunate that Aberdeen’s population has been so accustomed to accepting guidance on health matters’.

In January 1965 MacQueen used the same journal to counter-attack the Milne Committee. He argued that the Committee’s views could be ruled out on the grounds that ‘publicity aspects were completely outside its remit’ and ‘the Committee took no evidence from any health education officer, public relations officer, journalist, television producer or publicity expert of any type’. MacQueen’s colleagues in the Scottish branch of the Society for the Medical Officers of Health, of which he was a former president, supported him. They set up a sub-committee to investigate the findings of the Milne Committee and concluded that the report had treated MacQueen unfairly and commented that ‘the Medical Officer of Health did his work well. It should be noted that there were very few secondary cases. Publicity played a part in this and helped to have the cases detected earlier.’

MacQueen after typhoid, 1964–1972

MacQueen’s performance in the typhoid outbreak appears to have caused no permanent damage in terms of his standing in the world of health education. In 1970, he was elected chair of the Scottish Health Education Council, and in 1972 became a member of the Chief Medical Officers’ Advisory Committee on Health Education (Ref. 19, p. 12; Ref. 39, p. 13). And, despite the offence that MacQueen gave to GPs as a result of his handling of the outbreak, during the years that followed, the development of the health visitor attachment scheme gathered pace.

After the first experimental attachment in 1959, a second scheme began in 1961. In his report for 1964, MacQueen alluded to the many recent articles in medical journals on health visitor attachment. Some of Aberdeen’s GPs, it seems, were keen to keep up with national trends, but MacQueen observed that many health visitors were ‘not convinced that complete attachment is the best method of achieving good co-operation and co-ordination’. But the scheme subsequently expanded, as elsewhere, following the introduction of new financial arrangements for GPs – the concept of the ‘health care team’ with the GP taking a leading role, dating from this period. MacQueen, however, was by no means ready to embrace this concept with enthusiasm. Earlier, when comparing the public health department to a cricket team, he had also spoken of the health services as a whole as a football team, with the MOH as centre forward, flanked by his colleagues, the GPs in mid-field, and the hospital services as backs and in goal. He was reluctant to concede the leading position to the GP.

Nevertheless, by 1965 there were eight health visitors attached to six practices in Aberdeen, and MacQueen’s last report, for 1972, mentioned 36 practice-linked health visitors,
involved 22 practices and 60 GPs (Ref. 19, pp. 15, 21; Ref. 42).
However, MacQueen consistently discussed the possible dis-
advantages as well as advantages of health visitor attachment.
He preferred to speak of ‘linkage’ rather than ‘attachment’ and
noted that the linkages were only partial, in the sense that ‘linked’
health visitors still devoted time to school health visiting and
health education work (Ref. 39, p. 18). One observer has com-
mented that the issue at stake was control over the agenda of the
health visitors: by avoiding effective transfer of them to the GPs,
this remained with the MOH (Elizabeth Russell, personal com-

data from the authors, 10 August 2001; MacQueen’s caution
regarding health visitor attachment may also be usefully com-
pared with R. J. Donaldson’s enthusiasm17). Partly because of the
devolution of health visitors, the proportion of primary courses
against diphtheria and other immunizations administered by the
health department’s medical staff declined to about 35 per cent
by 1972. However, the Corporation ante- and postnatal clinics
remained viable (Ref. 19, pp. 49, 71).
During the 1960s MacQueen introduced a number of new
services. Encouraged by the professor of obstetrics and gynae-
cology of Aberdeen University, all contraception, including the
pill, was made free at the family planning clinics in 1967, and
unmarried women were included in the client base.43 Some
citizens were outraged, a letter appearing in a local paper under
the heading ‘Christ gave no licence to sin’.44 The numbers of new
attendees at the clinics rose by over 50 per cent and the number
of unwanted pregnancies declined.
In discussing the separation of social work from his depart-
ment, MacQueen was resigned to this depletion of his public
health team and emphasized that the health department would
remain large and complex. He even made some virtue of the
changes, suggesting that the loss of responsibility for old peo-
ple’s homes and occupation centres would allow the department
to ‘at last have time to tackle the improvement of physical,
emotional, mental and environmental health’ (Ref. 45, p. xvii).
There were some signs of development towards these goals
during the final years of MacQueen’s career. A physiotherapy
service, started in 1964, served 68 patients in 1968, but 2806 in
1972 (Ref. 19, p. 46; Ref. 45, p. 76). Similarly, his department
first employed a dietitian in 1960, but in the late 1960s this work
was expanded and in 1972 there was a total of 7878 attendances
at the Dietetic Clinic (Ref. 19, p. 12). Even during the final years
of the local authority public health, when the eventual fates of
MOsH posts were clear, MacQueen sought to innovate in order
to maintain a significant role for his department within the
health services.

MacQueen’s strategy: innovative traditionalism
A Medical Officer of Health such as MacQueen was likely to be
a controversial figure. The retired health visitors interviewed
during the preparation of this paper universally admired him
and his style of leadership. Miss Nairn, for example, Super-
intendent Health Visitor in the 1960s and early 1970s, com-
mented that MacQueen was a very accessible man who was
‘very clever … and sometimes too clever for the people he was
dealing with’.46 In contrast, Joan Burrell, a GP, described
MacQueen as ‘not often available’, ‘unapproachable’ and ‘not
helpful towards GPs’.47 An obituary in Aberdeen’s ‘Evening
Express’ quoted Bob Hughes, who was convener of the
Council’s Health and Welfare committee from 1963 to 1968,
describing MacQueen as a ‘visionary pioneer’ and a ‘revolution-
ary who seemed to thrive on the furore he caused in order to get
his ideas put into practice’.48 This echoed MacQueen’s own
perceptions of himself. In 1975, when an ‘Evening Express
reporter asked him what made a good MOH, MacQueen
replied, ‘the tenacity of a bull-dog and the hide of a rhinoceros’,
qualities which he regarded as his own.49
Despite the variety of opinion, it is clear that the view of
MOsH as complacent and unimaginative in the post-NHS era is
not supported by the example of Ian MacQueen. And yet
Welshman’s clear-cut terms of ‘watchdog’ and ‘lapdog’ both
seem inadequate as possible descriptions. Certainly MacQueen
sought to act as a watchdog monitoring health conditions and
taking appropriate action. But a phrase more descriptive of his
predominant strategy is required, which expresses his deter-
mination to preserve the integrity of the local authority public
health empire as far as possible but to develop new roles in
response to changing circumstances as necessary. His innova-
tions show a clear awareness of early ideas about the potential
of the media and importance of ‘lifestyle’, which were only
expressed in high-level policy documents in the 1970s. They
provide some indication of what public health might have
become, had its local base not been removed by changes in
central government policy.50 In Scotland, MOsH had longer
to become used to the idea of the loss of social work than in
England and Wales. The key policy document in Scotland was
the report of the Scottish Committee on Children and Young
Persons, published in 1964. The equivalent in England and
Wales, the report of the Committee on Local Authority and
Allied Personal Social Services, only appeared in 1968.51,52 In
the case of Aberdeen, in view of MacQueen’s careful mainten-
ance of the remaining traditional services as well as the develop-
ment of new roles, there was much left to hand over to Grampian
Health Board when his post was abolished in 1974.53 The Health
Board appointed a new community physician, Dr W. Bruce
Howie, with the title of Chief Administrative Medical Officer
(CAMO), but MacQueen was given a temporary supernumer-
ary post until his retirement. While the CAMO sought to
develop the new ‘community physician’ agenda, MacQueen
maintained a role in overseeing the practical services, in training
personnel, and in liaison work. He remained particularly
concerned with health education and health visiting, and in
maintaining contact with the Social Work Department and
Environmental Health Services. In the event, a new post was
created to take over this work when MacQueen retired in
1975.54
In conclusion, we suggest that MacQueen’s overall profession strategy is best described as ‘innovative traditionalism’. In the sequel to this paper, focusing on Teesside, the strategy of another MOH will be discussed and an additional descriptive phrase suggested.

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