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The role of Medical Officers of Health in Civil Defence and how they influenced modern emergency medical practice

Nathan Robert Hazlehurst*

University of Salford, United Kingdom

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ABSTRACT

Objectives: The article will examine the role of the Medical Officer of Health within United Kingdom Local Authorities in the period preceding the Second World War, the war itself, the residual impact of their work on emergency medical and public health practice and lessons that can be learned to improve.
Study design: The article uses archival and secondary source analysis of documents related to the work of the Medical Officer of Health, their staff, and associated organisations.
Methods and results: The Medical Officer of Health performed a key role in the Civil Defence of the United Kingdom, ensuring that the victims of aerial bombardment were treated quickly. They also worked to ensure the public health of the population was maintained, especially those covering areas receiving evacuees, and worked to improve conditions within deep shelters and other areas with displaced individuals.
Conclusions: The work of the Medical Officer of Health created the forerunner of modern emergency medical practice in the United Kingdom, often through local innovation, and embedded the work on health promotion and protection fulfilled by Directors of Public Health.

Introduction

Amid the plethora of films and popular culture related to the Second World War, there is one group of individuals who are very rarely featured: the staff of the Civil Defence Casualty Service. This organisation was responsible for immediate life-saving response to the various forms of aerial bombardment that threatened the United Kingdom. At its heart, coordinating prewar planning and wartime response was the Medical Officer of Health (MOH). Their role was instrumental in forging the Service, and they were vital in allowing innovation to thrive and be adopted locally, regionally, and nationally. The Medical Officers of Health (MOsH) had to continue their peacetime role of providing public health leadership for their locality, a role exacerbated by the evacuation of individuals during the conflict and conditions forged through bombing.

This article will explore the role of MOsH prewar, their significant role in creating their local Civil Defence Casualty Service, their wartime role and their impact on modern emergency medical and public health practice. The article will comprise a historical review, with a conclusion to explain the implications and importance of the study for modern practitioners, both in understanding the history and recognising modern parallels.

Prewar activities

The MOH, in the period before Air Raid Precautions (ARP), was already a role with significant and ever-increasing responsibilities. The MOH predated the Ministry of Health and had their origins in the Sanitary Boards that were amongst the first examples of Local Authority control in urban areas. Their duties encompassed the modern roles of Public Health and Environmental Health and were responsible for the health of the inhabitants of their locality. This included their physical health, mental health, and the wider sanitary conditions in which their area was based. Within many areas, infectious diseases were endemic, and the MOH had to ensure the provision of hospitals for treatment, alongside vaccination and public education. MOsH had the unenviable task of trying to coordinate the various medical establishments within their area. These included any hospitals run by the local authority, isolation hospitals for infectious diseases and voluntary and private hospitals. Following the Local Government Act 1931, the MOsH gained the duties of the Poor Law guardians and their eponymous

* Corresponding author. 6 Bower Court, Woking, GU22 8HB, UK. Tel.: 07988 551392.
E-mail address: n.r.hazlehurst@edu.salford.ac.uk.

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workhouses, which most transformed into municipal hospitals. Alongside these duties, the MOH's department coordinated general practice, midwifery and community nursing. The MOH was born of a period where the idea of universal health provision was alien and that health care was the preserve of local authorities and the private sector; central government became involved only in emergencies. There was little direction from the Ministry of Health on most areas of responsibility, a situation that had changed little from the Ministry's predecessors in the Local Government Board despite the lessons of the Flu Pandemic of 1918–1920.

In the period immediately after the First World War, there was disagreement within Whitehall over who had primacy of future ARP, with the War Office and Home Office both believing that it should be the other. It was agreed, because of the civilian areas that it would cover, that the Home Office and Local Authorities should be responsible for ARP, rather than local military commanders and their subordinates. By placing much of the responsibility for ARP onto Local Authorities, the government also recognised both the need for local knowledge and the difference in trust levels between central and local government amongst the population. It also demonstrated that expertise in directly running services still sat at the local level during this period rather than centrally.

The ARP department, founded in 1935, created a series of memoranda for the various services Local Authorities would need to create. The first of these memoranda, published in 1935, formed the Casualty Service. The service, created with little input from the Ministry of Health, was to be coordinated by the MOH in each scheme-making authority; these were to be upper tier and unitary authorities across the country in the same manner of Directors of Public Health today.[1] The service consolidated existing health provision within a local authority area to report to the MOH and created new wartime services; an enlarged ambulance service, a first aid party service, first aid posts and gas decontamination centres and emergency arrangements for war dead. It was assumed that the Voluntary Aid Societies, St John Ambulance, the British Red Cross and St Andrews would provide the bulk of the staffing for these new services, with the MOH liaising closely with the local units. In addition, it was expected that all hospitals within the Local Authority would be categorised into those that would receive casualties and those that were specialist or too small, with plans on each category's use.[2]

The MOH was to find themselves with significant extra work in creating these services. Their role involved considerable diplomacy, as many of the existing services were not under their direct control but under other council-aligned services, such as the Police, Fire Brigade or Voluntary Sector for Ambulances,[3] and private and voluntary bodies that ran hospitals. They also found themselves having to deal with the Home Office in regard to their compliance with the ARP requirements and attend the ARP Committee of the Local Authority, where they were a standing member and had to explain the necessities of health. Many MOsH, rather than carrying the full burden of this work alone, requested a deputy to fulfil the demands of the ARP work.[3] A number of these staff became experts in their own right, with Dr John Chapel completing a PhD thesis on Casualty Services in Leicester in 1937[4] and Dr Gerald Shirlaw, Deputy MOH for Battersea, writing two books on the subject in 1940[5] and 1941.[6]

For MOsH in rural areas, they had the additional difficulty of planning for potential evacuees and refugees to be placed in their area, including the need to respond to communicable diseases that, although endemic in the cities, were relatively unknown in their locality.[7] These needs, when balanced against national requirements, meant that MOsH would on occasion push back against directives to convert hospitals. In one particular case, the Cardiganshire MOH, Dr Jones, successfully argued that the County Maternity Home should remain as a specialist centre because of the expected numbers of refugees and evacuees that would be arriving in the area and the resulting need for specialist maternity care.[8]

Post-1938, the MOH gained the additional workload that resulted from a change in ARP oversight. Half of their service, Hospitals, Ambulances and First Aid Posts were now overseen by the Ministry of Health; the rest of their work stayed with the Home Office.[9] The Ministry of Health changed the requirements for First Aid Posts, reducing gas attack preparedness and increasing their ability to treat minor injuries resulting from high explosive and incendiary attack; consequently, the MOH had to adapt their operating model, staffing needs, and protections afforded to the buildings. The new arrangements meant that Medical Officers were serving two government departments with competing priorities, as well as being accountable to their local authority colleagues. The increased workload with the Ministry of Health also impacted workload through the co-location within their hospitals of Emergency Medical Service beds. This was the Ministry's first foray into directly running medical services on a nationwide level, and their local officers built up effective working relationships with the MOsH of which they were residing. This split between various departments can still be seen to this day, with Directors of Public Health having to provide support and assurance to their Local Authority (LA) colleagues and elected members, to their NHS Partners and to two central government departments.

The MOH also needed to respond to an issue not envisaged when planning ARP. The Voluntary Aid Societies, expected to provide the personnel for Casualty Services, informed the Government that they were committed to provide volunteers to the War Office and Admiralty and that their most able-bodied volunteers would be unavailable.[10] This resulted in MOsH actively recruiting staff they had not planned for and identifying where women would be best deployed as part of Casualty Services. In many cases, the role of ambulance attendant and driver was adjusted to become a female role, allowing male volunteers to be diverted to the first aid and rescue parties.

Wartime work

The wartime roles of the MOH were dependent on the location they covered. For officers who covered remote areas, their wartime work began earlier and aligned to their traditional responsibilities. These areas were the first to receive evacuees. This evacuation brought challenges for their receiving areas; in Cardiganshire, the MOH found that his staff were so inundated with infectious diseases and wider poor health that two dedicated medical facilities were established to provide treatment to the new residents. These medical facilities were to operate for the duration of the conflict and were adapted as the war continued from providing infectious disease response and health protection work to wider health promotion, including dentistry, optometry and dietary support.[7]

The rural MOH had to be more inventive than their urban colleagues when planning for aerial bombardment. As these areas did not have the wealth of resources of their urban colleagues, the MOH adapted their plans and made greater use of smaller, community-based response. Their creation, the First Aid Point, was built on the premise that a focal point within a village could be used to store equipment and provide a location for training and a deployment point for volunteers. The rural MOH also made greater use of combined mobile first aid post and ambulance units based at the main hospitals within their locality so that the volunteers within the First Aid Point would stabilise patients until definitive care arrived on scene before onward transport.[11]

For the MOsH covering areas at higher risk of aerial bombardment, their war was to prove exceptionally challenging. The

predicted gas attacks, which resulted in detailed planning by ARP, did not materialise and were replaced by widespread use of high-explosive and incendiary bombs. This resulted in the repurposing of many buildings by MOsH, as the need for significant numbers of gas decontamination centres reduced and First Aid Posts and hospitals increased. The creation of deep shelters, where it was hoped that high-explosive bombs would not reach, created issues for MOsH when considering the public health of those using them. The lack of sanitation, especially in the case of London Underground stations and deep caverns, meant that MOsH had to mandate that toilets and running water were provided in these locations and that their status was recognised and made official. Once this had been done, additional resources were created until each shelter had access to dedicated medical personnel, full sanitation including showers, and staff from the MOH's department to monitor them.[12]

At the height of the invasion risk to the United Kingdom, MOsH also began close liaison with their colleagues in the Regular Army and Home Guard. As the latter did not have medical staff of its own at this point, the MOH was to provide First Aid Parties to fighting forces in their area. In return, there was considerable cooperation between both services throughout the conflict, including joint training and exercising.[13] This cooperation occurred without many of the MOsH and their military colleagues being aware that, had the War Office been given primacy for ARP, it would have been the military in charge of Casualty Services and the MOsH operating in a supporting role.

As the conflict continued, the MOH had to grapple with the convergence of their wartime work and peacetime responsibilities in a similar way to their modern counterparts during the COVID-19 pandemic. During the period of the Second World War in the United Kingdom, only doctors and midwives were allowed by law to assist a woman in childbirth.[14] This in peacetime did not cause concern, but in wartime was proving difficult, as midwives could not reach patients and mothers could not reach maternity hospitals during air raids. A number of MOsH, alongside their Association and the Central Midwives Board, successfully lobbied the Ministry of Health for a position statement on the response needed for midwifery cases across the country during air raids; within London, this ensured that a midwife would be on duty each night within deep shelters in case of deliveries during raids.[15]

As the conflict continued, the MOH was often found at the heart of local innovation. This was in part because of the lack of clear guidance from government, and the independence and authority MOsH still had within their locality. With no national formulary in 1939, many MOsH were experimental in what they allowed doctors within their posts to administer. In Southampton, the MOH issued cocaine in liquid form to all First Aid Posts as a treatment for eye injuries.[16] The MOsH also adapted mandated services to suit the realities of the conflict. The Ministry of Health had instructed all local authorities to have mobile first aid posts available to deploy to incidents. Designed around vans or lorries, they were not designed to be treated on in the majority of cases but merely to transport significant amounts of equipment and personnel to the incident scene. These mobile units were heavily criticised in urban areas, as they were slow, unable to pass bomb craters, and rarely needed in the role envisaged. Many MOsH adapted the concept by placing the doctor, the element most needed, and a number of nurses in a car with equipment.[17] This adaptation, providing first aid staff at the scene with advanced medical support, was adopted by central government as a Light Mobile First Aid Post. In those areas where local medical practitioners had offered to join an Incident Doctor rota, there is also evidence of local uniformity of practice and equipment. Wolverhampton's MOH, Dr Jolly, ensured that his Incident Doctors were issued standardised haversack bags with equipment. This ensured that any doctor responding off the rota was trained and equipped to the same standard in a comparable way to the first aid and ambulance staff they would be responding alongside.[3]

Postwar legacy

The impact of MOsH and their wartime work can be seen across multiple areas. Their work helped to create the modern emergency medical system in the United Kingdom, albeit at different rates of adoption. The ambulance service was in many respects the earliest success story, as the wartime work it had undertaken showed that it could be more than just a patient transport service but a fully functioning emergency response service too.[18] It was unfortunate that as the Casualty Service had been run as part of the Local Authority rather than the Ministry-led Emergency Medical Service, many of the innovations highlighted through the Casualty Service were not included within the National Health Service but instead lay forgotten until being ‘re-invented’ in subsequent decades.

Within the field of public health, the wartime experience of MOsH showed that a balance between health protection and health promotion was vital and that these areas were closely intertwined. The work of MOsH in regard to evacuees also highlighted the stark nature of health inequalities within the United Kingdom and the urgent need to tackle it across the country. The wartime activities of MOsH in health protection and promotion linked closely with the findings of the Beveridge Report and helped cultivate the need for a National Health Service to respond to the issue of Squalor, as Beveridge worded it.

Conclusion

To conclude, it is of real importance to understand the wartime work of the MOH, both in its historic context and its wider impact on current Public Health practice. The ability of the MOsH to respond quickly to changing circumstances, and work alongside nascent services founded in crisis, has been reflected in modern practice during health protection incidents, larger incidents such as COVID and other incidents related to emergency preparedness, resilience and response.

By understanding the work of predecessors, public health practitioners can recognise parallels in their present work but also identify areas of innovation historically that can be adopted today. It is also important and timely to understand the historic foundations of public health practice to show that it is a field with a strong and ever-evolving foundation and that it is a field that has made a real difference to the health and well-being of the United Kingdom.

Author statements

Ethical approval

This article has not required ethical approval, as it has focused on archival and secondary literature and has not involved human subjects.

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Competing interests

There are no competing interests.

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