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CITY OF ABERDEEN.

REPORT

BY THE

MEDICAL OFFICER OF HEALTH

FOR THE YEAR

1955

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CONTENTS.

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SUMMARY OF STATISTICS.

The following is a summary of the principal statistics for the years 1952-55:—

	1952.	1953.	1954.	1955.
Population estimated to middle of year	183,626	185,232	185,725	186,352
Marriage rate per 1,000 population	10·5	10·4	10·2	10·6
Birth rate per 1,000 population	16·5	16·6	17·4	17·2
Illegitimate birth rate per 100 births	5·7	4·5	4·3	5·4
Still-birth rate per 1,000 total births	18	20	19	12
Infant mortality rate per 1,000 live births	30	27	22	21
Neo-natal mortality rate per 1,000 live births	18	19	15	11
Death rate per 1,000 population	11·7	11·3	11·1	11·5
Malignant diseases death rate per 1,000 population	2·28	2·00	1·80	2·19
All tuberculosis death rate per 1,000 population	0·22	0·16	0·12	0·09
Respiratory tuberculosis death rate per 1,000 population	0·20	0·14	0·10	0·08
Principal epidemic disease death rate per 1,000 population	0·03	0·02	0·03	0·04
Average age at death (in years	64·6	65·1	66·3	66·7

PREFACE.

During the last three years there has been a curious contrast between the vital statistics of the City and those of Scotland as a whole. In Scotland the years have witnessed little change in most of the figures that are commonly used as indices of health (*e.g.*, the infant death rate per thousand live births was 31 in 1953, 31 in 1954, and 30 in 1955; and the neonatal death rate was 19 in 1953, 21 in 1954, and 20 in 1955). The experience of the principal cities other than Aberdeen has been in line with that of the country. Aberdeen, on the other hand, has in each of these years advanced to new records. The vital statistics of Aberdeen for 1953 were summarised as "on the whole, the best yet recorded for the City"; the figures for 1954 were described as "so much better than those for 1953 as to be almost unbelievable"; and the figures for 1955 are much more favourable than those for 1954, new low records being established for the still-birth rate, neonatal death rate, infant death rate, total loss of young lives, maternal death rate, respiratory tuberculosis death rate and death rate from other forms of tuberculosis, and a new high record being created for the average age at death.

A great deal of further improvement would be required before Aberdeen could begin to draw level with the best Scandinavian cities, and some advances would be needed to bring Aberdeen abreast of the best cities of England and Wales. Nevertheless, the improvements in Aberdeen's vital statistics in three consecutive years are so spectacular and so at variance with general Scottish experience as to merit investigation and explanation. Indeed, it is only after analysing the causes of the sharp downward trend of the City's mortality figures that we can be in a position to devise measures to enable this trend to continue.

Accordingly, the first section of this preface is devoted to a consideration of the causes of the dramatic improvements in the City's vital statistics. Subsequent sections summarise the main figures for 1955 and discuss generally the health of the City, indicate the principal developments during 1955, outline the grave danger in which the disease-preventing services at present stand, and consider some miscellaneous points.

The report here presented deals with the health of the City and the activities of the Health and Welfare Department during 1955, except that the portion relating to the school health service covers the school year 1954-55. In general, the lay-out follows the same lines as in the report for 1954, and, for the convenience of those who may not wish to read each chapter in its entirety, the main sections are each prefaced by an introductory paragraph which outlines the principal features of the year, including any major changes that have occurred.

EXPLANATION OF THE IMPROVING STATISTICS.

Let us start by ruling out the possibility that a series of dramatic improvements in three consecutive years can be attributed to mere coincidence.

ELIMINATION OF CHANCE AS A FACTOR.

In the area of a small local health authority, pure chance can bring about a considerable year to year variation of some of the rates by which we try to measure health, but the more populous an area the less is the liability to chance variation. In a City of 186,352 population, such variation is fairly small but can, nevertheless, affect some rates to a slight extent, *e.g.*, the fact that the infant death rate in 1937 was 72 whereas in 1936 it was 70 may well be due to statistical chance and not to any deterioration in the health or the health services of the City. It is highly unlikely, however, that chance would operate in the direction of causing an apparent simultaneous improvement in a number of rates in a single year, and quite outside the bounds of normal experience that it would cause a whole series of apparent marked improvements in three consecutive years. **We can therefore eliminate chance variation and say definitely that,** on the statistics normally used as measures of health, **the health of the City has improved dramatically.**

Explanations of improvement of vital statistics may be sought in quite a number of directions—in alterations in the standard of living, change in the social class distribution of the population, absence of unemployment and industrial disturbances, better housing, changing climatic conditions, better treatment of disease, and improvements of the disease-preventing and health-promoting services. Let us glance at each of these in turn.

STANDARD OF LIVING—NO EXPLANATION.

The standard of living does not appear to have improved. According to the index produced by the Ministry of Labour and National Service, the cost of living (compared with a base of 100 in July, 1947) rose from 146 in January, 1955, to 154 in December. Certainly many people received salary and wage increases, but these increases usually followed rises in the cost of living and did not leave the persons concerned in a position more favourable than before the cost of living rose. There are unlikely to be many groups in the community with incomes that have risen by 54 per cent. since 1947, and there are very few whose earnings, after having been adjusted to the 1954 cost of living, have increased by a further 8 per cent. in 1955.

To corroborate the impression that the general standard of living did not improve in 1954 and 1955, it may be mentioned that the Annual Report for 1954 referred to an increase in the number of school entrants judged to be of defective nutrition, that in 1955 the medical officers and health visitors were somewhat disturbed by the frequent occurrence of anaemia in expectant mothers and that conversation with various shopkeepers has not suggested that 1954 and 1955 were years of abnormally high spending.

Moreover, the standard of living tends to improve or deteriorate on a national basis. A general change in the standard of living would not, for example,

explain why the infant death rate was falling in Aberdeen, rising in Dundee, and undergoing little change in Scotland as a whole.

SOCIAL CLASS DISTRIBUTION —NO CHANGE.

There is no evidence of any appreciable change in the **social class distribution** of the population. In the 1951 census, Aberdeen had a larger proportion of adult males in the poorest social class than had Edinburgh or Dundee or Scotland as a whole; the proportion was practically the same in Aberdeen and Glasgow, but if the second poorest social class was added, Aberdeen was in a less favourable position than Glasgow. Since then, there has been no large scale development of new industries or massive alteration of existing industries to change the social class structure in Aberdeen.

Incidentally, the fact that the vital statistics of Aberdeen (*e.g.*, infant death rate, still-birth rate, and tuberculosis death rate) are better than those of the other Scottish cities is the more remarkable in view of Aberdeen's relatively unfavourable social class distribution.

UNEMPLOYMENT—NO EXPLANATION.

The improved figures cannot be attributed to an absence of **unemployment** or of **industrial disturbances.** In 1954, unemployment in Aberdeen was described as "rather more than in most recent years;" and in 1955, although there was on the whole rather less unemployment in the City than in 1954, industrial disturbances were quite a prominent feature, *e.g.*, the railway strike affected Aberdeen as well as other places, and the dispute in the trawling industry affected Aberdeen primarily.

HOUSING—SLIGHT INFLUENCE ONLY.

While one is anxious to pay generous tribute to the vigorous housing programme of recent years, the fact remains that, at the 1951 census, Aberdeen was less favourably placed than the other Scottish cities in respect of the proportion of households with such facilities as a piped water supply, a water closet, a kitchen sink, and cooking equipment; and more than one Aberdeen citizen in every eight was living under seriously overcrowded conditions (at more than two persons per room). To overcome these defects, a vigorous housing programme will be needed for a number of years.

Better housing should in time help to improve the health of the people to such extent as its influence is not counteracted by less money being available for food—as a result of the larger rent usually payable by re-housed families, the higher cost of fuel and light, and (where the new house is on the outskirts of the City) the increased cost of travelling to work, &c. Anyway, while the housing programme may well have done something to advance the health of the public, Aberdeen is still striving to draw level in housing with the other cities, and improved housing of Aberdeen citizens in 1954 and 1955 cannot explain why the vital statistics are superior to those of cities that are better placed in respect of housing.

CLIMATIC CONDITIONS—NO EXPLANATION.

No explanation is afforded by **climatic conditions.** 1954 was characterised by a mild winter and a poor summer, and 1955 by a very severe winter and a remarkably good summer; and, in each year, the vital statistics as a whole were considerably better than ever before.

Moreover, the climatic conditions of Aberdeen differ very slightly from those of Dundee and Edinburgh: a study of meteorological records shows that Aberdeen tends to be about one degree colder than Edinburgh and has a very similar rainfall. Any influence of climate factors on public health would therefore tend to manifest itself all along the east coast, and not in a single city.

MEDICAL TREATMENT—NO EXPLANATION.

Clinicians have sometimes suggested that improvements in health statistics may be attributable to **advances in medical treatment.** Undoubtedly, the two greatest advances of the last twenty years—the introduction of the sulphonamides (about the beginning of the war) and of the antibiotics (about the end of the war)—each had an effect on vital statistics, although the effects were much smaller than is sometimes thought: for example, the maternal death rate, although influenced by the sulphonamides, actually began to fall before the sulphonamides were discovered; and the infant death rate averaged 71 in the three years 1936-38 (when sulphonamides were in process of discovery) and 74 in the three years 1939-41 (when sulphonamides were in common use).

During the last three or four years there has been no development in medical treatment comparable to the introduction of the sulphonamides and the antibiotics. While methods of treating various individual diseases have continued to improve, there have been no advances big enough to exert an appreciable influence on vital statistics. Further, if better methods of treatment afforded even a partial explanation of the improved statistics, we should expect to see parallel improvement in the figures for Scotland.

This argument holds even more strongly in the case of **facilities for treatment.** The enormous expansion of the curative sections of the National Health Service in recent years should manifestly have had more influence on the health statistics of areas previously "under-doctored" than on those of areas (like Aberdeen) that already had treatment services of good quality and reasonable quantity. Yet the enormous national enlargement of curative services—even to a stage where there are about three full-blown hospital consultants for every one public health doctor and nearly as many hospital consultants as health visitors—has not coincided with an apparent improvement in national health. We cannot logically suggest that better methods of treatment or increased facilities for treatment have played a part in improving Aberdeen's vital statistics, when the same methods and the same increased facilities have not improved the national statistics.

It is important, in this connection, to remember that the nation is not becoming healthier. The latest Annual Report of the Department of Health for Scotland said—

> "Demands on the curative services continue at a high level and show no signs of abating. In terms of hospital attendances and demands for hospital treatment, it might seem that ill-health was increasing."

The writer has no desire to disparage the excellent work of his clinical colleagues in general practice and in hospital. Indeed, he will have occasion later

in the report to acknowledge with gratitude the co-operation of members of other branches of the National Health Service. Nevertheless, in view of the present dangerous over-emphasis on curative services and under-valuing of preventive services, he feels it desirable to quote Sir Sheldon Dudley, formerly Medical Director-General of the Royal Navy, in support of the thesis that "clinical medicine is not nearly as valuable to the State as a whole as preventive medicine." In the preface to 'Our National Ill Health Service' (1953), Sir Sheldon says—

> "The prohibition of all medical and surgical treatment of individuals by medically qualified family doctors and hospital specialists would have an effect on the vital statistics of the Registrar-General of little if any *statistical significance* as a measure of the health of England and Wales. On the other hand, the abolition of all public health services and sanitary laws would be followed by a return to the death and sick rates of the eighteenth century and a liability to epidemics of plague, cholera, typhus, smallpox, &c."

In seeking an explanation of the dramatic improvements in Aberdeen's vital statistics over three consecutive years we have excluded chance, alterations in standards of living, changes in social class distribution, decreases in unemployment and in industrial disturbances, improved housing (at least as the main factor), alterations in climate, improvements in medical treatment, and increased availability of medical treatment. For the principal cause of the improved statistics we must, by exclusion, come to the **developments in the disease-preventing and health-promoting services.** If all other possible explanations are disproved, the one that remains must be the real explanation.

DEVELOPMENT OF HEALTH-PROMOTING SERVICES—THE MAIN FACTOR.

One would, of course, expect that development of health-promoting services for expectant mothers (*e.g.*, more adequate availability of the skilled advice of health visitors in the homes and of the wise guidance of medical officers, health visitors, and midwives in the clinics) would cause a decrease in the numbers of still-births and early infant deaths; one would expect that advances in child welfare services (*e.g.*, more or better trained health visitors and more or better clinics) would reduce the number of deaths in later infancy; one would expect that the creation of services designed to maintain the health of elderly citizens (*e.g.*, health visiting, chiropody, home nursing, and home help service) would not only reduce the numbers requiring admission to hospitals or hostels but would also tend to raise the average age at death. Apart, however, from these being eminently reasonable hypotheses, have we any definite evidence? Six points may perhaps suffice here.

CLOSE CORRESPONDENCE OF STAFF INCREASES AND BETTER STATISTICS.

In the first place, **the improvements in the vital statistics of Aberdeen have occurred with or immediately after certain considerable expansions of the disease-preventing services.** While it is a little difficult to assess the relative influences of such developments as post-qualification training for health visitors (refresher courses and study days), increase in the number of ante-natal clinic sessions,

and establishment of new child welfare clinics, it is fairly easy to take as a simple measure of the strength of the disease-preventing service the actual numbers of health visitors employed. The use of such a measure does not, of course, imply that members of staff other than health visitors play no part; but, by reason of her numerical preponderance and by reason of her unrivalled access to the home before any abnormal situation exists, the health visitor can be regarded as the key officer, and, in addition, alterations from time to time in the number of public health medical officers have kept the ratio of health visitors to medical officers fairly constant. If we set down (as in the table below) the average number of health visitors employed in each recent year, the infant death rate per thousand live births, and the average age in years at death, the correspondence is obvious without the application of statistical techniques.

	No. of Health Visitors.	Infant Death Rate.	Average Age at Death.
1952 . .	49	30	64·6
1953 . .	55	27	65·1
1954 . .	60	22	66·3
1955 . .	61	21	66·7

SIMILAR CORRESPONDENCE IN THE PAST.

In the second place, a study of **the past history of Aberdeen shows a similar relationship** between the strength of the service and the infant death rate, *e.g.*, the last year with a really high infant death rate (1947 with a rate of 64) was also the last year that the health visitor staff remained at the pre-war strength of 23: simultaneously with the expansion of the health visitor staff in 1948, the infant death rate fell suddenly to 34. Again, there is a similar parallelism between increase in health visiting staff and increase in the average age at death, *e.g.*, the marked rises in the average ages at death in 1948 and 1949 correspond with increases in the health visiting staff.

NATIONAL FIGURES SHOW THIS CORRESPONDENCE.

Thirdly, and even more important, **a similar parallelism can be seen in the country as a whole.** A glance at the coloured diagram (placed after page 12) will show that the Scottish infant death rate remained relatively constant until the period when maternity and child welfare services began to develop (about the end of the first world war, although there were some pioneers before that war), and that, as these services expanded, the infant death rate fell almost year by year—even in the period of general industrial depression and widespread unemployment. The downward trend in the country began to slow about 1951 and ceased about 1953, in close parallelism with the lack of recruits to the preventive service. In 1953-55, the Scottish infant death rate has almost ceased to improve, and the present national shortage of health visitors has been assessed at about 40 per cent.

STATISTICAL EVIDENCE.

Fourthly, **a statistical analysis published in the "Health Bulletin" of the Department of Health for Scotland** (January, 1949) **showed a remarkable association between infant mortality rates and inadequacy of health visitor staffing** in sixteen large burghs compared for the years 1941-43 and a similar association

in a parallel comparison for the years 1944-46. It may be worth while to quote at length the conclusions of that statistical investigation:—

"(1) Investigation of the periods 1944-46 and 1941-43 shows that the infant mortality rate is significantly associated with the number of births per health visitor, and that, if other factors remain unaltered, each successive expansion of the health visiting staff . . . . . can be expected to result in a reduction of infant deaths.

(2) In both periods the association is particularly marked in the case of infants aged 1 to 11 months; and an analysis by cause of such deaths in the earlier period suggests that health visitors play an important part in reducing mortality from diarrhœa, epidemic diseases, and respiratory conditions.

(3) Although mortality studies establish the high value of the preventive services, it is emphasised that reduction of mortality is not their main function, and a consideration of selected morbidity data suggests that the value of preventive services may be much greater than is generally realised."

ASSOCIATION WITH DISEASE AS WELL AS DEATH.

Fifthly, there is abundant statistical evidence of correspondence between the degree of adequacy of staffing and the diminution in some of the formerly common causes of death in childhood. As an example, there may be mentioned diphtheria which, as recently as 1939-42, caused in Aberdeen alone an average of 440 cases and 19 deaths each year. The reduction of diphtheria (to two cases and no deaths in the City in the last three years and to a modern Scottish total smaller than the Aberdeen figure for fifteen years ago) is, as everyone knows, due to immunisation; but immunisation itself depends not just on the availability of public health medical officers and general practitioners to give the necessary injections but, to an infinitely greater degree, on the availability of health visitors and other health workers to persuade parents that immunisation is in the children's interests—a form of persuasion that becomes steadily more difficult as diphtheria becomes less common. An analysis in the "Health Bulletin" of the Department of Health for Scotland (October, 1949) showed **a significant association between changes in the number of public health staff and alterations in the level of immunisation** in towns and counties: of 16 local authorities showing a fall in the number of children immunised, 9 had simultaneous decreases in their number of public health medical officers and 4 had decreases in their number of public health nurses, whereas, of 12 local authorities showing a rise in the number of children immunised, only one had any decrease in public health staff.

THE EXAMPLE OF SWEDEN.

Sixthly, **international comparisons** are interesting. Sweden, which leads the world in many of its vital statistics (*e.g.*, infant death rates and still-birth rates which appear to British workers as resembling dream fantasies of the distant future), shows the same association between well-staffed preventive services and

low mortality rates. Sweden spends much less than Britain per head of population on the treatment of disease. For equal populations it has fewer hospital doctors (and far fewer hospital consultants), fewer hospital nurses, and fewer general medical practitioners; but it has accepted that prevention is cheaper, as well as better, than cure, and it therefore has adopted standards of staffing of the public health service—and especially of public health nurses—much more generous than can be found anywhere in Britain; and it has also made the public health services sufficiently attractive financially to ensure an adequate supply of recruits of high quality.

In short, international comparisons reveal that, in a country with standards of living not unlike ours and a less favourable climate, a large scale development of the disease-preventing services has been accompanied by the appearance of phenomenally good vital statistics. Statistical comparison of Scottish towns over two separate periods of three years shows a significant association between degree of inadequacy of health visitor staff and infant death rates. In Scotland as a whole the reduction of the infant death rate over many years has occurred simultaneously with gradual expansion of the maternity and child welfare services, and cessation of that reduction in recent years has coincided with decrease of recruits to the preventive services. In Aberdeen, the remarkable improvements of the vital statistics in recent years have occurred with, or immediately after, considerable expansions of the disease-preventing services; and a study of the past history of Aberdeen shows a similar relationship between developments of the public health service and reduction of mortality rates. **The evidence is therefore overwhelming that the main cause of the progressive improvements in Aberdeen's vital statistics in recent years is the expansion of the professional staff of the Health and Welfare Department.**

PREVIOUS RECOGNITION THAT PREVENTIVE SERVICES ARE MAIN FACTOR.

The relationship between the professional staffing of health departments and the vital statistics of the areas served by these departments has, of course, been recognised for many years. To mention two examples, the highly-authoritative "Report on Infantile Mortality in Scotland" in 1943 referred to the excess infant death rates in Scotland as compared with England, pointed out that the proportions of health visitors and of child welfare clinics were lower in Scotland than in England, and advocated a considerable national expansion of health visitor staffing. Again, one of Aberdeen's most distinguished sons, the late Professor Andrew Topping, publicly claimed in 1949 that—

> "The fall in maternal mortality rates, even allowing for the important part played by chemotherapy, is attributable to the very marked improvement in arrangements for ante-natal supervision and domiciliary and institutional midwifery."

Nevertheless, it has been thought worth while to set out some of the overwhelming evidence, for at least four reasons:—

(*a*) In the years immediately following the inception of the National Health Services, an inevitable emphasis was placed on the curative services,

with consequent obscuring of the importance of prevention and with repercussions on the staffing standards, prestige, recruitment, and remuneration of all sections of the preventive services. To restore a proper balance between prevention and cure, iteration and re-iteration of the facts are essential.

(*b*) Since, in many areas, young lives are being needlessly lost through gross inadequacy of preventive services, it is important to make it clear that Aberdeen's relatively favourable position in respect of the preservation of young lives is not due to chance, but to the Corporation's deliberate policy of developing and expanding its services.

(*c*) As will be indicated in detail later, the preventive services are in imminent danger of collapsing through qualitative and quantitative inadequacy of recruits. In order that appropriate action should be taken to save these services before it is too late, the importance of the services to the community must be emphasised.

(*d*) Figures for child deaths are not only an indication of the extent to which a community is losing its greatest asset; they are also a reasonably good index of the health of a community. The people of Aberdeen are in the unfortunate position of having developed their preventive services (to such limited extent as is possible with the existing grave national shortage of health visitors and other health officers) and of having prevented a good deal of disease, but of being called upon—as taxpayers—to pay a share of the heavy cost of the treatment of unprevented disease in other areas. In this connection, it is interesting to compare, for example, the figures for the Eastern and North-Eastern Hospital regions: the North-Eastern region serves a slightly greater population and covers a much larger geographical area, but it carries out its work with fewer consultants and senior hospital medical officers than the Eastern region, and treats a smaller number of patients.

THE CITY'S HEALTH AND VITAL STATISTICS.

HEALTH OF THE CITY.

Satisfactory direct measurements of health (which is far more than just absence of disease) are not yet available, but the normal indirect methods—study of various death rates, sickness rates, &c.—can provide a reasonably good indication of the general health of a community and the state of its health services. From the evidence available it can be said—

(*a*) that Aberdeen still falls very far short of the health standards of the best Scandinavian cities;

(*b*) that Aberdeen is not yet as healthy as the best cities of England and Wales;

(*c*) that Aberdeen is by far the healthiest of the Scottish cities, and continues to have vital statistics much superior to those for Scotland as a whole; and

(*d*) that the health of the community in 1955 was better than in any previous year, even including the "year of records," 1954.

TWELVE RECORDS.

Attention may, in particular, be invited to the following points:—

(1) The **average age at death** (which was only 61·7 years as recently as 1948, and reached 66 years for the first time in 1954) is 66·7 years, a new high record.

(2) The **infant death rate** (which never fell below 70 per thousand live births before 1939, and fell below 42 for the first time in 1948) is 21 per thousand live births—as compared with the 1954 low record of 22 and a previous low record of 27. (The actual number of baby deaths was 66 in 1955, 70 in 1954, 84 in 1953, and 90 in 1952, and an average of 91 for the years 1949-51.)

(3) The **still-birth rate** is 12 per thousand total births—as compared with a previous low record of 18. (The actual number of still births was 40 in 1955, 64 in 1954, 62 in 1953, 57 in 1952, 66 in 1951, and 74 in 1950.) It may be noted in passing that, where the numbers of deaths have become small, rates are inevitably subject to slight year to year variation through the vagaries of statistical chance: the tremendous drop in the still-birth rate is probably best regarded as being partially a genuine fall (occasioned by better health services, &c.) and partially a favourable chance variation.

(4) The **maternal mortality rate** is 0·3 per thousand live and still births—as compared with 0·6 in 1954, 2·2 in 1953, and 0·6 in 1952. (The actual number of maternal deaths was 1 in 1955, 2 in 1954, and 7 in 1953.)

(5) The **neo-natal death rate** (*i.e.*, before the age of four weeks) is 11 per thousand live births—as compared with the 1954 rate of 15, and a previous low record of 16. (The actual number of neo-natal deaths was 36 in 1955, 50 in 1954, and 57 in 1953.)

(6) The **total loss of young lives** (*i.e.*, still births, infant deaths, and deaths of pre-school and school children) is 132—as contrasted with the 1954 low record of 153, and the 1953 figure of 180. It is interesting to note that as recently as 1947 the total loss of young lives was 410.

(7) The percentage of **deaths occurring in persons under the age of 45 years** was 9—being almost identical with the 1954 figure, and comparing with a previous low record of 11 for 1953, and the figure of 12 for 1952. (The actual numbers of deaths occurring in persons below the age of 45 years were 190 in 1955, 193 in 1954, 233 in 1953, and 267 in 1952.)

(8) The percentage of **deaths occurring in persons over the age of 75 years** was 39—identical with the 1954 high record of 39 per cent., and comparing with a previous record of 38 per cent. in 1953, and a figure of 37 per cent. in 1952.

(9) The percentage of **deaths occurring in persons over the age of 65 years** (including those mentioned in the last paragraph) was 66—being the same as the previous high record of 66 per cent. in 1954.

(10) The **respiratory tuberculosis death rate** is 0·08 per thousand population—as compared with previous low records of 0·10 in 1954, 0·14 in 1953, and 0·20 in 1952.

(11) The combined **death rate from all forms of tuberculosis** is 0·09 per thousand population—as compared with previous low records of 0·12 in 1954, 0·16 in 1953, and 0·22 in 1952; and for the first year in the history of Aberdeen, no pre-school or school child has died from tuberculosis. (The actual numbers of persons dying from tuberculosis were—17 in 1955, 23 in 1954, 30 in 1953, 40 in 1952, and 41 in 1951.)

(12) For the second successive year, there have been no **deaths from home accidents** in children aged 1-15 years, the age-group in which such accidents had previously been the commonest cause of death.

(13) The number of **deaths in children aged 1-5 years,** 13 in all, is higher than the low record established in 1954, but not higher than in the best of previous years. It is interesting to note that as recently as ten years ago (1945) the annual number of such deaths had never fallen below 34.

These records are the more remarkable in that in twelve cases out of the thirteen the previous record had been established in 1954.

(14) The **death rate from the principal infectious diseases** is 0·04 per thousand population—as compared with 0·03 in 1954.

(15) The illegitimate birth rate is 5·4 per hundred births—lower rates having been recorded only three times in the entire history of the City, in 1954 and 1953. The rise in the illegitimate birth rate is **the only disquieting feature in the vital statistics of 1955.**

ONLY ONE DISQUIETING FEATURE.

(16) The percentage of **school entrants** in 1954-55 found at medical examinations to have serious defects is 11·0—as compared with 11·7 in 1953-54; and, in general, the figures for routine medical inspection of school children suggest that the health of children is continuing to improve.

(17) A study of infectious diseases during the year shows that there were decreases in the numbers of cases of Scarlet Fever (from 178 to 69),

Paratyphoid Fever (from 16 to 1), Poliomyelitis (from 34 to 10), Puerperal Pyrexia (from 10 to 3), Influenzal Pneumonia, Primary Pneumonia, and Erysipelas; and increases in the numbers of cases of Measles, Whooping Cough, and Dysentery.

THE MAIN FACTOR IN THE IMPROVEMENTS.

As already demonstrated, the dominant factor in the creation, for the third year in succession, of a series of new health records has been the more adequate staffing of the Health and Welfare Department. It is fair to say that the improved health of the community is attributable in large measure to two things:—

(*a*) the policy steadily pursued by the Health and Welfare Committee of increasing the number of its disease-preventing officers, and

(*b*) the enthusiastic and devoted work of the staff of the Health and Welfare Department.

It is a supreme tragedy that the Committee's policy and the staff's enthusiasm and energy are both in danger of being rendered ineffective in the future by sheer lack of professional staff. Unless drastic steps are taken speedily at national level to improve both the quantity and the quality of recruits to the public health service, we are likely—instead of advancing to new health records in the years to come—to look back nostalgically at 1954 and 1955 as by far the healthiest years in our City's history. The impending collapse of the service is discussed in a subsequent section of this preface.

DEVELOPMENTS AND PROGRESS IN 1955.

A few of the main points are here selected for mention.

(1) Training of Health Visitors for Mental Health Work.

In 1954, the Corporation organised an intensive post-qualification course in mental health work and twenty health visitors attended. In 1955, the course was repeated and a further 26 health visitors attended. Since health visitors who qualified in 1954 or later have received in their ordinary health visitor training a considerable amount of instruction in mental health, practically every health visitor in the Corporation's employment can now be regarded as equipped for the prevention or reduction of diseases of nervous or emotional origin.

Since Aberdeen and London stand almost alone among local authorities in their efforts to "gear up" health visitors for work in the mental field (although the Women Public Health Officers' Association and the Royal College of Nursing have each organised courses on lines roughly parallel to those of Aberdeen), the writer proposes—*pour encourager les autres*—to repeat the substance of the remarks made in the Report for 1954.

In the opinion of the writer, the training of health visitors for mental health work is **incomparably the most important development in any recent year.** Indeed, when regard is had to the potentialities of this development, things like the introduction of immunisation against diphtheria (locally in 1925 and nationally

in 1941) and the starting of immunisation of school children against tuberculosis (locally in 1953 and nationally in 1954) fade in relative insignificance.

NEED FOR PREVENTION OF MENTAL AND EMOTIONAL DISEASE.

The increasing prevalence of diseases of mental and emotional origin constitutes a real menace to our civilisation. Already mental diseases and mental deficiency between them take up nearly half the beds provided by Regional Hospital Boards; already the neuroses constitute the commonest cause of absence from work; already an incalculable amount of suffering and distress is created by psychosmatic diseases; and to these can be added a vast number of cases of abnormal and anti-social behaviour—chronic alcoholism, drug addiction, juvenile delinquency, petty crime, sex perversions, prostitution, &c. "Treatment of a fully developed case of psychoneuroses involves the expenditure of much time and much money. We in Britain have not enough doctors, not enough nurses, not enough hospital beds, not enough money for the effective treatment of even the visible portion of this vast iceberg. Unless we can reduce the prevalence of these conditions by preventive measures, the outlook is dismal indeed."

INCREASING RECOGNITION OF ROLE OF HEALTH VISITOR.

It is becoming appreciated that at least one-half of all human disease and suffering has its origin in faulty emotional relationships, especially in childhood, and particularly in the pre-school years; and that measures designed to improve such relationships are imperative if our civilisation is not ultimately to be swamped by the rising tide of anxiety states, obsessions, depressions, hysterics, sex perversions, delinquency, and crime. It is also becoming appreciated that **the member of the community in the best position to undertake mental health teaching of parents and prospective parents is the modern, recently trained, family health visitor.** Indications of this appreciation are found, for instance, in a circular issued on 4th December, 1954, by the Secretary of State for Scotland, pointing out among other things that the health visitor's work "now extends to cover the whole field of prevention of ill-health including prevention of mental ill-health," and that she should receive information about signs of family difficulty from general practitioners, home nurses, hospitals, and schools; in similar statements made in England and Wales by the Minister of Health; and in the stress laid on the work of the health visitor in a recent detailed study by a London working party (which consisted of public health medical officers, psychiatrists, health visitors, and a psychiatric social worker).

To say that the modern family health visitor is in the best position to undertake mental health teaching is in no way to disparage either the public health medical officer or the family doctor, both of whom can also give valuable help. The health visitor has, however, certain specific advantages—

(*a*) in her training she receives considerably more instruction about normality than does the doctor taking a D.P.H. course as a preliminary to a career in public health, and in her work she obtains an unrivalled knowledge of the normal;

(*b*) in her training she nowadays receives a course of instruction in teaching methods whereas her medical colleague does not receive such instruction; and

(*c*) in her work she has the tremendous advantage of visiting families in their own homes while they are still healthy (before a faulty situation exists), whereas the public health medical officer sees the mother and healthy child in the rather less informal atmosphere of the clinic, and the general practitioner is under the disadvantage that he usually visits the home only after a faulty situation has occurred (when the need for treatment has arisen).

In general, the modern, recently trained health visitor has the knowledge and the teaching skill to help parents and prospective parents to appreciate more fully the emotional needs of children, *e.g.*, the need not merely for affection but for demonstrated affection, for consistency and security, for a proper balance between over-strictness and licence, and for the measures than can prevent sibling rivalry.

Relatively little of this help has been given to parents and prospective parents as yet, for two reasons.—In the first place, there have been grave shortages of staff: in mental health of all things, the teacher must have a close knowledge of the persons taught: it is quite hopeless for a health visitor to try at an infrequent visit to show a young mother that she is over-protecting her adventurous toddler or that she is demanding from a two-year-old the behaviour standards of a normal three-year-old. In Aberdeen, until 1955, staff shortages were gradually being overcome. In the second place, many of the older health visitors—although they too have an unrivalled knowledge of normality and are in many cases good practical psychologists by reason of their experience—received during their training insufficient teaching in the psychology of development to be able to profit fully from recent advances in that science. To try to overcome this difficulty, the Health and Welfare Department has been a pioneer in organising **post-qualification courses in mental heaith.**

POST-QUALIFICATION COURSES IN MENTAL HEALTH.

This endeavour to equip health visitors more fully for their important duties in the field of mental health should in course of time lead to considerable improvement in parent-child relationships and to an appreciable reduction in such conditions as psychoneurotic and psychosomatic diseases, delinquency, and petty crime.

Much more is, of course, desirable: one would like to see the health visitors even better trained for this work, and one would also like to see (whether by alteration of the D.P.H. course or otherwise) doctors who intended to specialise in public health given some instruction in teaching; but at least an excellent start has been made.

(2) Health Education or Health Guidance.

If the training of health visitors for mental health work is the most important development of recent years, the decision—taken before the end of 1955—to set

up a Health Guidance Section in the Health and Welfare Department probably marks the beginning of the second most important development.

HEALTH TEACHING—THE MAIN TASK OF A HEALTH DEPARTMENT.

Further improvement in the health of the people nowadays depends increasingly on the active co-operation of the people. We cannot keep various infections at bay by vaccinating or immunising children unless we first persuade parents that vaccination or immunisation is in their children's interests; we cannot eliminate food-borne diseases without persuading commercial and domestic food handlers to co-operate; we cannot reduce home accidents unless we persuade householders to pay attention to home safety; we cannot reduce mental and emotional disease unless we induce parents to learn more about children's emotional and social needs; we cannot improve the health of elderly citizens unless we induce these citizens both to listen to useful advice and to follow it. It is probably fair to say that **the main function of a Health Department to-day is health education,** using both words in the widest possible senses.

INDIVIDUAL HEALTH TEACHING—THE HEALTH VISITOR'S INCOMPARABLE ADVANTAGES.

Individual health teaching is, of course, the great province of the family health visitor. Other people—the general medical practitioner, the district nurse, the clergyman, the school teacher, the voluntary social worker, &c.—can help, often considerably, but the health visitor has various incomparable advantages:—

(*a*) She shares with the general practitioner and the district nurse a knowledge of disease and disease-processes and a certain authority in the eyes of the community;

(*b*) Unlike the other individuals mentioned, she has had a special, full-time training in methods of preventing disease and promoting health;

(*c*) Like the school teacher she has received in her training a considerable amount of instruction in the arts of teaching and persuading;

(*d*) Unlike most other workers she has access to the home **before** an abnormal situation occurs (and in this connection it may be stressed that the time when an individual is ill and the entire household upset is no time to begin the long laborious task of teaching the basic principles of healthy living);

(*e*) Unlike some of the other workers she is welcomed in practically every home (*e.g.*, in Aberdeen, in 1955, her visits were accepted by 99·8 per cent. of the mothers of young babies and also by over 99 per cent. of elderly persons or elderly couples living alone);

(*f*) From her knowledge of the personalities, temperaments, backgrounds, abilities, and interests of the individuals in her district, she is able not only to adapt her teaching to the individual but also in many cases to anticipate the particular health hazards most likely to occur (*e.g.*, she may judge that one young couple, unless suitably guided, will tend to over-discipline their offspring, while another couple will err in the direction of licence, and a third will be prone to inconsistency).

GROUP HEALTH TEACHING—A VALUABLE SUPPLEMENT.

While group health teaching (by formal classes, discussion groups, sporadic talks, parents' clubs, health exhibitions, &c.) is essentially a supplement to individual teaching, not a replacement, it is nevertheless an extremely useful supplement. Not only does it reinforce and support the health visitor's individual teaching, but, by convincing individuals on at least some points that would otherwise require detailed discussion with each person, it saves a considerable amount of health visitors' time—a thing of particular importance in these days of gross national shortage of health visitors.

In 1954 and 1955, a fair amount of group health teaching had already been undertaken by various members of staff, largely as additional, unpaid evening work. The Home Safety Campaign and many sporadic talks given to Church Guilds, Co-operative Guilds, Parent-Teacher Associations, &c., are cases in point; and it may be appropriate to mention in this connection, as being outstanding both in quantity and in quality, the additional unpaid work voluntarily carried out by the two health visitor tutors. The decision (taken during 1955 but not yet operative) to offer the tutors and five selected health visitors a little additional remuneration for undertaking work as health guidance lecturers and organisers marks a major advance; and at the end of the year plans were being made for the large-scale development of group health teaching.

(3) Prevention of Accidents in the Home.

In recent years, domestic accidents have become one of the leading causes of death and disability in children, actually the numerically largest cause of death between the ages of 1 and 15 years, and also frequent and serious at the upper end of life. Indeed, **home accidents have each year caused more deaths than traffic accidents.**

The Corporation's campaign for the reduction of home accidents began in 1954 but a description of the events of 1955 would not be intelligible without reference to the earlier year (since the war against disease and disability cannot easily be divided into phases corresponding exactly with calendar years). Broadly, the campaign was an attempt to apply to the problem of home accidents the well-tried techniques of health education.

HOME SAFETY CAMPAIGN.

(*a*) To focus public attention on home accidents and on the possibility of their prevention a **Home Safety Week** was organised (early in 1954) and conducted with maximum publicity. The Aberdeen Home Safety Week was the first of its kind, although London and Stirlingshire organised similar weeks a few months later. Incidentally, the total cost was only £208 or less than the cost to the community of two serious accident cases each treated in hospital for seven weeks at £15 per week.

WORK IN THE HOME.

(*b*) **In the homes of people** (in 1954 and 1955) health visitors and other health workers quietly pointed out potential causes of accidents and

reiterated the lessons of Home Safety Week in the ways most suitable for the individual or family addressed.

BOOKLET ON HOME SAFETY.

(*c*) As a supplementary measure **an illustrated booklet on Home Safety** was produced (early in 1955) without any cost to the Corporation, and distributed—free of charge—at the clinics and by health visitors.

NUFFIELD RESEARCH GRANT.

(*d*) Since it soon became obvious that, while sufficient knowledge already existed to render a considerable reduction of home accidents possible, there remained many gaps in that knowledge—gaps that could be rectified only by specific detailed investigation whether conducted in Aberdeen or elsewhere—the writer, with the consent of the Corporation, applied as an individual to the Nuffield Trust for a **research grant for the investigation of home accidents.** The application was granted (in 1955), a sum of over £1,300 was provided, a specialist health visitor was appointed for research work (paid by the Nuffield Trust), the hospitals and over forty general practitioners agreed to notify all cases of home accidents coming to their notice, all the health visitors undertook to notify all cases that became known to them, a detailed record card was devised, and the investigation began in the Autumn of 1955.

OUTSTANDING SUCCESS OF HOME SAFETY CAMPAIGN.

While it is far too early to say anything about the progress of the research study (except that no unforeseen snags have as yet appeared), the general success of the home safety campaign can be judged by the fact that in both 1954 and 1955 there have been **no deaths from home accidents in the age-group 1-15 years,** the group in which these accidents were formerly the commonest cause of death.

Not the least important aspect of the campaign is that it has, once and for all time, **dispelled the formerly prevalent idea that the proper sphere of health education is simply personal hygiene and the prevention of infectious diseases.** These subjects, while important, comprise only one small portion of the vast subject of health education.

(4) Bringing Maternity and Child Welfare Services to the People.

FUNCTIONS OF THE CLINICS.

Without in any way seeking to deny the basic importance of the health visitors' home visits to prospective parents, nursing mothers, and young children (and also to other members of the family), one must stress that the health visitors can do even better work if they are supported by an adequate clinic service. Since some clinicians, with little personal knowledge of the work of ante-natal, post-natal, and child welfare clinics, have suggested that a health visitor could easily refer to a general practitioner any individuals in need of medical treatment and so render clinics unnecessary, it is perhaps worth while to say a word about the functions of clinics. **Clinics are primarily educational,** rather than therapeutic. When teaching D.P.H. students and student health visitors we usually list some of the main functions of clinics thus:—

(*a*) *Ante-Natal Clinics*:

1. Obstetrical care—to foresee and minimise the hazards of child-bearing.
2. Attention to general health—often the first general overhaul since the mother's school days.
3. Preparation for confinement—including health maintenance, removal of fears, &c.
4. Mothercraft teaching—including the mental and physical needs of the child, the prevention of sibling jealousy, &c.
5. Arrangements for care of the rest of the family at period of confinement.
6. General health education.

(*b*) *Child Welfare Clinics*:

1. Full paediatric examination—by doctors specialising in, and interested in, healthy children.
2. Group health education—by examples from other mothers and from the building (where suitable), by group discussions, talks, demonstrations, &c.
3. Individual health education—by doctor or health visitor, and away from the distractions of family, mothers-in-law, &c.
4. Serving as a social centre for prevention of loneliness and promotion of mental health—especially important in new housing areas where people lack "roots."
5. Distribution of welfare foods.

GUILLEBAUD COMMITTEE ALARMED AT LACK OF USE OF CLINICS.

The **Committee on Economies in the National Health Service have expressed alarm** because many expectant mothers and young mothers are not getting the mothercraft teaching and health education that are available at local authority clinics: an expectant mother, for example, who receives obstetrical care at a hospital clinic or at a general practitioner's surgery, may get absolutely no instruction in mothercraft. The Committee have suggested that there should be **a duty on hospital doctors and general practitioners to urge their patients to attend local authority clinics** unless the doctors are themselves qualified to undertake—and prepared to undertake—instruction in mothercraft. While the Committee's alarm is undoubtedly justified for many towns and counties, in Aberdeen—largely owing to co-operation of hospital consultants, health medical officers, general practitioners, and health visitors—most women receive the undoubted benefits conferred by attendance at clinics. In 1954, 3,316 women attended ante-natal clinics in the City (the number of attendances being higher than in any previous year) and in 1955, 3,451 attended. In 1954, 2,381 women attended post-natal clinics (a number much higher than in any previous year) and in 1955, 2,966 attended. In 1954, 2,589 babies under one year and 3,842 children over one year were brought to child welfare clinics (numbers larger than ever before) and in 1955, the numbers

BUT IN ABERDEEN DEMAND FOR CLINICS CONTINUES AND INCREASES.

were 2,411 babies and 4,136 children over one year. When these figures are compared with a total of 3,228 live births in 1954 and 3,204 in 1955, it will be obvious that **the vast majority of expectant mothers and young babies in Aberdeen now attend the clinics.**

ABERDEEN PROBLEMS.

The problems that confronted the Health and Welfare Committee in 1955 were threefold:—

(A) **The existing clinics were not well adapted for health education,** being mostly situated in very old buildings, some of which (like the main ante-natal clinic at Castle Terrace and the child welfare clinic at Castlegate) were almost on the point of collapse. There was **not a single purpose-built clinic in the City.**

(B) As rehousing continued on the periphery, it was becoming **increasingly difficult** for expectant mothers or women with young children to **travel to clinics located mostly near the centre of the City;** and there was a limit to the extent to which the mobile clinic could supply needs.

(C) Some clinics (like the main ante-natal clinic) were **badly overcrowded.**

NEW CLINICS.

The Health and Welfare Committee tackled these problems by a **bold policy of decentralisation.** Having previously purchased a **mobile clinic** (in 1952) and **adapted a building at View Terrace** for use as a clinic (at the end of 1952), the Committee proceeded in 1954 and 1955 to erect its **first two purpose-built clinics at Holburn and Northfield respectively** (Holburn becoming available for use just after the end of 1955 and Northfield being expected to be completed before the middle of 1956). In 1955, it also provided—in existing buildings on a sessional basis—**clinic facilities at Seaton and Mastrick;** and, to replace clinics held in various semi-derelict buildings in the centre of the City, it **approved in principle of a scheme to erect a large polyclinic** on a central site.

(5) **Consultation Sessions at Clinics.**

IMPROVED INTERNAL CO-OPERATION.

Cases not infrequently arise where a health visitor is puzzled over a medical point that a doctor could clear up in a moment, or where a health visitor's advice is being rejected but would be accepted if reinforced by the authority of a doctor. At least equally common, are cases where a medical officer is puzzled over a point that a health visitor, with her more intimate knowledge of household and family, could clear up in a moment, or where a medical officer's advice is being rejected but would be accepted if reinforced by the persuasive skill of a health visitor.

In other words, the doctor (with more clinical knowledge and more authority) and the health visitor (with more training in teaching and more knowledge of the home) are complementary and can help each other.

To facilitate such mutual help, it was arranged during 1955 that at each clinic a portion of at least one session each week would be reserved for consultations over cases where either a medical officer or a health visitor felt that the

advice of the other would be helpful. It was also arranged that the medical officer in executive charge of the health services for the elderly should visit the clinics at pre-arranged times for similar consultations; and it is hoped in course of time to bring in other specialist medical officers and specialist health visitors.

Ideally, one would like also to include the general practitioner in such consultations; but at least—as indicated in the Report for 1954—every encouragement is given to direct two-way contact between general practitioners and health visitors.

KEEPING OLD FOLK HEALTHY.

(6) **Development of Domiciliary Services for the Elderly.**

The number of persons entered in the Health and Welfare Department's register of old people rose from 800 at the end of 1954 to about 1,350 at the close of 1955.

The number of old people receiving **regular visits from health visitors** rose from 300 at the end of 1953 and 723 at the end of 1954 to 1,335 at the close of 1955. This quiet and steady expansion, although now endangered by the shortage of health visitors, has probably done **more than any other single measure to improve the health of elderly citizens.**

The **chiropody service** was extended during the year and, just before the end of 1955, the Corporation decided to appoint a full-time chiropodist. Unquestionably, the provision of chiropody has saved many old people from becoming needlessly housebound.

HOME HELPS.

(7) **Expansion of Home Help Service.**

During the year, the establishment of home helps was again increased, the authorised total at the end of 1955 being the equivalent of 120 full-time workers.

OLD PEOPLE'S HOMES.

(8) **Services for Frail Old People.**

Additional hostels were opened at Polmuir Road and Newhills. With six hostels in operation and two others planned, the Corporation is approaching the end of its programme of hostel provision, although, of course, any collapse of recruitment to the disease-preventing service will—as mentioned later—necessitate a large-scale increase in the number of hostel places.

RECIPROCITY WITH HOSPITALS.

Since the borderline between health and sickness is as shadowy in the case of the elderly, as in the case of young children, co-operation between the hospital and local authority services is essential. To facilitate such co-operation, arrangements were in hand at the end of the year whereby the Corporation would appoint the Hospital Board's Geriatric Consultant as Honorary Deputy Medical Officer of Health (Geriatrics) and the Regional Hospital Board would appoint the Medical Officer of Health and the Principal Assistant Medical Officer as Honorary Consultants in Geriatrics.

(9) Clean Food.

FOOD HYGIENE.

Considerable efforts were made during the year to raise the standards of **hygiene in restaurants and food shops.** In addition to an intensification of the normal visits made by sanitary inspectors, a number of special visits were made by senior members of the medical and health visiting staffs and, in several cases, the health visitor tutors gave talks on food hygiene to employees in catering establishments.

Shortly before the end of the year, the Corporation authorised the production of an **illustrated booklet on food hygiene.** The booklet, which will be published without any cost to the Corporation, will deal with food hygiene in the home as well as in the canteen, restaurant, and food shop.

(10) Progress in the School Health Service.

SCHOOL HEALTH SERVICE.

An **orthoptist** was appointed and special apparatus was provided for the treatment of children suffering from squint.

Considerably more work than in past years was undertaken for **mentally-handicapped** and **physically-handicapped** children; and for the first complete year children referred to the Child Guidance Clinic were medically examined.

The **health surveys conducted by the health visitors** continued to become more and more complete health inspections (concerned with such matters as nutrition, fatigue, posture, &c.) as contrasted with the mere "cleanliness" inspections of the past.

The campaign for **protection against tuberculosis** was continued with great success, 96·7 per cent. of parents with children in the appropriate age-group giving consent. The campaign for **protection against diphtheria** was also highly successful, more re-inforcing injections being given than in any previous year.

(11) Increased Provision of Dental Facilities.

NEW DENTAL CLINICS.

An additional surgery was installed at the main dental clinic in North Silver Street, an X-ray apparatus was purchased, and arrangements were made for the creation of a new dental clinic at Linksfield School and for the equipment of a dental room at Beechwood School.

(12) Dramatic increase in number of Children receiving Dental Inspection and Treatment.

VAST INCREASE IN DENTAL INSPECTION.

The number of school children receiving dental inspection rose from 4,853 in 1953-54 to 19,333 in 1954-55—an increase of roughly 400 per cent. The number of school children treated by the dental officers rose from 2,577 in 1953-54 to 4,929 in 1954-55—an increase of almost 100 per cent. In addition, the number of pre-school children treated rose from 18 in 1953-54 to 114 in 1954-55.

(13) Extension and Improvement of Health Visitor Training School.

If the health visitor is really (in the words of the Royal Society of Health) "the spearhead of the social service," if she is really

> "Now concerned with the health care of the whole family, with the prevention of both physical and mental diseases, and with advice on matters ranging from the weaning of the baby and the behaviour difficulties of the toddler, to the problems of family budgetting and the maintenance of morale in the elderly,"

then, manifestly, facilities for her training must be in no way inferior to the facilities for the training of members of other professions.

STAFFING—TWO TUTORS AND FIFTY LECTURERS.

The Corporation, having recognised in 1954 that a single tutor training school was an anachronism which rendered impossible such developments as the introduction of post-qualification courses and study days, in that year increased the staff to **two tutors and over fifty part-time lecturers.** Following the development

REMARKABLE RESULTS.

the school not only repeated in 1955 the remarkable double triumphs of 1953 and 1954 (namely, in each year gaining a hundred per cent. pass of its students and taking top place in the national examination) but achieved the even more remarkable triumph of securing **six out of the first seven places in the national examination;** and increased staffing rendered possible the post-qualification courses in mental health that have already been described as incomparably the most important development during any recent year.

The School was, however, still grossly overcrowded and inadequately equipped and furnished: indeed, the brilliant results in the years 1953-55 are an indication

BETTER PREMISES.

of the extent to which ability and enthusiasm can overcome adverse physical factors. In the autumn of 1955, the School was transferred from the basement of No. 6, Castle Terrace, to the first and second floors, and the furniture and equipment were to some extent modernised. The School now contains two good-sized lecture rooms, a students' study, adequate offices for the tutors, a clerk's room, and a small kitchen.

While the new accommodation is by no means ideal, it should function satisfactorily until the School can be transferred to more suitable premises (*e.g.*, the top floor of the central polyclinic when it is erected).

(14) Research Projects.

RESEARCH.

Research is, of course, the life blood of a Health Department, and any Health Department which does not undertake research work is failing in its duties. There is even in the National Health Service (Scotland) Act a section specifically empowering local health authorities to engage in research.

In addition to **research into home accidents** (largely paid for by a grant from the Nuffield Trust), a specially appointed research team conducted during 1955 a long-term investigation of the efficacy of **combined immunisation** against diphtheria, whooping-cough, and tetanus. The entire cost of this investigation is being borne by the Advisory Council for Medical Research.

A **detailed study of all children born in 1953** was continued during the year, although sheer lack of time impeded and delayed the analysis of the information collected.

Various minor investigations were carried out, or started, *e.g.*, a study of the needs of old people and of the extent to which these needs were being met, an analysis of the needs of the physically handicapped, and a survey of the work of the gynæcological advisory clinic.

Members of the Health and Welfare staff also co-operated on research projects with several University and Regional Hospital Board Officers.

Tasks ahead.

TASKS FOR THE FUTURE.

Some of the tasks ahead are the development of health guidance, the provision of a clinic for the early diagnosis of deafness, the setting up of an occupation centre for the physically handicapped, the provision of maternity and child welfare clinics in certain districts, the provision of physiotherapy (both relaxation exercises for expectant mothers and physiotherapy for physically-handicapped children), and the creation of one or more occupation centres for the mentally handicapped. Apart, however, from the difficulty of securing suitable premises, there looms ahead with ever increasing menace the problem of staff shortages.

IMPENDING COLLAPSE OF PREVENTIVE SERVICES.

As pointed out earlier, there is overwhelming evidence that the biggest single factor in reducing preventable deaths is a public health service that is adequate both in quantity and in quality. At present, unfortunately, it looks as though the public health service was in process of collapsing.

THE GRAVEST DANGER—LACK OF HEALTH VISITORS.

The main imminent danger lies in the unparalleled qualitative and quantitative national shortage of student health visitors (and also in the lack of qualified tutors for the training of such students), but, it may be useful to start with a brief consideration of public health medical officers.

(1) Shortage of Public Health Medical Officers.

QUALITATIVE AND SOME QUANTITATIVE SHORTAGE OF MEDICAL OFFICERS.

In the old days, a medical student who sought to specialise knew that, if he reached the top of the tree, he could secure greater financial rewards in surgery or clinical medicine than in public health, but he also knew that the path to clinical eminence was precarious and involved many years of scanty earnings. Consequently, a due proportion of the best students elected to specialise in public health where the path was more certain although the highest rewards obtainable were smaller. The public health medical officers of the past included more than one who—like Professor Matthew Hay of Aberdeen—had been the top student of his year. That sprinkling of outstanding persons still remains but is slowly dying out: in 1955, the Health and Welfare Department of the City still contained four doctors who had gained university medals or post-graduate scholarships (and six doctors who, in addition to the D.P.H., held the qualifications of M.D., M.R.C.P., or D.R.C.O.G.). The salary awards after the inception of the National

Health Service not only took the insecurity out of the clinical field but made it at every stage much more attractive than public health; and progressive expansion of the number of consultants increased the attractiveness of that career. Thus, a doctor who has sufficient ability to aspire to become one of the 800 consultants in Scotland knows that his normal career expectation is to achieve consultant status (with a salary scale rising to over £3,000) in the middle thirties, and later to have a fair possibility of an additional merit award (given to one-third of all consultants); if, instead, he elects to become one of the 300 public health specialists in Scotland he knows that only one medical officer of health in Scotland receives over £3,000, that only a handful rise above £2,000, and that his normal career expectation is at best to become a medical officer of health of a small population unit (with a salary maximum of £1,830). He also knows that, in the event of his not proving good enough for a consultant post, he will at least earn £1,950 as a senior hospital officer, whereas, if he lacks the qualities for a senior post in public health, he will end at £1,375 as a departmental medical officer.

Since only a tiny fraction of the medical student's seven years of primary training is devoted to public health, interest and familiarity combine with the financial aspects to urge him to specialise in curative rather than preventive work. Consequently, public health has for some years been failing to attract to its ranks the all-important sprinkling of outstanding young doctors.

The people who should become the Matthew Hays and Parlane Kinlochs of the future are to-day specialising in the various "clinical" fields—*e.g.*, radiology or anæsthetics or orthopædics or dermatology; they are not taking the post-graduate course leading to the Diploma in Public Health. There is a lack of public health recruits of high calibre—a lack that bodes ill for the top-ranking posts in another fifteen or twenty years.

Indeed, to some extent, there is a lack of recruits of any sort. Most local health authorities have been forced by sheer necessity to fill some of their public health posts with doctors who do not possess the D.P.H., *i.e.*, to appoint as public health specialists doctors without the necessary specialist qualification.

AND DENTAL OFFICERS.

However, the shortage of medical officers (which is less severe than the shortage of dental officers despite the fact that the latter, with shorter under-graduate training and post-graduate qualification, are paid more than the doctors) pales into relative insignificance when compared with the **tremendous qualitative and quantitative shortage of health visitors.**

(2) Dangerous and Increasing Shortage of Health Visitors.

THE UNPARALLELED SHORTAGE OF HEALTH VISITORS.

The shortage of health visitors is so severe and universal that there is no single local health authority in whose area health visitors are undertaking all the duties placed on them by Act of Parliament. For example, only a few local authorities are yet doing more than touch the fringes of the prevention of emotional and psychosomatic diseases, the health maintenance of the elderly, the

after-care of cardiac conditions, or the prevention of home accidents; and no local authority is simultaneously tackling these four sets of problems.

Consequently, with every area understaffed, an assessment of the number of health visitors required cannot be made by general application of the standards already to be found in the best areas. An assessment can at present really be made only on theoretical grounds. Four careful assessments have been made—by Professor Brockington, by Dr. Peters of the Department of Health for Scotland, by the Scottish Branch of the Society of Medical Officers of Health, and by the present writer. **On the least generous of these four assessments, Scotland requires ten health visitors for every six at present employed.** In other words, the shortage is vastly greater than, say, the shortage of sanitary inspectors or the shortage of science teachers.

Moreover, **the number of students in training in the three health visitor training schools in Scotland is even smaller in 1955-56 than in 1954-55 and is inadequate even for replacement purposes.** The schools have accommodation for 106 students annually, but in recent years candidates of suitable personality and sufficient intelligence have been lacking, and there have therefore been vacant places each year. The total number of students in training at the end of 1955 was only 75. Hence, the unparalleled and highly dangerous shortage of health visitors is becoming steadily worse.

Here, in Aberdeen, the number of health visitors recruited is failing to keep pace with the number leaving the service. The number rose to 61 (out of an authorised establishment of 85) at the end of 1954, and to 64 in May, 1955, but has now fallen to 60. A stage is approaching where we must either devise drastic measures to stimulate recruitment or decide which statutory duties—apart from the ones not yet undertaken—can be neglected with least detriment to the health and the pocket of the community. (Shall we, for example, reluctantly discontinue the visiting of old people and face up to the consequential increased need for hostel places, or shall we sadly discontinue vaccination propaganda and await an outbreak of smallpox, or shall we cease to concern ourselves with the prevention of broken homes and ask the Children's Department to prepare for a massive increase in the number of children requiring to be taken into care?)

CAUSES OF THE SHORTAGE.

In the creation of this dangerous shortage several factors have played a part.

(*a*) Initially, all the professions open to women—*e.g.*, the various branches of nursing and of school teaching—were gravely underpaid by comparison with what were regarded as men's professions (*e.g.*, medicine, law, architecture, and engineering); but, as more and more professions opened their doors to women, the salaries of most women's professions began to rise.

(*b*) When salaries in women's professions began to rise, those of nurses (hospital and domiciliary) and social workers tended to lag behind.

This may have been due to the fact that the numerically largest number of nurses worked in residential posts and were to some extent shielded from the effects of increases in the cost of living; but, inevitably, careers outside hospital, being unshielded, became financially unattractive in relation to careers in other professions where the salaries were rising sharply.

(*c*) Until 1948, health visitors were paid about £55 a year more than hospital sisters, in recognition of their obligatory additional qualifications in midwifery and health visiting; but, in 1948, presumably because of the political necessity of staffing adequately the hospitals taken over by the State, that differential was removed. Since 1948, a trained nurse who takes additional full-time training first in midwifery and then in health visiting actually receives as a health visitor a salary which is—throughout its scale—£5 less than she would have received if she had remained a ward sister and not devoted an additional 1½ years of her life to the taking of extra qualifications. Since student nurses undertake their training in hospital and learn very little about public health, familiarity and interest combine with financial aspects to attract them to curative nursing.

(*d*) The adoption of the equal pay principle in such professions as medicine, dentistry, the civil service, and teaching has in each case substantially increased the salaries of the women involved; but there has been no parallel increase in nursing, where the small number of male nurses were from the beginning paid only the women's rates (or in some cases about £10 more). As an example of salary increases it may be mentioned that women assistant teachers in Scottish secondary schools have progressed from a maximum of £807 at the beginning of 1955 to a new maximum of £1,134, a total increase of £327.

(*e*) Not only were promotion avenues very scanty in health visiting, but the salaries paid to the few persons above the basic grade were very inadequate and, in course of time, the salaries offered to the persons at the extreme top of the health visiting profession came to be less than the amounts paid to rank and file members of various other professions. Hence, outstanding girls (*e.g.*, a girl who has been dux of a good secondary school) are tending to avoid nursing because the higher posts are much less well remunerated than the higher posts in other professions, and, if a vocational urge sends a few such girls into nursing, they tend to avoid health visiting because the higher posts are paid even more poorly than are the higher hospital posts.

(*f*) In other professions, a sprinkling of outstanding persons can obtain relatively well-paid teaching posts—*e.g.*, an outstanding social science student can, after a few years of experience, receive as a lecturer in social science considerably more than she would have earned as an almoner

or even a head almoner, and an outstanding student at a teachers' training college can, after a few years of experience, earn as a training college lecturer considerably more than she would have secured as an ordinary teacher. In health visiting, a higher qualification, the Tutor's Certificate, involving further full-time study, is obligatory for teaching posts, but—despite this additional qualification—a Health Visitor Tutor receives only a little more than an ordinary health visitor. Consequently, young health visitors of a calibre high enough to become tutors (if, indeed, there are any recruits of that calibre to-day) decline to take the Tutor's Certificate. Even if a large number of nurses and midwives with the qualities of intellect and personality to make good health visitors sought to embark on health visitor training, **many of them would have to be rejected because of the existing lack of tutors to train them.** Several health visitor training schools have vacancies for tutors, and there is not an unemployed qualified tutor in the United Kingdom.

(3) **Salary comparisons to explain shortages.**

A few comparisons will reveal how far health visiting has fallen out of line with other professions:—

COMPARISONS OF HEALTH VISITORS AND OTHER LOCAL GOVERNMENT OFFICERS.

(*a*) **Basic Grade Comparison.—Health visitors are paid considerably less than other local authority officers of comparable training and responsibility.** For example, a health visitor (with 4½ years of full-time professional training and usually several years of experience as hospital staff nurse and sister) rises to a maximum of £570; an **assistant sanitary inspector** (with a four years' apprenticeship) rises in England to £660 and to £700 if he possesses the Meat Certificate (obtainable by evening study without interruption of earnings); in Scotland, assistant sanitary inspectors are paid slightly less than in England, but still very much more than health visitors. The assistant sanitary inspector is thus rewarded for his shorter training by a salary maximum £130 above that of a health visitor, and, in addition, his prospects of promotion are infinitely greater.

Again, an **ordinary graduate woman teacher** (whose length of training is a little shorter than that of a health visitor) is—following the adoption of equal pay and a salary increase—in process of transition from a former maximum of £667 to a new maximum of £922, as contrasted with the health visitor's maximum of £570. It is perhaps worth noting that a couple of years ago the respective maxima were £627 and £545, *i.e.*, the health visitor was £82 behind; whereas now she is left £352 behind.

Yet again, if a health visitor is (in the words of the Royal Society of Health) "the spearhead of the social services," and if her work (in the phrase of the Secretary of State for Scotland) "now extends to cover the whole field of prevention of ill-health, including prevention of mental ill-health," it is curious that

she should receive considerably less than one-half of the salary of an assistant **dental officer** employed by a local authority.

Equally curious is the fact that a health visitor (with three professional qualifications) is paid less than a **driving test examiner.**

Consider again a post involving further full-time training. An intending **assistant health visitor tutor must,** after her threefold training as nurse, midwife, and health visitor, and after several years of experience as a practising health visitor, **take a further full-time training for the Tutor's Certificate,** conferred after what is probably the stiffest examination in the entire field of nursing. **With a total training almost as long as that of a doctor and with a final examination far beyond the standards demanded for a primary arts or science degree, she is nevertheless rewarded by a salary scale of £585-£685.** Yet a **teacher of carpentry at a Trades College,** if a fully qualified carpenter, rose (before the latest increase) to £865 and if, in addition, a certificated teacher, to £915, or **£230 more than the tutor.** (It may be mentioned, incidentally, that hospital sister tutors are also curiously underpaid, even in relation to administrative nursing officers in hospitals.)

While the whole range of nursing is remarkably badly paid, **health visitors are paid even less than hospital sisters.** A hospital sister has a shorter training (3 years against 4½), less responsibility (since medical advice is constantly at hand, whereas the health visitor in the home has to take her immediate decisions without advice), complete freedom from responsibility at the end of the working day (since a qualified deputy takes over, whereas the health visitor in many cases sacrifices her leisure by re-visiting homes in the evening), and none of the unpleasantness associated with dirty rooms, feet-wearying tenement stairs, and frequent sharp transitions from warm rooms to cold streets. Yet a general ward sister actually receives £5 a year more than a health visitor, and a maternity ward sister receives £25 more than a health visitor.

These comparisons explain the unparalleled quantitative shortage of health visitors. The financial unattractiveness of nursing in relation to other professions lowers recruitment (especially in respect of persons of the calibre to undertake subsequent post-qualification training), and the **inversion of normal differentials ensures that few nurses seek to embark on a career in prevention of disease.**

DISPARITY BETWEEN TOP-RANKING POSTS IN HEALTH VISITING AND IN OTHER PROFESSIONS.

(*b*) **Top-Ranking Posts.**—To explain the **equally serious qualitative shortage** —the lack of persons who can in the future successfully hold leading posts in the health visiting profession—it is necessary to compare top-ranking posts in various occupations.

A **Principal Health Visitor Tutor** (*i.e.*, a person who, after taking four obligatory qualifications involving some six years of full-time professional study, has subsequently passed through the grades of Assistant Tutor and Tutor-in-sole-charge, and risen to the very top of her profession—there are only two Principal Health Visitor Tutors in Scotland and about half a dozen in England) receives a salary maximum of £785. **The head of a university department of social science**

(undertaking work very similar to that of the tutor), **the chief dental officer** of a local authority, **the principal of a teachers' training college and the head mistress of a large secondary school all receive at least twice that salary.**

A **Superintendent Health Visitor** in charge of 45 health visitors is paid a maximum of £710, or roughly **half the salary of a Chief Sanitary Inspector** in charge of 45 inspectors; the Superintendent's remuneration also compares very unfavourably with that of an **Administrative Officer** in a local authority department employing 45 clerks, and with that of the **Matron of a large hospital.**

The salaries of top-ranking health visitors—the handful of Principal Tutors and the slightly larger handful of Superintendents in charge of large numbers of professional staff—**even compare unfavourably with the salaries of basic grade officers in other professions.** Such local authority officers as lawyers, accountants, architects, and secondary school teachers might be mentioned, but it will perhaps suffice to take as an example a group already mentioned as relatively underpaid, **public health doctors.**

COMPARISON WITH BASIC GRADE MEDICAL OFFICERS.

The obligatory training of a Tutor is nearly as long as that of a medical officer, and if a Superintendent takes the nursing administrator's qualification (as is now common) her training approximates in length to that of a tutor. While a medical officer of health might perhaps claim that senior members of his medical staff carried responsibilites greater than those of a Principal Tutor or a Superintendent Health Visitor, no unbiassed M.O.H. could maintain that the responsibilities of a junior assistant, a basic grade medical officer, were anything like as heavy as those of a Principal Tutor (in executive charge of a training school) or a Superintendent in a populous area (in charge of say, 120 health visitors). At the estimate least favourable to the nursing officers one would expect that the slightly longer training of the basic grade medical officer might be balanced against the heavier responsibilities of the Superintendent and the Tutor, and all three might be given similar salaries. Yet in actual fact **the assistant medical officer in the basic grade receives a salary maximum which is £590 above that of a Principal Health Visitor Tutor and £585 above that of a Superintendent Health Visitor in executive direction of the work of 120 health visitors.**

Outstanding girls, of a calibre to make leaders in a profession, are unlikely to be attracted to a profession in which the top-ranking persons are paid less than the rank and file of other professions.

THE KEY POSITION OF TUTORS.

In connection with health visitor tutors (who are in such short supply that it would be impossible at present to train sufficient students even if appropriate candidates for training were available) it is important to notice that they have hitherto been underpaid even by comparison with superintendent health visitors, just as hospital tutors have hitherto been underpaid even by comparison with administrative nursing officers in hospital. **The Scottish Health Visitors'**

Association, in a very excellent Memorandum on Salaries and Promotion Prospects of Health Visitors, has recognised this fact in making its four main recommendations:

(*a*) Material increase in health visitor salaries;

(*b*) Considerably greater increase in the salaries of Superintendent and Assistant Superintendent Health Visitors than of health visitors;

(*c*) An increase for health visitor tutors even greater than that needed for Superintendent Health Visitors; and

(*d*) The creation of a grade intermediate in salary between a health visitor and an Assistant Superintendent or Assistant Tutor.

The Association has claimed, rightly, that—

> "In many ways Health Visitor Tutors are the **key persons for the preventive service of the future.** Sufficient tutors and tutors of the highest calibre are essential for the training of the health visitors of to-morrow. One of the most disquieting features of to-day is the fact that not enough health visitors are seeking to take the additional full-time training for the Tutor's Certificate.
>
> We cannot hope to attract to health visiting a sprinkling of women with the general educational background, the intellectual capacity, and the qualities of temperament to make successful tutors unless we offer such outstanding women career possibilities comparable with those open to them in other professions. **In particular, an assistant health visitor tutor should not be considered of less value to the community than a lecturer in a teachers' training college or the head teacher in a department of a large secondary school."**

In connection with the key rôle of tutors, it is also interesting to note that a prominent educationalist, Professor Roger Wilson of Bristol, has recently stressed that **tutors should be accepted as teachers,** their recognised educational function distinguishing them from apprentice-masters, and should not be regarded as subordinate to doctors and matrons; and that a World Health Organisation Study Group has suggested that the supervision of nursing education should be in the hands of Ministries of Education rather than Ministries of Health.

(4) **Attitudes to the Shortages.**

The general public, public health administrators, legislators, health visitors, and the educated young women from whom should come the health visitors of the future are all aware—to a greater or less degree—of the dangerous qualitative and quantitative scarcity of health visitors and of its main causes.

GENERAL PUBLIC IS AWARE BUT APATHETIC.

To demonstrate that **the public is not wholly unaware,** it may be permissible to quote from two leading newspapers.

(*a*) In **"The Scotsman"** of 13th January, 1956, a long letter, signed not by a health visitor or even by a public health doctor but by a social science graduate, began as follows:—

"I had occasion to call yesterday at a health visitor training school, where a tutor was teaching student health visitors (adults with two previous professional qualifications) about social legislation. On my way I passed a secondary school, where a teacher was instructing girls of 16 (some of them the almoners and health visitors of the future) in the elements of social history. The tutor, with four obligatory qualifications, of which the last—the tutor's certificate—is far above the standard of a primary degree, is rewarded for her six years of full-time professional training by a salary maximum of £685. The teacher, with a specialised Arts degree (requiring three years in England or four in Scotland) and a year at a training college, now goes to a maximum of £1,060."

The letter goes on to contrast reasonably paid "mixed" professions (*e.g.*, local authority dentists, doctors, and teachers) with underpaid "women's" professions (*e.g.*, health visitors, almoners, district nurses, and psychiatric social workers) and advocates salaries of £800 for hospital sisters and district nurses, £950 for almoners and health visitors, and £1,100 for sister tutors. It ends with a blunt statement, "Only a completely new orientation of remuneration policy can halt the grave and steadily increasing shortage of psychiatric social workers, health visitors, almoners, mental nurses, and so forth."

(*b*) A leader-page article in **"The Glasgow Herald"** of 16th August, 1954, after stressing that "the disparity at all levels between the pay of the preventive specialist and that of his curative colleague is manifestly contrary to the public interest," points out that, in so far as remuneration is determined by principles of equity, health visitors are "in even greater need of salary increases": the health visitor's maximum—

"Certainly compares unfavourably with remuneration in other professions, and has the further disadvantage that opportunities for promotion are practically non-existent, since the number of superintendent health visitors and health visitor tutors is very small. Incidentally, the superintendent and tutors, who have to spend an additional year in full-time study to qualify themselves for their posts, are also badly underpaid."

And another article in the same newspaper on 17th August, 1955, says—

"For health visitors, who are at present by far the worst paid of the professional officers employed by central or local authorities, a substantial improvement of salaries and promotion prospects would be necessary, but even here an extra 70 recruits annually would put things right in a decade."

The public, then, is vaguely aware of the dangerous shortage, but is still somewhat apathetic. It has not yet fully realised that the existing shortage of health visitors is seriously harming the country in health and in pocket, and that the collapse of the public health service—through declining quantity and quality of its key officers—will cause an enormous rise in death rates, sickness rates, and

human suffering, to say nothing of vastly increasing the cost of treatment of disease and the loss of productive work occasioned by preventable sickness.

HEALTH ADMINISTRATORS AWARE AND ACTIVE.

Public health administrators are well aware of the danger. The Society of Medical Officers of Health, a learned society which enhances its prestige by playing no direct part in the negotiation of medical salaries and conditions of service, has spoken strongly about the dangerous national shortage of health visitors and the urgent need for substantial increases in the salaries of all sections of the health visiting profession. In evidence to a Working Party on the Recruitment, Duties, and Training of Health Visitors, the Scottish Branch of the Society of Medical Officers of Health made, *inter alia*, the following points:—

(*a*) **Case-load.** "Now that the Health Visitor's duties have expanded vastly the case-load must be calculated either in terms of population or in terms of families. In the areas of the country that have made the biggest attempt to extend their staffs of Health Visitors to cope with new duties, the ratio of Health Visitors to total population is now something like one Health Visitor to 2,500 total population. This ratio is probably about correct."

(*b*) **Extension of Training.** "The present Health Visitor training (subsequent to nursing and midwifery training) should be **extended at least to one academic year and probably to more than that.** There should be very considerable increases in the time given to the study of the mental development of children, general psychology (with particular reference to children and adolescents), methods of imparting information to individuals and to groups, the needs of the physically handicapped, and the needs of the elderly . . . The work of the Health Visitor in the community is too important for her training to be impaired in an effort to save a month or two."

(*c*) **Educational background.** "It is desirable that previous general education should be up to the stage of matriculation or an equivalent certificate corresponding to university entrance. If, as has been pointed out earlier, the Health Visitor is primarily a teacher, an educator, a persuader of individuals and of groups, then it is very important that her general education be up to a high level."

(*d*) **Main causes of present shortage.** "The main causes are—

(A) **Complete disparity between the remuneration of the nursing profession and the remuneration of comparable professions.** . . . It is perhaps appropriate to mention that the Assistant Chief Nursing Officer and, in a moderate-sized county or city, the Chief Nursing Officer, the Assistant Health Visitor Tutor (who has to spend a further year in obtaining her tutor's diploma) and the Principal Health Visitor Tutor, all receive salaries less than that of a woman assistant teacher in a secondary school in Scotland.

Again, a Health Visitor's training is not markedly inferior in length or intensity to that of a dentist, but a Health Visitor receives less than half the salary that a local authority dental officer was paid even before the recent increase in dental officers' remuneration.

(B) **Disparities between the remuneration of nurses in the preventive service and nurses in the hospital service.** In this connection, it is appropriate to mention that a ward sister who takes her midwifery and Health Visitor's certificates to qualify herself for Health Visiting receives a salary as a health visitor which is less than she would have received had she remained a hospital sister.

(C) **Lack of promotion prospects in Health Visiting.** . . . . The average Health Visitor has virtually no expectation of any promotion."

(*e*) **Urgent need for more Health Visitors.** "It is real national economy, both in the sense of economy of finance and of economy of woman power, to employ more, not fewer, Health Visitors and so to reduce hospital staffs. The very high value of the Health Visitor's work in the past in reducing diseases of childhood, for example, has been recognised by various authoritative bodies. Her work in the reduction of mental disease and her work in the preservation of the health of people of mature years are potentially just as valuable."

(*f*) **Need for substantial salary increases.** "Not the least economical measure would be to raise the salaries of Health Visitors to a level sufficient to attract a fair proportion of suitable persons. There is at present a quantitative inadequacy of Health Visitors but the danger is even greater from qualitative inadequacy. It is vital to the well-being of the community that a reasonable proportion of highly intelligent young women be induced to enter the Health Visiting ranks."

LEGISLATORS—AWARE TO SOME EXTENT.

Our legislators are to some extent aware of the danger. Nearly four years ago the Minister of Health and the Secretary of State for Scotland set up a Working Party on Health Visitors, and, as the years rolled by and the situation grew more and more grave, the Working Party has continued to hold meetings and to consider evidence. Incidentally, it is amusing—or perhaps saddening—to notice that, although one of the functions of the Working Party is to consider the training of health visitors, it does not contain even one person with intimate personal knowledge of the work of a modern health visitor training school.

Again, the dangers of the shortage have been **vigorously pointed out in the House of Commons by Mr. Hector Hughes, Q.C.** In particular, Mr. Hughes has stressed the important role of the health visitor in maintaining the health of elderly citizens, and the need for better remuneration of health visitors in the interests of the community.

HEALTH VISITORS—UNWILLING TO CLAMOUR.

Health visitors are themselves naturally aware both of the existing shortage and of the utter inadequacy of their remuneration and promotion prospects. But health visitors are on the whole hard-working officers with a keen sense of vocation;

and most of the financially minded minority have moved out to less inadequately paid posts in other lines. Those who have remained in health visiting may have felt frustrated, jealous of their acquaintances in other professions (often with shorter training, less responsibility, shorter hours, longer holidays, and better pay), but they have not—unlike various other professions—indulged in much public outcry about their wrongs.

EDUCATED GIRLS—AVOIDING NURSING AND ESPECIALLY HEALTH VISITING.

Girls leaving secondary schools are well aware that nursing in all its forms is a badly paid profession. Few girls with a full higher leaving certificate (*i.e.*, with the type of educational background suitable for those who intend later to take post-qualification courses of training) are to-day entering nursing; and, where such girls enter the nursing field, they are tending to avoid health visiting. To some extent, hospitals are trying to compensate for lack of suitable recruits to nursing by accepting girls with lower educational standards (a device tried by the teaching profession in the past), but, even if such girls can in time become satisfactory staff nurses and ward sisters, they are not in general suitable for training as family health advisers. In this connection, it is worth while to note that two writers in the *Nursing Times*, themselves holders of honours degrees in Arts, have suggested that the intellectual standards needed for a health visitor are not materially different from those required for the taking of an honours degree. It may also be worth while to note that in England **the minimum educational standard required for normal entry to most health visitor training schools** is the same as that for entry to a teachers' training college, namely, **the School Certificate.**

The collapse of recruitment indicates that suitable young women are not prepared to become health visitors at present salaries and promotion prospects.

COLLAPSE OF PUBLIC HEALTH SERVICE WOULD CRIPPLE THE COMMUNITY.

(5) **The Solution.**

In seeking a solution, let us remember the key importance to the community of an adequate cadre of well trained, intelligent health visitors, and the dire peril of the collapse of the whole disease-preventing service. A few examples will illustrate:—

(*a*) If diphtheria immunisation (which depends primarily on the persuasive efforts of health visitors) collapses, we may well return to the 1940 figure of 586 cases and 21 deaths in Aberdeen in a single year. Apart from the tragedy of 21 needless deaths, the treatment of 586 cases—at an average of £52 each—would cost £30,472, or more than the total present cost of the entire health visitor service.

(*b*) In previous Annual Reports it has been pointed out that Aberdeen's requirements in respect of hostels for old people have been calculated on the assumption that the vigorous policy of maintaining the health of elderly citizens at home has reduced by 150 places the total hostel accommodation needed. If, through lack of health visitors, that policy

collapsed, another 150 places would be required, at a total annual cost of just over £30,000, of which roughly one-third would be contributed by the old people themselves while the remaining two-thirds would fall to be met from the rates.

(*c*) The City has initiated a successful home safety programme. If the collapse of that programme through lack of health visitors was followed by an increase of accidents to the number of 2 serious and 22 less serious accidents each week, then (assuming that the serious cases each required 7 weeks in hospital at a cost of £15 weekly and the milder cases each needed one week in hospital) the annual cost to the community would be £28,080.

(*d*) A distinguished health visitor pointed out at an Annual Conference of the Royal Sanitary Association of Scotland that—

"If a health visitor by her advice to one borderline family containing four children enables that family to remain within the bounds of normal behaviour and saves these children from having to be taken into care, then the financial gain to the community during the whole childhood of these four is greater than the health visitor's total salary."

Aberdeen has approximately 251 such "borderline families." If, through lack of the advice and guidance of health visitors one-fifth of these families pass outside the bounds of normal behaviour, then the Children's Committee will have an additional 150 children (at 3 per family) to take into care. If one assesses the average total cost (including supervision and administrative expenses) at £200 per child per year, the additional cost would therefore be £30,000 annually.

Since these four examples alone indicate a probable additional cost of £120,000 a year in the event of the public health service collapsing (or more than four times the whole present cost of the health visitor service), and since there would be comparable increases in a great many diseases that the public health service has been instrumental in reducing, it is manifest that **the collapse of the public health service would cripple the community financially as well as producing a vast amount of needless suffering.**

THE SORT OF SALARY INCREASES NEEDED.

Since prevention is manifestly cheaper as well as pleasanter than cure, there is a clear economic necessity to raise the salaries of all public health officers to a level sufficient to attract and maintain an adequate supply of recruits of high calibre. The laws of supply and demand would doubtless determine the exact extent of the increases needed, but the writer believes that, for health visitors, increases ranging from £200 in the basic grade to £500 and £550 for Superintendents and Principal Tutors, respectively, would probably suffice. Certainly, an increase of £200 for health visitors would be considerably less than the improvements of salary given to women teachers in Scottish secondary schools since the

beginning of 1955; and certainly, an increase of £500 and £550 in the top-ranking posts would be rather less than was given to general medical practitioners by the Danckwerts award. Undoubtedly, too, such increases would still leave the ordinary health visitor further behind the ordinary graduate teacher than she was a couple of years ago, and would still leave the Superintending Nursing Officer and even the Principal Health Visitor Tutor below the present maximum of an assistant dental officer or an assistant medical officer. Nevertheless, increases of £200 in the basic grade and £500 and £550 in top-ranking posts might suffice.

TOTAL COST WOULD BE SMALL.

Since health visiting is a numerically small profession, the total cost of such increases would not be high, *e.g.*, about £15,000 for Aberdeen or about £300,000 for Scotland—amounts that seem trivial by comparison with the sums that have been expended on other professions.

The situation in essence is clear: the public health service stands in imminent danger of collapse through lack of health visitors; such collapse would cripple the community; and, because health visiting is a numerically small profession, the cost of preventing a collapse would be small. What obstacle hinders the taking of the necessary steps?

WHY EMPLOYERS MUST INITIATE REMEDIAL ACTION.

The negotiation of health visitors' salaries has been entrusted to the Nurses' and Midwives' Whitley Council, but the staff side of this body is dominated by the "big battalions" of representatives of hospital nurses. Although health visitors, when compared with hospital sisters, have obligatory additional qualifications, greater responsibilities, and none of the amenities of hospital life, one can hardly expect the appointed representatives of hospital nurses to put forward a claim that health visitors should (as in the past) be paid substantially more than hospital sisters.

Consequently, it appears that **the employers' side of the Whitley Council will have to take the initiative** in demanding, in the interests of the community, substantial salary increases for all grades of health visitor. If public health collapses, the community will suffer severely; action to prevent that collapse and that suffering can be initiated by the elected representatives of the community.

After the imminent danger occasioned by gross lack of health visitors has been averted, attention can usefully be devoted to the qualitative insufficiency of medical recruits to public health and to the shortage of dental officers; but unless the health visitor problem is tackled, and tackled speedily, there will be no public health service, since the service cannot function without its key officer.

MISCELLANEOUS.

AWARDS.

During the year, members of staff held the following awards:—

(1) A World Health Organisation Senior Travelling Fellowship—Miss D. J. Lamont, Principal Health Visitor Tutor;

(2) A Nuffield Research Grant—Dr. I. A. G. MacQueen;

(3) A Medical Research Council Grant—The Department generally;

(4) An Elliston Scholarship—Dr. S. Lorimer, Departmental Medical Officer; and

(5) A British Commonwealth Travelling Scholarship—Miss M. Nairn, Health Visitor.

In respect of the W.H.O. Fellowship it may be mentioned that, although Senior Fellowships have been held by a few outstanding medical officers of health, it is believed that this is the first time in this country that the award of a Senior Fellowship has been made to a public health nurse. In addition to reflecting great credit on the recipient, the award may be interpreted as indicating the rising prestige of the health visiting profession.

In respect of the Nuffield Research Grant it may be mentioned that it is believed that this is the first time that such an award has been made to a public health officer in Scotland.

As already mentioned, the Health Visitor Training School not only repeated its dual triumphs of 1953 and 1954—a hundred per cent. pass and top place in the national examination for the health visitor's certificate—but secured in 1955 six out of the first seven places in that examination.

POSTS HELD.

During the year, Dr. D. Younie, Senior Assistant Medical Officer, was President of the Scottish Child Health Group of the Society of Medical Officers of Health; Dr. I. A. G. MacQueen continued to hold the post of Honorary Secretary of the Scottish Branch of the Society of Medical Officers of Health; Mr. A. Hay, Chief Dental Officer, continued to serve as Honorary Secretary of the Public Health Group of the British Dental Association; Miss D. J. Lamont, Principal Health Visitor Tutor, was appointed Chairman of an *ad hoc* Committee of the Scottish Health Visitors' Association for the preparation of evidence for the Working Party on Social Workers; Dr. MacQueen served as a member of a Building Legislation Committee set up by the Secretary of State for Scotland; Dr. MacQueen was appointed Chairman and Miss D. J. Lamont was appointed a member of an *ad hoc* Committee set up by the Standing Conference of Representatives of Health Visitor Training Centres to make recommendations on the staffing of training schools; Miss M. M. Byrne, Health Visitor Tutor, was appointed Honorary Secretary. Dr. MacQueen was appointed Vice-President, and Dr. D. Barclay, Deputy Medical Officer of Health, was appointed Chairman of the Care Sub-Committee of the newly formed Aberdeen Tuberculosis Care Committee; Dr. MacQueen served on the Executive Council of the Scottish Association for Mental Health, the Department of Health Consultative Committee of Medical Officers of Health, and the Scottish Public Health Committee of the British Medical Association; Miss D. J. Lamont was a member of the Area Nurse Training Committee; Dr. MacQueen served on the Board of Management of the Aberdeen Special Hospitals and on the Aberdeen Local Medical

Committee; and Mrs. M. Bell, Social Worker, and Dr. MacQueen served as directors of the Aberdeen Association of Social Service.

ADDRESSES TO NATIONAL CONFERENCES.

While 1955 does not approach 1954 for the number of addresses given to national conferences, &c. (in 1954, members of staff delivered eight separate addresses to national conferences as well as taking part in one television and two radio programmes), the Medical Officer of Health was invited during the year to give the opening address at the Annual Conference of the Women Public Health Officers' Association (at Harrogate) and to address the Annual Conference of the Scottish Health Visitors' Association (at Aberdeen).

PUBLICATIONS.

Again, 1955 cannot compete with 1954 in the number of articles published by members of the staff, but nevertheless five articles were published during the year:

(1) "A Register of Old People living at Home," by Dr. D. Barclay *(The Medical Officer)*.

(2) "Records and Reports: their purpose and value," by Dr. I. A. G. MacQueen *(The Nursing Mirror)*.

(3) "In-service Training in Mental Health," by Miss D. J. Lamont and Dr. I. A. G. MacQueen *(The Nursing Times)*.

(4) "The Rôle of the Health Visitor in the Prevention of Mental and Emotional Disease," by Dr. I. A. G. MacQueen *(The Medical Officer)*.

(5) "Adequate Staffing Standards," by Dr. I. A. G. MacQueen *(Woman Health Officer)*.

UNUSUAL REFERENCES BY MINISTRY OF HEALTH.

The Ministry of Health does not normally mention developments in Scotland (just as the Department of Health for Scotland does not usually allude to advances in England and Wales). However, in its Report for 1954 (published in October, 1955), the Ministry of Health makes four references to Scottish work, of which two relate to Aberdeen:

(1) On page 69 the Report mentions Scottish research (conducted in the Health Departments of Aberdeen and Edinburgh) into the efficacy of simultaneous immunisation against whooping cough, diphtheria, and tetanus.

(2) On page 124 it refers to a study of still-births (conducted by the Medical Statistician of the Department of Health for Scotland).

(3) On page 152 it mentions a survey of home accidents (by medical officers of Edinburgh Health Department).

(4) On page 198 it summarises an address on the rôle of the health visitor in the health maintenance of the elderly (given by Miss D. J. Lamont, Principal Health Visitor Tutor, at a study day for Aberdeen health visitors and subsequently published in *The Medical Officer*.

TRIBUTE.

The writer wishes to thank the Convener and members of the Health and Welfare Committee for continued interest, appreciation, and help; to thank officers of other Corporation departments and of other branches of the National Health

Service for generous co-operation; and in particular to thank his colleagues in the Health and Welfare Department—medical officers, dental officers, health visitors, midwives, sanitary inspectors, welfare officers, clerks, staffs of nurseries and homes, &c.—who, despite staff shortages and often inadequate accommodation, have seldom contented themselves with simply carrying out the work for which they were paid, but, of their own volition, have devoted much additional time and energy to a sustained effort to improve the health and well-being of the community.

I. A. G. MACQUEEN,

Medical Officer of Health.

Health and Welfare Department,
Willowbank House,
Willowbank Road,
Aberdeen.
23*rd March*, 1956.

CITY OF ABERDEEN.

REPORT BY THE MEDICAL OFFICER OF HEALTH

For the year 1955.

1.—BACKGROUND DATA : DEMOGRAPHICAL, SOCIOLOGICAL, &c.

INTRODUCTION.

It is unfortunate but inevitable that any report on the health of a City during a year and on the work of its Health and Welfare Department in that year should consist largely of figures—death rates and sickness rates, numbers or percentages of persons examined, statistics relating to defects found on examination, numbers of persons attending various clinics, numbers of visits paid by members of staff, and so forth. The various figures can be rendered more easily comprehensible by the use of suitable diagrams, but (whether expressed in tabular or pictorial form) they cannot convey really accurate information unless they are interpreted in the light of the social, economic, industrial, and climatic circumstances of the area to which they relate. A particular infant mortality rate might, for instance, reasonably be judged high and regarded as an indication of inadequate or inefficient child welfare services in a wealthy, well-housed community, while the same rate in another town with much overcrowding, poverty, and unemployment might properly be deemed low and regarded as indicating that the services were functioning satisfactorily.

Of the many factors liable to influence the health of the City, some of the more obvious will already be known to practically every person who reads this report, *e.g.*, such points as that Aberdeen is a seaport with an extensive fishing fleet, that there is an airport just outside the City, that Aberdeen is a university town with a flourishing medical school, that the City contains one of the three Scottish training schools for health visitors, that Aberdeen is the natural commercial and industrial centre for a large agricultural hinterland, and that it has a bracing climate of the east-coast type. An attempt has been made below to set down very briefly some additional basic demographical and socio-economic data for the City. For a more detailed survey of social conditions, &c., reference may be made to the Annual Report for 1952.

The information set out in the next seven pages follows the same general lines as in the report for 1954. It may therefore be worth while to begin by attempting a brief summary.

(*a*) *General points influencing health*—

(1) Aberdeen has an unusually large proportion of men in the poorest socio-economic class, a proportion as high as in Glasgow and considerably higher than in other cities or in Scotland as a whole.

(2) Unfavourable housing circumstances (although in process of being overcome) still place Aberdeen at a disadvantage in relation to other cities. For example, the 1951 census showed that the proportion of households sharing the use of a water supply, sharing the use of a water-closet, having no piped water supply, and having no water-closet were in each case considerably greater in Aberdeen than in Glasgow, Dundee, or Edinburgh; and one person in every eight was living under seriously overcrowded conditions (at more than two people per room).

(*b*) *Points specifically related to 1955*—

(1) Unemployment during the year was not very extensive: *e.g.*, 2,233 on 12th December, 1955, in the area covered by the Aberdeen Employment Exchange, as compared with 2,358 on 6th December, 1954.

(2) The estimated population rose by 627 to 186,352.

(3) The number of houses rose by 857 to 54,914.

(4) The outstanding climatic features of the year were an abnormally severe winter and an unusually good summer.

GENERAL DATA.

Area of City.—After the extension of boundaries in 1952, the area (exclusive of inland water, tidal water, and foreshore) is 11,362 acres.

Population.—The 1951 census enumeration gave a total of 182,729, or, when corrected for normal residence, 183,247. The estimated population at the middle of 1954 was 185,725, and the estimated population at the middle of 1955 was 186,352.

Growth of the Population.—The growth of the City may be very roughly summarised as follows:—For many centuries Aberdeen had a population of under 15,000. During the 18th century it increased to 27,000. In the thirty years, 1801-1831, the population doubled. In the next sixty years it doubled again. By 1911, it had risen to 163,891. During the twenty years, 1911-1931, there was little growth; the population in 1931 was 167,258, representing an average annual increase of 168 over the period. During the twenty years, 1931-1951, the average annual increase in the population was 798 and, in the years since the last census, the estimated annual growth is of about that figure.

Density of Population.—On the latest estimate the density is 16·4 persons per acre.

Number of Houses.—The number in 1955 was 54,914, an increase of 857 on the total in the previous year. The distribution of houses in the various Wards was as follows:—

Ward.	No. of Houses.	Ward.	No. of Houses.
No. 1—St. Clement's	4,511	No. 7—Rosemount	3,660
No. 2—St. Nicholas	5,381	No. 8—Rubislaw	3,782
No. 3—St. Andrew's	4,509	No. 9—Holburn	4,437
No. 4—St. Machar	3,872	No. 10—Ruthrieston	4,405
No. 5—Woodside	4,615	No. 11—Ferryhill	4,356
No. 6—Cairncry	7,100	No. 12—Torry	4,286

Average Number of Persons per House.—In the Annual Report for 1952, there were given the census figures for the four cities. The figure for Aberdeen was 3·48; and the latest estimated figure, based on the Registrar-General's estimate of the population (186,352) for the middle of 1955 and the City Assessor's return as to the number of houses in the City, is 3·39.

Rateable Value (1954-55)—£2,201,516.

Population—Age Distribution.—The following table indicates the proportions of the population in various age-groups at census in 1911, 1921, 1931, and 1951:—

	Under 1 year.	1 and under 5 yrs.	5 and under 15 yrs.	15 and under 25 yrs.	25 and under 45 yrs.	45 and under 65 yrs.	65 yrs. and upwards.
1911	2·23	9·03	22·13	19·13	26·84	15·31	5·33
1921	2·35	6·66	19·41	20·00	27·00	18·42	6·16
1931	1·75	6·81	17·22	18·65	28·51	19·81	7·25
1951	1·63	7·44	14·14	14·76	28·84	23·21	9·98

The estimated population of 186,352 in 1955 includes 3,140 under 1 year, 11,974 aged 1-4, 28,357 aged 5-14, 27,464 aged 15-24, 53,662 aged 25-44, 43,186 aged 45-64, and 18,569 aged 65 and over.

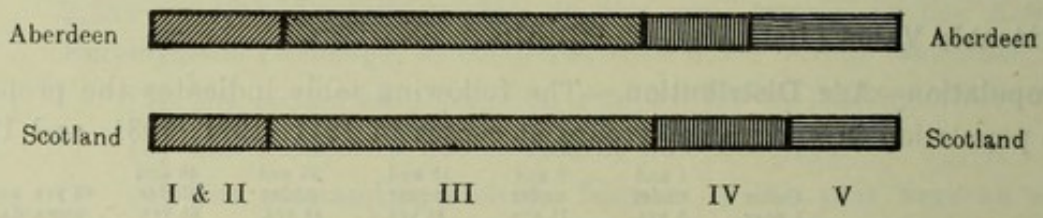
Population—Marital Condition.—The outstanding change revealed by a comparison with twenty years ago is that a far higher proportion of men and women aged 20-30 years are married. There is also a slight increase in the proportion of widows (but not of widowers), and a rise in the number of divorced persons (to nearly 1 per 200 population).

Social Class Distribution of Adult Males.—A convenient socio-economic classification is that adopted by the Registrar-General who divides adult males according to occupation into five social classes. Class I includes such categories as shipowners, company directors, architects, journalists, medical practitioners, solicitors, &c.; Class II contains farmers, farm managers, shopkeepers, nurses, teachers, police inspectors, &c.; Class III, the biggest group, consists mainly of skilled artists and foremen—market gardeners and market gardening foremen, blacksmiths, shipwrights, plumbers, bus drivers, shorthand typists, postmen, &c.; Class IV is mainly semi-skilled workers—railway ticket collectors, paint sprayers, fishermen, bus conductors, barmen, hospital orderlies, &c.; and Class V includes unskilled workers—agricultural labourers, dock labourers, lift attendants, newspaper sellers, hawkers, &c. Exact figures based on the census enumeration have not been published, but the following percentages, calculated from the gross figures given in the Registrar-General's One per Cent. Sample Tables (H.M. Stationery Office, 1952),

give, with a fairly small margin of error, comparative data for the four cities and for Scotland as a whole, while the diagram depicts the proportions in Aberdeen and in the country:—

	Percentage of Each Social Class.				
	I.	II.	III.	IV.	V.
Scotland . .	2·96	13·21	50·92	18·21	14·71
Aberdeen . .	3·65	14·12	48·84	14·12	19·27
Dundee . .	2·03	9·98	51·62	18·45	17·93
Edinburgh . .	5·36	12·71	56·65	10·79	14·50
Glasgow . .	2·07	10·17	54·88	13·60	19·28

Proportions in Social Classes.



Some important points that emerge from a study of the above figures are—

(1) The percentage of persons in the lowest social class is practically identical in Aberdeen and Glasgow, being much higher than in any other city and very much higher than in Scotland as a whole. It may also be mentioned that the percentage of persons in Class V is appreciably higher in Aberdeen than in most English cities.

(2) The proportion of persons in Classes IV and V taken together is greater in Aberdeen than in Glasgow.

(3) Aberdeen has a smaller percentage of persons in Class III than any other Scottish city.

(4) Aberdeen has a higher proportion of inhabitants in Class I than any city except Edinburgh.

Unemployment.—Unemployment during most of 1955 was not very extensive. At the latest date for which information is easily available (12th December, 1955), the numbers of unemployed persons in the area covered by the Aberdeen Employment Exchange were—

Men, 1,629; Boys, 15; Women, 576; Girls, 13; Total, 2,233.

Housing.—A detailed summary appeared in the Annual Report for 1952. Some salient points were—that more than one person in every eight was living under overcrowded circumstances (at more than two persons per room), and that Aberdeen was less favourably placed than the other Scottish cities in respect of the proportion of houses with such facilities as a piped water supply, a water-closet, a kitchen sink, and a cooking stove or range. Despite the vigorous housing programme of recent

years, it will obviously be some time before Aberdeen can hope to draw level with the other cities.

Occupations.—As in previous years, it has not proved possible to provide an exact analysis of the gainfully employed members of the community in respect of occupation.

The Aberdeen Employment Exchange serves Aberdeen City and an adjacent county area (Bucksburn, Dyce, and Cults) with a population of approximately 15,000. According to the Ministry of Labour and National Service, the main occupations in the area served by this Exchange are—

Agriculture and Horticulture.
Fishing.
Stone Quarrying.
Cast Concrete and Monumental Masonry.
Chemicals and Allied Trades.
Engineering, Shipbuilding, and Electrical Goods.
Motor Body Building and Motor Repairing (Garages)
Metal Goods not elsewhere specified.
Woollen and Worsted Manufacture.
Flax Manufacturers.
Net Making and Braiding.
Hosiery and Other Knitted Goods.
Clothing : Tailoring.
Dressmaking.
Shirtmaking.
Boot and Shoe Repairing.
Sawmilling.
Furniture and Upholstery.
Food and Drink: Grain Milling.
Bread and Biscuit Making.
Meat Products.
Milk Products.
Fish Curing.
Aerated Water Manufacture.
Wooden Container and Basket Manufacture.
Paper and Printing.
Horn Comb and Plastics Moulding.
Building and Contracting.
Gas, Electricity, and Water Services.
Transport and Communication Services.
Distribution Trades.
Insurance, Banking, and Finance.
Public Administration and Defence.
Professional Services.
Entertainment and Sport.
Catering—Hotels, &c.
Laundry and Dry Cleaning.
Hairdressing.

Meteorological Data.

General.—1955 was climatically a year of extremes. An abnormally cold winter, with very severe frost and prolonged snow, was followed by an unusually warm and dry summer.

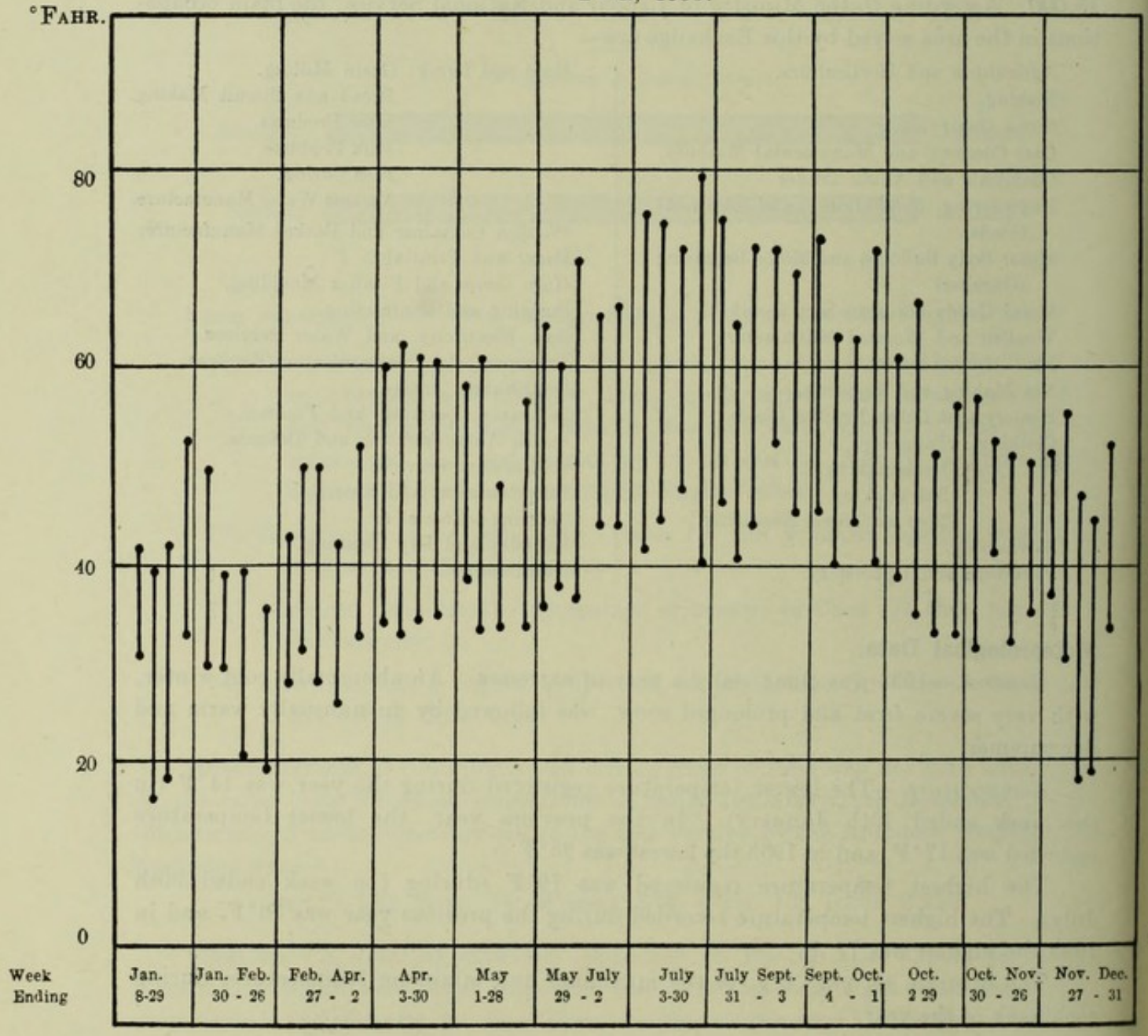
Temperature.—The lowest temperature registered during the year was 14°F (in the week ended 15th January). In the previous year, the lowest temperature recorded was 17°F, and in 1953 the lowest was 25°F.

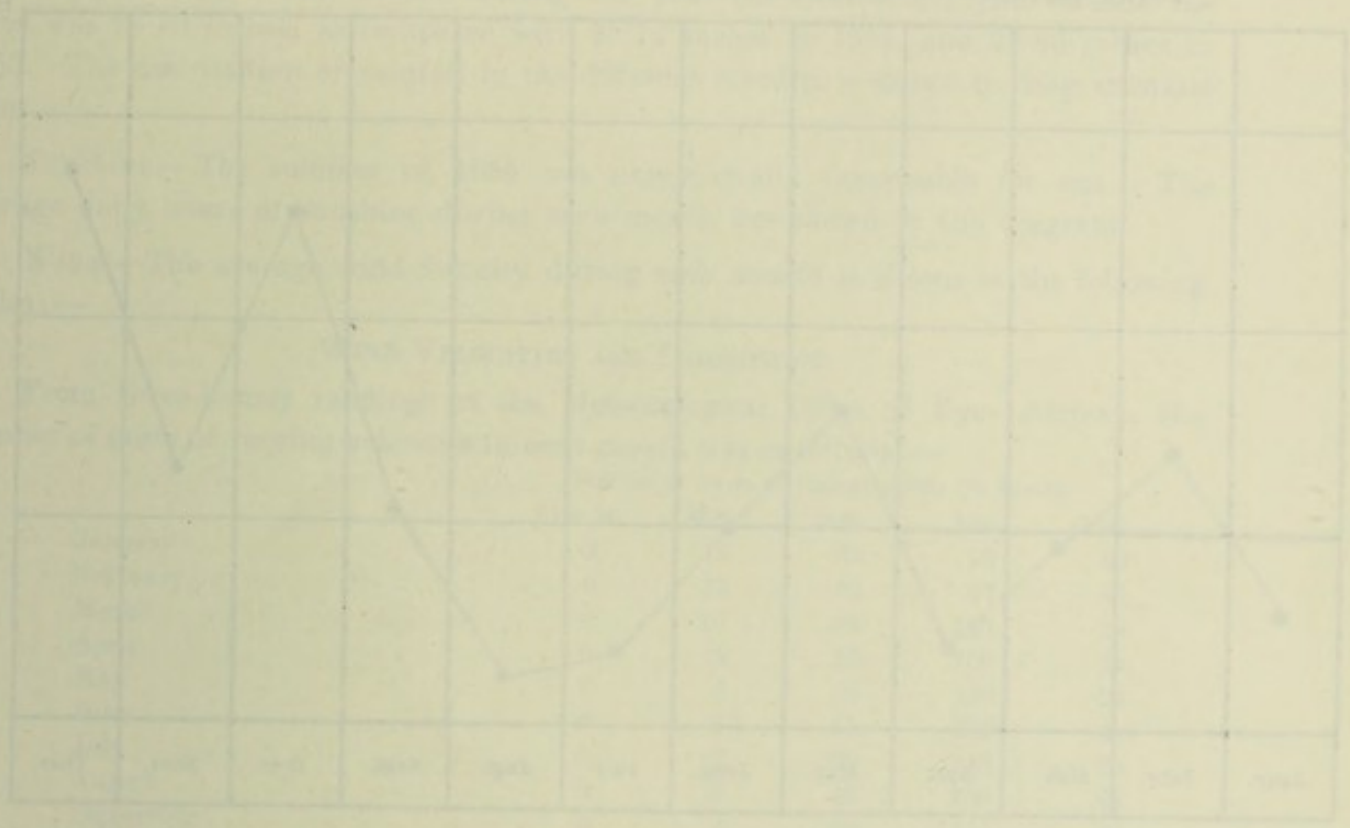
The highest temperature registered was 79°F (during the week ended 30th July). The highest temperature recorded during the previous year was 73°F, and in 1953 the highest was 77°F.

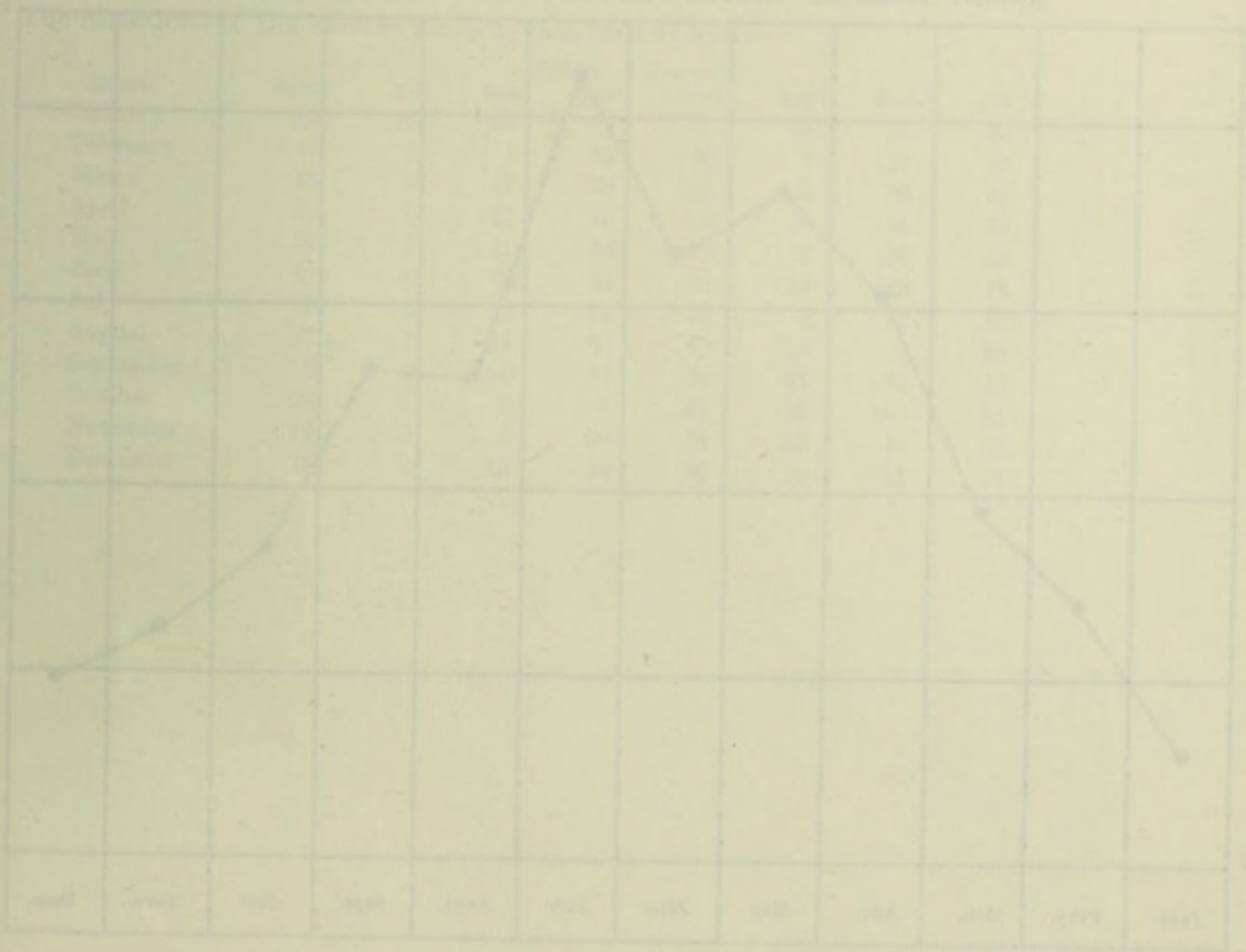
The diagram on page 6 gives the maximum and minimum temperatures during each week of the year.

CITY OF ABERDEEN.

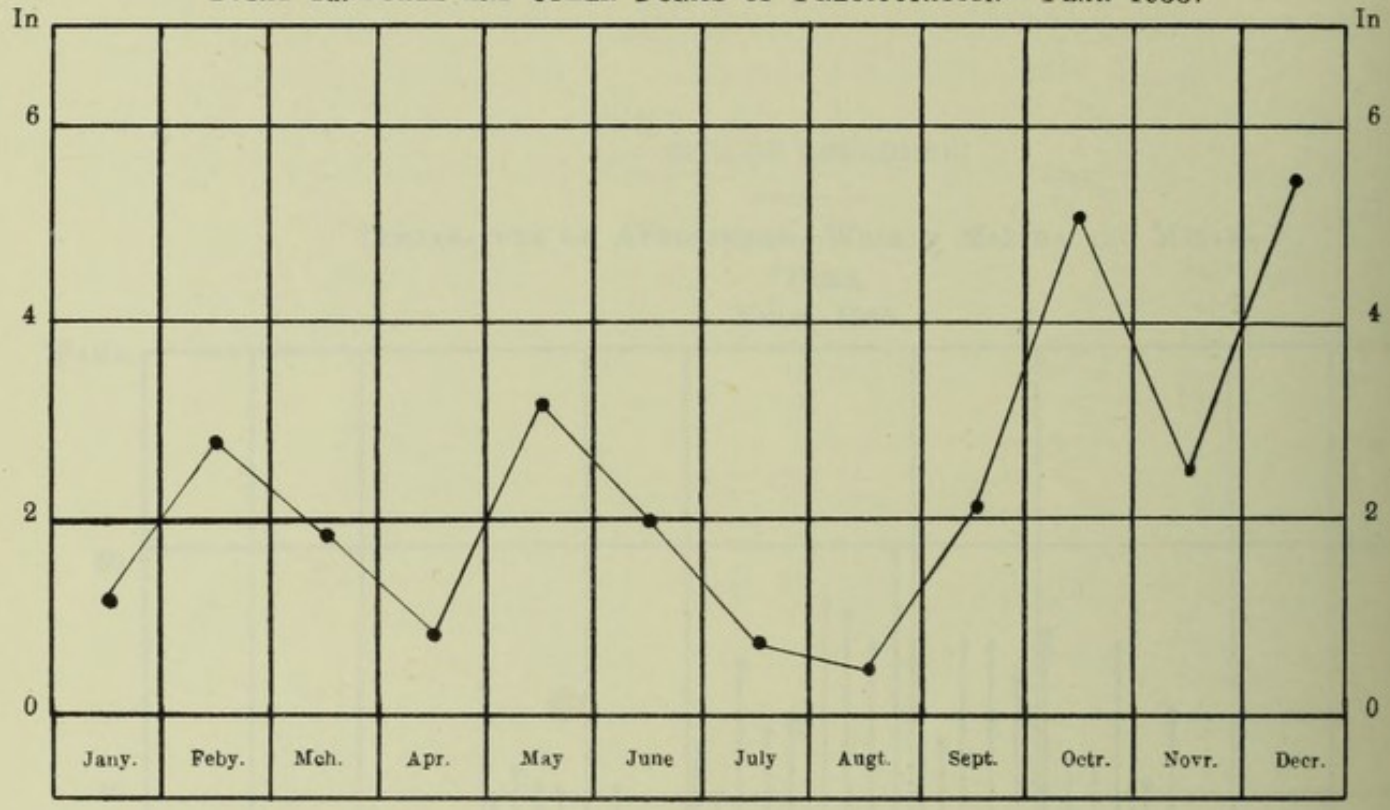
TEMPERATURE OF ATMOSPHERE—WEEKLY MAXIMA AND MINIMA
°FAHR.
YEAR, 1955.



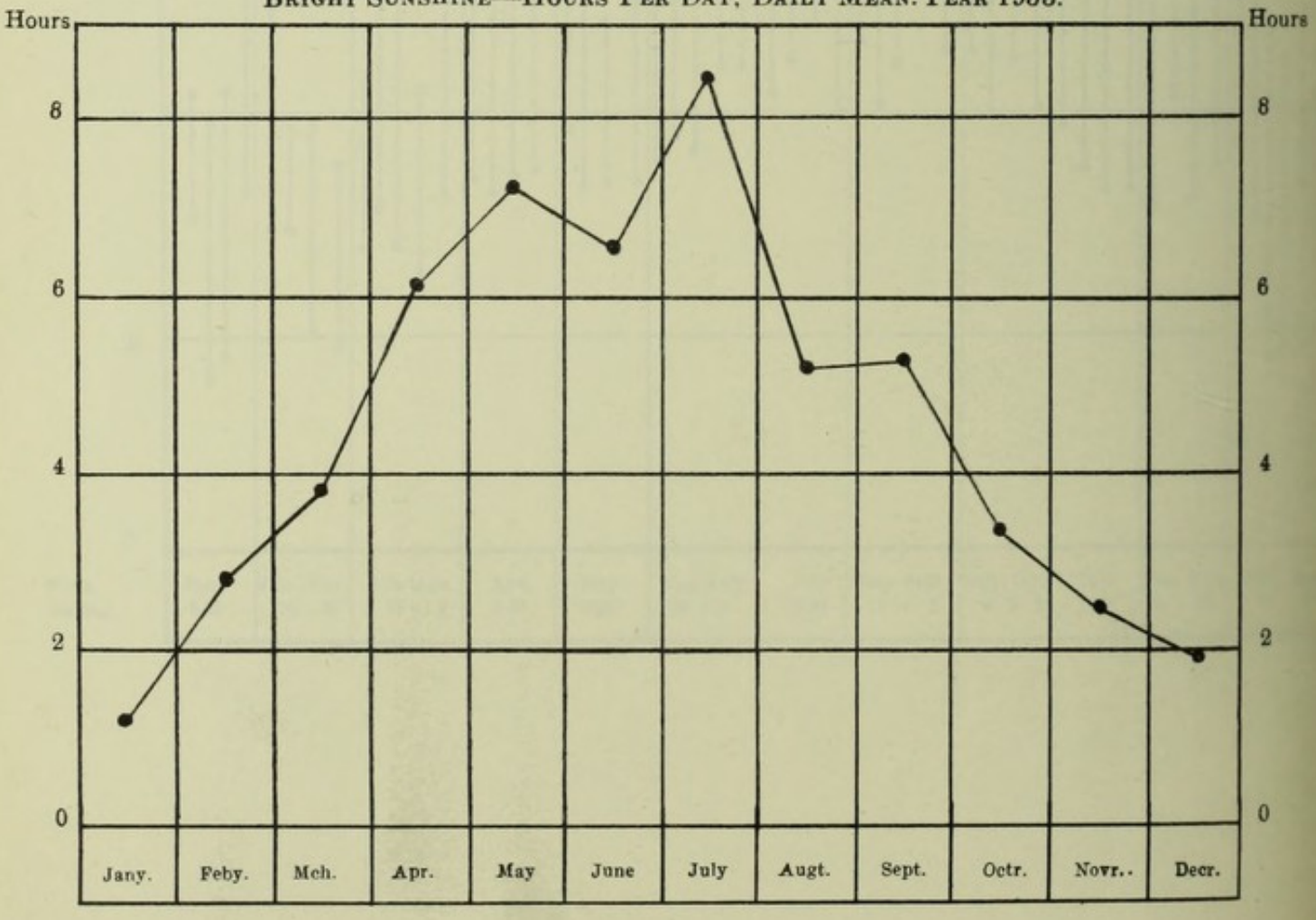




TOTAL RAINFALL AND OTHER FORMS OF PRECIPITATION—YEAR 1955.



BRIGHT SUNSHINE—HOURS PER DAY, DAILY MEAN. YEAR 1955.



Rainfall.—The total rainfall during the year (at Craibstone, just outside the City) was 28·10 inches, as compared with 35·12 inches in 1954, and 28·86 inches in 1953. The distribution of rainfall in the different months is shown in diagrammatic form.

Sunshine.—The summer of 1955 was exceptionally favourable for sun. The average daily hours of sunshine during each month are shown in the diagram.

Wind.—The average wind velocity during each month is shown in the following tables:—

Wind Velocities and Directions.

From three-hourly readings at the Meteorological Office of Dyce Airport, the number of gusts of varying velocities in each month was as follows:—

	Number of Gusts at various speeds (in knots).				
	Over 34.	22-33.	11-21.	1-10.	Calm.
January	0	15	95	99	39
February	0	14	62	97	51
March	0	16	84	120	28
April	0	3	57	136	44
May	0	5	85	136	22
June	0	1	61	138	40
July	0	0	20	143	85
August	0	0	48	138	62
September	0	4	88	110	38
October	0	7	104	98	39
November	1	2	66	120	51
December	0	11	110	92	35

The directions of the various gusts in each month were—

	Number of Gusts from							
Month.	North.	N-E.	East.	S-E.	South.	S-W.	West.	N-W.
January	15	3	23	15	58	30	25	40
February	44	1	5	26	36	4	12	45
March	48	5	12	19	26	9	30	71
April	20	0	11	13	53	26	41	32
May	36	2	11	38	33	19	25	62
June	17	16	28	31	61	19	13	15
July	28	5	22	34	36	2	12	24
August	27	7	11	37	69	10	2	23
September	8	0	0	14	54	47	61	18
October	28	1	2	8	41	33	40	56
November	14	0	5	26	34	29	43	38
December	16	2	14	19	30	34	53	45

2.—VITAL STATISTICS OF 1955.

Some of the main features of the year may be briefly summarised—

(1) The live birth-rate is slightly lower than in 1954, but considerably higher than in the three previous years.

(2) The illegitimate birth-rate is higher than in 1954 and 1953 though lower than in any other previous year. (Possible explanations of the increase are considered later in this chapter.)

(3) While for some years Aberdeen has had a still-birth rate appreciably lower than the rates in other Scottish cities and in Scotland as a whole, in 1955 the rate has fallen very far below any previous figure. (The main causes of Aberdeen's remarkably favourable position are indicated later in this chapter.)

(4) The infant mortality rate, although higher than in various Scandinavian cities and some English cities, is considerably lower than in other Scottish cities and Scotland as a whole; the rate is lower than the record low figure established in 1954.

(5) The neo-natal death rate constitutes another new low record.

(6) The number of deaths in children aged 1-5 years is higher than in 1954 but not higher than in any previous year. (An analysis of the decline in infant and pre-school deaths over a period of fifty years is given later in this chapter.)

(7) Only one maternal death occurred in 1955.

(8) The average age at death is higher than ever before.

(9) The proportion of deaths in persons under the age of 45 years has been falling for some years, and the low record of 9 per cent. for 1954 has been maintained.

(10) The proportion of deaths in persons aged 75 years and over has been rising steadily for some years, and the high level of 39 per cent. reached in 1954 has again been equalled.

The table on page 10 gives the numbers of births, still-births, and infant deaths over a series of years.

LIVE BIRTHS.

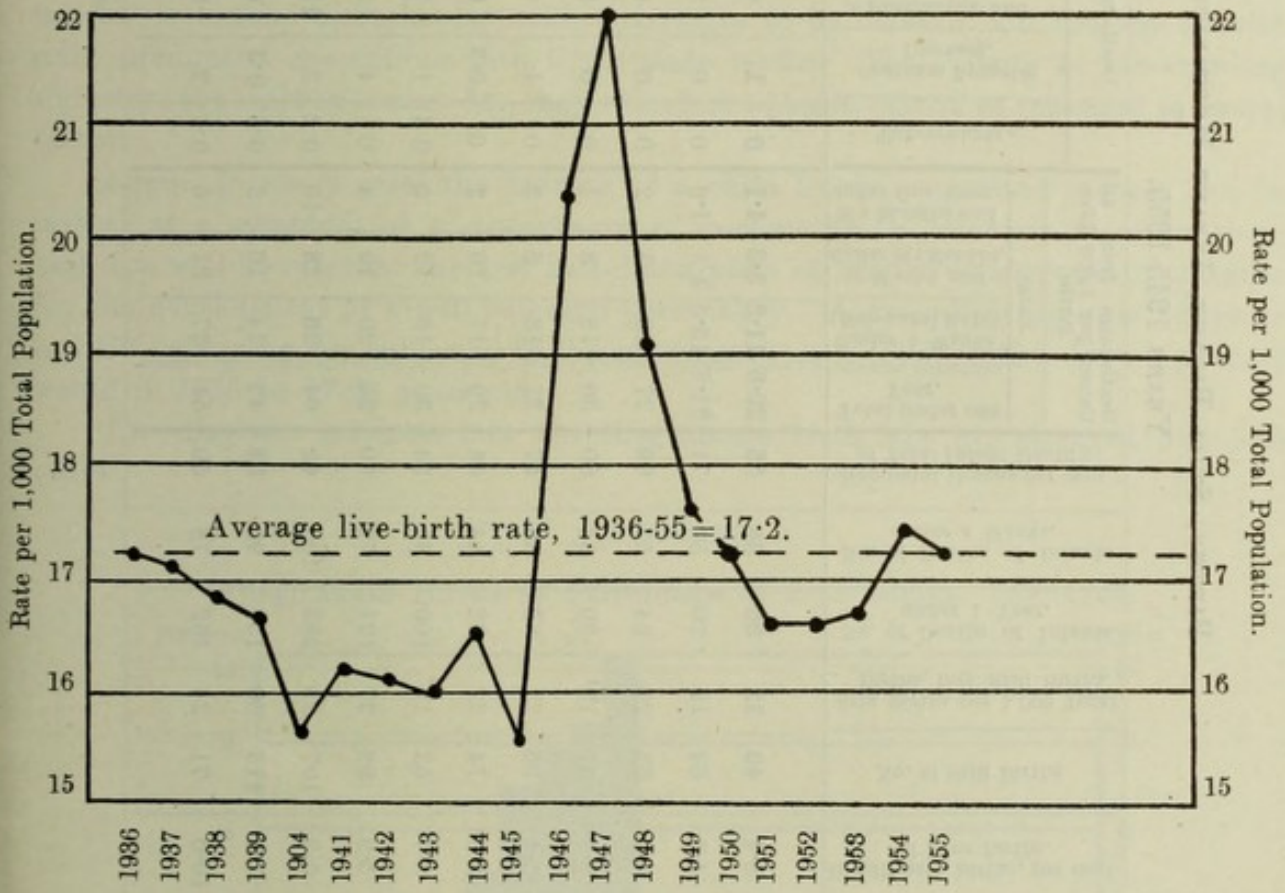
The total number of live births during 1955, corrected for "transfers," was 3,204, of whom 3,032 were legitimate and 172 illegitimate. The live birth-rate was 17·2 per 1,000 of population, slightly lower than in 1954 but a good deal higher than the figures for 1952 and 1953.

The following table shows the rates for Aberdeen and for all Scotland over a period of nine years. The trend in Aberdeen is very similar to that in the country as a whole;—

Year.	Live Birth Rate per 1,000 Population. Aberdeen.	Scotland.
1955	17·2	18·0
1954	17·2	18·0
1953	16·6	17·8
1952	16·5	17·7
1951	16·5	17·7
1950	17·2	17·9
1949	17·5	18·5
1948	19·1	19·4
1947	22·0	22·0

In 1955, the birth-rates in the other principal cities were:—Glasgow, 19·4; Edinburgh, 15·2; and Dundee, 17·5.

ABERDEEN.—LIVE-BIRTH RATE—1936-1955.



The **natural increase** for the year (*i.e.*, the excess of births over deaths) was 1,069, as compared with 1,172 in 1954, 986 in 1953, and 877 in 1952.

Births, Still-Births, Infant Mortality.

Years 1945-1955.

Year.	No. of Live Births.	Live Births per 1,000 of Population.	Illegitimate Births, per cent. of Live Births.	No. of Still Births.	Still Births per 1,000 Total Births, incl. Still Births.	No. of Deaths of Infants under 1 Year.	No. of Deaths of Infants under 4 Weeks.	Neo-natal Deaths per cent. of Total Infant Deaths.	Death-rates from all Causes per 1,000 Live Births. Rates. Total under one Year.	Under 4 Weeks (Neo-natal Rate)	4 Weeks and under SixMonths.	Six Months and under One Year.	Death-rates among Infants under 1 Year of Age from Various Causes per 1,000 Live Births. Tuberculosis.	Common Zymotic Diseases.	* Pneumonia and Bronchitis.	Diarrhœa and Enteritis.	Congenital Malformations.	Injury at Birth.	Atelectasis.	Immaturity.	Accidents.	Other causes.
1955 .	**3204**	**17·2**	**5·4**	**40**	**12**	**66**	**36**	**55**	**20·6**	**11·2**	**5·3**	**4·1**	**0**	**1**	**4**	**0**	**3**	**0·3**	**3·4**	**4**	**2**	**3**
1954 .	3228	17·4	4·3	64	19	70	50	71	21·7	15·5	4·3	1·9	0	0	5	0	3	1	7	2	0·3	4
1953 .	3077	16·6	4·5	62	20	84	57	69	27	19	6	2	0	0	6	0·3	4	2	8	3	1	3
1952 .	3025	16·5	5·7	57	18	90	54	60	30	18	8	4	0	0	6	0	5	1	8	2	1	7
1951 .	3028	16·5	5·4	66	21	82	55	67	27	18	6	3	0	1	6	0·3	4	2	5	6	2	1
1950 .	3226	17·2	5·3	74	22	92	54	54	29	17	10	2	0	0·3	6	0·3	5	2	4	5	2	5
1949 .	3306	17·5	5·7	63	19	100	54	54	30	16	12	2	0·3	1	7	3	5	1	5	4	1	3
1948 .	3598	19·1	5·9	98	27	121	72	60	34	20	10	4	0	1	5	5	4	4	5	6	2	2
1947 .	4124	22·0	5·9	107	25	263	108	41	64	26	28	10	0·2	2	13	22	4	2	8	5	2	6
1946 .	3762	20·4	7·0	115	30	158	92	58	42	24	16	2	0·5	0·3	6	9	5	3	7	7	1	3
1945 .	2830	15·5	10·0	71	24	152	76	50	54	27	21	6	0·4	2	8	11	5	6	4	11	0·4	6

*Including under 4 Weeks.

Sex-ratio of births.—Of the total 3,204 live births, 1,640 were males and 1,564 were females, giving a ratio of 1·05 (*i.e.*, 105 males per 100 females). The sex-ratio in Aberdeen has been consistently high in recent years; it was 1·10 in 1954, 1·07 in 1953, 1·09 in 1952, and 1·11 in 1951.

ILLEGITIMATE LIVE BIRTHS.

In 1955 there were 172 illegitimate live births, representing a rate of 5·4 per cent. of the total live births. For Scotland, the rate was 4·3 per cent.

For many years illegitimacy has been a very grave social problem in Aberdeen, and the illegitimate birth-rate has been high. The rate for 1955 is the third lowest in the history of the City, but it is nevertheless disappointing that it has risen above the low records established in 1954 and 1953.

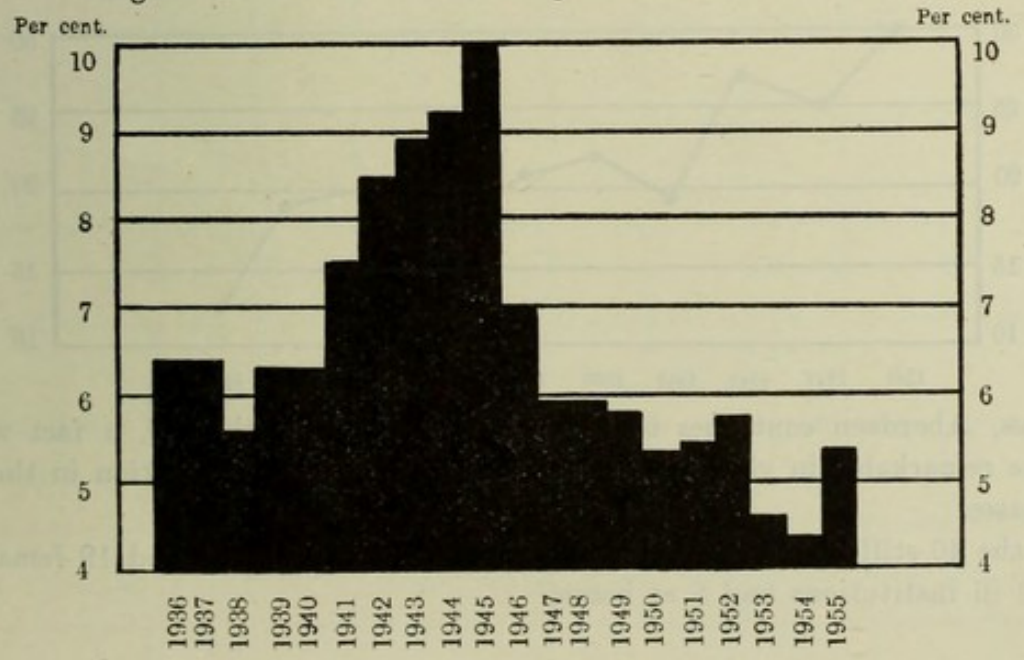
Two possible explanations may be suggested. In the first place, it is generally recognised that an increase in illegitimacy commonly follows a period of industrial unrest, partly as a result of the unsettling influence of such unrest, and partly because industrial disturbances cause marriages to be delayed and thereby convert some prenuptial conceptions into illegitimate births. The dispute in the trawling industry, the railway strike, &c., may therefore to some extent be regarded as causal factors.

Again, in many cases the bearing of a child by an unmarried mother can be viewed as a symptom of a disturbance of personality—a neurotic manifestation; and it is well known that the first half-dozen years of life are of supreme importance for the development of a well-balanced personality. A girl whose age was 1-5 years in 1939 (when she was subjected to the emotional strain of separation from a parent) would in 1955 be 17-22 years old.

The diagram indicates how the illegitimate birth-rate has changed over the years.

ABERDEEN.

Illegitimate Births as Percentage of Live Births, 1936-1955.



STILL-BIRTHS.

There were 40 still-births in 1955, as compared with 64 in 1954, 62 in 1953, 57 in 1952, 66 in 1951, and 74 in 1950. The still-birth rates for these years were—1955, 12; 1954, 19; 1953, 20; 1952, 18; 1951, 21; and 1950, 22.

The still-birth rate for 1955 is almost unbelievably low. Aberdeen has for some years had a still-birth rate considerably lower than those of other Scottish cities, but the lowest rate previously recorded for any Scottish city was the Aberdeen figure of 18 in 1952. While (as suggested in the preface) the phenomenally low rate of 1955 may be in some part due to chance, the highly satisfactory figures occurring year after year are largely attributable to the following features:—

(1) The overwhelming majority of expectant mothers attend the ante-natal clinics.

(2) Standards of ante-natal care—both as provided by doctors, health visitors, and midwives at the clinics and as provided by health visitors and midwives in the home—are very high.

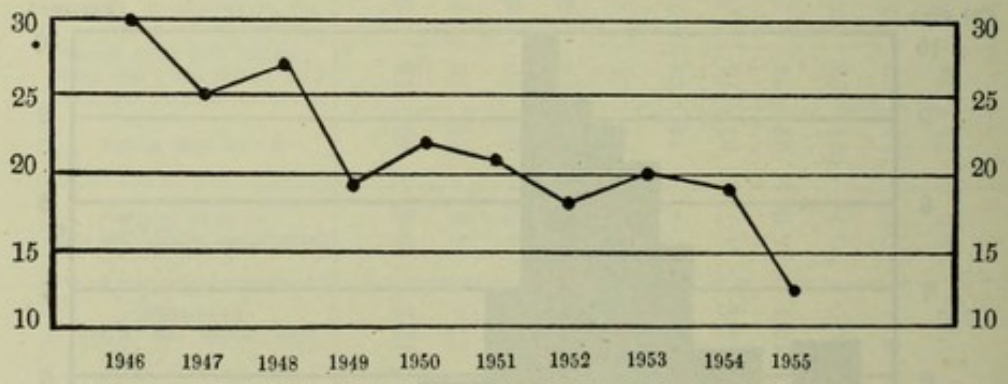
(3) Standards of obstetrical care are also very high.

(4) In the ante-natal services there is complete co-operation between the clinicians of the Regional Hospital Board and the public health doctors and public health nurses of the local health authority.

The following table gives the rates for Scotland and for the principal cities, and the graph shows the changes in the rate in Aberdeen over the last ten years.

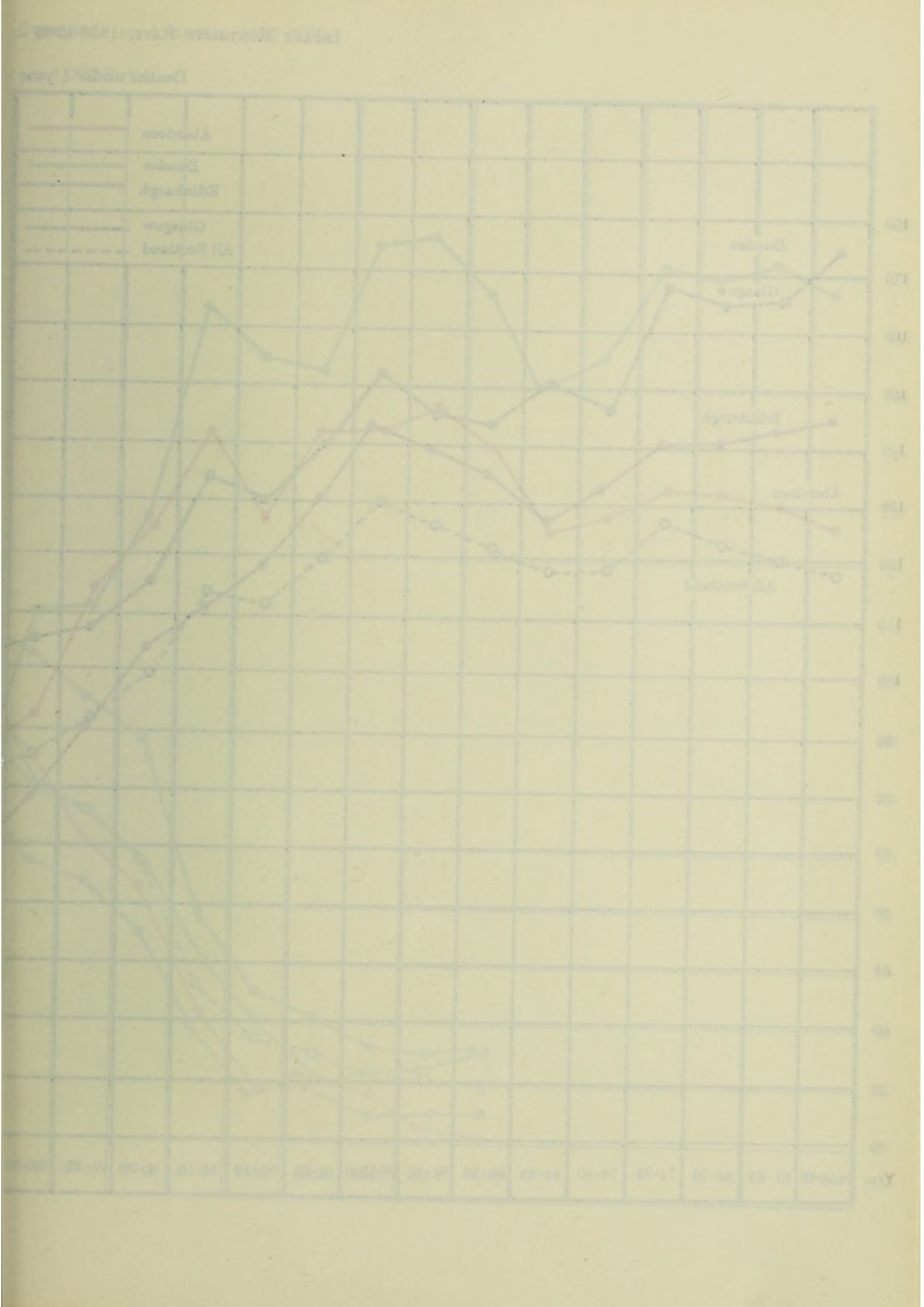
	Still-birth Rate per 1,000 Total Births.				
	1955.	1954.	1953.	1952.	1951.
All Scotland .	25	25	25	26	27
Glasgow . .	27	29	27	27	28
Edinburgh . .	24	21	22	27	27
Dundee . .	24	28	25	24	25
Aberdeen . .	**12**	**19**	**20**	**18**	**21**

ABERDEEN.—STILL-BIRTH RATE—1946-1955.

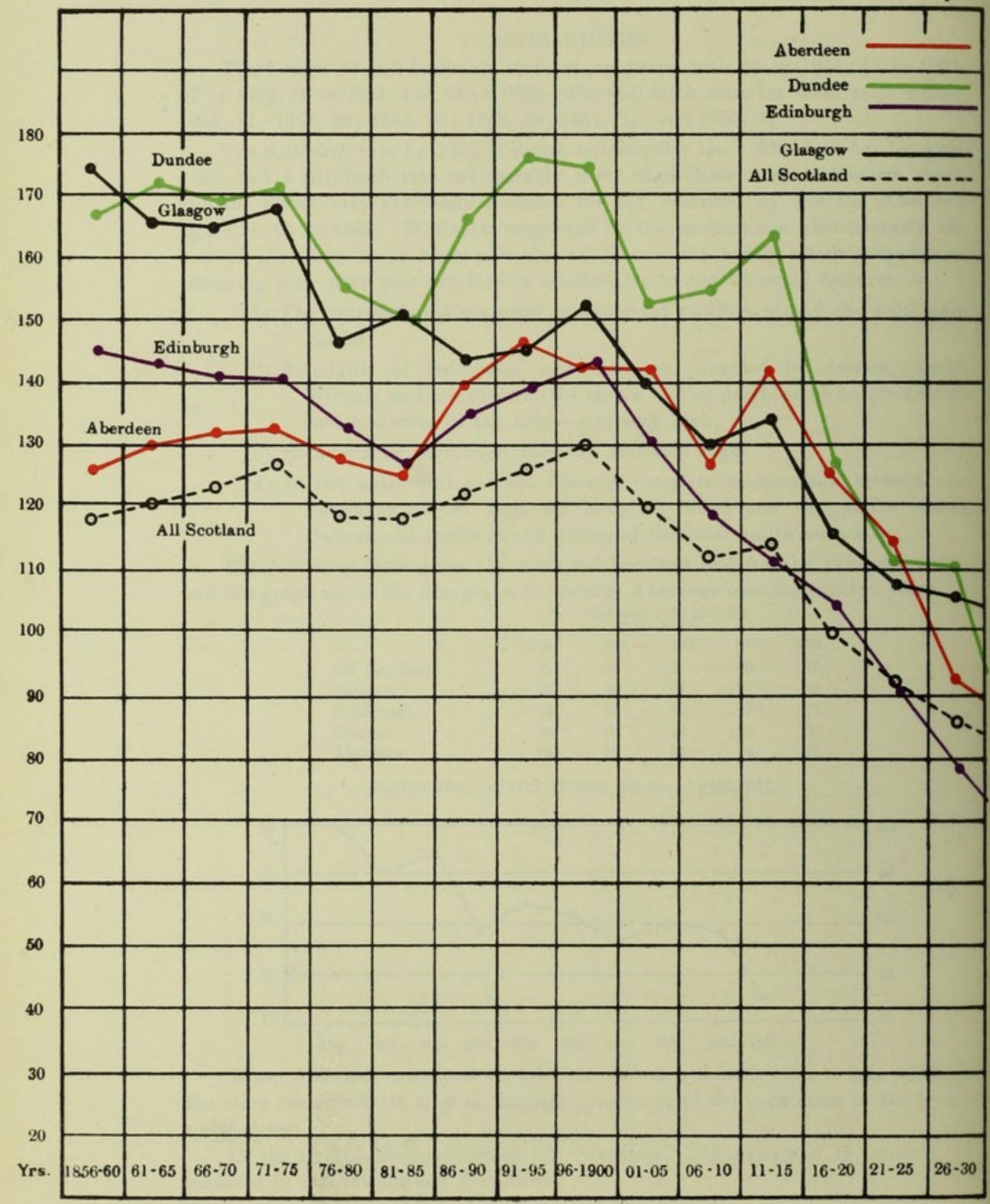


Thus, Aberdeen continues to have the lowest still-birth rate, a fact which is the more remarkable in view of the high percentage of the population in the lowest social classes.

Of the 40 still-births (corrected for "transfers") (21 males and 19 females), 32 occurred in institutions and 8 at home.

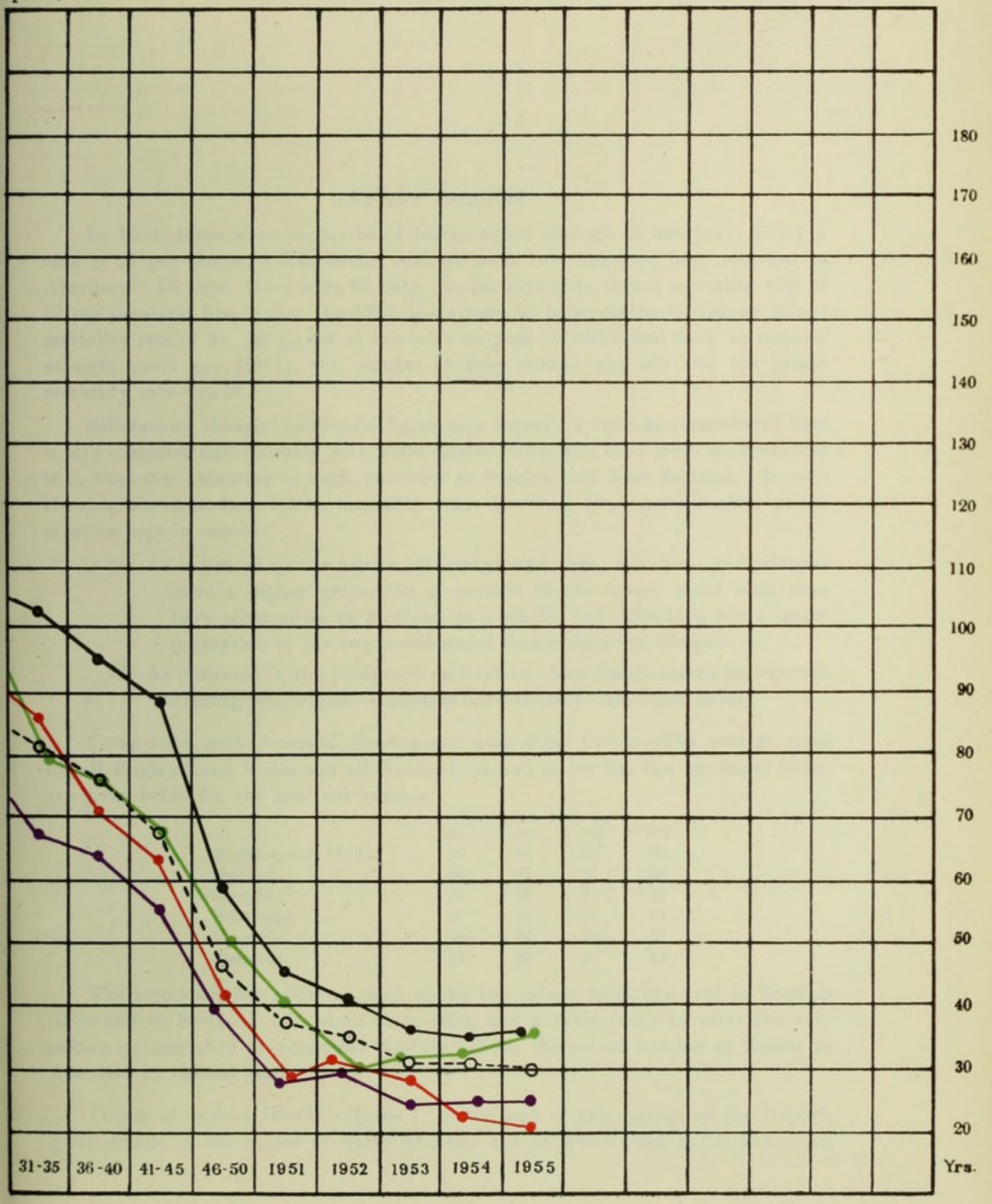


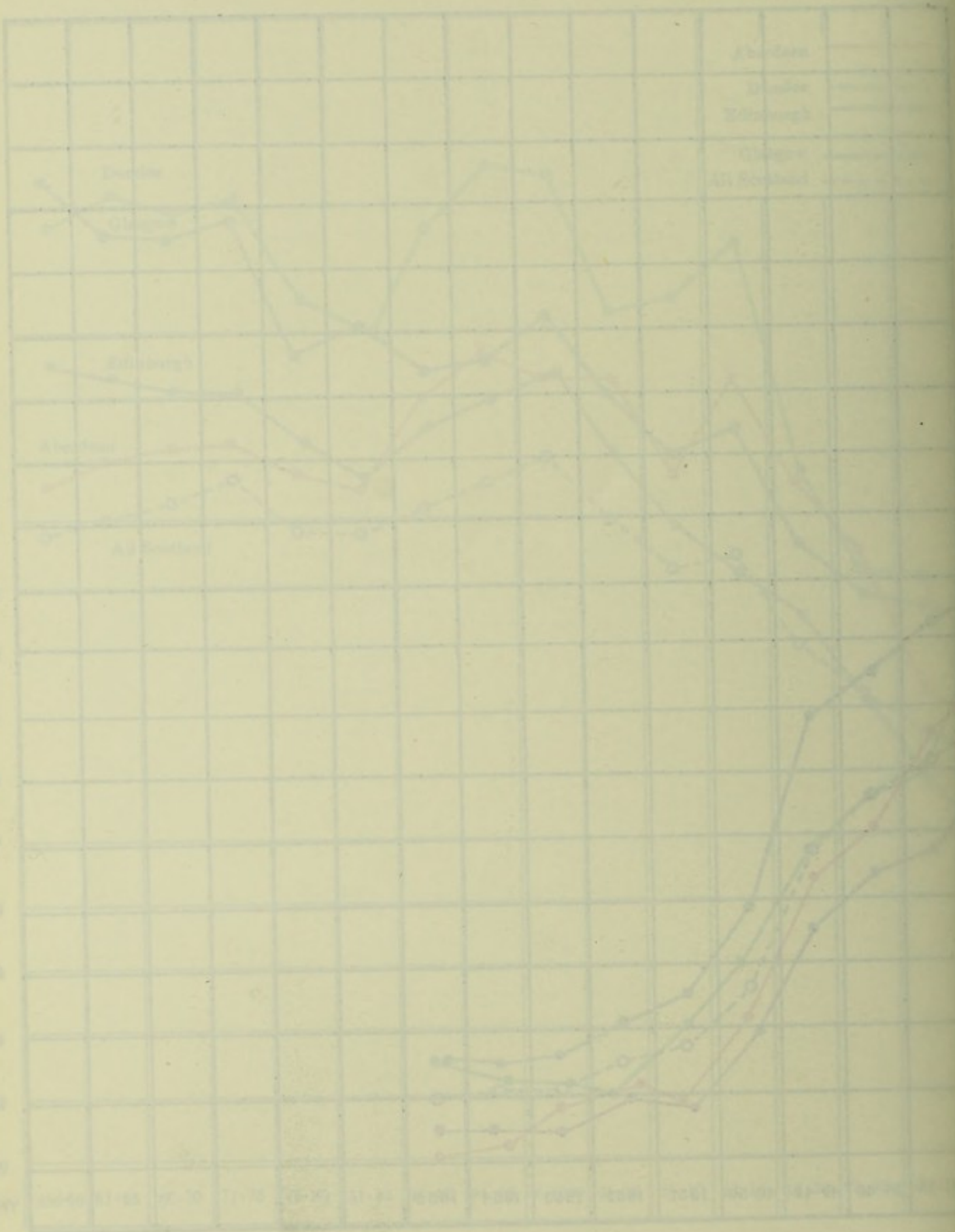
Infant Mortality Rate, 1856-1955



-Quinquennial Averages. 1856-1950.

per 1,000 Births.





INFANT DEATHS.

In 1953, there were 84 deaths of babies under the age of one year, giving a rate of 27 per thousand live births, and no lower rate had ever been recorded in Aberdeen. In 1954, there were 70 baby deaths, giving an infant mortality rate of 22 per thousand live births. In 1955, there were 66 baby deaths, giving an infant mortality rate of 21. A glance at the table on page 10 will reveal that, as recently as eight years ago (1947), the number of baby deaths was 263 and the infant mortality rate was 64.

Satisfactory though the present figure may appear, it must be remembered that it still compares unfavourably with some English cities and even more unfavourably with the rates obtaining in such countries as Sweden and New Zealand. In considering the Aberdeen infant mortality rate, however, two environmental points must be kept in mind—

(1) As indicated in the section on background data, Aberdeen and Glasgow have a higher proportion of persons in the lowest social class than have other cities or Scotland as a whole, and Aberdeen has a larger proportion in the two lowest social classes than has Glasgow.

(2) As indicated in the paragraph on housing, Aberdeen—despite its vigorous housing programme—compares unfavourably with other cities.

Comparison with National Figures and with other Cities.—The average rates for all England and Wales and all Scotland, as well as for the four principal cities, are given below for the last four years—

	Infant Death Rates.			
	1955	1954	1953.	1952.
England and Wales .	25	26	27	28
Scotland . . .	30	31	31	35
Glasgow . . .	36	35	36	41
Edinburgh . . .	25	25	24	29
Dundee . . .	36	33	32	31
Aberdeen . . .	**21**	**22**	**27**	**30**

The accompanying coloured chart shows the infant mortality rate in Scottish cities and in Scotland as a whole since 1856, and a table (inserted after the subsection on mortality in pre-school children) shows the actual number of deaths in Aberdeen in various years.

Causes of Infant Deaths.—Table I, at the end of this section of the Report, gives details of the causes of death and the age at which each child died. An

analysis of the infant deaths that have occurred during the last four years reveals that the death rates from various causes were as follows:

	Infant Death Rates, per 1,000 Live Births.			
	1955.	1954.	1953.	1952.
Congenital malformations	3	3	4	5
Atelectasis	3·4	7	8	8
Birth injuries	0·3	1	2	1·3
Diarrhœa and enteritis	0	0	0·3	0
Pneumonia and bronchitis	4	5	6	6
Common infections	1	0	0	0
Tuberculosis	0	0	0	0
Asphyxia and other accidents	2	0·3	1	1
Immaturity	4	2	3	2·3
Other causes	3	4	3	6
Total	21	22	27	30

Neo-Natal Deaths.—In 1955, the number of deaths of infants under the age of four weeks was 36, as compared with 50 in 1954, and 57 in 1953. The neo-natal death-rate of 11·2 per thousand live births is a new low record. The neo-natal death rates for Scotland and for the four principal cities in 1952-1955 are as follows:—

	Neo-natal Death Rates.			
	1955	1954.	1953.	1952.
Scotland	20	21	19	22
Glasgow	23	21	22	24
Edinburgh	18	19	16	17
Dundee	21	23	20	20
Aberdeen	**11**	**15**	**19**	**18**

Post-Natal Deaths.—In 1955, there were 30 deaths of infants aged four weeks to 12 months, a figure which compares unfavourably with the record low number of 20 in 1954. For further analysis, reference may be made to Table I at the end of this chapter.

MORTALITY IN PRE-SCHOOL PERIOD (1-5 years).

During 1955, 13 children aged 1-5 years died. 1954 is the only year in Aberdeen's history in which the number of deaths in this age-group was less than 13. Details are—

	Number of Deaths in		
	1955.	1954.	1953.
1 - 2 years	4	2	8
2 - 3 years	1	3	4
3 - 4 years	6	2	4
4 - 5 years	2	1	3
	13	8	19

Of the 13 deaths in 1955, 4 were due to accidents (3 on roadway, 1 in shop), 2 to congenital malformations, 2 to respiratory diseases, 1 to whooping-cough, and

4 to miscellaneous causes. There were no deaths from home accidents for the second consecutive year.

The decline of home accidents, which in most recent years has been the commonest cause of death at the age-period 1-5 years, is noteworthy.

DECLINE IN INFANT AND PRE-SCHOOL DEATHS.

In 1904 (when deaths were first allocated by the Registrar-General to the place in which the deceased had lived, instead of simply the place where they died), 733 infants under one year and 367 children aged 1-5 years died in Aberdeen, a total of exactly 1,100 young deaths. In 1955 there were 66 deaths of infants under 1 year and 13 of children aged 1-5 years, a total of 79. In other words, one child died in 1955 for every fourteen who died in 1904.

Some of the main factors in the decline were given in the report for 1954, but may be repeated here—

(1) The gradual development of the disease-preventing and health-promoting services of the Health Department (re-named, since 1948, the Health and Welfare Department). In this connection, it is worthwhile to note that, in the burghs of Scotland at two different periods investigated, a highly significant correlation has been found to exist between the infant death rate and the degree of inadequacy of health visitor staffing.

(2) Increase of health education (which is, of course, a very important facet of the work of a Health Department).

(3) The eradication of various infectious diseases by specific immunisation, contact tracing, isolation of patients, sanitary and hygienic measures, &c.

(4) Improvements in the standard of living and, in particular, better nutrition. This factor may be taken as including both the changes in living standards consequent on increases in the earnings of the lowest paid sections of the community and the changes produced by advice to housewives on wise spending of the money available.

(5) Better housing. We perhaps tend to be so aware of the problem of overcrowding and unsatisfactory housing to-day that we are in danger of forgetting how infinitely worse were circumstances in the past.

(6) Better ante-natal and obstetrical care. This factor may be taken as including both the clinical and the preventive and medico-social aspects.

(7) Development of medical knowledge and provision of better treatment facilities for sick children.

(8) Establishment of the family planning clinic, spread of knowledge of contraceptive techniques, and social recognition of the desirability of the spaced family.

(9) Measures for the reduction of illegitimacy, and measures for the better care of the unmarried mother and her child.

The following table gives the infant death-rate in various years and the actual number of children aged 0-1 year and 1-5 years dying in these years.

Year.	Infant Mortality Rate.	Actual Deaths under 1 year.	Actual Deaths, 1-5 years.	Actual Deaths, 0-5 years.	Year.	Infant Mortality Rate.	Actual Deaths under 1 year.	Actual Deaths, 1-5 years.	Actual Deaths, 0-5 years.
1905	138	678	233	911	1931	90	292	69	361
1906	127	599	273	872	1932	93	296	98	394
1907	125	561	256	817	1933	79	238	94	332
1908	129	577	260	837	1934	77	235	80	315
1909	149	671	277	948	1935	91	286	118	404
1910	111	478	167	645	1936	70	214	77	291
1911	139	563	285	848	1937	72	219	62	281
1912	127	530	232	762	1938	71	215	78	293
1913	152	591	400	991	1939	59	177	38	215
1914	121	487	259	746	1940	86	241	70	311
1915	173	654	405	1,059	1941	77	224	39	263
1916	112	398	182	580	1942	67	194	39	233
1917	139	399	270	669	1943	68	195	34	229
1918	143	390	267	657	1944	57	169	36	205
1919	118	399	159	558	1945	54	152	34	186
1920	121	591	144	735	1946	42	158	25	183
1921	108	460	80	540	1947	64	263	19	282
1922	133	527	284	811	1948	34	121	14	135
1923	104	391	156	547	1949	30	100	23	123
1924	122	421	207	628	1950	29	92	19	111
1925	109	368	143	511	1951	27	82	16	98
1926	96	328	105	433	1952	30	90	13	103
1927	105	334	101	435	1953	27	84	19	103
1928	94	313	142	455	1954	22	70	8	78
1929	95	297	113	410	1955	21	66	13	79
1930	80	265	85	350					

The gross numbers are, of course, a poorer guide than the rates; in a year in which the birth-rate was high (*e.g.*, 1955 or the four consecutive years 1946-1949) the number of baby deaths would—other things being equal—normally be larger than in a year in which the birth-rate was low (*e.g.*, 1951 or 1952). Even the rates are, of course, subject to slight variation from statistical chance; for instance, it would be unreasonable to argue that the health and health services of the City were worse in 1937 (when the infant death rate was 72) than in the previous year (when it was 70); but the general trend is clear enough.

MORTALITY IN SCHOOL PERIOD.

In 1955, there were 13 deaths of children of school age (as compared with 11 in 1954 and 15 in the previous year). The causes were as follows:—accidents on roadway, 4; malignant neoplasms, 3; diseases of nervous system, 3; and miscellaneous causes, 3. It is interesting to notice the decline in infectious diseases (the commonest cause of death in the past) and home accidents (which, in recent years, have tended to become the most numerous cause).

MARRIAGES.

During 1955, there were 1,980 marriages within the City. This is equivalent to a rate of 10·6 per thousand of the population. The rates in previous years were—1954, 10·2; 1953, 10·4; 1952, 10·5; 1951, 10·0; 1950, 9·9; and 1949, 9·7.

MATERNAL MORTALITY.

In Aberdeen, during 1955, there was 1 death from causes related to pregnancy and childbirth. In 1954 there were 2 deaths, and in 1953 there were 7 deaths, including 2 in which the death was ascribed to puerperal sepsis. When deaths are down to small numbers, it is probably wiser to study the average figures for a series of years, as in the last line of the table below, which gives a comparison between Aberdeen and all Scotland in recent years:—

Rates per 1,000 live and still births

Year	Maternal Mortality		Puerperal Sepsis		Other Puerperal Conditions	
	Scotland	Aberdeen	Scotland	Aberdeen	Scotland	Aberdeen
1955	**0·45**	**0·3**	**0·12**	**0·0**	**0·33**	**0·3**
1954	0·7	0·6	0·16	0·0	0·58	0·6
1953	0·9	2·2	0·2	0·6	0·7	1·6
1952	1·0	0·6	0·2	0·0	0·8	0·6
1951	1·1	1·3	0·3	0·3	0·8	1·0
Average 1951-1955	1·0	1·0	0·2	0·2	0·8	0·8

DEATHS.

The total number of deaths, the death rate per 1,000 of population, and the average age at death for each of the years 1949-1955 are given in the following table:—

Year.	Number.	Rate per 1,000 of Population.	Average age at Death.
1955	2,135 ...	11·5 ...	66·7
1954	2,056 ...	11·1 ...	66·3
1953	2,091 ...	11·3 ...	65·1
1952	2,148 ...	11·7 ...	64·6
1951	2,181 ...	11·9 ...	65·7
1950	2,266 ...	12·1 ...	64·9
1949	2,213 ...	11·7 ...	64·1

For all Scotland, the death rate was 12·0 in 1955, 12·0 in 1954, 11·5 in 1953, and 12·0 in 1952.

AGE AT DEATH.

The average age at death of all persons dying during 1955 was 66·7 years, as compared with 66·3 in 1954, 65·1 in 1953, and 64·6 in 1952. (1954 was the first year in which the average age at death reached 66.) It is interesting to note that, in the quinquennium 1891-95, the average age at death was 32·9 years, and that, as recently as eleven years ago (1944), it was 58·4 years.

Of the 2,135 deaths, 190 (or 9 per cent.) occurred in persons below the age of 45 years. This compares with a figure of 193 (or also 9 per cent.) in 1954, 233 (or

11 per cent.) in 1953, and 267 (or 12 per cent.) in 1952. An analysis of these 190 young deaths by cause is as follows:—

Malformations and diseases of early infancy	41
Violence	35
Malignant neoplasms	28
Disease of the circulatory system	26
Pneumonia and bronchitis	16
Diseases of nervous system	9
Diseases of digestive system	9
Tuberculosis	5
Genito-urinary	3
Infectious diseases—whooping cough, 4; measles, 1	5
Puerperium	1
Miscellaneous	12

The gradual reduction in the number of deaths from infections and violence in this age-group is particularly noteworthy. It is, however, well worth while to look carefully at this list of deaths in the first 45 years in order to ask the question—in respect of the main causes, are we as yet doing all that we can to prevent them?

537 (or 25 per cent.) of all deaths occurred in the age-period 45-64 years, so that a total of 727 fatalities (or 34 per cent.) occurred before the age of 65 years. 574 deaths (or 27 per cent.) occurred in the age-period 65-74 years, and 834 (or 39 per cent.) occurred at ages of 75 and over. The percentage of all deaths occurring at ages of 75 and over were—39 in 1955, 39 in 1954, 38 in 1953, and 37 in 1952.

Causes of Death.—Table II at the end of this section gives full details of the causes of death operating in each age-group, and the diagram below shows some of the more important causes. It is interesting to note that 77 per cent. of all deaths fall under three headings—diseases of circulatory system, diseases of nervous system, and malignant diseases. The comparable figures for 1954 and 1953 were 75 and 72, per cent. respectively.

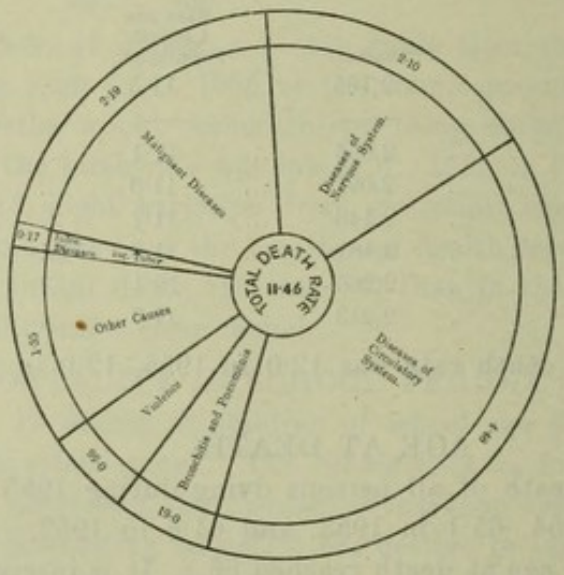


Table III gives for a number of successive years the death-rates at all ages from selected causes, and Table IV gives, in summary form, details of population, marriages, births, deaths, average age at death, and infant deaths for a number of years and for quinquennial averages.

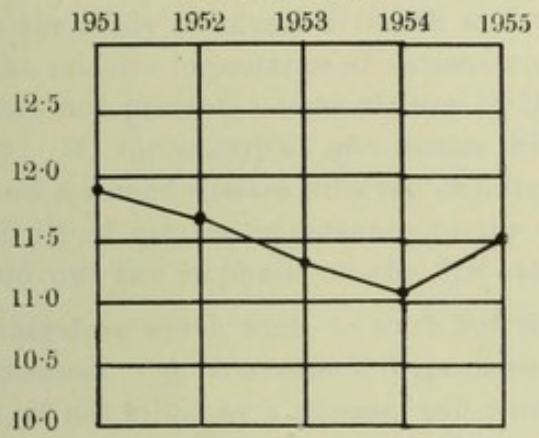
A diagram illustrates the trends of mortality from various causes in recent years.

CITY OF ABERDEEN.

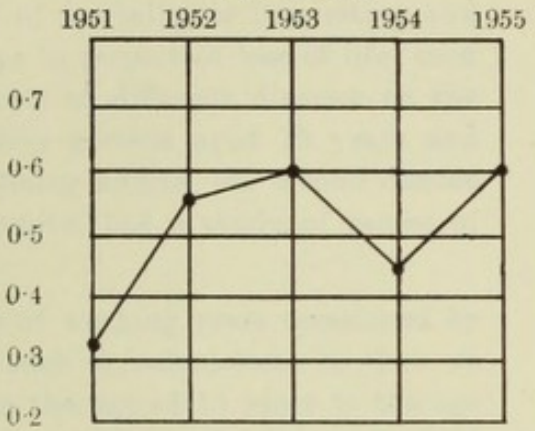
TRENDS OF MORTALITY, 1951-55.

DEATHS PER 1,000 POPULATION.

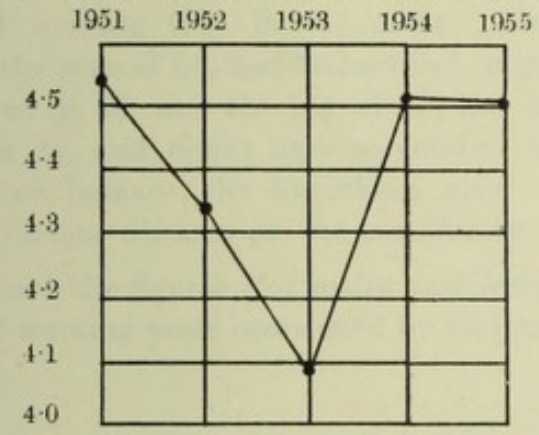
ALL CAUSES.



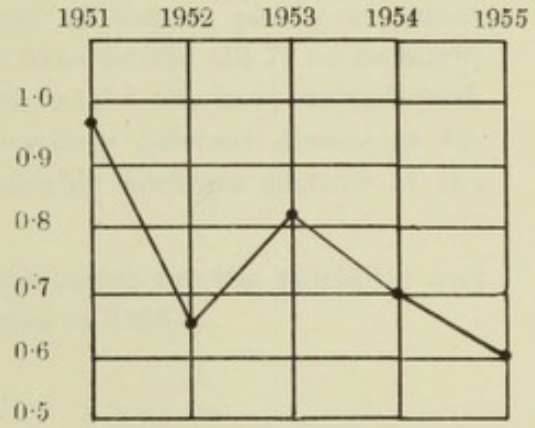
VIOLENCE.



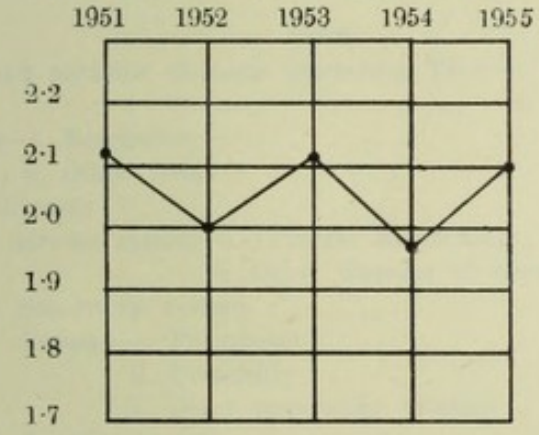
DISEASES OF CIRCULATORY SYSTEM.



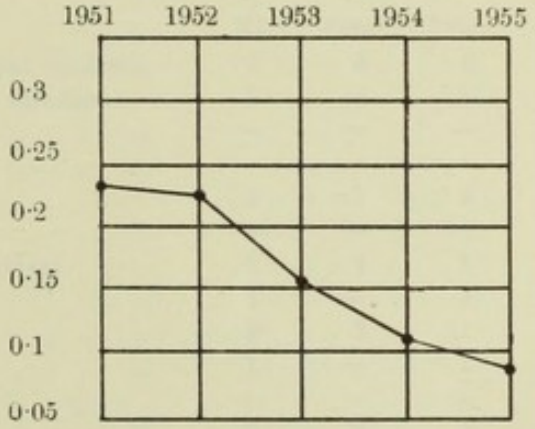
PNEUMONIA AND BRONCHITIS.



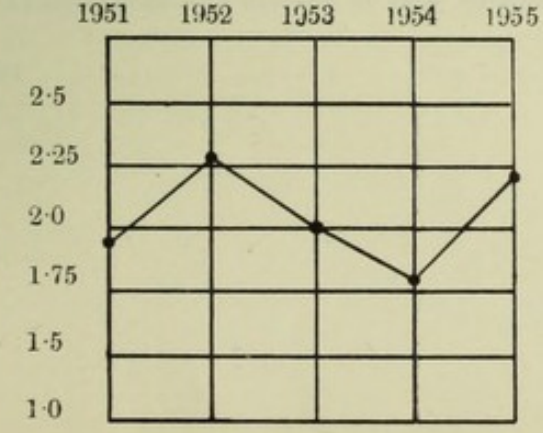
DISEASES OF NERVOUS SYSTEM.



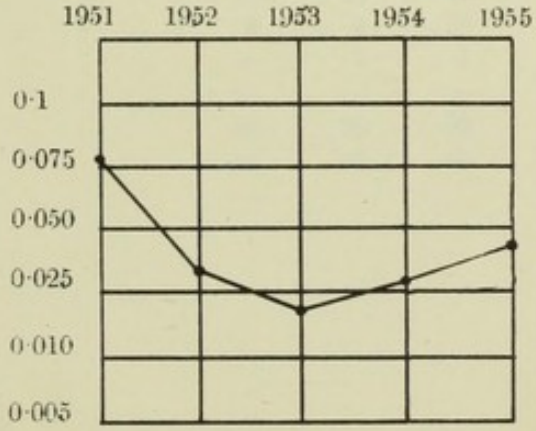
ALL TUBERCULOSIS.

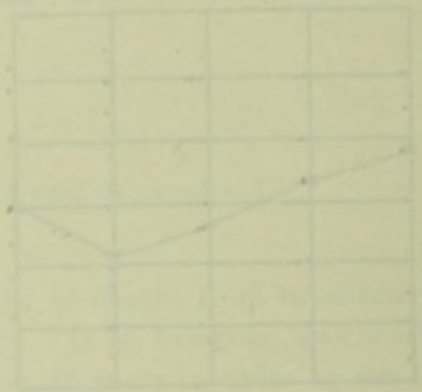


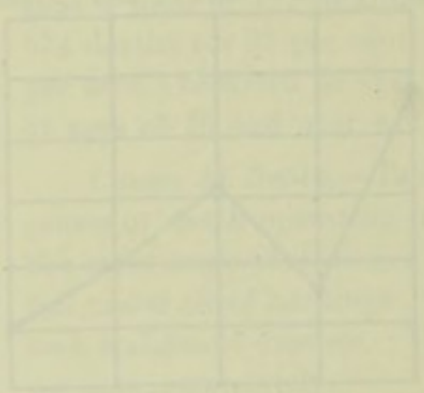
MALIGNANT DISEASES.

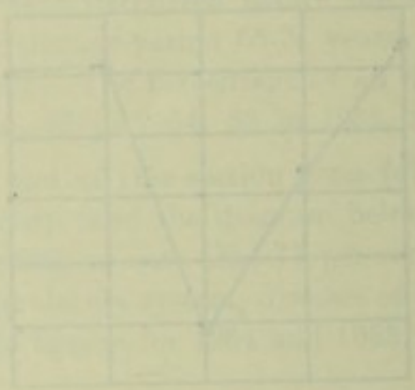


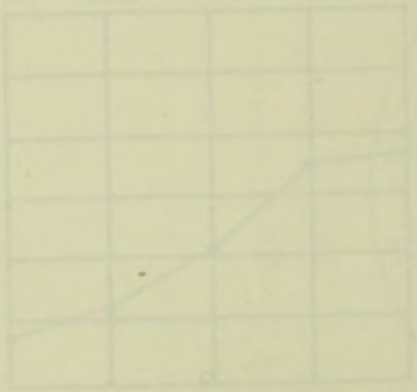
PRINCIPAL EPIDEMIC DISEASES.

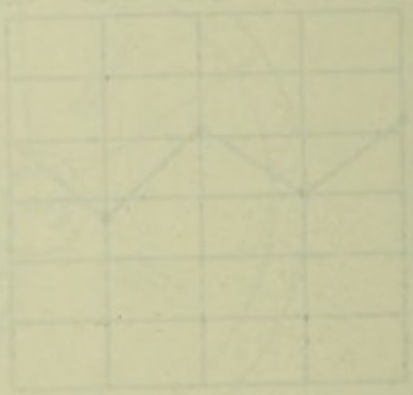


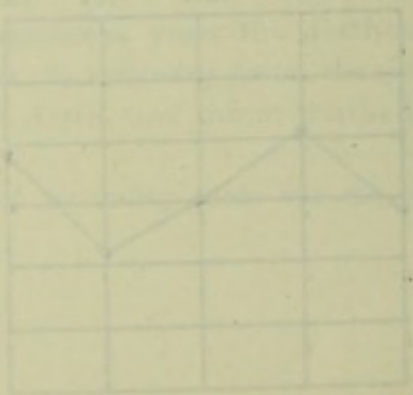












LOSS OF WORKING YEARS BY DEATH.

While the study of causes of death and trends of mortality is interesting and indicates the relative importance of various conditions in respect of loss of life, such a study does not present a true picture of the effects of different diseases on the community. If, for example, one disease kills thirty persons aged 75 years and upwards and a second disease kills ten children or young adults, the second disease is undoubtedly of greater importance to the community, but a study of causes of death would put the emphasis on the first disease.

It is therefore worth while to work out the loss of working years occasioned by different diseases. A convenient hypothesis for such a calculation is that an individual, if not killed by a disease, will work from the age of 15 years to the age of 65 years; so that, for example, if pneumonia causes the death of a man of 61 and a boy of 10 years, the loss of working life is 4 years in the one case and 50 years (an entire working life) in the other. There are, of course, plenty of minor fallacies: the man of 61, had he survived, might not have retired till 72 or he might have retired at 62; and the boy of 10, had he lived, might not have started work till he was 24, and might have succumbed to an entirely different disease at 40. However, on balance, the hypothesis gives a reasonably accurate picture of the effects of various diseases on the community.

Here are the figures (for males and females separately) for the mortality and the loss of working years occasioned by various diseases in 1955—

I.—Mortality of Persons under 15 from Various Causes.

Cause.	Male.	Female.	Total.
Infectious and parasitic diseases (excluding TB.)—i. Principal epidemic	2	3	5
ii. Other infections	1	—	1
Tuberculosis—i. Respiratory	—	—	—
ii. Other forms	—	—	—
Malignant diseases	3	1	4
Diseases of nervous system—i. Cerebral hæmorrhage, &c.	—	—	—
ii. Other diseases of nervous system	2	4	6
Diseases of circulatory system	1	—	1
Respiratory diseases—i. Pneumonia	9	2	11
ii. Bronchitis	1	—	1
iii. Other respiratory diseases	—	—	—
Diseases of digestive system	3	2	5
Diseases of genito-urinary system	—	1	1
Congenital malformations and diseases of early childhood	28	13	41
Violence	6	9	15
Miscellaneous	—	1	1
	—	—	—
	56	36	92
	=	=	=

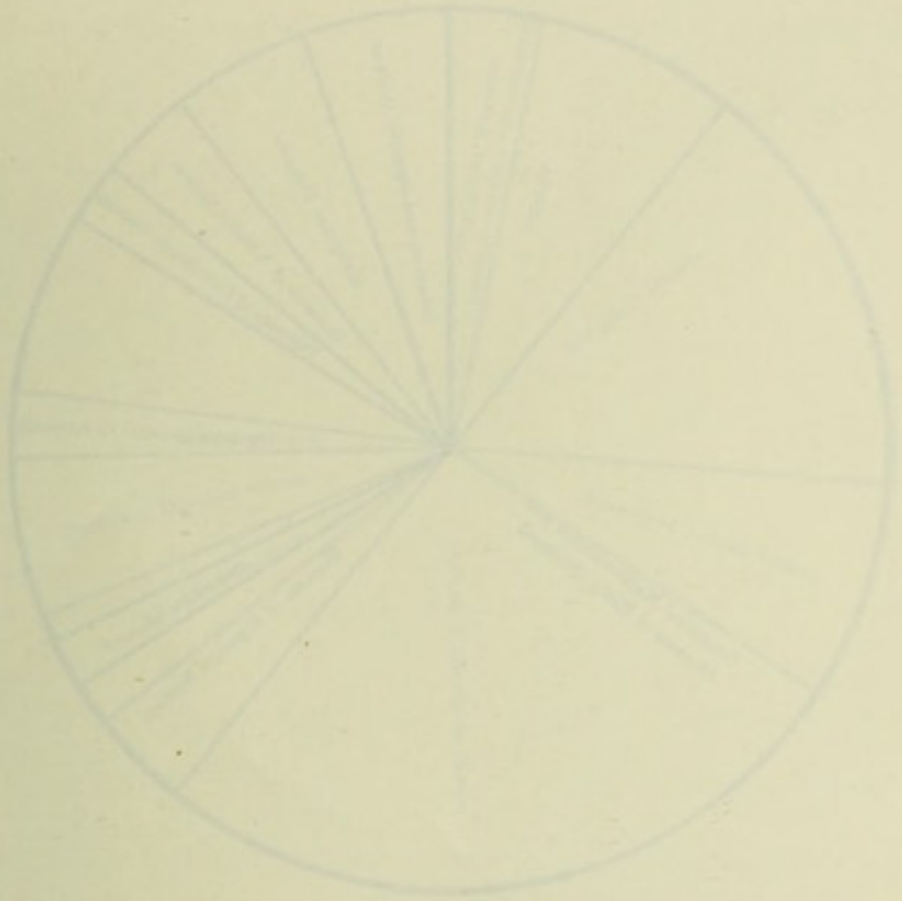
II.—Approximate Years of Working Life lost by Deaths of Persons under 15.

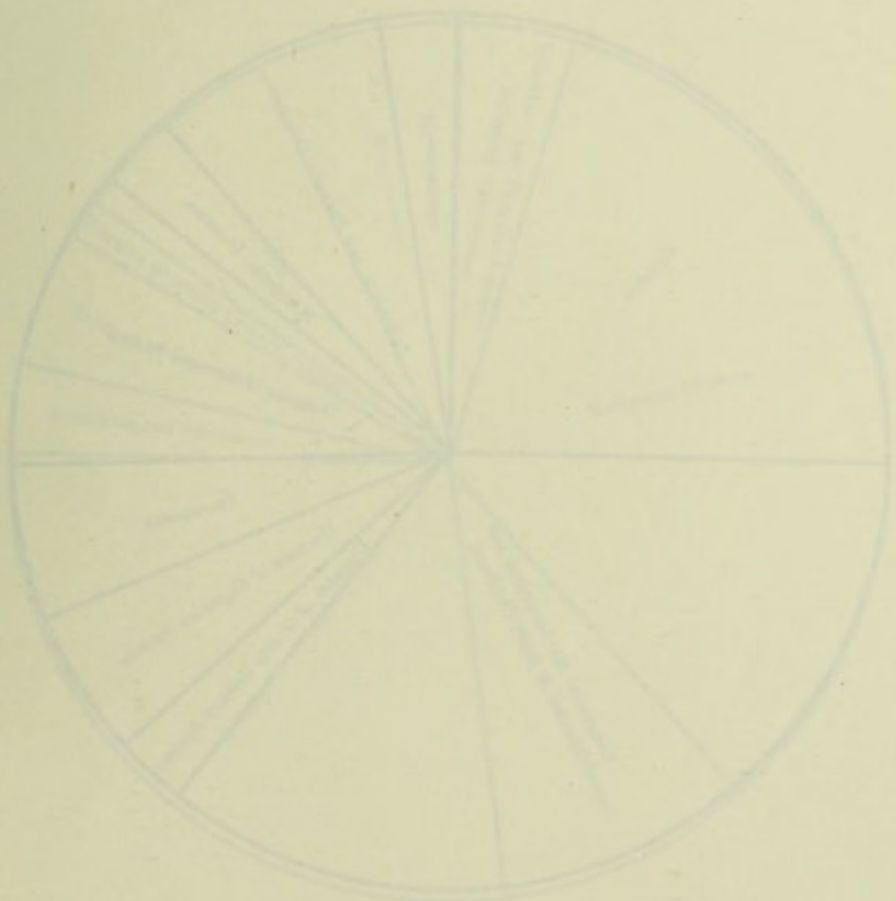
The working life is taken as from 15 to 65 years of age, *i.e.*, of 50 years' duration.

Cause.	Working Years lost. Male.	Female.	Total.
Infectious and parasitic diseases (excluding TB.)—i. Principal epidemic	100	150	250
ii. Other infections	50	—	50
Tuberculosis—i. Respiratory	—	—	—
ii. Other forms	—	—	—
Malignant diseases	150	50	200
Diseases of nervous system—i. Cerebral hæmorrhage, &c.	—	—	—
ii. Other diseases of nervous system	100	200	300
Diseases of circulatory system	50	—	50
Respiratory diseases—i. Pneumonia	450	100	550
ii. Bronchitis	50	—	50
iii. Other respiratory diseases	—	—	—
Diseases of digestive system	150	100	250
Diseases of genito-urinary system	—	50	50
Congenital malformations and diseases of early childhood	1,400	650	2,050
Violence	300	450	750
Miscellaneous	—	50	50
	2,800	1,800	4,600

III.—Mortality of Working Age-Groups from Various Causes.

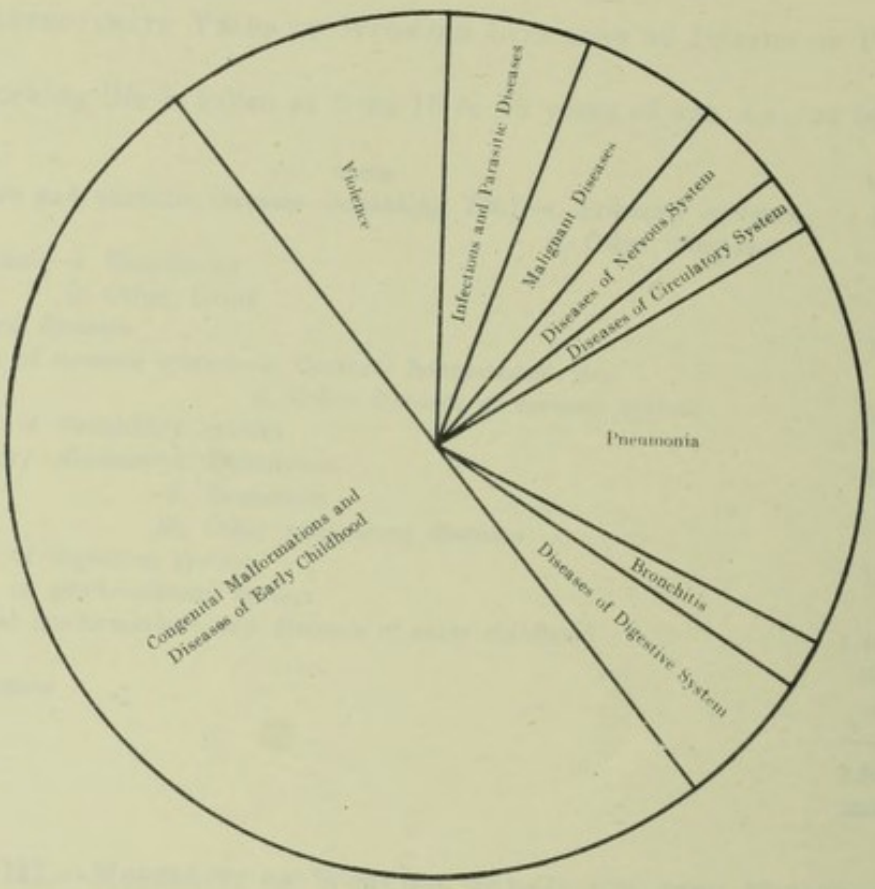
Cause.	Age-Groups. 15-24. M.	F.	25-34. M.	F.	35-44. M.	F.	45-54. M.	F.	55-64. M.	F.
Infectious and parasitic diseases (excluding TB.)										
i. Principal epidemic	—	—	—	—	—	—	—	—	1	—
ii. Other infections	—	—	—	—	—	1	—	1	—	—
Tuberculosis—i. Respiratory	—	—	1	2	1	1	4	—	1	1
ii. Other forms	—	—	—	—	—	—	1	—	1	—
Malignant diseases	—	4	2	3	7	8	23	26	68	45
Diseases of nervous system—										
i. Cerebral hæmorrhage, &c.	—	—	—	—	—	1	7	6	26	21
ii. Other diseases of nervous system	1	—	—	1	—	—	1	3	3	—
Diseases of circulatory system	—	1	3	4	12	5	31	22	71	53
Respiratory diseases—										
i. Pneumonia	—	1	—	—	—	1	2	1	3	1
ii. Bronchitis	—	—	—	—	2	—	1	—	15	3
iii. Other respiratory diseases	—	—	—	—	1	1	—	1	1	1
Diseases of digestive system	—	1	—	1	1	1	8	3	18	5
Diseases of genito-urinary system	—	—	1	—	1	—	2	3	3	1
Diseases of pregnancy and childbirth (excluding puerperal sepsis)	—	—	—	1	—	—	—	—	—	—
Violence	3	1	8	2	6	—	7	7	10	6
Miscellaneous	—	—	2	1	2	2	3	3	5	8
	4	8	17	15	33	21	90	76	226	145
	12		32		54		166		371	



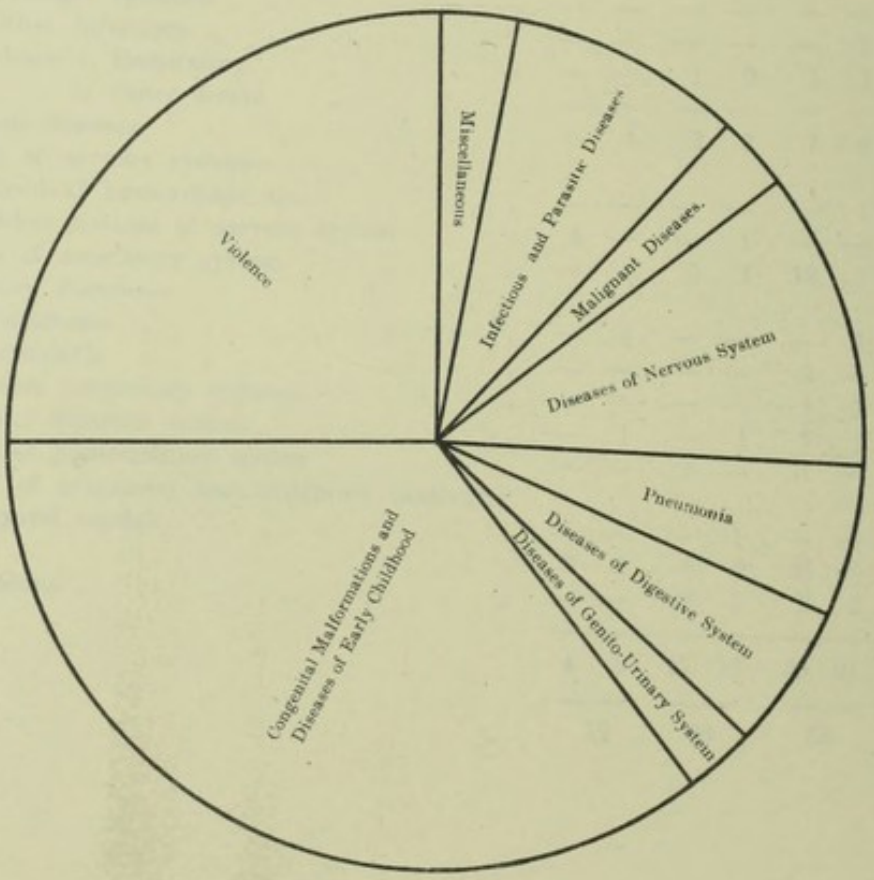


Working Years Lost by Mortality from Various Causes.

MALES—0-15 YEARS.

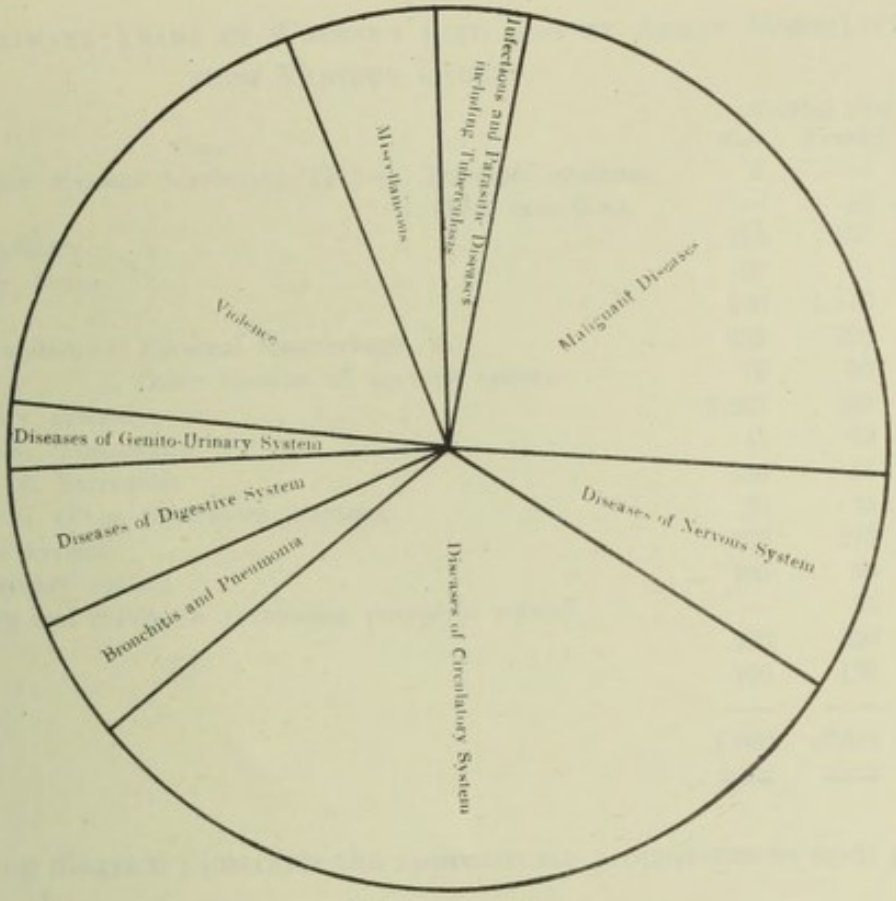


FEMALES—0-15 YEARS.

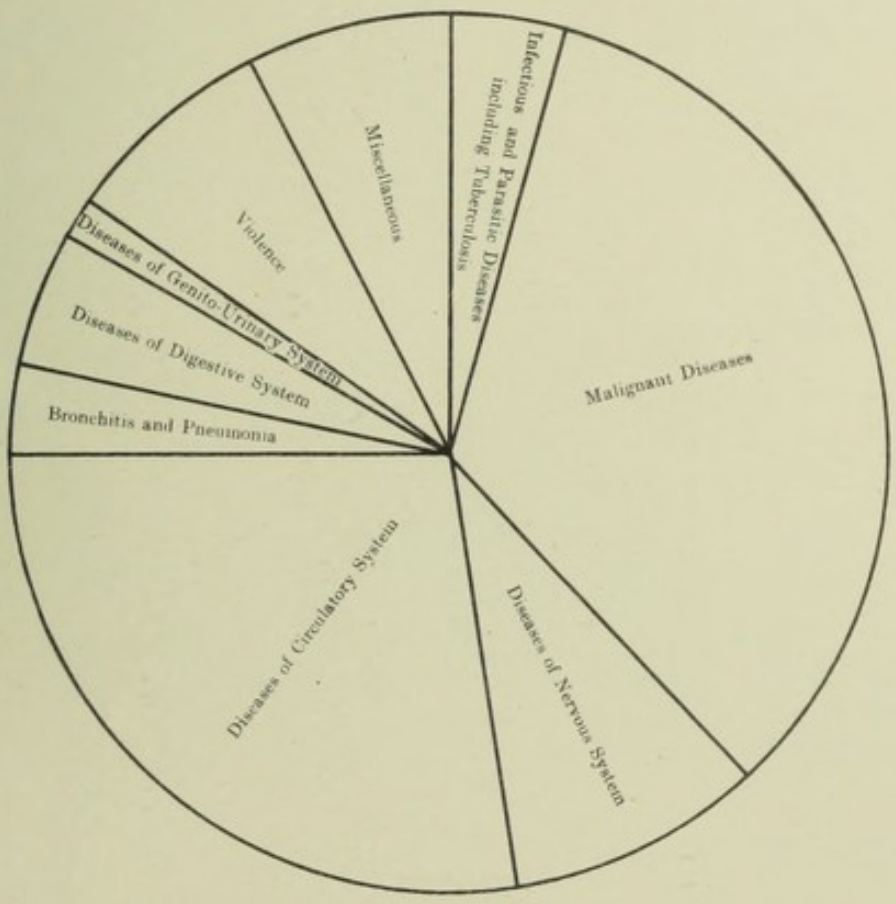


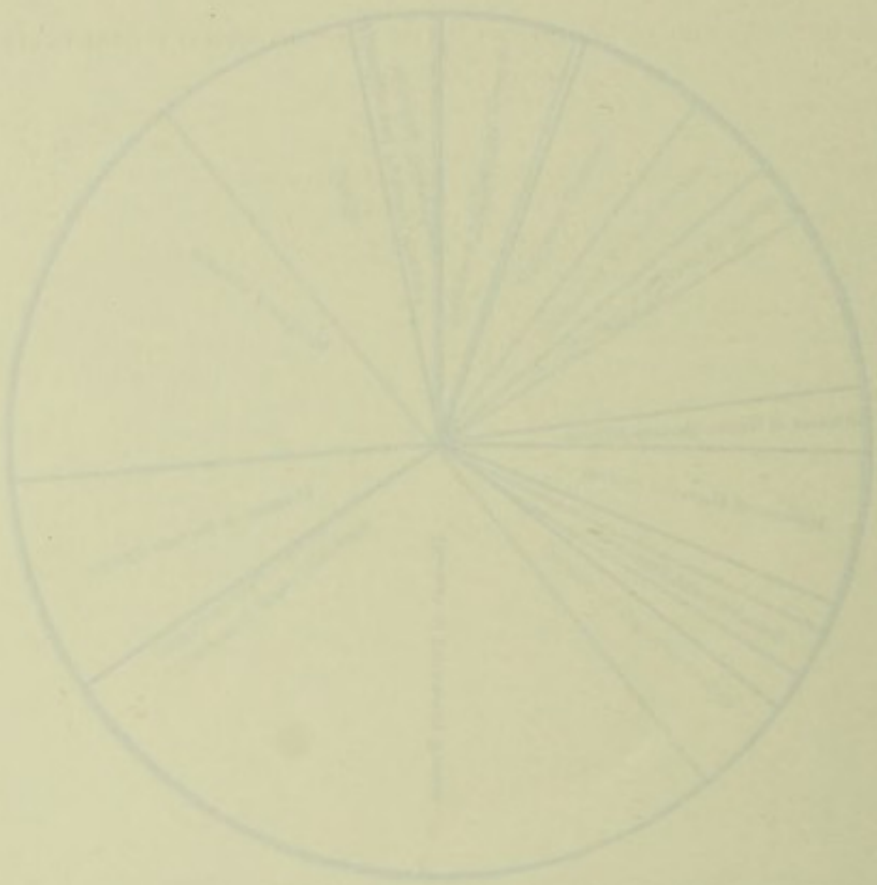
WORKING YEARS LOST BY MORTALITY FROM VARIOUS CAUSES.

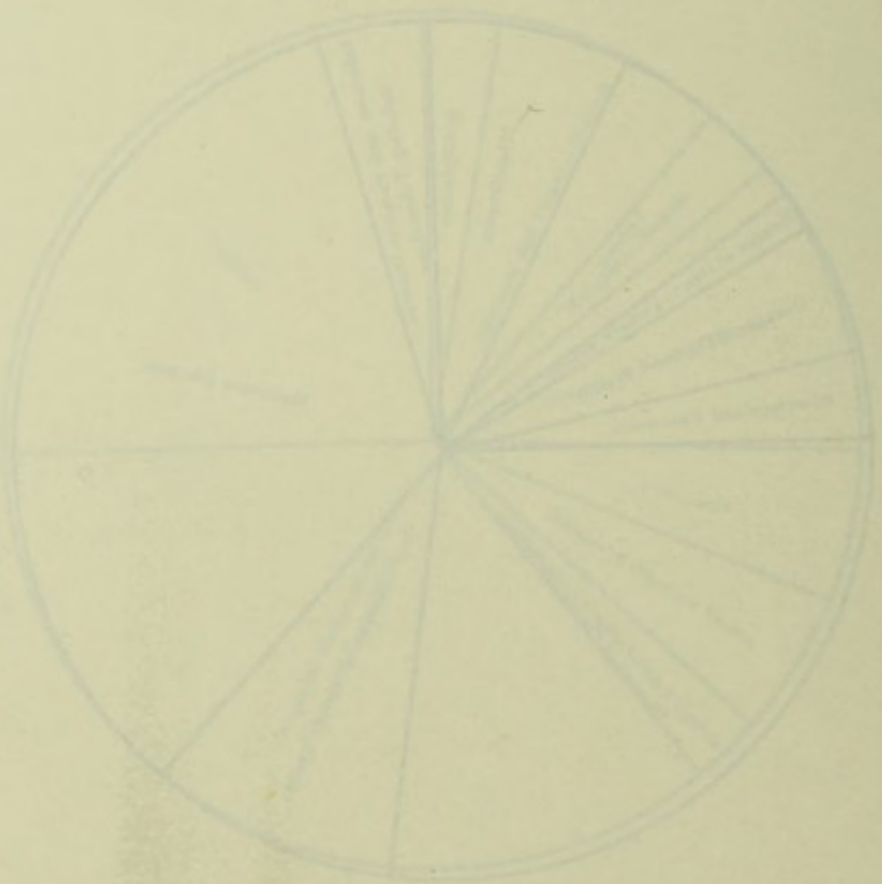
MALES—16 + YEARS.



FEMALES—16 + YEARS.







IV.—Approximate Years of Working Life lost by Adult Mortality from Various Causes.

Cause.	Working Years lost. Male.	Female.	Total.
Infectious and parasitic diseases (excluding TB.)—i. Principal epidemic	5	—	5
ii. Other infections	—	40	40
Tuberculosis—i. Respiratory	125	100	225
ii. Other forms	20	—	20
Malignant diseases	930	1,100	2,030
Diseases of nervous system—i. Cerebral hæmorrhage, &c.	235	220	455
ii. Other diseases of nervous system	75	80	155
Diseases of circulatory system	1,225	905	2,355
Respiratory diseases—i. Pneumonia	45	90	135
ii. Bronchitis	140	15	155
iii. Other respiratory diseases	30	45	75
Diseases of digestive system	235	175	410
Diseases of genito-urinary system	105	50	155
Diseases of pregnancy and childbirth (excluding puerperal sepsis)	—	35	35
Violence	720	250	970
Miscellaneous	190	170	360
	4,080	3,275	7,355

The accompanying diagram illustrates the approximate proportions in each group.

Table I.—Causes of Death among Children under Five Years of Age. Year 1955.

CAUSES OF DEATH	AGE																	Average for preceding 5 years (1950-54)	
	FIRST YEAR											SECOND TO FIFTH YEARS						
	First Four Weeks				First Three Months			The Four Quarters											
	0—1	—2	—3	—4	0—1	—2	—3	I*	II	III	IV	Total	—2	—3	—4	—5	Total	0—1	1—5
Tuberculosis { Respiratory	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	0·2
Tuberculosis { Other Forms	...	...	...	...	...	...	...	...	...	...	...	..	...	...	...	...	...	..	2
Diphtheria	..	..	..	..	...	...	...	...	...	..	..	...	....	...	...	...	...	...	0·2
Dysentery	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
Measles	..	...	...	..	...	...	...	...	...	1	...	1	...	...	..	...	...	0·2	...
Meningococcal Infections	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	1
Poliomyelitis, Acute	...	...	...	...	...	...	...	...	..	...	...	...	...	..	...	...	...	...	..
Scarlet Fever	...	...	...	...	..	...	...	...	...	...	...	...	...	...	..	...	..	...	...
Whooping Cough	..	...	...	...	..	...	1	1	1	...	1	3	...	...	...	1	1	0·6	1
Other Infective and Parasitic Diseases	...	...	...	...	...	...	1	1	...	...	...	1	...	...	...	...	...	1	1
Pneumonia	..	...	..	...	...	2	2	4	...	5	1	10	1	...	...	...	1	13	0·6
Bronchitis	...	...	...	...	...	...	...	...	..	...	...	...	1	...	...	...	1	1	0·2
Diarrhœa and Enteritis	...	...	...	..	...	...	..	...	...	...	...	...	...	...	...	...	...	0·6	0·4
Other Digestive Diseases	1	...	1	...	2	...	...	2	1	...	1	4	...	...	...	1	1	1	1
Congenital Malformations	5	...	...	...	5	1	...	6	1	...	2	9	..	1	1	...	2	12	1
Injury at Birth	1	...	...	..	1	...	...	1	...	...	...	1	...	...	...	...	..	5	...
Post-natal Asphyxia and Atelectasis	10	...	1	...	11	...	...	11	...	...	...	11	...	..	...	...	...	20	...
Pneumonia of New Born	3	...	...	...	3	...	...	3	...	...	...	3	...	..	...	..	...	4	...
Other Infections of New Born	...	...	...	...	...	..	...	..	..	...	...	...	...	...	...	..	...	0·6	...
Other Diseases peculiar to Early Infancy	2	...	...	...	2	...	...	2	...	...	...	2	...	...	...	.	...	4	...
Immaturity	10	1	...	...	11	1	...	12	...	...	...	12	...	...	..	...	..	12	...
Accidents or other Violence	...	...	1	...	1	3	...	4	1	2	...	7	...	...	4	...	4	4	4
Other Causes	...	...	...	..	...	...	1	1	1	..	...	2	2	...	1	...	3	4	3
All Causes	32	1	3	...	36	7	5	48	5	8	5	66	4	1	6	2	13	83	15
Average for preceding 5 years, 1950-1954	47	3	2	2	54	6	5	66	9	5	3	83	5	4	3	3	15	...	...

* This column includes all deaths in preceding columns.

Table II.—Aberdeen.—Mortality at Various Age Periods from Various Causes.

(Corrected for transferred deaths.)

Age.	All Causes.	Infectious and Parasitic Diseases (excl. Tuberculosis).		Tuberculous Diseases.		Malignant Diseases.	Dis. of Nervous Syst. and Sense Organs.		Dis. of Circulatory System.	Respiratory Diseases.			Dis. of Digest. System (incl. Diarrhœa and Enteritis).	Dis. of Genito-Urinary System.	Dis. of Pregnancy and Child-birth.		Malforms under 1 year and Diseases of Early Infancy.	Senility.	Violence.	Miscellaneous.
		Principal Epidemic.	Other Infections.	Respiratory.	Other Tuberculous.		Cereb. Hæm., etc.	Other Nervous.		Pneumonia.	Bronchitis.	Other Respiratory.			Puerperal Sepsis.	Other Diseases.				
A.—Number of Deaths—Year 1955.																				
Under 1 year . . .	66	4	1	—	—	—	—	1	—	10	—	—	4	—	—	—	38	—	7	1
1-4 years . . .	13	1	—	—	—	1	—	2	—	1	1	—	1	—	—	—	—	—	4	2
5-14 ,, . . .	13	—	—	—	—	3	—	3	1	—	—	—	—	1	—	—	—	—	4	1
15-24 ,, . . .	12	—	—	—	—	4	—	1	1	1	—	—	1	—	—	—	—	—	4	—
25-34 ,, . . .	32	—	—	3	—	5	—	1	7	—	—	—	1	1	—	1	—	—	10	3
35-44 ,, . . .	54	—	1	2	—	15	1	—	17	1	2	2	2	1	—	—	—	—	6	4
45-54 ,, . . .	166	—	1	4	1	49	13	4	53	3	1	1	11	5	—	—	—	—	14	6
55-64 ,, . . .	371	1	—	2	1	113	47	3	124	4	18	2	23	4	—	—	—	—	16	13
65-74 ,, . . .	574	1	3	2	—	132	116	6	228	9	14	2	29	5	—	—	—	—	8	19
75+ ,, . . .	834	—	2	2	—	86	190	4	404	37	13	2	15	18	—	—	—	9	31	21
All Ages . . .	2135	7	8	15	2	408	367	25	835	66	49	9	87	35	—	1	38	9	104	70
B.—Death-Rate per 100,000.																				
1955	1146	4	4	8	1	219	197	13	448	35	26	5	47	19	—	0·5	20	5	56	38

TABLE III.—ABERDEEN.—DEATHS AT ALL AGES FROM SELECTED CAUSES. (per 100,000 of population).—*Years* 1856-1955.*

Year.	Smallpox.	Scarlet Fever.	Diphtheria and Croup.	Measles.	Whooping Cough.	Influenza.	Typhus Fever.	Typhoid and Paratyphoid Fever.	Tuberc. Dis. Respiratory.	Tuberc. Dis. Other Tuberculosis.	Dis. of Digestive System (inc. Diarrhœa).	Cancer and other Malignant Diseases.	Bronchitis.	Pneumonia.	Diseases of the Circulatory System.
1955 . . .	**0**	**0**	**0**	**1**	**2**	**1**	**0**	**0**	**8**	**1**	**47**	**219**	**26**	**35**	**448**
1954 . . .	0	0	0	0	0	2	0	0	10	2	37	180	27	43	451
1953 . . .	0	0	0	0	0	2	0	0	14	2	42	200	26	56	407
1952 . . .	0	0	0	0	0	3	0	0	20	2	40	228	31	34	434
1951 . . .	0	0	1	1	2	5	0	0	20	3	44	195	38	58	454
†**1950** . . .	0	0	0	1	0	7	0	0	20	3	44	208	45	56	434
Mean of **1950-54** .	**0**	**0**	**0·2**	**0·4**	**0·4**	**4**	**0**	**0**	**17**	**2**	**41**	**202**	**33**	**49**	**436**
1949 . . .	0	0	0	1	0	5	0	0	32	3	44	182	43	58	414
1948 . . .	0	1	0	1	1	2	0	0	33	4	58	169	23	45	361
1947 . . .	0	0	0	2	3	1	0	1	35	6	90	177	38	59	402
1946 . . .	0	0	0	0	2	5	0	0	40	7	65	175	36	52	390
1945 . . .	0	0	6	2	2	4	0	0	43	9	64	177	35	44	383
Mean of **1945-49** .	**0**	**0·2**	**1**	**1**	**2**	**3**	**0**	**0·2**	**36**	**6**	**64**	**176**	**35**	**52**	**390**
Mean of **1941-45** .	**0**	**0·4**	**6**	**1**	**3**	**9**	**0**	**0·2**	**46**	**16**	**69**	**178**	**42**	**52**	**377**
,, ,, **1936-40** .	**0**	**1**	**11**	**4**	**7**	**15**	**0**	**1**	**41**	**11**	**69**	**160**	**50**	**73**	**331**
,, ,, **1931-35** .	**0**	**5**	**9**	**9**	**12**	**18**	**0**	**1**	**52**	**17**	**70**	**159**	**60**	**102**	**276**
,, ,, **1926-30** .	**0·2**	**2**	**10**	**11**	**11**	**21**	**0**	**0·2**	**62**	**30**	**78**	**145**	**61**	**100**	**240**
,, ,, **1921-25** .	**0**	**5**	**11**	**33**	**29**	**27**	**0**	**1**	**88**	**31**	**80**	**140**	**80**	**92**	**195**
,, ,, **1916-20** .	**0**	**6**	**16**	**22**	**23**	**73**	**0**	**3**	**106**	**43**	**87**	**121**	**99**	**122**	**178**
,, ,, **1911-15** .	**0·2**	**38**	**42**	**56**	**32**	**16**	**0**	**4**	**111**	**49**	**124**	**116**	**101**	**128**	**184**
,, ,, **1906-10** .	**0**	**6**	**15**	**26**	**42**	**20**	**0**	**2**	**116**	**61**	**115**	**103**	**105**	**116**	**180**
,, ,, **1901-05** .	**0·1**	**8**	**9**	**41**	**47**	**20**	**3**	**4**	**138**	**69**	**162**	**87**	**145**	**125**	**179**
,, ,, **1896-1900** .	**0**	**23**	**18**	**35**	**53**	**29**	**0**	**9**	**167**	**70**	**210**	**87**	**172**	**109**	**167**
,, ,, **1891-95** .	**0·4**	**21**	**22**	**63**	**52**	**56**	**1**	**10**	**181**	**72**	**190**	**81**	**210**	**100**	**156**
,, ,, **1886-90** .	**1**	**14**	**10**	**80**	**66**	**9**	**1**	**15**	**184**	**67**	**202**	**68**	**216**	**100**	**175**
,, ,, **1881-85** .	**0·2**	**13**	**15**	**36**	**67**	**1**	**6**	**13**	**204**	**74**	**185**	**69**	**251**	**82**	**159**
,, ,, **1876-80** .	**1**	**35**	**30**	**28**	**66**	**2**	**19**	**29**	**223**	**101**	**194**	**61**	**286**	**72**	**146**
,, ,, **1871-75** .	**48**	**68**	**30**	**53**	**68**	**5**	**20**	**35**	**243**	**107**	**214**	**56**	**281**	**60**	**136**
,, ,, **1866-70** .	**4**	**71**	**35**	**50**	**62**	**8**	**62**	**49**	**298**	**130**	**259**	**59**	**238**	**70**	**122**
,, ,, **1861-65** .	**36**	**93**	**49**	**51**	**62**	**12**	**176**		**274**	**128**	**280**	**57**	**220**	**59**	**122**
,, ,, **1856-60** .	**40**	**118**	**54**	**70**	**69**	**12**	**109**		**322**	**179**	**203**	**56**	**182**	**58**	**111**

*Corrected for transferred deaths in 1904 and subsequent years.

†From 1950 Causes of Death classified in accordance with Sixth Revision of International List of Causes of Death.

TABLE IV.—ABERDEEN—MARRIAGE, BIRTH, AND DEATH RATE—1856 TO 1955.
Per 1,000 of population.

Year	Population†	Marriages		Live Births *			Deaths *			Excess of Births over Deaths	Infantile Mortality
		Number	Rate per 1,000 of Population	Number	Rate per 1,000 of Population	Illegit Births per 100 Total Births	Number	Rate per 1,000 of Population	Average Age at Death		Deaths of Infants under 1 year per 1,000 Births
1955	**186,352**	**1,980**	**10·6**	**3,204**	**17·2**	**5·4**	**2,135**	**11·5**	**66·7**	**1,069**	**21**
1954	185,725	1,894	10·2	3,228	17·4	4·3	2,056	11·1	66·3	1,172	22
1953	185,232	1,928	10·4	3,077	16·6	4·5	2,091	11·3	65·1	986	27
1952	183,626	1,929	10·5	3,025	16·5	5·7	2,148	11·7	64·6	877	30
1951	183,248	1,833	10·0	3,028	16·5	5·4	2,181	11·9	65·7	847	27
1950	187,961	1,853	9·9	3,226	17·2	5·3	2,266	12·1	64·9	960	29
Mean of 1950-1954	**185,158**	**1,887**	**10·2**	**3,117**	**16·8**	**5·0**	**2,148**	**11·6**	**65·3**	**969**	**27**
1949	189,314	1,841	9·7	3,306	17·5	5·7	2,213	11·7	64·1	1,093	30
1948	188,853	2,104	11·1	3,598	19·1	5·9	2,098	11·1	61·7	1,500	34
1947	187,751	2,091	11·1	4,124	22·0	5·9	2,242	11·9	57·3	1,882	64
1946	176,939	2,186	11·9	3,762	20·4	7·0	2,124	12·0	60·3	1,638	42
1945	163,108	2,286	12·5	2,830	15·5	10·0	2,084	12·8	59·6	746	54
Mean of 1945-1949	†	**2,102**	**11·3**	**3,524**	**18·9**	**6·9**	**2,152**	**11·9**	**60·6**	**1,372**	**45**
1941-1945	**162,687**	**1,944**	**10·8**	**2,901**	**16·1**	**8·8**	**2,172**	**13·4**	**57·9**	**729**	**65**
1936-1940	†	**1,962**	**11·0**	**2,973**	**16·7**	**6·2**	**2,243**	**12·7**	**55·4**	**730**	**72**
1931-1935	**171,959**	**1,590**	**9·2**	**3,133**	**18·2**	**7·1**	**2,284**	**13·3**	**52·1**	**849**	**86**
1926-1930	**165,956**	**1,510**	**9·1**	**3,263**	**19·7**	**8·2**	**2,207**	**13·3**	**49·1**	**1,056**	**94**
1921-1925	**161,622**	**1,582**	**9·8**	**3,763**	**23·3**	**8·2**	**2,303**	**14·3**	**44·4**	**1,460**	**115**
1916-1920	**161,568**	**1,754**	**10·9**	**3,479**	**21·5**	**10·6**	**2,439**	**15·1**	**41·7**	**1,040**	**127**
1911-1915	**164,324**	**1,489**	**9·1**	**3,959**	**24·1**	**10·2**	**2,752**	**16·8**	**38·1**	**1,207**	**143**
1906-1910	**163,620**	**1,360**	**8·3**	**4,505**	**27·5**	**9·7**	**2,512**	**15·4**	**37·6**	**1,993**	**128**
1901-1905	**158,082**	**1,428**	**9·0**	**4,872**	**30·8**	**8·5**	**2,763**	**17·5**	**34·9**	**2,109**	**143**
1896-1900	**145,740**	**1,356**	**9·3**	**4,636**	**31·8**	**8·3**	**2,644**	**18·1**	**33·3**	**1,992**	**144**
1891-1895	**131,627**	**1,099**	**8·4**	**4,114**	**31·3**	**9·8**	**2,539**	**19·3**	**32·9**	**1,575**	**147**
1886-1890	**117,587**	**911**	**7·8**	**3,827**	**32·5**	**10·4**	**2,370**	**20·2**	...	**1,457**	**140**
1881-1885	**108,959**	**848**	**7·8**	**3,712**	**34·1**	**10·6**	**2,159**	**19·8**	...	**1,553**	**126**
1876-1880	**100,419**	**788**	**7·9**	**3,480**	**34·7**	**10·9**	**2,100**	**20·9**	...	**1,380**	**129**
1871-1875	**91,941**	**705**	**7·7**	**3,169**	**34·5**	**12·1**	**2,063**	**22·4**	...	**1,106**	**133**
1866-1870	**84,234**	**684**	**8·1**	**3,010**	**35·7**	**12·9**	**1,978**	**23·5**	...	**1,032**	**133**
1861-1865	**77,040**	**624**	**8·1**	**2,663**	**34·6**	...	**1,915**	**24·9**	...	**748**	**130**
1856-1860	**73,458**	**524**	**7.1**	**2,397**	**32·6**	...	**1,772**	**24·1**	...	**625**	**126**

* Corrected for transferred births for 1911 and for transferred deaths for 1904 and subsequent years.

† Civilian Population from 1940 to 1946 inclusive used for death-rate only.

3.—MATERNITY AND CHILD WELFARE.

Some of the main features of the year were—

(1) The number of women attending the ante-natal clinics and the total number of attendances at these clinics were greater than ever before.

(2) The number of women attending the post-natal clinics and the total number of attendances at these clinics were greater than ever before.

(3) The number of women attending the gynæcological advisory clinic and the total number of attendances at that clinic were substantially greater than ever before.

(4) An intensive follow-up was undertaken of expectant mothers found to be anæmic.

(5) Proposals designed to increase mothercraft teaching substantially were formulated during the year.

(6) The number of children aged 1-5 years attending the child welfare clinics was greater than ever before.

(7) The number of babies under one year attending the clinics showed a decline, probably due to a lack of clinic facilities in certain areas of the town.

(8) To provide the necessary clinic facilities, the Corporation erected its first two purpose-built clinics at Northfield and Holburn (neither completed by the end of the year), transferred two of the mobile clinic sessions to new districts, and increased by one the number of sessions at the gynæcological advisory clinic. Further proposals were under consideration at the end of the year.

(9) A laundry was provided at Pitfodels Residential Nursery.

(10) Despite the shortage of dental staff, a considerable increase took place in the number of pre-school children receiving dental inspection and treatment.

(*a*) EXPECTANT AND NURSING MOTHERS.

(i) Ante-Natal Clinics.

The number of weekly ante-natal sessions held at a central clinic equipped for ante-natal and post-natal work was increased to eight just before the beginning of 1955, and continued at eight throughout the year; and single sessions were held weekly at two of the child welfare centres in the City. Since all sessions except two are essentially double sessions (with two doctors present, &c.), the total is equivalent to 18 single weekly sessions.

Continuous and successful efforts are made to encourage the attendance of expectant mothers at these clinics, which, in addition to obstetrical and medical supervision, can provide instruction in mothercraft and make the expectant mother more fully aware of the physical and emotional needs of the child. In particular, women for whom institutional confinement has been arranged—approximately 85 per cent. of all expectant mothers in the City—attend the clinics. Of the remaining

15 per cent. who are under the care of general practitioners and/or municipal midwives, a few also attend the clinics for specialist consultation and health teaching; so that, in all, about 90 per cent. of expectant mothers attend the clinics—a highly satisfactory total.

At the clinics, the co-operation of hospital consultants and midwives on the one hand, and of medical and health visiting specialists in health matters on the other hand, ensures that the best practicable advice is offered both on clinical and on medico-social points; and the unusually high percentage of expectant mothers attending the clinics is undoubtedly causally related to the low still-birth rate, maternal death rate, and neo-natal death rate obtaining in the City during recent years.

At the close of the year, the distribution and medical staffing of the sessions were—

Castle Terrace—4 sessions—staffed by 1 consultant, 1 assistant medical officer of health, and 1 resident medical officer.
Castle Terrace—2 sessions—staffed by 1 consultant and 1 resident medical officer.
Castle Terrace—2 sessions—staffed by 1 consultant.
Torry—1 session—staffed by 1 assistant medical officer of health and 1 registrar.
Hilton—1 session—staffed by 1 assistant medical officer of health and 1 registrar.

At each session, health visitors are present in addition to the hospital and local authority medical staff. At the main centre (Castle Terrace), student midwives attend under the supervision of a midwife, and a receptionist and clerkess are also present. To prevent undue waiting, an appointments system is in operation at all clinics.

When an expectant mother visits a clinic for the first time, she is promptly interviewed by a health visitor, who allays fears and anxieties, explains the routine of the clinic, and records necessary particulars. The patient is then physically examined by one of the medical staff and is given an appointment for her next visit.

As a rule, samples of blood are taken from every patient for two purposes—performance of the Wassermann test and measurement of hæmoglobin. Until the autumn of 1954, a specimen of blood was examined for the Rhesus factor in the following cases:—

(*a*) all parous women without a previous live child;
(*b*) all parous women with a history of blood transfusion; and
(*c*) all third pregnancies and over.

During 1955, however, the blood of all women attending the clinics has been tested for the Rhesus factor, and, in addition, there has been an intensive follow-up of women found to be anæmic.

(ii) Post-Natal Clinics.

A specialist post-natal clinic is conducted each week at the Aberdeen Maternity Hospital and, in addition, post-natal clinics are held weekly at Castle Terrace (Monday morning), Hilton (Thursday afternoon), and Torry (Monday afternoon) Child

Welfare Centres. At the clinic at Castle Terrace, a consultant, an assistant medical officer of health, and a resident medical officer are in attendance, while, at Hilton and Torry, there are an assistant medical officer of health and a registrar who examine both post-natal and ante-natal cases during the weekly session.

(iii) Teaching of Mothercraft.

At all the ante-natal and post-natal clinics (and also at child welfare clinics) health visitors give advice on mothercraft. For more systematic instruction a special clinic session is held once a fortnight at the Castle Terrace Centre. It is hoped that it will be possible to expand this instruction very considerably in the near future: for further information on this point reference should be made to the chapter on Health Education.

(iv) Attendances at Ante-Natal and Post-Natal Clinics.

The table below shows the numbers attending and the number of attendances made at the ante-natal and post-natal clinics during 1955, with, for comparison, similar figures for 1954, 1953, and 1952. It will be noted that the number of women attending the ante-natal clinics approximates closely to the number of births during the year. It will also be noted that the numbers attending and the total number of attendances both at ante-natal clinics and at post-natal clinics have increased in 1955 to figures higher than in any previous year.

	Ante-Natal Clinics.		Post-Natal Clinics.	
	No. of Women.	No. of Attendances.	No. of Women.	No. of Attendances.
1955 .	3,451	22,721	2,966	5,113
1954 . .	3,316	22,037	2,381	4,647
1953 . .	3,392	21,081	1,763	2,098
1952 . .	2,874	21,237	1,786	2,065

(v) Gynæcological Advisory Clinic.

This clinic is held at the Castle Terrace Centre, where a specially trained health visitor is in attendance from 9 a.m. to 5 p.m. from Monday to Friday. On Monday and Tuesday mornings and on Wednesday afternoon a departmental medical officer is also in attendance. The number of mothers to avail themselves of the facilities of the clinic during the year was 1,162, and they made 2,976 attendances (as compared with 671 and 2,702, respectively, in 1954, and 632 and 2,607, respectively, in 1953).

(vi) Supply of Maternity Outfits and Layettes.

Maternity outfits are supplied free of charge to all women who are being confined at home. The contents of the outfit are in accordance with the suggestions of the Department of Health for Scotland.

Wherever possible, mothers are encouraged to provide their own layettes, but a layette is supplied free in exceptional circumstances. In certain cases, mothers are

given wool to make garments for the baby. Where a mother is entitled to receive Maternity Benefit, a charge of not less than £2 is made for a complete layette.

(vii) Arrangements for Care of Unmarried Mothers.

(i) *Aberdeen Mother and Baby Home.*

For a number of years the Corporation have had a standing arrangement with the Aberdeen Mother and Baby Home, Richmondhill House, King's Gate, which is conducted by a voluntary association. Under this arrangement, accommodation is provided for expectant unmarried mothers, and the Corporation pay thirty-five shillings per week towards the maintenance of each woman whom they send to the Home. The women may be admitted and discharged at any time, but the Corporation's responsibility is limited to a period of six weeks before the expected date of confinement and four months thereafter. Women are not confined at the Home but at the Maternity Hospital. During the year, the Corporation accepted responsibility for seven women admitted to the Home.

(ii) *Salvation Army Homes.*

Arrangements have also been made under which certain expectant unmarried mothers are sent by the Corporation to Salvation Army Homes in either Dundee or Glasgow. The payment made by the Corporation is 14s. per week for six weeks before the expected date of confinement, and 24s. per week for four months thereafter. During the year, one woman was sent to a Salvation Army Home.

The total number of illegitimate births for the City during the year under review was 172, as compared with 140 in 1954, 138 in 1953, and 172 in 1952.

(*b*) CHILD WELFARE.

(i) Child Welfare Centres.

Certain general points may first be mentioned—

(*a*) The scope of a child welfare clinic has widened appreciably, and now includes far more than just advice on physical health.

(*b*) As in most other areas, the public demand for child welfare clinics is continuing to increase: the total number of children attending clinics has increased each year from 1952 to 1955.

(*c*) The development of new housing areas on the periphery of the town is making the provision of peripheral clinics an increasing necessity: the fact that in 1955 (while the number of children over the age of one year attending the clinics increased sharply) the number of babies under one year attending actually fell slightly, tells its own story. Only about 75 per cent. of babies were brought to clinics, because clinics were inconveniently situated for many mothers.

(*d*) The mobile clinic (although valuable) having proved inadequate to meet the need for new clinics, the Corporation proceeded with the erection of clinics at Holburn and Northfield, although neither was completed

by the end of 1955, transferred a clinic session from St. Machar Church Hall to the Community Centre at Seaton, and transferred another clinic session from Stockethill Infant School to Mastrick Parish Church Hall. Further proposals to meet the demand for clinics were under consideration at the end of the year.

There are ten child welfare centres in the City, apart from the mobile unit.

Four full-time Child Welfare Centres are maintained at Castlegate, Charlotte Street, Hilton, and Torry, respectively. These are open daily from 9 a.m. to 5 p.m. with health visitors constantly in attendance, so that mothers may come at any time for skilled advice. At all clinic sessions, where a doctor is in attendance, vaccination against smallpox and immunisation against diphtheria and whooping cough are carried out. Clinic sessions are also held for baby weighing and advice about the care of children. Special morning sessions are reserved for advising mothers on infant feeding. For the examination of children by the medical staff, an appointments system is in operation and functions satisfactorily, thus saving mothers needless waiting.

A fifth clinic, which may ultimately become a full-time one, is held at No. 1A, View Terrace. So far, four sessions a week have sufficed at this clinic which serves the Rosemount area of the City.

In addition, weekly clinics are held at four other centres, viz.:—St. Machar's Church Hall; Powis Community Centre; the Lads' Club, Gallowgate; and Ruthrieston. A consultant or a registrar from the Aberdeen Hospital for Sick Children attends the Ruthrieston Clinic weekly.

At Hayton, a clinic is conducted thrice weekly.

(ii) Mobile Health Unit.

A mobile unit has now been in operation for three and a half years. The unit —the first used for child welfare work in any town in Scotland—was specially designed to provide facilities for medical examination and for immunisation and vaccination in the minimum amount of space.

It is staffed by a departmental medical officer and a health visitor. The same doctor attends at most sessions, but the health visitor varies with the district served. There is also a driver who, after uncoupling the unit from the van which tows it, is available for other duties while the unit is operating at any one point.

By the end of 1955, the clinic was operating in nine areas as follows:—Kaimhill (Monday afternoon), Mastrick Church Hall (Tuesday morning), Smithfield (Tuesday afternoon), Holburn (Wednesday morning), Seaton (Wednesday afternoon), Inverdee (Thursday morning), Stockethill (Thursday afternoon), Cummings Park (Friday morning), and Northfield (Friday afternoon).

While the mobile unit is of tremendous value in providing facilities for skilled examination and advice for parts of the town that are in process of becoming built up, it will be appreciated that it cannot cope with the needs of a densely populated area.

(iii) Attendances at Child Welfare Clinics.

The number of children who attended the child welfare clinics during the year, and the number of attendances were as follows:—

Total number of children under 5 years of age who first attended at the clinics during the year—

(*a*) Under 1 year of age, 2,411; (*b*) over 1 year of age, 4,136.

Total number of attendances made by children during the year—

(*a*) Under 1 year of age, 23,285; (*b*) over 1 year of age, 17,133.

As mentioned earlier, the total number of children attending is greater than ever before, but the number of babies attending has fallen slightly.

(iv) Facilities for Consultant Advice.

Clinical consultants do not attend at any of the Child Welfare Centres, which are regarded essentially as "well baby" clinics. If any condition is found on which expert clinical advice is required, the mother is told to take her child to her general practitioner, who is advised of the condition, and may, thereafter, seek the advice of an appropriate consultant. The system works reasonably satisfactorily.

(v) Ultra-Violet Light Clinics.

On the recommendation of an assistant medical officer of health, debilitated children can receive ultra-violet light treatment at clinics which are held for that purpose twice weekly at the Charlotte Street, Hilton, and Torry Centres.

(vi) Orthopædic Clinics.

An arrangement has been made with the Principal of the Dunfermline College of Physical Training whereby the Corporation's medical staff may send children suffering from postural defects to a clinic held in the College at Woolmanhill, where remedial exercises are given. This arrangement, in addition to being highly beneficial to the children, is very useful to students.

Pre-school children suffering from other orthopædic defects are referred to an orthopædic clinic which is also now held at Woolmanhill. The children attending this clinic are examined by an orthopædic surgeon from the North-Eastern Regional Hospital Board.

(*c*) CARE OF PREMATURE INFANTS.

All premature babies born at home are forthwith transferred to the special ward at the Royal Hospital for Sick Children. This enables such babies to secure skilled medical attention and continuous nursing, and gives them the best chance of survival. When it is considered that the babies can safely be sent home, the Health and Welfare Department is notified, and the appropriate health visitor immediately visits the home to ensure that everything necessary is done for the baby. In certain instances, equipment, such as cots, cot blankets, &c., is issued on loan, and the health visitor gives special instruction to the mother on the care of the baby.

(*d*) SUPPLIES OF WELFARE FOODS.

When the Corporation assumed responsibility for the issuing of cod liver oil, orange juice, and national dried milk, they took over from the Ministry of Food the premises at 112, George Street, but, during the year under review, the Corporation had to seek other premises. Unfortunately, no other premises could be obtained, and a portion of the child welfare clinic at Castlegate had to be utilised. In addition to the foods supplied at each child welfare centre, Vitamins A and D liquid (Adexolin) is distributed free of charge to necessitous cases. One outstanding feature of the distribution of welfare foods is the number of shopkeepers in the various peripheral housing areas who have offered to sell welfare foods. This has proved a boon not only to the residents in the area but also to the local authority, as the shopkeeeprs undertake this work on a purely voluntary basis. Certain proprietary milk foods are also issued at reduced prices at the discretion of the departmental medical officer at each clinic.

The amount of welfare foods issued to the public during December, 1954, and December, 1955, was as follows:—

	National Dried Milk.		Cod Liver	Vitamins	Orange
	Full Cream.	Half-Cream.	Oil.	A & D.	Juice.
December, 1954 .	6,482	488	1,987	523	8,137
December, 1955 .	7,539	628	2,160	823	10,775

The figures for December, 1953, *i.e.*, when the sale of the foods was undertaken by the Ministry of Food, are not available, so, unfortunately, a comparison cannot be made with the sale of foods in December, 1953.

(*e*) DENTAL CARE.

Out of an authorised establishment of seven dental officers, the number employed at the beginning of the year were three full-time and two part-time dental officers, while at the end of the year there were three full-time and one part-time dentists.

In spite of the severe shortage, the present dental staff managed to undertake more work than in previous years for the expectant mothers and young children who are referred to them by the medical officers at the ante-natal and child welfare clinics. The following figures show the work which the dental officers undertook during the year, data for 1954 being given in parenthesis for purposes of comparison:—

	Examined.	Found to need Treatment.	Treated.
Expectant and nursing mothers	12 (0)	11 (0)	10 (0)
Pre-school children . . .	464 (137)	270 (78)	136 (51)

(*f*) PREVENTION OF BREAK-UP OF FAMILIES.

Before the Department of Health for Scotland had issued Circular 77/1954, the Corporation had already accepted that (in the phrasing of that circular) the

health visitor's work "now extends to cover the whole field of prevention of ill-health, including prevention of mental ill-health." The Corporation has made no effort to secure either a social worker with special training or a health visitor with special training, but has preferred to tackle the problem of prevention of break-up of families by (i) extending its establishment of health visitors so that each health visitor would have adequate time available for "problem" and "borderline" families in her district, and (ii) conducting courses in mental health to equip health visitors more fully for their duties in this field.

As mentioned elsewhere in this report, shortage of health visitors and increasing decrease in the numbers of student health visitors are interfering seriously with all forms of preventive work.

(*g*) OTHER PROVISIONS FOR EXPECTANT AND NURSING MOTHERS AND YOUNG CHILDREN.

(i) Residential Nurseries.

The Corporation has one residential nursery—Pitfodels House (which has accommodation for 82 children). The nursery is recognised for the training of nursery students.

The residential nursery is used for the children of parents who, for an adequate reason (such as mother in hospital), cannot look after their young children. Children taken into the care of the local authority and under two years of age are also accommodated.

A laundry was provided at the nursery during the year.

(ii) Day Nurseries.

At present, the Corporation provide four day nurseries—Charlotte Street (with 60 places), View Terrace (44 places), Deeside (45 places), and Linksfield (30 places). All four have been recognised for training purposes. The Linksfield Nursery continues to be situated in one wing of Linksfield School, but more suitable accommodation has been obtained in another part of the school, and, after certain minor alterations, the children will be transferred to that accommodation. As an experiment, it has been decided to appoint at Linksfield a nursery warden who is a qualified teacher holding the Nursery Schools Endorsement, but it is not proposed to proceed with this appointment until the new premises are available.

4.—DOMICILIARY MIDWIFERY.

There were no important changes in the midwifery service during the year. The number of domiciliary confinements fell to 444, and the number of domiciliary births at which a doctor was present fell to 21. All the midwives are qualified to administer gas and air analgesia.

It is interesting to note that the attendance of a doctor at a domiciliary confinement has become a rarity in Aberdeen. Doctors were present at only 44 confinements in 1952, 31 in 1953, 29 in 1954, and 21 in 1955.

General.

The midwifery staff at the end of the year consisted of a Supervisor of Midwives (who also functions for the greater part of her time as Superintendent Health Visitor), an assistant, and eight whole-time midwives. A district of the City is allocated to each midwife. In addition, the Corporation have an arrangement with the Board of Management for the Aberdeen Special Hospitals whereby a central district of the City is served by three midwives on the staff of the Aberdeen Maternity Hospital, and the Corporation pay £825 per annum towards the remuneration of these midwives. The small number of midwives is explained by the fact that the overwhelming majority of confinements in Aberdeen take place in hospital.

The Supervisor of Midwives is responsible for the supervision of all practising midwives in the City—not only those on the staff of the Corporation. At present, fifty-one midwives are employed in hospitals and nursing homes. During the year, 342 confinements were attended by municipal midwives and 101 confinements by midwives employed by the Board of Management for the Aberdeen Special Hospitals, a total of 443 (as compared with 476 in 1954, 471 in 1953, and 417 in 1952).

Births.

Particulars of the births, including still-births, which occurred in the City during 1955, are as follows:—

(i) Total number of births occurring in the area during year—that is, before correction for mothers' residence:—Live births, 3,975; still-births, 73. Total	4,048
(ii) Total number of above births occurring in institutions (including private maternity homes)	3,604
(iii) Total number of above births occurring at home	444

These 444 may be further sub-divided thus to show attendance at birth:—

	Doctor engaged and present.	Doctor engaged but not present.	No doctor engaged.	Total.
Municipal midwives	17 ...	322 ...	3 ...	342
Hospital midwives "on district"	4 ...	90 ...	7 ...	101
Private practising midwives	— ...	— ...	— ...	—
No midwife	— ...	— ...	1 ...	1
Total	21 (4·8%)	412 (92·8%)	11 (2·4%)	444
Comparable figures for 1954	29 (6·1%)	422 (88·1%)	28 (5·8%)	479
Comparable figures for 1953	31 (6·5%)	412 (86·7%)	32 (6·7%)	475
Comparable figures for 1952	44 (10·4%)	355 (83·9%)	24 (5·7%)	423

Administration of Analgesics.

All the domiciliary midwives are qualified to administer gas and air analgesia; three sets of gas and air apparatus were in use at 31st December; and gas and air analgesia was administered by midwives in 377 cases during the year, while pethedine was administered in 215 cases. The comparable figures for 1954 were 400 and 251 respectively.

Use of cars.

At the end of the year no municipal midwife had a car. In emergency and at night, taxis are used.

Arrangements for ante-natal supervision by Midwives.

When a confinement is expected to take place at home, ante-natal supervision is given by the midwife concerned either in a duty room set aside for that purpose in the midwife's house or at the woman's own home. This supervision is given from the time of booking the midwife, and weekly visits are paid to the woman's own home during the last month. If any personal or environmental circumstances make it desirable that a confinement, originally booked as domiciliary, should in fact take place in hospital, the general practitioner and the midwife advise the woman accordingly. Wherever possible, however, arrangements for admission to hospital on social grounds or on grounds of anticipated obstetrical difficulty are made early in the pregnancy.

Refresher Course for Midwives.

No refresher course was attended in 1955, but one or more midwives have attended courses in each recent year other than 1955.

Training of Pupil Midwives.

The Aberdeen Maternity Hospital is, of course, a training hospital, and, as part of their training, midwives must obtain experience in domiciliary confinements under supervision. This is arranged through three midwives stationed at No. 32, Carden Place, and the Supervisor of Midwives gives lectures to the students before they begin their domiciliary work.

Use of Trilene.

At the end of the year the local authority had not yet decided to use trilene, but four of the midwives had commenced training in its use, and it is hoped that their training will be completed early in 1956, and the training of the remainder commenced.

5.—HEALTH VISITING.

Important features of the year included:—(1) a spectacular increase in the total number of home visits paid by health visitors (from 108,118 in 1954 to 123,864 in 1955), a result not of extra staff but of time saved by a policy of decentralisation; (2) a continuation of the increased proportion of visits paid to expectant mothers; (3) a further increase in the number of old persons receiving routine visits from health visitors (300 elderly citizens at the end of 1953, 723 at the close of 1954, and 1,238 at the end of 1955); (4) a continuation of the grave shortage of health visitors (61 employed and 24 unfilled vacancies at the end of 1954, and 60 employed and 25 unfilled vacancies at the end of 1955); (5) continuation of the efforts, begun in 1954, to improve liaison between general practitioners and health visitors; and (6) continuation of the use of health visitors in the training both of medical students (begun in 1952) and of students nurses (begun in 1954).

A post-qualification course in mental health is discussed in the chapter on Training, and developments in the field of health education are considered in a separate chapter.

Expansion of Health Visitors' Work.

It may be worth while to indicate briefly the vast expansion that the health visitor's rôle has undergone as a result of the National Health Service (Scotland) Act, 1947. Section 24 of the Act placed on local authorities a duty to make provision for the visiting of persons in their homes by health visitors to advise on the care, not only of expectant and nursing mothers and young children, but also of persons suffering from illness and on the measures necessary to promote health and to prevent the spread of infection. The duties of health visitors are, therefore, now statutory and are very much wider than they were before 1948. Instead of being concerned simply with the care of children and the prevention of infectious disease, the health visitor has become a recognised health adviser of the whole family, concerned with general promotion of physical and mental fitness, prevention of disease, and advising on the care and after-care of the sick. She is the person to whom a housewife can turn for advice on family budgeting, household economics, dietetics, personal hygiene, and matters relating to the physical and emotional health of all members of the family. Two factors, however, have made it impossible as yet for health visitors to cope fully with all the new duties; first, the fact that there is a grave and alarming national shortage of these highly-trained officers; and second, the fact that the health visitor trained before 1948, although highly skilled in matters relating to the physical health of children, usually had inadequate knowledge of the mental and emotional development of children and virtually no training about the health of adults. Nevertheless, in addition to continuation and extension of the older functions in relation to the care of young children and expectant and nursing mothers, many additional tasks are already being undertaken in Aberdeen. A few points may be selected for mention here. Where a premature baby is returned from the Maternity Hospital to its home, the appropriate health visitor immediately calls and, if deemed necessary, daily visits are paid to give advice to

the mother with a view to ensuring that everything possible is done to enable the baby to become a healthy child. Again, health visitors devote much time and energy to encouraging mothers to have their children vaccinated against smallpox and immunised against diphtheria and whooping cough. Then again, the health visitors give talks to the mothers on health and social problems at four full-time clinics; and, in addition, small groups of mothers who are expecting their first baby are given special talks and demonstrations at five centres in the City. These talks are deliberately given at the Child Welfare Clinics to encourage mothers to bring their babies afterwards to the Clinic.

It is becoming increasingly appreciated that the prevention of disease of mental and emotional origin is one of the most important facets of a health visitor's work. Indeed, the Secretary of State for Scotland has, himself, drawn attention to the rôle of the health visitor in the prevention of mental ill-health. Reference to in-service training in mental health work is made later, in the chapter on Training of Health Visitors.

Already there are over 20,000 people of pensionable age in the City, and the health care of the elderly is a field which, in magnitude, will probably ultimately be as large as that of child welfare. Although the number of health visitors is not yet anything like adequate, during the year a considerable development took place in respect of the visitation of old people, the health visitors having been previously "geared up" for this work by a Study Week-end on the elderly at the end of 1954. At the end of the year, regular visits were being paid to some 1,238 elderly persons, as compared with 723 at the end of 1954 and 300 at the close of 1953. Schemes were also continued during the year for improved services for cripples and physically handicapped persons.

Health Visitors as General Purpose Social Workers.

To enable the health visitor to get to know her families more closely, and to avoid having too many social workers visiting the same homes, the health visitor attends the school in her area as school nurse, and visits school children at home where necessary, as well as expectant mothers and pre-school children; she also visits elderly people in her area; and to a large extent she acts also as a social welfare visitor. It is intended that, ultimately, health visitors should also be responsible for the health and social welfare of cripples and handicapped persons in their area, although at present—while schemes are still in process of development—a specialist health visitor and a social worker are engaged on the visiting of physically handicapped persons.

Decentralisation.

To reduce the time spent in travelling, the old policy of having almost all the health visitors working from the main office has been abandoned. While the majority are still centred on Willowbank House, groups of health visitors have various clinics as their headquarters. This policy, which will be extended as new clinics are built, has already begun to bear fruits in a substantial increase in the number of domiciliary visits paid.

Staff Shortages.

The existing and increasing grave staff shortages have been discussed in the preface to this report and need not, therefore, be mentioned here.

Visitation by Health Visitors.

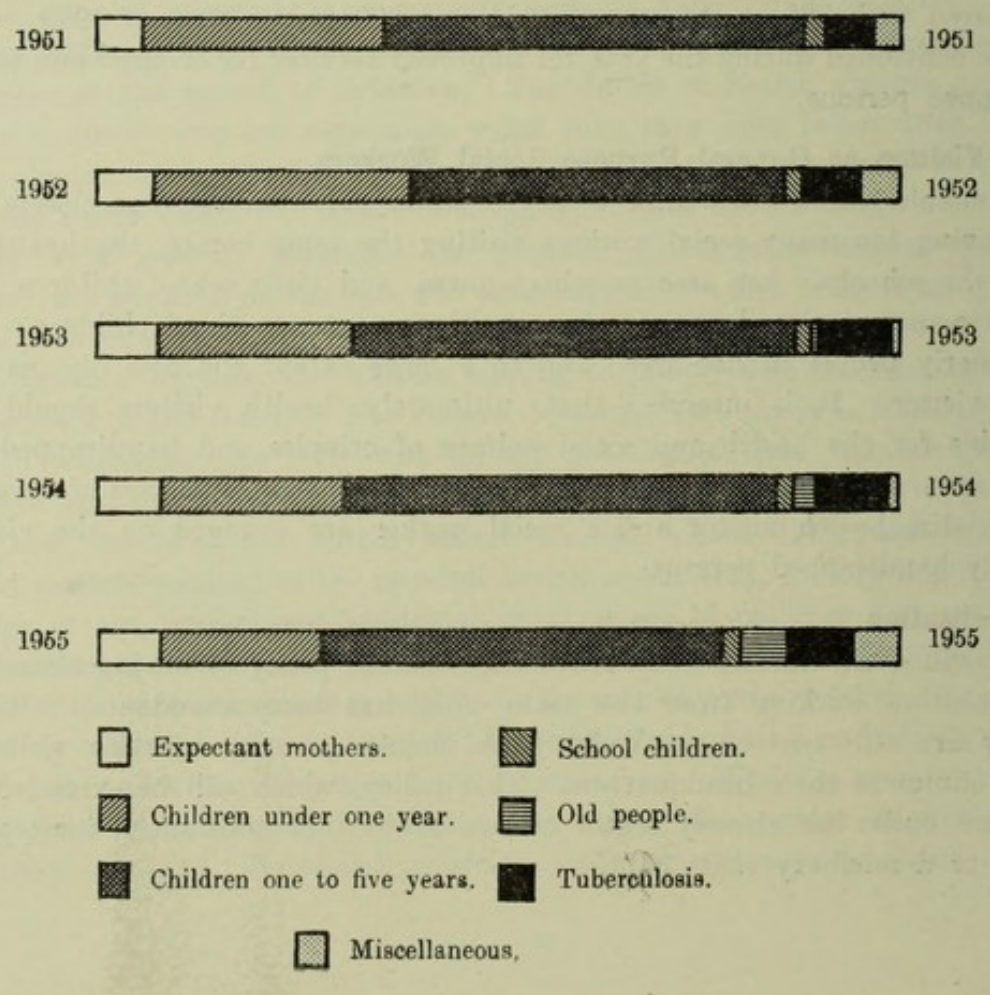
An analysis of the number of home visits made by health visitors during the year is given below, the total visits for 1954 and 1953 being also stated for purposes of comparison:—

	No. Visited	Total Visits.		
(*a*) Maternity and Child Welfare—	in 1955.	1955.	1954.	1953.
Expectant mothers . . .	2,328	9,473	8,745	8,420
Children under 1 year . .	3,079	24,144	24,889	28,930
Children aged 1-5 years . .	12,410	62,858	59,291	64,748
(*b*) Cases of tuberculosis . . .	1,727	11,799	10,882	9,988
(*c*) Other cases	6,242	13,239	4,611	2,730

In all, 123,864 home visits were paid, as compared with 110,845 in the previous year. It must, of course, be appreciated that, in addition to home visits, a good deal of work of the health visitors is carried out at Child Welfare Centres throughout the City. In point of fact, nearly 30 per cent. of their time is spent in clinic work and about another 20 per cent. in schools (including home visiting of school children where needed).

The diagram depicts the changes in visiting over recent years.

VISITING BY HEALTH VISITORS.



Liaison with Hospitals.

This is very close in the case of some hospitals, *e.g.*, the Maternity Hospital (from which intimation of discharge of patients is always passed to the department and full particulars made available), the infectious diseases hospital, and the tuberculosis hospitals (in respect of which six health visitors and an assistant nurse undertake work which might otherwise be done by hospital almoners). In addition, the Health and Welfare Department is notified about all babies discharged from the Mother and Baby Unit of the Aberdeen Royal Hospital for Sick Children, and also about children who are seen at the eye department; and all the local hospitals are at present intimating cases of home accidents and cases of pneumonia. The liaison is, therefore, in general, good, but attempts are constantly made to extend and increase it.

The discharge of an old person from hospital is not yet notified to the department (except that the almoner contacts the appropriate health visitor where nursing equipment is required). It is, of course, unfortunate that elderly patients (who so often require such domiciliary services as health visitor's advice on health and social problems, chiropody, the mobile meals service, &c.) should be discharged from hospital without any intimation to the local authority, which may thus be deprived of any opportunity to carry out its statutory tasks of care and after-care. The main barrier is, of course, that—partly as a result of the sweeping advances in preventive and social medicine in recent years—members of the staffs of hospitals are often unaware of many of the functions and duties of local health authority officers. The development mentioned in the next paragraph should in time help to remove that unawareness.

A development of profound importance followed the decision of the General Nursing Council to include preventive and social aspects of disease in the general nursing curriculum. Starting in the autumn of 1954, student nurses at the combined training school of Aberdeen Royal Infirmary and Woodend Hospital now receive, in their final year, a short course of lectures given by members of the staff of the Health and Welfare Department, and these lectures are followed by visits by each student to private houses, clinics, &c., under the supervision of a health visitor. A similar but shorter course is provided for fever nursing students at the City Hospital. While these theoretical and practical courses can naturally teach the student nurses only the rudiments of disease-prevention and health promotion, they are nevertheless of supreme importance for the future improvement of liaison and co-operation. No two parties can co-operate without some idea of each other's aims and methods of work. Hitherto, the departmental medical officer and the health visitor have understood the aims and methods of their hospital colleagues by reason of the fact that they themselves worked in hospital before specialising in public health; and (as mentioned in the next paragraph) the use of health visitors in the practical training of medical students should ensure that the doctor of the future—whether in hospital or in general practice—knows a little about the preventive service. The new development should complete the circle by

enabling the hospital nursing administrators and ward sisters of the future to understand something of what their colleagues in the preventive field are doing.

Liaison with General Practitioners.

Various degrees of co-operation and lack of co-operation are found, but it can be said with confidence that the amount of liaison between general practitioners and health visitors is slowly but steadily increasing. It is, of course, of the highest importance for the health and well-being of the community that every effort should be made to improve the co-operation of the two professional workers in closest touch with the family, the family doctor and the family health visitor; although it must be appreciated that, since the health visitor deals mainly with persons who are well while the general practitioner is concerned mainly with those who are sick, the opportunities for co-operation are less numerous than is sometimes suggested: the busy health visitor cannot devote more than a small fraction of her time to the sick, and the equally busy general practitioner may have little time to spare for those who are not yet ill.

In connection with liaison, three points may be mentioned, the first relating to a measure continued since 1952 and the others relating to measures initiated shortly before the beginning of 1955.

(*a*) In each of the last four years, health visitors have been used in the practical training of medical students. Each undergraduate spends the mornings of two weeks in visiting families in their own homes under the direction of a health visitor. Probably no measure yet devised has done more to improve co-operation in the future than this employment of the one professional officer in the training of the other.

Inevitably, this development consumes some of the time of the busy health visitor (and it has to be remembered that other encroachments on her time are in connection with the training of student health visitors and in connection with home visits now paid by student nurses), but it will undoubtedly pay rich dividends in the future.

(*b*) During 1954 an attempt was made to convince all health visitors that communication between themselves and general practitioners should as a rule be direct, not through the medium of the medical officer of health or the superintendent health visitor. A memorandum stressing the desirability of direct two-way contact was issued to all health visitors, and the theme was developed by the Medical Officer of Health at a meeting of health visitors. Particular emphasis was laid on these points —that the health visitor could often provide the general practitioner with information of considerable importance, that the general practitioner could frequently give the health visitor information of considerable importance, and that either party could take the initiative in contacting the other.

(*c*) After at least some health visitors had taken the initiative in endeavouring to develop better liaison with general practitioners, quite a number of practitioners evinced a desire for co-operation and for more knowledge of the special training and duties of health visitors. Through their representatives on the Standing Joint

Medical Committee (a committee set up in Aberdeen in 1954 and containing three representatives each from hospital doctors, general practitioners, and public health medical officers), the family doctors asked that, to facilitate co-operation, they be given an indication of the health visitor's professional qualifications and functions. In response, the following memorandum was prepared by the Medical Officer of Health, in consultation with appropriate health visitors, and circulated to all general practitioners in the City. (The memorandum appeared in the Report for 1954 but is here repeated because of its importance.)

MEMORANDUM ON HEALTH VISITORS.

(Prepared for the information of general practitioners at the request of the Aberdeen Standing Joint Medical Committee.)

The Health Visitor's Background.

A woman who seeks to qualify as a health visitor must start by becoming a fully-trained nurse and taking a further training in midwifery. Then, usually after working for several years as a hospital staff nurse and ward sister, she has to take yet another training in health visiting. The course for the health visitor's certificate is given in three University cities (which can provide the necessary variety of lecturers) and consists of two terms (in some training centres, a complete academic year) of full-time instruction in such subjects as health education, methods of imparting information to individuals and to groups, social and environmental aspects of disease, mental and physical development of children and adolescents, hygiene, and the prevention of physical and mental disease.

A health visitor is therefore a highly-trained professional worker who is well equipped for her primary task of acting as a health counsellor and health adviser in the community.

Her Duties.

Until 1948 she was concerned almost solely with health advice to expectant and nursing mothers, the health and well-being of pre-school children, and (as school nurse) the health of school children. The National Health Service (Scotland) Act extended her duties considerably : Section 24 of that Act conferred on her statutory duties in respect of

> *"giving advice as to the care of young children, persons suffering from illness, and expectant and nursing mothers, and as to the measures necessary to promote health and to prevent the spread of infection":*

and Section 27 mentioned

> *"the prevention of illness, the care of persons suffering from illness or mental deficiency, or the after-care of such persons."*

Broadly, a health visitor is to be regarded as a person whose main task is to act as a family health teacher. Her basic duty is that of teaching and guiding individuals and families to become physically and mentally healthier by their own efforts and to accept their family and community responsibilities.

Some of her many duties may be summarised thus:—

(a) Maternity and Child Welfare.—*Regular home visits to advise on infant feeding and development and on the physical, mental, and emotional aspects of the health of expectant mother and young child, including not merely the prevention of physical diseases but the prevention of the disturbed parent-child relationships and the inconsistencies in the handling of children in which so often lie the seeds of mental and psychosomatic illness. Teaching of parentcraft in homes, at ante-natal clinics, and at child welfare clinics.*

(b) School Nursing.—*Acting as a link between home and school, with knowledge of both; health surveys,* i.e., *seeing every child each term and paying special attention to evidence of insufficient sleep, faulty diet, defects of special senses, bad posture, &c.; follow-up home visits; health education of children and their parents; and advice to teachers on health matters.*

(c) Tuberculosis.—*(In Aberdeen, work is undertaken by six specialist health visitors, not by all health visitors.) Tracing and follow-up of contacts; reports on social and physical environment of patient; health education of patient and his family during illness and afterwards; helping patient to adjust emotionally to his disease; arrangements for after-care.*

(d) Infectious Diseases.—*Prevention by home teaching of rules of health and of need for immunisation and vaccination; follow-up of contacts; advice on after-care.*

(e) Mental Health.—*Advice on maintenance of proper parent-child relationships and on prevention of frustration, over-strictness, over-licence, and mismanagement—all of which can lead both to behaviour difficulties and to neuroses.*

(f) Care and After-care of Illness.—*Health advice, and bringing in of the various services needed for the welfare of the patient and his family. (Duties do not include home nursing, since this can be adequately done by nurses without subsequent public health training.)*

(g) Health and Welfare of the Aged.—*In people who are still reasonably healthy, prevention of premature senescence,* e.g., *by advice about habits, leisure interests, work, diet, hygiene, and exercise. In people already frail, assessment of their needs for such services as chiropody, meals-on-wheels, home helps, help from voluntary agencies, and admission to hostels, and advice about obtaining these services and about pensions, allowances, &c.*

(h) Prevention of Home Accidents, e.g., *by systematically making parents aware of the developmental needs of their children and of the special dangers associated with each stage of development; and similarly by making old people aware of dangers resulting from their particular disabilities* (e.g., *sight*) *and environments.*

(i) Home Management, e.g., *advice to the re-housed on the innumerable problems that arise (finance—increased rent and transport; changed environment—loneliness and isolation, &c.).*

ADMINISTRATION OF THE HEALTH VISITOR SERVICE.

Health visitors work under the general administrative direction of the Medical Officer of Health, assisted by the Superintendent Nursing Officer. However, since each health visitor is a highly trained professional woman working on her own in her district, it is manifest that such administrative direction cannot mean supervision and detailed instructions.

In this connection, a sharp contrast may be drawn between the health visitor and the home nurse. The home nurse, nursing a patient under treatment by a general practitioner, is in the position of carrying out his instructions. The health visitor, undertaking her statutory duties of health teaching and social education, is essentially an independent worker although it is often necessary for her to co-operate with the family doctor, the school teacher, the psychiatric social worker, the sanitary inspector, and various voluntary agencies.

CO-OPERATION OF GENERAL PRACTITIONER AND HEALTH VISITOR.

It is obviously greatly to the benefit of the family that the general practitioner and health visitor should, wherever possible, co-operate rather than work in isolation. Moreover, where a general practitioner and a health visitor are separately visiting a household without any contact with each other, the duplication of effort does not necessarily mean double benefit, and may even be harmful through conflicting advice. Again, there must be quite a number of cases in which a doctor or health visitor alone would need to make extensive enquiries to solve a medical or social problem, and in which a few words from the other with a differing background of knowledge would throw new light on the problem and make the enquiries superfluous.

Half-a-dozen examples may illustrate.

(1) *Where a baby is failing to gain weight without obvious cause, the general practitioner might be saved considerable investigation if the health visitor, from her detailed knowledge of the home, were able to explain that immature parents were handling the child too much and not allowing it sufficient rest.*

(2) *Where the health visitor hesitates to give advice because a baby is attending the doctor and yet feels doubtful about whether the mother is really carrying out the doctor's instructions, it would clearly be helpful if the health visitor learned from the doctor exactly what he had advised.*

(3) *The general practitioner investigating a case of enuresis might be appreciably helped if the health visitor could let him know that there was considerable marital disharmony between the parents or that there was a dominating grandmother.*

(4) *The health visitor concerned about the pallor of the mother of a young family might be helped if the general practitioner stated that he had already done a blood count and excluded the anæmias or begun to treat the disease.*

(5) *Much of the time of a general practitioner treating an elderly patient might be saved if he knew that the health visitor had already set in motion the machinery for providing a home help or meals-on-wheels.*

(6) *The health visitor anxious to rescue an old man from apparent apathetic refusal to get out of bed might benefit from knowing that the general practitioner had diagnosed serious organic disease or had excluded it.*

QUESTION OF CONFIDENTIALITY.

The general practitioner, as private medical attendant of a patient, often learns things that the patient has not revealed to the health visitor. The health visitor, through her frequent visits to the house, often learns things that the patient does not reveal to the general practitioner whom he sees less often. It would be useful if doctor and health visitor each realised that the other was a highly trained professional person who could in general safely be regarded as coming within the bonds of confidentiality.

HOW CO-OPERATION CAN BE ACHIEVED.

Co-operation implies three things—knowledge by each person of the functions, responsibilities, and special skills of the other; willingness to seek the help of the other in appropriate cases and to give help where it is sought; and easy, frequent direct, two-way communication.

Medicine is an older profession than health visiting, and it can be taken for granted that all health visitors are already well aware of the duties and skills of the family doctor. As some doctors may not yet be fully aware of the responsibilities and skills of the modern health visitor, this memorandum has started with a brief outline of her basic training and main duties.

Mutual requests for help will probably follow automatically if there is goodwill on both sides.

The real difficulty is to provide easy and satisfactory channels of communication. Some of the difficulties in the way of such communication are—

(a) *Sheer numbers—there are some 77 general practitioners and some 60 health visitors in the City;*

(b) *Scattered areas of general practitioners' practices which, in at least some cases, extend all over the City;*

(c) *The fact that, while, for every family, there is a family health visitor, there are some families which do not have a family doctor,* e.g., *two members of a household may have different medical attendants;*

(d) *The fact that, while approximately two-thirds of the health visitors have clearly defined districts, the remaining third are engaged on specialist*

duties and an individual doctor cannot reasonably be expected to know whether a particular case would fall within the sphere of the family health visitor for the particular district or of a health visitor handling specialist work;

(e) *The fact that the health visitors do not as a rule have telephones in their houses.*

The following suggestions are offered in the hope that they may enable some of the difficulties to be overcome.

1. Approaches to General Practitioners by Health Visitors.

Where a health visitor feels that it would be in the interests of any individual or family that she is visiting for her to make contact with the general practitioner, it should be easy for her to ascertain the name of the doctor concerned and to approach him either by telephone or otherwise. While such approach is often particularly desirable in cases originally referred to the Health and Welfare Department by the doctor, there is nothing to prevent a health visitor from taking the initiative in other cases.

2. Approaches to Health Visitors by General Practitioners.

(a) Initial approach to Health and Welfare Department.—*Probably the easiest method of initial contact is for the doctor to write or telephone to the Department (usually to the Superintending Nursing Officer), giving broad outlines of the case and for the letter or transcript of the telephone call to be passed to the appropriate health visitor, who can then contact the doctor for fuller information, if necessary. This method has advantages in that the general practitioner will not always know which health visitor has the district in which the patient lives, the general practitioner may not know whether the case is of a type that would normally be allocated to a specialist health visitor instead of to the district health visitor, and it is useful for the Department to have information about the types and numbers of cases for which help is being sought.*

(b) Initial approach to Health Visitor.—*If the general practitioner knows which health visitor is responsible for the district in which a particular patient lives, there is nothing to hinder him from making the initial approach directly to the health visitor. If it should happen that the health visitor feels that the case is not appropriate for her* (e.g., *that it is outside her district or that it is a case that would normally be handled by a specialist health visitor), she can easily enough explain this to the doctor and suggest that he makes his request to the Department as indicated in* (a) *above. If, however, the health visitor feels that the case is appropriate to her, she can then take action, and a certain amount of time will have been saved.*

(c) Approach in cases in which the Health Visitor is already visiting a house.—*Where a health visitor is already visiting a house, it should be easy for the general practitioner to ascertain her name and to make direct contact with her.*

6.—TRAINING OF HEALTH VISITORS.

Features of the year included—

(*a*) Not merely a continuation of the remarkable examination successes achieved in 1953 and 1954, but also the securing of six out of the first seven places in the national examination for the health visitor's certificate;

(*b*) the introduction of prizes for all-round distinction, family case work, and health teaching;

(*c*) the transfer of the school to more satisfactory premises, and some modernisation of the furniture and teaching equipment;

(*d*) a continuation of the in-service training for health visitors that had been introduced in 1954; and

(*e*) certain distinctions gained by members of staff and by a recent ex-student.

History of the Training School.

Until 1948 there were in Scotland only two training schools in which selected state-registered nurses with the necessary midwifery qualification could take the additional full-time course to enable them to sit the national examination for the health visitor's certificate. One of these was in Glasgow under the auspices of the Corporation of that City, and the other in Edinburgh originally under the ægis of the University and later under the Health Committee of the Corporation. The vast extension of the duties of health visitors under the National Health Service Act, 1947, made it obvious that two training schools would no longer be adequate to meet the needs of the country. The Corporation of the third largest city in Scotland therefore decided to establish a training school.

The necessary central approval having been obtained, and various University departments having agreed to make available the services of members of their staff for instruction in special subjects, premises were equipped on the basement floor of 6, Castle Terrace, and a qualified health visitor tutor was engaged to take charge of the school and to supervise the theoretical and practical training of the students. Initially, there were considerably less than forty part-time lecturers (although the number rapidly increased)—professors and lecturers from the University, consultants employed by the Regional Hospital Board, senior members of the staff of the Health and Welfare Department, and other suitable persons with specialised knowledge.

In its early years the Training School was grossly hampered by complete inadequacy of accommodation, by unsuitable furniture, by lack of proper library, and by insufficiency of modern teaching equipment; and it also suffered from being

a single-tutor school. Nevertheless, it did excellent work under the direction of Miss Milne (till 1952) and Miss Lamont (from 1952).

In 1953 the Corporation became aware that—despite the excellent results obtained—a one-tutor school was really an anachronism and that, if post-qualification training of trained health visitors was also to be undertaken, the appointment of a second tutor was imperative. Accordingly, in 1954 a second qualified health visitor tutor was engaged, so that the staff now consisted of a principal tutor, an assistant tutor, and over fifty part-time lecturers. In 1954 a fifty-hour post-qualification course in mental health was provided for twenty of the fifty health visitors who volunteered to take it, the course being held on Tuesday evenings and Saturday mornings, and the tutors acting as co-ordinators of the course and discussion leaders. In 1954 also, study days for health visitors on individual subjects were introduced.

Improved Premises and Equipment.

In the autumn of 1955 the school was transferred from the basement of 6, Castle Terrace to the first and second floors of the same building. The accommodation now available includes two lecture rooms (with accommodation for 26 students), students' study, an adequate office for each tutor, a clerk's room, a small kitchen, &c. The building is old and the accommodation is by no means ideal, but it is a vast improvement on the dingy, overcrowded basement flat, and should do well enough for a few years until better accommodation can be provided.

A start towards the supplying of better equipment and more suitable furniture had been made in 1953 and 1954, and in 1955 the furniture and equipment were brought up to a reasonable standard of adequacy.

Introduction of Prizes.

The Aberdeen Health Visitor Training School must, before 1955, have been one of the few educational institutions—if not the only one—training students for a profession but not encouraging the more able students by the provision of any prizes. In 1955 the Corporation decided to award each year a prize, to be known as the Corporation of Aberdeen prize, to the best all-round student; the two tutors offered to donate, during each year that they continued in their present posts, a prize for health teaching; and the medical officer of health offered to donate, during each year of his tenure of office, a prize for social case work.

The first prize-giving ceremony was held in April at Balnagask House (the premises then occupied by the School being too small), the prizes were presented by Dr. May D. Baird, and the prize-winners were—

Corporation of Aberdeen Prize . .	Miss Alice Hay, R.G.N., S.C.M., R.F.N.
Proxime accessit . . .	Mrs. Elizabeth J. Forsyth, R.G.N., S.C.M.
Medical Officer's Prize for Case Work	Miss M. M'Hattie, R.G.N., S.C.M., Q.N.
Tutors' Prize for Health Teaching .	Miss C. E. Greig, R.G.N., S.C.M.

Results.

The success of the School can be judged by its results. In three consecutive years, 1953, 1954, and 1955, not a single student from the School failed to pass the national examination at the first attempt. In 1953 and 1954, a student from the School took first place each year in the national examination, and in 1955 a student from the School and a Glasgow student tied for first place. In 1955 also, Aberdeen students took the next five places in the examination, thus securing six out of the top seven places.

Mention may also be made of certain distinctions gained by members of the staff and by a recent ex-student. Miss D. J. Lamont, Principal Health Visitor Tutor, held during 1955 a World Health Organisation Senior Travelling Fellowship. This was indeed a signal honour, for this is the first time that such an award has been made to a public health nurse in this country. Miss M. Nairn, who trained at the School in 1953-54 and has since served in the Health and Welfare Department, secured a British Commonwealth and Empire Travelling Scholarship. Miss Lamont was appointed a member of the Area Nurse Training Committee, and was appointed Chairman of a Committee set up by the Scottish Health Visitors' Association to prepare evidence for the Working Party on Social Workers. Miss M. M. Byrne, Health Visitor Tutor, was appointed Honorary Secretary of the Aberdeen Tuberculosis Care Committee. Dr. MacQueen was appointed Chairman and Miss Lamont was appointed a member of a special committee set up by the Standing Conference of Representatives of Health Visitor Training Centres to prepare—for transmission to the Ministry of Health—recommendations about the proper staffing of Training Schools; and an article by Miss Lamont, published in *The Medical Officer*, had the honour of being summarised in the Annual Report of the Ministry of Health.

Number of Students trained.

Owing to the grave national shortage of suitable recruits to health visiting, there are vacant places in all the Training Schools. From the aspect of local reputation, it is at least satisfactory that, at the end of 1955, there were only five vacant places in the Aberdeen School (as contrasted with about eight and eighteen in Edinburgh and Glasgow, respectively). The number of students trained each year and the number subsequently employed by the Corporation were as follows:—

Year.	Total Number of Students.	Number later Employed by Corporation.
1948	20 ...	6
1948-49 . . .	20 ...	8
1949-50 . . .	19 ...	7
1950-51 . . .	21 ...	9
1951-52 . . .	19 ...	7
1952-53 . . .	20 ...	10
1953-54 . . .	17 ...	4
1954-55 . . .	22 ...	10
1955-56 . . .	21 ...	Still in training.

Visitors to Training School.

Among overseas visitors to the Training School during 1955 were Dr. Kjellberg (of the World Health Organisation), Mrs. Dennison (Fullbright Scholar, U.S.A.), Miss Aye (Chief Nursing Officer, Burma), Professor Vivian (M'Gill University, Montreal), Miss van Kevien (Ministry of Social Work, Holland), and Miss Hansom (Quwait, Persian Gulf).

In-Service Training of Health Visitors.

Health visitors trained before 1948, and even those trained in the years of transition, 1949-53, were given theoretical and practical instruction mainly in the old aspects of a health visitor's work—advising about the physical aspects of the health of children and expectant mothers, the prevention of infectious diseases, &c. They received very little, if any, training in the promotion of mental health, the prevention of diseases of mental and emotional origin, the maintenance of health in the elderly, and the application of the techniques of health education to non-infectious diseases. To equip these health visitors for their important new duties, post-qualification training is essential; and, since medico-social knowledge is in a phase of rapid increase, a whole series of post-qualification courses will be necessary.

As a start, study days have been instituted, and 46 of the Corporation's health visitors have attended intensive courses in mental health, 20 in 1954 and 26 in 1955. The finding of suitable lecturers for these courses was no easy task, although the work of co-ordinating the courses and acting throughout as discussion-leaders was undertaken by the health visitor tutors. However, the courses—which have attracted a good deal of attention in medical and health visiting circles—have been outstandingly successful, so much so, indeed, that in the second course it was found necessary to make only one minor change in the programme arranged for the first course; and these periods of intensive study of mental health should enable the health visitors to discharge more fully their important duties.

It is a tribute to the quality and enthusiasm of the Aberdeen health visitors that their attendance at these evening meetings was maintained even when extremely bad weather made the strain of their daily work even greater than usual.

7.—HOME NURSING.

During the year there were, for the third year in succession, slight increases in the numbers of patients treated and of visits paid by the day nursing service, and sharp increases in the numbers of patients treated and the number of visits paid by the night nursing service.

General.

Aberdeen is one of the twelve local health authorities that do not themselves employ district nurses. The Corporation discharge their duty to secure the attendance of nurses on persons who require nursing in their own homes through the agency of the Aberdeen District Nursing Association, the expense being met by the

Corporation. The Lord Provost, the Treasurer, the Convener of the Health and Welfare Committee, and one other Councillor, together with the Medical Officer of Health, are members of the Committee of the District Nursing Association, and during the last three years the Superintendent Nursing Officer has been co-opted to the Committee.

Co-operation.

As might be expected, the majority of the cases dealt with by the nurses employed by the Nursing Association are referred to them by general practitioners, although quite a proportion are initially discovered by the health visitors and referred either through the Health and Welfare Department or *via* the appropriate general practitioner. Also, in cases where a patient is discharged from hospital and requires nursing attention, an almoner at the hospital may contact the Superintendent of the Nursing Association to arrange for a nurse to provide that attention.

There is a standing arrangement that each month a list of old people who are convalescent and no longer require nursing attention is furnished by the Nursing Association to the department, so that appropriate health visitors can pay periodic visits to the old people to give medico-social advice and to ensure that they are getting any necessary assistance, *e.g.*, home helps, meals on wheels, &c.

Nursing of Children.

In view of the decrease in diseases of children that has followed the expansion of the preventive services, and in view of the very adequate hospital facilities available, there would appear to be no need for special provision for the domiciliary nursing of sick children in Aberdeen. Where children require home nursing, each nurse is responsible for the nursing of children in her district.

Changes in Type of Nursing.

Four changes may be noted.

(*a*) The Superintendent of the Association reports that there has been a sharp decrease in the number of surgical dressings, especially septic ones, despite the fact that patients are being discharged earlier from hospital.

(*b*) An increasing amount of injection therapy is being carried out by the nurses.

(*c*) Over 60 per cent. of all visits are now paid to persons over the age of 65 years.

The day nursing service paid 67,935 visits to 2,181 persons over 65 years, and 40,743 visits to 2,638 persons under 65.

The night nursing service paid 2,380 visits to 291 persons over 65 years, and 916 visits to 95 persons under 65.

(*d*) In particular, an increasing number of cancer patients are being nursed at home.

Classification and proportions of main types of cases.

The number of patients visited during the year was 5,205, as compared with 4,920 in 1954, 4,373 in 1953, and 4,115 in 1952; and the total visits paid numbered 111,638 as compared with 102,860 in 1954, 88,870 in 1953, and 82,788 in 1952.

The classification and proportions of the main types of cases dealt with by the nurses employed by the Nursing Association are as follows:—

Classification and Proportions of Main Types of Cases nursed in 1955.

DAY NURSING SERVICE.

Diseases	No. of Patients			No. of Visits			Age		Termination of Cases			
	M.	F.	Total	M.	F.	Total	-65	65+	Conv.	Transfer to Hosp.	Died	Continuing at 31st Dec.
Abdominal	324	538	862	4,495	4,876	9,371	526	336	686	70	42	64
Accidents	65	129	194	1,165	2,533	3,698	105	89	157	9	5	23
Amputations	16	4	20	572	70	642	5	15	5	5	2	8
Anæmia	9	109	118	232	2,787	3,019	31	87	29	9	11	69
Cancer	100	166	266	2,862	6,034	8,896	118	148	41	24	167	34
Cardiac	219	349	568	6,475	11,190	17,665	210	358	187	74	99	208
Cerebral Hæm.	100	201	301	3,068	7,581	10,649	60	241	54	35	134	78
Diabetes	14	78	92	2,286	13,352	15,638	19	73	34	11	4	43
Gynæcological	—	51	51	—	633	633	29	22	40	2	—	9
Miscellaneous	369	786	1,155	4,080	8,479	12,559	906	249	990	58	17	90
Nervous	23	62	85	982	1,885	2,867	60	25	48	10	8	19
Respiratory	264	360	624	3,065	3,886	6,951	407	217	525	38	24	37
Rheumatism	60	130	190	721	3,953	4,674	116	74	108	20	15	47
Senility	60	147	207	1,640	5,372	7,012	16	191	40	25	89	53
Varicose Ulcers	11	75	86	371	4,033	4,404	30	56	41	8	2	35
Total	1,634	3,185	4,819	32,014	76,664	108,678	2,638	2,181	2,985	398	619	817

Staff.

The staff of the day nursing service totalled 34 full-time nurses at the end of the year (including the Superintendent and two assistants) and two part-time relief nurses. The night nursing staff are mentioned separately below. The total of 34 compares with 37 in 1954.

Night Nursing Service.

The night nursing service (inaugurated early in 1952, and slightly extended and somewhat re-organised during 1953 in the light of the experience gained during the first year of operation) underwent little alteration during 1954 and 1955 apart from steady increases in the numbers attended. The service has already proved very useful. Its main function will probably ultimately be the provision of occasional skilled nursing (*e.g.*, visiting patients for four-hourly injections of penicillin or for injection of pain-killing drugs), but, so far, it has served mainly to provide nursing care for persons living alone or for persons whose relatives were exhausted from looking after the patient on previous nights. In 1955 (as in 1954) the staff employed on night work amounted to four trained nurses and two assistant nurses on a full-time basis and four trained nurses on a part-time basis. In all,

386 cases were attended during the year, and 3,296 visits were made (as compared with 324 patients and 2,960 visits in 1954 and 265 patients and 2,683 visits in 1953).

Details of the cases dealt with are given in the following table:—

NIGHT NURSING SERVICE.

Diseases	No. of Patients			No. of Visits			Age		Termination of Cases				
	M.	F.	Total	M.	F.	Total	-65	65+	Conv.	Transfer to Hosp. Hosp.	Transfer to Hosp. P. Nurse	Died	Continuing at 31st Dec.
Abdominal . .	5	6	11	17	103	120	7	4	6	2	—	2	1
Anæmia . .	2	3	5	8	10	18	1	4	2	—	—	3	—
Cancer . .	28	49	77	237	479	716	35	42	6	1	2	67	1
Cardiac . .	18	55	73	103	439	542	9	64	26	9	5	32	1
Cerebral Hæm. .	28	55	83	262	414	676	15	68	16	12	2	46	7
Miscellaneous .	7	24	31	36	160	196	7	24	10	3	—	14	4
Nervous . .	9	8	17	83	65	148	10	7	7	1	—	8	1
Respiratory .	10	28	38	38	197	235	6	32	16	4	2	14	2
Rheumatism .	1	10	11	3	303	306	5	6	5	1	—	2	3
Senility . .	5	35	40	28	311	339	—	40	14	2	—	23	1
Total . .	113	273	386	815	2,481	3,296	95	291	108	35	11	211	21

Training of District Nurses.

The Association undertakes training for the Queen's Certificate. At the end of the year, five students were receiving training.

The Report of the Working Party on District Nurses—published just before the end of the year—has recommended certain changes, including a reduction in the length of training of trained nurses taking the district nursing course.

8.—DOMESTIC HELP SERVICE.

The main features of the year were an increase in the number of domestic helps, a comparable increase in the number of households assisted, and a very sharp increase in the number of elderly persons assisted by home helps.

During the year, the number of domestic helps employed was increased to the maximum figure authorised by the Corporation, and at the end of the year the authorised establishment was raised to 120 full-time helps or an equivalent number of part-time helps. The increase in the establishment is, of course, an indication both of the high value of the service and of the need for further development. The approval of the Secretary of State has been obtained for an ultimate extension of the number employed to 200.

Households which may qualify for the domestic help service (whole-time or part-time) include those where there is a sick person, an expectant mother, a mentally defective person, an elderly person, and certain other categories. A charge is made for the home help, and is based on the applicant's income. In the

lowest income group (persons on national assistance), the minimum charge is refunded by the National Assistance Board.

The following is a table showing the number of domestic helps in the service at December, 1955, as compared with the previous four years:—

	1955.	1954.	1953.	1952.	1951.
Whole-time . . .	48	44	36	36	35
Part-time . . .	132	97	52	39	27

The great demand in Aberdeen is for part-time service, especially in the mornings. The following statement shows the distribution of the cases attended during 1955, as compared with the previous three years:—

	1955.	1954.	1953.	1952.
Total number of cases for which helps were provided	1,214	1,070	899	807
(*a*) Maternity and Child Welfare cases .	226	236	208	207
(*b*) Infirm and elderly cases (over 65) .	608	420	287	225
(*c*) Long-term illnesses (other than (*b*)) .	71	75	53	32
(*d*) Short-term illnesses (other than (*a*) or (*b*))	309	339	351	343

As was mentioned above, there is a sharp increase in the number of elderly, infirm persons attended in 1955.

The question of a sitter-in service has not yet been considered by the Corporation.

9.—VACCINATION AND IMMUNISATION.

Some of the main features of the year may be summarised as follows:—

1. The proportion of babies receiving vaccination against smallpox remained fairly steady, 70 per cent. in 1955 as compared with 71 per cent. in 1954.

2. The proportion of pre-school children immunised against diphtheria continued to rise slowly but steadily—from 51 per cent. in 1952 to 56 per cent. in 1953, 59 per cent. in 1954, and 62 per cent. in 1955.

3. The number of school children receiving primary immunisation against diphtheria decreased (because the majority of school entrants had been immunised at an earlier age), but the number receiving reinforcing injections was considerably greater than in any previous year.

4. The number of babies inoculated against whooping cough was a shade larger than in 1954: approximately 70 per cent. of all babies were inoculated.

5. During the year the Health and Welfare Department held a research grant from the Advisory Council for Medical Research to pay in full for the cost of an investigation of the efficacy of combined immunisation against diphtheria, whooping cough, and tetanus.

6. In 1955, as in previous years, general practitioners undertook a smaller amount of vaccination, immunisation, and inoculation than did the local authority staff. For smallpox vaccination the proportion for the last three years are—

	1955.	1954.	1953.
General practitioners . . .	43%	41%	50%
Local authority staff . . .	57%	59%	50%

For primary immunisation against diphtheria the proportions are—

	1955.	1954.	1953.
General practitioners . . .	33%	31%	29%
Local authority staff . . .	67%	69%	71%

For inoculation against whooping cough the proportions are—

	1955.	1954.	1953.
General practitioners . . .	39%	36%	40%
Local authority staff . . .	61%	64%	60%

For reinforcing injections against diphtheria the figure for each of the last three years has been 95 per cent. by local authority staff and 5 per cent. by general practitioners.

It had been anticipated that the research project (mentioned above) might slightly further decrease the proportion of immunisations against diphtheria and whooping cough undertaken by general practitioners, but, in point of fact, immunisations by general practitioners in 1955 have shown a slight but nevertheless welcome increase.

(1) VACCINATION AGAINST SMALLPOX.

It is sometimes stated that compulsion is an indication of national immaturity, and that, as civilisation progresses, persuasion can often replace compulsion. Vaccination against smallpox is still as necessary as ever, or perhaps more necessary than ever, in view of the increased possibilities of infection consequent on the spread of air travel, but since 1948 compulsory vaccination has been abolished and reliance placed on the persuasive efforts of the local authority. In all clinics and also in the course of their visits to the infant's home, the health visitors impress upon each mother the necessity of having her baby vaccinated against smallpox. The actual vaccination is performed either by the child's general practitioner (who receives a standard fee for notifying vaccination to the local authority) or—more frequently—by local authority doctors at child welfare clinics.

The total number of primary vaccinations in 1955 was 2,493, as compared with 2,640 in 1954 and 2,716 in 1953. During 1955, 1,076 vaccinations were notified by general practitioners and 1,417 were done at local authority clinics. The comparable figures for 1954 were 1,091 by general practitioners and 1,549 at clinics. The following table gives an analysis of primary vaccinations by year of birth and type of reaction:—

ANALYSIS OF PRIMARY VACCINATIONS.

Year of Birth	Typical Vaccinia greatest at 7th-10th day	Accelerated (Vaccinoid) Reaction 5th-7th day	Greatest Reaction 2nd-3rd day	No Local Reaction	Total
1955	1,502	4	6	93	1,605
1954	703	3	4	29	739
1953	55	...	...	1	56
1952	20	...	...	...	20
1951	12	...	...	...	12
1950	10	...	...	...	10
1949	6	...	...	...	6
1948	3	...	...	...	3
1947	...	...	...	...	...
1946	...	...	...	...	...
1945 or earlier . . .	38	2	1	1	42
Totals . . .	2,349	9	11	124	2,493

In the era of compulsory vaccination, about 85 per cent. of children in Aberdeen were actually successfully vaccinated; the Registrar-General's report for 1947 gives the figure of 85·1 per cent. for children born during 1946. For children born in 1954, the proportion successfully vaccinated by the end of 1955 was 70 per cent., and from the table it would appear that this figure is likely to be maintained in the case of children born during 1955.

For propaganda purposes, reliance is more and more being placed almost exclusively on the influence of the family health visitor.

(2) IMMUNISATION AGAINST DIPHTHERIA.

(a) Cases of Diphtheria.

Two cases occurred in 1955, the first cases for three years. Both were in persons who had never been immunised. There has been no fatal case of diphtheria in the City since 1950, in which year a non-immunised child died.

(b) Propaganda employed for Primary Immunisation.

As in the case of vaccination against smallpox, the health visitors make a great effort to ensure as far as possible that all children are immunised against diphtheria in their first year of life. This effort is not confined to the clinics but is made primarily in the people's homes. Leaflets are handed out and posters are displayed at the clinics, but it is felt that the personal approach by the health visitor is the thing of supreme value; all other measures of propaganda are merely supplementary.

(c) Re-immunisation.

Efforts are made to ensure that as many children as possible receive a reinforcing dose either just before going to school for the first time or in their first year at school; and a second reinforcing dose is available about three years later.

(d) Numbers immunised.

The numbers of individuals who completed a full course of immunisation or who received a reinforcing injection during 1955 are given in the accompanying tables. Figures for 1954, 1953, and 1952 are also provided for purposes of comparison.

DIPHTHERIA IMMUNISATION.

	Primary Immunisation				Reinforcing Dose			
	1955	1954	1953	1952	1955	1954	1953	1952
Number Immunised—								
(*a*) By General Practitioners	1,074	1,031	1,105	1,168	223	200	186	204
(*b*) At Child Welfare Clinics	1,573	1,639	1,721	1,162	201	166	230	137
(*c*) By School Health Service	613	630	970	937	4,205	3,614	3,768	3,600
	3,260	**3,300**	**3,796**	**3,267**	**4,629**	**3,980**	**4,184**	**3,941**

In other words, 33 per cent. of primary inoculations were carried out by general practitioners and 48 per cent. by doctors at child welfare clinics. Nineteen per cent. of primary inoculations were undertaken at school (about four years late), and the school health service also carried out over 90 per cent. of the reinforcing injections.

A more detailed breakdown of the immunisations performed during 1955 is given in the table on the next page.

(e) Percentage of Pre-school children who were immunised against Diphtheria at end of 1955.

The percentage of children aged 0-5 years recorded as being immunised was 51 in 1952, 56 in 1953, 59 in 1954, and 62 in 1955. While the trend is definitely in the right direction, it is highly desirable that the figure be raised to a considerable further extent. It must be emphasised that immunisation is a valuable safeguard against a dangerous disease, and that the Aberdeen figures still compare poorly with those of many other areas.

Diphtheria Immunisation.

The following tabulated statement shows the number of children immunised each year since 1946:—

Age in years on 31st December of the corresponding year.	1946	1947	1948	1949	1950	1951	1952	1953	1954	1955	Total Immunised at 31st December, 1955.
Under 1 Year . . .	10	102	119	88	103	140	169	334	438	550	
1 Year	323	972	1,171	1,270	1,345	1,506	1,511	1,686	1,688	1,696	Aged under
2 Years . . .	438	427	268	426	671	418	351	398	253	188	5 Years
3 ,, ...	152	170	87	138	216	116	115	193	128	76	9,318
4 ,, ...	93	118	64	50	106	79	72	130	85	63	
5 ,, ...	226	286	220	196	230	236	281	266	206	153	
6 ,, ...	419	498	382	428	438	427	563	575	355	340	
7 ,, ...	75	47	32	25	32	16	16	27	17	6	
8 ,, ...	54	40	22	9	15	13	6	10	6	7	Aged 5 Years
9 ,, ...	337	393	350	236	142	209	171	164	119	169	and over
10 ,, ...	12	28	7	4	3	4	3	4	1	4	21,751
11 ,, ...	11	17	9	2	4	3	2	3	...	1	
12 ,, ...	9	14	16	3	3	9	2	3	1	...	
13 ,, ...	2	9	1	1	...	2	...	...	1	...	
14 ,, ...	7	4	2	1	...	...	...	1	...	1	
15 Years and over . .	18	5	9	3	3	2	5	2	2	6	
Total each Year Immunisations	2,186	3,130	2,759	2,880	3,311	3,180	3,267	3,796	3,300	3,260	**Grand Total—1946-1955** 31,069
Reinforcing Injections . .	2,740	2,785	2,998	2,855	3,189	3,210	3,941	4,184	3,980	4,629	34,511

(f) Percentage of School children immunised against Diphtheria.

As mentioned in the section of this report dealing with school health services, 95·1 per cent. of school children in Aberdeen have been immunised at some time.

(3) IMMUNISATION AGAINST WHOOPING COUGH.

Although the Department of Health for Scotland has not yet given official approval to any vaccine as being completely efficacious, the Corporation—which carried out diphtheria immunisation for sixteen years before that form of protection was officially accredited—undertakes immunisation against whooping cough at the child welfare clinics. The health visitors encourage all mothers to have their children immunised either at the clinics or by their own general medical practitioners.

The following summary gives the numbers immunised against whooping cough during 1954 and 1955:—

	1954.	1955.
By general practitioners . . .	903	981
At clinics	1,580	1,513
Total . .	2,483	2,494

(4) RESEARCH PROJECT—COMBINED IMMUNISATION AGAINST DIPHTHERIA, WHOOPING COUGH, AND TETANUS.

Tetanus, although not a common disease, has a very high mortality rate when it occurs. There are in Britain about 80 deaths a year from this cause. There would undoubtedly be many more cases were it not for the universal hospital practice of giving injections of anti-tetanic serum to every patient with an open injury. This serum quite frequently gives rise to very unpleasant, though not serious, reactions. For these reasons, if some other means of preventing tetanus can be used, it is desirable that it should be introduced into the normal programme of immunisation of children. As a result of war-time and other experience, it has been proved that there is an efficient agent. Unfortunately, to immunise children separately for tetanus would increase the number of injections necessary. One would be reluctant to contemplate young children receiving eight separate injections in their first year—one for smallpox, three for whooping cough, and two each for diphtheria and tetanus.

As a result of work in France and elsewhere, it is known that protection against diphtheria and tetanus can be given by injecting a mixture of the two antigens without decreasing the potency of either, and has also been shown in this country and in the United States that diphtheria and whooping cough antigens can similarly be used together. A preparation of all three has proved effective in the laboratory and, to assess clinical efficiency, the Advisory Council for Medical Research has made available funds for a survey which is being carried out in Edinburgh and

Aberdeen. The research grant pays in Aberdeen for the half-time services of a research medical officer, the full-time services of a research health visitor, and the half-time services of a clerk.

The actual immunisation part of the project extended over the autumn of 1954 and most of 1955. Half the children whose parents agreed to take part in the trial were given three injections of the combined vaccine, while the other half were immunised against whooping cough and then against the other diseases (receiving five injections in all). The response of parents was extremely good. For the next year—or possibly two years—all children in the trial will be visited frequently to find out any infection or contact with whooping cough as well as other control infections. A final statistical analysis will embrace all information from Edinburgh and Aberdeen.

(5) IMMUNISATION AGAINST TUBERCULOSIS.

(a) Immunisation of Contacts.

Immunisation of contacts is carried out under the direction of the Chest Physician at the City Hospital, although a small amount of skin testing is carried out at child welfare clinics.

(b) Immunisation of School Children.

In 1953, the Corporation decided to carry out tuberculin testing and B.C.G. immunisation of school leavers and particulars of the work done were recorded in the "School Health Service" section of the report for that year. The Department of Health for Scotland in 1954 recommended to all local authorities that they should make provision for similar services in their areas.

During 1955, B.C.G. immunisation was offered to all children aged 13 years and upwards. A summary is given in the section of this report dealing with Prevention of Illness, Care, and After-care.

(6) OTHER IMMUNISATIONS.

Persons going abroad to certain countries need to be immunised against such diseases as yellow fever, &c., and in Aberdeen this immunisation is normally carried out at the City Hospital.

10.—PREVENTION OF ILLNESS, CARE, AND AFTER-CARE.

It is perhaps fair to say of the last three years that 1953 was the year of foundation-laying (*e.g.*, the alteration of the Corporation's scheme to permit of future developments, and the decision to undertake B.C.G. immunisation in advance of the Government's general authorisation); 1954 was the year of building (*e.g.*, the extension of the chiropody service, the development of a register of elderly persons, the provision of health services for elderly persons, the first home-safety campaign conducted by a local authority, the setting up of a register of handicapped persons, and the starting of services designed to help such persons); and 1955 was essentially a year of consolidation, in which the new services quietly developed. In respect of services for elderly people, for example, the outstanding features of the year are not fresh schemes (although there was a decision at the end of the year to appoint a full-time chiropodist) but rather an increase by nearly 100 per cent. of the number of persons on the register of elderly citizens, an increase in the number of old people visited by health visitors—to more than four times the number that were being visited two years ago, and an increase in the number receiving chiropody.

With regard to tuberculosis, it may be appropriate to mention that the death rate from all forms of that disease fell to 0·10 per 100,000, as compared with the 1954 low record of 0·12 and the previous record of 0·16 in 1953.

(A) TUBERCULOSIS.

(a) Broad Outline.

Provision of institutional care and specialist services are the concern of the Regional Hospital Board, while all functions relating to prevention, care, and after-care are in the hands of the local authority. Some of the latter functions may be summarised as follows:—

(i) *Contact tracing and follow-up.*—A patient may be notified by a general practitioner but is more usually notified by a chest consultant to whom the patient has been referred by the practitioner. Immediately a case is notified, the health visitor for the particular area visits the home and ascertains the number of persons in the house, sleeping accommodation, family medical history, names and addresses of frequent visitors, &c.; and endeavours are made to have all members of the household and other close contacts radiologically examined at the City Hospital. This intensive follow-up of all cases is of greatest value and may be the means of other members of the household keeping clear of the disease. It is also of profound epidemiological importance; tuberculosis is spread principally by unsuspected, undiagnosed persons. Hence the stress on frequent visitors and other close contacts.

(ii) *Co-operating with the Regional Hospital Board and with general practitioners* in determining the need of patients for admission to hospital. The Senior Chest Physician acts in respect of preventive work as an honorary member of the staff of the department, with six health visitors seconded to him. He, therefore

has at his disposal his own clinical record, a comprehensive report submitted by the health visitor on home and social circumstances, and any information made available to him by general practitioners. Hence he is in a very strong position to make a sound decision about the relative need for the admission of different patients to hospital.

(iii) *Assisting households with a tuberculous member to obtain adequate accommodation.* The Corporation, some years ago, adopted a policy whereby tenancy of Council houses is, in appropriate cases, granted to persons suffering from "open" tuberculosis, so that segregation of the infectious case can be made. It will, however, be appreciated that, with over 200 cases of tuberculosis notified annually, it is not practicable to allot houses to all tuberculous patients.

(iv) *Advice by health visitors to persons suffering from tuberculosis and living at home.* This advice covers the proper segregation of the patient from the rest of the household and the precautions which should be taken with a view to improving environmental hygiene, maintaining general health, increasing resistance, and generally ensuring that the remainder of the household do not contract tuberculosis. It also includes advice about financial allowances available and sources of help.

(v) *Arranging, where necessary, for boarding-out of child contacts.* Under the Corporation's Proposals for the Discharge of Functions, arrangements are made whereby child contacts can be sent to Linn Moor Home, Culter, a convalescent home run by a voluntary organisation. The Corporation, of course, make a payment in respect of the boarding-out of such child contacts. The period of residence in Linn Moor Home varies according to the health of the child. In 1953, the Corporation amended their Proposals for the Discharge of Functions so that they are now empowered to send to Linn Moor Home any child who is debilitated, and are no longer restricted to the contacts of tuberculous patients.

(vi) *Providing beds, bedding, and nursing requisites.* In certain circumstances a loan is given of beds and bedding, on the recommendation of the Chest Physician after the health visitor has submitted a report on the home conditions.

(vii) *Co-operating with Ministry of Labour* in resettlement of tuberculous persons in employment or in their entry to sheltered employment. With regard to the resettlement of tuberculous persons, the Chest Physician is in close contact with the Ministry of Labour and National Service to ensure that patients who have suffered from tuberculosis obtain employment suitable to their condition. The Corporation also send patients to Papworth Village Settlement and to the British Legion Village at Preston Hall, where tuberculous patients unfit for their previous occupation may obtain training in other occupations. At the end of the year there were two persons resident in Papworth Village Settlement for whom the Corporation were making a contribution towards maintenance.

(viii) *Co-operation with the voluntary after-care committee for tuberculosis.* This committee is mentioned on page 63. Co-operation is assured since the Honorary Secretary, one of the two Vice-Presidents, and several members of the committee are members of the staff of the Health and Welfare Department.

(b) Co-ordination with diagnostic and curative service.

By arrangement with the Regional Hospital Board, the Senior Chest Physician and his staff are available for the medical supervision, under the administrative control of the Medical Officer of Health, of the operation of the Corporation's arrangements. When discharging functions under these arrangements, the physician is regarded as having the status and responsibilities of a Deputy Medical Officer of Health (Tuberculosis); and—as indicated above—a number of health visitors are employed full-time on tuberculosis work and operate under the direction of the Chest Physician.

Co-ordination is facilitated by the fact that the Chest Physician has himself had considerable experience of local authority work and by the fact that the tuberculosis health visitors undertake the duties which in some other areas are discharged by almoners. In practice, co-ordination is extremely good. When a case of tuberculosis is notified to the Medical Officer of Health by a general practitioner, the notification is forthwith intimated to the Chest Physician and, where a suspected case is referred by the practitioner to the Chest Physician, the notification is made by that officer whenever diagnosis is complete. Moreover, where deemed desirable, action can be taken in advance of any formal notification. A sanitary inspector's report and a health visitor's report are made available so that the Chest Physician has full information on clinical state, family circumstances, housing conditions, &c. In the light of the full information, the Chest Physician is enabled to reach decisions about the patient's admission to hospital. Contacts, as already mentioned, are followed up by local authority health visitors and urged to attend for examination by the Chest Physician, and health visitors advise patients about hygienic aspects when living at home, about allowances, and help available. When discharge of a patient from hospital is contemplated, the Medical Officer of Health is notified of any particular needs. Indeed, the complete co-ordination and co-operation that exists in respect of tuberculosis might well serve as a model for the setting up of schemes for other diseases.

(c) Examination of contacts.

The patient's family or household are regarded as a unit and, as already stated, an endeavour is made to have all members of the family (as well as other close contacts) radiologically examined at the City Hospital. Considerable persistence and persuasive skill on the part of the health visitor are sometimes necessary to gain the full co-operation of the family, but it is interesting to note that, during the year under review, 1,175 contacts were examined. The number of contacts who, during the year, were clinically examined, skin tested, and found to have tuberculosis was 20.

(d) B.C.G. Vaccination.

The following is a copy of the return which was submitted to the Department of Health, giving particulars of the B.C.G. vaccinations performed:—

B.C.G. Vaccination, 1955.

Return for Period 1st January, 1955, to 31st December, 1955.

GROUP	Tuberculin Tested		Negative Re-actors		Vaccinated during 1955	
	M.	F.	M.	F.	M.	F.
(1) Nurses	10	289	1	98	1	98
(2) Medical Students	54	26	16	9	14	8
(3) Contacts	251	225	218	198	194	180
(4) Special Groups:—						
(a) School leavers	1,099	1,229	729	854	709	819
(b) New born babies	—	—	—	—	13	20
(5) Others	189	97	92	53	68	45

(e) Mass Miniature Radiography.

The introduction of mass miniature radiography was curiously belated in Aberdeen. Not till 1953 did a radiography unit of the Regional Hospital Board commence large-scale operations. In that year a total of 31,687 persons were examined, and of these 92, or 0·3 per cent., were found to be suffering from tuberculosis. In 1954 the unit was, on the instructions of the Department of Health for Scotland, away from Aberdeen for a considerable part of the year; but, during the months that it was in the City, 19,073 persons were examined, of whom 42, or 0·2 per cent., were found to have tuberculosis. In 1955 a campaign was attempted during the coldest and least favourable part of the winter, and the unit was again away for a large portion of the year. Nevertheless, during the year, some 24,000 persons were examined.

(f) Supply of extra nourishment.

Extra nourishment (such as cod liver oil and milk) is given to necessitous cases on the recommendation of the Chest Physician. It is interesting to note that, during the year, 477 patients received milk free of charge at a cost to the Corporation of approximately £3,225.

(g) Notification.

Table A, on page 64, gives the number of tuberculous cases notified during 1955, and, for comparative purposes, the figures for 1954 and 1953 are also given. These are divided into respiratory and non-respiratory and arranged according to age-period and sex.

(h) Formation of a Tuberculosis Care Committee.

A noteworthy event of the year was the formation of a voluntary tuberculosis care committee to assist in the prevention and after-care of tuberculosis, and to try

to cover the gaps in the statutory services. The Committee got off to a very good start, and is undoubtedly undertaking work of high value.

TABLE A.—NUMBER OF CASES OF TUBERCULOSIS NOTIFIED IN 1955.

	NUMBER OF CASES NOTIFIED AS SUFFERING FROM TUBERCULOSIS.								
	AGE-GROUPS.								
	Under 1	1-5.	5-15.	15-25.	25-35.	35-45.	45-65.	65 upwards.	TOTAL.
RESPIRATORY.									
1955 Males	2	3	12	26	16	14	29	6	**108**
1954 Males	*2*	*7*	*3*	*8*	*23*	*20*	*54*	*6*	*123*
1953 Males	—	*7*	*8*	*35*	*20*	*19*	*30*	*8*	*127*
1955 Females	1	3	9	38	27	8	7	3	**96**
1954 Females	*1*	*6*	*5*	*6*	*48*	*22*	*15*	*2*	*105*
1953 Females	—	*4*	*15*	*46*	*32*	*11*	*7*	*1*	*116*
NON-RESPIRATORY.									
1955 Males	—	2	3	1	2	1	2	—	**11**
1954 Males	*1*	*3*	—	*2*	*2*	—	*2*	—	*10*
1953 Males	—	*4*	*1*	*1*	—	*1*	*2*	*1*	*10*
1955 Females	—	2	2	4	2	1	2	—	**13**
1954 Females	—	*3*	*2*	*3*	*3*	*3*	*1*	*1*	*16*
1953 Females	—	*5*	*3*	*3*	*4*	—	*6*	—	*21*
RESPIRATORY AND NON RESPIRATORY.									
1955 Male and Female	3	10	26	69	47	24	40	9	**228**
1954 Male and Female	*4*	*19*	*19*	*19*	*76*	*45*	*72*	*9*	*254*
1953 Male and Female	—	*20*	*27*	*85*	*56*	*31*	*45*	*10*	*274*

The appended graph shows the notifications and deaths from respiratory tuberculosis during the past few years.

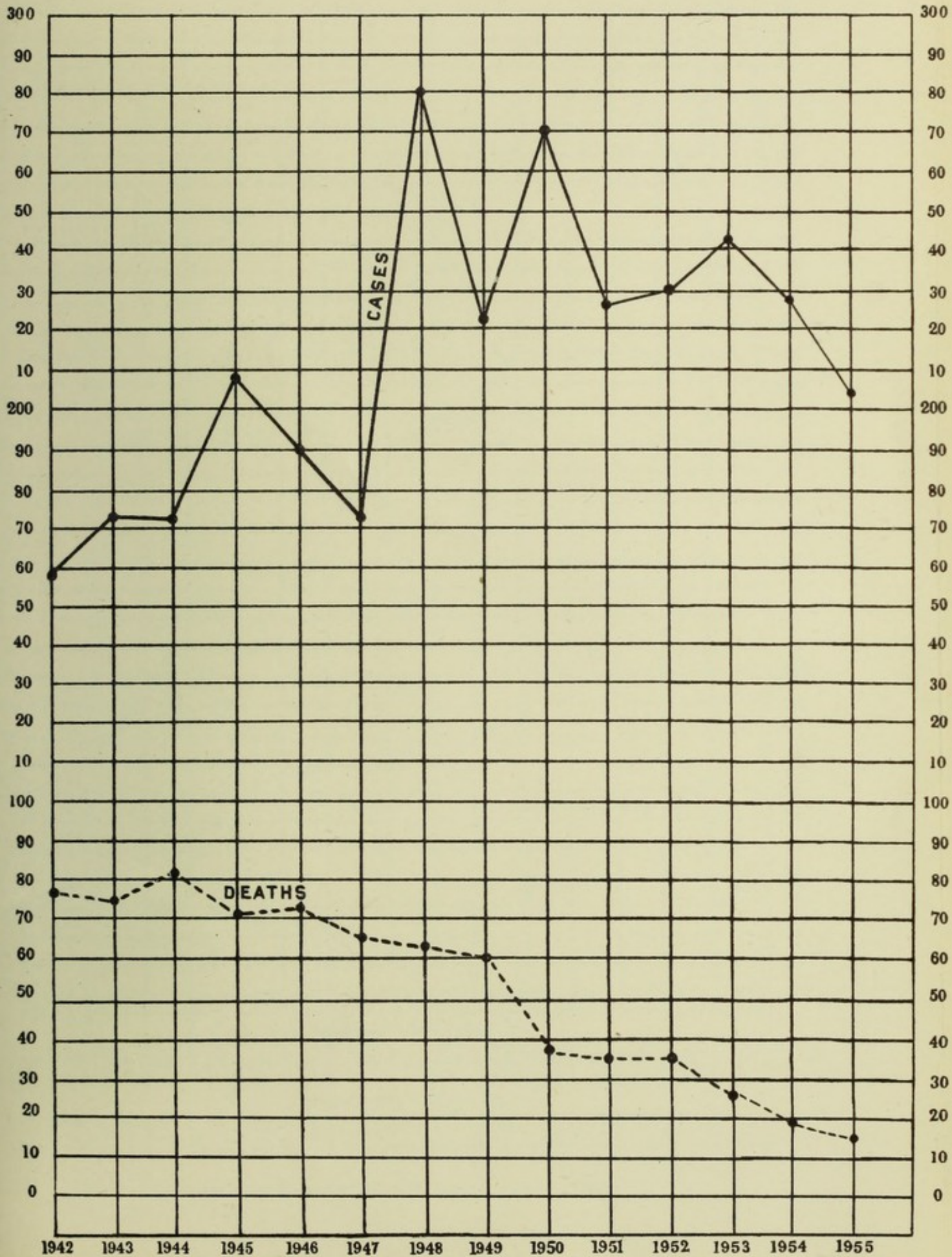
As regards the site of the disease, in the 24 cases notified as suffering from tuberculosis other than respiratory, 1 suffered from tuberculosis of the bones and joints (including spinal tuberculosis), 5 from tuberculous meningitis, 5 from tuberculous glands, 5 from genito-urinary tuberculosis, 6 from abdominal tuberculosis, and 2 from other forms of tuberculosis.

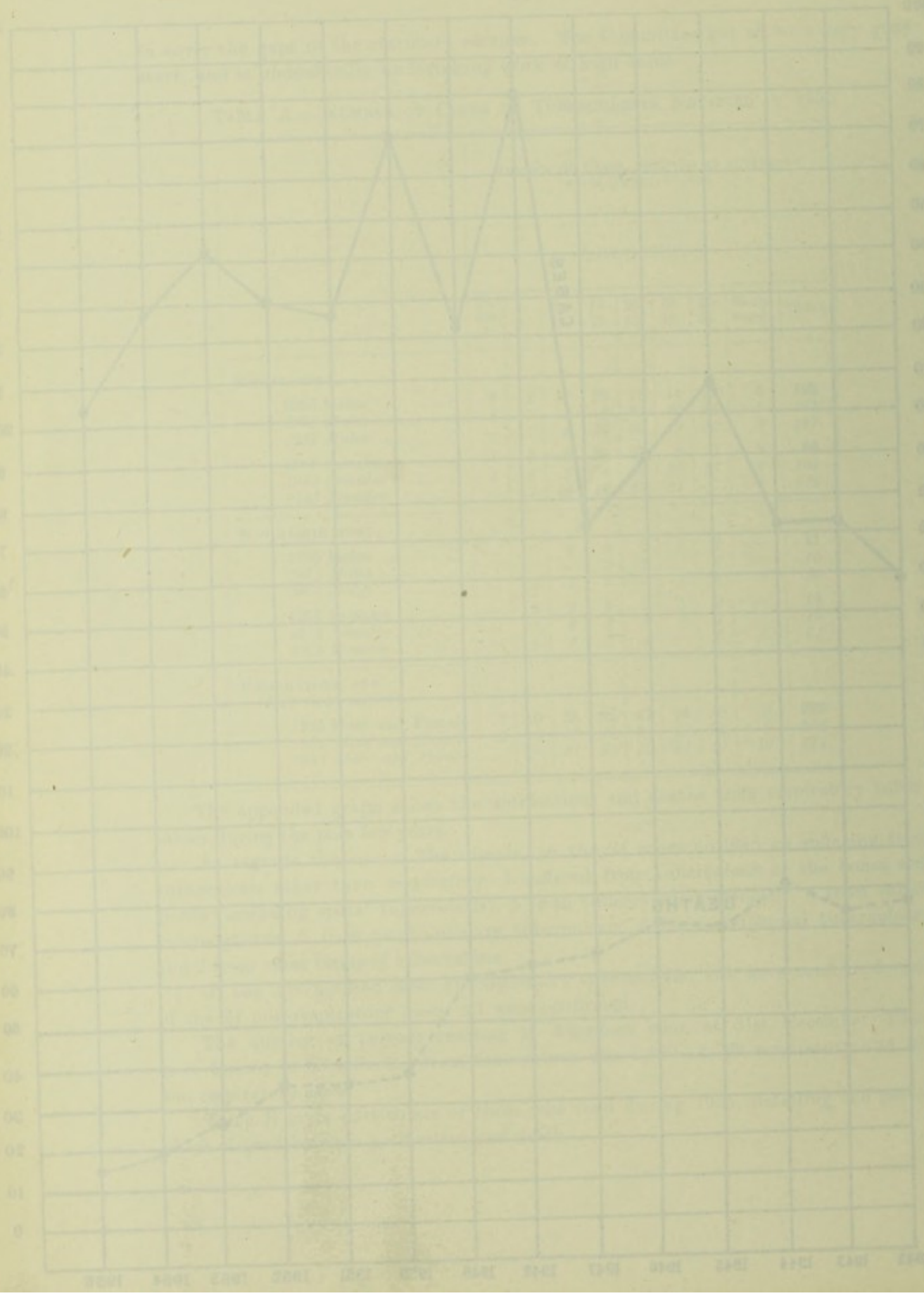
Of the 204 notified cases of respiratory tuberculosis, 191 were confirmed, and of the 24 non-respiratory cases, all were confirmed.

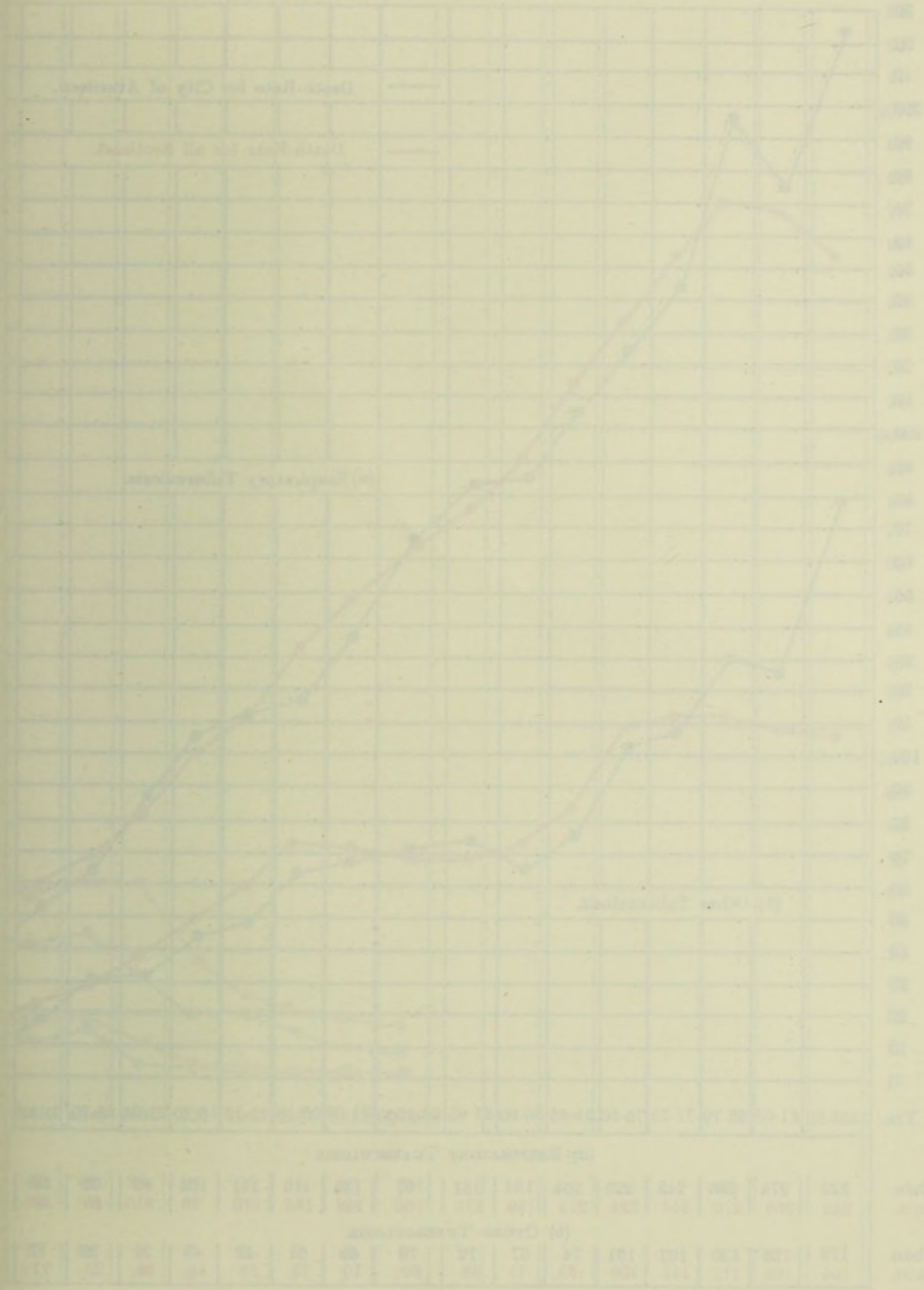
The number of persons residing in Aberdeen who, at 31st December, 1955, were known to be suffering from tuberculosis was 1,890—1,789 respiratory and 101 non-respiratory cases.

Table B gives particulars of those who died during 1955, detailing the period which elapsed between notification and death.

Cases and Deaths from Respiratory Tuberculosis, 1942-1955







ALL AGES

Deaths per 100,000 of Population. (Civilian

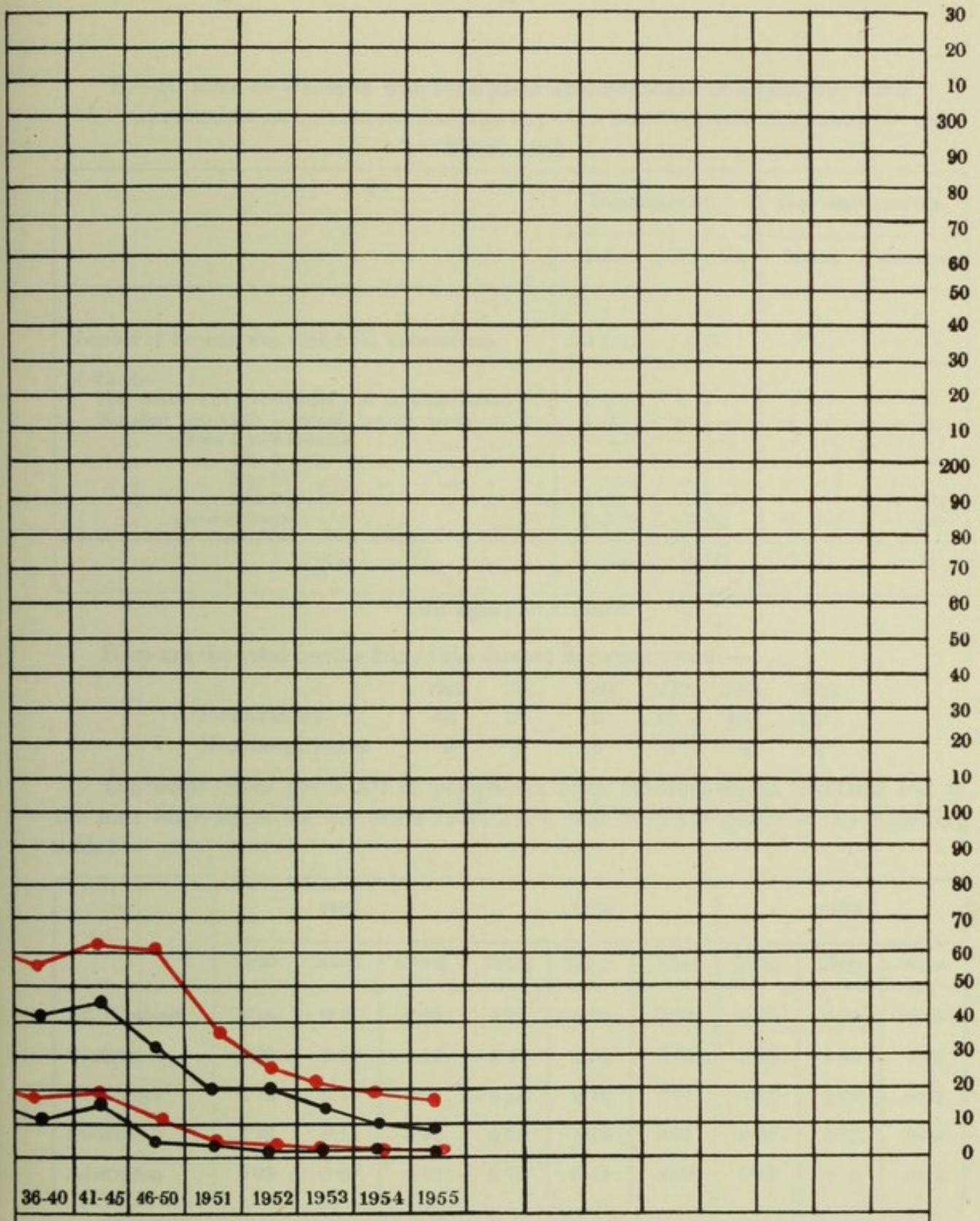
Yrs.	1856-60	61-65	66-70	71-75	76-80	81-85	86-90	91-95	96-1900	01-05	06-10	11-15	16-20	21-25	26-30	31-35
(a) RESPIRATORY TUBERCULOSIS.																
Abdn.	322	274	298	243	223	204	184	181	167	138	116	111	106	88	62	52
All Scot.	253	266	270	254	234	213	190	175	166	148	131	110	99	81	68	59
(b) OTHER TUBERCULOSIS.																
Abdn	179	128	130	107	101	74	67	72	70	69	61	49	43	31	30	17
All Scot.	104	109	112	111	109	83	71	68	69	70	73	59	48	36	28	21

(Corrected for transferred deaths in 1904 and subsequent years.)

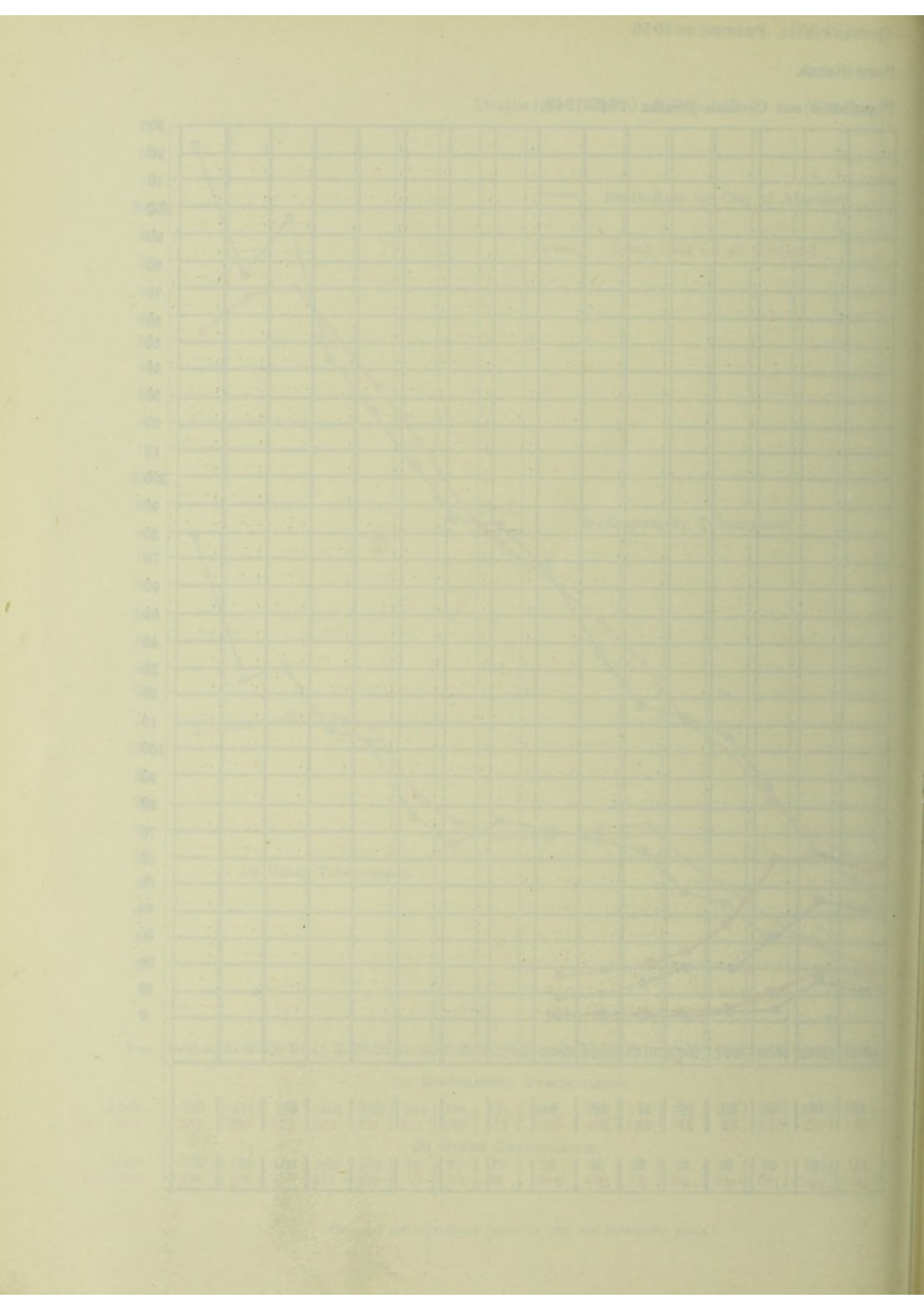
—Quinquennial Periods. to 1950.

Both Sexes.

Population and Civilian Deaths 1940-1946.)



41	46	32	20	20	14	10	8
56	62	61	37	27	23	20	17
11	16	5	3	2	2	2	1
18	20	11	6	4	3	2	2



B.—Number of Persons who died from Tuberculosis in Aberdeen, with particulars as to period elapsing between notification and death—

Year, 1955.

	Respiratory.		Non-respiratory.	
	Males.	Females.	Males.	Females.
	*	*	*	*
Number of Persons who died from Tuberculosis .	11 (15)	4 (4)	2 (1)	— (3)
of whom—				
Not notified or notified only at or after death .	2 (1)	— (—)	2 (1)	— (1)
Notified less than 1 month before death . .	1 (1)	— (—)	— (—)	— (1)
,, from 1 to 3 months ,, ,, . .	— (—)	— (—)	— (—)	— (—)
,, ,, 3 to 6 ,, ,, ,, . .	— (—)	— (—)	— (—)	— (—)
,, ,, 6 to 12 ,, ,, ,, . .	— (—)	— (—)	— (—)	— (—)
,, ,, 1 to 2 years ,, ,, . .	2 (1)	1 (—)	— (—)	— (1)
,, over 2 years	6 (12)	3 (4)	— (—)	— (—)
Total	11 (15)	4 (4)	2 (1)	— (3)

* 1954 figures in brackets.

Here are the total deaths from that disease in recent years:—

	1950.	1951.	1952.	1953.	1954.	1955.
Respiratory .	38	36	36	26	19	15
Non-respiratory	5	5	4	4	4	2

The death-rates per 1,000 of population from tuberculosis in Scotland and in the four large cities for the years 1955, 1954, and 1953 are given in the following table:—

	1955			1954			1953		
	Total	Resp.	Other	Total	Resp.	Other	Total	Resp.	Other
All Scotland .	**0·19**	0·17	0·02	**0·22**	0·20	0·02	**0·26**	0·23	0·03
Glasgow . .	**0·36**	0·33	0·03	**0·37**	0·34	0·03	**0·47**	0·43	0·04
Edinburgh .	**0·12**	0·10	0·02	**0·20**	0·19	0·01	**0·25**	0·23	0·02
Dundee .	**0·18**	0·15	0·03	**0·20**	0·19	0·01	**0·20**	0·17	0·03
Aberdeen .	**0·09**	0·08	0·01	**0·12**	0·10	0·02	**0·16**	0·14	0·02

The accompanying chart shows the death-rates since 1856, together with a comparison between Aberdeen and all Scotland.

(B) OTHER DISEASES.

Prevention—General Points.

(1) The measures employed for the specific prevention of diphtheria, whooping cough, tetanus, and smallpox have already been described in the chapter on vaccination and immunisation.

(2) General measures for the prevention of diseases in children have been outlined in the chapter on maternity and child welfare.

(3) Health education, including the important aspect of the promotion of mental health, and also including measures for the prevention of food-borne diseases, is discussed in a subsequent chapter.

The prevention of home accidents has been discussed in the preface to this report, and was more fully described in the report for 1954.

Prevention of diseases in the elderly.

Since prevention, after-care, and welfare are closely linked in the case of old people, it is convenient to discuss the measures for the health and welfare of the elderly in a subsequent section. However, it may be appropriate to mention two points here:—

(*a*) The register of elderly persons or couples living alone has amply justified itself. It now contains some 1,350 names, and over 99 per cent. of the old people visited by health visitors have welcomed the visits.

(*b*) The chiropody service has continued to develop. During the year 711 persons had 2,725 visits to the chiropody clinic; and 1,687 visits were paid to 450 persons in their homes. At the end of the year the Corporation decided to appoint a full-time chiropodist.

Care and After-Care.

The work of the local health authority has here again been very greatly extended by the National Health Service (Scotland) Act, but, as in so many other fields of the work, shortage of staff has as yet prevented the full implementation of the new duties.

Apart from care and after-care in cases of tuberculosis, it may be relevant to mention here the after-care services that are being developed for the elderly. District nurses refer to the Health and Welfare Department elderly patients whom they have been attending and are ceasing to attend and who, in their opinion, would benefit from visits by health visitors. Similarly, hospital staff refer quite a number of elderly patients on discharge from hospital.

After-care is required (but not yet available) for many patients discharged from hospital, *e.g.*, after being treated for cardiac diseases, peptic ulcer, cancer, and various mental diseases.

11.—HEALTH EDUCATION.

Features of 1955 included—(1) the organisation, for the second successive year, of a post-qualification course in mental health to enable health visitors more adequately to undertake their important duties in respect of mental health education; (2) a continuation of the campaign, initiated in 1954, for the prevention of home accidents; (3) an intensification—following a study day for health visitors in 1954 on the health care of elderly citizens and a study session for departmental medical officers on the same subject—of the individual health education of persons of ripe years; (4) a slight increase in the number of health talks given at clinics; (5) a considerable increase in the number of health talks given to pre-formed audiences; (6) an attempt to educate the staffs of various catering establishments in the principles of food hygiene; (7) a decision to produce in 1956 a booklet on Clean Food; and (8) a decision, taken during the year but not operative until 1956, to set up a Health Guidance Section in the Health and Welfare Department.

Several of these developments are discussed in other sections of the Report, *e.g.*, the mental health course is considered in the chapter dealing with Training.

The Need for Health Education.

Health education is by far the most important function of a local health authority, and its importance—both absolute and relative—is increasing year by year.

In the era of "environmental hygiene" many improvements in the health of the people were brought about by measures imposed by local authorities without the need for active co-operation by the individual members of the community. For example, the ordinary citizen did not have to take any action (beyond paying his rates) to secure the provision of safe water supplies and proper sewage disposal, with consequent reduction of water-borne diseases. Increasingly, however, further improvements in health are coming to depend on the activity of the citizens as a whole. This is true of most of the remaining infectious diseases: we cannot, for instance, eliminate food-borne infections without the active co-operation of the individuals who handle food in the shop and in the home; and we cannot immunise or vaccinate children against such diseases as diphtheria, whooping cough, tuberculosis, smallpox, and poliomyelitis unless the parents have become actively aware that inoculation is in their children's interests. It is even more true of non-infectious physical conditions: for example, we cannot do much to prevent domestic accidents unless the average householder is persuaded to pay some attention to home safety. It is true of the health maintenance of the elderly: we cannot preserve or improve the health of elderly citizens unless these citizens both understand the advice offered and are prepared to accept it. It is also true of diseases of mental and emotional origin: to reduce neurotic and psychosomatic disorders by improving

the standards of parent-craft and child-care and the serenity of the domestic atmosphere, the interested and active co-operation of parents is an obvious necessity. It is, therefore, of the highest importance to give as many individuals as possible an intelligent appreciation of how preventable diseases are caused, to let people get an insight into the nature of health problems, and to persuade them to adjust their patterns of living to prevent needless illness.

Moreover, health is far more than merely the absence of disease. A person can be listless, dispirited, apathetic, "only half alive," without suffering from any recognisable illness. Health is a condition of physical, mental, emotional, social, and spiritual well-being, a state in which body and mind are functioning efficiently, and in which the individual is correctly adjusted to all factors in his environment. The promotion of health as well as the prevention of disease can be achieved only by health education.

The National Health Service in Britain costs over £500,000,000 a year, three-fifths of the money being spent on the hospital treatment of disease and injury. Sickness benefit costs another £90,000,000 annually, and about 200,000,000 working days are lost each year through illness. These losses of money and time are bound to continue until preventive measures reduce the incidence of sickness; but already a goodly number of diseases and injuries are recognised as preventable. The main available method of prevention is health education. Various local health authorities have therefore created Health Education Sections in their Health Departments, and the Chairman of the Sheffield Health Committee appropriately summed up the financial aspects in his presidential address to the Royal Society of Health in 1954:

> "I believe that money provided for health education is a sound social investment, which will yield rich dividends in the social well-being and happiness of the people."

Varieties of Health Education.

All health education aims at the acceptable presentation of knowledge which will help to improve physical or mental health.

Probably the commonest misconceptions about health education are that it is simple and that it consists mainly of group-teaching. The misconception about simplicity is due to the early emphasis on the simple things necessary to prevent food-borne infections—hand-washing, physical cleanliness, &c. Actually, if one considers such aspects of health teaching as the rectification of the attitude of a mother who is over-protecting a delicate child or who is expecting from her three-year-old the behaviour standards of a child of four, or the convincing of a man previously engrossed with his work that he ought to cultivate hobbies in preparation for his retirement, it soon becomes obvious that health education (far from being simple) is about the most complex subject in the whole range of the medical and biological sciences.

As for group-teaching, while it is a valuable adjunct to individual health-teaching, it cannot as a rule be more than a supplement. Health Weeks, Health

Sundays, Health Exhibitions, Parents' Clubs, Classes for Expectant Mothers, Public Lectures, and so forth are of relatively little use by themselves, although they can be of the highest value when employed to reinforce the work of the individual health teacher in the home.

Individual Health Teaching.

The education of individual persons and individual families in their own homes is the primary task of the district health visitor, supplemented by other health workers. It is of basic importance, because the health visitor knows the personality, temperament, interests, abilities, and social and educational background of the individual, and can adapt her teaching to the particular needs and capacities of the person taught.

Individual health teaching comprises a large part of the work of health visitors and departmental medical officers. The family health visitor in the home advising on the immunisation of the baby or the behaviour difficulties of the toddler or the preparation for retirement by the elderly persons, the health visitor guiding the family as a whole towards a better integration with their environment (in the wider sense of that word), the doctor at the child welfare clinic advising an individual mother about the physical or emotional problems of her child, the doctor at the ante-natal clinic discussing with an expectant mother the hygiene of pregnancy, the health visitor at the same clinic discussing the emotional re-adjustments that will be necessitated by the birth of the child, the school doctor or school health visitor inculcating the idea of health maintenance as part of one's duty to oneself and to the community, the district nurse or the sanitary inspector or the home help striving in the case of an individual household to remove factors prejudicial to health—these are the various people who do most of the effective health education teaching. The family health visitor has, inevitably, the main rôle: she has considerably more training in health teaching than has the departmental medical officer, and she has the tremendous advantage of free access to the homes.

In Aberdeen, the vital rôle of the family health visitor in health teaching has been recognised: the establishment has been increased to 85 health visitors (or 1 per 2,200 total population), and efforts—at present unfortunately unsucessful—are being made to secure, over a series of years, the necessary staff to fill the vacancies. The existing district health visitors are already undertaking a considerable amount of individual health education, and attempts are being made—by study days, &c.—to equip them more fully for these tasks.

For the most complicated but also the most needed form of individual health teaching, education in mental health, it has been appreciated in Aberdeen that the health visitor not only possesses unique qualifications—an unrivalled knowledge of normality, a training in the art of persuading, an entry to the home before any faulty situation exists, an intimate knowledge of the family, and, in the eyes of the family, the authority conferred by her triple training as nurse and midwife and health visitor—but is about the only person in the community who is at all competent

to undertake this teaching. Accordingly, the better to enable health visitors to cope with the teaching of mental health, post-qualification courses were conducted in 1954 and 1955.

Group Health Teaching.

Although it tends to be unsatisfactory when employed alone, group health education can form a most useful supplement to individual teaching in the home and in the clinic. The formal lecture, the informal talk, the open forum, the discussion group, and the health exhibition all have their place in the work of a modern health department.

Group health education is perhaps best considered under two heads, systematic and sporadic.

An example of systematic group teaching is the setting up of mothers' clubs or parents' clubs, with a series of weekly meetings, perhaps devoted in one term to a discussion group on the emotional development of children, in another term to discussions on accident prevention, and in a third to the preparation of a small health exhibition. Another example is the organisation of a course of talks for prospective parents, preferably held in the evenings. Not a great deal of systematic group-teaching of adults has as yet been attempted in Aberdeen, but an attempt in 1955 to increase the previous small number of talks given at child welfare clinics suggested that very considerable expansion of these talks would be possible in the future—particularly if they were re-organised, well co-ordinated, and supported by films, film-strips, models, flannelgraphs, charts, &c.

Under the heading of sporadic group health teaching may be mentioned occasional talks or discussions at Church Guilds, Co-operative Guilds, Youth Clubs, Parent-Teacher Associations, Old People's Clubs, and so forth. During 1955 several members of staff, and in particular the two health visitor tutors, gave generously of their leisure time in an attempt to develop sporadic health teaching. The success of these efforts made it obvious that, if sufficient speakers were available, there would be a very considerable demand for health talks.

It may also be mentioned that, during 1955, an attempt was made to raise the standards of hygiene in several catering establishments. In addition to an intensification of the normal visits by sanitary inspectors, visits were paid by senior members of the medical and health visiting staffs, and the health visitor tutors gave talks on food hygiene and the prevention of food-borne disease to employees of selected catering establishments.

Press Advertisements, Booklets, Posters, &c.

Leaflets, brochures, public advertisements, and so forth, if well prepared and well timed, can be useful supplementary measures of health education, though they appear to have little effect if employed alone. It has always to be remembered, however, that health propaganda of this nature has to compete with commercial advertisements, so that preparation and timing require a considerable amount of skill and hard work.

The reception of the rhyming slogans (printed and issued in connection with the home safety campaign in 1954) and of the booklet on prevention of home accidents (in 1955) gave an indication of what could be achieved in this field. These successes not only led in 1955 to a decision to issue a booklet on Clean Food in 1956, but also helped to facilitate a decision to set up a Health Guidance Section in the Health and Welfare Department.

Varieties of Health Guidance Sections.

It was obvious, as mentioned above, that some expansion of systematic health education and considerable expansion of sporadic health talks had been achieved so easily that, if suitable personnel became available, very considerable further expansion would be possible. It was also obvious that such expansion would be very much in the interests of the community.

It was also clear, however, that any appreciable development of group health education would involve a very considerable amount of highly skilled work. The actual giving of health talks and leading of discussion groups would involve skills analogous to those required for further education work of an advanced type; and the preparation of suitable leaflets, the selection of appropriate films and film-strips, the arrangement of interesting and informative programmes of systematic instruction, the selection of demonstration material, the allocation of speakers to audiences, and the general co-ordination of the work would call for considerable administrative and organising capacity and would also consume much time. Broadly, it was realised that the people undertaking the work would require such talents and skills as—adequate technical knowledge of health matters, ability to select appropriate points, ability to lead community projects, adequate training in methods of imparting information to different types of audience, skill in public speaking, knowledge of some of the commoner aids to teaching, some knowledge of the interests and abilities of the people to be taught, and—in the persons responsible for the organisation and administration of the scheme—balanced judgment, organising power, and ability to delegate.

When the Health and Welfare Committee considered the creation of a health guidance section, it appeared that three separate patterns of health education lecturers had been evolved elsewhere—

(A) *Medical officers for health education*, generally assisted by less highly qualified officers and appropriate clerical staff. Disadvantages of this pattern were that medical officers have a more detailed training in the diagnosis and treatment of diseases than is strictly necessary for health guidance lecturers; that it is very difficult to find medical officers with the requisite knowledge of teaching methods; and that outstanding public health medical officers with organising ability and experience of teaching would be unlikely to seek employment in health education posts where their separation from other aspects of public health work would impair their chances of promotion.

(B) *Trained teachers* (e.g., *with degrees in biology) with some subsequent training in health matters*, with appropriate clerical assistance. Disadvantages of this pattern were that advanced further education work in any field demands considerable specialised knowledge on the part of the teachers; that no short course of instruction in health matters could provide sufficient information about the processes of physical and mental disease and the principles of the promotion of physical, emotional, and social health to convert the individuals into experts competent to teach others; that, once health education had passed beyond its simplest and most elementary phases, teachers with neither medical nor nursing backgrounds might possess no more knowledge of their subject than some members of their audiences; and that teachers with sufficient persuasive power to interest audiences that were free to depart and with sufficient organising power to take charge of health education would be unlikely to accept "dead end" jobs in a health and welfare department, since their qualities would be such as to mark them out for high promotion if they remained as school teachers.

(C) *Specialist health visitors*, with appropriate clerical assistance. This in many ways appeared to be the most satisfactory of existing patterns. Health visitors, by their training and experience, acquire adequate knowledge of disease-processes and of the implications and ramifications of disease, unrivalled knowlege of normality and its problems, an outlook oriented to prevention, skill in individual health teaching, and some training and experience in group health teaching: they have, in fact, an excellent background for health education lecturers. Moreover, because promotion prospects are very much poorer in health visiting than in medicine and teaching, outstanding health visitors are much more likely to accept posts as health education lecturers than are outstanding doctors and teachers. In this connection, it could be noted that one of the most successful ventures in health education is that of Buckinghamshire, where two selected health visitors are employed full-time on health education (at an extra remuneration of about £125 each), and that the appointment by the National Association for the Prevention of Tuberculosis of a selected health visitor as their lecturer has again been outstandingly successful.

The Health and Welfare Committee's decision.

It appeared to the Committee that, while the third pattern mentioned above was probably the most satisfactory of existing patterns, several points merited consideration—

(1) Most health visitors, however carefully selected for health education work, would benefit from the occasional advice and guidance of someone with more training and experience of actual teaching.

(2) The arrangement of having two officers working full-time on group health education might not be ideal; if, instead, a number of officers devoted part of their time to group teaching and the rest of their time to health visiting, they would retain their personal contact with individual families and their active awareness of the problems and difficulties of the people. Moreover, the scheme would acquire

greater flexibility: *e.g.*, if experience in three separate districts showed that the best times for health meetings were Tuesday nights and Wednesday afternoons, these requirements could be met, whereas, with two full-time lecturers, it would be necessary to allocate Monday evenings and Thursday mornings to one of the districts.

(3) While a health visitor has a very good background for health education work but has rather inadequate training in group teaching, and while a school teacher has a good training in group instruction but lacks knowledge of health principles and disease processes, a health visitor tutor combines the advantages of both. The background of any qualified health visitor tutor is—a good general education, a general nursing training, a training in midwifery, a period as hospital staff nurse or ward sister, a health visitor's training, some years as a practising health visitor, a year of full-time teaching training for the tutor's certificate, and subsequent experience in the teaching of student health visitors. This surely is the ideal background for a health education lecturer.

(4) The Corporation at present has as its Principal Health Visitor Tutor a tutor of quite outstanding calibre (as evidenced, for instance, by awards and distinctions gained both before her appointment to Aberdeen and subsequently) who possesses to a very high degree all the skills and qualities required for a health education lecturer and organiser; and in the present Assistant Health Visitor Tutor the Corporation has again been fortunate in securing an outstanding officer admirably fitted to undertake group projects and group education. Moreover, the tutors have already demonstrated, mainly in unpaid work performed during the evenings, their abilities both as lecturers and as organisers: the success of the Home Safety Week in 1954, for example, was in large measure attributable to their efforts.

The Health and Welfare Committee therefore decided to entrust the work of health guidance to seven persons, each devoting only a portion of her time to the subject. The seven persons were the two tutors (to be given some additional remuneration in respect of their additional duties—largely outside normal working hours—both as health guidance lecturers and in the organisation and administration of the health guidance section), and five selected health visitors (to be designated Senior Health Visitors, to be relieved of ordinary health visiting duties for about two afternoons weekly, and to receive an additional £75 annually in recognition of group teaching undertaken during normal working hours and on certain evenings).

The scheme will begin to operate during 1956 (subject to any necessary consent by the Department of Health for Scotland), and will be subject to review in 1957, but it has been outlined here as one of the major pieces of planning undertaken by the Health and Welfare Committee in 1955.

12.—CONTROL OF INFECTIOUS DISEASES.

The main features of the year may be summarised in tabular form:—

	No. of Cases. 1955.		1954.		Increase.	Decrease.	
Cerebro-spinal Fever	6		8		—	2	
Chickenpox	4		11		—	7	
Diphtheria	2		—		2	—	
Dysentery	262		129		133	—	
Erysipelas	18		33		—	15	
Infective Jaundice	1		2		—	1	
Measles	351		72		279	—	
Acute Influenzal Pneumonia	7	242	23	317	—	16	75
Acute Primary Pneumonia	235		294		—	59	
Poliomyelitis	10		34		—	24	
Puerperal Fever	5		2		3	—	
Puerperal Pyrexia	3		10		—	7	
Scarlet Fever	69		178		—	109	
Paratyphoid B. Fever	1		16		—	15	
Whooping Cough	398		284		114	—	

Cerebro-Spinal Fever.

Six cases were notified in 1955, as compared with eight in 1954, ten in 1953, and seven in 1952. None of the six cases was fatal.

Chickenpox.

In 1955, four cases were brought to the knowledge of the department. As this disease is not compulsorily notifiable, the number of cases intimated offers no real indication of the prevalence of chickenpox in the City.

Continued Fever (Undulant).

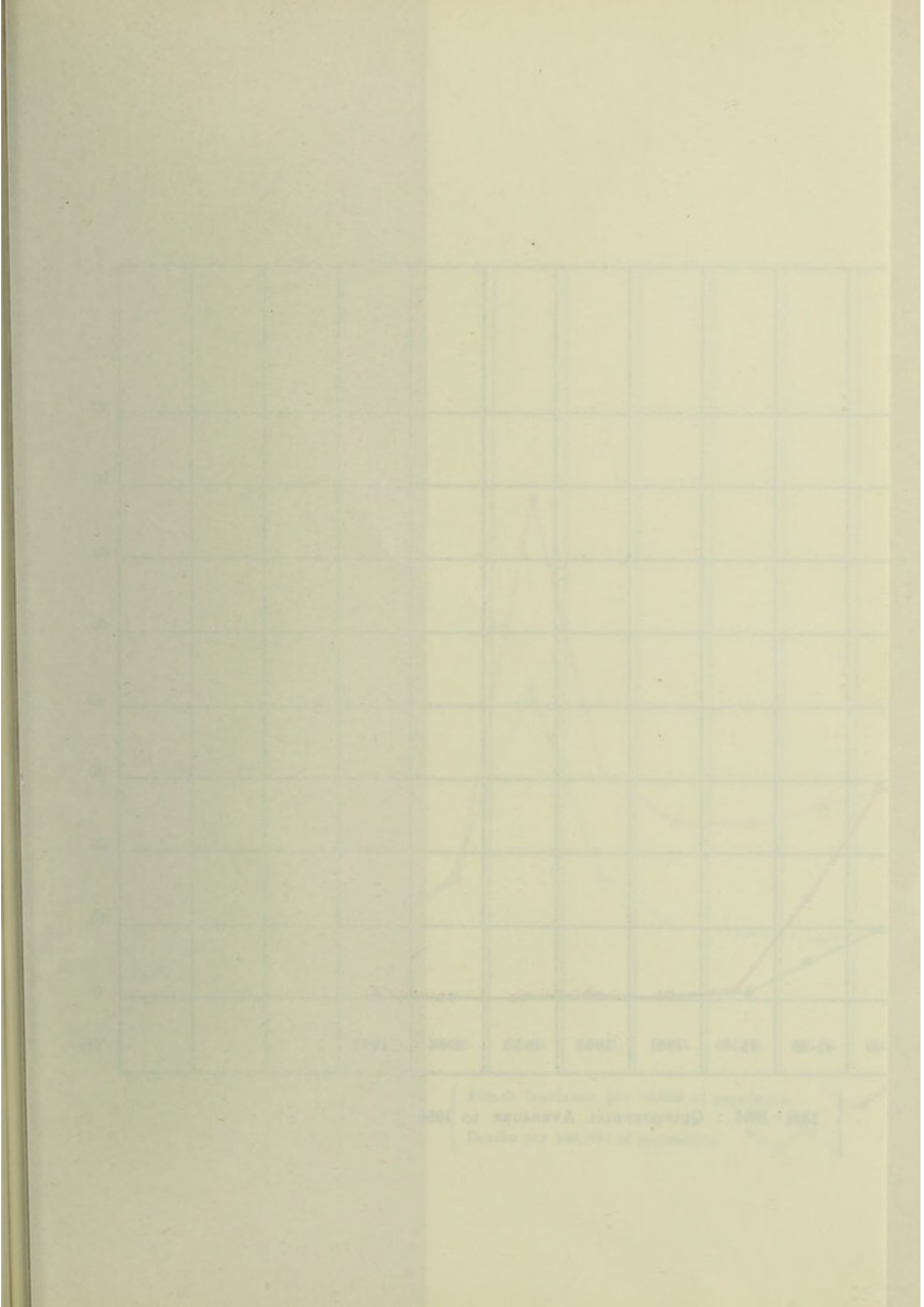
No cases were notified during the year.

Diphtheria.

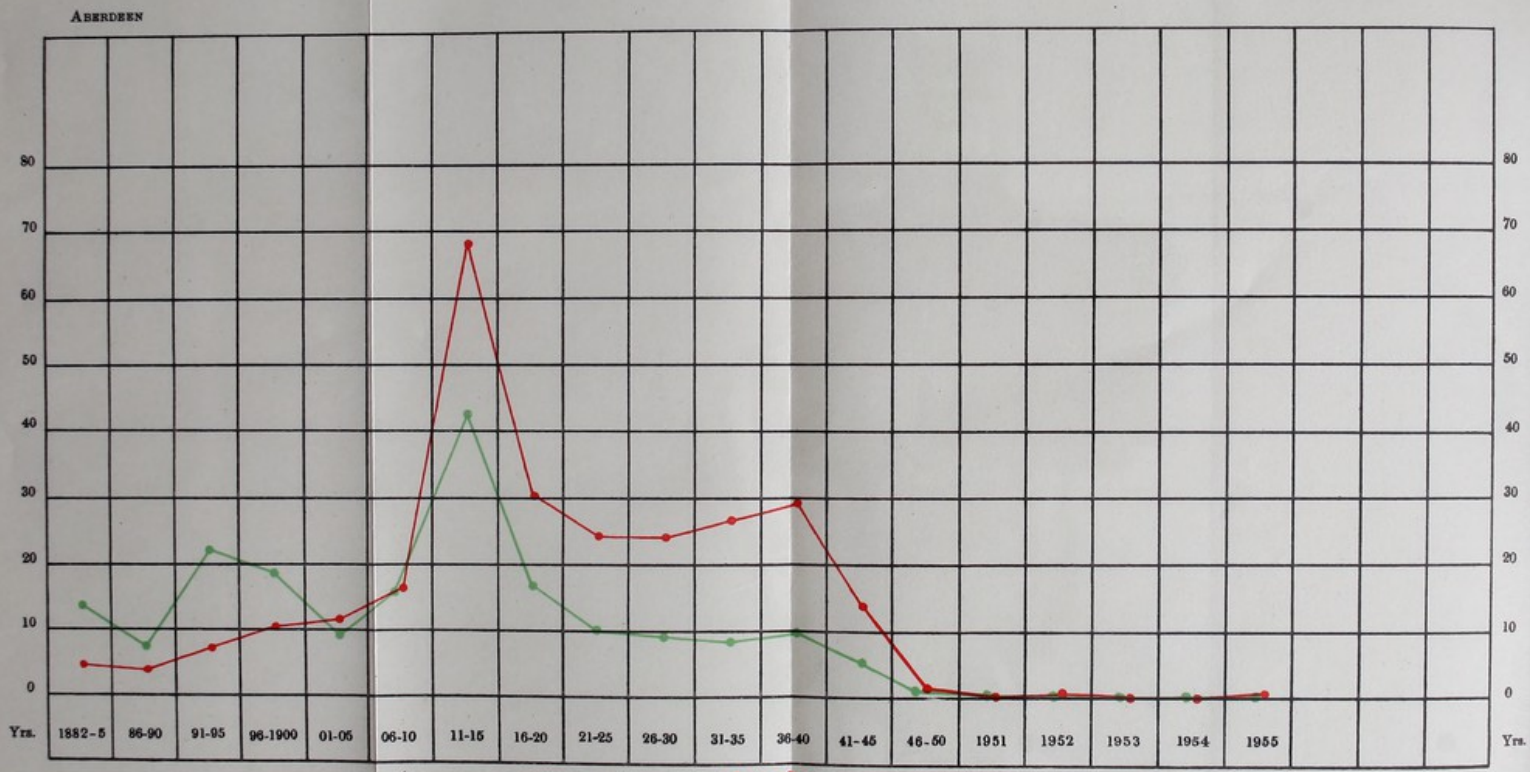
In 1951, a record was established: for the first time there were no confirmed cases during an entire year. In 1952, there were three cases; in 1953 and in 1954, there were no cases. In 1955, there were two cases—a child of five years and a girl of seventeen years, neither of whom had ever been immunised.

It may be of interest to set out the cases and deaths in five-yearly periods:—

	Cases.	Deaths.
1951-1955	5	0
1946-1950	86	1
1941-1945	1,148	53
1936-1940	2,548	97



ABERDEEN



DIPHTHERIA— { Attack Incidence per 10,000 of population / Deaths per 100,000 of population } 1882 - 1955.: QUINQUENNIAL AVERAGES to 1950.

The tremendous year by year reduction from 586 cases and 21 deaths in 1940 to the figures of to-day bear eloquent witness to the efficacy of diphtheria immunisation (which began on a nation-wide scale in 1941 although employed to a limited extent in Aberdeen before that year). Details about immunisation are recorded elsewhere in this report.

The accompanying chart gives the attack incidence and death rate from 1882.

Dysentery.

In 1955, there were 262 notified cases of this disease as compared with 129 in 1954, and 110 in 1953.

Encephalitis Lethargica.

No cases were notified during 1955.

Erysipelas.

There were 18 cases of erysipelas in 1955 as compared with 33 in 1954 and 27 in 1953.

Infective Jaundice.

During the year there was one confirmed case of infective jaundice. The case was a female fish worker. There have been no fatal cases since 1952.

Leprosy.

This disease has been compulsorily notifiable since 1st September, 1951. No case has been reported in this area.

Malaria.

Three cases were notified in 1955 as compared with one in 1954 and six in 1953.

Measles.

Compulsory notification of this disease in Aberdeen was, after a very short trial, discontinued in 1903 and has not as yet been re-instated. General practitioners are, however, encouraged to intimate cases to the department. In 1955, 351 cases were voluntarily intimated, and there was one death—a child of six months. The corresponding intimations for the preceding four years were:—1954—72; 1953—247; 1952—801; and 1951—824.

Ophthalmia Neonatorum.

No case was notified in 1955 or 1954. There was a case in 1953 and this was the only one during the last six years. The virtual eradication of this formerly serious cause of blindness constitutes one of the major triumphs of preventive medicine.

Pneumonia, Acute Influenzal.

Seven cases were notified in 1955. One death occurred in a male aged 61 years. In the preceding year 23 cases were notified with two deaths.

Pneumonia, Acute Primary.

During 1955, 235 cases were notified, with 11 deaths, as compared with 294 cases and 19 deaths in 1954. During the ten years, 1945-1954, the annual average

number of cases was 367, and the annual average number of deaths was 37. Of the 235 cases in 1955, 174 or 74 per cent. received institutional treatment.

Poliomyelitis (Infantile Paralysis).

Ten cases of this disease were notified in 1955, as compared with 34 in 1954 and 12 in 1953.

In 1955, there were no deaths from the disease. It may be worth while to mention that, in the 78 cases occurring in the years 1951-55, there have been only three deaths.

Of the 10 cases notified in 1955, each had a degree of paralysis.

Puerperal Fever and Puerperal Pyrexia.

Eight cases of puerperal fever and puerperal pyrexia were notified. Five were confirmed as suffering from puerperal fever. No deaths were registered from this cause.

Three cases were classified as cases of puerperal pyrexia, as compared with 10 in 1954.

All the cases received institutional treatment in the City Hospital.

Scarlet Fever.

In 1955, 69 cases of scarlet fever were notified, as compared with 178 in 1954 and an annual average of 306 in the decennium 1945-1954. There were no deaths for the seventh consecutive year. In recent years this disease has assumed a very mild character.

Smallpox.

Aberdeen has remained free from smallpox since 1930.

Analysis of the vaccinations carried out in 1955 by general practitioners and at child welfare clinics is given in an earlier section of this Report.

Typhoid and Paratyphoid Fevers.

There were no cases of typhoid fever and only one case of paratyphoid fever B was notified in 1955. In 1954, there were 16 cases of paratyphoid.

Whooping Cough.

On 1st January, 1950, this disease became compulsorily notifiable. The number of cases notified during 1955 was 398, as compared with 284 in 1954. In 1955, there were 4 deaths including 3 under one year of age.

As indicated elsewhere in this Report, whooping cough immunisation among infants and pre-school children is carried out at the various Child Welfare Centres and at home by general practitioners. During 1955, the number of children so immunised was 2,494 as compared with 2,483 in the previous year.

Infections generally.

The following tables deal with the various infectious diseases. Table I shows the seasonal variations in the prevalence of each infectious disease, whether compulsorily notifiable or not. In Table II are given the morbidity and mortality from

infectious diseases, classified according to age and to the allocation of patients to institutions for purposes of treatment. In Table III, the cases and deaths are detailed for each of the years from 1945 to 1955.

Arrangements for Laboratory Services.

Until 1948 the Corporation provided an up-to-date laboratory at the City Hospital, and, by arrangement with the Regional Hospital Board, the laboratory is still available to the authority. The Public Analyst, who is an employee of the Corporation, works in the laboratory at the City Hospital and undertakes some biochemical work for the Hospital Board. The arrangement works satisfactorily.

(At the end of 1955 arrangements were in hand to increase the analyst's staff by an apprentice technician.)

TABLE I.—PROGRESS OF INFECTIOUS DISEASES (EXCLUDING TUBERCULOSIS) DURING TWELVE MONTHS—YEAR, 1955.

Disease.		1955. Jan.	Feb.	Mar.	Apr.	May.	June.	July.	Aug.	Sept.	Oct.	Nov.	Dec.	Whole Year.
Cerebro-spinal Fever	Cases	—	—	1	—	1	1	—	1	—	—	1	1	6
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
*Chickenpox	Cases	—	1	—	—	1	1	—	—	—	—	—	1	4
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Continued Fever (Undulant)	Cases	—	—	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Diphtheria	Cases	—	1	—	—	—	—	—	—	—	—	—	1	2
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Dysentery	Cases	39	66	67	25	30	12	4	4	1	4	10	—	262
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Encephalitis Lethargica	*Cases*	—	—	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Erysipelas	Cases	2	3	2	2	1	1	—	2	—	1	1	3	18
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Jaundice, Acute Infective	Cases	—	—	1	—	—	—	—	—	—	....	—	—	1
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Leprosy	Cases	—	—	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Malaria	Cases	—	—	1	—	—	—	—	1	—	1	—	—	3
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
*Measles	Cases	87	110	69	36	31	15	2	—	1	—	—	—	351
	Deaths	—	—	—	—	—	—	—	—	*1*	—	—	—	*1*
Ophthalmia Neonatorum	Cases	—	—	—	—	—	—	—	—	—	—	—	—	—
Plague	Cases	—	—	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Pneumonia Acute Influenzal	Cases	3	—	1	1	—	—	—	—	—	2	—	—	7
	Deaths	—	—	*1*	—	—	—	—	—	—	—	—	—	*1*
Pneumonia, Acute Primary	Cases	31	34	38	15	12	22	9	6	9	15	15	29	235
	Deaths	*2*	*1*	*5*	*1*	—	*1*	—	—	—	*1*	—	—	*11*
Poliomyelitis, Acute	Cases	3	1	—	—	—	1	1	—	1	—	2	1	10
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Puerperal Fever	Cases	2	—	—	—	—	1	—	—	—	1	—	1	5
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Puerperal Pyrexia	Cases	1	—	—	—	—	—	—	—	—	1	1	—	3
Scarlet Fever	Cases	13	3	14	6	4	8	2	2	1	4	9	3	69
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Smallpox	Cases	—	—	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Typhoid Fever	Cases	—	—	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Para-Typhoid A.	Cases	—	—	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Para-Typhoid B.	Cases	—	—	—	—	—	—	—	—	—	—	—	1	1
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Typhus Fever	Cases	—	—	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Whooping Cough	Cases	127	133	53	28	23	13	9	8	2	—	—	2	398
	Deaths	*1*	*1*	*1*	*1*	—	—	—	—	—	—	—	—	*4*
Total	Cases	308	352	247	113	103	75	27	24	15	29	39	43	1,375
	Deaths	*3*	*2*	*7*	*2*	—	*1*	—	—	*1*	*1*	—	—	*17*
Influenza, excl. Influenzal Pneumonia	*Deaths*	—	—	—	—	—	—	—	—	—	—	—	—	—

*Not compulsorily notifiable.

Table II.—Morbidity and Mortality from Infectious Diseases (excluding Tuberculosis) during 1955.

DISEASE		No. of Cases and Deaths at various Age-Periods									Cases receiving Institutional Treatment	Cases not receiving Institutional Treatment
		At all Ages	Years									
			Under 1	1 and under 5	5 and under 15	15 and under 25	25 and under 35	35 and under 45	45 and under 65	65 and upwards		
Cerebro-spinal Fever	Cases	6	4	—	1	—	—	—	1	—	6	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—
*Chicken Pox	Cases	4	1	1	—	1	—	—	1	—	4	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Cholera	Cases	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Continued Fever (undulant)	Cases	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Diphtheria	Cases	2	—	1	—	1	—	—	—	—	2	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Dysentery	Cases	262	17	94	66	22	25	11	17	10	69	193
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Encephalitis Lethargica	Cases	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Erysipelas	Cases	18	—	—	—	—	1	4	11	2	3	15
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Infective Jaundice	Cases	1	—	—	—	—	—	1	—	—	—	1
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Leprosy	Cases	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Malaria	Cases	3	—	—	—	—	2	1	—	—	2	1
	Deaths	—	—	—	—	—	—	—	—	—	—	—
*Measles	Cases	351	4	47	297	1	—	2	—	—	31	320
	Deaths	*1*	*1*	—	—	—	—	—	—	—	*1*	—
Ophthalmia Neonatorum	Cases	—	—	—	—	—	—	—	—	—	—	—
Plague	Cases	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Pneumonia, Acute Influenzal	Cases	7	—	—	—	2	—	—	5	—	—	7
	Deaths	*1*	—	—	—	—	—	—	*1*	—	—	*1*
Pneumonia, Acute Primary	Cases	235	31	22	8	16	15	22	60	61	174	61
	Deaths	*11*	*5*	—	—	—	—	—	—	*6*	*9*	*2*
Poliomyelitis, Acute	Cases	10	—	6	3	1	—	—	—	—	10	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Puerperal Fever	Cases	5	—	—	—	2	2	1	—	—	5	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Puerperal Pyrexia	Cases	3	—	—	—	2	1	—	—	—	3	—
Scarlet Fever	Cases	69	—	27	38	3	1	—	—	—	10	59
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Small-pox	Cases	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Typhoid Fever	Cases	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Paratyphoid A	Cases	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Paratyphoid B	Cases	1	—	—	1	—	—	—	—	—	1	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Typhus Fever	Cases	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Whooping Cough	Cases	398	53	177	162	3	3	—	—	—	19	379
	Deaths	*4*	*3*	*1*	—	—	—	—	—	—	*3*	*1*
Total	Cases	1375	110	375	576	54	50	42	95	73	339	1036
	Deaths	*17*	*9*	*1*	—	—	—	—	*1*	*6*	*13*	*4*

* Not compulsorily notifiable.

TABLE III.—MORBIDITY AND MORTALITY FROM INFECTIOUS DISEASES, INCLUDING TUBERCULOSIS, DURING EACH YEAR FROM 1945 TO 1955.

Disease.		1955	1954	1953	1952	1951	1950	1949	1948	1947	1946	1945	ANNUAL AVERAGE 1945 to 1954.
Cerebro-Spinal Fever	Cases	**6**	8	10	7	24	14	9	5	12	28	25	**14·2**
	Deaths	*0*	*1*	*0*	*0*	*0*	*0*	*1*	*2*	*2*	*0*	*3*	*0·9*
*Chickenpox	Cases	**4**	11	12	48	16	26	23	62	23	60	14	**29·5**
	Deaths	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0·0*
Continued Fever (Undulant)	Cases	**0**	2	0	1	0	9	**4**	1	3	4	1	**2·5**
	Deaths	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0·0*
Diphtheria	Cases	**2**	0	0	3	0	2	3	4	9	68	136	**2·5**
	Deaths	*0*	*0*	*0*	*0*	*0*	*1*	*0*	*0*	*0*	*0*	*9*	*1·0*
Dysentery	Cases	**262**	129	110	14	225	67	34	137	13	100	331	**116·0**
	Deaths	*0*	*0*	*0*	*0*	*1*	*0*	*0*	*1*	*0*	*0*	*3*	*0·5*
Encephalitis Lethargica	Cases	**0**	0	0	0	0	1	0	0	0	0	0	**0·1**
	Deaths	*0*	*0*	*0*	*0*	*0*	*1*	*0*	*0*	*0*	*0*	*0*	*0·1*
Erysipelas	Cases	**18**	33	27	32	23	37	48	64	65	104	79	**51·2**
	Deaths	*0*	*0*	*1*	*0*	*1*	*0*	*0*	*0*	*0*	*2*	*2*	*0·6*
Infective Jaundice	Cases	**1**	2	13	10	4	10	11	10	6	6	4	**7·6**
	Deaths	*0*	*0*	*0*	*1*	*2*	*0*	*1*	*3*	*0*	*2*	*0*	*0·9*
Leprosy	Cases	**0**	0	0	0	0	0	0	0	0	0	0	**0·0**
	Deaths	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0·0*
Malaria	Cases	**3**	1	6	2	1	8	**9**	4	9	23	0	**6·3**
	Deaths	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0·0*
*Measles	Cases	**351**	72	247	801	824	26	402	199	527	500	887	**448·5**
	Deaths	*1*	*0*	*0*	*0*	*1*	*1*	*1*	*1*	*3*	*0*	*3*	*1·0*
Ophth. Neonatorum	Cases	**0**	0	1	0	0	0	1	3	7	6	3	**2·1**
Plague	Cases	**0**	0	0	0	0	0	0	0	0	0	0	**0·0**
	Deaths	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0·0*
Pneumonia, Acute Influenzal	Cases	**7**	23	5	18	10	32	10	7	4	13	3	**12·5**
	Deaths	*1*	*2*	*1*	*5*	*2*	*7*	*4*	*3*	*2*	*7*	*0*	*3·3*
Pneumonia, Acute Primary	Cases	**235**	294	263	301	242	422	443	444	404	379	347	**353·9**
	Deaths	*11*	*19*	*9*	*13*	*43*	*58*	*41*	*42*	*53*	*38*	*34*	*35·0*
Poliomyelitis, Acute	Cases	**10**	34	12	18	4	36	3	5	48	1	0	**16·1**
	Deaths	*0*	*1*	*1*	*1*	*0*	*2*	*0*	*0*	*6*	*0*	*0*	*1·1*
Puerperal Fever	Cases	**5**	2	26	17	13	35	46	25	42	52	37	**29·5**
	Deaths	*0*	*0*	*1*	*0*	*1*	*0*	*1*	*0*	*1*	*1*	*2*	*0·7*
Puerperal Pyrexia	Cases	**3**	10	13	13	10	11	13	34	33	26	4	**16·7**
Scarlet Fever	Cases	**69**	178	239	314	299	513	275	252	205	465	316	**305·6**
	Deaths	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*1*	*0*	*0*	*0*	*0·1*
Smallpox	Cases	**0**	*0*	0	0	0	0	0	0	0	0	0	**0·0**
	Deaths	*0*	0	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0·0*
Tuberculosis, Respiratory	Cases	204	228	243	230	226	270	222	279	172	190	207	**226·7**
	Deaths	*15*	*19*	*26*	*36*	*36*	*38*	*60*	*62*	*65*	*71*	*70*	*48·3*
Tuberculosis, Non-Respiratory	Cases	24	26	31	30	31	31	28	37	53	50	48	**36·5**
	Deaths	*2*	*4*	*4*	*4*	*5*	*5*	*6*	*8*	*12*	*12*	*15*	*7·5*
Typhoid and Para-typhoid Fevers	Cases	**1**	16	3	10	4	2	4	30	6	2	7	**8·4**
	Deaths	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*1*	*0*	*0*	*0·1*
Typhus Fever	Cases	**0**	0	0	0	0	0	0	0	0	0	0	**0·0**
	Deaths	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0·0*
Whooping Cough	Cases	**398**	284	175	549	551	449	58	194	176	151	195	**278·2**
	Deaths	*4*	*0*	*0*	*0*	*3*	*0*	*0*	*2*	*5*	*3*	*4*	*1·7*
Influenza, excl. Influenzal Pneumonia	*Deaths*	*0*	*1*	*2*	*0*	*7*	*6*	*6*	*1*	*0*	*2*	*7*	*3·2*

*Not compulsorily notifiable.

13.—MENTAL HEALTH.

With the appointment (at the end of 1953) of a Senior Assistant Medical Officer with duties primarily in the mental field, and with the provision (in 1954 and 1955) of post-qualification courses in mental health to equip health visitors more fully for their work in the prevention of diseases of emotional and mental origin, the way was clear for a considerable advance in mental health work. While most of the chapter that follows deals not with mental health but with mental disease, it will be appreciated that the prevention or reduction of the psychoneuroses, psychosomatic diseases, juvenile delinquency, anti-social behaviour, and so forth, constitute one of the main tasks of the Health and Welfare Department. Since most of that prevention or reduction is undertaken by health visitors in the home and by medical officers and health visitors in the clinic, reference to it is more appropriately made in the sections of the report dealing with Health Visiting, Maternity and Child Welfare, and the School Health Service.

I. ADMINISTRATION.

(1) Duties.

Although the Corporation have no responsibility for the institutional care of the mentally sick, they are responsible for each of the following aspects:—Prevention of mental disease; ascertainment, care and after-care of mental defectives and mentally ill persons in their own homes; and provision of suitable training and occupation for mental defectives over the age of 16 years and for ineducable defectives under that age.

(2) Committee Responsible.

The responsible Committee is the Health and Welfare Committee, except in the case of educable defectives under guardianship and aged 5 to 16 years. The latter are the responsibility of the Education Committee.

(3) Number and Qualifications of Staff Employed.

(*a*) *Medical Officers.*—The certification of insane persons requires two certificates. In general, the first of these certificates is given by the Medical Officer for Mental Health of the North-Eastern Regional Hospital Board, or, in his absence, by one of two other specialists in mental disease whose services have been made available to general practitioners by arrangements with the Executive Council. The second certificate is usually completed by the general practitioner normally attending the patient.

As indicated above, duties in regard to prevention, ascertainment, supervision, and after-care devolve on the medical officers of the Health and Welfare Department. The Medical Officer of Health, the Senior Assistant Medical Officer, and several of the Departmental Medical Officers hold the post-graduate certificate in mental assessment.

(*b*) *Psychiatric Social Worker.*—The Corporation have not appointed any psychiatric social worker. Until the middle of 1952, an arrangement operated whereby a psychiatric social worker employed by the University Department of Mental Health was available for a limited amount of time. When the last holder of that post left, the University decided for the present not to replace her. On occasions, a pyschiatric

social worker from the Regional Hospital Board visits local authority cases by special request.

(*c*) *Health Visitors.*—At the end of the year, 60 were employed (one less than at the beginning of the year) and there were 25 vacancies on the establishment. As mentioned in the section of the report dealing with training of health visitors, during the year 26 health visitors attended an intensive post-qualification course in mental health, 20 others having attended a similar course in 1954.

(*d*) *Other Mental Health Workers.*—As yet, none is employed.

(*e*) *Duly Authorised Officers.*—The Senior Assistant Welfare Officer has been designated authorised officer. His duties as authorised officer are (1) to make arrangements for the detention of persons apparently of unsound mind who have no relatives or friends willing or able to take such action; (2) to ensure that adequate domestic arrangements have been made when it is proposed to discharge insane persons from mental hospitals; (3) on the instructions of the Medical Officer of Health, to take steps to remove, pending the presentation of a petition, a supposed defective who is neglected, cruelly treated, or without visible means of support, to a place of safety; and (4) to deal with certain types of mentally handicapped children. The Senior Assistant Welfare Officer is assisted by three Assistant Welfare Officers, who are well versed in mental health certification procedure, &c.

(*f*) *Occupation Centre Supervisors, &c.*—As yet, none is employed. (The Corporation has approved of the provision of an occupation centre, but suitable premises have not yet been secured).

(4) Co-ordination.

Close liaison is maintained with the North-Eastern Regional Hospital Board and with the Board of Management for the Mental Hospitals.

On the one hand, where a certified defective is placed under guardianship or is boarded out or liberated on licence from a mental hospital, supervision, although legally a matter for the hospital authorities, is undertaken by members of the Corporation staff. On the other hand, in carrying out duties relating to mental illness and mental deficiency, the medical officers of the Corporation have the valuable co-operation and help of the Regional Hospital Board Medical Officer for Mental Health, of the Professor of Mental Health, and of the Physician Superintendents of Kingseat Mental Hospital and the Aberdeen Royal Mental Hospital. The co-operation is good and is appreciated on both sides.

(5) Duties delegated to Voluntary Associations.

No duties in relation to mental cases have been delegated to any voluntary associations, all duties being carried out by members of the Health and Welfare Department, with the exception of such duties as are, by mutual agreement, carried out by officers of the Regional Hospital Board (as mentioned above).

(6) Training of Staff.

No particular arrangements have been made, apart from (*a*) the provision of the post-qualification courses for mental health for health visitors, mentioned above, and (*b*) the sending of an occasional medical officer to mental deficiency courses.

II. AMOUNT OF WORK UNDERTAKEN.

1. Under Section 27 of the National Health Service (Scotland) Act.

(*a*) *Measures for prevention of Mental Illness.*

(i) *Health Education by Health Visitors and by Departmental Medical Officers.*

This constitutes an important part of the normal health education work undertaken by the department. As more and more of the physical diseases are conquered, the amount of attention focussed on mental health is being proportionately increased.

The particular importance of the role of the family health visitor—an expert in normality, skilled in the art of persuasion, and recognised by the family as a health counsellor—in the prevention of the "break-up" of the family, with its consequent bad effects on the physical and even more on the mental health of children, and in the prevention of mental ill-health in general, has been emphasised in D.H.S. Circular No. 77/1954.

(ii) *Attempts to assist families placed in situations of abnormal physical or mental or financial strain.*

For households under physical strain, home helps are available, as indicated elsewhere in this report. Again, physical strain on parents is frequently relieved by admission of young children to day or (less often) to residential nurseries. Financial strain is again frequently relieved by the same means, the mother being, for a time, enabled to undertake whole-time or part-time work with a view to obtaining sufficient money to permit of the paying off of debts, &c.

The health visitors give a vast amount of useful advice and guidance on family budgeting and on general domestic problems, and there is, in addition, a good liaison with the National Assistance Board and with the various voluntary societies.

Another factor of assistance to families in situations of abnormal physical, mental, or financial strain is the existence of a Joint Committee (already mentioned in this report) to deal with measures for the assistance of children who are neglected in their own homes. This Committee, by co-ordinating the efforts of health visitors and school nurses, school welfare officers, the National Society for the Prevention of Cruelty to Children, the National Assistance Board, and so on, as well as of bodies like the Council of Social Service, can sometimes find a practical means of relieving an intolerable strain on households. In addition, this co-ordinating mechanism makes for economy in that the number of persons concerned with each of these difficult families is kept down to a minimum.

(*b*) *Care and After-care of the Mentally Ill and Mental Defective.*

All patients released on probation from mental institutions and residing within the City or boarded out within the City are visited regularly by the authorised officer or one of the assistant welfare officers and are also medically supervised by a medical officer versed in mental health.

There is still considerable inadequacy of institutional accommodation for mentally defective persons who are in need of institutional care and supervision, and there is also a grave need for an occupation centre for defectives living at home. Suitable premises have not yet become available to meet the latter need, and, by arrangement with the Education Department, a number of children leaving the special schools at 16 years of age have continued to attend the occupational centres

run by the Education Department, a nominal fee being levied on the Health and Welfare Department in respect of the services provided.

2. Under Lunacy Act by Duly Authorised Officer and by Medical Staff.

The work undertaken under the Lunacy Act includes advice and guidance on budgeting and general domestic problems, reference to psychiatric clinic so as to secure early preventive treatment, where necessary; close liaison between general medical practitioners and psychiatric specialists and the Health and Welfare Department so as to ensure help of any nature required for mentally sick persons, completing and negotiating claims of all types of statutory benefits under the welfare, insurance, and sundry pensions Acts; ensuring adequate protection for property prior to admission to hospital and throughout any period of hospitalisation so as to allay any anxiety over such personal responsibilities which might otherwise retard the desired early improvement and recovery of patients; ensuring the proper care and supervision of all patients boarded out under guardianship and on probation or licence from mental institutions; and securing the certification of patients in terms of the 9th Schedule of the National Health Service (Scotland) Act, 1947, and the various Lunacy Acts.

The following is a short statement of the cases dealt with by the department during the year:—

Number of mental cases dealt with in terms of the 9th Schedule of the National Health Service (Scotland) Act, 1947, and Lunacy Acts.

	Males.	Females.	Total.
Cases fully certified under the Lunacy Acts, following medical examination	57	96	153
Cases admitted as voluntary boarders, following medical examination	68	77	145
Cases where no action was recommended following medical examination	7	19	26
	132	192	324

Number of patients on probation from mental hospitals who are under supervision.

Males.	Females.	Total.
4	4	8

Number of mental patients boarded-out from mental hospitals under private guardianship who are under care and supervision.

Males.	Females.	Total.
6	2	8

Number of patients on licence from certified institutions under care and supervision.

Males.	Females.	Total.
1	—	1

Number of reports to physician superintendents on home conditions prior to release of patients on probation, in terms of the 9th Schedule of the National Health Service (Scotland) Act, 1947.

Males.	Females.	Total.
2	10	12

Mental Deficiency and Lunacy (Scotland) Acts, 1913-1940.

	Males.	Females.	Total.
Number of cases reported by the Education Department	9	4	13
Number of cases committed to certified institutions by the department (including 8 males and 13 females transferred from Glenburn Wing of Woodend General Hospital to Woodhill House Institution, Aberdeen)	27	20	47

Number of cases under guardianship as at 31.12.1955.

	Males.	Females.	Total.
In the City	11	7	18
Outwith the City	12	6	18

(There were, at the end of 1955, 54 mentally-handicapped persons in the City awaiting admission to certified institutions.)

14.—WORK UNDER NURSERIES AND CHILD-MINDERS' REGULATION ACT.

The Nurseries and Child-Minders' Regulation Act, 1948, which came into operation on 30th July, 1948, empowers local authorities to supervise (1) nurseries where children up to school age are looked after for a day, or for longer periods not exceeding six days, and (ii) persons who, for reward, undertake the care of children under the age of five years for similar periods.

There were no applications for registration during the year.

15.—SCHOOL HEALTH SERVICE.

Some of the salient features of the year are outlined below:—

(1) An attempt was made to secure better integration of the Child Welfare and School Health Services. In the past it had seemed anomalous that, although the health visitors had for some years successfully combined the duties of health visitor and school nurse, the medical officers were still segregated in sectionalised work. From December three medical officers have been enabled to undertake work in the whole field of child health. This is, of course, only a beginning, since there are still four doctors engaged full-time on school health services, while other doctors concerned with the pre-school child have no contact with the schools. Nevertheless, a start has been made.

(2) The Dental Section was reorganised and considerably developed. An additional surgery was installed at North Silver Street, an x-ray apparatus was purchased, and arrangements were made for the creation of a new dental clinic at Linksfield School and for the equipment of a dental room at Beechwood School. The number of school children receiving dental inspection rose from 4,853 in 1953-54 to 19,333 in the present session, and the number of school children treated by the dental officers rose from 2,577 in 1953-54 to 4,929 in the present year. These figures speak for themselves. (In addition, 114 pre-school children were treated, as compared with 18 in the previous year.)

(3) An orthoptist was appointed and commenced duty in February. Special apparatus for the treatment of children suffering from squint was provided, and by the end of the school year over 200 children were in process of being treated.

(4) A feature of the year has again been the greater amount of work possible among mentally handicapped and physically handicapped children. 117 children were mentally assessed, as compared with 73 in the previous year. Children with orthopædic defects were examined in conjunction with an orthopædic surgeon, partially-sighted children were also examined, and, for the first complete year, children referred to the Child Guidance Clinic were medically examined.

(5) The health surveys conducted by the health visitors continued to become more and more complete health inspections concerned with nutrition, posture, fatigue, &c., as contrasted with the mere "cleanliness" inspections of the past. It is noteworthy that, while, as recently as three years ago, the number of inspections revealing defects other than those of cleanliness or of clothing was only 570, in the past year it has been 3,704, or very considerably more than the number of inspections revealing defects of cleanliness or clothing.

(6) The annual campaign for immunisation of children against diphtheria was extremely successful. More reinforcing doses were given than in previous years, the actual number being 4,205, as compared with 3,714 in 1953-54 and 3,504 in 1952-53.

(7) The campaign for protection against tuberculosis was continued with great success. It is noteworthy that 96·7 per cent. of parents in the appropriate age groups gave consent. In all, 4,894 children were tested for susceptibility to tuberculosis, and 1,689 who were deemed to need immunisation were immunised with B.C.G.

(8) The figures for routine medical inspection suggested that the health of the children was continuing to improve. In particular, it is noteworthy that the number of children found at these inspections to be free from defects has increased steadily during the last four years. The number of attendances at minor ailment clinics and dermatological clinics decreased, again suggesting that the health of children was improving.

Points to which attention might profitably be devoted in the future include—

(*a*) Attention to the problem of staff shortages. At the end of the year, the medical staff was equivalent to 4 6/11ths doctors while the real need for the school health service was at least 5. The medical shortage is, therefore, relatively slight, and it will probably be possible to bring the medical staffing up to a satisfactory standard in the near future. The shortage of dental officers and of health visitors is much more serious. At the end of the year, the dental staff was equivalent to 4 3/11ths full-time officers compared with an establishment of 7, and a probable ultimate need of 8; the health visitor staff (for all duties, including school nursing) was 61 out of a present establishment of 85, and a probable long-term need of about 90. Unfortunately, it is unlikely

that action by any individual local authority can reduce these shortages which are simply reflections of the very serious national shortage in these two fields. Nevertheless, until the shortages are remedied, the services cannot be fully efficient.

Although shortages exist in all areas, it may be interesting to compare the staffing of the school health services in Aberdeen and Glasgow, remembering that the population ratio of these cities is approximately 2 to 11. Here are the latest available figures:—

	Glasgow Total.	2/11ths of Glasgow.	Aberdeen Total.
School Medical Officers . .	21	3 9/11ths	4 6/11ths
Dental Officers . . .	17	3 1/11th	4 3/11ths
School Nurses . . .	77	14	10 5/11ths
Physiotherapists . . .	9	1 7/11ths	0

(*b*) Still better integration of the Child Welfare and School Health Services. As has been said already, the health visiting section of these services has been unified for some years and a start has been made on the unification of the medical portion. It is hoped that it will be found administratively possible gradually to transform child welfare medical officers and school medical officers into all-purpose departmental medical officers.

(*c*) Greater co-operation between medical officers and health visitors on the one hand and parents and teachers on the other, although this is not meant to imply that the co-operation is at present bad. The mere fact that 96·7 per cent. of parents of five-year-old children and 90·3 per cent. of parents of nine-year-old children are present at medical examinations is significant. Nevertheless, it is important that every opportunity be taken to improve co-operation. For example, talks by doctors and health visitors at parent-teacher associations could be developed, and those teachers who are not already aware of the role of the school medical officer and the school health visitor could be gradually brought to realise that both these officers are very highly trained experts whose guidance is constantly available to the teachers on all matters of physical and mental health. In this connection, it is perhaps necessary that teachers should become better informed about the role of the health visitor. In the early days, the school nurses generally found it necessary to concentrate on cleanliness and on the detection of the more obvious physical defects; and, in consequence of that history, a fair minority of teachers have not yet realised that the health visitor is a highly trained professional officer whose skilled advice and guidance can do much to promote the mental and physical well-being of the children. While many teachers are fully aware of the position, some of them do not yet really appreciate that the health visitor—by reason of her knowledge both of home and of school and by reason of the

authority deriving from her triple training as state registered nurse, midwife, and health visitor—is in an ideal position to form a link between home and school and to ensure that the influences of parents and teachers do not operate in contrary directions.

(*d*) Provision of physiotherapy facilities for certain physically handicapped children. This is becoming an obvious necessity.

STAFFING.

Medical.—At the beginning of the year four doctors were available, full-time, for the supervision of the health of 30,301 school children. From December, as a result of the appointment of an additional medical officer in the Health and Welfare Department, three doctors, whose main duties lay in other sections of the department, were each enabled to devote two sessions weekly to the School Health Section. Hence, the total staff available became 4 6/11ths medical officers, or one for every 6,666 children. However, as was pointed out in the Report for 1953-54, the optimum ratio is about one doctor for every 5,000-6,000 school children. In other words, medical understaffing persisted throughout the year, although to a smaller degree than in the past.

Before the end of the school year, however, the Health and Welfare Committee had taken a decision to appoint a further medical officer, and it is hoped that, by allocating a portion of his or her time to the School Health Service, the medical staffing of the service may within the near future be brought up to a reasonably adequate level.

The campaign of immunisation of school children against tuberculosis was undertaken by the school medical officers, but, to lessen strain, an additional doctor was employed for three months in connection with diphtheria immunisation work.

Dental.—At the beginning of the year, 3 7/11ths dental officers (including part-time staff) were available for all dental work, as compared with an authorised establishment of 7. During the year, an additional part-time dental officer was engaged, bringing the available staff to 4 3/11ths.

In the light of the persisting shortage of dental staff, great credit is due to the Chief Dental Officer, Mr. A. Hay (appointed at the beginning of the school year), and to his colleagues for vastly increasing the numbers of children examined—from 3,547 in 1952-53 and 4,853 in 1953-54 to 19,333 in 1954-55.

Nursing.—Here again the tale is one of grave shortages. To prevent needless breaks in the health supervision of children at the age of school entry, the work of school nurses is undertaken by the Corporation's health visitors, most of whom devote about 20 per cent. of their time to the School Health Service. The numbers of health visitors employed during 1954-55 may be reckoned as equivalent to about 10 full-time school nurses. In addition, a part-time nurse was employed at Beechwood School.

A more adequate number of health visitors will, of course, be employed when it becomes possible to fill the existing vacancies.

Ancillary Staff.—A full-time audiometrician was employed throughout the year, and a full-time orthoptist was appointed during the year and commenced duty in February. By the close of the school year, 641 children suffering from squint had begun treatment.

GENERAL STATISTICS.

The school population has continued to increase, the numbers on the registers being 323 more than in the previous session and approximately 1,000 more than in the session 1952-53. The rise is on the wane—a result of the high birth-rates of the years 1946-48. Details of schools and scholars are given below.

Number of schools—	
(*a*) Primary—Under Education Authority	43
(*b*) Junior Secondary do. do.	10
(*c*) Secondary do. do.	3
(*d*) Nursery do. do.	4
(*e*) (i) Special Schools do. do.	3
(ii) Special classes in ordinary schools	—
(iii) Nursery Classes	7
(*f*) In receipt of grant from Education Committee and under Medical Inspection	2
Number of children on the registers	30,301
Number of children in average attendance	28,914

SANITARY CONDITION OF SCHOOLS.

Since a fairly elaborate hygiene survey had been carried out in 1952-53 and a detailed study of washing and lavatory facilities had been conducted in 1953-54, no special investigation was deemed necessary in 1954-55. However, the school doctors and health visitors continued, during their visits to the schools, to survey buildings, classrooms, cloakrooms, lavatories, &c. Lighting, ventilation, cleanliness of rooms, heating and condition of lavatories, as well as the availability of drinking water and the nature of washing facilities all came under scrutiny. In addition, inspectors from the Sanitary Section of the Health and Welfare Department visited the schools from time to time.

During the year a number of defects were notified to the Architect's Department. These defects—usually minor defects in sanitary conveniences, drinking fountains, &c.—were, as a rule, swiftly rectified.

On the whole, it is fair to say that the conditions under which children are educated in Aberdeen can be regarded as satisfactory from a health point of view. Heating and lighting are in general good, sanitary conveniences are kept in a satisfactory condition, and the regulations for disinfection and cleansing of schools are adequately implemented.

In recent years, a considerable amount of new building has taken place, and also a considerable amount of reconstruction of older schools. It may be of interest

here to record information from the Architect's Department about new work undertaken during the year.

(*a*) *New Schools*

Cairncry Secondary . .	Under construction.
Mastrick Infant . . .	Do.
Mastrick Primary . .	Do.
Kincorth Primary . .	Do.
Kingswood Infant . .	Work almost completed.
Quarryhill Primary . .	Do.
Cairncry Infant . . .	Work completed.
Westerton Primary . .	Do.
Beechwood Special . .	Do.

(*b*) *Reconstructions, &c.*—

Rosemount Secondary . .	Work almost completed.
Aberdeen Academy . .	Work completed.
Middle Secondary . .	Do.
St. Peter's R.C. . . .	Re-build of front of buildings completed (subsidence).

Schools repainted during the year included Old Aberdeen Secondary (part), Commerce Street (part), Aberdeen Academy (hall), Skene Street (part), Middlefield (part), Ashley Road, Ferryhill, Mile-end, St. Clement Street, St. Paul Street, Seaton, and Walker Road Schools.

Repairs to lavatories were carried out in the following schools:—Ashley Road, Broomhill, Kittybrewster, and Torry Secondary Schools.

ORGANISATION AND ADMINISTRATION.

A. System and Extent of Medical Inspection and Treatment.

The Department of Health for Scotland each year designates certain age-groups for obligatory medical examination. The age-groups prescribed by D.H.S. Circular 45/1954 were entrants (approximately 5 years of age), pupils born in 1945 (approximately 9 years old), those born in 1941 (approximately 13), and those born in 1938 (approximately 16), as well as pupils born in 1947 (visual acuity and hearing only). These groups were duly examined, and, in addition, a rapid and less comprehensive survey was made of school entrants as soon as practicable after their initial entry. Owing to shortage of medical staff, no routine examinations other than the obligatory ones and the quick survey just mentioned were carried out.

In general, routine medical inspection was conducted very much as in former years, except that the hearing of the pupils born in 1947 was also tested by the audiometrician with a pure-tone audiometer.

Routine medical overhauls serve a dual purpose. In the first place, they permit of the detection of early defects, which in many cases have hitherto been unsuspected

by the parents, as well as the identification of more obvious disease conditions; and advice is given about the most appropriate measures by which the defects can be remedied. Secondly, and probably of even greater importance, advantage is taken of the presence of the parent to inculcate ideas of health maintenance and of the active promotion of health. Indeed, this is a valuable facet of health education work in schools.

In practically all cases of disease or defects requiring medical treatment, the parents are advised to consult their general practitioners. The provision of the National Health Service Act for "free" treatment has made an appreciable difference to the readiness of parents to take their children to their family doctors. Nevertheless, ample need remains for the various school clinics—*e.g.*, minor ailment clinics; skin diseases clinic; eye clinic; ear, nose, and throat clinic; dental clinics; orthopædic clinic; and (started this year) orthoptic clinic.

For some years, it has been noted that the numbers of children attending the minor ailments clinics and the skin diseases clinic were increasing. It is interesting to notice that, in the session under review, there were, for the first time, decreases in these numbers. It is perhaps too early to say whether these decreases are due to mere coincidence or to the success of the preventive services.

B. System and Extent of Dental Inspection and Treatment.

The report of the Chief Dental Officer is given later.

C. School Nursing and Arrangements for "Following-up."

The School Nursing Service is provided by the health visitors, who, as far as is practicable, are allocated to schools serving their particular districts.

Medical Inspection.—According to a practice that used to be universal and that still remains standard in most areas, the health visitor of the district accompanies the medical officer in school during a medical inspection—the weighing, measuring, and vision-testing of the children having taken place some days previously. It has been claimed in some quarters that to employ a health visitor on such work is to mis-use the time of a very highly trained officer; but the health visitor can often give valuable information to the medical officer about the child's physical and mental progress, background, and home conditions, and the contact with the mother at the time of medical inspection is helpful to the health visitor in her work with the child and the family.

Follow-up and Home Visiting.—Work of very high value is done by the health visitors in the following-up of children who are found at routine medical inspection to be in need of observation or treatment. This work entails numerous visits to schools and necessitates quite a lot of clerical work by the health visitors to maintain adequate records. In many cases home visits are paid as an essential part of the follow-up, to ascertain whether the treatment recommended for the child is being carried out, or to explain and interpret to parents the need for further examination

or further treatment. Such visits are also made to obtain any necessary information about a child's home background.

The school health visitor has the important duty of acting as a link between the home and the school. If she is to discharge that duty adequately, a sufficient number of home visits is essential; but the frequency of visits is, of course, governed by the adequacy or otherwise of the staff available.

Hygiene Inspections by the Health Visitors in Schools.—It is becoming increasingly realised that these inspections are perhaps the most important part of the whole school health service. Health surveys by the health visitors have been carried out in all primary, junior secondary, and special schools at least once every three months during the school session. The ideal is, of course, for the health visitor to see every child not less than once each term, but shortage of staff still renders this ideal impracticable.

During these health surveys, many children who are not making reasonable educational or physical progress, or who show signs of early disease, or who present deviations from normality in respect of growth or development or behaviour, are picked up, given any necessary advice, and—where needful—referred to the school medical officers or to general practitioners. At these inspections, children found to be mal-nourished, showing signs of excessive fatigue, nervous, dirty, inadequately clad, malodorous, or suffering from pediculosis are particularly noted, and the homes are visited where the health visitor deems this course desirable.

During these health inspections a great deal of informal instruction on the promotion of health and on personal hygiene is given to individual children and to small groups as the need and the opportunity arises. Although much of the home visiting done by the health visitors has in the past been for cases of neglect and dirty conditions, increasing attention is now being devoted to physical defects and behaviour problems.

At the end of the school year the health visiting staff consisted of 61 nurses, of whose time approximately 1/5th was devoted to school health work.

Home visitation is also carried out by the male inspector attached to the school health service when it is required in connection with arrangment for treatment of scabies and verminous cases, failure to provide spectacles or other prescribed treatment, and investigation of family circumstances for various reasons.

D. Co-ordination with the Public Health Service and with other Departments of the Authority which render Services to Children.

Complete co-operation with the other portions of the public health service in Aberdeen is ensured by the fact that the School Health Section is part of the Health and Welfare Department. As already mentioned, the health visitors act as school nurses and three of the medical officers undertake work partly in the maternity and child welfare field and partly in the field of school health. Four medical officers still work full-time on school health work but in all cases there is a very close liaison.

For instance, appropriate cases are referred to the School Eye Clinic or to the Dental Clinics by the Maternity and Child Welfare Section, and the entire resources of the Health and Welfare Department are available at need. Cases of chest conditions or suspected chest conditions are referred for investigation to the Chest Clinic under the auspices of the Regional Hospital Board. With regard to the control of infectious diseases, information about the incidence of the non-notifiable inspections (such as measles, rubella, and chickenpox) often reaches the Health and Welfare Department through the School Welfare (formerly Attendance) Department, and the statutory certificates of exclusion from school on account of infectious diseases are transmitted to the head teachers through that department.

Visits are paid by medical officers to the remand home (which is under the control of the Children's Department) for the purpose of examining children (usually delinquents) on entry to the Home, and also for the statutory examinations, both physical and mental, of children about to be admitted to Approved Schools. Children admitted to the Reception Centre (under the Children's Department) also receive medical examination.

E. Co-operation with Voluntary Bodies and other Outside Agencies.

There is full co-operation between the department and certain voluntary bodies which provide services for children. Although, as has been noted above, children in need of medical or surgical treatment are in the first instance usually referred to the general practitioner, certain types of case are referred directly to Aberdeen Royal Infirmary or to the Royal Aberdeen Hospital for Sick Children. There is, for example, a long-standing arrangement with the Dermatological Out-patient departments of these institutions to treat children suffering from ringworm (particularly those who are deemed likely to require X-ray treatment), verrucosis, &c. Similarly, the Eye Institution deals with cases of epidemic conjunctivitis occurring in school children. The Cleansing Station at the City Hospital, under the control of the Special Hospitals Management Committee, continues to deal with cases of scabies and dirty and verminous conditions occurring in school children and their families, the family being treated as a unit wherever possible.

There is also a long-standing arrangement with the Committee of Linn Moor Convalescent Home, Culter, by which school children suffering from pre-tuberculous conditions, debilitated, mal-nourished, or convalescent from illness, are given a period in the Home, the duration varying according to the circumstances of the individual case.

Any children who (*e.g.*, by reason of the mother's removal to hospital) are to be temporarily cared for in the Children's Shelter, controlled by the Aberdeen Association of Social Service, are inspected by school medical officers before admission, to minimise the possibilities of infectious or contagious disease occurring in the Shelter.

The School Health Service also co-operates, where appropriate, with the Royal Society for the Prevention of Cruelty to Children.

National Survey of the Health and Development of Children.—As was reported last year, an enquiry into the growth, health, and development of children is being carried out by the Joint Committee of the Institute of Public Health (University of London), the Society of Medical Officers of Health, and the Population Investigation Committee. Through the Maternity and Child Welfare Services, some 6,000 children born in England, Wales, and Scotland between 3rd and 9th March, 1946, have been carefully followed up during the early years of their lives and a unique amount of information has been collected about their home conditions, their illnesses, accidents, growth, and development. The children are drawn from all social classes, and it is hoped that their experiences will provide an unbiassed picture of the health and social environment of children in Great Britain. These children now attend school and the investigation is to be continued during their school lives. During the past year medical examination of the children has not been required but the school health visitors paid a home visit to each child and obtained certain additional information required for the enquiry. Records of absences from school are kept by the head teachers, and the health visitors are responsible for recording any illnesses which occur during vacations. Aberdeen's quota of the children concerned is 14.

F. Co-operation with Teachers and Parents.

Co-operation with parents and teachers is essential in the interests of the children.

It is pleasant to recall that in general the relations between the school doctors and health visitors on the one hand and the teaching staff on the other are good and mutually helpful. Most teachers are very ready to co-operate in measures taken for improving the mental and physical health of the children under their care. In some schools, the school medical officers and health visitors are frequently consulted by the teachers on aspects of the health education curriculum as well as on other matters. Nevertheless, there is need for considerably more co-operation in the future, and there are certainly some schools in which the teachers do not yet appear to appreciate that the school health visitor is—like the school doctor—a very highly trained professional officer whose expert guidance on matters of physical and mental health is constantly available to them.

The attendance of parents at routine medical inspections is pleasingly high, although it naturally varies according to the age-group being examined. At the inspection of five-year-old children, 96·7 per cent. of the children had a parent present; at the inspection of the nine-year-olds, the percentage was 90·3; it was 65·1 at the inspection of thirteen-year-olds; and it was 26·1 at the inspection of sixteen-year-olds; giving an over-all percentage of 82·4. Medical inspection is now completely accepted by parents as part of the school routine. Parents of children in the older age-groups are generally content to allow their children to come unaccompanied unless there is some known or suspected condition about which they wish advice. The attendance of 29 parents for every 30 school entrants and of 9 parents for every 10 children aged nine years is highly gratifying. At these inspections, advantage is taken by both doctor and health visitor of the attendance of the parents to instil principles of health maintenance in both parent and child and to inculcate the idea that promotion of health is part of one's duty to oneself and to the community.

Talks are occasionally given by the school doctors and health visitors to meetings of Parent-Teacher Associations connected with some of the schools, although this is a line that might usefully be much further developed in the future. The usefulness of these talks is undoubtedly limited by the fact that the parents to whom one most desires to talk are not present; but such talks nevertheless play a part in spreading knowledge of the principles of healthy living and thereby improve the health of the people.

THE FINDINGS OF MEDICAL INSPECTION.

General.

As mentioned above, systematic medical inspection was carried out in the four age-groups prescribed—(1) Entrants (usually 5-6 years), (2) children aged 9 years, (3) children aged 13 years, and (4) children aged 16 years. As it is not usually practicable without undue expenditure of time to examine the vision and hearing of children entering school for the first time, vision- and hearing-testing was carried out in the case of the 7-year-old children. In addition, a superficial inspection of 5-year-old children was carried out as soon as possible after their entry to school.

Four hundred and fifty-one visits were paid to schools by the medical officers in connection with systematic medical inspection, and before each inspection a good deal of preparatory work was done by the health visitors—*e.g.*, the weighing, measuring, sight-testing, and hearing-testing of the children.

Preliminary Inspection of "Entrants."

The preliminary rapid review of all school entrants for detection of obvious physical defects and verminous conditions revealed the following details:—

Total number inspected	2,559
Dirty heads—Nits	54 or 2·1 per cent.
Vermin	3 or 0·1 per cent.
Squints	124 or 4·8 per cent.
Other diseases	34 or 1·3 per cent.
Number excluded for various infections	10 or 0·4 per cent.
Unsatisfactory clothing	7 or 0·3 per cent.

Most of these proportions are slightly lower than in the previous year.

Systematic Medical Examination.

The routine medical overhauls provide valuable information about the frequency of common defects. From a study of the results of these examinations over the last four years, the heartening conclusion can be drawn that the health of Aberdeen school children is improving; the percentage of children wholly free from defects has risen steadily—31·9 per cent. in 1951-52, 36·4 per cent. in 1952-53, 38·4 per cent. in 1953-54, and now 42·7 per cent. in 1954-55. Similarly, the proportion free from defects, other than those of vision or teeth, has risen steadily from 43·3 per cent. in 1951-52 to 58·4 per cent. in 1954-55.

Details of the number and percentage of individual children in each age-group found to be suffering from particular defects are given in Table II at the end of this section of the Report. A summary is presented here.

Nature of Defect.	Number Examined.	Number Defective.	Percentage Defective.
1. Clothing unsatisfactory	7,834	3	·04
2. Footgear unsatisfactory	,,	5	·06
3. Cleanliness—			
(*a*) Head: Nits	,,	26	·3
Vermin	,,	5	·06
(*b*) Body: Dirty	,,	2	·03
Vermin	,,	—	—
4. Skin—			
(*a*) Head: Ringworm	,,	—	—
Impetigo	,,	38	·5
Other diseases	,,	49	·6
(*b*) Body: Ringworm	,,	2	·03
Impetigo	,,	5	·06
Scabies	,,	1	·01
Other diseases	,,	161	2·1
5. Nutritional State—			
Slightly defective	,,	154	2·0
Bad	,,	2	·03
6. Mouth and teeth unhealthy	,,	310	4·0
7. Naso-pharynx—			
(*a*) Nose:			
(i) Obstruction requiring observation	,,	325	4·1
(ii) Obstruction requiring operative treatment	,,	12	·2
(iii) Other conditions	,,	17	·2
(*b*) Throat:			
(i) Tonsils requiring observation	,,	997	12·7
(ii) Tonsils requiring operative treatment	,,	83	1·1
(*c*) Glands:			
(i) Requiring observation	,,	365	4·7
(ii) Requiring operative treatment	,,	5	·06
8. Eyes—			
(*a*) External diseases:			
Blepharitis	,,	108	1·4
Conjunctivitis	,,	3	·04
Corneal opacities	,,	2	·03
Strabismus	,,	371	4·7
Other diseases	,,	53	·7
(*b*) Visual acuity with/without glasses:			
Fair	4,885	976	20·0
Bad	,,	57	1·2
Recommended for refraction	,,	321	6·6

Nature of Defect.	Number Examined.	Number Defective.	Percentage Defective.
9. Ears—			
(*a*) Diseases:			
Otorrhœa	7,834	67	·9
Other diseases	,,	147	1·9
(*b*) Defective hearing:			
Grade I	4,885	9	·2
Grade II*a*	,,	4	·08
Grade II*b*	,,	—	—
Grade III	,,	—	—
10. Speech—			
Defective articulation	7,834	65	·8
Stammering	,,	20	·3
11. Mental and Nervous Condition—			
(*a*) Backward	,,	11	·1
(*b*) Dull	,,	2	·03
(*c*) Mentally deficient (educable)	,,	—	—
(*d*) Do. (ineducable)	,,	—	—
(*e*) Highly nervous or unstable	,,	39	·5
(*f*) Difficult in behaviour	,,	19	·2
12. Circulatory System—			
(*a*) Organic heart disease:			
(i) Congenital	,,	23	·3
(ii) Acquired	,,	6	·08
(*b*) Functional conditions	,,	14	·2
13. Lungs—			
Chronic bronchitis	,,	10	·1
Suspected tuberculosis	,,	46	·6
Other diseases	,,	225	2·9
14. Deformities—			
(*a*) Congenital	,,	45	·6
(*b*) Acquired (infantile paralysis)	,,	16	·2
(*c*) Acquired (probably rickets)	,,	120	1·5
(*d*) Acquired (other causes)	,,	232	3·0
15. Infectious disease	,,	2	·03
16. Other diseases or defects	,,	728	9·3
17. Classification:			
Group I	,,	3,343	42·7
Group II*a*	4,885	684	14·0
Group II*b*	7,834	123	1·6
Group II*c*	4,885	6	·1
Group III	7,834	2,985	38·1
Group IV*a*	,,	487	6·2
Group IV*b*	,,	206	2·6
Number notified to parents as suffering from defects	,,	600	7·7
Number under observation	,,	3,327	42·5
Number of parents present at inspection (6,454)	,,	—	82·4
Number wearing glasses	,,	749	9·6

Most of these figures show only the usual yearly slight variations. It is, however, pleasing to note that the figures for defective nutrition show a slight decrease compared with last year (from 2·5 per cent. in 1953-54 to 2·0 per cent. in 1954-55), that there are fewer cases of unsatisfactory clothing and footgear, that nasal conditions, enlarged tonsils, and enlarged cervical glands are all less frequent, that heart conditions are less numerous, that ringworm and scabies have virtually disappeared, and that impetigo remains something of a rarity.

Most of the changes are in the direction of improved health, and no points call for special mention.

The percentage of children notified to parents as suffering from defects (7·7) is slightly down compared with that in previous years. The percentage of children requiring to be kept under observation by the nurses (42·5) is also smaller than last year (47·4). The proportion of parents present at examination was 82·4 per cent. as compared with 83·1 per cent. last year, which was the highest recorded till then.

Classification on routine examination.

Figures for 1954-55 and percentages for the last four years are given below.

Classification.	1954-55. No.	1954-55. %	1953-54. %	1952-53. %	1951-52. %
I. Free from defects	3,343	42·7	38·4	36·4	31·9
*IIA. Defective vision but otherwise free from defects	684	14·0	11·4	9·4	10·0
IIB. Mouth and teeth unhealthy but otherwise free from defects	123	1·6	1·5	1·1	1·2
*IIc. Combination of IIA and IIB	6	0·1	0·2	0·2	0·2
III. Children with ailments from which recovery is expected in a few weeks	2,985	38·1	42·7	48·1	49·7
IV. Children with more serious defects—					
(*a*) Where cure is considered possible	487	6·2	7·6	6·5	8·1
(*b*) Where only improvement is considered possible	206	2·6	2·7	2·1	3·1

* Percentage with eye defects refers to children receiving visual tests, *i.e.*, a different total from number having routine medical overhauls. Hence the percentage when added will not come to exactly 100.

HEIGHTS AND WEIGHTS OF CHILDREN EXAMINED.

The following table gives particulars of the heights and weights of children examined. The small figure in the age column refers to months: thus 5^3 means 5 years 3 months.

	BOYS				GIRLS			
Age Group (years).	Number Examined.	Average Age.	Average Height in Inches.	Average Weight in Pounds.	Number Examined.	Average Age.	Average Height in Inches.	Average Weight in Pounds.
5—6	1,174	5[2]	42·4	42·4	1,076	5[3]	42·1	40·8
9—10	1,075	9[4]	51·7	64·3	1,079	9[3]	50·9	62·1
13—14	1,198	13[5]	59·5	94·1	1,134	13[5]	59·8	99·1
16—17	186	16[5]	67·8	138·5	142	16[4]	64·0	124·5

For comparison with previous years, reference should be made to Table V at the end of the report.

Re-Inspection.

Re-inspection includes the re-examination of children who have had some defect or defects discovered at routine medical examinations during the year and for whom treatment had been advised; it also includes certain children who were placed under observation because it was suspected that they might be suffering from some ailment.

The total number of children re-inspected was 6,123, as compared with 5,410 last year, and with 2,643 in 1952-53. Details of re-inspections are as follows:—

	Number Re-examined.	Treatment Completed.	2nd Notice.	Number Improved but kept under Observation.
Dirty heads	87	39	27	21
Defective vision	761	468	109	184
Enlarged tonsils	281	147	79	55
Skin diseases	9	6	3	—
Scabies	3	3	—	—
Other diseases	226	75	130	21
Number under observation	6,842	3,744	93	3,005
Total	8,209	4,482	441	3,286

It will be observed that it is stated that 6,123 represents the total number of children re-inspected, whereas in the table the number is given as 8,209. The difference is due to the fact that some of the children examined had more than one defect.

Other Examinations.

(1) *Visits by School Medical Officers.*

These are visits for the supervision of hygienic conditions, the investigation of outbreaks of infectious disease, the study of various influences affecting the physical and mental well-being of the children, and the examination of mentally-handicapped children. During the year, 238 such visits were paid by the medical officers (as compared with 231 in 1953-54 and 162 in 1952-53).

(2) *Unannounced Visits by Health Visitors.*

Ideally, the health visitors should inspect every child each term (with the possible exception of children who are receiving a routine medical overhaul during that term) and selected children at more frequent intervals. As in previous years, the available staff was insufficient for this purpose, but practically every child was inspected at least once during the year. It is of supreme importance that the number of these visits should be increased whenever staff permits.

Since the number of hygiene inspections was small in the past, an excessive prominence may then have been given to "cleanliness" which, of course, must never be neglected. Nowadays, however, at least equal emphasis is placed by the health visitors on such points as nervousness, nutrition, fatigue, posture, debility, &c., but (to allow comparisions with past years) all these are grouped here under the heading of "other diseases":—

Total number of ordinary inspections	54,043
Total number of inspections showing live vermin of head	137
,, ,, ,, ,, ,, nits in hair	1,669
,, ,, ,, ,, ,, impetigo	84
,, ,, ,, ,, ,, scabies	1
,, ,, ,, ,, ,, other diseases	3,704
,, ,, ,, ,, ,, unsatisfactory clothing	446
,, ,, ,, ,, ,, unsatisfactory footgear	252

Comparison with past years is interesting. In 1954-55 the number of inspections showing nits or vermin has at last fallen below the 2,000 total, the number of inspections showing scabies or impetigo has remained very small, and the number showing unsatisfactory clothing or footgear has fallen to under 700. On the other hand, the miscellaneous group for "other diseases" is rising year by year and now dominates the picture.

The number of inspections revealing "other diseases" was only 570 in 1952-53, in 1953-54 it soared to 2,873, and this year it has risen to the unprecedented total of 3,704. The explanation of this tremendous rise is not increased ill-health: for the figures for routine medical inspection show clearly that the health of the children is improving. The explanation is that the health visitors' surveys have become much more thorough: what was in the past a mere inspection for cleanliness has now developed into a valuable survey of each child, a thing of great importance both for the detection of early deviations from normality and for the promotion of physical and emotional health.

In addition, the health visitors examined 10,825 "selected" cases, many of whom had previously been found to have some defect of cleanliness. Of these, 116 (or 1·1 per cent.) were found to have live head vermin, and 1,683 (or 15·5 per cent.) to have nits of the hair.

(3) *Home Visits by Health Visitors.*

These visits are among the most important aspects of the school health service, and enable the visiting nurse to act as a link between home and school, to the

benefit of both. Unfortunately, the visits are also time-consuming, and shortage of staff prevented an adequate number of visits being paid.

Health visitors paid 2,053 visits to homes to give advice about school children. The total number of children involved was 2,343. During the year the classification of the visits of the health visitors was divided into "visits for medical reasons" and "visits for reasons of defective cleanliness in some form," with the following results:—

Medical		Cleanliness.	
1st visits.	Re-visits.	1st visits.	Re-visits.
903	476	379	542

As a result of their visits the health visitors reported 243 children as being "slightly improved," 121 as "markedly improved," and 108 as "cured."

(4) *Examination of vision of seven-year-old children.*

During the year 2,912 children born in 1947 had their vision tested, and 248 were referred to the school eye clinic for refraction.

(5) *Examination for Tertowie Residential School.*

During the year, 362 pupils (194 boys and 168 girls) from junior secondary schools were inspected before departure for a three weeks' period at Tertowie Residential School. Because of the length of time away from Aberdeen, a very strict standard of examination was required, but only two pupils had to be excluded as unfit.

(6) *Mental Assessment.*

In all, 117 examinations were made (as compared with 73 in the previous year). All children referred for report were dealt with during the year. Fewer children were referred as a result of group testing. Factors such as absence, ill-health in infancy, minor degrees of deafness, tended to affect the reliability of standardised tests undertaken within the first year or so of entering school, and further trial period in the infant room was considered necessary in over half of these cases. Pre-school children presenting possible educational difficulties were seen in their homes by appointment. Fifteen children were found to be unfit to enter school at the age of five on the grounds of either mental or physical handicap. Decision as to educability was postponed in 8 cases, home tuition for a period was recommended in 3 cases, and 4 children were reported as ineducable.

Fifty-four children were recommended for admission to the Special School, 15 as physically handicapped, 39 as mentally handicapped, and of the physically handicapped 4 required education as mentally handicapped. Of all these, 10 were admitted on trial. During the year, 16 were admitted to the Occupational Centre.

Children admitted to Woodlands during the year were seen along with the appropriate medical officer of the Regional Hospital Board.

(7) *Children suffering from Orthopædic Defects.*

Children at Beechwood School were examined at separate sessions, along with the orthopædic surgeon, the parents being present. The individual requirements of the children were assessed. Twenty children attending the school require daily treatment. For this treatment a full-time physiotherapist would be required.

(8) *Audiometric Examination of Seven-year-old and other Children.*

Systematic audiometric testing for the early and scientific detection of hearing defects, commenced in 1953, was continued during the year under review. The children tested were those born in the years 1947, 1945, and 1942, and also children of other ages who were suspected of having some degree of deafness by the teachers or health visitors. The method used was again the "sweep" method at 15 decibels of hearing loss by use of the pure-tone audiometer.

The classification of those found to have a hearing loss was the same as was described last year, and the cases of apparent defective hearing were followed up medically (including the use of the auriscope). In cases where there was no obvious temporary cause, or where it was thought that a hearing-aid might be necessary, the children were referred to the Ear, Nose, and Throat Department of the Royal Aberdeen Hospital for Sick Children.

Deafness is normally classified into four grades: Grade I—slightly hard of hearing; Grade II*a*—requiring favourable position in class and may need a hearing-aid; Grade II*b*—often needing to be taught in a special class by special methods; and Grade III—requiring to be taught in a school for the deaf.

The results of the work done during the year as as follows:—

	Number Tested.	Normal.	Defective.
Group I—			
All children born in 1947 . . .	3,195	3,094	101
,, ,, ,, ,, 1945 . . .	1,983	1,892	91
,, ,, ,, ,, 1942 . . .	2,068	1,983	85
Group II—			
Children of other ages suspected of deafness	210	103	107

CLASSIFICATION OF CHILDREN WITH DEFECTIVE HEARING.

	DEAF IN ONE EAR.		BOTH EARS AFFECTED.				
	Normal/1	Normal/2A	1	1/2A	2A	2B	3
GROUP I—							
Born 1947	70	12	15	1	3	—	—
,, 1945	69	5	15	—	2	—	—
,, 1942	58	11	9	1	6	—	—
GROUP II—							
Other ages	44	8	38	6	11	—	—

NUMBER OF CHILDREN REFERRED FOR INVESTIGATION AND/OR TREATMENT AFTER EXAMINATION BY SCHOOL MEDICAL OFFICERS.

	Group I			Group II
	1947.	1945.	1942.	Other ages.
Number referred to Hospital for Sick Children . . .	2	3	3	11
Number referred to School Ear, Nose and Throat Clinic .	4	6	9	5
Number referred to own doctor	20	10	9	23
Number where no action was necessary	60	59	36	51
Number absent	15	3	7	7
Number awaiting examination by school medical officers .	—	10	21	10

In addition to the above, children entering the Special Schools for the first time were tested (51 from Beechwood School, 65 from Rubislaw Occupational Centre, and 8 from Polmuir Road School for the Deaf). The classification of hearing defects was as follows:—

SCHOOL.	DEAF IN ONE EAR.		BOTH EARS AFFECTED.				
	Normal/1	Normal/2A	1	1/2A	2A	2B	3
Beechwood .	3	—	2	—	2	—	—
Rubislaw	2	1	—	—	—	—	—
Polmuir Road	—	—	—	—	—	3	5

(9) *Partially-sighted Children.*

Partially-sighted children were examined in a group along with the ophthalmic surgeon. The degree of useful vision was noted and the prognosis established in each case.

(10) *Leavers.*

Individual reports on 35 children leaving special schools were submitted to the Youth Employment Officers and a case conference was held on each. 11 children leaving the special schools were reported for the purposes of the Mental Deficiency Acts under Section 57. All these were considered suitable for admission to an Adult Day Occupational Centre if such were available and were recommended for admission to the present Centre for under 16's meantime.

(11) *Miscellaneous.*

Children at Residential Schools for special handicaps were visited while at home on holiday.

Home Tuition.—At the end of the session, 17 children were receiving home tuition. It is interesting to note that 6 of these suffered from tuberculosis and 5 from orthopædic defects. Of the further 26 children on the suspense roll for whom home tuition had not yet been provided, 9 are known to suffer from tuberculosis and 6 from orthopædic defects.

MEDICAL TREATMENT.

A—Minor Ailments, Skin Diseases, &c.

(1) *Cuts, Bruises, Sprains, Minor Injuries, &c.*

Cases occurring in schools while any of the medical or nursing staff are in the school are dealt with by them, but many cases are given first-aid treatment by the teaching staff, many of whom have had first-aid training. Children requiring further treatment are referred to their own doctor or, in serious cases (*e.g.*, fractures), to the Casualty Departments of the General Hospitals. No information is at present available about the number of children in this group who have received treatment by their own medical attendant or at any of the hospitals.

(2) *Attendance (Minor Ailments) Clinics.*

These clinics were held at Powis Secondary School on Thursdays at 9.30 a.m. and at the Child Welfare Centre, Castlegate, on Thursdays at 2 p.m., and also at the Dispensary Buildings, Guestrow, on Mondays at 2 p.m. Children are referred from various sources, such as health visitors, school welfare officers, and head teachers. During the year, 1,343 children were referred, and made 1,565 attendances: both figures represent a slight decrease from those for the previous year.

(3) *Diseases of the Ear, Nose, and Throat.*

The Ear, Nose, and Throat Clinic is held at Dispensary Buildings, Guestrow, on alternate Fridays at 2 p.m. A health visitor is in attendance daily at 4 p.m. to give treatment where necessary. The attendances during the school year 1954-55 were as follows:—

Number of new cases	47
Number referred to hospital	5
Number referred to own doctor	2
Number treated at clinic	33
Number discharged requiring no treatment	7
Total attendance at clinic	1,076
Number discharged cured	12

About 85 per cent. of the new cases are cases of diseases of the ear alone.

The vast majority of cases of enlarged tonsils and adenoids are not referred to the Ear, Nose, and Throat Clinic, but are referred to the family doctor in the first instance.

(4) *Diseases of the Eye, excluding Defective Vision.*

Cases continue to be referred, by arrangement, to the Eye Institution, 142, King Street, Aberdeen. The number of cases so referred was 2 of acute conjunctivitis and 127 of mild conjunctivitis, and 7 of severe blepharitis.

(5) *Diseases of the Skin.*

Only one case of ringworm of the scalp and 3 cases of ringworm of the body were found and treated, as compared with 1 and 11 respectively in the previous

year. Most cases of ringworm are referred, by arrangement, for treatment at the Skin Out-Patient Department, Aberdeen Royal Infirmary, Woolmanhill.

As for impetigo, 216 children were treated at the School Skin Clinic, Dispensary Buildings, Guestrow, Aberdeen; 1,635 attendances were involved. (The figures for the previous year were 234 children and 2,059 attendances, and for 1952-53 were 95 children and 627 attendances.) These figures show that, since autumn, 1953, there has been some increase in the prevalence of impetigo contagiosa, the figures for which had been low for some years preceding that year. It is possible that the bacteria which cause this disease have become rather more virulent.

With regard to scabies, cases are usually referred for treatment to the Cleansing Station at the City Hospital, along with all contacts, adults as well as children. Four families, of whom one or more school-child members of the family were found to be suffering from scabies were so dealt with, involving a total of 1 adult, 7 school children, and 1 child under school-age. These figures are lower than the corresponding figures for 1953-54, and are by far the lowest for this particular disease ever recorded in Aberdeen.

The number of children known to the department to have been treated for the undernoted skin ailments at the Skin Out-Patient Departments of the hospitals were as follows:—

Acne	2	Molluscum-contagiosum	3
Eczema	4	Verrucosus	1
Seborrhœa	1	Warts	44

B—Defective Vision and Squint.

As a result of vision testing in schools, 2,701 children (1,257 boys and 1,444 girls) were examined by eye specialists employed by the North Eastern Regional Hospital Board. The eye clinic was held at Dispensary Buildings, Guestrow, on Mondays, Wednesdays, Thursdays, and Fridays at 2 p.m. Spectacles were prescribed in all necessary cases.

In addition to the 2,701 children mentioned above, 130 pre-school children were also examined at the clinic. These figures compare with 2,438 school children and 134 pre-school children in the previous year.

Treatment of Squint—Orthoptic Department.

The purpose of orthoptics is to investigate defects of binocular vision and to treat them, where appropriate, by suitable exercises which aim at producing normal co-ordination of the two eyes. The exercises not only aim at the stimulation of the extra-ocular muscles, but require conscious mental effort of a re-educative nature; they are given to patients who have either lost binocular vision (as in manifest strabismus of childhood) or those who find its maintenance difficult (cases of latent squint), giving rise to ocular fatigue and headaches. Orthoptic treatment will suffice also for cases of convergence insufficiency where no other treatment is of value, and the orthoptist may also supervise occlusion of the dominant eye where diminished visual acuity does not seem due to any obvious cause.

The department in connection with the School Health Service was not fully established until May, 1955.

The cases attending the department at present can be divided as follows:—

(i) *Pre-school.*—These children are sent to the clinic from nursery schools, maternity and child welfare clinics, or referred by health visitors.

(ii) *School.*—This group are referred through the eye clinic.

(iii) *Post-school.*—A few children who require treatment after leaving school are referred from the Eye Institute or Woolmanhill.

The cases undergo full diagnosis and, if a defect of binocular vision is found to be present, are either rejected for treatment as unsuitable (perhaps due to a long period of neglect before attending the clinic, when the defect would not respond to orthoptic treatment, mental incapacity, unwillingness to attend, or excessive distance from clinic) or accepted for treatment.

Treatment may be weekly (over a period of 8 to 12 weeks) or, more usually, at monthly intervals. Some patients remain under observation either because they are too young to co-operate or until old enough to discharge as satisfactory. There is a large waiting-list for squint operation (over 50 children from the school clinic), and where the cases are unsuitable for exercises alone, these patients remain under observation until such time as they are admitted to hospital, after which orthoptic treatment is given.

The actual time involved in treating a case of squint cannot be estimated, as it depends on many extraneous factors—mainly the onset of the deviation and the time lapse between the onset and the treatment. Heterophorias (latent squint) and convergence insufficiencies generally respond well and are cured in 8 to 12 weekly orthoptic treatments.

Orthoptic treatment is carried out with full co-operation between orthoptist and surgeon to produce normal binocular single vision.

Attendances.—Persons attending the clinic included 294 new cases (of whom 174 were suitable for treatment, 84 were unsuitable, and 36 had no defect), 27 transferred from the Sick Children's Hospital, and 641 return cases.

C—Nose and Throat (Operative Treatment).

Cases which appear to require operative treatment are, in general, referred in the first instance to the family doctor.

D—Orthopædic and Postural Defects (Specialist Treatment).

The Orthopædic Clinic, controlled by the North-Eastern Regional Hospital Board, has, since October, 1952, been held at Dunfermline College of Physical Education, Old Infirmary Buildings, Woolmanhill. This change was made at the suggestion of the authorities of the College of Physical Education, and continues to be mutually helpful to both parties in as much as the schools were finding it increasingly difficult to carry out special remedial exercises for postural defects, &c., and the College is assured of suitable cases for demonstration and teaching purposes.

The clinics are held during the session at intervals of approximately one month, according to the number of cases to be examined, and are still conducted by one of the orthopædic surgeons of Aberdeen Royal Infirmary.

During the year, 79 children were examined by the orthopædic surgeons, and 3 of these were referred to one or other of the general hospitals for further investigation and treatment in hospital; special remedial exercises were recommended for 22; and no action, further than the slight raising of soles and heels of shoes in some cases, was considered necessary in the case of 54 children.

In addition to the above-mentioned cases, 114 children who had previously been attended at the clinic paid re-visits for ascertainment of the progress of the prescribed treatment.

E—Speech Defects.

The School Health Service continued to co-operate with the Speech Therapy Department in referring appropriate cases to that department. Patients treated during the year included 33 from special schools and 409 from ordinary schools.

F—Child Guidance.

During the year, medical inspection of children attending the child guidance clinic was continued, at first on the lines initiated in 1953-54, when medical inspection of these children started. Towards the end of the year, however, it was found that medical inspection of children referred to the clinic could be more suitably undertaken in the schools. In all cases, children referred to the clinic receive medical examination.

DENTAL INSPECTION AND TREATMENT.

Mr. Hay, Chief Dental Officer, reports as follows:—

Staffing.

In the course of the year there were several changes in the staff. Mr. I. H. Lawrence commenced duty on 1st September, 1954, and just over two months later Mr. J. Ogden resigned to take up a similar appointment in England. Mrs. I. A. Ruddiman was engaged on a part-time basis at the end of November. Advertising failed to attract any further applicants, and so, for the greater part of the year, the effective strength of the service was 4 3/11ths dental officers instead of an establishment of 7.

Inspection.

Forty primary and 8 secondary schools were inspected in the course of the year. Some 15,000 cards were used in completing the provision of a dental record card for almost every school child in the City.

One hundred and forty-one sessions were spent on the examinations of 19,333 children, and, of these, 15,015, or 78 per cent., were notified as requiring treatment. Six thousand five hundred and thirty-five, or 44 per cent., accepted treatment by the school service.

Treatment.

In all, 1,817 sessions were spent treating 4,929 of those children. There were 12,273 attendances, including 364 casual visitations, for the extraction of 6,459 temporary and permanent teeth, 7,931 temporary and permanent amalgam fillings, and 1,425 temporary and permanent cement fillings. Administrations of a general anæsthetic numbered 473, a reduction from the previous year.

During the month of July, six children on holiday in the City sought and obtained emergency treatment at the Central Clinic.

Miscellaneous Points.

Two nursery schools and Airyhall Children's Home were inspected, and, from these and others referred to the clinics, some 114 pre-school children made 193 attendances for 92 temporary extractions, 38 temporary amalgam fillings, 77 cement fillings, and 113 temporary other treatments. There were 25 administrations of a general anæsthetic for these children.

Towards the end of the session it was decided to undertake a limited amount of work on mothers referred from the ante-natal and post-natal clinics. One expectant and one nursing mother made 3 attendances for treatment.

Orthodontics.

A limited amount of orthodontic work was undertaken, but 34 children were referred for treatment to the Orthodontic Clinic at the Sick Children's Hospital.

Developments and Future Needs.

Clinic facilities do not exist for the complete establishment of dental officers, and so the re-equipping and augmenting of clinics was begun. A new surgery was installed at North Silver Street, and an existing room there re-equipped. A new clinic is almost ready for use in Linksfield School, and the medical room will be equipped for treating the children at Beechwood School early in the new session. There are now 3 clinics in the City with equipment compatible with modern standards.

An x-ray machine was installed at the Central Clinic in April, and the basement provided a suitable dark-room for the development of films. It is thus now possible to undertake any necessary x-ray work without having to refer the patient to the Infirmary and await the report by the radiographer. This makes for a more comprehensive service, and with the re-equipped surgeries should help in attracting recruits to the service.

The existing arrangement for the administration of general anæsthetics leaves much to be desired. At present, there is only a single dose machine, and, as frequently happens, patients have to return if all the necessary extractions are not completed in the time available. Also, two dentists are necessary for this, one for the administration, and the other operating, while a surgery has to be left vacant for the doctor who examines prior to the anæsthesia.

An up-to-date apparatus for continuous anæsthesia and the services of an anæsthetist would require only one dentist for this regrettably necessary part of the service. There would also be no need for a doctor in attendance, and an additional surgery would thus be vacant for more preventive work.

As the Hilton Clinic is now unable to cope with all the children in the north-west of the City, and to expedite the treatment of this area, the service was offered to children in those schools west of North Anderson Drive by 3 dental officers at the Central Clinic during the latter part of the session. The attendances for treatment were good, considering the distance and the expense on the part of mothers attending with children. Another clinic in this area is desirable, and one sited in the new school under construction at the junction of Provost Fraser Drive and North Anderson Drive would be excellent.

In conclusion, I should like to express my appreciation and thanks to the members of the Committees for their understanding co-operation in sanctioning so readily the provision of all the new equipment, thereby facilitating the provision of a dental service more in keeping with present-day standards. I should also like to thank the Medical Officer of Health and the members of the department for very willing help, the Head Teachers for their co-operation, and the Works and Printing Departments for their services throughout the year.

IMMUNISATION.

(*a*) *Diphtheria Immunisation.*

The annual campaign of immunisation against diphtheria—mainly reinforcing doses among the five-year-old "entrants" and the eight-year-olds—was completed during the summer term. The following figures show the work done during the campaign. The corresponding figures for the last three years are given for comparison.

	1955.	1954.	1953.	1952.
Total number of visits paid to schools	127	101	88	93
Number of school children fully immunised for the first time (*i.e.*, 2 injections)	613	661	1,006	974
Number of school children who have received a reinforcing injection	4,205	3,714	3,504	3,685

The satisfactory response to the offer of a reinforcing injection continues to be encouraging. The number receiving initial (primary) immunisation is, of course, declining as more children secure primary immunisation before reaching school age.

At the end of June, 1955, 26,983 children of school age (or 95·1 per cent. of all children attending infant, primary, and secondary schools) had been immunised at some time.

(*b*) *Immunisation against Tuberculosis.*

The campaign to offer protection against tuberculosis to all pupils of 13 years and over was resumed in the autumn term, 1954. The necessary technique, which was fully described in the Annual Report for 1952-53, and including the tuberculin skin-test, mass miniature radiography, and inoculation with B.C.G. (of those found

to be tuberculin negative), was carried out as before. Previous to this, "consents" had been received from the parents or guardians of 6,092, or 96·7 per cent., of these pupils—a really excellent response, even as compared with the response of 91 per cent. in 1953 when the campaign started.

Of that number, 1,087 pupils who had been dealt with in the 1953 campaign were x-rayed by mass miniature radiography only. Of the remainder, 111 pupils for various reasons had to be dropped from the scheme, *e.g.*, known contacts of cases of tuberculosis, children who left the district after acceptance, children whose x-ray plates showed signs of chest trouble, &c. Actually, 4,894 pupils were tested for their susceptibility to tuberculosis. Of these, 1,689 (or 34·5 per cent.) were tuberculin positive, *i.e.*, they had already acquired a "natural" immunity sufficiently high to make artificial immunisation unnecessary.

The remaining 3,205 (or 65·5 per cent.) were tuberculin negative, *i.e.*, had not acquired a "natural" immunity to tuberculosis and therefore were inoculated with B.C.G. vaccine.

At the end of six weeks (the minimum time for development of immunity) 324 (a sample 10 per cent. of the immunised pupils) were retested and were converted to tuberculin-positive reactors, *i.e.*, they now became "insusceptible" to tuberculosis.

Following radiological examinations, 24 cases with minor chest lesions were kept under observation by the medical officer of the mass radiography unit, while 5 cases were referred to the Chest Clinic at the City Hospital. In all these cases, the appropriate medical practitioners were notified.

ARRANGEMENTS FOR PHYSICAL EDUCATION AND PHYSICAL HYGIENE.

The following information is presented by courtesy of Mr. T. S. Fairley, the Superintendent of Physical Education.

Staffing.

Considerable difficulty was encountered during the past session in maintaining the necessary quota of teachers. Resignations and periods of prolonged illness account for the fact that an unprecedented number of part-time teachers were employed. At one period, out of a female staff of twenty-six, seven were engaged in a temporary part-time capacity. The number of male staff remained constant until May, when the death of one member reduced the number to sixteen.

Schools.

The primary school scheme of work, which has been in the course of preparation during the past two years, is now in the final stages of completion. The scheme, which, it is expected, will be published during the coming session, will be in book form, and will contain physical exercises, dancing, and indoor games.

The expected memorandum from the Scottish Education Department on work in secondary schools has not yet been issued. It is probable, however, that, following upon the recommendations of the recent conference, this memorandum will be

published in due course. In the meantime, schemes of work based upon various suggestions and circulars issued by the Department are in operation.

Treatment of Physical Defects.

The remedial clinic at the College of Physical Education, Woolmanhill, continues to function satisfactorily. During the past session, 32 children received treatment for a variety of physical defects, while the pre-school children's class inaugurated last session, continues to be well attended.

The clinic is visited and the children inspected regularly by an orthopædic surgeon.

Playfields.

With Nelson Street ground now in full operation, the number of playfields available for play has risen to six, while three areas of ground leased from the Links and Parks Department provide accommodation for seven schools. In addition, seven other schools have sufficient ground attached or adjacent to these schools for games.

It is gratifying to note that concrete proposals are now afoot to provide a suitable playfield for the Academy.

During the session, some 13,000 pupils attended the playfields weekly during school hours for organised games.

In addition, the usual competitive team games were played during Saturdays and in the evenings, although, during the winter term, considerable difficulty was encountered in completing fixture lists owing to the unusually severe weather.

Mention must be made of an addition to the games scheme and which has been indulged in with great enthusiasm by secondary school boys during last autumn and winter terms. Although basketball was introduced only during last session, eight secondary schools have taken part in the league and various competitions. It is fully expected that more teams will take part in this invigorating game during the coming season, including "B" teams from the schools already competing.

Swimming.

The usual classes for beginners were held in the Middle School pond. In addition, classes in life-saving were arranged for pupils who could already swim and who were in possession of the Committee's elementary swimming certificate: 20,300 attendances were recorded, representing an average weekly attendance of 530.

Similar classes for beginners were organised at the Corporation ponds from March to October: 10,300 attendances were recorded during this period, being an average of 470 pupils each week.

Attendances were somewhat lower than usual owing to illness and the severe wintry weather encountered in the opening months of the year.

On completion of the courses, 654 pupils were awarded the elementary certificates, while 67 advanced certificates were awarded. In addition, 57 candidates were successful in gaining awards of the Royal Life-Saving Society.

In the annual competition for the swimming shields, there was keen rivalry between schools. In the final test, Powis Secondary and King Street Schools gained the verdict by narrow margins.

Hanover Street Spray Baths.

Owing to a partial but prolonged breakdown in the plant, the number of pupils attending the baths was, of necessity, reduced. During the session under review, 13,000 attendances were recorded.

Athletics.

All secondary and a number of primary schools now hold their own school sports. The high-light of the session, however, is the inter-schools meetings which were held this year on the 22nd and 23rd June at King George's Field.

Every secondary school and practically all primary schools sent forward representative teams of runners and jumpers and both in the preliminary heats and final events there were many close tussles for supremacy. This was particularly noticeable in the primary section where the decision was delayed until the last event of the day, when Mile-end gained the trophy by one point. Rosemount, with a most efficient team, gained the Secondary School Flag for the second year in succession.

Scottish Inter-scholastic Sports.

Special mention must be made of the outstanding performances of a team of girls from the High School at the Girls' Sports held in Glasgow in June. Although only six in number, the team brought back to Aberdeen three trophies. These were—The Frances Barker Shield for the most meritorious performance (Marjory Bain's time for the 80-yards hurdle race was only 1/10 sec. outside the Scottish record), the Lady Alan Hay Cup for winning the senior relay race, and the Paisley Shield for the school gaining the most points. 560 competitors representing 82 schools took part in the sports.

OTHER ACTIVITIES IN RELATION TO SCHOOL CHILDREN.

(*a*) *Linn Moor Convalescent Home, Culter.*

During the year, 76 children (44 boys and 32 girls) were sent to this Home, as compared with 71 in the previous year. In addition, four batches of 66 children all told, sent to Linn Moor Home under the auspices of the Aberdeen Association of Social Service, were medically examined prior to leaving.

(*b*) *School Holiday Camps, 1955.*

During the months of June and July, the school medical officers visited all the junior secondary schools and five primary schools for the purpose of inspecting batches of children who proposed going to the holiday camps. Each batch was inspected twice. Of 953 children finally examined, only 2 girls had to be rejected because of unclean heads, and 3 because of failure to attend final inspection. This compares with the figures for the corresponding period last year of 1,044 children examined, 4 failures because of unclean heads and 1 because of absence.

(*c*) *Junior Club Camps, 1955.*

Visits of inspection were also paid in July to some Primary Schools for those younger children who belong to the appropriate junior clubs. In all, 261 children were finally examined. All were fit to go to camp.

(*d*) *Senior Club Camps, 1955.*

Three hundred members of senior clubs were examined before going to various camps. All were fit to go to camp.

(*e*) *School Meals.*

The Director of Education has kindly supplied the following information about the School Meals Service. In all, there were 15 kitchens, including 5 nursery school kitchens. An average of 170 breakfasts were supplied each day. The price of a two-course lunch has remained at 8d. per meal during the year. Two-course lunches have been supplied daily during the year to an average of 5,760 pupils. Three-course lunches to the daily average number of 95 were supplied to pupils attending the Trades College.

(*f*) *Milk.*

The average number of bottles (one-third pint) of pasteurised milk supplied daily was 27,855.

TABLES.

The following tables are appended:—

Table I. Numbers of children examined in the several age-groups.

Table II. Return of number and percentage of individual children in each age-group suffering from particular defects.

Table III. Classification of children examined at systematic medical examinations.

Table IV. Return of all exceptional children of school age in the area.

Table V. Average heights and weights—Years 1934-55.

TABLE I.

Total number of children examined at—

(*a*) Systematic examinations—	
Ordinary schools—	
Entrants	2,949
Second age-group	2,184
Third age-group	2,372
Fourth age-group	—
Secondary Schools—Age-group	329
	7,834
(*b*) Other examinations—	
Special cases	1,279
Re-inspections by Medical Officers	6,123
	7,402

Number of individual children inspected at systematic examinations who were notified to parents as requiring treatment (excluding uncleanliness and dental caries):—

Entrants	173
Second age-group	209
Third age-group	204
Fourth age-group	—
Secondary age-group	14
	600

TABLE

SYSTEMATIC

Return of number and percentage of individual children

NATURE OF DEFECT.	Total Examined. All ages.	ENTRANTS.			
		Boys 1,527		Girls 1,422	
1. Clothing unsatisfactory	7,834	2	·1	—	—
2. Footgear unsatisfactory	,,	—	—	1	·07
3. Cleanliness—					
(a) Head: Nits	,,	1	·07	9	·6
Vermin	,,	—	—	1	·07
(b) Body: Dirty	,,	1	·07	1	·07
Vermin	,,	—	—	—	—
4. Skin—					
(a) Head:					
Ringworm	,,	—	—	—	—
Impetigo	,,	14	·9	3	·2
Other Diseases	,,	7	·5	10	·7
(b) Body:					
Ringworm	,,	—	—	—	—
Impetigo	,,	3	·2	—	—
Scabies	,,	—	—	1	·07
Other Diseases	,,	35	2·3	31	2·3
5. Nutritional state—					
Slightly defective	,,	43	2·8	65	4·6
Bad	,,	—	—	2	·1
6. Mouth and Teeth Unhealthy	,,	93	6·1	78	5·5
7. Naso-Pharynx—					
(a) Nose:					
(i) Obstruction requiring observation	,,	93	6·1	52	3·7
(ii) Obstruction requiring Operative Treatment	,,	6	·4	2	·1
(iii) Other Conditions	,,	4	·3	5	·4
(b) Throat:					
(i) Tonsils requiring observation	,,	311	20·4	323	22·7
(ii) Tonsils requiring Operative Treatment	,,	37	2·4	28	2·0
(c) Glands:					
(i) Requiring observation	,,	114	7·5	100	7·0
(ii) Requiring Operative Treatment	,,	4	·3	1	·07
8. Eyes—					
(a) External Diseases:					
Blepharitis	,,	15	1·0	20	1·4
Conjunctivitis	,,	1	·07	1	·07
Corneal Opacities	,,	—	—	—	—
Squint	,,	103	6·7	100	7·0
Other Diseases	,,	7	·5	14	1·0
(b) Visual Acuity (Snellen):					
Defective—Fair	4,885	—	—	—	—
Bad	,,	—	—	—	—
Recommended for Refraction	,,	41	2·7	38	2·7
Number wearing Glasses	7,834	44	2·9	47	3·3
9. Ears—					
(a) Diseases;					
Otorrhœa	,,	9	·6	15	1·5
Other Diseases	,,	36	2·4	30	2·1

II.

EXAMINATIONS.

in each age-group suffering from particular defects.

SECOND AGE-GROUP.				THIRD AGE-GROUP.				FOURTH AGE-GROUP.				ALL AGES.			
Boys 1,080		Girls 1,104		Boys 1,219		Girls 1,153		Boys 187		Girls 142		Boys 4,013		Girls 3,821	
—	—	1	·09	—	—	—	—	—	—	—	—	2	·05	1	·03
2	·2	1	·09	—	—	1	·09	—	—	—	—	2	·05	3	·08
1	·09	8	·7	1	08	6	·5	—	—	—	—	3	·07	23	·6
—	—	2	·2	—	—	2	·2	—	—	—	—	—	—	5	·1
—	—	—	—	—	—	—	—	—	—	—	—	1	·02	1	·03
—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
8	·7	7	·6	3	·2	3	·3	—	—	—	—	25	·6	13	·3
3	·3	7	·6	10	·8	8	·7	4	2·1	—	—	24	·6	25	·7
—	—	—	—	—	—	1	·09	—	—	1	·7	—	—	2	·05
—	—	1	·09	—	—	—	—	1	·5	—	—	4	·1	1	·03
—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	·03
26	2·4	24	2·2	22	1·8	16	1·4	4	2·1	3	2·1	87	2·2	74	1·9
13	1·2	17	1·5	11	·9	5	·4	—	—	—	—	67	1·7	87	2·3
—	—	—	—	—	—	—	—	—	—	—	—	—	—	2	·05
38	3·5	43	3·9	28	2·3	28	2·4	2	1·1	—	—	161	4·0	149	3·9
69	6·4	42	3·8	18	1·5	42	3·6	4	2·1	5	3·5	184	4·6	141	3·7
—	—	2	·2	—	—	2	·2	—	—	—	—	6	·1	6	·2
4	·4	2	·2	—	—	2	·2	—	—	—	—	8	·2	9	·2
104	9·6	124	11·2	15	1·2	110	9·5	1	·5	9	6·3	431	10·7	566	14·8
7	·6	6	·5	—	—	4	·3	—	—	1	·7	44	1·1	39	1·0
63	5·8	48	4·3	23	1·9	17	1·5	—	—	—	—	200	5·0	165	4·3
—	—	—	—	—	—	—	—	—	—	—	—	4	·1	1	·03
16	1·5	14	1·3	10	·8	31	2·7	—	—	2	1·4	41	1·0	67	1·8
—	—	—	—	1	·08	—	—	—	—	—	—	2	·05	1	·03
—	—	—	—	2	·2	—	—	—	—	—	—	2	·05	—	—
41	3·8	42	3·8	33	2·7	44	3·8	5	2·7	3	2·1	182	4·5	189	4·9
9	·8	7	·6	4	·3	10	·9	—	—	2	1·4	20	·5	33	·9
184	17·0	210	19·0	231	18·9	248	21·5	55	29·4	48	33·8	470	18·9	506	21·1
10	·9	17	1·5	13	1·1	14	1·2	—	—	3	2·1	23	·9	34	1·4
63	5·8	81	7·3	70	5·7	98	8·5	6	3·2	3	2·1	139	5·6	182	7·6
111	10·3	127	11·5	160	13·1	164	14·2	52	27·8	44	31·0	367	9·1	382	10·0
8	·7	6	·5	10	·8	18	1·6	—	—	1	·7	27	·7	40	1·0
25	2·3	22	2·0	9	·7	23	2·0	1	·5	1	·7	71	1·8	76	2·0

TABLE

SYSTEMATIC

Return of number and percentage of individual children

NATURE OF DEFECT.	Total examined. All ages.	ENTRANTS.			
		Boys 1,527		Girls 1,422	
9. Ears—(Continued)—					
(*b*) Defective Hearing :					
Grade I	4,885	—	—	—	—
Grade IIA	,,	—	—	—	—
Grade IIB	,,	—	—	—	—
Grade III	,,	—	—	—	—
10. Speech—					
Defective articulation	7,834	36	2·4	15	1·5
Stammering	,,	5	·3	2	·1
11. Mental and Nervous Conditions—					
(*a*) Backward	,,	4	·3	4	·3
(*b*) Dull	,,	—	—	—	—
(*c*) Mentally deficient (Educable)	,,	—	—	—	—
(*d*) Mentally deficient (Ineducable)	,,	—	—	—	—
(*e*) Highly nervous or unstable	,,	7	·5	13	·9
(*f*) Difficult in behaviour	,,	6	·4	6	·4
12. Circulatory System—					
(*a*) Organic heart disease :					
(i) Congenital	,,	7	·5	8	·6
(ii) Acquired	,,	—	—	1	·07
(*b*) Functional conditions	,,	2	·1	2	·1
13. Lungs—					
Chronic bronchitis	,,	5	·3	2	·1
Suspected tuberculosis	,,	8	·5	13	·9
Other diseases	,,	84	5·5	50	3·5
14. Deformities—					
(*a*) Congenital	,,	15	1·0	11	·8
(*b*) Acquired (Infantile paralysis)	,,	6	·4	2	·1
(*c*) Acquired (Probably rickets)	,,	36	2·4	31	2·3
(*d*) Acquired (Other causes)	,,	99	6·5	39	2·7
15. Infectious diseases	,,	2	·1	—	—
16. Other diseases or defects	,,	179	11·7	141	9·9
17. Classification :					
Group I	,,	498	32·6	500	35·2
Group IIA	4,885	—	—	—	—
Group IIB	7,834	27	1·8	29	2·0
Group IIc	4,885	—	—	—	—
Group III	7,834	849	55·6	723	50 8
Group IVA	,,	118	7·7	134	9·4
Group IVB	,,	35	2·3	36	2·5
Number Notified to parents	,,	95	6·2	78	5·5
Number under observation	,,	872	57·1	809	56·9
Number of Parents present	,,	1,462	95·7	1,389	97·7

II (Continued.)

EXAMINATIONS.

in each age-group suffering from particular defects.

SECOND AGE-GROUP.				THIRD AGE-GROUP.				FOURTH AGE-GROUP.				ALL AGES.			
Boys 1,080		Girls 1,104		Boys 1,219		Girls 1,153		Boys 187		Girls 142		Boys 4,013		Girls 3,821	
3	·3	—	—	5	·4	1	·09	—	—	—	—	8	·3	1	·04
—	—	—	—	1	·08	3	·3	—	—	—	—	1	·04	3	·1
—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
7	·6	3	·3	2	·2	2	·2	—	—	—	—	45	1·1	20	·5
4	·4	—	—	7	·6	2	·2	—	—	—	—	16	·4	4	·1
3	·3	—	—	—	—	—	—	—	—	—	—	7	·2	4	·1
2	·2	—	—	—	—	—	—	—	—	—	—	2	·05	—	—
—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
4	·4	13	1·2	1	·08	1	·09	—	—	—	—	12	·3	27	·7
3	·3	2	·2	1	·08	1	·09	—	—	—	—	10	·2	9	·2
3	·3	2	·2	1	·08	1	·09	1	·5	—	—	12	·3	11	·3
—	—	—	—	1	·08	4	·3	—	—	—	—	1	·02	5	·1
—	—	2	·2	5	·4	3	·3	—	—	—	—	7	·2	7	·2
—	—	1	·09	2	·2	—	—	—	—	—	—	7	·2	3	·08
7	·6	6	·5	2	·2	8	·7	—	—	2	1·4	17	·4	29	·8
34	3·1	20	1·8	14	1·1	17	1·5	2	1·1	4	2·8	134	3·3	91	2·4
6	·6	2	·2	6	·5	4	·3	1	·5	—	—	28	·7	17	·4
2	·2	1	·09	3	·2	2	·2	—	—	—	—	11	·3	5	·1
13	1·2	17	1·5	5	·4	18	1·6	—	—	—	—	54	1·3	66	1·7
37	3·4	17	1·5	12	1·0	21	1·8	2	1·1	5	3·5	150	3·7	82	2·1
—	—	—	—	—	—	—	—	—	—	—	—	2	·05	—	—
116	10·7	116	10·5	41	3·4	116	10·1	1	·5	18	12·7	337	8·4	391	10·2
442	40·9	466	42·2	756	62·0	514	44·6	111	59·4	56	39·4	1,807	45·0	1,536	40·2
102	9·4	130	11·8	215	17·6	155	13·4	52	27·8	30	21·1	369	14·8	315	13·1
14	1·3	20	1·8	17	1·4	15	1·3	1	·5	—	—	59	1·5	64	1·7
—	—	1	·09	2	·2	2	·2	1	·5	—	—	3	·1	3	·1
416	38·5	400	36·2	167	13·7	367	31·8	15	8·0	48	33·8	1,447	36·1	1,538	40·3
72	6·7	65	5·9	43	3·5	49	4·2	2	1·1	4	2·8	235	5·9	252	6·6
34	3·1	22	2·0	19	1·6	51	4·4	5	2·7	4	2·8	93	2·3	113	3·0
98	9·1	111	10·1	82	6·7	122	10·6	6	3·2	8	5·6	281	7·0	319	8·3
454	42·0	439	39·8	273	22·4	397	34·4	34	18·2	49	34·5	1,633	40·7	1,694	44·3
957	88·6	1,016	92·0	717	58·8	827	71·7	46	24·6	40	28·2	3,182	79·3	3,272	85·6

Table III.

Systematic Medical Examinations.

Classification	Entrants		Second Age-group		Third Age-group		Fourth Age-group		Total	
	No. of Children	Percentage of the Children examined in this Group	No. of Children	Percentage of the Children examined in this Group	No. of Children	Percentage of the Children examined in this Group	No. of Children	Percentage of the Children examined in this Group	No of Children	Percentage of the children examined at systematic examinations
I. Children free from defects	998	33·8	908	41·6	1,270	53·5	167	50·8	**3,343**	**42·7**
II. Children (otherwise free from defects) who suffer from—										
(*a*) Defective vision not worse than 6/12 in the better eye with or without glasses	—	—	232	10·6	370	15·6	82	24·9	**684**	**8·7**
(*b*) Oral Sepsis, etc.	56	1·9	34	1·6	32	1·3	1	0·3	**123**	**1·6**
(*c*) Both (*a*) and (*b*)	—	—	1	0·05	4	·2	1	0·3	**6**	**·06**
Total	56	1·9	267	12·2	406	17·1	84	25·5	**813**	**10·4**
III. Children suffering from ailments (other than those mentioned in II.) from which complete recovery is anticipated within a few weeks	1,572	53·3	816	37·4	534	22·5	63	19·1	**2,985**	**38·1**
IV. Children suffering from (or suspected to be suffering from) defect less remediable than defects specified in II. and III., distinguishing cases—										
(*a*) Where complete cure or restoration of function (in the case of eye defect, full correction) is considered possible	252	8·5	137	6·3	92	3·9	6	1·8	**487**	**6·2**
(*b*) Where improvement only is considered possible, *e.g.*, without complete restoration of function	71	2·4	56	2·6	70	3·0	9	2·7	**206**	**2·6**
Total	323	11·0	193	8·8	162	6·8	15	4·6	**693**	**8·8**
Total number of children examined	**2,949**	**100%**	**2,184**	**100%**	**2,372**	**100%**	**329**	**100%**	**7,834**	**100%**

Table IV.

Return of all Exceptional Children of School Age in the Area.

Disability	At Ordinary Schools	At Special Schools or Classes	At no School or Institution	Total
1. Blind	—	3	—	3
2. Partially sighted—				
(*a*) Refractive errors in which the curriculum of an ordinary school would adversely affect the eye condition	—	1	—	1
(*b*) Other conditions of the eye, *e.g.*, cataract, ulceration, &c., which render the child unable to read ordinary school books or to see well enough to be taught in an ordinary school	—	11	—	11
3. Deaf—				
Grade I	326	—	—	326
Grade IIA	43	—	—	43
Grade IIB	—	22	—	22
Grade III	—	39	—	39
4. Defective Speech—				
(*a*) Defects of articulation requiring special educational measures	668	67	—	735
(*b*) Stammering requiring special educational measures	133	11	—	144
5. Mentally defective children (between 5 and 16 years)—				
(*a*) Educable (I.Q. approx. 50-70)	—	236	—	236
(*b*) Trainable	—	67	—	67
(*c*) Ineducable	—	—	11	11
6. Epilepsy—				
(*a*) Mild and occasional	19	10	—	29
(*b*) Severe (suitable for care in a residential school)	—	—	—	—
7. Physically defective children (between 5 and 16 years)—				
(*a*) Non-pulmonary tuberculosis (excluding cervical glands)	9	6	—	15
(*b*) General orthopædic conditions	159	36	8	203
(*c*) Organic Heart Disease	110	2	2	114
(*d*) Other causes of ill-health	—	4	4	8
8. Multiple defects—				
(*a*) Mentally defective and deaf	—	22	—	22
(*b*) Physically defective and mentally defective		24	—	24
(*c*) Mentally defective (ineducable) and blind	—	1	2	3

Table V.—Heights and Weights, 1934-1955.

Boys.

Year	GROUP I.—5 Years			GROUP II.—9 Years			GROUP III.—13 Years			GROUP IV.—16 Years		
	Average Age	Average Height in Inches	Average Weight in Lbs.	Average Age	Average Height in Inches	Average Weight in Lbs	Average Age	Average Height in Inches	Average Weight in Lbs.	Average Age	Average Height in Inches	Average Weight in Lbs.
	Yrs. Mths.			Yrs. Mths.			Yrs. Mths.			Yrs. Mths.		
1934-35	5 3	41·6	40·2	9 0	49·7	58·0	...	...	...	16 1	66·4	128·7
1935-36	5 3	41·9	40·4	9 0	49·9	58·6	...	...	...	16 0	66·2	125·1
1936-37	5 3	41·8	40·4	9 0	50·0	58·8	..	...	...	16 0	65·4	126·7
1937-38	5 3	41·8	40·7	9 0	50·3	59·6	...	...	...	16 0	66·7	129·6
1938-39	5 3	42·0	41·0	9 6	51·3	60·9	13 6	58·6	90·9	16 5	67·7	135·0
1939-40	5 4	42·3	41·6	9 6	50·9	61·3	13 6	58·5	89·8	16 6	67·0	134·1
1940-41	5 3	41·9	41·3	9 4	50·7	60·8	13 5	58·4	88·2	16 4	67·1	132·0
1941-42	5 4	42·0	41·4	9 4	50·8	61·1	13 4	58·3	88·3	16 5	67·4	133·2
1942-43	5 3	42·0	41·2	9 4	50·8	60·8	13 4	58·5	88·8	16 5	67·5	134·0
1943-44	5 3	42·0	41·8	9 5	50·9	62·0	13 5	58·6	89·4	16 7	67·4	134·7
1944-45	5 3	42·2	42·0	9 4	51·0	61·8	13 4	58·4	89·4	16 4	67·5	133·5
1945-46	5 3	42·4	42·1	9 5	51·0	62·2	13 5	58·7	90·1	16 6	67·5	134·3
1946-47	5 2	42·3	41·7	9 2	51·1	62·0	13 5	58·7	90·4	16 6	67·6	130·0
1947-48	5 2	42·3	41·8	9 5	51·1	62·4	13 4	58·7	90·6	16 6	67·5	134·5
1948-49	5 3	42·4	42·4	9 5	51·3	63·3	13 5	58·8	91·4	16 6	67·7	134·3
1949-50	5 3	42·8	42·8	9 5	51·6	63·6	13 5	59·0	91·6	16 6	67·6	135·3
1950-51	5 3	42·5	42·8	9 3	51·5	63·1	13 5	59·1	92·5	16 5	67·4	133·3
1951-52	5 3	42·7	42·9	9 4	51·3	63·0	13 5	59·9	93·1	16 5	68·0	136·3
1952-53	5 3	42·5	42·4	9 4	51·6	62·9	13 7	59·3	93·3	16 5	68·3	132·3
1953-54	5 3	42·3	42·1	9 4	51·5	63·9	13 5	59·6	93·7	16 6	67·7	133·6
1954-55	5 2	42·4	42·4	9 4	51·7	64·3	13 5	59·5	94·1	16 5	67·8	138·5

TABLE V.—HEIGHTS AND WEIGHTS, 1934-1955—*continued.*

Girls.

Year	GROUP I.—5 YEARS			GROUP II.—9 YEARS			GROUP III.—13 YEARS			GROUP IV.—16 YEARS		
	Average Age	Average Height in Inches	Average Weight in Lbs.	Average Age	Average Height in Inches	Average Weight in Lbs.	Average Age	Average Height in Inches	Average Weight in Lbs.	Average Age	Average Height in Inches	Average Weight in Lbs.
	Yrs. Mths.			Yrs. Mths.			Yrs. Mths.			Yrs. Mths.		
1934-35	5 3	41·4	38·9	9 0	49·6	55·9	...		...	16 0	63·1	118·8
1935-36	5 3	41·3	38·5	9 0	49·6	55·9	..	...	...	16 0	63·6	118·8
1936-37	5 3	41·4	38·7	9 0	49·6	56·1	...	...	...	16 0	63·1	119·2
1937-38	5 3	41·7	39·1	9 0	50·1	56·8	...	...	...	16 0	63·8	120·7
1938-39	5 3	41·7	39·3	9 7	51·1	60·5	13 6	59·6	94·4	16 4	63·6	120·2
1939-40	5 4	41·9	40·0	9 6	50·4	59·3	13 5	58·9	92·7	...	...	...
1940-41	5 3	41·7	39·7	9 4	50·2	58·5	13 5	59·0	91·6	16 6	63·6	120·5
1941-42	5 3	41·6	39·8	9 4	50·3	58·6	13 4	58·8	92·0	16 5	64·0	122·3
1942-43	5 3	41·8	40·0	9 4	50·4	58·2	13 4	59·3	92·2	16 6	63·9	120·6
1943-44	5 3	41·6	39·9	9 5	50·4	59·4	13 5	59·3	93·4	16 7	64·4	124·8
1944-45	5 3	41·9	40·1	9 5	50·3	60·5	13 5	59·3	93·4	16 6	63·6	123·8
1945-46	5 3	41·7	40·3	9 6	50·6	60·4	13 5	59·4	94·9	16 6	63·1	121·7
1946-47	5 2	42·7	40·2	9 5	50·7	60·3	13 4	59·3	92·6	16 6	64·2	124·2
1947-48	5 2	42·0	41·2	9 5	50·8	60·6	13 5	59·4	94·8	16 5	63·8	123·2
1948-49	5 3	42·4	41·1	9 5	50·9	61·5	13 5	59·6	96·5	16 5	64·0	123·9
1949-50	5 3	42·1	40·7	9 5	51·0	61·3	13 6	59·6	95·9	16 6	63·9	120·9
1950-51	5 3	42·1	41·0	9 5	51·4	61·1	13 4	59·5	96·1	16 6	63·9	120·3
1951-52	5 3	42·0	40·8	9 5	51·1	61·4	13 5	59·8	97·7	16 6	63·8	123·6
1952-53	5 3	41·9	40·5	9 5	51·0	61·2	13 5	59·8	97·1	16 6	63·9	123·4
1953-54	5 3	42·0	40·8	9 4	50·8	61·5	13 5	59·7	97·0	16 6	63·8	123·2
1954-55	5 3	42·1	40·8	9 3	50·9	62·1	13 5	59·8	99·1	16 4	64·0	124·5

16.—PORT HEALTH ADMINISTRATION.

The Medical Officer of Health is also Port Medical Officer, with control of port health work and port sanitary work. The environmental and sanitary portion of this work (*e.g.*, inspection of fish, fish premises, and boats) is mainly carried out by the staff of the Sanitary Section of the Health and Welfare Department. A District Sanitary Inspector is normally employed full-time on duties in connection with fish, and another Inspector devotes part-time to assisting him. A review of the work carried out by the sanitary inspectors will be given in the Annual Report of the Chief Sanitary Inspector.

The Public Health (Ships) (Scotland) Regulations, 1952, deal with measures to be taken by masters of vessels approaching ports if there is on board a suspected case of infectious disease or if the vessel has come from an infected port, and they also deal with the action to be taken by the Port Medical Officer in such circumstances. During the year, the usual declarations of health were received, and medical examinations were conducted in all cases where they were deemed necessary. No particular difficulties were encountered, and no points call for special mention here.

17.—FOOD SUPPLY AND FOOD HYGIENE.

In the ninety-five years that have elapsed since the passing of the first Food and Drugs Act, the control of food supplies by officers of local health authorities has gradually changed its direction. Although one still occasionally hears of water being added to milk or of cream being skimmed off, the gross adulterations of the past have now become rarities. Similarly, the more obviously unhygienic conditions of food production—the rat-infested, damp, insanitary underground bakehouse, for example—have, in the main, disappeared. In the examination of food samples, the bacteriologist has already begun to play a more important part than the biochemist, and in advice on the important subject of food hygiene it has become imperative that the medical officer take an active part instead of delegating this work entirely to the sanitary inspector. Also, since the biggest numerically handler of food is the housewife, it has become obvious that the district health visitor—with her unrivalled direct access to the home and her skill in teaching—has a big part to play, perhaps the biggest part of all.

With the important exclusion of hygiene in the home, however, it is fair to say that, up to the present, much of the work—*e.g.*, in connection with milk and ice-cream—has been undertaken by members of the sanitary section. It will, therefore, be appropriate to omit further mention of these matters here and simply to indicate that the administration of the Acts, Orders, and Bye-Laws relating to milk, the details of milk samples examined during the year, and the administration of the Ice-Cream (Scotland) Regulations, 1948, will be outlined in the Annual Report of the Chief Sanitary Inspector. His report will also contain information about food premises inspected, defects found and remedied, and assessment of hygienic standards attained.

Mention may be made here of some points in connection with meat and other foods. Of the four private slaughterhouses licensed within the Burgh, two belong to the Flesher Incorporation, and all were in operation during the year, either continuously or intermittently.

The following is a summary of the animals slaughtered and the results of the inspection of the carcases:—

Class of Animal.	Total Slaughtered.	Carcases totally Condemned.	Carcases partially Condemned.	Weight (in lbs.) of Condemned Meat and Offal.
Cattle	60,635	228	334	166,511
Sheep	112,817	277	153	20,979
Pigs	8,837	101	234	29,698
Calves	1,180	99	5	5,724
	183,469	705	726	222,912

In addition, 697 lots of organs or offal were condemned, and these weighed 81,170 lbs. The total weight of condemned meat and offal thus amounted to 304,082 lbs.

During 1955, there were no prosecutions under the Slaughter of Animals (Scotland) Act, 1928. Some seventy-two licences were issued for the use of the mechanically-operated instrument for the slaughter of animals.

The routine work necessary under the various Acts and Orders relating to Diseases of Animals was duly carried out. During 1955, there was no outbreak of swine fever.

During the year, no particular food hygiene campaigns were undertaken and no special action was taken in respect of general nutrition; but all members of the staff of the Health and Welfare Department—doctors, health visitors, sanitary inspectors, &c.—continued to exercise an educative influence on the public; and, as mentioned elsewhere in this report, a decision was taken to produce a booklet on clean food. In connection with food hygiene, reference should also be made to the chapter on Health Education.

18.—SERVICES UNDER NATIONAL ASSISTANCE ACT, &c.

The services available for the aged and infirm have been considerably expanded and improved during the year, and some of the main developments may be briefly summarised: There was a large increase in the number of old people on the register maintained in the Health and Welfare Department, visitation of the elderly by health visitors continued to increase, the supply of home helps to frail elderly persons was further extended, more meals were provided by the W.V.S., the chiropody service was still expanding, and two additional homes for the aged and infirm were opened. With regard to the physically handicapped, 356 persons had been registered by the end of 1955, and a social worker and a specialist health visitor were fully occupied visiting them and dealing with measures designed to meet their needs.

General.

When the National Health Service (Scotland) Act, 1947, and the National Assistance Act, 1948, came into operation, the Corporation decided to combine the former Health Committee and Welfare Committee and to appoint the Medical Officer of Health as principal officer of a combined Health and Welfare Department. The very considerable advantages of this arrangement, which in practice works admirably, have been indicated in previous reports.

Dr. David Barclay having taken over the duties of Deputy Medical Officer of Health, Dr. James M. Wallace was appointed as Principal Assistant Medical Officer in August, 1955. Under his supervision, and in co-operation with all the other agencies involved, continued progress was made in the development of the varied health and welfare services provided by the Corporation for aged and infirm persons.

In order to achieve closer liaison between the hospital and local authority services for the elderly, it was proposed that the consultant geriatrician of the Regional Hospital Board should be offered an honorary appointment on the Corporation's Health and Welfare staff and, reciprocally, the Medical Officer of Health and the medical officer in executive charge of the Corporation's services for the elderly should be offered appropriate honorary appointments on the staff of the Regional Hospital Board. Arrangements to this end were well forward, but not complete, at the end of the year.

Provision of accommodation for elderly, &c.

Section 21 of the National Assistance Act, 1948, places on local authorities a duty to provide residential accommodation for aged and infirm persons who cannot adequately look after themselves but who do not require the skilled medical treatment or continuous nursing care available in a hospital. When the Act came into operation, the only accommodation for the aged and infirm belonging to the Corporation was at Woodend Home. This (being quite unsuitable for active persons but capable for adaptation for hospital use) was sold to the Regional Hospital Board in 1951, although one of the conditions of sale was that a portion of the accommodation would remain available for aged and infirm persons for a period of seven years.

Since 1948, the Corporation have acquired or built hostels as follows:—

(1) Balnagask House was adapted and opened (as a home for 25 persons) in December, 1950;

(2) Nos. 3-5, Ferryhill Place, were adapted and opened in November, 1951, and November, 1953, respectively, and have been converted into a single home (for 22 persons);

(3) Northfield Lodge was specifically erected and opened (as a home for 40 persons) in April, 1953;

(4) No. 30, Albyn Place was adapted and opened (as a home for 24 persons) in February, 1954;

(5) Newhills Home was purchased from the Regional Hospital Board and, after adaptation to provide residential accommodation for 46 aged and

infirm persons and 6 places for persons in urgent unforeseen need of temporary accommodation, together with a Reception Centre for females and dependants, it was opened in March, 1955;

(6) No. 19, Polmuir Road, with accommodation for 32 persons, was opened by Dr. May Baird in May, 1955, the original building having been extensively adapted to incorporate the best features of modern trends in design.

(7) Plans have now been prepared for the conversion of the former residential nursery at Thorngrove into another home, and some additional accommodation at Newhills Home will be available in the near future. A proposal to erect an eighth home at Ashgrove Road is meantime in abeyance pending review of requirements on completion of Thorngrove Home.

At the end of 1955, the accommodation already available was, therefore, 189 places, with a further 13 places in process of becoming available at Newhills.

In addition, the Corporation has entered into an agreement with the Aberdeen Old People's Welfare Council, a voluntary body which has acquired four large houses for the reception of aged persons. By this agreement, the Corporation pay for the maintenance in these homes of Aberdeen persons who are financially unable to meet the charges personally. Similar arrangements have been made with the owners of the King Street Home for Girls, St. Margaret's Hostel, and with the Church of Scotland Committee on Social Service; these bodies receive into their homes certain aged and infirm persons who require accommodation which the Corporation cannot themselves provide, and the Corporation bears such proportion of the cost of maintenance as the persons are not able to meet.

At 31st December, 1955, the number of aged and infirm in residential accommodation (whether belonging to the local authority or to voluntary organisations) in respect of whom the Corporation make a contribution towards the cost of maintenance was as follows:—

	Male.	Female.	Total.
Local Authority Homes—			
No. 30, Albyn Place	7	16	23
Balnagask House	11	13	24
Nos 3-5, Ferryhill Place	10	11	21
Newhills Home	18	27	45
Northfield Lodge	11	28	39
No. 19, Polmuir Road	6	25	31
Glenburn Wing of Woodend Hospital	29	17	46
Voluntary Homes—			
Aberdeen Old People's Welfare Council	11	14	25
Church Homes	2	4	6
King Street Home for Girls	—	1	1
St. Margaret's Hostel	—	13	13
Homes in other Areas	3	—	3
Totals	108	169	277

The main differences from the totals at the end of 1954 are:—

(1) The number accommodated in local authority homes (other than Glenburn Wing) has risen from 99 to 183;

(2) The number accommodated in the Glenburn Wing has fallen from 115 to 46.

Medical Supervision in residential accommodation.

With a view to optimal utilisation of vacancies available, all applicants for admission to residential accommodation are now interviewed, in their own homes or elsewhere, by the Principal Assistant Medical Officer who also pays periodic visits to the Corporation homes to supervise the hygienic aspects of each home and to give advice about diet, heating, ventilation, and so on. All the residents have a free choice of private doctor and receive personal medical care in the same way as do any other members of the community. This system works satisfactorily.

In 1955, as in past years, it has been necessary, owing to the deterioration in the condition of one or two residents, to have them transferred to the chronic sick wards of one of the hospitals. This has, so far, not caused any major difficulty but, if the present appreciable shortage of beds for chronic sick persists, some difficulty could arise in the future. However, it is hoped that, should any such difficulty be encountered, it could be overcome by a suitable two-way arrangement, whereby convalescent persons would be transferred from hospital to hostel and sick patients from hostel to hospital. The closer liaison envisaged with the hospital authorities should facilitate such arrangements.

Cottages for the elderly.

The Corporation erected in the Kaimhill and Northfield areas, houses consisting of one room and a bedroom annexe together with a bathroom, for elderly couples. In certain other areas, the Corporation have erected similar types of houses and these houses have now been classified as special purpose houses and are not only for elderly couples but also for certain other classes.

General Provisions for elderly persons.

To keep elderly persons fit and healthy in their own homes is a task even more important than the provision of special hostels. It may be convenient to summarise here some provisions made by the Corporation for the health and welfare of the elderly in their own homes:—

(1) Visitation of the elderly by health visitors.—These visits are already proving particularly valuable, and the unification of the Health and Welfare Department is most helpful in that the health visitor (the person on whom rests the statutory duty of advising the whole family on many health matters) can bring her expert knowledge and experience to bear on the problems of the elderly individual. The health visitor's advice on diet, clothing, proper balance on rest and exercise, and on the development of leisure interests in preparation for retirement, can be of supreme importance in maintaining the health of persons of ripe years; and, where

an old person is beginning to need assistance (*e.g.*, a home help, or the mobile service or chiropody) the health visitor can assess the need and initiate any necessary action. Again, when an old person becomes perplexed about the various possible allowances available to him, the health visitor can frequently remove his confusion.

It is interesting to note that less than one elderly citizen out of each hundred visited expresses himself as not desiring visits by health visitors. In these very exceptional cases, visiting is, of course, discontinued. At the end of 1955, 1,238 elderly citizens were receiving routine visits from health visitors.

(2) Home Help Service.—The expansion of this service is described elsewhere, but it may be noted that an appreciable and increasing proportion of the home help service is devoted to old people, usually on a basis of two or three mornings per week per person. During 1955, 582 persons over 65 years of age received such assistance.

(3) Home Nursing Service.—This is described elsewhere, but 45 per cent. of cases dealt with by the district nurses on the day service and 75 per cent. of the cases of the nurses on the night service were persons over 65 years of age.

(4) Chiropody Service.—This service, in which Aberdeen was a pioneer, is discussed in the section on care and after-care. By the aid of the chiropody service many old people who would otherwise have become housebound have been enabled to remain ambulant and capable of maintaining an independent existence.

5.—Meals-on-wheels Service.—This service is run by the W.V.S. and subsidised by the Corporation. During the year the Corporation paid £220 18s. 8d. for 6,628 meals supplied, as compared with £189 9s. 4d. for 5.684 meals in 1954. While the trend is in the right direction, it is doubtful whether voluntary effort can ever expand the number of meals provided to an extent sufficient to meet local needs; and certainly at present members of the staff of the Health and Welfare Department have to exercise great care lest they recommend so many persons for meals that the W.V.S. becomes quite overloaded.

(6) A register of elderly persons living alone and elderly couples living alone.—To facilitate co-ordination of the various statutory and voluntary services available for old persons it was decided during 1953 that a register should be compiled of all such persons brought to the notice of the department. As mentioned in the section dealing with prevention, care and after-care, by the end of 1955, the register contained about 1,350 names and had already begun to prove of great value.

The register of old people—Survey of registrations.

The information available in respect of old people on the register has been analysed, and the findings relating to registrations in 1955 (when there were 789 new cases, comprising 202 males and 587 females) make interesting comparison with those for 1953-54. A selection of the points which have emerged is given below:—

(1) Age and Sex Grouping.—There was, in 1955, a higher proportion of cases under 70 years of age, over 25 per cent. of admissions to the register being under

that age, as compared with 18 per cent. in 1953-54. There was, however, no significant change in sex distribution and the fact that females outnumbered males by nearly three to one is particularly interesting when it is remembered that, according to the 1951 census tables, the proportion of females of pensionable age to males of pensionable age is, in Scotland as a whole 1·95/1, and in Aberdeen 2·27/1.

(2) Source of Referral of Cases.—Since the inception of the register this has altered profoundly. The fact that more cases are now being referred by general practitioners (who referred 208 cases in 1955), and from other sources external to the Health and Welfare Department, indicates increasing awareness of the benefits of this service.

(3) Assessment of Needs.—Over 60 per cent. of all persons registered had their own doctor in attendance at the time of registration; the proportion requiring visitation by the health visitor has shown a marked increase to over 60 per cent. in 1955—this is perhaps an indication of better realisation of the functions of the health visitors; more than 40 per cent. of persons registered required the services of a home help; over 30 per cent. required chiropody; in nearly 20 per cent. of cases financial help from the National Assistance Board was necessary; and in about 10 per cent. of cases the district nurse was in attendance.

(4) Acceptance of Registration and of Visits.—It is interesting to note that, of the 789 persons registered and visited for the first time in 1955, only six indicated that they would prefer not to be re-visited, while 783 welcomed the visits; the figures in 1954 were very similar, five persons out of over 800 desiring not to be re-visited.

WELFARE SERVICES (Section 29).

(*a*) *Physically handicapped adults.*

The scheme for physically handicapped persons, as approved by the Secretary of State in 1953, has been in operation for two years. There are at present 319 people on the register but a total of 356 have been registered since the inception of the scheme. The reduced number is accounted for by deaths and removals to other parts of the country. It is known that there are many more disabled persons in the City who are eligible for registration. If an occupational centre, for instance, were available others would realise the obvious benefit to be derived from the scheme and would, therefore, apply for registration.

All the new applicants in 1955 have been visited and the assessment of their problems has confirmed the major unsatisfied needs of the group.

During the year most people have been visited—some more often than others. A certain number were found to have diverse social problems and as a result required frequent visiting. They have been helped materially by other public and voluntary organisations to whom they have been referred by the local authority and with whom the local authority maintains close liaison. There is a section who have not needed quite the same type of help but who have felt the benefit of an occasional visit,

At these times they have been able to discuss their difficulties and obtain advice. A third group has been visited only infrequently but they can, by being registered, be notified of any developments in the scheme which will be to their benefit.

At present on the register there are 53 practising housewives. A recent investigation was carried out to see if assistance with normal household work could be given by suggesting adaptations to household equipment, *e.g.*, specially fitted table or draining board for use by hemiplegics. It was thought that such alterations might help to counteract the effects of their disabilities. Although certain needs of this type were found to be desirable, a larger problem emerged, viz.:—a need for more suitable accommodation. For instance, 20 of these housewives are living in upper flats and have difficulty in negotiating stairs. There are also the problems of shared w.c.'s, inconvenient coal storage and lack of suitable hand rails, all of which add to the housewives' difficulties.

During the past year there has been no amelioration in the employment position for the handicapped. No new light industries have been established in Aberdeen and Remploy (the publicly owned factory for the employment of severely disabled) has been unable to expand.

In spite of the increased rates of National Insurance and National Assistance benefits which came into operation in 1955, the long term unemployed disabled have difficulty in affording anything apart from the bare necessities of life as the increases were to cover the increased cost of living. Their special problems thus remain much the same.

Although the Corporation in 1954 approved that an Occupational Centre should be set up for the handicapped, no suitable building has yet become available. The need for a centre is still pressing and is constantly borne in mind.

Agreement has been reached with the Aberdeen Asylum for the Blind for the employment of a few who are not blind. These are either severely disabled but sighted or the partially sighted. Standards have now been laid down to determine what constitutes partial sight, and a register has been compiled. These on the register may be given the opportunity of employment in the Asylum for the Blind if they are suitable and other means of employment are found impossible.

Selection of partially sighted or severely disabled sighted persons for work in the Blind Asylum must be agreed by the Blind Asylum, the Ministry of Labour, and the Local Authority. During the initial period of training, which may last any length of time up to four years, costs are borne by the Ministry of Labour. Thereafter, if training has been completed satisfactorily, the Blind Asylum becomes eligible for a grant from the Corporation who, in turn, may claim from the Ministry of Labour.

(*b*) *Blind Persons.*

A clinic for the examination and ascertainment of blind persons is held each month at Woolmanhill, and is staffed by two consultants employed by the North-Eastern Regional Hospital Board and by a health visitor employed by the Corporation.

The Corporation carry out their responsibility for the blind under the Act through the agency of the Royal Aberdeen Asylum for the Blind, who provide training and employment in their workshops in Aberdeen, and the Aberdeen Association for the Teaching of the Blind at their Homes, who employ home teachers for the training of the blind and provide certain welfare services. In addition, the Corporation utilise the services provided by certain other voluntary organisations. The following is a summary of the organisations and the payments made to them:—

Royal Aberdeen Asylum for the Blind.—For the financial year ended 31st May, 1955, the Corporation paid to the Royal Aberdeen Asylum for the Blind the sum of £132 16s. 11d. in respect of each City worker registered under the Disabled Persons (Employment) Act, 1944. There were 52 workers employed and the total cost to the Corporation was £6,867 17s. 4d., of which sum a grant at the rate of £99 12s. 8d. per annum for each worker employed for a full year was recovered from the Ministry of Labour and National Service, making the net expenditure to the Corporation, £1,726 13s. 11d.

Aberdeen Association for Teaching the Blind at their Homes.—The sum of £3 15s. per annum is paid in respect of each certified blind person from Aberdeen on their roll. In addition, a grant of £20 per annum is made to the Association in respect of home workers who are assisted financially by the Association. At the end of the last financial year there were 280 certified blind persons on the roll, including 4 home workers, and the sum of £1,130 was paid by the Corporation to the Association.

Royal Blind Asylum, Edinburgh.—Two home workers are employed in Aberdeen, but are attached to the Edinburgh Home Workers' Scheme, and grant at the rate of £30 per annum for each of them is paid to the Royal Blind Asylum, Edinburgh.

Thomas Burns Homes, Edinburgh.—Two persons belonging to the City of Aberdeen reside in the Homes and are maintained by the Corporation. The net cost of maintenance for the two inmates during the year was £150 16s.

Book Production Grant.—£72 per year.

Donation to the National Library for the Blind.—£28 per year.

The number of blind persons on the Register of the Blind as at 31st December, 1955, was 343. The numbers according to the different age-groups are as follows:—

0-2		3-4		5-15		16-17		18-29		30-39		40-49		50-69		70+		Total		
M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	T.
—	—	—	—	4	4	—	—	7	3	13	6	19	25	55	75	49	83	**147**	**196**	**343**

During 1955, 48 persons were examined for the first time, 26 at the Blind Persons' Clinic and 22 at their homes. Re-examination was made of 23 persons.

The total number of persons examined was 71 as compared with 68 in 1954.

Of the 48 persons examined for the first time, 31 (or 65 per cent.) were certified blind within the meaning of the Blind Persons Act.

The following statement gives the number of blind persons of 16 years and upwards who were in employment at 31st December, 1955:—

	Males.	Females.
(*a*) *In Institutions for the Blind*—		
Undergoing industrial training	8	3
In workshops	38	11
(*b*) *Outwith Institutions for the Blind**	11	2

*Including 6 home workers (5 males and 1 female).

(*c*) *Deaf and Dumb Persons.*

Under the National Assistance Act, 1948, the Corporation are empowered to make provision for the training of deaf and dumb persons and also for their welfare. Pending the development of a fuller scheme, a payment of £441 was made to the Aberdeen Deaf and Dumb Benevolent Society for the year 1954-55 in respect of certain welfare services provided by the society.

(*d*) *Provision of temporary accommodation for persons in urgent need.*

During the year temporary accommodation was provided for 22 persons in urgent need arising in circumstances which could not reasonably have been foreseen. In addition, enquiries were received from 274 other persons, and the services of the department were made available to them.

In January, 1955, as a result of heavy frost affecting main water pipes, flooding occurred at Castlehill Barracks, and considerable damage resulted in the homes of eight families. By arrangement with the Director of Education, temporary sleeping accommodation for 5 adults and 16 children was provided in the gymnasium at the barracks for a short period pending replacement of saturated mattresses and bedding, &c., by the National Assistance Board or from other sources.

(*e*) *Registration and Inspection of Homes for Disabled or Old People's Homes.*

Under the National Assistance Act, no persons may open a home for the disabled and old persons without the home being registered by the appropriate local authority. During the year there were no further applications for registration, and the total number of Homes registered in the City is 8.

(*f*) *Section 48—Care and protection of property of persons admitted to hospital or to local authority or voluntary hostels.*

Care, protection, and storage was provided in 274 cases, in addition to handling, at the request of patients or responsible relatives, their varied contractual obligations while they were under care. This service performs a useful function by allaying distress and anxiety which, otherwise would retard the recovery of patients. In addition, 401 Old-Age Pensions, &c., were negotiated on behalf of pensioners during hospitalisation and periods of accommodation to ensure the provision of extra comforts and to defray general personal commitments while under care or treatment.

(*g*) *Section 50—Burial or Cremation of the Dead.*

During the year, 49 persons—23 men, 23 women, and 3 children—were dealt with under this Section.

(*h*) *Reception Centre—Sections 17 (2) and 25 (1) (2), National Assistance Act, 1948.*

By arrangement between the Corporation and the National Assistance Board, a Reception Centre has hitherto been provided at the "Gate House," Woodend General Hospital, to meet the needs of persons without a settled way of living. During 1954, the male portion of the Reception Centre was transferred to a wing of the Municipal Lodging-House; and, in March, 1955, the female portion was transferred to Newhills Home.

During 1955, accommodation was provided for males on 293 occasions, for females on 167 occasions, and for dependants on 5 occasions. The total of 465 occasions represents an average usage of less than 2 persons per night. (The corresponding figures for 1954, were 3,280 occasions, and an average usage of 9 persons per night.)

It is interesting to note that the undesirable types of persons, both males and females, who formerly took advantage of the accommodation provided at the "Gate House" under the direct jurisdiction of National Assistance Board officials, do not so readily utilise the accommodation at No. 33, East North Street, and at Newhills Home.

(i) *Removal of person by Sheriff's Order.*

Occasionally, persons are in need of care and protection in their own interests or in that of others but, although not certifiable under the lunacy acts, cannot be persuaded to enter a hospital or a residential institution. For such persons, it is possible to secure compulsory removal under Section 47 of the Act. This provision is a real necessity which must be interpreted with the utmost discretion and humanity, its provisions being utilised only after all powers of peaceful persuasion have failed. Dealing with such cases entails lengthy and patient visitation by experienced officers over a period of time in an endeavour to secure the peaceful co-operation of the person in need. The success of this mode of approach will be appreciated from the fact that, in 1955, the powers of this section had to be invoked on only one occasion, and peaceful persuasion achieved the acceptance of care and supervision in 20 cases where the need was really pressing. Such a need occurs not infrequently in cases of persons advanced in years and living alone, whose normal instincts for cleanliness, respectability, and order have become dulled by senility and advancing physical frailty.

19.—WORK UNDER NURSING HOMES REGISTRATION ACT.

No applications were received during the year.

20.—GENERAL SANITATION.

Such matters as water supplies, sewage, sewage disposal, nuisances, and offensive trades will be discussed in the annual report of the Chief Sanitary Inspector, but two points may be selected for mention here.

Water Supplies.

There is an ample supply of water for the City of Aberdeen, obtained from the upper reaches of the River Dee. The supply was sufficient to make alarm unnecessary even during the exceptionally dry summer of 1955. The water is filtered and chlorinated. Samples of water are taken regularly from the Dee at Braemar, from intake at Cairnton, from filters at Invercannie, and from taps in the City. These samples are tested bacteriologically and biochemically. The results from all samples taken during the year were satisfactory.

River Pollution.

Pollution of the River Don from outside the City still causes anxiety, and has been the subject of special reports. The degree of pollution is such as to be highly objectionable, but it seems probable that no adequate remedial measures will be undertaken until the matter is tackled by the Rivers Pollution Board.

21.—STAFF AT 31st DECEMBER, 1955.

Medical Officer of Health	Ian A. G. MacQueen, M.A., M.D., D.P.H.
Depute Medical Officer of Health	David Barclay, M.B., Ch.B., D.P.H.
Principal Assistant Medical Officer	James M. Wallace, B.Sc., M.B., Ch.B., D.P.H., D.I.H.
Senior Assistant Medical Officer	Dorothy Younie, M.D., D.T.M. & H.
Assistant Medical Officer (Schools)	Henry J. Dawson, M.A., M.B., Ch.B., D.P.H.
Departmental Medical Officers	Mary Hunter, M.B., Ch.B., D.P.H. Elizabeth C. Laing, M.D., D.P.H. Mary Macdonald, M.B., Ch.B., D.P.H. Margaret Ormiston, M.B., Ch.B., D.P.H. Jean Pattullo, M.B., Ch.B., D.P.H. Marie S. Sutherland, M.B., Ch.B., D.P.H. Doreen G. Warnock, M.B., Ch.B., D.P.H., D.R.C.O.G. Douglas M. Williamson, M.B., Ch.B. Margaret S. M. M'Gregor, M.D., D.P.H. (part-time). One vacancy.
Chief Dental Officer	Archibald Hay, L.D.S.
Senior Dental Officer	Vacant.
Assistant Dental Officers	Hugh Clunas, L.D.S. Ian Lawrence, L.D.S. Mary K. Shepherd, L.D.S. (part-time). Two vacancies.
Public Analyst	Thomas M. Clark, O.B.E., B.Sc., F.R.I.C.
Lay Administrative Officer	Colin C. Grainger.
Statistician (part-time)	Doris M. Brebner, M.A., Dip.Ed.
Superintending Nursing Officer and Supervisor of Midwives	Jane A. Stark, S.R.N., S.C.M., Health Visitor's Certificate.
Assistant Superintending Nursing Officer	Lisetta J. Stephen, S.R.N., S.C.M., Health Visitor's Certificate.
Health Visitors	85 (including 25 vacancies).
Midwives	10 (including 1 vacancy).
Principal Health Visitor Tutor	D. Joan Lamont, S.R.N., S.C.M., Health Visitor's Certificate, Health Visitor Tutor's Certificate.
Assistant Health Visitor Tutor	M. Monica Byrne, S.R.N., Part I, C.M.B., Health Visitor's Certificate, Health Visitor Tutor's Certificate.

Student Health Visitors . . . 21.

Social Worker (part-time) . . . Margaret Bell, B.A. (Admin.).

Supervisor of Nurseries . . . . Elizabeth C. Jackson, S.R.N., S.C.M., Health Visitor's Certificate.

Nurseries—

(*a*) RESIDENTIAL—

Pitfodels . . Matron—Anne Adam, S.R.N., S.C.M., Health Visitor's Certificate, 2 Deputy Matrons, 6 Staff Nurses, 10 Certificated Nursery Nurses, 1 Enrolled Assistant Nurse, 9 Nursery Assistants, 15 Probationer Student Nurses.

(*b*) DAY—

Charlotte Street . Matron—Penelope Sandison, R.G.N., 1 Deputy Matron, 3 Certificated Nursery Nurses, 1 Enrolled Assistant Nurse, 3 Nursery Assistants, 9 Student Nurses.

Linksfield . . Matron—Catherine Bruce, S.R.N., S.C.M., 1 Deputy Matron, 1 Staff Nurse, 1 Certificated Nursery Nurse, 1 Enrolled Assistant Nurse, 1 Nursery Assistant.

Deeside . . . Matron—Grace Florence, S.R.N., R.S.C.N., S.C.M., 1 Deputy Matron, 3 Certificated Nursery Nurses, 1 Enrolled Assistant Nurse, 9 Student Nurses, 1 Probationer Student Nurse.

View Terrace . . Matron—Christina Milne, S.R.N., 1 Deputy Matron, 1 Staff Nurse, 3 Certificated Nursery Nurses, 8 Student Nurses, 2 Probationer Student Nurses.

Old People's Homes—

BALNAGASK—

Superintendent and Matron . . Mr. and Mrs. F. W. Gibson.

NOS. 3 AND 5, FERRYHILL PLACE—

Matron . . . . . Annabella M'Millan.

NORTHFIELD LODGE—

Matron . . . . . Elsie M. Cameron.

No. 30, ALBYN PLACE—

Superintendent and Matron . . Mr. and Mrs. John Wilson.

Newhills Home—

Superintendent and Matron . . . Mr. and Mrs. D. Adam.

No. 19, Polmuir Road—

Superintendent and Matron . . Mr. and Mrs. H. T. Wallace.

Sanitary Section—

Chief Sanitary Inspector	Herbert B. Parry, Sanitary Inspector's Certificate, Meat Certificate.
Senior Assistant Sanitary Inspector	William Jackson, Sanitary Inspector's Certificate, Meat Certificate.
Fish Inspector	Sydney Howell, Sanitary Inspector's Certificate, Meat Certificate.
District Sanitary Inspectors	5.
Assistant District Sanitary Inspectors	8 (including 3 vacancies).
Apprentice Sanitary Inspectors	3.
Probationer Sanitary Inspector	1.
Shops Act Inspectors	2.
Senior Detention Officer	William M'Donald, Meat Inspector's Certificate.
Senior Assistant Detention Officer	William Lorimer, Meat Inspector's Certificate.
Detention Officers	4.

Welfare Section—

Senior Assistant Welfare Officer	James D. Davidson.
District Welfare Officers	3.

Clerical—

Senior Clerical Staff	A. M. Ledingham, Secretary to Medical Officer of Health; V. Anderson; M. M. Barry; A. G. Gall; C. P. Gibson; A. E. Munro; M. C. Veitch; M. A. Wilson.
Other Clerical Staff	General, 14; Clinics, 2; Dental Clinic, 2; Sanitary, 3; Welfare, 2.

Miscellaneous—

Audiometrician	Eileen N. F. Dowden.
Orthoptist	Moira Anderson.
Chiropodist	Vacant.
Assistant Nurses	2.
Dental Attendants	4 (including 1 vacancy).
Male Visitor, School Health Service	1.
Domestic Helps	Full-time, 51; Part-time, 135.
Drivers and Porters	3.
Rat-catchers	5.

Lodging House—

Superintendent and Matron	Mr. and Mrs. C. Greig.